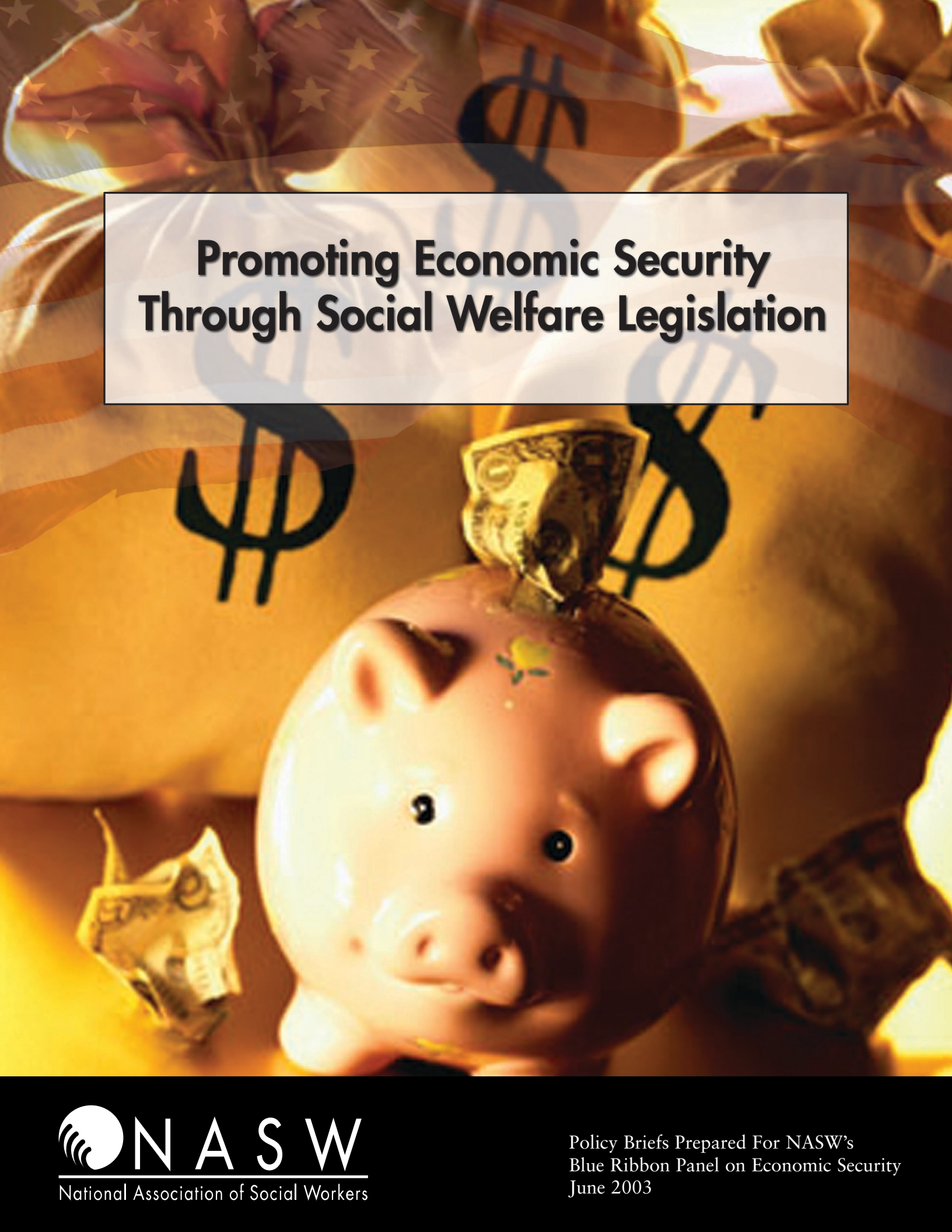


The background of the entire page is a warm-toned photograph. In the center is a pink piggy bank. Two US dollar bills are stuck into its ears, and another is partially visible near its tail. The background is filled with large, semi-transparent dollar signs and a faint American flag pattern.

Promoting Economic Security Through Social Welfare Legislation

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NASW Blue Ribbon Panel on Economic Security Purpose Statement:

“NASW seeks to be a visible leader in Washington, and among the states, in obtaining welfare reform legislation and policies that adhere to social work values; support the principles of economic justice, security, and self-sufficiency; and are based on sound knowledge.”

Members include:

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National Association of Social Workers

June 2003

Dear Colleagues:

The social work profession is in a unique position to champion a movement that reduces poverty and promotes economic security for all Americans—one that goes beyond the current debate for welfare reform and advances well-documented programs that promote economic self-sufficiency across the life span.

There is a critical difference between today and the 1960s, when the National Association of Social Workers (NASW) first established a priority to end poverty. We now have the facts that allow us to do more than just offer the ideological argument that it is morally wrong for the richest country in the world to allow millions of Americans to struggle in times of need.

Researchers from social work and other disciplines have demonstrated what it takes to get people out of poverty and to keep people from falling into it. We know that it takes a combination of education, support, resources, and opportunity. We know that it also takes a well-structured service-delivery system guided by committed and competent professionals.

Social workers care deeply about this issue because it is consonant with social work values — including the promotion of social and economic justice — and our mission to help people take full advantage of their potential. We also understand that, if we want to help create healthy people and healthy communities, basic human needs must first be met.

Our values of self-determination and informed choice impel us to support options for clients that include a range of educational benefits, meaningful job advancement, child care coverage, medical insurance, asset building, and the domestic arrangements necessary for self-sufficiency. They also propel us to oppose narrow, ideologically based government mandates, restrictions, and coercive policies, and to continue using facts to dispel the age-old myths about who is on welfare, and why. In addition, social work is the profession that can best reclaim and reshape a professionalized public support system that brings out the best in workers and the clients, not the worst.

Early in 2002, I established the National Association of Social Workers Blue Ribbon Panel on Economic Security to bring visibility to the Association's advocacy activities related to the congressional reauthorization of the Temporary Assistance to Needy Families (TANF) legislation. To be most effective in our current campaign to shape the reauthorization of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (Public Law 104-193), which includes TANF, we need our legislative, policy, practice, and research arms to work in concert.

Although the reauthorization of TANF is still pending in the first session of the 108th Congress, the Blue Ribbon Panel used the transition from the previous to the current Congress to develop brief policy statements covering the most critical components of a comprehensive safety net. This document contains nine policy briefs that will be available online for social work professionals and students, multiple partner organizations and media representatives. The Blue Ribbon Panel used the transition from the previous to the current Congress to develop brief policy statements covering the most critical components of a comprehensive safety net. We excluded a discussion about the private pension system because it was beyond the scope of this project. Our completed document contains nine policy briefs, which will be shared online with social work professionals and students, multiple partner organizations, and media representatives.

We hope this report will be useful in future advocacy efforts at the national, state, and local levels. As NASW continues to promote economic justice for all, we look forward to your continued support and advocacy on these issues in your communities and areas of practice.

Sincerely,

Terry Mizrahi, PhD, MSW
President, National Association of Social Workers

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MEDICARE

Program Description

Medicare was created with the passage of the Social Security Act Amendments of 1965. The program was intended to increase access to medical care and reduce the financial burden of medical care for elderly people. Today, Medicare covers 95 percent of the nation's population aged 65 and over, as well as many people receiving Social Security benefits because of disability. Medicare is the largest public payer for health care, financing 17 percent of all health spending in 2000. Total disbursements for Medicare in 2003 are estimated to be \$255 billion.

Medicare has three parts: 1) Hospital insurance, known as Part A; 2) supplementary medical insurance, known as Part B; 3) and Part C, the Medicare + Choice program, which began providing Medicare services through private health plans in 1998. (Beneficiaries are required to have Parts A and B in order to enroll in Medicare Part C.) In 2002, about 40 million people were enrolled in Parts A and B (one or both) of the Medicare program, and 5.2 million of them had chosen to participate in a Medicare + Choice plan.

Medicare Part A automatically provides those eligible for Medicare with substantial coverage for the costs of medically necessary hospital care. It also provides more limited coverage for skilled nursing facility care, home health services, and hospice services. Medicare Part A benefits cover approximately 40 million people. However, in any given year, only about one-fifth of Part A beneficiaries require the services it covers.

Medicare Part B helps to defray the costs of medically necessary physician's care, as well as the costs of certain other services, such as emergency and outpatient hospital services; physical, occupational, and speech therapy; laboratory tests; clinical social work services; clinical psychologist services; medical equipment; most supplies; diagnostic tests; ambulance services; and some other preventive, health, and therapeutic services. Part B also pays for some home health care services for which Part A does not pay. Medicare Part B pays 80 percent of approved charges for most covered services. The beneficiary is responsible for paying a \$100 deductible per calendar year, as well as the remaining 20 percent of the Medicare-approved charge.

Medicare Part B is available to almost all U.S. citizens over 65 years, as well as to disabled beneficiaries eligible for Part A. Part B coverage is optional, and requires a monthly premium. Almost everyone who is eligible enrolls in Part B because the premium is generously subsidized and, in many states, premiums are paid on behalf of low-income elderly and disabled people. In any given year, most Part B beneficiaries receive at least some covered services.

Medicare Part C (known as *Medicare + Choice*) enables beneficiaries enrolled in Medicare Parts A and B to choose to receive their Medicare benefits through a wide variety of health plans. Depending on the options available in a beneficiary's community, these may include Medicare managed care plans, private fee-for-service plans, Medicare medical savings account plans, or religious fraternal benefit society plans. These plans provide services covered by Parts A and B, and many offer additional benefits (such as preventive care, prescription drugs, dental care, hearing aids, or eyeglasses) not covered by traditional Medicare

Current Policy Challenges

In his January 2003 State of the Union address, President Bush announced intentions to reform the Medicare program. The debate over his reform proposal, and various counterproposals, is presently underway.

Two issues are providing the impetus for current proposals for Medicare reform. The first is concern about the long-term fiscal solvency of the Medicare program. Health care costs are rising and the baby boom generation is aging. The number of people on Medicare is expected to double by 2030 and some policy analysts argue that the program cannot be sustained with its current means of financing. Others argue that concerns about long-term fiscal solvency are without basis.

The second is a more immediate concern about Medicare's lack of prescription drug coverage—viewed by many as the program's most substantial inadequacy. Although some of the elderly retain prescription drug coverage through their retiree health plans, and others have purchased supplemental insurance that includes a prescription drug benefit, 24 percent of Medicare enrollees have no prescription drug coverage. Many more are burdened by the need to pay for all or part of the high, and ever rising, cost of prescription drugs.

Proposals to address Medicare's long-term fiscal solvency take several forms. Some would change the distribution of financial risks, perhaps through the use of vouchers or by requiring enrollment in managed care. Some would reduce coverage of services, possibly by making Medicare the payer of last resort, substantially increasing premiums, or by taxing the value of Medicare benefits. Finally, some would limit eligibility, by increasing the age of eligibility or by making eligibility subject to a means test.

Proposals to enhance Medicare's coverage of prescription drugs also take several forms. Coverage of prescriptions could be made an optional part of the standard benefit package; the Medicare program could be restructured into health plans (both managed care and fee for service), with government subsidizing the costs of plan premiums and

plans competing on the basis of price and quality; or benefits could be provided by subsidizing the purchase of private supplemental drug coverage.

Suggested Policy Directions

Proposals for Medicare reform—including the President’s March 2003 Medicare “modernization” proposal—tend to be complex. Some attempt to place Medicare’s financing on more solid footing—with or without the addition of prescription drug coverage. Others attempt only to expand Medicare’s coverage for prescription drugs.

NASW has proposed principles against which Medicare reform proposals should be judged. The association argues that reform should:

- Preserve a place for fee-for-service Medicare;
- Ensure the provision of a defined uniform benefit package for all beneficiaries;
- Include a comprehensive, affordable, and voluntary prescription benefit plan for all beneficiaries;
- Guarantee that beneficiaries receive necessary and appropriate care across the entire health care continuum, including social work services; and
- Assure federal consumer protections, including internal review and a fair and independent external appeals process.

We propose that these principles be used to evaluate the various competing Medicare reform proposals, and to advocate for the preservation of the program’s integrity, financial stability, and fundamental status as an entitlement program.

For Further Reading

Poisa, J.A., & Chulis, G.S. (2000). Medicare beneficiaries and drug coverage. *Health Affairs*, 19 (March/April): 250.

Potetz, L., & Rice, T. (2002, June). *Medicare tomorrow: The report of the Century Foundation Task Force on Medicare reform*. New York: The Century Foundation Press.

This policy brief was prepared by Janet D. Perloff, PhD, MSW, for NASW’s Blue Ribbon Panel on Economic Security.

MEDICAID

Program Description

Medicaid was created as part of the Social Security Act Amendments of 1965. The program covered close to 41 million people in 1998. Approximately 51 percent of Medicaid recipients are low-income children, 21 percent are low-income adults, 18 percent are low-income disabled people, and 11 percent are low-income elderly people. Total disbursements for Medicaid in 1998 were \$175 billion.

Medicaid makes federal matching payments available to states to help cover the costs of delivering services to eligible individuals. Federal law outlines broad guidelines for Medicaid and, within these guidelines, each state administers its own program and establishes its own eligibility standards, covered services, and provider payment rates. As a result, Medicaid varies widely from state to state.

In order to receive federal Medicaid matching payments, states must cover certain categories of low-income individuals. They also have the option of covering other categories of people, but vary considerably in the extent to which they do so. One group that can be covered at state option is the “medically needy,” people who qualify for Medicaid by “spending down”—that is, by incurring medical expenses that reduce their income to or below a medically needy protected-income level set by the state. The medically needy provisions of Medicaid offer protection against impoverishment for elderly people, the chronically ill, and other low-income people who incur high medical expenses.

State Medicaid programs provide coverage that extends well beyond the services covered either by Medicare or by most employer-sponsored health insurance plans. Services states are required to cover include inpatient and outpatient services; physician services; prenatal care; vaccines for children; nursing facility services for people 21 years of age or older; home health care for people eligible for skilled nursing care; and laboratory and x-ray services. In addition to the mandatory services, states have the option of covering approximately 34 other services. In 1998, nearly 54 percent of Medicaid recipients, mostly children and non-disabled adults, were enrolled in some type of managed care plan.

Medicaid is financed through federal and state general tax revenues. On average, the federal government pays 57 percent of the program’s costs. The size of the federal government’s contribution to a state’s Medicaid program can vary from 50 to 83 percent, and is determined by a formula that compares the state’s per-capita income level with the national average. States with a higher per-capita income level are reimbursed a smaller share of their Medicaid costs.

Although adults and children in low-income families comprise nearly 70 percent of Medicaid-eligible people, their medical care accounts for less than 30 percent of program expenditures. Elderly, blind, or disabled recipients, who comprise only about 29 percent of eligible recipients, account for 75 percent of the program’s expenditures because of their greater reliance on acute and long-term care services. Indeed, Medicaid is the nation’s major payer for long-term care services; in recent years, the program has paid for almost 46 percent of the total cost of care for people using nursing facility or home health services. Medicaid also is the largest single payer for services for people with AIDS.

Current Policy Challenges

Although Medicaid is credited with ensuring access to care and improving the health of many low-income Americans, the program is often criticized. Concerns are frequently raised about whether or not the program is adequately managed, services are sufficiently accessible, and services are of sufficient quality. The most frequent criticism of Medicaid, though, is that it is costly, and that because it is an open-ended entitlement program, its costs are inherently uncontrollable. This concern has long plagued both of the major partners in financing Medicaid: the federal and state governments.

Today, Medicaid’s accomplishments are seriously threatened by state fiscal crises. Shortfalls in states’ revenue have led to the most severe budgetary shortfalls many have faced in 50 years. Since most states are obligated to balance their budgets, and few states have moved to increase tax revenues, cuts in state spending will be needed. Medicaid is the second largest item in most state budgets (exceeded only by expenditures for elementary and secondary education), and stands out as a prominent place to make cuts. To date, cuts have mainly reduced provider reimbursement rates, but most analysts note that, without some fiscal relief, state cuts in eligibility and covered services will be hard to avoid in the next few years.

Various proposals have been made to relieve current pressures on state Medicaid programs. The Bush Administration proposes to give short-term fiscal relief to state Medicaid programs that agree to accept a Medicaid-SCHIP block grant. Under the block grant, states would have to preserve many of the federally mandated eligibility and benefit provisions, but they also would gain the freedom to change most any other aspect of Medicaid—without federal approval being required to do so. Various Congressional proposals would stop far short of the very fundamental restructuring of Medicaid that is likely to occur with state Medicaid-SCHIP block grants. Rather, these proposals would provide short-term fiscal relief to all states in the form of temporarily increasing the federal share of Medicaid costs.

Suggested Policy Directions

With Medicaid quickly approaching the chopping block, there is much for the social work profession to do to preserve the integrity of this historic social program:

Support proposals for genuine Medicaid fiscal relief. Several such proposals would temporarily raise Medicaid's federal matching assistance percentage (FMAP) as a means of helping state through their fiscal crises, without making substantial cuts in their Medicaid programs.

Protect the open-ended entitlement features of Medicaid, as a program serving the nation's poor, elderly, and disabled. Block grant programs would cap federal Medicaid contributions; the resulting fiscal pressures would no doubt force states to rescind the open-ended entitlement feature of Medicaid.

Protect the gains Medicaid has made in reducing the number of uninsured Americans, and support proposals that would use Medicaid as a platform from which to launch efforts to further reduce the number of uninsured adults and families. Current state fiscal crises threaten to erode Medicaid eligibility policy. Medicaid block grants also would likely lead to eligibility cuts. Advocacy on the part of social workers and the public will be necessary to protect Medicaid for many low income and vulnerable Americans who use Medicaid as a tool to help reduce the numbers of uninsured Americans and expand the comprehensiveness of Medicaid's covered services.

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Weil A. (2003). There's something about Medicaid. *Health Affairs*, 22(1): 13-30.

This policy brief was prepared by Janet D. Perloff, PhD, MSW, for NASW's Blue Ribbon Panel on Economic Security. Information was drawn from Perloff (cited above); The Center for Medicare and Medicaid Services web-based Medicaid Chartbook located at <http://cms.hhs.gov/charts/medicaid/2tchartbk.pdf>; Families USA. Preliminary Analysis of New Bush Proposal to Block Grant Medicaid. http://www.familiesusa.org/site/DocServer/IB_analysis_of_bush_block_grant.pdf?docID=326; Ku, L., Nathanson, M., Park, E., Cox, L. and Broaddus, M. Proposed State Medicaid Cuts Would Jeopardize Health Insurance for One Million People. <http://www.cbpp.org/12-23-02health.htm>

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

Program Description

The State Children's Health Insurance Program (SCHIP), Title XXI of the Social Security Act, was passed in 1997 as part of the Balanced Budget Act of 1997. SCHIP is the largest single expansion of health insurance coverage for children since Medicaid was enacted in 1965. The goal of the legislation is to expand rates of health insurance coverage among children whose families earn too much for Medicaid, but too little to afford private health insurance coverage. SCHIP enables states to provide coverage to uninsured children living at up to 200 percent of the federal poverty level, or up to 50 percentage points above the states' Medicaid eligibility level for children.

SCHIP establishes a block grant to states, with an allotment of funds that is distributed annually to each state, based on a formula targeting more funds to states with higher numbers of uninsured and low-income children. SCHIP provided the states with \$40 billion over the program's first 10 years (with \$20 billion available in the program's first five years), and states are given three years to spend each year's allotment. Under this block grant, state spending on SCHIP is matched (up to the amount of the state's SCHIP allotment) at a rate that is 30 percent higher than the rate currently available to states under Medicaid.

In addition to state funding and federal matching payments, states are allowed to make limited use of premiums, deductibles, co-payments, or other fees for some services and for some groups of eligible children.

SCHIP allows states to expand Medicaid, to create or expand a state program, or a combination of both. This choice is important because it affects a state's liability for spending on SCHIP once the federal allotment is exhausted. States using SCHIP to expand Medicaid are extending the Medicaid entitlement to additional children; if SCHIP funds are exhausted, these states will bear the costs of SCHIP under the existing Medicaid program (and at Medicaid's lower federal matching rate). States with separate programs can simply discontinue enrollment. This choice also affects the benefit package available through SCHIP. States expanding Medicaid must offer the same benefits available under Medicaid. States creating a separate program must provide a benefit package similar to that offered to federal or state employees.

All states now have approved SCHIP programs and about 5.3 million children were enrolled in SCHIP at some point during FY 2002. Most states use a Medicaid expansion as part of their SCHIP program, either alone or in combination with a separate program. It should also be noted, however, that two-thirds of all SCHIP children are

insured through a separate program which is not required to be as universal as Medicaid, and which is subject to a greater degree of state policy making discretion than is the case under Medicaid.

Current Policy Challenges

Most analysts agree that SCHIP has been quite successful. As a result of SCHIP's expanded eligibility provisions—and state efforts to streamline SCHIP and Medicaid enrollment and reach out to potentially eligible families—the proportion of low-income children who were uninsured dropped from 20.1 percent in 1997 to 16.1 percent in 2001.

Three problems persist. First, one-quarter of all children in families with incomes below 100 percent of the poverty line remain uninsured—a number which does not seem to be dropping. The reasons for this are, no doubt, complex. Despite efforts to simplify Medicaid/SCHIP enrollment, as well as the implementation of advertising campaigns, toll-free telephone numbers, and outreach through schools, employers, and social service agencies, some parents do not know their children are eligible for Medicaid and/or SCHIP. Other parents may not feel health insurance coverage is needed, may wish to avoid contact with the public agencies administering these programs (particularly parents who are immigrants), or may find enrollment processes too burdensome.

Second, although SCHIP has the potential to largely equalize the rates of uninsured children across the nation, rates of SCHIP participation continue to vary considerably from state-to-state. Many aspects of states' implementation of SCHIP vary widely, resulting in variations in the number of children who remain uninsured.

Third, despite concerted federal and state efforts to stop employers from dropping dependent coverage and, in effect, shifting children of employees onto SCHIP, rates of private insurance among children have been declining, especially in states with more generous SCHIP eligibility levels. The net gains attributable to SCHIP have been somewhat limited by this so-called "crowding out" of private insurance by the availability of a public program.

Given the budgetary pressures many states presently face, progress on reducing the numbers of uninsured children through SCHIP may begin to slow. For example, some states have already delayed planned expansions of their SCHIP programs, especially those expansions that would have led to the provision of insurance coverage for parents of SCHIP-eligible children. At the same time, the enhanced federal matching payments available for SCHIP offer states a strong incentive to continue to invest in the program. It is not clear which of these countervailing pressures will win out in the coming years.

Suggested Policy Directions

The social work profession has a key role to play in helping preserve the gains made by SCHIP and enabling more children, especially our nation's poorest children, to obtain health insurance through Medicaid/SCHIP.

Support proposals that would give states additional time to spend SCHIP allotments before unspent funds revert back to the U.S. treasury. Under current law, states have three years to spend each year's funds. Some states have been slow to ramp up their SCHIP programs, however, and these states should be granted additional time to allow their programs to reach full potential.

Support proposals that would allow unspent SCHIP funds to be re-allocated to other states. Some states simply cannot expand eligibility enough to spend their full SCHIP allotments. Under current law, such unspent funds revert to the U.S. treasury, but they could just as easily be re-allocated to enable other states to do more to reduce the rates of uninsured children.

Work closely with state agencies to find ways to improve children's participation in Medicaid and SCHIP.

Enrollment/re-enrollment processes may need to be further streamlined, and a variety of other steps may need to be taken, to better understand—and to lower—barriers to coverage.

For Further Reading:

Dubay, L., Hill, I., & Kenney, G. (2002). Five things everyone should know about SCHIP. [Online]
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This policy brief was prepared by Janet D. Perloff, PhD, MSW, for NASW's Blue Ribbon Panel on Economic Security. Information for this brief was drawn from Cunningham, P., Reschovsky, J. and Hadley, J. (2002). SCHIP, Medicaid Expansions Lead to Shifts in Children's Coverage." <http://www.kschange.org/CONTENT/508/?topic=topic17>; HHS Fact Sheet. (2001). "State Children's Health Insurance Program (SCHIP)" <http://www.fns.usda.gov/end/SCHIP/SCHIP.background.htm>; Oliver, L. (2003). "Insuring Kids in Hard Times." <http://www.ncsl.org/programs/health/303schip.htm>.

SOCIAL SECURITY

Program Description

Old Age, Survivors, and Disability Insurance (OASDI), the nation's major social insurance program—and the world's largest social welfare program—provides monthly cash benefits to eligible beneficiaries to partially replace a worker's income if he or she is unable to earn an income due to retirement, disability, or death. (An additional program, Medicare, is also part of this social insurance package and is discussed separately.) OASDI now covers approximately 96 percent of the workforce. In 2002, 46.4 million people, or one out of every six Americans, received social security benefits from these three programs, with benefits totaling \$478 billion.

OASDI is administered by the Social Security Administration, an independent agency known for its administrative efficiency. (Administrative costs for the program represent one percent of benefits.) OASDI is primarily a pay-as-you-go system: The contributions of today's workers provide the revenue to support today's beneficiaries. The program is financed through a payroll tax (Federal Insurance Contribution Act [FICA]), with the worker and the employer each contributing 6.2 percent of the worker's earnings up to a maximum amount, which is \$87,000 in 2003. Individuals who are self-employed pay the entire contribution of 12.4 percent.

The social security tax is viewed as a regressive tax, because low-wage earners pay a higher percentage of their total earning to FICA than do high-wage earners. Additionally, only wages, not all income, are taxed. However, this regressive aspect of funding the program is offset when workers draw benefits from the programs. Benefits provide proportionately more generous benefits to lower-wage earners. Additionally, social security benefits are taxable for those with higher incomes.

Workers (or their families) are eligible for benefits if they have contributed to the program for a specified number of quarters, and meet the other program requirements for being retired, disabled, or survivors of qualified workers. Benefit amounts are based on a worker's average earnings and are adjusted annually based on the cost of living.

Although all three programs share the above characteristics, each program has its own requirements for eligibility and specific formulas for determining benefit amounts. The largest and most frequently discussed program is Old Age Insurance, which is described below. However, in examining U.S. social insurance programs, both Disability Insurance and Survivors' Insurance are often overlooked, even though they provide critical benefits to millions of Americans. Together, these two programs account for more than one-third of all social security beneficiaries.

Survivors' Insurance, which was added to the Social Security Act in 1939, provides benefits to survivors of deceased workers and retirees. Survivors include a widowed spouse age 60 or over, a widowed spouse under 60 with dependent children, elderly parents, dependent children, and disabled adult children. Survivors are eligible for benefits as long their family member worked at least one-fourth of the time since age 21. Overall, survivors represent 15 percent of all social security beneficiaries. In 2002, the program supported approximately 6.8 million beneficiaries, including 1.9 million dependent children under age 18. For these surviving individuals and families, social security is an important source of income. Monthly benefits, averaging \$768 a month in 2002, are provided to survivors of deceased workers. The monthly benefit for children averages \$574.

Disability Insurance, which was added to the Social Security Act in 1956, provides benefits to workers who become totally and permanently disabled; support for their dependents was added in 1958. To be covered by disability insurance, an individual must have worked at least one-fourth of the time since age 21 and be unable to work due to severe illness or impairment that is expected to last for at least 12 months, or to result in death. Currently, disabled workers and their families represent approximately 18 percent of all social security beneficiaries. In 2002, about 5.5 million disabled workers and 1.5 million dependent children receive social security disability insurance benefits. The average monthly benefit for a disabled worker in 2003 is \$834 dollars. The monthly benefit for spouses is \$212; and, for children, \$245. Beneficiaries of disability insurance may receive Medicare after 29 months from the onset of their disability.

Old Age Insurance, commonly referred to as "Social Security," is the nation's largest social insurance program, providing benefits to 29.2 million retired workers, as well as an additional 2.6 million spouses and 210,000 dependent children of retirees. In general, retirees are eligible for full social security benefits if they have worked in covered employment for 10 years and are age 65. The age for full retirement benefits is increasing incrementally to age 67. Workers may retire as early as age 62, but receive reduced monthly benefits. Workers retiring later (age 70) receive larger monthly benefits compared to those retiring at standard retirement age. In 2002, retired workers' monthly benefits averaged \$874; spouses', \$457; and dependent children's, \$397.

Benefits levels vary, however, by an individual's previous average earnings. Low-wage workers received \$682; average-wage earners, \$1,127; and high-wage earners, \$1,467. The maximum social security benefit was \$1660. The formula for determining social security benefits is deliberately skewed to provide proportionately more to low-wage earners. For a person with average earnings who

retired in 2000, social security replaces about 41 percent of prior earnings. For the low-wage earners, the replacement rate is 55 percent; and, for high-wage earners, 25 percent.

The architects of social security envisioned the program as representing one leg of a three-legged stool, with social security benefits supplementing retirees' savings and pensions. However, for 30 percent of the retired beneficiaries, Social Security benefits represent 90 percent of their income. Another 36 percent rely on the program for at least half of their income. Social security may be viewed as the nation's most effective poverty program—without social security, more than one-half of all retired Americans would live in poverty.

Sustaining Social Security

The major issue facing Social Security is its long-term sustainability. Contrary to popular perception, however, there is no immediate fiscal crisis. Social Security is financed by contributions from today's workers and their employers; these contributions currently exceed the outlay in benefits. For 2003, this surplus is projected to be \$165 billion, which is invested in interest-bearing U.S. government securities. By the end of 2003, the overall investment, or the trust fund reserves for Social Security, will be \$1,543 billion.

However, projections based on the current tax rate and growth in the gross domestic product suggest that by 2042, the trust fund reserves will be depleted and contributions to the program will cover 73 percent of the program's cost. By 2077, contributions will cover only 65 percent of the projected benefits. The projected shortfalls are due to a number of factors, including: The currently low growth rate for the gross domestic product; increased longevity; the retirement of baby boomers, which will begin in 2011; and historically low birthrates. To close this projected shortfall, increasing FICA from 6.2 percent to 7.16 percent for employees (matched by employers) would be required immediately.

In the long term, sustaining Social Security represents a major challenge for the nation in the long-term. In addition to raising the payroll tax, other alternatives include more quickly increasing the retirement age to 67, further increasing the retirement age, supplementing Social Security by drawing on the general revenue, reducing benefit levels, and increasing taxes on received benefits. Another frequently discussed option is to replace Social Security, completely or partially, through privatization, creating a system of individual, mandated private savings accounts.

Privatization would represent a shift from an insurance perspective to a forced savings/investment perspective. Benefits from such accounts would be dependent on the performance of investment choices made by each individual. Without a guaranteed benefit, risks for poverty might

increase for the elderly under this approach. Costs for transitioning to privatization plans are estimated to be substantially greater than simply increasing the payroll tax to ensure the long-term sustainability of Social Security. Additionally, privatization would not adequately protect individuals against such risks as disability, death of an employed spouse, or outliving assets.

Numerous proposals for modifying Social Security are under debate. In evaluating these proposals, the U.S. General Accounting Office has suggested the following evaluative criteria:

Financing sustainable solvency. This criterion evaluates the extent to which the proposal achieves sustainable solvency, including its affect on the economy and the federal budget. It is important to consider the extent to which the proposal:

- Reduces future budgetary pressures
- Reduces debt held by the public
- Reduces the cost of the Social Security system as a percentage of the GDP
- Increases national savings
- Restores 75-year actuarial balance and create a stable system
- Raises payroll taxes, draws on general revenues, and/or uses Social Security trust fund surpluses to finance changes

Balance Adequacy and Equity. This criterion evaluates the balance struck between the twin goals of income adequacy (level and certainty of benefits) and individual equity (rates of return on individual contributions). It is important to consider the extent to which the proposal:

- Changes current-law benefits for current and future workers
- Maintains benefits for low-income workers who are most reliant on Social Security
- Maintains benefits for the disabled, dependents, and survivors
- Ensures that those who contribute receive benefits
- Provides higher replacement rates for lower income earners
- Increases returns on investments
- Improves intergenerational equity

Implementing and Administering Reforms. This criterion evaluates how readily such changes could be implemented, administered, and explained to the public. It is important to consider the extent to which the proposal:

- Provides reasonable timing and funds for implementation and result in reasonable administrative costs
- Allows the general public to readily understand its financing structure and increase public confidence
- Allows the general public to readily understand the benefit structure and avoid expectation gaps
- Limits the potential for politically motivated investing

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SUPPLEMENTAL SECURITY INCOME

Program Description

Supplemental Security Income (SSI) is a nationwide, federal cash assistance program for persons who are aged, blind, or disabled. The only means-tested program administered by the Social Security Administration, SSI provides a minimum level of income to 6.8 million people with benefits averaging \$411 each month. Enacted in 1972, the program provides uniform eligibility criteria and an income floor for recipients across the country. States may provide a supplement to the federal benefits and 45 states do so. In 2001, federal expenditures for the program were \$30.5 billion, with an additional \$3.5 billion in state expenditures for the state supplement.

To be eligible for the program, applicants must be at least 65 years of age, blind, or disabled. Uniform standards are used to determine blindness and disability. Disability criteria for age 18 or older are the same as those used for Social Security Disability Insurance: The physical or mental impairment must be expected to last at least 12 months or result in death, and must prevent employment. For those under 18, the impairment must result in severe functional limitations. Additionally, applicants must have limited incomes (less than \$552 a month for an individual and \$829 for a couple), and have countable resources no greater than \$2,000 for an individual and \$3,000 for a couple. Like Social Security, SSI benefits are indexed to the Consumer Price Index, and cost-of-living adjustments are made annually. A relatively high percentage of SSI recipients also receive Social Security Benefits—58 percent of the elderly and one-third of the disabled. In general, individuals eligible for SSI are also eligible for Medicaid and Food Stamps.

Overall, 19 percent of beneficiaries were awarded benefits on the basis of age, with women representing almost two-thirds of the older adult recipients. Approximately 1 percent of beneficiaries receive benefits on the basis of blindness. The remaining SSI beneficiaries receive benefits on the basis of disability, including almost 900,000 children, who represent 13 percent of all beneficiaries. Of those with a disability, 60 percent have a diagnosis of mental retardation or another mental disorder.

For recipients who want to work, the program has a number of work incentives. For example, a limited amount of earned income is disregarded in computing SSI benefits, and the cost of certain work-related or impairment-related expenses are excluded from earned income. Additionally, special provisions are made for recipients who are disabled and working, to allow them to continue receiving Medicaid coverage if their earnings are not sufficient to provide them with equivalent coverage. Five percent of recipients with disabilities engage in work, and some of these are able to take advantage of the program's work incentives.

Issues

Children and SSI Eligibility. To be eligible for SSI, children must be under age 18, unmarried, and meet the SSI criteria for income, resources, citizenship, and disability or blindness. In the early and mid-1990s, the numbers of children receiving SSI increased dramatically, due in part to outreach activities, reductions in reviews for continuing disability, expansion of the mental impairment category for children, and the use of individualized functional assessments. Alarmed by the rapid increase, and concerned about fraudulent claims, Congress restricted children's eligibility for SSI in 1996 by discontinuing the individualized functional assessments. Children are now required to have a "medically determinable physical or mental impairment which results in marked or severe functional limitations," that is expected to result in death or to last for no less than 12 months. These changes resulted in slightly more than 100,000 children becoming ineligible for SSI.

Further Restrictions on Eligibility. In 1996, as part of the Personal Responsibility and Work Opportunity Reconciliation Act, most noncitizens were denied eligibility for SSI. However, this law was modified in 1997, such that legal immigrants who were receiving SSI on August 22, 1996, and disabled, legal immigrants who were living in the U.S. on August 22, 1996 retained eligibility for SSI. Also, in 1996, eligibility for SSI and Disability Insurance was terminated for those whose drug addiction or alcoholism was a contributing factor to their disability. Approximately 125,000 individuals' benefits were terminated under this provision.

Continuing Increase in Recipients who are Disabled. Individuals with disabilities have accounted for an increasing percentage of SSI recipients. The percentage of persons with disabilities in the age 18-to-64 category has increased from 38 percent in 1974, to 57 percent in 2001. In recent years, attention to rehabilitative services for recipients has increased. Since the program began in 1974, SSI provisions have allowed reimbursement to state vocational rehabilitation services for the costs of serving recipients who are blind or disabled in achieving self-supporting work activities. In 1999, to further serve disabled or blind recipients, Congress expanded the rehabilitation provisions through the Ticket to Work and Self-Sufficiency program. This legislation increases the range of vocational rehabilitation providers available to serve recipients. Payment to providers is based on the achievement of outcomes. The Ticket to Work Program is being phased in gradually, and is expected to be fully operational by 2004.

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TEMPORARY ASSISTANCE TO NEEDY FAMILIES

Program Description

Temporary Assistance for Needy Families (TANF), enacted in 1996, provides block grant funding to states to support welfare programs for poor families and their children. TANF replaced Aid to Families with Dependent Children (AFDC), the federal entitlement program providing cash assistance to poor families and their children. Federal funding for TANF is \$16.4 billion annually, and the amount of federal money each state receives is based on prior federal expenditures for that state for AFDC. To receive full block grant funding, states must meet several requirements, including placing five-year lifetime limits on federal benefits for families, engaging recipients in work programs, and maintaining their own level of funding in support of poor and low-income families.

What are the states doing under “devolution?”

Thirty-eight states limit federal cash assistance to five years. Other states have established shorter time limits for receiving TANF. States may exempt up to 20 percent of their caseload from time limits, due to hardship. In 16 states, family caps, in which cash assistance is not increased after the birth of an additional child while on TANF, have been imposed.

States have maintained prior benefit levels, as well as categories for eligibility under TANF, but have shifted to a “work-first” strategy that emphasizes finding employment quickly. Additionally, the majority of states now have programs that divert families from TANF by providing short-term benefits or supports for critical needs. Many states have also developed procedures to screen or assess individuals for barriers to employment, such as domestic violence, mental health issues, learning disabilities, physical disabilities, and alcohol and drug dependence.

Who Receives TANF?

In 2002, 4.9 million people (about two percent of the U.S. population) received TANF. This represents a decline of 59 percent since the legislation was enacted, a decline generally attributed to the legislation as well as to the strong economy of the late 1990s. The majority of TANF families have one adult and two children. However, child-only cases in which no adult receives benefits represent 35 percent of the TANF caseload. Ninety percent of the adult recipients are women and 26.4 percent of recipients are employed. The average monthly benefit for a TANF family is \$349. However, benefits range widely from state to state. Whites represent 31 percent of the caseload; blacks, 39 percent; and Hispanics/Latinos, 25 percent.

Leaving Welfare

Typically, former welfare recipients who work are in jobs with low-wages, often without health insurance. Many families leaving welfare continue to be poor, and lack access

to programs like Food Stamps and Medicaid, for which they are often eligible. Some studies suggest that one-third of former welfare recipients are experiencing economic hardships, including providing food for their families.

Next Steps

Social work professionals, who work with children and families each day, consistently report that TANF provisions are discriminatory and perpetuate barriers to self-sufficiency for their clients. While TANF has contributed to the reduction of welfare caseloads, *the mission and primary purpose of TANF should now focus on the reduction of poverty.* To achieve this goal, an investment in the future of American families needs to be made by ameliorating current barriers within the system. NASW offers the following suggestions for improving TANF:

Increase Supports for Working Families through TANF. TANF needs to address the gap in the income support programs necessary to lift families out of poverty. Innumerable families who have left the welfare rolls still do not earn a living wage, and remain well below the federal poverty line. Increased TANF funding will allow states to maintain or introduce programs to further support low-income working families. Additionally, contingency funding for states during periods of economic downturns needs to be expanded.

Eliminate Education Barriers. TANF needs to reflect an increased investment in the education and training of recipients, if it is to reach toward the goal of poverty reduction. Participation in high school/GED, ESL, vocational training, internships, and post secondary education are integral to reducing welfare dependency, and should count as work participation. Furthermore, the one-year limit on vocational training for parents should be eliminated, allowing them adequate time to complete education and training. The ability to command a job that provides a living wage is the initial step to self-sufficiency and long-term poverty reduction.

Address Employment Barriers. TANF must address physical and mental illness, disability, substance abuse, and domestic and sexual violence issues as being barriers to employment. It is vital that, before the imposition of any sanctions for non-compliance, a trained professional is used to determine if such barriers exist. In such cases, plans should be modified to provide the services and supports the family needs to address these barriers. The Family Violence Option needs to be required of all states and its provisions fully implemented. Special accommodations also need to be made for recipients who are unable to comply with work requirements due to a lack of transportation, lack of childcare, parenting responsibilities for a child under the age of six, parenting responsibilities for a disabled child, and care giving responsibilities to an elderly or disabled adult family member.

Provide Child Poverty Reduction Bonus. TANF should include financial incentives to states that significantly reduce child poverty, and to those that lift sanctions denying aid to children whose parents engage in conduct that is deemed inappropriate.

Restore Immigrant Eligibility. Federal funding for assistance to immigrant populations needs to be fully restored. Under current TANF regulations, many states have no cash assistance or health programs for immigrants. States that have kept immigrants eligible for services limit their participation by imposing restrictions, because of the financial hardships imposed on the states for funding programs for immigrants.

Enhance the Capacity of the Welfare System Infrastructure. The transformation in welfare programs under TANF has resulted in changing demands and expectations for frontline workers. The additional tasks for service provision being placed on frontline workers calls for a significant investment in training to enhance their capacity to responsibly serve vulnerable families.

Expand Other Programs Supporting Low-Income Families. TANF alone cannot provide all the supports needed by low-income families. Further expenditures are called for under the Child Care Development Block Grant, which provides funding for child-care services. Additionally,

expanding the federal Earned Income Tax Credit, establishing or expanding state earned income tax credits, and making the federal Child and Dependent Care Credit refundable would further support families and contribute to reductions in child poverty. Families leaving welfare also should be automatically enrolled in the Food Stamp Program and Medicaid, if still eligible.

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FOOD STAMPS

Program Description

Originally intended as a nutrition program, the Food Stamp Program is now considered an income security supplement to help families increase their food budgets. More than 19 million people in eight million households participate in the program, which provides stamps, or coupons, redeemable for food products at local grocery stores, food marts, and farmers' markets. The average monthly benefit in 2002 was \$185 for a household, and \$80 for an individual. Federal spending for food stamp benefits in 2002 was \$18.2 billion.

Overseen by U.S. Department of Agriculture, food stamps are available nationwide and represent an important source of income for poor and low-income families. As the only non-categorical public assistance program in the U.S., it provides for a broad spectrum of those most in need. Eighty-nine percent of recipients have incomes below the federal poverty line, and the typical household receiving stamps in 2001 had an income of \$624 a month. Fifty-one percent of food stamp recipients are children, and another 10 percent are age 60 or older. The federal government pays all the costs of food stamp benefits, as well as 50 percent of states' administrative costs for operating the program through their welfare agencies. Participants apply for stamps through their local welfare or food stamp office.

The maximum food stamp benefit is based on the U.S. Department of Agriculture's Thrifty Food Plan (a nutritionally adequate and low-cost diet), which varies depending on household size, and is adjusted annually for inflation. Food stamp eligibility is determined for households, which may consist of individuals, or of families or groups of persons residing in the same household and sharing food. Recipient eligibility and benefit levels are determined through means testing by calculating household income and countable resources. The ceiling on household income and assets for eligibility depends on the number, ages, and abilities of household members. Households where all members receive Supplemental Security Income benefits (SSI) are automatically eligible for the food stamp program.

For able-bodied adults to be, or remain, eligible, they must be working, registered to work, and fulfill any job search or training requirements of the welfare agency. Able-bodied individuals between 18 and 50 without dependents have more limited access to food stamps; these recipients may only receive three months of stamps out of any 36-month period, unless they enroll in a training program or work at least 20 hours per week.

Recently enacted federal legislation (the Farm Security and Rural Investment Act of 2002) has restored benefits to some legal immigrants made ineligible under the 1996 welfare law. Legal immigrant children are again eligible for food

stamps, as are adult legal immigrants who have resided in the U.S. for five years or who receive disability benefits.

The program may soon have to be re-titled—89 percent of all participating households use the Electronic Benefits Transfer (EBT) system to buy groceries. Instead of paper coupons, most recipients now use an EBT card, which carries the balance of their food stamps benefits and is used at the register like a debit card. Benefits are automatically credited to the EBT card each month. Food stamp benefits are redeemed for food, and also for seeds to grow food, at grocery stores or other food retailers. Participants cannot buy non-food items, such as household cleaners and toiletries, alcoholic beverages, vitamins, or store-prepared hot meals with food stamps.

Recent Changes and Challenges

2002 Farm Bill Provisions. The Farm Bill includes many provisions to promote accessibility and increased eligibility for food stamp benefits. Provisions include funding to study and develop methods to increase access and simplify the application process; state options for loosening eligibility; higher resource exclusion for families with disabled individuals; and higher general income deduction accounting for family size. The bill also extends the transition time for receipt of food stamps from three to five months for families transferring off of TANF, and restores eligibility for some legal immigrants and immigrant children beginning in October 2003.

Cashing out food stamps. Some propose that the cash amount of food stamps should be added to other benefits such as SSI or TANF in order to simplify the transfer of the benefit and reduce the stigma associated with food stamps. California already provides the value of food stamps in cash benefits. Proponents of "cashing out" argue that purchasing at a grocery does not guarantee that families are buying nutritious food any more than providing the benefit in cash, and that stamps are a means to control the purchases of the needy. Detractors of "cashing out" believe that EBT ensures that these funds are spent on food, rather than other less essential items. Use of EBT also helps lessen the misuse of food stamps through the bartering of stamps for other goods. Also, because EBT is so much like using a debit card tied to a personal checking account to buy food, it reduces the stigma associated with food stamps.

Declining Participation Rates. The percentage of eligible families participating the food stamp program has declined dramatically in recent years. Between 1994 and 2000, the rate of participation by eligible families fell from 70 to 53 percent. The decline has been particularly noticeable among households with children and households with working members. While the reasons for the decline are probably multiple, a consensus is emerging that says programmatic barriers contribute to this decline, particularly for working

households. The program requires notification of changes in income and other circumstances on a monthly basis. This requirement has proven burdensome for working households whose income may vary more frequently than non-working households.

Additionally, because the state error rate for working households tends to be high, due to variations in income, states have attempted to reduce their error rates by imposing additional requirements for determining continuing eligibility on working households. Finally, families leaving TANF for work often do not understand that they may remain eligible for food stamps, and less than one-half of former TANF recipients continue to receive food stamps, even though they remain eligible for the program.

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TAX CREDITS AS SUPPORTS FOR LOW-INCOME FAMILIES

In the United States, several federal tax credits serve to benefit families with children. The largest of these is the Earned Income Tax Credit, which is refundable, and serves low-income working families. The Child Tax Credit, a second refundable tax credit, was recently enacted, and benefits working parents with children under the age of 17. A nonrefundable tax credit, the Child and Dependent Care Credit, is for working people who pay child or dependent care and may offset the amount of taxes owed.

Each of these tax credits is intended to help families meet the costs of raising children. However, the level of support provided to parents is significantly lower than that provided by many other countries. The U.S. remains distinctive in being one of the few industrialized nations that does not provide a family or children's allowance—a cash payment for families with children, regardless of income. In this brief, the Child Tax Credit and the Child and Dependent Care Credit are described first, followed by a more complete description of the Earned Income Tax Credit.

Child Tax Credit*

The Child Tax Credit (CTC) is a refundable tax benefit for taxpayers raising dependent children under age 17. Currently, this credit amounts to \$600 for each child, but its value will gradually increase until 2010, when it will be \$1000 for each child. The maximum CTC is available to single parents with incomes up to \$75,000 and married parents with combined incomes up to \$110,000. The amount of the credit is reduced as income level increases beyond these levels.

The credit reduces the federal tax liability and may provide a cash refund. A refund is provided when earnings exceed \$10,350 and the credit is greater than the tax liability. In this case, the refund equals either the remainder of the tax credit or 10 percent of earnings above \$10,350, whichever is less. CTC does not affect eligibility for the Earned Income Tax Credit or the Child and Dependent Care Credit. However, because the Child and Dependent Care Tax Credit is counted before figuring the CTC, and may eliminate any income tax liability, the size of the CTC received by the family may be affected.

Child and Dependent Care Credit*

The Child and Dependent Care Credit (CDCC) provides a non-refundable federal credit against income tax liability for up to 35 percent of a limited amount of employment-related dependent care expenses. The intent is to help make it possible for workers with responsibility for the care of children and other dependents to continue working, by

partially reimbursing their out-of-pocket costs of care. Generally, a qualifying individual is a child under age 13, or a physically or mentally incapacitated dependent or spouse. The maximum amount of eligible employment-related expenses is limited to \$3,000 for one qualifying individual, and to \$6,000 for two or more qualifying individuals, for credits of \$1050 and \$2100 respectively. The phase-down of the credit begins at adjusted gross incomes of \$15,000. In 1998, 6.1 million families claimed this credit, receiving on average \$433. The overall cost for this program was \$2.6 billion.

Earned Income Tax Credit

Often characterized as the nation's largest poverty program, the Earned Income Tax Credit (EITC) is a refundable tax credit for low- or moderate-income workers. Its purpose is to reduce the tax burden for low- or moderate-income workers, to supplement wages, and to make working more attractive than welfare. Workers who qualify may receive payments, even if they did not owe any federal income taxes. Enacted in 1975, EITC has been expanded significantly during the past 25 years, with the maximum value rising from \$400, in 1975, to \$4,140, in 2002. Federal spending for EITC in 2002 was projected to be \$32 million, well exceeding federal expenditures for TANF.

EITC is administered by the Internal Revenue Service. Families receive the credit by filing their regular tax return and completing schedule EIC. In 2001, over 19.2 million families and individuals received EITC. The average benefit in 1998 was \$1500 for families with one child, and \$2,300 for families with multiple children. The maximum benefit for families with two or more children was \$4,140 and \$2,506 for a family with one child. The benefit begins to phase out at \$13,520, and is eliminated at \$33,178 for a family with two or more children. Low-income families with no children are also eligible for EITC, but at significantly lower benefits; the maximum benefit is \$376.

Most workers receive a lump-sum refund after submitting their tax returns. Workers with children may elect to receive the credit incrementally through the advance payment option, but relatively few choose this option. It is estimated that 86 percent of those eligible for EITC receive the credit. Individuals who appear to be eligible for EITC, but who did not claim the tax credit, are notified by the Internal Revenue Service of their eligibility and encouraged to file an amended return.

About 60 percent of EITC payments go to taxpayers who would be poor in the absence of the credit. Working families with children and income just below the poverty line receive the largest EITC benefits. Because of this, EITC is highly effective in reducing poverty among children. In fact, more children are taken out of poverty by EITC than any other public assistance program. In 1999, EITC lifted

4.7 million people, including 2.6 million children, above the poverty line. (In general, EITC does not affect eligibility for public cash assistance, Medicaid, food stamps, Supplemental Security Income, or public or subsidized housing.) Research also suggests that, for the past 15 years, EITC has contributed significantly to the increasing employment rates for single mothers.

Issues

Claiming Benefits. Approximately 15 percent of those eligible for EITC are not receiving the tax credit. Research suggests that Hispanic families are less likely to know about the benefit than others, perhaps due to language barriers. Outreach to this population, including IRS notices regarding eligibility in Spanish, merits attention. Additionally, workers may not be knowledgeable about the option to receive the credit incrementally through the advance payment option, and should be informed of this.

Tax Preparation. Individuals may complete the required forms themselves and, if all the information is included, the IRS will calculate the EITC benefit. However, the IRS estimates that 68 percent of EITC recipients use commercial tax preparers, which ultimately reduces the benefit of EITC because of tax preparation fees. An alternative free service is available through the IRS-sponsored volunteer income tax assistance (VITA) program, which is available throughout the country.

Increasing Benefits for Families of Three or More. Currently, benefits from EITC are the same for all families with two or more children. Expanding the benefit for larger, low-income families is proposed to further target these benefits to families at high-risk for poverty.

State Earned Income Tax Credits. Ten states, plus the District of Columbia, offer refundable earned income credits, with most providing a percentage of the federal EITC. Five states offer nonrefundable tax credits. As a supplement to the federal EITC, state earned income credits serve to further reduce poverty among children, support a state's welfare reform efforts, and offset the local and state burden on low-income families. Although increasing the number of states offering refundable earned income tax credits is unlikely during a period of severe state fiscal distress, advocacy efforts in this area may be more successful in the future, when states are not facing budget shortfalls.

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**This material is drawn from the policy brief entitled "Utilizing the Tax System to Help Low and Moderate Income Working Families in New York" prepared by the Schuyler Center for Analysis and Advocacy, Albany, NY.*

UNEMPLOYMENT INSURANCE

Program Description

Unemployment Insurance (UI), operated cooperatively by the federal and state governments, was part of the original Social Security Act of 1935. UI provides weekly cash benefits to recently employed workers who are involuntarily unemployed. Additionally, the program seeks to help maintain the economy during periods of recession. Approximately 97 percent of all wage and salary workers and 89 percent of the civilian work force are covered by UI.

Overseen by the U.S. Department of Labor, each state administers its own program within federal guidelines. States retain authority to determine eligibility criteria for the program, benefit amounts, and the length of time benefits may be received. Typically, states provide benefits for a maximum of 26 weeks. Under the Federal-State Extended Benefit Program, benefits may be extended for 13 to 20 additional weeks. During periods of national recession, the federal government has further extended benefits through a temporary program (Temporary Emergency Unemployment Compensation).

To be eligible for UI benefits, workers must have lost their jobs through no fault of their own, and be willing and able to accept “suitable” new jobs. In addition, workers must have earned a specified amount during the previous year. This amount varies by state but, on average, in 2000, a worker was required to have worked at least two quarters in the past year, and to have earned \$1,734 to qualify for a minimum benefit. The weekly benefits provided by states are highly variable, with maximum weekly benefits in 2002 ranging from \$205 in Arizona to \$507 in Massachusetts. Nationally, the average weekly benefit of \$258 represented 38 percent of the average weekly covered wage in 2002.

In 2001, 9.7 million workers received benefits, at a cost of \$31.4 billion. Although a high percentage of the labor force is covered by UI, less than one-half (43 percent) of all unemployed workers received UI benefits in 2001. Many workers are ineligible for benefits because the state-specified requirements for minimum earnings exclude low-wage and part-time workers, as well as new entrants or recent re-entrants into the work force. Additionally, the program does not cover certain workers, such as agricultural and domestic workers, and those who are self-employed.

UI is financed primarily through a tax imposed on employers by state and federal governments. Each state establishes its own tax rate, as well as the amount of wages subject to the tax. The tax on employers is relatively small: .5 percent of all earnings of workers covered by the program. The states use the revenue generated by the tax to finance benefits. The federal tax revenue is used primarily to support the program’s administrative expenses.

Current Issues

The unemployment insurance system has not kept pace with changes in the work place, including part-time employment, the increasing percentage of women in the workforce, and the needs of lesser skilled workers. The issues currently faced by the program include the following:

Base Period for Eligibility. Less than one-half of all unemployed workers receive UI. Many are ineligible because they fail to meet the state-specified requirements for minimum earnings during a base period, usually the first four of the last five completed quarters prior to filing a claim. Under this approach, the last quarter before filing a claim for UI is excluded. An alternative base period, now used by 12 states, includes the last quarter of earnings, information that is now accessible due to advances in technology. Use of the alternative base period benefits many who are excluded under the traditional base period, including low-wage, part-time, and new and returning workers. Using the alternate base period also makes workers eligible for additional weeks of benefits. An additional approach to determining eligibility, as well as extending the program’s coverage, is to base eligibility on hours worked, rather than a minimum amount of earnings.

Exhausting Benefits. Annually, about one-third of all UI claimants exhaust their benefits. This is particularly likely to occur for workers who have lower skill levels, or who experience permanent (rather than temporary) job loss through lay-offs. The current program was not designed to provide the necessary extended financial support for dislocated workers, or the education and training or retraining necessary for lesser-skilled workers to participate in today’s economy.

Benefit Levels. Benefit levels under UI are low, covering less than 40 percent of the worker’s lost wages. In over one-half of the states, the benefits are not sufficient to bring a parent and one child to the poverty level. In the other states, benefits reach just above the poverty level for a one-parent, one-child family.

Baby UI: Underwriting Parental Leave through UI. In 2000, states were given the option of extending benefits to parents taking time off from work under the Family and Medical Leave Act following the birth or adoption of a child. The modification in federal rules for state programs was supported by acknowledgement of the need to keep pace with the changing workforce, particularly the dramatic increase in the number of working mothers. Paid maternal or parental leave is a common feature in social insurance programs worldwide, offered by 128 countries that provide paid leave for an average of 16 weeks.

Giving states the option to use UI to support parental leave for those covered by the Family and Medical Leave Act provides an opportunity to experiment with models of

paid parental leave, and may move the U.S. somewhat closer to the international norm for paid parental leave. However, the current provision does not create a national, universal program. Rather, it operates at state discretion and offers limited benefits to a restricted group of potential beneficiaries—those employed in settings covered by the Family and Medical Leave Act.

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Information for this policy brief was drawn from the 2002 Green Book available online at <http://aspe.hhs.gov/2000gb/sec4.txt> and the "Unemployment Issue Guide," Economic Policy Institute, Research and Ideas for Working People, available online at http://epi.lights.com/content.cfm/issueguides_unemployment_index

ADDITIONAL NASW RESOURCES

NASW's Welfare Reauthorization Web page

National Association of Social Workers. (2003). Welfare reauthorization: Creating economic security—Promoting the profession [Online]. Available at: <https://www.socialworkers.org/advocacy/welfare/default.asp>

Social Work Speaks

National Association of Social Workers. (2003). Social work speaks (6th ed.). Washington, DC: NASW Press. Also available online at: <https://www.socialworkers.org/resources/abstracts/default.asp>

Following are some of the policy statements that are posted on the NASW Web site:

Economic Security

<https://www.socialworkers.org/resources/abstracts/abstracts/economic.asp>

Health Care

<https://www.socialworkers.org/resources/abstracts/abstracts/healthCare.asp>

Long-Term Care

<https://www.socialworkers.org/resources/abstracts/abstracts/longTerm.asp>

Managed Care

<https://www.socialworkers.org/resources/abstracts/abstracts/ManagedCare.asp>

Mental Health

<https://www.socialworkers.org/resources/abstracts/abstracts/MentalHealth.asp>

Role of Government, Social Policy and Social Work

<https://www.socialworkers.org/resources/abstracts/abstracts/role.asp>

Senior Health, Safety, and Vitality

<https://www.socialworkers.org/resources/abstracts/abstracts/seniorHealth.asp>

Social Services

<https://www.socialworkers.org/resources/abstracts/abstracts/socialServices.asp>

Temporary Assistance for Needy Families

<https://www.socialworkers.org/resources/abstracts/abstracts/tanf.asp>

NASW Specialty Practice Sections (SPS)

The NASW Specialty Practice Sections are member-driven communities within the Association, which provide customized services and resources in eight practice areas. The program is designed to provide content expertise about current trends and policy issues that affect social work practice and service delivery. Sections include:

- Aging
- Alcohol, Tobacco and Other Drugs
- Child Welfare
- Health
- Mental Health
- Poverty and Social Justice
- Private Practice
- School Social Work

To learn more about NASW Sections go to: <https://www.socialworkers.org/sections/default.asp>

NASW Journal: Social Work Abstracts

For more than 30 years, NASW's abstracting service has been the starting point for literature searches in social work and social welfare. Social Work Abstracts reviews more than 400 U.S. and international journals and publishes approximately 450 abstracts in each issue. Abstracts originally published in other languages are translated into English. In print form, Abstracts can be used alone or as a guide to the Social Work Abstracts PLUS (SWAB+) database, available on CD-ROM and the Internet through SilverPlatter. To purchase go to: <http://www.naswpress.org/publications/journals/abstracts/swabintro.html>

NASW Press Book: Repackaging the Welfare State

Chatterjee, P. (1999). Repackaging the welfare state. Washington, DC: NASW Press.

To purchase go to: http://www.naswpress.org/publications/books/ethics/repackage_welfare_state/3045.html

NASW Press Book: Humane Managed Care

Schamess, G., & Lightburn, A., Eds. (1998). Humane managed care. Washington, DC: NASW Press.

To purchase go to: http://www.naswpress.org/publications/books/health/humane_mngd_care/2944.html