Professional Education Services, LP

Social Security and Medicare: A Survey of Benefits

#5485L

COURSE MATERIAL

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CHAPTER 1: INTRODUCTION AND OVERVIEW

Chapter Objective

After completing this chapter, you should be able to:

- Recall key characteristics of the social security system.

I. SOCIAL SECURITY: THE NUMBERS GAME

A. THE IMPORTANCE OF SOCIAL SECURITY

Social security is big business. For the year 2015, almost 60 million Americans received $883 billion in social security benefits. Social security is the major source of income for most of this nation's elderly population. Figures from the Social Security Administration show the following:

- Nearly nine out of ten individuals age 65 and older receive social security benefits;
- Social security benefits represent about 34% of income for the elderly;
- Among elderly social security beneficiaries, 48% of married couples and 71% of unmarried persons receive 50% or more of their income from social security; and
- Among elderly social security beneficiaries, 21% of married couples and about 43% of unmarried persons rely on social security for 90% or more of their income.

In addition to retirement benefits, social security provides benefits to family members and disabled workers:

- Retired workers and their dependents account for 71% of total benefits paid in 2015;
- Disabled workers and their dependents account for 16% of total benefits paid in 2015:
    - About 90 percent of workers age 21-64 in covered employment and their families have protection in the event of a long-term disability;
    - Just over 1 in 4 of today's 20 year-olds will become disabled before reaching age 67; and
    - 67% of the private sector workforce has no long-term disability insurance;
- Survivors of deceased workers account for about 13% of total benefits paid:
    - About one in nine of today's 20-year-olds will die before reaching age 67; and
    - About 96% of persons aged 20-49 who worked in covered employment in 2015 have survivors insurance protection for their young children and the surviving spouse caring for the children.

While some American workers are not covered under social security, the vast majority – 170 million – are. 51% of these workers have no private pension coverage, therefore increasing the importance of social security. Estimates also show that 31% of the American workforce has no savings set aside specifically for retirement.

B. FINANCING SOCIAL SECURITY

In 1940, the life expectancy of a 65-year-old was almost 14 years; today it is about 20 years. Table 1-1, below, is the actuarial table used by the Social Security Administration (SSA), which shows current life expectancies by gender.

By 2035, the number of Americans 65 and older will increase from 48 million today to over 79 million. There are currently 2.8 workers for each social security beneficiary. By 2035, there will be 2.2 workers for each beneficiary.

TABLE 1-1. PERIOD LIFE TABLE

Exact Age	Male Life Expectancy (Additional Years Person Is Expected to Live)	Female Life Expectancy (Additional Years Person Is Expected to Live)
0	76.28	81.05
1	75.78	80.49
2	74.82	79.52
3	73.84	78.54
4	72.85	77.55
5	71.87	76.56
6	70.88	75.57
7	69.89	74.58
8	68.90	73.58
9	67.90	72.59
10	66.91	71.60
11	65.92	70.60
12	64.92	69.61
13	63.93	68.62
14	62.94	67.63
15	61.96	66.64
16	60.99	65.65
17	60.02	64.67
18	59.05	63.68
19	58.09	62.70
20	57.14	61.72
21	56.20	60.75
22	55.27	59.77

23	54.33	58.80
24	53.40	57.82
25	52.47	56.85
26	51.54	55.88
27	50.61	54.91
28	49.68	53.94
29	48.75	52.97
30	47.82	52.01
31	46.89	51.04
32	45.96	50.08
33	45.03	49.11
34	44.10	48.15
35	43.17	47.19
36	42.24	46.23
37	41.31	45.28
38	40.38	44.33
39	39.46	43.37
40	38.53	42.43
41	37.61	41.48
42	36.70	40.54
43	35.78	39.60
44	34.88	38.66
45	33.98	37.73
46	33.08	36.81
47	32.19	35.89
48	31.32	34.97
49	30.44	34.06
50	29.58	33.16
51	28.73	32.27
52	27.89	31.38
53	27.05	30.49
54	26.23	29.62
55	25.41	28.74
56	24.61	27.88
57	23.82	27.01
58	23.03	26.16
59	22.25	25.31
60	21.48	24.46
61	20.72	23.62
62	19.97	22.78
63	19.22	21.95
64	18.48	21.13
65	17.75	20.32

These figures further highlight the importance of the solvency of the social security system for the welfare of this country's aging population. As a result, the solvency of the social security system and related issues, such as whether the system should be privatized, have captured headlines and been the focus of much political debate in the last several years.

1. Payroll Taxes

Social security is financed primarily through a dedicated payroll tax. Prior to January 1, 2011, employers and employees typically each paid 6.2 percent of wages up to the taxable maximum which is determined for each year ($118,500 in 2015 and 2016), while the self-employed pay 12.4 percent. As Table 1-2 shows, this tax rate had gradually increased since the inception of the system through 2010. A special "payroll tax holiday" originally reflecting a one-time (year 2011) 2% employee and self-employed rate reduction was enacted by Congress in the final days of December 2010, and extended another 12 months through all of 2012. See special year 2011 and 2012 employer and employee rate split-out in Table 1-2. Beginning in 2013, and continuing through 2016, the rates have returned to the pre-"holiday" levels – employer and employee both pay payroll taxes of 7.65% for each covered employee. Additionally, the self-employed pay 15.3%, as was the case prior to the two year "holiday."

2. Contribution and Benefit Base

Social Security's Old-Age, Survivors, and Disability Insurance (OASDI) program limits the amount of earnings subject to taxation for a given year. The same annual limit also applies when those earnings are used in a benefit computation. This limit increases each year with increases in the national average wage index. The SSA calls this annual limit the contribution and benefit base. Table 1-3 shows a history of the increase of the benefit base.

TABLE 1-2. SOCIAL SECURITY TAX RATES

The following tax rates apply to maximum earnings established yearly.

Calendar year	TAX RATES AS A PERCENTAGE OF TAXABLE EARNINGS					
	Rate for employees and employers, each			Rate for self-employed persons		
	OASDI[i]	HI[i]	Total	OASDI	HI	Total
1937-49	1.000	--	1.000	--	--	--
1950	1.500	--	1.500	--	--	--
1951-53	1.500	--	1.500	2.250	--	2.250
1954-56	2.000	--	2.000	3.000	--	3.000
1957-58	2.250	--	2.250	3.375	--	3.375
1959	2.500	--	2.500	3.750	--	3.750
1960-61	3.000	--	3.000	4.500	--	4.500
1962	3.125	--	3.125	4.700	--	4.700
1963-65	3.625	--	3.625	5.400	--	5.400
1966	3.850	0.350	4.200	5.800	0.350	6.150
1967	3.900	0.500	4.400	5.900	0.500	6.400
1968	3.800	0.600	4.400	5.800	0.600	6.400
1969-70	4.200	0.600	4.800	6.300	0.600	6.900
1971-72	4.600	0.600	5.200	6.900	0.600	7.500
1973	4.850	1.000	5.850	7.000	1.000	8.000
1974-77	4.950	0.900	5.850	7.000	0.900	7.900
1978	5.050	1.000	6.050	7.100	1.000	8.100
1979-80	5.080	1.050	6.130	7.050	1.050	8.100
1981	5.350	1.300	6.650	8.000	1.300	9.300
1982-83	5.400	1.300	6.700	8.050	1.300	9.350
1984[ii]	5.700	1.300	7.000	11.400	2.600	14.000
1985	5.700	1.350	7.050	11.400	2.700	14.100
1986-87	5.700	1.450	7.150	11.400	2.900	14.300
1988-89	6.060	1.450	7.510	12.120	2.900	15.020
1990-2010	6.200	1.450	7.650	12.400	2.900	15.300
2011-2012 (Employer)	6.200	1.450	7.650	--	--	--
2011-2012 (Employee)[iii]	4.200	1.450	5.650	10.400	2.900	13.300
2013-2016	6.200	1.450	7.650	12.400	2.900	15.300

i Social Security's Old-Age, Survivors, and Disability Insurance (OASDI) program and Medicare's Hospital Insurance (HI) program are financed primarily by employment taxes. Tax rates apply to earnings up to a maximum amount.

ii In 1984 only, an immediate credit of 0.3 percent of taxable wages was allowed against the OASDI taxes paid by employees, resulting in an effective employee tax rate of 5.4 percent. The OASDI trust funds, however, received general revenue equivalent to 0.3 percent of taxable wages for 1984. Similar credits of 2.7 percent, 2.3 percent, and 2.0 percent were allowed against the combined OASDI and HI taxes on net earnings from self-employment in 1984, 1985, and 1986-89, respectively.

iii Reflects "payroll tax holiday" reduction of 2% for employees only per TRUIRJCA of 2010 for 2011. An extension was passed by legislation and signed by the President February 21, 2012 covering all of calendar 2012.

TABLE 1-3. HISTORY OF THE OASDI CONTRIBUTION AND BENEFIT BASE

Year	Amount	Year	Amount	Year	Amount
1937-50	$3,000	1982	$32,400	1998	$68,400
1951-54	3,600	1983	35,700	1999	72,600
1955-58	4,200	1984	37,800	2000	76,200
1959-65	4,800	1985	39,600	2001	80,400
1966-67	6,600	1986	42,000	2002	84,900
1968-71	7,800	1987	43,800	2003	87,000
1972	9,000	1988	45,000	2004	87,900
1973	10,800	1989	48,000	2005	90,000
1974	13,200	1990	51,300	2006	94,200
1975	14,100	1991	53,400	2007	97,500
1976	15,300	1992	55,500	2008	102,000
1977	16,500	1993	57,600	2009-2011	106,800
1978	17,700	1994	60,600	2012	110,100
1979	22,900	1995	61,200	2013	113,700
1980	25,900	1996	62,700	2014	117,000
1981	29,700	1997	65,400	2015-2016	118,500

Note: *Amounts for 1937-74 and for 1979-81 were set by statute; all other amounts were determined under automatic adjustment provisions of the Social Security Act.*

3. 2016 Rates

The OASDI tax rate for wages paid in 2016 is set by statute at 6.2 percent for employers and employees. Thus, an individual with wages equal to or larger than $118,500 will contribute $7,347 to the OASDI program in 2016, and his or her employer would contribute $7,347 as well. The OASDI tax rate for self-employment income in 2016 is 12.4 percent. (Tax rates of 1.45 percent for employees and employers, each, and 2.9 percent for self-employed persons, are applied to all earnings – without a taxable maximum – under Medicare's Hospital Insurance program.)

In 2016, wages in excess of $200,000 ($250,000 MJ) are subject to an additional Medicare tax of .9% and a 3.8% additional tax on the lesser of unearned income (exclusions apply) or wages in excess of the $200,000 ($250,000 MJ).

C. SOCIAL SECURITY TAX PROCEEDS

Money collected from payroll taxes is placed in social security trust funds. The social security trust funds are financial accounts in the U.S. Treasury. There are two separate social security trust funds, the Old-Age and Survivors Insurance (OASI) Trust Fund that pays retirement and survivors benefits, and the Disability Insurance (DI) Trust Fund that pays disability benefits. Tables 1-4 and 1-5, following, show recent contributions to the Social Security Trust Fund and Medicare Trust Fund by program and source.

Social security taxes and other income are deposited in these social security trust funds, and social

security benefits are paid from them. The only purposes for which these trust funds can be used are to pay benefits and the costs of administering the programs. By law, excess funds are invested in special treasury bonds that are guaranteed by the U.S. government. A market rate of interest is paid to the trust funds on the bonds they hold, and when those bonds reach maturity or are needed to pay benefits, the treasury redeems them.

TABLE 1-4. CONTRIBUTIONS TO THE SOCIAL SECURITY TRUST FUND 2011-2015 (IN MILLIONS OF DOLLARS)

Program and Source	2011	2012	2013	2014	2015
Old-Age and Survivors' Insurance[i]	592,314	628,302	645,678	674,584	710,334
Employer	271,395	285,328	294,995	305,279	322,395
Employee	184,227	191,028	292,241	302,850	319,939
Self-Employed	26,728	27,538	33,578	38,104	37,169
General Fund Reimbursement	87,753	97,735	4,169	395	278
Taxation of Benefits	22,211	26,675	20,694	27,957	30,554
Disability Insurance[i]	98,389	102,744	106,523	111,488	116,508
Employer	46,086	48,451	50,095	51,840	54,747
Employee	31,259	32,487	49,603	51,427	54,330
Self-employed	4,537	4,677	5,704	6,470	6,312
General Fund Reimbursement	14,927	16,546	729	71	47
Taxation of Benefits	1,581	583	391	1,680	1,071

TABLE 1-5. CONTRIBUTIONS TO THE MEDICARE TRUST FUND 2011-2015 (IN MILLIONS OF DOLLARS)

Program and Source	2011	2012	2013	2014	2015
Hospital Insurance	214,003	227,814	238,544	248,762	264,489
Employer	91,381	95,618	102,318	104,720	112,027
Employee	91,381	95,618	102,318	104,720	112,027
Self-Employed	12,830	14,494	16,182	18,006	17,020
Voluntarily Enrolled	3,267	3,441	3,417	3,251	3,206
Taxation of Benefits	15,143	18,643	14,310	18,066	20,208
Supplemental Medical Insurance	57,514	58,024	63,085	65,644	69,446
Aged	47,646	48,495	52,814	55,164	58,593
Disabled	9,868	9,529	10,270	10,479	10,852

D. THE FUTURE OF SOCIAL SECURITY

The social security system is designed so that there is a link between how much workers and their employers pay into the system over their working years and how much they will get in benefits. Basically, high-wage earners receive a higher benefit payment than low-wage earners. However, the benefit "formula" is set up so that lower wage earners will get a higher percentage of their pre-retirement earnings.

1. Changing Population

The main reason for social security's long-range financing problem is demographics. People are living longer and healthier lives than ever before. When the social security program was created in 1940, a 65-year-old American had an average life expectancy of 14 more years; today, it is 20 years and rising.

In addition, 78 million "baby boomers" had begun retiring in 2008, and in about 30 years, there will be nearly twice as many older Americans as there are today. At the same time, the number of workers paying into social security per beneficiary will drop from 2.8 today to about 2.2 in 2035.

Table 1-6, below, shows the growth in the number of workers covered by social security benefits since 1940.

TABLE 1-6. ESTIMATED NUMBER OF INSURED WORKERS (DECEMBER 31, 1940-2016)

	Workers fully insured for retirement and/or survivor benefits (in millions)			
Year	Total	Permanently Insured	Not Permanently Insured	Workers insured in event of disability
1940	24.2	1.1	23.1	--
1941	25.8	1.4	24.4	--
1942	28.1	1.8	26.3	--
1943	29.9	2.3	27.6	--
1944	31.9	2.8	29.1	--
1945	33.4	3.4	30.0	--
1946	35.4	8.6	26.8	--
1947	37.3	11.6	25.7	--
1948	38.9	13.2	25.7	--
1949	40.1	14.9	25.2	--
1950	59.8	21.0	38.8	--
1951	62.8	22.9	39.9	--
1952	68.2	25.6	42.7	--
1953	71.0	27.7	43.4	--
1954	70.2	29.9	40.4	31.9
1955	70.5	32.5	38.0	35.4
1956	74.0	36.1	38.0	37.2
1957	76.1	38.3	37.9	38.4
1958	76.5	40.3	36.2	43.4
1959	76.7	42.2	34.6	46.4
1960	84.4	47.6	36.8	48.5
1961	88.5	53.3	35.3	50.5
1962	89.8	54.9	34.8	51.5
1963	91.3	56.6	34.7	52.3
1964	92.8	58.3	34.5	53.3
1965	94.8	60.2	34.6	55.0
1966	97.2	61.9	35.3	55.7
1967	99.9	63.3	36.6	56.9
1968	102.6	64.5	38.1	70.1
1969	106.0	66.4	39.5	73.2
1970	108.7	67.6	41.1	75.4
1971	111.2	68.8	42.4	77.1
1972	113.8	70.1	43.8	78.8
1973	117.0	71.4	45.6	81.4
1974	120.5	72.9	47.5	84.3
1975	123.9	75.0	48.9	86.3

1976	126.7	76.8	49.9	87.8
1977	129.7	78.8	50.9	89.7
1978	134.2	81.1	53.0	94.1
1979	138.1	83.6	54.5	97.8
1980	141.1	86.0	55.1	100.5
1981	143.5	88.6	54.9	102.3
1982	145.5	91.5	54.0	103.7
1983	147.0	94.5	52.5	104.7
1984	149.0	97.5	51.5	106.3
1985	151.5	100.6	50.9	108.8
1986	154.0	103.9	50.1	111.0
1987	156.4	108.0	48.4	113.2
1988	159.1	111.2	47.9	115.3
1989	161.9	114.0	47.9	117.5
1990	164.4	116.7	47.7	119.4
1991	166.3	119.0	47.3	120.7
1992	167.8	121.3	46.5	121.9
1993	169.2	123.7	45.6	123.3
1994	171.0	126.1	44.9	125.1
1995	173.2	128.3	44.8	127.1
1996	175.3	130.9	44.5	129.1
1997	177.6	133.5	44.1	131.1
1998	180.0	136.1	44.0	133.4
1999	182.6	138.3	44.2	135.7
2000	185.1	140.3	44.8	138.0
2001	187.4	142.2	45.2	140.0
2002	189.2	144.0	45.2	141.3
2003	190.9	146.0	44.9	142.4
2004	192.7	148.0	44.7	143.8
2005	194.8	150.2	44.6	145.5
2006	197.1	152.3	44.8	147.2
2007	199.4	154.5	44.9	148.8
2008	201.5	156.5	45.0	149.8
2009	202.9	158.4	44.5	149.5
2010	204.0	160.0	43.9	148.7
2011	205.3	161.6	43.7	148.6
2012	207.3	163.3	43.7	149.2
2013	209.2	165.3	43.9	149.9
2014	211.1	167.3	43.8	150.6
2015	213.1	169.4	43.8	151.2
2016	215.5	170.9	44.5	152.2

2. Pay-As-You-Go-System

The money a worker paid in social security taxes in 1976 is not sitting in an account bearing his or her name. Social security is a pay-as-you-go retirement system—the social security taxes paid by today's workers and their employers are used to pay the benefits for today's retirees and other beneficiaries.

Currently, social security is still taking in more money than it pays out in benefits, and the remaining money goes to the program's trust funds. There are now large "reserves" in the trust funds. However, this money is small compared to future scheduled benefit payments. In 2023, benefits owed will be more than the taxes collected, and social security will need to begin tapping into the trust funds to pay some benefits. The trust funds will be exhausted in 2034. At that time, barring any changes, social security will not be able to meet all of its benefit obligations.

3. Proposed Changes

There are several ways to guarantee that social security will continue to be there for future generations. Each option means difficult trade-offs.

For example, some people think that benefits should be reduced, or at least their future growth should be slowed. One way of doing this would be to increase the retirement age for full social security benefits. Proponents of this plan argue that Americans are living longer and healthier lives than ever before and that people are spending an increasing number of years in retirement. Critics of the proposal to further raise the retirement age say most Americans now choose to retire early, and that it would be hard for some people to work past the current retirement age because of their health or because their jobs are just too demanding.

Another camp believes that social security taxes should be raised so that all future benefits could be paid. This group wants to increase the current combined payroll tax rate, which is now 12.4 percent. Critics argue that payroll taxes are already very high, having been raised 20 times since the program began, and that almost 80 percent of workers already pay more in payroll taxes than they do in income taxes. And they point out that eventually social security taxes would have to be raised by about 50 percent to pay for all benefits owed.

Others believe the maximum taxable earnings (currently $118,500) should be raised, increasing the total social security taxes collected. Currently the cap covers about 83 percent of total national earnings. One commonly mentioned goal would be to raise the cap to cover 90 percent of earnings, which in 2016 would mean a cap of about $274,200.

Other people believe that the future financing problem can be solved without reducing benefits or raising taxes. They favor "pre-funding" benefits for younger workers by letting them have their own voluntary social security personal savings account. They say that by investing in stocks and bonds, workers could receive higher benefits. Supporters also say personal accounts would allow workers to leave a "nest egg" to their heirs.

Critics say that personal retirement accounts mean higher risks for workers, and that if investments were not doing well when a worker is ready to retire, plans would have to be changed. They also say personal

accounts could be expensive to administer. Some people think the government, and not individuals, should invest social security reserves in stocks and bonds, so that higher potential returns can be earned but the financial risks shared. Critics say the government should not invest in private companies, because the government could end up being the largest stockholder in a company.

II. SOCIAL SECURITY: A SNAPSHOT

A. THE SOCIAL SECURITY NUMBER

The benefits an individual receives from social security are calculated on the earnings recorded under their social security number. It is therefore critical that people use their correct social security number to ensure that they are getting proper credit for their earnings. Persons who change their name (such as the result of marriage) should also change the name on their social security card to preserve a correct record of their earnings.

B. PAYING SOCIAL SECURITY TAXES

1. Working for Others

If an individual works for someone else, his or her employer withholds social security and Medicare taxes from the individual's paycheck, matches that amount, sends those taxes to the Internal Revenue Service (IRS), and reports the earnings to social security.

2. Self-Employed

If an individual is self-employed, he or she pays his or her own social security taxes when he or she files a tax return, and the IRS reports those earnings to social security. Self-employed individuals pay a rate equal to the combined employee/employer share, but there are special deductions such people can take that offset their tax rate.

C. EARNING SOCIAL SECURITY CREDITS

As an individual works and pays taxes, he or she earns "credits" that count toward his or her eligibility for future social security benefits. Individuals can earn a maximum of four credits each year. Most people need 40 credits (10 years of work) to qualify for benefits. Younger people need fewer credits to qualify for disability or survivor's benefits.

D. SOCIAL SECURITY BENEFITS

An individual's social security benefit is a percentage of his or her earnings averaged over most of his or her working lifetime. Low income workers receive a higher rate of return than those in the upper income brackets, but a worker with average earnings can expect a retirement benefit that represents about 40 percent of his or her average lifetime earnings.

There are five major categories of benefits paid for through social security taxes: retirement, disability, family benefits, survivors, and Medicare. (SSI benefits are not financed by social security taxes, although they are discussed in this course).

1. Retirement

Benefits are payable at full retirement age (with reduced benefits available as early as age 62) for anyone with enough social security credits. The full retirement age is 65 for persons born before 1938. The age gradually rises until it reaches 67 for persons born in 1960 or later. People who delay retirement beyond full retirement age get special credit for each month they will not receive a benefit until they reach age 70.

2. Disability

Benefits can be paid to people at any age who have enough social security credits and who have a severe physical or mental impairment that is expected to prevent them from doing "substantial" work for a year or more, or who have a condition that is expected to result in death. Generally, earnings of $1,130 for 2016 or more per month are considered substantial. The disability program includes incentives to smooth the transition back into the workforce, including continuation of benefits and health care coverage while a person attempts to work.

3. Family Benefits

If an individual is eligible for retirement or disability benefits, other members of his or her family might receive benefits, too. These include a spouse if he or she is at least 62 years old, a spouse under 62 but caring for a child under age 16, and children if they are unmarried and under age 18, under 19 and still in school, or 18 or older but disabled. If an individual is divorced, his or her ex-spouse could also be eligible for benefits.

4. Survivors

When an individual dies, certain members or his or her family may be eligible for benefits if the individual earned enough social security credits while he or she was working. The family members include a widow(er) age 60 or older, 50 or older if disabled, or any age if caring for a child under age 16, children if they are unmarried and under age 18, under 19 and still in school, or 18 or older but disabled, and parents, if the deceased individual was their primary means of support.

A special one-time payment of $255 may be made to a spouse or minor children when an individual dies. If an individual is divorced, his or her ex-spouse could still be eligible for a widow(er)'s benefit.

5. Medicare

There are four parts to Medicare. Generally, people who are over age 65 and getting social security automatically qualify for Medicare. So do people who have been getting disability benefits for two years. Others must file an application. Part A is paid for by a portion of the social security tax of people still working. It helps pay for inpatient hospital care, skilled nursing care and other services. Part B is paid for by monthly premiums of those who are enrolled and from general revenues. It helps pay for such items

as doctors' fees, outpatient hospital visits and other medical services and supplies. Part C (Medicare Advantage) plans allow an individual to receive all of his or her health care services through a provider organization. These plans may help lower the costs of receiving medical services, or may provide extra benefits for an additional monthly fee. The individual must have both Parts A and B to enroll in Part C. Part D (prescription drug coverage) is voluntary and the costs are paid for by the monthly premiums of enrollees and Medicare. With Part D, the individual must opt in by filling out a form and enrolling in an approved plan.

6. Supplemental Security Income Benefits

SSI makes monthly payments to people who have a low income and few assets. To get SSI, an individual must be 65 or older, blind, or disabled. Children, as well as adults, qualify for SSI disability payments. As its name implies, supplemental security income "supplements" an individual's income up to various levels – depending on where he or she lives.

The federal government pays a basic rate and some states add money to that amount. Generally, people who get SSI also qualify for Medicaid, food stamps and other assistance.

SSI benefits are not paid from social security trust funds and are not based on past earnings. Instead, SSI benefits are financed by general tax revenues and assure a minimum monthly income for elderly and disabled persons.

CHAPTER 1: TEST YOUR KNOWLEDGE

The following questions are designed to ensure that you have a complete understanding of the information presented in the chapter (assignment). They are included as an additional tool to enhance your learning experience and do not need to be submitted in order to receive CPE credit.

We recommend that you answer each question and then compare your response to the suggested solutions on the following page(s) before answering the final exam questions related to this chapter (assignment).

1.	**Social security is the major source of income for most of the nation's elderly population.** **A.** true **B.** false
2.	**The benefit base for both social security and Medicare for 2016 is $118,500.** **A.** true **B.** false
3.	**High-wage earners receive a higher benefit payment than low-wage earners.** **A.** true **B.** false
4.	**Which of the following is the main reason the social security system is at risk of financial ruin:** **A.** the stock market crash of 2008 wiped out much of the fund **B.** poor government mismanagement **C.** people are living longer **D.** the benefits are too generous
5.	**Eligibility for future social security benefits is based on the credits an individual earns when he or she works.** **A.** true **B.** false

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CHAPTER 1: SOLUTIONS AND SUGGESTED RESPONSES

Below are the solutions and suggested responses for the questions on the previous page(s). If you choose an incorrect answer, you should review the pages as indicated for each question to ensure comprehension of the material.

1.	**A.** **CORRECT**. Nearly nine out of ten individuals age 65 and older receive social security benefits. **B.** Incorrect. Social security benefits represent about 34% of income for the elderly. *(See page 1 of the course material.)*
2.	**A.** Incorrect. Medicare tax rates are applied to all earnings, not just the first $118,500. **B.** **CORRECT**. Social security taxes are based on a benefit base of $118,500 for 2016, at a rate of 6.2 percent for employees and employers. Medicare does not have a limited wage base. *(See page 6 of the course material.)*
3.	**A.** **CORRECT**. However, the benefit "formula" is set up so that lower wage earners will get a higher percentage of their pre-retirement earnings. **B.** Incorrect. The social security system is designed so that there is a link between how much workers and their employers pay into the system over their working years and how much they will receive in benefits. *(See page 8 of the course material.)*
4.	**A.** Incorrect. Social security funds are not invested in the stock market, so while this was a devastating event for many people, it did not affect the social security system directly. **B.** Incorrect. The government does not actively manage this money in the financial markets. **C.** **CORRECT**. It is purely an issue of demographics. People are living longer and therefore collecting more money over the course of their lifetime. **D.** Incorrect. The problem is not the monthly benefit but that people are living longer and therefore collecting those benefits over a longer period of time. *(See page 8 of the course material.)*
5.	**A.** **CORRECT**. Individuals can earn a maximum of four credits each year, and most people need 40 credits to qualify for benefits. **B.** Incorrect. Although most people need 40 credits (10 years of work) to qualify for benefits, younger people need fewer credits to qualify for disability or survivor benefits. *(See page 12 of the course material.)*

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CHAPTER 2: SOCIAL SECURITY RETIREMENT BENEFITS

Chapter Objective

After completing this chapter, you should be able to:

- Recognize the social security benefits available to individuals and family members and how they are earned.

I. BENEFITS FOR INDIVIDUALS

A. QUALIFYING FOR SOCIAL SECURITY BENEFITS

When an individual works and pays social security taxes (called FICA on some pay stubs), he or she earns social security credits. Most people earn the maximum of four credits per year.

1. Number of Required Credits

The number of credits an individual needs to receive retirement benefits depends on his or her date of birth. Persons born in 1929 or later need 40 credits (10 years of work). People born before 1929 need fewer than 40 credits (39 credits if born in 1928; 38 credits if born in 1927; etc.).

2. Break in Work History

Individuals who stop working before they have accumulated enough credits to qualify for benefits retain their credits. They can return to work later and accumulate the remaining needed credits. However, no retirement benefits can be paid until an individual has the required number of credits, regardless of age.

3. No Benefit for Extra Credits

Most people earn more credits than they need to qualify for social security. These extra credits do not increase an individual's social security benefit. However, the income individuals earn while working will increase their benefit amount.

B. AMOUNT OF RETIREMENT BENEFIT

An individual's benefit amount is based on his or her earnings averaged over most of his or her working career. Higher lifetime earnings result in higher benefits. If an individual has some years of no earnings or low earnings, his or her benefit amount may be lower than if he or she had worked steadily.

The benefit amount is also affected by an individual's age at the time he or she starts receiving benefits. If an individual begins receiving his or her retirement benefits at age 62 (the earliest possible retirement age), his or her benefit will be lower than if the individual waited until a later age. Table 2-1, below, shows annual benefits payments made to retired workers and their dependents since 1937.

TABLE 2-1. BENEFITS PAID TO RETIRED WORKERS AND DEPENDENTS (IN MILLIONS)

Year	Total	Retired Worker	Wives and Husbands	Dependent Children
1937	$1	--	--	--
1938	10	--	--	--
1939	14	--	--	--
1940	35	$15	$2	[1]
1941	88	44	7	$1
1942	131	65	10	1
1943	166	79	13	1
1944	209	97	16	1
1945	274	126	21	2
1946	378	189	31	2
1947	466	245	40	3
1948	556	300	49	4
1949	667	373	60	5
1950	961	557	88	6
1951	1,885	1,135	175	11
1952	2,194	1,328	200	12
1953	3,006	1,884	275	16
1954	3,670	2,340	338	21
1955	4,968	3,253	466	29
1956	5,715	3,793	536	33
1957	7,347	4,888	756	43
1958	8,327	5,567	851	56
1959	9,842	6,548	982	77
1960	10,677	7,053	1,051	92
1961	11,862	7,802	1,124	106
1962	13,356	8,813	1,216	134
1963	14,217	9,391	1,258	146
1964	14,914	9,854	1,277	150
1965	16,737	10,984	1,383	175
1966	18,267	11,727	1,429	216
1967	19,468	12,372	1,456	221
1968	22,642	14,278	1,673	253
1969	24,209	15,385	1,750	160
1970	28,796	18,.438	2,029	303
1971	33,413	21,544	2,323	352
1972	37,122	24,143	2,532	382
1973	45,741	29,336	3,000	457
1974	51,618	33,369	3,309	533
1975	58,509	38,079	3,719	634

1976	65,699	43,083	4,117	736
1977	73,113	48,186	4,559	830
1978	80,352	53,255	4,983	921
1979	90,556	60,379	5,554	1,014
1980	105,074	70,358	6,405	1,142
1981	123,795	83,614	7,543	1,321
1982	138,800	95,123	8,539	1,223
1983	149,502	103,578	9,328	1,143
1984	157,862	109,957	9,860	1,135
1985	167,360	116,823	10,517	1,140
1986	176,845	123,584	11,152	1,166
1987	183,644	128,513	11,598	1,183
1988	195,522	136,987	12,292	1,219
1989	207,977	146,027	13,054	1,249
1990	222,993	156,756	13,953	1,316
1991	240,436	169,142	14,986	1,405
1992	254,939	179,372	15,810	1,494
1993	267,804	188,440	16,356	1,563
1994	279,118	196,400	16,854	1,637
1995	291,682	205,315	17,348	1,715
1996	302,914	213,423	17,715	1,799
1997	316,311	223,554	18,154	1,882
1998	326,817	232,324	18,395	1,940
1999	334,437	238,478	18,415	1,992
2000	352,706	253,542	18,969	2,133
2001	372,370	268,976	19,491	2,332
2002	388,170	281,624	19,884	2,475
2003	399,892	291,518	19,951	2,583
2004	415,082	304,261	20,164	2,714
2005	435,373	321,706	20,500	2,888
2006	460,457	342,865	21,005	3,082
2007	485,881	364,278	21,571	3,274
2008	509,056	383,999	22,022	3,482
2009	557,160	424,044	23,613	3,922
2010	577,448	443,390	24,001	4,114
2011	596,212	461,234	24,176	4,288
2012	637,948	497,471	25,348	4,583
2013	672,175	528,862	26,300	4,780
2014	706,821	560,120	27,484	4,974
2015	742,939	592,423	28,760	5,195

1 Less than $500,000

C. RETIREMENT AGE

1. Full Retirement Age

If you were born from 1943 to 1960, the age at which full retirement benefits are payable increases gradually to age 67. If your birth year is 1948 or earlier, you already are eligible for your full social security benefit. Table 2-2 below shows the ages needed to receive full retirement benefits.

TABLE 2-2. AGE TO RECEIVE FULL SOCIAL SECURITY BENEFITS

Year of Birth	Full Retirement Age
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

2. Early Retirement

An individual can begin receiving their social security benefits as early as age 62, but the benefit amount he or she receives will be less than if he or she waited until his or her full retirement age.

If an individual elects to take early retirement, his or her benefits will be permanently reduced based on the number of months he or she will receive checks before the individual reaches full retirement age. For example, if an individual's full retirement age is 66, the reduction for starting his or her social security at age 62 is about 75 percent. The reduction will be greater in future years as the full retirement age increases.

If an individual's full retirement age is older than 65 (that is, he or she was born after 1937), the individual will still be able to take retirement benefits at age 62, but the reduction in his or her benefit amount will be greater than it is for people retiring whose full retirement age was 65.

Example

Based on his year of birth, Jason's full retirement age is 67. The reduction for starting his benefits at 62 is about 30 percent; at age 63, it is about 25 percent; at age 64, about 20 percent; at age 65, about 13-1/3 percent; and at age 66, about 6-2/3 percent.

As a general rule, early retirement will give an individual about the same total social security benefits over his or her lifetime, but in smaller amounts to take into account the longer period they will be received.

Some people stop working before they reach age 62. In that case, it is important to remember that during years with no earnings, the individual will miss the opportunity to increase his or her benefit amount by replacing lower earnings years with higher earnings years.

Sometimes, for example, poor health forces an individual to retire early. If so, the individual should consider applying for social security disability benefits. The amount of the disability benefit is the same as a full, unreduced retirement benefit. And, if an individual is receiving social security disability benefits when he or she reaches full retirement age, those benefits will be converted to retirement benefits. Disability benefits will be discussed in more detail later in this course.

3. Delayed Retirement

Not everyone retires at full retirement age. An individual may decide to continue working full time beyond that time. In that case, an individual can increase his or her social security benefit in one of two ways:

- Each additional year an individual works adds another year of earnings to his or her social security record. Higher lifetime earnings may result in higher benefits when he or she retires; or
- An individual's benefit will be increased by a certain percentage if he or she chooses to delay receiving retirement benefits. These increases will be added in automatically from the time he or she reaches full retirement age until the individual begins receiving his or her benefits, or the individual reaches age 70. The percentage varies depending on the individual's year of birth. See Table 2-3, below for specific information on ages and rates.

TABLE 2-3. INCREASES FOR DELAYED RETIREMENT

Year of Birth	Yearly Rate of Increase
1933-1934	5.5%
1935-1936	6.0%
1937-1938	6.5%
1939-1940	7.0%
1941-1942	7.5%
1943 or later	8.0%

Example

An individual born in 1943 or later will receive an additional 8 percent per year (2/3 of 1 percent per month) to his or her benefit for each year he or she delays signing up for social security beyond his or her full retirement age (up to age 70).

People electing to delay retirement should still sign up for Medicare as soon as they reach age 65. It has no impact on their right to collect social security benefits.

D. SELECTING A RETIREMENT DATE

If an individual plans to start his or her retirement benefits after age 62, it is a good idea to contact social security in advance to see which month is best to claim benefits. In some cases, an individual's choice of a retirement month could mean additional benefits.

It may be advantageous, for example, to have social security benefits begin in January, even if the individual does not plan to retire until later in the year. Depending on his or her earnings and benefit amount, it may be possible for an individual to start collecting benefits even though he or she continues to work. Under current rules, many people can receive the most benefits possible with an application that is effective in January.

If an individual is not working, or his or her annual earnings are under the earnings limit discussed later, or, if the individual plans to start collecting social security when he or she turns 62, he or she should apply for benefits three months before the date the individual wants his or her benefits to start.

E. APPLYING FOR AND RECEIVING BENEFITS

Individuals applying for social security benefits need to consider the amount of time it will take between application and receipt in order to plan when to submit their application. Individuals can both apply for and calculate their benefit amount online.

1. Required Documents

The following original documents may be needed when signing up for social security:

- Social security card (or a record of the number);
- Birth certificate;
- Children's birth certificates (if they are applying);
- Proof of U.S. citizenship or lawful alien status if the individual (or a child who is applying) was not born in the United States;
- Spouse's birth certificate and social security number if he or she is applying for benefits based on applicant's earnings;
- Marriage certificate (if signing up on a spouse's earnings);
- Military discharge papers for persons with military service; and
- Most recent W-2 form, or tax return, if self-employed.

2. How Benefits Are Paid

Social security benefits generally are paid by direct deposit. Other arrangements can be made for people who do not want direct deposit.

II. BENEFITS FOR FAMILY MEMBERS

If an individual is receiving retirement benefits, some members of his or her family also can receive benefits. Those persons include:

- A wife or husband age 62 or older;
- A wife or husband under age 62, if she or he is taking care of the individual receiving retirement benefits or a child who is under age 16 or disabled;
- A former wife or husband age 62 or older;
- Children up to age 18;
- Children age 18-19; if they are full-time students through grade 12; and
- Children over age 18, if they are disabled.

A. SPOUSE'S BENEFITS

A spouse is entitled to receive one-half of the retired worker's full benefit unless the spouse begins collecting benefits before reaching full retirement age. In that case, the amount of the spouse's benefit is permanently reduced by a percentage based on the number of months before she or he reaches his or her full retirement age. For example, if an individual's spouse whose full retirement age is 67 begins collecting benefits at 66, the benefit amount would be about 46 percent of his or her full benefit. At age 65, it would be about 42 percent and 37.5 percent at age 64. However, if an individual's spouse is taking care of a child who is under age 16 or disabled and receiving social security benefits, his or her spouse will receive full benefits, regardless of age.

If an individual is eligible for both his or her own retirement benefits and for benefits as a spouse, the Social Security Administration will always pay the individual's own benefit first. If the benefit as a spouse is higher than the individual's own retirement benefit, he or she will receive a combination of benefits equaling the higher spouse benefit.

Example

Linda qualifies for a retirement benefit of $250 and a wife's benefit of $400. At full retirement age, she will receive her own $250 retirement benefit and an additional $150 from her wife's benefit, for a total of $400. If she takes her retirement benefit at any time before she reaches full retirement age, both amounts will be reduced.

B. MAXIMUM FAMILY BENEFITS

If an individual has children eligible for social security, each will receive up to one-half of the individual's full benefit. But there is a limit to the amount of money that can be paid to a family. If the total benefits due to a spouse and children exceed this limit, their benefits will be reduced proportionately. The individual's benefit will not be affected. This issue is discussed in more detail below.

C. BENEFITS FOR A DIVORCED SPOUSE

A divorced spouse can receive benefits on a former husband's or wife's social security record if the marriage lasted at least 10 years. The divorced spouse must be 62 or older and unmarried. If the spouse has been divorced at least two years, he or she can receive benefits, even if the worker is not yet retired. However, the worker must have enough credits to qualify for benefits and be age 62 or older. The amount of benefits a divorced spouse gets has no effect on the amount of benefits a current spouse can receive.

Example

Emily and Lonnie were married for 35 years before they divorced three years ago. Lonnie, 66, has yet to retire from his job as a plant manager. Emily, 64, never worked outside the home and is paying her living expenses from her portion of the marital estate divided when the couple divorced. Even though Lonnie continues to work, Emily is entitled to receive social security benefits based on Lonnie's earnings' history. Lonnie will still receive his full benefits when he eventually retires.

III. CALCULATING SOCIAL SECURITY BENEFITS

As an adult makes plans for his or her future, one of the questions he or she should ask is, "How much will I get from social security?" There are several ways individuals can find out. Previously, the Social Security Administration sent a yearly statement to everyone age 25 or older who had worked under social security and did not yet receive benefits.

In light of the current budget situation, the Social Security Administration has adjusted the "Request a Social Security Statement" service. Statements can be obtained online by using a personal "my Social Security account." Paper statements are generally mailed only to workers attaining ages 25, 30, 35, 40, 45, 50, 55, 60 and older three months prior to their birthday if they don't receive social security benefits and do not have a "my Social Security account." Statements can also be obtained online at www.socialsecurity.gov/hlp/global/hlp-statement-7004.htm.

A. REQUESTING INFORMATION FROM SSA

Individuals can also request a statement by calling social security and asking for a form SSA-7004, Request for Social Security Statement, or by downloading the form at www.socialsecurity.gov/online/ssa-7004.html on the Internet. There are also programs available for people to calculate their benefits themselves available at the social security website www.socialsecurity.gov/retire2 on the Internet.

It is sometimes surprising to see how a delayed retirement will affect monthly benefit payments. When considering when to begin receiving benefits, one of the key considerations is an individual's health. Someone in good physical condition who expects to live a long time after retirement should consider trying to delay the receipt of benefits so as to maximize his or her monthly payment.

B. FACTORS THAT CAN RAISE OR LOWER A RETIREMENT BENEFIT

The monthly benefit an individual receives from social security may not be the basic benefit. The actual benefit may be higher or lower than that amount if any of the following is true.

1. Early Retirement

Individuals can begin to receive social security benefits as early as age 62, but at a reduced rate. Their basic benefit will be reduced by a certain percent for each month that they receive benefits before their full retirement age. The closer an individual is to his or her full retirement age when he or she begins receiving benefits, the greater the benefit amount.

2. Cost-of-Living Increases

Individuals are eligible for cost-of-living benefit increases starting with the year they become 62. This is true even if an individual does not get benefits until age 65 or even age 70. Cost-of-living increases are added to an individual's benefit beginning with the year he or she reaches age 62 up to the year he or she begins receiving benefits. A more detailed discussion of this topic is provided below.

3. Delayed Retirement

An individual may continue working past his or her full retirement age and not begin to receive social security benefits. If an individual chooses to do this, his or her benefit amount will be increased by a certain percent for each month the individual is past his or her full retirement age, but do not receive benefits. These increases are automatically added to his or her benefit until the individual reaches age 70.

4. Certain Government Workers

If an individual is eligible for a pension from work where he or she did not pay social security taxes (usually a government job), a different formula is applied to his or her average monthly earnings.

C. ESTIMATING SOCIAL SECURITY BENEFITS

Social security benefits are based on earnings averaged over most of a worker's lifetime. An individual's actual earnings are first adjusted or "indexed" to account for changes in average wages since the year the earnings were received. Then social security calculates the individual's average indexed monthly earnings during the 35 years in which he or she earned the most. It applies a formula to these earnings to arrive at the individual's basic benefit, or "primary insurance amount" (PIA). This is the amount the individual would receive at his or her full retirement age. This age is based on the person's year of birth.

1. Average Indexed Monthly Earnings

When the SSA computes a worker's benefit, it first adjusts or "indexes" his or her earnings to reflect the change in general wage levels that occurred during the worker's years of employment. Such indexation ensures that a worker's future benefits reflect the general rise in the standard of living that occurred during his or her working lifetime.

Up to 35 years of earnings are needed to compute the average indexed monthly earnings. After the SSA determines the number of years, it 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. The SSA then rounds the resulting average amount down to the next lower dollar amount. The result is the average indexed monthly earnings.

A worker becomes eligible for retirement benefits when he or she attains age 62. If 2016 were the year of eligibility, for example, the SSA would divide the national average wage index for 2014 ($46,481.52) by the national average wage index for each year prior to 2014 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 2014. The SSA would consider any earnings in or after 2014 at face value, without indexing. The SSA would then compute the average indexed monthly earnings; this average would be used in computing the worker's primary insurance amount for 2016.

2. Primary Insurance Amounts

The primary insurance amount (PIA) is the sum of three separate percentages of portions of the average indexed monthly earnings. 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 2016 PIA formula, $856 and $5,157, apply for workers becoming eligible in 2016.

For example, a person who had maximum-taxable earnings in each year since age 22, and who retires at age 62 in 2016, would receive a reduced benefit based on a PIA of $2,787.80. The first COLA this individual could receive is the one effective for December 2016.

3. Monthly Benefit Amounts

Monthly benefits derived from the primary insurance amount (PIA) may be higher or lower than the PIA. SSA pays reduced benefits to someone who retires before his/her normal retirement age. A person cannot collect retirement benefits before age 62. In the case of a person retiring at exactly age 62 in 2016, the benefit will be 25 percent less than the person's PIA.

Benefits can be higher than the PIA if one retires after the normal retirement age. The credit given for delayed retirement will gradually reach eight percent per year for those born after 1942.

4. Old Law Benefit Tables

For eligibility before 1979, benefits are determined by means of a benefit table. Each year the primary insurance amounts and the maximum family benefits shown in the table are updated to reflect the latest cost-of-living increase. In addition, the table is extended to reflect the higher monthly wage and related

benefit possible under the latest contribution and benefit base. Such benefit tables for eligibility before 1979, sometimes called old-law benefit tables, are available beginning with the table for 1959.

5. Special Minimum Benefit Tables

"Special minimum" benefits are payable to certain individuals with long periods of relatively low earnings. To qualify for such benefits, an individual must have at least 11 "years of coverage." To earn a year of coverage for purposes of the special minimum, a person must earn at least a certain proportion (25 percent for years before 1991, and 15 percent for years after 1990) of the "old-law" contribution and benefit base." Tables showing the range of special minimum primary insurance amounts and corresponding maximum family benefit amounts are available for 1973 and later.

D. CALCULATING MAXIMUM FAMILY BENEFIT

The maximum family benefit is the maximum monthly amount that can be paid on a worker's earnings record. The formula for the maximum family benefit is based on the worker's primary insurance amount (PIA). There is a special formula for computing the maximum benefits payable to the family of a disabled worker.

The formula used to compute the family maximum is similar to that used to compute the PIA. It involves computing the sum of four separate percentages of portions of the worker's PIA. For 2016, these portions are the first $1,093, the amount between $1,093 and $1,578, the amount between $1,578 and $2,058, and the amount over $2,058. These dollar amounts are the "bend points" of the family-maximum formula. Thus, the family-maximum bend points for 2016 are $1,093, $1,578, and $2,058.

For the family of a worker who becomes disabled prior to age 62 or dies in 2015 before attaining age 62, the total amount of benefits payable will be computed so that it does not exceed:

- 150 percent of the first $1,093 of the worker's PIA, plus
- 272 percent of the worker's PIA over $1,093 through $1,578, plus
- 134 percent of the worker's PIA over $1,578 through $2,058, plus
- 175 percent of the worker's PIA over $2,058.

The SSA then rounds this total amount to the next lower multiple of $.10 if it is not already a multiple of $.10.

E. COST-OF-LIVING ADJUSTMENTS (COLA)

Legislation enacted in 1972 provides for automatic cost-of-living adjustments, or COLAs. The COLAs prevent inflation from eroding social security and Supplemental Security Income (SSI) benefits.

1. History

Social security benefit increases, also known as cost-of-living adjustments or COLAs, have been in effect since 1975. The 1975-82 COLAs were effective with social security benefits payable for June in

each of those years; thereafter, COLAs have been effective with benefits payable for December. Prior to 1975, social security benefit increases were set by legislation.

The first automatic COLA, for June 1975, was based on the increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) from the second quarter of 1974 to the first quarter of 1975. The 1976-83 COLAs were based on increases in the CPI-W from the first quarter of the prior year to the corresponding quarter of the current year in which the COLA became effective. After 1983, COLAs have been based on increases in the CPI-W from the third quarter of the prior year to the corresponding quarter of the current year in which the COLA became effective.

2. SSI COLAs

COLAs for the Supplemental Security Income (SSI) program are generally the same as those for the social security program. However, COLAs for SSI have generally been effective for the month following the effective month of social security benefit increases.

TABLE 2-4. SOCIAL SECURITY COST-OF-LIVING ADJUSTMENTS

Year	Cola	Year	Cola	Year	Cola
1975	8.0%	1989	4.7%	2003	2.1%
1976	6.4%	1990	5.4%	2004	2.7%
1977	5.9%	1991	3.7%	2005	4.1%
1978	6.5%	1992	3.0%	2006	3.3%
1979	9.9%	1993	2.6%	2007	2.3%
1980	14.3%	1994	2.8%	2008	5.8%
1981	11.2%	1995	2.6%	2009	0.0%
1982	7.4%	1996	2.9%	2010	0.0%
1983	3.5%	1997	2.1%	2011	3.6%
1984	3.5%	1998	1.3%	2012	1.7%
1985	3.1%	1999	2.5%	2013	1.5%
1986	1.3%	2000	3.5%	2014	1.5%
1987	4.2%	2001	2.6%	2015	1.7%
1988	4.0%	2002	1.4%	2016	0.0%

3. Latest Cost-of-Living Adjustment

There is no COLA effective December 31, 2015. This represents the third time the COLA has been zero in the past eight years.

TABLE 2-5. ESTIMATED AVERAGE SOCIAL SECURITY BENEFITS PAYABLE IN JANUARY 2016

Estimated Average Monthly Social Security Benefits Payable	
All Retired Workers	$1,341
Aged Couple, Both Receiving Benefits	$2,212
Widowed Mother and Two Children	$2,680
Aged Widow(er) Alone	$1,285
Disabled Worker, Spouse and One or More Children	$1,983
All Disabled Workers	$1,166

Legislation enacted in 1983 may limit the COLA if the combined assets of the Social Security trust funds are below 20 percent of annual expenditures. (This limitation only applies to Social Security; SSI would be unaffected.) Such limitation has not occurred in the past, nor does it affect the current COLA determination.

IV. COLLECTING BENEFITS WHILE OUTSIDE THE UNITED STATES

One of the benefits of retirement is the freedom to travel. However, there are important restrictions on the receipt of social security benefits while traveling outside of the United States.

A. WHEN IS A PERSON "OUTSIDE THE U.S."?

The SSA considers a person to be outside of the United States when he or she is not in one of the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa. Once a person has been out of the U.S. for at least 30 days in a row, he or she is considered to be outside the country until he or she returns and stays in the U.S. for at least 30 days in a row. If an individual is not a U.S. citizen, he or she may also have to prove that he or she was lawfully present in the U.S. for that 30-day period.

B. IMPACT ON SOCIAL SECURITY PAYMENTS

If a social security recipient is a United States citizen, he or she may receive his or her social security payments outside the U.S. as long as he or she is eligible for them. However, there are certain countries to which the SSA is not allowed to send payments.

1. Citizens of Certain Countries Remain Eligible

If an individual is a citizen of one of the countries listed below, his or her social security payments will keep coming no matter how long he or she remains outside of the United States as long as he or she is eligible for the payments:

Australia	Germany	Poland
Austria	Greece	Portugal
Belgium	Ireland	Slovak Republic
Canada	Italy	Spain
Chile	Japan	Sweden
Czech Republic	Korea (South)	Switzerland
Denmark	Luxembourg	United Kingdom
Finland	Netherlands	
France	Norway	

2. Special Requirements for Dependents and Survivors

If an individual receives benefits as a dependent or survivor of the worker, special requirements may affect his or her right to receive social security payments while he or she is outside the U.S. If the recipient is not a U.S. citizen, he or she must have lived in the U.S. for at least five years. During those five years, the family relationship on which benefits are based must have existed.

Children may meet this residency requirement on their own or may be considered to meet the residency requirement if it is met by the worker and other parent (if any). However, children adopted outside the U.S. will not be paid outside the U.S., even if the residency requirement is met.

The residency requirement does not apply to individuals who meet any of the following conditions:

- He or she was initially eligible for monthly benefits before January 1, 1985; or
- He or she is entitled on the record of a worker who died while in the U.S. military service or as a result of a service-connected disease or injury; or
- He or she is a citizen of:

Australia	Germany	Poland
Austria	Greece	Portugal
Belgium	Ireland	Slovak Republic
Canada	Italy	Spain
Chile	Japan	Sweden
Czech Republic	Korea (South)	Switzerland
Denmark	Luxembourg	United Kingdom
Finland	Netherlands	
France	Norway	

3. Countries to Which Payments Cannot Be Sent

U.S. Treasury Department regulations prohibit sending payments to an individual if he or she is in Cuba or North Korea. In addition, social security restrictions generally prohibit sending payments to individuals in Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, Turkmenistan, Ukraine, Uzbekistan and Vietnam. Individuals cannot receive payments while they are in one of these countries, and payments cannot be sent to a third person on their behalf.

If an individual is a U.S. citizen and he or she is in Cuba or North Korea, the individual can receive all of his or her payments that were withheld once he or she leaves that country and goes to another country where the SSA can send payments. Generally, if an individual is not a U.S. citizen, he or she cannot receive any payments for the months in which he or she lives in one of these countries, even though he or she leaves that country and satisfies all other requirements.

4. Other Rules

There are many other rules that limit payments based on an individual's citizenship or country of residence. Anyone who is either not a citizen of the United States or plans to reside outside of the United States, therefore, needs to carefully consult the rules regarding receipt of social security benefits while planning for his or her support.

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CHAPTER 2: TEST YOUR KNOWLEDGE

The following questions are designed to ensure that you have a complete understanding of the information presented in the chapter (assignment). They are included as an additional tool to enhance your learning experience and do not need to be submitted in order to receive CPE credit.

We recommend that you answer each question and then compare your response to the suggested solutions on the following page(s) before answering the final exam questions related to this chapter (assignment).

1.	**What benefits do individuals receive from compiling "extra credits" toward their social security eligibility:** **A.** they receive a stepped-up benefit directly related to those extra credits of service **B.** while the worker does not receive any extra benefit while alive, a surviving spouse receives a stepped up benefit on account of the extra credits **C.** there is no increased benefit on account of the extra credits **D.** the benefit level is increased but up to a cap
2.	**What is the full retirement age for a person born in 1966:** **A.** 60 **B.** 65 **C.** 67 **D.** 70
3.	**If an individual decides to work full time beyond his or her full retirement age, he or she may lose his or her social security benefits.** **A.** true **B.** false

4.	**Under what circumstances can a divorced spouse receive benefits from a former husband's or wife's social security record:** **A.** so long as the couple was married at least ten years **B.** only if the former husband or wife on whose account the benefits are being sought is actually retired **C.** so long as the divorced spouse seeking benefits is at least 62 years old and unmarried **D.** both A and C above
5.	**When the SSA computes a worker's benefits, it first adjusts his or her earnings to reflect the change in general wage levels that occurred during the worker's years of employment.** **A.** true **B.** false
6.	**Are otherwise eligible people entitled to receive social security benefits if they do not reside in the United States:** **A.** in most cases, people living outside of the United States are still entitled to receive their benefits **B.** people who leave the United States automatically lose their eligibility unless they can demonstrate "good cause" to reside outside the country **C.** people who leave the United States receive only 50 percent of the benefit they would have otherwise received based on the belief that the cost of living in most other places is less than the United States **D.** people only lose their benefits if they move to Cuba or Iran

CHAPTER 2: SOLUTIONS AND SUGGESTED RESPONSES

Below are the solutions and suggested responses for the questions on the previous page(s). If you choose an incorrect answer, you should review the pages as indicated for each question to ensure comprehension of the material.

1.	**A.** Incorrect. There is no such stepped up level of benefits. **B.** Incorrect. There is no increase in benefit levels for either the worker or his or her survivors. **C.** **CORRECT**. While the benefit level is affected by total earnings during the working life of the recipient, there is no extra benefit due to the increased number of credits. **D.** Incorrect. There is no increased benefit directly related to the number of credits beyond the minimum number needed to qualify for benefits. *(See page 19 of the course material.)*
2.	**A.** Incorrect. This is seven years younger than the actual full retirement age for someone born in 1966. **B.** Incorrect. A person could retire at this age but it would not be his or her full retirement age, and hence his or her benefit level would be less. **C.** **CORRECT**. Anyone born in 1960 or later is entitled to full benefits beginning at age 67. **D.** Incorrect. A person born in this year is eligible for full benefits at age 67. *(See page 22 of the course material.)*
3.	**A.** Incorrect. If an individual decides to work full time beyond his or her full retirement age, the individual can increase his or her social security benefit in two different ways. **B.** **CORRECT**. The individual's benefit may be increased rather than decreased. The individual's benefit can be increased either by increasing his or her lifetime earnings or by increasing the percentage he or she receives up until he or she begins receiving his or her benefits, or the individual reaches age 70. *(See page 23 of the course material.)*

4.	**A.** Incorrect. This is the minimum length of marriage required to even qualify for social security benefits based on the former spouse's account. However, this is not the best answer. **B.** Incorrect. In some cases, the former spouse can still be working while the other former spouse begins collecting benefits. **C.** Incorrect. This is the minimum age for collecting benefits on a former spouse's account. However, this is not the best answer. **D. CORRECT**. Both A and C are some of the requirements for a former spouse to collect social security benefits from the other former spouse's account. *(See page 26 of the course material.)*
5.	**A. CORRECT**. Such indexation ensures that a worker's future benefits reflect the general rise in the standard of living that occurred during his or her working lifetime. **B.** Incorrect. This indexing is known as computing the average indexed monthly earnings. *(See page 28 of the course material.)*
6.	**A. CORRECT**. Except in certain cases, such as when someone moves to a certain country, living abroad will not result in a loss of social security benefits for someone otherwise eligible. **B.** Incorrect. There is no automatic loss of eligibility, although there are certain places to which social security will not send payments. **C.** Incorrect. There is no such diminution in benefit. **D.** Incorrect. There are several nations to which the SSA will not send benefits, including Cuba, North Korea, and portions of the former Soviet Union. Iran is not on the list. *(See pages 32 to 33 of the course material.)*

CHAPTER 3: SELECT ISSUES AFFECTING SOCIAL SECURITY BENEFITS

Chapter Objective

After completing this chapter, you should be able to:

- Recall specific issues that affect the benefits, including the continuation of work and the "Windfall Elimination Provision."

I. HOW WORKING AFFECTS BENEFITS

Individuals can receive social security retirement or survivors benefits and work at the same time. However, an individual's benefits could be reduced if he or she earns more than certain amounts. Note that the rules discussed in this section do not apply to recipients of social security disability or Supplemental Security Income (SSI) payments. Recipients of those benefits must report all earnings to the Social Security Administration. Different rules also apply when work is performed outside of the United States.

A. EARNINGS LIMITS FOR SOCIAL SECURITY RECIPIENTS

If an individual who is at full retirement age or older decides to work, he or she may keep all of his or her benefits, no matter how much he or she earns. If, on the other hand, an individual is younger than the full retirement age all year, there is a limit to how much he or she can earn and still receive full social security benefits.

If an individual is younger than the full retirement age in all of 2016, for example, social security will deduct $1 from the recipient's benefits for each $2 the individual earned above $15,720. If the individual reaches full retirement age during 2016, social security will deduct $1 from the recipient's benefits for each $3 the individual earned above $41,880 until the month the individual reaches full retirement age.

Example 1

Estelle begins receiving social security benefits at age 62 in January 2016 and her payment is $600 per month ($7,200 for the year). During the year, Estelle works and earns $20,800 ($5,080 above the $15,720 limit). Social security will withhold $2,540 of her social security benefits ($1 for every $2 she earned over the limit). To do this, social security would withhold benefit payments from January 2016 to May 2016. Beginning in June 2016, Estelle would receive her $600 benefit, and this amount would be paid to her each month for the remainder of the year. In 2017, social security will pay her the additional $460 they withheld in May 2016.

Example 2

Ron was not full retirement age at the beginning of the year, but reached full retirement age in November 2016. His social security payment was $600 per month. He earned $42,900 in the ten months from January through October. During this period, social security would withhold $340 ($1 for every $3 Ron earned above the $41,880 limit). To do this, social security would withhold his first check of the year. Beginning in February 2016, Ron will receive his $600 benefit, and this amount will be paid to him each month for the remainder of the year. In 2017, social security would pay him the remaining $260 they withheld in January 2016.

B. INCOME THAT COUNTS AS EARNINGS

If an individual elects to work for someone else, only his or her wages are counted toward social security's earnings limits. If an individual is self-employed, social security will count net earnings from self-employment as earnings.

1. Investment Income

Other income, including other government benefits, investment earnings, interest, pensions, annuities or capital gains are not counted when determining the recipient's earnings from work. Employee contributions to a pension or retirement plan are included in gross wages.

2. Wages

If an individual works for wages, income is counted when it is earned, not when it is paid. Therefore, if an individual has income that was earned in one year, but not paid until the following year, it should not be counted as earnings for the year received. Some examples are accumulated sick or vacation pay and bonuses.

3. Self-Employed

If a recipient is self-employed, income counts when it is received, not when it is earned. The only exception is when earnings are paid in a year after the individual becomes entitled to social security but where the money was earned before becoming eligible.

C. SPECIAL RULES FOR FIRST YEAR OF RETIREMENT

Sometimes individuals who retire in mid-year already have earned more than the yearly earnings limit. That is why there are special rules that apply to earnings for one year, usually the first year of retirement. Under these rules, an individual can get a full social security check for any whole month he or she is retired, regardless of his or her yearly earnings.

A person under full retirement age is considered retired if monthly earnings are $1,310 or less for 2016.

Example

John Smith retires at age 62 on October 30, 2016. He will make $45,000 through October. He takes a part-time job beginning in November, earning $500 per month. Although his earnings for the year substantially exceed the 2016 limit ($15,720), he will receive a social security payment for November through December. This is because his earnings in those months are less than $1,310, the special "first year of retirement" monthly limit for people younger than full retirement age. If Mr. Smith earns more than $1,310 in any of those months (November through December), he will not receive a benefit for that month. Beginning in 2017, only the yearly limits will apply to him because he will be beyond his first year of retirement.

Also, if an individual is self-employed, social security administrators will consider how much work the person did in his or her business to determine whether he or she is retired. One way is by looking at the amount of time that the individual spends working. In general, if an individual works more than 45 hours a month in self-employment, he or she is not considered to be retired. If an individual works less than 15 hours a month, he or she is considered to be retired. Individuals who work between 15 and 45 hours a month will not be considered retired if it is in a job that requires a lot of skill or where the individual is managing a sizable business.

D. REPORTING CHANGES IN EARNINGS

The Social Security Administration will adjust the amount of a recipient's social security benefits for following years based on what he or she earned in the past. Therefore, individuals who believe they will be working less in the future should report such changes.

If other family members received benefits based on the work of the social security recipient, earnings after the recipient starts getting retirement benefits could reduce family members' benefits as well. However, if a recipient's spouse and children receive benefits as family members, their earnings affect only their own benefits.

E. SPECIAL PAYMENTS

After an individual retires, he or she may receive payments for work he or she did before the individual started getting social security benefits. Usually, those payments will not affect an individual's social security benefits if they are for work done before he or she retired.

If an individual worked for wages, income received after retirement counts as a special payment if the last thing the person did to earn the payment was completed before he or she stopped working. Some special payments to employees include bonuses, accumulated vacation or sick pay, severance pay, back pay, standby pay, sales commissions and retirement payments or deferred compensation reported on a W-2 form for one year, but earned in a previous year. These amounts may be shown on an individual's W-2 in the box labeled "Nonqualified Plan."

Example

Mr. DeSilva retired at age 62 in November 2015 and began to receive social security benefits. In January 2016, Mr. DeSilva received a check from his employer for $17,000 for his leftover vacation time. Because this was for vacation pay he accumulated before he retired, social security will consider it a special payment and will not count it toward the earnings limit for 2016.

If an individual was self-employed, any net income he or she receives after the first year he or she retires counts as a special payment if the individual performed the services to earn the payment before he or she was entitled to receive social security benefits. “Services” are any regular work or other significant activity an individual does for his or her business.

Some special payments to self-employed people include farm agricultural program payments, income from carryover crops, or income gained by an owner of a business who does not perform significant services in that business.

Many insurance salespeople continue to receive commissions after the year they retire for policies they sold prior to retirement. This income will not affect their social security benefits, as long as the income was the result of work done before they retired.

F. INCREASE IN BENEFITS POSSIBLE

The extra earnings could increase the recipient’s social security benefits. The individual’s original social security benefit was based on his or her highest years of earnings. Each year, the Social Security Administration reviews the records for all social security recipients who work. If it is determined that one of the latest years’ earnings is a person’s highest or one of his or her highest years, it could result in an increase in his or her benefit level. This is an automatic process and benefits are paid in December of the following year.

II. THE NOTCH PROVISION

The term “notch” refers to social security benefits paid to people born between 1917 and 1921. The notch resulted from a 1972 change in the social security law that provided an annual automatic cost-of-living adjustment (COLA) for benefits. The formula used to calculate the COLA was flawed, and the benefit levels actually rose faster than the rate of inflation. Before Congress corrected this error in 1977, the benefits for many people born between 1910 and 1916 were calculated using the flawed benefit formula, and they received an unintended windfall from social security.

When Congress fixed the mistake, it wanted to avoid an abrupt change for those who were about to retire, so it provided a transition period. Therefore, when social security benefits are calculated for people born between 1917 and 1921, two computations are used. One calculation uses the new (and correct) 1977 formula, and the other uses a special transition formula.

Benefits are based on whichever calculation pays the higher benefit. Benefits for everyone born in 1922 and later are calculated using only the new and correct 1977 formula which generally results in lower benefits than those computed using the "notch" calculation method.

III. WINDFALL ELIMINATION PROVISION

A. WINDFALL PROVISION DEFINED

If an individual works for an employer who does not withhold social security taxes from his or her wages, such as a government agency or an employer in another country, the pension he or she receives based on that work may reduce his or her social security benefits.

The "Windfall Elimination Provision" affects how the amount of an individual's retirement or disability benefits is calculated if he or she receives a pension from work in cases where social security taxes were not taken out of his or her pay. A modified formula is used to calculate the individual's benefit amount, resulting in a lower social security benefit.

B. WHEN BENEFITS MAY BE AFFECTED

The Windfall Elimination Provision primarily affects people who earned a pension from working for a government agency and also worked at other jobs where they paid social security taxes long enough to qualify for retirement or disability benefits. It also may affect an individual if he or she earned a pension in any job where he or she did not pay social security taxes, such as in a foreign country.

If an individual is a federal employee, the Windfall Elimination Provision will affect them only if he or she is receiving a Civil Service Retirement System (CSRS) pension. It will begin with the first month the individual receives both a social security benefit and the CSRS pension.

This provision affects social security benefits when any part of a person's federal service after 1956 is covered under the CSRS. However, federal service where social security taxes are withheld (Federal Employees' Retirement System or CSRS Offset) will not reduce an individual's social security benefit amounts.

An individual's social security benefit will be reduced if:

- He or she reached 62 after 1985; or
- He or she became disabled after 1985; or
- He or she first became eligible for a monthly pension based on work where he or she did not pay social security taxes after 1985, even if he or she is still working.

C. WHY DIFFERENT FORMULAS ARE USED

An individual's social security benefits are reduced because social security benefits were intended to replace only a percentage of a worker's pre-retirement earnings. The way social security benefit amounts are figured, lower-paid workers get a higher return than highly paid workers. For example, lower-paid

workers could get a social security benefit that equals about 48 percent of their pre-retirement earnings. The average replacement rate for highly paid workers is about 32 percent.

Before 1983, people who worked in jobs not covered by social security received benefits that were computed as if they were long-term, low-wage workers. They received the advantage of a higher percentage of benefits in addition to their other pension. Congress passed the Windfall Elimination Provision to eliminate this advantage.

D. EXCEPTIONS TO WINDFALL RULE

The Windfall Elimination Provision does not apply to survivors' benefits. It also does not apply if:

- An individual is a federal worker first hired after December 31, 1983;
- An individual who was employed on December 31, 1983, by a nonprofit organization that did not withhold social security taxes from his or her pay at first, but then began withholding social security taxes from his or her pay;
- The individual's only pension is based on railroad employment;
- The only work the individual did where he or she did not pay social security taxes was before 1957; or
- The individual had 30 or more years of substantial earnings under social security.

There is also a protection for individuals who receive a relatively low pension. The reduction in an individual's social security benefit cannot be more than one-half of that part of his or her pension based on earnings after 1956 from which social security taxes were not deducted.

Although the Windfall elimination provision does not apply to survivor's benefits, the SSA may reduce widows or widowers benefits because of another law, known as the Government Pension Offset, discussed later.

IV. GOVERNMENT EMPLOYEES

A. HISTORY OF TREATMENT

Unlike workers in the private sector, not all state and local employees are covered by social security. Some are covered only by their public retirement pension program; some are covered by both public pensions and social security; and some are covered by social security only.

When it began, the social security program did not include any of these employees. Over the years, the law has changed. Most employees have social security protection because their states and the Social Security Administration entered into special agreements called "section 218 agreements." Others were covered by a federal law passed in July 1991 when social security was extended to state and local employees who were not covered by an agreement and were not members of their agency's public pension system.

Each state has a designated official, called the State Social Security Administrator, who is responsible for the state's section 218 agreement. The State Administrator can provide information and answer questions about social security and Medicare coverage under the agreement.

Except for workers specifically excluded by law, employees hired after March 31, 1986 also have Medicare protection. States may obtain Medicare coverage for workers who have been continuously employed under section 218 agreements since before that date.

State and local government employees who are covered by social security and Medicare pay into these programs and have the same rights as private sector workers.

B. PENSION OFFSET

If an individual receives a pension from a federal, state or local government based on work where the employer did not pay social security taxes, his or her social security spouse's or widow's or widower's benefits may be reduced.

An individual's social security benefits will be reduced by two-thirds of his or her government pension.

Example

Robert receives a monthly civil service pension of $600. Two-thirds of that, or $400, must be deducted from his social security benefits. If Robert is eligible for a $500 spouse's, widow's or widower's benefit from social security, he will receive $100 per month from social security ($500 – $400 = $100).

If an individual takes his or her government pension annuity in a lump sum, social security still will calculate the reduction as if he or she chose to get monthly benefit payments from his or her government work.

1. Why Benefits Are Reduced

The benefits paid by the Social Security Administration to wives, husbands, widows and widowers are "dependent's" benefits. These benefits were established in the 1930s to compensate spouses who stayed home to raise a family and who were financially dependent on the working spouse. But as it has become more common for both spouses in a married couple to work, each earned his or her own social security retirement benefit. The law has always required that a person's benefit as a spouse, widow, or widower be offset dollar for dollar by the amount of his or her own retirement benefit.

In other words, if a woman worked and earned her own $800 monthly social security retirement benefit, but she was also due a $500 wife's benefit on her husband's social security record, social security would not pay that wife's benefit because her own social security benefit offset it. But, before enactment of the Government Pension Offset provision if that same woman was a government employee who did not pay into social security, and who earned an $800 government pension, there was no offset and social security was required to pay her a full wife's benefit in addition to her government pension.

If this government employee's work had instead been subject to social security taxes, any social security benefit payable as a spouse, widow or widower would have been reduced by the person's own social security retirement benefit. In enacting the Government Pension Offset provision, Congress intended to ensure that when determining the amount of spousal benefit, government employees who do not pay social security taxes would be treated in a similar manner to those who work in the private sector and do pay social security taxes.

2. When Benefits Are Not Reduced

Generally, an individual's social security benefits as a spouse, widow or widower will not be reduced if:

- The individual is receiving a government pension that is not based on his or her earnings;
- The individual is a state or local employee whose government pension is based on a job where he or she was paying social security taxes, and
    - The individual filed for and was entitled to spouses, widows, or widowers benefits before April 1, 2004; or
    - His or her last day of employment was before July 1, 2004; or
    - During the last five years of employment and his or her last day of employment was July 1, 2004, or later. (Under certain conditions, fewer than five years may be required for people whose last day of employment falls between July 1, 2004, and March 2, 2009.);
- The individual is a federal employee who switched from the Civil Service Retirement System to the Federal Employees' Retirement System (FERS) after December 31, 1987; and the individual:
    - Filed for and was entitled to spouses, widows, or widowers benefits before April 1, 2004; or
    - Had a last day of service (that his or her pension was based on) before July 1, 2004; or
    - Paid Social Security taxes on his or her earnings for 60 months or more during the period beginning January 1988 and ending with the first month of entitlement to benefits; or
- The individual received, or was eligible to receive, a government pension before December 1982 and met all the requirements for Social Security spouse's benefits in effect in January 1977; or
- The individual received, or was eligible to receive, a federal, state, or local government pension before July 1, 1983, and was receiving one-half support from his or her spouse.

Note

A Civil Service Offset employee is a federal employee, rehired after December 31, 1983, following a break in service of more than 365 days, with five years of prior CSRS coverage.

C. OTHER ISSUES

1. Medicare

Even if an individual does not receive cash benefits based on his or her spouse's work, he or she still can get Medicare at age 65 on his or her spouse's record if he or she is not eligible for it on his or her own record.

2. Application of Windfall Provisions

The offset applies only to social security benefits as a spouse or widow or widower. However, an individual's own benefits may be reduced because of the Windfall Elimination Provision, discussed above.

V. PRISONERS

Social security and Supplemental Security Income (SSI) benefits generally are not payable for months that an individual is confined to a jail, prison or certain other public institutions for committing a crime. And, such individuals are not automatically eligible for social security or SSI benefits when they are released.

Social security disability benefits can be paid to people who have recently worked and paid social security taxes and are unable to work because of a serious medical condition that is expected to last at least a year or result in death. The fact that a person is a recent parolee or is unemployed does not qualify as a disability. No benefits are payable for months an individual was in a jail, prison or other correctional facility or certain other public institutions.

Social security retirement benefits can be paid to people who are 62 or older. Generally, individuals must have worked and paid social security taxes for 10 years to be eligible. Benefits are not paid for the months individuals have been sentenced to a jail, prison or correctional facility or confined to certain public institutions for committing a crime.

Although individuals cannot receive monthly social security benefit payments while they are confined, their spouse or children can be paid benefits on their record if they are eligible. And if an individual has worked and paid social security taxes, survivors benefits also may be paid to certain family members in the event of the individual's death.

SSI payments can be paid to people who are 65 or older, or who are blind or disabled and whose income

and resources are below certain limits. No benefits are payable for any month in which an individual resides in a jail, prison or certain other public institutions.

VI. USE OF REPRESENTATIVE PAYEE TO COLLECT BENEFITS

Although there could be other reasons for deciding to use a representative payee, it is usually because the SSA has information that indicates the recipient of benefits needs help in managing his or her money. In addition to individuals, social service agencies, nursing homes or other organizations also can offer to serve as payees. The final selection of a payee is at the discretion of the SSA, not the recipient of the benefits.

A. DUTIES OF PAYEE

The payee receives the beneficiary's monthly benefits on the beneficiary's behalf and must use the money to pay for his or her current needs, including:

- Housing and utilities;
- Food;
- Medical and dental expenses;
- Personal care items;
- Clothing; and
- Rehabilitation expenses (if he or she is disabled).

After those expenses are paid, the payee can use the rest of the money to pay any past-due bills the beneficiary may have, give him or her spending money, support the beneficiary's dependents or provide entertainment for the beneficiary. Any leftover funds should be saved for the beneficiary.

A payee must keep accurate records of the beneficiary's money and how it is spent. A payee also must regularly report the information to the Social Security Administration and share it with the beneficiary.

If the beneficiary lives in an institution, such as a nursing home or hospital, the payee should pay the cost of the individual's care and provide money for his or her personal needs.

B. SPENDING LARGE AMOUNTS OF MONEY

When there has been a delay in approving an individual's benefits, his or her benefits may be paid in a large payment. If that happens, the payee must spend the money on the beneficiary's current needs. The rest of the money can be used to pay for medical services, education, improvements to the beneficiary's home or his or her debts. If the back payment is for more than one year of benefits, the benefits will be paid in several small payments.

If an individual receives Supplemental Security Income, he or she cannot have more than $2,000 in cash and property (other than his or her home and car). The individual must spend his or her back payment

within six months to keep his or her total resources below $2,000. If an individual's resources are higher than $2,000, the individual's payments may stop.

Also, if the beneficiary is a disabled child who is younger than age 18 and eligible for large past-due SSI payments, his or her payee is required to open a separate account at a financial institution. The past-due payment must be deposited directly into that dedicated account and can only be used for expenses related to the child's disability.

VII. MILITARY SERVICE AND SOCIAL SECURITY

Earnings for active duty military service or active duty training have been covered under social security since 1957. Social security has covered inactive duty service in the armed forces reserves (such as weekend drills) since 1988. If an individual served in the military before 1957, he or she did not pay social security taxes. However, the government provides such individuals with special credit for some of those years of service.

A. SOCIAL SECURITY AND MEDICARE TAXES

While an individual is in military service, he or she pays social security taxes just as civilian employees do. The tax rate is 7.65 percent, up to a maximum of $118,500 for 2016. If an individual earns more, he or she continues to pay the Medicare portion of the tax (1.45 percent) on the rest of his or her earnings.

In 2016, wages in excess of $200,000 ($250,000 MJ) are subject to an additional Medicare tax of .9% and a 3.8% additional tax on the lesser of unearned income (exclusions apply) or wages in excess of the $200,000 ($250,000 MJ).

B. SPECIAL CREDITS

If an individual served in the military from 1940 through 1956, including attendance at a service academy, he or she did not pay social security taxes. However, the SSA will credit him or her with $160 a month in earnings for military service from September 16, 1940, through December 31, 1956, if:

- He or she was honorably discharged after 90 or more days of service, or he or she was released because of a disability or injury received in the line of duty; or
- He or she is applying for survivors benefits based on a veteran's work and the veteran died while on active duty.

Individuals cannot receive these special credits if they are receiving a federal benefit based on the same years of service, unless they were on active duty after 1956. If an individual was on active duty after 1956, he or she can get the special credit for 1951 through 1956, even if he or she is receiving a military retirement based on service during that period.

If an individual served in the military in 1957 through 1977, he or she is credited with $300 in additional earnings for each calendar quarter in which he or she received active duty basic pay.

If an individual served in the military in 1978 through 2001, he or she is credited with an additional $100 in earnings, up to a maximum of $1,200 a year, for every $300 in active duty basic pay. After 2001, additional earnings will no longer be credited.

If an individual began his or her service after September 7, 1980, and did not complete at least 24 months of active duty or his or her full tour, the individual may not be able to receive the additional earnings.

C. BENEFITS

Benefit levels for military service people are calculated in the same way as other retired workers.

CHAPTER 3: TEST YOUR KNOWLEDGE

The following questions are designed to ensure that you have a complete understanding of the information presented in the chapter (assignment). They are included as an additional tool to enhance your learning experience and do not need to be submitted in order to receive CPE credit.

We recommend that you answer each question and then compare your response to the suggested solutions on the following page(s) before answering the final exam questions related to this chapter (assignment).

1.	**What effect, if any, does working have on a recipient's social security benefits:** **A.** if a formerly retired person decided to re-enter the workforce, he or she forfeits his or her social security benefits until he or she re-retires **B.** there is no impact whatsoever regardless of the circumstances **C.** persons who have not yet reached their full retirement age may have a reduction in benefits **D.** persons who have not yet reached full retirement age will lose their benefits until they reach that age
2.	**Income that counts as earnings as it relates to social security earnings limits include wages, investment income, and self-employment income.** **A.** true **B.** false
3.	**If an individual is self-employed, he or she will be considered retired if he or she works 45 hours or less a month in self-employment.** **A.** true **B.** false
4.	**Who does the "Windfall Elimination Provision" usually apply to:** **A.** former corporate executives who were overpaid when working and who therefore need less social security **B.** employees receiving pensions from businesses or government agencies that did not withhold or pay social security taxes **C.** spouses of highly compensated executives who do not need the money **D.** anyone who made over $100,000 per year while working

5.	**Which of the following statements regarding government employees' eligibility for social security benefits is correct:** **A.** all government workers, including those at the local, state and federal level, are covered by social security **B.** only some government employees are covered by social security **C.** the social security program originally covered only federal government workers when it was created **D.** none of the above

CHAPTER 3: SOLUTIONS AND SUGGESTED RESPONSES

Below are the solutions and suggested responses for the questions on the previous page(s). If you choose an incorrect answer, you should review the pages as indicated for each question to ensure comprehension of the material.

1.	**A.** Incorrect. While some people may have their benefits reduced depending on their income, there is no total loss of benefits. **B.** Incorrect. People who have reached full retirement age can re-enter the workforce without a negative impact, but the same is not true for persons who have yet to reach full retirement age. **C.** **CORRECT**. There is a loss of benefits up to a certain amount if people in this category earn more than a threshold amount of money during a year. **D.** Incorrect. There may be a reduction in benefits based on earnings, but they are not completely lost. *(See page 39 of the course material.)*
2.	**A.** Incorrect. Other income, including other government benefits, investment earnings, interest, pensions, annuities, or capital gains, is not counted when determining the recipient's earnings from work. **B.** **CORRECT**. Investment income is not included. If an individual works for wages, income is counted when it is earned rather than when paid. If a recipient is self-employed, income counts when it is received, not when it is earned. *(See page 40 of the course material.)*
3.	**A.** Incorrect. If a self-employed individual works less than 15 hours per month, he or she is considered retired. **B.** **CORRECT**. Individuals who work between 15 and 45 hours per month will not be considered retired if it is in a job that requires a lot of skill or where the individuals are managing a sizable business. *(See page 41 of the course material.)*

4.	**A.** Incorrect. People who earned large amounts do not lose social security benefits they would otherwise be entitled to. **B.** **CORRECT**. These people may receive fewer benefits from social security based on the pension they receive. **C.** Incorrect. There is no rule limiting benefits for these people. **D.** Incorrect. These people are not automatically affected by the rule unless they worked for a covered employer. *(See page 43 of the course material.)*
5.	**A.** Incorrect. Only some government employees are covered by social security benefits. Many have their own retirement or pension programs. **B.** **CORRECT**. Unlike most private sector workers, only some government employees participate in the social security system. **C.** Incorrect. Federal employees originally had a separate retirement plan. **D.** Incorrect. Because one of the statements is correct, this answer cannot be correct. *(See pages 44 to 45 of the course material.)*

CHAPTER 4: SELF-EMPLOYMENT TAX AND SOCIAL SECURITY

Chapter Objective

After completing this chapter, you should be able to:

- Recognize the application of the self-employment tax on social security.

I. OVERVIEW OF SELF-EMPLOYMENT TAX

A. THE IMPORTANCE OF SELF-EMPLOYMENT TAX

Most people who pay into social security work for an employer. Their employer deducts social security taxes from their paycheck, matches that contribution, sends taxes to the Internal Revenue Service (IRS), and reports wages to the Social Security Administration. Self-employed people, on the other hand, must report their earnings and pay their taxes directly to the IRS.

An individual is self-employed, for purposes of self-employment tax, if he or she operates a trade, business or profession, either by themselves or with a partner. A more detailed discussion of this definition is provided later in the chapter. Self-employed people report their earnings for social security when they file their federal income tax return. If an individual's net earnings are $400 or more in a year, he or she must report his or her earnings on Schedule SE in addition to the other tax forms he or she must file.

1. Benefits of Paying Self-Employment Tax

While accountants often look for ways to reduce their client's self-employment tax liability, it is also important to remember that self-employed individuals may benefit from paying into social security when they retire. Individuals who do not have the required number of credits will not be entitled to retirement and other benefits. In addition, individuals who do not get credit in their high earning years will have a lower benefit level than they would otherwise be entitled to. It is therefore important to consider the long-term benefit of higher social security benefits against the short-term cost of self-employment tax when considering whether to structure business interests to avoid such taxes.

2. Time Limit for Reporting Income

It is difficult to recast earnings later in order to increase social security benefits. The Social Security Administration (SSA) has a time limit for posting self-employment income. Generally, the SSA will give individuals credit only for self-employment income reported on a tax return filed within three years, three months, and 15 days after the tax year the individual earned the income. If an individual files his or her tax return or reports a change in self-employment income after this time limit, the SSA may change its

records, but only to remove or reduce the amount. The SSA will not change its records to increase an individual's self-employment income.

B. CURRENT RATES

The social security tax rate for 2016 is 15.3 percent on self-employment income up to $118,500. The rate consists of two parts: 12.4% for social security (old-age, survivors, and disability insurance) and 2.9% for Medicare (hospital insurance). If an individual's net earnings exceed $118,500, but are less than $200,000 ($250,000 MJ), he or she continues to pay only the Medicare portion of the social security tax on these earnings. Additionally, in 2016, earnings above $200,000 ($250,000 married filing jointly) are subject to an additional Medicare tax of .9%.

C. DEDUCTIONS FROM TAXES

There are two income tax deductions that reduce an individual's taxes. First, an individual's net earnings from self-employment are reduced by half of his or her total social security tax from self-employment. This is similar to the way employees are treated under the tax laws, because the employer's share of the social security tax is not considered wages to the employee.

Second, an individual can deduct half of the social security tax on IRS Form 1040. But the deduction must be taken from the individual's gross income in determining his or her adjusted gross income. It cannot be an itemized deduction and must not be listed on Schedule C.

If an individual has wages as well as self-employment earnings, the tax on the wages is paid first. But this rule is important only if an individual's total earnings are more than $118,500 in 2016.

Example

Felix had $30,000 in wages and $40,000 in self-employment income in 2016. He paid the appropriate social security taxes on both his wages and business earnings. However, if in 2016, Felix's wages are $78,000 and he has $40,700 in net earnings from a business, he does not pay dual social security taxes on earnings more than $118,500. Felix's employer will withhold 7.65 percent in social security and Medicare taxes on his $78,000 in earnings. He must pay 15.3 percent in social security and Medicare taxes on his first $40,500 in self-employment earnings and 2.9 percent in Medicare tax on the remaining $200 in earnings.

D. CALCULATING NET EARNINGS

Net earnings for social security are an individual's gross earnings from his or her trade or business, minus allowable business deductions and depreciation. Some income does not count for social security and should not be included in figuring net earnings:

- Dividends from shares of stock and interest on bonds, unless the individual received them as a dealer in stocks and securities;

- Interest from loans, unless the individual's business is lending money;
- Rentals from real estate, unless the individual is a real estate dealer or regularly provides services mostly for the convenience of the occupant; or
- Income received from a limited partnership.

1. Optional Method

If an individual's actual net earnings are less than $400, his or her earnings can still count for social security under an optional method of reporting.

Individuals can use the optional method only five times in their life when reporting non-farm income. Their actual net must have been $400 or more in at least two of the last three years, and their net earnings must be less than two-thirds of their gross income. This is how it works:

- If an individual's gross income from farm self-employment was not more than $7,560, or his or her net farm profits were less than $5,457, the individual may report the smaller of two-thirds (2/3) of gross farm income (not less than 0) or $5,040; or
- If the individual's net income from non-farm self-employment is less than $5,457 and also less than 72.189% of his or her gross non-farm income, and he or she had net earnings from self-employment of at least $400 in 2 of the prior 3 years.
- The individual can use both the farm and non-farm methods of reporting, and can report less than his or her total actual net earnings from farm and non-farm self-employment, but he or she can't report less than his or her actual net earnings from non-farm self-employment alone. If he or she uses both methods to figure net earnings, the individual can't report more than $5,040.

2. Special Note for Farmers

Farmers can use the optional reporting method every year. It is not necessary to have had actual net earnings of at least $400 in a preceding year.

3. Reporting Earnings

Taxpayers must complete the following federal tax forms by April 15 after any year in which they have net earnings of $400 or more:

- Form 1040 (U.S. Individual Income Tax Return);
- Schedule C (Profit or Loss from Business) or Schedule F (Profit or Loss from Farming) as appropriate; and
- Schedule SE (Self-Employment Tax).

Even if no income tax is owed, an individual must complete Form 1040 and Schedule SE to pay self-employment social security tax. This is true even for persons who already get social security benefits.

4. Family Business Arrangements

Family members may operate a business together. For example, a husband and a wife may be partners or run a joint venture. If two individuals operate a business together as partners, they should each report their share of the business profits as net earnings on separate self-employment returns (Schedule SE), even if they file a joint income tax return. The partners must decide the amount of net earnings each should report (for example 50 percent and 50 percent).

II. APPLICATION OF SELF-EMPLOYMENT TAX

An individual's net earnings from self-employment are based on his or her earnings subject to self-employment (SE) tax. Most earnings from self-employment are subject to SE tax. Some earnings from employment (certain earnings that are not subject to social security and Medicare taxes) are subject to SE tax. This section provides information to determine whether certain earnings are subject to SE tax.

A. COVERED GROUPS

The SE tax rules apply no matter how old an individual is and even if he or she is already receiving social security or Medicare benefits.

1. Aliens

Resident aliens are generally subject to the same rules that apply to U.S. citizens. Nonresident aliens are not subject to SE tax. Residents of the Virgin Islands, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, or American Samoa, however, are subject to the tax. For SE tax purposes, they are not nonresident aliens.

2. Church Employees

If an individual works for a church or a qualified church-controlled organization (other than as a minister or member of a religious order) that elected an exemption from social security and Medicare taxes, he or she is subject to SE tax if he or she receives $108.28 or more in wages from the church or organization. However, individuals may qualify for an exemption from the SE tax if they are a member of a recognized religious group.

3. State or Local Government Employee

Individuals are subject to SE tax if they are an employee of a state or local government, are paid solely on a fee basis, and their services are not covered under a federal-state social security agreement.

4. Foreign Government or International Organization Employee

Individuals are subject to SE tax if both the following conditions are true:

- They are a U.S. citizen employed in the United States, Puerto Rico, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, or the Virgin Islands by:
    - A foreign government,

- A wholly-owned instrumentality of a foreign government; or
- An international organization.

- Their employer is not required to withhold social security and Medicare taxes from their wages.

5. U.S. Citizen or Resident Aliens Residing Abroad

In most cases, individuals who are self-employed U.S. citizens or resident aliens living outside the United States must pay SE tax. They are not entitled to reduce their foreign earnings from self-employment by their foreign earned income exclusion.

However, the United States has concluded social security agreements with a number of other countries that help workers avoid double taxation while working abroad and also help protect their future benefit rights.

Table 4-1, below, lists the countries with which the United States has social security agreements and shows the effective date of each. Readers who have clients that work in one of these countries should go to the Social Security Administration website (ssa.gov) and obtain a copy of the applicable treaty for more specific information.

The rules that eliminate dual social security coverage and taxation for employed persons are similar in all U.S. agreements. Each agreement establishes a basic rule that assigns an individual's coverage to the country where the work is performed. Under this basic "territoriality" rule, if an individual is employed abroad in an agreement country, he or she will pay social security taxes only to that country and he or she will be exempt from paying U.S. social security taxes. In the same way, foreign nationals who work in the United States will pay U.S. social security taxes but will not pay to their home country.

TABLE 4-1. COUNTRIES WITH SOCIAL SECURITY AGREEMENTS

Country	Effective Date of Agreement
Australia	October 1, 2002
Austria	November 1, 1991
Belgium	July 1, 1984
Canada	August 1, 1984
Chile	December 1, 2001
Czech Republic	January 1, 2009
Denmark	October 1, 2008
Finland	November 1, 1992
France	July 1, 1988
Germany	December 1, 1979
Greece	September 1, 1994
Hungary	September 1, 2016
Ireland	September 1, 1993

Italy	November 1, 1978
Japan	October 1, 2005
South Korea	April 1, 2001
Luxembourg	November 1, 1993
Netherlands	November 1, 1990
Norway	July 1, 1984
Poland	March 1, 2009
Portugal	August 1, 1989
Slovak Republic	May 1, 2014
Spain	April 1, 1988
Sweden	January 1, 1987
Switzerland	November 1, 1980
United Kingdom	January 1, 1985

Each agreement (other than the one with Italy) includes an exception to the above noted territoriality rule. The exception applies to workers who are assigned temporarily from one country to another. Under this "temporary assignment" exception, if a worker is sent by his or her employer in the U.S. to work in an agreement country for no more than five years, he or she will pay only U.S. social security tax and will be exempt from foreign tax. The agreement with Italy includes a different rule that eliminates dual social security taxation based on the worker's citizenship.

Each agreement also includes rules that eliminate dual social security taxes for self-employed persons who work abroad and for international transport workers.

U.S. citizens and residents who will be exempt from foreign social security taxes while working abroad must obtain a "certificate of coverage" from the Social Security Administration to present as proof of their exemption in the other country. Similarly, foreign nationals who work in the United States must obtain a certificate from the social security authorities in their home country to establish their exemption from U.S. social security taxes.

U.S. social security agreements also help people who have worked in both the United States and an agreement country, but who have not worked long enough in one country or the other to qualify for social security retirement, disability or survivor benefits. Under an agreement, each country can count an individual's work credits in the other country if this will help them qualify for benefits.

Although each country may count an individual's work credits in the other country, his or her credits are not actually transferred from one country to the other. They remain on the worker's record in the country where they were earned. It is therefore possible for a person to qualify for a separate benefit payment from each country.

B. DETERMINING WHETHER AN INDIVIDUAL IS SELF-EMPLOYED

1. Basic Definition

An individual is self-employed if any of the following apply:

- He or she carries on a trade or business as a sole proprietor or an independent contractor; or
- He or she is a member of a partnership that carries on a trade or business; or
- He or she is otherwise in business for himself or herself.

2. Trade or Business

A trade or business is generally an activity carried on for a livelihood or in good faith to make a profit. The facts and circumstances of each case determine whether or not an activity is a trade or business. The regularity of activities and transactions and the production of income are important elements. An individual does not need to actually make a profit to be in a trade or business as long as he or she has a profit motive. An individual does need, however, to make ongoing efforts to further the interests of his or her business.

Example

Julia, a stay-at-home mom, takes up a new hobby making jewelry. She buys beads and other supplies at a local store and makes necklaces and other pieces while her children are at school. She gives the pieces as gifts and wears many of them herself. After receiving many compliments, Julia decides to start selling her pieces at a local flea market to make a little extra money. Although she sells her merchandise only occasionally – no more than twice a month – she is engaged with the intent to make a profit and is therefore self-employed for purposes of SE tax.

a. Part-time Business

An individual does not have to carry on regular full-time business activities to be self-employed. Having a part-time business in addition to a regular job or business also may be self-employment.

Example

Harold is employed full time as an engineer at the local plant. He also fixes computers during the weekends. Harold has his own shop, equipment, and tools. He gets his customers from advertising and word-of-mouth. Harold is self-employed as the owner of a part-time repair shop.

b. Sole Proprietor

An individual is a sole proprietor if he or she owns an unincorporated business (or otherwise lacking a formal legal structure such as a limited liability company) by themselves. A sole proprietor is, by definition, self-employed.

c. Independent Contractor

People such as doctors, dentists, veterinarians, lawyers, accountants, contractors, subcontractors, public stenographers, or auctioneers who are in an independent trade, business, or profession in which they offer their services to the general public are generally independent contractors. However, whether these people are independent contractors or employees depends on the facts in each case. The general rule is that an individual is an independent contractor if the payer has the right to control or direct only the result of the work and not what will be done and how it will be done. The earnings of a person who is working as an independent contractor are subject to SE tax.

An individual is not an independent contractor if he or she performs services that can be controlled by an employer (what will be done and how it will be done). This applies even if the individual is given freedom of action. What is legally significant is that the employer has the legal right to control the details of how the services are performed.

If an employer-employee relationship exists (regardless of what the relationship is called), the individual is not an independent contractor and his or her earnings are generally not subject to SE tax. However, the individual's earnings as an employee may be subject to SE tax.

3. Partners

A partner must include distributions in addition to any guaranteed payments as income subject to self-employment. Self-employment tax must be paid on these amounts, up to the annual limit.

The only exception is where the partnership is an investment club whose activities are limited to investing in securities. This income is not subject to self-employment tax (but is of course subject to other types of federal taxation).

Distributions and other payments received by a partner are included in a Schedule K-1 prepared annually by the partnership and provided to the individual partners (the partnership itself is not a taxable entity). For all general partners, this is true whether or not an individual was actively involved in the management of the partnership. Limited partners must include only any guaranteed payments, such as salaries or professional fees received during the tax year.

A retired partner who continues to receive income from the partnership is not required to include such distributions as self-employment tax where all of the following is true:

- His or her share of the partnership has been fully repaid (the partnership owes the individual no other assets other than the retirement income);
- The individual has not performed services for the partnership during the tax year; and
- The individual is receiving periodic payments for life.

C. GUIDELINES FOR SELECTED OCCUPATIONS

1. Retired Insurance Agent

Income paid by an insurance company to a retired self-employed insurance agent based on a percentage of commissions received before retirement is subject to SE tax. Also, renewal commissions and deferred commissions for sales made before retirement are generally subject to SE tax. However, renewal commissions paid to the survivor of an insurance agent are not subject to SE tax.

2. Former Insurance Agent

Termination payments an individual receives as a former self-employed insurance agent from an insurance company because of services they performed for that company are exempt from SE tax if all the following conditions are met:

- He or she received the payments after his or her agreement to perform services for the company ended;
- He or she did not perform any services for the company after his or her service agreement ended and before the end of the year in which he or she received the payment;
- He or she entered into a covenant not to compete against the company for at least a 1-year period beginning on the date his or her service agreement ended;
- The amount of the payments depended primarily on policies sold by or credited to an individual's account during the last year of his or her service agreement or the extent to which those policies remain in force for some period after his or her service agreement ended, or both; and
- The amount of the payment did not depend to any extent on length of service or overall earnings from services performed for the company (regardless of whether eligibility for the payments depended on length of service).

3. Public Official

Public officials generally are not subject to SE tax on what they earn for serving in public office. This rule applies to payments received by an elected tax collector from state funds on the basis of a fixed percentage of the taxes collected. Public office includes any elective or appointive office of the United States or its possessions, the District of Columbia, a state or its political subdivisions, or a wholly owned instrumentality of any of these.

However, public officials of state or local governments are subject to SE tax on their fees if they are paid solely on a fee basis and if their services are eligible for, but not covered by, social security under a federal-state agreement.

4. Real Estate Agent or Direct Seller

The earnings of licensed real estate agents or direct sellers may be subject to SE tax if both the following apply:

- Substantially all their pay for services as a real estate agent or direct seller directly relates to their sales or other output rather than to the number of hours they work; and
- They perform the services under a written contract that says they will not be treated as an employee for federal tax purposes.

5. Dealer in Securities

If an individual is a dealer in options or commodities, his or her gains and losses from dealing or trading in § 1256 contracts (regulated futures contracts, foreign currency contracts, nonequity options, dealer equity options, and dealer securities futures contracts) or property related to those contracts (such as stock used to hedge options) are subject to SE tax.

6. Executor or Administrator

If an individual administers a deceased person's estate, his or her fees are subject to SE tax if the individual is one of the following:

- A professional fiduciary;
- A nonprofessional fiduciary (personal representative) and both of the following conditions apply:
    - The estate includes an active trade or business in which the individual actively participates; and
    - The individual's fees are related to the operation of that trade or business.
- A nonprofessional fiduciary of a single estate that requires extensive managerial activities on his or her part for a long period of time, provided these activities are enough to be considered a trade or business.

7. Minister, Christian Science Practitioner, or Member of Religious Order

Individuals are generally subject to SE tax on earnings for services they perform as a minister, Christian Science practitioner, or member of a religious order who has not taken a vow of poverty. An exemption from SE tax on certain earnings is available by filing IRS Form 4361.

Individuals who belong to a religious order and took a vow of poverty are not subject to SE tax on earnings for performing duties required by the order.

8. Member of Recognized Religious Group

If an individual belongs to a recognized religious group opposed to insurance, he or she may qualify for an exemption from the SE tax. To qualify, the individual must be conscientiously opposed to accepting the benefits of any public or private insurance that makes payments because of death, disability, old age, retirement, or medical care, or that provides services for medical care. If an individual buys a retirement annuity from an insurance company, he or she will not be eligible for this exemption. Religious opposition based on group teachings is the only legal basis for the exemption. In addition, the individual's religious group (or division) must have existed since December 31, 1950.

To get the exemption, an individual must file in triplicate Form 4029 and waive all social security benefits.

9. Trader in Securities

As a trader in securities, an individual's gain or loss from the disposition of securities is not subject to SE tax. A trader in securities is someone who engaged in the business of buying and selling securities for his or her own account.

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CHAPTER 4: TEST YOUR KNOWLEDGE

The following questions are designed to ensure that you have a complete understanding of the information presented in the chapter (assignment). They are included as an additional tool to enhance your learning experience and do not need to be submitted in order to receive CPE credit.

We recommend that you answer each question and then compare your response to the suggested solutions on the following page(s) before answering the final exam questions related to this chapter (assignment).

1.	**For what reason would a business owner benefit from paying self-employment taxes:** **A.** it reduces his or her overall tax liability **B.** it provides a credit against state taxes **C.** it entitles the business owner to social security retirement benefits when he or she is older **D.** it entitles the business owner to receive enhanced Medicare benefits when he or she retires
2.	**Which of the following individuals are subject to federal social security tax:** **A.** a person receiving social security who opens a business **B.** resident aliens working in the United States **C.** employees of municipal governments **D.** all of the above
3.	**Which of the following people are subject to self-employment tax:** **A.** Fred, a CPA, who is a partner and works full-time at a successful accounting firm **B.** Sally, the sole proprietor of a shoe store that barely breaks even every month but has never turned a profit **C.** Mike, who works part-time doing carpentry work **D.** all of the above

4.	**Public officials generally are not subject to SE tax on what they earn for serving in public office.** **A.** true **B.** false

CHAPTER 4: SOLUTIONS AND SUGGESTED RESPONSES

Below are the solutions and suggested responses for the questions on the previous page(s). If you choose an incorrect answer, you should review the pages as indicated for each question to ensure comprehension of the material.

1.	**A.** Incorrect. To the contrary, it is an extra tax and a fairly expensive one. **B.** Incorrect. There is no such state tax credit. **C.** **CORRECT**. The theory of social security taxes is that you receive that money back in the form of benefits when you reach retirement age. Some self-employed people might find they want or need those benefits later in life. **D.** Incorrect. There is no such enhancement. Medicare benefits are the same for all people. *(See page 55 of the course material.)*
2.	**A.** Incorrect. Even if a person is already collecting social security benefits, he or she remains subject to social security tax to the extent he or she has self-employment income or receives wages. This occurs when a previously retired person re-enters the workforce or opens a business. However, this is not the best answer. **B.** Incorrect: They are generally subject to the same tax as U.S. citizens. However, this is not the best answer. **C.** Incorrect. Employees of state or local governments are not exempt from federal social security tax. However, this is not the best answer. **D.** **CORRECT**. All of the above groups are subject to social security tax. It is the exception to be exempt from this obligation. *(See page 58 of the course material.)*
3.	**A.** Incorrect. A partner in a trade or occupation is self-employed and subject to SE tax. However, this is not the best answer. **B.** Incorrect. Making a profit is not the lynchpin for being subject to SE tax. Although her tax might not be high, she is subject to SE tax. However, this is not the best answer. **C.** Incorrect. Even part-time work is subject to SE tax so long as it is being done as a business. However, this is not the best answer. **D.** **CORRECT**. All of the people above are self-employed for purposes of being subject to SE tax. *(See pages 60 to 62 of the course material.)*

4.	**A. CORRECT**. This rule applies to payments received by an elected tax collector from state funds on the basis of a fixed percentage of the taxes collected. **B.** Incorrect. However, public officials of state and local governments are subject to self-employment tax on their fees if they are paid solely on a fee basis and if their services are eligible for, but not covered by, social security under a federal-state agreement. *(See page 63 of the course material.)*

CHAPTER 5: TAXATION OF SOCIAL SECURITY BENEFITS

Chapter Objective

After completing this chapter, you should be able to:

- Identify basic rules regarding the taxation of social security benefits.

I. HOW SOCIAL SECURITY BENEFITS ARE TAXED

A. BASIC RULES

Some people who get social security benefits have to pay income taxes on their benefits. This will apply only if an individual has other substantial income in addition to his or her benefits (for example, wages, self-employment, interest, dividends and other taxable income that he or she has to report on his or her tax return). No one pays federal income taxes on more than 85 percent of his or her social security benefits and some pay on a smaller amount, based on the following IRS rules:

- If someone files a federal tax return as an "individual" and his or her combined income1 is between $25,000 and $34,000, he or she may have to pay income tax on 50 percent of his or her social security benefits. If the individual's combined income is above $34,000, up to 85 percent of his or her social security benefits is subject to income tax.
- If someone files a joint return, he or she may have to pay taxes on 50 percent of his or her benefits if he or she and his or her spouse have a combined income that is between $32,000 and $44,000. If their combined income is more than $44,000, up to 85 percent of their social security benefits is subject to income tax.
- If someone is married and files a separate tax return, he or she will probably pay taxes on his or her benefits.

Every January, benefit recipients will receive a Social Security Benefit Statement (Form SSA-1099) showing the amount of benefits they have received in the previous year. Recipients can use this statement when they complete their federal income tax return to find out if any of their benefits are subject to income tax.

In applying these rules, social security benefits include monthly survivor and disability benefits. They do not include Supplemental Security Income (SSI) payments, which are not taxable.

Although benefits recipients are not required to have federal taxes withheld from their social security benefits, some people may find it easier than paying quarterly estimated tax payments.

1. On a 1040 tax return, an individual's "combined income" is the sum of his or her adjusted gross income, plus nontaxable interest, plus one-half of his or her social security benefits.

To find out whether any benefits may be taxable, a social security recipient should compare the base amount for his or her filing status (defined below) with the total of:

- One-half of his or her benefits, plus
- All other income, including tax-exempt interest.

When making this comparison, individuals do not reduce their other income by any exclusions for:

- Interest from qualified U.S. savings bonds;
- Employer-provided adoption benefits;
- Foreign earned income or foreign housing; or
- Income earned in American Samoa or Puerto Rico by bona fide residents.

An individual's base amount is:

- $25,000 if single, head of household, or qualifying widow(er);
- $25,000 if married filing separately and lived apart from a spouse for the entire year;
- $32,000 if married filing jointly; or
- $–0– if an individual is married filing separately and lived with his or her spouse at any time during the year.

Example

Mark and Monica have regular income (such as interest income, dividend income, capital gain income, etc.) of $15,000. They also have tax-exempt interest income of $12,000. Together, they receive total social security benefits of $20,000. Since their modified AGI ($27,000) plus half of their social security benefits ($10,000) exceeds the $32,000 threshold, they will have to pay taxes on their social security benefits.

B. AMOUNT SUBJECT TO TAX

If part of an individual's benefits is taxable, how much is taxable depends on the total amount of his or her benefits and other income. Generally, the higher that total amount, the greater the taxable part of an individual's benefits.

Generally, up to 50% of a recipient's benefits will be taxable. However, up to 85% of benefits can be taxable if either of the following situations applies:

- The total of one-half of the recipient's benefits and all his or her other income is more than $34,000 ($44,000 if married filing jointly); or

- The individual is married filing separately and lived with his or her spouse at any time during the year.

C. DISABILITY AND SURVIVOR BENEFITS

These tax rules also apply to social security disability and survivor benefits. Also remember that, in the case of disability and survivor benefits, many of those benefits are paid to dependent children. This means that while a parent may deposit the funds in his or her account and use them for the benefit of his or her children, the funds will not be treated as the parent's benefits for tax purposes.

D. WHO IS TAXED?

The person who has the legal right to receive the benefits must determine whether the benefits are taxable. For example, if a widow and her child receive benefits, but the check for the child is made out in the mother's name, the mother must use only her part of the benefits to see whether any benefits are taxable to her. One-half of the part that belongs to the child must be added to the child's other income to see whether any of those benefits are taxable to the child.

E. TAX WITHHELD AND ESTIMATED TAX

A social security beneficiary can choose to have federal income tax withheld from his or her benefits. To do this, an individual must complete IRS Form W-4V and choose withholding at 7%, 10%, 15%, or 25% of his or her total benefit payment.

If an individual does not choose to have income tax withheld, he or she may have to request additional withholding from other income or pay estimated tax during the year.

F. PERSONS EXEMPT FROM TAX

1. U.S. Citizens Residing Abroad

U.S. citizens who reside in the following countries are exempt from U.S. tax on their benefits:

- Canada;
- Egypt;
- Germany;
- Ireland;
- Israel;
- Italy (individual must also be a citizen of Italy for the exemption to apply);
- Romania; and
- United Kingdom.

2. Lawful Permanent Residents

For U.S. income tax purposes, lawful permanent residents (green card holders) are considered resident aliens until their lawful permanent resident status under the immigration laws is either taken away or is administratively or judicially determined to have been abandoned. Social security benefits paid to a green card holder are not subject to 30% withholding.

3. Nonresident Aliens

A nonresident alien is an individual who is not a citizen or resident of the United States. If an individual is a nonresident alien, these rules do not apply. Instead, 85% of the recipient's benefits are taxed at a 30% rate, unless exempt (or subject to a lower rate) by treaty. Such recipients will receive a Form SSA–1042S or Form RRB–1042S showing the amount of their benefits. These forms will also show the tax rate and the amount of tax withheld from the recipient's benefits.

Under tax treaties with the following countries, residents of these countries are exempt from U.S. tax on their benefits:

- Canada;
- Egypt;
- Germany;
- Ireland;
- Israel;
- Italy;
- Japan;
- Romania; and
- United Kingdom.

Under a treaty with India, benefits paid to individuals who are both residents and nationals of India are exempt from U.S. tax if the benefits are for services performed for the United States, its subdivisions, or local government authorities. If a recipient is a resident of Switzerland, his or her total benefit amount will be taxed at a 15% rate.

If an individual's social security benefits are exempt from tax because he or she is a resident of one of the treaty countries listed, the SSA will not withhold U.S. tax from his or her benefits.

4. Canadian or German Social Security Benefits Paid to U.S. Residents

Under income tax treaties with Canada and Germany, social security benefits paid by those countries to U.S. residents are treated for U.S. income tax purposes as if they were paid under the social security legislation of the United States.

CHAPTER 5: TEST YOUR KNOWLEDGE

The following question is designed to ensure that you have a complete understanding of the information presented in the chapter (assignment). It is included as an additional tool to enhance your learning experience and does not need to be submitted in order to receive CPE credit.

We recommend that you answer the question and then compare your response to the suggested solution on the following page before answering the final exam question(s) related to this chapter (assignment).

1.	**Are there any circumstances under which a recipient must pay income taxes based on social security benefits:** **A.** none whatsoever **B.** while states have authority to tax these benefits, the federal government does not **C.** to the extent the individual has significant other income, he or she may have to pay federal income tax on up to 100 percent of his or her social security benefits **D.** to the extent an individual has other significant income, he or she may have to pay federal income taxes on up to 85 of his or her social security benefits

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CHAPTER 5: SOLUTION AND SUGGESTED RESPONSES

Below is the solution and suggested responses for the question on the previous page. If you choose an incorrect answer, you should review the page(s) as indicated for the question to ensure comprehension of the material.

1.	**A.** Incorrect. If a recipient has sufficiently high income from other sources, he or she may be subject to federal income tax on his or her benefits. **B.** Incorrect. States do not have authority to tax these benefits. **C.** Incorrect. Only up to 85 percent of benefits are subject to tax in situations where tax is applicable. **D.** **CORRECT**. No one is required to pay federal income tax on more than 85 percent of his or her social security benefits. The IRS has rules that determine the amount of benefit that is subject to tax in cases where the recipient has substantial other income. *(See page 71 of the course material.)*

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CHAPTER 6: DISABILITY AND SSI BENEFITS

Chapter Objective

After completing this chapter, you should be able to:

- Recall the disability and SSI benefits available for individuals and children with disabilities.

I. OVERVIEW OF FEDERAL PROGRAMS

The social security and Supplemental Security Income disability programs are the largest of several federal programs that provide assistance to people with disabilities. While these two programs are different in many ways, both are administered by the Social Security Administration (SSA) and only individuals who have a disability and meet medical criteria may qualify for benefits under either of the following programs:

- Social Security Disability Insurance pays benefits to individuals and certain members of their family if the individuals are "insured," meaning that they worked long enough and paid social security taxes; and
- Supplemental Security Income pays benefits based on financial need.

When an individual applies for either program, the Social Security Administration (SSA) will collect medical and other information from the applicant and make a decision about whether or not the applicant meets the social security's definition of disabled.

Both the SSI and SSDI programs are administered by the SSA. For most people, the medical requirements for each program are the same and the person's disability is determined by the same process, although each program has some distinctions, as noted below.

A. SOCIAL SECURITY DISABILITY INSURANCE (SSDI)

Social Security Disability Insurance (SSDI) is a program financed with social security taxes paid by workers, employers and self-employed persons. In order to be eligible for a social security benefit, the worker must earn sufficient credits based on taxable work. Disability benefits are payable to disabled workers, disabled widow(er)'s or adults disabled since childhood, who are otherwise eligible. Auxiliary benefits may be payable to a worker's dependents, as well.

The monthly disability benefit payment is based on the social security earnings record of the insured worker on whose social security number the disability claim is filed. In August 2016, the average benefit for a disabled worker was $1,165.46. The average amount for a spouse was $322.25, while the average amount for the child of a disabled worker was $351.70.

B. SUPPLEMENTAL SECURITY INCOME (SSI)

SSI is a program financed through general tax revenues. SSI disability benefits are payable to adults or children who are disabled or blind, who have limited income and resources, who meet the living arrangement requirements, and are otherwise eligible. The monthly payment varies up to the maximum federal benefit rate that is standardized in all states, but not everyone gets the same amount because it may be supplemented by the state or decreased by other countable income and resources.

C. SOCIAL SECURITY DEFINITION OF DISABLED

It is not easy for an adult to qualify for social security disability income. The social security definition of disability is a strict one. To be eligible for disability benefits, a person must be unable to do any kind of substantial gainful work because of a physical or mental impairment (or a combination of impairments):

- Which has lasted or is expected to last for a continuous period of at least 12 months, or
- That is expected to result in death.

It does not matter whether such work exists in the individual's immediate area, whether a specific job vacancy exists, or whether the individual would be hired if he or she applied for work. In addition, the impairment must be established by objective medical evidence.

There are also several limitations on the right of an individual to receive disability benefits even if his or her condition meets the legal definition. The main limitations apply to impairments that are the result of or related to an individual's commission of a felony and those which are the result of drug abuse.

1. Felony Acts and Incarceration

Under federal law, if an individual committed a felony after October 19, 1980, he or she is not entitled to disability cash benefits if:

- The individual's impairments (or the aggravation of preexisting impairments) are related to the commission of the felony; or
- The individual's impairments (or the aggravation of preexisting impairments) are related to his or her confinement in a correctional facility for the conviction of the felony.

2. Drug and Alcohol Abuse

Federal law also provides that individuals cannot be considered disabled if drug or alcohol abuse is a contributing factor of disability. This is true regardless of age.

Example

John, a construction worker, is paralyzed in an automobile accident he caused while driving under the influence of alcohol. Although he clearly meets the SSA's definition of "disabled," he is disqualified from disability benefits because alcohol was a contributing factor in causing his disability.

D. PROCESS TO DETERMINE WHETHER INDIVIDUAL IS DISABLED

The SSA process used to determine if an individual meets this definition involves the following five steps.

1. Is the Individual Working?

If an individual is working and the work is a substantial gainful activity, the SSA will find that the applicant is not disabled regardless of his or her medical condition, age, education or work experience.

Example

Gloria, who is a paraplegic, is an accountant who makes an annual salary of $85,000 for a publicly traded company. Although disabled, she is not entitled to disability benefits because she is involved in substantial gainful activity.

In 2016, the SSA generally finds that an individual is doing "substantial gainful activity" if his or her earnings average more than $1,130 a month for non-blind individuals, and $1,820 a month for blind individuals. If not, the SSA will go to the next step.

2. Is the Individual's Condition Severe?

An applicant's impairment or combination of impairments must interfere with basic work-related activities for his or her condition to be considered severe. If an individual does not have an impairment or combination of impairments that is severe, he or she will not be considered "disabled" for purposes of receiving social security benefits. If the SSA finds that an applicant does have a severe condition, they will go to the next step.

3. Does the Impairment Meet the Severity of Impairment in the Listing of Impairments?

The Listing of Impairments (published by the SSA and available on its website) contains examples of impairments for each of the major body systems that the SSA considers so severe as to prevent an individual from working. If an applicant's impairment's severity meets the severity of an impairment on the list and he or she meets the duration requirement, the SSA will conclude that the applicant is disabled.

4. Can the Individual Do the Work They Did in the Past?

If the applicant's condition is severe, but not at the same or equal level of severity as an impairment on the list, the SSA will determine if it nonetheless prevents the applicant from doing the same work he or

she did in the last 15 years. If it does not, the SSA will find that the applicant is not disabled. If it does, the applicant's claim will be examined further.

5. Can the Individual Do Any Other Work?

If an applicant cannot do the work he or she did in the last 15 years, the SSA will then look to see if the individual can adjust to any other work. The SSA will consider the applicant's age, education, and past work experience, and will review the job demands of occupations as determined by the Department of Labor in making this determination.

If an applicant cannot adjust to any other kind of work, and his or her impairment meets the duration requirement, the SSA will find that the applicant is disabled and his or her claim will be approved. If, on the other hand, the applicant can do other work – even if that work involves different skills or pays less than his or her past work – the SSA will find that the applicant is not disabled and his or her claim will be denied.

II. SELECT ISSUES IN DISABILITY BENEFITS

A. TIME LIMIT ON SOCIAL SECURITY DISABILITY BENEFITS

There is no limit in the number of periods an individual can receive social security disability benefits. An individual will continue to receive a disability benefit as long as he or she continues to be disabled and otherwise meets work or other eligibility requirements. However, all cases are reviewed periodically to see if there has been any improvement in an individual's condition and whether he or she is still eligible for benefits.

B. EFFECT OF AGE ON DISABILITY BENEFITS

1. Disabled Person Reaches Retirement Age

When a person receiving disability benefits reaches full retirement age, nothing will change, except that, for social security purposes, his or her benefits will be called "retirement" benefits instead of "disability" benefits.

Starting with the month the individual reaches full retirement age, the individual will receive his or her benefits with no limit on his or her earnings.

2. Earliest Age at Which Individual Can Receive Disability Benefits

There is no minimum age to qualify for disability benefits. However, to qualify for social security disability benefits, an individual must have worked long enough and recently enough under social security. Individuals can earn up to a maximum of four work credits per year. The amount of earnings required for a credit increases each year as general wage levels rise.

The number of work credits an individual needs for disability benefits depends on his or her age when he or she becomes disabled. Generally, individuals need 20 credits earned in the last 10 years ending with the year they become disabled.

However, younger workers may qualify with fewer credits. The rules are as follows:

- Before age 24 – Individuals may qualify if they have six credits earned in the three-year period ending when their disability starts;
- Age 24 to 31 – Individuals may qualify if they have credit for having worked half the time between 21 and the time they become disabled. For example, if an individual become disabled at age 27, they would need credit for three years of work (12 credits) out of the past six years (between age 21 and age 27); and
- Age 31 or older - In general, individuals will need to have the number of work credits shown in the chart shown below. Unless the individual is blind, at least 20 of the credits must have been earned in the 10 years immediately before he or she became disabled.

Table 6-1. below, shows the number of credits needed for individuals born after 1929 to qualify for disability benefits.

TABLE 6-1. CREDITS REQUIRED FOR DISABILITY

Became Disabled at Age:	Credits Needed
31 through 42	20
44	22
46	24
48	26
50	28
52	30
54	32
56	34
58	36
60	38
62 or older	40

In addition to the earnings requirement, individuals must meet social security's strict definition of disability, discussed above.

C. TICKET TO WORK PROGRAM

The Ticket to Work and Work Incentives Improvement Act was signed into law on December 17, 1999. This law includes several important new opportunities for people who receive social security and / or Supplemental Security Income disability benefits who want to go to work. This program has several components, including the following:

- Increases beneficiary choice in obtaining rehabilitation and vocational services to help them go to work and attain their employment goals;

- Removes barriers that require people with disabilities to choose between health care coverage and work; and
- Assures that more Americans with disabilities have the opportunity to participate in the workforce and lessen their dependence on public benefits.

The Ticket Program will offer SSA beneficiaries with disabilities a greater choice in obtaining the services they need to help them go to work.

D. EFFECT OF WORKERS' COMPENSATION AND OTHER DISABILITY PAYMENTS ON SOCIAL SECURITY BENEFITS

Disability payments from private sources, such as private pension or insurance benefits, do not affect an individual's social security disability benefits. However, workers' compensation and other public disability benefits may reduce social security benefits. Workers' compensation benefits are paid to a worker because of a job-related injury or illness. They may be paid by federal or state workers' compensation agencies, employers or by insurance companies on behalf of employers.

Other public disability payments that may affect social security benefits are those paid by a federal, state or local government and are for disabling medical conditions that are not job-related. Examples are civil service disability benefits, military disability benefits, state temporary disability benefits and state or local government retirement benefits that are based on disability.

1. Limit on Aggregate Benefits

If an individual receives workers' compensation or other public disability benefits and social security disability benefits, the total amount of these benefits cannot exceed 80 percent of the individual's average current earnings before he or she became disabled.

2. Public Benefits That Do Not Affect Social Security Benefits

Individuals who receive social security disability benefits and one of the following types of public benefits will not have their social security benefits reduced:

- Veterans Administration benefits;
- State and local government benefits, if social security taxes were deducted from the individual's earnings; or
- Supplemental Security Income (SSI).

3. Calculating the Reduction

An individual's monthly social security disability benefits, including benefits payable to his or her family members, are added together with his or her workers' compensation or other public disability payment.

If the total amount of these benefits exceeds 80 percent of the individual's average current earnings, the excess amount is deducted from his or her social security benefit.

Example

Before Thomas became disabled, his average current earnings were $4,000 a month. Thomas, his wife and two children would be eligible to receive a total of $2,200 a month in social security disability benefits. However, Thomas also receives $2,000 a month from workers' compensation. Because the total amount of benefits Thomas would receive ($4,200) is more than $3,200 (80 percent of his average current earnings), his family's social security benefits will be reduced by $1,000. Thomas' social security benefit will be reduced until the month he reaches age 65 or the month his other benefits stop, whichever comes first. Starting December 19, 2015, due to a change in the law, Thomas' benefits will continue to be reduced until he reaches his full retirement age.

Given its effect, individuals receiving other disability benefits must report changes in those benefit levels to the SSA.

E. DISABILITY DETERMINATION PROCESS

Most social security disability claims are initially processed through a network of local SSA field offices and state agencies (usually called Disability Determination Services or DDSs). Subsequent appeals of unfavorable determinations may be decided in a DDS or by an administrative law judge in SSA's Office of Disability Adjudication and Review.

Social security representatives in the field offices usually obtain applications for disability benefits in person, by telephone, by mail, or by filing online. The application and related forms ask for a description of the claimant's impairment(s), treatment sources, and other information that relates to the alleged disability. (The "claimant" is the person who is requesting disability benefits.)

The field office is responsible for verifying non-medical eligibility requirements, which may include age, employment, marital status, or social security coverage information. The field office then sends the case to a DDS for evaluation of disability.

The DDSs, which are fully funded by the Federal Government, are State agencies responsible for developing medical evidence and rendering the initial determination on whether or not a claimant is disabled or blind under the law.

Usually, the DDS tries to obtain evidence from the claimant's own medical sources first. If that evidence is unavailable or insufficient to make a determination, the DDS will arrange for a consultative examination (CE) to obtain the additional information needed. The claimant's treating source is the preferred source for the CE, but the DDS may obtain the CE from an independent source. After completing its development of the evidence, trained staff at the DDS makes the initial disability determination.

Then, the DDS returns the case to the field office for appropriate action. If the DDS found that the claimant is disabled, the SSA completes any outstanding non-disability development, computes the

benefit amount, and begins paying benefits. If the claimant was found not to be disabled, the file is kept in the field office in case the claimant decides to appeal the determination.

III. BENEFITS FOR CHILDREN WITH DISABILITIES

There are three ways a child might be eligible for benefits from social security or SSI. The three kinds of benefits are:

- Social Security Dependents Benefits – These are benefits payable to children under the age of 18 on the record of a parent who is collecting retirement or disability benefits from social security, or survivors' benefits payable to children under the age of 18 on the record of a parent who has died. Although children under age 18 who are eligible for these benefits might be disabled, the SSA does not need to consider their disability to qualify them for benefits. A child can continue receiving dependents or survivors benefits until age 19 if he or she is a full-time student in elementary or high school.
- SSI Benefits for Disabled Children – These are benefits payable to disabled children under age 18 who have limited income and resources, or who come from homes with limited income and resources.
- Social Security Benefits for Adults Disabled Since Childhood – Dependents benefits normally stop when a child reaches age 18 (or 19 if the child is a full-time student). However, those benefits can continue to be paid into adulthood if the child is disabled. To qualify for these benefits, an individual must be eligible as the child of someone who is getting social security retirement or disability benefits, or of someone who has died, and that child must have a disability that began prior to age 22. Although most of the people getting these benefits are in their 20s and 30s (and some even older), the benefit is considered a "child's" benefit because it is paid on the basis of a parent's social security earnings record.

A. SSI BENEFITS FOR CHILDREN WITH DISABILITIES

1. Non-Medical Rules

SSI is a program that pays monthly benefits to people with low incomes and limited assets who are 65 or older, or blind, or disabled. Children can qualify if they meet social security's definition of disability for SSI children and if their income and assets fall within the eligibility limits.

As its name implies, Supplemental Security Income supplements a person's income up to a certain level. The level varies from one state to another and can go up every year based on cost-of-living increases.

2. Rules for Children Under 18

The SSA considers the parent's income and assets when deciding if a child under 18 qualifies for SSI. This applies to children who live at home, or who are away at school but return home occasionally and are subject to parental control. This process is referred to as "deeming" of income and assets.

3. Rules for Children 18 and Older

When a child turns age 18, the SSA will no longer consider the parent's income and assets when they decide if he or she can get SSI. A child who was not eligible for SSI before his or her 18th birthday because the parent's income or assets were too high may become eligible at age 18. If a disabled child getting SSI turns 18 and continues to live with his or her parents, but does not pay for food or shelter, a lower SSI payment rate may apply.

4. How the SSA Decides If a Child Is Disabled for SSI

While the local social security office decides if a child's income and assets are within the SSI limits, all documents and evidence pertaining to the disability are sent to a state office, usually called the Disability Determination Service (DDS). There, a team, consisting of a disability evaluation specialist and a medical or psychological consultant, reviews each child's case to decide if he or she meets the SSA's definition of disability.

If the available records are not thorough enough for the DDS team to make a decision, the parents may be asked to take their child to a special examination that social security will pay for.

5. Deciding SSI Disability for Children Under 18

The law states that a child will be considered disabled if he or she has a physical or mental condition (or a combination of conditions) that results in "marked and severe functional limitations." The condition must last or be expected to last at least 12 months or be expected to result in the child's death. And, the child must not be working at a job that is considered "substantial work."

To make this decision, the disability evaluation specialist first checks to see if the child's disability can be found in a special listing of impairments that is contained in social security's regulations. These listings are descriptions of symptoms, signs or laboratory findings of more than 100 physical and mental problems, such as cerebral palsy, Down syndrome or muscular dystrophy, that are severe enough to disable a child. The child's condition does not have to be one of the conditions on the list. But, if the symptoms, signs or laboratory findings of the child's condition are the same as, or medically equal in severity to the listing, the child is considered disabled for SSI purposes.

If the child's impairment(s) does not meet or medically equal a listing, the DDS then decides whether it "functionally equals" the listings. They assess the effects of the condition or combination of conditions on the child's ability to perform daily activities by comparing that child's functioning to that of children the same age who do not have impairments. To do this, evaluators will consider questions such as:

- What activities is the child able or not able to perform?
- Which activities are limited in comparison with those of same-age peers?
- What type and amount of help does the child need to complete age-appropriate activities?

To determine whether a child's impairment causes "marked and severe functional limitations," the disability evaluation team obtains evidence from a wide variety of sources that have knowledge of the

child's condition and how it affects his or her ability to function on a day-to-day basis and over time. These sources include, but are not limited to, the doctors and other health professionals who treat the child, teachers, counselors, therapists and social workers.

The disability evaluation process generally takes several months. However, the law includes special provisions for people (including children) signing up for SSI disability whose condition is so severe that they are presumed to be disabled. In these cases, SSI benefits are paid for up to six months while the formal disability decision is being made. (These payments can be made only if the child meets the other eligibility factors.)

Following are some of the disability categories in which we can presume a child is disabled and make immediate SSI payments:

- HIV infection;
- Total blindness;
- Total deafness;
- Cerebral palsy;
- Down syndrome;
- Muscular dystrophy;
- Severe intellectual disability (child age 7 or older); and
- Birth weight below 2 pounds, 10 ounces.

If these special payments are made and it is later determined that the child's disability is not severe enough to qualify for SSI, the benefits do not have to be paid back.

6. Continuing Disability Reviews

After a child starts receiving SSI, the law requires that the SSA review the child's disability to verify that he or she is still disabled. The continuing disability review (CDR) must be done:

- At least every three years for children under 18 whose conditions are expected to improve; and
- Not later than 12 months after birth for babies whose disability is based on their low birth weight; unless the SSA determines the condition is not expected to improve by the child's first birthday, and they schedule the CDR for a later date.

At the time the SSA does a CDR, the representative must present evidence that the child's disability still severely limits his or her daily activities and has been receiving treatment that is considered medically necessary and available for the child's disabling condition. This requirement applies to all cases unless the SSA decides that such evidence would be inappropriate or unnecessary.

7. Disability Redeterminations at Age 18

Under the law, children who are eligible for SSI benefits in the month before they turn age 18 must have their eligibility reevaluated. The redetermination will be done during the one-year period beginning on the child's 18th birthday, or in place of a CDR whenever the SSA determine the individual's case is subject to a redetermination.

8. Children in Certain Medical Care Facilities

The monthly SSI payment is limited to $30 for children under age 18 who live, throughout a calendar month, in medical facilities where private health insurance pays for their care.

B. SOCIAL SECURITY BENEFITS FOR OLDER CHILDREN WITH DISABILITIES AND FOR ADULTS DISABLED SINCE CHILDHOOD

1. Non-Medical Rules

As indicated earlier, although children under 18 who are eligible for benefits might be disabled, the SSA does not need to consider their disability when deciding if they qualify for social security dependent's or survivor's benefits.

When a child who is getting a dependent's or survivor's benefit from social security reaches 18, however, those benefits generally stop unless one of the following conditions is met:

- The child is a full-time student in an elementary or high school. In this case, benefits continue until age 19; or
- The child is disabled. In this case benefits can continue as long as the child remains disabled, even into his or her adult years.

Many times, a person does not become eligible for a disabled child's benefit from social security until later in life.

Example

Jane starts collecting social security retirement benefits at the age of 62. She has a 38-year-old son, Ben, who has had cerebral palsy since birth. Ben will start collecting a disabled "child's" benefit on his mother's Social Security record.

2. Deciding If an Adult Child Is Disabled

The SSA will evaluate the disability of an adult child (age 18 or older) who is applying for social security for the first time, or who is being converted from a social security dependent child's benefit, by using adult disability criteria. To qualify for disability, an adult must have a physical or mental impairment, or combination of impairments, that is expected to keep him or her from doing any "substantial" work for at least a year or is expected to result in death. (Generally, a job that pays $1,130 for non-blind individuals or $1,820 for blind individuals (for 2016) or more per month is considered substantial.)

The person's condition is compared to a listing of impairments that are considered to be severe enough to prevent someone from working for a year or more. If the person is not working and has an impairment that meets or equals a condition on the list, then he or she is considered disabled for social security purposes.

If the SSA cannot match the person's impairment with one of the listings, then they assess his or her ability to perform the same type of work he or she did in the past (if any). If the person cannot do that work, or does not have any past work history, then SSA will consider his or her ability to do any kind of work he or she is suited for (based on age, education and experience). If, considering all these factors, SSA finds that a person is unable to do any substantial work, then he or she would qualify for disability benefits from social security.

3. Continuing Disability Reviews

Once benefits start, the law requires that the SSA periodically review all disability cases to verify that people continue to be disabled. The frequency of the review depends on whether the person's disability is expected to improve, might improve, or is not expected to improve.

C. MEDICAL CARE

1. Medicare and Medicaid

Medicaid is a health care program for people with low incomes and limited resources. In most states, children who get SSI benefits qualify for Medicaid. In many states, Medicaid comes automatically with SSI eligibility. In other states, you must sign up for it. And some children can get Medicaid coverage even if they do not qualify for SSI.

Medicare is a federal health insurance program for people 65 or older, and for people who have been getting social security disability benefits for two years. Because children, even those with disabilities, do not get social security disability benefits until they turn 18, generally no child can get Medicare coverage until he or she is 20 years old.

There are two exceptions to this rule. A child can get Medicare immediately if he or she has: (1) chronic renal disease and needs a kidney transplant or maintenance dialysis, or (2) Lou Gehrig's disease (amyotrophic lateral sclerosis). Children with these exceptions can get Medicare if a parent is getting social security or has worked enough to be covered by social security.

2. State Children's Health Insurance Program

The Children's Health Insurance Program enables states to provide children from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The program provides coverage for prescription drugs, vision, hearing and mental health services and is available in all 50 states, and the District of Columbia.

IV. SUPPLEMENTAL SECURITY INCOME (SSI)

Supplemental Security Income (SSI) pays monthly benefits to people who are age 65 or older, or blind, or have a disability, and who do not own much or have a lot of income. SSI is not just for adults. Monthly benefits can go to disabled and blind children, too. People who get SSI can usually get SNAP and Medicaid, too.

A. QUALIFICATIONS

To be eligible for SSI, an individual must be:

- Age 65 or older;
- Totally or partially blind; or
- Disabled.

In addition, the individual must meet the income limitations discussed below.

1. Blind

"Blind" means the individual is either totally blind or has very poor eyesight. Children as well as adults can get benefits because of blindness.

2. Disabled

Disabled means an individual has a physical or mental problem which prevents him or her from working and is expected to last at least a year or to result in death. Children as well as adults can get benefits because of disability. When deciding if a child is disabled, social security looks at how his or her disability affects everyday life.

Sometimes, a person whose sight is not poor enough to qualify for benefits as a blind person may be able to get benefits as a disabled person if his or her condition prevents him or her from working.

B. BENEFIT LEVEL

The maximum federal benefit changes annually. However, many states add money to the basic benefit. Effective January 1, 2016, the federal benefit rate is $733 for an individual and $1,100 for a couple.

1. State Added Supplements

Some states supplement the federal SSI benefit with additional payments. This makes the total SSI benefit levels higher in those states. SSI benefit amounts and state supplemental payment amounts vary based on an individual's income, living arrangements, and other factors.

2. No State Supplement

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

- Arizona

- Mississippi;
- North Dakota
- Northern Marianna Islands; and
- West Virginia.

C. SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

People who get SSI are normally eligible for SNAP. The SNAP program helps low-income people buy food. Although it is a federal government program, it is run by state or local agencies.

1. Household Requirements

To get SNAP, the applicant and the other people in his or her household must meet certain conditions. Everyone in the household must have or apply for a social security number and be in one of the following categories:

- U.S. citizen;
- U.S. national;
- American Indian born in Canada or Mexico; or
- Have status as a qualified alien.

2. Qualified Aliens

The following other qualified aliens may be able to get SNAP without a waiting period:

- Legal immigrant children under 18;
- Blind or disabled legal immigrants who receive disability assistance or benefits;
- Elderly individuals born on or before August 22, 1931, and who legally resided in the U.S. on August 22, 1996;
- Lawful Permanent Residents (LPR) with a military connection (includes Hmong or Highland Laotian tribes that helped the U.S. military during the Vietnam era, veterans, active duty, or a spouse or a child of a veteran or active duty service member);
- Refugees admitted under section 207 of the Immigration and Nationality Act (INA);
- Asylees under section 208 of the INA;
- Immigrants whose deportation or removal is withheld under section 243(h) or 241(b)(3) of the INA;
- Cuban or Haitian entrants under section 501(e) of the Refugee Education Assistance Act of 1980;

- Amerasian immigrants under section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988.

The following qualified aliens are eligible if they have lived in the United States for five years from date of entry or if they have a sufficient work history (40 work credits) to qualify:

- LPRs;
- Parolees (paroled for at least one year under section 212(d)(5) of INA);
- Conditional entrants under 203(a)(7) of INA in effect prior to April 1, 1980;
- A battered spouse, battered child, or parent or child of a battered person with a petition pending under 204(a)(1)(A) or (B) or 244(a)(3) of INA.

If you receive Supplemental Security Income (SSI) payments in California, you are not eligible for SNAP because the state includes extra money in the amount it adds to the federal SSI payment.

3. Registration for Work

Most able-bodied people between the ages of 18 and 60 must register for work to qualify for SNAP. Many people may be required to participate in an employment or training program. Some college students also may be eligible.

4. Resources

Generally, an eligible person's household cannot have more than $2,250 in resources. But, if the household includes a disabled person or a person age 60 or older, the limit is $3,250. The resources of a person who is getting Supplemental Security Income (SSI) or benefits under the Temporary Assistance for Needy Families (TANF) program are not counted for SNAP purposes. Resources include cash, bank accounts and other property.

Not all the things count as resources. For example, a home and the land it is on do not count for SNAP eligibility. A car or truck counts differently, depending on how it is used. Most states now use TANF rules in place of SNAP vehicle rules if the TANF rules are more beneficial to the SNAP household. Some states also have chosen to exclude certain resources excluded by TANF or Medicaid.

Most households also must meet an income limit. Certain things do not count as income and can be subtracted from income. A household may qualify for other income exclusions if it includes a person age 60 or older or disabled. The income limits vary by household size and may change each year.

D. MEDICAID AND MEDICARE

Persons eligible for SSI can typically also qualify for Medicaid. Some states will help SSI recipients pay Medicare premiums and, in some cases, other expenses such as deductibles and coinsurance.

E. INCOME LIMITATIONS

In addition to the age and other requirements listed above, whether an individual can receive SSI depends on what he or she owns and how much income he or she has. Income includes wages, social security benefits and pensions. Income also includes non-cash items an individual receives such as food, clothing or shelter. If an applicant is married, the SSA will also examine the income of his or her spouse and the things he or she owns.

If an applicant is under age 18, the SSA may look at the income of his or her parents and the things they own. And, if the individual is a sponsored alien, the SSA also may look at the income of his or her sponsor and what he or she owns.

1. Income

The amount of income an individual can have each month and still get SSI depends partly on where he or she lives. Individuals can call the SSA at 1-800-772-1213 to find out the income limits in a particular state.

Social security does not count all of an individual's income when they decide if the individual is eligible for SSI. For example, the following is not taken into account:

- The first $20 of most income received in a month;
- The first $65 a month earned from working and half the amount over $65;
- The value of Supplemental Nutrition Assistance Program (food stamps) received;
- Shelter supplied by private nonprofit organizations; and
- Most home energy assistance.

If an applicant is a student, some of the wages or scholarships he or she receives may not count.

If an individual is disabled but works, social security does not count any wages he or she uses to pay for items or services required to work because of the disability. For example, if an individual needs a wheelchair, the wages used to pay for the wheelchair are not counted as income.

Also, social security does not count any wages a blind person uses to pay expenses that are caused by working. For example, if a blind person uses wages to pay for transportation to and from work, the transportation cost is not counted as income.

2. The Things an Individual Owns

The things a person owns that are considered when determining eligibility for SSI includes real estate, bank accounts, cash, and stocks and bonds. A person may be able to get SSI if he or she has items worth no more than $2,000. A couple may be able to get SSI if they have items worth no more than $3,000. If an individual owns property or another resource that he or she is trying to sell, he or she may be able to get SSI while trying to sell it. Social security does not count everything a person owns, including the following:

- The home in which the person lives and the land that it is on;
- Life insurance policies with a face value of $1,500 or less;
- A car (usually);
- Burial plots for the individual and members of his or her immediate family;
- Up to $1,500 in burial funds for the individual and up to $1,500 in burial funds for his or her spouse; and;
- For persons who are blind or who have a disability, certain items the individual plans to use to work or earn extra income.

3. Special Rules for Individuals Who Are Blind or Disabled

Blind or disabled individuals who work may be able to keep getting some money from SSI while working. But as an individual earns more money, his or her SSI may go down or stop. Even if the SSI stops, the individual may be able to keep his or her Medicaid coverage.

Blind or disabled individuals may also be able to set aside some of their money for a work goal or to go to school. The money they set aside does not count toward the SSI limits on income or resources and therefore will not reduce the SSI benefit level.

Blind or disabled individuals who apply for SSI may get special services from their state. These services include counseling, job training, and help in finding work.

F. OTHER RULES

Before receiving SSI, individuals must also meet the following rules:

- They must live in the U.S. or Northern Mariana Islands;
- They must be a U.S. citizen or national (or in one of certain categories of aliens); and
- If eligible for social security or other benefits, they must apply for them (they can get SSI and social security if they are eligible for both).

People who live in city or county rest homes, halfway houses, or other public institutions usually cannot get SSI. But, there are some exceptions. Individuals who live in a publicly operated community residence that serves no more than 16 people may get SSI. If an individual lives in a public institution mainly to attend approved educational or job training that will help them get a job, he or she may get SSI. Individuals living in a public emergency shelter for the homeless may also be able to get SSI for up to six months during any nine-month period.

Individuals living in a public or private institution where Medicaid is paying more than half the cost of their care may also receive a small SSI benefit.

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CHAPTER 6: TEST YOUR KNOWLEDGE

The following questions are designed to ensure that you have a complete understanding of the information presented in the chapter (assignment). They are included as an additional tool to enhance your learning experience and do not need to be submitted in order to receive CPE credit.

We recommend that you answer each question and then compare your response to the suggested solutions on the following page(s) before answering the final exam questions related to this chapter (assignment).

1.	**Who is eligible to receive Social Security Disability Insurance payments:** **A.** anyone who qualifies for Supplemental Security Income **B.** anyone injured on the job **C.** only people who have sufficient credits based on their length of work **D.** anyone who can show financial need
2.	**What are the eligibility requirements for Social Security Disability Insurance:** **A.** fairly lenient; anyone who is unable to return to their normal trade or occupation due to injury or illness is qualified **B.** very narrow and strictly interpreted; it is difficult to qualify for these benefits **C.** moderately hard; someone must have been out of work for at least one year due to accident or illness **D.** easy; anyone who misses four weeks or more of work due to illness or injury qualifies
3.	**There is no limit to the amount of time that an individual can receive social security disability benefits.** **A.** true **B.** false
4.	**Which of the following children are eligible for SSI benefits:** **A.** any severely disabled child living at home, regardless of income level **B.** any institutionalized disabled child, regardless of the family's income level **C.** any sufficiently disabled child whose family has limited income **D.** children with moderate disabilities so long as their family has a low income

5.	**Under no circumstances can a child receive Medicare benefits.** **A.** true **B.** false
6.	**Social security counts all of an individual's income when deciding if the individual is eligible for SSI.** **A.** true **B.** false

CHAPTER 6: SOLUTIONS AND SUGGESTED RESPONSES

Below are the solutions and suggested responses for the questions on the previous page(s). If you choose an incorrect answer, you should review the pages as indicated for each question to ensure comprehension of the material.

1.	**A.** Incorrect. While the programs have many similarities and some overlap, the qualifications for SSDI are different and require a sufficient work history. **B.** Incorrect. People injured at work are generally covered by workers' compensation insurance. Those people may or may not also qualify for SSDI. **C.** **CORRECT**. In addition to meeting the medical requirements, a person must have earned a sufficient number of social security credits to qualify for payments. **D.** Incorrect. This is a criteria for SSI, not SSDI. *(See page 79 of the course material.)*
2.	**A.** Incorrect. The requirements are narrow and enforced as such. People must be unable to hold virtually any type of job to qualify, not just their normal trade or occupation. **B.** **CORRECT**. It is very difficult to qualify for these benefits. In general, a person must be physically or mentally unable to do any kind of substantial gainful work in order to qualify. **C.** Incorrect. Just being out of work is not sufficient, even if it is due to illness or injury. **D.** Incorrect. The opposite is true; it is very difficult to qualify, and a month absence from work is far from sufficient. *(See page 80 of the course material.)*
3.	**A.** **CORRECT**. An individual will continue to receive a disability benefit as long as he or she continues to be disabled and otherwise meet work or other disability requirements. **B.** Incorrect. All cases are reviewed periodically to determine if there is any improvement in an individual's condition and whether he or she is still eligible for benefits. When a person receiving disability benefits reaches full retirement age, the benefits will continue, but be called "retirement" benefits instead of "disability" benefits. *(See page 82 of the course material.)*

4.	**A.** Incorrect. There are two components to payments, medical and financial. The individual must meet both. **B.** Incorrect. The fact that a child is institutionalized does not automatically qualify them for benefits under this program. **C.** **CORRECT**. A child must meet an income eligibility and a medical condition test to qualify for benefits under this program. **D.** Incorrect. Only fairly severe disabilities are covered by this program. *(See pages 86 to 87 of the course material.)*
5.	**A.** Incorrect. A child with chronic renal disease who needs a kidney transplant or maintenance dialysis or a child with Lou Gehrig's disease can get Medicare if a parent is getting social security or has worked enough to be covered by social security. **B.** **CORRECT**. Generally, no child can get Medicare coverage until he or she is 20 years old, but there are two exceptions to this rule. *(See page 90 of the course material.)*
6.	**A.** Incorrect. Examples of items not included are the first $20 of most income received in a month, the first $65 a month earned from working, Supplemental Nutrition Assistance Program (SNAP), and most home energy assistance. **B.** **CORRECT**. The amount of income an individual can receive each month and still get SSI depends partly on where he or she lives. The SSA does not include all of an individual's income when they determine the individual's eligibility, including the first $20 of most income received in a month, SNAP, and shelter supplied by private nonprofit organizations. *(See page 94 of the course material.)*

CHAPTER 7: SURVIVORS BENEFITS

Chapter Objective

After completing this chapter, you should be able to:

- Identify who is eligible for survivors benefits and how to apply for them.

I. OVERVIEW

Individuals paying into social security expect that they will be around to receive benefit checks in their retirement years. This, of course, does not always happen. When a worker dies prematurely, his or her family may be entitled to benefits based on the earnings of the deceased. These benefits are referred to as "survivors benefits."

Many people are unaware of the breadth of the program. The Social Security Administration (SSA) has estimated that 98 of every 100 children could get benefits if a working parent dies. And social security pays more benefits to children than any other federal program. Social security pays monthly survivors benefits to approximately 6 million Americans (August, 2016), almost two million of whom are children. This does not include benefits to widows and widowers.

A. SOCIAL SECURITY "LIFE INSURANCE"

Many people think of social security only as a retirement program. But some of the social security tax individuals pay goes toward providing survivors insurance for workers and their families.

1. Value of Benefits

The value of social security survivors benefits is often more than the value of a person's individual life insurance. The difference, of course, is that social security survivors benefits are paid monthly and not in a lump sum, as are most life insurance proceeds.

The average monthly payment for a family consisting of a widow(er) with two children is roughly $2,000 per month. Social security payments also increase over time based on the annual cost-of-living index.

2. Earning Survivors Insurance

As an individual works and pays social security tax, either as an employee or a self-employed person, he or she earns credits toward his or her social security benefits. The number of years an individual needs to work for his or her family to be eligible for social security survivors benefits depends on his or her age at death. The younger a person is, the fewer years he or she needs to work. But no one needs more than 10 years of work to be eligible for any social security benefit.

Under a special rule, if an individual who has worked for only one and one-half years in the three years just before his or her death, benefits can be paid to the individual's children and his or her spouse who is caring for the children.

3. One-Time Death Payment

There is a one-time payment of $255 that can be made when an individual dies if he or she worked long enough. This payment can be made only to a spouse or minor children if he or she meets certain requirements. A surviving husband or wife is eligible for the payment if he or she was living in the same household as the worker when the worker died. The surviving spouse must also file an application for the payment within two years. Normally, the two-year filing period ends with the second anniversary of the insured person's death.

If there is no spouse to receive the lump-sum death payment, the lump-sum is payable to a child or the children of the deceased worker. The child or children must have been entitled to or eligible for benefits on the deceased's earnings record for the month the worker died.

In the case of several children, each child is eligible for an equal share of the lump-sum. If one or more of the children choose not to apply, those children who do apply are paid only their equal share of the lump-sum. The unpaid balance remains unpaid, unless those children who originally chose not to apply later decide to do so.

B. PERSONS ELIGIBLE FOR SURVIVORS BENEFITS

The following categories of persons are eligible for social security survivors benefits:

- A widow or widower can receive full benefits at full retirement age or reduced benefits as early as age 60;
- A disabled widow or widower can get benefits at age 50;
- A widow or widower can receive benefits at any age if she or he takes care of a child (or children) of the deceased who is entitled to a child's benefit and is younger than age 16 or who is disabled;
- A deceased's unmarried children who are under age 18 (or up to age 19 if they are attending elementary or secondary school full time) also can receive benefits. A deceased's children can get benefits at any age if they were disabled before age 22 and remain disabled;
- Under certain circumstances, benefits also can be paid to a deceased's stepchildren, grandchildren, stepgrandchildren or adopted children. A child born or adopted after an individual begins to receive benefits may also qualify for benefits; and
- A deceased's dependent parents can receive benefits if they are age 62 or older.

A more detailed discussion of these requirements is provided next.

1. Widow(er)s

A widow or widower is entitled to insurance benefits on a worker's social security record if the following conditions are met:

- He or she is either: (1) age 60 or over, or (2) at least age 50 but not age 60 and disabled and he or she meets certain disability-related requirements (Note: A widow(er) age 60-64 and under a disability is entitled to disabled widow(er)'s benefits for Medicare purposes.);
- The worker died fully insured;
- He or she is not entitled to a retirement insurance benefit that is equal to or larger than the worker's primary insurance amount;
- He or she has filed an application for widow(er)'s insurance benefits;
- He or she is not married or his or her marriage can be disregarded; and
- One of the following conditions is met:
    - He or she was married to the deceased worker for at least the nine months just before the worker died;
    - He or she is the biological mother or father of the worker's son or daughter (this requirement is met if a live child was born to the survivor and the worker, even if the child did not survive);
    - He or she legally adopted the worker's son or daughter during his or her marriage and before the child reached age 18;
    - He or she was married to the worker when both legally adopted a child under age 18;
    - The worker legally adopted the survivor's son or daughter during the marriage and before the child reached age 18; or
    - In the month before the month the survivor married the deceased worker, he or she was entitled or potentially entitled to either: (1) spouse's, widow(er)'s, father's, mother's, parent's, or childhood disability benefits under the Social Security Act, or (2) widow(er)'s, child's (age 18 or over), or parent's insurance annuity under the Railroad Retirement Act.

a. Exception to Nine-Month Requirement

The nine-month duration-of-marriage requirement provided above is waived if the widow(er) was married to the insured person at the time of the insured person's death and either:

- The insured person's death was accidental; or
- The insured person's death occurred in the line of duty while he or she was a member of a uniformed service serving on active duty; or

- The widow(er) was previously married to and divorced from the insured person and the previous marriage had lasted at least nine months.

The exception to the nine-month duration-of-marriage requirement does not apply if, at the time of the marriage, the insured person could not reasonably have been expected to live for nine months.

b. Accidental Death

The insured person's death is defined as accidental only if:

- He or she received bodily injuries through violent, external, and accidental means;
- The insured worker died within three months after the day that the injuries were received; and
- The worker's death was a direct result of the bodily injuries, independent of all other causes.

c. Benefit Rate

The widow(er)'s insurance benefit rate equals 100 percent of the deceased worker's primary insurance amount plus any additional amount the deceased worker was entitled to because of delayed retirement credits.

Under some circumstances, however, a widow(er)'s benefit level may be less. It will be less if any of the following conditions exist:

- A reduction is necessary because the "family maximum" applies;
- The widow(er) is also entitled to a smaller retirement insurance or disability insurance benefit (only the difference between the larger widow(er)'s insurance benefit and the other benefit is payable as the widow(er)'s insurance benefit; however, this amount is payable in addition to the other benefit);
- The widow(er) is entitled for months before the month he or she reaches retirement age;
- The widow(er) chooses to receive and is paid a reduced widow(er)'s benefit for months before he or she reaches retirement age. A reduced benefit rate is payable for as long as the individual is entitled to widow(er)'s benefits;
- The deceased worker was entitled to a reduced retirement benefit for the month before the month he or she died; or
- The widow(er) is caring for your deceased spouse's child and:
    - The child is under age 16 or disabled;
    - The child is entitled to child's insurance benefits; and

- The widow(er) has not reached retirement age. In this case, the widow(er)'s benefits are not reduced for those months below 75 percent of the deceased spouse's primary insurance amount.

2. Surviving Divorced Spouse

In some cases, a divorced spouse is entitled to benefits on the deceased worker's social security record. To be eligible, a person must be unmarried and either over age 60 or over age 50 and disabled. The worker must also have died fully insured.

To be considered a "surviving divorced spouse," the individual must have been married to the worker for 10 years just before the date the divorce became final. This definition can be met even if the person was divorced within the 10-year period, provided the survivor and the worker remarried no later than the calendar year after the year of the divorce.

A former spouse, however, does not have to meet the age or length-of-marriage rule if he or she is caring for his/her child who is under age 16 or who is disabled and also entitled based on the work of the deceased. The child must be the former spouse's natural or legally adopted child.

Survivors benefits paid to a divorced spouse will not affect the benefit rates for other survivors getting benefits.

3. Children's Benefits

A surviving child is entitled to child's insurance benefits if the conditions below are met:

- The worker-parent died either fully or currently insured;
- The child is the child of the deceased;
- The child is under 18, under 19 and a full-time elementary or secondary school student, or age 18 or over and under a disability which began before age 22;
- The child was dependent upon the deceased parent;
- The child is not married; and
- An application for child's insurance benefits is filed.

Note, however, that an application is not required if the child was entitled to child's insurance benefits on the deceased parent's earnings record for the month before the month in which the parent died.

A surviving child's insurance benefits end when any of the conditions below are met:

- The child dies;
- The child reaches age 18 and is neither under a disability nor a full-time elementary or secondary school student (Note: Entitlement to childhood disability benefits ends when the child age 18 or older is no longer under a disability that began before age 22. However, benefits may continue if the child is still under age 19 and a full-time elementary or secondary school student);

- The child marries;
- The child's entitlement is based on a legal adoption and the adoption is annulled; or
- The child is a stepchild of the worker, and the marriage between the worker and the stepchild's parent ends in divorce.

The effective date of the termination of benefits is the month in which any of the above events occurs. However, a disabled child's benefits terminate effective with the second month following the month in which he or she is no longer under a disability. Also, a stepchild's benefits terminate effective with the month after the divorce becomes final.

4. Surviving Parents

Parents of a deceased worker are entitled to parent's benefits if the following conditions are met:

- The insured person was fully insured at the time of death;
- The parents file an application for parent's benefits;
- They have reached age 62;
- They are not entitled to a retirement insurance benefit that is equal to or larger than the amount of the unadjusted parent's insurance benefit after any increase to the minimum benefit;
- They were receiving at least one-half support from the insured person at the applicable time;
- They filed evidence that the support requirement was met with the Social Security Administration within the required time limit;
- If a widow(er) or divorced, he or she has not remarried since the insured person's death; and
- One of the following conditions is met:
    - They are a natural parent and would be eligible under the law of the state where the worker lived to share in the intestate personal property of the worker as the worker's parent;
    - They legally adopted the insured person before he or she turned 16; or
    - They became the deceased's stepparent by a marriage entered into before the deceased turned 16.

C. APPLYING FOR BENEFITS

1. Individuals Not Currently Receiving Social Security Benefits

Individuals should apply for survivors benefits promptly because, in some cases, benefits will be paid from the time an application is made and not from the time the worker died.

Individuals can apply by telephone or at any social security office. Original or certified copies of the following documents are required to process an application for survivors benefits:

- Proof of death – either from a funeral home or death certificate;
- The applicant's social security number, as well as the deceased worker's;
- The applicant's birth certificate;
- A marriage certificate, if the applicant is a widow or widower;
- Divorce papers, if the applicant is applying as a divorced widow or widower;
- Dependent children's social security numbers, if available and birth certificates;
- Deceased worker's W-2 forms or federal self-employment tax return for the most recent year; and
- The name of the applicant's bank and his or her account number so benefits can be deposited directly into the account.

2. Individuals Already Receiving Social Security Benefits

If an individual is already receiving benefits as a wife or husband based on his or her spouse's work, the SSA will change his or her payments to survivors benefits when his or her application is made.

If the applicant is receiving benefits based on his or her own work, the SSA will determine if he or she is entitled to more money as a widow or widower. If so, an individual will receive a combination of benefits that equals the higher amount.

Benefits for any children automatically will be changed to survivors benefits after the death is reported.

D. AMOUNT OF BENEFIT

How much a family can get from social security depends on the deceased worker's average lifetime earnings. That means the more a worker has earned, the more his or her family's benefits will be.

Social security uses the deceased worker's basic benefit amount and calculates what percentage survivors are entitled to. The percentage depends on the survivors' ages and relationship to the worker. Here are the most typical situations:

- A widow or widower, at full retirement age or older, receives 100 percent of the worker's basic benefit amount;
- A widow or widower, age 60 or older, but under full retirement age, receives about 71-99 percent of the worker's basic benefit amount;
- A widow or widower, any age, with a child under age 16, receives 75 percent of the worker's benefit amount; and

- Children receive 75 percent of the worker's benefit amount.

1. Maximum Family Benefits

There is a limit to the benefits that can be paid to you and other family members each month. The limit varies, but is generally between 150 and 180 percent of the deceased's benefit amount.

2. Effect of Working on Benefits

If an individual works while receiving social security survivors benefits and is younger than full retirement age, his or her benefits may be reduced if the individual's earnings exceed certain limits. (The full retirement age is 66 for people born in 1945-1956 but will gradually increase to 67 for people born in 1962 or later.)

There is no earnings limit after an individual reaches full retirement age. In addition, an individual's earnings will reduce only his or her benefits, not the benefits of other family members.

3. Effect of Remarrying

Generally, an individual cannot get widow's or widower's benefits if he or she remarries before age 60. But remarriage after age 60 (or age 50 if an individual is disabled) will not prevent him or her from receiving benefit payments based on his or her former spouse's work. And at age 62 or older, an individual may get benefits based on his or her new spouse's work, if those benefits would be higher.

CHAPTER 7: TEST YOUR KNOWLEDGE

The following questions are designed to ensure that you have a complete understanding of the information presented in the chapter (assignment). They are included as an additional tool to enhance your learning experience and do not need to be submitted in order to receive CPE credit.

We recommend that you answer each question and then compare your response to the suggested solutions on the following page(s) before answering the final exam questions related to this chapter (assignment).

1.	**Which of the following statements about social security survivors benefits is <u>not</u> correct:** **A.** more children receive benefits from social security than from any other federal program **B.** the average monthly survivors benefit for a widower with two children is $1,000 per month **C.** the value of survivors benefits is often greater than a person's individual life insurance policy **D.** 98 out of 100 American children are eligible for benefits
2.	**Can a surviving former spouse of a deceased person receive benefits based on his or her former spouse's working record:** **A.** no, because that would be bad public policy **B.** not unless the deceased formally requested that the former spouse receive benefits **C.** only if the deceased did not remarry **D.** yes, assuming he or she was married to the deceased for at least 10 years and other requirements are met

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CHAPTER 7: SOLUTIONS AND SUGGESTED RESPONSES

Below are the solutions and suggested responses for the questions on the previous page(s). If you choose an incorrect answer, you should review the pages as indicated for each question to ensure comprehension of the material.

1.	**A.** Incorrect. This is a true statement. This program has broad coverage. **B.** **CORRECT**. The actual benefit level is currently about $2,000 per month and is eligible for cost of living increases. **C.** Incorrect. This makes survivors benefits an important safeguard for many working families. **D.** Incorrect. Most children live in families eligible for survivor benefits if one or more of their parents were to die prematurely. *(See page 101 of the course material.)*
2.	**A.** Incorrect. Federal law does provide for benefits for surviving former spouses in many cases, so the public policy is in favor of this type of coverage. **B.** Incorrect. There is no such express request required. A former spouse can receive benefits if normal requirements are met. **C.** Incorrect. The surviving spouse must not have remarried, but the same rule does not apply to the deceased. **D.** **CORRECT**. Other requirements include that the surviving spouse be at least 60 years old and unmarried or over age 50 and disabled. *(See page 105 of the course material.)*

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CHAPTER 8: THE APPEALS PROCESS

Chapter Objective

After completing this chapter, you should be able to:

- Recall rules related to the appeal of a determination made by the Social Security Administration (SSA).

I. FILING AN APPEAL

If the Social Security Administration (SSA) decides that an individual is not eligible or no longer eligible for benefits, or that the amount of his or her payments should be changed, the individual will receive a letter explaining the SSA's decision. Individuals have the right to appeal such a determination. If an appeal is filed, the SSA will review their entire decision, even those parts that were made in the applicant's favor.

A. WHEN TO APPEAL

If an individual wants to file an appeal, he or she must make his or her request in writing within 60 days from the date he or she receives the letter of determination from the SSA. When the last day of a time limit is on a Saturday, Sunday or national holiday, the time limit ends on the next workday. The SSA will assume that an individual received such letter five days after the date on it, unless the individual can show that it was actually received later.

B. LEVELS OF APPEAL

There are four levels of appeal. They are (in order from lowest to highest level):

- Reconsideration;
- Hearing by an administrative law judge;
- Review by the Appeals Council; and
- Federal court review.

1. Reconsideration

A reconsideration is a complete review of an individual's claim by someone who did not take part in the first decision. The SSA will look at all the evidence submitted when the original decision was made, plus any new evidence.

Most reconsiderations involve a review of an individual's files without the need for him or her to be present. But when an individual appeals a decision that he or she is no longer eligible for disability benefits

because his or her condition has improved, he or she can meet with a Social Security representative and explain why he or she believes he or she still has a disability.

2. Hearing

If an individual disagrees with the reconsideration decision, he or she may ask for a hearing. The hearing will be conducted by an administrative law judge who had no part in the first decision or the reconsideration of the case. The hearing is usually held within 75 miles of the applicant's home. The administrative law judge will notify the applicant of the time and place of the hearing.

In certain situations, the SSA may hold the applicant's hearing by video conference rather than in person. If so, the applicant will be notified ahead of time. With video hearings, the SSA can make the hearing more convenient for the applicant. Often, an appearance by video hearing can be scheduled faster than an in-person appearance. Also, a video hearing location may be closer to the applicant's home.

Before the hearing, the SSA may ask the individual to give them more evidence and to clarify information about the claim. The individual has the right to review the information in his or her file and to provide new information.

The administrative law judge will question the applicant and any witnesses he or she brings to the hearing. The applicant or his or her representative also may question the witnesses. It is usually to the applicant's advantage to attend the hearing. Individuals who do not wish to attend must notify the SSA in writing that they will not be attending.

Applicants will receive written notification of the decision of the administrative law judge in the mail.

3. Appeals Council

If an applicant disagrees with the hearing decision, he or she may ask for a review by Social Security's Appeals Council.

The Appeals Council looks at all requests for review, but it may deny a request if it believes the hearing decision was correct. If the Appeals Council decides to review a case, it will either decide the case itself or return it to an administrative law judge for further review. The applicant will receive a copy of the Appeals Council's decision or order sending it back to an administrative law judge.

If the Appeals Council denies a request for a review, the SSA will send a letter explaining the denial.

4. Federal Court

Individuals who disagree with the Appeals Council's decision – or if the Appeals Council decides not to review their case – may file a lawsuit in a federal district court.

C. CONTINUATION OF BENEFITS

In some cases, individuals may ask the SSA to continue paying benefits while a decision is being made on an appeal. Individuals can ask for this continuation of benefits when:

- They are appealing an SSA decision that they are no longer eligible for social security disability benefits because their condition has improved; or
- They are appealing an SSA decision that they are no longer eligible for SSI payments or that their SSI payment should be reduced.

Individuals who want benefits to continue must notify the SSA within 10 days of their receipt of the SSA letter of determination. If the appeal is later denied, individuals may have to pay back the money they were not eligible for.

II. USING A REPRESENTATIVE

Individuals appealing a decision of the SSA have the right to represent themselves or to use a representative (representatives can also be used before an application has reached appeal).

Once an individual appoints a representative, he or she can act on his or her behalf in most Social Security matters by:

- Getting information from his or her client's social security file;
- Helping his or her client get medical records or information to support the client's claim;
- Coming with his or her client, or on the client's behalf, to any interview, conference or hearing he or she has with the SSA;
- Requesting a reconsideration, hearing or Appeals Council review; and
- Helping his or her client and witnesses prepare for a hearing and questioning any witnesses.

A representative also will receive a copy of the decision(s) made on his or her client's claim(s).

1. Choosing a Representative

Individuals can select an attorney or other qualified person to represent them. An individual can also have more than one representative. However, individuals cannot have as a representative someone who has been suspended or disqualified from representing others before the Social Security Administration or who may not, by law, act as a representative.

An individual can appoint one or more people in a firm, corporation or other organization as their representative, but he or she may not appoint the firm, corporation or organization itself.

After an individual has chosen a representative, the SSA must be notified in writing as soon as possible. Notification must include the name of the person appointed and the signature of the person making the appointment. If the representative is not an attorney, he or she must, in writing, give his or her name, state that he or she accepts the appointment, and sign the form.

2. What a Representative May Charge

In order to charge a fee for services, a representative first must file either a fee agreement or a fee petition with the SSA. A representative cannot charge a client more than the fee amount the SSA approves. If the client or the representative disagree with the fee approved, either can ask for a review.

A representative who charges or collects a fee without SSA approval, or charges or collects too much, may be suspended or disqualified from representing anyone before the Social Security Administration and also may face criminal prosecution.

3. Filing a Fee Agreement

If a client and his or her representative have a written fee agreement, the representative may ask the SSA to approve it any time before it decides the claim. Usually, the SSA will approve the agreement and notify the parties in writing how much the representative may charge as long as:

- Both parties signed the agreement;
- The claim was approved and resulted in past-due benefits; and
- The fee agreed on is no more than 25 percent of past-due benefits or $6,000, whichever is less.

If the fee agreement is not approved, the SSA will notify the parties that they must file a fee petition. A representative files a fee petition after completing work on the claim. This written request should describe in detail the amount of time spent on each service the representative provided. The representative must give his or her client a copy of the fee petition and each attachment. If the client disagrees with the fee requested or the information shown, the client must contact the SSA within 20 days. The SSA will consider the reasonable value of the representative's services and tell the client, in writing, the amount of the fee approved. If the client disagrees with the approved fee, the client must notify the SSA in writing within thirty days from the date it was authorized.

The amount of the fee SSA decides a representative may charge is the most a client owes for his or her services, even if the client agreed to pay his or her representative more. However, a representative can charge for out-of-pocket expenses, such as medical reports, without the SSA's approval.

If an attorney acts as a representative, the SSA usually withholds 25 percent (but never more) of the client's past-due benefits to pay toward the fee. The SSA pays the attorney's fee from this money and sends the client any money left over.

A client must pay his or her representative directly under some circumstances, including when the SSA did not withhold 25 percent from past-due social security benefits or the attorney did not make a timely request for a fee and the SSA sent the client the funds that should have been withheld.

Even when someone else will pay the fee for a client (for example, an insurance company), the SSA must approve the fee unless:

- The client or any auxiliary beneficiaries are free of direct or indirect liability to pay the fee or expenses, either in whole or in part, to a representative or to someone else; and
- It is a nonprofit organization or federal, state, county or city agency that will pay the fee and any expenses from government funds; and
- The representative gives the SSA a written statement that he or she will not have to pay any fee or expenses.

4. Cases Appealed to Federal Court

The court can allow a reasonable fee for an attorney. The fee usually will not exceed 25 percent of all past-due benefits that result from the court's decision. An attorney cannot charge any additional fee for services before the court.

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CHAPTER 8: TEST YOUR KNOWLEDGE

The following question is designed to ensure that you have a complete understanding of the information presented in the chapter (assignment). It is included as an additional tool to enhance your learning experience and does not need to be submitted in order to receive CPE credit.

We recommend that you answer the question and then compare your response to the suggested solution on the following page before answering the final exam question(s) related to this chapter (assignment).

1.	**What is the lowest level of appeal when someone believes he or she was wrongly denied social security benefits:** **A.** a hearing by an administrative law judge **B.** reconsideration **C.** review by the Appeals Council **D.** a federal court review

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CHAPTER 8: SOLUTION AND SUGGESTED RESPONSES

Below is the solution and suggested responses for the question on the previous page. If you choose an incorrect answer, you should review the page(s) as indicated for the question to ensure comprehension of the material.

1.	**A.** Incorrect. A hearing in front of an administrative law judge is the second level of appeal after reconsideration. **B.** **CORRECT**. The lowest level is a reconsideration. In this situation, a complete review of an individual's claim is performed by someone who did not take part in the first decision. **C.** Incorrect. This comes after a hearing in front of an administrative law judge. **D.** Incorrect. This is the highest level of appeal for someone who believes he or she was wrongly denied benefits. *(See page 113 of the course material.)*

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CHAPTER 9: AN OVERVIEW OF MEDICARE

Chapter Objective

After completing this chapter, you should be able to:

- Identify the basic types of Medicare benefits that are available.

I. MEDICARE: AN OVERVIEW

Anyone planning for their retirement must consider how they will pay for healthcare after they stop working. For most Americans, Medicare plays an important role in providing health care in later life. It is therefore important to understand what Medicare will cover and what it will not cover when planning for retirement.

A. HISTORY OF MEDICARE

The first U.S. President to propose a prepaid health insurance plan was Harry S. Truman. On November 19, 1945, in a special message to Congress, President Truman outlined a comprehensive, prepaid medical insurance plan for all people through the social security system. The plan included doctors and hospitals, and nursing, laboratory, and dental services; it was dubbed “National Health Insurance.” Furthermore, medical insurance benefits for needy people were to be financed from federal revenues.

Over the years, lawmakers narrowed the field of health insurance recipients largely to social security beneficiaries. A national survey found that only 56 percent of those 65 years of age or older had health insurance. President John F. Kennedy pressed legislators for health insurance for the aged. However, it was not until 1965 that President Lyndon B. Johnson signed H.R. 6675 (The Social Security Act of 1965) to provide health insurance for the elderly and the poor.

President Johnson signed the Medicare and Medicaid Bill (Title XVIII and Title XIX of the Social Security Act) in Independence, Missouri in the presence of former President Truman, who received the first Medicare card at the ceremony; Lady Bird Johnson, Vice-President Hubert Humphrey, and Mrs. Truman also were present. President Johnson remarked, “We marvel not simply at the passage of this Bill but that it took so many years to pass it.”

Medicare extended health coverage to almost all Americans aged 65 or older. About 19 million beneficiaries enrolled in Medicare in the first year of the program. Medicaid provided access to health care services for certain low-income persons and expanded the existing federal-state welfare structure that assisted the poor.

The 1972 Social Security Amendments expanded Medicare to provide coverage to two additional high risk groups – disabled persons receiving cash benefits for 24 months under the social security program and persons suffering from end-stage renal disease.

B. ADMINISTRATION OF MEDICARE

The Social Security Act established both Medicare and Medicaid. Medicare was a responsibility of the Social Security Administration (SSA), while federal assistance to the state Medicaid programs was administered by the Social and Rehabilitation Service (SRS). SSA and SRS were agencies in the Department of Health, Education, and Welfare (HEW). In 1977, the Health Care Financing Administration (HCFA) was created under HEW to effectively coordinate Medicare and Medicaid. In 1980, HEW was divided into the Department of Education and the Department of Health and Human Services (HHS). In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).

Medicare is financed by a portion of Federal Insurance Contributions Act (FICA) taxes, or payroll taxes, paid by workers and their employers. It also is financed in part by monthly premiums paid by beneficiaries.

II. MEDICARE ELIGIBILITY

Medicare does not provide benefits to all older Americans. Below is an explanation of the persons eligible for Medicare benefits.

TABLE 9-1. SUMMARY OF PERSONS ELIGIBLE FOR MEDICARE

Medicare is a health insurance program for:

- People age 65 or older;
- People under age 65 with certain disabilities; and
- People with End-Stage Renal Disease (ESRD): permanent kidney failure requiring dialysis or a kidney transplant, or amyotrophic lateral sclerosis (ALS - also known as Lou Gehrig's disease).

A. PEOPLE AGE 65 AND OLDER

Most people age 65 or older who are citizens or permanent residents of the United States are eligible for Medicare hospital insurance (Part A) without paying a monthly premium based on their own – or their spouse's – employment. An individual is eligible at age 65 if:

- He or she receives or is eligible to receive social security benefits on the individual's own work record or on someone else's work record as a spouse, divorced spouse, widow, widower, divorced widow, divorced widower, or parent; or
- He or she receives or is eligible to receive railroad retirement benefits;
- The individual or his or her spouse worked long enough in a government job where Medicare taxes were paid; or
- The individual is the dependent parent of a fully insured deceased child.

If an individual does not meet these requirements, he or she may still be able to get Medicare hospital insurance 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.

B. PEOPLE UNDER AGE 65

Before age 65, an individual is eligible for premium-free Medicare hospital insurance if:

- He or she has been entitled to social security disability benefits for 24 months. This includes widows, widowers and children who receive benefits because of disability; or
- He or she receives a disability pension from the railroad retirement board and meet certain conditions;
- He of she received social security disability benefits because he or she has Lou Gehrig's disease (amyotrophic lateral sclerosis); or
- The individual, a parent or a spouse (living or deceased, including a divorced spouse) has worked long enough in a government job where Medicare taxes were paid and he or she meets the requirements of the social security disability program.

C. PERSONS WITH KIDNEY FAILURE

Individuals with permanent kidney failure are eligible for free Medicare hospital insurance at any age. This is true if the individual is receiving maintenance dialysis or a kidney transplant and:

- He or she is eligible for or receives monthly benefits under social security or the railroad retirement system; or
- He or she has worked long enough in a Medicare-covered government job; or
- He or she is the child or spouse (including a divorced spouse) of a worker (living or deceased) who has worked long enough under social security or in a government job where Medicare taxes were paid.

III. TYPES OF BENEFITS

Medicare has four parts. They are:

- Hospital insurance (Part A) that helps pay for inpatient care in a hospital or skilled nursing facility (following a hospital stay), some home health care and hospice care.
- Medical insurance (Part B) that helps pay for doctors' services and many other medical services and supplies that are not covered by hospital insurance.
- Medicare Advantage plans (Part C) are available in many areas. People with Medicare Parts A and B can choose to receive all of their health care services through one of these provider organizations under Part C.

- Prescription drug coverage (Part D) that helps pay for medications doctors prescribe for treatment.

A. PART A: HOSPITAL INSURANCE

Medicare hospital insurance can help pay for inpatient care in a hospital or skilled nursing facility following a hospital stay, home health care and hospice care.

1. Cost

Individuals who have paid Medicare taxes while they were working (or those with a spouse who paid Medicare taxes while working) receive Part A insurance at no cost. If an individual buys Part A, the cost is $411 each month for 2016.

2. Automatic Enrollment

Individuals who are already receiving benefits from social security or the Railroad Retirement Board will automatically receive Medicare Part A starting the first day of the month they turn age 65. Individuals who are under age 65 and disabled will receive Medicare Part A after they receive social security disability or Railroad Retirement benefits for 24 months. Individuals who have elected not to receive social security at age 65 must apply for Medicare Part A. There is no benefit to delaying receipt of Medicare benefits.

Note

Even though Social Security's full retirement age is no longer 65, individuals should sign up for Medicare three months before their 65th birthday.

3. Covered Services

Medicare Part A provides coverage for the following services:

- **Hospital Stays:** Semiprivate room, meals, general nursing, and other hospital services and supplies. Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime;
- **Skilled Nursing Care Facility:** Semiprivate rooms, meals, skilled nursing and rehabilitative services and other services and supplies;
- **Nursing Home Care:** Certain skilled nursing facility (SNF) if it is medically necessary, i.e., changing sterile dressings.
- **Home Health Care:** Part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, etc; and
- **Hospice Care:** For people with a terminal illness, including drugs for symptom control and pain relief.

B. PART B: MEDICAL INSURANCE

Anyone who is eligible for free Medicare hospital insurance (Part A) can enroll in Medicare medical insurance (Part B) by paying a monthly premium. Premiums are discussed in more detail below. If an individual is not eligible for free hospital insurance, he or she can buy medical insurance, without having to buy hospital insurance, if he or she is age 65 or older, and a citizen or lawfully admitted alien who has lived in the U.S. for at least five years. The medical insurance premiums are much less costly than the hospital insurance premiums.

1. Cost

In addition to the standard monthly premiums (which in 2016 is $104.90 per month), there are other "out-of-pocket" costs for Medicare. These are the amounts an individual pays when he or she actually receives medical services, known as "deductibles" and "coinsurance."

For example, if an individual is hospitalized, he or she will be required to pay a deductible amount, and may have to pay coinsurance amounts, depending on the length of the hospital stay. If an individual receives medical services from a doctor, he or she will pay a yearly deductible amount as well as a coinsurance amount for each visit. The monthly premiums, deductibles and coinsurance for Medicare change each year.

2. State Financial Assistance

If an individual is unable to afford his or her Medicare premiums and other costs, he or she may be able to get help from his or her state. The individual may qualify for a Medicare assistance program known as a "Qualified Medicare Beneficiary" (QMB), "Specified Low-Income Medicare Beneficiary" (SLMB), or "Qualifying Individual" (QI).

These programs are for certain people who are entitled to Medicare and have low income. They may pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance. To qualify, the individual must have Part A (hospital insurance), a limited income, and his or her assets, such as bank accounts, stocks and bonds, must not be more than $7,280 for a single person or $10,930 for a couple.

3. Enrolling in Part B

Enrolling in Medicare Part B is a choice. Individuals who do not want to enroll are not required to do so.

4. Initial Enrollment Period

Individuals can sign up for Medicare Part B during their Initial Enrollment Period. This period begins three months before an individual turns age 65 and ends three months after he or she turns age 65.

5. General Enrollment Period

Individuals who did not sign up for Medicare Part B when they first became eligible can still sign up during the General Enrollment Period, which runs from January 1 through March 31 of each year. The Medicare Part B will begin on July 1 of the year the individual signed up.

The cost of Medicare Part B will go up 10% for each 12-month period that an individual could have had Medicare Part B but did not take it, except in special cases. This extra amount will be due as long as the individual has Part B.

6. Special Enrollment Period

This period is available if an individual was eligible to enroll in Medicare and waited to enroll in Part B because the individual or his or her spouse were working and had group insurance coverage through an employer or union based on this employment. If this applies, an individual can sign up for Medicare Part B:

- Any time he or she is still covered by an employer or union group health insurance plan, through the individual's own or his or her spouse's current employment; or
- During the eight months following the month that the employer or union group health insurance ends, or when the employment ends (whichever is first).

The special enrollment period may also apply to persons who are disabled and working or have group health insurance from a working family member.

People who sign up for Medicare Part B during this special enrollment period do not pay a higher premium. However, persons who are eligible and do not sign up during the special enrollment period will only be able to sign up during the general enrollment period and the cost may go up.

7. Coverage by Employer-Based Plan

If an individual is 65 or older and is covered under a group health plan either from his or her own or his or her spouse's current employment, he or she has a "Special Enrollment Period" in which to sign up for Medicare Part B. This means that he or she may delay enrolling in Medicare Part B without having to wait for a general enrollment period or pay the 10 percent premium surcharge for late enrollment.

If an individual enrolls in Part B while covered by an employer-provided group health plan or during the first full month when not covered by that plan, he or she has the option to have his or her coverage begin the first day of the month he or she enrolls or to delay coverage until the first day of any of the following three months.

If an individual enrolls during any of the seven remaining months of the special enrollment period, his or her coverage will begin the month after he or she enrolls. Special enrollment period rules do not apply if employment or employer-provided group health plan coverage ends during his or her initial enrollment period. If an individual does not enroll by the end of the eight-month period, he or she will have to wait until the next general enrollment period, which begins January 1 of the next year.

People who receive social security disability benefits and are covered under a group health plan from either their own or a family member's current employment also have a special enrollment period and premium rights that are similar to those for workers age 65 or older.

8. Premiums for High Income Enrollees

The Part B premium a beneficiary pays each month is based on his or her annual income. Specifically, if a beneficiary's "modified adjusted gross income" is greater than the legislated threshold amounts ($85,000 in 2016 for a beneficiary filing an individual income tax return or married and filing a separate return, and $170,000 for a beneficiary filing a joint tax return), the beneficiary is responsible for a larger portion of the estimated total cost of Part B benefit coverage.

In addition to the standard Part B premium, affected beneficiaries must pay an income-related monthly adjustment amount. Less than 5 percent of current Part B enrollees are expected to be subject to these higher premium amounts.

C. MEDICARE RATES

The Department of Health and Human Services (HHS) annually sets rates for premiums, deductibles and coinsurance amounts to be paid by Medicare beneficiaries.

For Medicare Part A, which pays for inpatient hospital, skilled nursing facility, and some home health care, the deductible paid by the beneficiary in 2016 is $1,288, an increase of $28 from the 2015 deductible. The monthly premium paid by beneficiaries enrolled in Medicare Part B, which covers physician services, outpatient hospital services, certain home health services, durable medical equipment and other items, is $104.90 (for existing enrollees) in 2016. New enrollees will pay $121.80 in 2016.

The deductible for Medicare Part B is $166 in 2016.

1. Rates Set by Law

Medicare deductibles and premiums are updated annually in accordance with formulas set by law. The Part B premium is required to be the amount needed to cover 25 percent of the estimated program costs for enrollees aged 65 and older. General revenue tax dollars cover the other 75 percent of the costs. The same statute prescribes the method for computing the Part A inpatient hospital deductible.

Most Medicare beneficiaries enrolled in Part B pay the monthly premium. The Part A deductible applies only to those enrolled in the original fee-for-service Medicare program. Those who enroll in private Medicare Advantage plans may not be affected by the Part A increase, and may receive additional benefits with different cost-sharing arrangements. These plans and their costs are discussed in more detail in the following chapter.

About 95 percent of Medicare's 55 million beneficiaries (2016) are enrolled in the optional Part B, which helps pay for physician services, hospital outpatient care, durable medical equipment and other services, including some home health care. Nearly 90 percent also have some form of supplemental coverage (such as Medigap, Medicaid, or Medicare Advantage) to help reduce out-of-pocket medical costs.

The Part A deductible is the beneficiary's only cost for up to 60 days of Medicare-covered inpatient hospital care. However, for extended Medicare-covered hospital stays, beneficiaries must pay an additional $322 per day for days 61 through 90 in 2016, and $644 per day for hospital stays for days 91 and beyond. Beyond lifetime reserve days, all costs are paid by the beneficiary.

For beneficiaries in skilled nursing facilities, the daily co-insurance for days 21 through 100 is $161.00 in 2016, and then all costs for each day after day 100 of the benefit period.

2. Purchasing Coverage

Most Medicare beneficiaries do not pay a premium for Part A services since they have 40 quarters of Medicare-covered employment. However, persons 65 or older and certain persons under age 65 with disabilities who have fewer than 30 quarters of coverage may obtain Part A coverage by paying a monthly premium set according to a formula in the Medicare statute at $411 for 2016. In addition, persons 65 or older with 30 to 39 quarters of coverage, and certain disabled persons with 30 or more quarters of coverage, are entitled to pay a reduced premium of $226.

TABLE 9-2. MEDICARE PREMIUMS

Part A (Hospital Insurance) Premium	Part B (Medical Insurance) Premium
• Most people do not pay a monthly Part A premium because they or a spouse has 40 or more quarters of Medicare-covered employment. • The Part A premium is $226.00 in 2016 for people having 30-39 quarters of Medicare-covered employment. • The Part A premium is $411.00 in 2016 per month for people who are not otherwise eligible for premium-free hospital insurance and have less than 30 quarters of Medicare-covered employment.	• $104.90 per month for existing participants (2016). New participants $121.80 in 2016. • High income participants are subject to a monthly premium adjustment that increases their actual costs beyond the standard $104.90 amount.

TABLE 9-3. MEDICARE COINSURANCE RATES

Part A (pays for inpatient hospital, skilled nursing facility, and some home health care)	Part B (covers Medicare eligible physician services, outpatient hospital services, certain home health services, durable medical equipment)
For each benefit period Medicare pays all covered costs except the Medicare Part A deductible ($1,288 in 2016) during the first 60 days and coinsurance amounts for hospital stays that last beyond 60 days and no more than 150 days. **For each benefit period an individual pays:** • A total of $0 in 2016 for a hospital stay of 1-60 days. • $322 in 2016 per day for days 61-90 of a hospital stay. • $644 in 2016 per each "lifetime reserve day" after day 90 (up to 60 days over your lifetime). • All costs for each day beyond lifetime reserve days. **Skilled Nursing Facility Coinsurance** $166.00 in 2016 per day for days 21 through 100 each benefit period.	$166.00 per year in 2016. (**Note:** Individuals pay 20% of the Medicare-approved amount for services after they meet the deductible.)

IV. SELECTED COVERED SERVICES

A. HOME HEALTH CARE

Individuals who have Medicare can use their home health care benefits if they meet all the following conditions:

- Their doctor must decide that the individual needs medical care at home, and makes a plan for their care at home;
- They must need at least one of the following: intermittent skilled nursing care, or physical therapy or speech-language therapy, or continue to need occupational therapy; and

- They must be homebound, or normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious services.

A need for adult day care does not keep an individual from getting home health care for other medical conditions. In addition, the home health agency caring for the individual must be approved by the Medicare program (Medicare-certified). Eligibility is also based on the amount of services an individual needs.

Medicare covers an individual's home health services for as long as he or she is eligible and his or her doctor says he or she needs these services. However, the skilled nursing care and home health aide services are only covered on a part-time or "intermittent" basis. This means there are limits on the number of hours per day and days per week that an individual can get skilled nursing or home health aide services. Therapy services do not have to be part-time or intermittent.

Medicare defines part time or "intermittent" as skilled nursing care that is needed or given on fewer than seven days each week or less than eight hours each day over a period of 21 days (or less) with some exceptions in special circumstances.

Example

Jane's doctor says that she needs a nurse to visit her every day for the next 15 days to care for a wound. The total time that the nurse will be at Jane's house will be less than an hour each day, and Jane only needs the nurse to come for 15 days. Jane's need for home health care meets the Medicare definition of "intermittent."

Hour and day limits may be extended in exceptional circumstances when an individual's doctor can predict when his or her need for care will end.

Once an individual is receiving home health care, Medicare defines part-time or intermittent as skilled nursing or home health aide services combined to total less than 8 hours per day and 28 or fewer hours each week. Based on an individual's need for care, on a case-by-case basis, the weekly total may be increased to 35 hours.

Example

Fred has been getting home health care for 3 weeks. Fred's condition is improved, but his doctor would like Fred to continue to get home health care. Fred's doctor says that he needs a nurse to come in 4 days a week for 3 hours each day (a total of 12 hours) and a home health aide to come in 5 days a week for 3 hours each day (a total of 15 hours). This means that Fred is getting a total of 27 hours of home care per week. This meets Medicare's definition of "part-time or intermittent" home health care.

B. HOSPITAL CARE

1. Medicare Part A Coverage

Medicare Part A covers inpatient hospital care when all of the following are true:

- A doctors says the individual needs inpatient care for the treatment of his or her illness or injury;
- The individual needs the kind of care that can only be given in a hospital;
- The hospital has agreed to participate in the Medicare program;
- The Utilization Review Committee of the hospital does not disapprove the individual's stay while he or she is in the hospital; and
- A Quality Improvement Organization or an intermediary does not disapprove the individual's stay after the bill is submitted.

Medicare-covered hospital services includes a semi-private room, meals, general nursing, and other hospital services and supplies. It does not include private nurses, a television or telephone or a private room, unless medically necessary.

2. Cost of Hospitalization (in 2016)

Costs are based on benefit periods. A benefit period begins the day an individual goes into the hospital and ends when the individual has not received hospital care for 60 days in a row. If an individual is hospitalized after the initial benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods an individual can have. The costs are shown in Table 9-2, earlier in this chapter.

C. PRESCRIPTION DRUGS

Medicare offers insurance coverage to help people pay for prescription drugs. The program, known as Medicare Part D, started on January 1, 2006. Everyone with Medicare is eligible for this coverage, regardless of income and resources, health status, or current prescription expenses.

If individuals do not sign up when they are first eligible, they may pay a penalty, and their next opportunity to join will be from October 15 to December 7 of the upcoming year. This period is known as the open enrollment period.

There are two ways to get Medicare prescription drug coverage. Individuals can join a Medicare prescription drug plan, or they can join a Medicare Advantage Plan or other Medicare Health Plan that offers drug coverage.

Like other insurance, participants will generally pay a monthly premium, which varies by plan, and a yearly deductible (between $0-$360 in 2016). Individuals will also pay a part of the cost of their prescriptions, including a copayment or coinsurance. Costs will vary depending on which drug plan each individual

chooses. Some plans may offer more coverage and additional drugs for a higher monthly premium. If an individual has limited income and resources, and he or she qualifies for extra help, he or she may not have to pay a premium or deductible.

D. OTHER BENEFITS UNDER THE ORIGINAL MEDICARE PLAN

Table 9-4 details a sampling of other benefits covered by the Original Medicare Plan. Remember that additional benefits are available for beneficiaries who select other plans, which are discussed in the next chapter.

TABLE 9-4. SELECTED BENEFITS IN THE ORIGINAL MEDICARE PLAN

Benefit	What Is Covered	Cost to Beneficiary	Part A or B
Acupuncture	Not covered.	Individual pays 100%.	
Canes / Crutches	Medicare covers canes and crutches. It does not cover white canes for the blind.	Individual pays 20% of Medicare-approved amount.	**B**
Chemotherapy	Chemotherapy is covered for patients who are hospital in-patients or out-patients. If in-patient, it is covered by Part A. If out-patient, it is covered by Part B.	Individual pays 20% of Medicare-approved amount for inpatient and set copayment for outpatient.	**A or B**
Chiropractic Services	Medicare covers manipulation of the spine to correct subluxation when provided by chiropractors or qualified providers.	Individual pays 20% of Medicare-approved amount.	**B**
Cosmetic Surgery	Generally not covered unless it is needed because of accidental injury or to improve function of malformed part of body.	Generally individual pays 100%.	
Dental Care	Medicare does not cover most routine dental care. Medicare Part A will pay for certain services provided while hospitalized.	In general, individual pays 100%.	

Diagnostic Tests	Medicare covers diagnostic tests such as CT scans, MRIs, EKGs and X-rays and other tests performed by certified laboratories participating in Medicare. Does not cover routine screening tests.	Individual pays 20% percent of Medicare-approved cost for covered diagnostic tests, a set copayment for diagnostic tests performed in hospital outpatient setting.	**B**
Doctor's Office Visit	Medicare covers medically necessary services received from a doctor in his or her office, clinic, hospital or any other location. Routine physical exams are not covered.	Individual pays 20% of the Medicare-approved amount, except for certain preventive services (in which case individual pays nothing).	**B**
Emergency Department Services	Medicare covers emergency department services when the individual believes his or her health is in serious danger, he or she has a bad injury, sudden illness or an illness which is suddenly getting worse. Medicare covers emergency services in other countries only in rare circumstances.	Individual pays set copayment amount for each emergency department visit. No charge if individual is admitted to hospital for the same condition within 1-3 days of the emergency department visit.	**B**
Eye Exams	Medicare does not cover routine eye exams.	Individual pays 100% for routine eye exams.	
Eyeglasses	Medicare does not generally cover eyeglasses or contact lenses. There is an exception for certain individuals following cataract surgery with an intraocular lens.	Individual generally pays 100%.	
Flu Shot	Medicare covers one flu shot per season.	Individual pays nothing for shot if doctor or other provider accepts assignment.	**B**

Physical Therapy	Medicare helps pay for medically necessary outpatient physical and occupational therapy and speech pathology services when the doctor or therapist sets up the plan of treatment, and the doctor periodically reviews the plan to see how long the patient will need therapy.	Medicare pays up to yearly limits on these services when received from most outpatient providers. Limits are called therapy caps and are adjusted annually.	**B**
Preventive Visits	Medicare covers 2 types of routine preventive visits: one when individual is new to Medicare and one each year after that.	Generally, individual pays nothing.	**B**
Second Surgical Opinions	Medicare covers a second opinion before surgery.	The individual pays 20% of the Medicare-approved amount in most cases.	**B**
Travel Outside of the United States	Medicare generally does not cover an individual while he or she is traveling outside of the United States. Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands are considered part of the United States in most cases.	Individual generally pays 100% of costs outside of the United States. In rare circumstances, Medicare may cover a portion of medically necessary physician and ambulance services (individual pays 20% of the Medicare-approved amount).	**B**

V. MEDICAID: AN OVERVIEW

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

A. STATE CONTROL

Within broad national guidelines established under federal law, each state:

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

Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, state legislatures may change Medicaid eligibility, services, and/or reimbursement during the year.

B. BASIS OF ELIGIBILITY AND MAINTENANCE ASSISTANCE STATUS

Before 2014, Medicaid did not offer health care services for all poor persons. To qualify for the program, an individual needed not only to have low income; he or she also had to be a child (or the parent or adult caretaker of an eligible child), an aged adult, or disabled. Other criteria also applied; for example, in many cases eligibility depended on having financial assets beneath a certain threshold.

Beginning in 2014, the Affordable Care Act expanded eligibility to include all individuals younger than age 65 in households with income up to 138 percent of the FPL, as explained in more detail below. Under this legislation, many of the pre-2014 Medicaid eligibility criteria no longer applied for most persons. However, a 2012 Supreme Court ruling had made expanded eligibility effectively optional for each state's Medicaid program. In response, some states chose not to implement expanded eligibility.

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

C. CATEGORICALLY NEEDY

The following are considered to be “categorically needy” under Medicaid rules. These are the eligibility groups for which federal matching funds are provided:

- Limited-income families with children, as described in section 1931 of the Social Security Act, are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their state on July 16, 1996.
- Children under age 6 whose family income is at or below 133 percent of the FPL. (As of 2015-2016, the FPL has been set at $24,300 for a family of four in the continental U.S.; Alaska and Hawaii’s FPLs are $30,380 and $27,950, respectively.)
- Pregnant women whose family income is below 133 percent of the FPL. (Services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care.)
- Infants born to Medicaid-eligible women, for the first year of life with certain restrictions.
- Supplemental Security Income (SSI) recipients in most states (or aged, blind, and disabled individuals in states using more restrictive Medicaid eligibility requirements that pre-date SSI).
- Recipients of adoption or foster care assistance under Title IV-E of the Social Security Act.
- Special protected groups (typically individuals who lose their cash assistance under Title IV-A or SSI because of earnings from work or from increased social security benefits, but who may keep Medicaid for a period of time).
- All children under age 19, in families with incomes at or below the FPL.
- Certain Medicare beneficiaries

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

- Infants up to age one and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL (the percentage amount is set by each state);
- Children under age 21 who meet the more liberal AFDC income and resources requirements that were in effect in their state on July 16, 1996;

- Institutionalized individuals, and individuals in home and community based waiver programs, who are eligible under a "special income level" (the amount is set by each state – up to 300 percent of the SSI federal benefit rate);
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers;
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL;
- Aged, blind, or disabled recipients of state supplementary income payments;
- Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work;
- Tuberculosis-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, coverage is limited to tuberculosis-related ambulatory services and tuberculosis drugs);
- Certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 provides these women with medical assistance and follow-up diagnostic services through Medicaid;
- "Optional targeted low-income children" included within the Children's Health Insurance Program (CHIP) established by the Balanced Budget Act (BBA); and
- "Medically needy" persons.

The medically needy (MN) option allows states to extend Medicaid eligibility to additional persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their state for these groups. Persons may qualify immediately or may "spend down" by incurring medical expenses greater than the amount by which income exceeds their state's MN income level.

Medicaid eligibility and benefit provisions for the medically needy do not have to be as extensive as for the categorically needy, and may be quite restrictive. Federal matching funds are available for MN programs. However, if a state elects to have an MN program, it must meet federal requirements that certain groups (including children under age 19 and pregnant women) be covered and that certain services (including prenatal and delivery care for pregnant women and ambulatory care for children) be provided.

A state may elect to provide MN eligibility to certain additional groups and may elect to provide certain additional services as part of its MN program. As of 2016, thirty-six states, plus the District of Columbia, have elected to have an MN program and are providing to at least some MN beneficiaries. All remaining states utilize the "special income level" option to extend Medicaid to the "near poor" in medical institutional settings.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 – known as the Welfare Reform Act – made restrictive changes regarding eligibility for SSI coverage that affected the Medicaid program. For example, legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 are ineligible for Medicaid for five years. States have the option of providing Medicaid coverage for most aliens entering before that date and coverage for those eligible after the five-year ban; emergency services, however, are mandatory for both of these alien coverage groups. For aliens who lose SSI benefits because of these restrictions regarding SSI coverage, Medicaid benefits can continue only if these persons can be covered under some other eligibility status (again with the exception of emergency services, which are mandatory).

In addition, welfare reform repealed the open-ended federal entitlement program known as Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF), which provides states with grants to be spent on time-limited cash assistance. TANF generally limits a family's lifetime cash welfare benefits to a maximum of 5 years and permits states to impose a wide range of other requirements as well – in particular, those related to employment. However, the impact on Medicaid eligibility has not been significant. Under welfare reform, persons who would have been eligible for AFDC under the AFDC requirements in effect on July 16, 1996 are generally still eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, it is not required by law.

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

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

The Deficit Reduction Act (DRA) of 2005 refined eligibility requirements for Medicaid beneficiaries by tightening standards for citizenship and immigration documentation and by changing the rules concerning long-term care eligibility -- specifically the look-back period for determining community spouse income and assets was lengthened from 36 months to 60 months, individuals whose homes exceed $500,000 in value are disqualified, and the states are required to impose partial months of ineligibility.

Beginning in 2014, the Affordable Care Act expanded Medicaid eligibility to include all individuals under age 65 in families with income below 138 percent of the FPL. (Technically, the income limit is 133 percent of the FPL, but the Act also provides for a 5-percent income disregard.) In addition to the higher level of allowable income, the new legislation expands eligibility to people under age 65 who have no other qualifying factors that would have made them eligible for Medicaid under prior law, such as being under age 18, disabled, pregnant, or parents of eligible children. Because individuals are not required to be parents of eligible children under the new law, nondisabled nonaged adults comprise the category expected to have the greatest increase in Medicaid enrollment. However, in *National Federation of Independent Business v. Sebelius* (2012), the U.S. Supreme Court ruled that states could

not be required to implement the expansion of Medicaid eligibility as a condition of continuing to operate their existing Medicaid programs and receiving Federal financial participation. This ruling has made the eligibility expansion effectively optional for each state's Medicaid program. As of July 2016, 31 states and the District of Columbia have adopted the Medicaid expansion.

D. SCOPE OF MEDICAID SERVICES

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:

- Inpatient hospital services;
- Outpatient hospital services;
- Pregnancy-related services, including prenatal care and 60 days postpartum pregnancy-related services;
- Vaccines for children;
- Physician services;
- Nursing facility services for persons aged 21 or older;
- Family planning services and supplies;
- Rural health clinic services;
- Home health care for persons eligible for skilled nursing services;
- Laboratory and x-ray services;
- Pediatric and family nurse practitioner services;
- Nurse-midwife services;
- Federally qualified health center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings; and
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

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

- Diagnostic services;
- Clinic services;

- Intermediate care facility services;
- Prescribed drugs and prosthetic devices;
- Optometrist services and eyeglasses;
- Nursing facility services for children under age 21;
- Transportation services;
- Rehabilitation and physical therapy services;
- Hospice care;
- Home and community-based care to certain persons with chronic impairments; and
- Targeted case management services.

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

E. AMOUNT AND DURATION OF MEDICAID SERVICES

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

In general, states are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions: (1) medically necessary health care services that are identified under the EPSDT program for eligible children, and that are within the scope of mandatory or optional services under federal law, must be covered even if those services are not included as part of the covered services in that state's plan; and (2) states may request waivers to pay for otherwise uncovered home and community-based services for Medicaid-eligible persons who might otherwise be institutionalized.

As long as the services are cost effective, states have few limitations on the services that may be covered under these waivers (except that states may not provide room and board for the beneficiaries, other than as part of respite care). With certain exceptions, a state's Medicaid program must allow beneficiaries to

have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely.

F. PAYMENT FOR MEDICAID SERVICES

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or states may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within federally imposed upper limits and specific restrictions, each state for the most part has broad discretion in determining the payment methodology and payment rate for services.

Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid beneficiaries for certain services. The following Medicaid beneficiaries, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid beneficiaries must be exempt from copayments for emergency services and family planning services. Under the DRA, new cost sharing and benefit rules provided states the option of imposing new premiums and increased cost sharing on all Medicaid beneficiaries except for those mentioned above and for terminally ill patients in hospice care. The DRA also established special rules for cost sharing for prescription drugs and for nonemergency services furnished in emergency rooms.

The federal government pays a share of the medical assistance expenditures under each state's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs.

By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. In fiscal year (FY) 2016, the FMAPs varied from 50 percent in eleven states to 74.2 percent in Mississippi.

The Patient Protection and Affordable Care Act significantly expanded both eligibility for and federal funding of Medicaid. Under the law as written, all U.S. citizens and legal residents with income up to 133% of the poverty line, including adults without dependent children, would qualify for coverage in any state that participated in the Medicaid program. However, the United States Supreme Court ruled in National Federation of Independent Business v. Sebelius that states do not have to agree to this expansion in order to continue to receive previously established levels of Medicaid funding, and many states have chosen to continue with pre-ACA funding levels and eligibility standards.

G. THE MEDICAID-MEDICARE RELATIONSHIP

Unlike Medicaid, Medicare is a social insurance program funded at the federal level and focuses primarily on the older population. Per the Centers for Medicare and Medicaid Services (CMS), Medicare is a health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end stage renal disease. The Medicare Program provides a Medicare Part A which covers hospital bills, Medicare Part B which covers medical insurance coverage, and Medicare Part D which covers prescription drugs.

Medicaid is a program that is not solely funded at the federal level. States provide up to half of the funding for the Medicaid program. In some states, counties also contribute funds. Unlike the Medicare entitlement program, Medicaid is a means-tested, needs-based social welfare or social protection program rather than a social insurance program. Eligibility is determined largely by income. The main criterion for Medicaid eligibility is limited income and financial resources, a criterion which plays no role in determining Medicare coverage. Medicaid covers a wider range of health care services than Medicare. Some people are eligible for both Medicaid and Medicare and are known as Medicare dual eligibles. In 2013, payments for beneficiaries enrolled in both Medicare and Medicaid constituted an estimated 33.7 percent of total Medicaid expenditures.

CHAPTER 9: TEST YOUR KNOWLEDGE

The following questions are designed to ensure that you have a complete understanding of the information presented in the chapter (assignment). They are included as an additional tool to enhance your learning experience and do not need to be submitted in order to receive CPE credit.

We recommend that you answer each question and then compare your response to the suggested solutions on the following page(s) before answering the final exam questions related to this chapter (assignment).

1.	**When did the Medicare program go into effect:** **A.** 1943 **B.** 1948 **C.** 1965 **D.** 1972
2.	**How is Medicare funded:** **A.** solely through employee payroll taxes **B.** solely though employer payroll taxes **C.** solely by premiums paid by covered individuals **D.** through a combination of sources, including payroll taxes by employers and employees and premium payments by enrollees
3.	**Medicare does not provide any prescription drug coverage.** **A.** true **B.** false
4.	**Which of the following statements about Medicaid is correct:** **A.** it is a state program and receives no funding from the federal government **B.** while Medicaid is a federal program, states have broad discretion in its implementation **C.** every poor person in America is entitled to Medicaid coverage **D.** only elderly people are eligible for Medicaid

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CHAPTER 9: SOLUTIONS AND SUGGESTED RESPONSES

Below are the solutions and suggested responses for the questions on the previous page(s). If you choose an incorrect answer, you should review the pages as indicated for each question to ensure comprehension of the material.

1.	**A.** Incorrect. Although President Roosevelt was responsible for many landmark American laws, this was not one of them. **B.** Incorrect. President Truman, who was president at this time, first proposed the idea. However, it was not signed into law until later. **C.** **CORRECT**. The legislation enacting Medicare was signed by President Johnson in 1965. **D.** Incorrect. Additions to Medicare coverage were made in 1972, but the law was originally enacted in 1965. *(See page 123 of the course material.)*
2.	**A.** Incorrect. Employee-paid payroll taxes are just one source of financing for the Medicare program. **B.** Incorrect. Employer-paid payroll taxes are just one part of the financing puzzle. **C.** Incorrect. Premiums by enrollees help pay some of the cost, but the largest portion is financed via employer and employee payroll taxes. **D.** **CORRECT**. All of these sources are used to finance the Medicare program. *(See page 124 of the course material.)*
3.	**A.** Incorrect. Beginning January 1, 2006, Medicare started offering Medicare Part D to help people pay for prescription drugs. **B.** **CORRECT**. Beginning January 1, 2006, everyone with Medicare is eligible for prescription drug coverage using Medicare Part D. *(See page 133 of the course material.)*
4.	**A.** Incorrect. Medicaid is a federal program administered by the states. **B.** **CORRECT**. It is a federal and state program in which individual states have discretion in many areas as to how to administer the program and as to eligibility criteria. **C.** Incorrect. Being poor is not necessarily sufficient to receive Medicaid benefits. There are specific criteria set by each state. **D.** Incorrect. Elderly people may be entitled to benefits in some cases, but they are certainly not the only eligible persons. Many younger, poor people are eligible. *(See pages 137 to 138 of the course material.)*

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CHAPTER 10: MEDICARE PLAN CHOICES

Chapter Objective

After completing this chapter, you should be able to:

- Recognize the various optional Medicare health plans.

I. MEDICARE PLAN CHOICES

Medicare offers participants different ways to get their Medicare benefits. These different options are called Medicare health plans. One option is the Original Medicare Plan. Some private companies contract with the Medicare program to offer Medicare health plans. These are called Medicare Advantage plans. How an individual gets his or her health care in the Medicare program depends on which plan he or she chooses. Depending on where an individual lives, he or she may have more than one plan to choose from.

A. THE ORIGINAL MEDICARE PLAN

This plan is sometimes called fee-for-service. Everyone with Medicare can join the Original Medicare Plan. This plan is available nationwide. Many people in the Original Medicare Plan also have a Medigap (Medicare Supplemental Insurance) policy or supplemental coverage provided by his or her former employer to help pay health care costs that this plan does not cover.

B. OPTIONAL MEDICARE HEALTH PLANS

1. Medicare Advantage Plans

This plan was formerly referred to as the Medicare + Choice Plan. Congress created this plan to give individuals more choices and, in certain circumstances, extra benefits, by allowing private companies to offer Medicare benefits. The Medicare Advantage Plan an individual chooses may include the following:

- Health Maintenance Organizations (HMO);
- Medicare Special Needs Plans;
- Private Fee-for-Service Plans; and
- Medicare Preferred Provider Organizations (PPO).

Medicare Advantage Plans must cover at least the same benefits covered by Medicare Part A and Part B except hospice care. However, an individual's costs may be different and may include extra benefits, such as vision, hearing, dental, and/or health and wellness. Most include Medicare prescription drug coverage (Part D).

Because the insurance company decides where it will do business, it may only offer Private Fee-for-Service plans in some parts of the country. The insurance company can decide that the plan will be available to everyone with Medicare in a state, or be available only in certain counties. The insurance company may also offer more than one plan in an area, with different benefit levels and different costs. Each year, the insurance company offering the coverage can decide to offer such a plan in a given area.

TABLE 10.1. DIFFERENCES BETWEEN ORIGINAL MEDICARE AND MEDICARE ADVANTAGE PLANS

	Original Medicare	Medicare Advantage Plans
Costs	Individuals pay Medicare premiums, deductibles, and coinsurances (usually 20 percent of the Medicare-approved cost for outpatient care).	Individuals pay Medicare premiums and the plan's premium, if it charges one. Individuals plan sets its own deductibles and copays (usually a fixed cost for each office visit). Individuals may pay the full cost if they don't follow the plan's rules.
Supplemental insurance	Individuals can buy a Medigap policy. (But only at certain times, depending on where they live.)	Individuals can't buy a Medigap policy to help pay out-of-pocket costs in a Medicare Advantage plan.
Covers extra services like vision and dental?	No. Covers medically-necessary inpatient and outpatient health care. Doesn't cover certain services such as routine vision, hearing or dental care.	Maybe. May cover some services Original Medicare doesn't cover such as routine vision, hearing and dental care. All plans must cover the same inpatient and outpatient services Original Medicare covers.
Lets individual see providers nationwide?	Yes. Individuals can go to any doctor or hospital in the U.S. that accepts Medicare.	Usually not. Most people have HMOs, which typically have local networks of providers individuals must use for the plan to cover their care. PPOs and PFFS plans should cover care individuals get outside the network, but they will pay more.
Need referrals to see specialists?	No. Individuals don't need a referral.	Maybe. Individuals often need to get a referral from their Primary Care Physician if they want to see a specialist.

Covers drugs?	No, but if individuals want Medicare prescription drug coverage, they can buy a separate Part D plan.	Usually. Most plans include Part D drug coverage. Individuals usually can't get a separate Part D plan if they have a Medicare Advantage plan (some exceptions).
Out-of-pocket limit?	No. There's no cap on what individuals spend on health care.	Yes. Plans must have an annual out-of-pocket limit, which can be high but protect individuals if they need expensive care. The plan pays the full cost of their care after they reach the limit.

2. Private Fee-for-Service Plans

The following are the significant characteristics of a Private Fee-for-Service Plan:

- An insured can go to any Medicare-approved doctor or hospital that is willing to provide care and accepts the terms of the insured's insurance plan;
- An insured can get services outside of his or her service area;
- The insurance company, rather than Medicare, decides how much the insured pays for the services received;
- The insured will receive all of the services covered under Medicare Part A and Medicare Part B;
- An insured may receive more benefits than offered under the Original Medicare Plan, (these increased benefits are normally subject to an increased cost);
- Private Fee-for-Service plans can charge an insured a premium amount above the Medicare Part B premium;
- Private Fee-for-Service plans can charge deductible and coinsurance amounts that are different than those under the Original Medicare Plan; and
- Private Fee-for-Service plans can let providers charge the insured 15 percent over the plan's payment amount for services. This 15 percent balance billing amount applies to providers who have a written contract with the Private Fee-for-Service plan.

Example

Philip must go to the hospital for bypass surgery. The hospital he is going to has a contract with Philip's Private Fee-for-Service plan. This plan lets contracting providers "balance bill" (charge the insured 15 percent over the plan's payment amount) for services. Philip has a 20 percent coinsurance amount that he must pay for all inpatient hospital services. The Private Fee-for-Service plan's payment amount for Philip's hospital services is $15,000. Philip must pay $3,000 (the 20 percent coinsurance amount). The hospital also charges Philip 15 percent over the $15,000 plan payment amount. This amount is $2,250. Philip owes a total of $5,250 ($3,000 + $2,250) to the hospital for his services.

a. Private Fee-for-Service Plan Costs

An individual who selects this type of plan will generally pay the following:

- The applicable monthly Medicare Part B premium;
- Any additional monthly premium the plan charges above the Medicare Part B premium;
- Any additional monthly premium the plan charges for extra benefits, such as prescription drug coverage; and
- Any plan deductible, coinsurance or copayment amounts that the Private Fee-for-Service plan charges. For example, a plan may charge a copayment of $10 for each doctor visit.

Example

Sally is considering a Private Fee-for-Service plan. The plan she is looking at has a $75 monthly premium, but covers additional benefits Medicare does not cover. To be in this plan, Sally would have to pay the monthly Medicare Part B premium ($104.90 in 2016) and the additional premium the plan charges. This plan also charges $10 per doctor visit. If Sally goes to her doctor three times in one month, her total cost for the month would be $209.90.

b. Out-of-Pocket Costs

Private Fee-for-Service plans differ in the amounts they charge for premiums, deductibles and services. The plan decides how much to charge for services. The cost an individual will pay depends on a number of factors, including the following:

- Which private plan he or she chooses;
- When the plan charges an additional monthly premium;

- How much the plan charges per visit to a health care provider;
- Whether the plan allows doctors, hospitals and other providers to bill the insured more than the plan pays for services;
- How often and the type of health care an individual receives; and
- Which extra benefits are covered by the plan.

c. Joining a Private Fee-for-Service Plan

An individual can join one of these plans if:

- He or she has both Medicare Part A and Medicare Part B and he or she continues to pay the Medicare Part B premium;
- He or she lives in the service area of the plan; and
- He or she does not have End-Stage Renal Disease (permanent kidney failure treated with kidney dialysis or a transplant, sometimes called ESRD).

C. CHOOSING THE RIGHT PLAN

How an individual receives his or her Medicare health benefits affects many things, like cost, extra benefits, doctor choice, convenience, and quality. They are all important, but some may be more important to one person than another. It is therefore important for each individual to look at what plans are available in his or her area, what each plan offers, and make the best choice for them. An individual's choice of plan will affect the following:

- **Cost –** What will out-of-pocket costs be?
- **Benefits –** Will an individual need extra benefits and services, such as prescription drugs, eye exams, hearing aids, or routine physical exams?
- **Doctor Choice –** Will an individual be able to see the doctors and specialists he or she wants to see?
- **Convenience –** Where are the doctors' offices and what are their hours? Is there paperwork?

The following table outlines which plans offer which features.

TABLE 10-2. MEDICARE PLAN CHOICES AND FEATURES

		Medicare Advantage Plans	
	Original Medicare Plan	**Managed Care Plan**	**Private Fee-for-Service Plan**
Costs Total Out-of-Pocket Costs	**High**	**Low to Medium**	**Medium to High**
Extra Benefits In addition to Medicare covered benefits	**None**	**Most** Like prescription drugs, eye exams, hearing aids, or routine physical exams.	**Some** Like foreign travel or extra days in the hospital.
Doctor Choice	**Widest** Choose any doctor or specialist who accepts Medicare	**Some** Usually must see a doctor or specialist who belongs in your plan.	**Wide** Choose any doctor or specialist who accepts the plan's payment.
Convenience	**Varies** Available nationwide	**Varies** Available in some areas. May require less paperwork and have phone hotline for medical advice.	**Varies** Available in some areas. May require less paperwork and have phone hotline for medical advice.

Before making a health plan decision, it is important to learn more about what the different health plans cover and how that may affect the individual's out-of-pocket costs. For example, the Original Medicare Plan does not pay for or cover everything. To get extra coverage, an individual may buy a Medigap policy, or join an optional Medicare plan.

Generally, an individual can join an optional Medicare plan at any time. However, some plans limit the number of members in their plans. These plans may not accept new members when they reach their limit. A plan will tell individuals if it is signing up new members. Individuals can leave their plan at any time and for any reason.

II. OTHER GOVERNMENT PROGRAMS

Because Medicare may not pay for all required medical care, individuals need to be aware that they may qualify for other types of government programs, some of which are discussed below.

A. TRICARE

TRICARE for Life (TFL) provides expanded medical coverage to:

- Medicare-eligible uniformed services retirees, including retired guard members and reservists;
- Their Medicare-eligible family members and widow/widowers; and
- Certain former spouses if they were eligible for TRICARE before age 65.

An individual must have Medicare Parts A and B to be eligible for TFL. If eligible, the individual will receive all Medicare-covered benefits under the Original Medicare Plan, plus all TFL-covered benefits.

B. PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is an optional benefit under both Medicare and Medicaid that focuses entirely on older people who are frail enough to meet their state's standards for nursing home care. It features comprehensive medical and social services that can be provided at an adult day health center, home, and/or inpatient facilities.

For most patients, the comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized. A team of doctors, nurses and other health professionals assess participant needs, develop care plans, and deliver all services which are integrated into a complete health care plan. PACE is available only in states which have chosen to offer PACE under Medicaid.

1. Eligibility

Eligible individuals who wish to participate must voluntarily enroll. PACE enrollees also must:

- Be at least 55 years of age;
- Live in the PACE service area;
- Be screened by a team of doctors, nurses, and other health professionals; and
- Sign and agree to the terms of the enrollment agreements.

2. Services

PACE offers and manages all of the medical, social and rehabilitative services their enrollees need to preserve or restore their independence, to remain in their homes and communities, and to maintain their quality of life. The PACE service package must include all Medicare and Medicaid services provided by that state.

At a minimum, there are an additional 16 services that a PACE organization must provide, e.g., social work, drugs, and nursing facility care. Minimum services that must be provided in the PACE center include primary care services, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals. When an enrollee is receiving adult day care services, these services also include meals and transportation. Services are available 24 hours a day, 7 days a week, 365 days a year.

Generally, these services are provided in an adult day health center setting, but may also include in-home and other referral services that enrollees may need. This includes such services as medical specialists, laboratory and other diagnostic services, hospital and nursing home care.

An enrollee's need is determined by PACE's medical team of care providers. PACE teams include:

- Primary care physicians and nurses;
- Physical, occupational, and recreational therapists;
- Social workers;
- Personal care attendants;
- Dietitians; and
- Drivers.

Generally, the PACE team has daily contact with their enrollees. This helps them to detect subtle changes in their enrollee's condition and they can react quickly to changing medical, functional, and psycho-social problems.

3. Payment

PACE receives a fixed monthly payment per enrollee from Medicare and Medicaid. The amounts are the same during the contract year, regardless of the services an enrollee may need.

Persons enrolled in PACE also may have to pay a monthly premium, depending on their eligibility for Medicare and Medicaid.

4. Current Sites

In 2016, there were 116 PACE programs operational in 32 states and the District of Columbia. Limited new sites may be added each year. Sites are available in the following states: Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Texas, Utah, Vermont, Virginia, Wisconsin, and Wyoming.

C. EMPLOYER OR UNION GROUP HEALTH INSURANCE

Some employer and union-provided health insurance policies can continue or switch over to provide coverage for individuals when they are 65 and retired.

Medicare has special rules that apply to beneficiaries who have group health plan coverage through their own or their spouse's current employment. Group health plans of employers with 20 or more employees must offer these people the same health insurance benefits under the same conditions that younger workers and spouses receive.

III. MEDIGAP

The best time to buy a Medigap plan is during an individual's Medigap open enrollment period. The Medigap open enrollment period lasts for 6 months. It starts on the first day of the month in which an individual is both age 65 or older and enrolled in Medicare Part B.

In some situations, an individual will have the right to buy a Medigap policy outside of his or her Medigap open enrollment period. These rights are called "Medigap Protections" or "Guaranteed Issue Rights." Medigap Protections are important because without them, if an individual is not in his or her Medigap open enrollment period, an insurance company can refuse to sell him or her a policy, or the individual may be charged more for the policy. In addition, if an individual drops his or her Medigap policy, he or she may not be able to get it back except in very limited situations.

A. MEDIGAP POLICY BASICS

A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. There are fourteen standardized Medigap plans called "A" through "N." The front of a Medigap policy must clearly identify it as "Medicare Supplement Insurance."

Each plan, A through N, has a different set of benefits. Plan A covers only the basic (core) benefits. These basic benefits are included in all the Plans A through N. If an individual lives in Massachusetts, Minnesota, or Wisconsin, different types of standardized Medigap plans are sold in his or her state.

Notes:

- Insurance companies selling Medigap policies are required to make Plan A available. If they offer any other Medigap policy, they must also offer either Medigap Plan C or Plan F. Not all types of Medigap policies may be available in your state.
- Plans D and G, effective on or after June 1, 2010, have different benefits than Plans D or G bought before June 1, 2010.
- Plans E, H, I, and J are no longer sold, but, if you already have one, you can generally keep it.

When an individual buys a Medigap policy, he or she pays a premium to the insurance company. This premium is different than the Medicare Part B premium he or she must also pay. As long as an individual

pays his or her premium, the policy is guaranteed renewable, which means it is automatically renewed each year. Coverage will continue year after year as long as the premium is paid. If an individual buys a Medigap policy, it only covers his or her health care costs. It does not cover any costs for a spouse.

Medigap policies only help pay health care costs if an individual had the Original Medicare Plan. Individuals do not need to buy a Medigap policy if they are in a Medicare Advantage Plan. In fact, it is illegal for anyone to sell someone a Medigap policy if he or she knows the individual is in one of these plans. It is also illegal for an insurance company to sell an individual a Medigap policy if the individual has Medicaid except in certain situations.

B. ELIGIBLE PERSONS

To buy a Medigap policy, an individual generally must have Medicare Part A and Part B. If he or she is under age 65, has a disability, End-Stage Renal Disease (ESRD) or ALS, he or she may not be able to buy a Medigap policy until he or she turns 65.

C. BENEFITS OF A MEDIGAP POLICY

The reason some people elect to buy a Medigap policy is that Medicare does not pay for all of an individual's health care. There are "gaps" or costs that an individual must pay in the Original Medicare Plan. Remember, no Medigap policy will cover all the gaps in the Original Medicare Plan.

For individuals in the Original Medicare Plan, a Medigap policy may help:

- Lower their out-of-pocket costs; and
- Get more health insurance coverage.

What an individual pays in out-of-pocket costs under the Original Medicare Plan will depend on the following:

- Whether his or her doctor or supplier accepts "assignment," which means it takes Medicare's approved amount as payment in full;
- How often an individual needs health care;
- What type of health care an individual needs;
- Whether an individual buys a Medigap policy;
- Which Medigap policy an individual buys; and
- Whether the individual has other health insurance.

Table 10-3, next, shows some of the gaps individuals may face.

TABLE 10-3. GAPS IN MEDICARE

Some Examples of Gaps in Medicare Covered Services: What an Individual Paid in 2016	Would a Medigap Policy Have Helped Decrease These Costs?
Hospital Stays • $0 for the first 60 days • $322 per day for days 61-90 • $644 per each "lifetime reserve day" for days 91 and beyond (up to 60 days over lifetime)	Yes
Skilled Nursing Facility Stays • Up to $161 per day for days 21-100	Yes
Blood • Cost of the first 3 pints	Yes
Medicare Part B yearly deductible $147 per year	Yes
Medicare Part B covered services • 20% of Medicare-approved amount for most covered services • 50% of the Medicare-approved amount for outpatient mental health treatment* • Copayment for outpatient hospital services	Yes

*Medigap Plans A through J pay 50% of the coinsurance for outpatient mental health treatment services. Medigap Plan K pays 50%, and Plan L pays 75% of the coinsurance.

Some Medigap policies also cover other extra benefits that are not covered by Medicare. Some examples of these benefits include the following:

- Routine yearly check-ups; and
- Medicare Part B excess charges (the difference between a doctor's charge and Medicare's approved amount). The excess charge only applies if the individual's doctor does not accept assignment.

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CHAPTER 10: TEST YOUR KNOWLEDGE

The following questions are designed to ensure that you have a complete understanding of the information presented in the chapter (assignment). They are included as an additional tool to enhance your learning experience and do not need to be submitted in order to receive CPE credit.

We recommend that you answer each question and then compare your response to the suggested solutions on the following page(s) before answering the final exam questions related to this chapter (assignment).

1.	**Which of the following statements about Medicare Advantage Plans is <u>not</u> correct:** **A.** all participants in this plan have the exact same coverage **B.** benefits must be at least as great as original Medicare coverage, except hospice care **C.** the insurance company offering the plan decides where it will do business **D.** Congress created this program to give Medicare participants greater choice in their health care coverage
2.	**Which of the following groups was the PACE program created to serve:** **A.** the homeless **B.** those below the poverty level **C.** those considered frail enough to qualify for a nursing home **D.** all of the above
3.	**Medigap policies are required to be purchased if the individual has Medicare Part B.** **A.** true **B.** false

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CHAPTER 10: SOLUTIONS AND SUGGESTED RESPONSES

Below are the solutions and suggested responses for the questions on the previous page(s). If you choose an incorrect answer, you should review the pages as indicated for each question to ensure comprehension of the material.

1.	**A.** CORRECT. These plans offer a variety of options to participants, including either an HMO or fee-for-service plans. Enrollees get to select from a menu of options. **B.** Incorrect. It is true that these plans must offer at least as broad a coverage as original Medicare, although in reality the coverage is usually broader. **C.** Incorrect. Because this is true, some plans only operate in certain areas of the nation. **D.** Incorrect. These plans provide additional choices and, in many cases, additional benefits as well. *(See pages 149 to 150 of the course material.)*
2.	**A.** Incorrect. The program is targeted at a certain group based on health conditions and not on economic ones. **B.** Incorrect. This is not an income-based program, but focuses on those needing in-home or institutionalized care. **C.** CORRECT. The program was designed for those in need of nursing home care. **D.** Incorrect. Only one answer is correct; therefore, all of the above cannot be true. *(See page 155 of the course material.)*
3.	**A.** Incorrect. A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. A Medigap policy is supplemental and not required. **B.** CORRECT. When an individual buys a Medigap policy, he or she pays a premium to the insurance company. This premium is different than the Medicare Part B premium he or she must also pay. Medigap policies only help pay health care costs if an individual had the Original Medicare Plan. It is not required. *(See pages 157 to 158 of the course material.)*

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CHAPTER 11: PAYING FOR LONG-TERM MEDICAL CARE

Chapter Objective

After completing this chapter, you should be able to:

- Identify the different methods for paying for long-term health care.

I. LONG-TERM CARE: AN INTRODUCTION

Long-term care is a variety of services that includes medical and non-medical care to people who have a chronic illness or disability. Long-term care helps meet health or personal needs. Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living or in nursing homes.

It is currently estimated that the number of people in need of long-term care is ten million. By 2020, 12 million older Americans will need long-term care. Most will be cared for at home; family and friends are the sole caregivers for 70 percent of the elderly. A study by the U.S. Department of Health and Human Services says that people who reach age 65 will likely have a 70 percent chance of using some form of long-term care during their lives. About 20 percent of the people who enter a nursing home will stay for five years or more.

A. ROLE OF MEDICARE

Long-term care services are often very expensive. It is therefore important for individuals to think ahead about how they will pay for the care if it is ever needed. Generally, Medicare does not pay for long-term care. Medicare pays only for medically necessary skilled nursing facilities or home health care. However, the skilled nursing care and home health aide services are only covered on a part-time or “intermittent” basis. In addition, individuals must meet certain conditions for Medicare to pay for these types of care when they get out of the hospital.

Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Medicare does not pay for this type of care called “custodial care.” Custodial care (non-skilled care) is care that helps individuals with activities of daily living. It may also include care that most people do for themselves, for example, diabetes monitoring.

B. MEDICAID AND LONG-TERM CARE

Medicaid is a state and federal government program that pays for certain health services and nursing home care for older people with low incomes and limited assets. In most states, Medicaid also pays for some long-term care services at home and in the community.

Eligibility and services covered vary from state to state. In most cases, eligibility is based on income and personal resources.

C. CHOOSING LONG-TERM CARE

Choosing long-term care is a very important decision. Planning for long-term care requires individuals to think about possible future health care needs. It is very important to look at all options. It is very important to think about long-term care before it is needed.

Key questions to consider include:

- The type of care that may be needed;
- How an individual's needs may change over time;
- What are the best long-term care options; and
- How will the individual pay for the care.

The last question, how an individual will finance long-term care, is addressed in detail in the next section.

II. PAYING FOR LONG-TERM CARE

A. SELF-INSURING

An individual with enough resources can certainly use his or her savings or other personal resources to pay for long-term care. This is also called "self-insuring." Some personal resources may include money in a checking or savings account, stocks, bonds, investments, life insurance policies, pensions, and income. Long-term care is very expensive, however. This option is therefore not practical for many people.

Table 11-1, below, contains some opportunities and requirements/limits for a self-insurance/personal savings plan:

TABLE 11-1. SELF-INSURANCE FOR LONG TERM CARE

Self-Insurance/Personal Savings Plan Opportunities	Self-Insurance/Personal Savings Plan Requirements/Limits
If an individual does not need long-term care, he or she will still have the money that was set aside for long-term care needs. This money can be used for any purpose or put in trust for family members.	The money an individual sets aside should only be used for long-term care needs. An individual might not save enough money to pay for all of his or her long-term care costs. To be self-insured, most individuals will have to start at a young age, save a lot of money, and stick with this plan for a long period of time.
If an individual sets aside enough money for his or her long-term care needs, he or she will be able to choose where and how he or she receives his or her care.	There may be rules about when an individual can use his or her investments for paying long-term care. In some cases, an individual may have to pay a penalty for withdrawing the money to cover an unexpected expense.
Individuals who can self-insure do not have to worry about qualifying for a long-term care insurance policy.	If an individual needs long-term care and uses his or her money, he or she might not be able to leave anything to his or her heirs.

B. DEFERRED ANNUITY AND IMMEDIATE ANNUITY

One financing option for paying for long-term care is the purchase of an annuity. There are two major types of annuities available on the market for this purpose.

1. Deferred Annuity

A deferred annuity has two funds:

- A long-term care fund that can directly pay for long-term care services or pay for long-term care insurance. This fund may grow at a high interest rate; and
- A regular cash fund that grows at a guaranteed rate of three percent.

To be eligible for this annuity, an individual must be under age 85 and answer a few questions about his or her current health condition. There are some conditions that will disqualify an individual for an annuity (for example, if an individual has dementia or Parkinson's disease). If an individual is eligible, his or her long-term care coverage can start after the seven-day waiting period.

The monthly long-term care benefit pay out depends on the deferred annuity value. Most deferred annuities provide coverage for up to 36 months. An individual may be able to buy additional months of coverage for an extra cost.

Listed below are some of the opportunities and requirements/limitations for deferred annuities:

TABLE 11-2. DEFERRED ANNUITIES FOR LONG-TERM CARE

Deferred Annuities Opportunities	Deferred Annuities Requirements/Limits
It may be easier to qualify for a deferred annuity rather than for a long-term care insurance policy.	Deferred annuities are non-tax qualified long-term care policies and may subject persons to certain tax liabilities.
This is a separate fund and an individual can use the money right away to pay for his or her long-term care needs or to buy a long-term care insurance policy.	If the annuity does not include inflation, an individual might not have enough money to pay for his or her long-term care needs.
An individual might be allowed to use the funds to buy prescription drugs.	The benefit amounts might not be enough to pay for long-term care needs.
If an individual does not use the entire long-term care annuity, he or she can leave something to his or her heirs.	Usually provides coverage for up to 36 months. An individual may be able to pay for more months of coverage.

2. Immediate Annuity

An immediate annuity is for people who are unable to get insurance because of health conditions (for example, dementia or Parkinson's disease). Individuals can also get an immediate annuity if they are already getting long-term care.

Medical underwriting is typically used with this type of annuity. Individuals usually must answer medical questions on an application. Some insurance companies may want to review an individual's medical record before giving him or her this type of annuity. The insurance company can use this information to decide how much to charge and what the pay out schedule will be for this type of annuity.

If an individual qualifies, a single premium payment is converted (changed) to a guaranteed monthly income. The individual will get this monthly income for the rest of his or her life.

Table 11-3, below, lists some of the opportunities and requirements/limits to this type of financing option for long-term care.

TABLE 11-3. IMMEDIATE ANNUITIES FOR LONG-TERM CARE

Immediate Annuities Opportunities	Immediate Annuities Requirements/Limits
Individuals can use the money to pay for their long-term care needs.	If an individual does not know the type or cost of the long-term care they will need, the income he or she receives may not be enough to pay for his or her long-term care needs.
If an individual is already receiving long-term care, he or she can still get this type of annuity.	If the annuity does not include inflation adjustments, an individual might not have enough money to pay for his or her long-term care needs.
An individual might be able to leave something to his or her heirs.	An individual may or may not have to pay taxes on this annuity.

C. PRIVATE INSURANCE

A private long-term care insurance policy can help pay for many types of long-term care, including both skilled and non-skilled care.

Long-term care insurance coverage can vary widely. Some policies may cover only nursing home care. Others may include coverage for a whole range of services like care in an adult day care center, assisted living, medical equipment, and formal and informal home care.

Long-term care insurance premiums vary, depending on an individual's age and health status when he or she buys the long-term care insurance policy and how much coverage he or she wants. Additionally, an individual must be in generally good health to pass underwriting when purchasing a policy. For this reason, it may be better to buy long-term care insurance at a younger age when premiums are lower. If this is done, a periodic review is advised to make sure an individual's policy covers his or her current and future long-term care needs.

1. Tax Benefits

Most long-term care insurance policies offer certain tax benefits. These policies are called Tax-Qualified, or TQ, policies. Depending on an individual's age, he or she can include some or all of the premium for a TQ policy as a medical deduction on his or her federal income tax return if he or she itemizes deductions. Also, when an individual receives payments from a Tax-Qualified policy, he or she generally does not have to pay federal tax on them.

2. Options for Purchasing Policy

Private insurance companies sell long-term care insurance policies. Individuals can buy them from an insurance agent or online. Or, they may be able to buy a group policy through an employer or through membership in an association. Insurance companies may let an individual keep coverage after his or her

employment ends or his or her employer cancels the group plan. An individual may be able to continue his or her coverage or convert it to another long-term care insurance policy.

3. Federal Long Term Care Insurance Program

The Federal Long Term Care Insurance Program (FLTCIP) offers Federal and U.S. Postal Service employees, and annuitants, members and retired members of the Uniformed Services, their spouses and other qualified relatives the opportunity to buy long-term care insurance at a group rate. Under this program, insurers that are selected and approved by the Government will make long-term care insurance policies available to those individuals who qualify.

4. Partnership for Long-Term Care

The Partnership for Long Term Care, a partnership between Medicaid and long-term care insurers, is currently (March 2014) available in 41 states to provide an alternative to spending down or transferring assets. The 41 Partnership States have focused on creating affordable products that encourage people to self-insure, enable purchasers to provide better protection against impoverishment, and reduce long-term care costs for the Medicaid program. The participating states are:

Alabama	Iowa	New Hampshire	South Dakota
Arizona	Kansas	New Jersey	Tennessee
Arkansas	Kentucky	New York	Texas
California	Louisiana	North Carolina	Virginia
Colorado	Maine	North Dakota	Washington
Connecticut	Maryland	Ohio	West Virginia
Delaware	Minnesota	Oklahoma	Wisconsin
Florida	Missouri	Oregon	Wyoming
Georgia	Montana	Pennsylvania	
Idaho	Nebraska	Rhode Island	
Indiana	Nevada	South Carolina	

In 2010, the President signed historic health care reform legislation into law. The Patient Protection and Affordable Care Act of 2010 (also known as the Affordable Care Act or the ACA) provides new opportunities for older adults, caregivers, and aged individuals. The impact of the ACA on the previously existing Partnership for Long-Term Care program is beyond the scope of this course. Readers are advised to seek up-to-date information and professional advice should your clients need long-term care planning services.

TABLE 11-4. OPPORTUNITIES AND LIMITS OF LONG-TERM CARE INSURANCE

Long-Term Care Insurance Opportunities	Long-Term Care Insurance Requirements/Limits
Long-term care insurance provides an individual with financial protection against the cost of long-term care services.	If an individual does not buy a long-term care insurance policy from a reliable insurance company, he or she might not get the coverage he or she needs in the future.
It helps give an individual more control and choices over his or her long-term care coverage. Individuals are able to choose the type of services and customize their care based upon their personal needs.	Some policies offer more coverage than other polices. Individuals may have to pay additional long-term care costs. Individuals considering a policy should read it carefully to see what is and what is not covered.
An individual will not have to rely on his or her savings to pay for long-term care.	Some people might not be able to get a long-term care insurance policy because they have a pre-existing medical condition.
The Federal Long Term Care Insurance Program offers long-term care insurance at a group rate for federal and U.S. Postal Service employees, and annuitants, members and retired members of the Uniformed Services.	Long-term care insurance policies can be expensive. It is always better to purchase such a policy at a younger age, if possible.
An individual's family or friends will not have to worry about how the individual will get or pay for his or her long-term care.	Generally, if a long-term care insurance policy is purchased without a nonforfeiture benefit and it is not used, the individual will not get his or her money back for the policy.

D. VIATICAL SETTLEMENTS

If an individual is terminally ill or chronically ill, he or she might be able to sell his or her life insurance policy to a third party and use the proceeds to pay for long-term care. A policy holder will usually have to sell his or her life insurance policy for a lower amount of the full face value. The amount that is paid is usually based on the remaining life expectancy of the insured. The death benefit usually ranges from 40% to 85%. When the insured dies, the third party will get the full death benefit.

Listed below are some opportunities and requirements/limits of viatical settlements:

TABLE 11-5. OPPORTUNITIES AND LIMITS OF VIATICAL SETTLEMENTS

Viatical Settlements Opportunities	Viatical Settlements Requirements/Limits
A policy-holder can get money immediately, although it will be less than his or her original death benefit.	If an individual lives longer than expected, he or she might need more money to pay for his or her long-term care needs than the settlement provides.
If an individual does not qualify for a long-term care policy, this might be an option for paying for long-term care needs.	The death benefit will go to the third party, not the individual's previously designated beneficiary.
After making the settlement, the individual does not need to continue making premium payments for his or her life insurance. This is because he or she no longer owns the policy.	Most people cannot get these types of settlements because their life expectancy is considered to be more than five years.
This may be tax-free.	The definition of a terminal illness may vary among insurers, providers, and states.

E. ACCELERATED DEATH BENEFITS

An Accelerated Death Benefit (ADB) is a benefit that can be added to an individual's life insurance policy. It can provide cash advances against the insured's death benefit while he or she is still alive. The policy holder can use this benefit if he or she has a terminal illness, needs nursing home care permanently, or is unable to perform activities of daily living for themselves. Some examples of activities of daily living include eating, bathing, dressing, and using the bathroom. There might be spending limits (caps) on ADB policies.

Listed below are the opportunities and requirements/limits for ADB:

TABLE 11-6. OPPORTUNITIES AND LIMITS OF ACCELERATED DEATH BENEFITS

ADB Opportunities	ADB Requirements/Limits
From one insurance policy, a policy holder can benefit in two ways: Paying for his or her long-term care needs. Leaving a death benefit to his or her heirs.	These policies can only be used if the insured has a terminal illness, needs nursing home care permanently, or cannot perform activities of daily living. There may be limitations on these policies.
If an individual can get an ADB at the time he or she buys a life insurance policy, it may help them later because he or she might not qualify for a long-term care policy at an older age.	The individual must continue to own the policy and pay the premiums.
Individuals can usually add an ADB benefit to a life insurance policy for little or no additional cost.	The face value of a life insurance policy might not be large enough. In this case, the ADB payment will not be enough to pay for a policy holder's long-term care needs.
	Compared to long-term care insurance, the monthly benefit from an ADB policy might be lower and the coverage period is usually shorter.
	These policies usually do not offer an inflation protection.
	Policy holders may not be eligible for Medicaid.
	If there is a need for a lot of health care and the ADB is used, there may be little or no death benefit for heirs.
	There might not be enough coverage if long-term care is needed for an extended period of time.

F. LIMITED PAY INSURANCE POLICIES

Some insurance companies offer payment options in which premiums are paid for a limited period of time, rather than over the life of the policy. Rather than paying premiums as long as the policy stays in force, payments are made for a predetermined number of years or up to a certain age. Common examples are:

- Single pay – one premium payment;

- Ten pay – paying premiums for 10 years;
- Twenty pay – paying premiums for 20 years; and
- To age 65 – paying premiums until insured turns 65.

Individuals can use cash, certificates of deposit (CDs), annuities, or other resources to buy a limited pay/long-term care policy. For example, if an individual purchases a policy that offers a single premium payment, he or she is guaranteed that there will not be any additional premium charges. The policy includes a set amount of money for his or her long-term care needs. The longer an individual has the policy and does not file a claim, the more money he or she will have for his or her future long-term care needs. These policies also pay a death benefit.

Listed below are some opportunities and requirements/limits of limited pay/long-term care policies:

TABLE 11-7. OPPORTUNITIES AND LIMITS OF LIMITED PAY LONG-TERM CARE POLICIES

Limited Pay/Long-Term Care Policies Opportunities	Limited Pay/Long-Term Care Policies Requirements/Limits
Individuals can pay for their long-term care needs within a specified shortened period.	Limited pay options add to the premium amount, sometimes rather significantly.
An individual's heirs may get paid a death benefit.	If an individual buys a long-term care policy at a young age, his or her policy may not cover his or her long-term care needs as he or she gets older. The individual must make sure his or her policy will cover his or her current and future long-term care needs.
An individual might be able to move money from his or her life insurance policy to this policy without paying any tax penalties.	To keep pace with rising long-term care costs, an individual might need to purchase additional coverage or buy a rider for inflation (future price increases) and have to keep making these additional payments.

G. USING HOME EQUITY

A home equity conversion (reverse mortgage) is a special type of loan used to convert the equity in an individual's home into money. The money from a reverse mortgage can help an individual to pay for his or her health care needs, pay off debts, make home repairs, and supplement his or her monthly income. It may also help pay for long-term care services through a long-term care insurance policy, annuity, out-of-pocket, or single premium life/long-term care policy.

The amount of money an individual can get depends on his or her age at the time he or she applies for the loan, the equity (value) of his or her home, type of loan, and current interest rates.

How an individual receives payments is his or her choice. An individual can receive his or her payments all at once (lump sum), fixed monthly payments, a line of credit, or combination of any of the ways just described. However, most people like to get their payments as a line of credit. This allows them to use their money at any time.

It is sometimes necessary to pay costs to secure a reverse mortgage. These costs can include an origination fee, appraisal fee, and other fees, like title work. Usually, these costs can be added into the loan.

The money an individual receives from a reverse mortgage is tax-free. It also does not affect his or her social security or Medicare benefits. However, the money an individual receives from a reverse mortgage counts toward his or her income when determining his or her eligibility for Medicaid or other state assistance programs.

Reverse mortgages are different from first and second mortgages. Instead of the homeowner making monthly payments to a lender, the lender makes payments to the homeowner. An individual does not have to make payments on the loan until he or she no longer lives in the home permanently. However, an owner can make payments whenever he or she wants. The owner will have to pay the loan back plus interest and other costs when he or she either sells the home, moves out permanently, or when the owner dies.

The Home Equity Conversion Mortgage Program (HECM) is a program in which federally insured reverse mortgages are backed by the Federal Housing Administration (FHA, an agency of HUD) and insured by the federal government through the HECM Program. Since there is a chance of fraud, this program requires individuals to receive free reverse mortgage housing counseling from a HUD-approved reverse mortgage counseling agency before applying for a reverse mortgage. In addition, FHA insures HECM loans to protect lenders against loss if amounts withdrawn exceed equity when the property is sold.

Reverse mortgages that are not backed by the federal government may be more expensive but often have the flexibility of providing larger loan amounts.

To be eligible for a HECM, an individual must be at least 62 years old, have low or no mortgage balance, and have received HUD-approved reverse mortgage counseling to learn about the program.

Listed next are some of the opportunities and requirements/limits about home equity conversions:

TABLE 11-8. OPPORTUNITIES AND LIMITS OF REVERSE MORTGAGES

Reverse Mortgages Opportunities	Reverse Mortgages Requirements/Limits
How the individual receives his or her reverse mortgage payments is his or her choice.	*The cost of an individual's long-term care expenses might be more than the amount borrowed. An individual may have to sell his or her home to repay back the reverse mortgage loan.
There are no income or medical requirements to qualify.	*An individual may outlive the length of a reverse mortgage. If this happens, he or she may have to sell his or her home to pay back the reverse mortgage loan.
An individual can use money from the reverse mortgage to buy a long-term care insurance policy, annuity, out-of-pocket, or single premium life/long term care policy.	If an individual sells his or her home or no longer lives in the home permanently, and if he or she used all of his or her money (equity) to pay off the reverse mortgage loan, then he or she might not have anything left.
It can increase an individual's monthly income.	The money an individual receives from a reverse mortgage counts towards his or her income. This may affect their eligibility for Medicaid or other state assistance programs.
The money an individual receives from a reverse mortgage is tax-free.	Because an individual owns his or her home, he or she must still pay for his or her property taxes, homeowner's insurance, home repairs, and utilities (such as phone and electric). If he or she does not pay for these, then he or she might have to repay the loan in full immediately.
When an individual sells his or her home, no longer lives in his or her home permanently, or when he or she dies, the individual or his or her estate will have to repay the money back that was received from the reverse mortgage. Any equity that is left belongs to the individual or his or her heirs.	Loan amounts do not adjust for inflation (future price increases).
Reverse mortgages do not affect any of an individual's other assets (such as his or her personal checking or savings accounts).	If the cost of long-term care exceeds the loan amounts, then an individual may need to apply for Medicaid eligibility and spend down his or her assets to cover the costs of long-term care.

** In the HECM program, a borrower cannot be forced to sell the home to pay off the mortgage, even if the mortgage balance is more than the value of the property. A HECM loan does not need to be repaid until the borrower moves, sells, or dies. When the loan must be paid, if it exceeds the value of the property, the borrower (or the heirs) will owe no more than the value of the property. Federal Housing Administration (FHA) insurance will cover any balance due to the lender.*

H. CHARITABLE REMAINDER TRUST

A charitable remainder trust will allow an individual to receive an income for life or a specified period of time based on a percentage of assets in the trust. When that person dies, the charity will get the remainder of the trust. Additionally, if an individual gives specific types of assets to a public charity at fair market value, he or she will get a tax deduction based on the market value of the amount, avoid paying a capital gains tax on any appreciated assets they donate, and may save on estate taxes. Usually an individual needs a lot of money to set up a charitable remainder trust.

Listed below are some opportunities and requirements/limits for charitable remainder trusts:

TABLE 11-9. OPPORTUNITIES AND LIMITS OF CHARITABLE REMAINDER TRUSTS

Charitable Remainder Trusts Opportunities	Charitable Remainder Trusts Requirements/Limits
An individual can use his or her own assets for paying for long-term care and reduce his or her taxes.	To do this requires a lot of money. Few people have enough assets to get this type of trust.
An individual will be able to leave something to a desired charity.	An individual who does this might not be eligible for Medicaid.

I. MEDICAID DISABILITY TRUST

This type of trust is set up by the beneficiary and is not a government program. There are two types of Medicaid Disability Trusts that do not need to meet the rules regarding trusts and Medicaid eligibility. They include:

- A parent, grandparent, or legal guardian can establish a trust for a disabled person under the age 65; and
- A non-profit association that keeps a separate account for each beneficiary.

With either type of trust, if an individual receives Medicaid benefits, the state will get his or her money when the person dies.

Listed below are some opportunities and requirements/limits for Medicare Disability Trusts:

TABLE 11-10. OPPORTUNITIES AND LIMITS OF MEDICAID DISABILITY TRUSTS

Medicaid Disability Trusts Opportunities	Medicaid Disability Trusts Requirements/Limits
You must already be disabled.	If you aren't disabled, this isn't an option for you.

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CHAPTER 11: TEST YOUR KNOWLEDGE

The following questions are designed to ensure that you have a complete understanding of the information presented in the chapter (assignment). They are included as an additional tool to enhance your learning experience and do not need to be submitted in order to receive CPE credit.

We recommend that you answer each question and then compare your response to the suggested solutions on the following page(s) before answering the final exam questions related to this chapter (assignment).

1.	**Does Medicare pay for most long-term care:** **A.** yes; Medicare covers long-term care for all enrollees who meet their medical standards for requiring such care **B.** yes, but because the program is so inexpensive, there is a long waiting list to receive long-term care **C.** no; Medicare only pays for long-term care on a temporary basis and does not cover the cost of services referred to as “custodial care” **D.** yes, but for up to 36 months only
2.	**All long-term care insurance policies cover both non-skilled and skilled nursing care.** **A.** true **B.** false
3.	**All of the following statements about the use of reverse mortgages to pay for or finance the cost long-term care are correct <u>except</u>:** **A.** monies received are not taxable income **B.** persons must be medically eligible **C.** the funds can be used to finance private insurance coverage **D.** income from a reverse mortgage does not affect eligibility for Medicare or social security

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CHAPTER 11: SOLUTIONS AND SUGGESTED RESPONSES

Below are the solutions and suggested responses for the questions on the previous page(s). If you choose an incorrect answer, you should review the pages as indicated for each question to ensure comprehension of the material.

1.	**A.** Incorrect. Medicare only pays for medically necessary skilled nursing facilities or home health care. It does not pay for "custodial care." **B.** Incorrect. Because the service is not available, there is no waiting list. **C.** **CORRECT**. Most long-term care is to assist people with support services, such as activities of daily living like dressing, bathing, and using the bathroom. Medicare does not pay for this type of care. **D.** Incorrect. The coverage, where applicable, is only on an intermittent basis and therefore there is no such broad cap. *(See page 165 of the course material.)*
2.	**A.** Incorrect. Long-term care insurance coverage can vary widely. Some policies may cover only nursing home care. **B.** **CORRECT**. A private long-term care insurance policy can help pay for many types of long-term care, including both skilled and non-skilled care. Coverage may vary widely. *(See page 169 of the course material.)*
3.	**A.** Incorrect. The income from a reverse mortgage is not subject to income tax. **B.** **CORRECT**. This is purely a financial transaction; there are no health requirements or limitations. This is unlike applying for a health or long-term care insurance policy. **C.** Incorrect. The money can be used in any way, including pay-for-service or insurance premiums. **D.** Incorrect. The income does not affect a person's eligibility for these programs or have any tax implications. *(See pages 175 to 176 of the course material.)*

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APPENDIX: THE HISTORY OF SOCIAL SECURITY

Note: *Much of the following materials are from "A Brief History of Social Security," issued by the Social Security Administration in 2005, the 65th anniversary of the program.*

A FOUNDATION OF ECONOMIC SECURITY

For most of human history, people lived and worked on farms in extended families and this was the foundation of their economic security. However, this changed as the developed world underwent the Industrial Revolution. The extended family and the family farm as sources of economic security became less common as more and more people became wage-earners, working for others. Along with the shift from an agricultural to an industrial economy, Americans moved from farms and small rural communities to larger cities. In 1890, only 28 percent of the U.S. population lived in cities, by 1930 this percentage had exactly doubled, to 56 percent.

In Europe in the late 19th century the idea developed for social security as one form of economic security in a modern industrialized world. The world's first social security retirement program was put into effect in Germany in 1889, designed by Germany's legendary Chancellor, Otto von Bismarck.

In the United States, the Great Depression of the 1930s triggered a crisis in the nation's economic life. It was against this backdrop that the Social Security Act emerged.

THE SOCIAL SECURITY ACT

On June 8, 1934, President Franklin D. Roosevelt, in a message to the Congress, announced his intention to provide a program for social security. Subsequently, the President created by Executive Order the Committee on Economic Security, which was composed of Frances Perkins, Secretary of Labor, Chairwoman; Henry Morgenthau, Jr., Secretary of the Treasury; Henry A. Wallace, Secretary of Agriculture; Homer S. Cummings, Attorney General; and Harry L. Hopkins, Federal Emergency Relief Administrator. The committee was instructed to study the entire problem of economic insecurity and to make recommendations that would serve as the basis for legislative consideration by the Congress.

In early January 1935, the Committee made its report to the President, and on January 17 the President introduced the report to both Houses of Congress for simultaneous consideration. Each House passed its own version, but eventually the differences were resolved and the Social Security Act was signed into law on August 14, 1935. In addition to several provisions for general welfare, the new Act created a social insurance program designed to pay retired workers age 65 or older a continuing income.

IMPLEMENTING THE ACT

One provision of the Act established a bipartisan Social Security Board (SSB) composed of three members appointed by the President. The original members were John G. Winant, Chairman; Arthur J. Altmeyer; and Vincent M. Miles. (Eventually, SSB would be replaced by the current Social Security Administration, headed by a single Commissioner rather than a board.) In 1935, SSB was faced with the task of providing employers, employees and the public with information on how earnings were to

be reported, what benefits were available and how they were to be provided. In addition, sites for field installations had to be chosen and personnel to staff these offices had to be selected and trained.

The monumental first job was the need to register employers and workers by January 1, 1937, when workers would begin acquiring credits toward old-age insurance benefits and payroll taxes would start to be collected. Since the SSB did not have the resources available to accomplish this, they contracted with the U.S. Post Office to distribute the applications, beginning in November 1936. The post offices collected the completed forms, typed the social security number cards, and returned the cards to the applicants. The applications then were forwarded to the SSB's processing center located in Baltimore, Maryland, where the numbers were registered and various employment records established. Over 35 million social security cards were issued through this procedure in 1936-37.

FIRST PAYMENTS

Under the 1935 law, monthly benefits were to start in 1942. From 1937 until 1942, social security was to pay benefits to retirees in the form of a single, lump-sum refund payment. The earliest reported applicant for a lump-sum refund was a retired Cleveland motorman named Ernest Ackerman, who retired one day after the social security program began. During his one day of participation in the program, a nickel was withheld from Mr. Ackerman's pay for social security, and, upon retiring, he received a lump-sum payment of 17 cents. The average lump-sum payment during this period was $58.06. The smallest payment ever made was for 5 cents.

1939 AMENDMENTS

The original Act provided only retirement benefits, and only to the worker. The 1939 Amendments made a fundamental change in the social security program. The Amendments added two new categories of benefits: payments to the spouse and minor children of a retired worker (called dependents benefits) and survivors benefits paid to the family in the event of the premature death of the worker. The 1939 Amendments also increased benefit amounts and accelerated the start of monthly benefit payments from 1942 to 1940.

MONTHLY BENEFITS

Payment of monthly benefits began in January 1940. On January 31, 1940, the first monthly retirement check was issued to a retired legal secretary, Ida May Fuller, of Ludlow, Vermont, in the amount of $22.54. Miss Fuller died in January 1975 at the age of 100. During her 35 years as a beneficiary, she received over $22,000 in benefits.

1950 AMENDMENTS

From 1940 until 1950 virtually no changes were made in the social security program. Because the program was still in its infancy, social security's retirement benefits were very low. In fact, until 1951, the average welfare benefit received under the old-age assistance provisions of the Act was higher than the average retirement benefit received under social security. Only about 50% of America's workers were covered under the program at that time. In 1950 major amendments were enacted. These amendments raised benefits for the first time and placed the program on the road to the virtually universal coverage it has today.

THE STORY OF COLAS

Most people are aware that there are annual increases in social security benefits to offset the effects of inflation on fixed incomes. These increases, known as cost-of-living adjustments (COLAs), are such an accepted feature of the program that it is difficult to imagine social security without them. But in fact, when Ida May Fuller received her first $22.54 benefit payment in January of 1940, this was the amount she could expect to receive for life. It was not until the 1950 Amendments that Congress legislated the first COLA – a 77 percent increase. From that point on, benefits were increased only when Congress enacted special legislation.

In 1972, the law was changed to provide, beginning in 1975, for automatic annual COLAs based on the annual increase in consumer prices. No longer did beneficiaries have to await a special act of Congress to receive a benefit increase and no longer did inflation drain value from social security benefits.

SOCIAL SECURITY BENEFIT INCREASES 1950-2015

Effective Date	Percent Increase	Effective Date	Percent Increase
9/50	77.0	12/90	5.4
9/52	12.5	12/91	3.7
9/54	13.0	12/92	3.0
1/59	7.0	12/93	2.6
1/65	7.0	12/94	2.8
2/68	13.0	12/95	2.6
1/70	15.0	12/96	2.9
1/71	10.0	12/97	2.1
9/72	20.0	12/98	1.3
3/74	7.0	12/99	2.5
6/74	11.0	12/00	3.5
6/75	8.0	12/01	2.6
6/76	6.4	12/02	1.4
6/77	5.9	12/03	2.1
6/78	6.5	12/04	2.7
6/79	9.9	12/05	4.1
6/80	14.3	12/06	3.3
6/81	11.2	12/07	2.3
6/82	7.4	12/08	5.8
12/83	3.5	12/09	0.0
12/84	3.1	12/10	0.0
12/85	3.1	12/11	3.6
12/86	1.3	12/12	1.7
12/87	4.2	12/13	1.5
12/88	4.0	12/14	1.7
12/89	4.7	12/15	0.0

Notes: *The increase in 3/74 was a special, limited-duration increase. It was effective for only 3/74-5/74. In June 1974 all payment levels reverted to their 2/74 level and the 11% increase was permanently applied on this base. The COLA for December 1999 was originally determined as 2.4 percent, however, it was subsequently raised to 2.5 percent. Initially, the automatic COLAs were effective in June each year (and received in the July payment) but a 1983 change in the law shifted the effective date to December (for payments received in January).*

DISABILITY BENEFITS

The Social Security Amendments of 1954 initiated a disability insurance program that provided the public with additional coverage against economic insecurity. At first, there was a disability "freeze" of workers' social security records during years when they were unable to work. While this measure offered no cash benefits, it did prevent such periods of disability from reducing or wiping out retirement and survivor benefits. On August 1, 1956, the Social Security Act was amended to provide benefits to disabled workers aged 50-65 and disabled adult children. Over the next few years, Congress broadened the scope of the program, permitting the dependents of disabled workers to qualify for benefits, and eventually disabled workers at any age could qualify.

MEDICARE & OTHER CHANGES

The decade of the 1960s brought additional changes to the social security program. Among the most significant was a provision in the Amendments of 1961 lowering the age at which men were first eligible for retirement benefits to 62 (women previously were given this option in 1956).

The most significant change involved the passage of Medicare. Under Medicare, health coverage was extended to social security beneficiaries aged 65 or older (and eventually to those receiving disability benefits as well). Nearly 20 million beneficiaries enrolled in Medicare in the first 3 years of the program. Social security would continue to have responsibility for the Medicare program until a 1977 reorganization created the Health Care Financing Administration (HCFA). The HCFA assumed administrative responsibility for Medicare at that time. (In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services.)

THE DECADE OF THE 1970s

In addition to the automatic annual COLA provision, the 1972 law also introduced wage-indexing of the initial benefit amount upon retirement, in order to ensure that social security benefits keep up with standards of living. These two changes, taken together, introduced the principle of automatic adjustments in social security benefits to compensate for both wage and price inflation in the economy.

The 1970s also saw stress on program financing as the adverse economic conditions of that era combined with a maturing program to produce the first period of sustained fiscal imbalance in the system. Amendments enacted in 1977 sought to restore financial balance to the system. The current tax-rate schedule for social security was set in these amendments in 1977 (the schedule was slightly modified in 1983).

SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM

In addition to the financing changes introduced in the legislation of 1972 and 1977, the 1970s also saw the creation of the Supplemental Security Income (SSI) program.

THE DEVELOPMENT OF SOCIAL SECURITY

In the original 1935 Social Security Act, programs were introduced for needy aged and blind individuals and, in 1950, needy disabled individuals were added. These three programs were known as the “adult categories” of welfare and were administered by state and local governments with partial federal funding. Over the years, the state programs became more complex and inconsistent, with as many as 1,350 administrative agencies involved and payments varying more than 300% from state to state. In 1969, President Nixon identified a need to reform these and related welfare programs to “bring reason, order, and purpose into a tangle of overlapping programs.” In 1971, Secretary of Health, Education and Welfare, Elliot Richardson, proposed that Social Security assume responsibility for the adult categories. In the Social Security Amendments of 1972, Congress federalized the adult categories by creating the (SSI) program and assigned responsibility for it to social security.

THE DECADE OF THE 1980s

The Social Security Amendments of 1980 made changes in the disability program. Most of these changes focused on various work incentive provisions for both social security and SSI disability benefits. The 1980 Amendments also required social security to conduct periodic reviews of current disability beneficiaries to certify their continuing eligibility. This was to become a massive workload and one that was controversial. By 1983, the reviews had been halted, and in 1984, Congress passed the Disability Benefits Reform Act modifying several aspects of the disability program, including how disability reviews are conducted.

In the early 1980s the social security program faced a serious short-term financing crisis. President Ronald Reagan appointed a blue-ribbon panel, known as the Greenspan Commission, to study the financing issues and make recommendations for legislative changes. The final bill, signed into law in April 1983, made numerous changes in the social security program, including the taxation of social security benefits; the first coverage of federal employees; raising the retirement age starting in 2000; and increasing the reserves in the social security trust funds.

THE DEVELOPMENT OF SOCIAL SECURITY

In 1989, as part of the Omnibus Budget Reconciliation Act, President George Bush signed into law the requirement that social security send annual Social Security Statements to almost all persons working under social security. These Statements are an important financial planning tool available from social security.

THE DECADE OF THE 1990s

Social security had its status in the government upgraded when it became an independent agency in the federal government in March 1995. This means the Commissioner of social security reports directly to the President. Under the 1994 legislation, the periodic Social Security Advisory Councils were abolished

and a permanent seven-member bipartisan Social Security Advisory Board was formed to provide independent advice and counsel on social security.

Welfare reform legislation, signed by President Clinton in August 1996, eliminated the old Aid to Families with Dependent Children program from the original Social Security Act and replaced it with new time-limited benefits linked to a work requirement. The legislation also terminated SSI eligibility for most noncitizens (this provision was scaled-back in 1997). Also the eligibility rules for awarding SSI disability benefits to children were tightened.

On December 17, 1999, the "Ticket to Work and Work Incentives Improvement Act of 1999" became law, providing disability beneficiaries with a voucher they may use to obtain vocational rehabilitation services, employment services, and other support services from an employment network of their choice. In addition to allowing beneficiaries to obtain vocational services, the law provides incentive payments to providers for successful rehabilitations in which the beneficiary returns to work. The provisions also provide a number of safeguards to the beneficiaries to protect their benefits and health.

THE NEW MILLENNIUM

On April 7, 2000, President Clinton signed into law H.R. 5, "The Senior Citizens' Freedom to Work Act of 2000," eliminating the Retirement Earnings Test (RET) for beneficiaries at or above full retirement age. (The test still applies to beneficiaries below the full retirement age.) This allowed approximately 900,000 people who were collecting benefits but also working to not have their benefits reduced because of work. The aim of this bill was to avoid penalizing seniors who choose to work in retirement.

On May 1, 2001, President George W. Bush appointed a 16-member bipartisan "President's Commission to Strengthen Social Security." In December 2001, the Commission held its final meeting and voted unanimously to approve the Draft Final Report. The Commission offered three possible scenarios for how personal accounts might be introduced into the social security program.

The report also recommended that "there be a period of [national] discussion…before legislative action is taken to strengthen and restore sustainability to social security."

At the start of his second term, in his state-of-the-union address, President Bush emphasized the need to "pass reforms that solve the financial problems of social security once and for all." The President established basic principles to guide reform, including the "guarantee that there is no change for those now retired or nearing retirement" and that "any changes in the system are gradual." He has pledged to work with Congress to find the most effective combination of reforms to strengthen social security for future generations.

THE DEVELOPMENT OF SOCIAL SECURITY

Administratively, the "Ticket to Work" regulations were finalized in late 2001, and the program launched in the first set of states in early 2002. In recent years, improvements have been made to enhance the integrity of social security numbers, to guard against "identity theft," to ease the wage reporting burdens on small businesses and to streamline the processing of disability claims.

In late 2003, President Bush signed into law the Medicare Prescription Drug Improvement and Modernization Act. The Social Security Administration has significant administrative responsibilities in the implementation of this law. In 2004, the President signed into law the Social Security Protection Act (improving the management of the representative payee process) and the Identity Theft Penalty Enhancement Act.

SOCIAL SECURITY IN THE OBAMA ADMINISTRATION

On February 17, 2009, the President signed H.R. 1, the "American Recovery and Reinvestment Act of 2009" (Public Law 111-5). This law appropriated an additional $1 billion to the Social Security Administration's administrative budget, $500 million of which is to be used to replace the National Computer Center, and the information technology costs associated with such Center; and $500 million for processing disability and retirement workloads, including information technology acquisitions and research in support of such activities. The bill also provided for a special one-time economic recovery payment of $250 to adults who were eligible for benefits from one of the four following Federal benefit programs: Social Security, Railroad Retirement, Veterans Disability, and Supplemental Security Income (SSI).

On September 18, 2009, the President signed into law H.R. 3325, which became Public Law 111-63. This legislation extends, through fiscal year 2010, funding authorization for the Work Incentives Planning and Assistance program and the Protection and Advocacy for Beneficiaries of Social Security program.

On December 15, 2009, President Obama signed H.R. 4218, the "No Social Security Benefits for Prisoners Act of 2009", which became Public Law 111-115. The bill prohibits the payment of any retroactive Title II and Title XVI benefits to individuals while they are in prison, are in violation of conditions of their parole or probation, or are fleeing to avoid prosecution for a felony or a crime punishable by sentence of more than one year.

THE GROWTH OF SOCIAL SECURITY*

Social security has grown to become a major facet of modern life. One in six Americans receives a social security benefit, and about 98 percent of all workers are in jobs covered by social security. From 1940, when slightly more than 222,000 people received monthly social security benefits, until today, when almost 47 million people receive such benefits, social security has grown steadily. The SSI program, meanwhile, provides needed income support to over seven million people.

Social Security*			SSI*		
Year	Beneficiaries	Dollars (b)	Year	Beneficiaries (c)	Dollars (d)
1937	53,236 (a)	$1,278,000	1974	3,996,064	$5,096,813,000
1938	213,670 (a)	$10,478,000	1975	4,314,275	$5,716,072,000
1939	174,839 (a)	$13,896,000	1980	4,142,017	$7,714,640,000
1940 (e)	222,488	$35,000,000	1985	4,138,021	$10,749,938,000
1950	3,447,243	$961,000,000	1990	4,817,127	$16,132,959,000

1960	14,844,589	$11,245,000,000	1995	6,514,134	$27,037,280,000
1970	26,228,629	$31,884,000,000	2000	6,601,686	$30,671,699,000
1980	35,584,955	$120,598,000,000	2001	6,688,489	$32,165,856,000
1990	39,832,125	$247,816,000,000	2002	6,787,857	$33,718,999,000
2000	45,414,794	$407,635,000,000	2003	6,902,364	$34,693,278,000
2001	45,877,506	$431,931,000,000	2004	6,987,845	$36,065,358,000
2002	46,444,317	$453,821,000,000	2005	7,113,879	$37,236,000,000
2003	47,038,486	$470,778,000,000	2006	7,235,565	$41,312,000,000
2004	47,687,722	$493,212,000.000	2007	7,359,525	$41,205,000,000
2005	48,434,436	$520,767,000,000	2008	7,520,501	$43,040,000,000
2006	49,122,831	$541,619,000,000	2016	8,319,000	$57,396,000,000
2007	49,864,838	$584,939,000,000			
2008	50,898,244	$615,344,000,000			
2016	60,617,000	$900,612,000,000			

a. Recipients of one-time lump-sum payments. Beneficiaries as of December.

b. Benefit payments only, annual totals.

c. Recipients of federally-administered payments only. Beneficiaries as of December.

d. Includes both federal payment and federally-administered state supplementation payments. Annual totals.

e. Start of monthly retirement benefits under social security, prior years are single lump-sum payouts only.

***Note:** The Social Security Administration has not updated this history since dates and discussion points expressed above.

KEY DATES IN THE HISTORY OF SOCIAL SECURITY

Here is a summary of some of key dates in the development of the social security program:

06/8/34	Federal legislation to promote economic security was recommended in President Franklin D. Roosevelt's Message to Congress.
06/29/34	President Roosevelt created the Committee on economic Security to study the problems related to economic security and to make recommendations for a program of legislation.
01/17/35	The Committee on Economic Security's recommendations were introduced in the 74th Congress.
04/19/35	Social Security Act was passed in the House of Representatives, 372 to 33.
06/19/35	The Social Security Act was passed in the Senate by a vote of 77 to 6.
08/14/35	The Social Security Act became law with President Roosevelt's signature.
08/23/35	The Senate confirmed the President's nomination of the original members of the Social Security Board, John G. Winant, Chairman; Arthur J. Altmeyer, and Vincent M. Miles.
10/36	The first social security field office was opened in Austin, Texas.
11/09/36	The Baltimore office for record-keeping operations opened in the Candler Building.
11/24/36	Applications for social security account numbers were distributed by the Post Office.
01/01/37	Workers began to acquire credits toward old-age insurance benefits – payroll taxes collected for the first time.
01/37	First applications for benefits filed. Ernest Ackerman, a retired Cleveland motorman, was among the first to apply.
03/11/37	First social security benefits paid (one-time payment only).
07/01/39	Under the Federal Reorganization Act of 1939, the Social Security Board was made part of the newly established Federal Security Agency (FSA).
08/10/39	The Social Security Amendments of 1939 broadened the program to include dependents and survivors benefits.
1/31/40	Ida May Fuller became the first person to receive an old-age monthly benefit check.
07/16/46	Under the President's Reorganization Plan of 1946, the Social Security Board was abolished and the Social Security Administration was established. Arthur J. Altmeyer was appointed as the first Commissioner.
08/28/50	President Truman signed the 1950 Social Security Amendments.
04/11/53	President Eisenhower abolished the FSA and created a new Department of Health, Education and Welfare (HEW). Social security was made part of this new cabinet agency.

09/01/54	Social Security Amendments established a disability “freeze” to help prevent the erosion of a disabled worker’s benefits.
08/01/56	The Social Security Act was amended to provide monthly benefits to permanently and totally disabled workers aged 50-64 and for adult children of deceased or retired workers, if disabled before age 18.
06/30/61	The Social Security Amendments of 1961 were signed by President John Kennedy, permitting all workers to elect reduced retirement at age 62.
07/30/65	President Johnson signed the Medicare Bill at the Truman Presidential Library in Independence, MO.
10/12/66	President Johnson visited the social security headquarters to participate in the 15th Annual Honor Awards Ceremony -- the first visit by a President.
07/01/72	President Nixon signed into law P.L. 92-336 which authorized a 20% cost-of-living adjustment (COLA), effective 9/92, and established the procedures for issuing automatic annual COLAs beginning in 1975.
10/30/72	Social Security Amendments of 1972 signed into law by President Nixon -- creating the Supplemental Security Income (SSI) program.
01/01/74	SSI program went into operation as a result of the Social Security Amendments of 1972.
03/09/77	HEW reorganization plan published in Federal Register, creating the Health Care Financing Administration to manage the Medicare and Medicaid programs.
05/4/80	HEW was abolished and replaced by the Department of Health and Human Services (HHS). Social security became a part of HHS at this time.
06/09/80	President Carter signed the Social Security Amendments of 1980. Major provisions involved greater work incentives for disabled social security and SSI beneficiaries and continuing disability reviews.
08/13/81	The Omnibus Budget Reconciliation Act of 1981 made numerous changes in social security, SSI and AFDC. These included: a phasing out of student’s benefits; stopping young parent’s benefits when a child reached 16; limiting the lump-sum death payment and changes in the minimum benefit.
01/20/83	The National Commission on Social Security Reform sent its recommendations for resolving the social security program’s financial problems to the President and Congress.
04/20/83	President Reagan signed into law the Social Security Amendments of 1983.
10/09/84	Disability Benefits Reform Act of 1984 signed by President Reagan.
06/06/86	President Reagan signed the Federal Employees’ Retirement System (FERS) Act, which established social security coverage for federal employees hired after December 31, 1983.

10/01/88	Social security's nationwide 800 number telephone service implemented.
05/17/94	Social security's Internet site (Social Security Online) was launched on the World-Wide Web.
03/31/95	Social security became an independent agency.
04/19/95	The Alfred P. Murrah Federal Building in Oklahoma City, Oklahoma, was bombed, killing 168 individuals, including 16 social security employees.
08/22/96	President Clinton signs welfare reform bill.
12/98	The first-ever White House Conference on social security was held in Washington, D.C. on December 8 and 9, 1998.
10/01/99	Social security begins annual mailing of Social Security Statement to all workers age 25 and over.
12/17/99	President Clinton signed the "Ticket to Work and Work Incentives Improvement Act of 1999."
04/07/00	President Clinton signed into law a bill eliminating the Retirement Earnings Test for those beneficiaries at or above full retirement age.
11/02/00	Social security announced the availability of its new online application process for social security retirement claims.
05/02/01	President Bush announced the appointment of a 16-member bipartisan President's Commission to Strengthen Social Security.
06/14/01	The Health Care Financing Administration changed its name to the Centers for Medicare & Medicaid Services.
12/11/01	The President's Commission to Strengthen Social Security held its final meeting and voted unanimously to approve to Draft Final Report. The Commission offered three possible scenarios for how personal accounts might be introduced into the social security program.
02/05/02	The "Ticket to Work" program was officially launched in the first 13 states.
02/19/02	New updated rules, better reflecting the state of medical science, took effect regarding the evaluation of disabilities based on problems of the musculoskeletal system (the most common type of disability under social security).
04/15/02	The U.S. House of Representatives Committee on Reform, Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations, gave the Social Security Administration the highest grade in the federal government for its financial management practices.

06/07/02	Social security implemented the first number of policies to protect the integrity of the social security number and help ensure that only those who should receive a number do so. In June, social security began verifying with the state bureaus of vital statistics all birth records submitted by U.S.-born citizens age one or older applying for numbers. In July, the agency began verifying with the Department of Homeland Security all immigration documents for noncitizens requesting numbers.
01/06/03	Social security implemented a new service for small business owners, providing electronic wage reporting capabilities to businesses with 20 or fewer employees.
12/08/03	President Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The Act required social security to undertake a number of additional Medicare-related responsibilities. Social security and the Centers for Medicare & Medicaid Services began working together to provide persons with limited income and resources extra help paying for their prescription drugs. Social security's role in this partnership is to help the public understand how they may qualify and apply.
03/02/04	President Bush signed into law H.R. 743, the Social Security Protection Act of 2004 (Public Law 108-203). This law contains more than 50 main provisions, many affecting the conduct of representative payees under the law, as well as a wide variety of other administrative and technical matters.
07/15/04	President Bush signed into law H.R. 1731, the Identity Theft Penalty Enhancement Act, which imposes criminal penalties for theft of another person's identity, including for purposes of obtaining social security-related benefits.
01/26/05	Mississippi became the first state to fully implement social security's law fully electronic disability application process under its eDib initiative.
05/23/07	At a hearing before the Senate Finance Committee, Commissioner Astrue presented his initiatives to reduce the hearings backlogs and address the shortfalls of the disability determination process.

AGENCY ORGANIZATIONAL HISTORY

This list summarizes the major organizational changes to the agency over the years.

The Social Security Board is Created

The Social Security Administration (SSA) began life as the Social Security Board (SSB). The SSB was created at the moment President Roosevelt inked his signature on the Social Security Act (August 14, 1935). The SSB was an entirely new entity, with no staff, no facilities and no budget. The initial personnel were donated from existing agencies, and a temporary budget was obtained from the Federal Emergency Relief Administration. The Board itself consisted of three executives appointed by the President and such staff as they needed to hire.

The Federal Security Agency Absorbs the Board

On 7/1/39 the Social Security Board lost its independent agency status when the new sub-cabinet level Federal Security Agency was created. The FSA encompassed the SSB, the Public Health Service, the Office of Education, the Civilian Conservation Corps, and the U.S. Employment Service.

Agency is Created

On 7/16/46, under the President's Reorganization Plan of 1946, the SSB was replaced by the Social Security Administration under the leadership of a Commissioner. Arthur Altmeyer, who had been chairman of the Board of the SSB, became social security's first commissioner.

HEW Replaces the Federal Security Agency

On 4/11/53 President Eisenhower abolished the FSA and created a new Department of Health, Education and Welfare (HEW). SSA was made part of this new cabinet agency.

HEW Replaced by HHS

On 5/4/80 the Department of Health and Human Services replaced HEW. Social security was a major part of HHS until it returned to its original status as an independent agency.

SSA Becomes an Independent Agency

Throughout the years, arguments had been made that social security should be returned to independent agency status. This debate was given impetus in 1981 when the National Commission on Social Security recommended that the agency once again become an independent Social Security Board. The 1983 National Commission on Social Security Reform (a.k.a., the Greenspan Commission) again raised this issue and recommended a special study be commissioned of the matter. This special study was completed in 1984 and it outlined several options for making social security an independent agency. This led to numerous legislative proposals in the ensuing years, and in 1994 the legislation passed both houses of Congress unanimously making social security, once again, an independent agency. President Clinton signed the bill on August 15, 1994 (59 years and one day after FDR signed the original Act). The change took effect on March 31, 1995.

Note: The Social Security Administration has not officially updated this agency organizational history document since 2007.

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GLOSSARY

Automatic cost-of-living increase: The annual increase in benefits, effective for December, reflecting the increase in the cost of living. The benefit increase equals the percentage increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers measured from the average over July, August, and September of the preceding year to the average for the same 3 months in the current year. If the increase is less than one-tenth of 1 percent, when rounded, there is no automatic increase for the current year; the increase for the next year would reflect the increase in the cost of living over a 2-year period. If the "stabilizer provision" applies, the increase may be less than the cost of living.

Average indexed monthly earnings-AIME: The amount of earnings used in determining the primary insurance amount (PIA) for most workers who attain age 62, become disabled, or die after 1978. A worker's actual past earnings are adjusted by changes in the "average wage index," in order to bring them up to their approximate equivalent value at the time of retirement or other eligibility for benefits.

Average monthly wage-AMW: The amount of earnings used in determining the primary insurance amount (PIA) for most workers who attain age 62, become disabled, or die before 1979.

Average wage index: The average amount of total wages for each year after 1950, including wages in noncovered employment and wages in covered employment in excess of the OASDI contribution and benefit base. These amounts are used to index the earnings of most workers first becoming eligible for benefits in 1979 or later, and for automatic adjustments in the contribution and benefit base, bend points earnings test exempt amounts, and other wage-indexed amounts.

Bend points: The dollar amounts defining the AIME or PIA brackets in the benefit formulas.

COLA: See "Automatic cost-of-living increase."

Consumer Price Index-CPI: Relative measure of inflation.

Contribution rate: A tax rate applicable to covered earnings up to the earnings base.

Disability Insurance (DI) Trust Fund: See "Trust fund."

Earnings base: Annual dollar amount above which earnings in employment covered under the OASDI program are neither taxable nor creditable for benefit computation purposes. (Also referred to as "contribution and benefit base".)

Hospital Insurance (HI) Trust Fund: See "Trust fund."

Insured status: The state or condition of having sufficient quarters of coverage to meet the eligibility requirements for retired-worker or disabled-worker benefits, or to permit the worker's spouse and children or survivors to establish eligibility for benefits in the event of his or her disability, retirement, or death. See "Quarters of coverage-QC."

Maximum family benefit-MFB: The maximum monthly amount that can be paid on a worker's earnings record. Whenever the total of the individual monthly benefits payable to all the beneficiaries entitled on one earnings record exceeds the maximum, each dependent's or survivor's benefit is proportionately reduced to bring the total within the maximum. Benefits payable to divorced spouses or surviving divorced spouses are not reduced under the family maximum provision.

Medicare: A federal health insurance program for people age 65 and older and for individuals with disabilities.

Military service wage credits: Credits recognizing that military personnel receive wages in kind (such as food and shelter) in addition to their basic pay and other cash payments.

Old-Age and Survivors Insurance (OASI) Trust Fund: See "Trust fund."

Primary insurance amount-PIA: The monthly amount payable to a retired worker who begins to receive benefits at normal retirement age or (generally) to a disabled worker. This amount, which is related to the worker's average monthly wage or average indexed monthly earnings, is also the amount used as a base for computing all types of benefits payable on the basis of one individual's earnings record.

Quarters of coverage-QC: Basic unit of measurement for determining insured status. The amount of earnings required for a quarter of coverage is subject to annual automatic increases in proportion to increases in average earnings.

Railroad retirement: A federal insurance program, somewhat similar to social security, designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the social security program.

Substantial gainful activity: The level of work activity used to establish disability. A finding of disability requires that a person be unable to engage in substantial gainful activity.

Supplementary Medical Insurance (SMI) Trust Fund: See "Trust fund."

Trust fund: Separate accounts in the United States Treasury in which are deposited the taxes received under the Federal Insurance Contributions Act, the Self-Employment Contributions Act, contributions resulting from coverage of state and local government employees; any sums received under the financial interchange with the railroad retirement account; voluntary hospital and medical insurance premiums; and transfers of federal general revenues. Funds not withdrawn for current monthly or service benefits, the financial interchange, and administrative expenses are invested in interest-bearing federal securities, as required by law; the interest earned is also deposited in the trust funds.

- **Old-Age and Survivors Insurance (OASI).** The trust fund used for paying monthly benefits to retired-worker (old-age) beneficiaries and their spouses and children and to survivors of deceased insured workers.

- **Disability Insurance (DI).** The trust fund used for paying monthly benefits to disabled-worker beneficiaries and their spouses and children and for providing rehabilitation services to the disabled.
- **Hospital Insurance (HI).** The trust fund used for paying part of the costs of inpatient hospital services and related care for aged and disabled individuals who meet the eligibility requirements.
- **Supplementary Medical Insurance (SMI).** The trust fund used for paying part of the costs of physician services, outpatient hospital services, and other related medical and health services for voluntarily enrolled aged and disabled individuals.

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