



## 2022 Benefits Scorecard Addendum

### *Scoring Methodology and Data*

We used publicly available data and research to assess the benefits in the scorecard. Through our comprehensive analysis of the benefit research and data, we created a basis of comparison of public and private benefits that function and are designed in vastly different ways by identifying four key indicators to assess the performance of all benefits: Dollar Value the Benefit Provides; Benefit Delivery; Benefit Access and Use; and Interactions Between Benefits. Each indicator receives a score with an underlying value of one to three, with one indicating the lowest performance and three indicating the highest performance.

#### **Scoring of Benefit Indicators:**

The Scorecard is an effort to standardize performance assessment of benefits along four indicators that most directly and meaningfully align with worker financial security. To do so, we reviewed secondary research and captured publicly available data on each of the benefit performance indicators (e.g., benefit dollar values and income replacement rates and how adequately they support financial security; delivery channels, and payment conditions and barriers that impact the dollar value of the benefit; participation rates and access gaps to determine the use of benefits and worker exclusions; and benefit interactions such as benefit cliffs and asset limits, and their role in holistically supporting the financial stability of workers). We then use this data to assign each of the four indicators a score.

Existing research on these indicators and the benefit's impact on financial security informs the indicator scores. However, this existing data is not standardized and differs considerably due to the significant variation in publicly available data on public and private benefits, and the vast differences in benefit programs and policies across states, localities, and employers. Therefore, our score for each indicator, determined by available data on benefit indicators and how benefits compare to one other by indicator design features that impact financial security outcomes, represents our best educated assessment given available data, rather than a full apples-to-apples comparison. We encourage states, administrators, and employers to adopt the scorecard framework and strengthen data collection and analysis. Collecting the data for these four indicators will provide them with the opportunity to quantitatively assess how their benefits are performing, and make improvements and innovate, to meet the financial security needs of workers and their families.

#### **Assessing Benefits:**

##### *How Well Does the Benefit Individually Perform in Supporting the Financial Security of Workers Using it Today?*

To assess how a benefit individually performs in supporting workers using the benefit today, we looked at both the dollar value the benefit provides (indicator 1) and the benefit delivery (indicator 2).

To calculate the score, we use a weighted calculation of the benefit value and benefit delivery numerical scores. We weight them according to our review of the literature on these benefit indicators, and the role benefit value and delivery play in impacting the financial security support provided by the benefit. With value critical to ensuring adequate support, in our calculation, it receives a weight of 75%, while delivery—which impacts the value received—receives a weight of 25%. The resulting weighted benefit performance score assessing how well the benefit individually performs in supporting workers using it today is in a five-scale range from needs significant improvement to perform significantly well.

##### *How Well Does the Benefit Perform in Holistically Supporting the Financial Security of All Workers?*

To assess how the benefit is holistically supporting the financial security of all workers, we looked at all four indicators: dollar value the benefit provides (indicator 1), benefit delivery (indicator 2), benefit access and use (indicator 3), and interactions between benefits (indicator 4). We used a weighted calculation, building off the numerical score received for how well the benefit individually performs in supporting workers using it today, and incorporating the numerical scores for benefit access and use (indicator 3) and interactions between benefits (indicator 4). Consistent with our Benefits21 goal and the scorecard goal of ensuring all workers have access to and can use the benefits they need, and that the benefits work together to holistically support workers, we give these indicators 75% of the overall score weight.

The initial score—how well does the benefit individually perform to support workers using it today—receives a weight of 25% in the overall performance score. This weight allows us to build off the initial score to account for gaps in access and use and how benefits interact with each other to provide an overall score of how the benefit is holistically and equitably supporting all workers. Benefit access and use (indicator 3) and interactions between benefits (indicator 4) receive a total weight of 75% in the overall score.

Given our review of the literature on these benefit indicators and the role benefit access and use and interactions between benefits play in impacting the financial security support provided by the benefit, access and use receives a weight of 75% and interactions between benefits a weight of 25% of this remaining 75% of the score. The resulting score assessing how well the benefit performs in holistically supporting all workers today is in a five-scale range from needs significant improvement to perform significantly well.

**Below is the data supporting the scoring of benefit indicators for all 22 benefits assessed in the scorecard.**

## Temporary Assistance for Needy Families (TANF)

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Needs Significant Improvement	Needs Significant Improvement

### Dollar Value the Benefit Provides (*Not Effective*)

In every state, the maximum TANF benefit leaves a family of three below 60% of the federal poverty line. In more than one-third of states, it leaves a family of three below just 20% of the poverty line. In 2021, benefits in just six states had a real (inflation-adjusted) value that was the same as or higher than in 1996. At the other end, 12 states' benefits have fallen by 41% in inflation-adjusted terms. Four states—Arizona, Hawaii, Idaho, and Oklahoma—cut benefits without restoring them later, so these benefits are below their 1996 levels even without adjusting for inflation. In the remaining 29 states, benefit increases were insufficient to keep pace with inflation, leading to an average value loss of 21%.<sup>1</sup> Because TANF's four purposes are so broad, states have been able to shift funds that were previously providing basic cash assistance toward other uses. Some of these funds are used to finance programs and services, such as childcare, that encourage and support employment among low-income families, while a significant portion (and, in some states, the majority) of funds are used neither to meet families' ongoing basic needs nor to support work. Also, states have often diverted TANF funding from providing basic assistance to families with the lowest incomes to providing services to families with incomes well above the poverty line.<sup>2</sup> The maximum monthly cash benefit is usually paid to a family that receives no other income (e.g., no earned or unearned income) and complies with program rules. Families with income other than TANF are often paid a reduced benefit. Some families are financially sanctioned for not meeting a program requirement (e.g., a work requirement) and are also paid a lower benefit. While benefits are insufficient to meet all of a family's basic needs, their support is critical for those with low or no income. In July 2021, the maximum monthly benefit for a family of three ranged from \$204 in Arkansas to \$1098 in New Hampshire. Fifty-two percent of all Black children in the United States live in the 16 states with benefit levels below 20% of the poverty line, compared to 41% of Latinx children and 37% of White children. TANF benefits cover an especially small share of housing costs in states where Black and Latinx children are more likely to live. Because decent housing can prove expensive, TANF families without housing assistance often live with families and friends or opt for more affordable but substandard housing. As a result, they have high rates of housing instability, leading to frequent involuntary moves, eviction, or homelessness. Such instability can harm both adults and children and is associated with poor school performance, poor cognitive development, increased health risks, and mental health problems.<sup>3</sup> The work programs in TANF rarely move parents into jobs that lift them out of poverty; most studies show employment rates were modestly higher after exit than before exit, with at least six in 10 and up to eight in 10 leavers working during their first year after exit. But few worked steadily throughout that year; many TANF recipients are among the millions of workers in the low-wage labor market, which is characterized by high-income volatility and job turnover. In addition, parents who left TANF due to sanctions or time limits, who often face significant physical or mental health challenges that reduce their employment prospects, had lower employment rates than other leavers. Most TANF leavers did not earn enough to afford the basics.<sup>4</sup>

### Benefit Delivery (*Significantly Reduces*)

Electronic Benefit Transfer (EBT) payment card fees have restrictions on the frequency or number of cash withdrawals, and the amount that a recipient may withdraw at any one time varies by state. Transaction fees vary from \$0.40 per withdrawal to \$1.25, while ATM out-of-network surcharges, which are tacked on to any transaction fees charged, can be as high as \$6 per withdrawal. Kansas adopted a law to limit EBT cash withdrawals to \$25 a day, increasing the number of ATM fees EBT users will have to pay to access their aid. In a small survey conducted in California, respondents reported a scarcity of free ATMs that are conveniently located and accessible.<sup>5</sup> Texas allows for withdrawals of less than \$50 with no fees and two fee-free withdrawals of over \$50 per month. For the third and subsequent TANF cash withdrawals of \$50 or more in a calendar month, a retailer has the option to charge recipients a fee of \$0.50 per transaction. California provides four transactions per month that are fee-free, excluding certain ATM surcharges. Beginning with the fifth ATM cash withdrawal, an \$0.80 fee is charged in addition to any ATM withdrawal fees. Even if the state TANF program provides fee-free transactions, recipients may still be subject to ATM surcharges imposed by the ATM network owner.<sup>6</sup> While states can set their own time limit policies, they cannot provide cash assistance from federal TANF funds for longer than 60 months to a family that includes an adult recipient; however, states can exceed the 60-month limit for up to 20% of families based on hardship.<sup>7</sup> More recently, states have been curtailing the use of EBT cards and expressly prohibiting their use in certain locations, including casinos, liquor stores, or other gaming establishments. At least 25 states have laws placing restrictions or prohibitions on using EBT cards, and some states prohibit out-of-state use.

In addition, Massachusetts and Missouri require that the EBT card include the person's photo.<sup>8</sup> Basic assistance is often—but not exclusively—paid monthly and as cash. In 2020, states spent just 22% of their federal and state TANF funds on basic assistance, including monthly cash assistance to families, down from 71% in 1997.<sup>9</sup> In addition to funding basic assistance, TANF also contributes funds for childcare, employment services (for both assistance recipients and others), state refundable tax credits for low-income families, pre-kindergarten and Head Start programs, and services for children who have been, or are at risk of being, abused or neglected.<sup>10</sup>

**Benefit Access and Use** (*Significantly Exclusive*)

Participation in the TANF program among eligible families declined for the eighth consecutive year, from 33.9% in 2011 to 24.2% in 2018. States have broad discretion to determine eligibility for their TANF cash assistance programs. Most states have set income eligibility thresholds far below the federal poverty line, and all but four states limit earned income to below 85% of the poverty line, a value of \$17,663 for a family of three in 2018, for initial TANF eligibility. Many states limit income to below 50% of the poverty line for TANF, about \$10,390 annually for a family of three.<sup>11</sup> Thirty-five states and the District of Columbia have asset limits at or below \$3,000, but asset limits range from \$1,000 in Texas and New Hampshire to \$10,000 in Delaware. Eight states have eliminated their TANF asset limit for applicants and recipients. Some states account for the value of the applicant's vehicle.<sup>12</sup> In addition to defining financial need and setting benefit levels, states have broad discretion to set other policies that restrict who can receive cash assistance and in what amount. Federal law bars states from using federal TANF dollars and other forms of assistance to aid most people with "qualified" immigration status who immigrated after 1996 until they have been in the U.S. for at least five years, with certain exceptions. U.S. citizen children are eligible for TANF benefits and services even if they have non-citizen immigrant parents who do not, or do not yet, qualify. Federal law requires TANF participants to assign their rights to child support to the state, meaning that the state can keep the money it collects from the non-custodial parent to reimburse itself and the federal government for the cost of providing cash assistance. Seven states maintain a full lifetime ban on people with drug felony convictions. In comparison, 18 states and D.C. have partially lifted the ban, meaning that some people with drug felony convictions are still ineligible. Twenty-five states have fully lifted the ban.<sup>13</sup> As of February 2019, 13 states require those applying for and/or receiving cash assistance under TANF to undergo screening for illicit substance use and, dependent on screening results, chemical drug testing.<sup>14</sup> TANF agencies require face-to-face interviews.<sup>15</sup> TANF law requires states to engage 50% of all families and 90% of two-parent families with work-eligible individuals in work activities, though these standards can be reduced by "credits." Therefore, the effective standards states face are often less than the 50% or 90% targets and vary by state.<sup>16</sup> Federal law requires that a state impose sanctions on an individual who refuses without good cause to participate in work activities.<sup>17</sup> Estimates suggest that in 2016, 3.7 million families eligible did not receive the benefit.<sup>18</sup> Many states require contact information for all household members, which could deter Hispanic families, who are more likely than non-Hispanic families to have non-citizen and unauthorized household members.<sup>19</sup> In a Maryland study, 54.2% of churn cases were closed because the client did not finish a redetermination for the continuation of benefits.<sup>20</sup> Nationally, states report that 22% of cases close due to employment or excess income or resources, 21% due to inability to complete requirements, 13% due to sanctions or time limits, and 33% for unspecified reasons.<sup>21</sup>

**Interactions Between Benefits** (*Undermines Stability*)

Loss of TANF could trigger transitional SNAP benefits in the 23 states that provide them, resulting in households maintaining a higher SNAP benefit for up to five months after their TANF ends.<sup>22</sup> Some states combine TANF application with SNAP and Medicaid, with one study citing 12 states with an online TANF application use a combined application form for TANF and other social support programs. They note that the more stringent program eligibility requirements seen in some states' TANF applications may deter applicants to other programs with less stringent eligibility requirements.<sup>23</sup> On an average month in 2018, 4.2% of the recipient population, 1.9 million people, received benefits from TANF and SNAP.<sup>24</sup> Asset limits can impact the use of benefits that build financial resilience and wealth as asset limits impact financial behaviors of households<sup>25</sup>.

## Supplemental Nutrition Assistance Program (SNAP)

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Performs Moderately Well	Needs Minor Improvement

### Dollar Value the Benefit Provides (*Effective*)

SNAP's benefit value is based on families spending 30% of their net income on food. Families with no net income receive the maximum benefit, which is tied to the cost of USDA's Thrifty Food Plan (TFP), a diet plan intended to provide adequate nutrition low-income households can purchase and prepare, assuming they take significant steps to stretch their food budget.<sup>26</sup> In August 2021, USDA announced an update to the TFP that will increase maximum SNAP benefits by 21%, raising average benefits per person per day by about \$1.20 to about \$5.45 in fiscal year 2022—a modest but meaningful increase to SNAP benefit levels for millions of participating households. The updated TFP will lift 2.4 million SNAP participants—including over 1 million children—above the poverty line, improving food security and promoting children's health.<sup>27</sup> For households with net income, the monthly SNAP benefit equals the maximum benefit for that household size minus the household's expected contribution of 30% of its net income. For example, consider a family of three: if that family had no income, it would receive the maximum benefit of \$658 per month; and if it had \$600 in net monthly income, it would receive the maximum benefit (\$658) minus 30% of its net income (30% of \$600 is \$180), or \$478. On average, SNAP households received about \$240 a month in fiscal years 2019 and 2020, prior to the pandemic and the TFP increase. The average SNAP benefit per person was about \$121 per month, which worked out to less than \$1.40 per person per meal. After the 21% increase to the Thrifty Food Plan, 79% of households will receive adequate maximum SNAP benefits. However, a gap still exists in 21% of U.S. counties.<sup>28</sup> Research shows improvements in short-run health and academic performance as well as in long-run health, educational attainment, and economic self-sufficiency. SNAP benefits lifted at least 4.7 million people out of poverty in 2014 and more than 1.3 million children out of deep poverty, or above half of the poverty line. Research shows food insecurity rates are up to 30% lower among households who receive SNAP than they otherwise would be. Diminished food budgets at the end of the month are associated with a drop-off in caloric intake of about 10% to 25% over the month.<sup>29</sup>

### Benefit Delivery (*Significantly Reduces*)

After eligibility is determined, benefits are received no later than 30 days from the date of application unless the family qualifies for faster service. Some individuals with very little income may qualify for seven-day service.<sup>30</sup> SNAP beneficiaries use an electronic benefit transfer card that works like a debit card in grocery stores, but it can only be used at authorized retailers.<sup>31</sup> States can implement expiration dates for SNAP EBT cards, while, generally, a SNAP EBT card that is not used at all for a nine-month period will permanently lose any unused benefits. However, SNAP benefits that are not used the same month they were issued will be carried over into the next month, even if the recipient is no longer receiving benefits. SNAP EBT cards can be used in all states, apart from Puerto Rico.<sup>32</sup> Massachusetts and Missouri require that the EBT card include the person's photo and there is controversy over the burden associated with the use of these cards.<sup>33</sup> There is limited access to locations and what EBT cards can be used for (e.g., non-food grocery items or hot foods)<sup>34</sup> Generally, SNAP does not allow participants to redeem benefits at restaurants. Only restaurants located in a state that operates the Restaurant Meals Program (RMP) State Option can participate in SNAP.<sup>35</sup> Farmer's Markets cite barriers to accepting SNAP, with the most frequently cited barriers including lack of internet access, increased burden for processing payments, increased need for bookkeeping, and limited availability of information about the application process and payment system.<sup>36</sup>

### Benefit Access and Use (*Somewhat Exclusive*)

According to a USDA study, in 2019, approximately 41 million individuals were eligible for SNAP, and nearly 34 million participated in SNAP. The individual participation rate was 82%, and the household rate was 84%. The study finds that seven million people eligible for SNAP, nearly one in five, went unserved in an average month in 2019, and, in some states, about half of the people eligible participate.<sup>37</sup> Everyone in the household applying for benefits must have a social security number.<sup>38</sup> Gross monthly income (household income before any of the program's deductions are applied) generally must be at or below 130% of the poverty line, except for households with elderly and disabled individuals, or household income after deductions are applied, must be at or below the poverty line. For a family of three, the poverty line used to calculate SNAP benefits in the federal fiscal year 2021 is \$1,810 a month. Thus, 130% of the poverty line for a three-person family is \$2,353 a month, or about \$28,200 a year. Most households receiving SNAP must report changes when their income exceeds 130% of the poverty line for their household size (if in simplified reporting). Some people are categorically ineligible, including individuals on strike, all people without a documented immigration status, some students attending college more than half time, and certain immigrants who are lawfully present.<sup>39</sup> The standard federal asset limit is \$2,250, rising to \$3,250 for households with an elderly or disabled member. Thirty-four states and the District of Columbia have eliminated their SNAP asset limits for most recipients, while another five states have used Broad-Based Categorical Eligibility (BBCE) to raise their asset limits to \$5,000—more than doubling the federal standard—and Nebraska has raised its asset limit to \$25,000 in liquid assets.

States must disregard up to \$4,650 of the value of a single car per household and may exclude one vehicle per household.<sup>40</sup> Individuals over 18 and under 50 are limited to three months of SNAP benefits out of every three years unless they are working or in a work or training program 20 hours a week. Some individuals are exempt from this requirement, such as those who live with children in the household, those determined to be physically or mentally unfit for work, pregnant women, and others determined to be exempt from SNAP work requirements.<sup>41</sup> General work requirements apply to individuals aged 16 to 59 and able to work. The general work requirements include registering for work, participating in SNAP Employment and Training, taking a suitable job if offered, and not voluntarily quitting a job or reducing your work hours below 30 a week without a good reason.<sup>42</sup> Recipient burdens include longstanding compliance costs, such as lengthy applications, documentation requirements, in-person interviews, and recertification.<sup>43</sup> Certification periods can last for 6, 12, or 24 months depending on household circumstances.<sup>44</sup> State agencies must generally conduct an interview with a household member or its authorized representative at least once every 12 months for households certified for 12 months or less. For elderly and disabled households with certification periods greater than 12 months, States must interview these households at the end of the certification period.<sup>45</sup> According to one study, in Michigan, half of SNAP recipients lost their benefits during recertification, even though most were still eligible.<sup>46</sup>

### **Interactions Between Benefits** (*Supports Stability*)

Adjunctive eligibility enables applicants of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), to be automatically income-eligible for WIC by participating in SNAP, Temporary Assistance for Needy Families (TANF), or Medicaid. Through direct certification, school districts that participate in the school lunch program match the names of children living in households that receive benefits from SNAP or TANF with school enrollment records. Children who match are certified for free school meals without needing their families to complete a school meals application.<sup>47</sup> In 2018, 3.6% (11.8 million) of the total population received more than half of their total annual family income from TANF, SNAP, and/or SSI. On an average month in 2018, 14.7% of the recipient population, about 6.6 million people, received benefits from more than one program. More than 10% of the recipient population received benefits from SSI and SNAP (10.5%; 4.7 million people).<sup>48</sup> Broad-based categorical eligibility (BBCE) in SNAP means households may become categorically eligible for SNAP because they qualify for a non-cash TANF or state maintenance of effort (MOE) funded benefit,<sup>49</sup> extending benefits to more families in need by allowing states to raise gross income limits up to 200% of the federal poverty guidelines (FPG) and remove or align asset tests with those for state-funded TANF programs.<sup>50</sup> Forty-four jurisdictions have implemented BBCE.<sup>51</sup>

## Earned Income Tax Credit (EITC)

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Needs Minor Improvement	Needs Minor Improvement

### Dollar Value the Benefit Provides (*Partially Effective*)

The average EITC amount received per tax filer was \$2,411 during the 2020 tax year.<sup>52</sup> For the 2020 tax year, credit ranges from \$538 to \$6,600, depending on your filing status and your number of children: no Children (Credit rate (7.65%), earned income amount (\$7,030), max credit (\$538), phaseout rate (7.65%), phaseout amount threshold (\$8,790 unmarried, \$14,680 married), income where credit 0 (\$15,820 unmarried, \$21,710 married)); 1 child (Credit rate (34%), earned income amount (\$10,540), max credit (\$3,584), phaseout rate (15.98%), phaseout amount threshold (\$19,330 unmarried, \$25,220 married), income where credit 0 (\$41,756 unmarried, \$47,646 married)); 2 children (Credit rate (40%), earned income amount (\$14,800), max credit (\$5,920), phaseout rate (21.06%), phaseout amount threshold (\$19,330 unmarried, \$25,220 married), income where credit 0 (\$47,440 unmarried, \$53,330 married)); or 3 children (Credit rate(45%), earned income amount (\$14,800), max credit (\$6,660), phaseout rate (21.06%), phaseout amount threshold (\$19,330 unmarried, \$25,220 married), income where credit 0 (\$50,954 unmarried, \$56,844 married)).<sup>53</sup> For 2018, 3% of all EITC dollars were received by taxpayers with no qualifying children, and 97% were received by taxpayers with qualifying children. Though childless taxpayers received 3% of all EITC dollars for 2018, they accounted for more than a quarter (26%) of all EITC recipients<sup>54</sup>. EITC works to the disadvantage of children in larger families by capping the credit at a maximum of three children and places additional strain on all children in large families (with 4 + children), as the credit does not adequately reflect the resource needs of families of larger size.<sup>55</sup> In 2018, the EITC lifted about 5.6 million people out of poverty, including about 3 million children, and reduced the severity of poverty for another 16.5 million people, including 6.1 million children. However, for workers without dependent children, the EITC is too small to fully offset federal taxes for workers at the poverty line.<sup>56</sup> A credit worth about \$3,000 (in 2005 dollars) during a child's early years may boost their achievement by the equivalent of about two extra months of schooling. Children whose families receive more income from refundable tax credits do better in school, are more likely to attend college, and can expect to earn more as adults. These children are also more likely to avoid the early onset of disabilities and other illnesses associated with child poverty, which some research suggests further enhances their earnings ability as adults.<sup>57</sup>

### Benefit Delivery (*Slightly Reduces*)

A refundable tax credit, with claims filed annually. Recipients using tax preparation companies are typically charged fees equal to 13% to 22% of the EITC amount. At national tax preparation chains, workers eligible for the EITC continue to spend large sums, averaging around \$400. Government and nonprofit studies consistently show a high error rate for returns filed on behalf of EITC beneficiaries by paid tax preparers.<sup>58</sup> In a SHIFT study, the median worker paid almost \$100 to file taxes, equating to six hours of work or 7% of their tax refund. The average cost for in-person tax services ranged from \$600 to \$130. The average cost for online services ranged from \$400 to \$90.<sup>59</sup> Refund anticipation checks (RACs) work as a short-term loan of the tax return preparation fee by deferring payment until the refund arrives. For the 2019 filing season, the most recent IRS data available to the National Consumer Law Center (NCLC), taxpayers paid for nearly 21 million RACs, a slight decrease from the previous year. Paying \$40 to defer a tax preparation fee of \$300 for three weeks is equivalent to paying an annual percentage rate (APR) of 232% for a short-term loan to pay tax prep fees.<sup>60</sup> The Protecting Americans from Tax Hikes (PATH) Act imposes mandatory delays in the payment of refunds for returns claiming EITC and CTC in which no credit or refund for an overpayment for a tax year will be made to a taxpayer before February 15 following the close of that tax year. The purpose of the delay is to give time to identify invalid or fraudulent claims before the IRS makes payments.<sup>61</sup> An analysis of IRS data also indicates that the issuance of EITC and ACTC refunds was delayed by an average of two weeks in 2017, relative to prior tax seasons, and some filers may experience three-to-four-week delays. Even though February 15 was the earliest date the IRS would release refunds for EITC and Additional Child Tax Credit (ACTC) claimants, tax filers were instructed to not expect their refunds until at least the week of February 27. Fifty-six percent of lower-income online tax filers using free, online tax filing software and claiming the EITC or ACTC filed their taxes before February 15 in 2016. This statistic suggests that over half of this population could be potentially affected by a multiple-week delay. A study found that 80% of lower-income tax filers experienced material hardship in the months just before tax filing, and half said a refund delay would negatively affect their finances. Following the implementation of the PATH Act, the IRS had delayed almost \$58 billion in refunds from 10.7 million tax returns of filers who claimed the EITC and/or ACTC by February 15 of the 2019 tax season.<sup>62</sup>

### Benefit Access and Use (*Somewhat Exclusive*)

Filers must have and show proof of earned income, and they must be a U.S. citizen or resident alien all year with a valid social security number (SSN) to be eligible for the EITC. If one spouse doesn't have a social security number, the entire family is ineligible. For 2020, the limit on investment income to be eligible is \$3,650. Generally, if a taxpayer has no qualifying children, they must be between 25 and 64 years of age. The maximum age limit is inconsistent with when a recipient is eligible for the Social Security full retirement benefits at 67. There is no age requirement for taxpayers with qualifying children. A taxpayer is barred from claiming the EITC for a period of 10 years after the IRS makes a final determination to reduce or disallow a taxpayer's EITC because that individual made a fraudulent claim.

For the one in four eligible people not claiming the credit, the average benefit loss is \$1,096, equivalent to a month of earnings.<sup>63</sup> Based on their number of kids, workers must earn a minimum income to achieve maximum eligible credit (\$7,030 no children, \$10,540 1 child, \$14,800 2 children). As of December 2021, 25 million workers and families received about \$60 billion in EITC.<sup>64</sup> About five million potentially eligible taxpayers do not claim the credit each year, resulting in about \$7 billion in unclaimed benefits annually. Among eligible non-claimants, 1.7 million filed taxes but did not claim the credit, while the other 3.3 million individuals did not file a federal tax return.<sup>65</sup> IRS researchers found workers who are living in rural areas, self-employed, receiving certain disability pensions, have children with disabilities, without a qualifying child, not proficient in English, grandparents raising their grandchildren, recently divorced, recently unemployed, or recently experienced other changes to their marital, financial or parental status are more likely to be EITC non-participants.<sup>66</sup> In addition, eligible workers who do not (and are not required to) file a federal income tax return due to their low incomes will not receive the credit. Families without SSN<sup>67</sup> and some U.S. citizen children are ineligible for it based on co-residence with a parent who is not a U.S. citizen or not otherwise authorized to work in the United States. This ineligibility leaves about 17% of U.S. citizen children in poverty because they live in mixed-status families with parents who file taxes without Social Security.<sup>68</sup>

### **Interactions Between Benefits** (*Supports Stability*)

EITC cannot be counted as income in determining eligibility for, or the amount of, any federally funded public benefit program, including Supplemental Nutrition Assistance Program (SNAP) food assistance, low-income housing, Medicaid, Supplemental Security Income (SSI), and Temporary Assistance for Needy Families (TANF). When a filer saves their EITC, it does not count against the resource/asset limits of any federally funded public benefit program for 12 months after the refund is received. The combination and interaction of various child tax benefits—including the Child Tax Credit (CTC), EITC, and Child and Dependent Care Tax Credit (CDCTC)—results in complexity, vagueness, duplication, and inefficiency for filers and the Internal Revenue Service (IRS).<sup>69</sup> If an EITC-eligible family has any income tax liability and receives one or more of other credits, including the CDCTC and the CTC, the total amount of their EITC will remain unchanged, but the amount they receive as the refundable portion of the credit (i.e., the amount which exceeds income tax liability) will change. Specifically, if nonrefundable tax credits can reduce a family's tax liability, a greater amount of their EITC will be received as the refundable portion, and less will offset their income tax liability.<sup>70</sup>



**Child Tax Credit (CTC)**

<b>Benefit Performance Score for Supporting Workers Using It Today</b>	<b>Overall Benefit Performance Score for Supporting All Workers</b>
<b>Needs Minor Improvement</b>	<b>Needs Minor Improvement</b>

**Dollar Value the Benefit Provides** *(Partially Effective)*

Not fully refundable. Taxpayers may claim a maximum credit of \$2,000 for each child, with a portion of the credit refundable. If the credit exceeds the taxpayer's liability, they may receive a refund of up to \$1,400 based on an earned income formula. The maximum credit amount is reduced by 5% once adjusted gross income (AGI) reaches \$200,000 for single filers and \$400,000 for married taxpayers filing jointly. This refundable portion of the credit is called the "Additional Child Tax Credit" (ACTC) and is calculated by multiplying earned income above the refundability threshold of \$2,500 by 15%. For example, a taxpayer with \$3,000 of earned income would receive a \$75 refundable credit ( $\$3,000 - \$2,500 = \$500 \times .15 = \$75$ ). The TCJA created a nonrefundable \$500 credit for certain dependents who do not meet the CTC eligibility guidelines. This new credit is for children between ages 17 to 18, dependents between ages 19 to 24 in school for at least five months of the year, and some older dependents. This was created in part to offset the elimination of the personal exemption. This credit is subject to the same phaseout as the CTC.<sup>71</sup> An unmarried parent of one child working full-time at the federal minimum wage would earn about \$16,000 per year, just below the federal poverty threshold for a two-person family and below the applicable filing threshold for 2019. If the individual were to file, they would be eligible for the maximum EITC benefit (\$3,526) for a one-child household but would only qualify for \$1,400 of the CTC due to the cap on refundability. A single filer with one qualifying child would have to earn \$24,350 to receive the full \$2,000 CTC, which represents a household with earnings of about 145% of the federal poverty line.<sup>72</sup> In 2017, the average refundable portion of credit claimed per filer was \$1,321.<sup>73</sup> A credit worth about \$3,000 (in 2005 dollars) during a child's early years may boost their achievement by the equivalent of about two extra months of schooling. Some research suggests children whose families receive more income from refundable tax credits do better in school, are more likely to attend college, and likely earn more as adults. They also are likelier to avoid the early onset of disabilities and other illnesses associated with child poverty, which further enhances their earning ability as adults.<sup>74</sup> In 2014, the EITC and CTC together lifted more than 10 million people out of poverty, including more than five million children, and they brought 21 million people closer to the poverty line.<sup>75</sup>

**Benefit Delivery** *(Slightly Reduces)*

Filing costs are similar to EITC. Claiming the EITC and CTC can be complicated and involves filing additional tax forms, which leads to errors of both over- and underpayment.<sup>76</sup> In a SHIFT study, the median worker paid almost \$100 to file taxes, equating to six hours of work or 7% of their tax refund. The average cost for in-person tax services ranged from \$600 to \$130. The average cost for online services ranged from \$400 to \$90.<sup>77</sup> Refund anticipation checks (RACs) work as a short-term loan of the tax return preparation fee by deferring payment of that fee until the refund arrives. For the 2019 filing season, the most recent IRS data available to the National Consumer Law Center (NCLC), taxpayers paid for nearly 21 million RACs, a slight decrease from the previous year. Paying \$40 to defer a tax preparation fee of \$300 for three weeks is equivalent to paying an annual percentage rate (APR) of 232% for a short-term loan to pay tax prep fees.<sup>78</sup> The Protecting Americans from Tax Hikes (PATH) Act imposes mandatory delays in the payment of refunds for returns claiming EITC and CTC in which no credit or refund for an overpayment for a tax year will be made to a taxpayer before February 15 following the close of that tax year. The purpose of the delay is to give time to identify invalid or fraudulent claims before the IRS makes payments.<sup>79</sup> An analysis of IRS data also indicates that the issuance of EITC and Additional Child Tax Credit (ACTC)—a refund families may receive if their CTC exceeds total amount of taxes owed—refunds were delayed by an average of two weeks in 2017, relative to prior tax seasons, and some filers may experience three-to-four-week delays. Even though February 15 was the earliest date by which the IRS would release refunds for EITC and ACTC claimants, tax filers were instructed to not expect their refunds until at least the week of February 27. Fifty-six percent of lower-income online tax filers using free, online tax filing software and claiming the EITC or ACTC filed their taxes before February 15 in 2016. This statistic suggests that over half of this population could be potentially affected by a multiple-week delay. A study found that 80% of lower-income tax filers experienced material hardship in the months just before tax filing, and half said a refund delay would negatively affect their finances. Following the implementation of the PATH Act, the IRS had delayed almost \$58 billion in refunds from 10.7 million tax returns of filers who claimed the EITC and/or ACTC by February 15 of the 2019 tax season.<sup>80</sup>

**Benefit Access and Use** *(Somewhat Exclusive)*

In 2019, more than 90% of taxpayers with children and income between \$30,000 and \$500,000 received the child tax credit, with lower shares for the lowest- and highest-income taxpayers. About half of the lowest-income taxpayers with children received the credit and about a quarter of taxpayers with children who have income over \$500,000 received the credit.<sup>81</sup> In 2017, 28.2 million filers claimed the CTC, and the average credit per filer was \$998.24. To claim the CTC for 2020 and earlier tax years, all taxpayers must meet all seven requirements, and eligibility depends on 1) age test, 2) relationship test, 3) support test, 4) dependent test, 5) citizenship test, 6) residence test, and 7) family income test (with some exceptions).<sup>82</sup>

The CTC's current structure is complicated by various elements that make it difficult for the taxpayer to understand and increase compliance for the federal government to ensure proper payments are collected and refunds disbursed.<sup>83</sup> One-third of all children do not receive the full CTC because their parents earn too little, but children of color are twice as likely to be left out. Over 50% of all Black and Hispanic children are left behind, compared to 23% of White, non-Hispanic children.<sup>84</sup> One 2020 study finds that Black children are particularly unlikely to be eligible for the CTC, constituting one in four ineligible children, despite representing only 14% of all children. Approximately 10% of children are completely ineligible, corresponding to about 6.7 million individuals in the U.S. Apart from entirely ineligible children, another 25% of children—corresponding to approximately 17 million individuals—are partially eligible for the CTC i.e., their tax filing unit has income below the CTC phase-out and receive a positive CTC benefit that is less than \$2,000 per child. Such children are part of tax filing units with incomes above the \$2,500 earnings threshold but receive less than the full credit because of one or more of the limits on refundability. The children in this group also reside in lower-income households, with an average household income of \$23,460 and a 25% poverty rate. This group's average CTC benefit per child is about \$1,200—about 60% of the full per-child credit amount. Like ineligible children, the children who receive a partial credit are more likely than the overall population to be Black children (19% compared to 14%) or Hispanic children (39% compared to 24%), and less likely to be White children (32% compared to 50%). Seventy-nine percent of children are ineligible because their tax filing unit fails the earnings test – they do not have income above the minimum \$2,500 required to receive any CTC benefit. Eleven percent receive no CTC benefit because their income exceeds the top of the phase-out range.<sup>85</sup>

### **Interactions Between Benefits** (*Supports Stability*)

The combination and interaction of various child tax benefits—including the CTC, EITC, and Child and Dependent Care Tax Credit (CDCTC)—results in complexity, vagueness, duplication, and inefficiency for filers and the Internal Revenue Service (IRS). Since its inception, the CTC has evolved into a multidimensional dependent tax benefit interacting with similar credits such as the EITC. The CTC partially offsets increasing marginal tax rates due to benefit phase-outs in other credits or the decline in effectiveness from the dependent exemption.<sup>86</sup> The Child Tax Credit is not considered income or for asset limits for any family for 12 months following its receipt. It will not affect Medicaid, SNAP/Food Stamps, TANF Cash Assistance, SSI, SSDI, Unemployment Insurance, Section 8, or Public Housing.<sup>87</sup> Nonrefundable tax credits and the nonrefundable portions of the CTC can affect EITC. If an EITC-eligible family has any income tax liability and receives one or more of these credits, the total amount of their EITC will remain unchanged, but the amount they receive as the refundable portion of the credit (i.e., the amount which exceeds income tax liability) will change. Specifically, if nonrefundable tax credits can reduce a family's tax liability, a greater amount of their EITC will be received as the refundable portion, and less will offset their income tax liability.<sup>88</sup>

**Paid Sick Leave**

<b>Benefit Performance Score for Supporting Workers Using It Today</b>	<b>Overall Benefit Performance Score for Supporting All Workers</b>
<b>Needs Minor Improvement</b>	<b>Needs Moderate Improvement</b>

**Dollar Value the Benefit Provides** *(Partially Effective)*

Specific rules vary by state, but most allow employees to begin accruing sick time on the first day of employment, and they can begin using that time after 90 days on the job. Sick time is generally earned at a rate of one hour for every 30 hours worked, equaling about one full sick day earned every six weeks.<sup>89</sup> For 68% of workers with paid sick leave, sick leave plans provide a fixed number of days per year with an average of eight days available for their use. Three percent of workers have an as-needed sick leave plan. For the remaining 30%, their sick leave plan is part of a consolidated leave plan, which provides a single amount of time off for workers to use for multiple purposes, such as vacation, illness, or other personal business.<sup>90</sup> Employees at establishments with 1 to 49 workers and 50 to 99 workers were offered an average of six days of sick leave per year, with a median of five days. Employees at establishments with 100 to 499 workers were offered an average of seven days of sick leave, with a median of six days. Employees at establishments with 500 or more workers had the most generous sick leave, with an average of eight days per year and a median of seven days. Even in a state like California, with high coverage (81%), just 14% of employees had access to at least two weeks of paid sick leave, so the majority do not have enough paid time off to cover an illness lasting one week or more. On average, workers in private industry receive seven days of sick leave per year after one year of service. The average also was seven days after 5, 10, and 20 years of service.<sup>91</sup> In a SHIFT study with a sample of 30,000 workers, 45% of workers reported some access to paid sick leave, but only 8% of workers reported having earned at least 14 days of leave. Twenty-three percent of workers without paid sick leave reported that it was very difficult to cover all their expenses and pay their bills in a typical month, and 45% of workers without paid sick leave reported that they were not confident they could cope with an unexpected \$400 shock.<sup>92</sup> It takes at least 10 or more paid sick leave days to significantly increase the odds (from 26% to 85%) that workers in America get a flu shot, check their cholesterol, check their blood pressure, and get a fasting blood sugar test to check for diabetes. Female workers need at least six to nine paid sick leave days to see significantly increased odds of getting a mammogram.<sup>93</sup> One study found that access to paid sick days decreases the probability of job separation by 25%, leading to increased financial stability when workers can take time off to recover from illness.<sup>94</sup>

**Benefit Delivery** *(Slightly Reduces)*

Of the workers with a fixed allotment of sick days, about a fifth (21%) can “bank” an unlimited number of unused sick days for future use, 37% are limited in how many unused sick days they can carry over from one year to the next, and 42% are subject to “use it or lose it” rules. Private businesses generally have much tighter caps on sick-leave accumulation than the public sector: The median cap for private sector workers is 20 days, versus 120 days for state and local government workers.<sup>95</sup> Probationary periods vary by state from 0 days in Colorado, 90 in California, to 120 days in New Jersey.<sup>96</sup> Employers can determine “blackout periods” when employees are not permitted to take paid leave, including paid sick leave. For example, in the retail industry, employers may not want to permit time off during busy holiday periods.<sup>97</sup>

**Benefit Access and Use** *(Significantly Exclusive)*

The U.S. does not have national standards for paid sick leave policy. Employers, state, and local laws determine policies, or policies are negotiated through labor contracts. Offer rates vary between employers, the reasons for needing leave, and the employment status of their workers. Thirteen states plus D.C. and 23 cities and counties have passed laws requiring eligible employees to get paid time off to care for themselves or sick family members.<sup>98</sup> Paid sick leave was available to 79% of civilian workers in March 2021. Among wage categories, access to paid sick leave ranged from 95% of workers whose average hourly wage placed them in the top 10% of civilian workers to 35% of those in the bottom 10% of all civilian workers. For the highest wage quartile, access to paid sick leave is 94% versus 53% for the lowest wage quartile. Paid sick leave was more prevalent among full-time workers (89%) than among part-time workers (48%), and it was also more prevalent among union workers (92%) than among nonunion workers (77%). In addition, access to sick leave varied by occupation, with workers in management, professional, and related occupations having the highest access rate (93%) and workers in service occupations having the lowest rate (63%). According to these estimates, approximately 28 million workers did not have access to paid sick leave in 2021.<sup>99</sup> Among private industry workers in 2020, 49% of workers in the lowest wage quartile (\$13.25/hour on average) had paid sick leave, compared to 92% in the highest quartile. The lower likelihood of paid sick leave for part-time workers disproportionately impacts women, who are more likely than men to hold part-time jobs.<sup>100</sup> According to the National Partnership, more than 7.3 million Black workers—nearly 40% of Black workers—in the United States cannot earn a single paid sick day, and more than half (54%) of Latinx workers are unable to earn a single paid sick day.<sup>101</sup> Workers may report a lack of paid sick leave due to a myriad of reasons: their employer does not offer it to any hourly workers; the benefit is conditional on job tenure or hours; or administrative or cultural barriers hinder full utilization of the benefit.<sup>102</sup> Workload may not allow for necessary time off in certain sectors, with 29% of respondents in a survey indicating that their workloads often prevent them from taking sick days.<sup>103</sup>

Workers are supposedly protected from discharge, discipline, or any other retaliation or discrimination, but there can be complexities in case-by-case basis, with some cases of businesses denying workers paid sick leave through the Families First Coronavirus Response Act (FFCRA). Most of these workers were low-wage earners in the fast-food, hotel, and construction industries.<sup>104</sup>

**Interactions Between Benefits** (*Enhances Stability*)

According to a 2019 study, workers with paid sick leave had retirement savings 29.6% higher than those workers who lacked paid sick leave benefits. In addition, when measuring the number of paid sick days, workers with six to 10 paid sick leave days and workers with more than 10 paid sick leave days annually had a statistically and significantly higher amount in their retirement savings (30.1% and 40.7%, respectively).<sup>105</sup> A 2021 study found that despite mandated sick coverage in some states leading to small increases in labor costs associated with newly covered employees, there is little evidence that mandating paid sick leave crowds-out other non-mandated fringe benefits an employer may provide.<sup>106</sup>

**Paid Family and Medical Leave**

<b>Benefit Performance Score for Supporting Workers Using It Today</b>	<b>Overall Benefit Performance Score for Supporting All Workers</b>
<b>Needs Minor Improvement</b>	<b>Needs Moderate Improvement</b>

**Dollar Value the Benefit Provides** *(Partially Effective)*

A minimum of three months of paid parental leave is essential for mothers. Six months of paid parental leave substantially increases health and economic benefits to the household. Three months of paid medical leave for personal illness will cover the time needed for many major health conditions. However, six months of paid medical leave provides critical coverage for common life-threatening conditions like cancer.<sup>107</sup> Some families may not use it because the benefit amount may be less than their normal earnings and thus insufficient to meet their financial needs during the leave period. Additionally, workers may fear losing their jobs or facing other penalties if they take time off.<sup>108</sup> Among workers who were able to use leave, 47% received full pay, 36% received no pay, and 16% received partial pay.<sup>109</sup> State paid leave programs vary in the duration of leave provided and other design elements, and nine states plus the District of Columbia provide paid leave for comprehensive reasons, including medical leave, family caregiving, and parental leave.<sup>110</sup> The maximum weeks of benefits available to workers and wage replacement rates vary across states. Massachusetts is to provide up to 12 weeks for family leave, unless workers use it to provide care for a seriously ill or injured military service member, when workers may use up to 26 weeks.<sup>111</sup> Paid leave durations for an employee's own serious medical condition range from six to 52 weeks and four to 12 weeks for family leave.<sup>112</sup> In California, workers may take up to 52 weeks of medical leave insurance (MLI) and up to six weeks family leave insurance (FLI). Washington provides a total of 16 benefit weeks per year, of which up to 12 weeks of benefits may be claimed for FLI, and up to 12 weeks of benefits for MLI.<sup>113</sup> Wage replacement ranges from 50% to 100% of regular pay, up to certain caps. Some states provide benefits on a sliding scale, with a higher percentage of wage replacement for lower-income workers. Coverage for public sector and self-employed workers varies by state.<sup>114</sup> Some state programs provide inadequate benefits for workers paid low wages, making it difficult for them to afford to participate.<sup>115</sup> Working adults aged 21 to 64 lose an estimated \$9,578 in wages after taking 12 weeks of unpaid leave, equating to families losing 58% of their quarterly income. For Black, Asian, and Latinx families, the percent of household income lost is even greater. California's paid leave program increased the average income of mothers with a one-year-old child by \$3,407 and reduced their risk of dropping below the poverty line by 10.2%.<sup>116</sup> Economic studies have shown that access to paid family leave significantly increases the likelihood that workers will return to their jobs instead of leaving the labor force or spending time out of work to search for a new job. Workers are also more likely to maintain their pre-wage level if they stay with the same employer than if they need to find a new job. This effect can lead to higher long-term earnings.<sup>117</sup>

**Benefit Delivery** *(Slightly Reduces)*

All state programs are funded through employee-paid payroll taxes, and some are also partially funded by employer-paid payroll taxes.<sup>118</sup> The state or employers with qualifying programs administer paid leave benefits. All state programs have minimum earnings or employment length requirements to qualify, and some have seven-day unpaid waiting periods.<sup>119</sup> Payments can be delivered via direct deposit, check, or prepaid debit card.<sup>120</sup> Some recipients have experienced significant delays in payment from state programs.<sup>121</sup> Employer provision of PFML in the private sector is voluntary. However, some states and localities require employers to allow employees to accrue paid sick leave or paid time off that they may use for short family and medical absences. Employers can provide paid leave directly (i.e. by continuing to pay employees during leave) and, as an alternative, some employers offer short-term disability insurance (STDI) to employees to reduce wage-loss during periods of unpaid medical leave (i.e., when employees are unable to work due to a non-work-related injury or illness).<sup>122</sup> Most of the current paid leave laws contain some form of anti-retaliation provision to protect employees engaging in paid family and medical leave. Yet, the U.S. Equal Employment Opportunity Commission found that retaliation for engaging in a protected activity, including paid family and medical leave, accounts for 55.8% of all charges filed in FY2020.<sup>123</sup>

**Access and Use** *(Significantly Exclusive)*

According to March 2021 U.S. Bureau of Labor Statistics (BLS) data, only 23% of civilian workers had access to paid family leave in 2021, meaning that over 102 million workers did not have access. For workers with wages in the bottom 10%, 7% had access, while 40% of workers with wages in the top 10% had access. For the highest wage quartile, access to paid family leave is 35% versus 12% for the lowest wage quartile. Eleven percent of part-time workers had access, and 27% of full-time workers had access. Data on the share of workers with access to paid medical leave for a longer, serious illness is limited, but BLS also estimates that 40% of workers have access to short-term disability insurance.<sup>124</sup> A 2014 study found that 48% of workers report being able to take paid leave for any family-related illness. Only 39% reported access to paid family leave for the birth of a child. At this time, only California and New Jersey had state implemented paid leave policies, reaching 15% of the U.S. population. The remainder of those with access to paid leave either had employers that voluntarily provided paid family leave or could utilize other forms of paid leave, such as vacation time or comp time for the birth of a child.

Some of those who reported access to paid family leave likely take only minimal time off—in some cases, access to paid leave for the birth of a child might mean using only a few paid vacation days.<sup>125</sup> While some employers offer paid family leave, state programs exist in California, Colorado, Connecticut, Massachusetts, Maryland, New Jersey, New York, Oregon, Rhode Island, Washington, and the District of Columbia.<sup>126</sup> Program eligibility typically involves in-state employment of a minimum duration, minimum earnings in covered employment, or contributions to the insurance funds. Various rules exist regarding the establishment of need, dependent on state and employer policy. Many barriers may limit take-up, including lack of policy awareness, too-low pay, or the absence of job protection. These barriers may be especially high for workers in low-wage jobs, who are less likely to be eligible for job protection through the current federal unpaid leave law and less likely to be able to afford to take even partially paid leave.<sup>127</sup> In the absence of a supportive “care culture,” employees worry that admitting to caregiving responsibilities penalizes their career growth. Few employees are willing to admit to their organizations that they are caregivers, fearing it will undermine their career prospects. Among self-professed caregivers, only 28% were willing to admit that caregiving harmed their careers. These caregivers perceived harmful consequences, such as demotivation due to a lack of challenging assignments (54%), lower salary increases or bonuses (50%), and an unsatisfactory career path (46%).<sup>128</sup> The American Time Use Survey (ATUS) asked workers if they *can* take paid leave to care for a new child or ill family member, regardless of whether this is the defined purpose of the leave benefit. Among survey respondents who did not take leave when needed, 21% said they could not afford to take leave or feared job loss or other negative employment consequences. Almost half of these respondents (9% of 21%) were in the bottom wage quartile. Workers in the bottom quartile were also more likely to report that their leave request was denied or that they could not find someone to cover their shift, whereas workers toward the top of the wage distribution tended to report that they had too much work to take leave.<sup>129</sup> Employers who find leaves costly may discriminate against groups most likely to take leave—new mothers or females of childbearing age—by being less likely to hire them or offering them lower wages.<sup>130</sup>

#### **Interaction Between Benefits** (*Enhances Stability*)

Enhancing when workers have access to paid family and medical leave allows them to utilize other benefits, such as paid sick and vacation leave, for other purposes. Workers not covered by a formal family or medical leave benefit may access time off for these purposes using other forms of leave, such as general paid time off, vacation days, or informal arrangements with employers.<sup>131</sup> For instance, in New York, new mothers may be eligible for both short-term disability benefits and Paid Family Leave after giving birth. While eligible employees cannot take the two benefits at the same time, they can choose how they can use both benefits to support the needs of their families. PFML benefits will only be reduced if the total received from both payments is greater than your average weekly wage.<sup>132</sup> In California, you may not receive either Disability Insurance or Unemployment Insurance benefits during the same period in which PFL benefits are paid, but you may partially receive your workers’ compensation benefit if the weekly amount is less than your weekly PFL benefit amount.<sup>133</sup>

## Short-Term Disability/Temporary Disability Insurance

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Performs Moderately Well	Needs Moderate Improvement

### Dollar Value the Benefit Provides (*Effective*)

Short-term disability plans are intended to replace lost wages for a short, fixed amount of time. Short-term and long-term disability insurance policies are intended to offer income protection (cash benefits) to people who become unable to work for medical reasons.<sup>134</sup> The median salary replacement rate for short-term disability plans is 60%. Among workers covered by a short-term disability insurance plan, 75% have a plan with a maximum benefit amount. Among those with maximum payout provisions in the plan, the median amount that a worker would be eligible to receive was \$584 in March 2014. In states with short-term disability plans, state laws specify minimum and maximum amounts payable for a week. Rhode Island also pays benefits to dependents. A fixed-duration plan covers 93% of private industry workers. The length of time that benefits are payable depends on the total amount of base period earnings and the length of employment.<sup>135</sup> Short-term disability usually replaces 50%-80% of a worker's regular wage or salary, up to a maximum amount. The maximum duration of benefits typically varies between 12 and 52 weeks, with the median being 26 weeks (or six months). Income from a short-term disability policy may be taxable, depending on whether it was funded with pre-tax or post-tax income. Most employer-sponsored disability plans are paid on a pre-tax basis, either directly from the employer or through payroll deduction from the employee (or a combination of both). In these cases, the insurance proceeds would be taxable since taxes were not paid on the income used to fund the policy.<sup>136</sup> Most civilian workers are not required to contribute toward the costs of these disability benefits, with 15% of civilian workers having a contribution requirement.<sup>137</sup> One study finds that three in 10 households have experienced at least one disability leave in the past 10 years, and 55% say it had a major financial impact on their household. This study found that people with disability insurance were less likely to be negatively impacted, as 38% of those with insurance saw a negative impact compared to 62% without disability insurance. Among those without disability insurance, 80% shared they have not fully recovered financially.<sup>138</sup>

### Benefit Delivery (*Slightly reduces*)

Short-term disability coverage is typically provided through one of three means: (1) private insurance policies, (2) self-funded plans, or (3) mandatory state programs. Under self-funded plans, employers assume all the risk and expense. These plans may take the form of unfunded salary continuation, where the employer funds the plan from operating revenue, or non-commercially insured plans, where the employer is required to have sufficient assets to cover the plan's projected liability, and the plan must meet certain federal requirements. Larger employers are more likely to self-fund their short-term disability plans. Some states provide coverage through mandatory state temporary disability insurance (TDI) or PML. Under these programs, participation is compulsory for workers and employers who meet the coverage requirements of state law. Coverage is often provided through a state-run plan with the option for employers to use private plans (STDI or self-funded) in lieu of the state-run plan. However, in some cases, coverage is provided solely through a state-run plan or solely through private plans under an employer mandate. State TDI/PML programs cover nearly all private-industry workers who work in states with such programs. In addition, some state TDI/PML programs cover certain state and local government workers or self-employed individuals who elect coverage voluntarily.<sup>139</sup> Once a claim is filed, there's usually a short waiting period—the elimination period—of one to 14 days before an employee can begin collecting benefits from the policy. Short-term disability typically imposes a one-week to a two-week waiting period before benefits are first payable.<sup>140</sup> The policy terms will specify the waiting period during signup. For most disability claims, the employee must provide a medical form signed by a doctor that details the illness or injury. The form asks for the first date of illness or injury, which is typically used as the beginning of the elimination period.<sup>141</sup> There are also bad-faith delays and wrongful denials that can occur, with the burden and cost on the individual to navigate and appeal. Being granted short- or long-term disability insurance benefits while you are off work does not prevent your employer from taking your job away.

### Benefit Access and Use (*Significantly Exclusive*)

Short-term disability insurance was available to 40% of civilian workers in March 2021, meaning over 79 million workers did not have access. For workers with wages in the bottom 10%, 10% had access, while 64% of workers with wages in the top 10% had access, with respective take-up rates of 98% and 100%. For the highest wage quartile, access to short-term disability insurance is 56% versus 20% for the lowest wage quartile. Forty-seven percent of full-time and 18% of part-time workers had access to short term disability insurance. The lowest paid occupational group—service workers—is also the group least likely to be covered by employer-provided short-term plans, with an access rate of 23%.<sup>142</sup> Workers in service occupations (such as waiters/waitresses, hair stylists, and dental hygienists) have the lowest access rates for both short- and long-term disability insurance. Low-paid workers are also the group most likely to apply for Social Security disability insurance (SSDI), which has led to financial problems for the program. This analysis focuses on access because most workers with access to these plans participate in them.<sup>143</sup> Five states have state-mandated disability insurance requirements: California, Hawaii, New Jersey, and Rhode Island.<sup>144</sup>

**Interactions Between Benefits** (*Supports Stability*)

Because of their different applications, an employee cannot qualify for benefits under both workers' compensation and short-term disability for the same incident at the same time.<sup>145</sup> However, disability payments from private sources, such as private pensions or insurance benefits, don't affect SSDI benefits.<sup>146</sup> Employer-provided disability insurance programs help fill the gap in benefits for individuals who apply for SSDI since SSDI benefits are payable the sixth full month after the disability begins, but delays in applying and processing results in the receipt of benefits several months later. Short-term and long-term disability insurance provide income protection much faster.<sup>147</sup> SSDI requires that your disability last longer than a year, so it can pick up where state disability insurance leaves off. You can receive state disability insurance payments at the same time as SSDI, but SSDI may be "offset" by these short-term disability payments.<sup>148</sup> Short-term disability insurance often works in tandem with long-term disability insurance to ensure continuity of support with long-term illnesses and injuries.<sup>149</sup>



## Long Term Disability Insurance

<b>Benefit Performance Score for Supporting Workers Using It Today</b>	<b>Overall Benefit Performance Score for Supporting All Workers</b>
<b>Performs Moderately Well</b>	<b>Needs Moderate Improvement</b>

### **Dollar Value the Benefit Provides** (*Effective*)

Long-term disability insurance plans also are typically a fixed percentage of annual earnings. Depending on your policy, your long-term disability insurance (LTDI) plan will typically pay between 50% and 80% of your "pre-disability earnings," up to a maximum. All LTD plans have a maximum monthly payment, which can range between \$4,000 to \$25,000 per month. Long-term disability (LTD) benefits pay a percentage of your salary or wages. They can be increased by cost-of-living adjustments (COLAs) and/or decreased by offsets of other benefits and earnings from work.<sup>150</sup> Once long-term disability benefits have been approved, an employee can continue to receive benefits for the length of the policy term or until they return to work. Most long-term disability plans provide coverage for 36 months, although some can provide coverage for up to 10 years or even for the policyholder's life.<sup>151</sup> The terms of each policy will dictate how long benefits continue. Although many plans pay benefits until age 65, others pay for a fixed number of years, often five or 10. Among private industry workers covered by a long-term disability insurance plan, 95% had plans that cover a fixed percentage of annual earnings. The median amount covered by long-term plans is 60% of annual earnings. Most long-term plans (88%) have a maximum amount payable, and the median maximum payout in 2014 was \$8,000 per month.<sup>152</sup> In most cases, LTDI benefits are coordinated to begin after the company's short-term disability plan benefits are exhausted. Important features of LTDI plans are rehabilitation benefits, accommodation supports, and work incentives.<sup>153</sup> Most civilian workers were not required to contribute toward the costs of these disability benefits, with 6% contributing to long-term disability plans.<sup>154</sup> Workers with LTDI access in 2013 were more likely to work full time, be employed by large establishments, have relatively high wages, and work in industries and regions with a relatively low percentage of workers with disabilities.<sup>155</sup> One study finds that three in 10 households have experienced at least one disability leave in the past 10 years, and 55% say it had a major financial impact on their household. This study found that people with disability insurance were less likely to be negatively impacted, whereas 38% with insurance saw a negative effect compared to 62% without disability insurance. Among those without disability insurance, 80% shared they have not fully recovered financially.<sup>156</sup>

### **Benefit Delivery** (*Slightly Reduces*)

Long-term disability is an insurance plan that often works in tandem with short-term disability. Once short-term disability benefits are exhausted, a long-term disability policy continues to provide the employee with some income. Once a plan is in place, the employee must provide medical proof of a qualifying illness or injury lasting beyond the long-term disability elimination period. The most common elimination period for long-term disability is 90 days, but the policy will specify the exact terms of the elimination period. If short-term disability coverage is available, the effective waiting period before receiving benefits will be relatively short. However, when a short-term policy is unavailable, employees may have to wait several months with no income before qualifying for long-term benefits. Once the employee meets the burden of proof, they can begin receiving the benefits specified in the policy. Benefits will continue until the employee is medically cleared to return to work or has exhausted the policy benefits. Benefits are typically paid in a lump sum or monthly.

### **Benefit Access and Use** (*Significantly Exclusive*)

Long-term disability insurance is available to 35% of all civilian workers, meaning over 86 million workers do not have access to this benefit. For workers with wages in the bottom 10%, 5% had access, while 66% of workers with wages in the top 10% had access, with respective take-up rates of 95% and 97%. For the highest wage quartile, access to long-term disability insurance is 60% versus 10% for the lowest wage quartile. Six percent of part-time workers have access, while 44% of full-time workers have access.<sup>157</sup> LTDI plans have relatively minimal work experience requirements, often covering workers within a year or less of starting a job. Benefits are calculated by using the worker's most recent earnings under the current employer.<sup>158</sup> If you become disabled after age 60, most plans allow you to receive benefits even after you turn 65. Most employer sponsored LTDI plans require full-time employee status at the time the worker becomes disabled.<sup>159</sup> To prove disability, a claims administrator will require objective proof and request all medical records related to the disability, including relevant clinic notes, lab results, x-rays, MRIs, exam findings, and surgical reports. To show that the disability is ongoing, the recipient should continue receiving treatment while the LTD claim is pending and even after benefit approval. Failure to continue treatment may be grounds for the insurance company to cut off benefits. Claims can be denied for insufficient medical evidence, failure to meet the company's definition of a disability, missed deadlines, and potential video surveillance inconsistent with the disability claim.<sup>160</sup>

### **Interactions Between Benefits** (*Supports Stability*)

In cases of overlap in LTDI and Social Security Disability Insurance (SSDI) eligibility, LTDI insurers have a strong incentive to help their claimants apply for SSDI benefits. Most LTDI contracts deduct other benefits received (including SSDI) from the LTDI benefit amount, dollar for dollar. Because this offset greatly reduces the cost to the private insurer, private insurers often encourage LTDI beneficiaries to apply for SSDI, and some insurers might even require that they do so.

SSDI implicitly provides a subsidy for LTDI in that the insurers would have to charge a much higher premium to offer the same LTDI replacement rate in the absence of SSDI. In other words, the existence of SSDI allows LTDI carriers to offer higher replacement rates for any given premium than they could in the absence of SSDI. The downside is that the subsidy likely positively impacts the number of SSDI applications by LTDI claimants.<sup>161</sup> Long-term disability often works in tandem with short-term disability to provide income for long-term illnesses and injuries.<sup>162</sup>

## Workers' Compensation

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Needs Significant Improvement	Needs Significant Improvement

### Dollar Value the Benefit Provides (*Not Effective*)

State worker's compensation programs vary by statutory waiting periods, coverage requirements, maximum temporary total disability benefits, compensation rates, and maximum benefit durations. Total disability benefits are generally paid at a level of *two-thirds* of the employee's pre-disability wage. Workers with high earnings may see their benefits capped below two-thirds of their pre-disability wage.<sup>163</sup> The average weekly max is \$867.91, with Iowa heading the list at \$1,543 (2014)<sup>164</sup>. The National Commission's benchmark for wage replacement adequacy is two-thirds of lost earnings, at least up to a maximum of the state average weekly wage. However, research suggests that this goal has never been met due to lack of compliance. A study from the Journal of Occupational and Environmental Medicine finds that workers' compensation only pays 21% of the cost of workplace injuries, with federal programs, such as SSDI, paying 11% of the costs. This cost-shift has forced injured workers, their families, and taxpayers to subsidize most of the lost income and medical care costs. Even with workers' compensation benefits, injured workers' incomes are, on average, almost \$31,000 lower over 10 years than if they had not been injured.<sup>165</sup> One study found that about half of workers injured on the job had to pay their bills out-of-pocket (33%) or use their health insurance to cover the expenses (22%). Workers' compensation insurance paid medical expenses for only 6% of the injured workers in the sample.<sup>166</sup> One comprehensive analysis found significant variability in maximum compensation for similar injuries across states—while the national average maximum benefit for losing an arm in 2015 was \$169,878, state maximums ranged from \$48,840 in Alabama to \$859,634 in Nevada.<sup>167</sup> For payments, \$31.2 billion (50.3%) were for medical benefits, and \$30.8 billion (49.7%) were for cash disability.<sup>168</sup> There are concerns about low-quality health care provided through workers' compensation claims.<sup>169</sup> Benefits are so low or restrictive in certain states that courts have ruled state laws unconstitutional, including Florida and Alabama where their 15% cap on attorney fees was considered unconstitutional. The Kentucky legislature passed a bill weakening workers' compensation benefits even though it already fell 18% below the national median workers' comp premiums.<sup>170</sup> When workers' compensation is inadequate and does not function as intended, a workplace injury creates a trap for working families already struggling to meet basic necessities and set aside some savings, leaving them less able to save for the future or to make the investments in skills and education that provide the opportunity for advancement. These injuries and illnesses force working families out of the middle class and into poverty.<sup>171</sup>

### Benefit Delivery (*Significantly Reduces*)

Workers' compensation systems vary from state to state. State statutes and court decisions control many aspects, including handling claims, evaluating impairment and settling disputes.<sup>172</sup> There is typically a waiting period of several days before cash benefits begin. Benefits for days during the waiting period are generally retroactively paid once it is determined that the claim is for a long-term or permanent disability.<sup>173</sup> Workers' compensation benefits are typically paid on a weekly basis only to those with workplace injuries that are severe enough to prevent them from returning to work, either temporarily (for at least seven days) or permanently. Medical bills will be paid as they are incurred. Doctors bill your employer or employer's workers' compensation insurance company directly. Lump sum payments are possible, but instead of providing a lump sum settlement for permanent disability, some agreements require the employer to pay out the settlement amount in small portions, over a period of time.<sup>174</sup> Some states require insurance companies to pay workers' compensation checks at the same frequency as previous normal wages. Some insurers have started offering direct deposit, though this option is still not a legal requirement for compensation payments. Late payments are common.<sup>175</sup> Some states allow penalties for late temporary disability benefits under workers' compensation (which are typically paid every two weeks). Many states require insurance companies to pay interest on late payments, separate from any penalties. Some insurance companies deny legitimate workers' compensation claims to reduce their costs.<sup>176</sup> A study of workers in low-wage industries in Chicago, Los Angeles, and New York City found that the workers' compensation system is not functioning for workers in the low-wage labor market. Of the workers in our sample who experienced a serious injury on the job, only 8% filed a workers' compensation claim. When workers told their employer about the injury, 50% experienced an illegal employer reaction—including firing the worker, calling immigration authorities, or instructing the worker not to file for workers' compensation.<sup>177</sup> Vulnerable reduce the adequacy of cash benefits and limit options for returning to work.<sup>178</sup> Some states have no laws protecting workers from retaliation from their employer; OSHA staff members have encountered many injured immigrant workers who have not filed for workers' compensation out of fear of losing their job.<sup>179</sup>

### Benefit Access and Use (*Significantly Exclusive*)

One hundred and forty million workers, accounting for more than \$7.8 trillion in wages, were covered by a state or federal workers' compensation system. In all states, except Texas and Oklahoma, which both allow employers to opt-out of coverage, workers' compensation is mandatory for nearly all employers.<sup>180</sup> According to a 2015 ProPublica report, since 2003, 33 states have passed workers' compensation laws that reduce benefits or make it more difficult to access through stricter qualification measures.<sup>181</sup> According to a 2009 NELP study, only 8% of workers in their sample who experienced a serious injury on the job filed a claim.

When workers told their employer about the injury, 50% experienced an illegal employer reaction—including firing the worker, calling immigration authorities, or instructing the worker not to file for workers' compensation.<sup>182</sup> Several studies have found that fewer than 40% of eligible workers even apply for any workers' compensation benefits. A review of all recordable work-related amputations in Massachusetts found that around 20% of the cases did not receive any workers' compensation benefits. A similar California study found that one-third of workers who had amputations that their employers recorded had not received workers' compensation benefits. One study estimates that as many as 97% of workers with occupational illness are uncompensated. Most cases of work-related chronic disease are never diagnosed as work-related. When a linkage is made, the diagnosis generally comes long after employment ends. Even when a proper diagnosis is made, a worker eligible for benefits under Medicare, Medicaid, Veterans' Benefits, or private insurers is more likely to take that route and avoid the barriers to obtaining benefits through the workers' compensation system. Additionally, researchers estimated that more than 500,000 construction workers were misclassified as independent contractors in three states alone. Misclassifying workers increases the likelihood of work injuries since employers do not have to worry about the OSHA requirement to provide a safe workplace since it does not cover the self-employed. These employers avoid paying workers' compensation insurance premiums (as well as unemployment insurance and other benefits and taxes) for these independent contractors and do not need to worry about rising premiums following a work injury, so they are less likely to invest in safety.<sup>183</sup> Workers typically not covered by workers' compensation include domestic workers, agricultural and farm workers, leased or loaned employees, seasonal workers, and undocumented workers.<sup>184</sup>

### **Interactions Between Benefits** (*Undermines Stability*)

A worker may receive disability benefits under both workers' compensation and the Social Security Disability Insurance (SSDI) program. However, the combined benefits cannot exceed 80% of the worker's pre-disability wage in any month, with either the workers' compensation or SSDI benefits offset, depending on the state, to get the worker below the 80% threshold.<sup>185</sup> Workers' compensation can also impact access to other public assistance programs, as it counts as income for eligibility into programs such as SSI and Medicaid. Despite the sizable cost of workers' compensation, employers bear only a small portion of the overall costs of occupational injury and illness, with growing evidence that costs of workplace-related disability are being transferred to other benefit programs.<sup>186</sup> Shifting cases and costs from workers' compensation to SSDI and Medicare creates subsidies that may reduce employer financial incentives to prevent work-related injury and illness.<sup>187</sup>

## Unemployment Insurance (UI)

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Needs Minor Improvement	Needs Significant Improvement

### Dollar Value the Benefit Provides (*Partially Effective*)

In the fourth quarter of 2021, average weekly benefits were \$347 nationwide, ranging from an average of \$187 per week in Louisiana to \$489 per week in Hawaii. Prior to the Coronavirus Aid, Relief and Economic Security Act (CARES Act), most states replaced 30% to 50% of lost earnings.<sup>188</sup> In 2021, replacement rates ranged from 33% in Louisiana to 57% in Hawaii, with a U.S. average of 43%.<sup>189</sup> UI caps vary widely from \$823 a week in Massachusetts to \$235 a week in Mississippi and \$190 a week in Puerto Rico. Tipped workers are especially likely to receive benefits much lower than their regular take-home pay because of underreporting of tips (the Treasury Department estimates that employers do not report 52% of tips). Findings also suggest the highest-cost areas of the country have very low benefits.<sup>190</sup> Even for those who meet eligibility requirements, in 2019, nonsupervisory and production employees had a 36% replacement rate.<sup>191</sup> When accounting for the time-limited nature of UI income and the nonwage benefits that are part of the compensation package for many workers (benefits like employer-provided health insurance and retirement contributions), the true pay replacement rate is much lower. In no state are UI benefits enough to cover a worker's basic needs.<sup>192</sup> Women and workers of color are further disadvantaged because they are disproportionately clustered in low-paying jobs and thus, receive lower levels of benefits than their more highly compensated counterparts.<sup>193</sup> Unemployment insurance is an effective strategy to reduce and mitigate the consequences of income volatility because it prevents a total disruption in income and significantly reduces the magnitude of wage losses.<sup>194</sup> UI softens the drop in family income due to job loss from roughly \$1,826 a month—a 46% drop in monthly income—to just \$617 a month—a 16% drop. Spending drops by just 5% upon job loss because UI benefits boost spending dramatically, averting 74% of the potential drop absent UI.<sup>195</sup>

### Benefit Delivery (*Slightly Reduces*)

It generally takes two to three weeks after you file your claim to receive your first benefit check. Some states require a one-week waiting period; in other words, you would receive your first payment for the second week of your unemployment claim.<sup>196</sup> It may take longer depending on the state where you work and the circumstances surrounding your claim for benefits. For example, it may take longer if your wages are not in the state's system. If your state has waived the waiting week, you will receive your first payment for the first week of your unemployment claim.<sup>197</sup> Procedural details can result in an additional one-week to three-week delay. In most states, you can receive your money either on a state-issued prepaid debit card or an existing prepaid card, or you can have it directly deposited into your own bank or credit union account. In some states, receiving paper checks is also an option. You may pay a fee to cash your check, and when depositing a check, there might be a delay in when funds are available to use. For a prepaid card, you may incur fees for certain types of transactions, such as withdrawing funds from an out-of-network ATM.<sup>198</sup> In 2019, UI's estimated improper payment rate (including overpayment and underpayment) was 9.2%, while the overpayment rate was 8.7%.<sup>199</sup> Nonfraudulent claims leading to benefit overpayment can stem from any number of errors made by claimants or agency administration. These include applying when unqualified after initial approval, inaccurate wage history, reporting incorrect earnings, or other inaccuracies.<sup>200</sup> Many states provide waivers for overpayments that are not fraudulent or if the overpayment is not the individual's fault. States offer waivers for agency error, employer error, equity or good conscience, financial hardship, and other reasons. State law also provides for the recovery of benefits. States have a variety of methods to recover overpayments, including offsetting the value of future benefits and tax refunds. In addition, some states permit civil action to recover overpayments. Some states also charge interest on overpayments. Interest ranges from 0% to 18%.<sup>201</sup> Considering the pandemic, Virginia updated its unemployment claims system to allow applicants to receive funds while their claims are being reviewed. If a claim is denied through no fault of the applicant's but the applicant already has been paid a benefit, Virginia may waive repayment. Kentucky also created a path to waive repayments. However, the circumstances by which overpayments may be waived vary by case and state.<sup>202</sup> In California, claimants can pay a penalty if the claimant makes a "willful false statement" to the Employment Development Department (EDD) to obtain benefits. This penalty can be up to 30% of the amount the EDD believes was wrongfully paid to the claimant.<sup>203</sup>

### Benefit Access and Use (*Significantly Exclusive*)

From 2012 to 2016, the UI application rate was 54%. In 2016, only 27% of unemployed workers received UI. In 2016, there were 12 states with rates below 20%, including six states below 15% (Florida, North Carolina, Louisiana, Georgia, Tennessee, and South Carolina).<sup>204</sup> Overall, about 29% of unemployed Americans, or 2.1 million out of 7.37 million, received UI benefits in March 2020, where most received them through their states' regular UI program.<sup>205</sup> Benefit eligibility varies across states in terms of job classifications and wage requirements, and many unemployed workers are unaware of their eligibility status. Each state has its own filing system where applications can be submitted in-person, through the telephone, or online. In June 2020, almost 40% of beneficiaries had waited for more than a month between their initial claim and benefit receipt.<sup>206</sup> Every state has a work search requirement, and most requirements specify an expected number of employer contacts per week. States are disqualifying more workers for reasons unrelated to the cause of their unemployment, especially through stricter work search documentation rules, reaching a denial rate of nearly one in every four claims filed.<sup>207</sup>

Some states (Arizona, Florida, Georgia, Utah, Tennessee, North Carolina) have acted legislatively to expand disqualifications that formerly applied only to public education employees between academic years and terms to apply to private-sector employees serving school systems (e.g. school bus drivers, cafeteria workers). These kinds of changes effectively disqualify entire categories of employees (typically low-wage workers) and have the immediate impact of discouraging workers from applying for UI benefits. Many state legislatures increased work search requirements as part of UI solvency reform strategies and moved to require work search documentation (weekly or bi-weekly), either online or in writing. This increased focus on work search has resulted in more denials of benefits. From 2012 to 2016, the number of claimants disqualified for reasons related to a claimant’s status as able to work, available for work, or actively searching for work was seven in every 100. After the Department of Labor issued a “call to action” to all states to implement strategies to reduce improper UI payments, there were record high denial rates for non-separation issues directly related to tightening administrative processes. Spurred by the federal program integrity push, some states have used automation to enforce inflexible procedural rules they had previously elected not to enforce. When states leave claimants on their own to complete online resumes or skills questionnaires, time lost securing staff assistance to deal with system problems often results in some form of disqualification, even if just for one to three weeks. Numerous states have mandated, either legislatively or administratively, that all claims be filed exclusively online, which present barriers for workers with limited English proficiency, literacy challenges, limited computer fluency, or limited online access.<sup>208</sup> As states move primarily to online claim filing, disqualifications for procedural reasons nearly doubled from 2012 to 2016, compared to the prior five-year period, with 14 states denying more than one in every 10 claims for an essentially procedural reason. These denials generally include claimant failure to comply with a filing instruction rather than meet a substantive eligibility condition. The percentage of unemployed workers applying for UI dropped by nearly one-fifth during the five years from 2012 to 2016, compared to the prior five-year period. While some of the decline may be related to improved economic conditions, stricter state eligibility policies that discourage workers from applying for UI are also major contributing causes.<sup>209</sup>

### **Interactions Between Benefits** (*Supports Stability*)

Individuals currently enrolled in SNAP, Medicaid, or TANF who are approved for UI may need to report receipt of the UI to the state agency, which may affect their benefits. All UI benefits are countable as unearned income for SNAP households. Receipt of UI may reduce benefits for households, although they may continue receiving the maximum benefit if the state is issuing emergency allotments during a public health emergency. For other households, the receipt of UI can put them over the income threshold and make them ineligible. States have flexibility in TANF on how to consider income, but they typically treat UI benefits as unearned income. UI receipt could result in an overpayment for SNAP and TANF if it isn’t reported in a timely manner (if required) and acted on by the state agency. Most states have automated data matches and will automatically update cases. Because of delays in processing UI applications and how UI payments can be retroactive, many UI recipients will receive payments that include lump sum retroactive benefits upon application approval. Treatment of a lump sum varies by state. Some states exclude the lump sum entirely, some count it as income or an asset in the month received, and some create a period of ineligibility based on the amount of the lump sum (“lump sum rule”). For states with a lump sum rule, a large retroactive benefit could disqualify a family from TANF beyond the UI benefit period.<sup>210</sup> UI and SNAP are both part of the recessionary safety net, with increases in joint participation in both programs at times of recession critical to helping households stabilize.<sup>211</sup>

## Social Security Retirement

<b>Benefit Performance Score for Supporting Workers Using It Today</b>	<b>Overall Benefit Performance Score for Supporting All Workers</b>
<b>Performs Well</b>	<b>Performs Moderately Well</b>

### **Dollar Value the Benefit Provides** (*Effective*)

The estimated average Social Security retirement benefit in 2022 is \$1,657 a month. The maximum benefit—the most an individual retiree can get—is \$3,345 a month for someone who files for Social Security in 2022 at full retirement age (FRA), the age at which you qualify for 100% of the benefit calculated from your earnings history. FRA is 66 years and four months for people born in 1956 and is gradually rising to 67 years for those born in 1960 or later.<sup>212</sup> You can get Social Security retirement benefits as early as age 62. However, the benefit is reduced if you retire before your full retirement age. For example, if you turn age 62 in 2022, your benefit would be about 30% lower than it would be at your full retirement age of 67.<sup>213</sup> While there is no explicit dollar cap on Social Security benefits, top benefits are not excessive. That’s because Social Security caps the amount of earnings on which workers pay taxes and accrue credit toward future benefits and because the program’s progressive benefit formula replaces a greater share of past earnings for low-paid workers than high-paid ones.<sup>214</sup> In 2022, the cap is \$147,000 (it’s adjusted annually to reflect historical wage trends). Benefits for a low earner (with 45% of the average wage) retiring at age 65 in 2021 replace about half of their prior earnings. But benefits for a high earner (with 160% of the average wage) replace about 30% of prior earnings, though they are larger in dollar terms than those for the low-wage worker.<sup>215</sup> Once someone starts receiving Social Security, their benefits increase to keep pace with inflation, helping to ensure that people do not fall into poverty as they age.<sup>216</sup> Social Security plays a crucial role in reducing poverty among older adults and enabling retirees to cover basic expenses.<sup>217</sup> For about half of seniors, it provides at least 50% of their income, and for about one in four seniors, it provides at least 90% of income.<sup>218</sup> Social Security is especially important for women and people of color. Women tend to earn less than men, take more time out of the paid workforce, live longer, accumulate less savings, and receive smaller pensions. Social Security brings 9.5 million older women above the poverty line. Without Social Security, the poverty rate among older Latino adults would be 45%, and the poverty rate among older Black adults would be 48%.<sup>219</sup>

### **Benefit Delivery** (*Reinforces*)

Payments are made monthly through direct deposit, prepaid debit card, or electronic transfer account (a bank account for federal payment recipients without a checking or savings account). Prepaid cards can incur fees for certain services and transactions at ATMs that are out of network, and there is one free ATM withdrawal per month. If you receive both Social Security and SSI benefits, your Social Security payment will arrive on the third of the month, and your SSI payment will arrive on the first of the month.<sup>220</sup>

### **Benefit Access and Use** (*Nearly Inclusive*)

Over 65 million people, or more than one in every six U.S. residents, collected Social Security benefits in June 2020. About 96% of people aged 20-49 who worked in jobs covered by Social Security in 2020 have earned life insurance protection through Social Security.<sup>221</sup> About 3.5% of the total population, or 2.4 million, aged 60 or older never receive Social Security benefits. Late-arriving immigrants (45.8%) and infrequent workers (who have insufficient earnings to qualify for social security) (39.6%) comprise 86% of never beneficiaries and have the highest poverty rates among never beneficiaries.<sup>222</sup> You become eligible to collect Social Security retirement benefits at age 62. Eligibility by working and paying Social Security taxes, either through payroll deductions or income tax filings if you are self-employed. You qualify for Social Security by compiling credits when you pay Social Security tax on your earnings. You can earn up to four credits per year. Workers qualify for Social Security retirement benefits when they reach 40 lifetime credits. In 2022, \$1,510 in income from “covered” employment—work in which you paid Social Security taxes—equals one work credit. You can reach your four-credit maximum by earning at least \$6,040 for the year.<sup>223</sup>

### **Interactions Between Benefits** (*Supports Stability*)

Social Security benefits count as income for safety net programs including SNAP<sup>224</sup> and Supplemental Security Income (SSI). In 2021, about 4.8 million seniors, adults over the age of 60, were enrolled in SNAP. Seniors who spend more than \$35 a month on out-of-pocket medical costs may be able to deduct that from their gross income when applying for SNAP, thus increasing their monthly benefit amount.<sup>225</sup> Social security encourages private pensions and personal savings because it isn’t means-tested.<sup>226</sup> People already collecting Social Security retirement benefits are automatically enrolled into Part A and Part B of Medicare when they’re first eligible.<sup>227</sup> Individuals receiving Social Security retirement benefits may also qualify for SSI benefits, and the SSI application is also an application for Social Security.<sup>228</sup> Social Security checks can be garnished for unpaid debts such as federal income taxes, child or spousal support, or federal student loans.<sup>229</sup>

## Social Security Disability Insurance (SSDI)

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Needs Minor Improvement	Needs Significant Improvement

### Dollar Value the Benefit Provides (*Partially Effective*)

The average disabled-worker benefit is about \$1,236 a month, and 90% of beneficiaries get less than \$2,000 a month. SSDI payments range on average between \$800 and \$1,800 per month. The maximum benefit you could receive in 2020 is \$3,011 per month. Most beneficiaries, especially unmarried ones, rely on SSDI for most of their income. SSDI benefits replace about half of past earnings for a median beneficiary.<sup>230</sup> A study in 2014 found that 28% of SSDI-only recipients, whose income was too high to qualify for Supplemental Security Income (SSI), were living in poverty.<sup>231</sup>

### Benefit Delivery (*Slightly Reduces*)

Payment type and frequency is consistent with other social security payments. Payments are made monthly through direct deposit, prepaid debit card, or electronic transfer account (a bank account for federal payment recipients without a checking or savings account). Prepaid cards can incur fees for certain services and transactions at ATMs that are out of network, and there is one free ATM withdrawal per month. If you receive both Social Security and SSI benefits, your Social Security payment will arrive on the third of the month, and your SSI payment will arrive on the first of the month.<sup>232</sup> SSDI differs in that there is a five-month waiting period, and benefits are payable during the sixth full month after the disability begins. However, recipients usually do not receive benefits until several months later because of delays in applying and processing.<sup>233</sup> If the SSA overpaid SSDI benefits and you're still receiving benefits, the SSA will withhold the full amount of your benefit check each month until the overpayment is paid off. The withholding will start 30 days after you receive the notice of overpayment.<sup>234</sup> A 2019 study conducted by the Social Security Administration (SSA) found that it overpaid 1.9 % of SSDI beneficiaries because of work in one or more months during their benefit period. Although overpayments were rare among beneficiaries overall, among those with earnings sufficient to put them at risk of a work-related overpayment, 71% were overpaid. Work-related overpayments lasted for a median of nine months and accrued a median amount of \$9,282. This study cites anecdotal evidence suggesting that overpayments and their aftermaths can be traumatic experiences for beneficiaries and may function as disincentives to work. Additional findings from semi-structured interviews with 84 overpaid SSDI beneficiaries found that more than half of the interviewed beneficiaries immediately terminated employment upon learning of their overpayment.<sup>235</sup>

### Benefit Access and Use (*Significantly Exclusive*)

Some 8.2 million people receive disabled-worker benefits from Social Security. Payments also go to some of their family members: 104,000 spouses and 1.4 million children. Ultimately, Social Security awards disability benefits to fewer than four in 10. Among applicants who meet the program's technical requirements, slightly more than half are found medically eligible for SSDI. Eligibility criteria are strict, and SSA rejects most applicants. Applicants for SSDI benefits must be insured for disability benefits (essentially, they must have worked for at least one-fourth of their adult life and five of the last 10 years) and suffering from a severe, medically determinable physical or mental impairment that is expected to last 12 months or result in death based on clinical findings from acceptable medical sources. Applicants must be unable to perform "substantial gainful activity" (any job that generates earnings of \$1,310 per month for most people, \$2,190 for blind people) anywhere in the national economy—regardless of whether such work exists in the area where the applicant lives, whether a specific job vacancy exists, or whether they would be hired. Lack of education and low skills are considered for older, severely impaired applicants who can't realistically change careers—but not for younger applicants. SSA denies applicants who are technically disqualified (chiefly because they haven't worked long enough). Roughly half of the people who get an initial denial pursue an appeal. Social Security pays benefits only for total disability; it does not pay benefits for partial disability or short-term disability. To be eligible for benefits, a person must: be insured for benefits, be younger than full retirement age, have filed an application for benefits, and have a Social Security–defined disability.<sup>236</sup> The final award rate for disabled-worker applicants has varied over time, averaging 33% for claims filed from 2007 through 2016. Denied disability claims have averaged 63%. SSDI allowances in 2017 were 45.5%.<sup>237</sup> To be eligible for disability benefits, a person must be unable to engage in substantial gainful activity (SGA). A person earning more than a certain monthly amount (net of impairment-related work expenses) is ordinarily considered to be engaging in SGA. Rather than SSDI benefits stepping down as earned income steps up, the "benefits cliff" causes SSDI recipients to lose 100% of their SSDI benefit at the point they earn as little as \$1,131 per month for nine months (or \$1,820 if an individual is blind). Fear of the "benefits cliff," complex challenges with reinstatement, and other complications combine to create profound disincentives for SSDI recipients to return to meaningful participation in work.<sup>238</sup> In general, benefits will continue if a person still has a disability that prevents them from working. Any person who receives disability benefits must have their medical conditions reviewed.<sup>239</sup> Recertification requirements through continuing disability review (CDR). The SSA periodically reviews the case of SSDI recipients to determine whether they are still unable to work and, therefore, still considered disabled.



For someone who has had their disability case classified as medical improvement expected (MIE), the case will be scheduled for a review within six to 18 months after the applicant was first confirmed to have a disability, otherwise, review is typically once every three years.<sup>240</sup> The documentation required to determine eligibility and benefit amounts for Social Security is complex.<sup>241</sup>

**Interaction Between Benefits** (*Supports Stability*)

SNAP counts SSDI income for eligibility.<sup>242</sup> Twenty-one percent of non-elderly disabled individuals participate in SNAP.<sup>243</sup> SSDI provides critical support to many with disabilities, and SNAP benefits are also incredibly important for the economic well-being and food security of low-income people with disabilities. People who are already collecting SSDI are automatically enrolled into Medicare Part A and Part B when they're first eligible.<sup>244</sup> There are limits to how much SSDI recipients can earn from work while collecting SSDI payments, but there are no restrictions on assets. Individuals can have a savings account with as much money as they would like to save.<sup>245</sup> In certain circumstances, individuals can collect Supplemental Security Income (SSI) and SSDI at the same time. This simultaneous collection is called "concurrent benefits" and happens when the SSDI approval benefit amount is small due to low wages or hours when the worker was employed.<sup>246</sup> A trial work period promotes continued benefit access, where a beneficiary may test their ability to work and still be considered disabled. The SSDI benefit continues during the trial periods until the beneficiary has performed services in at least nine months (not necessarily consecutive) in a rolling 60-month period.<sup>247</sup> Social Security checks can be garnished for unpaid debts such as federal income taxes, child or spousal support, or federal student loans.<sup>248</sup>

**Section 8 Housing Choice Vouchers (HCV)**

<b>Benefit Performance Score for Supporting Workers Using It Today</b>	<b>Overall Benefit Performance Score for Supporting All Workers</b>
<b>Performs Moderately Well</b>	<b>Needs Moderate Improvement</b>

**Dollar Value the Benefit Provides** *(Effective)*

With vouchers, a family pays about 30% of its income for rent and utilities, a widely used standard for the amount a household can reasonably be expected to pay for housing. The voucher covers the rest, up to a cap based on HUD estimates of typical market rents in the local area. HUD estimates the average annual rental subsidy cost for an HCV-assisted household is between \$7,500 and \$9,500.<sup>249</sup> The public housing authority (PHA) determines a payment standard that is the amount generally needed to rent a moderately-priced dwelling unit in the local housing market, and that is used to calculate the amount of housing assistance a family will receive. A family, which receives a housing voucher, can select a unit with a rent that is below or above the payment standard. The housing voucher family must pay 30% of its monthly adjusted gross income for rent and utilities. If the unit rent is greater than the payment standard, the family is required to pay the additional amount. By law, whenever a family moves to a new unit where the rent exceeds the payment standard, the family may not pay more than 40% of its adjusted monthly income for rent.<sup>250</sup> Once a family receives a voucher, it has at least 60 days to find housing, and housing agencies can extend that period. A family can use a voucher to help pay the rent either for its current unit or a new unit. In either case, the housing agency must verify that the unit meets federal housing quality standards and that the rent is reasonable compared to market rents for similar units in the area. By lowering rental costs, vouchers also allow low-income people to spend more on other basic needs like food and medicine, as well as on goods and services that enrich their children’s development.<sup>251</sup> Households in the Housing Choice Voucher program stayed the longest, compared to Project Based Rental Assistance (PBRA) recipients, with leavers in 2015 staying an average of 6.6 years and a median of 4.8 years.<sup>252</sup> Participants may have to pay security deposits to their landlord. A report prepared for HUD found that 46% of HCV holders in 2015 were cost-burdened, spending more than 30% of their income on housing costs, and 8% were severely cost-burdened, spending more than half of their income on housing.<sup>253</sup> While families may be paying more in income-based rent as their adjusted income rises through employment, housing assistance payments (HAP) will continue if there is a difference in the amount the family is paying to the landlord and the total rent for the property. Once the family’s income-based payment amount covers the entire rent, the family may continue in the program for six months following the reassessment of rent by the PHA. If the family circumstances change during the six-month period and the family needs assistance again, the PHA conducts an interim reexamination and reinstates assistance. At the end of six months, the HAP contract will terminate if the subsidy has not been restored.<sup>254</sup> Vouchers make housing affordable, reduce housing instability, and help children to grow up healthier. Children in homeless families that receive housing vouchers change schools less often and are 42% less likely to be separated from their families and placed into foster care. Their families are also 20% less likely to be food insecure and 34% less likely to experience domestic violence. Research traces several positive outcomes to using housing vouchers.<sup>255</sup> Vouchers and other rental assistance lifted 2.8 million people—including about 900,000 children—above the poverty line in 2014 under the federal government’s Supplemental Poverty Measure. Vouchers alone likely produced at least half of the effect.<sup>256</sup>

**Benefit Delivery** *(Significantly Reduces)*

A housing subsidy is paid to the landlord directly by the PHA on behalf of the participating family. The family then pays the difference between the actual rent charged by the landlord and the amount subsidized by the program. Under certain circumstances, if authorized by the PHA, a family may use its voucher to purchase a modest home. The voucher is portable, with the participant free to choose any housing that meets the program’s requirements and is not limited to units located in subsidized housing projects. Few metropolitan families with children using vouchers live in low-poverty neighborhoods (poverty rate below 10%, despite affordable units in those neighborhoods. On average, 18% of all voucher-affordable housing units are in high-opportunity neighborhoods. Low-opportunity neighborhoods account for 21% of voucher-affordable homes, a similar share. But only 5% of families with vouchers live in high-opportunity areas—whereas 40% live in low-opportunity areas.<sup>257</sup> Vouchers have not been as effective in promoting residential mobility and choice among minority recipients as they have been for White recipients. Still, vouchers perform better than public and assisted housing projects in giving families access to low-poverty neighborhoods. Due to many reasons, including shortages of moderately priced rental homes, tight market conditions, discrimination, and unwillingness of landlords to accept voucher payments, not all families who receive vouchers can find a house or apartment where they can use them. And, despite the portability of vouchers, it is not easy to use for both families and housing authorities.<sup>258</sup>

**Benefit Access and Use** *(Significantly Exclusive)*

While 2.3 million low-income families use vouchers, only one in four families eligible for federal rental assistance receive it due to funding limitations.<sup>259</sup> HUD data shows that 48% of voucher-holders were Black, 32% were White, 17% were Hispanic, and 2% were Asian in 2017. Applicants’ incomes cannot be higher than 50% of the area median income to qualify for vouchers. HUD also requires that PHAs provide at least 75% of their vouchers to applicants whose incomes do not exceed 30% of the area median income.

Federal fair housing laws do not protect voucher holders, and, in most places in the U.S., landlords can legally reject housing applicants solely because a portion of their income comes from vouchers—regardless of the applicants’ other qualifications as tenants. Discrimination by landlords can prevent voucher holders from finding housing during the time allowed for a housing search. In response to the lack of federal protections for voucher holders, 12 states and 87 local governments passed laws prohibiting landlords from discriminating against voucher holders. In 2015, Texas passed a preemption law that prevents local governments from adopting such protections. In many jurisdictions, voucher holders are also more likely to be people of color, older adults, and female-headed households than the general population of renters.<sup>260</sup> According to CBPP, in 2019, the voucher program assisted about 37,000 fewer households than in early 2017.<sup>261</sup> For Housing Choice Vouchers, most noncitizens with permanent status are eligible for assistance, whereas temporary and unauthorized immigrants are ineligible. Mixed-status families (comprised of both eligible and ineligible members) may receive prorated or reduced benefits.<sup>262</sup> The demand for housing assistance often exceeds the limited resources available to HUD and the local housing agencies, so long waiting periods are common. A PHA may close its waiting list when it has more families on the list than can be assisted in the near future.<sup>263</sup> Among the 50 largest housing agencies, only two have average wait times of under a year for families that have made it off the waiting list, while the longest have average waiting times of up to eight years.<sup>264</sup>

### **Interactions Between Benefits** (*Supports Stability*)

Section 8 subsidized housing eligibility counts income from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits, and other similar types of periodic receipts, including a lump-sum amount or prospective monthly amounts such as unemployment insurance, disability compensation, worker's compensation, severance pay, and welfare assistance payments like TANF. Income excludes lump sum deferred payments of social security benefits, which occurs when the beneficiary appealed a denial of benefits or if prior payments were underestimated.<sup>265</sup> Current law disregards earned income for certain public housing residents and Section 8 HCV holders. Specifically, certain residents who begin employment or increase their earnings can have 100% of their increased earnings disregarded in the first year, and 50% disregarded in the second year. Section 8 HCV holders with a disability are eligible for the same disregard.<sup>266</sup> There is no asset limitation to participating in HUD-assisted housing programs, but the definition of annual income includes net income from family assets.<sup>267</sup> The Family Self Sufficiency (FSS) program allows HUD-assisted families to increase their earned income and reduce their dependency on welfare assistance and rental subsidies. Some services coordinated through the program include childcare, transportation, job training, financial literacy, and homeownership counseling. The PHA establishes an interest-bearing escrow account, and any increases in the family’s rent because of increased earned income during the family’s participation in the program results in a credit to the escrow account. Once a family graduates from the program, they can access the escrow.<sup>268</sup>

## Section 8 Project-Based Rental Assistance (PBRA)

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Performs Moderately Well	Needs Moderate Improvement

### Dollar Value the Benefit Provides (*Effective*)

Tenants pay 30% of their income (after certain deductions are taken out) for rent and utilities, or a minimum of \$25 per month. A monthly Section 8 PBRA payment to the private owner of the building fills the gap between the tenant contribution and the cost of maintaining and operating the apartment.<sup>269</sup> An example of rent at 30% income: a household with one full-time worker at \$7.25/hour might pay \$348 per month.<sup>270</sup> The average monthly subsidy per unit in 2011 was \$665.<sup>271</sup> PBRA enables people to maintain financial stability by helping them avoid housing instability and afford housing. It can allow older adults and people with disabilities to continue to live in their home community. I paired with supportive services, it can help people with chronic conditions maintain stable housing.<sup>272</sup> Both Housing Choice Voucher (HCV) and public housing provide positive income effects for households. By relaxing the budget constraint faced by participating households, these programs may enable parents to devote more time and financial resources to develop the human capital of children residing in the household. The increase in human capital would suggest that childhood residence in assisted housing should improve adult labor market outcomes and decrease adult incarceration.<sup>273</sup>

### Benefit Delivery (*Slightly Reduces*)

Project-based assistance is tied to particular units and does not travel with individual tenants.<sup>274</sup> Oftentimes, there is a waiting list that can be several months long. Once families are selected from the waiting list, they may be offered a unit; however, there may be a limited number of available units to choose from.<sup>275</sup> When project-based Section 8 contracts expire, owners may opt-out of their contracts, enabling them to increase rents to market levels or convert units to market-rate condominiums, thereby rendering apartments unaffordable to lower income tenants. Owners must give tenants one-year advance notice of an intent to opt-out. Most tenants will receive enhanced vouchers to enable them to remain in their homes.<sup>276</sup> Management issues have resulted in consequences for tenants, from overpaying hundreds of dollars in rent to facing improper evictions.<sup>277</sup> For project-based Section 8 rental assistance, HUD enters Housing Assistance Payment (HAP) contracts with owners. These contracts can be renewed in 1-year, 5-year, or 20-year increments. Participating private owners enter into multi-year rental assistance agreements with the Department of Housing and Urban Development (HUD)—or with public housing agencies for contracts funded under the Section 8 Moderate Rehabilitation program—and they maintain responsibility for the management of their Section 8 PBRA properties. About 18% of PBRA-assisted units are in rural areas.<sup>278</sup> Through PBRA, participating private owners enter into multi-year rental assistance agreements with the Department of Housing and Urban Development (HUD)—or with public housing agencies for contracts funded under the Section 8 Moderate Rehabilitation program. A monthly PBRA subsidy payment to the owner covers the difference between the tenant contribution and the cost of maintaining and operating the apartment.<sup>279</sup>

### Benefit Access and Use (*Significantly Exclusive*)

The Section 8 Project-Based Rental Assistance (PBRA) programs enable more than two million people in 1.2 million low-income households to afford modest apartments. The programs work by contracting with private owners to rent some or all the units in their housing developments to low-income families. A family or individual must have a “low income”—meaning that their income may not exceed 80% of the local median—to live in Section 8 PBRA housing. For each participating housing development, at least 40% of the subsidized units that become available annually must go to families with “extremely low incomes” (up to the poverty line or 30% of the local median, whichever is higher). Most of the remaining units are restricted to families or individuals with incomes not above half of the local median. In 2016, 64% of recipients were female compared to 36% male. Forty percent of recipients were Black, 19% were Latinx, 33% were White, and 5% were Asian American or Pacific Islander. Eighteen percent of people had a disability, and 31% were 62 and older. Older adults or people with disabilities head two-thirds of PBRA-assisted households.<sup>280</sup> For Section 8 project-based rental assistance, most noncitizens with permanent status are eligible for assistance, whereas temporary and unauthorized immigrants are ineligible. Mixed-status families (comprised of both eligible and ineligible members) may receive prorated or reduced benefits, depending on the program.<sup>281</sup> The private market and public rental assistance programs made available only 62 affordable units per 100 very low-income renters in 2019 and only 40 affordable units for every 100 extremely low-income renters.<sup>282</sup>

### Interactions Between Benefits (*Supports Stability*)

Section 8 subsidized housing eligibility counts income from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits, and other similar types of periodic receipts, including a lump-sum amount or prospective monthly amounts such as unemployment insurance, disability compensation, worker's compensation, severance pay, and welfare assistance payments like TANF. Income excludes lump sum deferred payments of social security benefits, which occurs when the beneficiary appealed a denial of benefits or if prior payments were underestimated.<sup>283</sup> Current law disregards the earned income for certain public housing residents and Section 8 HCV holders. Specifically, certain residents who begin employment or increase their earnings can have 100% of their increased earnings disregarded in the first year, and 50% disregarded in the second year. Disabled Section 8 HCV holders are eligible for the same disregard.<sup>284</sup>

There is no asset limitation to participating in HUD assisted housing programs, but the definition of annual income includes net income from family assets.<sup>285</sup> The Family Self Sufficiency (FSS) program allows HUD assisted families to increase their earned income and reduce their dependency on welfare assistance and rental subsidies. Some services coordinated through the program include childcare, transportation, job training, financial literacy, and homeownership counseling. PHA establishes an interest-bearing escrow account, and any increases in the family's rent because of increased earned income during the family's participation in the program results in a credit to the escrow account. Once a family graduates from the program, they can access the escrow.<sup>286</sup>

## Home Mortgage Interest Rate Deduction (HMID)

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Needs Minor Improvement	Needs Significant Improvement

### Dollar Value the Benefit Provides (*Partially Effective*)

The value of the deduction to a homeowner typically increases with taxpayer income for three reasons. First, the higher-income households are more likely to itemize their tax deductions, which is a prerequisite for benefiting from the mortgage interest deduction. For example, according to Tax Policy Center (TPC) estimates, about 1% of households in the bottom 40% of the income distribution itemized in 2018 compared to 40% of households in the top 20%. Second, marginal tax rates increase with income. An individual in the 35% marginal tax bracket who pays \$10,000 in mortgage interest would realize a reduction in taxes of \$3,500 compared to an individual in the 24% bracket who would realize a \$2,400 reduction in taxes. Third, higher-income individuals tend to purchase more expensive homes, which results in larger mortgage interest payments, and hence, larger deductions. These three reasons explain why the benefits of the mortgage interest deduction mostly accrue to upper-income households. Economists express caution over how effective the deduction may be at promoting homeownership since the deduction does not address the primary barrier to homeownership, the down-payment requirement.<sup>287</sup>

### Delivery (*Slightly Reduces*)

Delivered as a tax deduction that reduces taxable income for households that itemize deductions (versus taking a standard deduction). High-income households are more likely to itemize deductions since they pay more in state and local taxes, take out larger mortgages, and have more disposable income to donate to charity.<sup>288</sup> The HMID is regressive in design since it is a tax deduction that benefits more higher-income households.

### Benefit Access and Use (*Significantly Exclusive*)

In 2018, the Tax Policy Center estimated only 8% of all tax filers exercised this benefit. The 2017 Tax Cuts and Jobs Act (TCJA) doubled the standard deduction, thus reducing the number of filers claiming the HMID. Because the value of the HMID to an individual tax filer goes up with the value of the loan, the cost savings from interest deductions overwhelmingly skew towards higher-income households who can afford those larger monthly mortgage payments. One analysis found that over 63% of the tax savings from the HMID were accrued to households earning over \$200,000 per year, despite this income bracket representing only 37% of all tax filers. Meanwhile, households earning under \$100,000 received less than 10% of the benefit. Because households realize the benefits of the HMID after purchase of a home, it is ineffective as a tool for lowering barriers to entry for households who might find it difficult to buy a home.<sup>289</sup> White households account for 66% of the U.S. population yet receive 71% of the benefit. In contrast, while comprising 13% of the overall population, Black households receive only 8% of the benefit. Latino households constitute 14% of the U.S. population but receive 10% of the benefit. Eligibility for the HMID is selective and exclusionary. A household needs to own a home with a documented mortgage with a lender, excluding renters and homeowners without mortgages. Under these eligibility criteria and historic homeownership gaps, the HMID advantages White households with consistently higher rates of homeownership than households of color.<sup>290</sup> By reducing pre-tax income and relying on taxpayers to take up the policy themselves, the deduction primarily benefits a subset of higher-income taxpayers, or those earning between the 90th and 95th percentile of the income distribution. Research suggests that this policy does not encourage more people to buy homes; instead, it incentivizes people to buy more homes.<sup>291</sup>

### Interactions Between Benefits (*Undermines Stability*)

According to one report, experts suggest the HMID encourages households to take on higher levels of debt, disrupts the housing market by increasing costs for everyone, and primarily benefits those who do not need federal assistance to live in a stable home.<sup>292</sup> Studies consistently show that the HMID fails to increase the homeownership rate, and, instead, it inflates home prices and encourages borrowing against equity.<sup>293</sup> Significant disparities exist in the distribution of federal housing expenditures between high- and low-income households, with a need to consider how to reform HMID to reinvest in Section 8 and other housing assistance programs that assist low-income households.<sup>294</sup>

## Child Care and Development Fund (CCDF)

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Needs Significant Improvement	Needs Significant Improvement

### Dollar Value the Benefit Provides (*Not Effective*)

The federal government suggests that states set their childcare subsidy payment rates at the 75th percentile of the current market rate. In other words, states should set the rate at a level that would give families access to three out of four available childcare slots or programs in a state-determined region. However, in 2019, only four states did this; a significant drop from 2001, when 22 States set their payment rates at the recommended level. There is significant variation in payment rates within states, based on factors like childcare program type—such as home-based family childcare or center-based childcare—a child’s age, the program’s locality, and quality level of the childcare program. Family childcare receives a lower rate than center-based programs in nearly every state, even when family childcare may provide longer hours of care than center-based programs. There is a broad range of payment rates across states, ranging from an average annual subsidy per child of \$3,000 in Hawaii to \$11,000 in the District of Columbia.<sup>295</sup> States are required to provide parents receiving a childcare subsidy with the ability to take that subsidy to any childcare program, including center-based and home-based, care in the child’s home, and relative caregivers. States must also set subsidy base payment rates at a sufficient level for childcare programs to be able to cover the costs of meeting CCDF health, safety, quality, and staffing requirements and consider the cost of providing higher-quality childcare.<sup>296</sup> When families get childcare assistance, parents benefit from improved employment outcomes, including higher employment rates and greater job retention.<sup>297</sup> The Child Care Development Block Grant (CCDBG), which authorizes the Child Care and Development Fund, allows parents to enroll their children in higher-quality care than they could otherwise afford<sup>298</sup>, with quality childcare fostering healthy development in children. When families cannot obtain childcare assistance, they may go into debt, return to public assistance programs, choose lower quality childcare, or make difficult household choices (e.g., paying for rent or childcare).<sup>299</sup>

### Benefit Delivery (*Significantly Reduces*)

CCDF funds are allocated to states and subsidize the childcare expenses of low-income working families with children under age 13. Key revisions in 2014 included strengthening health and safety requirements for childcare providers, increasing quality, and improving transparency.<sup>300</sup> States usually make funds available to families through vouchers that typically do not cover the full cost of care. Several states have long waiting lists for this assistance, with fewer than one in six eligible children receiving support from the block grant.<sup>301</sup> Childcare services are provided to families on a sliding fee scale basis. Parents may choose to receive assistance through vouchers or certificates, which they can use through a provider of their choice, including religious providers and relatives.<sup>302</sup> In some states, participation in the CCDBG, the law that authorizes the CCDF program,<sup>303</sup> is limited to licensed providers or providers who meet certain quality standards. In others, subsidy policies and consumer outreach strategies encourage but do not require parents to choose licensed providers or providers that participate in quality rating systems. If parents are required or encouraged to choose licensed or quality-rated programs, they may have with limited options. Research suggests that more than half of the U.S. population lives in a community with a low supply of licensed childcare, with Latinx and Native American populations overrepresented in such neighborhoods. Rural areas and communities with lower average household incomes are also more likely to have limited or no access to licensed childcare. Providers that participate in quality rating systems—much less those that achieve high levels of quality based on these standards—may be even lower in supply. If eligible providers aren’t available in a given community or don’t meet parents’ employment needs, parents may choose to forgo childcare assistance altogether.<sup>304</sup>

### Benefit Access and Use (*Significantly Exclusive*)

As a block grant, states have substantial discretion in setting rules for CCDBG. CLASP analysis finds that in FY2016, just 8% of the 17.4 million potentially eligible children based on federal eligibility guidelines received subsidies, while 12% of the 10.9 million potentially eligible children based on state eligibility guidelines received subsidies. The Office of the Assistant Secretary of Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services estimates that CCDF served 15% of eligible children under federal eligibility parameters in federal childcare assistance programs in FY 2015. This estimate includes children receiving childcare assistance through CCDBG, TANF, and the Social Services Block Grant (SSBG). According to CLASP’s analysis, CCDF served only 15% of eligible Black children nationally based on federal eligibility parameters. In most states, Latinx and Asian children have far less access, with just 2% of eligible Asian children, and 4% of eligible Hispanic children served in CCDBG nationally. The share of potentially eligible children served in CCDBG varied tremendously across states, both overall and by race and ethnicity. States set their own income eligibility limits, which varied widely in FY 2016—ranging from 118% of the federal poverty level (FPL) (or \$30,114 for a family of three) in Michigan to 314% FPL (or \$64,119 for a family of three) in North Dakota. States have the flexibility to set income eligibility limits anywhere below 85% of state median income, and most do.

In 2016, a family with an income above 200% FPL (\$40,320 per year for a family of three) was ineligible for assistance in 39 states. Low qualifying income eligibility levels give an advantage to families with the greatest need but leave families who are ineligible for subsidies—many who still have low incomes—unable to afford childcare.

Notably, based on estimates, no state is even serving a quarter of all potentially eligible children regardless of qualifying income thresholds. Many states require parents to work a minimum number of hours per week as a condition of eligibility, which may make it difficult for parents with variable work schedules or those enrolled in education or training programs to meet eligibility requirements. Some states also restrict allowable education activities to high school or GED courses, leaving out parents enrolled in English as a Second Language, workforce training, or postsecondary education programs. States determine how to accept applications (e.g., online versus in-person); whether and how to verify income, employment, and other information on a parent's application; whether and how parents must report changes in their circumstances; and whether to terminate assistance in cases of a non-temporary loss of employment or education. Notably, complex application, enrollment, and redetermination procedures can be especially difficult to navigate for parents with limited English proficiency. Parents may be deterred from even applying for assistance if application materials aren't available in their native language or if they are unable to communicate with enrollment specialists.<sup>305</sup>

#### **Interactions Between Benefits** (*Supports Stability*)

The intersection of CCDF and TANF funds helps provide parents with access to childcare. Cross-system collaborations can result in administrative efficiencies by streamlining eligibility processes. Some states have implemented streamlined eligibility processes by allowing families to apply for and manage benefits, including change-reporting, through a single application. Additional examples of collaboration include cross-training caseworkers, allowing TANF activities to qualify families as eligible for CCDF-subsidized care, and using TANF funds for early care and education programs. In New Mexico and Tennessee, state-funded kindergarten is partially funded with TANF dollars. In Vermont, TANF caseworkers may determine eligibility for childcare subsidies and share this information with community childcare support agencies to initiate access to childcare subsidy benefits. Approximately 13% of families receiving CCDF-funded childcare in 2016 also reported receiving TANF assistance. Therefore, changes made to CCDF as the result of CCDBG reauthorization directly impact TANF recipients.<sup>306</sup>



**Child and Dependent Care Tax Credit (CDCTC)**

<b>Benefit Performance Score for Supporting Workers Using It Today</b>	<b>Overall Benefit Performance Score for Supporting All Workers</b>
<b>Needs Minor Improvement</b>	<b>Needs Significant Improvement</b>

**Dollar Value the Benefit Provides** *(Partially Effective)*

The CDCTC is not refundable and is calculated by multiplying the amount of qualifying expenses—a maximum of \$3,000 if the taxpayer has one qualifying individual and up to \$6,000 if the taxpayer has two or more qualifying individuals—by the appropriate credit rate. The maximum dollar amounts of allowable expenses are not adjusted for inflation under current law. For taxpayers with two or more qualifying individuals, the maximum expense threshold is per taxpayer irrespective of actual child and dependent care expenses of each qualifying individual. Hence, if a taxpayer has two qualifying individuals and has incurred no qualifying expenses for one individual and \$6,000 for the other, they can claim a credit for up to \$6,000 of qualifying expenses. The credit rate depends on the taxpayer’s adjusted gross income (AGI), with a maximum credit rate of 35%, declining as Adjusted Gross Income (AGI) increases to 20% for taxpayers with AGI above \$43,000. If an unmarried taxpayer had two qualifying individuals and \$6,000 of qualifying expenses but \$4,000 of earned income, the maximum amount of expenses that could be applied toward the credit would be \$4,000. If an individual (either an unmarried taxpayer or each spouse among married taxpayers) does not have earnings for each month of a calendar year, they can calculate their total earned income for the year by summing up their earnings for those months in which they do have earned income. Among married taxpayers, both spouses may need to calculate their earned income for the year to determine which spouse is the lower-earning spouse. Total expenses cannot be more than the earned income of the lower-earning spouse. For example, if an unmarried taxpayer (or the lower-earning spouse of a two-earner couple) earned \$500 for three months of the year and did not work the remaining nine months of the year, their earned income for the purposes of the earned income limitation would be \$1,500 and they could not use more than \$1,500 of child and dependent care when calculating the credit.<sup>307</sup> Hence, for lower-income taxpayers, the credit will phase in with earned income. Since 1988, the real average value of the CDCTC has steadily fallen as the parameters of the credit are not indexed for inflation, including the maximum amount of qualifying expenses and the income brackets for each applicable credit rate. According to the Economic Policy Institute, the average cost of childcare for a four-year-old exceeds the average cost of in-state tuition at a four-year university in 25 states. Additionally, infant care costs are higher than tuition in 35 states. The price of care during non-standard hours, when between 28% to 50% of families work, exceeds average costs. Black workers are more likely to work non-standard hours than other racial groups, meaning that Black parents could face higher childcare costs due to their work schedules. Lack of access to affordable care negatively impacts working and student caregivers. One study found that mothers who reported difficulty finding affordable childcare were less likely to be employed. Another found that time constraints related to caregiving responsibilities negatively impacted caregivers’ academic performance. In a recent survey, 64% of student caregivers who needed or used childcare reported missing at least one day of class or work in the previous semester due to childcare challenges.<sup>308</sup>

**Benefit Delivery** *(Slightly Reduces)*

Delivered as a nonrefundable tax credit, so taxpayers can only use it to offset taxes owed with a maximum amount up to the taxpayer’s liability. Like EITC and CTC, CDCTC is a yearly tax credit, and many individuals file their tax returns with an accountant or tax preparer for a fee. Many workers pay to complete their tax forms each year. This fee can cost from \$50 to \$100 or more. Paid tax preparers may also charge additional fees for filers who want a “rapid refund”.<sup>309</sup> In a SHIFT study, the median worker paid almost \$100 to file taxes, equating to six hours of work or 7% of their tax refund. The average cost for in-person tax services ranged from \$600 to \$130. The average cost for online services ranged from \$400 to \$90.<sup>310</sup> For the expense to qualify, taxpayers must provide names of all persons or organizations that provided care, including their address and either their social security number or their employer identification number.<sup>311</sup>

**Benefit Access and Use** *(Significantly Exclusive)*

The Urban-Brookings Tax Policy Center estimates that 12% of families benefit from the credit. To qualify for the CDCTC, a single parent must be working or in school. For married couples, both adults must be working or attending school. In general, allowable expenses are capped at the earnings of the lower-earning spouse. Some families with children will not benefit from the CDCTC because they do not have childcare expenses or, in the case of married couples, only one partner works or goes to school.<sup>312</sup> In 2017, the CDCTC was estimated to provide almost \$3.5 billion in childcare assistance to nearly 6.3 million families. Almost 75% of benefits were estimated to accrue to families with AGIs above \$75,000 in 2018. This result is likely because families with a lower income have lower federal tax liability and receive less assistance from the nonrefundable CDCTC.<sup>313</sup> Twenty-eight states (including the District of Columbia) have Child and Dependent Care tax provisions.<sup>314</sup> A study found that increases in the generosity of the CDCTC lead to providers raising prices, although not enough to offset the benefit of the credit.<sup>315</sup>

Between 2017 and 2018, The Tax Policy Center found that the share of taxpayers with incomes between \$20,000 and \$30,000 benefitting from the CDCTC fell from 5% to 2%. Similarly, for taxpayers with income between \$30,000 and \$40,000, the share of taxpayers who benefited from the CDCTC fell from 9% to 6%.<sup>316</sup> In 33 states, Black and Latinx children are twice as likely to live in poverty as their White peers, meaning that these families are less likely to benefit if the credit is expanded but is still nonrefundable. Taxpayers must identify all persons or organizations that provided care for the child, dependent, or spouse. To identify the care provider, taxpayers must give the provider's name, address, and taxpayer identification number (TIN). Credit may not be allowed if the care provider's information is incorrect or incomplete. A qualifying person is a taxpayer's dependent who is: a child under age 13 when the taxpayer provides care; the taxpayer's spouse who lives with the taxpayer more than half the year and is mentally or physically unable to care for themselves; or a person who lives with the taxpayer more than half the year and is mentally or physically unable to care for themselves.<sup>317</sup> If a stay-at-home taxpayer is caring for older dependents, any expenses incurred for their care will not be considered qualifying expenses (because the caregiver is not considered to be working or looking for work). In addition, certain eldercare expenses, like nursing home expenses, are not considered qualifying expenses for the CDCTC because the individual being cared for is not living with the taxpayer for at least eight hours each day.<sup>318</sup>

### **Interactions Between Benefits** (*Supports Stability*)

If a family has childcare expenses that exceed the amount set aside in a flexible spending account, the family may qualify for a CDCTC and claim a CDCTC based on the difference. For example, a family with two or more children can qualify for up to \$16,000 to apply toward a CDCTC. If that family excluded \$10,500 from salaries to pay for childcare expenses in an FSA, they could claim the difference between the two (\$5,500) as childcare expenses for a CDCTC. The exclusion is only available to taxpayers whose employers offer FSAs. Neither the CDCTC nor the FSA are indexed for inflation. Thus, each year, the two provisions' real (inflation-adjusted) value of benefits erodes.<sup>319</sup> Because both the CDCTC and CTC operate by reducing a taxpayer's federal income tax liability, receiving the CDCTC affects how much a family can receive from the CTC. The IRS indicates that the CDCTC reduces tax liability first. Then, the CTC is calculated using post-CDCTC tax liability. If the CTC is not fully refundable and a family claims both credits, the increased CDCTC may decrease the amount a family receives from the CTC. This result effectively cancels any net credit gains. Families can claim both the CDCTC and the Dependent Care Assistance Program (DCAP) exclusion, but only for a separate out-of-pocket child or dependent care expenses. Each dollar a taxpayer excludes for DCAP results in a dollar-for-dollar reduction in the maximum expenses the taxpayer may apply toward the CDCTC. In effect, a family that sets aside \$5,000 cannot claim any CDCTC if they have one child and only \$1,000 of CDCTC if they have two children. While these two policies are intended to support families, it is unlikely that many are aware of their interconnected nature and how setting aside funds in a DCAP might limit their ability to receive a CDCTC credit at the end of the tax year. The combination and interaction of various child tax benefits—including the Child Tax Credit (CTC), EITC, and Child and Dependent Care Tax Credit (CDCTC)—results in complexity, vagueness, duplication, and inefficiency for filers and the IRS.<sup>320</sup>

## Employer-Sponsored Health Insurance

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Needs Minor Improvement	Needs Significant Improvement

### Dollar Value the Benefit Provides (*Partially Effective*)

Most employees face potential out-of-pocket exposure greater than their household savings. High inflation in the cost of employer-sponsored health coverage and costs shifting to employees have contributed to leaving the average working-age household financially insecure.<sup>321</sup> Out-of-pocket costs and financial risk for this group have increased substantially over the last decade despite reforms, such as co-pay waivers for preventive care and the elimination of annual and lifetime benefit limits.<sup>322</sup> The average premium for family coverage has increased 22% over the last five years and 47% over the last ten years. On average, covered workers contribute 17% of the premium for single coverage and 27% of the premium for family coverage. Compared to covered workers in large firms, covered workers in small firms, on average, contribute a higher percentage of the premium for family coverage (35% vs. 24%). Covered workers in firms with a relatively large share of lower-wage workers have higher average contribution rates for family coverage (38% vs. 26%) than those in firms with a smaller share of lower-wage workers. The average annual dollar amounts contributed by covered workers for 2021 are \$1,299 for single coverage and \$5,969 for family coverage, like the amounts last year. The average dollar contribution for family coverage has increased 13% since 2016 and 45% since 2011. Eight percent of covered workers, including 20% of covered workers in small firms, are in a plan with a worker contribution of \$12,000 or more for family coverage. Eighty-three percent of covered workers have a general annual deductible for single coverage that must be met before the plan pays for most services. Among covered workers with a general annual deductible, the average deductible for single coverage is \$1,644. The average deductible for covered workers is higher in small firms than in large firms (\$2,295 vs. \$1,418). The average single coverage annual deductible among covered workers with a deductible has increased 25% over the last five years and 79% over the last 10 years. The 2020 value of \$1,364 is 27% higher than the average general annual deductible for single coverage of \$1,077 in 2015 and 111% higher than the average general annual deductible of \$646 in 2010. Over the past five years, the percentage of covered workers with a general annual deductible of \$2,000 or more for single coverage has grown from 19% to 26%. Among covered workers in plans with an out-of-pocket maximum for single coverage, 11% are in a plan with an out-of-pocket maximum of less than \$2,000, while 18% are in a plan with an out-of-pocket maximum of \$6,000 or more.<sup>323</sup> Among low-income adults enrolled in employer-sponsored insurance who had multiple chronic conditions and were enrolled in high-deductible health plans, almost half (46.9%) had a family out-of-pocket health care burden exceeding 20% of disposable family income. For clinicians and patients, high out-of-pocket costs for low-income adults with employer-sponsored insurance may create a barrier to effective treatment for managing multiple chronic conditions.<sup>324</sup> While many newly insured adults report difficulty affording their monthly premium, they also report lower rates of problems with medical bills and lower rates of worry about future medical bills than their uninsured counterparts. In 2019, non-elderly uninsured adults were nearly twice as likely as those with private insurance to have problems paying medical bills (24.1% vs. 11.6%). Uninsured adults are also more likely to face negative consequences due to medical bills, such as using up savings, having difficulty paying for necessities, borrowing money, or having medical bills sent to collections resulting in medical debt.<sup>325</sup> According to a study conducted by economists at the University of Illinois, Chicago, workers in the bottom fifth of the family income distribution get a lower value of benefits with annual benefits of less than \$500 from employer-sponsored health insurance, while those in the top fifth get benefits averaging \$4,500. This study used the combined effects of differences in tax rates and differences in offer and acceptance rates and found that the value of health benefits to well-paid workers has grown substantially over the period, while the value for the lowest-paid workers decreased slightly.<sup>326</sup>

### Benefit Delivery (*Slightly Reduces*)

The type of insurance coverage and the type of plans offered by employers impacts how workers use their benefit. Most working-age individuals obtain health insurance through an employer-sponsored plan, but out-of-pocket costs and the variability of financial costs for this group have increased substantially over the last decade despite reforms, such as co-pay waivers for preventive care and the elimination of annual and lifetime benefit limits.<sup>327</sup> Seventy-four percent of firms that offer health benefits offer only one type of health plan, with large firms being more likely than small firms to offer more than one plan (58% vs. 25%). Seventy-eight percent of covered workers in firms offering health benefits work in firms that offer one or more Preferred Provider Organizations (PPOs). Sixty-two percent of covered workers work in firms that offer one or more High-Deductible Health Plans with a Savings Option (HDHP/SOs) with deductibles of at least \$1,000 for single coverage and \$2,000 for family coverage. Thirty percent of covered workers are in firms that offer one or more Health Maintenance Organizations (HMOs), a plan that does not cover non-emergency out-of-network services. Fifteen percent of covered workers are in firms that offer one or more Point-of-Service plans (POS), those that have lower cost-sharing for in-network provider services but do require a primary care gatekeeper to screen for specialist and hospital visits.

The remaining 3% of covered workers are in firms that offer one or more conventional plans have no preferred provider networks and the same cost-sharing regardless of physician or hospital.<sup>328</sup> COBRA is a federal law that allows individuals to stay on employee health insurance for a limited time after the job ends (usually 18 months) but at a higher cost to the employer, including premiums plus a small administrative fee.<sup>329</sup>

#### **Benefit Access and Use** (*Significantly Exclusive*)

Calculations from BLS data show that nearly 36 million workers are not eligible for employer-sponsored health insurance, and nearly 31 million with access to plans do not participate. Seventy-three percent of civilian workers have access to a medical care benefit, with 88% of full-time workers having access and 70% taking it up. While 23% of part-time workers have access to the benefit, only 40% of these workers take it up. For workers with wages in the bottom 10%, 27% had access, with 46% taking it up, while 95% of workers with wages in the top 10% had access, with 76% taking it up. Forty-one percent of workers in the lowest quartile wage category have access, with 55% taking it up versus 94% of workers in the highest quartile wage category having access and 74% taking it up.<sup>330</sup> A 2018 BLS analysis found that contingent workers were half as likely as non-contingent workers to be covered by health insurance. Only 25% of contingent workers had employer-sponsored health coverage.<sup>331</sup> However, other estimates derived from the Current Population Survey and the American Community Survey suggest that, in 2019, the percentage of people who were insured under employer-provided coverage at the time of the interview was 55.4% in 2019.<sup>332</sup> Each year, employees must go through the often confusing open enrollment process. As employees enroll in benefits, they often feel they are spending more of their income on insurance that doesn't provide as much value as it used to. When employees switch jobs mid-year, even if they've already met their health insurance deductible on their previous employer's plan, they must effectively start over under their new employer's plan. There are other downstream effects too, like potential changes to in-network providers and coverage. These factors may create increased, unanticipated out-of-pocket responsibilities and sometimes impact people's ability to access the care they need. When employers make decisions about health insurance plan designs, they balance the needs and wants of a diverse employee population with a few, limited, one-size-fits-all options.<sup>333</sup>

#### **Interactions Between Benefits** (*Supports Stability*)

Only 22% of the overall low-income population had full-year employer-sponsored insurance. However, if they have employer-sponsored insurance offers, they are likely not eligible for the premium and cost-sharing subsidies in the Health Insurance Marketplace that other adults in this income group can access. Moreover, they may not qualify for Medicaid depending on their income and whether their state expanded Medicaid.<sup>334</sup> For workers whose employer only pays for the individual premium and not the family's, they can shop for coverage on the Marketplace. Still, their family members won't be eligible for tax credits to help pay the premium. When people are eligible for employer-sponsored coverage, they can only qualify for Marketplace premium tax credits if the employer-sponsored coverage is considered unaffordable. Coverage is considered unaffordable only if the cost for coverage for the worker under the employer plan is more than 9.83% of their income in 2021. The Marketplace does not consider the cost of adding their spouse and children to family coverage.<sup>335</sup>

**Medicaid**

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Performs Moderately Well	Needs Minor Improvement

**Dollar Value the Benefit Provides** *(Effective)*

Federal rules require state Medicaid programs to cover certain “mandatory” services, such as hospital and physician care, laboratory and X-ray services, home health services, and adult nursing facility services. Federal rules also require states provide a more comprehensive set of services, known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, for children under age 21. All states cover prescription drugs, and most cover other common optional benefits, including dental care, vision services, hearing aids, and personal care services for frail seniors and people with disabilities. About three-quarters of all Medicaid spending on services pay for acute-care services, such as hospital care, physician services, and prescription drugs, while the rest pays for nursing homes and other long-term care services and supports. Medicaid covers more than 60% of all nursing home residents and roughly 50% of costs for long-term care services and supports. States can impose copayments, coinsurance, deductibles, and other similar charges on most Medicaid-covered benefits, both inpatient and outpatient services. The amounts that can be charged vary with income. The individual state’s payment for a service is the basis for all associated out-of-pocket charges. Out-of-pocket costs cannot be imposed for emergency services, family planning services, pregnancy-related services, or preventive services for children.<sup>336</sup> Medicaid eligibility was associated with \$7.27 in average out-of-pocket costs per emergency department (ED) visit, compared with \$106.21 in Marketplace coverage. Marketplace coverage was also associated with ten-fold higher out-of-pocket costs for low-income enrollees than Medicaid. This finding is consistent with prior research that found that Marketplace enrollees are exposed to higher out-of-pocket costs and are at greater risk of extremely high spending even with significant federal subsidies.<sup>337</sup> There is ample evidence showing that Medicaid coverage helps people gain better access to healthcare services, leading to improved health and well-being. Researchers found that low-income adults in Arkansas, which has expanded Medicaid eligibility, have better access to primary care and preventive health services, improved medication compliance, and better self-reported health status than their counterparts in Texas, which has not expanded eligibility for the program. Other studies show Medicaid expansion is associated with increased cancer diagnosis rates, improved treatment for diabetes and other prevalent conditions, and better access to medications and services for people with behavioral and mental health problems.<sup>338</sup> Research has found a significant relationship between Medicaid expansion and financial well-being. The National Bureau of Economic Research found that expansions beginning in 2014 significantly reduced the number of unpaid medical bills and the amount of non-medical debt sent to third-party collection agencies for individuals living in zip codes most likely to be impacted by Medicaid expansions. The estimated effect of the reduction in unpaid collection balances was between \$600 and \$1,000. A study by the New England Journal of Medicine found that Medicaid coverage eliminated catastrophic expenditures (when out-of-pocket costs exceed 30% of income), and it significantly decreased beneficiaries having medical debt.<sup>339</sup>

**Benefit Delivery** *(Slightly Reduces)*

Private managed care plans cover most Medicaid beneficiaries. For others, state Medicaid programs pay hospitals, doctors, nursing homes, and other health care providers for covered services that they deliver to eligible patients. (Health care providers are not required to participate in Medicaid; not all do).<sup>340</sup> Because Medicaid covers particularly low-income and often very sick patients, providers cannot withhold services for failure to pay, but enrollees may be held liable for unpaid copayments. States have the option to establish alternative out-of-pocket costs. These charges may be targeted to certain groups of Medicaid enrollees with income above 100% of the federal poverty level. Alternative out-of-pocket costs may be higher than nominal charges depending on the type of service, and they are subject to a cap not exceeding 5% of family income. In addition, Medicaid enrollees may be denied services for nonpayment of alternative copayments.<sup>341</sup> Waiting periods for Medicaid ranged from 24 hours to over 45 days, with varying processing times across states. Among the 46 states that reported Medicaid Modified Adjusted Gross Income (MAGI), the basis for determining Medicaid income eligibility, and Children’s Health Insurance Program (CHIP) application processing time data to the Centers for Medicare and Medicaid Services for the February through April 2020 period, states conducted nearly 57% of MAGI determinations at applications in less than seven days.<sup>342</sup> Any increase in income or inheritance can affect a person’s eligibility for Medicaid, and beneficiaries must report changes and income and assets even if it is not time for renewal. Most states allow between 10 to 30 days to report such changes, and failure to do so can result in loss of Medicaid benefits, repayment of services for which Medicaid paid, fines, and even jail time.<sup>343</sup>

**Benefit Access and Use** *(Somewhat Exclusive)*

In 2018, Medicaid provided health coverage for 97 million low-income Americans over the year. In any given month, Medicaid served 32 million children, 28 million adults, six million seniors, and nine million people with disabilities.<sup>344</sup> To participate in Medicaid, federal law requires states to cover certain groups of individuals. Low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups.

States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community-based services and children in foster care who are not otherwise eligible. In addition, some eligibility groups are limited by age, pregnancy, or parenting status. Medicaid beneficiaries must generally be residents of the state where they are receiving Medicaid. They must be either a citizen of the United States or a certain qualified non-citizen, such as a lawful permanent resident.<sup>345</sup> Under the Affordable Care Act (ACA), eligibility for children was extended to at least 133% of the federal poverty level (FPL) plus a 5% income disregard in every state. States were given the option to extend eligibility to adults with income at or below 138% of the FPL (\$20,385 for an individual in 2022). Most states have chosen to expand coverage, and those that have not yet expanded may choose to do so at any time.<sup>346</sup> After the expansion of the ACA, the gap between Black and White adult uninsured rates dropped by 4.1 percentage points, while the difference between Hispanic adult and White adult uninsured rates fell 9.4 points. While Black working-age adults have benefited significantly from Medicaid expansion, they disproportionately (46%) reside in the 15 states that haven't yet expanded their programs.<sup>347</sup> Adults who fall into the coverage gap have incomes above their state's eligibility for Medicaid but below poverty, the minimum income eligibility for tax credits through the ACA marketplace. Eligibility for adults in states that did not expand their programs is limited. The median income limit for parents in these states is just 41% of poverty, or an annual income of \$8,905 for a family of three in 2020, and, in nearly all states not expanding, childless adults remain ineligible. In states that have adopted the ACA Medicaid expansion, nationally, more than two million poor, uninsured adults fall into the "coverage gap" resulting from state decisions not to expand coverage to families and individuals whose incomes fall at or below 138% of the FPL. These individuals would be eligible for Medicaid if their state expanded coverage. If states currently not expanding Medicaid coverage decide to expand, about 2.2 million adults in the coverage gap would gain Medicaid coverage, and an additional 1.8 million uninsured adults with incomes between 100 and 138% of poverty would also become eligible.<sup>348</sup> Take-up rates among eligible parents range from 50% in Texas to 96% in Massachusetts. Some states have instituted work requirements. States imposing work requirements saw reductions in people covered, with nearly 17,000 people in Arkansas losing coverage in just four months. In 2018, Tennessee dropped approximately 10% of Medicaid-enrolled children from the program via their mail-only recertification process. Mail-in forms often do not reach target populations, mostly because poorer families move frequently. Families that failed to complete the forty-seven-page form, returned it late, or made errors lost benefits. Of 319,000 forms mailed out, more than 200,000 were never returned and about 20,000 more were incomplete or late.<sup>349</sup> Through a Commonwealth Fund study of those who remain uninsured despite ACA expansions, researchers found that nearly half of those uninsured would be eligible for subsidized insurance through the Marketplace or their state's expanded Medicaid.<sup>350</sup> Additionally, studies show that physicians are significantly less likely to accept new patients covered by Medicaid than those covered by Medicare or private insurance.<sup>351</sup> Any increase in income or inheritance can affect a person's eligibility for Medicaid, and beneficiaries must report changes to income and assets even if it is not time for renewal. Most states allow between 10 to 30 days to report such changes, and failure to do so can result in loss of Medicaid benefits, repayment of services paid for by Medicaid, fines, and even jail time. Medicaid renewal for seniors and disabled individuals must occur once every year, and some states may choose to do redeterminations more frequently.<sup>352</sup>

### **Interactions Between Benefits** (*Supports Stability*)

The Supplemental Security Income (SSI) program provides automatic Medicaid enrollment for applicants upon SSI award in most states. Other states require applicants to file a separate Medicaid application. Some use the SSI eligibility criteria for both programs; others use Medicaid eligibility rules that are more restrictive.<sup>353</sup> Nearly 10 million low-income seniors and people with disabilities are enrolled in both Medicare and Medicaid.<sup>354</sup> "Dual eligible" or "dual enrollees" receive both Medicare and Medicaid. People enrolled in both Medicaid and Medicare may receive greater healthcare coverage and have lower out-of-pocket costs. For Medicare-covered expenses, such as medical expenses and hospitalization, Medicare is always the first payer (primary payer). If Medicare does not cover the full cost, Medicaid (the secondary payer) will cover the remaining cost, given they are Medicaid-covered expenses. Medicaid also covers some expenses that Medicare does not, such as personal care assistance in the home and community and long-term skilled nursing home care (Medicare limits nursing home care to 100 days).<sup>355</sup> Generally, a single Medicaid applicant who is 65 or older can keep up to \$2,000 in countable assets to qualify, but some states allow flexibility. For example, in New York, a Medicaid applicant who is blind, disabled, or over age 65 can have \$16,800 in liquid assets.<sup>356</sup> In California, the asset test elimination will be phased in, with the asset limit increased to \$130,000 for an individual in July 2022 and complete elimination in 2024. This increase in the asset limit will help with the prevention of benefits cliffs associated with Medicaid reciprocity.<sup>357</sup>

**Medicare**

<b>Benefit Performance Score for Supporting Workers Using It Today</b>	<b>Overall Benefit Performance Score for Supporting All Workers</b>
<b>Needs Minor Improvement</b>	<b>Performs Moderately Well</b>

**Dollar Value the Benefit Provides** *(Partially Effective)*

Medicare consists of four "parts": Part A pays for hospital care; Part B provides medical insurance for doctor's fees and other medical services; Part C is Medicare Advantage, which allows beneficiaries to enroll in private health plans to receive Part A and Part B Medicare benefits; Part D covers prescription drugs. Almost all seniors are automatically enrolled in Part A at no additional cost once they turn 65. Parts B, C, and D are voluntary and require enrollees to pay premiums to receive coverage. In 2019, Part A provided protection against hospital costs and specific other medical care to 60.9 million people (52.2 million aged and 8.7 million disabled enrollees).<sup>358</sup> Annual out-of-pocket costs average \$2,243 a year for Medicare beneficiaries who are dual-eligible for Medicaid and have incomes below 150% of poverty and three or more chronic conditions or impairments. Out-of-pocket costs rise to \$3,731 annually for Medicare beneficiaries who meet the same criteria but have no supplemental coverage. In 2020, traditional Medicare beneficiaries paid annual premiums of \$1,735 for Part B Medicare coverage. The hospital deductible is \$1,408 per hospital episode, and physician services are covered after a \$198 annual deductible is met. Beneficiaries then pay 20% in coinsurance for all covered charges (including the costs of surgeons and physician-administered drugs, such as cancer treatments). Beneficiaries also face, on average, \$476 a year for Medicare Part D prescription drug premiums. Even for outpatient prescription drugs, after reaching the out-of-pocket maximum of \$6,350 in 2020, beneficiaries remain on the hook for 5% of drug costs for the remainder of the year. Given Medicare's inadequate financial protection, 90% of Medicare beneficiaries have Medicare Advantage managed care plans or supplemental coverage through retiree health plans, Medi-gap private coverage, or Medicaid. The cost of Medicare Part B and Part D premiums as well as private supplemental coverage and out-of-pocket expenses consumes a large share of beneficiary incomes, particularly for those without Medicaid.<sup>359</sup> For dual-eligible enrollees who qualify for full Medicaid, that coverage picks up where Medicare leaves off, covering coinsurance and deductibles, as well as services not covered by Medicare (such as dental, vision, and long-term care). Thirty percent of Medicare beneficiaries receive employer or union-sponsored benefits that supplement Medicare. Nineteen percent of Medicare beneficiaries (six million) with traditional Medicare have no supplemental coverage (either from Medicaid, an employer-sponsored plan, or Medigap). Traditional Medicare does not pay for some important services for older people and people with disabilities, including long-term services and supports, dental services, eyeglasses, and hearing aids. Healthcare costs, in some cases, result in Medicare beneficiaries not receiving or delaying necessary care.<sup>360</sup> In 2018, one in 10 Medicare beneficiaries reported delaying care in the past year due to cost, up to 17% among low-income beneficiaries. Twelve percent of low-income beneficiaries reported that they sometimes or often did not get prescription medications due to cost. Not receiving necessary care also has been reported for services not covered by Medicare, with reports of financial barriers to care highest among low-income beneficiaries. One in 10 low-income Medicare beneficiaries reported not going to the dentist due to cost, while most of the spending on non-covered services was attributable to dental costs. Even for those with Medicare coverage, out-of-pocket costs for one in eight older adults who receive paid long-term services and supports can exceed \$250,000.<sup>361</sup>

**Benefit Delivery** *(Slightly Reduces)*

Medicare provides protection against the costs of many healthcare services, but traditional Medicare has relatively high deductibles and cost-sharing requirements and places no limit on beneficiaries' out-of-pocket spending for services covered under Parts A and B. Considering Medicare's benefit gaps, cost-sharing requirements, and lack of an annual out-of-pocket spending limit, most beneficiaries covered under traditional Medicare have additional insurance coverage through Medicaid, employer health insurance, long-term care insurance or medigap supplementary insurance.<sup>362</sup> Original Medicare covers most, but not all, costs for approved healthcare services and supplies. After meeting their deductible, individuals pay their share of costs for services and supplies as they are received. There's no limit on what is paid out-of-pocket in a year unless there is other coverage (like Medigap, Medicaid, or employee or union coverage). Services covered by Medicare must be medically necessary. If a recipient goes to a doctor or other health care provider that accepts the Medicare-approved amount, the share of costs may be less. If Medicare doesn't cover services received, full costs are paid by the recipient.<sup>363</sup> In general, there's no upper dollar limit on Medicare benefits. As long as medical services used are covered by Medicare—and if they're medically necessary—the benefit can be used as much as needed, regardless of cost, in any given year or over the rest of the beneficiary's lifetime.<sup>364</sup> Most services and equipment are considered medically necessary. Still, occasionally, Medicare beneficiaries may need equipment that needs to be approved as medically necessary by a doctor for Medicare to cover it. Examples include "excessive therapy," "excessive procedures" used to diagnose a condition, or "excessive hospital stays." Sometimes not every part of the equipment is covered. For example, although lift chairs are considered medically necessary for people with severe arthritis, only the contraption that helps the person get up or lay down is covered. There is a form needed to prove that something is medically necessary.<sup>365</sup> Under Medicare, the skilled nursing facility benefit is available if a recipient needs continued skilled nursing care after being in the hospital for at least three days, under certain conditions, but it comes with limits. Medicare pays the full cost for up to 20 days; from day 21 through day 100, recipients pay a share of the cost (\$152 a day in 2014); beyond 100 days, recipients pay the full cost.<sup>366</sup>

**Benefit Access and Use** (*Nearly Inclusive*)

When Americans become eligible for nearly universal Medicare coverage at age 65, there are substantial reductions in racial and ethnic disparities in health insurance coverage, access to care, and self-reported health. Entry to Medicare reduced disparities between White and Hispanic people by 29% for the share of people with previous physician care, 39% for the share of people unable to see a physician before because of cost, and 59% for flu vaccination rates.<sup>367</sup> In 2021, there were more than 62.7 million Medicare beneficiaries, and 26 million people are enrolled in a Medicare Advantage plan, accounting for 42% of the total Medicare population.<sup>368</sup> Certain people younger than age 65 can also qualify for Medicare, including those with disabilities and permanent kidney failure. Most people ages 65 and over are entitled to Medicare Part A if they or their spouse are eligible for Social Security payments and do not have to pay a premium for Part A if they paid payroll taxes for 10 or more years. People under age 65 who receive Social Security Disability Insurance (SSDI) payments generally become eligible for Medicare after a two-year waiting period. In contrast, those diagnosed with end-stage renal disease (ESRD) and amyotrophic lateral sclerosis (ALS) become eligible for Medicare with no waiting period.<sup>369</sup> For those eligible at age 65, the initial enrollment period begins three months before their 65th birthday and ends three months after that birthday. A beneficiary that chooses not to enroll in Medicare Part B and then decides to do so later may have delayed coverage and pay a higher monthly premium for as long as they have Part B, although Plan B is optional. Their monthly premium goes up 10% for each 12-month period they were eligible for Part B but didn't sign up for it unless they qualify for a "Special Enrollment Period" (SEP). According to the SSA, it takes less than 10 minutes, and there are no forms to sign and, usually, no documentation is required to apply online for just Medicare.<sup>370</sup> Individuals already receiving Social Security or RRB benefits at least four months before being eligible for Medicare and residing in the United States (except residents of Puerto Rico) are automatically enrolled in both premium-free Part A and Part B. Individuals not receiving a Social Security or RRB benefit are not automatically enrolled. These individuals must apply by contacting Social Security.<sup>371</sup> Beneficiaries must purchase Medicare Part D to help cover the cost of prescription drugs (including many recommended shots or vaccines). To get Medicare drug coverage, you must join a Medicare-approved plan that offers drug coverage. Each plan can vary in cost and specific drugs covered but must give at least a standard level of coverage set by Medicare. Plans can vary the list of prescription drugs they cover (called a formulary) and how they place drugs into different "tiers" on their formularies. Plans have different monthly premiums and how much is paid depends on recipients' election to a plan.<sup>372</sup>

**Interactions Between Benefits** (*Enhances Stability*)

When an individual has Medicare and additional health insurance (like from an employer), one will pay first (called a "primary payer") and the other second (called a "secondary payer"). If an individual has another insurance, who pays first depends on multiple items, like if the individual is still working, the type of insurance, and if they have a special situation, like End-Stage Renal Disease (ESRD). If the individual has a group health plan coverage through an employer with 20 or more employees, the group health plan pays first, and Medicare pays second. If the individual has group health plan coverage through an employer with less than 20 employees, Medicare pays first, and the group health plan pays second.<sup>373</sup> Nearly 10 million low-income seniors and people with disabilities are enrolled in both Medicare and Medicaid.<sup>374</sup> "Dual eligible" or "dual enrollees" receive both Medicare and Medicaid. Persons enrolled in both Medicaid and Medicare may receive greater healthcare coverage and lower out-of-pocket costs. Medicare is always the first payer (primary payer) for Medicare-covered expenses, such as medical and hospitalization. If Medicare does not cover the full cost, Medicaid (the secondary payer) will cover the remaining cost, given they are Medicaid-covered expenses. Medicaid also covers some expenses that Medicare does not, such as personal care assistance in the home and community and long-term skilled nursing home care Medicare limits nursing home care to 100 days).<sup>375</sup> SNAP participation was also linked to lower overall health care expenditures and Medicaid/Medicare costs.<sup>376</sup> People who are already collecting Social Security retirement benefits are automatically enrolled into Part A and Part B of Medicare when they're first eligible.<sup>377</sup>



## Employer-Sponsored Defined Contribution Plan

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Needs Minor Improvement	Needs Significant Improvement

### Dollar Value the Benefit Provides (*Partially Effective*)

A 401(k) Plan is a defined contribution plan that is a cash or deferred arrangement. Employees can elect to defer receiving a portion of their salary, which is instead contributed on their behalf, before taxes, to the 401(k) plan. Sometimes, the employer may match these contributions. There is a dollar limit on the amount an employee may elect to defer each year. An employer must advise employees of any limits that may apply. Employees who participate in 401(k) plans assume responsibility for their retirement income by contributing part of their salary and, in many instances, by directing their own investments. The employee, the employer, or both contribute to the employee's individual account under the plan. These contributions generally are invested on the employee's behalf. The employee will ultimately receive the balance in their account, which is based on contributions plus or minus investment gains or losses. The account's value will fluctuate due to the changes in the value of the investments.<sup>378</sup> If you contribute a dollar, your employer may add a portion of a dollar in return, up to a certain percentage of your salary (usually 3% to 6%, though these percentages may vary). Each plan determines what your employer matches and is typically a dollar-for-dollar amount up to a certain percentage. For example, if your annual salary is \$50,000 and you send 5% of your check to your retirement account, you'd have \$2,500 saved. If your employer matches your contributions up to 5%, you'd have an additional \$2,500 for a total of \$5,000 per year. Some employers offer a partial match that isn't dollar-for-dollar or a lower percentage after a certain threshold.<sup>379</sup> Fifty-one percent of employers with a defined contribution plan match into the plan with a median match of 3% of a worker's salary. Sixty-nine percent of defined contribution plans offered automatic escalation in 2019, which increases the percentage of pay employees save over time.<sup>380</sup> Employee 401(k) contributions for 2022 will top off at \$20,500—a \$1,000 increase from the \$19,500 cap for 2021 and 2020. Participants aged 50 or older can contribute an additional \$6,500, unchanged from 2021. Retirement plan contribution limits are adjusted for inflation. The limit on total employer-plus-employee contributions to defined contribution plans will increase to \$61,000 in 2022, up by \$3,000 from \$58,000 in 2021.<sup>381</sup> The median working age family had, on average, only \$7,800 saved in 401(k) and IRA accounts, and the 90<sup>th</sup> percentile families had \$320,000 saved in 2016. The mean savings for all families is \$120,809, reflecting the inequality of savings where the large account balances of families with the most savings drive up the average for all families.<sup>382</sup>

### Benefit Delivery (*Slightly Reduces*)

Defined contribution retirement plans allow workers to rollover their retirement savings when they transition out of a job; however, there are limitations to the portability of these benefits with burdens on recipients, including potential rollover-related expenses and leakages. In 2010, pre-retirement withdrawals from 401(k)s and IRAs reduced retirement assets by at least \$82.4 billion, effectively offsetting 24.4% of all contributions to such accounts that year. Policies limiting or prohibiting certain types of leakage could reduce its negative impact on retirement assets. However, they might also induce workers to save less in 401(k)s or IRAs or to shift their savings to other types of assets.<sup>383</sup> Leakages come from three sources: cash-outs when participants change jobs; hardship withdrawals; and the failure to repay loans. The government has attempted to discourage leakages by generally imposing a 10% penalty, in addition to regular income taxes, on withdrawals before age 59.5. Employers must also withhold 20% of any distributions paid directly to recipients. Nevertheless, considerable money still leaks out.<sup>384</sup> The need to rollover funds at job transition can lead to significant burdens on workers, with funds left behind (one in four workers leaving jobs in 2019 left an average of \$1,710 in savings)<sup>385</sup> and cash out leakages (89% a result of job transitions)<sup>386</sup>. Upon retirement age, the account balance becomes available to the employee for retirement income. Savings set aside for retirement generally may not be withdrawn before retirement without paying a tax penalty, except in limited circumstances, such as paying for college, first-time homebuyer expenses, or unexpected personal hardships.<sup>387</sup>

### Benefit Access and Use (*Significantly Exclusive*)

According to 2021 BLS data, 61% of civilian workers had access to defined contributions with 71% take up, for a participation rate of 43%. Only 37% of workers in the service sector had access, with 54% taking it up. Sixty-nine percent of full-time workers had access, with 74% taking it up versus 36% of part-time workers had access and 47% of these workers taking it up. For workers with wages in the bottom 10%, 31% had access, with 44% taking it up, while 81% of workers with wages in the top 10% had access, with 84% taking it up. Forty-one percent of workers in the lowest quartile wage category had access, with 52% taking it up, while 75% of workers in the highest quartile wage category had access, with 81% taking it up.<sup>388</sup> According to a 2019 Deloitte survey, 69% of plan sponsors include an automatic enrollment feature, with 3% or 6% being the most common default deferral percentages. A plan can also accept rollover contributions from other qualified retirement plans or IRAs. Employers may require an employee eligible to participate in the plan to complete a year of service before becoming eligible to receive employer contributions, even if the employee becomes eligible to make employee contributions at an earlier date. Starting in 2021, plans need to consider long-term and part-time employees for eligibility, vesting, and company contribution purposes. They also need to meet age requirements (generally age 21 for participation and age 18 for vesting). The first year any long-term, part-time employee will be required to be eligible for the 401(k) Plan is 2024.<sup>389</sup>

According to a 2021 Vanguard study of 4.7 million DC plan participants, 58% of plans in the study offered immediate eligibility in 2011; in 2020, 70% did. Because larger plans are more likely to offer immediate eligibility for employee-elective contributions, 77% of participants in 2020 were in plans offering immediate eligibility. Similar trends are observed for both employers matching contributions and other employer contributions. Plans with automatic enrollment had a 92% participation rate compared to a 62% participation for plans with voluntary enrollment. While 95% of employees with an income of more than \$150,000 contributed to their employer's DC plan in 2020, 37% of eligible employees with an income of less than \$15,000 contributed. Participation rates were lowest for employees younger than 25. Only one-half of those employees made employee-elective deferrals to their employer's plan in 2020, while more than eight in 10 eligible employees between ages 35 and 64 made such deferrals. Tenure also had a considerable influence on plan participation. Sixty-five percent of eligible employees with less than two years on the job participated in their employer's plan, while more than eight in 10 employees with four or more years of tenure participated. Women are more likely than men at all income levels to join their employer's plan.<sup>390</sup>

#### **Interactions Between Benefits** (*Supports Stability*)

For Social Security recipients who have not reached full retirement age, account pensions, retirement-account distributions, annuities, or the interest and dividends from an individual's savings and investments are not included as earned income for the annual earned income limit. Contributions to an individual's IRA or 401(k) cannot be deducted from income for purposes of the earnings test. Social Security uses an individual's gross income before tax-deferred allotments to determine earnings. Income from all sources goes into determining whether and what portion of Social Security benefits are taxable.<sup>391</sup> SNAP eligibility excludes many retirement accounts, including defined benefit plans, from being considered towards an applicant's resources.<sup>392</sup> However, at retirement, the payments can count as income for means-tested public assistance programs, including Medicaid and SNAP.

## Employer-Sponsored Defined Benefit Plan

Benefit Performance Score for Supporting Workers Using It Today	Overall Benefit Performance Score for Supporting All Workers
Performs Well	Needs Moderate Improvement

### Dollar Value the Benefit Provides (*Effective*)

Defined benefit plans can be a major source of retirement income. When combined with Social Security, they're generally designed to replace a certain percentage (e.g., 70%) of your pre-retirement income. Benefits do not hinge on the performance of underlying investments, so you know how much you can expect to receive at retirement ahead of time. Most benefits are insured up to a certain annual maximum by the federal government through the Pension Benefit Guaranty Corporation (PBGC). A formula provides the basis for retirement benefits under a defined plan. This formula can provide for a fixed dollar amount for each year you work for the employer, or it can provide for a specified percentage of earnings. Many plans calculate an employee's retirement benefit by averaging the employee's earnings during the last few years of employment (or averaging an employee's earnings for their entire career), taking a specified percentage of the average, and then multiplying it by the employee's number of years of service. Like other qualified plans, they offer tax incentives both to employers and to participating employees.<sup>393</sup> These plans provide a guaranteed benefit, typically paid in the form of a life annuity, based on a predetermined formula generally calculated by age at retirement, years of service, and final compensation. The employer generally makes most contributions; sometimes, employee contributions are required, or voluntary contributions may be permitted.<sup>394</sup>

### Benefit Delivery (*Reinforces*)

Many defined benefit plans allow recipients to choose how they want their benefits to be paid. Payment options commonly offered include: a single life annuity, with a fixed monthly benefit until they die, and no further payments made to their survivors; a qualified joint and survivor annuity, with a fixed monthly benefit until they die and continued benefits to their surviving spouse in an amount equal to at least 50% of benefit until their death; a lump sum payment, with the entire value of their plan in a lump sum and no further payments to them or their survivors.<sup>395</sup> Benefit payments are typically paid in the form of lifetime monthly payments. Taxes are paid on lump sum payout, and the benefit is generally treated as ordinary income for the years received (rollovers don't count). For this reason, employers must withhold 20% of the payout if an employee chooses to receive a lump sum payout instead of a monthly benefit upon retirement. In addition to paying income tax, employees will owe an additional 10% penalty tax if the employee takes the lump sum payout before age 59.5. Typically, the payment can be through direct deposit to checking or savings account, or check.<sup>396</sup>

### Benefit Access and Use (*Significantly Exclusive*)

According to 2021 BLS data, 25% of all civilian workers have access to defined benefit plans with a take-up rate of 80%, so a 20% participation rate.<sup>397</sup> Seventy-nine percent of union workers have access compared to 17% of nonunion workers. Thirty percent of full-time workers have access, and 10% of part-time workers have access. For workers with wages in the bottom 10%, 4% had access, with 76% taking it up, while 44% of workers with wages in the top 10% had access, with 77% taking it up. While 8% of workers in the lowest quartile wage category had access, with 75% taking it up, 46% of workers in the highest quartile wage category had access, with 81% taking it up.<sup>398</sup> The plan provides a predictable benefit, and the benefits are not dependent on asset returns.<sup>399</sup> DB plans are disappearing from the private sector as workers are much more likely to be covered by defined contribution plans. A worker must work for an employer that provides a DB plan to be covered by one.<sup>400</sup>

### Interactions Between Benefits (*Supports Stability*)

If the pension is from an employer that withheld FICA taxes from an individual's paychecks, as almost all do, it won't affect the individual's Social Security retirement benefits. However, if there is no withholding, the worker may be subject to the Windfall Elimination Provision. This provision covers people who earned pensions from "non-covered" jobs—typically federal, state, and local government workers hired before 1984—but also qualify for Social Security through other types of work. For these workers, Social Security uses a modified formula to calculate the full retirement age amount, which results in a lower Social Security benefit. However, the benefit is never reduced to \$0. The provision affects about 1.9 million Social Security beneficiaries. Separately, a Government Pension Offset (GPO) affects spouses, widows, and widowers who collect spousal or survivor benefits from Social Security and receive pensions from federal, state, or local government jobs that did not withhold Social Security taxes. Their benefits are reduced by two-thirds of their government pension and can be eliminated entirely if that two-thirds exceeds the Social Security payment. Pension income does not count against the Social Security earnings limit, regardless of the pension's source.<sup>401</sup> SNAP eligibility excludes many retirement accounts, including defined benefit plans, from being considered towards an applicant's resources.<sup>402</sup> However, at retirement, the payments can count as income for means-tested public assistance programs, including Medicaid and SNAP.

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