SIC 9441

ADMINISTRATION OF SOCIAL, HUMAN RESOURCE, AND INCOME MAINTENANCE PROGRAMS

This category covers government agencies engaged in assistance to the elderly, child welfare, aid to families with dependent children, aid to the blind and disabled, medical assistance, human resource development, and related activities. The actual operations of the programs are classified in various social services industries, but both the administration and operation of Social Security, disability benefits under OASDI, disability insurance, Medicare, unemployment insurance, worker's compensation, and other social insurance programs for the aged, survivors, or disabled persons are classified under this industry. The offices that administer veterans' programs are classified in **SIC 9451: Administration of Veterans' Affairs, Except Health Insurance.** Local employment service offices are classified in Services under **SIC 7361: Employment Agencies.**

NAICS CODE(S)

923130 (Administration of Social, Human Resources and Income Maintenance Programs)

INDUSTRY SNAPSHOT

Federal activities directed toward the social welfare of Americans are overseen by divisions within the U.S. Department of Health and Human Services (HHS). It was created in 1953 as the Department of Health, Education, and Welfare (HEW). Following the Department of Education Organization Act, the Administration for Children and Families (ACF) is considered the largest (in terms of government-originated spending) and most expensive under HHS's umbrella. In 2003 this agency was expected to spend approximately $47 billion on programs and agency overhead. Approximately 2.2 million families received aid to families with dependent children (AFDC) payments in 1970, but two decades later that number had grown to 4.1 million families. In 1997, new welfare reform legislation was implemented, replacing the AFDC with Temporary Assistance to Needy Families (TANF), a state-federal program. After peaking at 5 million in 1994, the number of families receiving government assistance gradually declined into the early 2000s, reaching 2.1 million in 2001.

In August 1997 The Children's Health Insurance Program (CHIP) was enacted as Title XXI to the Social Security Act to expand health insurance coverage for low-income children. By the early 2000s, HHS was taking steps to modernize CHIP in a number of different ways, along with welfare, Medicare, and Medicaid. In its fiscal year 2004 budget the agency requested $400 million for this purpose, which would be used over the course of the following decade.

ORGANIZATION AND STRUCTURE

Social Security Administration. The National Old-Age, Survivors, and Disability Insurance (OASDI) program, commonly called Social Security, is the largest federal income maintenance program. The benefits, administered by the Social Security Administration (SSA), are for retired workers (Social Security Act of 1935), disabled workers (1956 amendment), and their dependents and survivors (1939 amendment). Compulsory tax withholdings from employees, employers, and the self-employed are put in the OASI and DI trust funds to be used for retirement, death or disability benefits, benefits for survivors, vocational rehabilitation, and administrative expenses.

Also administered by the SSA is the Supplemental Security Income program (SSI). Established in 1972, SSI replaced Old-Age Assistance (OAA), Aid to the Blind (AB), and Aid to the Permanently and Totally Disabled (APTD). The program was intended for people without any other source of income.

Centers for Medicare & Medicaid Services. In the early 2000s, some 77 million Americans were beneficiaries of Medicare and Medicaid programs administered by the Centers for Medicare & Medicaid Services (CMS). The CMS, formerly known as the Health Care Financing Administration (HCFA), was renamed on June 14, 2001. Medicare recipients are the aged and disabled. Medicare consists of two programs: hospital insurance (HI) and supplementary medical insurance (SMI). Medicaid is for persons of limited means and is administered by the states.

Other Departments and Programs. The Office for Civil Rights within the Department of Health and Human Services is also responsible for the administration and enforcement of laws (e.g., the Americans with Disabilities Act of 1990 or the provisions of the Equal Employment Opportunity Acts) prohibiting discrimination in federally assisted health and human services programs.

Unemployment insurance, a federal and state program, provides benefits for the involuntarily unemployed. Worker's compensation, mainly administered by the states, is for insured injured workers. Other work-related programs, such as Black Lung, are administered by the U.S. Department of Labor.

BACKGROUND AND DEVELOPMENT

The concept of social welfare has existed in some form or another throughout much of history. Some 4,000 years ago, Babylonian ruler Hammurabi was among the first in government to voice concern for protecting the needy. Ancient Greek and Roman philosophers, too, sup-

ported the concept of society helping those in need, and grounds for assistance of the poor are found in a number of religious traditions, including Judaism and Christianity.

America's Social Welfare Roots. In the European Middle Ages (476 to 1453) Christian monasteries served the needy. Their hospitals provided a broad range of services for the ill, homeless, aged, orphans, and even travelers. They were, of course, far removed from the acute care institutions of modern America. Under the laws of the day, the medieval church was responsible for public welfare and could collect taxes to support its activities.

Medieval life was characterized by feudalism, and under this system most people were assured of at least minimal assistance for life. In the cities, those in need received some assistance from social, craft, and merchant guilds. Social stability, limited mobility, and a sense of obligation to the poor and needy of the community were essential to the social welfare activities of the Middle Ages. But eventually a series of upheavals resulted in a breakdown of this basic social welfare system. These included the bubonic plague (1348 to 1349), which killed nearly one-third of the English population, and several other natural disasters. With the decline of the Church of England, which had been largely responsible for social welfare, a new system was needed.

In response the English government in the mid-fourteenth century began placing restrictions on the poor and unemployed, as well as taking some responsibility for organizing voluntary assistance. These early English laws regarding the needy included: restrictions on begging and later laws against it (with death as one possible consequence to repeat offenders), involuntary apprenticeships for the children of the poor, and taxes and assessments to help provide for the needy and the poor. Such laws were drawn together under the Elizabethan Poor Law of 1601. It was this law that became the basis for early social welfare laws in America.

Problems of the Old World arrived in the New World in spite of an abundance of land and opportunity. The needs of the poor, the aged, the sick, and others were at first taken care of by the individual colonies, but as towns grew so did needs, and the colonists turned to the English Poor Law for guidance. Another strong influence was the Puritan value and belief system regarding poverty—the poor were considered inferior but part of God's order and were to be assisted by the people higher up on God's natural hierarchy. Some colonies made decisions regarding the poor in town meetings. One application of aid was to place a needy person in a private home for a fee. Other colonies gave tax relief directly to the poor or to physicians aiding the poor.

In general, communities took care of their own but showed resistance to assisting a growing number of strangers or newcomers. Some colonies, such as early seventeenth-century Boston, passed laws allowing for forced removal of unemployed strangers, and the Plymouth Colony passed a residency statute regarding public assistance. Registering, bonding, fines, and whippings were other methods New England colonies used to deal with nonresidents they feared would become dependent on or destructive to the community.

Yet by the late 1700s, just prior to the American Revolution, certain colonies were spending as much as 35 percent of municipal funds on urban poverty. Urban problems had been exacerbated by war refugees and disabled soldiers from the French and Indian War in Canada, illegitimate children (up to one-half of all births during the Revolutionary period), widows of seafaring workers, and people affected by economic depressions, fires, and epidemics.

Religious, ethnic, and fraternal groups, as well as wealthy philanthropists, played major roles in assisting the poor: it was a period of cooperation between the public and private sectors, influenced by the humanitarian tenets of the Great Awakening (an evangelistic religious movement that occurred around 1740) and the Enlightenment (a philosophical movement that generally took place in Europe and elsewhere from 1700 to about 1789, or the beginning of the French Revolution). But the tradition of local assistance was widely disrupted following the American Revolution. Immigrants came in huge numbers. Also, industrialization, the spread of wage labor, and the growth of urban areas resulted in increased burdens on local governments.

In addition, broader social and economic changes in the Western world were transforming the traditional view of poverty. Classical economists of the eighteenth century supported the concept of an unregulated economy and saw social welfare programs as interfering with a natural economic process. In England, the Poor Law of 1601 was revised to reflect these new views. The law that had upheld the belief that the needy should be assisted came to an end after nearly 250 years. The new view was that poverty was a moral, not a social, problem. Such factors of the work environment as low wages, depressed industries, limited opportunity, and seasonal and technological unemployment were dismissed as barriers to individual achievement. Communities became reluctant to assist the needy and larger county- and state-run institutions were formed to take care of the problem. In 1824 the New York legislature passed the County Poor House Act and thus marked a shift from the towns to the counties as social-service providers. During the same period mental hospitals, prisons, and orphanages also were being established.

Another shift in American attitudes toward social welfare came during the Civil War. The needy benefited from the general understanding that in war, circumstances were

beyond the control of the individual. Significantly, the first national public-health group was formed and mainly operated by women. The United States Sanitary Commission organized local voluntary organizations to provide health education programs for soldiers. For the first time, the federal government was seen as the coordinator of social welfare needs that were universal in nature.

Problems that the United States faced prior to the war, such as those created by industrialization and urbanization, had to be contended with following the war; in addition, the nation was faced with the urgent needs of ex-slaves. The Congress created the first federal welfare agency, the Bureau of Refugees, Freedmen, and Abandoned Lands in the U.S. Department of War, to help during the transition from slavery to freedom. In existence from 1865 to 1872, the Bureau distributed food and assisted with employment, educational costs, and medical care. The federal government would not get as deeply involved in social welfare again until almost 100 years later. The nation continued to depend on voluntary organizations and local, county, and state governments for social welfare services.

Mothers' Pensions. Mothers' (or widows') pensions were early twentieth-century programs to assist single or widowed women with children. These programs marked yet another turning point in the debate between the deserving and the undeserving poor. The programs set some precedents for America's social welfare policy-to-come by keeping children with their mothers and keeping mothers at home rather than in the workplace.

The Birth of Social Security. In March 1933 Franklin Delano Roosevelt assumed the presidency and, with it, the daunting task of bringing the nation out of the Great Depression. Within his first hundred days in office he oversaw the passage of much of his New Deal program. But it was not until 1935 that the Social Security Act was passed. In its original form, this law established unemployment relief and old-age assistance, or social insurance, for American workers and designated that monthly benefits begin in 1940. The system was designed to return at least as much in benefits as an individual worker had paid in to the government. However, a 1939 amendment to the act weakened this commitment by instituting a formula in which benefits received would be based on average earnings during a confined period. The act also extended benefits to survivors and dependents, as well as the retired. In essence, Social Security was made to benefit a large cross-section of the population at the expense of its original intent.

In 1972 Congress added an automatic cost-of-living index to Social Security, so that benefits would rise accordingly. However, due to an error in the indexing plan, benefits began to rise faster than earnings. Despite 1977 legislation designed to correct the error, the Social Security fund continued to experience problems, largely due to high inflation and unemployment. Further legislation was introduced in 1983 to ensure OASDI's long-term health by, among other things, requiring a rise in the retirement age from 65 to 67, to take place between the years 2003 and 2027.

With the majority of American workers still under 45 years of age and years away from retirement, public sentiment during the early 1990s was toward changing Social Security policy to deal with the staggering financial burden. Changes suggested included: increasing retirement age to 72 years of age to delay payments; elimination of income limits on retirees in order to increase tax revenue; and the termination of surplus Social Security funds held in Treasury bills that are costly to redeem. Other changes suggested included separating out low-income old-age benefits from benefits related to contributions to the Social Security system. The federal Social Security retirement fund solvency was guaranteed until 2010 by 1983 congressional amendments, but the program's future beyond that date was considered uncertain.

With unemployment rates dropping in 1999 to the lowest levels since the 1970s (approximately 4 percent), America's attention shifted from welfare programs to retirement benefits. The Social Security Solvency Act of 1998, a contentious piece of legislation, never made it through in its proposed form. Notwithstanding, by 1999 the use of an estimated $2.5 trillion Social Security surplus was hotly debated in Congress, resolved by a joint measure (referred to as the ''lockbox'' bill) to secure the trust fund from congressional meandering. Beginning in October 1999, the SSA began providing annual updates to the nation's employed, age 25 and older, timed to arrive three months before an annual birthday. The statements, at a cost of $75 million annually, show current personal balances in each individual's account and project estimated retirement benefits. For those born after 1970, there will be a gradual increase in age requirement before full retirement benefits may be withdrawn: from 65 to 67. This measure was expected to affect 96 percent of the employed population in 2000.

Because of the extreme 1998-99 bull market in stocks, the ''privatization'' of Social Security accounts gained much attention—and political exposure. Two schools of thought emerged: one giving the federal government the authority to invest Social Security funds into speculative growth funds, and another allowing individuals to direct the destiny of their own funds, equal to an amount currently deducted from their paychecks. Negative consequences attach to both alternatives, so the twentieth century ended without any major changes to policy.

By 1999 all 50 states and the District of Columbia had complied with CHIP's requirement to develop plans

for children's health insurance. Some 18 states chose to implement this under Medicaid, whereas 17 states developed programs independent of Medicaid. By the year 2007, nearly $40 billion was expected to be earmarked for this program.

Another critical issue in 1999 was Medicaid reimbursements to nursing homes, affecting 70 percent of nursing-home residents in the country. Average reimbursement rates in 1998 varied from $329 per day in Alaska down to just $62 per day in Nebraska. The disparity was the result of the Balanced Budget Act of 1997, giving block grants to states to control their own Medicaid costs. On the agenda were plans for legislators to tie reimbursement funds to quality of care received.

CURRENT CONDITIONS.

By the early 2000s, debates about privatizing Social Security continued to rage on. A number of different proposals were on the table concerning how private investment accounts could be used as part of the program. Some of these plans called for the devotion of 33 percent of individual tax payments to private stock accounts, which many argued would exacerbate an already growing federal deficit to the tune of $200 billion per year. Other plans, such as one proposed by Representative E. Clay Shaw (R-Florida), relied on government-funded accounts that could be used in conjunction with benefits to which a person was entitled. However, no easy answers existed to the dilemma, and many political analysts stressed that no real developments would likely occur until the conclusion of the 2004 presidential election.

In March of 2003, the Social Security Board of Trustees issued an annual report to Congress explaining that the long-term outlook for the Social Security program remained bleak. Costs were expected to exceed tax revenues in 2018, at which point gaps would be made up from monies in the Social Security Trust Fund. The report projected that the trust fund would be depleted by 2042 and that the fund ''would require another $3.5 trillion in today's dollars, earning interest at Treasury rates, to pay all scheduled benefits over the next 75 years.'' This amount was about $200 billion higher than the figure cited in 2002's report.

After the report was issued, Social Security Commissioner Jo Anne Barnhart called it ''yet another reminder of what we have known for some time: Social Security's long-term financing problems are very serious, and will not be fixed by wishful thinking alone.'' President George W. Bush, who strongly advocated privatizing the Social Security system, stressed that it was yet another reason to provide working people with a greater degree of choice, control, and ownership in the plan.

The report to Congress also contained bad news for the future of Medicare. According to the report, the Medicare program was expected to lose its solvency in 2026. This date was sooner than previously expected; 2002's report projected the program would lose solvency in 2030. The *Boston Globe* cited comments from trustees about rising inpatient hospital costs, as well as lower projected tax revenues marked for Medicare, as reasons for the adjusted date. President Bush also touted the private sector as a solution to the Medicare dilemma, arguing that competition would serve to reduce costs. Bush's plan involved private ''preferred provider plans,'' which supporters claimed would lower costs by slowing down the rate of Medicare growth via heightened competition. However, studies conducted by the private Center for Studying Health System Change and the nonpartisan Medicare Payment Advisory Commission presented figures showing that such plans have the potential to increase costs instead of resulting in desired savings.

One proposal on the table in April of 2003 involved the addition of prescription drug coverage for senior citizens willing to switch from traditional Medicare to a Medicare HMO. However, this drew opposition from all political sides. The *Boston Globe* dubbed a subsequent proposal, introduced in May 2003, as a ''poorly disguised variation'' of the first plan, in which senior citizens with traditional Medicare would get drug benefits only after paying deductibles ranging from $4,500 to $7,500. In the meantime, premiums for supplemental Medicare HMOs, which participants used to cover costs not paid for by Medicare (including prescription drugs), continued to increase, while benefits offered declined. In addition, many insurance companies began to drop these increasingly unprofitable plans from their portfolios. Although no one solution appeared to be a ''silver bullet'' for the challenges facing Social Security and Medicare in the early 2000s, one thing was clear: the price for inaction was too costly. Thus, as the nation moved toward the mid-2000s, it appeared that substantial developments of some kind were inevitable.

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SIC 9451

ADMINISTRATION OF VETERANS AFFAIRS, EXCEPT HEALTH AND INSURANCE

This category includes government establishments primarily engaged in administration of programs of assistance, training, counseling, and other services to veterans and their dependents, heirs, or survivors. Also included are offices that maintain liaison and coordinate activities with other service organizations and governmental agencies. Veterans hospitals are classified in Hospitals categories, and veterans' insurance in the Insurance Carriers industries.

NAICS CODE(S)

923140 (Administration of Veteran's Affairs)

INDUSTRY SNAPSHOT

In 2002, there were an estimated 25 million veterans in the United States, most of whom served during periods of armed conflict. More than 70 million Americans, including veterans and their dependents, were potentially eligible for veterans benefits provided by the U.S. government, representing approximately one-third of the nation's population.

Veterans' benefits were administered by the Department of Veterans Affairs, second in size only to the Department of Defense among government departments. In 2004, the Department of Veterans Affairs had a budget of approximately $63.6 billion. About $30.2 billion of the department's budget went to discretionary funding and $33.4 billion to entitlements. Department-wide employment was about 203,000 in 2000, down from 266,000 in 1993.

ORGANIZATION AND STRUCTURE

The U.S. Department of Veterans Affairs is organized into three functional agencies: the Veterans Health Administration (VHA), the Veterans Benefits Administration, and the National Cemetery System. The VHA operates the largest health care system in the nation, including 173 medical centers, 133 nursing homes, 40 domiciliary care units, and 398 outpatient clinics. An estimated 3.6 million veterans received medical treatment in 1999. Combat veterans also received counseling at more than 200 Vietnam Veteran Outreach Centers for a variety of problems, including posttraumatic stress disorder. The budget for medical programs in 1999 accounted for more than 40 percent of the total budget.

The Veterans Benefits Administration is responsible for most nonmedical benefit programs, including disability compensation, pensions, burial benefits, rehabilitation assistance, home loan guarantees, and insurance. These entitlement programs amounted to $20.1 billion in 1999, when the agency processed approximately 3.5 million claims by veterans seeking disability compensation or pensions. Another 631,640 widows, children, or parents of deceased veterans were receiving survivor benefits. In addition, more than 370,000 veterans or their dependents were receiving educational benefits, and about 343,954 veterans had received home loan guarantees for new mortgages, as well as refinancing. Since the GI Bill of Rights was passed in 1944, the government has guaranteed home loans for more than 15 million veterans and their dependents. About 20.7 million veterans and dependents have attended college or received job training. The Veterans Benefits Administration also administers the fourth largest insurance program in the United States, with 2.2 million policyholders.

The National Cemetery System consists of 114 cemeteries and 34 memorials and monuments to veterans of the nation's wars. More than 2 million veterans and family members are buried in these national cemeteries, which occupy more than 5,000 developed acres. The U.S. Department of Veterans Affairs also provides headstones and markers for veterans' graves in private cemeteries. In