

monthly cash benefits to coal miners who are totally disabled by pneumoconiosis (black lung) contracted as a result of employment in and around the Nation's coal mines. Benefits are payable to a worker's dependents or to the survivors of a worker who has died as a result of this disease. A coal miner is considered to be totally disabled if unable to engage in comparable and gainful work by reason of pneumoconiosis that has lasted or can be expected to last for 12 months or to result in death.

The Social Security Administration (SSA) generally exercises jurisdiction over all black lung claims filed by miners from enactment of the law through June 1973 and, therefore, pays monthly benefits to a declining number of people. The Department of Labor (DOL) has primary responsibility for all claims filed after June 1973. Although the DOL makes the disability determinations, the SSA field offices accept black lung applications for the DOL on a reimbursable basis.

Black Lung (Part B) Program Data, 1996

- The total number of beneficiaries: 131,100. The beneficiaries included 21,500 miners, 85,600 widows, and 24,100 dependents.
- Total annual payments: \$654.6 million.
- Average monthly benefits for miners were \$663.80, and \$448.50 for widows.
- 96% of miners and widows were over 64 years old.
- 72% of all beneficiaries resided in five States: Pennsylvania, West Virginia, Kentucky, Virginia, and Ohio.

Temporary Disability Insurance

Temporary disability insurance, sometimes referred to as cash sickness benefits, provides workers with partial compensation for loss of wages caused by temporary nonoccupational disability. Only five States, Puerto Rico, and the railroad industry have temporary disability insurance laws.

It was during the severe depression of the thirties that the United States began its national social insurance programs of unemployment insurance and old-age insurance. Consequently, providing protection against costs of sickness that are more or less recurring regardless of economic conditions did not seem to have the same urgency as providing protection against cyclical unemployment and old-age dependency. The Federal law provided no basis for a system of compensation for wage loss due to short-term sickness or disability that was comparable to the Federal-State system of unemployment insurance.

The first State temporary disability insurance or cash sickness insurance law was enacted by Rhode Island in 1942, followed by legislation in California in 1946, New Jersey in 1948, and New York

in 1949. Then came a hiatus of two decades before Puerto Rico and Hawaii passed laws in 1968 and 1969, respectively.

The Railroad Unemployment Insurance Act of 1938 established a system of benefits for persons employed in the railroad industry. The Act was amended in 1946 to include sickness benefits. (This federally operated program is described in the section on programs for railroad workers.)

Coverage

The temporary disability insurance laws, like the unemployment insurance programs, cover most commercial and industrial wage and salary workers in private employment. Principal occupational groups excluded are domestic workers, family workers, government employees, and the self-employed (except California law permits elective coverage for self-employed persons). State and local government employees are included in Hawaii, and the other State laws permit some or all public employees to elect coverage. Only California, Hawaii, New Jersey, and Puerto Rico cover agricultural workers.

In Rhode Island and the railroad industry, all benefits are provided from publicly operated disability insurance funds. In California, New Jersey, and Puerto Rico, employers may “contact out” of the public plan by providing an approved private plan, usually one insured by a commercial company or financed on a self-insured basis. The laws in Hawaii and New York require employers to provide sickness protection of a specified value for their employees by establishing a privately insured or self-insured plan, or in the case of New York, by insuring with a State fund that itself has many characteristics of a private carrier. In jurisdictions that allow private plans, union or union-management plans may provide the sickness benefits required by law.

Eligibility for Benefits

To qualify for benefits, a claimant must have a specified amount of past employment or earnings and be disabled. The laws generally define disability as the inability to perform regular or customary work because of a physical or mental condition.

In most jurisdictions with private plans, workers become immediately insured upon their employment or, in some cases, some probationary period of employment is required, usually from 1 to 3 months. Upon cessation of employment after a specified period, workers generally lose their private plan coverage and must look to the State fund for such protection.

All the laws restrict payment of benefits when the claimant is also receiving workers’ compensation. However, the statutes usually contain some exceptions to this rule—for example, if the workers’ compensation is for partial disability or for previously incurred work disabilities. California and the railroad program will pay the difference if the temporary disability payment is larger than the

workers' compensation benefit (and, in the case of the railroad program, if the temporary disability benefit is larger than benefits from certain other social insurance programs as well).

The laws differ with respect to the treatment of sick leave payments. Rhode Island pays temporary disability benefits in full even though the claimant draws wage-continuation payments. New York deducts from the benefits any payment from the employer or from a fund contributed to by the employer, except for benefits paid pursuant to a collective bargaining agreement. In California, New Jersey, and Puerto Rico, benefits plus paid sick leave for any week during disability may not exceed the individual's weekly earnings before his or her disablement. Railroad workers are not eligible for temporary disability benefits while they receive sick leave pay.

All the laws provide that a claimant cannot receive disability benefits for any week for which he or she receives unemployment benefits. The New Jersey law deducts from disability payments the amount of any pension received if the pension was contributed to by the claimant's most recent employer. Puerto Rico disallows benefits if a pension is being received without the claimant's having had insured work for at least 15 weeks immediately preceding the disability claim.

Types and Amounts of Benefits

In all seven temporary disability insurance systems, as with unemployment insurance in the United States, weekly benefit amounts are related to the claimant's previous earnings in covered employment. In general, the benefit amount for a week is intended to replace at least one-half of the weekly wage loss for a limited time. All the laws, however, specify minimum and maximum amounts payable for a week. In three States (Hawaii, New Jersey, and Rhode Island), the maximum amount is recomputed annually so that it will equal a specified percentage of the State's average weekly wage in covered employments. Rhode Island also pays benefits to dependents.

The maximum duration of benefits varies between 26 and 52 weeks. The length of time that benefits are payable depends on the total amount of base period earnings and the length of employment.

A noncompensable waiting period of a week or 7 consecutive days of disability (4 days for railroad workers) is generally required before the payment of benefits for subsequent weeks. The waiting period, however, applies only to the first sickness in a benefit year in Rhode Island, and is waived in California and Puerto Rico from the date of confinement in a hospital. In New Jersey, the waiting period is compensable after benefits have been paid for 3 consecutive weeks. In each of the temporary disability insurance programs, a worker may be paid benefits on a prorated basis for partial weeks of sickness after the waiting period has been satisfied.

The statutory provisions described above govern the benefits payable to employees covered by the State-operated plans. In

those States where private plans are permitted to participate, the public plans represent standards against which the private plan can be measured (in accordance with provisions in the State law). Thus, although identical statutory provisions apply to all covered workers under the public system in Rhode Island, a different situation prevails in the other States where private plans may deviate sharply from statutory specifications.

In California, before a private insurance plan can be substituted for the State plan, it must afford benefit rights greater than those under the State-operated plan. In Hawaii, New Jersey, and Puerto Rico, private plan benefits must be at least as favorable as those under the government plans. Hawaii permits deviation from statutory benefits if the aggregate benefits provided under the private plan are actuarially equal or better. In New York, adherence to precise statutory benefits is not required; the benefit package provided by alternate private plans must be “actuarial equivalent” to the statutory formula and must meet certain minimum standards. Some features of an alternate private plan can be inferior to the standards of State law if other features are more favorable. Moreover, the New York law also provides that medical, hospital, and surgical care benefits may be substituted for cash sickness benefits for up to 40% of the statutory benefits.

Private plans may also deviate from the statute with respect to conditions under which benefits will be paid, as long as benefits are not denied in any case in which they would have been paid under the statute. In fact, financial considerations tend to operate as a restrictive force on the liberalization of private plans in relation to State-operated plans or statutory formulas. To exceed the statutory formula would mean higher costs for the average employer, since the law forbids requiring employees to pay higher premiums for private plan coverage than for State plan coverage.

In areas where private plan participation is permitted, special arrangements are needed to ensure continuity of coverage for a worker who changes employers or experiences periods of unemployment. In New York, the law requires that a worker be covered by a private plan for 4 weeks after termination of employment unless he or she is reemployed, in which case he or she will be covered by the new employer without a waiting period. Puerto Rico requires that benefits under a private plan be payable for periods of disability that begin during unemployment or employment in uninsured work. In the other three States that allow private plans—California, Hawaii, and New Jersey—the employer’s responsibility for coverage lasts only 2 weeks after separation.

After such coverage lapses, the worker may be eligible for continued disability benefits through the State fund. Special

benefit and eligibility provisions are also in effect for disabled unemployed workers in Hawaii, New Jersey, and New York.

In Rhode Island and in the railroad industry, there is no reason to make a distinction between employed and unemployed workers because all benefits are paid from a single fund and workers are assured of continuous protection during short periods of unemployment and job turnover.

Financing

Under each of the laws, except for that governing the railroad program, employees may be required to contribute to the cost of the temporary disability insurance. In five of the jurisdictions (all but California and Rhode Island), employers are also required to contribute. In general, the government does not contribute.

Under programs in California, New Jersey, and Puerto Rico, workers covered by approved private plans are relieved from contributing to the government-operated fund; but when they are asked to contribute to the private plan, they may not pay more than they otherwise would be required to pay for the State fund. When benefit costs exceed this amount, employers must pay the balance. In Hawaii and New York, higher contributions than specified in the law may be required of employees if the level of benefits provided bears a reasonable relationship to costs.

The administrative costs of the government-operated plans, like the benefit outlays, are met from the payroll taxes collected under the law. California, New Jersey, New York, and Puerto Rico levy assessments on private plans to cover the added administrative costs to the States of supervising these plans. In Hawaii, the administrative costs are paid from general revenues. In New Jersey, employers covered by the State-operated plan pay an extra assessment for the costs of maintaining separate accounts for experience-rating purposes.

Those disability laws that permit private insurance require these plans to pay part of the cost of paying benefits to insured workers who become disabled while unemployed—generally by means of a levy proportional to the insurable payroll covered by private plans. This arrangement is considered necessary so that the cost of benefits to unemployed workers will not be borne exclusively by the public funds.

Administration

Five of the seven temporary disability insurance programs are administered by the same agency that administers unemployment insurance. Under these five programs, unemployment insurance administrative machinery is used to collect contributions, to maintain wage records, to determine eligibility, and to pay benefits to workers under the State-operated funds. The New York law is administered by the State Workers' Compensation Board, and the

Hawaii law is administered separately in the Department of Labor and Industrial Relations.

By way of contrast, claims in New York and Hawaii are filed with and paid by either the employer, the insurance carrier, or the union health and welfare fund that is operating the private plan. The State agency limits its functions with respect to employed workers to exercising general supervision over private plans, setting standards of performance, and adjudicating disputed claims arising between claimants and carriers. A similar situation applies to claimants under private plans in California, New Jersey, and Puerto Rico.

All the laws require the claimant to be under the care of a physician (or, in California and Hawaii, the claimant may be under the care of an authorized religious practitioner of the claimant's faith). The first claim must be supported by a physician's certification. It must include a diagnosis, the date of treatment, an opinion as to whether the illness or injury prevents the claimant from carrying on his or her customary work, and an estimate of the date when the claimant will be able to work again.

An individual whose claim for benefits is denied, in whole or in part, has the right to appeal the determination through the State courts. Decisions by private carriers are also subject to appeal to the State administrative agency and then to the courts. If a carrier should fail to pay promptly in accordance with a decision on appeal, the benefits may be paid by the State agency and assessed against the employer.