OWCP

Annual Report to Congress FY 2008

Submitted to Congress 2010
U.S. Department of Labor

Office of Workers' Compensation Programs

2008

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Office of Workers' Compensation Programs
Washington, D.C. 20210

MAY 6 2010

THE HONORABLE PRESIDENT OF THE SENATE
THE HONORABLE SPEAKER OF THE HOUSE OF REPRESENTATIVES

I have enclosed the Department of Labor's annual report to Congress on the FY 2008 operations of the Office of Workers' Compensation Programs. The report covers administration of the Federal Employees' Compensation Act as required by Section 8152 of that Act, the Black Lung Benefits Act as required by Section 426(b) of that Act, the Longshore and Harbor Workers' Compensation Act (LHWCA) as required by Section 42 of that Act, and the Energy Employees Occupational Illness Compensation Program Act, for the period October 1, 2007, through September 30, 2008.

Separate enclosures contain reports on annual audits of the Longshore and Harbor Workers' Compensation Act Special Fund and the District of Columbia Workmen's Compensation Act Special Fund accounts as required by Section 44(j) of LHWCA.

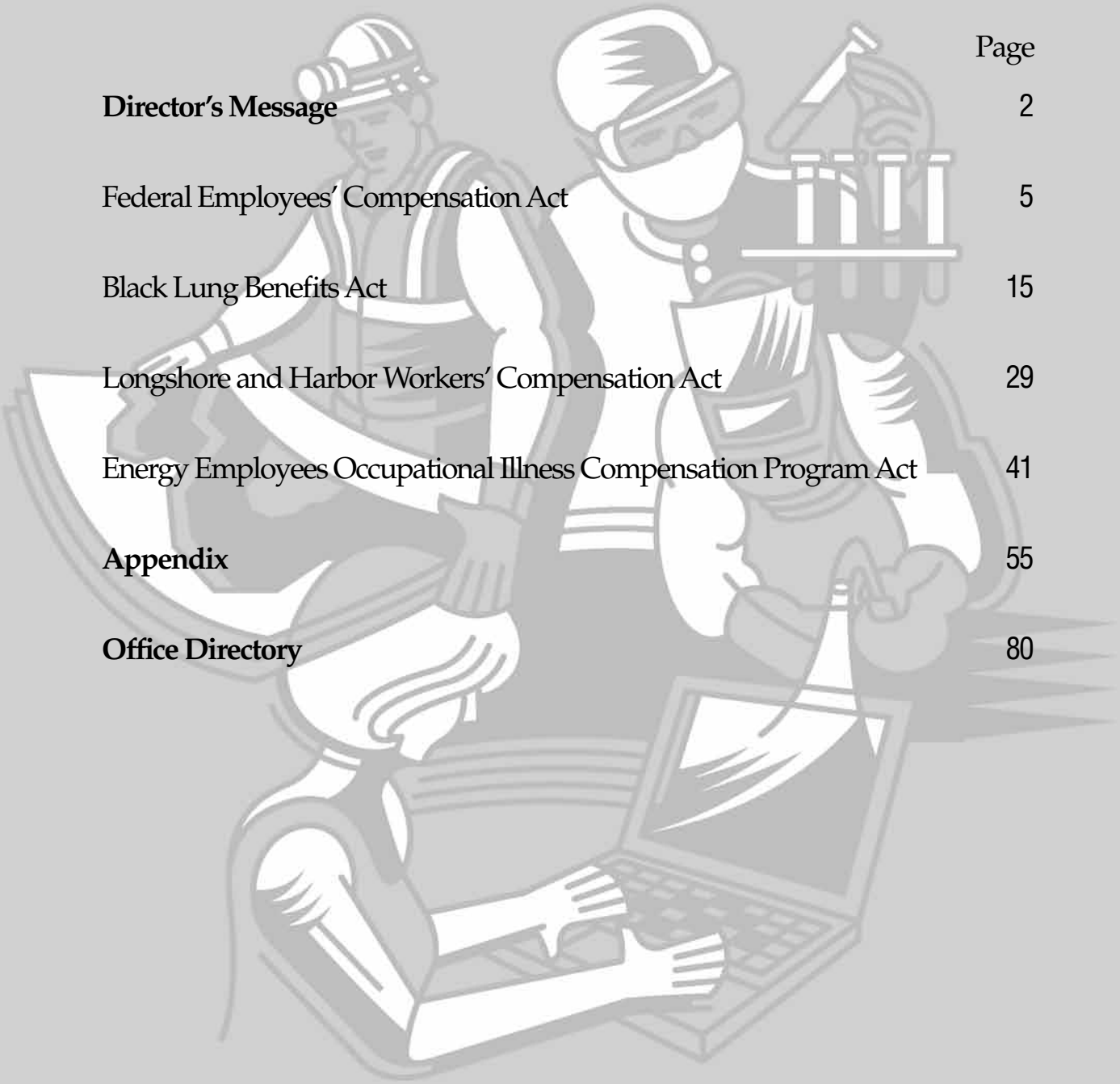
I trust that this report both fulfills the requirements of the respective laws and is useful to Congress and other interested parties as a comprehensive source of information on the administration and operation of Federal workers' compensation programs.

Sincerely,

Shelby Hallmark
Director

Enclosures

Contents



Director's Message

Fiscal Year (FY) 2008 was another very productive and positive year for the Office of Workers' Compensation Programs (OWCP). The four OWCP programs paid out a total of $4 billion in compensation and benefits while meeting nine of their ten key performance goals.

The Federal Employees' Compensation (FEC) program met all five of its Government Performance Results Act (GPRA) targets, including the very difficult goal of lowering Postal Service lost production days. FEC continued to enhance its integrated claims management/payment system (iFECS), and as a result increased the timeliness of both the claims adjudication and compensation payment processes. In addition, FEC enhanced the Agency Query System to provide for the electronic submission of claims and expanded access to its Claimant Query System, doubling the number of Federal employees that have access to their claims online. All of these improvements had a direct impact on the continued success of the Safety, Health, and Return-to-Employment (SHARE) initiative, as all four of the Federal government-as-a-whole goals were achieved in SHARE's fifth year of operation, including both the continued improvement in the filing of injury notices, with over 77 percent of non-postal cases filed in a timely manner, and the reduction of lost production days.

The Longshore program continued to successfully manage the large workload created by incoming Defense Base Act (DBA) cases, with over 11,000 DBA cases reported and filed during the year. To address this continued high volume, the program redistributed the DBA case workload among

all its district offices in FY 2008. While the program continued to exceed its GPRA goal to resolve disputed issues in contested cases, a revised baseline was developed for this measure and new performance goals to track and measure benefit facilitation and rehabilitation and job placement services were added to drive improvements in performance in these areas.

The Black Lung program provided its usual excellent customer service in the management and delivery of benefits while continuing to exceed its goal for claims processing timeliness, lowering its average days to reach claim decisions by 8.5 percent to 205 days. Culminating many years of effort, the Black Lung Disability Trust Fund was placed on the road to eventual solvency with the enactment into law of most of the program's long-proposed refinancing plan during the first few days of FY 2009.

The Energy Employees Occupational Illness Compensation program continued to receive and process a substantial number of new claims while at the same time continuing to work off the backlog stemming from the transfer of more than 25,000 cases with the creation of Part E and the requirement to re-open many cases due to changes in the dose reconstruction methodology. For FY 2008, the program paid out over $1 billion in compensation and medical benefits under Parts B and E, an all-time high. Outreach activities were expanded to offer new and improved services for existing and potential claimants, including tasking the network of Resource Centers to assist claimants with resolving medical billing issues and encouraging medical providers to provide services to program beneficiaries. The Energy program's three GPRA case processing timeliness goals were achieved during the year.

The delivery of these positive and crucial services to the four programs' tens of thousands of deserving customers was accomplished through the energy and dedication of the entire OWCP staff. The staff's commitment to providing quality service, and their ongoing efforts to continually improve the accuracy, timeliness and effectiveness of that service, are the foundation of OWCP's success.

Shelby Hallmark
Director, Office of Workers' Compensation Programs

Federal Employees' Compensation Act

Introduction

In 1916, President Wilson signed the first comprehensive law protecting Federal workers from the effects of work injuries. Amended several times, the Federal Employees' Compensation Act (FECA) now provides workers' compensation coverage to approximately 2.7 million Federal workers. The

FECA also provides coverage to Peace Corps and VISTA volunteers, Federal petit and grand jurors, volunteer members of the Civil Air Patrol, Reserve Officer Training Corps Cadets, Job Corps, Youth Conservation Corps enrollees, and non-Federal law enforcement officers when injured under certain circumstances involving crimes against the United States.

For over 90 years, the Federal Employees' Compensation (FEC) program has continuously evolved to meet its commitment to high quality service to employees and Federal agencies, while minimizing the human, social and financial costs of work-related injuries.

Benefits and Services

The primary goal of the FEC program is to assist Federal employees who have sustained work-related injuries or disease by providing financial and medical benefits as well as help in returning to work. FECA benefits include payment for all reasonable and necessary medical treatment for work-related injury or disease. In timely-filed traumatic injury claims, the FECA requires the employer to continue the injured worker's regular pay during the first 45 calendar days of disability. If the disability continues after 45 calendar days, or in cases of occupational disease, the FEC program will make payments to replace lost income. Compensation for wage loss is paid at two-thirds of the employee's salary if there are no dependents, or three-fourths if there is at least one dependent. The FECA provides a monetary award to injured workers for permanent impairment of limbs and other parts of the body and provides benefits to survivors in the event of work-related death. Training and job placement assistance is available to help injured workers return to gainful employment.

In Fiscal Year (FY) 2008, the FEC program provided 254,000 workers and survivors approximately $2.7 billion in benefits for work-related injuries, illnesses, or deaths. Of these benefit payments, over $1.7 billion were for wage-loss compensation, $782 million for medical and rehabilitation services, and $139 million for death benefit payments to surviving dependents.

The FECA is the exclusive remedy by which Federal employees may obtain disability, medical, and/or survivor benefits from the Federal government for workplace injuries. Decisions for or against the payment of benefits may be appealed to the Employees' Compensation Appeals Board (ECAB), an independent body in the Department of Labor (DOL). Program activities are carried out in the 12 program district offices around the country.

Funding

Benefits are paid from the Employees' Compensation Fund. Agencies are billed each August for benefits paid for their employees from the Fund, and most agencies, other than the U.S. Postal Service (USPS) and non-appropriated fund agencies, include those chargeback costs in their next annual appropriation request to Congress. Remittances to the Fund are not made until the first month of the subsequent fiscal year (or later, if an agency's full-year appropriation is enacted after the subsequent fiscal year begins). The annual

Benefit Outlays Under FECA FY 2008

TOTAL BENEFITS: $2,658 MILLION*

Long Term Disability (Wage-Loss)	**52.5**%	$1,395 Million
Medical Benefits	**29.4**%	$ 782 Million
Temporary Disability (Wage-Loss)	**12.9**%	$ 342 Million
Death Benefits	**5.2**%	$ 139 Million

*Actual Obligations

DOL appropriation makes up any difference between prior year remittances and current year need, which is affected by Federal wage increases and inflation in medical costs.

Expenses for a small number of cases are not charged back to employing agencies, but also are covered by the DOL appropriation. For FY 2008, these non-chargeback expenses were approximately $36.0 million. Non-chargeable costs are attributable to injuries that occurred before December 1, 1960, when the chargeback system was enacted, to employees of agencies that are no longer in existence, or to injuries which have FECA coverage under various "Fringe Acts" such as the Contract Marine Observers Act, Law Enforcement Officers Act, and the War Hazards Compensation Act, that did not contain mechanisms for billing employers.

For FY 2008, administrative expenditures for the FEC program totaled $155.3 million. Of this amount, $142.7 million, approximately 5.1 percent of total program costs, were direct appropriations to the DOL's Office of Workers' Compensation Programs (OWCP), including $89.4 million in salaries and expenses and $53.2 million in "fair share" expenditures out of the FECA Special Benefits account. These latter funds are specifically earmarked for OWCP capital investments for the development and operation of automated data management and operations support systems, periodic roll case management, and benefit oversight. Another $12.6 million are separately appropriated to the Department for legal, investigative, and other support from the ECAB, Office of the Solicitor, the Office of the Inspector General, and the U.S. Treasury.

Government Performance Results Act

In FY 2008, the Division of Federal Employees' Compensation (DFEC) achieved all five of its indicators under DOL's Government Performance Results Act (GPRA) goal to "minimize the human, social, and financial impact of work-related injuries for workers and their families." As a result:

DFEC far exceeded its Lost Production Days rate (LPD per 100 employees) target of 48.5 days for all government less U.S. Postal Service cases, by reducing lost days to 41.3.

The average LPD for U.S. Postal Service cases was 133.6 days, significantly better than DFEC's FY 2008 target of 142 days.

Through use of Periodic Roll Management, DFEC produced $16.9 million in first-year savings, exceeding its target of $14 million.

The program achieved a rate of increase of 3.2 percent in per-case medical costs in FECA compared to an increase of 7.6 percent for nationwide health care costs.

Targets were met by DFEC in five key communication performance areas: access to Claimant Query System; average caller wait times; average callback response times; calls responded to on same day; and call handling quality.

Safety, Health, and Return-to-Employment Initiative

The Safety, Health and Return-to-Employment (SHARE) Initiative for Federal Executive Branch agencies was established in 2004. The Department of Labor was designated to lead the Initiative. The Secretary of Labor assigned the Occupational Safety and Health Administration and the OWCP responsibility for administering and monitoring program efforts.

To reaffirm the commitment to improving safety and health in the Federal sector, the SHARE initiative was extended for three years on September 29, 2006. The goals and goal-setting methodology for SHARE II remain essentially the same; FY 2003 agency performance data will remain the baseline for the first three goals of the initiative. However, all agencies were required to achieve at least a 55 percent timely filing rate under Goal 3 in FY 2008. Those agencies for which a five percent per year improvement from their FY 2003 baseline resulted in a FY 2008 goal higher than 55 percent, continued to have their performance tracked against that formula-driven target, except that no agency's goal was required to exceed 95 percent. In FY 2009, the minimum thresholds will rise to 60 percent. The Goal 4 target also has been slightly modified. Lost production days (LPD) figures were revised due to a data system change which yields a more accurate compilation of lost days. FY 2006 outcomes were recalculated using the new computation methodology and will be used as the new baseline for LPDs. Agencies with FY 2006 baseline LPDs at or below 15 days will be charged with maintaining an LPD rate of 15 or less. All other agencies will have their progress measured against the formula-driven targets of reducing LPDs by one percent per year.

OWCP has completed the fifth year of data collection and performance tracking under the SHARE Initiative. As in FY 2007, the Federal government as a whole (less the U.S. Postal Service) was successful in achieving all four goals by the end of FY 2008. Four departments and nine independent agencies met each of the performance measures in FY 2008. OWCP continued to collaborate with agencies in achieving two of the Initiative's goals: to increase the timely filing of injury notices; and to reduce lost production days due to workplace injuries and illnesses by at least one percent per year.

A major accomplishment in the fifth year of SHARE was the continued improvement in the timely filing of injury notices. OWCP's ability to act promptly on medical bills and prevent any interruption of income is directly and critically related to the early submission of claim forms. By filing 77.2 percent of their cases with OWCP within 14 days, non-Postal agencies far exceeded the FY 2008 goal of 63.3 percent. FY 2008's performance represents more than a 55 percent improvement over the government's FY 2003 base year timely filing rate of 49.6 percent.

With non-Postal agencies averaging 41.3 lost days per 100 employees versus a goal of 48.5 lost days, the SHARE goal for LPDs was met for the third time in FY 2008. The achievement of this difficult goal in FY 2008 demonstrates that agencies are focusing on the long-term changes needed to improve their disability case management programs.

iFECS

In late FY 2008 DFEC initiated the CA-7 enhancement project in order to improve the turn-around times to process CA-7 compensation claims and to streamline the benefit payment process. The project encompassed the enhancements of multiple applications within DFEC's integrated Federal Employees' Compensation System (iFECS) to improve three major business needs:

Increasing the timeliness of compensation payments;

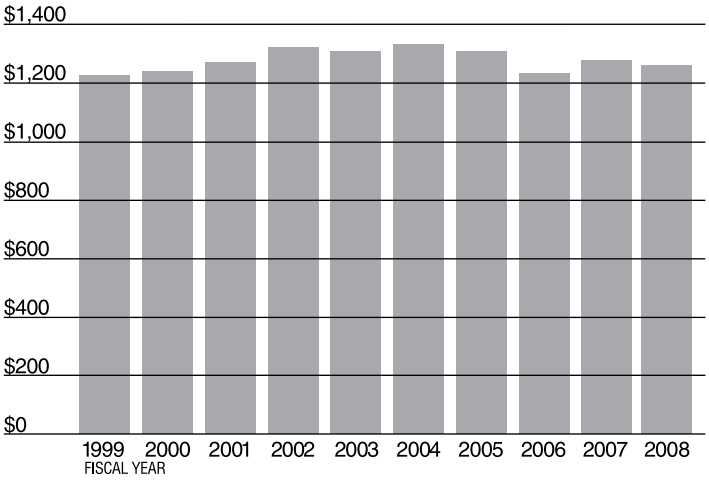
Streamlining the adjudicatory and payment process within iFECS; and

Capturing accurate performance metrics related to Claims Examiner actions and the timelines of compensation payments.

Also initiated in FY 2008 was the design and development of an electronic method to submit CA-7 claims through the Agency Query System. Once deployed the system will improve CA-7 timeliness submission on the part of employing agencies and allow DFEC to more promptly pay wage loss and permanent impairment claims.

FECA Benefit Expenditures

IN MILLIONS OF CONSTANT DOLLARS*



*Actual Obligations in current dollars deflated by CPI-W (urban wage earners and clerical workers, U.S. city average, all items), 1982-1984=100.

Case Adjudication and Management

Approximately 134,000 new injury and illness claims were filed under FECA in FY 2008. Eighty-six percent were for traumatic injuries, such as those caused by slips and falls. The rest were for medical conditions arising out of long-term exposure, repeated stress or strain, or other continuing conditions of the work environment. For traumatic injury claims, 97.9 percent were adjudicated within 45 days of the day OWCP received notice of the injury. In FY 2008, the FEC program also achieved a high rate of timeliness in deciding non-traumatic injury claims despite the complexities involved. For "basic" occupational disease cases with an uncomplicated fact pattern, 95.5 percent were adjudicated within 90 days. Of the more complex non-traumatic cases, 87.8 percent were adjudicated within 180 days.

The FEC program has achieved a 20 percent reduction in the past decade in the average length of disability in new injury cases under its Quality Case Management (QCM) program. Under QCM, implemented in FY 1993 as another means of reducing the number of days an injured worker was out of work, every injury case with a wage-loss claim filed and no return-to-work date is reviewed for assignment to an early intervention nurse contracted by the FEC program. From the earliest stages after the injury, the nurse meets with the injured worker and serves as the human face of OWCP. Coordinating medical care and return-to-work issues, the nurse not only works with the injured employee but also the attending physician and the employing agency. If it seems that the injured worker will not return to work soon, the nurse coordinates the transfer of the case for vocational rehabilitation services and/or more aggressive medical intervention.

In FY 2008, 7,821 injured Federal employees were returned to work as a result of early nurse intervention. Additionally, vocational rehabilitation counselors arranged training and successfully placed 621 injured workers into non-Federal employment. Due, in part, to these successful early intervention actions, the average length of disability (lost production days within the first year from the date FECA wage-loss began)

continued to be reduced from 148 days in FY 2007 to 145 days in FY 2008.

The FEC program continued to dedicate resources to the thorough review of long-term disability cases. As part of that review, Periodic Roll Management (PRM) staff arranges second opinion medical examinations to reassess changes in medical condition and fitness for work and recommends referral to vocational rehabilitation and placement assistance with a goal of reemploying injured workers. Of the cases that were screened in FY 2008, the disability in 1,573 cases had either resolved or lessened to the point that return to work was possible. Adjustments or termination of benefits resulting from the changes in these cases produced $16.9 million in compensation benefit savings, exceeding FEC's FY 2008 target of $14 million.

Central Medical Bill Processing

OWCP's medical bill processing service continued to achieve improvements in operating efficiencies. During FY 2008, DFEC avoided $70.6 million in additional costs due to further improvements in the editing of bills, which in turn reduced costs charged back to agencies.

Timely and accurate medical bill processing is a critical element in administration of the FECA. In FY 2008, the bill processing system was enhanced to include Ambulatory Surgical Center (ASC) pricing enhancements. These enhancements are for approved surgeries and ancillary services performed in an ASC setting and were assigned indicators to determine billing appropriateness, pricing category, and reimbursement levels. An additional enhancement, Modifier Level Pricing, covers various procedure codes and contains appropriate and valid modifiers for proper payment of services.

In FY 2008, the vendor processed 5,182,096 bills and handled 764,795 telephone calls. Authorizations for treatment were processed in an average of one work day and 99.8 percent of bills were processed in 28 days. Enrollment of 8,360 new providers brought the total of enrolled providers to 201,939.

Hearings and Review

Individuals who disagree with an Office formal decision on a claim may exercise their appeal rights by requesting an oral hearing or a review of the written record from the Branch of Hearings and Review. In FY 2008, the Branch received a total of 6,584 incoming requests for reviews of the written record and oral hearings, and issued a total of 6,789 decisions.

In FY 2008, customer service and turnaround times improved in most of the measured areas. The period of time between receipt of a case file and the issuance of a remand or reversal before a hearing decreased by an average of 21 percent, from 85 days in FY 2007 to 67 days in FY 2008. For those case files where a hearing was held, the time period for issuance of a decision decreased by 8 percent, from an average of 209 days in FY 2007 to 193 days in FY 2008. For appeals initiated from a review of the written record, the Branch exceeded its goal by issuing decisions in an average of 93 days for FY 2008.

In the interest of improving appeals processing times, the Branch continues to convert hearing requests originating in geographical areas less traveled to telephone hearings. In FY 2008, the branch introduced video teleconferencing to increase productivity associated with hearings. The Branch found that video teleconferencing expedited the hearing process by avoiding unnecessary wait times in cities where a full docket was not available.

FECA Benefits Charged To Employing Agencies

CHARGEBACK YEAR 2008

Chargeback Total: $2,573 Million

Postal Service	$ 979 Million
Defense	$ 614 Million *
Veterans Affairs	$ 176 Million
Homeland Security	$ 161 Million
Justice	$ 99 Million
Transportation	$ 98 Million
Agriculture	$ 73 Million
All Other	$ 374 Million

*Defense Includes Navy ($242M), Army ($180M), Air Force ($131M), and Dept. of Defense ($61M)

Note: The sum of individual agencies may not equal total due to rounding

Performance Assessment

During FY 2008, the FEC program was rated "Moderately Effective" under the Program Assessment Rating Tool (PART) process. The findings can be summarized as follows:

The FEC program is well managed, with operational authority and responsibility clearly defined. The program's design provides checks and balances to ensure proper program administration, while maintaining sufficient flexibility to enable operational and procedural improvements.

The FEC program's purpose is clear and its design is free of major flaws.

Administrative and litigation costs are reduced through FECA's design as a non-adversarial system. FEC program direct administrative costs generally constitute around 5.1 percent of total program obligations.

The FEC program's performance goals are clear, measure outcomes, and align with agency mission. Long-term targets aim for continuous improvement and provide the basis for establishing performance standards comparable to industry standards.

FEC program action items in FY 2008 related to this PART evaluation included:

Working with Congress to update the benefit structure, adopt best state practices, and convert benefits for retirement-age individuals to a typical retirement level.

Implementing recommendations from an independent evaluation to improve significant components of FECA processes, including industry best practices.

Conducting preliminary work, including the development of a logic model that will serve as a basis for future impact evaluation of FECA's disability management activities and program effectiveness.

Legislative Reform

Although reform of the Federal Employees' Compensation Act was not adopted in the FY 2008 budget, DFEC continued to pursue changes to the FECA that would enhance incentives for injured employees to return to work; address retirement equity issues; and update and make other benefit changes. Specifically, the reform proposed to:

Convert compensation for new injuries or new claims for disability to a lower benefit at the Social Security retirement age.

Move the 3-day waiting period during which an injured worker is not entitled to compensation to the point immediately after an injury.

Change the way that schedule awards are paid to allow uniform lump sum payments to Federal employees eligible for such awards.

Eliminate augmented compensation for dependents but raise the basic benefit level for all claimants.

Allow OWCP to recover the costs, estimated at over $2 million annually, paid by responsible third parties to FECA beneficiaries during the continuation of pay period.

Increase benefit levels for funeral expenses from $1,000 to $6,000.

Increase benefit levels for disfigurement resulting from work injury, and

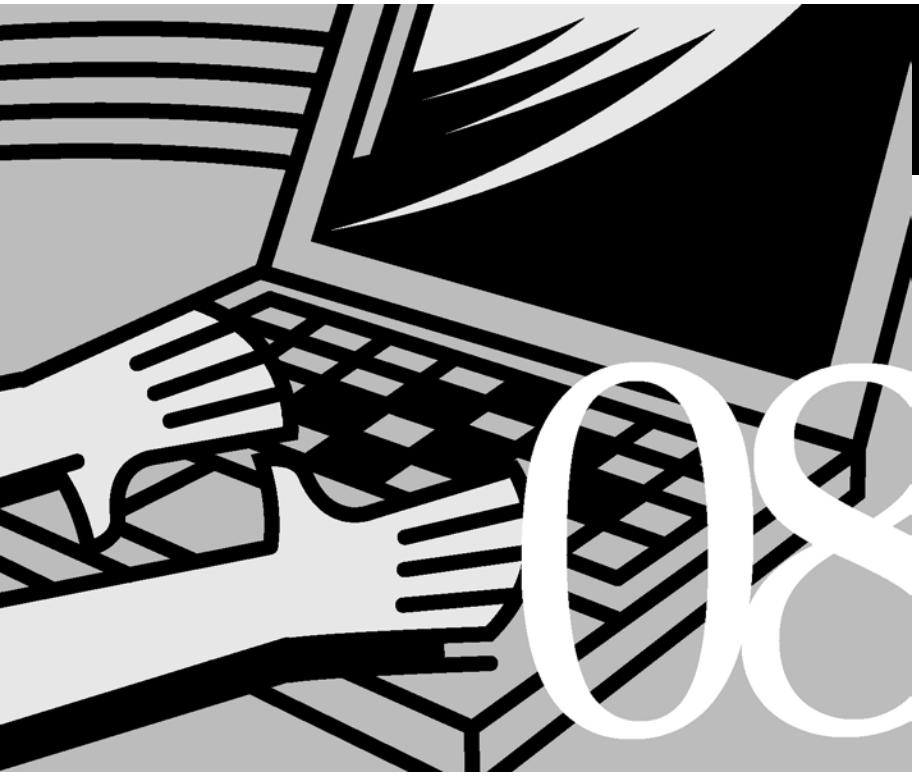
Identify unreported work earnings and receipt of Federal Employees Retirement System retirement benefits through regular database matching with the Social Security Administration.

FECA Program Evaluation

A process evaluation of the FECA Continuation of Pay (COP) Nurse Program, "Improved Early Disability Management" (SRA International, Inc., February 2008), was conducted in FY 2008 that considered industry best practices in early case intervention. The study recommended actions to improve the delivery of nurse intervention services during the initial 45 day COP period immediately following injury. The study recommended that DFEC clarify purpose, objectives, and outcomes; streamline the nurse referral process; speed reporting of return-to-work and filing of nurse reports; and improve information sharing with employing agencies. In response to these findings and recommendations, DFEC began to develop (1) an electronic capability for employing agencies to report when an injured worker has returned to work; (2) a Web portal for COP nurses for transmitting case status reports; and (3) a standardized case evaluation guide for publication.

Also during FY 2008, DFEC began an evaluation of the coordination between its Nurse Intervention and Vocational Rehabilitation programs. The study will result in an assessment of current case management processes and make recommendations to produce more efficient and effective returns to work for injured Federal employees. The study is slated to be completed during FY 2009.

These studies, which effectively bookend DFEC's Case Management processes, will be used to improve the current program, adopt effective practices and assist employing agencies to create re-employment opportunities, facilitate job retention, better process new injury claims, and manage injury caseloads. Best practices, new approaches, and efficiency recommendations resulting from the performance studies also will directly support the objectives of the SHARE initiative to reduce Federal injury rates, speed submission of claims and reduce lost production days.



Federal Employees' Compensation Act

	FY 2007	FY 2008
Number of Employees (FTE Staffing Used)	894	892
Administrative Expenditures [1]	$144.1 M	$142.7 M
Cases Created	134,436	134,013
Wage-Loss Claims Initiated	19,104	19,187
Total Compensation and Benefits (Actual Obligations) [2]	$2,563.1 M	$2,657.6 M
Number of Medical Bills Processed	4,538,626	5,182,096

[1] OWCP expenditures; excludes DOL support costs, but includes "fair share" capital expenditures of $54.0 million in FY 2007 and $53.2 million in FY 2008, respectively.

[2] Compensation, medical, and survivor benefits.

Services to Claimants and Beneficiaries

Quality customer service and customer satisfaction are key components of DFEC's mission and "Pledge to Our Customers." Over 1.3 million calls were received by the DFEC district offices, the majority of which were handled by Customer Service Representatives (CSRs) in the 12 district office call centers. Since 2003, average caller wait times have been reduced by half; turnaround time to caller inquiries has been reduced by more than 70 percent; and response effectiveness has improved by nearly 40 percent. During FY 2008, calls were answered in an average of 1.45 minutes, which is well below the goal of three minutes. This represents a significant decrease in the average wait time of 2.13 minutes in FY 2007.

To help ensure quality and to identify areas where additional CSR training is needed, silent monitoring of calls to the district office phone banks continued during the fiscal year. Communications Specialists on DFEC's staff listen to both sides of a conversation and, using a standardized Quality Monitoring scorecard, document the CSRs' performance. The results of quality silent monitoring coupled with local telephone survey results show that 97.6 percent of callers received courteous service in FY 2008. The use of clear and understandable language was reported in 98.3 percent of calls, and 96.4 percent of calls met knowledge and accuracy standards. The goal of 95 percent was exceeded in each of these quality categories.

Seventy-one percent of calls to the district offices were responded to on the same day they were received, exceeding the goal by two percent. The average response time for all calls in FY 2008 was less than one day (0.87 days), which represents the most significant customer service improvement. Ninety-five percent of all calls were responded to in two days or less.

Also in FY 2008, DFEC expanded access to its Claimant Query System and doubled – to approximately 1.2 million – the number of Federal employees that can obtain information about their claims online.

Black Lung Benefits Act

Introduction

The Division of Coal Mine Workers' Compensation (DCMWC) completed its thirty-fifth year administering Part C of the Black Lung program in 2008. The initial Black Lung benefits program was enacted as part of the Coal Mine Health

and Safety Act of 1969 (the Act). This law created a system to compensate victims of dust exposure in coal mines with public funds initially administered by the Social Security Administration (SSA).

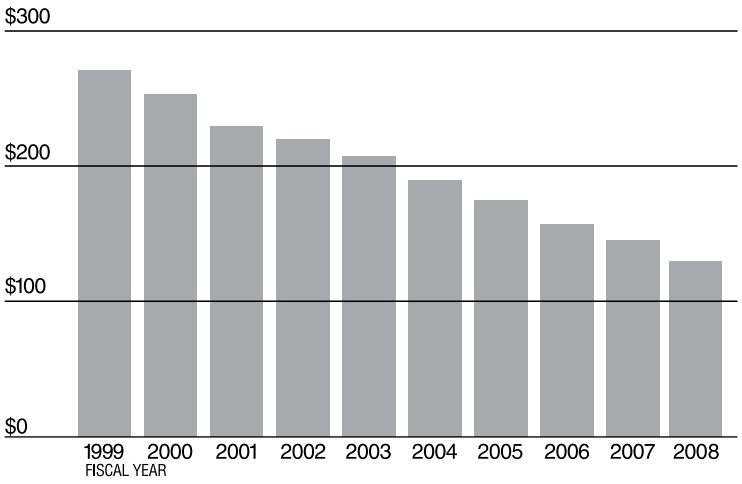
The number of claims filed in the early 1970's greatly exceeded expectations. The Act was amended by the Black Lung Benefits Act of 1972 (BLBA) to require the use of simplified interim eligibility criteria for all claims filed with SSA, and to transfer the receipt of new claims to the Department of Labor (DOL) in 1973. The Office of Workers' Compensation Programs (OWCP) assumed responsibility for processing and paying new claims on July 1, 1973. Until recently, most of the claims filed prior to that date remained within the jurisdiction of SSA. Further amendments in the Black Lung Benefits Reform Act of 1977 (Public Law 95-239) mandated the use of interim criteria to resolve old unapproved claims. The Black Lung Benefits Revenue Act of 1977 (Public Law 95-227) created the Black Lung Disability Trust Fund (Trust Fund), financed by an excise tax on coal mined and sold in the United States. The law authorized the Trust Fund to pay benefits in cases where no responsible mine operator could be identified and transferred liability for claims filed with DOL based on pre-1970 employment to the Trust Fund. It also permitted miners approved under Part B to apply for medical benefits available under Part C. These amendments made the Federal program permanent but state benefits continued to offset Federal benefits where they were available.

Current administration of the Black Lung Part C program is governed by legislation enacted in 1981. These amendments tightened eligibility standards, eliminated certain burden of proof presumptions, and temporarily increased the excise tax on coal to address the problem of a mounting insolvency of the Trust Fund, which was indebted to the U.S. Treasury by over $1.5 billion at that time.

In 1997, the responsibility for managing active SSA (Part B) Black Lung claims was transferred to DOL by a Memorandum of Understanding between SSA and DOL. This change improved customer service to all Black Lung beneficiaries and was made permanent in 2002 when the Black Lung Consolidation of Administrative Responsibilities Act placed the administration of both programs with DOL.

Black Lung Benefit Expenditures

IN MILLIONS OF CONSTANT DOLLARS*



*Current dollars deflated by CPI-W (urban wage earners and clerical workers, U.S. city average, all items), 1982-1984=100.

Benefits and Services

The Black Lung Part C program provides two types of benefits: monthly wage replacement and medical services. The program pays a standard monthly benefit (income replacement) to miners who are determined to be totally disabled from black lung disease and to certain eligible survivors of deceased miners. The monthly rate of benefits is adjusted upward to provide additional compensation for up to three eligible dependents. In Fiscal Year (FY) 2008, monthly and retroactive benefit payments totaled $235.3 million.

The Part C program also provides both diagnostic and medical treatment services for totally disabling pneumoconiosis. Diagnostic testing is provided for all miner-claimants to determine the presence or absence of black lung disease and the degree of associated disability. These tests include a chest x-ray, pulmonary function study, arterial blood gas study, and a physical examination. Medical coverage for treatment of black lung disease and directly related conditions is provided for miner-beneficiaries. This coverage includes prescription drugs, office visits, and hospitalizations. Also provided, with prior approval, are durable medical equipment (primarily home oxygen), outpatient pulmonary rehabilitation therapy, and home nursing visits.

Medical expenditures under the Black Lung Part C program during FY 2008 were $37.9 million. This includes payments of $4.1 million for diagnostic services, $32.4 million for medical treatment, and $1.4 million in reimbursements to the United Mine Workers of America Health and Retirement Funds for the cost of treating Black Lung beneficiaries. Approximately 168,000 bills were processed during the year.

Total Black Lung Part C program expenditures for all benefits in FY 2008 were $273.2 million, a decrease of $18.1 million from FY 2007. In FY 2008, benefits were provided from the Trust Fund to approximately 30,000 beneficiaries each month.

State workers' compensation laws require coal mine operators to obtain insurance or qualify as a self-insured employer to cover employee benefit liabilities incurred due to occupational diseases that are covered by state law. If state workers' compensation is paid for pneumoconiosis, any Federal black lung benefit received for that disease is offset or reduced by the amount of the state benefit on a dollar-for-dollar basis. As of September 30, 2008, there were 1,306 Federal black lung claims being offset due to concurrent state benefits.

As an additional benefit to claimants, the law provides for payment of attorneys' fees and legal costs incurred in connection with approved benefit claims. The fees must be approved by adjudication officers. During the past year DCMWC processed 141 fee petitions and paid approximately $0.6 million in attorneys' fees from the Trust Fund.

In FY 2008, 1,086 claims were forwarded for formal hearings before the Office of Administrative Law Judges (OALJ) and 442 claims were forwarded on appeal to the Benefits Review Board (BRB). At the end of FY 2008, the OALJ had 1,928 claims pending while 486 were pending before the BRB.

In the Black Lung Part B program, nearly 33,000 active beneficiaries (with more than 3,300 dependents) were receiving over $22 million in monthly cash benefits as of September 30, 2008. Part B benefits in FY 2008 totaled over $262 million. DCMWC completed 6,000 maintenance actions on Part B claims during the year, on average less than one week from notification.

Black Lung Disability Trust Fund

The Trust Fund, established in 1977 to shift the responsibility for the payment of black lung claims from the Federal government to the coal industry, is administered jointly by the Secretaries of Labor, the Treasury, and Health and Human Services. Claims that were approved by SSA under Part B of the BLBA are not paid by the Trust Fund, but rather from the general revenues of the Federal government.

Trust Fund revenues consist of monies collected from the industry in the form of an excise tax on mined coal that is sold or used by producers; funds collected from responsible mine operators (RMOs) for monies they owe the Trust Fund; payments of various fines, penalties, and interest; refunds collected from claimants and beneficiaries for overpayments; and repayable advances obtained from Treasury's general fund when Trust Fund expenses exceed revenues. Excise taxes, the main source of revenue, are collected by the Internal Revenue Service and transferred to the Trust Fund. In FY 2008, the Trust Fund received a total of $653.2 million in tax revenues. An additional $5.0 million was collected from RMOs in interim benefits, fines, penalties, and interest. Total receipts of the Trust Fund in FY 2008 were nearly $1.1 billion, including $426 million in repayable advances from the Department of the Treasury.

Total Trust Fund disbursements during FY 2008 were almost $1.1 billion. These expenditures included $273.2 million for income and medical benefits, $739.5 million for interest payments on repayable advances from the Treasury, and $58.3 million to administer the program ($32.8 million in OWCP direct costs and $25.5 million for legal adjudication and various financial management and investigative support provided by the Office of the Solicitor, the OALJ, the BRB, Office of the Inspector General, and the Department of the Treasury).

In 1981, the Black Lung Benefits Revenue provisions temporarily increased the previous excise tax to $1.00 per ton for underground coal and $0.50 per ton on surface mined coal, with a cap of four percent of sales price. In 1986, under the Comprehensive Budget Reconciliation Act of 1985, excise tax rates were increased again by 10 percent. The rates for underground and surface mined coal were raised to $1.10 and $0.55 per ton respectively, and the cap was increased to 4.4 percent of the sales price. Under the law in effect at the end of FY 2008, these tax rates will remain until December 31, 2013, after which the rates will revert to their original levels of $0.50 underground, $0.25 surface, and a limit of two percent of sales price.

Central Medical Bill Processing

OWCP's medical bill processing service continued to achieve improvements in operating efficiency and effectiveness. Timely and accurate medical bill processing is a critical element in administration of the Black Lung program. During FY 2008, DCMWC avoided $189,000 in medical costs due to further improvements in the editing of bills.

In FY 2008, the vendor processed 167,507 Black Lung bills. A total of 99.5 percent of bills were processed within 28 days. The number of telephone calls handled was 58,042. Enrollment of 389 new providers brought the total of enrolled providers to 107,535.

Performance Assessment

Since DCMWC was reviewed in 2003 using the Program Assessment Rating Tool, the Black Lung program has proceeded with initiatives that were recommended by this evaluation. These have included a renewed focus on reducing the Trust Fund's debt (see below for details), evaluating personnel utilization and allocation, and setting a schedule of annual targets for improving performance in both Government Performance Results Act (GPRA) goals and claims processing times (see below).

In FY 2007, an independent consulting firm completed and delivered a statistical projection of claim trends to 2020 and a study of best practices of other compensation systems. In FY 2008, DCMWC continued to evaluate these studies in order to incorporate their recommendations into ongoing revisions of the program's Accountability Review procedures.

Legislative Proposal to Address Trust Fund Insolvency

Although tax receipts to the Trust Fund were sufficient to cover benefits, current operating costs, and some interest charges, the Trust Fund needed to borrow $426 million from the Treasury to pay the balance of the FY 2008 interest due. By the end of FY 2008, the Trust Fund's cumulative debt to the Treasury was $10.5 billion. Since benefit payments for Black Lung claims in the late 1970's and early 1980's far exceeded revenues, the Trust Fund was forced to draw on repayable advances from the Treasury to meet benefit obligations. While operating costs were covered by revenue, the Trust Fund's debt continued to climb. The Trust Fund borrowed to cover its debt service, which amounted to more than $739 million at the end of FY 2008.

To remedy this financial problem, DOL and Treasury proposed a legislative package which would:

Provide for the restructuring of the outstanding Trust Fund debt, much of which was incurred at the higher Treasury interest rates prevalent during the 1980's, thereby taking advantage of current and lower Treasury interest rates.

Extend until the debt is repaid the current Trust Fund excise tax levels ($1.10 per ton for coal mined underground; $0.55 per ton for surface), which are set to decline after December 31, 2013. The tax rate will revert to the lower (original 1978) rates of $0.50 per ton for underground-mined coal sold and $0.25 per ton for surface in the year following the elimination of the Trust Fund's debt.

Provide a one-time appropriation to the Trust Fund to cover the Treasury's loss of income caused by the restructuring.

After consultation with interested parties and the staffs of the appropriate Congressional committees, DOL and Treasury staffs prepared a revised version of the proposed legislation that was previously transmitted to Congress in 2000, 2002, 2004, and 2005. The Secretaries of Labor and the Treasury jointly transmitted the revised legislative proposal to the Congress on April 4, 2007. While this proposal was never introduced, a number of its provisions were included in the Emergency Economic Stabilization Act of 2008, H.R. 1424, which was pending at the end of FY 2008. (This Act was approved and became law in October 2008, during the first week of FY 2009.)

Government Performance Results Act

In FY 2008, DCMWC continued its efforts to reach DOL's GPRA goal to "minimize the human, social, and financial impact of work-related injuries for workers and their families." DCMWC achieved its goal to:

Reduce the average time required to process a claim from the date of receipt to the issuance of a Proposed Decision and Order (PDO) to no more than 220 days.

By the end of FY 2008, the average time required to process a claim from the date of receipt to the date of the PDO had been reduced to 205 days, down from 224 in FY 2007.

The total number of new claims declined 13.1 percent from 4,913 in FY 2007 to 4,270 in FY 2008. These claim numbers include survivor's conversions that are automatically awarded. Conversion claims numbered 580 in FY 2007 and 480 in FY 2008. The total inventory of claims pending a PDO declined from 2,567 at the end of FY 2007 to 1,975 at the close of FY 2008.

The second GPRA goal for FY 2008 was new, and it proved to be more elusive. DCMWC adopted the National Health Expenditure Projection (NHEP) as a guide against which the program would:

Measure its medical treatment costs with a goal of keeping the average cost per miner below the level of inflation predicted by the NHEP.

In FY 2008 the Black Lung program compared its medical cost trend to forecasts reported in the NHEP published by the Centers for Medicare and Medicaid Services, Office of the Actuary. The annual change in average Black Lung costs in FY 2008 was above the program's target to maintain costs at or below the NHEP FY 2008 projection of 6.1 percent. The increase in average cost was primarily caused by a surge in the number of costly in-patient hospital billings. Because of the small number of eligible miners, costs are volatile and not easily distributed across the population. Nevertheless, DCMWC was actively pursuing cost-containment measures at the end of the fiscal year, including tightened auditing of contractor-paid bills and imposing stricter controls on prescription payments.

Although the Program no longer maintains its original GPRA goal of ensuring that 80 percent of claims have no requests for further action pending one year after receipt of the claim, it continued to monitor this figure. In FY 2008, 81.8 percent of claims were resolved with no pending requests for further action. The Black Lung program will continue to work closely with both its stakeholder and authorized provider communities to ensure that delivery of services continues to improve and performance standards are met.

Management of SSA Part B Black Lung Claims FY 2008

Professional and Timely Claims Maintenance Services Provided to Part B Claimants by DCMWC Included:

Completing 6,000 Maintenance Actions, With Average Completion Time of Less Than One Week from Notification

Managing the Expenditure of More Than $262 Million in Benefits

DCMWC was Responsible for Nearly 33,000 Active Part B Cases

Operation and Maintenance of Automated Support Package

DCMWC's Automated Support Package (ASP) is provided through a contract. The ASP includes a client-server computer system for all black lung claims, statistical and data processing, medical bills processing, telecommunications support, and administrative functions.

During FY 2008, DCMWC continued to enhance the user interface to the main application, ASP. Several new screen edits were implemented to reduce user input errors and improve data accuracy and input efficiency. DCMWC also implemented several changes which improved the accuracy of data stored in the system and to assist in the detection and prevention of erroneous payments.

Compliance Assistance

Section 423 of the BLBA requires that each coal mine operator subject to the BLBA secure payment of any benefits liability by either qualifying as a self-insurer or insuring the risk with a stock or mutual company, an association, or a qualified fund or individual. Any coal mine operator failing to secure payment is subject to a civil penalty of up to $1,100 for each day of noncompliance.

According to FY 2008 estimates by DOL's Mine Safety and Health Administration, there were 2,030 active coal mine operators subject to the requirements of the BLBA. Under the BLBA, the Secretary of Labor can authorize a coal mine operator to self-insure after an analysis of the company's application and supporting documents. At the close of FY 2008, 75 active companies were authorized by the Secretary of Labor to self-insure. These self-insurance authorizations cover approximately 690 subsidiaries and affiliated companies.

The Responsible Operator (RO) Section staff in DCMWC's national office is specifically assigned to record the existence of coal mine operators and their insurance status. The staff answers frequent written, telephone, and e-mail inquiries from operators and insurance carriers and evaluates requests for self-insurance.

During FY 2008, the RO section sent form letters to 914 coal mine operators reminding them of their statutory requirement to insure and stay insured against their potential liability for black lung benefits. Of these, 760 were found to be insured, 110 were insured through a parent entity or not engaged in coal mining, and 23 were uninsured companies that required assistance. The remaining 21 were returned

unclaimed, delivered with no response, or failed delivery for another reason. Letters also were mailed to commercial insurers reminding them of the statutory requirements for writing black lung insurance and for annual reporting to DCMWC of the companies insured and policy numbers. These letters generated many questions from underwriters and resulted in improved compliance. During FY 2008, DCMWC received 3,795 reports of new or renewed policies.

Section 413(b) of the BLBA requires DCMWC to provide each individual miner who files a claim for benefits with the opportunity to undergo a complete pulmonary evaluation at no cost to the miner. The project to improve the quality of these medical evaluations and reports continued during FY 2008, with District Directors and national office staff making a number of visits to clinics and individual physicians. At these site visits, DCMWC staff reviewed the physicians' written evaluations of the medical information obtained during the complete pulmonary evaluations and made suggestions for improving and standardizing the evaluations and reports. DCMWC officials also met several times with physicians at state and national conferences of the National Coalition of Black Lung and Respiratory Disease Clinics to help improve reporting. During FY 2008, the program also focused on updating the list of approved diagnostic physicians by contacting many physicians in order to ensure that highly-qualified doctors were available to perform medical evaluations.

In FY 2008 the program enhanced its long-standing commitment to ensuring that payments to beneficiaries requiring assistance are properly utilized for their use and benefit. DCMWC continued to track district office actions in the appointment of representative payees and the monitoring of their expenditure of benefits, a process began in FY 2007. During FY 2008, over 98 percent of representative payee appointments and expenditure reports were evaluated and acted on within thirty days. The program also developed a new reporting procedure for representative payees that reduced paperwork for both payees and DCMWC staff and sustained the same high level of benefit monitoring.

DCMWC greatly expanded its presence on the World Wide Web in FY 2008, adding new pages that offer assistance to diagnostic physicians, claimants, representative payees, insurers, and coal operators. Statistical pages also were added for the first time.

Litigation

COURTS OF APPEALS

During FY 2008, the courts of appeals issued thirty-nine decisions in cases arising under the BLBA. Forty-two new appeals were filed. The following summarizes the most significant appellate decisions:

Irrebuttable Presumption of Entitlement: 30 U.S.C. § 921(c)(3)(A)-(C); 20 C.F.R. §§ 718.205(c), 718.304. The statute and the regulations provide that the survivor of a miner is entitled to benefits if she can prove that the miner died due to pneumoconiosis. They also provide that the miner will be irrebuttably presumed to have died due to pneumoconiosis if she establishes that the miner suffered from a chronic dust disease of the lung, and she proves that condition by 1) X-ray evidence of large opacities; 2) biopsy or autopsy evidence of massive lesions; or 3) a diagnosis by other equivalent means. In *The Pittsburg & Midway Coal Mining Co. v. Director, OWCP*, 508 F.3d 975 (11th Cir. 2007), the Eleventh Circuit agreed with the Director that once invoked, the presumption of death due to pneumoconiosis is irrebuttable and cannot be rebutted by any evidence whatsoever, including affirmative proof that the miner's death was not, in fact, due to pneumoconiosis. The court also accepted the Director's position that "massive lesions"—an undefined term contained in the second criterion—may be established by a diagnosis of "complicated" pneumoconiosis. Finally, the court agreed with the Director, and disagreed with the Fourth Circuit, and held that a diagnosis of massive lesions/complicated pneumoconiosis is sufficient to invoke the irrebuttable presumption; thus, the court held that the diagnosis need not further state that the lesions, if X-rayed, would be equivalent to the large opacities required by the first criterion.

Chronic Obstructive Pulmonary Disease Within the Definition of Pneumoconiosis: 30 U.S.C. § 902(b); 20 C.F.R. § 718.201(a)(2). To obtain benefits under the Act, a miner must prove that he suffers from pneumoconiosis. The statute defines pneumoconiosis as "a chronic dust disease of the lung . . . arising out of coal mine employment." The implementing regulations provide that both restrictive and obstructive lung diseases are included within the definition of pneumoconiosis as long as coal mine employment was a substantial contributor to their development. In *Consolidation Coal Co. v. Director, OWCP*, 521 F.3d 723 (7th Cir. 2008), the Seventh Circuit considered whether the ALJ properly discredited doctors who reported that the miner's chronic obstructive pulmonary disease was due solely to smoking, with coal mine employment playing no role. The court held that the ALJ properly rejected these opinions: one physician's opinion was conclusory and unexplained while the second physician merely spoke in generalities rather than addressing the particulars of the miner's condition. The court further faulted the second physician because he indicated that he would never connect coal mine employment with obstructive disease since, in his view, the connection rarely happens. The court held that the physician's categorical refusal to consider coal mine employment as a possible cause of the miner's obstructive lung disease was contrary to the Department of Labor's conclusion, rendered after reviewing the available scientific and medical literature, that coal mine employment may cause clinically significant obstructive disease.

Attorney Fees: 30 U.S.C. § 932(a), Incorporating 33 U.S.C. § 928, and 20 C.F.R. § 725.366(a)-(b). The statute provides that, under certain circumstances, successful claimants are entitled to reasonable attorney fees from their employers, and the regulations set forth various factors that may be considered in determining the fee amount. In *B & G Mining, Inc. v. Director, OWCP*, 522 F.3d 657 (6th Cir. 2008), the Sixth Circuit affirmed the fees awarded by lower tribunals. In doing so, the court held that the lodestar method — calculating fees by multiplying "the number of hours reasonably expended on the litigation … by a reasonable hourly rate" — is applicable to black lung claims; the regulatory factors do not impermissibly enhance or supplant the lodestar method; hourly rates awarded in prior cases may be used as a guideline if the prevailing market rate is unknown; risk of loss may not be considered when determining a reasonable hourly rate; and the number of hours worked may be calculated based upon quarter-hour increments.

BENEFITS REVIEW BOARD

During FY 2008, the Benefits Review Board (BRB) issued 727 black lung decisions, several of which significantly affect the Secretary's administration of the benefits program. The following summarizes some of the more significant decisions of the Board, categorized by issue:

Modification. Under the Act's modification provision, a party may request reconsideration of the denial of a claim or an award of benefits based on a mistake in the determination of a fact or a change in conditions. Modification must be requested within one year of the decision denying benefits or, in the case of an award, within one year of the last payment of benefits.

The Department significantly revised the black lung program regulations in 2001. Among other changes, district director procedures for the adjudication of claims were simplified. For example, under the revised regulations, an employer is deemed to have contested a claimant's entitlement to benefits even if it does not respond to notification of a claim. Under the prior regulatory scheme, an employer was required to contest the claimant's entitlement, and if it failed to do so, was barred from challenging the claimant's entitlement in future proceedings, including on modification. In *D.S. v. Ramey Coal Co.*, 24 BLR 1-33 (2008), the BRB held that, in a claim governed by the revised regulations, an employer may request modification even if it did not previously participate in the claim's adjudication. Agreeing with the Director, the BRB reasoned that because the employer is deemed to have contested claimant's entitlement, the employer's failure to participate in the initial claim proceedings does not preclude it from challenging the claimant's entitlement through modification.

The black lung program regulations allow the withdrawal of a claim until a denial of the claim becomes effective; a withdrawn claim is treated as if it were never filed. The rules do not address withdrawal of modification petitions, however. In *W.C. v. Whitaker Coal Co.*, 24 BLR 1-20 (2008), the BRB held that, given this regulatory void, it is reasonable to treat a request for withdrawal of a modification petition in the same manner as a request for withdrawal of an original claim. Thus, the BRB held that a request for modification may be withdrawn until an effective decision on modification is entered. If withdrawal is allowed, the modification request is treated as if it were never filed.

Entitlement Criteria. Under the program regulations, a miner may establish total pulmonary disability based on pulmonary function test results that meet certain published values, which are calculated based on a miner's age and height. The tables of these "qualifying" values extend only to age 71, however. In *K.J.M. v. Clinchfield Coal*, 24 BLR 1-40 (2008), the BRB addressed how pulmonary function studies should be interpreted in black lung claims filed by miners older than 71. Agreeing with the Director, the BRB held that a fact-finder may not independently determine qualifying values for such a miner, but must apply the table values for a miner aged 71. The party opposing entitlement may submit evidence to prove that the test results are normal or otherwise do not establish total disability.

Evidentiary Limitations. The Black Lung program regulations limit the amount of medical evidence a party may submit in support of its affirmative case, in rebuttal of the opposing party's affirmative case, and to rehabilitate affirmative evidence that was the subject of rebuttal. Records of medical treatment or hospitalization for respiratory or pulmonary disease are not subject to the limitations, however. In *J.V.S. v. Arch of West Virginia*, 24 BLR 1-78 (2008), the BRB addressed several issues relating to the evidence-limiting rules. First, the BRB held that under the plain language of the regulations, each private party is allowed to submit a reading of the chest x-ray generated as a result of the medical examination the Department is statutorily required to provide each miner/claimant; the reading need not contradict the original reading by the government's physician. Second, the BRB held that a biopsy report contained in medical treatment records is subject to the exception for treatment records. Finally, the BRB held that although the rules do not provide directly for rebuttal of treatment records, they do allow for review of the records through other avenues, and therefore protect the due process rights of the parties. Thus, for example, the party opposing the claimant's entitlement may have the claimant's treatment records reviewed by the physicians who prepared its affirmative medical reports. In addition, an employer may have any biopsy slides contained in the miner's medical records reviewed by a pathologist and may then submit the resulting report as part of its affirmative evidence.

In *L.P. v. Amherst Coal Company*, 24 BLR 1-55 (2008), the BRB agreed with the Director and held that a party has the right to cross-examine a physician whose treatment records are submitted into evidence by the miner/claimant. The BRB reasoned that under Supreme Court precedent, the Administrative Procedure Act and the program regulations, "a party has a right to cross-examine a physician whose report is admissible under" the medical treatment records exception if "the physician's report is material and cross-examination is necessary to ensure the integrity and fundamental fairness of the adjudication of the claim and for a full and true disclosure of the facts." *Id.* at 1-63.

Time Limit for Requesting Hearing. Under the program regulations, a party has 30 days after the district director issues a proposed decision and order within which to request a hearing. The rules require that decisions be served by certified mail but do not specifically identify the date a decision is considered to be issued. Agreeing with the Director, the BRB held that a district director's

decision is not considered issued, and the period for requesting a hearing does not begin, until the decision is served on the parties by certified mail. *W.L. v. Director, OWCP*, 24 BLR 1-99 (2008).

Statute of Limitations. The Act provides that a claim for benefits must be filed within three years of a medical determination of total disability due to pneumoconiosis that has been communicated to the miner. Under the program regulations, each claim for benefits is presumed to be timely filed. Agreeing with the Director, the BRB held that a summary of a medical report included in a decision issued in a prior denied claim does not constitute a medical determination sufficient to commence the running of the Act's limitations period. In addition, the BRB held that communication of a medical determination to claimant's representative is insufficient, by itself, to establish that the determination was communicated to the claimant. *W.C. v. Benham Coal*, 24 BLR 1-50 (2008).

Black Lung Benefits Act

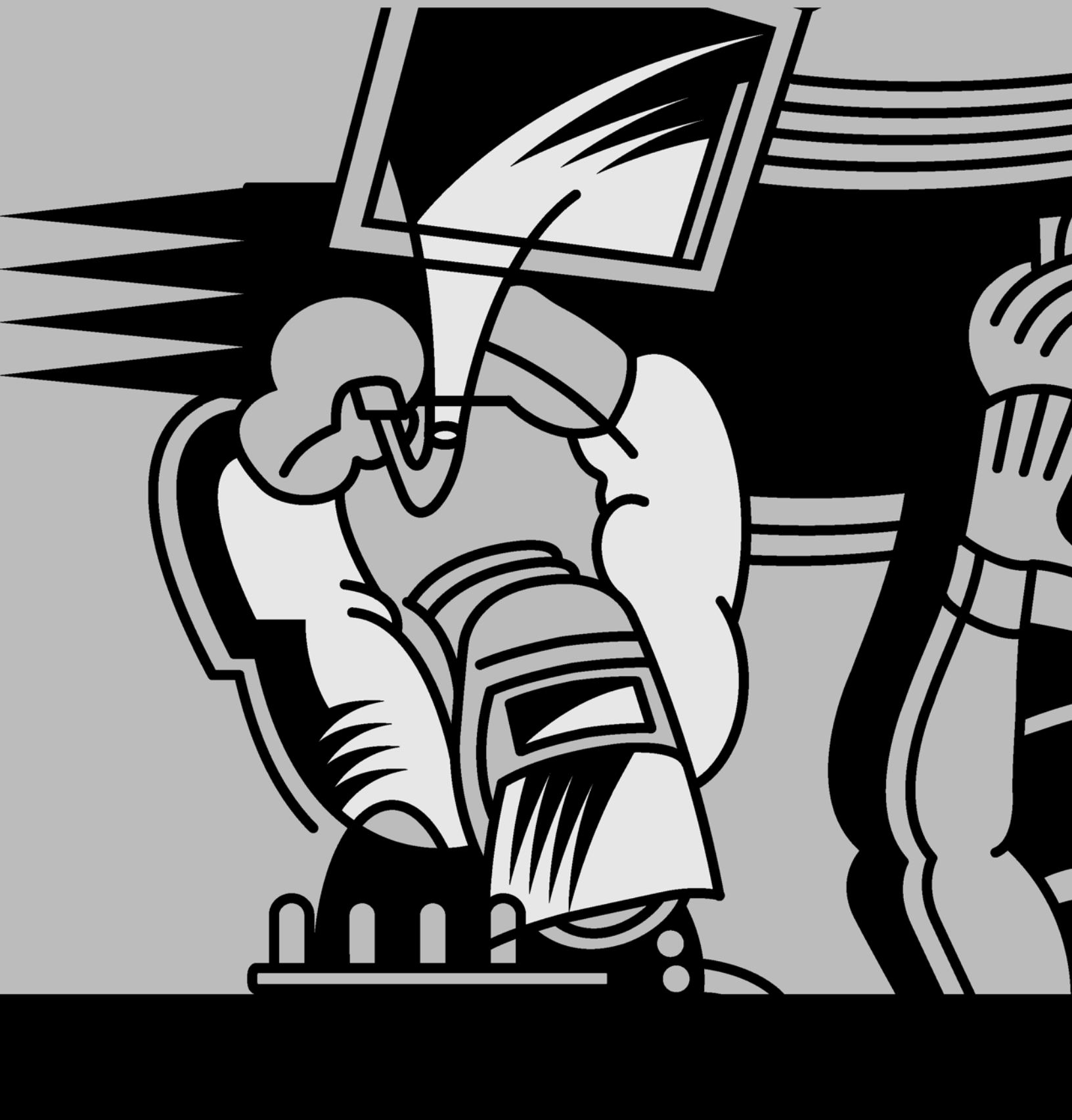
	Part C [1]		Part B [2]	
	FY 2007	FY 2008	FY 2007	FY 2008
Number of Employees (FTE Staffing Used)	185	179	17	16
OWCP Administrative Expenditures [3]	$ 33.2 M	$ 32.4 M	$ 5.4 M	$ 5.4 M
Total Compensation and Benefit Payments [4]	$291.3 M	$273.2 M	$289.5 M	$262.3 M
Beneficiaries in Pay Status at End of Fiscal Year				
Monthly	31,305	28,597	36,888	32,732
Medical Benefits Only	2,324	1,924	N/A	N/A
Responsible Coal Mine Operator Beneficiaries in Pay Status at End of Fiscal Year				
Monthly	4,830	4,616	N/A	N/A
Medical Benefits Only	777	662	N/A	N/A

[1] Part C benefits are paid out of the Black Lung Disability Trust Fund or by the liable coal mine operator or insurer.

[2] Part B benefits are paid out of general revenue funds from the U.S. Treasury.

[3] Part C figures exclude DOL and Department of Treasury support costs of $26.3 million in FY 2007 and $25.9 million in FY 2008, respectively. Also excludes interest on the Trust Fund debt.

[4] Part C figures exclude collections from responsible coal mine operators for benefits paid by the Trust Fund on an interim basis, refunds for OWCP administrative costs paid, and other miscellaneous reimbursements.



Longshore and Harbor Workers' Compensation Act

Introduction

Enacted in 1927, the Longshore and Harbor Workers' Compensation Act (LHWCA) provides compensation for lost wages, medical benefits, and

rehabilitation services to longshore, harbor, and other maritime workers who are injured during their employment or who contract an occupational disease related to employment. Survivor benefits also are provided if the work-related injury or disease causes the employee's death. These benefits are paid directly by an authorized self-insured employer, through an authorized insurance carrier, or in particular circumstances, by an industry-financed Special Fund.

In addition, LHWCA covers certain other employees through the following extensions to the Act:

The Defense Base Act (DBA) of August 16, 1941, extends the benefits of the LHWCA to employees working outside the continental United States under certain circumstances set out in jurisdictional provisions. Primarily it covers all private employment on U.S. military bases overseas, land used for military purposes on U.S. territories and possessions, and U.S. Government contracts overseas.

The Nonappropriated Fund Instrumentalities Act of June 19, 1952, covers civilian employees in post exchanges, service clubs, etc. of the Armed Forces.

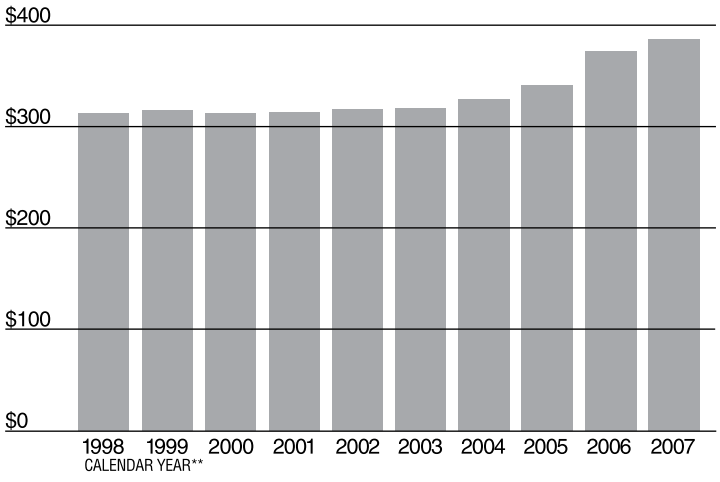
The Outer Continental Shelf Lands Act of August 7, 1953, extended Longshore benefits to employees of firms working on the outer continental shelf of the United States, such as off-shore drilling enterprises engaged in exploration for and development of natural resources.

The District of Columbia Workmen's Compensation Act (DCCA), passed by Congress on May 17, 1928, extended the coverage provided by the Longshore Act to private employment in the District of Columbia. Since the District of Columbia passed its own workers' compensation act effective July 26, 1982, OWCP handles claims only for injuries prior to that date.

The original law, entitled the Longshoremen's and Harbor Workers' Compensation Act, provided coverage to certain maritime employees injured while working over navigable waters. These workers had been held excluded from state workers' compensation coverage by the Supreme Court (*Southern Pacific Co. v. Jensen*, 244 U.S. 205 (1917)).

Longshore Benefit Expenditures

IN MILLIONS OF CONSTANT DOLLARS*



*Current dollars deflated by CPI-W (urban wage earners and clerical workers, U.S. city average, all items), 1982-1984=100.

**Includes total industry compensation and benefit payments under LHWCA and its extensions as reported on a calendar year basis.

Operations

Disability compensation and medical benefits paid by insurers and self-insurers under LHWCA and its extensions totaled $782.3 million in Calendar Year (CY) 2007, a 6.2 percent increase compared to CY 2006.

In Fiscal Year (FY) 2008, total DOL expenditures for program operations and the administration of LHWCA and its extensions were $23.9 million, of which $10.6 million were the direct costs of OWCP. The remaining $13.3 million represents the cost of legal, audit, and investigative support provided by the Office of Administrative Law Judges (OALJ), the BRB, the Office of the Solicitor, and the Office of the Inspector General.

At year's end, the Division of Longshore and Harbor Workers' Compensation (DLHWC) employed 97 people in the national office and 11 district offices.

During FY 2008, approximately 560 self-insured employers and insurance carriers reported 29,170 lost-time injuries under the LHWCA. At year's end, 14,365 maritime and other workers were in compensation payment status.

The conflicts in Iraq, Afghanistan, and related military activities in the Middle East continued to generate interest in Longshore program operations as they relate to the administration of the DBA in FY 2008. Injuries occurring under DBA are reported to DLHWC District Offices determined by the geographic location of the injury occurrence. To address the high volume of DBA cases and reduce the anticipated growth in claims backlog in the New York District Office, the Longshore program began redistributing the Middle East DBA workload among all its district offices in FY 2008. During the year, a total of 11,367 cases of injury and death were reported under DBA.

Longshore Special Fund

The Special Fund under the LHWCA was established in the Treasury of the United States pursuant to section 44 of the Act and is administered by the national office of DLHWC. Proceeds of the fund are used for payments under section 10(h) of the LHWCA for annual adjustments in compensation for permanent total disability or death that occurred prior to the effective date of the 1972 amendments, under section 8(f) for second injury claims, under section 18(b) for cases involving employer insolvency, under sections 39(c) and 8(g) for providing rehabilitation assistance to persons covered under the LHWCA, and under section 7(e) to pay the cost of medical examinations.

The Special Fund is financed through fines and penalties levied under the LHWCA; $5,000 payments by employers for each instance in which a covered worker dies and when it is determined that there are no survivors eligible for benefits; interest payments on Fund investments; and payment of annual assessments by authorized insurance carriers and self-insurers. Fines, penalties, and death benefit levies constitute a small portion of the total amount paid into the Special Fund each year. The largest single source of money for the fund is the annual assessment.

A separate fund under the DCCA is also administered by OWCP. Payments to and from this fund apply only to the DCCA.

The LHWCA Special Fund paid $126.9 million in benefits in FY 2008, of which $116.9 million was for second injury (section 8(f)) claims. FY 2008 expenditures from the DCCA Special Fund totaled $10.0 million, of which $9.1 million was for second injury cases.

Government Performance Results Act

In FY 2008, DLHWC revised the baseline for the following indicator under the DOL strategic goal to "minimize the human, social, and financial impact of work-related injuries for workers and their families":

For average time required to resolve disputed issues in LHWCA program contested cases, the FY 2008 baseline is 239 days. Targets for the following years will be established using this result.

This indicator is intended to measure OWCP's success in resolving claim disputes between injured workers and their employers and insurers. Dispute resolution is one of the core missions of the Longshore program. While not a judge or a hearing officer, a Longshore claims examiner contributes to the resolution of disputed issues by acting as a mediator in informal proceedings designed to help parties to a claim reach amicable agreement and thereby avoid the time and expense required by formal litigation. In FY 2008, the district offices conducted 2,885 informal conferences that were designed to establish the facts in each case, define the disputed issues and the positions of the parties in respect to those issues, and encourage their voluntary resolution by means of agreement and/or compromise.

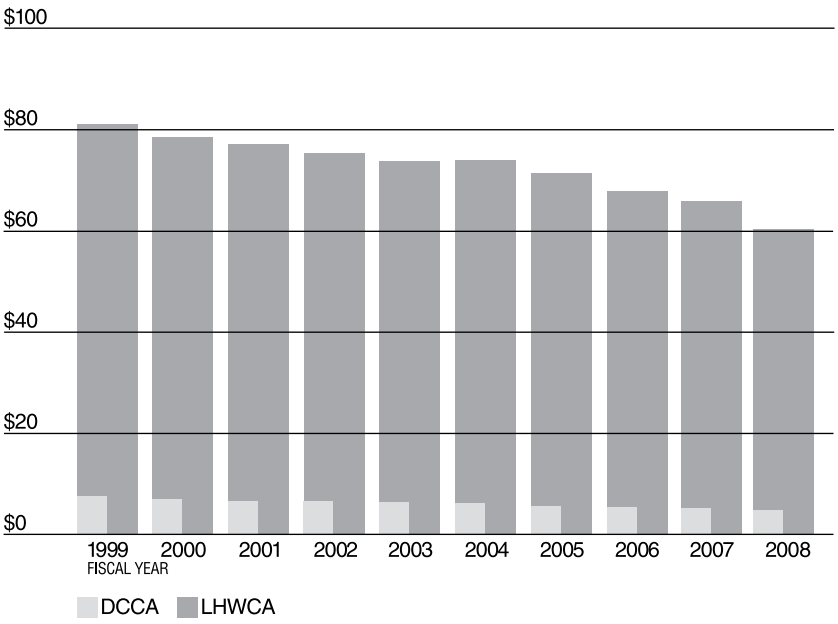
OWCP continues to provide its claims staff with additional training to improve mediation skills and case management strategies to shorten the time required to resolve disputes.

Performance Assessment

In response to the recommendations from the 2005 Program Assessment Rating Tool (PART), the Longshore program completed action to re-baseline and develop out-year targets for the dispute resolution measure and added an improvement plan to create two new performance measures to track and measure benefit facilitation. The results of an independent study completed in FY 2006 by a private consulting firm, SRA Corporation, included recommendations for extensive upgrades to the automated claims management system to improve benefit tracking and allow benchmarking against workers' compensation programs in various states. The program continues to evaluate means to update its automated systems. A second study completed at the end of FY 2007 with the same contractor

LHWCA and DCCA Special Funds' Expenditures, FY 1999-FY 2008

IN MILLIONS OF CONSTANT DOLLARS*



*Current dollars deflated by CPI-W (urban wage earners and clerical workers, U.S. city average, all items), 1982-1984=100.

evaluated the overall effectiveness and efficiency of the program. Longshore has completed SRA's recommendations to further expand the number of offices that handle Middle East DBA cases by redistributing DBA cases to all district offices based on the claimant's current address and computerized tracking of the movement of cases in and out of the district offices. The remaining recommendations are under review and evaluation by the program for implementation.

Based on the PART evaluation and in reaction to the submission of legislative reform proposals by industry, the program continues its evaluation of the statute with the intention of submitting any requested responses or technical assistance. Although industry-submitted legislation was not acted upon in FY 2008, future industry proposals are anticipated.

DLHWC program performance, as measured by GPRA outcome metrics, quarterly reviews of district office performance, and periodic accountability reviews, continues to be excellent.

Claims Management and Compliance Assistance Activities

The number of DBA injury and death reports of civilian contractors in Iraq and Afghanistan continued at its elevated level in FY 2008, with cases totaling 9,494, of which 225 involved the death of a worker. Between FY 2003 and FY 2008, a total of 39,423 DBA cases were reported, including 1,545 deaths, of which 30,769 cases (1,384 deaths) originated in Iraq and Afghanistan.

The Longshore program continued its efforts to address issues and questions about the ongoing increases in DBA claims arising from Iraq and Afghanistan. The staff has worked diligently to address such issues as the effective handling of Post-traumatic Stress Disorder claims and the challenges of managing the claims of Iraqi nationals in a nation with complex cultural differences, communications challenges, banking and infrastructure difficulties, and lack of available medical care. The major participants, including insurance companies and contracting agencies, were invited to meetings throughout the year to discuss and resolve these issues in advance of their becoming major problems.

In response to the burgeoning number of DBA claims, DLHWC has continued the distribution of claims from Iraq and Afghanistan from the New York City District Office, which in the past handled all claims from that region, to the district office closest to the claimant's residence. Without this management step, the New York office would have quickly become overwhelmed by the workload, and customer service would have deteriorated.

Additionally, the quickly escalating number of Freedom of Information Act requests, Congressional inquiries, requests for data and analysis, media questions, and submissions from contracting agencies, contractors, insurers, attorneys, and claimants continued at very high levels, requiring prioritization.

The Longshore program's efforts to enhance its Compliance Assistance to the public continued in FY 2008, with more information added to its website, continued local surveys of industry to identify pockets of coverage compliance deficiencies, and public speaking at many conferences and seminars around the country.

Rehabilitation Reforms

During FY 2008, DLHWC began relying on the new rehabilitation performance measure to provide a new perspective on the work of the district office rehabilitation specialists in their efforts to recruit claimants to participate in the rehabilitation program; to shepherd participants successfully through evaluation, planning, and service provision; and to focus efforts on successful job placement. The program exceeded its vocational rehabilitation goal in FY 2008 with 54.6 percent of rehabilitation plan completers returning to work within 60 days against a target of 51.2 percent, despite significant challenges in the job market.

The rehabilitation pilot project in the Jacksonville District Office continued through the fiscal year, although the initial results were not impressive. The effort was intended to use financial incentives to improve the return-to-work outcome in the program but, in fact, the preliminary results appeared to be increased costs with no change in the outcome.

Litigation

During FY 2008, the courts of appeals published six decisions, and the Benefits Review Board (BRB) twenty-two decisions, that discussed issues arising under the LHWCA or its extensions. Important points from some of these cases are summarized below.

COURTS OF APPEALS

Attorney Fees for Obtaining Additional Compensation Under 33 U.S.C. § 914(f). The Ninth Circuit agreed with the Fourth Circuit and held that a claimant's attorney may receive a fee for services performed in obtaining additional compensation for the claimant pursuant to 33 U.S.C. § 914(f) based on the employer's failure to pay the compensation due within ten days after filing and service of a compensation order. *Tahara v. Matson Terminals, Inc.*, 511 F.3d 950 (9th Cir. 2007). The Ninth and Fourth Circuits therefore disagree with the Second Circuit as to the claimant's attorney's entitlement to a fee. The LHWCA shifts liability for a claimant's attorney fee to the employer if the employer declines to pay compensation and the claimant, represented

by counsel, successfully prosecutes his claim. 33 U.S.C. § 928(a). The Court held that the award of twenty percent additional compensation under section 14(f) is an award of compensation for purposes of 33 U.S.C. § 928(a) and therefore affirmed the district court's award of a claimant's attorney fee to be paid by the employer. In so holding, the Court considered the plain language of section 914(f), its legislative history, and its purpose of encouraging the prompt payment of awards.

Attorney Fees – 33 U.S.C. § 928(a). The Sixth Circuit held that a claimant's counsel is not entitled to receive a fee for work performed on a LHWCA claim before the employer controverts the claim. *Day v. James Marine, Inc.*, 518 F.3d 411 (6th Cir. 2008) (Rogers, J., dissenting). Section 928(a) provides that a claimant's attorney fee liability shifts to the employer if the employer declines to pay compensation within thirty days after receiving written notice of the claim and the claimant "shall thereafter have utilized the services of an attorney" to secure a compensation award. 33 U.S.C. § 928(a). A majority of the panel held that the word "thereafter" imposes a temporal point before which the employer is not liable for a fee; fee liability attaches only to attorney work performed after the employer controverts the claim. In so holding, the majority rejected the Director's position that once fee liability is found to have shifted to an employer, the claimant's attorney is entitled to a reasonable fee for necessary work performed prior to the employer's controversion of the claim.

Timeliness – 33 U.S.C. § 913(a). The Third Circuit held that the one-year statutory period for filing a timely claim does not commence until the claimant is fully aware of the connection between his condition and a work-related injury. *C & C Marine Maintenance Co. v. Bellows*, 538 F.3d 293 (3rd Cir. 2008). In this case, the employee suffered chemical burns to his ankle in a work-related accident; two years later, a physician informed the claimant's attorney that the chemical burns could have aggravated pre-existing degenerative changes in his ankle. The Court held that the claimant was not aware of the full extent of the harm caused by the work injury until the physician informed his attorney of the possible connection. Because the claimant filed within one year of learning this information, the Court held the claim was timely filed.

Invocation of the Presumption and Secondary Medical Conditions – 33 U.S.C. § 920(a). The Fifth Circuit held that a secondary medical condition is causally connected to the primary work-related injury for purposes of invoking the section 920(a) presumption only if the claimant proves the secondary condition is the natural or unavoidable result of the primary injury. *Amerada Hess Corp. v. Director, OWCP (Dover)*, 543 F.3d 755 (5th Cir. 2008) (Reavley, J., concurring). Here, the employee injured his back at work. He received steroid injections as part of his treatment and eventually sustained significant weight gain, hypertension, and heart attacks. Based solely on lay testimony concerning the timing of the steroid treatment and the secondary cardiac problems, an ALJ found the claimant's heart condition could have arisen from the steroid treatment and invoked the section 920(a) presumption as to this secondary condition. The Court vacated the ALJ's finding. Holding that the section 920(a) presumption applied only to the claim for the back injury, the Court concluded that the ALJ erroneously applied the presumption to the secondary condition. Instead, the Court

required a separate determination, without the benefit of the statutory presumption, as to whether the claimant's cardiac condition "naturally or unavoidably" resulted from the back injury. The Court also suggested that expert medical evidence might be necessary to establish the required connection.

LHWCA Exclusivity, Third-Party Tort Claims – 33 U.S.C. §§ 905(b) and 933. The Fifth Circuit held that the LHWCA did not preempt an injured shipyard worker's state negligence claim against a vessel's owner as a third-party for injuries sustained in the course of employment because the worker could not recover from the vessel owner under section 905(b) and section 933 expressly preserves all claims against third parties. *McLaurin v. Noble Drilling (U.S.), Inc.*, 529 F.3d 285 (5th Cir. 2008). The claimant, an employee of a shipyard, was injured while working on a vessel owned by Noble Drilling; the injury occurred on land away from the vessel. The claimant sued the vessel owner for negligence. The district court dismissed the section 905(b) suit because the injury occurred on land, and the remaining negligence claims on the theory that section 905 provided the exclusive remedy against the vessel owner. The Fifth Circuit affirmed dismissal of the section 905(b) claim because an injury on land does not invoke "maritime" jurisdiction but reversed as to the unavailability of the tort action. Because a section 905(b) "maritime tort" must occur on navigable waters, the Court held that the claimant's section 905(b) action failed. The Court reversed the district court's determination that the exclusivity provision of section 905 preempted any other tort action, however. It reasoned that the vessel owner's status was irrelevant; the determinative issue was the type of negligence the claimant alleged and the duty the owner owed the claimant. The Court held that section 933 preserves a claimant's ability to pursue tort claims against a vessel owner as a third-party tortfeasor regardless of the section 905 exclusivity provision.

Manifest Requirement for Employer's Relief from Liability – 33 U.S.C. § 908(f). To be eligible for section 908(f) relief, an employer must prove that its employee's pre-existing disability was manifest. An employer can satisfy the manifest requirement by demonstrating that it had either actual or constructive knowledge of the pre-existing disability. Constructive knowledge can be established by showing that the employer could have discovered the disability by looking at an employee's medical records. In this case, the Third Circuit held that the employer failed to meet its burden to prove that the disability was manifest when it argued that medical records must exist although it failed to produce them. *C & C Marine Maintenance Co. v. Bellows*, 538 F.3d 293 (3rd Cir. 2008).

BENEFITS REVIEW BOARD

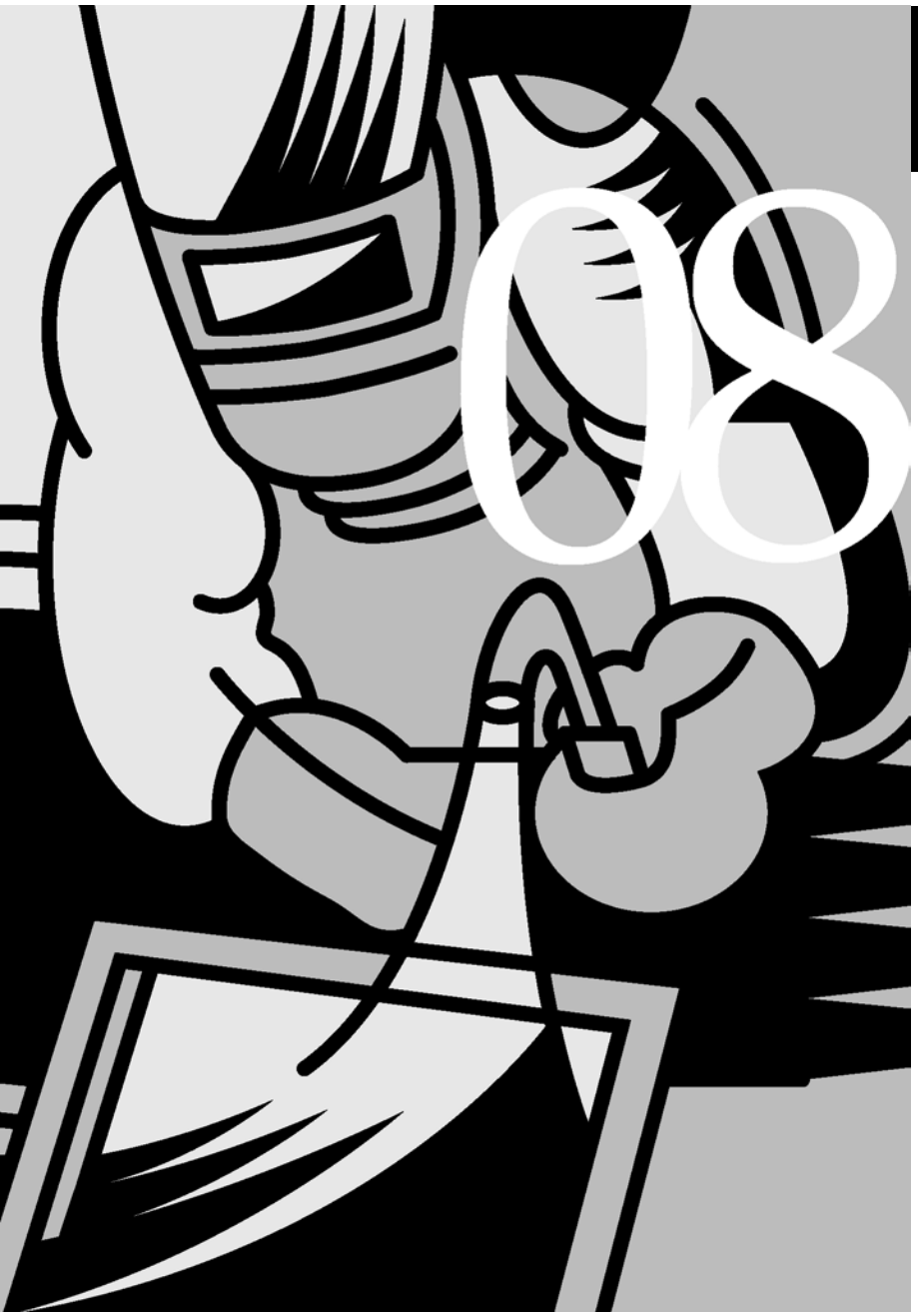
DBA – "Zone of Special Danger" and 33 U.S.C. § 920(a). Defense Base Act (DBA) cases comprised an increased percentage of the BRB's workload. The BRB held that a claimant's injury was covered by the DBA as it occurred "in the course of employment" and within the "zone of special danger," despite the fact it resulted from personal misconduct and was not the direct result of his employment. *N.R. v. Halliburton Services*, 42 BRBS 56 (2008) (McGranery, J. dissenting). In this case, the claimant terminated his employment in Afghanistan and requested transportation to the United States. An altercation ensued over the proposed transportation, and the claimant was injured when he refused to comply with military police orders. The ALJ found that the claimant did not invoke the section 920(a) presumption because these facts did not bring him within the DBA's "zone of special danger." Specifically, the ALJ found that claimant's own conduct in resisting lawful authority caused his injury, and that his actions "so thoroughly disconnected" him from his employment that the injury did not arise out of, or in the course of, that employment. The BRB reversed. It rejected the ALJ's reliance on the claimant's fault in causing his injury and the lack of any direct connection between the injury and his employment. The BRB held, as a matter of law, that the claimant's injury came within the "zone of special danger" because the injury originated due to conditions of his employment and that employment placed him within an environment of unique risks.

Liability of Corporate Officers For Failure to Secure the Payment of Compensation – 33 U.S.C. § 938. In a case of first impression, the BRB held that an ALJ erroneously reopened an issue concerning corporate officer liability at the hearing after issuing pre-hearing orders disposing of it. *E.B. v. Atlantico, Inc.*, 42 BRBS 40 (2008). In pre-hearing orders, the ALJ denied motions to dismiss filed by two corporate officers of an uninsured, bankrupt employer based on evidence supplied by the Director. At the hearing, the ALJ stated he would dismiss the officers because no evidence supported their individual liability under 33 U.S.C. § 938. The ALJ denied the claimant's motion to reopen the record and accept the documents previously submitted by the Director; he thereafter dismissed all four corporate officers. The BRB vacated the ALJ's dismissal. It held that the ALJ erroneously reopened the corporate officer liability issue without notice to the parties and after having issued dispositive pre-hearing orders denying dismissal. The BRB further held that the ALJ abused his discretion in refusing to reopen the record for receipt of evidence bearing on an issue he had unilaterally reopened.

Sufficient Audiogram to Establish Pre-existing Permanent Partial Disability – 33 U.S.C. § 908(f). In two separate cases, the BRB held that an employer may support its application for relief from liability pursuant to 33 U.S.C. § 908(f) with an audiogram even though it did not provide the claimant with a copy of that audiogram as required by the regulations. *G.K. v. Matson Terminals, Inc.*, 42 BRBS 15 (2008), *mot. for recon. den'd*, unpublished, BRBS Nos. 05-0293 & 07-0643

(Sept. 29, 2008); *R.H. v. Bath Iron Works Corp.*, 42 BRBS 6 (2008). Section 702.321 of the regulations requires an audiogram to comply with 20 C.F.R. § 702.441 in order to constitute evidence of a pre-existing hearing loss for purposes of section 908(f). 20 C.F.R. § 702.321(a). Section 702.441 requires that in order for an audiogram to be deemed "presumptive" evidence of hearing loss, a copy of the audiogram and the interpretive report must be provided to the employee. 20 C.F.R. § 702.441(a)(2). In both cases, the employer relied on an audiogram to establish the employee's hearing loss, but did not provide the employee with a copy of the audiogram or the interpretive report. The BRB concluded that the employer's failure to provide the employee with a copy of the audiogram did not preclude the employer from relying on it for purposes of section 908(f) relief. Rather, the employer need only submit audiograms that are reliable and probative evidence in order to support a section 908(f) request.

Suspension of Compensation for Failure to Attend Independent Medical Examination – 33 U.S.C. § 907(f). The BRB held that only the adjudicator before whom a claim is pending is authorized to suspend compensation payments if the claimant refuses to attend an independent medical examination (IME) scheduled by the district director. *L.D. v. Northrop Grumman Ship Systems, Inc.*, 42 BRBS 1 (2008), *mot. for recon. den'd*, 42 BRBS 46 (2008). Here, the district director scheduled the claimant for an IME and selected a physician to perform the examination. 33 U.S.C. § 907(e). The claimant refused to attend the examination, alleging that the physician was not qualified because he had received payments from the employer for workers' compensation examinations within the past two years. The claimant argued that the physician was therefore prohibited from performing an IME by statute: 33 U.S.C. § 907(i). The district director transferred the claim to OALJ for a hearing, and thereafter suspended the claimant's compensation for the duration of his refusal to attend the IME. The BRB vacated the district director's suspension order holding that only the ALJ could suspend compensation while the claim was pending before him. On reconsideration, the BRB further held that the statutory suspension of "proceedings" for the duration of the claimant's refusal to attend the IME does not prevent the BRB from reviewing an appeal from the order suspending compensation. 33 U.S.C. §§ 907(f), 919(h).



Longshore and Harbor Workers' Compensation Act

	FY 2007	FY 2008
Number of Employees (FTE Staffing Used)	95	97
Administrative Expenditures[1]	$ 12.8 M	$ 12.6 M
Lost-Time Injuries Reported	33,395	29,170
Total Compensation Paid[2]	$882.3 M	$926.7 M
Wage-Loss and Survivor Benefits	$619.5 M	$642.9 M
Medical Benefits	$262.8 M	$283.8 M
Sources of Compensation Paid		
Insurance Companies[2]	$367.6 M	$456.8 M
Self-Insured Employers[2]	$368.7 M	$325.5 M
LHWCA Special Fund	$131.9 M	$126.9 M
DCCA Special Fund	$ 10.1 M	$ 10.0 M
DOL Appropriation	$ 2.4 M	$ 2.3 M

[1] Direct administrative costs to OWCP only; excludes DOL support costs of $16.0 million in FY 2007 and $13.3 million in FY 2008, respectively.

[2] Figures are for CY 2006 and CY 2007, respectively. Note: Total compensation paid does not equal the sum of the sources of compensation due to the different time periods (CY v. FY) by which the various data are reported. For Special Fund assessment billing purposes as required by section 44 of LHWCA, compensation and medical benefit payments made by insurance carriers and self-insured employers under the Acts are reported to DOL for the previous calendar year.

Energy Employees Occupational Illness Compensation Program Act

Introduction

Congress passed the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act) in October 2000. Part B of the Act, effective on

July 31, 2001, compensates current or former employees (or their survivors) of the Department of Energy (DOE), its predecessor agencies, and certain of its vendors, contractors, and subcontractors, who were diagnosed with a radiogenic cancer, chronic beryllium disease, beryllium sensitivity, or chronic silicosis as a result of exposure to radiation, beryllium, or silica while employed at covered facilities. The EEOICPA also provides compensation to individuals (or their eligible survivors) awarded benefits by the Department of Justice (DOJ) under Section 5 of the Radiation Exposure Compensation Act (RECA).

Part E of the Act (effective October 28, 2004) replaced the former Part D and compensates DOE contractor/subcontractor employees, eligible survivors of such employees, and uranium miners, millers, and ore transporters as defined by RECA Section 5 for illnesses that are linked to toxic exposures in the DOE or mining work environment.

On July 31, 2008, the Department of Labor (DOL) marked the seventh anniversary of its administration of the EEOICPA. DOL has served a far larger audience than even the proponents of the statute predicted at the time of enactment, and the compensation totals have far exceeded Congress' initial expectations. From the program's inception to the end of Fiscal Year (FY) 2008, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) has awarded compensation and medical benefits totaling nearly $4.2 billion under both Parts B and E of the Act. During this time, over 44,600 employees or their families have received more than $3.9 billion in compensation and nearly $255 million in medical expenses associated with the treatment of accepted medical conditions. Part B compensation has totaled more than $2.6 billion (since 2001) while Part E compensation was nearly $1.3 billion (since 2005).

In FY 2008 alone, nearly 6,000 employees or their families received $484.4 million in Part B compensation. In addition, more than 4,700 employees or their families received $456.7 million in Part E compensation. A total of $71.4 million was paid in covered medical benefits in FY 2008 under both Parts B and E of the Act, bringing total benefits to more that $1 billion for the year.

Administration

The EEOICPA continues to be an intergovernmental activity, involving the coordinated efforts of four federal agencies to administer the Act: DOL, DOE, DOJ, and the Department of Health and Human Services (HHS). DOL has primary responsibility for administering the Act, including adjudication of claims for compensation and payment of benefits for conditions covered by Parts B and E.

DOE designates Atomic Weapons Employer (AWE) facilities and provides DOL and HHS with verification of covered employment and relevant information on exposures including access to restricted data. DOJ notifies beneficiaries who have received an award of benefits under RECA Section 5 of their possible EEOICPA eligibility and provides RECA claimants with information required by DOL to complete the claim development process.

HHS, through its National Institute for Occupational Safety and Health (NIOSH), establishes procedures for estimating radiation doses, develops guidelines to determine the probability that a cancer was caused by workplace exposure to radiation, establishes regulations and procedures for designation of new Special Exposure Cohort (SEC) classes, and carries out the actual dose reconstruction for cases referred by DOL. Under the Act, Congress established the SEC to allow eligible claims to be compensated without the completion of a radiation dose reconstruction or determination of the probability of causation. To qualify for compensation under the SEC, a covered employee must have at least one of twenty-two "specified cancers" and have worked for a certain period of time at an SEC facility. HHS also provides administrative services and other necessary support to the Advisory Board on Radiation and Worker Health. The Board advises HHS on the scientific validity and quality of dose reconstruction efforts and receives and provides recommendations on petitions submitted requesting additional classes of employees for inclusion as members of the SEC.

Benefits Under the Act

Part B. To qualify for benefits under Part B of the Act, an employee must have worked for DOE or a DOE contractor or subcontractor during a covered time period at a DOE facility, or have worked for a private company designated as a covered AWE or beryllium vendor. The worker must have developed cancer, chronic beryllium disease, or beryllium sensitivity due to exposures at a covered work site, or chronic silicosis (for individuals who worked in Nevada and Alaskan nuclear test tunnels). A covered employee who qualifies for benefits under Part B may receive a one-time lump-sum payment of $150,000, plus medical expenses related to an accepted, covered condition. Survivors of these workers may also be eligible for a lump-sum compensation payment. Part B also provides for payment of $50,000 to individuals (or their eligible survivors) who received an award from DOJ under Section 5 of the RECA.

For all claims filed under Part B of the Act, the employment and illness documentation is developed by claims staff and evaluated in accordance with the criteria in the EEOICPA and relevant regulations and procedures. DOL district offices then issue recommended decisions to claimants. Claims filed under Part B for the $50,000 RECA supplement are the least complex, involving verification by DOJ that a RECA award has been made and documentation of the identity of the claimant (including survivor relationship).

DOL can also move quickly on cases involving "specified cancers" at SEC facilities because the Act provides a presumption that any of the twenty-two listed cancers incurred by an SEC worker was caused by radiation exposure at the SEC facility. For cases involving claimed cancers that are not covered by SEC provisions (that is, either cancers incurred at a non-SEC facility, a non-specified cancer incurred at an SEC facility, or an employee who did not have sufficient employment duration to qualify for the SEC designation), there is an intervening step in the process to determine causation called "dose reconstruction." In these instances, once DOL determines that a worker was a covered employee and that he or she had a diagnosis of cancer, the case is referred to NIOSH so that the individual's radiation dose can be estimated. After NIOSH completes the dose reconstruction and calculates a dose estimate for the worker, DOL takes this estimate and applies the methodology promulgated by HHS in its probability of causation regulations to determine if the statutory causality test is met. The standard is met if the cancer was "at least as likely as not" related to covered employment, as indicated by a determination of at least a 50 percent probability.

Part E. EEOICPA's Part E establishes a system of federal payments for employees of DOE contractors and subcontractors (or their eligible survivors) for illnesses determined to have resulted from exposure to toxic substances at a covered DOE facility. Uranium miners, millers, and ore transporters as defined by Section 5 of the RECA may also receive Part E benefits. Benefits are provided for any illness if it can be determined that it was "at least as likely as not" that exposure to a toxic substance was a significant factor in causing, contributing to, or aggravating the illness or death of an employee. Additionally, the Act provides that any determination made under Part B to award benefits (including RECA Section 5 claims), is an automatic acceptance under Part E for causation of the illness, where the employment criteria is also met. The maximum payable compensation under Part E is $250,000 for all claims relating to any individual employee.

Under Part E, a covered employee may also be eligible to receive compensation for the varying percentage of impairment of the whole person that is related to a covered illness. The Act specifically requires that impairment be determined in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment (*AMA's *Guides).* Impairments included in ratings are those that have reached maximum medical improvement (MMI), *i.e.*, they are well-stabilized and unlikely to improve substantially with or without medical treatment. MMI is not required if an illness is in a terminal or progressive stage. Eligible employees receive $2,500 for each percentage point of impairment found to be attributable to a covered illness under Part E.

Also under Part E, covered employees may be eligible to receive compensation for wage-loss. Wage-loss is based on each qualifying year (prior to normal Social Security Administration retirement age) in which, as a result of the covered illness, an employee's earnings fell a specific percentage below his or her average annual earnings for the 36-month period prior to suffering wage-loss (not including periods of unemployment). The Act provides that covered, eligible employees may receive $15,000 for any year in which they made less than 50 percent of their pre-disability average annual wage, as a result of a covered illness, and $10,000 for any year in which they made more than 50 percent but less than 75 percent of that average annual wage. Medical benefits for the covered condition are also payable, in addition to compensation.

Part E survivor benefits include a basic lump sum of $125,000 where it is established that the employee was exposed to a toxic substance at a DOE facility and that the exposure was "at least as likely as not" a significant factor in causing, contributing to, or aggravating the illness and death of the employee. Part E also provides $25,000 in additional benefits to eligible survivors, if the deceased employee had, as of his or her normal retirement age under the Social Security Act, at least ten aggregate calendar years of wage-loss of at least 50 percent of his or her average annual wage. If an employee had twenty or more such years, the additional amount paid to an eligible survivor may increase to $50,000. The maximum Part E compensation benefit for a survivor is $175,000.

Funding

DOL funding covers direct and indirect expenses to administer the Washington, D.C., National Office; five Final Adjudication Branch Offices; four DEEOIC District Offices in Seattle, Washington; Cleveland, Ohio; Denver, Colorado; and Jacksonville, Florida; and eleven Resource Centers operated by a contractor. A private contractor processes medical bills to reduce overhead and to increase program efficiency. In FY 2008, DOL spent $50.5 million under Part B and $56.1 million under Part E to administer EEOICPA. These funds supported 299 full-time equivalent (FTE) staff for Part B and 244 FTE for Part E. Under Part B in FY 2008, additional funding in the amount of $55.4 million was passed through DOL to support activities at NIOSH. The NIOSH portion included $4.5 million in funds for the radiation dose reconstruction process and support of the Advisory Board on Radiation and Worker Health. Under Part E, $0.8 million in additional funds were used to support an Ombudsman position.

Adjudication of Claims

In FY 2008, DEEOIC continued to receive a substantial number of new claims, creating a total of 5,462 new cases (7,794 new claims) for living or deceased employees under Part B and 6,313 new cases (8,373 new claims) under Part E. Each case represents an employee whose illness is the basis for a claim; however, a single case may contain multiple survivor claims. Under the Act, workers or their survivors may qualify for Part B benefits only, Part E benefits only, or benefits under both Parts B and E.

Under the Act, the Secretary of HHS is responsible for adding new classes of employees to the SEC where dose reconstruction cannot be done by NIOSH. The Act initially designated four sites (the three gaseous diffusion plants in Oak Ridge, Tennessee; Paducah, Kentucky; and Portsmouth, Ohio; and an underground nuclear test site on Amchitka Island, Alaska) as belonging to the SEC. As of September 30, 2008, NIOSH had added 35 additional SEC classes to the four statutory classes, which combined, represent workers at 31 facilities. During FY 2008, NIOSH added 10 SEC classes at the following facilities: Combustion Engineering in Windsor, Connecticut; Hanford Engineer Works (200 & 300 Areas) in Richland, Washington; Horizons, Inc. in Cleveland, Ohio; Kellex/Pierpont in Jersey City, New Jersey; Lawrence Livermore National Laboratory (LLNL) in Livermore, California; Mound Plant in Miamisburg, Ohio; Nuclear Materials and Equipment Corporation (NUMEC) in Parks Township, Pennsylvania; SAM Laboratories, Columbia University, New York, New York; Spencer Chemical in Pittsburg, Kansas; and the Y-12 Plant in Oak Ridge, Tennessee. When a new SEC class is identified, DOL reviews all affected cases to determine if the employee in question meets the new criteria. Any previously

denied claim with employment meeting the new definition is reopened for additional development and a new recommended decision.

In addition to the added SEC classes, NIOSH also at times issues modifications to the underlying scientific rationale for performing a dose reconstruction based on further research into the etiology of specific cancers and issues changes in instructions for completing dose reconstructions for particular groups of employees and facilities. These modifications are issued in the form of a Program Evaluation Report (PER) and Program Evaluation Plan (PEP). Whenever a PER or PEP is issued, DOL works with NIOSH to identify all cases affected by the changes and, where necessary, reopens claims for new dose reconstructions to be performed. This process has led to the review of several thousand cases with DOL returning over 4,000 cases to NIOSH for rework.

For claims filed under Part E, claims examiners use an array of tools including the Site Exposure Matrices (SEM) database that provides information about substances commonly used in DOE facilities and the types of occupational illnesses and health effects associated with exposure to toxic substances. District offices also rely on DOE's records that contain employees' radiological dose records, incident or accident reports, industrial hygiene or safety records, personnel records, job descriptions, medical records, and other records that prove useful in determining causation. Additionally, a referral to a District Medical Consultant (DMC) may be required to determine a medical diagnosis, whether or not an illness is indicative of toxic substance exposure versus a natural medical process, whether there is a causal relationship between all claimed conditions and the occupational exposure history, or to evaluate an employee's cause of death. DMC referrals may also be necessary for impairment evaluations and for opinions regarding the causal relationship between a covered illness and claimed wage-loss. As of September 30, 2008, 88 DMCs were providing services to the program, and in FY 2008, DEEOIC processed a total of 6,126 referrals to DMCs. Additionally, claims are sometimes referred to a health physicist, industrial hygienist, or a toxicologist when a scientific determination regarding the case is required. In FY 2008, DOL's health physicists, industrial hygienists, and toxicologists received and reviewed 42 technical objections, 148 exposure referrals, and 631 rework requests on case files.

Recommended Decisions and Final Decisions. The DEEOIC district offices issue recommended decisions to claimants, recommending either acceptance or denial of claims. The Final Adjudication Branch (FAB) provides reviews of each recommended decision made by the district office to ensure that the Act's requirements, program policies, and procedures are followed. The FAB also considers challenges brought forth by claimants through reviews of the written record or oral hearings. For each claim, the FAB reviews the evidence of record, the recommended decision, and any objections/testimony submitted by the claimant and issues a final decision either awarding or denying benefits. The FAB may also remand a decision to the district office if further development of the case is necessary. Additionally, claimants may challenge the FAB's final decisions through reconsideration and reopening processes or may seek review of a final decision in a U.S. District Court. While Part B and Part E of the EEOICPA each have unique eligibility criteria, DEEOIC adjudicates all claims for benefits under Parts B and E as a unified claim for greater efficiency and, where possible, decisions are issued that address both Parts B and E simultaneously.

However, partial decisions may also be issued in cases where benefits under some provisions can be awarded, but claims under other provisions require further development.

In FY 2008, DEEOIC district offices issued 12,928 Part B claim-level recommended decisions and 14,066 Part E claim-level recommended decisions. The FAB in FY 2008 conducted 1,079 oral hearings and issued 12,200 Part B claim-level final decisions and 13,440 Part E claim-level final decisions. As of September 30, 2008, DOL approved benefits in 53.2 percent of Part B covered cases and 56.1 percent of Part E covered cases that were issued a final decision.

Outreach Activities

The DEEOIC continues to sponsor outreach activities to disseminate information about EEOICPA benefits and to provide one-on-one assistance to claimants applying for benefits.

Resource center and district office personnel supported the collaborative outreach efforts led by DEEOIC's Branch of Outreach and Technical Assistance (BOTA) in the national office. As additional classes of employees were designated by the Secretary of HHS to the SEC, DOL sponsored seven town hall meetings and traveling resource centers to present details about the new SEC classes and to answer claimant questions. Further, DEEOIC sponsored 18 town hall meetings focused on providing information to the Section 5 uranium worker community. Over 900 individuals attended these meetings conducted in Arizona, New Mexico, Texas, Wyoming, Colorado, Oklahoma, Idaho, Washington, Oregon, and West Virginia. As a result of this outreach effort, more than 200 new claims were filed under the Act.

Other examples of DEEOIC outreach activities in FY 2008 included meetings with local governments and chambers of commerce, presentations to personnel at covered facilities and unions, and other community initiatives. Additionally, in FY 2008 the district offices received 152,280 phone calls and the FAB received 6,915 phone calls. Nearly all calls that required a return call were returned within two business days.

Services to Claimants

The Departments of Labor, Health and Human Services, Energy, and Justice provide assistance to current and potential claimants and surviving family members to help them understand the EEOICPA and claimants' rights and obligations under the program. DOL has implemented several strategies to assist workers and survivors in filing claims, collecting evidence to support claims, and understanding the adjudication process from start to finish:

Web Site. DEEOIC's web site provides information about the statute and regulations governing Part B and Part E of the EEOICPA and gives claimants access to brochures, claim forms, and electronic filing of claims. The web site also provides the locations and times of town hall meetings; district office and resource center locations and contact numbers; press releases; and medical provider enrollment information. Additionally, claimants can view DEEOIC and NIOSH weekly web statistics; payments statistics at the national, state, and facility levels; a searchable database of DEEOIC final decisions; a link to Part E information that includes the EEOICPA Part E procedure manual; and all final policy bulletins and circulars. The site also provides links to DOE, DOJ, and NIOSH web sites and toll-free numbers where additional information and assistance can

be obtained. In FY 2008, 42 policy bulletins and eight circulars clarifying the administration of both Parts of the program were posted to the site.

Expanded Role of Resource Centers. DEEOIC's network of Resource Centers (RCs) at major DOE sites provides an initial point-of-contact for workers interested in the program and in-person and toll-free telephone-based assistance to individuals filing claims under the Act. In FY 2008, the RC contractor had 79 employees at 11 sites to help claimants complete necessary claim forms and gather documentation that can support their claims. The RCs assist with initial employment verification and Part E occupational history development and forward all claims and associated documentation to the appropriate district office. The RCs also answer claimants' initial questions regarding impairment and wage-loss benefits. During FY 2008, The RCs received 103,194 telephone calls, conducted 39,552 follow-up actions with claimants, processed 6,966 initial employment verification requests, conducted 5,808 occupational history interviews, and made 6,152 contacts with claimants regarding impairment and wage-loss benefits.

In FY 2008, the RCs were given additional responsibilities to assist claimants with the medical bill process, preparation of requests for pre-authorized medical travel, and submission of claims for reimbursement related to medical travel. As a result of their expanded role, the RCs made 15,142 contacts related to medical bills. In addition, the RCs enrolled over 700 new medical providers into the program. The medical benefits component of the EEOICPA also was enhanced to include the establishment of a web portal to allow claimants to find medical providers who are enrolled in the EEOICPA program (including physicians, hospice centers, and home health care providers). In FY 2008, DEEOIC also eliminated the payment cap on prescriptions for accepted illnesses and streamlined the process for approving travel of over 200 miles round trip to receive treatment for an accepted illness.

Center for Construction Research and Training. In FY 2008, DEEOIC again renewed its contract with the Center for Construction Research and Training (CCRT), formerly known as the Center to Protect Workers' Rights, which has been tasked with researching and providing employment information for construction/trade workers (who worked at DOE, AWE, or beryllium vendor facilities) in cases where DOL has been unable to obtain reliable information through available resources. In FY 2008, CCRT provided responses to more than 1,000 requests for information.

Site Exposure Matrices (SEM) Database. In FY 2008, DEEOIC continued to enhance its database of "site exposure matrices" to assist claims examiners in determining the types of chemicals and toxic substances that existed at the major DOE facilities, easing claimants' evidentiary burdens and speeding the claims process. The SEM project team conducted record reviews at 45 major DOE sites during FY 2008. In conjunction with the record review project, 11 roundtable meetings and 15 sets of telephone interviews were held with current and former DOE workers. As of September 30, 2008, the SEM database housed information on 6,846 toxic substances/chemicals that were present at 71 DOE sites, 4,170 uranium mines, 48 uranium mills, and 17 uranium ore buying stations covered under EEOICPA. In FY 2008, the SEM website was made available to the public for viewing and comment at www.sem.dol.gov.

In conjunction with exposure development, the SEM project continued working to improve exposure and medical data available in the Haz-Map website database. Haz-Map is a database housed by the National Library of

Medicine (NLM) that contains a wide array of information regarding occupational exposure to hazardous agents. DOL contracted with the author of Haz-Map to evaluate exposure information obtained during covered facility document reviews and to upload the author's analysis into Haz-Map. This effort with NLM and the Haz-Map database has allowed DEEOIC to assist in profiling hundreds of substances since the inception of the agreement, with over 1,640 agents profiled in FY 2008. This work for the SEM project assists DOL in developing and adjudicating claims filed under Part E of EEOICPA and relieves claimants of some of the burden of proof in their claims.

Database Systems. DEEOIC's Branch of Automated Data Processing Systems (BAS) is responsible for providing DEEOIC's internal and external customers an entire array of secure and reliable computer services and support. A major accomplishment for BAS was the collaborative effort with DOL's Employment Standards Administration's Division of Information Technology Management and Services (DITMS) to establish a comprehensive new computing infrastructure, setting the stage for future achievement of long-term DITMS strategic goals as well as near-term DEEOIC development of an integrated, modernized, and expanded mission-critical case management system. The new system will replace the separate Part B and Part E case management systems that have supported DEEOIC's users since Part B (2001) and Part E (2004) program inception.

Among other notable achievements for BAS in FY 2008 were enhancements to statistical presentations on the DEEOIC web site and expansion of workload and statistical reporting that enabled claims personnel and managers to once again meet and exceed strategic and operational goals.

Ombudsman. Under the Defense Authorization Act for Fiscal Year 2005, Public Law 108-375, 42 U.S.C. § 7385s-15, signed into law on October 28, 2004, an Office of the Ombudsman was created for a period of three years to provide information to claimants, potential claimants, and other interested parties on the benefits available under Part E of the EEOICPA and how to obtain those benefits. In October 2007, the Secretary of Labor extended the term of this office. The Office of the Ombudsman, independent from OWCP, reports annually to Congress concerning complaints, grievances, and requests for assistance received during the calendar year covered by the report. In FY 2008, the Ombudsman's 2007 Annual Report was made available through a link from DEEOIC's web site, and DEEOIC continues to work directly with the Ombudsman's office to promptly resolve any issues and concerns.

Government Performance Results Act

DOL is committed to measuring its outcomes and maintaining accountability for achieving the fundamental goals of the Energy Employees Occupational Illness Compensation Program (EEOICP). High performance standards, focusing on moving EEOICP claims rapidly through the initial and secondary adjudication stages, have been established, and DOL has maintained a strong record of meeting its key performance goals under the GPRA.

DEEOIC's three indicators achieved under DOL's GPRA goal to "minimize the human, social, and financial impact of work-related injuries for workers and their families" were as follows:

In FY 2007, EEOICP began to measure average days for completion of initial processing as that measure is a good indicator of overall effectiveness

in delivering initial services to claimants. In FY 2008, it took an average of 164 days to process initial claims under Part B, far better than the target of 226 days.

The claims processing goal under Part E also was improved upon, as 284 days on average were needed to process initial claims in FY 2008 against a target of 290 days.

Timely processing also extends to final decisions by EEOICP's FAB. The timeliness standards for both Part B and Part E claims are to complete final decisions within 180 days where there is a hearing and within 75 days where there is no hearing. In the processing of Part B and Part E final decisions through the efforts of FAB, 93 percent of Part B and Part E decisions in FY 2008 were within the program standards, well in excess of the goal of 87 percent.

Central Medical Bill Processing

The OWCP central bill processing service continued to provide a high level of service to eligible claimants and providers in FY 2008. In addition, DEEOIC avoided $5.6 million in costs during the year due to further improvements in the editing of bills.

Timely and accurate medical bill processing is critical in the administration of the EEOICPA. In FY 2008, Ambulatory Surgical Center and Modifier Level pricing enhancements were implemented.

By the end of FY 2008, the vendor had processed 109,779 EEOICPA bills and handled 35,692 telephone calls. Authorizations for medical treatment were processed in an average of 1.5 workdays and 98.3 percent of bills were processed within 28 days. Enrollment of 506 new providers brought the total of enrolled providers to 106,580.

Program Evaluation

Management Study. In FY 2008, a management study of the DEEOIC was completed by Omnitec Solutions, Inc., a private company hired to review the overall structure of the division. The company interviewed claims examiners (CE), supervisors, and managers in the district offices, Final Adjudication Branch, and national office; gathered information from organizational strategic planning documents, including mission statements, goals, performance metrics, workload assessments, training materials, bulletins, and organizational staffing charts; and reviewed position descriptions, permanent and term designations, classification standards, and performance standards for CE and senior CE positions. Omnitec Solutions, Inc. submitted several suggestions for improving program management, organizational structure, claims processing, workload management, cost analysis, communications, training, technology and tools, and interaction with stakeholders. The recommendations were reviewed by the Director of DEEOIC and the OWCP Director, and several strategies were adopted by DEEOIC in its efforts to continually improve program operations.

U.S. Department of Labor, Office of Inspector General (OIG) Evaluation. In response to several members of Congress and the general public, OIG conducted an evaluation (Report No. 04-09-002-04-437, November 12, 2008) to:

Determine if DOL issued claim decisions that complied with applicable law and regulation.

Assess whether DOL ensures that claims are adjudicated as promptly as possible and that claimants are kept informed.

In its evaluation, OIG found that DOL's decisions to accept or deny claims complied with applicable Federal law and regulations, and the decisions were based on the evidence provided by or obtained on behalf of claimants and followed a deliberative process with several layers of review to ensure that claims were substantiated or properly denied. OIG also found that DOL has made strides in reducing the processing time of claims for the portion of the process controlled by DOL. OIG assessed the validity of allegations from a former claims examiner that claims examiners had been directed to inappropriately deny claims and determined that these allegations could not be corroborated.

OIG made six recommendations to the Assistant Secretary, Employment Standards Administration (ESA), designed to further reduce the time required to process claims, better utilize Resource Centers, and increase contact with claimants to keep them informed of the status of their claims. ESA disagreed with the conclusions regarding the timeliness of the program in adjudicating claims, but did concur with most of the recommendations and has efforts underway to respond to these recommendations. The full report, including the scope, methodology, and full agency response, is available at http://www.oig.dol.govpublic/reports/oa/2009/04-09-002-04-437.pdf.

Program Assessment Rating Tool. In FY 2007, the EEOICP was assessed using the Program Assessment Rating Tool (PART) and received a rating of "adequate." DEEOIC's response to the PART's key recommendations during FY 2008 included:

Working with NIOSH to establish compatible timeliness measures that are consistent with program goals and reporting performance against those goals on an ongoing basis.

Obtaining an independent, comprehensive evaluation of the program. As stated previously, the Energy program underwent a management study in FY2008 to evaluate and recommend ways to enhance program operations, including an analysis of workflow, training, technology workload, claims processing, and organization and management structure. DOL's Inspector General also conducted a program evaluation in FY 2008 and made several recommendations for improving the program. In addition, a customer satisfaction survey will be conducted in FY 2009.

Improving coordination with state workers' compensation systems to prevent duplicate payments. DEEOIC's cross match with the State of Ohio is ongoing, and procedures for obtaining information from claimants and the state were developed and will be distributed to program employees in FY 2009.

Litigation

DEEOIC strives in every case to administer the Energy program in accordance with the law and governing regulations. During FY 2008, one U.S. District Court and one U.S. Court of Appeals published decisions in cases arising under EEOICPA. Important points from these cases are summarized below.

DISTRICT COURT

In *Stephens v. U.S. Department of Labor*, 571 F.Supp.2d 186 (D.D.C. 2008), the plaintiff (who had been awarded lump-sum compensation under Part B of EEOICPA for his CBD) petitioned the U.S. District Court for the District of Columbia for an order under the Administrative Procedure Act directing DEEOIC to determine that the Loral

American Beryllium Company facility, which DOE had designated as a beryllium vendor facility, was also a "DOE facility" as defined in EEOICPA for the purposes of his claim for CBD under Part E of EEOICPA. In its order, the court granted summary judgment for DEEOIC and affirmed the November 9, 2006 and March 13, 2007 determinations that the plaintiff was not a "covered DOE contractor employee" and was rather a "covered beryllium employee" of the Loral America Beryllium Company, a beryllium vendor, and therefore he was not eligible for Part E benefits. The court found that DEEOIC had properly recognized the eligibility issue in the plaintiff's administrative claim, that it had given careful consideration to the many arguments he had raised in support of his Part E claim, and that it had rationally decided that he did not fit within the statutory definition of a covered DOE contractor employee because the Loral American Beryllium Company's facility did not constitute a DOE facility, as that statutory term is defined in EEOICPA. Therefore, the court found that the November 9, 2006 and March 13, 2007 DEEOIC decisions were not "arbitrary and capricious" under 42 U.S.C. § 7385s-6(a).

COURT OF APPEALS

In *Hayward v. U.S. Department of Labor*, 536 F.3d 376 (5th Cir. 2008), the appellant sought review of a decision of the U.S. District Court for the Northern District of Texas that had affirmed DEEOIC's final decision denying her claim for survivor benefits under Part B of EEOICPA. She argued on appeal that the district court erred in finding that DEEOIC did not act arbitrarily or capriciously when it refused to adjust certain default settings in NIOSH-IREP, the interactive software program it uses to calculate the probability that various cancers were caused by exposure to radiation, to account for the rare form of prostate cancer that her late husband had contracted. In a July 16, 2008 decision, the Court of Appeals for the Fifth Circuit determined that the district court had properly reviewed DEEOIC's final decision under the "arbitrary or capricious" standard set forth in § 706(2)(A) of the Administrative Procedure Act. Under that standard, the Fifth Circuit found that DEEOIC's final decision fully considered the appellant's objections and set forth a rational connection between the relevant factors and its decision to retain the default settings in NIOSH-IREP.

Energy Employees Occupational Illness Compensation Program Act

	Part B		Part E[1]	
	FY 2007	FY 2008	FY 2007	FY 2008
Number of Employees (FTE Staffing Used)	296	299	211	244
Administrative Expenditures[2]	$ 53.1 M	$ 50.5 M	$ 62.5 M	$ 56.1 M
Claims Created	8,709	7,794	11,090	8,373
Recommended Decisions (Covered Applications)	13,326	12,928	15,928	14,066
Final Decisions (Covered Applications)	12,079	12,200	17,427	13,440
Number of Claims Approved (Final)	6,374	6,486	7,057	7,541
Total Lump Sum Compensation Payments[3]	$464.4 M	$484.4 M	$361.7 M	$456.7 M
Number of Medical Bill Payments	116,662	133,788	2,458	6,923
Total Medical Payments[4]	$ 54.9 M	$ 69.1 M	$ 0.7 M	$ 2.2 M

[1] Part E became effective during FY 2005 (October 28, 2004).

[2] Includes Department of Labor expenditures only; Part B excludes funds apportioned to the Department of Health and Human Services for that agency's responsibilities under EEOICPA ($54.8 million in FY 2007 and $55.4 million in FY 2008, respectively), while Part E excludes funding for the Office of the Ombudsman ($0.7 million in FY 2007 and $0.8 million in FY 2008, respectively).

[3] Excludes payments made by DOL for Department of Justice (DOJ) Radiation Exposure Compensation Act (RECA) Section 5 claims. DOL serves as a pass through and utilizes the compensation fund established under EEOICPA for DOJ's payments of $100,000 to qualifying Section 5 RECA claimants as provided for in 42 U.S.C. § 7384u(d). These payments totaled $80.1 million in FY 2007 and $45.7 million in FY 2008, respectively.

[4] Part B medical payments represent payments made for cases accepted under both Part B and Part E. Part E medical payments represent payments made for Part E only.

Appendix

Note: Unless otherwise stated, the financial information in the appendix tables below may differ from what is reported in the Department of Labor's Consolidated Financial Statement. These differences are due to accrual versus cash basis financial reporting requirements and adjustments made during statement compilation.

Table A-1

Federal Employees' Compensation Rolls

FY 1999 - FY 2008
(Cases at End-of-Year)

	Fiscal Year									
Roll Type	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Total Periodic Roll	54,897	54,709	56,133	56,751	58,621	57,827	60,709	55,433	51,125	**50,263**
Long-Term Disability	48,957	48,870	50,409	51,092	53,099	52,377	55,257	49,910	46,258	**45,604**
Death	5,940	5,839	5,724	5,659	5,522	5,450	5,452	5,523	4,867	**4,659**

Table A-2

Federal Employees' Compensation Program
Summary of Claims Activity

FY 1999 - FY 2008

	Fiscal Year									
Claim Activity	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Incoming Cases										
Cases Created	**166,544**	**174,471**	**165,915**	**158,118**	**168,174**	**162,965**	**151,690**	**139,874**	**134,360**	**134,013**
Traumatic	140,383	145,915	137,877	132,250	142,325	138,521	129,427	119,082	114,592	**115,715**
No Lost Time	83,472	91,620	86,402	80,439	84,368	80,018	74,071	67,127	64,896	**66,812**
Lost Time	56,911	54,295	51,475	51,811	57,957	58,503	55,356	51,955	49,696	**48,903**
Occupational Disease	25,999	28,406	27,869	25,739	25,747	24,320	22,114	20,592	19,633	**18,190**
Fatal Cases	162	150	169	129	102	124	149	200	135	**108**
Wage-Loss Claims Initiated	**19,759**	**21,899**	**23,386**	**23,193**	**24,245**	**24,189**	**21,455**	**19,819**	**19,104**	**19,187**
Hearings and Review										
Total Requests for Hearing	7,164	6,992	6,875	6,820	6,751	8,132	6,757	6,241	6,556	**6,584**
Total Hearing Dispositions	7,926	7,418	6,599	6,272	6,743	7,682	6,961	7,424	7,581	**6,789**

Table A-3

Federal Employees' Compensation Program Obligations

FY 1999 - FY 2008
($ thousands)

Type of Obligation	Fiscal Year 1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total Obligations	$2,076,475	$2,170,247	$2,308,595	$2,418,364	$2,475,108	$2,568,390	$2,602,815	$2,553,930	$2,707,196	**$2,800,284**
Total Benefits	1,989,050	2,078,715	2,199,276	2,307,942	2,345,472	2,434,609	2,476,479	2,418,796	2,563,055	**2,657,634**
Compensation Benefits	1,370,206	1,403,154	1,453,740	1,509,275	1,556,845	1,600,501	1,664,405	1,621,357	1,684,248	**1,736,649**
Medical Benefits	492,835	548,596	617,414	667,797	658,121	703,571	672,006	668,205	743,124	**781,594**
Survivor Benefits	126,009	126,965	128,122	130,870	130,506	130,537	140,068	129,234	135,683	**139,391**
Total Administrative Expenditures	87,425	91,532	109,319	110,422	129,636	133,781	126,336	135,134	144,141	**142,650**
Salaries and Expenses	67,567	70,634	78,971	81,210	86,358	86,253	86,811	88,435	90,113	**89,416**
Fair Share	19,858	20,898	30,348	29,212	43,278	47,528	39,525	46,699	54,028	**53,234**

Table A-4

Federal Employees' Compensation Program Chargeback Costs, by Major Federal Agency

CBY 1999 - CBY 2008
($ thousands)

	Chargeback Year [1]									
Federal Agency	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Total Costs	$1,908,256	$2,024,634	$2,129,097	$2,219,448	$2,323,288	$2,339,782	$2,334,194	$2,440,711	$2,494,096	**$2,572,864**
U.S. Postal Service	594,503	666,310	720,518	785,199	846,876	852,945	840,141	884,078	924,138	**978,629**
Department of the Navy	240,492	241,585	246,881	248,250	245,461	245,145	237,791	244,318	244,037	**242,440**
Department of the Army	163,127	166,989	169,219	174,832	181,298	177,250	174,660	180,248	178,993	**179,503**
Department of Veterans Affairs	137,865	143,221	145,909	151,612	157,315	155,391	156,170	164,091	166,087	**175,637**
Department of Homeland Security	N/A	N/A	N/A	N/A	83,975	121,089	138,342	156,734	158,529	**161,070**
Department of the Air Force	123,349	128,134	134,106	132,538	135,509	129,229	124,516	126,663	130,298	**131,059**
Department of Justice	76,319	83,873	91,197	95,620	66,131	74,011	80,090	89,156	94,395	**98,825**
Department of Transportation	97,155	96,936	99,556	101,716	94,682	92,659	92,687	92,830	93,609	**97,931**
Department of Agriculture	59,851	64,882	66,750	69,563	72,312	69,245	68,681	70,185	70,802	**72,869**
Department of Defense	63,563	64,797	64,761	63,888	65,429	63,816	62,996	65,460	62,630	**60,737**
All Other Agencies	352,033	367,907	390,201	396,230	374,299	359,003	358,120	366,948	370,578	**374,164**

[1] A year for chargeback purposes is from July 1 through June 30.

Table B-1

Part C Black Lung Claims Adjudications at the District Director Level

FY 2008

Type of Claim	PDO's Issued [1]	Approval Rate
Trust Fund	725	
Approved	114	**15.72%**
Denied	611	
Responsible Operators	3,691	
Approved	446	**12.08%**
Denied	3,245	
Total Decisions	4,416	
Total Approved	560	**12.68%**
Total Denied	3,856	

[1] PDO is "Proposed Decision and Order".

Table B-2

Distribution of Part C Black Lung Claims and Disbursements, by State

FY 2008

State	Total Claims Received [1]	MBO Claims [2]	In Payment [3]	Total Benefits ($ 000) [4]
Alabama	34,365	40	798	$6,494
Alaska	152	0	8	65
Arizona	2,059	5	118	960
Arkansas	3,832	7	154	1,253
California	6,474	6	206	1,676
Colorado	7,064	9	364	2,962
Connecticut	1,002	1	57	464
Delaware	781	1	53	431
District of Columbia	286	0	12	98
Florida	11,938	42	697	5,672
Georgia	1,676	4	155	1,261
Hawaii	17	0	1	8
Idaho	253	0	18	146
Illinois	31,523	33	976	7,943
Indiana	17,988	32	663	5,396
Iowa	5,147	4	196	1,595
Kansas	2,179	1	51	415
Kentucky	93,682	632	4,470	36,380
Louisiana	349	0	15	122
Maine	45	0	4	32
Maryland	6,672	17	314	2,555
Massachusetts	238	1	15	122
Michigan	10,515	11	355	2,889
Minnesota	145	0	5	41
Mississippi	367	1	22	179
Missouri	4,650	2	151	1,229
Montana	856	2	27	220
Nebraska	130	0	6	49
Nevada	434	1	31	252
New Hampshire	27	0	7	57
New Jersey	4,309	8	224	1,823
New Mexico	2,426	1	103	838
New York	4,034	7	177	1,440
North Carolina	3,542	21	302	2,458
North Dakota	159	0	4	32
Ohio	54,023	92	2,362	19,222
Oklahoma	3,790	8	115	936
Oregon	629	0	28	228
Pennsylvania	137,313	462	8,905	72,473
Rhode Island	40	0	2	16
South Carolina	950	8	108	879
South Dakota	51	0	4	32
Tennessee	21,339	97	946	7,699
Texas	1,743	2	97	789
Utah	4,146	11	220	1,790
Vermont	49	0	4	32
Virginia	44,375	366	3,190	25,961
Washington	1,592	3	54	439
West Virginia	112,498	647	6,608	53,779
Wisconsin	454	0	28	228
Wyoming	2,628	0	128	1,042
All Other	449	1	16	130
TOTAL	**645,385**	**2,586**	**33,574**	**$273,232**

[1] All filings since July 1, 1973, including terminated and nonapproved claims.

[2] Active Medical Benefits Only (MBO) claims as of 9/30/08.

[3] Active claims in payment status, excluding MBO claims, as of 9/30/08.

[4] Disbursements of income and medical benefits for all claims, including claims paid by the Trust Fund and claims in interim pay status.

Note: Data in column no. 1 may not be consistent with changes from previous years due to a change in computer systems.

Table B-3

Part C Black Lung Claims, by Class of Beneficiary

FY 1999 - FY 2008 [1]

	Number of Beneficiaries [2]									
Class of Beneficiary	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Primary Beneficiaries:										
Miners	24,838	22,568	18,248	16,395	14,773	13,398	12,012	10,857	9,744	**8,654**
Widows	40,517	39,053	35,660	34,236	32,615	30,810	29,110	27,366	25,556	**23,690**
Others	1,508	1,497	1,467	1,221	1,238	1,247	1,248	1,258	1,241	**1,230**
Total Primary Beneficiaries	66,863	63,118	55,375	51,852	48,626	45,455	42,370	39,481	36,541	**33,574**
Dependents of Primary Beneficiaries:										
Dependents of Miners	19,953	17,978	13,924	12,432	11,131	10,020	9,004	8,088	7,205	**6,442**
Dependents of Widows	1,384	1,306	1,123	1,077	1,052	1,006	944	874	840	**777**
Dependents of Others	516	508	108	386	353	238	213	146	140	**132**
Total Dependents	21,853	19,792	15,155	13,895	12,536	11,264	10,161	9,108	8,185	**7,351**
Total, All Beneficiaries	**88,716**	**82,910**	**70,530**	**65,747**	**61,162**	**56,719**	**52,531**	**48,589**	**44,726**	**40,925**

[1] As of September 30 of each year.

[2] Active claims, including those paid by a RMO, cases paid by the Trust Fund, cases in interim pay status, cases that are being offset due to concurrent Federal or state benefits, and cases that have been temporarily suspended. Does not include MBO beneficiaries.

Table B-4

Department of Labor Part C Black Lung Benefits Program Obligations

FY 1999 - FY 2008
($ thousands)

Type of Obligation	Fiscal Year 1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total Obligations	$1,005,246	$1,013,593	$1,016,994	$1,034,096	$1,046,303	$1,053,246	$1,061,698	$1,060,006	$1,068,295	**$1,070,958**
Total Benefits [1]	439,442	422,656	396,928	384,234	370,389	346,864	329,933	307,067	291,310	**273,232**
Income Benefits [2]	363,871	350,266	336,813	320,039	307,371	292,555	279,965	265,365	252,020	**235,347**
Medical Benefits [3]	75,571	72,390	60,116	64,196	63,018	54,309	49,968	41,702	39,290	**37,885**
Administrative Costs [4]	50,788	49,820	52,252	54,273	55,332	55,803	56,872	57,975	59,772	**58,257**
Interest Charges [5]	515,016	541,117	567,814	595,589	620,582	650,579	674,894	694,964	717,214	**739,469**
Repayable Advances [6]	402,000	490,000	505,000	465,000	525,000	497,000	446,000	445,000	426,000	**426,000**
Cumulative Debt [7]	**$6,258,557**	**$6,748,557**	**$7,253,557**	**$7,718,557**	**$8,243,557**	**$8,740,557**	**$9,186,557**	**$9,631,557**	**$10,057,557**	**$10,483,557**

[1] Excludes collections from responsible mine operators for benefits paid by Trust Fund on an interim basis, refunds for OWCP administrative costs paid, and other miscellaneous reimbursements.

[2] Monthly and retroactive benefit payments.

[3] Includes diagnostic and treatment costs, and reimbursements to the Centers for Medicare & Medicaid Services of the Department of Health and Human Services and the Health and Retirement Funds of the UMWA.

[4] Administrative expenses include reimbursements to SSA.

[5] Starting in 1979, the Trust Fund had to borrow funds from the Treasury Department to pay operating costs not covered by revenues. Interest charges reflect the cost to the Trust Fund for those advances from the Treasury.

[6] Reflects advances from the Treasury Department during the fiscal year.

[7] Shows the cumulative debt of the Trust Fund to the Treasury.

Note: Detail may not add to totals due to rounding.

Table B-5

Monthly Part C Black Lung Benefit Rates

1973 - 2008

Period	Benefit Rates by Type of Beneficiary			
	Claimant	Claimant and 1 Dependent	Claimant and 2 Dependents	Claimant and 3 or More Dependents
7/1/73-9/30/73	$169.80	$254.70	$297.10	$339.50
10/1/73-9/30/74	177.60	266.40	310.80	355.20
10/1/74-9/30/75	187.40	281.10	328.00	374.80
10/1/75-9/30/76	196.80	295.20	344.40	393.50
10/1/76-9/30/77	205.40	308.10	359.50	410.80
10/1/77-9/30/78	219.90	329.80	384.80	439.70
10/1/78-9/30/79	232.00	348.00	405.90	463.90
10/1/79-9/30/80	254.00	381.00	444.50	508.00
10/1/80-9/30/81	279.80	419.60	489.60	559.50
10/1/81-9/30/82	293.20	439.80	513.10	586.40
10/1/82-12/31/83	304.90	457.30	533.60	609.80
1/1/84-12/31/84[1]	317.10	475.60	554.90	634.20
1/1/85-12/31/86	328.20	492.30	574.30	656.40
1/1/87-12/31/87	338.00	507.00	591.50	676.00
1/1/88-12/31/88	344.80	517.20	603.40	689.60
1/1/89-12/31/89	358.90	538.30	628.10	717.80
1/1/90-12/31/90	371.80	557.70	650.60	743.60
1/1/91-12/31/91	387.10	580.60	677.40	774.10
1/1/92-12/31/92	403.30	605.00	705.80	806.60
1/1/93-12/31/93	418.20	627.30	731.90	836.40
1/1/94-12/31/94	427.40	641.10	748.00	854.80
1/1/95-12/31/95	427.40	641.10	748.00	854.80
1/1/96-12/31/96	435.10	652.70	761.50	870.20
1/1/97-12/31/97	445.10	667.70	779.00	890.20
1/1/98-12/31/98	455.40	683.10	796.90	910.70
1/1/99-12/31/99	469.50	704.30	821.60	939.00
1/1/00-12/31/00	487.40	731.00	852.80	974.70
1/1/01-12/31/01	500.50	750.80	875.90	1,001.00
1/1/02-12/31/02	518.50	777.80	907.40	1,037.00
1/1/03-12/31/03	534.60	801.90	935.50	1,069.20
1/1/04-12/31/04	549.00	823.50	960.80	1,098.00
1/1/05-12/31/05	562.80	844.10	984.80	1,125.50
1/1/06-12/31/06	574.60	861.80	1,005.50	1,149.10
1/1/07-12/31/07	584.40	876.50	1,022.60	1,168.70
1/1/08-12/31/08	**599.00**	**898.40**	**1,048.10**	**1,197.90**

[1] These benefit rates include the additional one-half percent increase that was granted retroactive to January 1, 1984. The rates in effect prior to the retroactive payments (1/1/84 through 6/30/84) were: $315.60 for a claimant only; $473.30 for a claimant and 1 dependent; $552.20 for a claimant and 2 dependents; and, $631.10 for a claimant and 3 or more dependents.

Table B-6

Funding and Disbursements of the Black Lung Disability Trust Fund

FY 2008
($ thousands)

	Funding				Disbursements						
Month	Coal Excise Tax Revenue	Treasury Advances	Reimburse[1]	Total	Income Benefits[2]	Medical Benefits Diagnostic	Medical Benefits Treatment[3]	Total Benefits	Admin. Costs	Interest on Advances	Total
October 2007	$9,570	$0	$405	**$9,975**	$20,373	$397	$2,801	$23,570	$4,187	$0	**$27,757**
November 2007	60,099	0	332	**60,431**	20,073	406	$2,332	22,810	3,999	0	**26,809**
December 2007	53,749	0	334	**54,083**	19,934	389	$2,882	23,206	3,284	0	**26,489**
January 2008	49,480	0	314	**49,794**	19,721	306	$2,768	22,794	5,252	0	**28,047**
February 2008	77,682	0	580	**78,262**	19,903	392	$3,188	23,482	5,243	0	**28,725**
March 2008	58,003	0	220	**58,223**	19,668	367	$2,812	22,847	5,246	0	**28,093**
April 2008	60,482	0	465	**60,947**	19,855	400	$3,936	24,191	5,207	0	**29,398**
May 2008	44,828	0	391	**45,219**	19,418	312	$2,957	22,687	5,208	0	**27,895**
June 2008	54,224	0	300	**54,524**	19,311	289	$2,480	22,080	5,207	0	**27,287**
July 2008	53,198	0	523	**53,721**	19,271	328	$3,213	22,812	5,300	0	**28,111**
August 2008	52,013	0	563	**52,576**	18,962	244	$2,099	21,305	5,298	0	**26,603**
September 2008	79,853	426,000	586	**506,439**	18,860	228	$2,360	21,448	4,826	739,469	**765,743**
Totals	**$653,181**	**$426,000**	**$5,013**	**$1,084,194**	**$235,347**	**$4,057**	**$33,828**	**$273,232**	**$58,257**	**$739,469**	**$1,070,958**

[1] Reimbursements include collections from RMOs, and fines, penalties, and interest.

[2] Includes monthly and retroactive benefit payments.

[3] Treatment expenditures include reimbursements to the United Mine Workers' Health and Retirement Funds.

Table C-1

Total Industry Compensation and Benefit Payments Under LHWCA[1]

CY 1998 - CY 2007[2]
($ thousands)

	Calendar Year									
Payments By:	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Self-Insured Employers	$261,559	$283,991	$278,952	$307,708	$310,940	$309,843	$322,520	$325,694	$368,744	**$325,544**
Insurance Carriers	238,464	232,778	249,671	236,726	246,603	262,753	278,887	325,027	367,625	**456,773**
Total Payments	**$500,023**	**$516,769**	**$528,623**	**$544,434**	**$557,543**	**$572,596**	**$601,407**	**$650,721**	**$736,369**	**$782,317**

[1] Includes disability compensation and medical benefit payments under LHWCA, DCCA, and all other extensions to the Act.

[2] Industry payments are reported to the Department of Labor on a calendar year basis.

Table C-2

National Average Weekly Wage (NAWW) and Corresponding Maximum and Minimum Compensation Rates and Annual Adjustments Pursuant to Sections 6(b), 9(e), and 10(f) of LHWCA

Period	NAWW	Maximum Payable	Minimum Payable	Annual Adjustment (% Increase in NAWW)
11/26/72-9/30/73	$131.80	$167.00	$65.90	—
10/01/73-9/30/74	140.26	210.54	70.18	6.49
10/01/74-9/30/75	149.10	261.00	74.57	6.26
10/01/75-9/30/76	159.20	318.38	79.60	6.74
10/01/76-9/30/77	171.28	342.54	85.64	7.59
10/01/77-9/30/78	183.61	367.22	91.81	7.21
10/01/78-9/30/79	198.39	396.78	99.20	8.05
10/01/79-9/30/80	213.13	426.26	106.57	7.43
10/01/80-9/30/81	228.12	456.24	114.06	7.03
10/01/81-9/30/82	248.35	496.70	124.18	8.87
10/01/82-9/30/83	262.35	524.70	131.18	5.64
10/01/83-9/30/84	274.17	548.34[1]	137.09	4.51
10/01/84-9/30/85	289.83	579.66	144.92	5.71[2]
10/01/85-9/30/86	297.62	595.24	148.81	2.69
10/01/86-9/30/87	302.66	605.32	151.33	1.69
10/01/87-9/30/88	308.48	616.96	154.24	1.92
10/01/88-9/30/89	318.12	636.24	159.06	3.13
10/01/89-9/30/90	330.31	660.62	165.16	3.83
10/01/90-9/30/91	341.07	682.14	170.54	3.26
10/01/91-9/30/92	349.98	699.96	174.99	2.61
10/01/92-9/30/93	360.57	721.14	180.29	3.03
10/01/93-9/30/94	369.15	738.30	184.58	2.38
10/01/94-9/30/95	380.46	760.92	190.23	3.06
10/01/95-9/30/96	391.22	782.44	195.61	2.83
10/01/96-9/30/97	400.53	801.06	200.27	2.38
10/01/97-9/30/98	417.87	835.74	208.94	4.33
10/01/98-9/30/99	435.88	871.76	217.94	4.31
10/01/99-9/30/00	450.64	901.28	225.32	3.39
10/01/00-9/30/01	466.91	933.82	233.46	3.61
10/01/01-9/30/02	483.04	966.08	241.52	3.45
10/01/02-9/30/03	498.27	996.54	249.14	3.15
10/01/03-9/30/04	515.39	1,030.78	257.70	3.44
10/01/04-9/30/05	523.58	1,047.16	261.79	1.59
10/01/05-9/30/06	536.82	1,073.64	268.41	2.53
10/01/06-9/30/07	557.22	1,114.44	278.61	3.80
10/01/07-9/30/08	**580.18**	**1,160.36**	**290.09**	**4.12**

[1] Maximum became applicable in death cases (for any death after September 28, 1984) pursuant to LHWCA Amendments of 1984. Section 9(e)(1) provides that the total weekly death benefits shall not exceed the lesser of the average weekly wages of the deceased or the benefits that the deceased would have been eligible to receive under section 6(b)(1). Maximum in death cases not applicable to DCCA cases *(Keener v. Washington Metropolitan Area Transit Authority, 800 F.2d 1173 (D.C. Cir. (1986)).*

[2] Five percent statutory maximum increase applicable in FY 1985 under section 10(f) of LHWCA, as amended. Maximum increase not applicable to DCCA cases (see note [1], above).

Table C-3

LHWCA and DCCA Special Funds' Expenditures[1]

FY 1999 - FY 2008
($ thousands)

FY	LHWCA Expenditures ($)					Number of Second Injury Cases	DCCA Expenditures ($)					Number of Second Injury Cases
	Total	Second Injury Cases[2]	Pre Amend. Cases[3]	Rehab.[4]	Other[5]		**Total**	Second Injury Cases[2]	Pre Amend. Cases[3]	Rehab.[4]	Other[5]	
1999	**$131,152**	$117,574	$2,439	$4,888	$6,251	5,145	**$11,879**	$10,748	$747	$6	$377	617
2000	**131,564**	119,198	2,459	4,595	5,313	5,025	**11,804**	10,521	728	0	555	612
2001	**133,374**	119,952	2,295	5,121	6,006	4,953	**11,341**	10,368	708	0	265	601
2002	**131,715**	119,661	2,240	4,801	5,013	4,880	**11,386**	10,214	702	0	469	585
2003	**131,589**	119,965	2,153	4,628	4,844	4,778	**11,184**	9,997	664	0	523	572
2004	**135,247**	122,358	2,081	4,990	5,818	4,694	**10,920**	9,867	645	0	408	544
2005	**134,549**	122,418	1,973	5,002	5,156	4,588	**10,604**	9,767	597	0	240	527
2006	**133,270**	123,412	1,811	2,749	5,298	4,908	**10,246**	9,418	588	0	240	621
2007	**131,920**	117,524	1,796	6,715	5,885	4,728	**10,087**	9,260	613	0	214	603
2008	**126,933**	**116,894**	**1,673**	**2,330**	**6,035**	**4,533**	**9,960**	**9,104**	**630**	**0**	**226**	**582**

[1] Special Fund expenditures shown in this table are reported on a cash basis, i.e., expenses are recognized when paid.

[2] Section 8(f) payments to employees who sustain second injuries that, superimposed on a pre-existing injury, result in the employee's permanent disability or death.

[3] Section 10(h) of the Act requires that compensation payments to permanent total disability and death cases, when the injury or death is caused by an employment event that occurred prior to enactment of the 1972 amendments, be adjusted to conform with the weekly wage computation methods and compensation rates put into effect by the 1972 amendments. Fifty percent of any additional compensation or death benefit paid as a result of these adjustments are to be paid out of the Special Fund accounts.

[4] In cases where vocational or medical rehabilitation services for permanently disabled employees are not available otherwise, and for maintenance allowances for employees undergoing vocational rehabilitation, sections 39(c) and 8(g) of the Act authorize the cost of these services to be paid by the Special Fund.

[5] For cases where impartial medical exams or reviews are ordered by the Department of Labor (section 7(e) of Act) and where a compensation award cannot be paid due to employer default (section 18(b)), the expenses or payments resulting from these actions may be covered by the Special Fund. Also included as "Other" expenditures of the Funds are disbursements under section 44(d) to refund assessment overpayments in FY 1991 - FY 1993, and FY 1995 - FY 2006. Excluded are disbursements from proceeds of employer securities redeemed under section 32 of the Act. These monies are exclusively for payment of compensation and medical benefits to employees of companies in default.

Note: Special Fund expenditure totals for some years as shown above may differ from those reported to Congress in the Appendix to the President's budget. The figures here are from year-end Status of Funds reports while the President's budget reflects total outlays as reported to the Department of Treasury and may include technical adjustments made by Treasury or the Office of Management and Budget.

Table C-4

LHWCA and DCCA Special Funds' Assessments[1]

CY 1999 - CY 2008
($ thousands)

CY	LHWCA			DCCA		
	Total Industry Assessments[2]	Preceding Year Total Industry Payments[3]	Assessment Base Yr.	Total Industry Assessments[2]	Preceding Year Total Industry Payments	Assessment Base Yr.
1999	130,000	343,146	CY 1998	11,300	6,232	CY 1998
2000	133,000	353,462	CY 1999	12,700	5,179	CY 1999
2001	133,000	361,549	CY 2000	12,000	5,103	CY 2000
2002	125,000	372,376	CY 2001	11,000	5,552	CY 2001
2003	125,000	364,194	CY 2002	10,800	4,746	CY 2002
2004	137,000	368,671	CY 2003	11,500	4,286	CY 2003
2005	135,000	388,258	CY 2004	11,500	5,402	CY 2004
2006	125,000	418,714	CY 2005	10,500	4,277	CY 2005
2007	125,000	471,133	CY 2006	10,000	4,185	CY 2006
2008	**124,000**	**495,148**	**CY 2007**	**8,500**	**4,758**	**CY 2007**

[1] Annual assessments of employers and insurance carriers are the largest single source of receipts to the Special Funds. Other receipts to the Funds include fines and penalties, payments for death cases where there is no person entitled under the Act to the benefit payments, interest earned on Fund investments, overpayment and third party recoveries, and monies received from redemption of securities under section 32 of the Act to pay compensation due employees of companies in default. These payments constitute a small portion of the total receipts of the Special Funds.

[2] Assessments as shown here are not receipts to the Fund that were received during a given calendar year, but total assessments that are receivable from employers and insurance carriers based on the Special Fund assessment formula as prescribed under section 44(c) of the Act.

[3] Annual industry assessments prior to CY 1985 were based on each employer's or insurance carrier's total disability compensation and medical benefit payments under the Act during the preceding calendar year. The LHWCA Amendments of 1984 revised the method for computuing assessments in two ways. Effective in CY 1985, assessments are based on disability compensation payments only, thereby excluding medical benefits from the computation. Also, a factor for section 8(f) payments attributable to each employer/carrier was added to the assessment base.

Table C-5

Summary of Case Processing Activities Under LHWCA[1]

FY 1999 - FY 2008

Adjudication Level and Case Status	Fiscal Year 1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
District Offices										
Pending Inventory of Cases	9,006	8,675	6,489	7,391	5,495	6,051	6,375	6,338	8,563[4]	**7,726**
OALJ										
Carryover from Previous FY	3,862	3,668	3,562	3,388	2,980	2,517	2,355	2,318	1,984	**2,123**
New Cases	3,462	3,566	3,500	3,276	3,036	2,926	2,763	2,413	2,614	**2,657**
Total Docket	7,324	7,234	7,062	6,664	6,016	5,443	5,118	4,731	4,598	**4,780**
(Dispositions)	3,656	3,672	3,674	3,529	3,499	3,088	2,800	2,747	2,475	**2,612**
Pending Inventory	3,668	3,562	3,388	2,980[3]	2,517	2,355	2,318	1,984	2,123	**2,168**
BRB										
Carryover from Previous FY	318	326	295	248	208	267	222	211	182	**152**
New Cases	421	423	317	260	332	297	288	248	241	**226**
Total Docket	739	749	612	508	540	564	510	459	423	**378**
(Dispositions)	438	467	384	319	282	355	304	288	282	**260**
Pending Inventory	326[2]	295[2]	248[2]	208[2]	267[2]	222[2]	211[2]	182[2]	152[2]	**134**[2]

[1] Beginning in FY 1988, DCCA cases are excluded from DLHWC's District Offices' inventory as administration of these cases was delegated to the District of Columbia government effective July 18, 1988. Case processing and adjudication activities at the Office of Administrative Law Judges (OALJ) and Benefits Review Board (BRB) levels continue to include both LHWCA and DCCA cases.

[2] Data adjusted by BRB to account for misfiled, duplicate, or reinstated appeals.

[3] Includes dispositions of Boone 33(g) cases.

[4] The increase in pending inventory compared to FY 2006 was due to the large number of new Defense Base Act cases created in the second quarter of FY 2007. The total number of new cases increased by 42 percent during FY 2007.

Table D-1 Part B

Status of All EEOICPA Applications at the End of FY 2008[1]

Case Status/Claims Activity	Case[2]	Claim[3]
Total Applications Received-Program Inception Through 9/30/2008	63,603	93,336
Total Covered Applications Received-Program Inception Through 9/30/2008	49,576	76,487
Final Decisions Completed by Final Adjudication Branch (FAB)[4]	41,610	60,679
Final Approved	23,493	35,031
Final Denied	18,117	25,648
Recommended Decisions by District Offices[5]	1,764	3,262
Outstanding Recommended Decision to Approve	479	1,060
Outstanding Recommended Decision to Deny	1,285	2,202
Completed Initial Processing - Referred to NIOSH	3,783	7,806
Pending Initial Processing In District Office[6]	2,419	4,740
Lump Sum Compensations	21,668	32,781
Total Payment Amounts		**$2,646,153,225**

[1] Statistics show the status of all applications filed from program inception through September 30, 2008.

[2] "Case" counts are numbers of employees (or survivors of employees) whose work and illness or death are the basis for a "claim." (One case may have multiple survivor claims).

[3] "Claim" counts are greater than case counts because they include numbers of employees and all survivors of employees who filed for benefits.

[4] Each case or claim also received recommended decision by district office.

[5] Each case or claim still pending final decision by FAB.

[6] Includes remanded cases now in development and closed cases.

Table D-1 Part E

Status of All EEOICPA Applications at the End of FY 2008[1]

Case Status/Claims Activity	Case[2]	Claim[3]
Total Applications Received-Program Inception Through 9/30/2008	54,023	75,483
Total Covered Applications Received-Program Inception Through 9/30/2008	44,188	50,543
Final Decisions Completed by Final Adjudication Branch (FAB)[4]	34,233	35,705
Final Approved	18,015	18,847
Final Denied	16,218	16,858
Recommended Decisions by District Offices[5]	2,467	2,929
Outstanding Recommended Decision to Approve	798	1,035
Outstanding Recommended Decision to Deny	1,669	1,894
Completed Initial Processing - Referred to NIOSH	2,266	2,677
Pending Initial Processing In District Office[6]	5,222	9,232
Compensation Payments (Unique Cases and Claims)	11,296	11,848
Total Compensation Payment Amts.		**$1,292,253,624**
Lump Sum Allocations (Unique Cases and Claims)	7,394	7,907
Total Lump Sum Payment Amts.		**$911,545,547**
Wage Loss Allocations (Unique Cases and Claims)	1,170	1,462
Total Wage Loss Payment Amts.		**$49,345,716**
Impairment Allocations (Unique Cases and Claims)	3,901	3,901
Total Impairment Payment Amts.		**$331,362,361**

[1] Statistics show the status of all applications filed from program inception through September 30, 2008.

[2] "Case" counts are numbers of employees (or survivors of employees) whose work and illness or death are the basis for a "claim." (One case may have multiple survivor claims).

[3] "Claim" counts are greater than case counts because they include numbers of employees and all survivors of employees who filed for benefits.

[4] Each case or claim also received recommended decision by district office.

[5] Each case or claim still pending final decision by FAB.

[6] Includes remanded cases now in development and closed cases.

Table D-2 Part B

Processing Activity During FY 2008 on All EEOICPA Cases/Claims[1]

Processing Activity	Case[2]	Claim[3]
Total Cases/Claims Received-FY 2008	5,462	7,794
Total Cases/Claims (Covered Applications) Received-FY 2008	4,939	7,201
Final Decisions by FAB Offices in FY 2008	8,457[4]	12,200
Final Approved	4,216	6,486
Final Denied	4,241	5,714
Modification Orders in FY 2008	230	241
Recommended Decisions by District Offices in FY 2008	9,012	12,928
Recommended Decision Only, to Approve	4,320	6,593
Recommended Decision Only, to Deny	4,692	6,335
Referrals to NIOSH in FY 2008	6,607	8,769
Lump Sum Compensation Payments in FY 2008	see claim statistics	5,992
Remands	379	594

[1] Activity statistics capture actions made during FY 2008 only, therefore the number of activities reported do not add up to the total number of cases/claims received during FY 2008. (Many activities recorded occurred on cases/claims received prior to FY 2008).

[2] "Case" counts are numbers of employees (or survivors of employees) whose work and illness or death are the basis for a "claim." (One case may have multiple survivor claims).

[3] "Claim" counts are greater than case counts because they include numbers of employees and all survivors of employees who filed for benefits.

[4] Total includes cases with recommended decisions in FY 2008.

Table D-2 Part E

Processing Activity During FY 2008 on All EEOICPA Cases/Claims[1]

Processing Activity	Case[2]	Claim[3]
Total Cases/Claims Received-FY 2008	6,313	8,373
Total Cases/Claims (Covered Applications) Received-FY 2008	5,507	6,508
Final Decisions by FAB Offices in FY 2008	13,002[4]	13,440
Final Approved	7,315	7,541
Final Denied	5,687	5,899
Modification Orders in FY 2008	252	257
Recommended Decisions by District Offices in FY 2008	13,538	14,066
Recommended Decision Only, to Approve	7,721	7,965
Recommended Decision Only, to Deny	5,817	6,101
Referrals to NIOSH in FY 2008	4,134	4,351
Compensation Payments in FY 2008 (Unique Cases and Claims)	4,538	4,730
Total Compensation Payment Amts.		**$456,734,026**
Lump Sum Allocations (Unique Cases and Claims)	1,938	2,122
Total Compensation Payment Amts.		**$233,708,492**
Wage Loss Allocations (Unique Cases and Claims)	445	555
Total Wage Loss Payment Amts.		**$21,433,444**
Impairment Allocations (Unique Cases and Claims)	2,509	2,509
Total Impairment Payment Amts.		**$201,592,090**
Remands	697	**790**

[1] Activity statistics capture actions made during FY 2008 only, therefore the number of activities reported do not add up to the total number of cases/claims received during FY 2008. (Many activities recorded occurred on cases/claims received prior to FY 2008).

[2] "Case" counts are numbers of employees (or survivors of employees) whose work and illness or death are the basis for a "claim." (One case may have multiple survivor claims).

[3] "Claim" counts are greater than case counts because they include numbers of employees and all survivors of employees who filed for benefits.

[4] Total includes cases with recommended decisions in FY 2008.

Table D-3 Part B

EEOICPA Cases With Approved Decisions and Payments by Catergory, Program Inception Through September 30, 2008

Category	Number of Approved Cases [1]	Percentage of Total Final Approvals	Number of Paid Claimants [1]	Total Compensation Paid [2] ($ thousands)	Percentage of Total Compensaton Paid
Radiation Exposure Comp. Act (RECA) [3]	5,970	25.5%	9,201	$296,123	11.2%
Special Exposure Cohort Cancer (CN)	8,105	34.6%	12,415	1,175,226	44.5%
Dose Reconstructed Cancer (CN)	5,877	25.1%	8,312	869,262	32.9%
Beryllium Disease (CBD) [4]	1,785	7.6%	2,360	263,090	10.0%
Beryllium Sensitivity-Only (BS)	1,456	6.2%	N/A	N/A	N/A
Silicosis (CS)	74	0.3%	88	10,800	0.4%
Multiple Conditions [5]	190	0.8%	212	27,450	1.0%
TOTAL	**23,457**	**100.0%**	**32,588**	**$2,641,952** [6]	**100.0%**

[1] There is not a direct correlation between number of approved cases and number of paid claimants for two reasons: (1) more than one claimant can receive payment on a single approved case, and (2) some cases were approved prior to 9/30/2008, but payments were not issued.

[2] Represents total lump sum compensation payments from EEOIC program inception through September 30, 2008.

[3] RECA cases are not counted in any other category of this table.

[4] Cases approved for both CBD and BS are counted in the CBD category, only.

[5] Cases counted in the Multiple Conditions category were approved for CN and CBD, or CN and CS, or CBD and CS, or CN and BS, or CS and BS.

[6] Total does not include 44 cases that have data anomalies, primarily due to cases that could not be attributed to the designated categories.

Table D-4 Part B

EEOICPA Cases With Final Decision to Deny, Program Inception Through September 30, 2008

Reason for Denial	Number of Cases [1]
Employee Did Not Work at a Covered DOE Facility, Atomic Weapons Employer, or Beryllium Vendor During a Covered Time Period	4,073
Alleged Survivor Not an Eligible Beneficiary	540
Claimed Condition Not Covered Under Part B of EEOICPA	9,627
Dose Reconstruction Reveals the Probability That the Cancer is Related to Employment is Less Than 50 Percent	12,502
Medical Evidence is Insufficient to Establish Entitlement	5,075
Total	**31,817**

[1] A case may have more than one final decision. (For example, a request for modification may result in a second final decision on a case). Therefore, the total number shown does not represent the number of cases with final decisions to deny.

Table D-4 Part E

EEOICPA Cases With Final Decision to Deny, Program Inception Through September 30, 2008

Reason for Denial	Number of Cases[1]
Employee Did Not Work at a Covered DOE Facility, Atomic Weapons Employer, or Beryllium Vendor During a Covered Time Period	2,762
Alleged Survivor Not an Eligible Beneficiary	6,641
Claimed Condition Not Covered Under Part E of EEOICPA	161
Dose Reconstruction Reveals the Probability That the Cancer is Related to Employment is Less Than 50 Percent	4,222
Medical Evidence is Insufficient to Establish Entitlement	11,835
Total	**25,621**

[1] A case may have more than one final decision. (For example, a request for modification may result in a second final decision on a case). Therefore, the total number shown does not represent the number of cases with final decisions to deny.

Table D-5 Part B

Most Prevalent Non-Covered Medical Conditions, EEOIC Program Inception Through September 30, 2008

Non-Covered Medical Condition	Percentage of All Denials For This Condition [1]
Other Lung Conditions	22 %
Heart Condition/Failure/Attack/Hypertension	11
Chronic Obstructive Pulmonary Disease & Emphysema	8
Asbestosis	6
Renal Condition or Disorder (Kidney Failure, Kidney Stones)	5
Hearing Loss	4
Benign Tumors, Polyps, Skin Spots	3
Diabetes	3
Neurological Disorder	2
Thyroid Conditions (e.g., Hypothyroidism)	2
Anemia	1
Back or Neck Problems	1
Parkinson's Disease	1
Psychological Conditions	1
All Other Non-Covered Conditions (Each Less Than 1%) or Other (Not Listed)	22
No Condition Reported on Claim Form or Blank Condition Type	8

[1] Based on cases that were denied because claimed condition was not covered under Part B of EEOICPA. These figures exclude cases that have a "covered" condition, whereas Table D-4 Part B includes these cases.

Note: The sum of individual items may not equal 100 percent due to rounding.

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Nancy M. Flynn

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Division of Federal Employees' Compensation (www.dol.gov/owcp/dfec)
Douglas C. Fitzgerald, Director

Division of Coal Mine Workers' Compensation (www.dol.gov/owcp/dcmwc)
Steven D. Breeskin, Acting Director
Steven D. Breeskin, Deputy Director

Division of Longshore and Harbor Workers' Compensation (www.dol.gov/owcp/dlhwc)
Michael Niss, Director

Division of Energy Employees Occupational Illness Compensation (www.dol.gov/owcp/energy)
Rachel P. Leiton, Director
Christy A. Long, Deputy Director
LuAnn Kressley, Chief, Final Adjudication Branch

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