OWCP

Annual Report to Congress FY 2009

Submitted to Congress 2011
U.S. Department of Labor

Office of Workers' Compensation Programs

2009

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SECRETARY OF LABOR
WASHINGTON, D.C. 20210

APR 27 2011

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 2009 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, 2008, through September 30, 2009.

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,

Hilda L. Solis

HILDA L. SOLIS
Secretary of Labor

Enclosures

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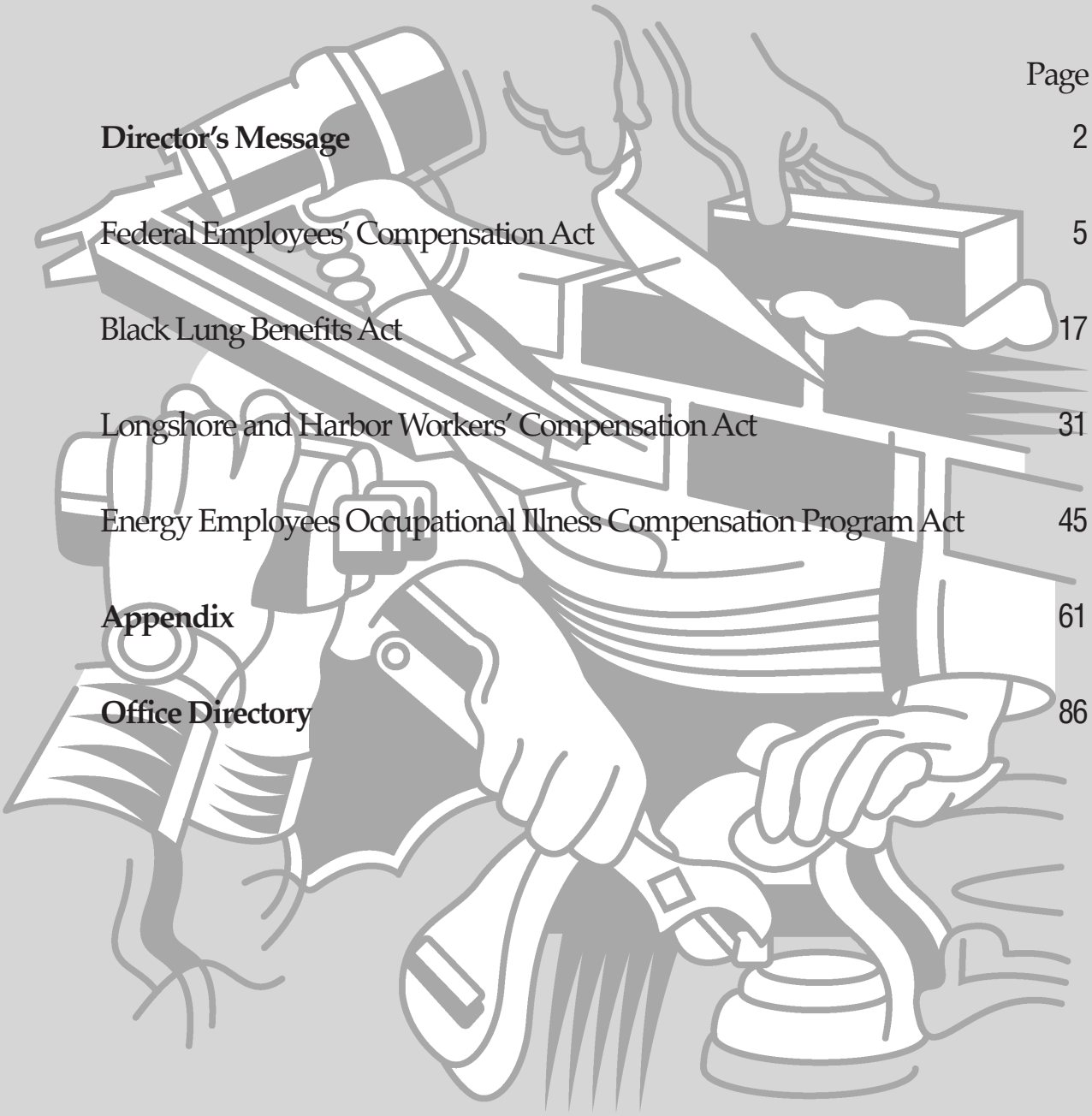


Director's Message

Fiscal Year (FY) 2009 was another successful year for the Office of Workers' Compensation Programs (OWCP). The four OWCP programs paid out over $4.1 billion in compensation and benefits while meeting a large majority of their eleven key performance goals. FY 2009 was the last year during which OWCP was a component of the Employment Standards Administration, which was abolished in November 2009. This reorganization made OWCP a stand-alone agency reporting directly to the Secretary of Labor, reflecting the growing salience and complexity of our mission.

The Federal Employees' Compensation (FEC) program achieved all of its goals under the Safety, Health, and Return-to-Employment (SHARE) initiative in its sixth and final year of operation. SHARE goals met included the continuing overall reduction of lost production day rates and the timely filing of 80 percent of non-Postal agency injury cases. Additional improvements were made to FEC's integrated case management/payment system (iFECS) during the year, including enhancements to the Continuation of Pay/Return-to-Work website to assist nurses in their management of injury cases and improvements that have streamlined the FECA benefit payment processes. At the same time, FEC staff continued to achieve high rates of timeliness in all aspects of program operations. Nearly 98 percent of traumatic injury claims were adjudicated within 45 days, and under the Quality Case Management (QCM) initiative the program has reduced time lost in serious new injury cases by 28 percent since QCM began sixteen years ago. Seriously injured workers are returning to the job nearly two months earlier on average as a result of the

coordinated efforts of OWCP, the employing agency, and the employee.

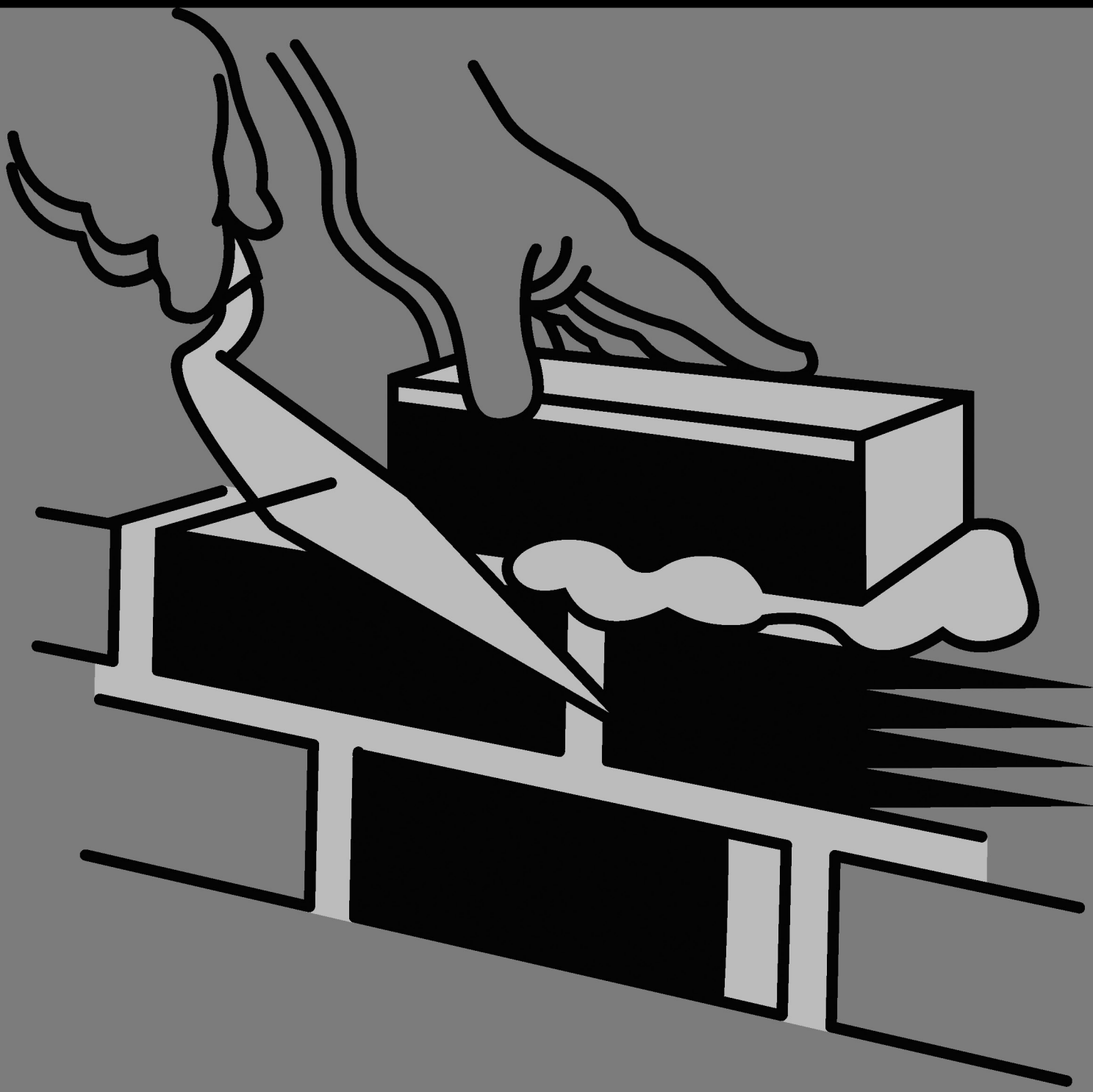
The Black Lung Disability Trust Fund, the source of benefits under Part C of the Black Lung Benefits Act, was operated under the legislatively-mandated financial restructuring during FY 2009, allowing the Fund to not only cover all its expenditures during the year, but also meet the established goal for the initial year's bond repayment of $342 million. The Black Lung program met both of its Government Performance Results Act (GPRA) goals by reducing average times to render a decision on a claim and keeping the program's average medical treatment costs below the National Health Expenditure cost projections. In addition, nearly 82 percent of claims were resolved during the year with no pending request for further action. Notably, the average time for the district offices to render a decision was reduced to 201 days, a full four months faster than the 323 days it took in FY 2005 when this goal was initiated.

The Longshore program continued to successfully manage the large Defense Base Act (DBA) caseload, including the elevated levels generated by civilian contract service claims arising from Iraq and Afghanistan, with no added resources. Total DBA-covered injury and death cases reported during FY 2009 reached 12,255, with nearly 52,000 total cases reported between FY 2003 and FY 2009. Along with its outstanding handling of this important and sensitive workload, Longshore staff continued to professionally manage its many other responsibilities under the Longshore Act, including monitoring industry benefit payments, dispute resolution, management of the second injury funds, vocational rehabilitation efforts, and performance of important compliance assistance and outreach services.

During its nine years of administering the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), OWCP has provided more than $5 billion in compensation and medical benefits to more than 54,000 claimants nationwide. In FY 2009 alone, nearly $987 million in benefits under both Parts B and E of the Act were paid, affecting nearly 5,300 employees or their survivors under Part B and almost 4,900 employees or survivors under Part E. The EEOICPA program achieved all three of its GPRA indicators during the year, reducing the average number of days to process initial claims by very large increments (from 164 to 113 days (31 percent) under Part B and from 284 to 159 days (44 percent) under Part E) and timely processing ninety-two percent of all final decisions, exceeding the 88 percent target. Also during FY 2009, the EEOICPA program maintained its outreach efforts. These activities during the year included town hall meetings, traveling resource centers, joint outreach task group meetings, and enhancements to its website and customer call handling systems.

These positive outcomes for our customers and stakeholders were possible only through the dedicated service of OWCP's eighteen-hundred employees. They assisted hundreds of thousands of injured workers and their families – one case at a time – and thereby made each of OWCP's programs a functioning and reliable part of our nation's safety net.

Gary A. Steinberg
Acting 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) 2009, the FEC program provided 253,000 workers and survivors over $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, $847 million for medical and rehabilitation services, and $138 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.

Benefit Outlays Under FECA FY 2009

TOTAL BENEFITS: $2,733 MILLION*

Long Term Disability (Wage-Loss)	**51.1**%	$1,396 Million
Medical Benefits	**31.0**%	$ 847 Million
Temporary Disability (Wage-Loss)	**12.9**%	$ 352 Million
Death Benefits	**5.0**%	$ 138 Million

*Actual Obligations

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 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 2009, these non-chargeback expenses were approximately $43.2 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 (WHCA), that did not contain mechanisms for billing employers. War Hazards payouts were higher in FY 2009 as the increased involvement of contractor staff in Iraq and Afghanistan resulted in a growing volume of claims under the Defense Base Act, leading to reimbursement requests under the WHCA for injuries and deaths caused by hostile action.

For FY 2009, administrative expenditures for the FEC program totaled $155.3 million. Of this amount, $142.2 million, approximately 4.9 percent of total program costs, were direct appropriations to the DOL's Office of Workers' Compensation Programs (OWCP), including $90.0 million in salaries and expenses and $52.1 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 $13.2 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 2009, the Division of Federal Employees' Compensation (DFEC) achieved three of its five 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 exceeded its Lost Production Days rate (LPD per 100 employees) target of 42 days for all government less U.S. Postal Service cases, by reducing lost days to 35.8.

The average LPD for U.S. Postal Service cases was 147.1 days, higher than DFEC's FY 2009 target of 139 days.

Through use of Periodic Roll Management, DFEC produced $14 million in first-year savings, falling short of its target of $15 million.

The program achieved a rate of increase of 6.4 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 initially established in 2004 to run through FY 2006. The Department of Labor was designated to lead the Initiative with the Occupational Safety and Health Administration and the OWCP having the responsibility for administering and monitoring program efforts. In FY 2006, SHARE was extended for another three years.

The four SHARE goals for FY 2009 were:

Reduce total case rates for injuries and illnesses by at least three percent.

Reduce case rates for lost time injuries and illnesses by at least three percent.

Increase the timely filing of injury and illness notices by at least five percent.

Reduce rates of lost production days due to injuries and illnesses by at least one percent.

OWCP's goal-setting methodology remained essentially the same except for two modifications. Goals for timely filing of Notices of Injury were revised to set a minimum of at least a 66.5 percent timeliness rate. Goals for those agencies exceeding the minimum continued according to a formula at a five percent per year improvement, except that no agency's goal was required to exceed 95 percent.

The lost production days (LPD) calculation was modified in FY 2006 to yield a more accurate compilation of lost days. Agencies with FY 2006 baseline LPDs at or below 15 days were charged with maintaining an LPD rate of 15 or less. All other agencies had their progress measured against the formula-driven targets of reducing LPDs by one percent per year.

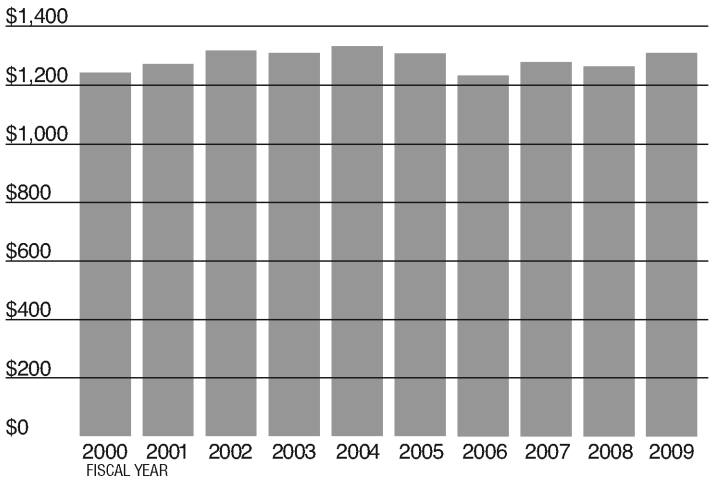
In FY 2009, the Federal government as a whole (less the U.S. Postal Service) successfully achieved all four SHARE goals. Nine departments and independent agencies met each of the performance measures in FY 2009. OWCP continued to collaborate with agencies in achieving the timely injury notice and lost production days goals.

Timely filing of injury notices continued to improve. By filing 80.1 percent of their cases with OWCP within 14 days, non-Postal agencies far exceeded the FY 2009 minimum of 66.5 percent. Performance has improved by more than 61 percent since the FY 2003 base year timely filing rate of 49.6 percent. The timely submission of claim forms enables OWCP to minimize interruptions of income and to promptly pay medical bills.

With non-Postal agencies averaging 35.8 lost days per 100 employees versus a goal of 42 lost days, the SHARE goal for LPDs was substantially exceeded once again in FY 2009. The achievement of this difficult goal in FY 2009 demonstrates that agencies are focusing on the long-term changes needed to improve their disability case management programs, and that FEC staff are managing long-term QCM cases very effectively to speed return to work.

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.

iFECS

Early in FY 2009 the Continuation of Pay/Return to Work (COP/RTW) website was released into production. The project developed a website for users that provides:

COP Nurses with necessary details to make contact with the claimant;

A capability for the COP Nurses to transmit current claimant information and status back to the district office, and close the case when appropriate; and

A secure mechanism for these tasks in order to protect Personally Identifiable Information (PII).

In mid-FY 2009 DFEC delivered the substantial 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 processes within iFECS; and

Capturing accurate performance metrics related to claims examiner actions and the timeliness of compensation payments.

In late FY 2009 DFEC initiated the Fair Share modernization initiative which consisted of three distinct areas of functionality: An Integrated Voice Response (IVR) system; a forms processing system; and a consolidation of district office scanning and data entry.

IVR Improvements (O-ECS). An improvement to the present IVR system can automate the process of providing data from every call electronically. By providing data through the means of telephony, the CA-110 (DFEC call record form) would be generated upon the completion of all calls within the system. O-ECS will provide monitoring and reporting capabilities for tracking workforce performance and supporting workload projections. Both of these functions are built within the system for seamless integration and performance improvements.

Web Portal Forms Processing (E-COMP). With E-COMP, DFEC proposes to supplement the current EDI-based system with a web-based system. This proposed system will enable all Federal employers and claimants to "e-file" DFEC forms and claims information at minimal / negligible costs to the agencies. E-COMP will allow users to select, initiate, complete, approve and submit forms online through an interactive internet environment.

Centralization of Case-Create/Imaging (3CI). On average, over 11,000 new cases are created for DFEC claimants each month. In December 2008 alone, 526,358 documents were imaged to support those cases and others in progress. DFEC has recognized a potential for cost savings through centralization of both these functions. Through the 3CI enhancement, DFEC seeks to reduce administrative costs for these functions while improving productivity, accuracy and consistency of output. Analysis has shown that consolidation will not only lower costs but also improve DFEC customer services and maximize controls for closer supervision of the case creation operations.

Case Adjudication and Management

Approximately 130,000 new injury and illness claims were filed under FECA in FY 2009. Eighty-seven 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, 97.6 percent were adjudicated within 45 days of the day OWCP received notice of the injury. In FY 2009, 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, 94.8 percent were adjudicated within 90 days. Of the more complex non-traumatic cases, 88.1 percent were adjudicated within 180 days.

The FEC program has reduced time loss in new injury cases by nearly 28 percent under its Quality Case Management (QCM) program since QCM was implemented in FY 1993. Under QCM 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 2009, 7,692 injured Federal employees were returned to work as a result of early nurse intervention. Additionally, vocational rehabilitation counselors arranged training and successfully placed 555 injured workers into non-Federal employment. The average length of disability in QCM cases (lost production days within the first year from the date FECA wage-loss began) was reduced to 142 days in FY 2009, down from the 145 days in FY 2008.

FECA Benefits Charged To Employing Agencies

CHARGEBACK YEAR 2009

Chargeback Total: $2,669 Million

Postal Service	$1,055 Million
Defense	$ 616 Million *
Veterans Affairs	$ 180 Million
Homeland Security	$ 165 Million
Justice	$ 105 Million
Transportation	$ 99 Million
Agriculture	$ 74 Million
All Other	$ 376 Million

*Defense Includes Navy ($240M), Army ($182M), Air Force ($131M), and Dept. of Defense ($63M)

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

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 2009, the disability in 1,280 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 $14 million in compensation benefit savings.

Central Medical Bill Processing

OWCP's medical bill processing service continued to achieve improvements in operating efficiencies. During FY 2009, DFEC avoided $77 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 2009, the bill processing system was enhanced to include Multiple Surgeries and Maximum Units pricing. The multiple surgeries enhancements allow the automated selection of the primary surgical procedure code from multiple codes billed to ensure appropriate pricing cutback. Maximum units enhancements enforce a maximum units allowed for procedures based on service description and complexity to ensure proper payment.

In FY 2009, the medical bill processing vendor processed 4.9 million bills and handled 782,242 telephone calls, meeting FECA communication goals. Authorizations for treatment were processed in an average of 1.1 work days and 99.8 percent of bills were processed in 28 days. Enrollment of 16,271 new providers brought the total of enrolled providers to 203,952.

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 2009, the Branch received a total of 6,438 incoming requests for reviews of the written record and oral hearings, and issued a total of 7,085 decisions.

In FY 2009, customer service and turnaround times improved in all 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 from an average of 67 days in FY 2008 to 64 days in FY 2009. For those case files where a hearing was held, the time period for issuance of a decision decreased from an average of 193 days in FY 2008 to 190 days in FY 2009. For appeals initiated from a review of the written record, the time period for issuance of a decision decreased from an average of 93 days in FY 2008 to 90 days in FY 2009.

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 2009, the branch continued to hold proceedings via 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.

Legislative Reform

DFEC continues to pursue changes to the Federal Employees' Compensation Act 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 proposal includes the following:

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, and make such payments earlier.

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

Allow OWCP to recover the costs 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. In response to the findings from this study, in FY 2009 DFEC developed (1) an electronic capability for employing agencies to report when an injured worker has returned to work; (2) a Web portal for COP nurses to transmit case status reports; and (3) a standardized nurse case evaluation report.

Early in FY 2009, the COP Return to Work website was released for production. This new website provided a secure mechanism for the protection of PII while simultaneously providing the COP nurse with the information needed to expedite contact with the claimant and a vehicle to transmit information back to the district office. Planning for the next phase of the project began later in the year. The COP/RTW Phase II project will transition the functionality of the website to an iFECS Delphi module and integrate the COP operations more thoroughly with other iFECS applications. COP data will be better propagated throughout iFECS and more case data will be accessible to COP nurses. Additionally, data input by the COP Nurse will be available to the staff nurse and claims examiner, and selected data will be made available to the claimant's agency and supervisor via changes to the AQS web application.

An evaluation of the FECA Program, "Dual Tracking of DFEC Quality Case Management Nurse and Vocational Rehabilitation Processes" (SRA International, Inc.), was conducted in FY 2009. The purpose of the evaluation was to provide recommendations for the design of an improved program for providing Quality Case Management (QCM) nurse intervention and vocational rehabilitation services to injured Federal workers and to strengthen the integration of these services. The recommendations centered on areas such as earlier intervention by nurses, claims examiners and rehabilitation specialists; effective and efficient communication to drive teamwork among all stakeholders in the FECA program; broadening timely work hardening and return-to-work options; system enhancements; and changes to current reporting mechanisms to better organize and track information.

In conjunction with the prior evaluation, the information is being used to improve the current program; adopt effective practices; enhance case management processes; and assist employing agencies with the creation of re-employment opportunities. Best practices, new approaches, and efficiency recommendations resulting from the performance studies should also improve agency and injured worker customer satisfaction while simultaneously supporting the objective to reduce lost production days.

Services to Claimants and Beneficiaries

Quality customer service and customer satisfaction are key components of DFEC's mission and "Pledge to Our Customers." During FY 2009, over 1.2 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 nearly two-thirds; turnaround time to caller inquiries has been reduced by more than 70 percent; and response effectiveness has improved by nearly 40 percent. During FY 2009, calls were answered in an average of 1.3 minutes, which is well below the goal of three minutes.

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 98.5 percent of callers received courteous service in FY 2009. The use of clear and understandable language was reported in 98.8 percent of calls, and 97.6 percent of calls met knowledge and accuracy standards. The goal of 95 percent was exceeded in each of these quality categories.

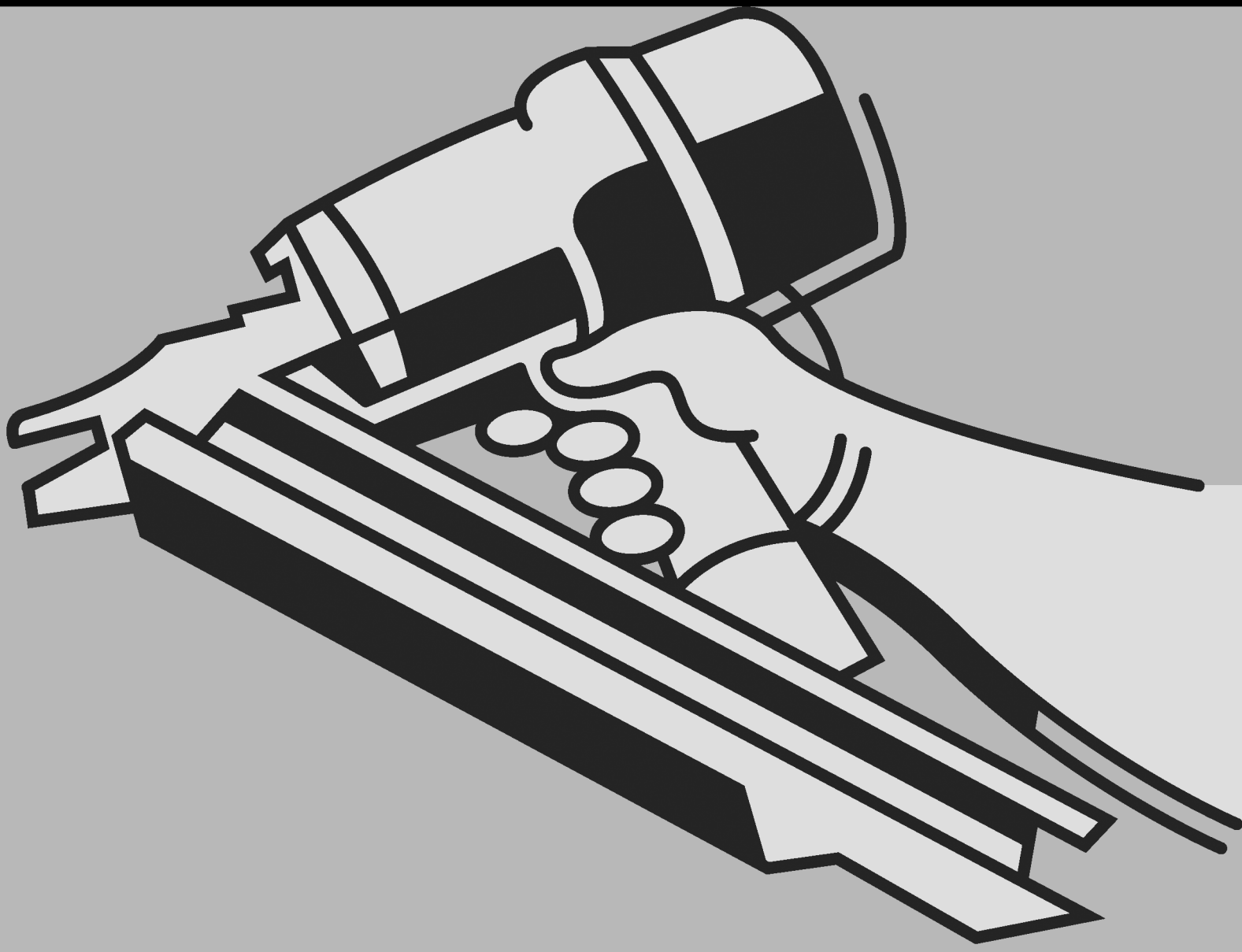
During FY 2009, 75 percent of calls to the district offices were responded to on the same day they were received, exceeding the goal by two percent. The average response time for all calls in FY 2009 was less than one day (0.84 days), which represents the most significant customer service improvement. Ninety-seven percent of all calls were responded to in two days or less.

Federal Employees' Compensation Act

	FY 2008	FY 2009
Number of Employees (FTE Staffing Used)	892	883
Administrative Expenditures [1]	$142.7 M	$142.2 M
Cases Created	134,013	129,690
Wage-Loss Claims Initiated	19,187	18,808
Total Compensation and Benefits (Actual Obligations) [2]	$2,657.6 M	$2,732.6 M
Number of Medical Bills Processed	5,182,096	4,926,575

[1] OWCP expenditures; excludes DOL support costs, but includes "fair share" capital expenditures of $53.2 million in FY 2008 and $52.1 million in FY 2009, respectively.

[2] Compensation, medical, and survivor benefits.



Black Lung Benefits Act

Introduction

The Division of Coal Mine Workers' Compensation (DCMWC) completed its thirty-sixth year administering Part C of the Black Lung program in 2009. The initial Black Lung benefits program was enacted as part of the Coal Mine Health

and Safety Act of 1969 (the Act), which marked its 40th anniversary during the year. 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).

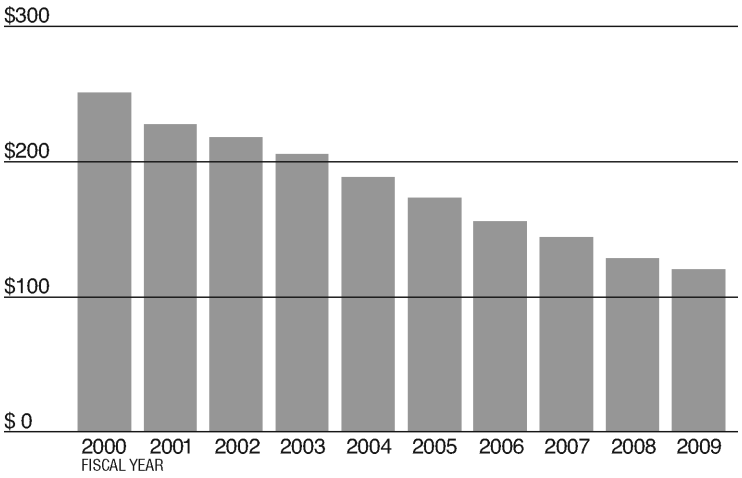
The number of claims filed in the early 1970's greatly exceeded expectations. The Act was amended by the Black Lung Benefits Act of 1972 (BLBA) to require the use of simplified interim eligibility criteria for all claims filed with SSA, and to transfer the receipt of new claims to the Department of Labor (DOL) in 1973. The Office of Workers' Compensation Programs (OWCP) assumed responsibility for processing and paying new claims on July 1, 1973. Until 1997, 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.

At the end of Fiscal Year (FY) 2009, administration of the Black Lung Part C program was 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 FY 2009, monthly and retroactive benefit payments totaled $221.3 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 2009 were $33.7 million. This includes payments of $3.7 million for diagnostic services, $28.6 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 207,000 bills were processed during the year.

Total Black Lung Part C program expenditures for all benefits in FY 2009 were $255.0 million, a decrease of $18.2 million from FY 2008. In FY 2009, benefits were provided from the Trust Fund to approximately 28,000 beneficiaries each month.

In addition to Trust Fund expenditures, self-insured mine operators and insurance companies paid approximately $39 million to over 4,500 miners and survivors. An estimated $7.8 million was also paid in medical treatment benefits, for a total cost to the industry of $46.8 million during FY 2009.

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, 2009, there were 1,140 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 72 fee petitions and paid approximately $0.5 million in attorneys' fees from the Trust Fund.

In FY 2009, 1,000 claims were forwarded for formal hearings before the Office of Administrative Law Judges (OALJ) and 516 claims were forwarded on appeal to the Benefits Review Board (BRB). At the end of FY 2009, the OALJ had 1,681 claims pending while 476 were pending before the BRB.

In the Black Lung Part B program, nearly 29,000 active beneficiaries (with more than 2,600 dependents) were receiving nearly $19 million in monthly cash benefits as of September 30, 2009. Part B benefits in FY 2009 totaled nearly $238 million. DCMWC completed 5,000 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 2009, the Trust Fund received a total of $644.9 million in tax revenues. An additional $9.2 million was collected from RMOs in interim benefits, fines, penalties, and interest. Total receipts of the Trust Fund in FY

2009 were nearly $7.2 billion, including $6.5 billion in a one-time appropriation from the Department of the Treasury.

Total Trust Fund disbursements during FY 2009 were almost $7.2 billion. These expenditures included $255.0 million for income and medical benefits, $6.5 billion to the Treasury for debt retirement, $57.7 million to administer the program ($32.3 million in OWCP direct costs and $25.4 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), and $341.9 million in bond payments.

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 2009, these tax rates will remain until December 31, 2018, 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 2009, DCMWC avoided $676,000 in medical costs due to further improvements in the editing of bills.

In FY 2009, the vendor processed 207,000 Black Lung bills. A total of 99.5 percent of bills were processed within 28 days. The number of telephone calls handled was 32,368. Enrollment of 2,239 new providers brought the total of enrolled providers to 110,007.

Legislative Action to Address Trust Fund Insolvency

The 1977 Amendments to the Act established a Trust Fund that would pay benefits to miners who last worked prior to 1970, or in cases where no responsible mine operator could be identified. The Black Lung Disability Trust Fund is financed by excise taxes on coal produced and sold, recoveries from coal mine operators and insurers of previously-paid benefits, interest and penalties, and repayable advance from the Treasury. Because the Trust Fund was established at the same time the Reform Act liberalized eligibility for b enefits, and because retroactive benefits far exceeded the collection of excise taxes (which were not applicable retroactively), the Fund soon began to require advances from the Treasury.

These advances were made in the late 1970's and early 1980's, when interest rates were high. Consequently, the Trust Fund continued to require advances for the purpose of debt servicing, even though excise tax receipts and benefits eventually stabilized. Despite a moratorium on interest from 1986 through 1990, and several extensions of the excise tax rates set in 1981, by the end of FY 2008 the Trust Fund was over $10 billion in debt to the Treasury. After many years of legislative proposals to reduce this debt, the Congress addressed it as part of P.L. 110-343, the Emergency Economic Stabilization Act of 2008, enacted in FY 2009. The debt was restructured by a one-time allocation from the Treasury and the issuance of zero-coupon Treasury bonds at current interest rates. As a result, the Fund not only covered its expenditures during FY 2009, but also made two repayments to the Treasury totaling $342 million, meeting the established goal for the first year's bond retirement.

Government Performance Results Act

In FY 2009, 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 218 days.

By the end of FY 2009, the average time required to process a claim from the date of receipt to the date of the PDO had been reduced to 201 days, slightly improved from the 205 days average in FY 2008.

The total number of new claims increased slightly (by 2.0 percent) from 4,270 in FY 2008 to 4,354 in FY 2009. These claim numbers include survivor's conversions that are automatically awarded. Conversion claims numbered 480 in FY 2008 and 444 in FY 2009. The total inventory of claims pending a PDO increased from 1,975 at the end of FY 2008 to 2,290 at the close of FY 2009.

The second GPRA goal for FY 2009 was also achieved. 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.

Although the NHEP appeared to be a good model for the Black Lung program's average expenditure growth during the study period and base year, recent experience has shown that the program's per capita expenditures, while

Management of SSA Part B Black Lung Claims FY 2009

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

Completing 5,000 Maintenance Actions, With Average Completion Time of Less Than One Week from Notification

Managing the Expenditure of More Than $238 Million in Benefits

DCMWC was Responsible for Nearly 29,000 Active Part B Cases

still below the NHEP's long-range projections, are more volatile on an annual basis than the projections. Nevertheless, while DCMWC did not meet its goal in FY 2008, measures taken in FY 2009, including closer review of in-patient bills and adjustments in pharmacy reimbursements, enabled the program to meet the goal for FY 2009 with an increase of 2.8 percent against the NHEP projection of 4.6 percent. Even as DCMWC considers alternative indices, it continues to take concrete steps to reduce costs without reducing services.

Although DCMWC 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 continues to monitor this figure. In FY 2009, 81.6 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.

Black Lung Program Evaluation

In FY 2009 DCMWC completed its implementation of a number of efficiencies and best practices recommended by an independent study in 2007. Among the most important items, a task force was established to study and recommend new accountability review standards, including financial controls. Also, training for the national office and district office staffs was enhanced by the use of internet and remote access technology, while another workgroup met to study enhancements to the Automated Support Package that will enable staff to track and identify responsible coal mine operators more efficiently.

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 2009, DCMWC worked to successfully migrate the Production ASP database to a server in the National Office from the server in Lee Summit, Missouri. DCMWC implemented several enhancements to its ASP that improved user's search capability and database integrity. In addition, the Division consolidated representative payee communications into a single new form.

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 2009 estimates by DOL's Mine Safety and Health Administration, there were just over 2,000 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 2009, 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 2009, the RO section sent form letters to 730 coal mine operators reminding them of their statutory requirement to insure and stay insured against their potential liability for black lung benefits. Of these, 594 were found to be insured, 70 were insured through a parent entity or not engaged in coal mining, and 30 were uninsured companies that required assistance. The remaining 36 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 2009, DCMWC received 2,860 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 2009, 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 2009, 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 2009 the program continued 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 2009, over 98 percent of representative payee appointments and expenditure reports were evaluated and acted on within thirty days. The program also finalized and implemented 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.

Litigation

COURTS OF APPEAL

During FY 2009, the courts of appeals issued twenty-four decisions in cases arising under the BLBA. Thirty-eight new appeals were filed. The following summarizes the most significant appellate decisions:

Subsequent Claims; 20 C.F.R. 725.309.
Pneumoconiosis may be both latent and progressive. For that reason, the BLBA permits a miner whose claim is denied to file another claim if his condition changes. In *RAG American Coal Co. v. Office of Workers' Compensation Programs*, 576 F.3d 418 (7th Cir. 2009), the miner's first claim was denied in part because the ALJ found that the miner's pulmonary impairment was unrelated to coal dust exposure. The miner later filed another claim and prevailed. The Seventh Circuit rejected the employer's assertion that the miner's second claim should be denied because the miner was improperly re-litigating his denied first claim. Recognizing that pneumoconiosis may remain hidden and progress in severity over time, the court held that the earlier finding that the miner's impairment was unrelated to coal dust exposure does not preclude a finding in the second claim that the miner now has pneumoconiosis that contributes to his disability. The court also held

that the finding of pneumoconiosis may be based on a new opinion of a doctor who diagnosed pneumoconiosis in the prior claim.

Due Process. In *Energy West Mining Co. v. Oliver,* 555 F.3d 1211 (10th Cir. 2009), the Tenth Circuit rejected the responsible coal mine operator's assertion that it was denied due process and thus should be relieved of liability for the claim. The miner had originally filed for benefits in 1980. That claim was denied and the file eventually destroyed pursuant to the Department's records-retention policy. The miner continued to work until 1993 and later filed a second, successful claim in 2002. The operator argued that the destruction of the first claim file prevented it from mounting a meaningful defense to the second claim. Noting that "[t]he Constitution is concerned with procedural outrages, not procedural glitches," the court held that the operator failed to demonstrate that the file's destruction constituted deliberate misconduct or prevented it from fully defending its interests. Consequently, the court concluded that it was not "fundamentally unfair to make the (operator) live with the outcome of [the] proceeding[.]"

Statute of Limitations; 30 U.S.C. 932(f)(1). The BLBA 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. In *Arch of Kentucky, Inc. v. Hatfield,* 556 F.3d 472 (6th Cir. 2009), the responsible operator argued that the miner's subsequent claim for benefits was untimely because he had received a diagnosis of totally disabling pneumoconiosis, which was rendered more than three years earlier, in connection with his prior claim. The Sixth Circuit rejected this argument, holding that a medical determination of totally disabling pneumoconiosis that is generated in connection with a denied claim is a misdiagnosis and does not start the three-year limitations period. The court noted that its interpretation both encourages miners to seek early medical treatment and does not constrain a miner's ability to file a later claim if his condition deteriorates.

Death Due to Pneumoconiosis; 20 C.F.R. 718.205. A miner's survivor is entitled to benefits if she establishes that coal workers' pneumoconiosis caused or contributed to the miner's death. Under the program regulations, pneumoconiosis contributes to a miner's death if it hastens death in any tangible way. In *Hill v. Director, OWCP,* 562 F.3d 264 (3d Cir. 2009), the Third Circuit addressed several issues regarding the necessary medical proof for establishing death due to pneumoconiosis. The court held that if the miner has been found to have pneumoconiosis, a physician's opinion that the miner's lung

condition contributed to death may be legally sufficient to establish entitlement even if the doctor does not specifically identify the lung condition as pneumoconiosis; that a doctor's explanation for how pneumoconiosis contributed to death may be credible even if phrased in conditional or hypothetical terms; and that the absence of medical records for the period immediately before the miner's death does not invalidate an otherwise credible medical opinion that the miner's death was due to pneumoconiosis.

Medical Evaluation Provided by DOL; 30 U.S.C. 923(b). Section 413(b) of the Act requires the Department to provide each miner/claimant with the opportunity to substantiate his claim by means of a complete pulmonary evaluation. In *Greene v. King James Coal Mining, Inc.*, 575 F.3d 628 (6th Cir. 2009), the Sixth Circuit addressed the amount of reasoning and documentation that a medical report must contain in order to meet the Department's statutory obligation. The court held that the Department's duty is met if the miner is provided an evaluation report that includes all medical tests and that links the physician's conclusion on all essential elements of entitlement to the results of those tests. The court also noted that an opinion is not deficient simply because it lacks extensive detail or ultimately fails to carry the miner's burden of proof when weighed against contrary evidence.

BENEFITS REVIEW BOARD

During FY 2009, the Benefits Review Board issued 624 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:

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. Consistent with the holdings of three United States Courts of Appeals, and with the position of the Director, the Board held that the limitations provision applies to all claims filed by a miner and that a medical determination of totally disabling pneumoconiosis that predates the denial of a prior claim is a misdiagnosis that does not trigger the running of the limitations period for filing a subsequent claim. *J.O. v. Helen Mining Co.*, 24 BLR 1-117 (2009).

Medical Evaluation Provided by DOL. Section 413(b) of the Act requires the Department to provide each miner/claimant with the opportunity to substantiate his claim by means of a complete pulmonary evaluation. In this case, the ALJ concluded, prior to the hearing, that the 413(b) examination was defective and remanded the claim to the district director. At the urging of the Director, the Board rejected the responsible coal mine operator's argument that the ALJ was without authority to issue the order and could not remand to cure the 413(b) defect until after a

hearing. The Board held that the program regulations authorize an ALJ to order such a remand at any time prior to a hearing. The Board also rejected the operator's argument that liability for the claim should transfer to the Black Lung Disability Trust Fund because the remand violated its due process rights. The Board reasoned that the operator failed to show how remand to correct a flawed medical report prior to the hearing denied it a meaningful opportunity to defend its interests. *R.G.B. v. Southern Ohio Coal Co.,* 24 BLR 1-129 (2009).

Black Lung Benefits Act

	Part C [1]		Part B [2]	
	FY 2008	FY 2009	FY 2008	FY 2009
Number of Employees (FTE Staffing Used)	179	171	16	17
OWCP Administrative Expenditures [3]	$ 32.4 M	$ 31.9 M	$ 5.4 M	$ 5.2 M
Total Compensation and Benefit Payments [4]	$273.2 M	$255.0 M	$262.3 M	$237.8 M
Beneficiaries in Pay Status at End of Fiscal Year				
Monthly	28,597	26,080	32,732	28,911
Medical Benefits Only	1,924	1,571	N/A	N/A
Responsible Coal Mine Operator Beneficiaries in Pay Status at End of Fiscal Year				
Monthly	4,616	4,415	N/A	N/A
Medical Benefits Only	662	563	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 administrative expenditures exclude DOL and Department of Treasury support costs of $25.9 million in FY 2008 and $25.8 million in FY 2009, respectively. Also excludes interest on the Trust Fund debt.

[4] Part C payments include only Trust Fund compensation and benefits (excluding 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). Excluded are self-insured mine operator and insurance carrier payments that totaled approximately $48.6 million in FY 2008 and $46.8 million in FY 2009, respectively.

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.

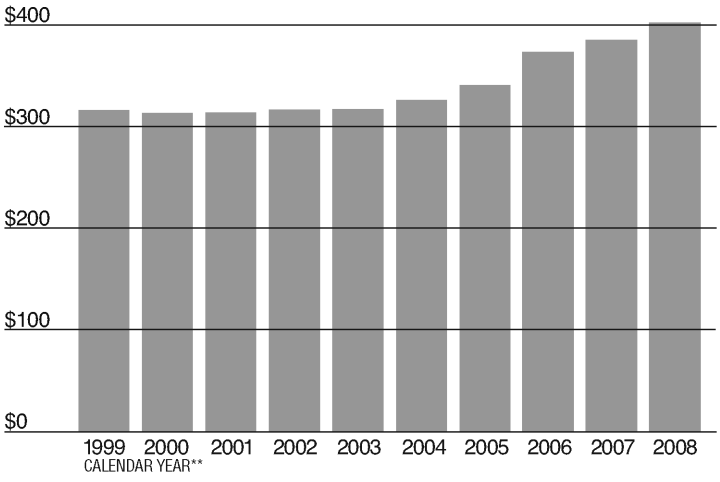
The Outer Continental Shelf Lands Act of August 7, 1953, extended Longshore benefits to employees of firms working on the outer continental shelf of the United States, such as off-shore drilling enterprises engaged in exploration for and development of natural resources.

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 $844.7 million in Calendar Year (CY) 2008, an 8.0 percent increase compared to CY 2007.

In Fiscal Year (FY) 2009, total DOL expenditures for program operations and the administration of LHWCA and its extensions were $24.4 million, of which $10.7 million were the direct costs of OWCP. The remaining $13.7 million represent 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 98 people in the national office and 11 district offices.

During FY 2009, approximately 530 self-insured employers and insurance carriers reported 28,952 lost-time injuries under the LHWCA. At year's end, 14,450 maritime and other workers were in compensation payment status.

The conflict 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 2009. 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 backlogs, the Longshore program continued to distribute the Middle East DBA workload among all its district offices in FY 2009. During the year, a total of 12,255 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 $132.7 million in benefits in FY 2009, of which $121.2 million was for second injury (section 8(f)) claims. FY 2009 expenditures from the DCCA Special Fund totaled $10.1 million, of which $9.2 million was for second injury cases.

Government Performance Results Act

In FY 2009, DLHWC measured 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":

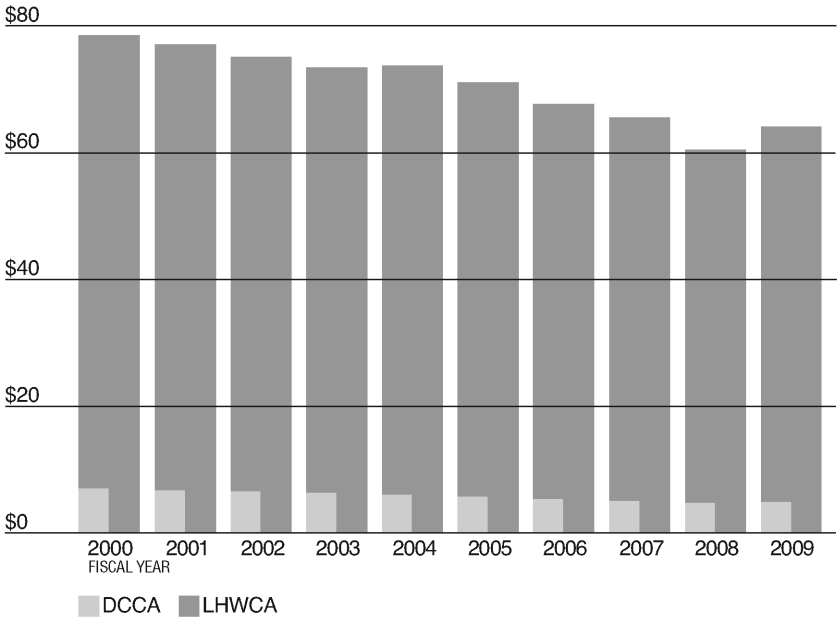
For average time required to resolve disputed issues in LHWCA program contested cases, the FY 2009 target is 242 days..

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 2009, the district offices conducted 3,221 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.

In FY 2009, disputed issues covered by this measure were resolved in an average of 251 days, or nine days over the target of 242 days. The program's failure to meet the target was in large part due to the complexities of injury and death cases in connection with the conflicts in Iraq and Afghanistan. DBA claims present unique challenges and require more time and claims expertise to process than general Longshore claims. Claims development and documentation are more complicated and time-consuming, processing is more labor-intensive, response times

LHWCA and DCCA Special Funds' Expenditures, FY 2000-FY 2009

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.

from overseas are extended, medical issues are more complex, and disputes are more difficult to resolve, especially for complex claims such as Post-Traumatic Stress Disorder. In addition, the continued high level of claims has reduced the amount of staff time available for dispute resolution per case.

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.

During FY 2009, Longshore collected data to determine the average elapsed days between date of injury/employer's date of knowledge and the receipt of the LS-202 (Employer's First Report of Injury) and between the date of onset of disability and date of first payment of benefits. The results will be the basis of performance targets that will be integrated into Longshore GPRA goals for FY 2010 and beyond.

Performance Assessment

In response to the recommendations from the 2005 Program Assessment Rating Tool (PART) and two independent studies by the private consulting firm SRA Corporation, the Longshore program completed action to re-baseline and develop out-year targets for the dispute resolution measure and is in the process of developing baselines and out-year targets for two new performance measures to track and measure benefit facilitation. DLHWC is developing and implementing an electronic database of authorized insurers. Currently the program collects handwritten 3x5 cards that are then filed in a cabinet for record-keeping purposes. Working with the National Council on Compensation Insurance, a non-profit workers' compensation data collecting organization, DLWHC is developing the means for insurers to report policies electronically for purposes of determining proof of coverage. The new system will save insurers the costs of creating, handling, and mailing the 3x5 cards, and save the Division the work of sorting, storing, and retrieving paperwork. The Special Fund system was updated to create the ability to enter and track medical bills on the system, enhancing management controls, accuracy, and security.

Language in the American Recovery and Reinvestment Act of 2009 amends the Longshore Act to exclude workers who repair recreational vessels or dismantle them for repair, regardless of the length of the vessel on which they work. DLHWC is working on a regulation to address the lack of a definition for "recreational vessel", ensuring employees do not move in and out of coverage, and addressing employees who are excluded from State workers' compensation coverage.

Although the Longshore program did not meet its GPRA target for FY 2009, program performance, as measured by GPRA outcome metrics, quarterly reviews of district office performance, and periodic accountability reviews, continues to be excellent despite continuing high incoming case loads.

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 2009, with cases totaling 8,486, of which 268 involved the death of a worker. Between FY 2003 and FY 2009, a total of 51,678 DBA cases were reported, including 1,875 deaths, of which 39,255 cases (1,652 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 2009, 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

The depressed economy and concomitant rate of unemployment placed enormous pressure on the Longshore Rehabilitation program during FY 2009. As jobs were eliminated nationwide in great numbers and the unemployment rate rose to historic levels, the opportunities to return injured workers to work became increasingly more difficult to secure. Despite these challenges and in addition to the hurdles experienced in normal rehabilitation efforts, the program was very successful during the year, achieving 100 percent of its placement goal due to the excellent work of the professional providers and the oversight of DLHWC's district office staff. The program missed its vocational rehabilitation outcomes goal in FY 2009 with 49.4 percent of rehabilitation plan completers returning to work within 60 days against a target of 51.7 percent, due to the significant challenges that existed in the job market resulting from the downturn in the economy.

Although the previous year's pilot project to use financial incentives to improve return-to-work outcomes did not produce the anticipated results, a novel trial effort to provide focused services at the largest employers did result in excellent outcomes. Expanding this method across the program will require some contractual revisions in the way rehabilitation cases are referred to the professional service providers, but will create better opportunities for Longshore program clients and better working relations with the employer community. Work on those changes will begin to coincide with the next round of contract renewals in FY 2012.

Litigation

During FY 2009, the courts of appeals published twelve decisions, and the Benefits Review Board (BRB) published thirty-one decisions, that discussed issues arising under the LHWCA or its extensions. Important points from some of these cases are summarized below.

COURTS OF APPEALS

Coverage for an Employee Injured on an Oil Production Platform – 33 U.S.C. §§ 902(3), 903. The Fifth Circuit issued an important coverage decision holding that an employee who was injured while working on an oil production facility that included a platform and a permanently attached storage barge with a loading dock satisfied the situs and status tests for LHWCA coverage. *Coastal Production Services, Inc. v. Hudson,* 555 F.3d 426 (5th Cir. 2009) (DeMoss, J., dissenting). The production facility received oil from satellite wells, separated gas and water from the oil, and transferred the oil to holding tanks on the platform. Thereafter, the oil was transferred from the barge's loading dock onto customers' vessels for delivery onshore. The employee's regularly assigned duties included repairing the storage barge loading equipment and participating in loading the oil onto the customers' vessels. He was injured while working on the platform performing a task unrelated to loading. A majority of the panel held that the entire area consisting of both the platform and the storage barge was a covered situs because both parts of the facility were an "other adjoining area" "customarily used" in loading vessels. 33 U.S.C. § 902(3). The majority further held that the employee satisfied the status test for a maritime "employee" because he regularly performed work that was integral to

the loading process regardless that the covered duties represented only a fraction of his overall employment. 33 U.S.C. § 903(a).

"Filing" a Compensation Order by the District Director – 33 U.S.C. § 919(e). In *Carillo v. Louisiana Ins. Guaranty Assoc.*, 559 F.3d 377 (5th Cir. 2009), the Fifth Circuit reached and decided a question reserved in *Grant v. Director, OWCP*, 502 F.3d 361 (5th Cir. 2007), i.e., whether the filing of a compensation order under section 919(e) and 20 C.F.R. § 702.349 also includes service of the order upon the parties by the District Director. Section 919(e) requires the District Director to file a compensation order and serve the parties by registered or certified mail. Section 702.349 requires the District Director to date the compensation order and other specified documents by the close of business on the day following receipt; the District Director must serve the compensation order on the parties that same day. Agreeing with the Third and Seventh Circuits and disagreeing with the Ninth Circuit, the Fifth Circuit held that an order is "filed" in the Office of the District Director when the District Director completes the actions required by 20 C.F.R. § 702.349, and that sending the order to the parties is not part of filing. The Court therefore rejected the argument that actual receipt of a compensation order is a necessary part of filing. In addition, the Fifth Circuit declined to address, as not properly presented, LIGA's argument that its state enabling statute barred its liability for additional compensation under section 914(f).

Definition of "Subdivision" of a State – 33 U.S.C. § 903(b). The Ninth Circuit held that the term "subdivision" of a State as used in section 903(b) includes the Golden Gate Bridge, Highway & Transportation District. *Wheaton v. Golden Gate Bridge, Highway & Transportation District*, 559 F.3d 979 (9th Cir. 2009). The LHWCA excludes from coverage employees of a subdivision of a State. The Court held that a repairman and maintenance employee of the Golden Gate District's Ferry Division works for a subdivision of the State of California based on the factors considered in determining whether an entity is a subdivision or a private corporation for purposes of the National Labor Relations Act.

Definition of "Wages" – 33 U.S.C. § 902(13). An employer that denominated half the money it paid its employee "per diem" payments, and did not report those payments to the IRS, failed to convince the Fifth Circuit to adopt a strict rule that only taxable income can constitute wages under the LHWCA. The court held that section 902(13)'s definition of "wages" included the per diem payments at issue here. *B & D Contractors v. Pearley*, 548 F.3d 338 (5th Cir. 2009). The Court based its decision on the manner in which the employer made the payments: they appeared in the same paycheck as the claimant's normal wages; they were based on the number of hours worked; they bore no relationship to the actual costs of travel, meals or lodging; all employees received the same payment regardless of where they lived; and the payments represented almost half of the claimant's paycheck. Relying on a Fourth Circuit case that found payments characterized as "per diem ... nothing more than a disguised wage," the Fifth Circuit concluded that the "per diem" payments here "played the role of wages" and should therefore be treated as wages in calculating the disability benefits due to the claimant.

The topic of attorney fees continued to be the subject of numerous decisions in fiscal year 2009:

Prevailing Market Rate for Attorney Fees – 33 U.S.C. § 928. Perhaps the most contentious of the attorney fee issues, the hourly rate, was addressed in two companion cases in the Ninth Circuit. The court vacated hourly rate determinations by the district director, the ALJ, and the BRB holding that LHWCA adjudicators must award reasonable attorney fees calculated according to the rates prevailing in the relevant community. *Christensen v. Stevedoring Services of America*, 557 F.3d 1049 (9th Cir. 2009); *Van Skike v. Director, OWCP*, 557 F.3d 1041 (9th Cir. 2009). Both cases held that an adjudicator could not rely on awards in other LHWCA cases because such a method ignored current market rates by effectively perpetuating an historical rate, and overlooked the fact that there is no private market for attorney fees under the LHWCA because the Act prohibits claimant attorneys from negotiating fee agreements. Both cases also noted that in order to attract competent counsel to take LHWCA cases, counsel should receive fees commensurate with those they could obtain by taking other types of cases.

Attorney's Entitlement to Pre-Controversion Fees – 33 U.S.C. 928. Where liability for the claimant's attorney fee is imposed on the employer, the question arises as to which part of the fees must be borne by the employer. Section 928(a) provides that a claimant's attorney is entitled to a fee once the employer controverts a claim and the claimant "thereafter" employs the attorney in the successful prosecution of a claim. The Ninth Circuit held that a claimant's attorney is entitled to what has come to be known as both pre- and post-controversion fees when an employer controverts a claim and the claimant "thereafter" employs the attorney to obtain benefits. *Dyer v. Cenex Harvest States Cooperative*, 563 F.3d 1044 (9th Cir. 2009). The Ninth Circuit disagreed with the Fourth and Fifth Circuits, which have held that a claimant's attorney is limited to fees for work performed after the employer controverts the claim. The Ninth Circuit concluded that the word "thereafter" does not impose a temporal bar on pre-controversion fees, but only requires the claimant to employ the attorney after controversion in order to shift fee liability.

Relevant "Community" for Awarding Attorney Fees – 33 U.S.C. § 928. The Seventh Circuit held that an ALJ acted within his discretion in basing a fee award on the attorney's hourly billing rate for the community in which she practiced rather than the market rate where the case was litigated. *Jeffboat, LLC v. Director, OWCP (Furrow)*, 553 F.3d 487 (7th Cir. 2009). The injured employee's case was heard by an ALJ in Indiana, but his attorney was from Connecticut. The attorney used the market rate for attorneys practicing in Connecticut as her hourly billing rate. The Supreme Court has held that an attorney receiving an award under a fee-shifting statute (like the LHWCA) must establish the requested fee is in line with the prevailing hourly rate used by comparable attorneys in the "community." The Court held that "community" as used by the Supreme Court could be the community where the attorney practiced rather than the "local market area" where the case was litigated because the subject matter of the litigation is highly specialized and the market for legal services is a national market.

Employer's Attorney Fee Liability Based on Acceptance of a Favorable District Director Recommendation Denying Additional Compensation – 33 U.S.C. § 928. Continuing its literal and restrictive reading of section 928, the Fifth Circuit held that an employer is not liable for a claimant's attorney fee if it accepts the District Director's recommendation denying claimant additional compensation even though the claimant later prevails before an ALJ. *Andrepont v. Murphy Exploration and Production Co.*, 566 F.3d 415 (5th Cir. 2009). Among the conditions that section 928(b) establishes for an employer to be liable for a claimant's attorney fee is that it refuse to accept a District Director's written recommendation concerning additional compensation and the claimant later obtains such compensation. Agreeing with the Fourth and Sixth Circuits and disagreeing with the Ninth Circuit, the Fifth Circuit held that an employer need not reject the District Director's recommendation in order to assume liability for a claimant's attorney's fee. Based on a literal interpretation of Section 928(b), the Court concluded that the employer was not liable for an attorney's fee because it had accepted, not rejected, the District Director's recommendation.

BENEFITS REVIEW BOARD

Reflecting the increased use of contractors overseas, especially to support military activities in Iraq and Afghanistan, the BRB issued a number of important decisions in cases arising under the Defense Base Act (DBA), 42 U.S.C. § 1651 et seq.

Computing a DBA Claimant's Average Weekly Wage – 33 U.S.C. § 910. The BRB vacated an ALJ's application of the so-called "blended approach" to calculating the average weekly wage (AWW) of DBA employees injured shortly after starting their foreign assignments. The BRB held that an ALJ should consider only the higher wages the employee received while working overseas notwithstanding that section 910(c) authorizes the adjudicator to consider an employee's earnings in previous employment together with wages earned at the time of injury. The employee worked overseas for only a short period before being injured, and the domestic wages were much lower than those earned abroad. *K.S. v. Service Employees Int'l, Inc.* 43 BRBS 18 (2009), *mot. for recon. den.* 43 BRBS 136, 2009 WL 3308377 (Sept. 25, 2009) *(en banc)*. The BRB reasoned that the higher overseas wages reflected the premium rate the employer was willing to pay for the claimant to work under dangerous conditions. The BRB noted that the claimant had a one-year, full-time, employment contract; that he intended to fulfill that contract; and that he expressed the intent to continue working in Iraq beyond the one year. The BRB concluded "blending" the claimant's domestic and overseas wages would distort his earning capacity by compensating him at a lower rate than the employer agreed to pay for work performed in a war zone. On reconsideration, the BRB rejected the employer's arguments that the BRB improperly intruded on the ALJ's broad discretion to make AWW findings and that its decision required adjudicators to consider only overseas earnings in every DBA case.

DBA and Non-Appropriated Fund Instrumentalities Act (NAFI) Coverage for Foreign Citizens Working Abroad at a Military Post-Exchange – 42 U.S.C. § 1651 *et seq.*; 5 U.S.C. § 8171 *et seq.* Two resident-citizens of the Republic of Phillippines were denied death benefits under

either the DBA or the Non-Appropriated Fund Instrumentalities Act (NAFI), 5 U.S.C. § 8171 et seq., because (i) the NAFI has superseded the DBA and is the exclusive remedy for such claimants; and (ii) the NAFI requires the claimants to seek compensation from the Secretary of the military department involved. *A.P. (widow of R.P.) v. Navy Exchange Service Command*, 43 BRBS 123 (2009). Because the NAFI requires a claimant to seek compensation as provided by regulations of the Secretary of the appropriate military department, the BRB affirmed the ALJ's finding that he lacked jurisdiction to consider the claims on the merits.

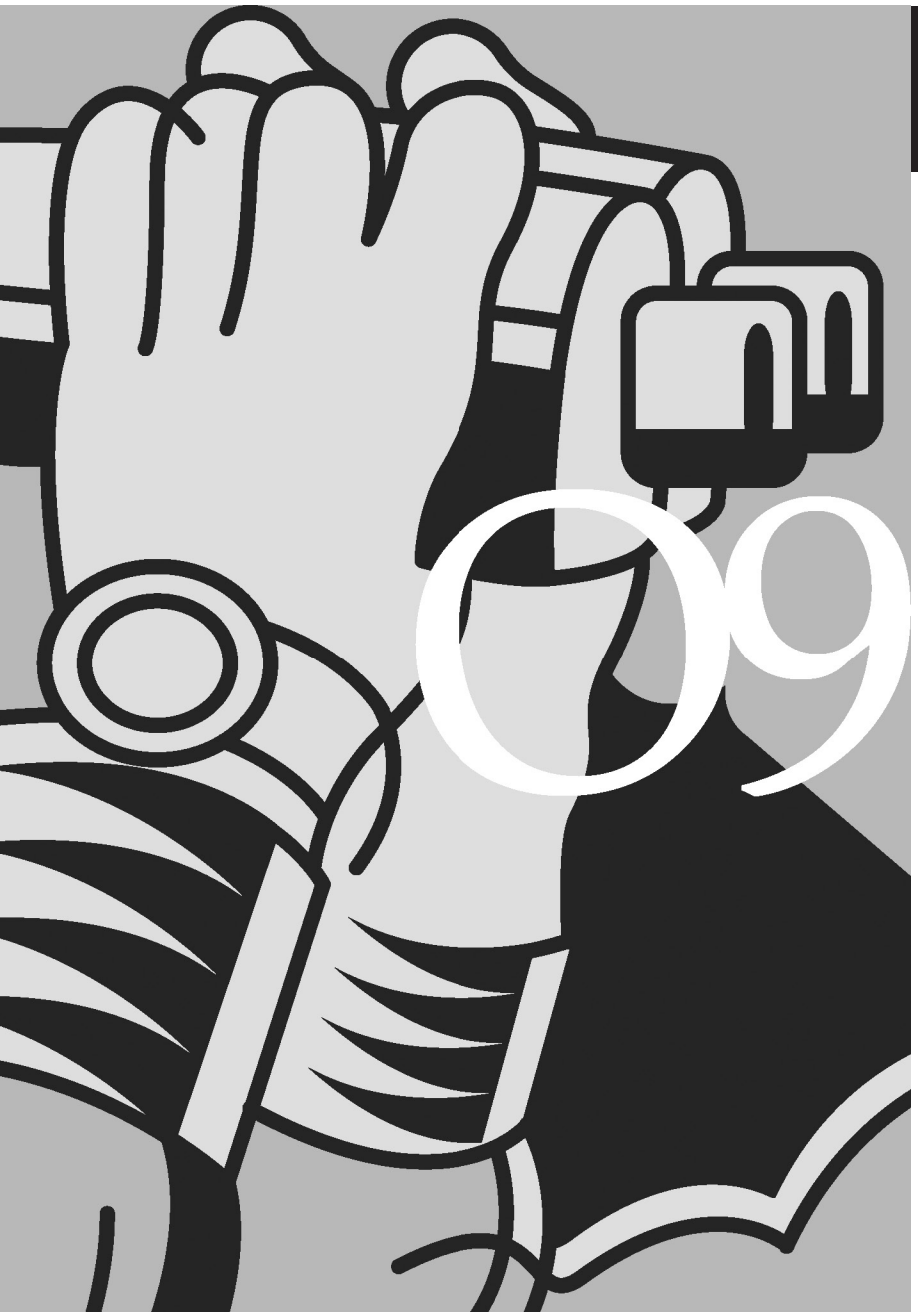
Definition of a "Military Base" under the DBA – 42 U.S.C. § 1651 *et seq.* Affirming an ALJ's denial of a claim by the employee of a US contractor who suffered PTSD after the hotel at which she was staying in Baghdad's Green Zone was attacked by rocket fire, the BRB found that the DBA did not cover the employee. *Z.S. v. Science Applications Int'l Corp., 42 BRBS 87 (2008).* The DBA covers individuals employed at "any military, air, or naval base acquired . . . by the United States" from a foreign government. 42 U.S.C. § 1651(a)(1). The DBA, however, does not define military base. The BRB held that to constitute a "military base" for purposes of the DBA, the area had to be under the control of the United States military in accordance with definitions adopted by the United States Code and regulations issued by the Secretaries of the military departments. These definitions focus on whether the United States military owns, controls, or exercises jurisdiction over, the facility. Thus, the Board held that the Green Zone was not a military base. The DBA also covers individuals employed under a contract with any agency of the United States where the contract is for public work and to be performed outside the continental US. 42 U.S.C. § 1651(a)(4). The BRB affirmed the ALJ's findings that the claimant was not working on such a contract at the time of her injury. Rather, she was hired to go to Iraq to develop new business for her employer.

Illegal Alien's Entitlement to Benefits as an "Employee" – 33 U.S.C. § 902(3). The BRB held that an employee's status as an undocumented alien is irrelevant to determining whether that individual is entitled to LHWCA benefits. *J.R. v. Bollinger Shipyard, Inc.*, 42 BRBS 95 (2008). Section 902(3) defines "employee" as a person engaged in maritime employment with certain exceptions involving excluded types of employment. 33 U.S.C. § 902(3)(A)-(H). The BRB concluded that the statutory definition, including exceptions, does not premise coverage on citizenship status. The BRB therefore held that an employee who is an illegal alien is not precluded from receiving benefits.

Application of LHWCA to Overseas Injuries – 33 U.S.C. § 903(a). The BRB held that an employee injured while employed in Asian ports is not covered by the Act because he was abroad on a "prolonged foreign assignment" rather than a temporary assignment. *J.T. v. Global Intern'l Offshore, Ltd.*, 43 BRBS 92, BRB Nos. 08-0119 & 08-0119A (July 29, 2009). Section 903(a) limits coverage of the LHWCA to injuries "occurring upon the navigable waters of the United States." 33 U.S.C. § 903(a). In *Weber v. S.C. Loveland Co.*, 28 BRBS 321 (1994), *decision after remand*, 35 BRBS 75 (2001), the BRB noted that precedent establishes that for purposes of the LHWCA the navigable waters of the United States include the high seas and found covered an employee injured in

Kingston, Jamaica. In *J.T.,* the BRB distinguished *Weber* finding it critical that the employee's assignment to the foreign ports was prolonged and not merely temporary. J.T. worked for a domestic-based company, but was assigned overseas for a four-year period during which he had no work-related reason to return to the United States. The BRB reasoned that the employee was not covered because he was assigned overseas for a lengthy period; all of his employment-related contacts were with the foreign countries where he worked; and his assignments commenced and terminated in those countries. Thus, the BRB held that the employee's injury did not occur upon the navigable waters of the United States.

Section 17 Trust Fund's Entitlement to a Lien and Participation in a Settlement – 33 U.S.C. §§ 917, 907(d). Addressing a little-litigated provision of the Act, the BRB held that a section 917 trust fund with a vested lien on disability benefits it paid to the claimant under its welfare plan must agree to any settlement between the claimant and employer affecting the fund's right to recover the benefits it paid. *M.K. v. California United Terminals,* 43 BRBS 1 (2009), *mot. for recon. den.* 43 BRBS 115, 2009 WL 2845676 (Aug. 28, 2009). Thus, claimants and employers cannot settle claims in which the section 917 trust fund has a financial interest without simultaneously satisfying the trust fund's claims. Section 917 provides that a trust fund established pursuant to a collective bargaining agreement is entitled to a lien on a claimant's LHWCA compensation if the trust fund pays disability benefits to the claimant and the claimant becomes legally obligated to repay those benefits because he is entitled to compensation under the LHWCA. Section 907(d)(3) authorizes an award to any party in interest who has paid for an employee's medical treatment that should have been borne by the employer. The BRB held that a section 917 trust fund may, under section 907(d)(3), intervene in settlement proceedings in order to seek reimbursement of medical benefits it paid and the adjudicator must make provision for reimbursing the trust fund as part of the compensation order approving the settlement. The BRB further held that the trust fund's right to reimbursement of Section 907 medical benefits must be resolved simultaneously with the claimant's medical benefits claims because the fund's rights derive from the claimant's rights. Otherwise, a separate settlement of the medical benefits claims without trust fund participation would leave the fund without legal recourse. On reconsideration, the BRB reiterated its holding that the trust fund is entitled to participate in settlement proceedings involving medical expenses already paid by the fund. Because the settlement agreement at issue purported to settle the claimants' entitlement to all past and future medical benefits, the BRB concluded that the trust fund had a financial interest in the settlement and its rights would be impaired if the medical benefits claims were settled separately from the compensation claims. Finally, the BRB clarified that its Section 907(d)(3) holding pertained only to those parties with an actual financial interest in the settlement.



Longshore and Harbor Workers' Compensation Act

	FY 2008	FY 2009
Number of Employees (FTE Staffing Used)	97	98
Administrative Expenditures[1]	$ 12.6 M	$ 12.8 M
Lost-Time Injuries Reported	29,170	28,952
Total Compensation Paid[2]	$926.7 M	$983.8 M
Wage-Loss and Survivor Benefits	$642.9 M	$706.0 M
Medical Benefits	$283.8 M	$277.8 M
Sources of Compensation Paid		
Insurance Companies[2]	$456.8 M	$504.3 M
Self-Insured Employers[2]	$325.5 M	$340.3 M
LHWCA Special Fund	$126.9 M	$132.7 M
DCCA Special Fund	$ 10.1 M	$ 10.1 M
DOL Appropriation	$ 2.3 M	$ 2.2 M

[1] Direct administrative costs to OWCP only; excludes DOL support costs of $13.3 million in FY 2008 and $13.7 million in FY 2009, respectively.

[2] Figures are for CY 2007 and CY 2008, 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) in October 2000. Part B of EEOICPA, 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 EEOICPA (enacted 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, 2009, the Department of Labor (DOL) marked the eighth 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) 2009, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) has awarded compensation and medical benefits totaling over $5.1 billion under both Parts B and E of the EEOICPA. During this time, 54,308 employees or their families have received nearly $4.8 billion in compensation and over $377 million in medical expenses associated with the treatment of accepted medical conditions. Part B compensation has totaled more than $3 billion (since 2001) while Part E compensation has totaled more than $1.7 billion (since 2005).

In FY 2009 alone, 5,286 employees or their eligible survivors received $437.5 million in Part B compensation. In addition, 4,881 employees or their survivors received $428.7 million in Part E compensation. A total of $120.6 million was paid in covered medical benefits in FY 2009 under both Parts B and E of the EEOICPA, bringing total benefits to nearly $987 million for the year.

Administration

Implementation of the EEOICPA is a uniquely intergovernmental activity, involving the coordinated efforts of four federal agencies to administer: DOL, DOE, DOJ, and the Department of Health and Human Services (HHS). DOL has primary responsibility for administering the EEOICPA, 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 procedures for designation of new Special Exposure Cohort (SEC) classes, and carries out the actual dose reconstruction for cases referred by DOL. Under the EEOICPA, 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 EEOICPA

Part B. To qualify for benefits under Part B of the EEOICPA, 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, 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 EEOICPA 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 regulation 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 50 percent probability.

Part E. The 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 once it is determined that the illness was "at least as likely as not" that work-related exposure to a toxic substance was a significant factor in causing, contributing to, or aggravating the illness or death of an employee. Additionally, the EEOICPA 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 are also met. The maximum payable compensation under Part E is $250,000 for all claims relating to any individual employee, meaning that a total of $400,000 can be paid in Part B plus E compensation with respect to a single worker.

Under Part E, a covered employee may also be eligible to receive compensation for the percentage of impairment of the whole person that is related to a covered illness. The EEOICPA 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 wage-loss benefits. Wage-loss benefits are paid for each qualifying calendar year (prior to reaching normal Social Security Act 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 the month in which the employee first experienced wage-loss (not including periods of unemployment). The EEOICPA provides that covered, eligible employees may receive $15,000 for any year in which they made less than 50 percent of their baseline 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 baseline wage. Medical benefits for the covered illness are also payable, in addition to monetary 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 baseline 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 2009, DOL spent $50.6 million under Part B and $65.2 million under Part E to administer the EEOICPA. These funds supported 316 full-time equivalent (FTE) staff for Part B and 281 FTE for Part E. Under Part E, $0.8 million in additional funds supported the Office of the Ombudsman position. Funding for the NIOSH radiation dose reconstruction process and the Advisory Board on Radiation and Worker Health was provided in the Health and Human Services appropriation.

Adjudication of Claims

In FY 2009, DEEOIC continued to receive a substantial number of new claims, creating a total of 4,873 new cases (7,179 new claims) for living or deceased employees under Part B, and 5,762 new cases (7,509 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 EEOICPA, workers or their survivors may qualify for Part B benefits only, Part E benefits only, or benefits under both Parts B and E. Claims and cases under Parts B and E are counted separately (that is, if a claimant is potentially eligible under both Parts, his or her claim will be counted under both Part B and Part E).

Under the Act, the Secretary of HHS is responsible for adding new classes of employees to the SEC where a complete dose reconstruction cannot be performed by NIOSH. The Act itself initially designated certain employees at 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, 2009, NIOSH had added 44 additional classes of employees to the four statutory classes in the SEC which combined represent workers at 39 facilities. During FY 2009, NIOSH added nine classes of employees at the following facilities: the Connecticut Aircraft Nuclear Engine Laboratory (CANEL) in Middletown, Connecticut; the Mallinckrodt Chemical Co., the Destrehan Street Plant in St. Louis, Missouri; Vitro Manufacturing in Canonsburg, Pennsylvania; the Metallurgical Laboratory in Chicago, Illinois; the Westinghouse Atomic Power Development Plant in East Pittsburgh, Pennsylvania; the Tyson Valley Powder Farm near Eureka, Missouri; the Hood Building in Cambridge, Massachusetts; Standard Oil Development Co. of New Jersey in both Linden and Bayway, New Jersey; and Area IV of the Santa Susana Field Laboratory in Ventura County, California. When a new class of employees is added to the SEC, DOL reviews all affected cases and makes a determination on whether the employee in question meets the criteria for inclusion in the new class. Any previously denied claim with employment meeting the new definition is reopened for additional development and a new recommended decision.

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 used in specific DOE facilities and the occupational illnesses and health effects associated with exposure to specific 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. 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 claimed illnesses 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, 2009, 77 board-certified physicians were enrolled as DMC contractors for the program. Claims may also be referred to a health physicist, industrial hygienist, or a toxicologist when a scientific determination regarding the case is required.

Recommended Decisions and Final Decisions. The DEEOIC district offices process EEOICPA claims to the "recommended decision" stage: for each claim they issue a recommended decision to approve or deny the claim. Each recommended decision made by the district office must be

reviewed by the Final Adjudication Branch (FAB), which ensures that the EEOICPA's requirements, program policies, and procedures are followed and issues a final decision. Before making a final decision, the FAB considers any challenges brought by the claimant through either a review of the written record or an oral hearing. During FY 2009, the FAB conducted 1,451 reviews of the written record and oral hearings for 1,141 claimants. For each claim, the FAB reviews the evidence of record, the recommended decision, and any objections/testimony submitted by the claimant or his/her representative, 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. A claimant may challenge the FAB's final decisions by requesting a reconsideration or reopening of the claim, or may file a petition for review of a final decision with the appropriate U.S. District Court. While Part B and Part E of the EEOICPA each have unique eligibility criteria, DEEOIC usually 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.

During FY 2009, DEEOIC district offices issued 10,979 Part B claim-level recommended decisions and 11,726 Part E claim-level recommended decisions. Further, the FAB issued 11,606 Part B claim-level final decisions and 11,889 Part E claim-level final decisions. DOL approved benefits in 46.9 percent of covered Part B claims and 57.9 percent of covered Part E claims that received a final decision during FY 2009.

Outreach Activities

DEEOIC's staff continues to sponsor outreach activities to disseminate information about EEOICPA benefits and to provide one-on-one assistance to claimants in 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. During FY 2009, as additional classes of employees were added by the Secretary of HHS to the SEC, DOL sponsored four town hall meetings and traveling resource centers in Pittsburg, Kansas; Washington, Pennsylvania; Cromwell, Connecticut; and Simi Valley, California, to present details about new SEC classes at the Spencer Chemical Company Jayhawks Works, Vitro Manufacturing (Canonsburg), the Westinghouse Atomic Power Development Plant, the Connecticut Aircraft Nuclear Engine Laboratory (CANEL), and Area IV of the Santa Susana Field Laboratory. Over 150 individuals attended these town hall meetings and traveling resource centers and as a result of these meetings, resource center staff submitted 58 new claims to DOL for adjudication. DOL also sponsored 2 town hall meetings in Grand Junction, Colorado, and Farmington, New Mexico, focused on providing information to the Section 5 uranium worker community. Over 90 individuals attended these two meetings and 28 new claims were filed as a result of these events.

Many former Section 5 uranium workers live in remote or rural areas where communications are difficult, such as the Navajo

and other reservations in Arizona, New Mexico, Utah, and Colorado. Therefore, DEEOIC resolved in these western states to conduct additional outreach activities. In response to large attendance at past town hall meetings held in the Navajo Nation, DEEOIC continues to sponsor monthly traveling resource centers in Shiprock, New Mexico, and Kayenta, Arizona, to provide in-person assistance to Navajo and other EEOICPA claimants.

The Office of the Ombudsman conducted town hall meetings in Shoreham, New York; St. Charles, Missouri; Cincinnati and Columbus, Ohio; and Des Moines, Iowa, during FY 2009. At the request of the Ombudsman, DEEOIC national office, district office, and resource center staff participated in each of these town hall meetings by providing claim status updates to claimants, taking new claims, and answering questions as needed. Further, working with DOE's Worker Medical Screening Program and HHS, DEEOIC staff participated in a joint outreach task group in order to provide information and clarification to former nuclear workers and their families about the EEOICPA.

Other examples of DEEOIC outreach activities conducted during FY 2009 include meetings with local governments and chambers of commerce, presentations to personnel at covered facilities and unions, and other community initiatives. During FY 2009 the district offices received 155,637 phone calls and the FAB received 6,237 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:

Website. DEEOIC's website provides important information about the statute and regulations governing Parts B and E of the EEOICPA, and gives claimants access to brochures, claim forms, and electronic filing of claims. During FY 2009, fifteen policy bulletins and one circular concerning the administration of the EEOICPA were posted to the site. Further, the website 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. Claimants can also view DEEOIC and NIOSH weekly web statistics; payment statistics at the national, state, and facility levels; and the searchable database of DEEOIC final decisions. The website also provides links to DOE, DOJ, and NIOSH's websites and toll-free numbers where additional information and assistance can be obtained.

During FY 2009, in an effort to be as accessible and transparent as possible to the claimant community, the DEEOIC added new information to its website providing the public with additional information concerning DEEOIC's administration of the EEOICPA. This information included stories highlighting DEEOIC accomplishments; statistical information displaying the overall average adjudication time for certain types of claims, including those claims requiring

a NIOSH dose reconstruction; graphs showing DEEOIC performance in meeting its Government Performance Results Act goals; and additional statistical graphs showing the amount of compensation paid over time at various facilities covered under the EEOICPA including the Hanford Site, the Iowa Ordnance Plant, the Oak Ridge Gaseous Diffusion Plant (K-25), Lawrence Livermore National Laboratory, Los Alamos National Laboratory, the Nevada Test Site, the Paducah Gaseous Diffusion Plant, Rocky Flats, and several other covered facilities.

Unified Procedure Manual. During FY 2009, DEEOIC undertook to revise and update the program's procedure manual that claims staff nationwide use to adjudicate claims. The new Unified Procedure Manual incorporates the former Part B Procedure Manual and the former Part E Procedure Manual into one guidance document. Further, the Unified Procedure Manual also includes DEEOIC policy bulletins and circulars currently posted on DEEOIC's website.

While the complete Unified Procedure Manual will be released in the first quarter of FY 2010, certain chapters were released and posted on DEEOIC's website during FY 2009 to expedite the implementation of new policies and procedures, including expanding the authority of the district offices to review cases for reopening and granting the district offices the authority to communicate directly with the Social Security Administration to speed up the decision process. Each chapter of the Unified Procedure Manual becomes effective upon publication.

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 EEOICPA. In FY 2009, the RC contractor had 68 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 2009, the RCs helped claimants file 9,935 claims, received over 110,000 telephone calls, conducted over 42,000 follow-up actions with claimants, processed over 7,600 initial employment verification requests, conducted over 6,100 occupational history interviews, and made 6,150 contacts with claimants regarding impairment and wage-loss benefits.

The RCs continued to assist claimants with the medical bill payment 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 approximately 40,000 contacts related to medical bills. In addition, the RCs enrolled over 2,300 new medical providers into the program.

Center for Construction Research and Training. DEEOIC renewed its contract with the Center for Construction Research and Training, formerly called the Center to Protect Workers' Rights (CPWR), in FY 2008. CPWR 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 2009, CPWR provided responses to 1,095 requests for information. CPWR also maintains a website-accessible database that identifies and confirms the existence of contractual relationships between contractor and subcontractor employers and certain covered facilities. This database is available to DEEOIC claims examiners.

Site Exposure Matrices (SEM) Database. In FY 2009, 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 added information on 15 new DOE sites and updated existing SEM matrices of 24 DOE sites during FY 2009. A total of 212 new toxic substances were added to the SEM database as a result of public and worker input. As of September 30, 2009, SEM housed information on 9,100 toxic substances/chemicals used at 99 DOE sites, 4,170 uranium mines, 47 uranium mills, and 17 uranium ore buying stations covered under the EEOICPA.

DOL continued to provide funding to support further development and expansion of the National Library of Medicine (NLM) Haz-Map Occupational Health Database. This database contains information about the possible effects of exposure to hazardous agents that 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. The funding provided in FY 2009 allowed NLM to add 1,234 new health/chemical profiles to its Haz-Map database.

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. This includes the support of the Energy Case Management System (ECMS) which serves as a repository for data related to claims adjudication activities and compensation benefits. New software releases delivered in FY 2009 provided additional claims processing support mechanisms and multiple reporting and caseload management tools and reports. These enhancements facilitated the claims adjudication process and enabled claims personnel and managers to once again meet and exceed strategic and operational goals.

DEEOIC is currently developing an integrated, modernized and expanded mission-critical case management system. The new unified 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's (2005) inception.

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 January 2008, the National Defense Authorization Act of 2008 extended the term of this office to October 28, 2012; on October 28, 2009, the National Defense Authorization Act of 2009 expanded the authority of the Office to also include Part B of the EEOICPA. The Office of the Ombudsman, within the Department of Labor but independent from OWCP, reports annually to Congress concerning complaints, grievances, and requests for assistance received during the calendar year covered by the report. DEEOIC continues to work directly with the Ombudsman's office to promptly resolve any issues and concerns stemming from the Ombudsman's findings.

Government Performance Results Act

DOL is committed to measuring its outcomes and maintaining accountability for achieving the fundamental goals of the EEOICPA. High performance standards, focusing on moving EEOICPA 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 Government Performance Results Act (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. During FY 2008, it took an average of 164 days to process initial claims under Part B. Therefore, in FY 2009 a goal of 160 days was set.

DEEOIC far exceeded this goal by taking an average of only 113 days to process initial claims under Part B of the EEOICPA during FY 2009.

The claims processing goal under Part E also was exceeded. During FY 2008, 284 days on average were needed to process initial claims. For FY 2009, a target of 195 days was set. Again, DEEOIC far exceeded this goal, as 159 days on average were needed to process initial claims under Part E of the EEOICPA during FY 2009. These results reflect DEEOIC's success in clearing the backlog of older claims such that a "steady state" processing of current cases is now the norm.

Timely processing also extends to final decisions issued by DEEOIC'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 the FAB, 92 percent of Part B and Part E decisions in FY 2009 were within the program standards, in excess of the goal of 88 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 2009. Timely and accurate medical bill processing is critical in the administration of the EEOICPA. In FY 2009, Multiple Surgeries and Maximum Unit pricing enhancements were implemented. In addition, DEEOIC avoided $8.1 million in costs during the year due to further improvements in the editing of bills. These savings were achieved without impacting on services to claimants.

By the end of FY 2009, the bill processing vendor had processed 254,000 EEOICPA bills and handled 41,236 telephone calls. Authorizations for medical treatment were processed in an average of 1.2 workdays and 98.3 percent of bills were processed within 28 days. Enrollment of 4,115 new providers brought the total of enrolled providers to 110,148.

Program Evaluation

U.S. Department of Labor, Office of the Inspector General (OIG), Report Number #04-09-002-04-437, November 12, 2008. In response to inquiries from several members of Congress and the general public, OIG conducted an evaluation to: a) determine if DOL issued claim decisions that complied with applicable law and regulation; and b) to 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 alleged that claims examiners had been directed to inappropriately deny claims, and determined that these allegations could not be corroborated. The full report, including the scope, methodology and full agency response, is available at: http://www.oig.dol.gov/public/reports/oa/2009/04-09-002-04-437.pdf.

OIG made six recommendations to the former Assistant Secretary for the Employment Standards Administration (ESA) designed to reduce the time required to process claims and to 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 OIG's recommendations.

In response to OIG recommendations, DEEOIC compiled and posted statistics on its website displaying the overall average duration for certain types of claims filed under the EEOICPA, including those requiring a NIOSH dose reconstruction. Further, DEEOIC provided the Resource Centers with increased access to ECMS claims data so as to be able to better explain to claimants the status of their specific case and help them identify any steps they needed to take in order to support their claim. Procedures regarding how the Resource Centers explain Part

E survivor eligibility to claimants were refined and DEEOIC directed Resource Center staff, where appropriate, to explain the alternative filing mechanism that is available for individuals seeking definitive answers regarding the cause of a worker's death even though they do not seek benefits under the EEOICPA. Procedures were also implemented to simplify and expedite the processing of wage-loss and impairment claims under Part E of the EEOICPA and DEEOIC's national office issued policy guidance allowing for quicker interaction with the Social Security Administration to obtain employment and wage-loss information when needed to support a claim under the EEOICPA.

Litigation

DEEOIC strives in every case to administer the Energy program in accordance with the law and governing regulations. During FY 2009, 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 *Barrie v. U.S. Department of Labor,* 597 F.Supp.2d 1235 (D.Colo. 2009), the plaintiff sought review of a FAB decision denying his claim for additional benefits under Part E of EEOICPA. The former employee of the Department of Energy's Rocky Flats Plant in Golden, Colorado, sought benefits under Part E of EEOICPA for twenty-three medical conditions allegedly caused by exposure to toxic substances at the Rocky Flats Plant. In its decision, FAB accepted his claim for chronic atrophic gastritis and denied his claims for benefits for each of the other conditions. FAB also awarded the plaintiff compensation for permanent impairment due to his accepted chronic atrophic gastritis, which was reduced to reflect the amount of a state workers' compensation settlement he had received for that same condition, but denied his claim for wage-loss due to chronic atrophic gastritis. The District Court rejected the plaintiff's arguments that DEEOIC violated his due process rights by not providing him an opportunity for a hearing subsequent to the issuance of FAB's decision and by not providing him with copies of documents relied upon by its medical specialists. The District Court affirmed the denial of his claim in regard to all of his other medical conditions except nephritis. The Court, however, found that DEEOIC had acted arbitrarily and capriciously by: (1) failing to exclude from the amount of the state workers' compensation settlement to be coordinated with the plaintiff's Part E award any portion of the settlement attributed to medical benefits; (2) denying the plaintiff's claim for wage-loss by relying upon the opinion of a medical specialist that considered other medical evidence in the claim file that DEEOIC had decided should have no probative weight and failed to controvert the opinion of plaintiff's attending physician regarding his inability to work; and (3) failing to address an inconsistent finding of a Department of Energy Physicians' Panel that had reviewed the claim in denying the plaintiff's Part D claim for nephritis. The District Court therefore remanded the matter to DEEOIC with instructions to determine the amount of the state workers' compensation settlement attributable to medical benefits, and for further inquiry consistent with the order.

COURT OF APPEALS

In *Opal Harger, et al. v. U.S. Department of Labor,* 569 F.3d 898 (9th Cir. 2009), the attorney representing multiple claimants in an ongoing action in United States District Court took an interlocutory appeal to the Ninth Circuit Court of Appeals from the District Court's order denying his motion asserting an equitable lien for attorney's fees for work he had performed, both prior to and independently from the District Court action, in connection with a successful petition he filed with the Department of Health and Human Services to designate a class of approximately 400 former employees at the Department of Energy facility at Hanford, Washington, as an addition to the Special Exposure Cohort under EEOICPA. In the order appealed, the District Court denied the motion on the ground that the United States had not waived its sovereign immunity regarding the requested equitable lien and also noted that, even if sovereign immunity were waived, the District Court could not award attorney's fees under the "common fund" theory relied upon by the attorney because it had no control over the government funds at issue. The Ninth Circuit upheld the District Court's order denying the motion for an equitable lien for attorney's fees, finding that § 702 of the Administrative Procedure Act (5 U.S.C. § 702) did not constitute an express waiver by the United States of its sovereign immunity with respect to the fund created under EEOICPA for the payment of claims. As a result of its holding, the Ninth Circuit did not address whether the "common fund" doctrine was applicable in this case.

Energy Employees Occupational Illness Compensation Program Act

	Part B		Part E[1]	
	FY 2008	FY 2009	FY 2008	FY 2009
Number of Employees (FTE Staffing Used)	299	316	244	281
Administrative Expenditures[2]	$ 50.5 M	$ 50.6 M	$ 56.1 M	$ 65.2 M
Claims Created	7,794	7,179	8,373	7,509
Recommended Decisions (Covered Applications)	12,928	10,979	14,066	11,726
Final Decisions (Covered Applications)	12,200	11,606	13,440	11,889
Number of Claims Approved (Final)	6,486	5,447	7,541	6,879
Total Lump Sum Compensation Payments[3]	$484.4 M	$437.5 M	$456.7 M	$428.7 M
Number of Medical Bill Payments	133,788	199,437	6,923	16,057
Total Medical Payments[4]	$ 69.1 M	$ 115.7 M	$ 2.2 M	$ 4.9 M

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

[2] Includes Department of Labor expenditures only; Part B in FY 2008 excludes $55.4 million in funds apportioned to the Department of Health and Human Services (HHS) for that agency's responsibilities under EEOICPA (beginning in FY 2009, such funds are a direct appropriation to HHS), while Part E excludes funding for the Office of the Ombudsman ($0.8 million in FY 2008 and $0.8 million in FY 2009, 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 $45.7 million in FY 2008 and $36.3 million in FY 2009, 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 2000 - FY 2009
(Cases at End-of-Year)

	Fiscal Year									
Roll Type	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Total Periodic Roll	54,709	56,133	56,751	58,621	57,827	60,709	55,433	51,125	50,263	**49,672**
Long-Term Disability	48,870	50,409	51,092	53,099	52,377	55,257	49,910	46,258	45,604	**45,162**
Death	5,839	5,724	5,659	5,522	5,450	5,452	5,523	4,867	4,659	**4,510**

Table A-2

Federal Employees' Compensation Program
Summary of Claims Activity

FY 2000 - FY 2009

	Fiscal Year									
Claim Activity	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Incoming Cases										
Cases Created	**174,471**	**165,915**	**158,118**	**168,174**	**162,965**	**151,690**	**139,874**	**134,360**	**134,013**	**129,690**
Traumatic	145,915	137,877	132,250	142,325	138,521	129,427	119,082	114,592	115,715	**112,640**
No Lost Time	91,620	86,402	80,439	84,368	80,018	74,071	67,127	64,896	66,812	**75,696**
Lost Time	54,295	51,475	51,811	57,957	58,503	55,356	51,955	49,696	48,903	**36,944**
Occupational Disease	28,406	27,869	25,739	25,747	24,320	22,114	20,592	19,633	18,190	**16,951**
Fatal Cases	150	169	129	102	124	149	200	135	108	**99**
Wage-Loss Claims Initiated	**21,899**	**23,386**	**23,193**	**24,245**	**24,189**	**21,455**	**19,819**	**19,104**	**19,187**	**18,808**
Hearings and Review										
Total Requests for Hearing	6,992	6,875	6,820	6,751	8,132	6,757	6,241	6,556	6,584	**6,438**
Total Hearing Dispositions	7,418	6,599	6,272	6,743	7,682	6,961	7,424	7,581	6,789	**7,085**

Table A-3

Federal Employees' Compensation Program Obligations

FY 2000 - FY 2009
($ thousands)

Type of Obligation	Fiscal Year 2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total Obligations	$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	**$2,874,754**
Total Benefits	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	**2,732,577**
Compensation Benefits	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	**1,747,650**
Medical Benefits	548,596	617,414	667,797	658,121	703,571	672,006	668,205	743,124	781,594	**847,373**
Survivor Benefits	126,965	128,122	130,870	130,506	130,537	140,068	129,234	135,683	139,391	**137,554**
Total Administrative Expenditures	91,532	109,319	110,422	129,636	133,781	126,336	135,134	144,141	142,650	**142,177**
Salaries and Expenses	70,634	78,971	81,210	86,358	86,253	86,811	88,435	90,113	89,416	**90,049**
Fair Share	20,898	30,348	29,212	43,278	47,528	39,525	46,699	54,028	53,234	**52,128**

Table A-4

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

CBY 2000 - CBY 2009
($ thousands)

	Chargeback Year [1]									
Federal Agency	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Total Costs	$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	**$2,669,115**
U.S. Postal Service	666,310	720,518	785,199	846,876	852,945	840,141	884,078	924,138	978,629	**1,055,221**
Department of the Navy	241,585	246,881	248,250	245,461	245,145	237,791	244,318	244,037	242,440	**240,004**
Department of the Army	166,989	169,219	174,832	181,298	177,250	174,660	180,248	178,993	179,503	**181,775**
Department of Veterans Affairs	143,221	145,909	151,612	157,315	155,391	156,170	164,091	166,087	175,637	**179,922**
Department of Homeland Security	N/A	N/A	N/A	83,975	121,089	138,342	156,734	158,529	161,070	**164,611**
Department of the Air Force	128,134	134,106	132,538	135,509	129,229	124,516	126,663	130,298	131,059	**131,301**
Department of Justice	83,873	91,197	95,620	66,131	74,011	80,090	89,156	94,395	98,825	**104,772**
Department of Transportation	96,936	99,556	101,716	94,682	92,659	92,687	92,830	93,609	97,931	**99,251**
Department of Agriculture	64,882	66,750	69,563	72,312	69,245	68,681	70,185	70,802	72,869	**73,670**
Department of Defense	64,797	64,761	63,888	65,429	63,816	62,996	65,460	62,630	60,737	**63,051**
All Other Agencies	367,907	390,201	396,230	374,299	359,003	358,120	366,948	370,578	374,164	**375,537**

[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 2009

Type of Claim	PDO's Issued [1]	Approval Rate
Trust Fund	543	
Approved	95	**17.50%**
Denied	448	
Responsible Operators	3,058	
Approved	397	**12.98%**
Denied	2,661	
Total Decisions	3,601	
Total Approved	492	**13.66%**
Total Denied	3,109	

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

Table B-2

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

FY 2009

State	Total Claims Received [1]	MBO Claims [2]	In Payment [3]	Total Benefits ($ 000) [4]
Alabama	34,664	30	734	$6,071
Alaska	153	0	8	66
Arizona	2,096	5	108	893
Arkansas	3,836	6	133	1,100
California	6,479	7	185	1,530
Colorado	7,075	6	328	2,713
Connecticut	1,003	0	47	388
Delaware	785	1	47	388
District of Columbia	285	0	10	83
Florida	11,967	38	643	5,319
Georgia	1,685	3	142	1,175
Hawaii	17	0	1	8
Idaho	250	0	12	66
Illinois	31,609	26	875	7,238
Indiana	18,068	29	601	4,970
Iowa	5,152	3	164	1,357
Kansas	2,181	1	43	356
Kentucky	94,820	534	4,198	34,725
Louisiana	353	0	14	116
Maine	45	0	4	33
Maryland	6,697	14	294	2,432
Massachusetts	240	1	14	116
Michigan	10,521	9	318	2,630
Minnesota	145	0	4	33
Mississippi	368	1	20	165
Missouri	4,660	2	138	1,142
Montana	855	1	23	190
Nebraska	130	0	4	33
Nevada	440	2	31	256
New Hampshire	27	0	5	41
New Jersey	4,316	7	206	1,741
New Mexico	2,434	1	90	744
New York	4,032	4	149	1,233
North Carolina	3,589	19	283	2,341
North Dakota	159	0	3	25
Ohio	54,197	74	2,137	17,677
Oklahoma	3,800	5	107	885
Oregon	627	0	23	190
Pennsylvania	137,700	359	8,065	66,712
Rhode Island	40	0	2	16
South Carolina	965	8	98	811
South Dakota	53	0	6	50
Tennessee	21,513	81	879	7,271
Texas	1,757	3	86	711
Utah	4,163	9	202	1,671
Vermont	50	0	4	33
Virginia	44,961	313	2,992	24,749
Washington	1,594	3	50	414
West Virginia	113,639	527	6,139	50,781
Wisconsin	459	1	23	190
Wyoming	2,637	0	120	993
All Other	449	1	14	116
TOTAL	**649,740**	**2,134**	**30,826**	**$254,987**

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

[2] Active Medical Benefits Only (MBO) claims as of 9/30/09.

[3] Active claims in payment status, excluding MBO claims, as of 9/30/09.

[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 2000 - FY 2009 [1]

Class of Beneficiary	Number of Beneficiaries [2] 2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Primary Beneficiaries:										
Miners	22,568	18,248	16,395	14,773	13,398	12,012	10,857	9,744	8,654	**7,699**
Widows	39,053	35,660	34,236	32,615	30,810	29,110	27,366	25,556	23,690	**21,913**
Others	1,497	1,467	1,221	1,238	1,247	1,248	1,258	1,241	1,230	**1,214**
Total Primary Beneficiaries	63,118	55,375	51,852	48,626	45,455	42,370	39,481	36,541	33,574	**30,826**
Dependents of Primary Beneficiaries:										
Dependents of Miners	17,978	13,924	12,432	11,131	10,020	9,004	8,088	7,205	6,442	**5,726**
Dependents of Widows	1,306	1,123	1,077	1,052	1,006	944	874	840	777	**723**
Dependents of Others	508	108	386	353	238	213	146	140	132	**122**
Total Dependents	19,792	15,155	13,895	12,536	11,264	10,161	9,108	8,185	7,351	**6,571**
Total, All Beneficiaries	**82,910**	**70,530**	**65,747**	**61,162**	**56,719**	**52,531**	**48,589**	**44,726**	**40,925**	**37,397**

[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 2000 - FY 2009
($ thousands)

Type of Obligation	Fiscal Year 2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total Obligations	$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	**$7,152,627**
Total Benefits [1]	422,656	396,928	384,234	370,389	346,864	329,933	307,067	291,310	273,232	**254,987**
Income Benefits [2]	350,266	336,813	320,039	307,371	292,555	279,965	265,365	252,020	235,347	**221,298**
Medical Benefits [3]	72,390	60,116	64,196	63,018	54,309	49,968	41,702	39,290	37,885	**33,689**
Administrative Costs [4]	49,820	52,252	54,273	55,332	55,803	56,872	57,975	59,772	58,257	**57,712**
Interest Charges [5]	541,117	567,814	595,589	620,582	650,579	674,894	694,964	717,214	739,469	**0**
Bond Payments [6]	-	-	-	-	-	-	-	-	-	**341,939**
Repayable Advances [7]	490,000	505,000	465,000	525,000	497,000	446,000	445,000	426,000	426,000	**6,497,989**
Cumulative Debt [8]	**$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**	**$6,158,245**

[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 benefits, and reimbursements to the UMWA Health and Retirement Funds.

[4] Administrative costs include support for DCMWC, Office of the Inspector General, Office of the Solicitor, Office of Administrative Law Judges, and Benefits Review Board within DOL, and reimbursements to the Department of Treasury and the Social Security Administration.

[5] Interest charges on repayable advances to the Trust Fund from the Department of Treasury.

[6] Scheduled repayments of principal and interest on zero-coupon bonds issued to refinance the BLDTF debt as mandated under the Emergency Economic Stabilization Act of 2008 (EESA).

[7] Advances from the Department of Treasury. FY 2009 is a one-time non-repayable appropriation under the EESA.

[8] Shows the cumulative debt of the Trust Fund to the Department of Treasury. In FY 2009, this includes principal being repaid by the proceeds of the zero-coupon bonds issued under EESA.

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

Table B-5

Monthly Part C Black Lung Benefit Rates

1973 - 2009

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
1/1/09-12/31/09	**616.30**	**924.50**	**1,078.50**	**1,232.60**

[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 2009
($ thousands)

Month	Funding				Disbursements							
	Coal Excise Tax Revenue	Treasury Advances	Reimburse[2]	**Total**	Income Benefits[3]	Medical Benefits Diagnostic	Medical Benefits Treatment[4]	Total Benefits	Admin. Costs	Interest on Advances	Payments to Treasury	**Total**
10/08	$14,132	$6,497,989[1]	$1,010	$6,513,131	$18,973	$330	$2,617	$21,920	$4,471	$0	$6,497,989[5]	$6,524,380
11/08	52,690	0	629	53,319	18,377	316	2,203	20,896	4,414	0	0	25,310
12/08	50,215	0	610	50,825	18,944	286	3,062	22,291	4,471	0	0	26,763
01/09	48,999	0	395	49,394	18,185	172	2,102	20,459	2,708	0	0	23,239
02/09	59,061	0	1,174	60,235	18,834	303	2,512	21,649	5,956	0	0	27,605
03/09	47,780	0	650	48,430	18,462	269	2,318	21,050	2,409	0	0	23,459
04/09	53,422	0	1,119	54,541	18,790	364	3,046	22,199	7,774	0	126,526[6]	156,499
05/09	73,525	0	514	74,039	18,371	306	2,412	21,089	5,373	0	0	26,462
06/09	61,126	0	1,144	62,270	18,025	243	2,148	20,416	5,574	0	0	25,990
07/09	69,304	0	565	69,869	18,180	413	2,784	21,377	4,856	0	0	26,233
08/09	57,619	0	735	58,354	18,230	294	2,157	20,681	2,773	0	0	23,454
09/09	57,008	0	616	57,624	17,927	415	2,618	20,960	6,860	0	215,413[6]	243,234
Totals	**$644,881**	**$6,497,989**	**$9,161**	**$7,152,032**	**$221,298**	**$3,712**	**$29,978**	**$254,987**	**$57,712**	**$0**	**$6,839,928**	**$7,152,627**

[1] One-time non-repayable appropriation from the Department of Treasury for BLDTF debt refinancing under the Emergency Economic Stabilization Act of 2008 (EESA).

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

[3] Includes monthly and retroactive benefit payments.

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

[5] Includes accrued interest, repayment of debt principal, and a premium payment as mandated under the EESA.

[6] Repayment of principal and interest on principal for the zero-coupon bonds issued to refinance the BLDTF debt under the EESA.

Table C-1

Total Industry Compensation and Benefit Payments Under LHWCA[1]

CY 1999 - CY 2008[2]
($ thousands)

	Calendar Year									
Payments By:	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Self-Insured Employers	$283,991	$278,952	$307,708	$310,940	$309,843	$322,520	$325,694	$368,744	$325,544	**$340,336**
Insurance Carriers	232,778	249,671	236,726	246,603	262,753	278,887	325,027	367,625	456,773	**504,348**
Total Payments	**$516,769**	**$528,623**	**$544,434**	**$557,543**	**$572,596**	**$601,407**	**$650,721**	**$736,369**	**$782,317**	**$844,684**

[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
10/01/08-9/30/09	**600.31**	**1,200.62**	**300.16**	**3.47**

[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 2000 - FY 2009
($ thousands)

FY	LHWCA Expenditures ($) Total	Second Injury Cases[2]	Pre Amend. Cases[3]	Rehab.[4]	Other[5]	Number of Second Injury Cases	DCCA Expenditures ($) Total	Second Injury Cases[2]	Pre Amend. Cases[3]	Rehab.[4]	Other[5]	Number of Second Injury Cases
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
2009	**132,688**	**121,203**	**1,656**	**2,832**	**6,996**	**4,378**	**10,094**	**9,197**	**590**	**0**	**306**	**550**

[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 2000 - CY 2009
($ 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.
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
2009	**125,000**	**564,798**	**CY 2008**	**11,500**	**3,598**	**CY 2008**

[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 2000 - FY 2009

Adjudication Level and Case Status	Fiscal Year 2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
District Offices										
Pending Inventory of Cases	8,675	6,489	7,391	5,495	6,051	6,375	6,338	8,563[4]	7,726	**8,075**
OALJ										
Carryover from Previous FY	3,668	3,562	3,388	2,980	2,517	2,355	2,318	1,984	2,123	**2,168**
New Cases	3,566	3,500	3,276	3,036	2,926	2,763	2,413	2,614	2,657	**2,696**
Total Docket	7,234	7,062	6,664	6,016	5,443	5,118	4,731	4,598	4,780	**4,864**
(Dispositions)	3,672	3,674	3,529	3,499	3,088	2,800	2,747	2,475	2,612	**2,540**
Pending Inventory	3,562	3,388	2,980[3]	2,517	2,355	2,318	1,984	2,123	2,168	**2,324**
BRB										
Carryover from Previous FY	326	295	248	208	267	222	211	182	152	**134**
New Cases	423	317	260	332	297	288	248	241	226	**229**
Total Docket	749	612	508	540	564	510	459	423	378	**363**
(Dispositions)	467	384	319	282	355	304	288	282	260	**256**
Pending Inventory	295[2]	248[2]	208[2]	267[2]	222[2]	211[2]	182[2]	152[2]	134[2]	**114**[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 2009[1]

Case Status/Claims Activity	Case[2]	Claim[3]
Total Applications Received-Program Inception Through 9/30/2009	67,604	100,499
Total Covered Applications Received-Program Inception Through 9/30/2009	53,201	82,991
Final Decisions Completed by Final Adjudication Branch (FAB)[4]	46,692	69,061
Final Approved	26,607	40,213
Final Denied	20,085	28,848
Recommended Decisions by District Offices[5]	1,259	2,387
Outstanding Recommended Decision to Approve	266	665
Outstanding Recommended Decision to Deny	993	1,722
Completed Initial Processing - Referred to NIOSH	3,158	7,157
Pending Initial Processing In District Office[6]	2,092	4,386
Lump Sum Compensations	24,667	38,011
Total Payment Amounts		**$3,080,139,018**

[1] Statistics show the status of all applications filed from program inception through September 30, 2009.

[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 2009[1]

Case Status/Claims Activity	Case[2]	Claim[3]
Total Applications Received-Program Inception Through 9/30/2009	58,798	82,957
Total Covered Applications Received-Program Inception Through 9/30/2009	48,087	55,245
Final Decisions Completed by Final Adjudication Branch (FAB)[4]	40,039	42,303
Final Approved	21,748	23,025
Final Denied	18,291	19,278
Recommended Decisions by District Offices[5]	1,572	1,985
Outstanding Recommended Decision to Approve	437	663
Outstanding Recommended Decision to Deny	1,135	1,322
Completed Initial Processing - Referred to NIOSH	1,778	2,226
Pending Initial Processing In District Office[6]	4,698	8,731
Compensation Payments (Unique Cases and Claims)	15,466	16,297
Total Compensation Payment Amts.		**$1,718,240,306**
Lump Sum Allocations (Unique Cases and Claims)	9,070	9,739
Total Lump Sum Payment Amts.		**$1,112,126,796**
Wage Loss Allocations (Unique Cases and Claims)	1,564	1,925
Total Wage Loss Payment Amts.		**$70,064,082**
Impairment Allocations (Unique Cases and Claims)	6,513	6,513
Total Impairment Payment Amts.		**$536,049,428**

[1] Statistics show the status of all applications filed from program inception through September 30, 2009.

[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 2009 on All EEOICPA Cases/Claims[1]

Processing Activity	Case[2]	Claim[3]
Total Cases/Claims Received-FY 2009	4,873	7,179
Total Cases/Claims (Covered Applications) Received-FY 2009	4,436	6,662
Final Decisions by FAB Offices in FY 2009	8,046[4]	11,606
Final Approved	3,475	5,447
Final Denied	4,571	6,159
Modification Orders in FY 2009	281	303
Recommended Decisions by District Offices in FY 2009	7,649	10,979
Recommended Decision Only, to Approve	3,147	4,911
Recommended Decision Only, to Deny	4,502	6,068
Referrals to NIOSH in FY 2009	3,798	5,126
Lump Sum Compensation Payments in FY 2009	3,314	5,286
ECMS-Generated Payments	3,265	5,220
Non ECMS-Generated Payments	49	66
Remands	245	369

[1] Activity statistics capture actions made during FY 2009 only, therefore the number of activities reported do not add up to the total number of cases/claims received during FY 2009. (Many activities recorded occurred on cases/claims received prior to FY 2009).

[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 2009.

Table D-2 Part E

Processing Activity During FY 2009 on All EEOICPA Cases/Claims[1]

Processing Activity	Case[2]	Claim[3]
Total Cases/Claims Received-FY 2009	5,762	7,509
Total Cases/Claims (Covered Applications) Received-FY 2009	5,074	5,687
Final Decisions by FAB Offices in FY 2009	11,445[4]	11,889
Final Approved	6,691	6,879
Final Denied	4,754	5,010
Modification Orders in FY 2009	378	386
Recommended Decisions by District Offices in FY 2009	11,302	11,726
Recommended Decision Only, to Approve	6,542	6,735
Recommended Decision Only, to Deny	4,760	4,991
Referrals to NIOSH in FY 2009	2,089	2,199
Compensation Payments in FY 2009 (Unique Cases and Claims)	4,721	4,881
ECMS-Generated Payments	4,654	4,809
Non ECMS-Generated Payments	67	72
Total Compensation Payment Amts.		**$428,723,354**[5]
Lump Sum Allocations (Unique Cases and Claims)	1,713	1,855
Total Compensation Payment Amts.		**$199,981,250**
Wage Loss Allocations (Unique Cases and Claims)	439	505
Total Wage Loss Payment Amts.		**$20,579,144**
Impairment Allocations (Unique Cases and Claims)	2,783	2,783
Total Impairment Payment Amts.		**$197,244,038**
Remands	378	**452**

[1] Activity statistics capture actions made during FY 2009 only, therefore the number of activities reported do not add up to the total number of cases/claims received during FY 2009. (Many activities recorded occurred on cases/claims received prior to FY 2009).

[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 2009.

[5] Total includes compensation payments of $10,918,922 that were generated by Energy Case Management System.

Table D-3 Part B

EEOICPA Cases With Approved Decisions and Payments by Catergory, Program Inception Through September 30, 2009

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]	6,414	24.1%	9,883	$318,192	10.3%
Special Exposure Cohort Cancer (CN)	9,765	36.7%	15,564	1,444,220	46.9%
Dose Reconstructed Cancer (CN)	6,686	25.1%	9,482	993,445	32.3%
Beryllium Disease (CBD) [4]	1,883	7.1%	2,492	278,180	9.0%
Beryllium Sensitivity-Only (BS)	1,535	5.8%	N/A	N/A	N/A
Silicosis (CS)	80	0.3%	97	11,350	0.4%
Multiple Conditions [5]	222	0.8%	247	32,700	1.1%
TOTAL	**26,585**	**100.0%**	**37,765**	**$3,078,087** [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 9/30/2009, but payments were not issued.

[2] Represents total lump sum compensation payments from EEOIC program inception through September 30, 2009.

[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 compensation paid does not include 11cases 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, 2009

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	4,609
Alleged Survivor Not an Eligible Beneficiary	590
Claimed Condition Not Covered Under Part B of EEOICPA[2]	9,536
Dose Reconstruction Reveals the Probability That the Cancer is Related to Employment is Less Than 50 Percent	14,066
Medical Evidence is Insufficient to Establish Entitlement	5,429
Total	**34,230**

[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.

[2] Non-covered applications.

Table D-4 Part E

EEOICPA Cases With Final Decision to Deny, Program Inception Through September 30, 2009

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	3,191
Alleged Survivor Not an Eligible Beneficiary	7,230
Claimed Condition Not Covered Under Part E of EEOICPA[2]	151
Dose Reconstruction Reveals the Probability That the Cancer is Related to Employment is Less Than 50 Percent	5,436
Medical Evidence is Insufficient to Establish Entitlement	12,704
Total	**28,712**

[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.

[2] Non-covered applications.

Table D-5 Part B

Most Prevalent Non-Covered Medical Conditions, EEOIC Program Inception Through September 30, 2009

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	9
Asbestosis	6
Renal Condition or Disorder (Kidney Failure, Kidney Stones)	6
Hearing Loss	3
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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Deputy Director, Office of Workers' Compensation Programs
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Director, Division of Planning, Policy and Standards
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Division of Federal Employees' Compensation (www.dol.gov/owcp/dfec)
Douglas C. Fitzgerald, Director
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Division of Coal Mine Workers' Compensation (www.dol.gov/owcp/dcmwc)
Steven D. Breeskin, Director
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Division of Energy Employees Occupational Illness Compensation (www.dol.gov/owcp/energy)
Rachel P. Leiton, Director
Christy A. Long, Deputy Director
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Long Beach Longshore District Office
Marco Adame, District Director
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Seattle Longshore District Office
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National Operations Office

(District of Columbia, Maryland, Virginia)

Joseph Poole, District Director
U.S. Department of Labor
OWCP/DFEC
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