Testimony of

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Thank you Mr. Chairman and members of the Subcommittee for the opportunity to appear to share my thoughts on the Federal Back Lung program - a subject area I've been working on since 1973. My practice involves providing consulting services to organizations charged with paying Federal Black Lung claims. My clients have included insurance companies, Workers Compensation rating bureaus, self-insured coal companies, State funds and other State government agencies, and on several occasions, the agency charged with administering the program since 1973 - the U.S. Department of Labor, Office of Workers Compensation Programs. My staff and I have processed and calculated the liabilities for the bulk of the claims that have been filed since the late 1970s and, in this regard, have reviewed many thousands of claims files in order to understand the factors upon which approval and denial decisions are based.

As you think about the operation of the Federal program, there are three key facts I ask that you keep in mind, each of which I'll discuss in greater detail below:

- First, today's approval/denial decisions are being driven by factors that, because of DOL's poorly explained regulatory provisions, have little relationship to lung disease arising from coal mine employment. These implied principles are contained in the 2001 preamble to the regulations which were never subject to the notice and comment process of the Administrative Procedure Act and are now being applied as if part of the formal regulations. These principles extend to virtually every aspect of the claims adjudication process and frequently result in the payment of benefits to miners who do not suffer from Black Lung disease.
- Second, while there has been a considerable amount of attention focused on what some perceive as bias by certain company/insurer physicians, in my experience the same biases, which are easily documented, exist among certain claimant physicians – this is not something new, but rather is endemic to the program, having been present since the earliest days of the program.

- Third, the processes driving the approval rates of the program have been driven more by public policy considerations focused on circumstances of coal mining employment than by actual incidence of dust-induced lung disease among the active and retired miner population.

History of the Federal Black Lung Program

The federal black lung program was initiated in 1969 as Title IV of the Federal Coal Mine Health and Safety Act of 1969. It was designed to provide benefits to miners totally disabled due to progressive massive fibrosis, otherwise know as complicated Coal Workers Pneumoconiosis, associated with simple Coal Workers Pneumoconiosis arising out of coal mine employment and for survivors of miners whose deaths were a result of the disease. Coupled with a significant reduction in the permissible exposure to coal mine dust beginning in 1970, its sponsors assured their colleagues that it was to be:

> *… a one-shot effort. This [program] is not a continuing arrangement to establish Federal based compensation for this or any other industry. We are only taking on those who are now afflicted with pneumoconiosis in its fourth stage – complicated pneumoconiosis. However, this is only one shot. I want to say this today and I want to have it placed on the record indelibly… (Remarks of Hon. John Dent, Congressional Record, Oct. 27, 1969)*

The original Act created three presumptions to aid miners and their survivors in establishing claims. The bill finally enacted differed in one material respect from the one presented to the House and explained by Congressman Dent in that it removed the word complicated, thus providing compensation to claimants who exhibited symptoms at any stage of simple CWP in spite of the fact that only in its most serious form; i.e, complicated CWP or Progressive Massive Fibrosis (PMF), is it progressive, totally disabling and eventually fatal. The Surgeon General testified to this fact and stated "simple pneumoconiosis seldom produces significant ventilation impairment..." S. Rpt. No. 1254, 94th Congress, reprinted in the Legislative History of the Reform Act.

In 1972, Congress greatly liberalized the medical criteria, added a new presumption of eligibility based on coal mining exposure of fifteen years or more, extended eligibility for survivor benefits to survivors of miners who died from causes other than pneumoconiosis and made several additional changes in evidentiary and eligibility requirements. The new fifteen-year presumption was, and is, of particular concern to the coal industry in that no medical evidence has shown a clear causal relationship between duration of employment and the incidence of disability due to pneumoconiosis. Supporting this contention was testimony presented by the Surgeon General who stated, "The occurrence of pneumoconiosis is spotty for work periods of less than 15 years." S. Rpt. No. 743, 92nd Congress. Further, the National Academy of Sciences in testimony before the Senate Subcommittee on Labor stated, "At best, the evidence presented to Congress indicates that it takes 10 to 15 years of underground mining for coal miners even to begin to develop coal workers' pneumoconiosis."

By 1977, the Social Security Administration, which had administered the program prior to July 2, 1973, had paid a cumulative total of nearly $5 billion in Black Lung benefits and there were over 490,000 beneficiaries on its rolls (this number eventually grew to approximately 600,000). In addition, the Department of Labor, which had begun administering the program on July 1, 1973 with less than half the personnel it had requested, had approved only an additional 4,000 claims with approximately 50,000 claims on file pending review.

Against this background, Congress in 1977 amended the Act for a second time and again liberalized the eligibility criteria. Pneumoconiosis, which was previously defined as a chronic dust disease of the lung arising out of coal mine employment was broadened to include the, "sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." "Miner" was broadened to include certain transportation and construction workers as well as employees of coal mining companies who were not engaged in coal mining activity and "total disability" was broadened enabling those still capable of work, or those still working, to receive benefits. The liberalization resulted in truck drivers, and other coal company employees who were never exposed to coal mine dust qualifying under the definition of "miner". Finally, a new twenty-five year presumption was added and the Labor Department was directed to re-examine all

claims which had been denied prior to March1, 1978, and adopted language to limit the government's ability to re-read x-rays. This last point is of particular concern since the x-ray is regarded as the best evidentiary tool for diagnosing pneumoconiosis in a living miner. This change in the law required the Secretaries of HHS and DOL to accept a local reader's x-ray diagnosis even though testimony presented before the Senate Committee on Labor stated that local doctors often mistook another lung disease for pneumoconiosis or completely overlooked the presence of a separate disease when interpreting x-rays.

As the Part C program began to identify responsible coal mine operators to pay the costs of the program, DOL, through regulations promulgated in 1978, specified medical criteria to be applied upon which award decisions were rendered. Claims adjudications at the administrative level at DOL and in the Federal courts specifically addressed if the claimant had positive X-ray evidence of Coal Workers Pneumoconiosis (CWP) and if the miner had a loss of lung function within pulmonary function test ranges set by regulation to equate to total pulmonary disability. Tens of thousands of Federal Black Lung claims had been litigated at the administrative level at DOL and in the Federal courts by the late 1990s. Many claimants had neither positive X-ray evidence of CWP, nor a loss of lung function sufficient to qualify for benefits and were denied. Many claimants with a measurable loss of lung function were denied on the basis of medical opinions that such loss was the result of their long-term cigarette smoking, or other common respiratory conditions, as opposed to coal mine dust. The approval rate for both operator defended and DOL defended claims declined across the mid-to-late 1980s and 1990s and by1995 was approximately 5 percent. Note that if denials of claims from individuals who were not long-term underground coal miners are removed from the approval rate calculation, the approval rate was higher – generally in the 10% range in the Eastern coal fields. A 10% rate, while higher, is in the general range of the actual incidence of all categories of CWP in the Eastern coal fields, indicating that the Federal Black Lung program's operations had some, albeit significantly higher, relationship with the actual dust disease although much higher than the incidence of disabling CWP. The primary reasons for the reduction in the approval rate were: (1) the 1981 amendments that repealed entitlement presumptions that existed in the program in its early days; and (2) findings that the primary reason for the loss of lung function was the claimant's long-term cigarette smoking or

other conditions not caused by coal mine dust exposures, including lung cancer and heart disease.

In 1981 Congress, in the face of an exploding debt in the Black Lung Disability Trust Fund, amended the program again to tighten the eligibility criteria and provide for the award of benefits where disability decisions were based on medical criteria and not the number of years of underground employment. The 1981 amendments, which were supported by coal operators and the United Mine Workers of America, were intended to require disability or impairment as a precondition to compensation and to eliminate years of employment as a determinant for eligibility. The shortcomings of the program that gave rise to the 1981 amendments were highlighted in a report by the Comptroller General entitled “Legislation Allows Black Lung Benefits to be Awarded without Adequate Evidence of Disability” (HRD-80-81, July 28, 1980). According to this report, 88.5 percent of the claims reviewed by GAO, which had been approved by the Social Security Administration, did not contain adequate medical evidence to establish disability or death from CWP. A study conducted a year later by GAO showed that 84% of approved DOL claims were not supported by reliable evidence of coal mine dust-related disease or disability. The 1981 amendments succeeded in bringing financial stability to the program, but unfortunately, this was short-lived.

In 1999 the DOL proposed new regulations, which, after extensive comments, hearings, and litigation, were promulgated as final on the last date of the Clinton administration. In the preamble to these regulations DOL stated that Coal Workers Pneumoconiosis is latent and progressive. In spite of the Justice Department’s concession before the DC Circuit Court of Appeals that CWP was not latent in its most common forms, and the Surgeon General’s report that simple pneumoconiosis was not progressive, it left only a very small number of “complicated” pneumoconiosis cases where latency or progressivity might be a factor. DOL has now reinvented the program since 2001 on the central concept that CWP is latent and progressive in essentially all cases and COPD in retired coal miners is related to previous exposures to coal mine dust. Thus, today on these premises, miners are allowed to file as many claims as they like no matter how many times their claims are denied, and the vast majority of awards are made on account of COPD due to smoking. There is no comparable State or Federal Workers Compensation program where nothing is final until an award of benefits is achieved, and where evidence justifying a

differential diagnosis pointing to cigarette smoking alone is either ignored or deemed irrelevant.

These central concepts are not well documented or supported by scientific research. Since Chronic Obstructive Pulmonary Disease (COPD) resulting in loss of lung function from past or ongoing smoking is central, or required, for most awards today, the Black Lung program is now operating to confer lifetime disability benefits to smokers who may or probably may not have even a low level of minimally disabling CWP. I cannot stress this point strongly enough - **the vast majority of claimants receiving benefits today are receiving them not because of their coal mine employment but rather as a result of having been a smoker**. What this means is that a miner leaving the workforce at the end of his coal mine career who has not developed a loss of lung function at that point in his life can, at a later age while continuing to smoke, file for Federal Black Lung benefits and support such claim with a showing of loss of lung function that developed in the intervening years. This is contrary to 40 years of specific medical studies of CWP that clearly show that CWP rarely, if at all, progresses once the exposure to coal mine dust has ended. DOL has correctly referenced observational clinical studies that indicate that some levels of COPD appear in some miners that may be related to their dust exposures, but then leaps to conclusions that all COPD must be caused by coal mine dust exposures. The medical studies fail to show evidence that severe COPD from coal dust exposure alone is a risk for coal mining populations.

Status of the Program

Since its inception, well over 1 million coal miners and/or their dependents have filled one, two or more claims. Over 700,000 have received entitlements. The bulk of the benefits paid to date have been direct payments from U.S. General Revenues (Part B) or indirect payments from The Black Lung Disability Trust Fund, a mechanism created in 1978 to provide benefits to miners whose last employer was no longer in business. The Fund, while funded through an excise tax on coal sales, incurred substantial borrowings from the U.S. Treasury in the early years of its operation. By 1980 both the direct U.S. funded Part B program and the following Part C program had run approval rates in excess of 60%. The dominant reasons for denials of benefits were that the miner was still working in the mines, or that the claimant was not in fact a coal miner under the Act. Scant attention was paid to the medical evidence submitted with

the claim, and expectations emerged early on that the program was a pension plan, intended to confer benefits to miners with more than 10 years of service with no regard to the presence of actual pulmonary disability. When realistic medical criteria began to be applied, the approval rate began to reduce both for operator defended and DOL defended claims. Claim denials predominated the process.

The inevitable result of DOL's emerging COPD focused approach to Black Lung compensation will be to increase the approval rate up to the level of the incidence of COPD in the coal mining population. If the coal mine population filing Back Lung claims had the normal national ratio of non-smokers to smokers, then basing the Federal Black Lung Program on compensation for COPD regardless of its source would produce a relatively small number of claim awards each year. The Eastern underground coal mining populations however have a much higher incidence of smoking than the general population - 85% + vs 20% - 25% in the general population. The medical literature suggests that 25% - 30% of long-term smokers will develop COPD over their life. This gives rise to an expectation that an approval rate based primarily on loss of lung function from any cause should be in the 21% to 26% range. In fact the approval rate is at 23% in one major Eastern coal mining state (Virginia) and is approaching the 15% range in the other Eastern coal mining states. If the approval rate passes the 25% range, then increases over that level will indicate that the claims adjudication process is returning to the 1970s levels, where most miners worked all of their careers under far dustier conditions, representing compensation with minimum regard to the actual medical facts of each claim. It is also important to note that under DOL's current approach to Federal Black Lung compensation X ray evidence of CWP – the well defined disease the program was set up to compensate is almost completely ignored. The use of the "legal CWP" construct, which encompasses COPD, and the decision to reinstate the use of the presumptions based on years of employment, results in claims awards regardless of the X-ray evidence presented in the case. Today, an award to a miner with any stage of simple pneumoconiosis diagnosed by X-ray or autopsy is very rare indeed.

The Federal Black Lung program is, for many, viewed as a workers compensation program, most especially with respect to coal mine operations being required to obtain commercial insurance coverage as an add-on to their regular workers compensation polices. The operation of the

program has been and continues to be very different from the 50 state workers compensation programs. This is most apparent in the lack of finality to the claim process. All 50 state workers compensation programs have statutes of limitations on the filing of claims - generally 3 to 5 years. Once a claim has been formally litigated and a decision rendered, appeals must be filed within short periods of time and all claims reach a final status as to the payment of benefits or a denial of benefits in, at most, a few years. The only statute of limitations applicable to Federal Black Lung claims - that the claimant must file the claim within 3 years of the date the claimant knew or should have known that he was totally disabled under the Act - has been undermined by DOL decisions and very rarely successfully invoked. A claimant leaving the work force today, usually in his mid-50s, may wait 10, 20, 30 or more years to file a first claim. If that claim is denied, he may re-file it as many times as he chooses to (some claimants have re-filed a dozen times or more).

Successful Black Lung compensation programs have operated alongside[1] the Federal Black Lung program in the Eastern coal mining states. Generally, the compensation has been proportional to the extent to which the claimant has CWP and to the degree of loss of lung function. A key difference between the federal and the state black lung programs is that in U.S. workers compensation, settlements of future claim liabilities are permitted, even encouraged, by Workers Compensation Judges in all but a few states. Thus, complex issues such as the interactions of COPD and CWP are worked out among the parties with a full and final resolution of the claim. Claim settlements have never been permitted with respect to the Federal Black Lung Program. Although settlements should be permissible, legally DOL has opposed all efforts to settle claims and demanded and received deference for the agency's interpretation of the Act. DOL has argued in court that claimants and their attorneys cannot be trusted to bargain for a fair settlement, even though all settlements would require approval by an ALJ.

While Federal Black lung claims pay lower monthly benefits than the monthly benefits paid for total disability under almost any state worker's compensation act (and certainly those paid in the Eastern coal mining states), the federal benefit is subject to a cost of living adjustment each

[1] Claimants cannot get paid twice - Federal benefits are reduced dollar-for-dollar by state benefits on a monthly basis.

year. The result is that a Federal Black Lung claim for a married miner in his mid-50s will pay out over $500,000 making Federal Black Lung claim values equivalent to, or in excess of, permanent total workers compensation awards in the Eastern coal mining states. Claims from older miners or dependents are of course less, but still exceed $100,000 for even elderly married miners, and medical costs, which are not meaningfully cost-controlled by DOL, are skyrocketing.

Conclusion

The course of the Federal Black Lung Program appears to be headed for a steep increase with respect to the number of claim awards, both from the miners who have recently exited the work force, and from the tens of thousands of miners who exited the work force over the last 10 years or more. This is not due to an increase in the incidence of disease, aside from some evidence of slight increases in X-ray evidence of pneumoconiosis in narrow Appalachian “hot spots”. CWP Disease diagnosed by Category 2o or higher X-rays is not driving the awards in any area of the country which would occur if the incidence of serious CWP was increasing. Rather, the current construct of the regulations governing the program and its administration denying any possibility of finality and any possibility of distinguishing dust disease from smoker’s disease are the reasons why claims are being awarded today at much higher levels than we have seen over the last twenty years. To continue the current progression will produce financial consequences not seen since the 1970s, and bring sharply into focus the fundamental unfairness of the compensation process for employers, insurers and, in fact, for many claimants who are coaxed into repeated filings and related litigation over decades.

I would suggest that the ongoing focus be on:

(1) addressing abuses, from all sides that have been part of this program since its inception, to ensure that those truly disabled from lung disease arising out of their coal mine employment are fairly compensated;

(2) removing hurdles that preclude the expeditious disposition of claims;

(3) bringing certainty and finality to the claims adjudication process to ensure the financial viability of the program into the future.