COAL MINERS’ STRUGGLE FOR JUSTICE: HOW UNETHICAL LEGAL AND MEDICAL PRACTICES STACK THE DECK AGAINST BLACK LUNG CLAIMANTS

HEARING
BEFORE THE
SUBCOMMITTEE ON EMPLOYMENT AND WORKPLACE SAFETY
OF THE
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
UNITED STATES SENATE
ONE HUNDRED THIRTEENTH CONGRESS
SECOND SESSION
ON
EXAMINING COAL MINERS, FOCUSING ON BLACK LUNG CLAIMANTS

JULY 22, 2014

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COAL MINERS’ STRUGGLE FOR JUSTICE: HOW UNETHICAL LEGAL AND MEDICAL PRACTICES STACK THE DECK AGAINST BLACK LUNG CLAIMANTS

TUESDAY, JULY 22, 2014

U.S. Senate,
Subcommittee on Employment and Workplace Safety,
Committee on Health, Education, Labor, and Pensions,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:45 a.m., in room SD–430, Dirksen Senate Office Building, Hon. Robert P. Casey, Jr., chairman of the subcommittee, presiding.

Present: Senators Casey and Isakson.

OPENING STATEMENT OF SENATOR CASEY

Senator CASEY. Good morning, everyone. The subcommittee hearing will come to order. I want to thank the witnesses who are with us. I want to thank our ranking member, Senator Isakson, for his presence here today and his work to help schedule this hearing and to ask questions of our witnesses.

Today the Subcommittee on Employment and Workplace Safety convenes to focus on an issue that doesn’t get a lot of attention. In particular, we’re here today to talk about and to focus on the alleged actions of certain coal industry doctors and the alleged actions of certain lawyers as well as others in attempting to deny benefits to miners who are suffering from the debilitating effects of black lung disease. Black lung disease is caused through the inhalation of coal mine dust, and it leads to severe breathing complications and is found mostly in central Appalachia, in particular, the States of Pennsylvania, West Virginia, Kentucky, and Virginia.

According to the Department of Labor, black lung disease contributed to the deaths of over 75,000 miners from 1968 to 2007. That averages to over 1,900 miner deaths per year over a 39-year period. That’s an extraordinary number. I’m not sure how widely reported that number is. While overall rates have dropped since 1968, research conducted by the National Institute for Occupational Safety and Health shows that there has been a spike since the early 1990s, particularly in the most severe, fast progressing type of black lung disease, which has increasingly affected younger miners.

Last October, the Center for Public Integrity and ABC News released findings from a year-long investigation examining how coal industry doctors and lawyers helped defeat and delay benefit
claims from the growing number of miners suffering from black lung disease and their grieving survivors, who have been consistently denied or delayed justice from a system that seems increasingly stacked against them. The investigation specifically highlighted the alleged medical practices of Dr. Paul Wheeler, who failed to find a single case of complicated black lung in over 1,500 cases he reviewed since 2000.

Without objection, I would like to enter the CPI, the Center for Public Integrity, report entitled “Breathless and Burdened,” into the record.

[Editor’s Note: Due to the high cost of printing, previously published materials are not reprinted in the hearing record. The above referenced document may be found at https://cloudfront-files-1.publicintegrity.org/documents/pdfs/CPI+Breathless+and+Burdened.pdf.]

Following this report, as well as inquiries from my office as well as other Members of Congress, the Department of Labor has taken steps to address the issues identified in the black lung benefit process. The Department announced that it will issue a new rule to address disclosures that lawyers representing coal companies have withheld medical evidence from miners in black lung benefit cases.

The Department also issued a field memo instructing staff to no longer credit evidence presented by Dr. Wheeler. And, finally, the Department has sent letters to black lung claimants whose cases involved medical evidence from Dr. Wheeler and whose benefits were subsequently denied, explaining the process for reopening their cases.

I am pleased to work with the Department of Labor in its efforts to begin leveling the playing field for black lung claimants. But there’s still more that needs to be done, particularly in relation to the growing backlog of cases at the Department’s Office of Administrative Law Judges.

I am deeply concerned that miners who have been afflicted have to wait years for their cases to be decided. According to data from the Department of Labor, black lung claimants are waiting an average of 429 days just for their cases to be assigned, just to be assigned to an administrative law judge and an additional 90 to 120 days after assignment before their cases are heard in court. That’s over 520 days for claimants, 520 days. Many claimants too disabled to work are just starting to make the case that they deserve benefits.

One of my constituents from Glen Lyon, PA, not far from my hometown of Scranton—where we have a coal mining tradition and history, after finding out about the hearing—contacted my office to describe her five-plus year struggle as a widow fighting for black lung survivor benefits following her husband’s death in 2008. I’m entering into the record a letter detailing her long and tortured pursuit of justice.

[The information referred to may be found in additional material.]

Justice delayed, as we often have said, is justice denied, and in this case, for coal miners suffering from the debilitating effects of black lung disease. Our Nation’s hardworking miners and their families deserve much, much, better than that.
I called this hearing today so we can do the following three things. No. 1 is highlighting the struggles that black lung claimants face in seeking and finding justice, basic justice, particularly how legal and medical practices place an undue and often insurmountable burden on miners in the black lung claims process. No. 2, we're going to review the actions taken by the Administration to help level the playing field for claimants and determine what additional steps need to be taken. And third is to discuss the growing backlog of cases at the Department and explore actions that can be taken by the Administration and Congress to begin reducing and ultimately eliminating the lengthy wait times that miners face in seeking the benefits that they deserve and that they desperately need.

I'm also entering into the record statements from Senators Rockefeller and Harkin, who have been great champions for coal mine workers during their nearly 60 years combined service in the U.S. Senate.

[The prepared statements of Senator Harkin and Senator Rockefeller can be found in additional material.]

We will miss their leadership in addressing the important issues facing hardworking miners when both of these Senators retire at the end of this year. But they aren't finished yet. They're still working on these issues, and I'm currently working with Senators Rockefeller, Harkin, Manchin, as well as Representative George Miller, to update Senator Rockefeller's Black Lung Health Improvements Act of 2013. We're exploring ways to tackle the issues highlighted in the Center for Public Integrity and ABC News investigation, and we'll incorporate any additional information or ideas brought forward in this hearing.

I look forward to the testimony and ensuing discussion from our two witness panels. With that, I'll turn it over to Senator Isakson for his opening remarks.

[The prepared statement of Senator Casey follows:]

PREPARED STATEMENT OF SENATOR CASEY

This hearing of the Subcommittee on Employment and Workplace Safety will come to order.

We are here today to talk about the real and disheartening effects caused by the actions of certain coal industry doctors and lawyers in attempting to deny benefits to miners who are suffering from the debilitating effects of black lung disease.

Black lung disease is caused through the inhalation of coal mine dust. The accumulation of dust particles in the lungs ultimately leads to severe breathing complications, such as shortness of breath and moderate to severe airway obstruction, decreasing quality of life. The disease is diagnosed through chest x-rays and breathing tests and is found mostly in central Appalachia, particularly in Pennsylvania, West Virginia, Kentucky, and Virginia.

According to the Department of Labor, which administers the black lung benefits program, black lung disease contributed to the deaths of over 75,000 miners from 1968 to 2007—that averages to over 1,900 miner deaths per year over the 39 year period. And while overall rates have dropped since 1968, research conducted by the National Institute for Occupational Safety and Health shows
that there has been a spike since the early 1990s, particularly in the more severe, fast-progressing type of the disease, which has increasingly affected young miners.

Last October, the Center for Public Integrity and ABC News released findings from a yearlong investigation examining how coal industry doctors and lawyers have helped defeat and delay benefits claims from the growing number of miners suffering from black lung disease and their grieving survivors, who have been consistently denied or delayed justice from a system that seems increasingly stacked against them.

This CPI and ABC News investigation found that lawyers at Jackson Kelly PLLC, a firm that advocates on behalf of coal companies, often withheld medical evidence in black lung benefits cases if it supported a miner’s claim. According to the Department of Labor, less than one-third of miners have a lawyer when first filing their claims and this practice of withholding medical evidence further prevents a miner from having a fair shot at presenting his or her case. Withholding evidence also prevents a miner from knowing exactly when black lung disease was first diagnosed, which is important for determining if and when back pay is warranted.

The investigation also highlighted the unethical medical practices of Dr. Paul Wheeler, of Johns Hopkins, who failed to find a single case of complicated black lung in the over 1,500 cases he reviewed since 2000, even though x-ray readings from other B Reader certified doctors (including one of the witnesses at this hearing, Dr. Parker), biopsies, or autopsies have repeatedly proven him wrong. Dr. Wheeler’s questionable methods led to the denial of benefits to many deserving claimants, who were then forced to suffer through this terrible disease without the financial support that they and their families so desperately needed.

Johns Hopkins, to its credit, quickly shut down its black lung clinic when news of Dr. Wheeler’s unethical practices surfaced, pending an investigation into the matter.

Following the October 2013 CPI and ABC News report, as well as inquiries from myself and other Members of Congress, the Department of Labor has taken steps to address the issues identified in the black lung benefits process.

The Department announced that it will issue a new rule to address disclosures that lawyers representing coal companies have withheld medical evidence from miners in black lung benefits cases. The Department also issued a field memo instructing staff to no longer credit evidence presented by Dr. Wheeler. And finally, the Department has sent letters to black lung claimants, whose cases involved medical evidence from Dr. Wheeler and whose benefits were subsequently denied, explaining the process for reopening their cases.

I am pleased with the Department of Labor’s efforts to begin leveling the playing field for black lung claimants, but there is still more that needs to be done—particularly in relation to the growing backlog of cases at the Department’s Office of Administrative Law Judges.

I am deeply concerned that sick miners have to wait years for their cases to be decided. According to data from the Department of Labor, black lung claimants are waiting an average of 429 days
just for their cases to be assigned to an administrative law judge and an additional 90–120 days after assignment before their cases are heard in court. That’s over 520 days for claimants, many too disabled to work, just to start making the case that they deserve benefits.

I, along with other Members, sent a letter to the President in February asking him to make the reduction of backlogged cases a priority in his fiscal year 2015 budget request. He responded with a $2.9 million increase in funding, which is a step in the right direction, but does not go far enough—even with this level of funding, the backlog would continue to grow, from just over 11,000 cases in fiscal year 2013 to almost 15,000 cases by the end of fiscal year 2015, based on data from the Department of Labor. Based on these figures, my staff estimates that it will take about $10 million more than what the President requested to not only stop the backlog from growing, but to actually begin reducing the number of backlogged cases.

I encourage Members on the Appropriations Committee to work with me to look into this issue and to come up with a way to find, what amounts to a very small amount of funds in relation to the overall budget, but an amount that could have an enormously positive impact on this overwhelmed program and for the sick miners who rely on it.

One of my constituents from Glen Lyon, PA, not far from my hometown of Scranton, after finding out about this hearing, contacted my office to describe her 5-plus year struggle as a widow fighting for black lung survivor benefits following her husband’s death in 2008. I am entering a letter detailing her long and tortured pursuit of justice into the record.

Justice delayed is often justice denied for coal miners suffering the debilitating effects of Black Lung disease. Our Nation’s hard-working miners and their families deserve much better than that. I called this hearing today so that we can do the following three things:

• Highlight the struggles that black lung claimants face in seeking and finding justice—particularly how legal and medical practices place an undue and often insurmountable burden on miners in the black lung claims process.
• Review the actions taken by the Administration to help level the playing field for black lung claimants and determine what additional steps need to be taken.
• Discuss the growing backlog of cases at the Department of Labor’s Office of Administrative Law Judges and explore actions that can be taken by the Administration and Congress to begin reducing and, ultimately, eliminate the lengthy wait times that miners face in seeking the benefits that they deserve and so desperately need.

I am also entering into the record statements from Senators Rockefeller and Harkin, who have been great champions for coal mine workers during their nearly 60 combined years in the U.S. Senate. We will all miss their leadership on addressing the important issues facing hard working miners when they retire at the end of the year.

But they aren’t finished just yet—I am currently working with Senators Rockefeller, Harkin, Manchin, and Representative George
Miller to update Senator Rockefeller’s Black Lung Health Improvement Act of 2013. We are exploring ways to tackle the issues highlighted in the CPI and ABC News investigation and will also incorporate any additional information or ideas brought forward in this hearing.

I look forward to the testimony and ensuing discussion from our two witness panels. With that I’ll turn it over to Senator Isakson for his opening remarks.

**Opening Statement of Senator Isakson**

Senator Isakson. Thank you, Mr. Chairman, for calling this hearing on a critical subject. The Black Lung Compensation Program is critical to those who work in the mining industry for workers’ compensation, and it’s absolutely our responsibility to see to it that the information is accurate and that the program has great integrity.

Understanding that we have three votes at 10:45 and understanding the stars of this show are our witnesses rather than me, I’ll ask unanimous consent that my entire statement be entered into the record and turn it over to the chairman to introduce our guests.

[The prepared statement of Senator Isakson was not available at time of print.]

Senator Casey. Senator Isakson, thank you very much.

We are joined by Senator Harkin, and he missed only by seconds my commendation of his service in the Senate, especially as it relates to miners. We’re grateful that he’s here with us.

First, I’ll introduce our first panel, and then we’ll get right to the testimony. I would urge the witnesses to keep—because of what Senator Isakson referred to, our votes—keep your statements to 5 minutes, and, of course, your full statements will be entered into the record.

First, Chris Lu was sworn in as the Deputy Secretary of the U.S. Department of Labor on April 4th of this year, where he serves as the chief operating officer for a 17,000 employee organization that works to create greater opportunities for all Americans. Previously, he held many governmental positions, including White House Cabinet Secretary and Assistant to the President, Legislative Director and Acting Chief of Staff for then Senator Obama. Prior to working in the Senate and the White House, Mr. Lu worked for 8 years with Representative Henry Waxman as the Deputy Chief Counsel of the House Oversight and Government Reform Committee.

Mr. Lu, thank you for being here.

Patricia Smith was confirmed by the Senate as the Solicitor of Labor on February 4, 2010. Prior to becoming Solicitor of Labor, Patricia Smith was the New York State Commissioner of Labor and the chief of the Labor Bureau for the New York State Attorney General. She also argued and won two cases before the Supreme Court and has an extensive history of representing employees in various legal service organizations.

Ms. Smith, thank you very much for being here.

Third and finally for this panel, Dr. John Howard serves as the Director of the National Institute for Occupational Safety and Health in the U.S. Department of Health and Human Services. Dr.
Howard was first appointed by President George W. Bush and was reappointed to serve in this capacity under President Obama. Prior to his appointment as Director of NIOSH, the acronym which we'll hear a lot about today, Dr. Howard served as the chief of the Division of Occupational Safety and Health in the California Department of Industrial Relations. Dr. Howard is board certified in internal medicine and has written numerous articles on occupational health law and policy.

Doctor, thank you for being with us today.

Let me start with Mr. Lu. Thank you for your presence here, we look forward to your testimony.

STATEMENT OF CHRISTOPHER P. LU, DEPUTY SECRETARY, DEPARTMENT OF LABOR, WASHINGTON, DC; ACCOMPANIED BY PATRICIA SMITH, SOLICITOR, DEPARTMENT OF LABOR, WASHINGTON, DC

Mr. Lu. Thank you, Chairman Casey, Ranking Member Isakson, Senator Harkin. Thank you for inviting me and Solicitor Patricia Smith to testify about the Department of Labor’s administration of the Black Lung Benefits Act.

Mr. Chairman, when I first appeared before this committee in February, I assured you and Senator Harkin that if confirmed I would be committed to ensuring fairness for America’s coal miners and their families. Let me restate that commitment to you today.

The Department’s Office of Workers’ Compensation Program, OWCP, administers the Black Lung Benefits Program. When a claim is filed, OWCP provides a complete pulmonary evaluation at the Department’s expense. OWCP considers the evidence from the evaluation along with other evidence submitted by the parties and then makes a claim determination. Any claimant or employer dissatisfied with OWCP’s decision may request a hearing before the Department’s Office of Administrative Law Judges and from there may appeal to the Benefit Review Board and then to the appropriate Federal circuit court.

Senator Casey, as you indicated, last fall the Center for Public Integrity and ABC News published a series of reports highlighting the difficulties faced by claimants seeking black lung benefits. The reports described litigation tactics of coal company attorneys to selectively disclose medical evidence. In particular, the reports focused on a case involving Gary Fox in which his employer’s attorneys concealed evidence that Mr. Fox had advanced black lung disease. Due to this concealment, Mr. Fox was initially denied black lung benefits.

CPI and ABC News also looked at the routine use of certain physicians by coal companies. As you indicated, the reports focused on the Johns Hopkins Medical Center B Reader program led by Dr. Paul Wheeler. Those reports found that Dr. Wheeler failed to diagnose complicated black lung disease in over 1,500 cases while other experts reading the same x-rays found the disease in 390 of those cases.

In response to these reports, on February 24th of this year, the Department of Labor launched a pilot project to strengthen the complete pulmonary evaluation given to miners when they initially file a claim, which will increase the accuracy of decisions. The De-
partment also announced a new black lung rulemaking initiative that will consider whether all parties must disclose medical evidence related to a claim. Such a requirement will help ensure that coal miners have full access to information about their health.

With regard to Dr. Wheeler, OWCP issued a bulletin instructing its district directors not to credit evidence submitted by Dr. Wheeler’s x-ray readings in the absence of evidence rehabilitating his credibility. OWCP has searched its records to identify denied claims that contained x-ray interpretations made by Dr. Wheeler and has attempted to contact almost 1,100 affected claimants about their right to request a reopening of their claim or their right to file a new claim.

Finally, the Department has launched a new training initiative in connection with NIOSH to further improve the quality of its decisions. As the subcommittee has also recognized, there is a backlog of black lung claims awaiting hearing and decision by the Office of Administrative Law Judges.

To begin to address this situation, the president’s fiscal year 2015 budget for the ALJs proposes a programmatic increase of $2.72 million. In total, OALJ’s budget reflects an 11.5 percent increase over the fiscal year 2014 budget and is the largest increase the Department has sought in 10 years.

In fiscal year 2015, the Department plans to hire two new ALJs for the Pittsburgh office primarily to adjudicate black lung cases. The Department will also bring back a retired ALJ in Pittsburgh to focus predominantly on black lung cases. In addition, we are instituting a number of efficiencies that we believe will increase the productivity of ALJs and speed up the disposition of black lung cases.

Nevertheless, the Department’s outreach efforts to miners whose claims contained Dr. Wheeler’s interpretations are likely to result in a significant number of new claims. And even without this recent outreach effort, the number of claims filed in 2014 is projected to increase by 10.6 percent.

In conclusion, let me assure you that the Department of Labor is committed to improving the effectiveness of these programs, and we look forward to working with the subcommittee on this important effort.

Thank you.

[The prepared statement of Mr. Lu and Ms. Smith follows:]

**PREPARED STATEMENT OF CHRISTOPHER P. LU**

Chairman Casey, Ranking Member Isakson, and distinguished members of the subcommittee, thank you for inviting me to testify about the Department’s administration of the Black Lung Benefits Act. The Department is committed to the Nation’s coal miners and their families, and to ensuring fairness in the claims process.

You have asked us to address the steps the Department has taken in response to the October 2013 Center for Public Integrity (CPI) and ABC News reports about difficulties miners and their survivors have encountered in pursuing black lung benefits. You have also asked us to address the backlog of black lung cases pending before the Office of Administrative Law Judges. We appreciate your ongoing interest in the Black Lung program and welcome the opportunity to discuss the program with you, Mr. Chairman, and the subcommittee today. We look forward to your continuing leadership on these issues.
INTRODUCTION

Recognizing that coal miners were sacrificing both their health and economic futures to produce the coal necessary to meet the Nation’s energy needs, and that State workers’ compensation programs were inadequate for them, Congress enacted the Black Lung Benefits Act in 1969. Since then, the Act has provided compensation and medical-treatment benefits to thousands of disabled coal miners and compensation to their surviving family members. Currently, the Act provides benefits to coal miners who are totally disabled by black lung disease and to the survivors of miners who died due to the disease. The Byrd Amendments, enacted in 2010, also restored automatic entitlement to survivors of miners who were found entitled to benefits based on their own lifetime claims.1

Generally, a miner must establish that he or she has a lung disease arising from coal mine employment, a totally disabling respiratory impairment, and that the lung disease contributed to the impairment. A survivor who cannot benefit from the Byrd automatic entitlement provisions must establish that the miner had a lung disease arising from coal mine employment, and that the lung disease hastened the miner’s death. Any claimant, miner, or survivor, must prove his or her case by a preponderance of the evidence.

In making his case, a claimant may be able to take advantage of two important statutory presumptions. First, if the claimant proves the miner has or had complicated black lung disease—an advanced form of the disease also known as progressive massive fibrosis—the claimant can invoke a presumption of entitlement that the liable party is not permitted to rebut.2 Second, if the miner engaged in underground coal mine employment, or substantially similar above-ground coal mine employment, for at least 15 years and the claimant proves that the miner has or had a totally disabling respiratory impairment, the claimant can invoke a presumption that the miner had black lung disease and that the miner’s disability or death was due to the disease. The liable party may rebut this presumption only by showing the absence of black lung disease and that no part of the miner’s disability or death was related to coal mine employment.3

The Department’s Office of Workers’ Compensation Programs (OWCP) administers the program. OWCP’s District Directors, whose offices are located around the country, develop claims and conduct initial adjudications. OWCP offers all miners who file claims a complete pulmonary evaluation at the Department’s expense. OWCP then considers this evidence, along with that submitted by the private parties, in adjudicating the claim. Any claimant or coal company dissatisfied with the District Director’s decision may request a de novo hearing before the Department's Office of Administrative Law Judges (OALJ). Before the administrative law judge, parties may offer additional evidence—within the limitations established by the Department’s regulations—on contested issues. The judge will also conduct an oral hearing unless waived by the parties. After hearing the case and receiving evidence, the judge issues a decision either awarding or denying benefits. An aggrieved party may seek appellate review by the Department’s Benefits Review Board, and thereafter by the United States Court of Appeals for the circuit in which the miner’s coal mine employment occurred.

The Act originally divided responsibility for the program between the Social Security Administration, which administered early claims that were payable directly by the Federal Government, and the Department of Labor, which administered all claims filed after 1973. Claims administered by the Department are payable by coal mine companies (or their insurance carriers) that employed the miner; if there is no liable coal mine company available, the Black Lung Disability Trust Fund pays benefits.

THE CPI/ABC NEWS REPORTS

Last fall, CPI and ABC News published a series of reports highlighting hurdles claimants face in seeking black lung benefits. They focused primarily on two areas. First, the reports described litigation tactics used by attorneys representing coal companies. These tactics included selective disclosure of company-developed medical evidence to the adjudicator as well as to the company’s other medical experts and the miner. The reports used miner Gary Fox’s case, among others, to illustrate the problem. In that particular case, the coal company’s attorney did not share medical evidence that was indicative of complicated pneumoconiosis—an advanced form of black lung disease that when proved, establishes entitlement to benefits—with ei-

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ther the coal miner or the company’s other medical experts who ultimately testified that Mr. Fox did not have black lung disease. The company’s evidence resulted in denial of Mr. Fox’s initial claim for benefits.

Second, CPI and ABC News looked at coal companies’ routine use of certain physicians in developing medical evidence to defend against claims. The reports mainly focused on the Johns Hopkins Medical Center B-reader program, led by Dr. Paul Wheeler. (A “B-reader” denotes a physician who has passed the National Institute for Occupational Safety and Health’s examination on proficiency in using the International Labor Office (ILO) classification system to describe or “classify” the presence or absence of, and the severity of, radiographic opacities visible on chest X-rays, that are consistent with black lung or other dust-induced diseases.) Many employers, including coal companies, use B Readers to classify miners’ chest X-rays and serve as expert witnesses in contested proceedings. The CPI and ABC News reports stated that Dr. Wheeler had failed to diagnose complicated pneumoconiosis in over 1,500 cases, while other experts who evaluated the same cases had found complicated pneumoconiosis in 390 of them. The stories also documented that Dr. Wheeler was failing to properly classify chest X-rays showing obvious large opacities because he argued that the opacities were due to diseases other than Black Lung.

Johns Hopkins suspended the program shortly after the CPI and ABC News stories were published and launched an internal review. To our knowledge, the program remains suspended today.

**THE DEPARTMENT’S RESPONSE**

The Department took these reports seriously. We conducted an extensive review of the program to look for innovative ways to address the disparity in resources between coal companies and benefits claimants within the existing statutory and regulatory framework. The Department also looked for other changes that could be made to improve the fairness of the claims process and increase the accuracy of decisions made on claims.

I would like to share with you some of the actions the Department has taken as a result of this review.

1. **Pilot Program to Develop Supplemental Medical Evidence**

On February 24, 2014, the Department launched a pilot project to strengthen the complete pulmonary evaluation given to miners. When a miner files a claim, the miner picks a doctor to conduct an examination from an approved list the Department maintains. The physician examines the miner, conducts medical tests to determine whether the miner is disabled from black lung disease, and prepares a written report of his or her findings. OWCP then bases its initial entitlement determination on the report. All claims filed by miners follow this procedure.

But these initial medical reports do not always hold their value as a claim moves through the adjudication process. They are often rejected because they are outdated or do not consider all of the medical data added later to the record by miners and coal companies. The Department launched the pilot program to help alleviate these problems. In a small subset of claims—generally those where the miner worked 15 or more years in the mines (and thus might be able to invoke the 15-year statutory presumption of entitlement) and whose initial medical report supports an award of benefits—the Department is developing additional medical evidence. We ask the doctor who conducted the initial examination to review any evidence submitted by the miner or the coal company and update his or her initial opinion by drafting a supplemental report. Depending on the particular circumstances of any given case, we may ask for supplemental reports during both the OWCP and administrative law judge adjudication phases.

The Department chose this approach in response to the CPI and ABC News stories because it had multiple advantages. Developing additional medical evidence at no expense to the miner would: (1) address concerns about disparate resources; (2) improve decision making; and (3) fit within the existing legal framework, making speedy implementation possible.

The pilot project is still in its early stages. OWCP has sent out 79 requests for supplemental reports in cases being adjudicated by District Directors and has received 42 in response. OWCP has issued 37 decisions: 25 awards, 11 denials, and 1 claimant withdrew his application for benefits. We have also requested supplemental opinions in several cases set for hearing before an administrative law judge, but these cases have not yet been decided.

The Department hopes the pilot project gives deserving miners stronger medical reports that strengthen OWCP’s initial entitlement decisions and that withstand scrutiny when weighed against the coal companies’ contrary evidence. Stronger OWCP decisions may lead to fewer hearing requests in the future. While it is too
soon to assess the pilot’s effectiveness, the Department will consider expanding this procedure to all claims filed by miners if the pilot is judged successful.

2. New Regulatory Initiative

In addition to the pilot project, the Department announced a new black lung rule-making initiative on May 23, 2014, motivated in part by Gary Fox’s case and the CPI and ABC News reports. The Department plans to address three important issues in a proposed rule: whether all parties involved in a claim must disclose medical evidence they obtain in connection with a claim; the fee schedule used for payment of a miner’s medical expenses related to black lung disease; and a liable coal company’s responsibility to pay benefits under an effective award while seeking modification of the award.

The first of these issues—the medical-evidence disclosure rule—is the most relevant here. We want to ensure that coal miners have full access to information about their health. We also want to render accurate decisions in adjudicating claims. Having access to medical evidence developed by all parties can help us accomplish both of these goals.

The Department invited stakeholders to comment on all three rulemaking topics during outreach sessions held earlier this month on July 8 and 9. Both sessions were well attended and productive. The information the Department gathered will be of great assistance in drafting a proposed rule.

3. X-ray Interpretations Made by Dr. Wheeler

The Department also responded quickly to the allegations made in the CPI and ABC News reports about Dr. Paul Wheeler’s potentially incorrect X-ray readings. We immediately verified that OWCP was not employing Dr. Wheeler for any purpose. Shortly thereafter, OWCP’s National Office shared the news reports with their District Directors, instructed them to closely scrutinize any evidence offered by Dr. Wheeler and to consult with National Office staff on cases involving Dr. Wheeler’s X-ray readings.

The CPI and ABC News reports continued to be discussed in routine bi-weekly management meetings involving OWCP National Office and District Director staffs. Not surprisingly, coal companies, for the most part, stopped submitting X-ray readings made by Dr. Wheeler. One attorney who represents coal companies asked a District Director to disregard any earlier requests he had made for OWCP to forward radiographs for re-reading Dr. Wheeler’s X-ray readings. When OWCP’s National Office learned that one of its district offices was not following these oral instructions, the Department issued more detailed, written guidance.

The Department made the judgment that the CPI and ABC News reports and Hopkins’ suspension of its B-reader program were sufficiently trustworthy and reliable to warrant consideration when weighing X-ray interpretations made by Dr. Wheeler. Accordingly, on June 2, 2014, OWCP issued a bulletin instructing its District Directors to consider this information when weighing Dr. Wheeler’s negative X-ray interpretations, and not to credit Dr. Wheeler’s interpretation in the absence of persuasive evidence either challenging the CPI and ABC News conclusions or otherwise rehabilitating Dr. Wheeler’s readings. The Solicitor’s Office is also asking administrative law judges and the Benefits Review Board to take official notice of the CPI and ABC News reports in appropriate cases.

In addition to issuing this guidance, OWCP searched its records to identify denied claims that contained X-ray interpretations made by Dr. Wheeler. The search included claims filed from 2001 to the present. OWCP broke these claims into two groups: those denied within the past year that could be reopened under the Act’s 1-year modification provision, and those denied more than 1 year ago.

OWCP identified 83 claims that had been denied within the past year and sent a letter to those claimants alerting them to OWCP’s new guidance on Dr. Wheeler’s X-ray readings. The letter informed the claimants that they could request reopening of their claims, included the date by which they had to make the request, and told them that the request could be made either by telephoning or writing OWCP. In four instances, the 1-year modification deadline was quickly approaching, so OWCP telephoned the claimants in addition to sending the letter. To date, 13 claimants have sought modification in response to OWCP’s letter.

OWCP also identified approximately 1,000 claims filed by miners between 2001 and 2013 that contained Dr. Wheeler X-ray interpretations and had been denied for more than 1 year. Although modification is no longer available to these miners, a miner may always file a new claim because his or her condition may significantly deteriorate over time. Black lung disease can be latent and progressive, appearing after a miner’s coal mine employment ends or progressing to total disability with or without continued mining exposure. OWCP sent letters to these miners advising them of the new guidance regarding Dr. Wheeler’s X-ray interpretations and that
they could file new claims. The letter told them that the Department would once again provide each miner with a complete pulmonary evaluation at no expense. Because the letters were sent earlier this month, we do not yet know whether any miners will file new claims in response.

Unfortunately, most survivors (unlike miners) whose claims were denied more than 1 year ago have no avenue of relief. These survivors cannot ask for modification because the 1-year period has expired. And under the current statutory and regulatory scheme, such survivors cannot be found entitled to benefits based on a new claim.

I can assure you that if a claimant files a timely modification request or a miner files a new claim, OWCP intends to follow its stated policy and not credit Dr. Wheeler’s X-ray interpretations without persuasive evidence either challenging the CPI/ABC News conclusions or otherwise rehabilitating Dr. Wheeler’s readings. The Solicitor’s Office will also continue to ask administrative law judges and the Benefits Review Board to take official notice of the CPI/ABC News stories where appropriate. To address any similar issues that may arise going forward, the Department has begun exploring with the National Institute for Occupational Safety and Health (NIOSH) the feasibility of establishing an inter-agency quality assurance program for B-readers whose X-ray classifications are submitted and considered in black lung claims adjudications.

4. Training Initiatives

The Department has also launched a new training initiative to further improve the quality of its decisions in black lung claims. We have worked closely with NIOSH to develop advanced training for Department personnel who adjudicate claims and physicians who examine miners on behalf of the Department. The program will keep staff up-to-date on medical developments relevant to black lung claims. A potential curriculum for the program was reviewed and evaluated by a broad range of participants—including physicians and other medical providers, coal miners, claimant representatives and attorneys, OWCP staff, and Solicitor’s Office staff—at the West Virginia Black Lung Clinics Program Conference in Pipestem, WV, last month. The curriculum will be refined based on the feedback received at that session. We have engaged a contractor, Dr. Robert Cohen from the University of Illinois, to develop the training program with input from NIOSH. We believe the training will increase the quality of the medical evaluations the Department provides to miners and enhance the Department’s evaluation of the medical evidence when adjudicating claims.

OWCP is committed to ongoing training, and, in addition to entering into the contract noted above, recently added a training coordinator to its National Office black lung staff.

5. Communications and Outreach

OWCP has used a variety of forums to communicate the steps that it is taking to improve the program. OWCP leaders have discussed the pilot project, the agency’s expanded consultations with NIOSH, and the new training program at several conferences attended by miners and their representatives, doctors, and other medical providers who are involved with the program. OWCP has also placed on its website information about the pilot project, OWCP’s guidance on Dr. Wheeler’s X-ray readings, and a set of Questions and Answers about the rights of claimants whose claims were potentially impacted by Dr. Wheeler’s readings. OWCP also shared the Questions and Answers with interested congressional offices and OWCP’s District Offices.

6. Looking Forward

In addition to the actions already taken, the Department is planning for the future. We have committed to consult regularly with NIOSH on recurring medical issues raised in claims litigation. If science resolves a particular issue, the Department will consider promulgating a rule to address it. Promulgating rules where the science is clear can lead to less litigation and help resolve miners’ and survivors’ claims more quickly. Both OWCP staff and the Solicitor’s Office attorneys who litigate black lung cases are on the lookout for recurring medical and scientific issues so that we can consult with NIOSH in a timely manner.

We will be enhancing our accountability review process within OWCP. OWCP’s National Office staff performs onsite reviews of its District Offices and assesses their performance on critical program activities such as initial claim adjudications, administering benefit payments, and performing related activities associated with financial management and program administration. Each District Office is reviewed based on a sample of approximately 450 case files and other documents reflecting the work of the particular office.
We are considering adding spot audits that would require District Directors to review a sample of awards and denials after lower management reviews have been completed but before the award or denial is issued. The spot audits will be used as a quality enhancement tool and address whether the decision is appropriate, well-reasoned and in compliance with applicable statutes, regulations and policies.

CASES PENDING BEFORE THE OFFICE OF ADMINISTRATIVE LAW JUDGES

As the committee has recognized, there is a backlog in black lung claims awaiting hearing and decision by the Office of Administrative Law Judges. The number of judges available to hear cases has gone down over the past 10 years from 45 to 36 due to retirement and other departures. We are working on replacing those that we have lost, but that process has been hindered by sequestration reductions. In addition, the President’s fiscal year 2015 budget provides funding for OALJ to hire additional staff to address the backlog. The budget proposes a programmatic increase in OALJ for 10 full-time employees, $2,027,000 in general funds and $693,000 in Black Lung resources. In total, the budget reflects an 11.5 percent increase for OALJ over the fiscal year 2014 enacted budget and is the largest increase the Department has sought in 10 years. The fiscal year 2015 budget also includes a plan for fully replacing the automatic sequester cuts with smarter, better targeted reductions. If allowed to continue, sequestration will further reduce available Black Lung funding for OALJ’s administrative needs. These additional resources proposed in the President’s budget will increase OALJ’s ability to hear and decide claims more quickly.

OALJ is also tackling the black lung case backlog in other ways. Some actions are directly related to adjudicating black lung cases while others are designed to free administrative law judges in other areas so that they have more time to devote to black lung cases. These actions include:

- Hiring two new administrative law judges for OALJ’s Pittsburgh District Office in fiscal year 2015 to adjudicate black lung cases predominantly. In the meantime, an administrative law judge who had previously retired will be brought back as a Senior AJ in the Pittsburgh office, where he will focus predominantly on black lung cases. OALJ will also be hiring two new administrative law judges for the National office in Washington. The Washington office has the largest staff of judges and disposes of more black lung claims than any individual district office.
- Hiring a Senior Attorney in each OALJ District Office, instead of relying solely on law clerks who serve 2-year terms. A Senior Attorney would develop greater expertise in black lung law and thus be better able to assist administrative law judges faced with difficult issues. Given the funding issues involved, OALJ is launching this as a pilot program only.
- Exploring the use of contract attorneys, who are usually former law clerks, to draft black lung decisions on a fixed cost per case. In the past, this has proved a cost-effective method of reducing decision backlogs.
- Routinely advising represented parties in black lung cases that a decision may be made on the documentary record, without an oral hearing, if all parties agree. Where the parties do agree, OALJ will be able to proceed more quickly to a final disposition of the claim.
- Monitoring the productivity of all administrative law judges with regard to the disposition of black lung cases, and counseling judges who are less productive.
- Using rehired annuitants to form additional Board of Alien Labor Contract Appeals panels to dispose of Permanent Labor Certification (PERM) cases. This will free up administrative law judges to hear and decide more black lung cases.
- Continuing to explore using electronic systems for hearings. This could reduce travel costs and conserve valuable administrative law judge time that could be devoted to decisionmaking.
- Developing 10–15 training modules in conjunction with NIOSH to help administrative law judges and staff better understand the medical issues typically presented in black lung claims. This training could speed up the disposition of these claims.

You have also asked whether the Department’s actions taken in response to the CPI and ABC News reports might have an impact on the backlog. The Department’s outreach efforts to miners whose claims contained Dr. Wheeler X-ray interpretations are likely to result in a significant number of new claim filings. We project approximately 330 new claims will be filed in fiscal year 2014 with an additional 300 to 400 in fiscal year 2015 in response to the 1,000 letters sent to miners whose claims were denied. In addition, new claim filings thus far in fiscal year 2014 have exceed earlier estimates. OWCP now projects 7,100 new claim filings (not including any new claims filed in response to the letters sent about Dr. Wheeler) by the end of
this fiscal year, a 10.6 percent increase over claim filings in fiscal year 2013. Although the reason for this increase is difficult to determine, drivers likely include OWCP’s publication of regulations in September, 2013, implementing the Byrd Amendments; the increased publicity the program has received; and OWCP’s outreach efforts to the coal-mining community. The increase in new claim filings will, of course, be reflected in the Department’s workload at all adjudication levels, including OALJ.

CONCLUSION

Coal miners who have sacrificed their health because of their occupation deserve a fair process when they file claims for black lung benefits. The actions the Department has taken will further that goal. We look forward to continuing to work with you to improve the program and the lives of coal miners and their families.

Senator CASEY. Thank you, Deputy Secretary Lu. And I want to explain that because you and Solicitor Smith are in the same department, you’ve submitted joint testimony. So there’s joint written testimony, but only one oral testimony. Of course, Solicitor Smith will be available for questions.

Next we’ll move to Dr. Howard.

STATEMENT OF JOHN HOWARD, M.D., DIRECTOR, NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH, WASHINGTON, DC

Dr. HOWARD. Good morning, Mr. Chairman, Ranking Member Isakson, and Senator Harkin. I would like to provide an update on NIOSH’s efforts to provide high-quality health surveillance for coal miners and to assist in ensuring accurate assessment of chest radiographs for coal workers’ pneumoconiosis or black lung disease.

Surveillance for coal workers’ pneumoconiosis, a progressive lung disease even after cessation of coal dust exposure, was first required by the Coal Mine Health and Safety Act of 1969. It was quickly recognized that there was substantial disagreement between physicians in determining whether chest radiographs showed evidence of pneumoconiosis.

In 1978, NIOSH promulgated regulations that took steps to ensure accurate chest radiograph readings for the NIOSH Coal Workers’ Health Surveillance Program. The regulations required physicians to meet certain requirements before participating in the NIOSH surveillance program and a rigorous process to evaluate chest radiographs for evidence of pneumoconiosis. This process is based on multiple independent evaluations that are summarized in a way that emphasizes mainstream views and minimizes the impact of extreme or outlying views.

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The NIOSH B Reader Certification Program based on these regulations trains and tests physicians for their ability to use the system from the International Labor Organization, or ILO, for standardized description or classification of changes on chest radiographs that are associated with pneumoconiosis. Physicians can become a B Reader by passing an examination in which they are graded on their ability to classify a group of chest radiographs using the ILO system.

Currently, there are 221 B Readers in the United States, down from a high of 634 in 1997. Besides their role in the NIOSH surveillance program, B Readers provide classifications in non-NIOSH settings, such as the Department of Labor’s Black Lung Compensation Program.
NIOSH was also concerned by reports from the Center for Public Integrity and ABC News suggesting that a B Reader involved in the Department of Labor’s Black Lung Compensation Program systematically chest radiographs. NIOSH took four actions in response.

First, we immediately offered Johns Hopkins our assistance to help them with its inquiry. Second, NIOSH noted that the Johns Hopkins B Reader in question reportedly asserted that clearly visible chest radiographic changes need not be classified if the B Reader believed they had a cause other than pneumoconiosis. This is not consistent with the purpose of the ILO classification system.

In response, NIOSH obtained approval from the OMB to revise the NIOSH form, which many B Readers use in non-NIOSH settings. The new form clearly requires that all findings described by the ILO classification system that are seen on the chest radiograph must be classified regardless of the physician’s opinion about their underlying cause.

Third, NIOSH has entered into a partnership with the Department of Labor’s Office of Workers’ Compensation Programs to work together to establish a quality assurance program that will allow the Department of Labor to assess whether physicians performing classifications of chest radiographs in connection with black lung compensation cases are doing so accurately.

Fourth, NIOSH reiterated that when it is provided with a written complaint about the ethics or competence of an individual B Reader that performs services in non-NIOSH settings, NIOSH would refer the complaint to the appropriate State licensing board if it involved medical interpretation. The practice of medicine is regulated at the State level, and State licensing boards have investigative authorities in non-NIOSH settings not available to NIOSH.

Since 1978, NIOSH is aware of only two B Readers who have lost their licenses to practice medicine because of the way they classified chest radiographs. NIOSH offers its technical assistance to any State medical licensing board that makes the decision to investigate chest radiograph classifications performed by a B Reader. More information about the NIOSH B Reader program, including a list of best practices, is provided in my written testimony.

Thank you, Mr. Chairman, and I am happy to answer any questions.

[The prepared statement of Dr. Howard follows:]

PREPARED STATEMENT OF JOHN HOWARD, M.D.

Good morning, Mr. Chairman, Ranking Member Isakson, and distinguished members of the subcommittee. My name is John Howard and I am the director of the National Institute for Occupational Safety and Health, or NIOSH, which is part of the Centers for Disease Control and Prevention (CDC) within the U.S. Department of Health and Human Services (HHS). I am here today to provide an update on NIOSH’s efforts to provide high-quality health surveillance to coal miners to protect their respiratory health.

B READER CERTIFICATION PROGRAM

The need for the B Reader Certification Program was recognized soon after NIOSH was established in 1970. One of NIOSH’s very first responsibilities was to provide ongoing, periodic health surveillance to underground coal miners, using chest radiographs to screen for a type of dust-induced lung disease (pneumoconiosis). The requirement to provide this surveillance was established in 1969 by
section 203(a) of the Federal Coal Mine Health and Safety Act (Public Law 91–173), hereby referred to as the “Coal Act.”

The Coal Act required that miners found to have evidence of pneumoconiosis be offered the opportunity for transfer to jobs with lower dust exposures to minimize progression of their disease. It was found at that time that there was substantial disagreement between physicians in determining whether chest radiographs showed evidence of pneumoconiosis. This was attributed in part to physicians’ lack of experience with the classification systems employed to describe chest radiographic changes and their lack of familiarity with the radiographic manifestations of pneumoconiosis. In response, efforts were initiated to develop a pool of physicians with the skills needed to provide high quality, reproducible documentation of changes in miners’ chest radiographs. These efforts led in 1978 to the regulations, codified at 42 CFR part 37, under which the B Reader Certification Program operates. It was also recognized that accurate, reproducible results depended as much on the system within which B Readers were used as upon their individual skills. Thus, Part 37 also included regulations describing how B Readers were to be employed in classifying chest radiographs for the presence and severity of changes associated with pneumoconiosis.

The B Reader Certification Program trains and tests physicians for their ability to use a standardized system for describing changes found on chest radiographic images that are associated with pneumoconiosis. This system is called the International Labor Organization (ILO) International Classification of Radiographs of the Pneumoconioses. The ILO Classification System is used in many countries to provide a framework for reproducible “classification” or description of chest radiograph quality and the presence and severity of changes associated with pneumoconiosis on chest radiographs. The focus of the classification is to have standardized, reproducible reporting of what changes can be seen on the chest radiographs. Relatively few physicians are familiar with the system since it is not typically used to provide clinical care. Rather, a classification using the ILO system (sometimes referred to as a “B reading”) is more often used in epidemiological research, health surveillance, legal and compensation systems where greater standardization is required. Making a clinical diagnosis about what medical condition or disease has caused visible radiographic changes that are classified in an individual is a separate process from image classification. Clinical diagnosis involves considering additional clinically relevant information, for example: work or exposure history, medical history and physical examination, and the results of other medical tests.

Physicians seeking to become B Readers can learn to perform ILO classification using a self-study syllabus available from NIOSH or can take a course periodically offered by the American College of Radiology. Physicians can become B Readers by taking a certification examination in which they are graded on their ability to classify a group of chest radiographs. They must take a re-certification examination every 4 years to maintain their certification. Over the years, the certification examination has had an approximately 50 percent pass rate and the recertification examination an approximately 85 percent pass rate. There are currently 221 B Readers in the United States—down from the high of 634 in 1997.

Part 37 specifies how B Readers are employed to classify chest radiographs for the NIOSH Coal Workers’ Health Surveillance Program (CWHSP). At least two readers independently classify each chest radiograph. If the first two readers are in disagreement, a third reader classifies the film and, if there is sufficient agreement, a median classification is used. However, if there is still insufficient agreement, up to five readers may be used. This system inherently assures that classifications represent mainstream views and minimizes the impact of extreme individual classifications that differ from those of other B Readers.

The B Reader Certification Program was developed to improve the quality of NIOSH’s CWHSP and the same regulations that established the B Reader Program also established an appropriate system of employing B Readers to optimize the accuracy and reproducibility of their classifications. Over time, successful completion of the B Reader Certification Examination has been recognized internationally as evidence of competence in using the ILO Classification System to classify changes on chest radiographs. Even though only physicians with U.S. licensure can become B Readers, NIOSH allows international physicians and scientists to take the B Reader certification and recertification examinations. If they pass, their names are listed on the NIOSH website. The website currently lists 63 of these successful international examinees.
BURDEN OF PNEUMOCONIOSIS DOCUMENTED BY THE COAL WORKERS’ HEALTH
SURVEILLANCE PROGRAM

The ability of the CWHSP to obtain accurate classifications of underground coal miners’ chest radiographs has allowed it to longitudinally monitor the burden of pneumoconiosis in U.S. underground coal miners since the 1970s. Because it takes 5 years to complete a full national surveillance cycle, NIOSH typically shows pneumoconiosis rates over 5-year intervals.

Pneumoconiosis most often takes several decades to become apparent, so only trends for those engaged in underground coal mining for 20 years or more are discussed.

In this tenure group, prevalence of pneumoconiosis in CWHSP participants was at its highest, 29.3 percent, in the 5-year period of 1970–74. Rates fell continuously after that until 1995–99, reaching a low of 3.2 percent. Rates subsequently increased to 6.1 percent and 6.4 percent in 2000–2004 and 2005–2009, respectively. NIOSH will soon complete another 5-year period and it appears that rates will be similar. Prevalence rates have been higher among underground coal miners working in the Central Appalachian region and in smaller mines, although pneumoconiosis continues to be a problem nationwide.

NIOSH does not have similar longitudinal data for surface coal miners, who have not previously been required to be offered health surveillance. This situation will change as of August 1, 2014, when the Mine Safety and Health Administration’s new respirable coal mine dust regulations go into effect. At that time, NIOSH’s CWHSP will be expanded to include surface coal miners. Required health surveillance will also add a lung function test called spirometry to the screening that is offered to coal miners.

UPDATING THE B READER CERTIFICATION PROGRAM TO DIGITAL FORMAT

In recent years, most clinical facilities have moved from film-based chest radiography to digital chest imaging. In response, NIOSH assisted the ILO to enable digital chest images to be classified using the ILO system. This involved doing research to document technical approaches that would yield the same classification regardless of whether an individual was evaluated using a film-based chest radiograph or a digital chest image. NIOSH is now updating the B Reader Certification Program to digital format. NIOSH has entered into a contract with the American College of Radiology to accomplish this work, which will include updating the B Reader Certification Program’s educational syllabus, certification examination, and recertification examination into modern digital format. This modernization of the program is critically important for us to maintain an adequate pool of physicians able to classify chest radiographs using the ILO Classification System.

B READER CLASSIFICATIONS IN NON-NIOSH SETTINGS

The B Reader Certification Program is the only formal national program that provides training and evidence of competency in classifying chest radiographs according to the ILO Classification System. Because there is also a need for classification of chest radiographs using the ILO Classification System in a range of non-NIOSH settings, B Readers have been sought after to provide classification in those settings. Examples include research, industry health surveillance programs, legal proceedings, and various governmental eligibility programs, including the Department of Labor’s Black Lung Compensation Program. Examples of non-NIOSH employers in these settings include academia, medical practices, industry, legal firms, and other governmental agencies.

Because NIOSH’s authority for operating the B Reader Certification Program is tied to operation of the Coal Workers Surveillance Program, we do not have any formal role or authority in many of these settings. For example, we do not have the authority to obtain information about what non-NIOSH classifications are performed, the results of the classifications, or to obtain the images that were classified. Also, many of these settings—chiefly adversarial proceedings—do not employ B Readers in a way that optimizes accuracy and mainstream classifications, as I have described for the Coal Workers Surveillance Program.

Thus, over the decades that the B Reader Certification Program has been in existence, NIOSH has not monitored or guaranteed the accuracy of classifications performed by B Readers in non-NIOSH settings. For those seeking to assess the quality of classifications performed in non-NIOSH settings, NIOSH has developed a set of recommended practices for obtaining accurate classifications of chest radiographs, which are posted on the NIOSH website. Classifications resulting from practices such as using a summary classification of multiple independent readers, blinding
the readers to the source of the radiograph, picking readers randomly (or taking other steps to assure they are in the mainstream), and conducting quality assurance can in general be viewed as more credible than classifications that do not employ these measures to optimize accuracy.

NIOSH ACTIONS IN RESPONSE TO CENTER FOR PUBLIC INTEGRITY/ ABC NEWS REPORTS

Even though NIOSH has a limited role and a limited ability to address chest radiograph classifications performed in non-NIOSH settings, we still want to do what we can to promote high quality, accurate classifications of chest radiographs. We also believe that B Readers should demonstrate high levels of ethics and integrity, which is why we developed a B Reader Code of Ethics. Devotion to accurate classification of chest images is an important feature of the Code. In view of this, NIOSH was disturbed by evidence presented in the Center for Public Integrity and ABC News reports suggesting that a B Reader involved in Black Lung compensation cases systematically misclassified chest radiographs. NIOSH has taken several actions in response to these reports.

First, when the particular B Reader's employer, Johns Hopkins University, announced that they were suspending their program of providing expert medical testimony for legal firms, NIOSH offered Johns Hopkins help with their internal investigation. NIOSH subsequently answered questions and provided information to help them with their investigation.

Second, in reading the Center for Public Integrity report and viewing the companion report on ABC News, NIOSH noted that the particular B Reader reportedly argued he should not classify clearly visible chest radiographic changes because he thought they had a cause other than pneumoconiosis. As I have previously described, this is not consistent with the purpose of the ILO Classification System, which provides a standardized way to record the changes that can be plainly seen on a radiograph. In response, NIOSH obtained approval from the Office of Management and Budget (OMB) to revise the NIOSH form which many B Readers use in non-NIOSH settings to report the results of chest radiograph classifications. The new form clearly requires that all findings described by the ILO Classification System that are seen on the chest radiograph must be classified regardless of opinions about underlying cause, which are entered elsewhere on the form.

Third, NIOSH has been in discussions with the Department of Labor (DOL), Office of Workers' Compensation Programs (OWCP), which operates the Black Lung Compensation Program about the feasibility of implementing a quality assurance program to determine whether B Readers are providing accurate classifications of chest radiographs for consideration in compensation proceedings. NIOSH and OWCP have agreed in principle to establish the program and are currently evaluating technical issues such as the availability of chest radiographic images for re-classification, appropriate methods for using re-classifications to assess B Reader performance, and how this information will be used for quality improvement. It should be noted that the quality assurance program will operate separately from the process of adjudicating individual compensation claims. We hope to implement the quality assurance program during fiscal year 2015.

Fourth, for many years, NIOSH has had a policy that if provided with a written complaint about the ethics or competence of an individual B Reader that performed services in non-NIOSH settings, NIOSH would refer the complaint to the appropriate State Medical Licensing Board. The reasoning for this policy was that the practice of medicine in the United States is regulated at the State level and thus State Medical Licensing Boards have investigative authorities in non-NIOSH settings that are not available to NIOSH. State Boards also have the ability to restrict or suspend a physician’s privilege to practice medicine based on the outcome of an investigation. It should be noted that since the B Reader Certification Program was established in 1978, we are aware of only two B Readers who have lost their licenses to practice medicine because of the way they classified chest radiographs. In response to the current situation, NIOSH is taking the additional action of formally offering our technical assistance to any State Medical Licensing Board that makes the decision to investigate chest radiograph classifications performed by a B Reader. NIOSH will also consider requests for technical assistance from other government agencies that wish to develop quality assurance programs or to investigate the performance of individual B Readers in chest image classification.

CONCLUSION

Since the current NIOSH B Reader Certification Program was established in 1978, it has played a critical role in ensuring the availability of a pool of physicians
able to classify chest radiographs for the NIOSH Coal Workers’ Health Surveillance Program using the ILO system. Part 37 also specifies that readers be employed in a way that favors mainstream classifications and minimizes the impact of outliers, thus optimizing the accuracy of chest radiograph classifications used by the surveillance program. Because the B Reader Certification Program is unique in providing formal documentation of the competency of physicians to classify chest radiographs using the ILO system, B Readers are often sought after to perform classifications in non-NIOSH settings. These settings do not always follow NIOSH recommendations to ensure high quality classifications.

NIOSH has taken action to help DOL in its efforts to improve the quality of classifications submitted for consideration by the Black Lung Compensation Program, and, within our ability to do so, NIOSH stands ready to assist others undertaking similar efforts in other non-NIOSH settings.

Thank you for the opportunity to provide this testimony. I am pleased to answer any questions you may have.

Senator CASEY. Thank you, Doctor. We’ll start a round of questions.

Deputy Secretary Lu, I wanted to ask you about the question of resources. We’ve had some discussion about this. I’ve noticed that over time, especially in the last several months, and really within the last year, when you consider the additional responsibilities that you have to deal with as well as the resources you’re going to need because of the new initiatives that you’ve embarked upon, I believe that you’re going to need substantially more resources for the work that you’re doing.

We know that based upon data from the Department, we estimate that approximately $10 million in funding above the president’s fiscal year 2015 budget request for the— and I’m talking now about the Office of Administrative Law Judges—would be necessary to begin reducing and ultimately trying to eliminate the backlog. So I’d ask you, in particular, will you continue to work with us to ensure, not just to try, but to ensure that the Department has the resources to adequately address the backlog of cases?

Mr. Lu. Mr. Chairman, I’d like to first of all commend you on your longstanding leadership on this issue. As I indicated in my opening statement, we have asked for an 11.5 percent increase in fiscal year 2015 for the ALJs. But as you’ve recognized, the ALJ caseload is increasing both because of the Dr. Wheeler cases and because of other factors like greater publicity and greater outreach. So the Department is absolutely interested in working with you and your staff to ensure that we have sufficient resources on this important issue.

Senator CASEY. We’ve got some work to do on that, and I’m grateful for your willingness to work with us on that.

Solicitor Smith, I wanted to ask you about the allegation that’s often made that miners are allowed to file as many claims as they like no matter how many times their claims are denied. Can you describe how the process for resubmitting a previously denied claim differs based on whether or not it falls within the 1-year time limit?

Ms. SMITH. Yes, Senator. Thank you. This is an issue which many courts have looked at, and all of them have felt that the rule is proper. There are two possibilities. If a miner has been denied a claim within a year he may move to reopen that claim on the basis of there’s a mistake or his condition has changed.

I’d like to point out that a coal mine operator also has that ability to ask for a modification of a claim where benefits were award-
ed within 1 year after the last payment of benefits. Both of those re-opening have to be on the basis of either a mistake or a change in condition. If an award is granted or denied, it is on the basis of the current claim.

On the other hand, after 1 year, a miner may file a claim for new benefits. It is a new claim. It is a new time period. That’s because, as Dr. Howard has pointed out, black lung disease can be progressive and latent even after there’s been a cessation of exposure to coal mine dust.

What a miner must prove in that situation as a threshold matter is that there has been a change in some condition of eligibility since the last claim. If they can’t prove that as a threshold matter, the claim is denied. If then they can prove that the change in condition has made it clear that they have black lung disease and it’s totally disabling, they would be able to get an award of benefits.

But that award of benefits does not go back to the previous time. It only goes back from when that new claim has been made. Again, this is because the black lung can be progressive and latent. So if there are changes in conditions and now the miner is eligible when they may not have been eligible before, we don’t want to bar them forever when they have become eligible.

Senator CASEY. You’re talking about the situations where you have a new claim.

Ms. SMITH. Right. That’s a new claim. It’s not a reopening of an old claim. It does not go back to the time period of the old claim. Once the old claim has been denied for over a year, it’s barred by res judicata. You cannot reopen that claim. But if you can prove that you have a change in your condition and you are now eligible, you can file a new claim for a new time period.

Senator CASEY. Before we wrap this up, why don’t we put on the record your best definition of res judicata.

Ms. SMITH. Res judicata means that the claim is final and you cannot reopen it.

Senator CASEY. Thanks very much.

Senator Isakson.

Senator ISAKSON. Thank you, Mr. Chairman. I have one question for Dr. Howard.

Since the CPI report was published, NIOSH has created a new form which requires that all findings described by the ILO classification system that are seen on the chest radiograph be classified—and you mentioned this in your opening remarks—regardless of opinions about the underlying cause. My question is this: Under the new system, how would a physician be able to exercise their professional judgment or annotate their own medical conclusion regarding other causes if this is classified?

Dr. HOWARD. Thank you, Senator Isakson. They can certainly do that by providing their own medical interpretation of the findings that they see. So there are two parts to the process of looking at a chest x-ray. One is to assess what they see visibly in terms of the profusion score, et cetera, all the findings on the ILO form, and those have to be recorded. Then the second process is their medical interpretation of those findings. So they can do both.

Senator ISAKSON. So if it’s classified, what does that classification mean? What restriction does that imply?
Dr. Howard. The restriction on classification, the actual reading of what's on the x-ray, is within the bounds of the ILO classification system. The interpretation of what is seen on the x-ray is a medical activity, a diagnostic activity. So the physician can draw his or her own conclusions about what they see. But the accuracy of what they see is what we certify, what they're certified for as a B Reader.

Senator Isakson. I don't want to belabor this, but this is an important question, I think. So the ILO classification system sets out the parameters by which a doctor may make a medical determination of the radiograph?

Dr. Howard. No. The ILO classification system sets out the parameters for looking at the visible findings on the x-ray and has a number of different categories that the physician checks or does not check. That's what we train physicians to do, to match that with the ILO classification system. And then at the end of that process, they can add their interpretation about what they've seen. But the two are different.

Senator Isakson. So they're not professionally restricted from——

Dr. Howard. No. We do not control the practice of medicine, per se. But we do certify people on the accuracy with which they read an x-ray according to the ILO classification system.

Senator Isakson. Thank you, Dr. Howard. That's my only question.

Senator Casey. Thank you, Senator Isakson.

Senator Harkin.

OPENING STATEMENT OF SENATOR HARKIN

The Chairman. Thank you very much, Mr. Chairman. First, let me commend you for your great leadership on this very important issue. I thank Senator Isakson for being a good partner in helping to try to change some of the ways we do business with regard to coal miners.

We often talk about how coal produces some of the cheapest electricity and energy that we have in the United States. That's true for a number of reasons. One is because the forces of nature created the coal over hundreds of millions of years.

But I think it's also true because those who mine the coal have not been adequately compensated in the last century or so that we've been mining coal in this country. They're compensated both in terms of wages and salaries, which are much better now because of the work of the United Mine Workers and others. But the other thing is the compensation that goes to these miners who develop serious health problems because of mining coal.

Many of the good producers, good coal mine owners, have taken great steps to keep the dust down to provide that miners do not inhale a lot of coal dust when they're mining. But there's still a lot of bad actors out there, too, who have not done that.

The Department has now issued a new rule—or I think you're in rulemaking now—for keeping that level of dust down. Is that correct, Mr. Lu?

Mr. Lu. That is correct.

The Chairman. When will we see that rule?
Ms. SMITH. That rule is effective August 1st.
The CHAIRMAN. So it is effective August 1st?
Ms. SMITH. Yes.
The CHAIRMAN. I'll be checking to see how that works. Coal companies claim that costs them a lot of money. Well, of course, it does. But what's the cost of a miner that lives out the remainder of his life for 30 or 40 years unable to breathe, hooked up to an oxygen machine, unable to even do some of the most rudimentary things of daily life.

As the chairman knows, I come at this from a personal standpoint. My father mined coal for over 23 years in Iowa. A lot of people don't know that Iowa had a lot of coal. We were once the second largest coal producing State in the Nation. John L. Lewis, the great coal mine leader, came from Iowa, not from West Virginia or the chairman's State, Pennsylvania.

But in those days, they had nothing. I mean, they worked underground, and they had nothing. They didn't call it black lung. I never heard that until I came here. But we always called it the miner's cough, the miner's lung, and that's just what they had. They might not have been totally disabled, but, boy, their lives were not worth very much in terms of what they could do physically as they reached into their fifties, sixties, and seventies. So I'm glad that we got the rule out.

Second, the chairman hit upon the backlog of cases. But I also want to know what the Department basically—you touched on that, Mr. Lu, in your testimony—how we're leveling the playing field. A lot of times, these miners don't have a lot of money. They don't have adequate counsel. They file their claim. It goes to Dr. Wheeler, who I hope is not a part of our program any longer. But they don't have any recourse to adequate counsel.

How are we going to help those individuals who live in remote places, small communities? How are we going to help them level that playing field?

Maybe Ms. Smith from the solicitor's office could respond.

Ms. SMITH. Senator, there's a few things that we've been doing lately. We have really been thinking about this, what we can do for miners who do not have counsel, which is why in our pilot program, where we have a miner who has filed a claim and he's unrepresented, we have an initial determination that he is eligible for benefits—in order to strengthen his evidence, because he does not have counsel—if there is evidence to the contrary, we are sending that evidence back to his original doctor to reassess it, to come up with up-to-date medical evidence, something that unrepresented miners would not do on their own. That's one thing that we're doing to try to strengthen the medical evidence.

Second, at the ALJ level, in the same circumstances where we have an unrepresented miner, I have instructed officers in the solicitor's office, who normally do not get involved in these cases, to look for those cases, to get the medical evidence which may have been submitted at the ALJ level, and send it back to the original doctor. Sometimes the original doctor's evidence is 2 or 3 years old, so it's considered outdated—send it back and get more evidence.

The CHAIRMAN. What's the backlog? I don't even know that number. Do you know the number, Chris?
Mr. LU. Senator, we can get you the number. What I can tell you is that the number of cases that have been filed has increased from about 6,400 in fiscal year 2013. We believe it will be about 7,400 in fiscal year 2014. So the number of claims filed has increased by about 1,000, and we can get you more detailed information on what the backlog numbers are.

The CHAIRMAN. Counsel has told us there’s probably around 14,000. Does that sound about right?

Mr. LU. I think that’s about right.

The CHAIRMAN. I hope and trust that we’re going to be providing the kind of support, legal support and otherwise, so that we don’t just wait until they all die off. They deserve compensation, and they deserve it now.

Thank you.

[The prepared statement of Senator Harkin follows:]

PREPARED STATEMENT OF SENATOR HARKIN

I would like to thank Senator Casey for holding this important hearing so that we can learn more about the struggles that coal miners and their families face when filing for benefits under the Black Lung Benefits Act. I would also like to thank my colleagues Senators Rockefeller and Manchin and Congressman George Miller for all their work helping us try to address the issues raised by the Center for Public Integrity and others. It is my hope that this hearing shines a brighter light on these issues and helps inform our work on legislation to try to restore justice for our Nation’s coal miners.

Although we don’t really mine coal in Iowa anymore, protecting the health, safety, and benefits of our Nation’s miners has always been important to me because of my father, who was a coal miner. The topic of today’s hearing—black lung or what we used to call miners’ lung—is personal for me because I know what it is like to see a loved one fight for breath after years of working in clouds of coal dust and struggle to support a family.

My father’s work as a coal miner was long before the passage of the Coal or Mine Acts and the establishment of a benefits program for miners stricken with debilitating black lung. When my father reached the age of 65 in 1951—and I was 11 years old—his health was pretty poor from his years laboring in the mines. At most, he could work odd jobs like painting houses or fixing things up, but even that was hard.

His total Social Security check at that time was about $120 a month, the sole source of income for our family. We had no outside income, no savings, no stocks, just the little house that we lived in. My father would go and get his lungs cleared out at Mercy Hospital in Des Moines because the nuns would let him pay what he could when he could. He was really happy when he finally got his Medicare card because he didn’t have to rely on charity anymore, and he felt like that was something that he earned from his years of hard work.

Although conditions in the mining industry have improved from my father’s time, many of the same issues remain—coal miners are still getting sick just from going to work and even though there is a system in place to provide them benefits and healthcare when
they become disabled, many still struggle to take care of their families.

In reading the remarkable investigative reports that tell the stories of countless coal miners and their families who were denied justice, it seems to me that one common theme explains it all—greed.

For decades, coal miners have gone underground and done the most dangerous of jobs so they could provide for their families and help build America into the economic power it is today. Some were lucky to have a union looking out for them, while others had to fend for themselves.

I can’t help but believe that greed and the desire to reap large profits lead some coal companies to fight against miners and the government every time issues regarding miner safety and health and benefits are debated. Not all, but historically, far too many coal operators have put profits ahead of the safety and health of the miners they employ. A recent example of this was the terrible disaster at the Upper Big Branch Mine that took the lives of 29 men. When we tried to pass a reasonable piece of legislation—the Byrd bill—to strengthen our mine safety laws to address the problems raised by the investigations, we were blocked by the coal industry and their allies in Congress.

For years, some of these same companies have worked together with allies in the legal and medical communities to deny miners and their families justice and a fair shot to receive benefits to which they are entitled. Sadly, it is a playbook that has become all too familiar, use every trick and resource advantage to game the system long enough for miners to give up hope and fight the government tooth and nail when it takes actions to protect miners that could eat into the industry’s profits.

Although this hearing is focused on black lung benefits, I would be remiss if I didn’t also mention how pleased I was when the Department of Labor’s Mine Safety and Health Administration announced in April that it had finalized a strong rule to prevent miners from developing black lung disease in the first place. I strongly support the Department’s efforts to combat black lung and hope that once these protections are in effect, the miners that make up today’s workforce won’t suffer from black lung and need to file claims for benefits in the first place.

In closing, I would like to commend the Department of Labor for the actions that it has already taken to address the problems plaguing the black lung benefits program, including the pilot program to help strengthen miners’ medical evidence and expand legal assistance. Moreover, I was encouraged that DOL recently announced intentions to promulgate a regulation to reform the black lung program. Based off the information in the reports, the testimony from today’s hearing, and input from miners and other stakeholders, it is my hope that the Department puts forth a robust rule to make the system more efficient and fair. I would also like to thank the National Institute for Occupational Safety and Health (NIOSH) for participating in today’s hearing and for all the great research that it produces to help make miners healthier and safer on the job.
At the end of the day, if a miner is willing to travel into the bowels of the earth every day knowing that he may one day suffer from a lung disease, the least we can do is make sure he has a fair shot at justice and that the cards aren’t stacked against him when he applies for benefits to support his family.

Senator CASEY. Mr. Chairman, thank you very much. I know we’re running out of time for this panel. But I wanted to ask Dr. Howard a question about the prevalence of black lung disease. We sometimes hear people assert that the approval rates for black lung benefits are driven more by public policy considerations than by the actual circumstances or the actual incidence, I should say, of dust induced lung disease.

Based upon your knowledge, what’s the scientific evidence, as best you can summarize it, about the prevalence of black lung disease?

Dr. HOWARD. Thank you, Senator. We publish at NIOSH 5-year prevalence rates. We wait until 20 years or more, because this is a slow, progressive disease. Starting back in the 5-year time period of 1970 to 1974, the prevalence rate was 29.3 percent. It dropped considerably to around 3.2 percent, which was the lowest, in the period 1995 through 1999. And then recently, 2000 to 2004, it rose to 6.1 percent, and in 2005 to 2009, which is our last 5-year prevalence period that we’re reporting on currently, it is 6.4 percent.

We’re going to complete our most recent 5-year report soon, and we can provide you with those figures.

Suffice it to say that prevalence rates have risen, as you said. They have spiked and predominantly among underground coal miners in the Central Appalachian region of the United States and in smaller mines, although coal workers’ pneumoconiosis continues to be a nationwide problem.

We don’t have any data with regard to surface miners, and we’re awaiting, as Ms. Smith pointed out, the new MSHA coal dust rule, which goes into effect August 1st. At that time, surface coal miners will be covered, and we’ll be assessing the prevalence of coal workers’ pneumoconiosis in that population also.

Senator CASEY. Doctor, I want to make sure I got this right. What years was the prevalence 3 percent?

Dr. HOWARD. That was the lowest period of time, and that was 1995 through 1999. Since that time, throughout the decade of 2000, it has risen. Our latest numbers are 6.4 percent prevalence.

Senator CASEY. So more than double.

Dr. HOWARD. Exactly.

Senator CASEY. Thank you. I’ll have more questions for you for the record after the hearing, because I know we’ve got to transition here.

Before I wrap up, Solicitor Smith, I wanted to ask you about one part in your prepared testimony, where the Department states, “Survivors whose claims were denied more than 1 year ago have no avenue for relief.” I want to ask you what that means. Does it mean that survivors’ claims that were denied using evidence from Dr. Wheeler cannot be either reopened or modified if they were denied more than 1 year ago? And does it also mean that these survivors are unable under current statutes to ever receive benefits?
Ms. Smith. Unfortunately, yes, Senator. I will have to go back and give you my plain language view of res judicata. I'll try to explain that. Basically, a survivor's claim that was denied more than a year ago, as I discussed, could not be reopened. Then the question is could they file a new claim.

The basis of a miner filing a claim is that his condition could have changed since then. However, the issue in a survivor's claim is whether the death of the coal miner was caused by black lung disease. Because the coal miner was dead and is dead, there is no change in the condition of his death. So under the principles of res judicata, it's final. There's not a new issue to be dealt with.

This could be taken care of by legislation, which could allow a survivor whose claim was denied more than a year ago and who has Dr. Wheeler evidence to be basically legislatively relieved from the bar of finality and to reopen a claim, but it would have to be done through legislation.

It could also be done for miners through legislation. As I discussed with you before, a new claim for a miner is for a new time period. But in that situation, if they were relieved from that bar, they could go back to the date of their original claim. Right now, they cannot do that when they file a new claim.

Senator Casey. Thank you. So you've told us we need statutory change.

Ms. Smith. Exactly.

Senator Casey. Thank you very much, and I know each of us will probably have more questions, but we're going to transition.

Senator Casey. I want to thank all three of our witnesses for being here and for your testimony and for your public service.

We will go to panel No. 2, and I'll begin the introductions while our witnesses are taking their seats. I'll just run through the biographies for each so we can continue to move forward.

First, John Cline. John Cline is an attorney in Pitney View, WV, who specializes in the representation of Federal black lung claimants. Mr. Cline earned his J.D. degree from the West Virginia College of Law in Morgantown, WV.

Prior to starting private practice in 2005, he spent many years working on behalf of coal miners as a VISTA volunteer, Black Lung Association member, benefits counselor, and lay representative. Mr. Cline grew up in East Aurora, New York, and is married to his wife, Tammy, and is the father of three children.

Mr. Cline, thank you for being here.

Dr. John Parker has been practicing at West Virginia University since 1985. He has published numerous peer-reviewed studies and textbook chapters on occupational lung disease. He has consulted for the World Health Organization and the International Labor Office on issues related to respiratory diseases and traveled the world over doing teaching and training related to occupational lung disease.

He is currently a professor and chief of Pulmonary and Critical Care Medicine at West Virginia University. Dr. Parker is married to his wife, Christine, and has two children, Josh and Katie.

Doctor, thank you for being with us.

Robert Bailey, Jr., is a retired coal miner and member of the United Mine Workers of America with complicated black lung dis-
ease. He began working in the coal mines in July 1972 after graduating from high school. He retired after 36½ years due to the debilitating effects of black lung disease.

Mr. Bailey was born in Bluefield, WV, and has been married to Brenda Bailey for 41 years. They have three children and nine grandchildren.

Mr. Bailey, thank you for being with us.

Robert Briscoe, our fourth witness on this panel, is a principal and senior consultant with the New York office of the actuarial firm of Milliman. Mr. Briscoe specializes in the valuation and cost determination of individual large and long-term workers' compensation claims, particularly occupational disease.

He has worked on analysis of compensation for occupational lung disease since the early 1970s. He is also Director of the American Society of Workers' Compensation Professionals and New York Workers' Compensation Policy Institute.

Mr. Briscoe, thank you very much.

I'll ask our witnesses to keep your testimonies to 5 minutes, and we'll do a round of questions after that.

Mr. Cline, you can start.

STATEMENT OF JOHN CLINE, ATTORNEY, PINEY VIEW, WV

Mr. Cline. Thank you, Chairman Casey, Ranking Member Isakson, Senator Harkin.

As you know, the Coal Mine Health and Safety Act is intended to protect the health and safety of working miners and also to provide modest benefits when miners become totally disabled from black lung disease. Like all workers' compensation programs, it is remedial and intended to provide benefits at the time of need.

But in order to qualify, a disabled miner or widow must engage in fairly complex, adversarial litigation and must prevail against large coal companies with experienced attorneys and significantly greater resources. In addition, as revealed by the Pulitzer prize winning articles by Chris Hamby and the Center for Public Integrity plus the news coverage of ABC, the adversarial process is not only complex, but it has been abused by deceptive tactics by coal companies and their attorneys, or at least some of them.

In my written statement, I provided five examples, and I would like to focus my remarks today on the case of Gary Fox, who I represented near the end of his life. In short, Mr. Fox was born in 1950. After high school, he entered the Army and served in Vietnam. He worked as a coal miner for 32 years, from 1974 to 2006.

Three years later, he died of complicated black lung at the age of 58. He had what is being recognized now as a very aggressive form of complicated pneumoconiosis that seems to progress more rapidly. But if we take a closer look, there could have been a different outcome, in my opinion, if the purposes of the act had not been subverted.

In 1997, the West Virginia Occupational Pneumoconiosis Board issued a report to both Mr. Fox and his employer, Elk Run Coal Company, stating that Mr. Fox's x-ray findings were consistent with progressive massive fibrosis, another term for complicated black lung. However, Mr. Fox's treating physicians also were concerned about the possibility of lung cancer, and they removed a 5
centimeter mass from his right upper lung that, thankfully, was not cancer, but the local pathologist did not diagnosis black lung, even though he said it contained numerous anthracotic deposits.

Mr. Fox was still working but realized that he needed to get out of the dust and filed a claim for Federal black lung benefits. His claim was approved, but Elk Run appealed. Elk Run, who was represented by experienced attorneys from the law firm of Jackson Kelly, hired two expert pathologists who both found that the samples of Mr. Fox’s lung tissue actually were consistent with complicated black lung.

Lawyers and judges familiar with black lung litigation know that pathology is the gold standard and that Elk Run’s two expert pathology reports met the requirements for benefits under the act. In other words, Elk Run knew that Mr. Fox qualified. But Elk Run’s attorneys not only withheld those two reports, but also used the discredited opinion of the local pathologist to convince four reviewing expert pulmonologists and the administrative law judge that Mr. Fox did not have black lung at all.

Without black lung benefits, Mr. Fox continued working until 2006, when he was too short of breath to continue. When Elk Run’s deception was later disclosed to the administrative law judge who had denied his earlier claim, the judge aptly said that Elk Run’s actions “were really misleading the court, misleading the witnesses, and tainting the witnesses’ testimony.” So if Mr. Fox had prevailed in his first claim and been able to get out of the dust 8 years sooner as the act intended, his life may have been prolonged.

In response to Mr. Fox’s case and others, as mentioned earlier, the Department has announced that it will consider a new regulation requiring disclosure of medical evidence, “to ensure that miners have full access to information about their health and that accurate benefit determinations are made.” I would add that in a program that is intended to protect the health of miners, it makes no sense to withhold medical information that would adversely affect their health. Requiring the disclosure is the only way, I think, to properly protect the health of miners.

Mr. Fox asked me to pursue this issue. He knew it wouldn’t benefit him, but he dearly hoped that it would help others not to have to go through the same experience.

I just want to make a brief comment about the problem of administrative delays, particularly at the ALJ level, that are creating a great deal of hardship for claimants waiting for benefits and making it even more difficult for them to get legal representation. There is just an urgent need for more ALJs, more clerks, and more up-to-date technology.

Thank you for considering my remarks.

[The prepared statement of Mr. Cline follows:]

PREPARED STATEMENT OF JOHN CLINE

Chairman Casey, Ranking Member Isakson, and Senators, my name is John Cline, and I have represented miners and widows with Federal black lung claims as a lay representative from 1993 to 2005 and as a lawyer from 2005 to the present.

THE BLACK LUNG BENEFITS PROGRAM

When President Nixon submitted the Coal Mine Health & Safety Act to Congress in 1969, he recognized that:
“[d]eath in the mines can be as sudden as an explosion or a collapse of a roof and ribs, or it comes insidiously from pneumoconiosis or black lung disease.”

The purpose of the Act was to protect miners on the job and also to provide modest benefits to coal miners and their dependents in the event of a miner’s death or total disability from black lung.

Like other workers’ compensation programs, it is remedial and intended to provide benefits at the time of need. In order to qualify for the benefits, however, a disabled miner or widow must engage in fairly complex, adversarial litigation and must prevail against large coal companies or insurance companies with experienced lawyers and significantly more financial resources. As revealed in the Pulitzer Prize winning articles by Chris Hamby and the Center for Public Integrity, this adversarial process is not only complex but has been significantly abused by some coal companies and their attorneys.

THE BLACK LUNG CASE OF GARY FOX

In particular, the black lung case of Gary Fox that is featured in the first article by Chris Hamby is a tragic example of how the purpose of the Act was subverted by unscrupulous legal tactics. In short,

- Mr. Fox was born in 1950.
- After high school, he went into the Army and served in Vietnam.
- He worked as a coal miner for 32 years from 1974 to 2006, and
- Three years later, he died of complicated black lung at the age of 58.
- He was married and had a daughter, but didn’t live long enough to see either one of his two grandchildren.

But, if we take a closer look, there is an underlying story about how Mr. Fox tried to get out of the dust 7 years earlier by filing a claim for Federal black lung benefits and how his employer, Elk Run Coal Company (which is a division of A.T. Massey) defeated his claim by misleading its own experts and the Court:

- In 1997, Mr. Fox filed a claim for State black lung benefits, and the West Virginia Occupational Pneumoconiosis Board issued a report to both Mr. Fox and to Elk Run that said he had x-ray findings “consistent with progressive massive fibrosis,” which is another term for complicated pneumoconiosis or complicated black lung.
- Mr. Fox continued to work because he needed to support his family, but in 1998, his physician became concerned about the possibility of lung cancer. A lobectomy was performed to remove a 5 cm mass from his right upper lung. The local pathologist who examined the tissue samples said it was not cancer and described the mass as a pseudotumor with “numerous anthracotic deposits.”
- After recovering from the lung surgery, Mr. Fox went back to work in the mines but realized that he needed to get out of the dust before his breathing got worse. This time he filed a Federal black lung claim because the Federal program has an irrebuttable presumption of total disability when the miner has progressive massive fibrosis or complicated black lung. If the West Virginia Occupational Pneumoconiosis Board correctly found that he had “progressive massive fibrosis,” the Federal program would provide a modest monthly income to help support his family and also provide medical benefits for his declining pulmonary condition. His claim was initially approved by the DOL District Director, but Elk Run appealed to an administrative law judge.
- Mr. Fox tried unsuccessfully to find a lawyer, so he appeared without representation. Elk Run, however, was represented by experienced attorneys from the law firm of Jackson Kelly who hired two expert pathologists to review the pathology slides from Mr. Fox’s lobectomy along with his work record, and additional radiographic readings. Both experts found that the pathology was consistent with complicated pneumoconiosis and not a pseudotumor. Moreover, one of the pathologists reviewed an x-ray taken after the lobectomy and noted that Mr. Fox had radiographic evidence of even more large opacities that were consistent with complicated pneumoconiosis.


As stated by a long term defense attorney in an article published in the West Virginia Law Review in 2003, “Currently . . . [Federal black lung] claimants must confront the vastly superior economic resources of their adversaries: coal mine operators and their insurance carriers. Often, these parties generate medical evidence in such volume that it overwhelms the evidence supporting entitlement that claimants can procure.” William S. Mattingly, Id Due Process is a Big Tent, Why Do Some Feel Excluded from the Big Top? 15 W. Va. L. Rev. 791, 792 (2003).

See also Brian C. Murchison, Due Process, Black Lung, and Shaping of Administrative Justice, 54 Admin. L. Rev. 1025, 1030 (2002).
• Any lawyer familiar with Federal black lung claims would know that pathology is the “gold standard” for determining the presence of complicated pneumoconiosis and also would recognize that these two expert pathology reports supported Mr. Fox’s entitlement to benefits. However, despite being advised by its own expert pathologists that Mr. Fox had complicated coal workers’ pneumoconiosis and not a pseudotumor as the local pathologist had opined, Elk Run’s lawyers presented the local pathologist’s discredited report to its four reviewing pulmonologists and to the administrative law judge as though it was “all” of the pathology evidence.

• Based on the skewed opinions of those four pulmonologists that Mr. Fox did not have pneumoconiosis plus a number of negative x-ray readings by Dr. Wheeler at Johns Hopkins, the judge had no basis for awarding benefits and denied Mr. Fox’s claim.

• Without the black lung benefits, Mr. Fox continued working in order to support his family until 2006 when he was too short of breath to continue. He filed again for Federal black lung benefits and eventually prevailed.

• During the course of Mr. Fox’s second claim, I was his lawyer, and Elk Run went to extraordinary lengths to hide its deception in the prior claim, but eventually, after exhausting all of its options, Elk Run finally had to disclose those two expert pathology reports that would have entitled Mr. Fox to benefits in his previous claim.

• After Elk Run’s tactics were exposed, the judge who was misled in the prior claim aptly said, “That’s really misleading the Court. It’s misleading the witnesses. It’s tainting the witness testimony.”

• If Mr. Fox had been able to get out of the dust back in 1999, as the Act intended, he might have lived long enough to see his two grandchildren.

OTHER EXAMPLES OF EMPLOYER MISCONDUCT

Unfortunately, Mr. Fox’s case is not an isolated example of deception by employers in Federal black lung claims. As Chris Hamby and the Center for Public Integrity disclosed, there have been numerous other examples:

1. In the case of Elmer Daugherty (a miner for 42 years), the Jackson Kelly attorney representing his employer, Westmoreland Coal Company, submitted the “exam report of Dr. George Zaldivar” as if it were the entire report but had removed Dr. Zaldivar’s narrative finding of complicated pneumoconiosis. The West Virginia Supreme Court eventually determined that the lawyer’s conduct involved “dishonesty, fraud, deceit, or misrepresentation.”

2. The same tactic was used in the case of Clarence Carroll (a miner for 45 years), the Jackson Kelly attorney for Westmoreland Coal Company submitted the “report of Dr. Harold B. Spitz containing his interpretation of [a single] x-ray film” as if it were Dr. Spitz’s entire reading of that x-ray but did not disclose the fact that Dr. Spitz had read the same x-ray 2½ years earlier as part of a serial reading of five x-rays taken over several years. Dr. Spitz’s single reading said the x-ray was consistent with a high profusion of simple pneumoconiosis and the coalescence of smaller opacities whereas his more probative serial reading was consistent with complicated pneumoconiosis. As in the Daugherty and Caldwell cases, Jackson Kelly presented a misleading portion of a physician’s opinion as though it was his entire opinion.

3. In the case of Norman Eller (a miner for 39 years), Jackson Kelly was told by a leading expert that a set of chest CT images was incomplete and insufficient to exclude coal workers’ pneumoconiosis. Nevertheless, Jackson Kelly obtained and submitted two interpretations of the same incomplete CT images that were negative for coal workers’ pneumoconiosis. Like the Fox case, this intentional submission of unreliable evidence is misleading to the court.

5. And, more recently, we also have learned about an x-ray service that will obtain radiographic readings for employers and retain the ones that would favor the claimant.

Thus, there is ample evidence that the intentional skewing of so-called “medical” opinions by employers is fairly common and rarely discovered because the practice goes undetected whenever:

1. The claimant is pro se and does not know how to pursue discovery.
2. The claimant is represented by an attorney who does not pursue discovery.

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3. The claimant has an attorney who pursues discovery, but the claimant’s motion to compel discovery is denied by an ALJ, or

4. The claimant has an attorney who pursues discovery; the ALJ grants a motion to compel discovery; but then, the employer withdraws its challenge to the claim and accepts liability in order to avoid discovery.

Moreover, there is no practical remedy, particularly when an employer can avoid disclosure by simply agreeing to withdraw its challenge to entitlement and accept liability for a claim that the employer probably had no legitimate basis for contesting in the first place.

DOL’S RESPONSE

To its credit, the Department of Labor has taken some positive steps in response to these deceitful tactics that have been undermining the purpose of the Act. One very important step is the recent announcement that the DOL will consider a new regulation requiring the disclosure of medical evidence “to ensure that miners have full access to information about their health and that accurate benefit determinations are made.” Requiring the disclosure of all interpretations of radiographs and pathology slides is critically important because:

(1) It would provide a significant deterrent to fraud and deception, and

(2) It would be consistent with Section 923 of the Act, which requires adjudicators to consider “all relevant evidence” in determining the validity of claims.

In a program that is intended to protect miners, it makes no sense to withhold medical evidence that could have an adverse effect on their health, and I urge the committee to ensure that the Department implements this regulatory change as rapidly as possible.

In the meantime, however, as explained in a letter to the Secretary of Labor from Chairman Casey and other Members of Congress back in February, it would be a real setback if the Department of Labor implements a more restrictive discovery rule that would require a showing “exceptional circumstances” and the inability to obtain similar evidence without implementing the rule requiring disclosure of medical evidence in Federal black lung claims first. Otherwise, the “exceptional circumstances” rule would apply to black lung cases, and coal companies or their attorneys could employ deceptive tactics to defeat the meritorious claims of miners like Mr. Fox with virtually no fear of detection.

DR. WHEELER AND THE BLACK LUNG UNIT AT JOHNS HOPKINS

Another significant problem documented by Chris Hamby, the Center for Public Integrity, and ABC News was the availability of negative radiographic readings from the Black Lung Unit at Johns Hopkins and from Dr. Paul Wheeler in particular. Based on statistical evidence and Dr. Wheeler’s own statements, he was not properly following the official criteria for classifying radiographs. In more than 100 cases decided since 2000, Dr. Wheeler’s negative readings were contradicted by undisputed biopsy or autopsy evidence of black lung. And one of those miners is Mr. Bailey who is testifying here today.

To its credit, DOL has taken corrective measures to also address this problem. It has notified the District Directors that Dr. Wheeler’s radiographic readings are not entitled to probative weight unless the employer can provide additional evidence that would rehabilitate his interpretations. The Department also is notifying claimants whose claims contain negative radiographic readings by Dr. Wheeler that they may have a basis for refiling or requesting modification of a prior denial. I commend the Department for these actions.

ADMINISTRATIVE DELAYS

Finally, I would like to emphasize that massive delays in the processing of claims, particularly at the ALJ level, are creating huge problems for claimants. We have been advised that the caseload at the ALJ level has nearly doubled since 2004 and the number of ALJs for both Longshore and Black Lung cases has dropped from 45 to 36. As a result, the number of days it takes for an appealed case to be assigned to a judge has increased from 160 to 429. Put differently, the delay has gone from a little over 3 months to more than 14 months. And then, it still takes a number of months for a hearing date to be set and usually a year or more for the judge to

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6 30 U.S.C. 923(b).
7 Although the regulations set evidentiary limits to preclude unnecessarily repetitious evidence, an adjudicator can find “good cause” to exceed those limits in order to prevent the kind of deception described in the examples above. See 20 CFR § 725.456(b)(1).
I cannot emphasize enough that these long delays are causing huge problems for claimants. If a miner or widow is denied benefits at the District Director level but has a valid claim, it will take years for the miner or widow to prevail with no benefits during the interim. Or, if a claimant is awarded benefits by the District Director, the miner or widow has to live with the uncertainty that those benefits could be overturned on appeal, which means that the miner or widow may have to repay all the benefits he or she received while the award was tied up in litigation.

These long delays also make it much more difficult for claimants to obtain representation. It is completely unrealistic to expect that lawyers who only get paid if the claimant prevails will want to represent miners or widows if they also have to wait years to be paid an hourly rate for their time and will not be paid at all if the claimant does not prevail.

Thank you for considering my remarks.

Respectfully submitted by,

JOHN CLINE.

Senator CASEY. Thank you, Mr. Cline.

Dr. Parker.

STATEMENT OF JOHN E. (JACK) PARKER, M.D., PULMONARY SECTION CHIEF, WEST VIRGINIA UNIVERSITY DEPARTMENT OF MEDICINE, MORGANTOWN, WV

Dr. PARKER. Thank you, Chairman Casey, Senator Isakson, and Senator Harkin, for the invitation. Of course, I’m here today because of the power of the pen, the power of the pen to shine a light on injustice. We could all be reminded that the Coal Mine Safety and Health Act challenged us to have the first priority and concern of all in the coal mining industry to be the health and safety of its most precious resource, the miner.

As we’ve been hearing, unfortunately, black lung disease is not a disease of the past, and as a treating physician, I’ve cared for miners who have died at home, who have died in the hospital, who have died in the intensive care unit, who have died in hospice care, and who have died after lung transplantation has failed. I still grieve with their widows and their family members.

I understand that concerns have been advanced about the accuracy of the medical work of physicians in matters of compensation for coal miners. More specifically, I’ve been asked to provide testimony on the medical standards that should be used when coal miners’ chest x-rays are classified. I have also been asked to give a range of fees that physicians may charge to read such chest x-rays.

Let me provide a very short discussion about the diagnosis of dust related diseases. Workplace lung diseases are diagnosed during life with a history of exposure and an abnormal chest x-ray or lung function testing and no better medical explanation for the findings other than the workplace dust exposure.

Because of the important role of chest x-rays in establishing such a diagnosis, the quality and accuracy of chest x-ray interpretation is, of course, central to the process and quite critical. We’ve heard that the ILO classification system is that system, and NIOSH has provided education and training and certification of physicians for many years and devoted substantial resources to the NIOSH B Reader program.

\(^8\)It is my understanding that the lack of modern technology and a significant shortage of clerks as well as judges are contributing to the delays.
They also have quality assurance programs that produce very highly validated and accurate readings and diagnosis and that, in fact, have served as the gold standard for research and education around the world. I'm quite confident that if compensation programs for miners introduce quality assurance programs similar to those that NIOSH uses, it would add a layer of quality, integrity, and oversight that would significantly reduce the inaccurate readings.

Let me mention again that these diseases are preventable and that we've heard that regulation at 2 to 3 milligrams per cubic meter of ambient dust was in place for many years, and it's now been reduced to 1.5 milligrams per cubic meter of ambient air. I would like to clarify my written testimony that I used liters instead of cubic meters, which is common for physicians to make an error.

How much do B readings cost? Well, in my four-decade career, I've seen physician reimbursement for the ILO classification of images range from $2 a film to $100 a film. I've even heard of higher fees, but I would depend upon others to document that fee. Two dollars is what NIOSH paid readers in the 1980s and 1990s. The current NIOSH payment for digital radiographs is $12 an image.

Chest x-rays that are interpreted in a hospital and clinical setting for clinical purposes are currently reimbursed at about $9 per image, so for clinical purposes, $9 per image. And chest CTs are reimbursed at a higher rate of about $60.

Let me close by a short discussion about the professional integrity of physicians in compensation and litigation. I've been aware in my career of apparent systematic over-reading and under-reading in compensation matters. In the Judge Jack case in 2005, there was systematic over-reading of radiographs, and in a RICO claim of CSX Transportation v. Peirce in 2012, there was also over-reading. Chris Hamby and the Center for Public Integrity's report has outlined substantial under-reading.

NIOSH maintains a web page which is in full concert with the American Medical Association and the American College of Radiology. Realizing that the impartial objective and unbiased testimony has to be scientifically valid and capable to withstand peer review, that physicians have to be careful that their medical and legal and social implications from their readings are critical, I have no doubt that if all involved in the evaluation of miners for compensation utilize the principles embodied in these guidelines of professional societies that the Nation and its miners would be better served.

Thank you for your attention.

[The prepared statement of Dr. Parker follows:]

PREPARED STATEMENT OF JOHN E. (JACK) PARKER, M.D.

“The first priority and concern of all in the coal or other mining industry must be the health and safety of its most precious resource—the miner.”


Thank you for the invitation to provide testimony at this Employment and Workplace Safety Subcommittee hearing “Coal Miners' Struggle for Justice: How Unethical Legal and Medical Practices Stack the Deck Against Black Lung Claimants.”

I could not resist introducing the profound quote above as a preface to my remarks and comments. This meaningful quotation always reminds me of the noble mission and indeed the challenge that was issued over 45 years ago—to protect the miner from disease and injury.
The questions. It is my understanding that concerns have arisen about the backlog of unresolved claims at the Department of Labor’s (DOL) Office of Administrative Law Judges (OALJ). I also understand concerns have been advanced about the veracity of medical work performed by physicians and ethical questions about the legal work provided by attorneys representing mining companies in these matters of compensation claims for coal miners.

I have been more specifically asked to provide testimony focused on the consensus medical standards for reading or classifying chest radiographs of miners and the diagnosis or recognition of the presence or absence of pneumoconiosis. I have also been asked to explain common fee structures for evaluating such radiographs and to describe a typical range of reimbursement or fees charged by physicians.

I am honored to be asked to render testimony on these questions and issues.

My background. Let me briefly introduce the experience and training that I believe qualifies me to provide such testimony. I am currently a professor and chief of Pulmonary and Critical Care Medicine at West Virginia University Health Sciences Center. I am the program director of the Pulmonary and Critical Care Fellowship at West Virginia University. I am the director of the Adult Cystic Fibrosis Center. I have maintained an active clinical practice at West Virginia University since 1985, participating in the care of patients with pulmonary diseases, sleep disorders, and other life threatening illnesses in the intensive care unit. I have evaluated over 100,000 patients, research subjects, and/or their imaging studies, both nationally and internationally, for occupational lung diseases, including asbestosis, silicosis, coal workers' pneumoconiosis, occupational asthma, hypersensitivity pneumonitis, or malignancies.

From 1985 through 1998, I worked in a number of capacities for the National Institute for Occupational Safety and Health (“NIOSH”). I was the chief of the Examination Processing Branch at the Division of Respiratory Disease Studies for NIOSH from July 1991 through August 1998. In this position, I provided oversight for the NIOSH Coal Workers’ Respiratory Health Program as well as the NIOSH B Reader program, and served as teaching faculty for the American College of Radiology Viewbox Seminar on Pneumoconiosis. Additionally, I was the co-author of NIOSH Hazard Alerts regarding toxicity of silica in sand blasters, rock drillers, and construction workers.

I also developed a cooperative agreement with the Finnish Institute for Occupational Health for studying the health effects of asbestos on Russian asbestos miners and millers. Concurrently while serving as chief of the Examination Processing Branch, I was also the acting chief of the Clinical Investigations Branch and the acting chief of the Epidemiological Investigations Branch at the Division of Respiratory Disease Studies for NIOSH. I also served as the chief of the Protective Technology Branch of the Division of Safety Research for NIOSH. In this capacity, I supervised NIOSH research in workplace respiratory protection.

I offered extensive expert testimony in the In re Silica MDL about the proper methods for conducting an ILO classification (B-reading) of chest radiographs; generating a differential diagnosis of chest radiographic abnormalities, and the implausibility of thousands of claimants having both asbestosis and silicosis. I also testified in June 2003 before the U.S. Senate Judiciary Committee while they were considering “Fair Act” legislation, which related to establishing uniform medical criteria for asbestos related disease compensation.

I have consulted for both the World Health Organization and the International Labor Office (ILO) on many issues related to respiratory diseases. I have assisted the ILO in the 2000 and 2011 revision of the ILO system and on issues of quality assurance, training and the adoption of digital radiology, and the role of high resolution computed tomography.

I’ve published numerous peer-reviewed studies, a textbook and textbook chapters on occupational lung disease. I was an invited participant at three Helsinki criteria meetings, which addressed asbestos, asbestos-related diseases, and imaging methodology. I also served as a B Reader for ATSDR in multiple studies of health effects from potential exposure to tremolite in Libby, MT and was a co-author of a peer-reviewed published HRCT study of this cohort. I have made over 100 international trips to nearly 60 nations for research, teaching, training, or patient care, primarily related to occupational and infectious lung diseases. I have a passionate commitment to the recognition, prevention, and treatment of occupational lung diseases. The important role for imaging in dust related diseases has been of particular interest. I have also a strong interest in the ethical conduct of physicians as they have a sacred social contract with the Nation and its citizens to accurately present scientific truth in medical legal proceedings.
Lung diseases in miners. Let me provide the following short background discussion about dust related lung diseases, with an emphasis on coalmine related dust diseases.

The pneumoconiosis, silicosis, asbestosis, and coal workers’ pneumoconiosis are diseases related to the cumulative respiratory exposures to the respective dusts, and the lung tissue reaction to the dust. The diagnosis is made during life, typically without a lung biopsy, based primarily upon a history of exposure and latency, a compatible chest radiographic abnormality, and no better medical explanation for the findings than the dust exposure. These concepts are well described in medical textbooks and other medical literature.

The major radiographic system to establish the presence or absence of abnormalities in dust exposed workers is the International Labour Office (ILO) classification system, and this is also used in the United States, and NIOSH devotes staff and resources to administering a B Reader program, for education, training, and certification of qualified chest radiographic interpreters, or physicians.

Coal mine dust levels in coal mines have historically been regulated at about 2 to 3 milligrams of respirable dust per liter of ambient air. Respirable dust is dust that is five microns or less in aerodynamic diameter. The permissible respirable dust level has more recently been reduced to 1.5 mg/liter by the Mine Safety and Health Administration. This is an effort to further protect miners from the adverse health effects of coalmine dust.

These regulatory levels are in general agreement with enforced levels of exposure throughout the world. The science supporting this recommendation is well documented and is available for review in the publication—Criteria for a recommended standard: Occupational exposure to respirable coal mine dust (DHHS (NIOSH) Publication No. 1995–106).

Coal miners are at risk to develop several lung diseases from their mining exposures to respirable dusts, such as bronchitis, expiratory airflow obstruction, and the radiographic abnormalities of coal workers’ pneumoconiosis. Recent advances in the understanding of respiratory health issues in coal miners have focused on the spectrum of disease caused by inhalation of coal mine dust, termed coal mine dust lung disease (CMDLD).

This disease, CMDLD includes the classic occupational interstitial lung diseases such as coal workers pneumoconiosis (CWP), silicosis, and mixed dust pneumoconiosis, but also include the more recently described entity labeled dust-related diffuse fibrosis (DDF). Again, CMDLD is a preventable occupational disease that results from inhalation of coal mine dust into the lungs leading to parenchymal and airway damage, not only from the foreign material itself but also the tissue’s reaction to the dust.

As most readers of this testimony will know, Congress passed comprehensive legislation with the Federal Coal Mine Health and Safety Act of 1969. This Act went above and beyond previous legislation by providing for the first mandatory standards for working conditions in U.S. mines, a system for enforcement, and ongoing monitoring of miner health, as well as a mechanism for seeking financial compensation for coal miners who could demonstrate total disability arising from their dust exposure (aka “black lung”).

Since the time of this landmark legislation further acts by Congress and enforcement agencies have improved miners’ working conditions, which now fall under the purview of the Mine Safety and Health Administration (MSHA). Much of our improved understanding of the nature and extent of lung disease associated with mining coal in the United States over the past half century comes from the large number of studies performed by the National Institute for Occupational Safety and Health (NIOSH).

Despite increased understanding of CWP and previous reports of stable or improved dust levels in mines, dust-related respiratory disease remains a significant burden. Most worrisome are recent data suggesting that contemporary dust exposure is leading to rapidly progressive pneumoconiosis particularly in young miners, with a significant impact on pulmonary function and premature death.

Medical diagnosis of lung diseases in miners. Establishing a medical diagnosis of “black lung disease” requires several elements, including but not limited to, a careful medical history and examination, an occupational exposure history, the use of lung function testing, and chest radiographic imaging studies, along with considerations of alternative causes of any and all abnormalities identified.

For chest imaging, it is the ILO radiographic classification system that is the most widely accepted and standardized method to classify chest radiographs for the presence or absence of dust related radiographic lung injury. The system uses written guidelines, standard comparison films, and a recording or reading sheet.
The system provides a method to record findings, after classifying chest radiographs for film quality, parenchymal abnormalities, pleural abnormalities, and additional observations to allow systematic categorizations and/or comparisons between readers, using a common measure or standard. The lung parenchyma is assigned profusion abnormalities in one of four major categories. Category 0 designates normal films, and categories 1, 2, and 3 record progressive degrees of profusion abnormality. Profusion is further expanded into a 12 point scale. Major category 0 includes designations 0/0, 0/1, and 0/2; and so forth for major categories 2 (2/1, 2/2, 2/3) and major category 3 (3/1, 3/2, 3/3, 3/+).

It is noteworthy that the ILO system, including refinements over time has been used for over five decades, and is a critical tool that has provided the scientific data for exposure-response relationships in occupational dust diseases. This data has allowed the United States and nations throughout the world to establish protective workplace standards.

The ILO system has been consistently validated by workplace dust exposure histories, cumulative dust measurements, pathology, tissue mineral measurements, and additional radiological techniques such as high resolution computed tomography. When correctly applied without bias, the ILO system is a reliable tool to assess both groups and individuals for radiologic abnormalities from workplace exposures.

With this background, allow me to address the specific concern about application of consensus medical standards for reading or classifying chest radiographs of miners and the diagnosis of the presence or absence of pneumoconiosis, and the common fee structures for evaluating such radiographs, and to describe a typical range of fees charged by physicians.

The ILO system for classifying radiographs is the consensus standard medical method. Ideally, more than one reader should be used to reach consensus normal or abnormal. Science and experience has shown, multiple readers are more reliable than one reader alone with veto power. Typically, two readers with a third tie-breaker reader, or three readers by consensus have been the most widely used methods. NIOSH and other authorities have traditionally reached profusion consensus among three readers of the same PA radiograph based upon the median profusion classification.

Profusion is a concept embracing severity of disease of the lung parenchyma by comparison to standard example images. Again, the numerical designations 0/0 and 0/1 are normal or nearly normal, while designations with a number higher than 1 as the first numeral are abnormal. Most research, surveillance and compensation systems use 1/0 or greater as abnormal (the scale progresses to include 12 values 0/-, 0/0, 0/1, 1/0, 1/1, 1/2, 2/1, 2/2, 2/3, 3/1, 3/2, 3/3, 3/+). A median profusion consensus reading is the middle reading of the three classifications for profusion abnormality. For example, if the three reader classifications are 1/0, 1/1, 1/2, the consensus reading is 1/1; if classifications are 1/0, 1/1, 1/1, the consensus reading is 1/1, and so on.

As previously stated, the ILO system is highly validated with research comparing radiographic findings to pathology, exposure assessment, lung tissue mineral analysis, and other techniques.

Physician fees for radiographic readings. Information regarding fee structures. In my four decade career, I have seen the professional or physician reimbursement for the ILO classification of images, ranging from two dollars per radiograph to one hundred dollars per radiograph. Two dollars per radiograph was what NIOSH paid readers in the 1980s and early 1990s, in their research and surveillance programs. The U.S. Navy often reimbursed at about $6 to $8 per image for their asbestos related screening programs, during that time period. The current NIOSH payment for images in their coal miner surveillance program is $12 per radiograph. A chest radiograph professional interpretation in the hospital or clinic setting for clinical purposes is reimbursed at a lower rate than ILO classifications, and this is currently by most insurance companies about $9 per image. Chest computed tomography is reimbursed at a higher rate, about $60 per study. There is also technical component charge for radiographic imaging by hospitals or clinics, as they often own, operate, and maintain the radiographic equipment and supplies. For a single view chest that technical component reimbursement is about $12, and for Chest computed tomography it is about $150.

Integrity in science and medical testimony. Now a short discussion about profession integrity of physicians, in compensation and litigation of occupational lung disorders.

In my career, I have been aware examples of apparent systematic over-reading of radiographic abnormalities, as well as, systematic under-reading of radiographic...
abnormalities in dust exposed workers. Some of the apparent mis-application of the ILO system has led to concern about large scale fraud as outlined in the written decision from Judge Jack in the In re Silica MDL in 2005; and another Federal court decision, a Racketeer Influenced and Corrupt Organizations Act (RICO) claim in CSX Transp. Inc. v. Peirce, et al. in 2012. Other examples of potential mis-application of the ILO system have been outlined in the Center for Public Integrity reporting by Mr. Chris Hamby.

As I have explained before, these reports of systematic un-reliable diagnosis, give credence to justified and serious concern about bias and the lack of scientific independence or credibility of some physicians in compensation and medical legal matters. Are some medical experts not being “scientifically credible”; being “disingenuous and scientifically dishonest”; presenting testimony that is “invalid and scientifically wrong”; reporting incorrect medical decisions “not explainable as an ‘honest mistake’ or through lack of competence and skill”; but rather reporting medical findings that are the product of a purposeful and systematic pattern of incorrect reading that does not match the scientific literature?"

And again, rather than rely exclusively on my thoughts on this matter, I would refer readers to the NIOSH website that provides guidance to B Readers about the proper methodology for reviewing and classifying chest images, including ethics for contested readings.

The website contains some of the following succinct and forceful language, and I primarily quote NIOSH in the following:

“NIOSH has prepared ethical guidelines that should be considered when readers classify radiographs in contested settings.”

“Also, the American Medical Association (AMA) and the American College of Radiology (ACR) have published guidelines for physicians serving as expert witnesses (ACR 2007, AMA H–265.994, AMA E–9.07).”

“All of these professional bodies and these guidelines discuss the need to be impartial, objective, and unbiased. Testimony must be scientifically valid and be able to withstand peer review.”

“The NIOSH B Reader Code of Ethics is intended to assist B Readers in recognizing and maintaining a high level of ethical conduct. The outcome of chest radiograph classification can have important medical, legal, and social implications. It is critical that B Readers perform chest radiograph classifications properly and with integrity. This code, modeled after those of the American Medical Association (AMA) and the American College of Radiology (ACR), is a framework to help B Readers achieve this goal.”

**B Reader Code of Ethics is as follows:**

“The B Reader’s primary commitment is to serve the welfare and best interests of patients, workers, and society by striving to classify chest radiographs as accurately as possible.

B Readers shall uphold the standards of professionalism, be honest and objective in all professional interactions, and strive to report individuals or enterprises that they know to be deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

B Readers shall recognize the limitations of chest radiograph classifications, and shall not make clinical diagnoses about pneumoconioses based on chest radiograph classification alone.

When a contemporary chest radiograph is classified, the B Reader shall either take responsibility for assuring to the extent feasible that the examined individual is promptly notified of all clinically important findings or must be assured that another appropriate party is taking that responsibility.

B Readers shall respect the law; the rights of patients, other health professionals, and clients; and shall safeguard medical information and other confidences within the constraints of the law.

B Readers shall continue to study and apply advances or changes to the International Labour Office International Classification of Radiographs of Pneumoconioses as specified by the NIOSH B Reader Program.

In providing expert medical testimony, B Readers shall ensure that the testimony provided is unbiased, medically and scientifically correct, and clinically accurate.

B Readers shall recognize and disclose any conflicts of interest in the outcome of a chest radiograph classification. B Readers shall not accept compensation that is contingent upon the findings of their chest radiograph classifications or the outcome of compensation proceedings or litigation for which they undertake readings.

B Readers shall not advertise or publicize themselves through any medium or forum of public communication in an untruthful, misleading, or deceptive manner.
B Readers shall promptly report to the NIOSH B Reader Program any revocation or suspension of a medical license, voluntary relinquishment of a medical license or conversion to inactive status, or the voluntary surrender of a medical license while under investigation."

I have no doubt that if all involved in the evaluation of miners for potential adverse respiratory health consequences of mining utilized the principles embodied in these guidelines outlined by NIOSH and other professional organizations, the Nation and its miners, and its system of justice, would be better served.

"The first priority and concern of all in the coal or other mining industry must be the health and safety of its most precious resource—the miner."


PERTINENT REFERENCES


Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses.


Senator CASEY. Doctor, thank you very much for your testimony. Mr. Bailey.

STATEMENT OF ROBERT BAILEY, JR., FORMER COAL MINE WORKER, PRINCETON, WV

Mr. BAILEY. What is it like to have black lung? I thought I knew after spending so many years in the mines, but, really, I never knew until I got to this chapter of my life. Some days are a lot better than others. But every day is not a good day.

When I signed up for black lung, I was initially denied, as stated in medical records from Johns Hopkins Hospital doctors in a negative way. My doctor, Dr. Rasmussen, said I had complicated pneumoconiosis. The board that he represents—I’ve done several records from them, and they’ve always supported that I had black lung. I felt within myself that this disease was here. I couldn’t settle for the other reading, so I proceeded, and they also added that there could be other diseases. That’s another burden they lay upon you, and you wonder what to do. I had a lung biopsy—took three samples, said two mostly black, that I had complicated black lung. Then after that event, I was awarded my black lung benefits.

You get awarded, but it’s still not easy. It’s hard. You still have the disease. You struggle with the different things. And the other miners—which I’m fortunate. It took me almost 4 years. Other miners have been there a lot longer and they haven’t received anything, and a lot of it is through negative reading of the records.

So I hope to support them with this, what we do today, for those that are still trying to get their benefits and for those who haven’t gotten to where we are now. I hope to prevent them from experiencing that.
But the coverages, once you get them, you think that you’re covered. Social security gives me disability on pneumoconiosis and sleep apnea. But even now, I’m in the process of a lung transplant procedure. My black lung insurance provider does not want to approve evaluation procedures or a transplant, after being already approved twice through social security and the black lung program.

So that’s another thing that we have to face, not just the daily struggles of our disease, but the outcome of all uncertainty of ourselves and the other miners that we represent. I’m still thankful that I am a UMWA member, and I feel like I have a comfort zone. Someone is there that will help back me and will stand behind us. And just like everyone is here today—we’re here for the same reason. So I look to you all to help us to get that which we need.

For those that are not union workers, I feel a deeper compassion for them also, because they don’t have too many places they can go to for help, except maybe black lung clinics. They are limited, and they need more support from them. I would like to see Congress step in and make some changes to help process these claims that have taken so long for most miners to even receive. Unfortunately, most of them are turned down.

I know that to have this black lung disease, some of it is simple, some of it is complicated, and the more complicated it is, the more help that you need, financially and emotionally. But it’s not just the miners. It’s their families. Our families suffer just as much, if not more, than the miner himself. So my heart goes out to the families also.

I’d like to thank you, each and every one. I’m humbled to be here, and I’m honored. Thank you.

[The prepared statement of Mr. Bailey follows:]

PREPARED STATEMENT OF ROBERT BAILEY, JR.

Chairman Casey, Ranking Member Isakson, and Senators, my name is Robert Bailey, Jr., and I am a retired and disabled union coal miner with complicated black lung disease. I graduated from high school in June 1972, and began working in the coal mines in July 1972. I retired after working in the coal mines for 36 1/2 years due to having black lung disease.

I appreciate all the hard work that our elected officials have endured during these long struggles to get the changes that are needed. I also appreciate the support of the UMWA.

If you would ask me, “What it is like living with black lung disease,” I would think, “Where do I start?” First of all, living with black lung is hard. With this disease, I have had to learn to change my normal way of doing things to a much more simple way or just not doing it at all. Living with black lung is thinking about every breath you take. Breathing is something most people take for granted as it is a normal involuntary function of our bodies. It comes natural as we walk, do our daily jobs, come and go. But with this disease, I am reminded constantly as I struggle to breathe whether I am simply walking up my slight incline of a yard, or grocery shopping or trying to participate in Operation Compassion at our church when we give out food. My wife says she can see the pain on my face as I struggle to take in enough oxygen to do those things in my life. There are days that I feel so bad that I end up doing mostly nothing all day. I feel like this disease has taken about 80 percent to 90 percent of my active life away. I have always been an active, hardworking person who always had a hard time sitting still.

With this disease, I end up with infections in my lungs and my breathing gets so bad that I have no choice but to go to the hospital. There, they pump me full of IV Antibiotics, steroids, nebulizers, etc. to build my system back up for a while. I am now having a once a month IV treatment at the hospital in hopes that it will help keep the infections down. I leave the hospital feeling better, strap on the oxygen tank, and thank God for another day to try again.
When I originally filed for Black Lung Benefits in 2009, I had worked as an underground coal miner for more than three decades in very dusty conditions and had never smoked except for sneaking cigarettes for a few years as a teenager. I was denied because Dr. Wheeler gave a negative reading of my x-ray. In other words, he gave his opinion that I didn’t qualify for black lung or didn’t have severe black lung. I feel that Dr. Wheeler’s negative reading was given more weight simply because he graduated from Harvard University and worked at Johns Hopkins, than Dr. Rasmussen’s reading who is also a very accredited doctor in the Black Lung field with years of studying coal miners and their disease.

I continued my claim and was finally, after nearly 4 years, awarded my Black Lung Benefits by a Federal Judge from Washington, DC, after much further testing, x-rays, MRIs, and a lung biopsy. They took three samples of my lungs and two of those samples were stated as “mostly black.” The final result of the lung biopsy was “complicated Pneumoconiosis.”

My lung doctor, Dr. Vasudevan of Princeton, WV, and I talked about the possibility of a lung transplant. His office started trying to find a hospital willing to see me to be evaluated for a transplant. We found Inova Fairfax Hospital in Falls Church, VA. The financial coordinator contacted Underwriters Insurance which I have through Patriot Coal as my insurance for anything related to black lung disease. Underwriters in turn approved a one-time evaluation. My one-time evaluation was scheduled for February 11, 2014.

After this initial evaluation, it was determined by Dr. Steven Nathan that I needed a transplant and in his words “you are in the perfect window of opportunity for a transplant.” This would require a complete evaluation of testing which would have to be approved through the Underwriters Insurance. My next appointment was scheduled for May 27 for a followup (a regular checkup) with Dr. Nathan, but I received a letter of denial from Underwriters so this appointment was rescheduled for June 12. I started on the trip for this appointment without knowing if it would be approved. Finally, as I was halfway there, I received a phone call from Inova saying this visit was approved. When I got back home, I received a letter from Underwriters (from the attorney with Bowles Rice) stating that they authorized the June 12 appointment but do not authorize any lung transplant procedure and that Patriot reserves the right to approve or disapprove any further testing or transplant in keeping with the “applicable regulations and law.”

As I write this letter, I am here in Fairfax for the week for all of the additional evaluation testing required to determine my eligibility for a lung transplant. I have no idea if this week of testing will be approved and paid for nor do I know if after all this testing, the insurance will agree to the transplant since Patriot is reserving their right to approve or disapprove based on the “applicable regulations and law.” Today, as I write this letter, Underwriters has not sent me any letter of approval or denial concerning this week of testing.

I worked in the coal mines for 36½ years. Through the years, I have met a lot of good men who became like family. We were all there to make a living and none of us deserved this terrible disease, but sadly, there are a lot of us going through this. When I was working, I knew a lot of my co-workers who were afraid to have this x-ray. I knew that the company was afraid that the hospital would be used against them somehow, and they would lose their jobs. Even now, when a coal miner files for Black Lung Benefits, they know they are in for a battle. I just recently met a man who fought for 11 years and just recently won his benefits. He told me he was ready to give up several times but held on through much encouragement from people in the Black Lung Clinic.

It seems like the coal companies and/or the insurance company wants to put you off as long as possible hoping you will give up or die before they have to pay any benefits. In my case, I have been awarded my Federal Black Lung Benefits and Disability Social Security benefits based on my black lung disease. Yet, Patriot Coal wants to reserve the right to approve or deny my testing or transplant. Patriot’s lawyers said they would need to review the medical records again (a stall tactic) and want to definitely determine the disease process present in the lungs.

I feel like I need to prove over and over again that I have this terrible disease. I feel that the “applicable laws and regulations” mentioned in the letter need to be changed to protect the diseased coal miner more than the coal companies. I’m hoping you can help me and all other coal miners who have this amount of medical evidence and physical needs to be approved in a more timely manner and can stop the long drawn-out stalling techniques by using policies and criteria that help the insurance company and coal operators, but do nothing for the coal miners who are dying from black lung disease. There are coal miners who have died waiting on the approval for a transplant. Policies and laws need to be changed to give hope and life to those who don’t have time for stall tactics. Once a coal miner has been award-
ed his Federal black lung benefits and no appeals were made in protest by the company, there should be no question about paying for anything concerning the coal miner's health and quality of life.

Senator CASEY. Mr. Bailey, thank you for your testimony and for your presence here today to bring your own story to this issue. We're grateful.

And, finally, Mr. Briscoe.

STATEMENT OF ROBERT BRISCOE, WCP, PRINCIPAL AND SENIOR CONSULTANT, MILLIMAN, NEW YORK, NY

Mr. BRISCOE. Mr. Chairman and members, if I could correct the record, my firm is not a law firm. It's an actuarial firm. I'm here having spent almost 40 years measuring the things that are going on in the Federal black lung program. Primarily, what my staff and I do is calculate the dollar liabilities for these claims or pretty much every entity out there that ends up having to pay one.

I think you've heard today a number of times several key words. One of them is latent and progressive. The other is complicated pneumoconiosis. That's not the whole story. It is certainly regrettable, and my heart goes out to the coal miners who have serious lung disease. There is no question that I think the process should be and could be made better, certainly faster, to deal with those people.

I would point out, though, that those people are a very small fraction of the total universe of claims that go by every day. We're really talking about three diseases here. They are separate and distinct diseases. Complicated pneumoconiosis is, without question, latent and progressive. Simple pneumoconiosis, which is the majority of the cases that have ever been compensated for Federal black lung, is controversial, but there are strong arguments that it is neither latent nor progressive, and if it is, it's to a very small degree, very few people.

The other disease, which has not been mentioned yet today, is chronic obstructive pulmonary disease—all the other lung diseases, emphysema, asthma, bronchitis, that the general population experiences and the coal mine population experiences. The difference here—and it's a very important difference—is that the prevalence of smoking in the eastern underground coal mine populations is four times higher than it is in the general population, which means that the prevalence of COPD is that much higher.

What DOL has done in the latest 2001 regulations has been to try to apply to all black lung claims the latent and progressive issues that really are associated with complicated pneumoconiosis. And we are well on the way, as we sit here today, toward entitling claims where the claimant's principal lung problem is COPD. Perhaps there's a small fraction of black lung mixed in with that, and this is a very, very difficult medical-legal conundrum with respect to how these claims should proceed.

I would point out—and I do work in pretty much all 50 State workers' comp programs and have for many, many years—that the U.S. workers' compensation is very rapidly moving toward evidence-based medicine. All the major workers' comp States have medical treatment guidelines and disability rating guidelines that require evidence-based medicine to be applied. The concepts that
are embedded in DOL's preamble to the 2201 regs are pretty much in the opposite direction of that, and the program faces very great difficulties going forward trying to sort all of this out.

I think that, without question, the miners who have very serious lung disease should be compensated, and they should be compensated rapidly. And I would point out that in my experience, the vast majority of claimants who have been diagnosed with complicated pneumoconiosis have had their claims paid, unfortunately, not as rapidly as perhaps they should be because of the litigation process, both administrative, the DOL, and the Office of ALJs.

But the large body of claims that have always moved through the system—there’s been over 700,000 coal miners compensated for black lung since 1970. Since 1973, when the burden of paying for those claims was shifted to the coal mine operators, what is little understood, I think, is that these claims are very expensive. They're at the high end of workers' compensation claim cost. A married miner in his midfifties will eventually receive something on the order of half a million dollars.

So because these claims are extremely expensive, that obviously generates litigation. What the Federal black lung program has not done, which the successful black lung programs operating in the major coal mine States did long ago, is to introduce a gradient of disability that pays more toward the very serious injuries, serious claims, and less toward the others and/or permits settlements of the claims, which DOL has adamantly refused to do over the history of the program.

So I certainly would suggest that any and all things that can be done to speed up the adjudication process for those claimants with serious lung disease should be explored. But I think that we need to also focus on the bulk of the claims with lesser, if any, degree of disability arising from coal mine dust and try to make the program responsive to the full spectrum of the diseases that are arising out of coal mining.

[The prepared statement of Mr. Briscoe follows:]

PREPARED STATEMENT OF ROBERT BRISCOE, WCP, PRINCIPAL AND SENIOR CONSULTANT, MILLIMAN INC.

Thank you Mr. Chairman and members of the subcommittee for the opportunity to appear to share my thoughts on the Federal Black Lung program—a subject area I have 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 known 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 15 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 15-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, 92d 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 25-year presumption was added and the Labor Department was directed to re-examine all claims which had been denied prior to March 1, 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 were denied at the administrative level at DOL and in the Federal courts on the specific criteria 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 by 1995 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 percent range in the Eastern coal fields. A 10-percent 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 provided for the award of benefits where 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 of 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 94 percent 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 exposure. 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 percent. 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 percent vs 20 percent—25 percent in the general population. The medical literature suggests that 25 percent–30 percent 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 percent to 26 percent range. In fact the approval rate is at 23 percent in one major Eastern coal mining State (Virginia) and is approaching the 15 percent range in the other Eastern coal mining States. If the approval rate passes the 25 percent 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
Claimants cannot get paid twice—Federal benefits are reduced dollar-for-dollar by State benefits on a monthly basis.

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 policies. 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 workforce today, usually in his mid-fifties, 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 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 year. The result is that a Federal Black Lung claim for a married miner in his mid-fifties 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 workforce, and from the tens of thousands of miners who exited the workforce 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 20 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:

1Claimants cannot get paid twice—Federal benefits are reduced dollar-for-dollar by State benefits on a monthly basis.
(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.

Senator CASEY. Mr. Briscoe, thank you very much. I know we just had a vote that was called, so I'll be brief in my first question or two, and then I want to turn to Senator Harkin so he can ask his question or two, whatever he has, and then be able to vote.

Mr. Cline, I wanted to focus on the end of the recitation of the case of Mr. Fox. I want to make sure I heard you right. You talked about what happened to him, and I'm looking at your testimony where you say,

“If Mr. Fox had been able to get out of the dust back in 1999, as the act intended, he might have lived long enough to see his two grandchildren.”

I want to make sure I understood the timeframe here. You're saying that, in essence, he was in the mines, working for—I thought you said something on the order of 8 years that he would not have been working had there been a different determination made, a determination that flowed from the fraudulent pathology reports. Is there anything about that that I'm not stating accurately?

Mr. CLINE. Yes, you have that correct, Senator.

Senator CASEY. So just walk through again why he was in the mines for—you said for 8 years.

Mr. CLINE. He filed his first claim in 1999 and was initially approved but lost on appeal. And because he didn't have the modest benefits from the workers' compensation program, he needed to continue to work to support his family. So he worked until 2006 when he was just too short of breath to continue. He progressed during that time period from mild impairment to severe impairment and was in need of a lung transplant. He filed a second claim, and in the second claim, he prevailed, in 2008, 1 year before he died.

Senator CASEY. In terms of what Congress can do or should do, in your judgment, what would you hope we would do if you had to itemize one or two actions you would hope we'd take?

Mr. CLINE. The first would be to require the disclosure of at least all radiographic interpretations and pathology interpretations developed for the purpose of litigation just to protect the miner's health and to deter misleading the judges.

Senator CASEY. I may have more questions for you. I wanted to go to Mr. Bailey before turning to Senator Harkin.

Mr. Bailey, thank you for the testimony. It's very difficult, I think, for any witness to come before a panel in the U.S. Senate to talk about your own life and your own experiences. That's particularly difficult. With no disrespect to other witnesses here or on other occasions, it's easier to talk about something when it doesn't involve your own individual experiences and that of your family. So we're especially grateful for your willingness to talk about not just an issue or a public policy question, but really a question that involves your work, your life, and your family.
You expressed in going through your testimony—as much as you focused on your own experiences and your own work situation, you talked as much about others as you did about yourself. And, in particular, you talked about those who don’t have the representation that you’ve had with the United Mine Workers.

I’m assuming that you know other miners now, or have known them over the years, that did not have representation and were on their own. Could you talk about that or highlight some of those friends of yours or people you’re acquainted with?

Mr. Bailey. Thank you. A lot of the miners that don’t work at union mines—it’s like one on one. You’re there yourself. You’re alone. You’re sometimes lucky to even maintain your job, much less receive any benefits after that job is over due to illness and different reasons. So it makes it very hard for them to get what they need, because they don’t know where to go.

Senator Casey. I’ll turn to Senator Harkin, because I know we’re short on time. Thank you.

The Chairman. Thank you, Mr. Chairman.

Mr. Cline, when you take these cases, is there any compensation you receive, let’s say, at the first instance or maybe at the first filing or after the first appeal? Or do you have to wait until the absolute end before you get compensated?

Mr. Cline. You have to wait until the absolute end, until the claim is finally decided, and you only get paid if the claimant prevails.

The Chairman. And that could be a couple of years or 3 years.

Mr. Cline. It’s more like four or five or longer, Senator.

The Chairman. I’m very familiar with that—and I’m sure you are, Mr. Chairman—the social security claimants’ representatives, NOSSCR, the National Organization of Social Security Claimants’ Representatives, where the lawyers take up social security disability claims that have been denied, and then they go through the appeal process.

But it seems to me that there has to be some way of, in the first instance, helping attorneys be able to represent them and to be compensated somewhat along the track. Otherwise, how are attorneys going to pick up the cases?

Mr. Cline. The legislation you’ve been working on with Senator Rockefeller and Senator Casey is a step in the right direction. Then if the claimant prevails at the administrative law judge level, they might get some payment without waiting until the case is finally——

The Chairman. Exactly. That’s in our legislation, and we hope to have it introduced, I hope, Mr. Chairman. But I wanted to make that point clear. That’s why you don’t get many attorneys taking this up. I mean, they have families to feed. They’ve got things they’ve got to do.

Mr. Cline. Absolutely.

The Chairman. So they can’t continue to just hope that 4 or 5 years from now they’re going to get paid.

Mr. Cline. It’s a ridiculous expectation. I wanted to add, if I could, just one thing. Mr. Bailey and Gary Fox both had simple pneumoconiosis before they had complicated pneumoconiosis. If simple couldn’t progress, they wouldn’t get complicated.
The CHAIRMAN. Dr. Parker, let me just ask you—is black lung disease a progressive illness?

Dr. PARKER. Yes, sir. Absolutely, yes, sir. It can progress after coal mine dust exposure ceases, and it can be certainly progressive while coal mine dust continues to accumulate in workers' lungs.

The CHAIRMAN. I thought I heard from Mr. Briscoe, or at least in his written testimony, in which he said that once you're out of the mines, it doesn't progress anymore. He said, “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.”

Mr. Briscoe, is that so? Are there 40 years of evidence?

Mr. BRISCOE. Yes, sir, there are. That is the predominant medical literature. We're not saying it never progresses. It certainly can in isolated cases. The question is one of degree. Does simple pneumoconiosis progress in every case? We don't believe so.

The CHAIRMAN. I'm just a layman at this, but I watched what happened to my own father. When he was younger, we all assumed he had black lung, but that was before people called it that. But all those people who worked in mines, as they progressively got older and their systems became less immune to illnesses and stuff, they became more and more inundated with things like pneumonia, lung problems, things like that.

In other words, when you're young, perhaps the effect of simple black lung or pneumoconiosis—I can hardly pronounce it—is not that pronounced. But as you age, it becomes more pronounced on you. That's why I keep telling people that don't think about black lung as something that totally disables a person—what about someone like Mr. Bailey that can't even play with his grand kids, can't even go for a walk? I mean, it's that kind of a situation that really takes away your enjoyment of life in your sixties and seventies.

Mr. BRISCOE. Senator, we're really talking about two separate issues here. The medical literature indicates that simple coal workers' pneumoconiosis—let's say somebody leaves the mines with category one simple pneumoconiosis. It is very rare for that claimant to develop category two or three. The x-rays don't progress.

Lung function does decline with age. It can also decline with smoking. It can decline for lots of other reasons. The issue is causality here. Does coal mine dust exposure causing a category one black lung situation—is that going to progress to category two or three down the road? The answer is there's no basis in the literature for that.

The CHAIRMAN. Dr. Parker.

Mr. BRISCOE. Will the lung function decrease? Yes.

The CHAIRMAN. Dr. Parker.

Dr. PARKER. NIOSH has a coal mine dust criteria document that was published a number of years ago, and it's the basis of MSHA changing some of the recent rulemaking. And it, along with substantial medical literature, makes it very clear that lung function and radiographic change can progress after dust exposure ceases.

The CHAIRMAN. Mr. Bailey, thank you for being here, and thank you for fighting the good fight and not giving up. You're a strong...
person and don’t give up. Keep fighting, and I hope you get that lung transplant.

Mr. Bailey. Thank you, and I’d like to add that I’m also a non-smoker.

The Chairman. I read that in your testimony. You haven’t smoked since you were a teenager or something like that?

Mr. Bailey. Yes. I used to sneak around at 13 or 16, when I could.

[Laughter.]

The Chairman. Exactly.

Mr. Bailey. I learned better.

The Chairman. Thank you, Mr. Bailey.

Thank you, Mr. Chairman.

Senator Casey. Mr. Chairman, thank you, and we’re grateful that you’re here with us and grateful that you have been in the trenches on these issues for many, many years.

I know we have to vote, but before we wrap up—and I have a number of questions for the record that I’ll submit.

Mr. Bailey, you submitted a picture to us of you. I guess this is you over here, second from the right on the back. I won’t ask you to identify everybody.

Mr. Bailey. The good-looking one.

[Laughter.]

Senator Casey. Well, let me wrap up. I know that we have lots more we could cover. But let me wrap up. First, we’ll have a period within which other Senators can submit questions for the record.

And as Chairman Harkin noted, we’re working with Senators Rockefeller, Harkin, and Manchin, and Representative George Miller to continue working with the Department and NIOSH to make sure we’re doing everything we can to level the playing field for hardworking miners who have had the misfortune of developing black lung disease and now face the uphill battle, the struggle for benefits.

For all witnesses, please know that members may want to submit additional questions for your written responses, as I mentioned.

And for members who want to submit statements for the record or questions, the hearing record will be open for 7 days. And with that, unfortunately, because of time, the hearing is adjourned.

Thank you very much.

[Additional material follows.]
Senator Casey, thank you for holding this very important hearing today to discuss pneumoconiosis, commonly referred to as “Black Lung” disease. There are few Members of Congress who match your commitment to protecting the health and safety of our Nation’s coal miners, particularly as it relates to this debilitating and deadly disease.

Today’s hearing provides an important opportunity to both educate our fellow Senators about how this terrible disease impacts coal miners and their families, and impress upon our colleagues our shared obligation to make sure that coal miners who are suffering get the benefits they deserve under the Federal Black Lung Benefits Program.

I look forward to hearing from our distinguished panel of government officials who will testify about our Federal Black Lung program and how we can improve it: Deputy Secretary of Labor, Christopher Lu, who oversees many Federal programs that are important to our coal miners; Solicitor of Labor, Patricia Smith, who defends our health and safety laws against a seemingly endless barrage of attack from companies who would rather do the bare minimum when it comes to protecting their employees from injury and illness; and Director of the National Institute for Occupational Safety and Health, Dr. John Howard, whose agency monitors the prevalence of Black Lung disease and whose work has proved invaluable to our understanding of how we can protect miners from developing this disease in the first place.

We are also extremely fortunate to have three West Virginians testify today, each of whom is on the front lines of the battle to make sure that coal miners suffering from Black Lung disease are provided the benefits and treatment they so badly need and deserve: John Cline, an attorney who has devoted his career to litigating cases on behalf of coal miners and widows suffering from this dreadful disease; Dr. Jack Parker, Pulmonary Section Chief from the West Virginia University Department of Medicine and a recognized expert on Black Lung disease; and Robert Bailey, a former coal miner who knows first-hand what it is like to struggle each and every day with Black Lung disease and the unfair burden our laws and litigation system place on miners who are simply trying to access their Federal benefits.

Since first coming to West Virginia 50 years ago, to the small mining community of Emmons, I have spent countless hours talking with miners and their families about the toll this devastating and deadly disease takes on men and women who have worked their entire careers mining coal. They tell me that everyday activities most people take for granted—walking from one room of the house to another, mowing the lawn, hunting and fishing, playing with their grandchildren—become all-but-impossible. These once vibrant, strong, independent men and women find themselves confined to a chair in the living room, hooked up to an oxygen tank nearly 24 hours a day just so they can continue breathing.

Listening to their stories reaffirms in me the simple yet extremely important principle that coal miners—who work long hours
to support their families—should not have to live in fear that 1 day they will develop a respiratory disease that will prevent them from experiencing the simple joys in life.

One of the most troubling aspects of the public debate over Black Lung disease is that many people believe it is a thing of the past—that somehow coal miners are no longer at-risk of developing the disease. The sad reality, however, is that the disease is very real and on the rise in coal mining communities throughout the country.

In the 1970s, shortly after Congress passed major legislation to combat Black Lung disease, 6.5 percent of all active coal miners had the disease. By the 1990s, that number had dropped to 2.1 percent. But, in the 2000s, we saw the prevalence of Black Lung disease increase to 3.2 percent—the first increase of the disease in three decades. Between 1999 and 2009, almost every single region in the country saw an increase in the percent of miners suffering from Black Lung disease. Some areas in West Virginia, Pennsylvania, Virginia, and Kentucky are seeing rates as high as 9.0, 10.0, and even 13.2 percent.

Sadly, research is also showing that younger miners are now developing more progressive forms of the disease earlier in their careers. These findings were confirmed as part of the investigation into the Upper Big Branch disaster, which took the lives of 29 coal miners in West Virginia. Autopsies of 24 victims revealed that 17 of them, or 71 percent, suffered from Black Lung disease. Even more alarming is that five of those victims with Black Lung disease had been working for less than 10 years underground, including one miner who was only 25 years old. So, while the explosion that took their lives did so almost instantaneously, another disaster, hidden from view, was taking their lives more slowly—but just as tragically.

This rise in Black Lung disease is unacceptable. Congress and the Administration have a solemn obligation to provide coal miners with every protection from this debilitating, incurable, but preventable disease. That is why I was proud to join Secretary of Labor Thomas Perez in West Virginia in April to announce the finalization of new rules that—for the first time in 40 years—will lower coal miners’ exposure to the respirable dust that causes Black Lung disease. The Administration should be commended for taking this major step forward. With strong enforcement and implementation, these rules will undoubtedly save lives and improve the quality of life for current and future generations of coal miners.

While the primary purpose of that rule is to prevent Black Lung disease, today's hearing rightly focuses on the equally important goal of providing assistance to miners who already suffer from this dreadful disease. Sadly, as we will learn from today's testimony, accessing Federal Black Lung benefits remains an uphill battle for coal miners and their families.

Congress has long known that coal miners with Black Lung disease are at a tremendous disadvantage when attempting to access Federal benefits. Several years ago, I asked the Government Accountability Office to conduct a comprehensive review of the Federal Black Lung Benefits Program and to identify barriers that miners, as well as their survivors and dependants, face when ap-
plying for benefits. That report, released in 2009, concluded that “there are a number of administrative and structural problems that could impede the ability of eligible miners to pursue claims.” Among the challenges identified in that report were a difficulty finding legal representation and developing sound medical evidence, as well as a lack of financial resources to cover the costs associated with supporting their claims.

The findings of that report are extremely troubling—but last year we learned from a Center for Public Integrity and ABC News investigation that the problems in our Federal Black Lung Benefits Program are much worse than many of us had imagined. That investigation confirmed not only that miners have fewer legal, financial, and medical resources, it also documented numerous cases in which coal operators and their attorneys intentionally withheld evidence of the existence of Black Lung disease from miners, widows, and even judges. At least one company-hired doctor profiled in that investigation had never diagnosed a miner with complicated pneumoconiosis in more than 1,500 cases since 2000.

In other words, under our current system, miners with little or no financial resources are forced to litigate their claims against deep-pocketed coal operators, some of whom—with help from corporate lawyers and hired doctors—are all-too-willing to engage in unethical practices to evade responsibility for paying monthly benefits and health care expenses for miners suffering from Black Lung disease. These reports and investigations make absolutely clear that our system is broken and must be reformed.

To make matters worse, these cases can literally drag on for years, depriving coal miners of the certainty that should come with qualifying for Federal Black Lung benefits. Some of these delays result from seemingly endless appeals and may require structural reforms to the program, but Congress can also help by providing funding to hire additional administrative law judges to decide these cases in a timely manner. Right now, it takes 429 days for a Black Lung case just to be assigned to an administrative law judge. That is way too long.

To be clear, the Democratic majority in Congress, along with President Obama, has taken action in recent years to improve our Black Lung system. As part of the Affordable Care Act, we passed one of the most significant protections for victims of Black Lung disease in decades. That law restores a presumption that long-term miners with disabling respiratory impairments are entitled to Black Lung benefits, and also automatically entitles widows to Black Lung benefits if their spouses were receiving benefits at the time they passed away.

The Department of Labor has also been working to restore fairness to our Black Lung system by establishing a new pilot program to help miners develop additional medical evidence to support their claims; partnering with the National Institute for Occupational Safety and Health to train its staff on medical and scientific issues associated with Black Lung claims; instructing its staff to disregard medical reports from at least one doctor whose diagnoses have proven to be unreliable; and, notifying claimants of their right to reopen their cases if that doctor’s testimony resulted in the denial of their benefits.
The Department has also announced that it will be working on a new rule to address issues surrounding the disclosure of medical evidence in Black Lung cases. This is an issue I raised with Secretary Perez earlier this year, and I am continuing to urge the Department to do everything in its power to prevent coal operators and their attorneys from misleading our courts and withholding critical medical evidence from miners and their families.

I appreciate the Department’s willingness to take steps to make sure that miners can access the Federal benefits they deserve, but I also believe that Congress itself has an obligation to look at our laws and make corrections when injustices arise.

Senator Casey and I have a bill, The Black Lung Health Improvements Act, which addresses some of the systematic problems we have seen in our Black Lung system. Our legislation expands miners’ access to medical evidence; creates a program to help miners secure legal representation when applying for benefits; and, makes grant funding available for research into the disease. He and I are now working together with Senator Harkin, Senator Manchin, and Congressman George Miller to revise and update that bill to address some of the newer issues that were raised in the Center for Public Integrity and ABC News investigation.

I am confident today’s hearing will provide invaluable information that will help us craft a bill that restores fairness to our Black Lung system and provides miners, their spouses, and dependants with the support they need and deserve.

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PREPARED STATEMENT OF SENATOR MANCHIN

First, I would like to thank Senator Casey for holding this hearing. Black lung and our miners who suffer its devastating effects do not get the attention they deserve. We need to work together to do everything in our power to end black lung and I appreciate the committee recognizing this need.

I would also like to thank all of the witnesses, including those from West Virginia. Specifically, I appreciate Mr. Bailey taking the time to share his experiences.

I am proud to come from West Virginia, where we produce the coal that has powered this Nation for more than a century. Our miners have mined the coal that keeps our lights on, heats our homes and powers our businesses and it is unacceptable that they still face the threat of black lung disease.

As Governor and as a U.S. Senator, the health and safety of our miners has always been and will continue to be my top priority. During my time in the Senate, I am proud to have worked with Senator Rockefeller, as well as Senators Casey and Harkin, to ensure that our miners have every available opportunity to access black lung benefits. As we saw with the ABC News and Center for Public Integrity reports last year, too often our miners face insurmountable obstacles to access benefits they have undeniably earned. Since those reports, our offices have worked to address concerns with the Department of Labor’s proposal to change evidentiary standards in black lung cases that could unfairly burden miners, and we have come together to voice opposition to cuts in funding to the Office of Administrative Law Judges. Our offices,
along with Congressman George Miller, continue to work on legislation to more fully address the issues raised in the CPI and ABC News Reports.

I am also proud to have worked with Senator Rockefeller and Congressman Rahall to fight for adequate Federal funding for West Virginia’s Black Lung Clinics. West Virginia is home to more black lung clinics than any other State. These clinics provide not only medical care, but benefits counseling as well, something we have seen is sorely lacking. In fact, Mr. Bailey’s testimony mentions the clinics’ role in helping one of his colleagues.

I ask that the Administration continue to work with our offices to ensure that all miners have access to adequate medical care and legal counseling, and to ensure that unfair practices do not delay or deny a miner their benefits.

CONGRESS OF THE UNITED STATES, WASHINGTON, DC 20510, February 18, 2014.

PRESIDENT BARACK OBAMA, The White House, 1600 Pennsylvania Avenue NW, Washington, DC 20500.

DEAR MR. PRESIDENT: We are writing to highlight the need for action to address budget and staffing cuts in the Department of Labor’s (DOL) Office of Administrative Law Judges (OALJ), which is resulting in untenable delays in adjudicating claims, such as claims under the Black Lung Benefits Act and alleged violations of employment law. These delays directly and severely impact the lives of workers throughout the country, placing an undue financial and emotional burden on the affected individuals and their families.

In an April 16, 2013 memo from Chief Judge Stephen Purcell to then-Acting Secretary Seth Harris, Judge Purcell expressed concerns that the OALJ is rapidly nearing the point where the ever-growing backlog of cases will become unmanageable due to the lingering effects of sequestration and furloughs, increased resource requests from other DOL agencies, and inadequate staffing support of judges. The memo also details an inability to replace judges who have or will soon retire with qualified judges with substantial litigation experience due to the lack of funding and relocation expense when qualified judges can’t be found locally.

Hearings concerning Black Lung benefits and Longshore Workers’ compensation constitute the largest part of the office’s work, in addition to the growing number of Permanent Labor Certification (PERM) Immigration cases. The Department’s administrative law judges also hear and decide cases arising from over 80 labor-related statutes and regulations, including whistleblower complaints involving corporate fraud, nuclear, environmental, pipeline safety, aviation, commercial trucking, railways, and other statutes; minimum wage disputes; enforcement actions involving the working conditions of migrant farm laborers; disputes involving child labor violations; and civil fraud in Federal programs.

OALJ is being overwhelmed with cases as their staffing level decreases. The number of judges nationwide is down to 35, from 41 earlier this year and 45 a decade ago. For fiscal year 2013 there were a total of 11,325 total cases pending, almost doubled from a decade ago. The costs and delays in filling vacancies, the inability to assign new cases to departing judges and the inherent learning curve for new judges further reduces the Agency’s ability to efficiently and effectively adjudicate cases. Meanwhile, new and pending cases are up 68 percent and 134 percent, respectively, since 2009, as the attached chart illustrates. These staffing difficulties and increased workload lead directly to longer delays in adjudicating cases.

Black Lung claimants, for example, are waiting an average of 429 days for their cases to be assigned to an administrative law judge and an additional 90–120 days after assignment before their cases go to court. That’s over 520 days for claimants, many too disabled to work, just to start making the case that they deserve benefits. Miners who were not awarded benefits during their initial filings before DOL district directors face a specific burden from these delays. They cannot begin receiving these badly needed benefits that are necessary to continue supporting their families
until their cases are finally adjudicated. Justice delayed is justice denied for those coal miners suffering the debilitating effects of Black Lung.

The fiscal year 2014 request level of $26.7 million will not reduce the growing backlog, nor will it meet the need for the projected increase in casework driven by new statutes and more cases generated by other DOL agencies. We fully support increases in funding for enforcement of our labor laws, but believe that these increases should be met with corresponding increases for administrative law judges to hold hearings and issue opinions in a timely manner. Unfortunately, the current funding level precipitates even longer delays in the adjudication of claims going forward.

We encourage the White House to make the elimination of this unsustainable backlog of cases a priority in the fiscal year 2015 budget. Each day a case is delayed adds to the hardship for the affected individuals, who simply want the timely justice they so rightly deserve.

Sincerely,

Senator Robert P. Casey, Jr.,
Senator John D. Rockefeller IV,
Senator Joe Manchin,
Representative George Miller,
Representative Bobby Scott,
Representative Joe Courtney.

ALJ Law Clerk levels change during a fiscal year. The numbers noted above are derived from staffing levels at or near the beginning of each fiscal year.
Hon. Robert Casey, Jr.
607 Hart Senate Office Bldg.,
Washington, DC 20510.

Dear Senator Casey: I am writing today to provide you a summary of the long and tortured history of Patricia Padogomas’ pursuit of Federal Black Lung Benefits. Please note that when I spoke to Mrs. Padogomas, she broke down crying. She faces
the imminent loss of her home; she cannot afford to travel to Washington DC for both financial and health reasons. While she cannot be in Washington physically, she would like her story told and she has given me full authority to add her case to the public record, for the July 22, 2014 Employment and Workplace Safety Subcommittee hearing titled: Coal Miners’ Struggle for Justice: How Unethical Legal and Medical Practices Stack the Deck Against Black Lung Claimants.

After not appealing an initial denial of benefits, her husband, Edward Padagomas, filed a claim in September 2, 2008. During the pendency of this claim, Edward died on October 16, 2008. A widowed Patricia then filed her own claim on November 3, 2008. Almost 6 months later the Department of Labor issued proposed Orders denying both claims. Mrs. Padagomas requested a hearing before an administrative law judge.

Not until a year later, on April 27, 2010, did the administrative law judge conduct the hearing. Not until almost another year later, on February 2, 2011, did the administrative law judge issue a decision denying benefits.

In her decision the administrative law judge found that the claimant did not establish that the miner had pneumoconiosis (“black lung”). Mrs. Padagomas appealed this decision to the Benefits Review Board.

After another year passed, the Benefits Review Board issued a Decision and Order on February 23, 2012. In this Decision and Order the Board agreed with Mrs. Padagomas’ argument that the administrative law judge improperly reviewed the x-ray and medical opinion evidence of record and remanded both cases to the administrative law judge for further review.

Eighteen months later, on September 19, 2013, the Administrative Law Judge issued her second Decision and Order again denying benefits. This time the administrative law judge found that Mr. Padagomas did have black lung but, in a convoluted and circuitous decision, improperly and irrationally found that during his life time the miner was not totally disabled due to black lung and that black lung did not contribute to his death.

Mrs. Padagomas appealed both of these denials again to the Benefits Review Board. The matters have been fully briefed as of February 10, 2014.

In Mrs. Padagomas’ letter reply brief, she correctly noted for the Board that:

a. the director never filed a cross-appeal to the administrative law judge decision and order challenging any administrative law judge finding that Mrs. Padagomas established that her husband had black lung; and

b. because of the director’s failure to file a timely cross-appeal, the director waived any right to have the issue of the existence of black lung in this claim.

Despite their failure, the director, in a blatant and brazen disregard for the applicable statutes, regulations and case law, irrationally tried to raise this issue once again in their brief.

In another cruel twist of fate, today, I reviewed the Benefits Review Board Order affirming (more like rubber stamping) the administrative law judge denial of benefits. The decision was long on reiteration of the evidence of record but very short on any proper analysis of the evidence and the law. Mrs. Padagomas is again disappointed. She has authorized me to appeal this to the United States Court of Appeals and I will take the steps to file this appeal.

Edward Padagomas died over 5 years ago. He never saw justice. Patricia Padagomas suffers financially and is in poor health. The hope is that she will see some measure of justice.

Very truly yours,

GEORGE E. MEHALCHICK, Esq.

BOWLES RICE LLP, ATTORNEYS AT LAW, CHARLESTON, WV 25301,
February 18, 2014.

INova FairFax Hospital,
Dr. Steven Nathan, DirectoR of Lung Transplants,
Attn: Rachel,
3300 Gallows Road,
Falls Church, VA 22042.
Re: Robert Bailey, Jr.; US & C Claim #4533214926; Date of injury: 02/23/2009;
DOB: 06/22/1953

Dear Dr. Nathan: Patriot Coal hereby authorizes the additional evaluation and testing of Mr. Robert Bailey, Jr., requested for June 12, 2014, for an evaluation only for a possible lung transplant. This authorization does not authorize any lung trans-
plant procedure and Patriot reserves the right to approve or disapprove any further testing or transplantation in keeping with the applicable regulations and law. We continue to note that we expect that any evaluation will include any appropriate procedure for definitively determining the disease process present in the lungs of Mr. Bailey which necessitates this evaluation or treatment and that copies of all records, reports and results of the evaluation will be sent to my attention.

If you have any questions, please do not hesitate to contact me.

Very truly yours,

PAUL E. FRAMPTON.

UNITED MINE WORKERS OF AMERICA (UMWA),
TRIANGLE, VA 22172–1779,
August 20, 2014.

Hon. ROBERT P. CASEY, JR.,
Employment and Workplace Safety Subcommittee,
U.S. Senate,
393 Russell Senate Office Building,
Washington, DC. 20510.

Re: Thank You and Update On Coal Miner and Black Lung Advocate Robert Bailey

DEAR SENATOR CASEY: Thank you for being a long-time friend of coal miners. We greatly appreciate your efforts to reduce the backlog of Federal black lung claims, and are especially grateful that you organized the hearing last month at which UMWA-member and black lung advocate Robert Bailey had an opportunity to address the Employment and Workplace Safety Subcommittee. In addition to our thanks, I want to provide you an update as to Mr. Bailey’s health and ongoing fight to secure from his former employer a firm commitment to pay for a much-needed double lung transplant.

You may recall at last month’s hearing that Mr. Bailey testified to the difficulty he experienced obtaining pre-authorization from Patriot Coal for a medical evaluation to determine the necessity of a lung transplant. Initially, the company denied payment authorization for a medical evaluation. After significant lobbying from Mr. Bailey, Patriot Coal’s attorney Paul Frampton sent Mr. Bailey a letter indicating that the company would pay for the evaluation.

However, Mr. Frampton’s letter explicitly refused authorization for a lung transplant.

In the week prior to the July 22nd hearing, Mr. Bailey spent several days undergoing medical evaluation at Inova Hospital in Fairfax, VA. Shortly after the hearing, he received word that the doctors who supervised and reviewed his evaluation prescribed a double lung transplant. When Mr. Bailey returned to West Virginia from Washington, DC, he experienced extreme shortness of breath and other complications related to his disease. The weekend after the hearing, he was admitted to the hospital near his home in Princeton, WV, where he remained for 2 days of treatment and observation.

While Mr. Bailey received medication that has somewhat stabilized his condition in recent weeks, he is unfortunately experiencing the progressive deterioration wrought by black lung. He urgently needs a transplant. Unfortunately, Mr. Bailey has informed me that Patriot has not yet approved his transplant. Rather, he reports the last correspondence he received from Patriot is a lengthy questionnaire asking Inova to explain the protocols used in its medical evaluation to determine that Mr. Bailey needs the transplant.

We are working with Mr. Bailey and the Department of Labor with a hope that Mr. Bailey will soon receive his much-needed transplant. Thank you for your attention to this and the thousands of other cases of miners having to fight too long to obtain black lung benefits.

Sincerely,

ARTHUR TRAYNOR,
Associate General Counsel,
United Mine Workers of America.
[Whereupon, at 11:03 a.m., the hearing was adjourned.]