OFFICE OF WORKERS' COMPENSATION PROGRAMS

2019 ANNUAL REPORT TO CONGRESS

OFFICE OF WORKERS' COMPENSATION PROGRAMS
UNITED STATES DEPARTMENT OF LABOR

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THE HONORABLE PRESIDENT OF THE SENATE

THE HONORABLE SPEAKER OF THE HOUSE OF REPRESENTATIVES

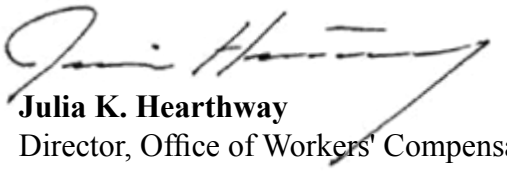
I have enclosed the Department of Labor's Annual Report to Congress on the fiscal year 2019 operations of the Office of Workers' Compensation Programs. The report covers administration of the Federal Employees' Compensation Act as required by Section 8152 of that Act, the Black Lung Benefits Act as required by Section 426(b) of that Act, the Longshore and Harbor Workers' Compensation Act as required by Section 42 of that Act, and the Energy Employees Occupational Illness Compensation Program Act, for the period October 1, 2018, through September 30, 2019.

The information in this report is available to Congress and the public in near real-time from the OWCP website.

- Federal Employees' Compensation Act Program: **https://www.dol.gov/agencies/owcp/dfec**
- Black Lung Program: **https://www.dol.gov/agencies/owcp/dcmwc**
- Energy Program: **https://www.dol.gov/agencies/owcp/energy**
- Longshore Program: **https://www.dol.gov/agencies/owcp/dlhwc**

Separate enclosures contain the annual audit reports for the fiscal year 2019 financial statements of the Longshore and Harbor Workers' Compensation Act Special Fund and the District of Columbia Workmen's Compensation Act Special Fund accounts (as required by Sections 42 and 44(j)).

This report both fulfills the requirements of the respective laws and provides a comprehensive source of information on the administration and operation of federal workers' compensation programs.



Julia K. Hearthway
Director, Office of Workers' Compensation Programs

Enclosures

DIRECTOR'S MESSAGE

I am pleased to submit the Department of Labor's Office of Workers' Compensation Programs (OWCP) Annual Report to Congress for fiscal year 2019. This report provides an overview of OWCP's activities for all four of its programs.

Each of OWCP's four programs provides workers' compensation benefits to different sets of workers.

- The Federal Employees' Compensation Act program serves injured or ill federal employees. Beneficiaries of the program, which has been in place for over 100 years, are Federal Bureau of Investigation agents, postal workers, office workers, emergency responders, forest rangers, air traffic controllers, and many others.
- The Longshore program serves those engaged in maritime work, such as dockworkers, longshore workers, shipbuilders, as well as government contractors outside of the United States and certain employees working on the Outer Continental Shelf.
- The Black Lung program supports coal miners, construction workers, and transportation workers who are regularly exposed to respirable coal mine dust and who have pneumoconiosis, more commonly known as black lung disease.
- The Energy program serves current and former nuclear weapons workers who have been exposed to radiation or other toxic substances at covered Department of Energy and designated private facilities, such as nuclear physicists, uranium miners and millers, and the plumbers, electricians, office workers, janitors and others who maintained the facilities.

OWCP strives to provide each worker with timely and accurate decisions on claims, prompt payment of benefits, and, where appropriate, opportunities for returning to work. The success of OWCP flows from the effectiveness of our staff of approximately 1,460 federal employees and several hundred contractors.

We continue to improve benefit delivery by strengthening program integrity, improving information technology solutions, implementing operational efficiencies, and modernizing policy. Our efforts, particularly in the past year, have shown some promising results. OWCP implemented a reorganization of its senior leadership management structure to move from a geographically based leadership structure to a program-focused structure. The reorganization resulted in elimination of the disconnect between program responsibility for Operating Plan goals and regional control of staffing resources; a single, clear, consistent communication of policy and priorities to field staff nationwide; and a stronger voice from the field to the program directors. The reorganization has already demonstrated significant improvement in the effectiveness and efficiency of program operations including greater consistency of claims processing across the country, faster and more effective change management, and greater accountability in performance management.

Federal Employees' Compensation Act Program

The Federal Employees' Compensation Act (FECA) program continued aggressive fraud detection policy controls. Investments have yielded: a reduction in compounded medication expenditures from an average of $23.1 million per month during the first half of 2016 to less than $56,000 per month in fiscal year 2019; a reduction in the improper payment rate from 3.54% in fiscal year 2016 to 2.44% in 2019; and an increase in referrals of suspected fraud sent by the FECA program to the Department of Labor's Office of Inspector General from none in fiscal year 2016 to 27 in 2017, 62 in 2018, and 71 in 2019 (encompassing 140 individual providers).

The FECA program also kept its focus on the national opioid crisis, replacing its 30-day initial fill limit with a seven-day limit, and requiring prior authorization and a physician's letter of medical necessity for all opioids beyond 28 days of the initial fill, replacing the prior requirement after 60 days. This will further the already dramatic decrease in opioid use among the approximately 200,000 federal employees who receive FECA benefits each year. The results when comparing January 2017 with January 2020 are notable:

- A 40% decline in overall opioid use.
- A 26% drop in new opioid prescriptions.
- A 57% decline in new opioid prescriptions lasting more than 30 days.
- A 75% drop in claimants with a Morphine Equivalent Dose of 500 or more.
- A 49% drop in users with an Morphine Equivalent Dose of 90 or more.

The OWCP reorganization was the foundation for the FY 2019 FECA program implementation of an end-to-end case management system that standardized all claims processing duties. For the prior 20 years, the variance in claims management processes in offices led to poor customer service, inhibited the ability to operationalize uniformity program-wide, and created inefficiencies in human capital. This is no longer the case. This change will achieve more equitable work assignments, standardize the process for how cases are adjudicated, and will benefit our stakeholders by working with a single claims examiner who is familiar with the entire life of a claim. Aside from the countless options for workload shifts this provides when necessary, it also enforces personal accountability built into a completely transformed performance management process. Previously, each district office was audited as a single entity for quality claims processing, a system that ignored individual accountability. Under the new system, FECA program supervisors nationwide sample hundreds of case management actions for each claims examiner, resulting in almost 80,000 samples compared to the previous 8,000.

Energy Program

The Energy program also enhanced its focus on personal accountability and performance management. Prior to fiscal year 2019, Energy program supervisors reviewed an average of 20,000 case action samples per year to assess program and individual performance. Now, supervisors review a much more robust 62,500 samples measuring both individual and program performance. In order to focus on and improve customer service, in FY 2019 the Energy program also implemented a national phone queue, in which the resource center staff answer all calls that come into the Queue. This change resulted in an increase in the number of calls answered by a live representative, efficiency in answering basic questions, and decreased hold times.

Final Regulations last revised in 2006 were updated and became effective on April 9, 2019. The new regulations update obsolete terms, incorporate programmatic determinations regarding the claims adjudication process, codify current procedures, and allow for greater consistency and control in how home health care benefits are approved. Claimants benefit from a streamlined approval process.

Longshore Program

The Longshore program continued to develop its new case management system (OWCP Workers' Compensation System), while also partnering with the longshore industry to increase electronic submissions. This has resulted in an increase in the timely submission of First Reports of Injury while reducing the costs associated with mailing and manual processing. The amount of correspondence received electronically increased from 52% in fiscal year 2016 to 70% in 2019.

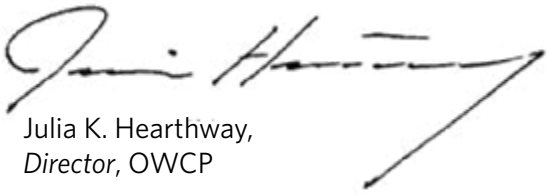
Black Lung Program

The Black Lung program revised the self-insurance approval process to ensure coal mine operators have adequate security for their black lung liabilities, which will help shield the Black Lung Disability Trust Fund should an operator become insolvent and unable to cover their obligations.

Following the new OWCP operating model, the Black Lung program transitioned to an end-to-end claims processing model that best aligns staffing resources to deliver mission-driven results, provides exceptional service, and effectively stewards taxpayer dollars. As a part of this transition, the Black Lung program identified aged, pending cases as a serious obstacle that threatened momentum in other key areas. The program initiated the Aged Case Elimination project in order to proactively address the backlog of cases pending for more than a year. The effort was an overwhelming success. The Black Lung program reduced the percentage of claims pending for more than 365 days from 20% in 2018 to 12%, exceeding the Department's 2018 - 2022 Strategic Plan goal of 15%.

A Final Rule governing the Black Lung Disability Trust Fund's payment of medical benefits under the Black Lung Benefits Act, promulgated near the end of fiscal year 2018, achieved cost savings of over $11.4 million in 2019 and will continue to realize millions of dollars in savings for years to come. The Final Rule adopted industry-standard formulas for paying medical bills, speeding payment to providers, making it easier for the Trust Fund to obtain reimbursement from coal companies, and prohibiting providers from seeking additional payments from miners for covered services that have been paid by the Trust Fund.

Our mission is an important one, and we remain committed to serving our claimants, beneficiaries, and their families.



Julia K. Hearthway,
Director, OWCP

FEDERAL EMPLOYEES' COMPENSATION ACT (FECA)

INTRODUCTION

In 1916, President Woodrow Wilson signed the first comprehensive law protecting federal workers from the effects of work injuries. Amended several times, with the most recent substantive changes made in 1974, the Federal Employees' Compensation Act (FECA) now provides workers' compensation coverage to approximately 2.6 million federal employees.

The Act provides the following benefits:

- Wage-replacement payments at 66 2/3 percent of the employee's salary or 75 percent if there is a dependent.
- Payments for reasonable and necessary medical treatment related to the injury.
- Vocational rehabilitation training and job-placement assistance to help disabled workers return to gainful employment.
- Compensation for permanent impairment of limbs and other parts of the body.
- Compensation for survivors of employees due to a work-related death.

The FECA also provides coverage to Peace Corps and AmeriCorps Volunteers in Service to America; federal petit and grand jurors; volunteer members of the Civil Air Patrol, Reserve Officer Training Corps Cadets, Job Corps, and Youth Conservation Corps enrollees; and non-federal law enforcement officers when injured under certain circumstances involving crimes against the United States.

For over a century, the FECA program has continuously evolved to meet its commitment to federal employees and agencies, while minimizing the human, social, and financial costs of work-related injuries. This report highlights the FECA program's activities and accomplishments in fiscal year 2019.

BENEFITS AND SERVICES

The primary goal of the FECA program is to assist federal employees who have sustained work-related injuries or disease by providing financial and medical benefits, as well as assistance with returning to work. In traumatic injury claims where the evidence establishes disability, the Act requires a Continuation of Pay of the injured worker's salary for up to 45 days if the disability extends through that period. If the disability continues after 45 days, or where the evidence establishes disability in cases of occupational disease, the injured worker must file a claim for compensation and the FECA program will process that claim. Compensation for wage loss is paid at 66 2/3 percent of the employee's salary if there are no dependents or at 75 percent if there is at least one dependent. The program compensates injured workers for permanent impairment of limbs and other parts of the body, and it provides benefits to survivors in the event of work-related death. FECA benefits also include payment for services and medications that are likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation.

The FECA program is the exclusive remedy by which federal employees may obtain disability, medical, and survivor benefits from the federal government for workplace injuries or illnesses. Twelve district offices and four prescription management units around the country carry out program activities, including claims adjudication, disability management, and return-to-work support. The claims adjudication process involves receipt and review of the claim,

development of the facts including medical documentation where appropriate, and a formal adjudication decision. Individuals who disagree with a formal decision may exercise their appeal rights by requesting:

1. Reconsideration by a claims examiner not previously associated with the case; or
2. An oral hearing or a review of the written record by the Branch of Hearings and Review in the FECA National Office; or
3. Review of final decisions for or against the payment of benefits by the Employees' Compensation Appeals Board, an independent entity in the Department of Labor (DOL).

If a case is accepted and disability is involved, the program auto-assigns a Continuation of Pay Nurse who makes a three-point contact: the nurse communicates with the injured worker, the attending physician, and the employer to determine if the disability will persist. If so, the staff makes a referral to a full-time nurse to assist with medical appointments and facilitate certain treatment.

If it appears that the injured worker will not return to work within a reasonable timeframe, or can work in a limited capacity but the employer cannot accommodate his or her restrictions, the nurse works with the claims examiner to refer the case to vocational rehabilitation. Vocational rehabilitation counselors perform labor skills assessments and assist the worker in finding new positions in the labor market.

For long-term disability cases, the FECA program dedicates resources to thoroughly review the medical evidence and question the physician on the claimant's wage-earning capacity. As part of that review, the FECA program can arrange for second opinion medical examinations to assess any changes in the injured worker's medical condition and fitness for work. The goal of the FECA program staff is to return every worker to gainful employment or accurately determine any loss of wage-earning capacity.

FUNDING

The Office of Workers' Compensation Programs (OWCP) pays FECA benefits from the Employees' Compensation Fund (ECF), which is funded from two sources. One portion of the ECF is a direct appropriation under extensions of FECA for certain groups such as War Hazards Compensation Act claimants, non-Federal law enforcement officers, Job Corps enrollees, and certain Federally supported volunteers. The funding is deposited into and assumes the attributes of the ECF and remains available until expended. The other portion of the ECF is from offsetting collections reimbursed from agencies. OWCP bills agencies each August for benefits paid for their employees from the Fund, and most agencies, other than the U.S. Postal Service (USPS) and other non-appropriated fund agencies, include those chargeback costs in their next annual appropriation request to Congress. Agencies do not make remittances to the ECF until the first month of the subsequent fiscal year (or later, when Congress enacts an agency's full-year appropriation after the subsequent fiscal year begins).

FECA administrative funding is provided from two sources. One portion of the administrative funding is provided under OWCP's annual Salaries and Expenses appropriation. The other portion of administrative funding is derived from reimbursements from agencies such as USPS and other corporations or instrumentalities required under 5 U.S.C. 8147(c) to pay an amount for its fair share of the cost of administration.

FECA Table 1 highlights chargeback costs billed in Chargeback Year 2019. FECA Table 2 provides a comparison of OWCP enacted funding.

FECA Table 1 – FECA Benefits Paid and Charged to Employing Agencies, Chargeback Year 2019[1]

Agency	2019
USPS	$1,279 million
Department of Defense	$464 million
Department of Homeland Security	$220 million
Department of Veterans Affairs	$195 million
Department of Justice	$125 million
Department of Transportation	$76 million
Department of Agriculture	$61 million
All Others	$311 million
Total	$2,732 million

[1] The figures in the chart are rounded.

FECA Table 2 – OWCP Enacted Funding for Administering/Operating the Program, Fiscal Year 2019[1]

Enacted Funding	2019
Number of Employees (Full-time Equivalent (FTE) staffing used)[2]	784
Salaries and Expenses	$102.7 million
"Fair Share" (FECA Special Benefits Account) – for the development/operation of automated data management and operations support systems, periodic roll case management, and program integrity	$74.8 million
Total Enacted Funding[3]	$177.4 million

[1] The dollar amounts in the chart are rounded.

[2] The FTE totals include FECA Salaries and Expenses and FECA Fair Share.

[3] Support costs for legal, investigative, and other kinds of services from the Employees' Compensation Appeals Board, the Office of the Solicitor, the Office of Inspector General, and the U.S. Treasury are not included.

DOL's Agency Financial Report provides additional information on the FECA program's finances:

- https://www.dol.gov/sites/dolgov/files/OPA/reports/2019annualreport.pdf

ACCOMPLISHMENTS & PERFORMANCE

The FECA program's key performance measures revolve around three fundamental tenets of workers' compensation:

1. Learn about the injury as soon as possible;
2. Provide timely access to treatment; and
3. Return the injured worker to pre-injury status both economically and medically.

Rapid Intake of Forms

Shortening the duration of time between when the injury occurs and when the FECA program learns of it will improve the speed with which the program can authorize benefits when needed. The FECA program, therefore, tracks how long it takes the employer to send DOL the notice of injury and the use of electronic claims filing systems, such as the Employees' Compensation Operations and Management Portal (ECOMP).

Faster Delivery of Benefits

The FECA program's focus on delivering benefits faster is what drives the workforce. To measure performance, the FECA program looks at how promptly staff adjudicates benefit claims. The prompt adjudication of claims filed for wage-loss compensation is of particular importance to help ensure that the worker does not undergo unnecessary financial hardship.

FECA Table 3 presents claims, benefit payment, and medical bill processing totals for fiscal year 2019. The table also represents timeliness of authorization for medical treatment and medical bill processing.

FECA Table 3 – Claims Intake, Benefits Paid, and Medical Bill Processing, Fiscal Year 2019[1]

Claims, Benefits Paid, and Medical Bill Processing		2019
Claims	New claims from injured/ill federal workers or their survivors	100,534
	Wage-loss claims received	16,335
Benefits	Number of beneficiaries	217,465
Benefit Payment Outlays	Compensation payments	$1.959 billion
	Medical and rehabilitation services benefit payments	$902 million
	Death benefit payments to surviving dependents	$153 million
	Total compensation and benefit payments	$3.013 billion
Medical Bill Processing	Number of medical bills processed	3 million
	Number of enrolled providers — new	1,632
	Number of total enrolled providers (end of fiscal year)	219,687
	Average number of workdays to authorize medical treatment	2 days
	Percent of medical bills processed within 28 days	99.8%

[1] The table presents claims and medical bill processing information by fiscal year and benefit payment outlays by chargeback year. Benefit payment outlays include both payments billed to employing agencies and payments not billed to employing agencies. The dollar amounts are rounded.

Return-to-Work

The FECA program is committed to helping disabled workers return to gainful employment as soon as possible. To measure performance, the FECA program measures the percentage of injured workers that are re-employed within two years and incentivizes active agency management through performance management and enhancements to ECOMP that accelerate communication involving return-to-work efforts.

FECA Table 4 measures the FECA program's performance on form intake, timely delivery of compensation benefits, and return-to-work for all agencies.

FECA Table 4 – Performance Measure Results, Fiscal Year 2019

Performance Measures	2019 Target	2019 Result
Percent of traumatic injury cases adjudicated within 45 days	90.0%	97.2%
Percent of basic non-traumatic injury cases adjudicated within 90 days	85.0%	96.0%
Percent of extended non-traumatic injury cases adjudicated within 180 days	75.0%	87.6%
Percent of extended non-traumatic injury cases adjudicated within 365 days	98.0%	98.4%
Percent of wage-loss claims adjudicated within 14 days (claims not requiring further development)	90.0%	93.2%
Percent of wage-loss claims adjudicated within 90 days (all claims)	90.0%	94.7%
Percent of Notices of Initial Injury filed by employer within 10 working days	92.0%	95.4%
Percent of wage-loss claims filed by employer within five working days	90.0%	93.5%
Percent of federal employees with work-related injuries or illnesses that are employed within two years	88.0%	89.7%

Leveraging Information Technology Systems: One Approach for All Federal Employers

In addition to a 2018 deployment of the Disability Management Interface to ECOMP that accelerates transactions that return employees to work, the program further improved ECOMP performance and reliability in March 2019 through a system upgrade to a Hypertext Markup Language 5.0 platform that simultaneously provided a new modern user interface. After extensive discussions on the benefits of ECOMP and successful pilot programs, USPS began to roll out its use of DOL's ECOMP system nationwide, beginning in the fall of 2019 for completion in the spring of 2020. With USPS fully utilizing ECOMP, USPS will file the majority of all federal workers' compensation forms via ECOMP, improving the speed of forms filing, benefits delivery, and return-to-work. The FECA program will continue to upgrade ECOMP so that it provides even better results and near real-time communications between the employer, the injured worker, and DOL staff.

Providing Improved and Consistent Customer Service

In fiscal year 2019, the FECA program completed three critical changes to improve the experience for our stakeholders:

1. Implemented an end-to-end case management system and standardized all claims processing duties so that claims examiners around the country all complete the entire lifecycle of a claim in a consistent manner;

2. Increased assessment of the quality of individual adjudications and communications, in addition to a continued emphasis on timeliness; and
3. Routed claimant and stakeholder phone calls directly to the responsible claims examiner for a response by the individual who knows the most about the claim.

Stakeholders benefit from working with a single claims examiner that is familiar with the entire life of a claim and whom they can reach directly on the telephone. These changes also drive improvements in customer service by increasing the responsibility and personal accountability of claims examiners for their own cases, creating an incentive to make timely and appropriate actions.

PROGRAM MANAGEMENT AND INTEGRITY

Implementing Controls on Compounded Medications
The FECA program saw an increase in costly compounded medication prescriptions and beginning in 2016, OWCP introduced several policy changes that have resulted in a substantial decrease in compounded drug costs. In July 2016, the FECA program implemented a tiered reimbursement rate for compounded drugs. Subsequently, in October 2016, the agency implemented a prior-authorization for compounded medications, and in March 2017, introduced restrictions on herbal supplements. The FECA program also placed all compounded medications containing opioids under a prior authorization process in June of 2017. These efforts significantly reduced compounded medication expenditures from an average of $23.1 million per month during the first half of 2016 to less than $56,000 per month in fiscal year 2019.

Aggressive Fraud Detection
The FECA program processes $3 billion in payments annually; reducing fraud and improper payments is a high priority. The FECA program utilizes a robust analytics platform to detect problematic trends and anomalous billing patterns from medical providers and works with Inspectors General government-wide to support prosecution efforts.

In order to keep pace with nefarious providers, the FECA program continues to detect new and emerging fraud schemes and to implement controls to curtail them. In fiscal year 2018, the FECA program implemented exception-based policies after monitoring rapid increases in spending on often unnecessary and overpriced medication "convenience kits" and other physician-dispensed drugs. In fiscal year 2019, the FECA program issued three circulars to similarly address increased spend on: unnecessary prescriptions that have an inexpensive over-the-counter alternative available, "prescription medical devices" that were being billed to bypass controls on convenience kits and compounded medications, and shutting down a loophole on unlisted physician-dispensed drugs that began to be used to bypass other controls.

These collective policy controls and investments, beginning with addressing compounded drugs in 2016, have yielded the following:

- Saved taxpayers over $600 million in pharmaceutical costs from 2017 through 2019.
- The improper payment rate decreased from 3.54% in fiscal year 2016 to 2.44% in 2019.
- Chargeback costs dropped over $200 million from 2016 to 2017 and has since remained relatively level.
- An increase in referrals of suspected fraud sent by the FECA program to the DOL Office of Inspector General from none in fiscal year 2016 to 27 in 2017, 62 in 2018, and 71 in 2019 (encompassing 140 individual providers).

Combatting the Opioid Epidemic

Before fiscal year 2017, OWCP had taken little action to combat the opioid epidemic. A few limited controls were in place, but none considered whether the opioids were medically necessary or monitored the specific durations and dose levels being utilized. In late fiscal year 2017, the FECA program started a focused effort to reduce the potential for opioid misuse and addiction among injured federal workers. The program used data to drive policy, instituting targeted controls, tailored treatment, and meaningful communications.

In August 2017, the FECA program implemented a first-step policy requiring the prescribing physician to complete a medical evaluation and attest to the medical necessity of continued opioid treatment for new opioid prescriptions that lasted for more than 60 days. The FECA program then reviewed this evaluation for approval.

In fiscal year 2018, the FECA program received 37 additional FTE staff for Prescription Management Units to support these efforts. With the added resources dedicated to monitoring opioid prescriptions, the FECA program began addressing longer-term and high-dose opioid use among injured federal workers. The FECA program first issued targeted communications to all prescribers with a patient on a morphine equivalent dose (MED) level of 90 or more, and to all injured workers who had been receiving opioids for at least six months or more, urging a discussion and evaluation of their treatment options. In June 2018, the FECA program implemented a policy regarding long-term and high-dose opioid use and began in-depth case reviews of injured federal workers prescribed high MED levels. This included tailored letters requesting more detailed information on the injured worker's specific medical condition and the implementation of treatment plans aimed at reducing opioid levels. The policy has resulted in nurse assignments to provide assistance and education on opioid risk, to coordinate alternative treatment, and to arrange second opinion medical examinations where appropriate. The FECA program then published a policy in August 2018 to encourage alternative pain management, minimize barriers to treatment, and increase access to treatment for claimants facing challenges related to opioid use.

While these efforts yielded significant results, the FECA program instituted a new policy effective September 2019. It replaced the initial 30-day limit with an initial seven-day fill limit, and allows three subsequent seven-day opioid prescriptions for a maximum of 28 days, down from 60 days previously. Prescriptions beyond that initial 28 days now require FECA program approval.

The results when comparing January 2017 with January 2020 are notable:

- A 40% decline in overall opioid use.
- A 26% drop in new opioid prescriptions.
- A 57% decline in new opioid prescriptions lasting more than 30 days.
- A 75% drop in claimants with a MED of 500 or more.
- A 49% drop in users with an MED of 90 or more.

LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT (LONGSHORE)

INTRODUCTION

Enacted in 1927, the Longshore and Harbor Workers' Compensation Act (LHWCA) provides compensation for lost wages, medical benefits, and rehabilitation services to longshore, harbor, and other maritime workers who are injured during their employment or who contract an occupational disease related to employment. The Act also provides survivor benefits if the work-related injury or disease causes the employee's death. An authorized self-insured employer or an authorized insurance carrier directly pays these benefits in most cases; in particular circumstances, the industry-financed Longshore Special Fund pays these benefits.

The original law, entitled the Longshoremen's and Harbor Workers' Compensation Act, was enacted to provide coverage to certain maritime employees injured while working over navigable waters who had been excluded from state workers' compensation coverage by the Supreme Court (Southern Pacific Co. v. Jensen, 244 U.S. 205 (1917)). Over the years, there have been extensions to the Act granting coverage to certain additional employees including:

- The Defense Base Act (DBA) of August 16, 1941, extended benefits to employees working outside the continental United States. This primarily covers all private employment on U.S. military bases overseas, land used for military purposes in U.S. territories and possessions, and U.S. Government contracts overseas.
- The Nonappropriated Fund Instrumentalities Act of June 19, 1952, extended benefits to civilian employees in Armed Forces post exchanges, service clubs, etc.
- The Outer Continental Shelf Lands Act of August 7, 1953, extended benefits to employees of firms working on the outer continental shelf of the United States, such as offshore drilling enterprises engaged in the exploration for and development of natural resources.
- The District of Columbia Workmen's Compensation Act (DCCA), passed by Congress on May 17, 1928, extended coverage to private employment in the District of Columbia. As the District passed its own workers' compensation act effective July 26, 1982, the Office of Workers' Compensation Programs (OWCP) handles claims only for injuries before that date.

BENEFITS AND SERVICES

Except in a small percentage of cases, the Longshore program does not pay benefits directly; rather, self-insured employers and insurance carriers pay compensation and medical benefits. The program is responsible for overseeing the private administration of claims and implementing the plans, policies, regulations, and procedures necessary for the authorization and monitoring of the approximately 550 insurance carriers and self-insured employers that provide workers' compensation liability protection. This includes oversight of over $3.2 billion held in security deposits and two carrier/employer-funded trust funds with approximately $100 million in annual assessments and disbursements and 3,800 recurring benefit recipients. Longshore Table 1A highlights lost-time injuries in fiscal year 2019 and the number of those covered by DBA; Longshore Table 1B highlights benefit payments for calendar year 2019.

LONGSHORE TABLE 1A – LOST-TIME, FISCAL YEAR 2019

Lost Time Injuries	2019
Number of injuries and deaths reported	30,682
Number of cases covered under DBA	8,448

LONGSHORE TABLE 1B – BENEFIT PAYMENTS, 2019

Benefits Payments	2019
Number of workers and survivors in compensation payment status	13,049
Total compensation paid[1]	$840,860,633
Wage-loss and survivor benefits[1]	$528,388,153
Medical benefits[1]	$312,472,480
Payments by Sources of Compensation	**2019**
Insurance companies[1]	$737,983,052
Self-insured employers[1]	$413,348,689
LHWCA Special Fund	$96,785,666
DCCA Special Fund	$6,056,213
Administration of Compensation Benefits	$1,046,592

[1] Figure is for calendar year 2019, which does not correspond to federal fiscal years.

Note: Total compensation paid does not equal the sum of the sources of compensation due to the different periods (calendar year vs. fiscal year) by which the various data are reported. For the Longshore Special Fund assessment billing purposes, as required by Section 44 of LHWCA, insurance carriers and self-insured employers report compensation payments made during the calendar year under the Acts to the Department of Labor (DOL) by June for the previous calendar year. Insurance carriers and self-insured employers also report compensation and medical benefit payments for the DCCA Special Fund on a calendar year basis.

FUNDING

OWCP administers two funds for the Longshore program: the Longshore Special Fund, which was established in the Treasury under Section 44 of the LHWCA; and a separate fund applying only to cases arising under the DCCA. The proceeds of the Longshore Special Fund cover:

- Annual adjustments in compensation for permanent total disability or death that occurred before the effective date of the 1972 amendments (Section 10(h));
- Second injury claims (Section 8(f));
- Cases involving employer insolvency (Section 18(b));
- Rehabilitation assistance (Sections 39(c) and 8(g)); and
- The cost of independent medical examinations (Section 7(e)).

The Longshore Special Fund is financed through a variety of sources:

1. Fines and penalties;
2. $5,000 payments by employers for each instance in which a covered worker dies and there are no survivors eligible for benefits;
3. Interest payments on Fund investments; and
4. An annual assessment of authorized insurance carriers and self-insurers, which is the largest source.

Longshore Tables 2A and 2B highlight Longshore and DCCA Special Fund Expenditures for fiscal year 2019.

LONGSHORE TABLE 2A – LONGSHORE SPECIAL FUND EXPENDITURES, FISCAL YEAR 2019

Longshore Special Fund	2019
Total benefits paid	$96,785,666
Second injury claim (section 8(f)) payments	$84,690,736

LONGSHORE TABLE 2B – DCCA SPECIAL FUND EXPENDITURES, FISCAL YEAR 2019

DCCA Special Fund	2019
Total benefits paid	$6,056,213
Second injury claim (section 8(f)) payments	$4,895,651

Enacted funding covers the salaries and expenses of the approximately 100 Longshore program employees in nine district offices and the National Office. Longshore Table 3 provides a comparison of OWCP enacted funding in fiscal year 2019.

LONGSHORE TABLE 3 – OWCP ENACTED FUNDING, FISCAL YEAR 2019

Enacted Funding	2019
Number of employees (Full-time equivalent staff)	84
Longshore General Salaries and Expenses	$12.7 million
Longshore Special Fund Salaries and Expenses	$2.2 million
Total OWCP Enacted funding[1]	$14.9 million

[1] Support costs for legal, investigative, and other kinds of services from the Office of Administrative Law Judges, Benefits Review Board, the Solicitor's Office, and the Office of Inspector General are not included.

DOL's Agency Financial Report provides additional information on the Longshore program's finances:

- **https://www.dol.gov/sites/dolgov/files/OPA/reports/2019annualreport.pdf**

ACCOMPLISHMENTS AND PERFORMANCE

The Longshore program continues to improve the efficiency of its processes by leveraging technology, improve the speed at which it assists in dispute resolution, and exceed its goals concerning the timeliness of each step in its process.

Oversight and Tracking of First Report of Injury and First Payment of Compensation

The Longshore program utilizes a set of measures to help ensure the oversight of the private administration of claims. The First Report of Injury measure tracks the time from the date of injury or death, or the date of the employer's knowledge of the injury and the onset of the disability, to the date the written notice of injury was received by a Longshore district office. The First Payment of Compensation measure tracks the time it takes the employer or insurance carrier to issue the first payment after the worker becomes disabled or after death. While the Longshore program can influence these measures through outreach and technical assistance, the work associated with the measures is the responsibility of insurance carriers and self-insured employers.

A major initiative for the program was leveraging technology to facilitate claims submission, and this improved the timeliness of the First Report of Injury. This initiative, which started in fiscal year 2016, allows employers' or insurance carriers' private claims systems to connect to the Longshore program's system, and thereby eliminate the need for the Longshore program to manually create cases. The program will continue to work with willing partners moving forward to expand electronic submission.

Dispute Resolution

A principal function of the Longshore program is to resolve disputes between claimants and self-insured employers or insurance carriers. District offices conducted informal conferences for 2,558 claims in fiscal year 2019. The Longshore program uses the informal conference to establish the facts in each case, define the disputed issues and the positions of the parties concerning those issues, and encourage voluntary resolution by means of agreement and/or compromise. The Longshore program continued to work to improve the speed of its process to assist injured workers and employers/carriers to resolve disputed claim issues. The program also provided training for its employees so that they have the tools and techniques necessary to resolve disputes.

Longshore Table 4 presents the First Report of Injury, the First Payment of Compensation, and dispute resolution targets and results, showing that the program exceeded the targets in fiscal year 2019.

LONGSHORE TABLE 4 – PERFORMANCE MEASURE RESULTS, FISCAL YEAR 2019

Performance Measures	2019 Target	2019 Result
First Report of Injury and First Payment of Compensation		
Percent of First Report of Injury filed within 30 days for DBA cases	88%	94%
Percent of First Payment of Compensation issued within 30 days for DBA cases	68%	70%
Percent of First Report of Injury filed within 30 days for non-DBA cases	89%	94%
Percent of First Payment of Compensation issued within 30 days for non-DBA cases	87%	89%
Dispute Resolution		
Average number of days to resolve disputed issues in district offices (all cases)	88 days	79 days
Average number of days to resolve disputed issues in district offices (DBA cases only)	102 days	92 days

STAKEHOLDER ENGAGEMENT AND OUTREACH

The Longshore program continued to expand its outreach activities in the area of compliance assistance. To improve the timeliness of First Payment of Compensation and First Report of Injury, the Longshore program continued to assign policy examiners to review cases and hold quarterly meetings with industry representatives to identify improvement opportunities. The stakeholders received this effort well as it helped them to understand where gains in performance are possible.

The Longshore program invited major stakeholders, including insurance companies, to meetings throughout the year to discuss and resolve DBA challenges, such as timely payment of benefits to foreign workers and their families in areas with cultural differences, communications obstacles, limited banking and infrastructure, and lack of available medical care. The discussions also focused on timely reporting of injuries, timely payment of benefits, and sharing best practices. The Longshore program staff, at both the national and district office levels, participated in educational programs directed toward stakeholders for purposes of increasing awareness and technical skills across the community. The program also continued to generate monthly reports to facilitate the review of performance results with industry executives and share DBA carrier results with its larger customers. Sharing this information resulted in greater compliance with established performance standards, such as reporting of injuries within 30 days and percent of timely first payment, in fiscal year 2019, as seen in Longshore Table 4.

PROGRAM MANAGEMENT AND INTEGRITY

The Longshore program continued to focus on assuring Special Fund obligations under the statute, making significant technological improvements for electronic claims submission and electronic document submission. This makes claims easier to file and oversee.

Insurance Authorization, Risk Securitization, and Management of the LHWCA and DCCA Special Funds
The Longshore program authorizes private employers to self-insure and insurance carriers to provide coverage for benefits provided under the law while overseeing proper collateralization to ensure the continuing provision of benefits for covered workers in case of insolvency. Further, the Longshore program administers, provides oversight, and protects the solvency and financial strength of the Longshore and DCCA Special Funds through annual industry assessments authorized under the LHWCA.

Information Technology Modernization
The Longshore program continued to focus on leveraging technology to facilitate claims submission and document management.

Electronic Claims Submission: Previously, the Longshore program received new Longshore claims in paper format, which staff entered manually to create new cases. In fiscal year 2016, the Longshore program conducted a pilot project to receive claims electronically. In fiscal year 2019, the program continued to partner with industry carriers/employers and self-insurance groups on this initiative. This initiative allows private claims tracking systems to connect to the Longshore program system, and thereby eliminate the need to manually create cases. By accelerating the delivery of documents to the Longshore staff, the claims examiners may intervene sooner to assist with the resolution of outstanding issues and to facilitate more timely delivery of benefits.

Electronic Document Submission: The Longshore program continued partnering with its larger stakeholders to reduce the time and cost associated with mailing and processing paper correspondence and forms used in the later life of a claim. For stakeholders that already stored their documents in digital format, the program offered to accept documents electronically through a direct network connection. This significantly reduced mail time and eliminated the expense and burden of processing paper. The program received 52% of correspondence and forms in digital format in fiscal year 2016. In fiscal year 2019, the Longshore program increased the percentage to 70%. The Longshore program will continue to establish these connections with any stakeholder that wishes to participate in this process.

BLACK LUNG BENEFITS ACT (BLACK LUNG)

INTRODUCTION

The Office of Workers' Compensation Programs' (OWCP's) Black Lung program has administered Part C of the Black Lung Benefits Act (BLBA) for more than 40 years. Part C provides lifetime disability compensation and medical treatment benefits to miners totally disabled due to pneumoconiosis (commonly called black lung disease) arising out of coal mine employment, and compensation to their eligible survivors. Liability for compensation generally rests with the miner's coal mine employers or their insurance carriers. The initial program, contained in Part B, was administered by the Social Security Administration (SSA) and compensation paid with public funds. The BLBA has been amended several times over the years to shift responsibility to the Department of Labor (DOL) and update eligibility requirements and funding mechanisms.

- The BLBA of 1972 simplified eligibility criteria for all claims filed with the SSA under Part B, and transferred the processing of new claims to DOL in 1973 under Part C.
- The Black Lung Benefits Reform Act of 1977 mandated that all pending and denied Part C claims be reopened and reviewed using less stringent interim medical criteria.
- The Black Lung Benefits Revenue Act of 1977 created the Black Lung Disability Trust Fund (Trust Fund), financed by an excise tax on coal mined and sold in the United States. It also permitted miners approved under Part B to apply for medical benefits available under Part C. These amendments made the federal program permanent; however, state benefits continued to offset federal benefits, where they were available.
- The 1981 Amendments to the Coal Mine Health and Safety Act of 1969 tightened eligibility standards, eliminated certain burden of proof presumptions, and temporarily increased the excise tax on coal to address the problem of mounting insolvency of the Trust Fund.
- The Black Lung Consolidation of Administrative Responsibilities Act of 2002 placed the administration of both Parts B and C with DOL. This made permanent an arrangement between SSA and DOL in a 1997 memorandum of understanding that transferred responsibility for managing Part B claims to DOL.
- The Affordable Care Act of 2010 amended the BLBA by restoring two provisions that had been eliminated by the 1981 Amendments. It reinstated the provision that dependent survivors are automatically entitled to benefits if the miners were entitled to benefits at the time of their deaths. It also restored a rebuttable presumption that a miner's total disability or death was due to pneumoconiosis upon proof that the miner worked at least 15 years in qualifying coal mine employment and suffered from a totally disabling respiratory or pulmonary impairment.

The Black Lung program now administers both Parts B and C of the BLBA. Part B provides income replacement compensation to beneficiaries who filed claims on or before July 1, 1973. Part C covers all other beneficiaries and provides both monthly wage replacement and medical services.

BENEFITS AND SERVICES

Each year, the Black Lung program receives thousands of applications for benefits from coal mine workers and their survivors. The majority of the applications are either new claims by a miner (the first time the claimant has filed) or subsequent miner claims (the claimant has filed at least once before). In addition, a smaller number of successor claims and survivor conversions are submitted each year.[1]

Federal Black Lung claims – which are often contested by coal mine operators – are only approved when the evidence establishes that the miner is totally disabled by pneumoconiosis arising out of coal mine employment or, in the case of a survivor claim, that the miner's death was attributable to the disease. The approval rate for Black Lung claims was 32.7% in fiscal year 2019. Furthermore, in fiscal year 2019, the number of Part B beneficiaries declined by 13.9% and benefit payments decreased by 12.0% from fiscal year 2018. The number of Part C beneficiaries increased only nominally, by 0.3% in fiscal year 2019, while benefit payments decreased by 5.7% from fiscal year 2018.

In calculating benefits, the Black Lung program must consider whether or not the beneficiary receives other compensation. If a miner receives state workers' compensation for a coal mine dust-related respiratory disability, any federal Black Lung benefit received for that disease is offset or reduced by the amount of the state benefit on a dollar-for-dollar basis. In addition, claims may be offset due to other federal benefits or earnings offsets. Black Lung Table 1 reflects the total number of beneficiaries for Part B and Part C and benefit payment amounts paid out of Federal funds. In fiscal year 2019, 990 claims were either partially or fully offset; 93.8% of these offsets were due to concurrent state benefits.

BLACK LUNG TABLE 1 – BENEFITS, PARTS B AND C, FISCAL YEAR 2019

Benefits	Part B	Part C
	2019	2019
Total number of beneficiaries	7,975	25,699
Benefit payments		
Compensation benefit payments	$65.6 million	$126.6 million
Medical benefit payments[1]	Not Applicable	$40.0 million
Total compensation and medical benefit payments	$65.6 million	$166.6 million

[1] Part C medical benefit payments include payments made for cases accepted under both Part B and Part C.

[1] A successor claim is a survivor's claim filed on a miner's record by another person; a conversion occurs when a dependent survivor is automatically entitled to benefits.

FUNDING

Black Lung benefits are paid for with general revenues from the U.S. Treasury (Part B claims) or by responsible mine operators (RMOs) or the Trust Fund (Part C claims). Black Lung Table 2 reflects Part B and Part C enacted funding and expenditures.

BLACK LUNG TABLE 2 – ENACTED FUNDING AND EXPENDITURES, FISCAL YEAR 2019[1]

Enacted Funding and Expenditures		2019	
Part B — Special Benefits for Disabled Coal Miners — General Revenue Enacted Funding and Expenditures	**OWCP Enacted Funding**	**Number of Employees (Full-time Equivalent (FTE) staff)**	16
		OWCP Enacted Funding	$4.9 million
	Benefits — Compensation		$65.6 million
	Total		$70.5 million
Part C — Black Lung Disablity Trust Fund — Enacted Funding and Expenditures	**OWCP Enacted Funding and Expenditures**	**Number of Employees (FTE staff)**	158
		OWCP Administrative Funding	$35.9 million
		Other Administrative Expenditures[2]	$30.7 million
		Total	$66.6 million
	Trust Fund — Payments to the Treasury	**1-year obligation payments to Treasury (for advances and interest)**	$1,949.5 million
		Bond payments	$181.5 million
		Total Payments to the Treasury	$2,131.0 million
	Benefits — Compensation and Medical Benefits[3]		$166.6 million
	Total		$2,364.2 million

[1] Funding totals are post-sequestration.

[2] Other administrative expenses include legal, financial, and investigative support provided by the Office of the Solicitor, the Office of Administrative Law Judges, the Benefits Review Board, the Office of Inspector General, and the Department of the Treasury. These amounts are transferred to the appropriate agencies.

[3] Includes only Trust Fund compensation and benefits (excluding collections from responsible coal mine operators for benefits paid by the Trust Fund on an interim basis, refunds for OWCP administrative costs paid, and other miscellaneous reimbursements). Excluded are self-insured mine operator and insurance carrier payments. Part C medical benefit payments include payments made for cases accepted under both Part B and Part C.

Part B — General Revenues
In fiscal year 2019, Part B expenditures, paid for with general revenues from the U.S. Treasury, came to $70.5 million, down 5.5% from the previous year. The program used 93.0% of expenditures to pay benefits and the remaining 7.0% covered administrative expenses.

Part C — Black Lung Disability Trust Fund
Created by the Black Lung Benefits Revenue Act of 1977, the Trust Fund pays Part C benefits in cases where the program cannot identify an RMO or where the liable operator does not meet its payment obligations. It also covers claims filed with DOL based on pre-1970 employment. The Secretaries of Labor, Treasury, and Health and Human Services jointly administer the Trust Fund.

Trust Fund generated revenues from several sources including:

1. An excise tax on mined coal that is sold or used by producers in the United States (the principal source of revenue);
2. Funds collected from RMOs for monies they owe the Trust Fund including payments of various fines, penalties, and interest;
3. Refunds collected from beneficiaries due to an overpayment; and
4. Repayable advances obtained from Treasury's general fund when Trust Fund expenses exceed revenues.

Black Lung Table 3 contains a breakdown of Trust Fund revenues in fiscal year 2019.

BLACK LUNG TABLE 3 – TRUST FUND REVENUES, FISCAL YEAR 2019

Revenues	2019
Excise tax collections	$216.6 million
Other RMO collections — interim benefits, fines, penalties, interest	$21.5 million
Repayable advances from Treasury	$1,870.0 million
Total revenues	$2,108.1 million

DOL's Agency Financial Report provides additional financial information on the Trust Fund.

- **https://www.dol.gov/sites/dolgov/files/OPA/reports/2019annualreport.pdf**

ACCOMPLISHMENTS AND PERFORMANCE

Until December 31, 2018, the coal excise tax rates were $1.10 per ton of underground-mined coal and $0.55 per ton of surface-mined coal sold, with a cap of 4.4% of the sales price. Beginning January 1, 2019, the coal excise tax rates reverted to the statutory limit under the Internal Revenue Code: $0.50 per ton of underground-mined coal and $0.25 per ton of surface-mined coal sold, with a limit of 2.0% of total sales. As a result, excise tax collections decreased by 43.7% between fiscal years 2018 and 2019, from $384.4 million to $216.6 million, respectively. Other RMO collections also decreased by $13.0 million, or 37.7%, between fiscal years 2018 and 2019. Advances from Treasury remained relatively stable between fiscal years 2018 and 2019, but still decreased by $30.0 million. Overall, the decreases in excise tax collections, other RMO collections, and repayable advances from Treasury combined to result in a total revenue decrease of 9.1% between fiscal year 2018 and fiscal year 2019.

In fiscal year 2019, the Black Lung program continued to focus on strategic operational initiatives designed to enhance overall productivity, boost program efficiency, and improve decision quality. These initiatives – which included focused claims inventory management, transition to end-to-end claims processing, streamlining and centralization of key operational processes, and standardization of performance management – are discussed below.

The Operational Environment

Incoming claims reached 7,448 in fiscal year 2016 and held relatively steady at 7,386 in 2017 before declining moderately to 6,673 in 2018. In fiscal year 2019, the program received 6,806 claims, which represents a 2.0% increase from the previous year.

In addition, economic factors resulted in 12 coal company bankruptcies since 2013, which increased the number of claims accepted and handled by the Trust Fund for six of the bankrupt companies. Bankruptcies are especially challenging for the Black Lung program because the program must handle claims timely and appropriately, so that there are no disruptions to benefit payments expected by the beneficiaries.

As a result of high claims volumes and the transfer of some claims to the Trust Fund following coal company bankruptcies, the program's overall workload expanded. To keep pace with the increasing workload, the program continued to implement key strategic operational initiatives in fiscal year 2019 designed to enhance overall productivity and boost program efficiency.

Claims Inventory Management

An increased workload, coupled with the loss of experienced staff, has resulted in a large inventory of claims pending a decision. While staff handled the majority in the normal course of business, there was a moderately sized group of aged claims. The program used its overall focus on inventory management to effectively reduce the number of claims pending. At the end of fiscal year 2018, there were 5,281 claims pending a decision. Fiscal year 2019 saw an almost 4.0% reduction in pending claims, with 5,079 claims pending at year end. Overall, the program issued 6,241 Proposed Decisions and Orders (PDOs) in fiscal year 2019.

The program worked with Departmental leadership to develop a new DOL Strategic Plan Goal that created a five-year plan to address pending claims inventory management. In response to the goal outlined in the fiscal years 2018-2022 DOL Strategic Plan under Strategic Objective 3.1, the program sought to reduce the number of claims pending for more than 365 days as a percentage of the total pending claims inventory to 15.0% in fiscal year 2019. The program's claims inventory that was 365 days or older was reduced from 15.2% at the end of fiscal year 2018 to 12.3% at the end of fiscal year 2019.

In fiscal year 2019, the program implemented four new performance measures with an emphasis on adjudication "touch times" rather than a focus only on overall timeliness. The new "touch time" measures focus on both the length of time between claim receipt and claim development actions, and the issuance of a decision after the completion of claim development. The intent of these new measures is to focus on actions that drive the completion of claim development and decision issuance, thereby decreasing overall claim processing time. As outlined in Black Lung Table 4, the program exceeded the targets for the four measures.

BLACK LUNG TABLE 4 – PERFORMANCE MEASURE RESULTS, FISCAL YEAR 2019

Performance Measures	2019 Target	2019 Result
Average number of days to issue Notice of Claim following claim receipt	65 days	37 days
Average number of days to complete medical authorization after receipt of provider selection	15 days	10 days
Average number of days to complete Schedule for the Submission of Additional Evidence following completion of initial claim development	65 days	47 days
Average number of days to complete PDO following completion of all claim development for all Responsible Operator Merit claims	35 days	29 days

In addition to exceeding the new touch time goals, overall timeliness also improved. In fiscal year 2018, the aggregate average number of days to issue a PDO was 335 days and in fiscal year 2019, that average decreased to 304 days. This represents a decrease in processing days of approximately 9.3%.

Transition to End-to-End Claims Processing

The program transitioned to end-to-end claims processing in fiscal year 2019. Previously, the Black Lung program had specialized claims examiners who had a focused workload, which was different from non-specialized claims examiners. After the transition to end-to-end claims processing, the program eliminated its specialized workload and all claims staff in the program began to perform all the work on a claim from end-to-end. In the end-to-end model, the program assigned claims equitably from the day they are filed and claims are managed by the same claims examiner throughout the life of the claim. This gives claims examiners better control over the work that they perform on their cases and ensures that all claims examiners are cross-trained on all claims processes, which is an important part of the program's succession planning.

Process Streamlining and Automatization

In recent years, the program piloted and has now fully implemented the Outgoing Correspondence Center (OCC), which centralizes printing and mailing functions with contract staff. The OCC now includes both telework and in-office printing for all eight district offices and furthers the program's efforts to maximize and prioritize the time claims examiners spend on their primary mission of adjudicating claims and issuing decisions. In fiscal year 2019, the program made additional changes to streamline mailing functions by eliminating the practice of requesting return receipts when sending certified mail. Return receipts incurred additional postage costs, which were determined to be unnecessary for proof of sending documents via certified mail. The change saves both claims examiners and contract staff time and the program the postage expenditure.

The program continues to utilize the Central Case Create and Assignment (CCCA) to promote uniformity, consistency, and standardization across all district offices through equity in case distribution. In fiscal year 2019, the program fully automated the CCCA process. Contract staff no longer manually assigned claims; instead, the program automatically assigned them through the Automated Support Package computer program. The enhancement improved accuracy of case assignments and allowed the program to assign contract staff resources to other duties. Additionally, in fiscal year 2019, the CCCA began using a true round-robin logic for all case assignments. Cases were assigned equally across the program without consideration to geographic jurisdiction. Previously, the program utilized a hybrid model that considered previous geographic jurisdictions as a factor in case assignments.

Prototype Performance Standards

In recent years, the program has developed prototype performance standards for both claims examiners and workers' compensation assistants. This work continued in fiscal year 2019 with the implementation of prototype standards for supervisors and district directors. The program aligned key productivity, quality, and timeliness metrics with specific measures in supervisor prototype performance standards. In this way, the program integrated its priorities with overarching operational metrics that cascade from executive leadership at the national and regional level to district office staff nationwide.

STAKEHOLDER ENGAGEMENT

The Black Lung program is committed to providing a high-quality customer experience – for its claimants and beneficiaries as well as its many stakeholders, including: medical providers; RMOs and insurance carriers; federal partners (SSA, the Department of Health and Human Services' National Institute for Occupational Safety and Health, and the Health Resources and Services Administration (HRSA)); and internal DOL organizations (Mine Safety and Health Administration, the Office of the Administrative Law Judges (OALJ), and the Benefits Review Board (BRB)). In fiscal year 2019, the Black Lung program continued outreach to these groups.

Medical providers are a key component of the Black Lung program – both in providing medical data to determine whether the miner has compensable totally disabling pneumoconiosis and in providing medical services to approved beneficiaries. Section 413(b) of the BLBA requires OWCP to provide each miner who files a claim with the opportunity to undergo a complete pulmonary evaluation at no cost to the miner. The Black Lung program continued to work with the medical community and program stakeholders to improve the quality of these medical evaluations and reports. The program worked with HRSA to encourage the inclusion of medical scheduling timeliness standards in the awarding of grants to clinics partially funded by HRSA. The program also continued to update the list of approved diagnostic physicians by requesting accurate certification and specialty information to help ensure that highly qualified doctors were available to perform medical evaluations.

PROGRAM MANAGEMENT AND INTEGRITY

The Black Lung program implemented changes to strengthen program management and program integrity. These changes focused on four general areas: quality assurance, information technology, medical bill processing, and improper payments.

Quality Assurance
The program continues to work on strengthening the integrity of its adjudication process by reviewing claims for quality before the release of the PDO, obtaining supplemental medical evidence when warranted, and conducting annual reviews for quality assessments across all district offices.

Spot Audits: The Black Lung program continued to use spot audits as a precursor to the annual accountability review process and to provide an additional means of monitoring decision quality on a regular basis. Under this program, approximately 5% of decisions are randomly selected by district office managers for review before issuance of a PDO. In addition, the program reviews all decisions involving a diagnosis of complicated pneumoconiosis—an especially severe form of black lung disease characterized by large lesions in the lungs—as part of the spot audit initiative.

Section 413(b) Pilot Initiative: The Black Lung program continued to use a supplemental medical evidence review process to strengthen the complete pulmonary evaluations given to miners by developing additional medical evidence for claims in which the miner worked at least 15 years in coal mine employment and the initial medical evaluation supports an award of benefits. In these cases, any additional evidence received from the RMO or claimant is referred to the physician who provided the miner's DOL-sponsored examination. The physician is asked to provide a supplemental report based on the full body of evidence, which the district director then factors into the decision-making process.

Annual Accountability Review: The program conducts an annual accountability review to target quality assurance improvement. In recent years, the program revised the annual accountability review to simultaneously have virtual teams review work from all district offices instead of in person reviews of only half of the district offices. The annual accountability review addresses the quality of case processing, financial and management controls, and administrative functions. Annualizing the review of all district offices with a one-year review period allows the program to identify areas for correction, training, and process improvement and to implement uniform, program wide solutions. The annual accountability review no longer requires any travel, saving time and money, and consolidating the review resulted in one robust document for the Black Lung program to use as a learning tool.

In fiscal year 2019, the program transitioned to using claims examiners from the Branch of Standards, Regulations, and Procedures to perform the annual review. The review team composition alleviates workflow disruption allowing district office staff to focus on claims development and adjudication. The program analyzed remands from the OALJ and BRB and the impact of those remands on the Trust Fund. Additionally, the program analyzed PDO reversals to determine the reason for the reversal. The program evaluated if each PDO reversal originated due to district office error or due to the introduction of new evidence. The program continues to use quarterly spot audits as its primary means of monitoring decision quality, yielding real-time quarterly and annual aggregate performance data.

Efforts to Address Improper Payments and Payment Accuracy
The Black Lung program continued to match its beneficiary file to the SSA Death Master File weekly to reduce the incidence of improper payments. The program also continued to maintain the accuracy of payments by updating beneficiary information annually and conducting Annual Benefit Evaluations to minimize erroneous payments. In addition, the program continued to carefully evaluate the appointment of representative payees (appointed when a beneficiary requires assistance with his or her finances) and related expenditure reports to verify that benefits are used in the beneficiaries' best interest.

The program is responsible for ensuring that it provides all benefits accurately and on time. As part of its benefits management program, the Black Lung program conducts Annual Benefit Evaluations to assess whether or not beneficiaries are receiving the appropriate benefits. The program tracks the extent to which it is accurately delivering benefits and meeting established standards. The annual evaluation of beneficiaries allows for early detection of fraud and safeguards against the overpayment of benefits. In fiscal year 2019, the Black Lung program was able to complete 99% of its benefit evaluations within 60 days.

Responsible Mine Operator Oversight

Coal mine operators must self-insure or purchase commercial insurance, or they are subject to civil money penalties (specified in 20 C.F.R. 726.302) for each day of noncompliance. Under the Act, the Secretary of Labor can authorize a coal mine operator to self-insure after an analysis of the company's application and supporting documents.

The program evaluates whether or not it should authorize a RMO to self-insure, monitors insurance policy coverage, and oversees RMO's timely payment of benefits as required. In fiscal year 2019, the program implemented a new process to set security amounts based on operators' actuarial-estimated liabilities and financial health or risk of default. The improvements in the new self-insurance process allow the program to estimate operator liability more accurately, require adequate security, recalculate security amounts as necessary in response to emerging developments, and better protect the Trust Fund from any future defaults by operators on benefits payments. Black Lung Table 5 outlines the current information concerning RMOs for fiscal year 2019.

BLACK LUNG TABLE 5 – RESPONSIBLE MINE OPERATORS, FISCAL YEAR 2019

Responsible Mine Operators (RMOs)	2019
Number of active RMOs authorized to self-Insure (at year-end)[1]	21
Number of commercial insurance policies w/a Federal Black Lung endorsement attached	1,268
Number of Covered Chief Beneficiaries paid by RMOs (does not include eligible dependents)	5,386

[1] RMOs or parent companies who are actively mining.

Information Technology

During fiscal year 2019, the program modernized the "case create" section to allow new claims to be automatically system-assigned to claims examiners. In addition, the program has initiated a project to fully digitize all claims by scanning all paper cases in all offices. Modernization efforts have also included the initial development of new business intelligence reporting platform software, to enhance the program's reporting and data analyzing capabilities. These information technology improvements are more fully described below. The program:

- Enhanced the program's ability to system-generate the assignment of new incoming claims to claims examiners across the nation. This allows for more equalized workloads for all claims examiners, and provides for a more efficient method of completing PDOs in a timely manner.
- Initiated a nationwide scanning effort to convert all paper claim files to digital, to be housed in the OWCP Imaging System. During the 2019 fiscal year, the district offices in Johnstown, Pennsylvania and Greensburg, Pennsylvania transitioned to 100% digital case files, saving on office space and providing for a more secure environment for case file documents. The remaining six district offices simultaneously started to convert their paper claim files to digital, with the expectation that more district offices will be transitioning to 100% digital case files.

- Began testing and development of Microsoft Power Business Intelligence software, which will modernize the program's current data reporting and data analysis methods by providing expanded capabilities for National Office and district office staff to more efficiently obtain ad hoc and standardized reporting data. This business intelligence software will also further increase the program's ability to identify trends, potential issues, and to more effectively respond to customer service needs in a timely manner.

Medical Bill Processing

Timely and accurate medical bill processing is a critical element in the administration of the Black Lung program. In fiscal year 2019, the program (through the Central Bill Processing contract) processed 76,581 Black Lung medical bills of which 99.5% were processed within 28 days. A total of $12,000,000 in medical costs were avoided due to improvements in medical bill pay processing. In fiscal year 2019, 176 new medical providers were enrolled to provide services to beneficiaries, bringing the total of actively enrolled providers to 55,680.

REGULATORY INITIATIVES

Medical Testing Standards under the Black Lung Benefits Act

In September of 2019, OWCP published a Request for Information in the Federal Register seeking public input by January 2020 on updating the standards for administering and interpreting medical testing done in connection with claims for benefits under the BLBA. OWCP sought public input on: how existing standards for administering and interpreting pulmonary function tests should be updated; how existing standards for administering and interpreting arterial blood gas studies should be updated; whether OWCP should adopt standards for pulse oximetry or lung diffusion testing; and the potential economic impact of any such changes. OWCP sought input from medical professionals, medical associations, black lung clinics, employers, miners, insurance carriers, trade associations, and any other interested parties.

The Request for Information is available on the Federal Register website at: **https://www.federalregister.gov/documents/2019/09/27/2019-20851/black-lung-benefits-act-quality-standards-for-medical-testing**.

ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT (ENERGY)

INTRODUCTION

The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) was enacted in October 2000. The Department of Labor (DOL) began providing benefits under Part B of the EEOICPA on July 31, 2001. Part B compensates current or former employees (or their eligible survivors) of the Department of Energy (DOE), its predecessor agencies, and certain vendors, contractors, and subcontractors, who were diagnosed with a radiogenic cancer, chronic beryllium disease, beryllium sensitivity, or chronic silicosis as a result of exposure to radiation, beryllium, or silica while employed at covered nuclear weapons facilities. The law also provides compensation to individuals (or their eligible survivors) awarded by the Department of Justice (DOJ) under Section 5 of the Radiation Exposure Compensation Act (RECA). Part E of the EEOICPA, enacted on October 28, 2004, compensates DOE contractor/subcontractor employees (or their eligible survivors) and uranium miners, millers, and ore transporters for occupational illnesses that are linked to toxic exposures at covered DOE facilities.

Implementation of the EEOICPA involves the coordinated efforts of four federal agencies:

- DOL, through the Office of Workers' Compensation Programs (OWCP), has primary responsibility for the adjudication of claims for compensation, payment of benefits for conditions covered by Part B and Part E, and determining covered DOE facilities.
- DOE's role is to designate Atomic Weapons Employer facilities, provide information to identify covered facilities, and provide DOL and the Department of Health and Human Services (HHS) with verification of covered employment and relevant information on exposures.
- DOJ notifies beneficiaries who have received an award of benefits under RECA Section 5 of their possible EEOICPA eligibility and provides RECA claimants with the information required by DOL to complete the claim development process.
- HHS, through the National Institute for Occupational Safety and Health (NIOSH), establishes procedures for estimating radiation doses and designating new Special Exposure Cohort (SEC) classes; develops guidelines to determine the probability that cancer was caused by workplace exposure to radiation; and carries out dose reconstruction for cases referred by DOL. HHS also provides administrative services and other necessary support to the Advisory Board on Radiation and Worker Health (ABRWH). The ABRWH advises HHS on the scientific validity and quality of dose reconstruction efforts, and receives and provides recommendations on petitions requesting additional classes of employees for inclusion as members of the SEC.

BENEFITS AND SERVICES

To determine whether an individual is eligible for benefits under the EEOICPA, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) program staff must analyze both the employee's employment history and medical evidence.

A covered employee who qualifies for benefits under Part B may receive a one-time lump-sum payment of $150,000, plus medical expenses related to an accepted, covered condition. Survivors of these workers may also be eligible for a lump-sum compensation payment. Part B also provides for payment of $50,000 to uranium workers (or their eligible survivors) who received an award from DOJ under Section 5 of RECA.

In some Part B cases, NIOSH must estimate an individual's radiation dose so the Energy program staff can determine whether it is "at least as likely as not" that the individual contracted cancer because of exposure to radiation at a covered facility. In other cases, claimants may qualify for benefits as part of a class of employees in the SEC. Congress established the SEC in the EEOICPA legislation to allow for the compensation of eligible cancer claims without the completion of a radiation dose reconstruction. To qualify for compensation under the SEC, a covered employee must have one of 22 specified cancers and have worked for a certain period of time at a facility designated in the statute or as a class added to the SEC.

Part E provides benefits to employees of DOE contractors and subcontractors (or their eligible survivors) for illnesses determined to have resulted from exposure to toxic substances at a covered DOE facility. Uranium miners, millers, and ore transporters may also be eligible to receive Part E benefits. Benefits are provided for any illness if it can be determined that it was "at least as likely as not" that work-related exposure to a toxic substance was a significant factor in causing, contributing to, or aggravating the illness or death of an employee. In addition, the EEOICPA provides that any determination made under Part B to award benefits (including RECA Section 5 claims) is an automatic acceptance under Part E for causation of the illness, if the employee also met the employment criteria. Under Part E, a covered employee may be eligible to receive compensation for the percentage of impairment that is related to a covered illness, as well as any illness, injury, impairment, or disease shown by medical evidence to be a consequence of an accepted Part E illness. Eligible employees receive $2,500 for each percentage point of impairment related to the accepted condition(s). Also, covered employees may be eligible to receive wage-loss benefits of $15,000 for any year in which they made less than 50% of their baseline wage, as a result of a covered illness, and $10,000 for any year in which they made more than 50% but less than 75% of that baseline wage. The maximum payable compensation under Part E is $250,000 for all claims relating to any individual employee. Workers who are covered by both parts can receive a total of $400,000 in compensation ($150,000 for Part B and $250,000 for Part E). In addition to monetary compensation, the program pays medical benefits for covered illnesses.

Part E survivor benefits include a basic lump sum of $125,000. Survivors may receive $25,000 in additional benefits if the deceased employee had, at normal retirement age under the Social Security Act, at least 10 aggregate calendar years of wage loss of at least 50% of his or her baseline wage. If an employee had 20 or more such years, the additional amount paid to eligible survivors may increase to $50,000. The maximum Part E compensation benefit for survivors is $175,000.

Claims and Benefits

From its inception to the end of fiscal year 2019, the Energy program awarded approximately 122,000 claimants compensation and medical benefits totaling over $16.96 billion. This included $11.71 billion in compensation and $5.25 billion in medical expenses. Part B compensation accounts for approximately $6.87 billion (since 2001) of the $11.71 billion, and Part E accounts for approximately $4.84 billion (since October 28, 2004). In fiscal year 2019, the Energy program provided benefits to 16,662 individual claimants (including lump-sum, impairment, wage-loss, or medical benefits).

While the program is experiencing a general downward trend in the number of new claims, the overall caseload is not decreasing. A substantial number of prior claims now require additional or ongoing review based on new information, although the Energy program does not count them as new claims. For instance:

1. New policies or procedures and changes to the NIOSH dose reconstruction methods result in coverage to individuals who may have previously been denied;
2. The addition of new classes of employees to the SEC can result in the need for re-review of old claims; and
3. There have been more requests for claim reopening, which a claimant can request at any time after a final decision.

These instances result in a re-review of existing or previous cases and often newly recommended and final decisions, in effect extending the period of time over which the Energy program staff actively works such claims. Energy Table 1 displays information on the number of claims and/or decisions received and approved in fiscal year 2019.

ENERGY TABLE 1 — CLAIMS, DECISIONS, AND APPROVALS, FISCAL YEAR 2019

Claims, Decisions, and Approvals	Part B	Part E
	2019	2019
Number of new claims	4,763	4,736
Number of Recommended Decisions	6,913	14,275
Number of claims that received Final Decisions	6,844	14,349
Number of claims approved (Final)	2,853	7,844
Percent of claims approved (of those issued a Final Decision each year)	42%	55%
Number of claimants who received compensation during the year	1,970	4,961

In addition to the growing number of prior claims requiring additional or ongoing review, the annually increasing cumulative number of approved claims increases the workload related to ongoing case management. This increasing workload primarily consists of:

1. Consequential condition claims, which are additional medical conditions claimed as a result of previously accepted medical conditions but are not counted as new claims; and
2. Medical authorizations granting approval of medical benefit requests for accepted medical conditions (e.g., home health care, durable medical equipment, and other treatments) that require review, determination, and oversight.

The number of consequential condition claims (Part B and E combined) for fiscal year 2019 is 8,558. Energy Table 2 shows the total benefit payments in fiscal year 2019.

ENERGY TABLE 2 — BENEFIT PAYMENTS, FISCAL YEAR 2019

Benefit Payments	Part B	Part E
	2019	2019
Lump sum compensation benefit payments[1]	$238,272,922	$346,160,388
Medical benefit payments[2]	$735,014,010	$105,728,234
Total compensation and medical benefit payments	$973,286,933	$451,888,623

[1] Excludes payments made by DOL for DOJ RECA Section 5 claims. DOL serves as a pass-through and utilizes the compensation fund established under the EEOICPA for DOJ's payments of $100,000 to qualifying RECA Section 5 claimants as provided for in 42 U.S.C. § 7384u(d). These payments totaled over $6.7 million in fiscal year 2019.

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

FUNDING

The EEOICPA account funds both Energy program benefits and administrative costs. Administrative expenditures cover the Washington, D.C., headquarters; five Final Adjudication Branch (FAB) offices; four district offices; and 11 Resource Centers nationwide that are operated by a contractor. Energy Table 3 provides OWCP administrative expenditures for fiscal year 2019.

ENERGY TABLE 3 – OWCP ADMINISTRATIVE EXPENDITURES, FISCAL YEAR 2019

Administrative Expenditures	2019
Part B	
Number of employees (Full-time Equivalent (FTE) staff)	228
Part B administrative expenditures[1]	$54.7 million
Part E[2]	
Number of employees (FTE staff)	223
Part E administrative expenditures[1]	$72.1 million
Total	
Number of employees (FTE staff)	451
Total OWCP administrative expenditures[3]	$126.8 million

[1] Funding for HHS responsibilities under the EEOICPA is provided for in that agency's appropriation. Expenditures include Ombudsman B and E.

[2] Part E funding includes funding for the Energy Advisory Board.

[3] Funding totals are post-sequestration.

DOL's Agency Financial Report provides additional information on the Energy program's finances:

- **https://www.dol.gov/sites/dolgov/files/OPA/reports/2019annualreport.pdf**

ACCOMPLISHMENTS AND PERFORMANCE

During fiscal year 2019, the Energy program continued to make significant improvements in the areas of claims adjudication, medical bill processing, and provision of medical benefits and home health care benefits.

Adjudication

One of the major functions of the Energy program is to determine whether an individual qualifies for Part B and/or Part E benefits. For claims filed under Part B, the district office staff collects, develops, and evaluates employment and illness data following the EEOICPA criteria and relevant regulations and procedures. The district offices then issue recommended decisions to claimants. Claims may also be filed under Part B for the $50,000 RECA supplement.

The Energy program can act relatively quickly on claims involving "specified cancers" at SEC facilities because EEOICPA provides a presumption that any of the 22 listed specified cancers incurred by an SEC worker was caused by radiation exposure at the SEC facility. As of September 30, 2019, the SEC covered 123 classes of employees at 78 facilities.

During fiscal year 2019, NIOSH added five classes of employees to the SEC for the following facilities listed below. There were two classes of employees added for Y-12 Plant. The first covered the period between January 1, 1958 and December 31, 1976. The second covered the period between January 1, 1977 and July 31, 1979.

- Sandia National Laboratories in Albuquerque, New Mexico
- Y-12 Plant in Oak Ridge, Tennessee
- Idaho National Laboratory in Scoville, Idaho
- West Valley Demonstration Project in West Valley, New York
- Y-12 Plant in Oak Ridge, Tennessee

When NIOSH adds a new class of employees to the SEC, DOL reviews all potentially affected cases and determines whether the employee in question meets the criteria for inclusion in the new class. DOL reopens any previously denied claim meeting the new SEC class definition for additional development.

For cases involving claimed cancers that are not covered by SEC provisions under Part B (including cancers incurred at a non-SEC facility, a non-specified cancer incurred at an SEC facility, or an employee who did not have sufficient employment duration to qualify for the SEC designation), there is an intervening step to determine causation called "dose reconstruction." In these instances, once DOL determines that a worker was a covered employee and that he/she had a diagnosis of cancer, DOL refers the case to NIOSH so that NIOSH can estimate the individual's radiation dose. After NIOSH calculates a dose estimate for the worker, DOL takes this estimate and applies the methodology promulgated in the HHS probability of causation regulation to determine if the dose estimate met the statutory causality test. The standard is met if the cancer was "at least as likely as not" related to covered employment, as indicated by a determination of at least 50% probability.

Adjudication under Part E involves collecting, developing, and evaluating data to determine exposure and causation. This includes assessing health effects, utilizing the Site Exposure Matrices, assessing exposure evidence to make findings, and establishing causation. As part of the adjudication, DEEOIC makes referrals to Toxicologists, who provide analysis and opinion on health effects. In addition, DEEOIC makes referrals to an Industrial Hygienist (IH) who utilizes expertise and knowledge to make well-rationalized unbiased opinions on the nature, frequency, and duration of exposure. In fiscal year 2019, DEEOIC made 1,795 referrals to an IH. DEEOIC also uses the services of a contractor to coordinate referrals of cases to qualified medical specialists. A Contract Medical Consultant (CMC) is a contracted

physician who conducts a review of case records to render opinions on medical questions. The function of a CMC is to provide clarity to claims situations in the absence of pertinent or relevant medical evidence from other sources that support the claim. In fiscal year 2019, DEEOIC made 2,634 referrals to a CMC.

Recommended and Final Decisions

The district offices issue a recommended decision to approve or deny a specific claim. The FAB must review each recommended decision. Individuals who disagree with the recommended decision on a claim may object by requesting an oral hearing or a review of the written record from the FAB. The FAB issues a final decision on each claim either awarding or denying benefits. The FAB may also remand a decision to the district office if further development of the case is necessary. A claimant may challenge the FAB's final decision by requesting reconsideration or reopening of the claim, or may file a petition for review of a final decision with the appropriate U.S. District Court.

Of the claims on which the FAB issued final decisions in fiscal year 2019, DOL approved benefits for 42% of Part B claims and 55% of Part E claims. Energy Table 4 provides the number of reviews, hearings, and decisions by type for fiscal year 2019.

ENERGY TABLE 4 – REVIEWS, HEARINGS, AND DECISIONS, FISCAL YEAR 2019

Parts B and E	2019
Number of Recommended Decisions – District Office	21,188
Number of Reviews of the Written Record – FAB	844
Number of oral hearings conducted – FAB	595
Number of claims that received Final Decisions – FAB	21,193

The Energy program continued its strong record of performance, focusing on both timeliness and quality standards for the claims adjudication and decision-making processes in both the district offices and the FAB. Energy Table 5 presents performance targets and results for claims adjudication measures for fiscal year 2019.

ENERGY TABLE 5 – PERFORMANCE MEASURE RESULTS, FISCAL YEAR 2019

Performance Measures	2019 Target	2019 Result
Average number of days between filing date and final decision for cases sent to NIOSH when a hearing is held – Parts B and E[1]	Contextual	522 days
Average number of days between filing date and final decision for cases sent to NIOSH when a hearing is not held – Parts B and E[1]	Contextual	369 days
Average number of days between filing date and final decision for cases not sent to NIOSH when a hearing is held – Parts B and E	315 days	318 days
Average number of days between filing date and final decision for cases not sent to NIOSH when a hearing is not held – Parts B and E	170 days	155 days
Average number of days to process initial claims – Parts B and E	100 days	86 days
Percent of sampled Part B and Part E initial claims rated as being accurate	90.00%	94.00%
Percent of sampled Part B and Part E initial claims with final decisions rated as being accurate	90.00%	95.37%

[1] While the timeliness data for claims that go to NIOSH is informative, it is not useful for judging agency performance; the Energy program made the performance targets related to NIOSH contextual in fiscal year 2015.

Medical Bill Processing

In addition to adjudicating claims, the Energy program is responsible for seeing that beneficiaries receive the appropriate benefits – in terms of both compensation and medical benefits. As part of the Energy program benefit structure, OWCP provides home health care services to severely ill covered employees where medically necessary. The volume of these requests continues to increase due to the aging claimant population and their physical needs. Seeing that beneficiaries receive prompt authorization for medical treatment, and that OWCP pays providers quickly and correctly, is critical to the administration of EEOICPA. Energy Table 6 presents medical bill processing information for fiscal year 2019.

ENERGY TABLE 6 – MEDICAL BILL PROCESSING ACTIVITY, FISCAL YEAR 2019

Volume	2019
Average number of workdays to process medical authorizations	1 day
Number of medical bills processed	606,227
Percent of medical bills processed within 28 days	97.9%
Number of newly enrolled providers	250
Number of total enrolled providers (end of year)	163,218
Cost avoidance due to improvements in medical bill processing	$57 million

Medical Benefits and Home Health Care Management

The volume of requests for medical benefits continues to increase due to the growing home health care industry and the program's elderly claimant population. Given instances of fraud previously seen in the home health care and medical bill sectors, it is important that the program verify the services provided to claimants.

Consequently, the Energy program centralized the processes for these requests in the Branch of Medical Benefits in the National Office. Staff is comprised of bill payment and coding analysts, medical benefit examiners, and program integrity analysts for audits and data analysis. The staff specializes in supporting medical benefits billing, adjudicating home health care requests, and analyzing data to reduce potential waste, fraud, and abuse. Energy Table 7 displays performance results and targets for the management of home health care benefits for fiscal year 2019.

ENERGY TABLE 7 – PERFORMANCE RESULTS - HOME HEALTH CARE BENEFITS MANAGEMENT, FISCAL YEAR 2019

Performance Measures	2019 Target	2019 Result
Average annual cost of home health care payments for an employee	Contextual	$90,021
Percent of sampled Part B and Part E home health care authorizations rated as being accurate	90.00%	90.00%

STAKEHOLDER ENGAGEMENT AND OUTREACH

The Energy program continues to focus its outreach on both nuclear weapons workers and health care providers. The purpose of the outreach is to:

1. Educate potential claimants and current beneficiaries about the program, assist with filing claims, and provide an understanding of the adjudication process; and
2. Inform health care providers (including physicians and home health care organizations) about EEOICPA benefits as well as their responsibilities in prescribing care and providing services.

The program also posts information and technical assistance on its website.

In fiscal year 2019, the program conducted a series of face-to-face outreach events across the country with nuclear weapons workers and their families, to make qualified workers and their survivors aware of the program and discuss how to complete and submit claims. Energy Table 8 presents details on the face-to-face and telephonic outreach events sponsored by the Energy program in fiscal year 2019.

ENERGY TABLE 8 – ENERGY PROGRAM SPONSORED OUTREACH, FISCAL YEAR 2019

2019 Energy Program Sponsored Outreach			
Location	**Principal Audience**	**Number of Participants**	**Purpose**
Washington, District of Columbia	Authorized Representatives; claimants; medical providers; advocates; and unions	80	Provide an overview of the DEEOIC program, duties of each branch, how the program manages medical benefits, as well as, upcoming website and program changes.
Lynchburg, Virginia	Current and former nuclear weapons workers of BWX Technologies Plant and survivors.	100	Provide information regarding the mission of the EEOICPA and the medical benefits available to approved claimants, including medical authorizations, home health care services, and travel expense reimbursement.
Conference Call Dates	**Principal Audience**	**Number of Participants**	**Purpose**
April 25 and 26, 2019	Medical Providers	112	Share information on EEOICPA benefits and how to better serve claimants.

Resource Centers

The Energy program's network of resource centers near major DOE sites provides an initial point-of-contact for workers interested in the program and to individuals filing claims under the EEOICPA. As of fiscal year 2019, approximately 61 resource center contract employees at 11 sites are available to assist claimants in completing necessary claim forms and gathering documentation that can support their claims. The staff assists with initial claim filing and Part E occupational history development, forwards all claims and associated documentation to the appropriate district office, and supports town hall meetings, traveling resource centers, and Joint Outreach Task Group (JOTG) events. Energy Table 9 presents the resource centers' technical assistance accomplishments for fiscal year 2019.

The DEEOIC implemented a national phone queue in the Interactive Voice Response phone system to improve customer service by having all incoming calls flow to a National Queue. In 2019, the resource center staff began answering all calls that come into the Queue. This change has resulted in an increase in the number of calls answered by a live representative, efficiency in answering basic questions, ensuring calls are directed to the correct person, and increased documentation of all calls. Additionally, the change has resulted in a dramatic decrease in hold times.

ENERGY TABLE 9 – RESOURCE CENTER ACCOMPLISHMENTS, FISCAL YEAR 2019

Activity	2019
Claims filed	8,481
Telephone calls received	56,317
Follow-up actions with claimants conducted	125,247
Occupational history interviews conducted	3,971

Joint Outreach Task Group

The JOTG consists of representatives from the DOL's Energy program, DOL's Office of the Ombudsman for EEOICPA, NIOSH, and the Ombudsman to NIOSH for the EEOICPA, DOE, and DOE's Former Worker Program. In fiscal year 2019, the program hosted two new outreach events for authorized representatives. The Authorized Representative Workshop is a two-day event for Authorized Representatives and attorneys who represent claimants under EEOICPA. During the workshop, DOL staff, as well as representatives from DOE, NIOSH, DOJ, and the Offices of the Ombudsman to both NIOSH and DOL present information on their roles in the program. Energy Table 10 displays JOTG sponsored outreach activities completed in fiscal year 2019.

ENERGY TABLE 10 – JOTG SPONSORED OUTREACH, FISCAL YEAR 2019

2019 JOTG Sponsored Outreach Events			
Location	**Principal Audience**	**Number of Participants**	**Purpose**
Cincinnati, Ohio	Authorized Representatives	30	Training session regarding adjudication, compensation, and medical benefits under the EEOICPA.
Oak Ridge, Tennessee	Current and former nuclear weapons workers and survivors	100	Information session regarding the Y-12 Plant SEC.
Brookhaven Middle Island, New York	Current and former nuclear weapons workers and survivors	95	Information session regarding compensation and medical benefits covered under the EEOICPA.
Las Vegas, Nevada	Authorized Representatives	51	Training session regarding adjudication, compensation, and medical benefits under the EEOICPA.
Paducah, Kentucky	Claimants, Authorized Representatives, and Providers	163	Information session regarding compensation, and medical benefits covered under the EEOICPA.
Bolingbrook, Illinois	Current and former nuclear weapons workers of Argonne National Laboratory, Metallurgical Laboratory, Fermi National Accelerator Laboratory, and survivors.	75	Information session regarding compensation, and medical benefits covered under the EEOICPA.

PROGRAM MANAGEMENT AND INTEGRITY

Information Technology and Program Enhancements

The Energy program made significant strides in expanding and enhancing its use of Information Technology to improve program performance and better meet customer needs. Accomplishments include:

Energy Document Portal and the Central Mail Room: The Energy Document Portal (EDP) allows the Energy program claimants to upload documents directly into their imaged case files. Electronically submitted documents are available to claims staff immediately after the document upload is complete, thus eliminating the delays of mailing. The program uses a Central Mail Room (CMR) to process incoming correspondence and transmit it to the OWCP Imaging System (OIS) for electronic access. Energy Table 11 shows the number of documents submitted through EDP and through the CMR.

ENERGY TABLE 11 – EDP AND CMR ACTIVITY, FISCAL YEAR 2019

Activity	2019
EDP documents received	97,617
CMR documents transmitted to OIS	48,007

Correspondence Creation and Tracking System: Correspondence Creation and Tracking System (CCAT) is a tool that pulls case-specific information from the Energy Compensation System and places it within correspondence issued to various stakeholders, leading to a reduction in errors and faster correspondence creation time. The first release of CCAT occurred in September 2016. In fiscal year 2017, over 19,000 documents were created using CCAT. The number of documents created using CCAT has since steadily increased; in 2019, 35,495 documents were created using CCAT. The Energy program plans to work with OWCP to continue the development of the tool for a broader library of correspondence document types.

Secure Access Management Service: The Energy program fully implemented the Secure Access Management Service portal, a method that allows for the sharing of documents to and from NIOSH electronically, with the anticipation that the use of the technology will continue to help bring down end-to-end claims adjudication time when NIOSH referrals occur.

Center for Construction Research and Training: Formerly called the Center to Protect Workers' Rights, Center for Construction Research and Training (CPWR) has continued its work under contract with the Energy program. The program tasked the CPWR with electronically tracking all evidence collected or received in support of a contractor or subcontractor relationship with the DOE. The web-accessible database identifies and confirms the existence of contractual relationships between contractor and subcontractor employers and certain covered facilities and is available to claims examiners for use in the adjudication of claims. Additionally, the database is available to the public to view the contractors and subcontractors and the sites at which they have worked. In 2018, the Energy program shifted priorities from only adding subcontractors to the database to finding additional documentation to strengthen the evidence showing contractual relationships between contractor and subcontractor employers and certain covered facilities. In fiscal year 2019, a total of 2,358 claims examiners and members of public viewed the database 18,262 times. CPWR responded to 129 requests for assistance with contractual relationships from claims examiners. In fiscal year 2019, CPWR added 217 new subcontractors to the database with a total of 13,287 contractors and subcontractors.

Site Exposure Matrices Database: The Energy program continued to enhance its Site Exposure Matrices (SEM) database, which is a relational database that contains information regarding the toxic substances linked to job categories at particular DOE facilities. The Energy program built the SEM with the intent of easing claimants' evidentiary burdens and expediting the claims process. The publicly viewable Internet Accessible SEM (IAS) website contains the same information on each DOE and RECA site that DEEOIC uses, delayed by approximately six months for classification reviews by DOE.

In fiscal year 2019, the Energy program continued to enhance the SEM database by adding nine initial profiles for smaller DOE sites that the DOE Formerly Utilized Sites Remedial Action Program remediated. In addition, significant increases in content were completed for several DOE sites including the addition of Depleted Uranium Conversion Facility data in the Portsmouth and Paducah Gaseous Diffusion Plant profiles; a 60% increase in content of the General

Electric-Ohio (Evendale) profile; a 22% increase in Savannah River Site information; and an 87% increase in the profile information for the Waste Isolation Pilot Plant. The program also continued to add profiles for decontaminated and decommissioned DOE sites with the completion of a profile for closure activities at Area IV of the Santa Susanna Field Laboratory.

The Energy program updated the public IAS twice (during November and May). As of September 30, 2019, the SEM housed information on more than 16,400 toxic substances or chemicals used at 139 DOE sites and approximately 4,000 additional RECA sites (including uranium mines, mills, ore buying stations, and ore transporters covered under the EEOICPA).

OMBUDSMAN

The National Defense Authorization Act for Fiscal Year 2005 (Public Law 108-375) created an Office of the Ombudsman at DOL for a period of three years to provide information to claimants, potential claimants, and other interested parties on the benefits available under Part E of the EEOICPA. Subsequent legislation extended the term of the Ombudsman's office through October 28, 2020. The National Defense Authorization Act of 2009 expanded the authority of the Office to also include Part B.

The Office of the Ombudsman is within DOL, but independent from OWCP. It reports annually to Congress on complaints, grievances, and requests for assistance. The Energy program continues to work directly with the Ombudsman's office to promptly resolve any issues and concerns stemming from the Ombudsman's findings.

ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER HEALTH

The National Defense Authorization Act of 2015 (Public Law 113-291), as amended, modified the EEOICPA to include Section 3687, creating the Advisory Board on Toxic Substances and Worker Health to advise the Secretary of Labor (as delegated by Executive Order 13699) concerning technical aspects of the EEOICPA program. The Advisory Board is charged with advising the Secretary on four statutorily-specified technical issues related to EEOICPA: DOL's SEM; medical guidance for claims examiners with respect to the weighing of medical evidence of claimants; evidentiary requirements for claims under Part B related to lung disease; and the work of IHs, staff physicians, and consulting physicians to ensure quality, objectivity, and consistency; the claims adjudication process generally, including review of procedure manual changes prior to incorporation into the manual and claims for medical benefits; and such other matters as the Secretary considers appropriate.

The Advisory Board Chair forwarded its fifth and sixth set of recommendations to the Secretary during fiscal year 2019. The Advisory Board sunsets on December 19, 2024 (Public Law 115-91). For more information, see the Advisory Board's website at **https://www.dol.gov/owcp/energy/regs/compliance/AdvisoryBoard.htm**.

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TABLES

Federal Employees' Compensation Act (FECA) Program Tables

TABLE A1 – FEDERAL EMPLOYEES' COMPENSATION ROLLS, FISCAL YEARS 2010 – 2019 (CASES AT END-OF-YEAR)

Type	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total Periodic Roll	49,517	45,382	49,436	47,511	46,415	45,412	43,656	42,577	41,417	40,168
Long-Term Disability	45,263	45,382	45,490	43,726	42,762	42,128	40,524	39,572	38,551	37,441
Death	4,254	4,106	3,946	3,785	3,653	3,284	3,132	3,005	2,866	2,727

TABLE A2 – FEDERAL EMPLOYEES' COMPENSATION PROGRAM SUMMARY OF CLAIMS ACTIVITY, FISCAL YEARS 2010 – 2019

Incoming Cases	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Cases Created	127,526	121,290	115,697	113,880	114,316	112,332	109,249	108,406	106,956	100,534
Traumatic	111,121	105,688	99,832	98,203	100,124	98,974	96,750	95,962	94,811	89,166
Occupational Disease	16,300	15,501	15,757	15,579	14,488	13,549	13,084	12,402	12,146	11,283
Fatal Cases	105	101	108	98	93	103	128	120	91	71
Wage-Loss Claims Initiated	19,861	20,239	19,806	18,703	18,895	17,988	16,934	16,801	16,762	16,335

TABLE A3 – FEDERAL EMPLOYEES' COMPENSATION PROGRAM EXPENDITURES AND ENACTED FUNDING, FISCAL YEARS 2010 – 2019 ($ THOUSANDS)

Category	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total Expenditures	$3,015,333	$3,137,372	$3,184,480	$3,106,876	$3,103,626	$3,173,085	$3,264,535	$2,995,372	$3,164,346	$3,096,789
Total Benefits	2,857,806	2,983,866	3,024,890	2,949,366	2,944,428	3,013,578	3,202,966	2,940,947	3,110,035	3,039,017
Compensation Benefits	1,807,450	1,931,505	1,955,968	1,904,397	1,854,931	1,943,121	1,930,729	1,879,237	2,000,724	2,005,406
Medical Benefits	912,796	913,141	928,957	911,618	959,403	951,308	1,106,487	908,927	949,490	883,859
Survivor Benefits	137,560	139,220	139,965	133,351	130,094	167,899	165,751	152,784	159,822	149,752
Total Enacted Funding	157,527	153,506	159,590	157,510	159,198	158,517	162,689	169,005	173,858	177,447
Salaries and Expenses	98,116	98,085	97,442	98,308	97,242	98,447	100,519	102,330	102,670	102,670
Fair Share	59,411	55,421	62,148	59,202	61,956	60,070	62,170	66,675	71,188	74,777

TABLE A4 – FEDERAL EMPLOYEES' COMPENSATION PROGRAM CHARGEBACK COSTS, BY MAJOR FEDERAL AGENCY, CHARGEBACK YEARS[1] 2010 – 2019 ($ THOUSANDS)

Agency	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total Costs	$2,697,107	$2,875,430	$3,005,857	$2,927,296	$2,894,429	$2,987,192	$3,001,244	$2,780,096	$2,780,902	$2,731,820
U.S. Postal Service	1,101,200	1,240,014	1,320,011	1,305,073	1,306,840	1,382,944	1,410,617	1,282,076	1,303,681	1,278,975
Department of the Navy	234,251	236,471	239,855	222,803	213,717	206,012	196,612	189,311	180,078	171,819
Department of Veterans Affairs	182,212	186,254	200,569	199,368	202,300	213,914	219,188	196,957	200,125	195,300
Department of Homeland Security	160,502	166,514	178,037	183,968	181,225	196,190	216,461	206,142	215,095	220,286
Department of the Army	177,236	176,941	178,289	166,731	162,699	164,437	158,791	148,834	146,479	140,325
Department of the Air Force	129,323	135,596	133,305	126,470	120,541	118,230	112,217	102,811	99,690	97,839
Department of Justice	104,573	109,850	117,253	115,768	119,872	124,399	123,960	119,900	121,820	125,260
Department of Transportation	97,687	97,457	102,258	93,652	89,411	88,862	85,767	81,207	78,613	76,094
Department of Agriculture	72,876	72,621	73,875	72,365	70,725	69,234	70,621	65,645	61,012	60,556
Department of Defense, other	63,581	65,331	69,788	66,517	64,820	63,719	62,359	56,809	56,337	54,181
All Other Agencies	373,666	388,381	392,617	374,581	362,280	359,252	344,650	330,405	317,972	311,185

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

Longshore Program Tables

TABLE B1 – LOST TIME INJURIES, FISCAL YEARS 2010 – 2019

Lost Time Injuries	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Lost-time injuries and death reported	31,628	29,169	29,287	28,145	27,212	23,939	24,333	27,237	28,208	30,682
Number of cases of injury and death reported under the Defense Base Act	14,562	11,443	12,122	11,549	7,876	5,867	6,089	6,622	6,694	8,448

TABLE B2 – TOTAL INDUSTRY COMPENSATION AND BENEFIT PAYMENTS UNDER THE LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT (LHWCA)[1], 2009 – 2018[2] ($ THOUSANDS)

Year	Payments By Self-Insured Employers	Payments By Insurance Carrier	Total Payments
2009	$388,088	$551,716	$939,804
2010	$408,534	$589,387	$997,921
2011	$425,581	$710,330	$1,135,912
2012	$430,853	$801,902	$1,232,755
2013	$417,776	$927,417	$1,345,193
2014	$429,307	$961,542	$1,390,849
2015	$420,839	$892,886	$1,313,724
2016	$415,506	$879,868	$1,295,374
2017	$406,737	$865,076	$1,271,813
2018	$413,349	$737,983	$1,151,332

[1] Includes disability compensation payments under the LHWCA and all other extensions to the Act, except the District of Columbia Workmen's Compensation Act (DCCA), which includes both disability compensation and medical benefit payments.

[2] The industry reports payments to the Department of Labor (DOL) on a calendar year basis.

TABLE B3 – NATIONAL AVERAGE WEEKLY WAGE (NAWW) AND CORRESPONDING MAXIMUM AND MINIMUM COMPENSATION RATES AND ANNUAL ADJUSTMENTS UNDER SECTIONS 6(b), 9(e), AND 10(f) OF LHWCA, FISCAL YEARS 2011 –2019

Year	NAWW	Maximum Payable[1]	Minimum Payable	Annual Increase in NAWW[2]
2011	$628.42	$1,256.84	$314.21	2.63%
2012	$647.60	$1,295.20	$323.30	3.05%
2013	$662.59	$1,325.18	$331.30	2.31%
2014	$673.34	$1,346.68	$336.67	1.62%
2015	$688.51	$1,377.02	$344.26	2.25%
2016	$703.00	$1,406.00	$351.50	2.10%
2017	$718.24	$1,436.48	$359.12	2.17%
2018	$735.89	$1,471.78	$367.94	2.46%
2019	$755.38	$1,510.76	$377.69	2.65%

[1] Maximum became applicable in death cases (for any death after September 28, 1984) under the LHWCA Amendments of 1984. See 33 U.S.C. § 906(b)(1). Section 9 (e)(1) provides that the total weekly death benefits shall not exceed the lesser of the average weekly wages of the deceased or the benefits that the deceased would have been eligible to receive under section 6(b)(1). Maximum in death cases not applicable to DCCA cases (Keener v. Washington Metropolitan Area Transit Authority, 800 F.2d 1173 (D.C. Cir. (1986)).

[2] 5% statutory maximum increase applicable in fiscal year 1985 under section 10(f) of LHWCA, as amended. The maximum increase does not apply to DCCA cases (see note 1, above).

TABLE B4 – LHWCA SPECIAL FUNDS' EXPENDITURES, FISCAL YEARS 2010 – 2019 ($ THOUSANDS)[1]

Year	Total	Second Injury Cases[2]	Pre-Amend. Cases[3]	Rehab.[4]	Other[5]	Number of Second Injury Cases
2010	$128,110	$116,703	$1,484	$3,183	$6,740	4,201
2011	$125,329	$112,876	$1,389	$2,821	$8,243	4,089
2012	$122,667	$111,143	$1,341	$2,323	$7,861	3,946
2013	$120,532	$109,501	$1,245	$2,066	$7,719	3,842
2014	$118,802	$109,286	$1,172	$1,689	$6,656	3,643
2015	$113,865	$104,695	$1,048	$1,543	$6,579	3,639
2016	$110,114	$99,483	$962	$1,083	$6,577	3,547
2017	$108,229	$91,995	$1,025	$748	$1,845	3,340
2018	$101,843	$89,137	$1,725	$751	$9,959	3,116
2019	$97,697	$85,498	$1,640	$393	$9,541	3,001

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

[2] Section 8(f) payments to employees who sustain second injuries that, superimposed on a pre-existing disability, result in a greater degree of permanent disability or death.

[3] Section 10(h) of the Act requires that compensation payments in permanent total disability and death cases, when injury or death is caused by an employment event that occurred before the enactment of the 1972 amendments, be adjusted to conform with the weekly wage computation methods and compensation rates put into effect by the 1972 amendments. The Special Fund pays 50% of any additional compensation or death benefit paid because of these adjustments.

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

[5] For cases where DOL ordered impartial medical exams or reviews (section 7(e) of the Act) and where the otherwise liable private payer cannot pay a compensation award due to default (section 18(b)), the expenses or payments resulting from these actions may be covered by the Special Fund. Also included as "Other" expenditures of the Funds are disbursements under section 44(d) to refund assessment overpayments in fiscal years 2003 – 2006. The program excluded disbursements from proceeds of employer securities redeemed under section 32 of the Act. These monies are exclusively for payment of compensation and medical benefits to employees of companies in default.

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

TABLE B5 – DCCA SPECIAL FUNDS' EXPENDITURES, FISCAL YEARS 2010 – 2019 ($ THOUSANDS)[1]

Year	Total	Second Injury Cases[2]	Pre-Amend. Cases[3]	Rehab.[4]	Other[5]	Number of Second Injury Cases
2010	$9,388	$8,598	$548	$0	$241	516
2011	$9,528	$8,265	$504	$4	$755	497
2012	$8,726	$8,005	$475	$1	$245	473
2013	$8,444	$7,736	$441	$0	$266	455
2014	$8,200	$7,487	$412	$6	$296	437
2015	$8,371	$7,154	$389	$0	$828	429
2016	$7,200	$6,445	$360	$0	$93	420
2017	$5,825	$5,759	$361	$0	$459	405
2018	$7,005	$5,468	$575	$0	$960	370
2019	$6,477	$5,063	$481	$0	$933	359

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

[2] Section 8(f) payments to employees who sustain second injuries that, superimposed on a pre-existing disability, result in a greater degree of permanent disability or death.

[3] Section 10(h) of the Act requires that compensation payments in permanent total disability and death cases, when injury or death is caused by an employment event that occurred before the enactment of the 1972 amendments, be adjusted to conform with the weekly wage computation methods and compensation rates put into effect by the 1972 amendments. The Special Fund pays 50% of any additional compensation or death benefit paid because of these adjustments.

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

[5] For cases where DOL ordered impartial medical exams or reviews (section 7(e) of the Act) and where the otherwise liable private payer cannot pay a compensation award due to default (section 18(b)), the expenses or payments resulting from these actions may be covered by the Special Fund. Also included as "Other" expenditures of the Funds are disbursements under section 44(d) to refund assessment overpayments in fiscal years 2003 – 2006. The program excluded disbursements from proceeds of employer securities redeemed under section 32 of the Act. These monies are exclusively for payment of compensation and medical benefits to employees of companies in default.

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

TABLE B6 – LHWCA SPECIAL FUNDS' ASSESSMENTS, 2009 – 2018 ($ THOUSANDS)[1]

Year	Total Industry Assessments[2]	Preceding Year Total Industry Payments[3]	Assessment Base Year
2009	$125,000	$564,798	2008
2010	$124,000	$621,671	2009
2011	$123,000	$666,985	2010
2012	$124,000	$770,364	2011
2013	$123,000	$857,003	2012
2014	$118,000	$946,294	2013
2015	$110,000	$908,059	2014
2016	$110,000	$953,833	2015
2017	$114,000	$961,033	2016
2018	$107,000	$948,926	2017

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

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

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

TABLE B7 – DCCA SPECIAL FUNDS' ASSESSMENTS, 2009 – 2018 ($ THOUSANDS)[1]

Year	Total Industry Assessments[2]	Preceding Year Total Industry Payments[3]	Assessment Base Year
2009	$11,500	$3,598	2008
2010	$7,500	$3,437	2009
2011	$8,000	$3,540	2010
2012	$8,000	$3,085	2011
2013	$9,000	$4,775	2012
2014	$5,000	$3,404	2013
2015	$8,000	$2,910	2014
2016	$6,000	$2,338	2015
2017	$6,000	$2,269	2016
2018	$7,000	$1,082	2017

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

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

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

Black Lung Program Tables

TABLE C1 – PART C BLACK LUNG CLAIM DECISIONS AT THE DISTRICT DIRECTOR LEVEL, FISCAL YEARS 2010 – 2019

Year	Total Approvals[TF]	Total Approvals[RO]	Total Approvals[1]	Merit Denials[2,4]	Non-merit Denials[TF,3,4]	Non-merit Denials[RO,3,4]	Total Denials	Total Decisions	Approval Rate[5]
2010	77	432	509	2,096	126	978	3,200	3,709	13.72%
2011	110	645	755	3,298	167	1,961	5,426	6,181	12.21%
2012	97	632	729	2,565	229	1,780	4,574	5,303	13.75%
2013	87	566	653	2,361	184	1,573	4,118	4,771	21.67%
2014	92	518	610	2,664	224	1,719	4,607	5,217	18.63%
2015	157	728	885	2,222	240	2,037	4,499	5,384	28.48%
2016	249	877	1,126	2,706	364	2,150	5,220	6,346	29.38%
2017	343	915	1,258	3,153	594	2,054	5,801	7,059	28.52%
2018	258	1,113	1,398	2,761	542	1,975	5,278	6,676	33.61%
2019	181	1,014	1,195	2,458	460	2,126	5,044	6,239	32.71%

[TF] Black Lung Disability Trust Fund liability

[RO] Responsible coal mine operator (RMO) liability

[1] Approvals do not include conversions of miner to survivor benefits under 422(l) of the Act.

[2] Merit denials: claims that received a Proposed Decision and Order (PDO) after all evidence is considered.

[3] Non-merit denials: claims that are abandoned or withdrawn before a PDO.

[4] Merit/non-merit categories were not quantified until fiscal year 2008.

[5] Effective fiscal year 2015, approval rates are calculated using approved and denied claims and do not include withdrawn and abandoned claims (non-merit decisions). The program applied this change retroactively to approval rate calculations for fiscal years 2013, 2014, and 2015.

TABLE C2 – PART C NUMBER OF BENEFICIARIES, FISCAL YEARS 2010 – 2019[1]

Class of Beneficiary		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Part C Primary Beneficiaries[2]	**Miners**	6,967	6,633	6,375	6,083	5,917	5,974	6,363	6,792	7,262	7,751
	Widows	20,495	19,014	17,553	16,137	14,801	13,558	12,510	11,554	10,661	9,886
	Others	1,209	1,182	1,178	1,158	1,142	1,123	1,108	1,084	1,039	1,006
	Total Primary Beneficiaries	28,671	26,829	25,106	23,378	21,860	20,655	19,981	19,430	18,962	18,643
Dependents of Primary Beneficiaries	**Dependents of Miners**	5,202	5,028	4,939	4,746	4,703	4,871	5,237	5,700	6,147	6,576
	Dependents of Widows	681	647	593	564	510	483	483	459	435	402
	Dependents of Others	113	110	106	101	101	102	97	90	81	78
	Total Dependents	5,996	5,785	5,638	5,411	5,314	5,456	5,817	6,249	6,663	7,056
Total, Part C Beneficiaries		**34,667**	**32,614**	**30,744**	**28,789**	**27,174**	**26,111**	**25,798**	**25,679**	**25,625**	**25,699**

[1] As of the end of the fiscal year on September 30.

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

TABLE C3 – PART B NUMBER OF BENEFICIARIES, FISCAL YEARS 2012 – 2019[1]

Class of Beneficiary		2012	2013	2014	2015	2016	2017	2018	2019
Part B Primary Beneficiaries	**Miners**	1,424	1,163	957	784	622	509	408	325
	Widows	14,906	12,765	11,015	9,382	8,012	6,784	5,790	4,847
	Others	3,349	3,216	3,075	2,898	2,774	2,590	2,433	2,272
	Total Primary Beneficiaries	19,679	17,144	15,047	13,064	11,408	9,883	8,631	7,444
Dependents of Primary Beneficiaries	**Dependents of Miners**	881	713	582	467	358	283	214	165
	Dependents of Widows	544	470	421	366	303	257	222	189
	Dependents of Others	301	272	254	227	221	207	193	177
	Total Dependents	1,726	1,455	1,257	1,060	882	747	629	531
Total, Part B Beneficiaries		**21,405**	**18,599**	**16,304**	**14, 124**	**12,290**	**10,630**	**9,260**	**7,975**

[1] As of the end of the fiscal year on September 30.

TABLE C4 – CLAIMS FILED UNDER PART C OF THE BLACK LUNG BENEFITS ACT, FISCAL YEARS 2010 – 2019

Year	New Claims	Refiled Claims[1]	Successor Claim[2]	Survivor Conversions[3]	Total[4]
2010	2,683	3,088	636	637	**7,044**
2011	2,410	2,383	635	631	**6,059**
2012	2,176	2,140	494	559	**5,369**
2013	2,544	2,655	624	597	**6,420**
2014	2,877	3,458	589	470	**7,394**
2015	2,860	2,879	601	478	**6,818**
2016	3,334	3,114	573	427	**7,448**
2017	3,021	3,287	600	478	**7,386**
2018	2,588	3,345	317	423	**6,673**
2019	2,580	3,471	296	459	**6,806**

[1] Refiled Claim: the claimant has filed at least once before.

[2] Successor Claim: a subsequent claim filed on a miner's record by another person.

[3] Conversion: some dependent survivors are automatically entitled to benefits.

Energy Program Tables

TABLE D1 – PART B PROCESSING ACTIVITY ON ALL ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT (EEOICPA) CASES/CLAIMS RECEIVED, PROGRAM INCEPTION THROUGH SEPTEMBER 30, 2019

Case Status/Claims Activity	Case[1]	Claim[2]
Total Received	109,420	172,488
Final Decisions Completed by the Final Adjudication Branch (FAB)[3]	103,542	157,498
Final Approved	54,760	85,102
Final Denied	48,782	72,396
Recommended Decisions by District Offices[4]	1,271	2,857
Recommended Decision to Approve	274	839
Recommended Decision to Deny	997	2,018
Completed Initial Processing - Referred to National Institute for Occupational Safety and Health (NIOSH)[5]	1,583	6,989
Pending Initial Processing In District Office[6]	3,048	5,310
Lump Sum Compensations	51,610	79,543
Total Payment Amounts		**$6,870,124,477**

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

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

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

[4] Each case or claim still pending a final decision by the FAB.

[5] Counts only the first trip to NIOSH.

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

TABLE D2 – PART B STATUS OF ALL EEOICPA APPLICATIONS, FISCAL YEAR 2019

Processing Activity	Case[1]	Claim[2]
	2019	2019
Total Cases/Claims Received	3,763	4,829
Final Decisions by FAB Offices[3]	4,806	6,075
Final Approved	2,049	2,805
Final Denied	2,757	3,270
Modification Orders	0	0
Recommended Decisions by District Offices	5,701	7,054
Recommended Decision Only, to Approve	2,258	3,108
Recommended Decision Only, to Deny	3,443	3,946
Referrals to NIOSH	848	1,181
Lump Sum Compensations Payments	1,780	2,431
Remands	397	488

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

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

[3] Total includes cases with recommended decisions in fiscal year 2019.

Note: Recommended Decisions are standalone counts and are not influenced by the Final Decision.

TABLE D3 – PART B EEOICPA CASES WITH APPROVED DECISIONS AND PAYMENTS BY CATEGORY, PROGRAM INCEPTION THROUGH SEPTEMBER 30, 2019

Category	Number of Approved Cases[1]	Percentage of Total Final Approvals	Number of Paid Claimants[1]	Total Compensation Paid[2] ($ thousands)	Percentage of Total Compensation Paid
Radiation Exposure Compensation Act (RECA)[3]	8,391	15.3%	12,607	$427,837.34	6.2%
Special Exposure Cohort Cancer (CN)	27,610	50.4%	45,016	$4,121,974.58	60.0%
Dose Reconstructed Cancer (CN)	12,100	22.1%	15,317	$1,621,016.00	23.6%
Beryllium Disease (CBD)[4]	2,398	4.4%	3,103	$356,561.35	5.2%
Beryllium Sensitivity-Only (BS)[5]	2,057	3.8%	Not Applicable (N/A)	N/A	N/A
Silicosis (CS)	626	1.1%	693	$80,612.50	1.2%
Multiple Conditions[6]	1,578	2.9%	2,807	$262,122.71	3.8%
Total	**54,760**	**100%**	**79,543**	**$6,870,124.48**	**100%**

[1] There is not a direct correlation between the number of approved cases and the number of paid claimants for two reasons: (1) more than one claimant can receive payment on a single approved case, and (2) the program approved some cases before September 30, 2019, but the program did not issue payments.

[2] Represents total lump sum compensation payments from Energy Eemployees Occuptional Iillness Compensation program inception to September 30, 2019.

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

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

[5] The Division of Energy Employees Occuptional Illness Compensation only provides medical monitoring for Beryllium Sensitivity (BS), and therefore there is no monetary compensation.

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

TABLE D4 – PART B EEOICPA CASES WITH FINAL DECISION TO DENY, PROGRAM INCEPTION THROUGH SEPTEMBER 30, 2019

Reason for Denial	Number of Cases[1]
Employee Did Not Work at a Covered Department of Energy (DOE) Facility and/or Did Not Work During Covered Time Period, or the Employee Worked for an Atomic Weapons Employer (AWE) or Beryllium Vendor[1]	7,219
Alleged Survivor Not an Eligible Beneficiary	2,282
Claimed Condition Not Covered Under Part B of EEOICPA	6,566
Dose Reconstruction Reveals the Probability That the Cancer is Related to Employment is Less Than 50%	22,897
Medical Evidence is Insufficient to Establish Entitlement	8,260
Causation other than Probability of Causation (POC)	1,558
Total[2]	**48,782**

[1] Part E of the EEOICPA does not cover DOE federal employees, AWE, and Beryllium Vendors.

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

TABLE D5 – PART B MOST PREVALENT NON-COVERED MEDICAL CONDITIONS, PROGRAM INCEPTION THROUGH SEPTEMBER 30, 2019

Non-Covered Medical Condition	Percentage of All Denials For This Condition[1]
Other Lung Conditions	17%
Heart Condition/Failure/Attack/Hypertension	10%
Chronic Obstructive Pulmonary Disease & Emphysema	10%
Asbestosis	7%
Hearing Loss	6%
Renal Condition or Disorder (Kidney Failure, Kidney Stones)	5%
Benign Tumors, Polyps, Skin Spots	3%
Diabetes	3%
Neurological Disorder	2%
Thyroid Conditions (e.g., Hypothyroidism)	2%
Anemia	1%
Back or Neck Problems	1%
Parkinson's Disease	1%
Psychological Conditions	1%
All Other Non-Covered Conditions (Each Less Than 1%) Or "Other (Not Listed)"	26%
No Condition Reported on Claim Form or Blank Condition Type	5%

[1] Based on cases that were denied because the claimed condition was not covered under Part B of EEOICPA. This figure excludes cases that have a "covered" condition whereas Table D4 includes these cases.

TABLE D6 – PART E STATUS OF ALL EEOICPA APPLICATIONS, PROGRAM INCEPTION THROUGH SEPTEMBER 30, 2019

Case Status/Claims Activity	Case[1]	Claim[2]
Total Received	100,610	141,701
Final Decisions Completed by the FAB[3]	92,834	126,617
Approved	47,718	58,141
Denied	45,116	68,476
Recommended Decisions by District Offices[4]	1,731	3,127
Recommended to Approve	444	898
Recommended to Deny	1,287	2,229
Completed Initial Processing[5]	1,277	4,953
Pending Initial Processing In District Office[6]	4,840	7,505
Compensation Payments (Unique Cases & Claims)	37,594	42,299
Total Compensation Payment Amounts		**$4,844,854,104**
Lump Sum Allocations (Unique Cases & Claims)	19,045	20,599
Total Lump Sum Payment Amounts		**$2,206,015,171**
Wage-loss Allocations (Unique Cases & Claims)	3,612	4,334
Total Wage-loss Payment Amounts		**$181,547,529**
Impairment Allocations (Unique Cases & Claims)	21,755	21,818
Total Impairment Payment Amounts		**$2,457,503,981**

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

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

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

[4] Each case or claim still pending a final decision by the FAB.

[5] Completed Initial Processing refers to cases sent to NIOSH, and cases with Recommended Decision, Final Decision, or cases closed.

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

TABLE D7 – PART E PROCESSING ACTIVITY ON ALL EEOICPA CASES/CLAIMS RECEIVED, FISCAL YEAR 2019

Processing Activity	Case[1]	Claim[2]
	2019	**2019**
Total Cases/Claims Received	330	4,796
Final Decisions by the FAB Offices	10,424	10,925
Approved	6,373	6,502
Denied	4,051	4,423
Modification Orders	0	0
Recommended Decisions by District Offices	14,056	14,475
Recommended to Approve	8,142	8,245
Recommended to Deny	5,914	6,230
Referrals to NIOSH[3]	633	786
Compensation Payments (Unique Cases & Claims)	4,906	4,961
Total Compensation Payment Amounts		**$346,622,902**
Lump Sum Allocations (Unique Cases & Claims)	747	792
Total Lump Sum Payment Amounts		**$73,899,270**
Wage-loss Allocations (Unique Cases & Claims)	177	184
Total Wage-loss Payment Amounts		**$6,154,856**
Impairment Allocations (Unique Cases & Claims)	3,982	3,985
Total Impairment Payment Amounts		**$266,568,776**
Manual Payments		0
Remands	1,128	1,177

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

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

[3] Part E claims awaiting Part B NIOSH Return for further evidence.

Note: Recommended Decisions are standalone counts and are not influenced by the Final Decision.

TABLE D8 – PART E EEOICPA CASES WITH FINAL DECISION TO DENY, PROGRAM INCEPTION THROUGH SEPTEMBER 30, 2019

Reason for Denial	Number of Cases
Employee Did Not Work at a Covered DOE Facility and/or Did Not Work During Covered Time Period, or the Employee Worked for an AWE or Beryllium Vendor[1]	5,673
Alleged Survivor Not an Eligible Beneficiary	6,006
Medical Evidence is Insufficient to Establish Entitlement	10,443
Other Denied	22,994
Total[2]	45,116

[1] DOE federal employees, AWE, and Beryllium Vendors are not covered under Part E of the EEOICPA.

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

APPENDIX B
ACRONYMS

ABRWH	Advisory Board on Radiation and Worker Health
AWE	Atomic Weapons Employer
BRB	Benefits Review Board
CBD	Beryllium Disease
BS	Beryllium Sensitivity-Only
BLBA	Black Lung Benefits Act of 1972
CPWR	Center for Construction Research and Training, formerly called the Center to Protect Workers' Rights
CMR	Central Mail Room
CCCA	Central Case Create and Assignment
CMC	Contract Medical Consultant
CCAT	Correspondence Creation and Tracking System
DBA	Defense Base Act
DOE	Department of Energy
HHS	Department of Health and Human Services
DOJ	Department of Justice
DOL	Department of Labor
DCCA	District of Columbia Workmen's Compensation Act
DEEOIC	Division of Energy Employees Occupational Illness Compensation
CN	Dose Reconstructed or Special Exposure Cohort Cancer
ECF	Employees' Compensation Fund
ECOMP	Employees' Compensation Operations and Management Portal
EDP	Energy Document Portal
EEOICPA	Energy Employees Occupational Illness Compensation Program Act
FECA	Federal Employees' Compensation Act
FAB	Final Adjudication Branch
FTE	Full-time Equivalent
HRSA	Health Resources and Services Administration
IH	Industrial Hygienist
IAS	Internet Accessible SEM
JOTG	Joint Outreach Task Group
LHWCA	Longshore and Harbor Workers' Compensation Act
MED	Morphine Equivalent Dose
NAWW	National Average Weekly Wage
NIOSH	National Institute for Occupational Safety and Health
N/A	Not Applicable
OALJ	Office of Administrative Law Judges
OWCP	Office of Workers' Compensation Programs
OIS	OWCP Imaging System
OCC	Outgoing Correspondence Center
POC	Probability of Causation
PDO	Proposed Decision and Order
RECA	Radiation Exposure Compensation Act
RMO	Responsible Mine Operator
CS	Silicosis
SEM	Site Exposure Matrices
SSA	Social Security Administration
SEC	Special Exposure Cohort
USPS	U.S. Postal Service

APPENDIX C
DISTRICT OFFICES LIST

FECA Program: Twelve District Offices

San Francisco, California
Denver, Colorado
Washington, District of Columbia
Jacksonville, Florida
Chicago, Illinois
Boston, Massachusetts
Kansas City, Missouri
New York, New York
Cleveland, Ohio
Philadelphia, Pennsylvania
Dallas, Texas
Seattle, Washington

Black Lung Program: Eight District Offices

Denver, Colorado
Pikeville, Kentucky
Mount Sterling, Kentucky
Columbus, Ohio
Greensburg, Pennsylvania
Johnstown, Pennsylvania
Charleston, West Virginia
Parkersburg, West Virginia

Longshore Program: Nine District Offices

Long Beach, California
San Francisco, California
Jacksonville, Florida
New Orleans, Louisiana
Boston, Massachusetts
New York, New York
Houston, Texas
Norfolk, Virginia
Seattle, Washington

Energy Program: Four District Offices

Denver, Colorado
Jacksonville, Florida
Cleveland, Ohio
Seattle, Washington

OFFICE OF THE WORKERS' COMPENSATION PROGRAMS
UNITED STATES DEPARTMENT OF LABOR

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