

DOL has a long history of preventing release of documents to the public by claiming they are proprietary. DEEOIC Teleconference notes and Generic Exposure Profiles have been used to decide individual claims as well as the administration of claims. DOL calls these proprietary and will not release them. Now documents the advisory board is using are being withheld from the public as well. One of the reasons stakeholders pushed for the advisory board to be independent rather than under DOL was so the process would be transparent. Documents used by the board must be available for release with proper redactions for PPI. Public meetings mean public documents.

The NIOSH Advisory Board has many years of experience that this Advisory Board could learn from. Here are some suggestions.

- Allow people to sign up at the door for public comments like the NIOSH board does. Many concerned citizens are not comfortable with, or have access to the internet. Requiring people to sign up on line and follow the Federal Register to be able to speak is too hard for many folks. I know some people skipped this meeting because they were not sure they would be able to have their say. This is unacceptable.
- Filming and photography must be allowed at the Board meetings.

Some other suggestions:

- Add a time for the advocates to speak to the meeting agenda outside of the public comment period so workers and advocates don't have to compete for time. We need to hear from all stakeholders.

- The Final Adjudication Branch should not hold Hearings on the days the Advisory Board meets. At least one person who wanted to attend this week's meetings could not because they had an in person hearing.

Last week DEEOIC reversed 14 years' of approving claims under Special Exposure Cohorts for people with ureter cancer, fallopian tube cancer, and chondrosarcoma of the cricoid cartilage of the larynx by rescinding Final Bulletins & Circulars from 2002-2012. This means that workers with these cancers within a SEC period before last week were paid while those with the same cancers after last week will not be paid. This is inequitable and unfair. Making these changes in the Policy and Procedure Manual may also be improper. Changes like these need to go through the Rule-making process since they reduce the workers' benefits.

And speaking of the Rules—I strongly encourage DOL to withdraw the proposed Rules changes. These changes are detrimental to the workers for all the reasons I stated at the last board meeting.

This month EECAP developed a survey for claimants on Medical Benefits. This survey will be open until the end of October and it may be accessed on the EECAP website. I also have paper copies with me if anyone would like one.

Because ANWAG and Cold War Patriots both sent email alerts to their members, as of today we have received XXXX responses, with XXX providing information on their experience with how the program's medical benefits work. Although the survey is still open we received enough data that I put together a preliminary report for the board. The survey is divided up into 5 parts. Here are some highlights reported to far.

1. Part one is on the claimant's experience with medical benefits. This shows that 21% of all respondents have had problems with medical billing. 13% have had problems finding providers who will take the EEOICPA medical card, commonly known as the White Card. 10% complain of DOL inefficiency.
 2. Part two is on the claimants' doctors' experience. Respondents report that their doctors have asked them to use a different insurance 35% of the time. The doctors have asked sick workers to self-pay 27% of the time and 18% have stopped taking the White Card at all.
 3. Part three is on the claimants experience with home health care benefits. 22% of the respondents found accessing their home health care benefits difficult, while 11% found their benefits were reduced improperly, the reevaluation process was too difficult, and their doctors were overruled by DOL.
 4. Part four was on problems families with Authorized Representatives have. 25% of respondents found DOL restricted their choice of an authorized representative, their spouses were unable to work on medical reimbursement issues when another AR was involved, and problems with ACE and DOL not coordinating acknowledgment of ARs.
1. I also took a look at how the different District Offices deal with medical benefit problems. There seem to be some huge differences from one to another. For example claimants' doctors dealing with the Denver District Office had problems 41% of the time as opposed to 11% of the time at the Cleveland District Office. Doctors were able to reach a satisfactory result at the Cleveland Office 60% of the time as opposed to 14% of the time with Denver.

2. Medical reimbursement issues are very difficult for claimants to deal with. ACS does not provide any information to claimants about expenses that have been submitted unless the claimant has access to the internet and can navigate the ACS database. Even then there is no way to track a charge directly. Another huge problem is that a sick worker can submit a claim to ACS and ACS does not pay the claim or deny it. For one charge for a claimant I have submitted the charge at least half a dozen times and it has still not shown up as either paid or denied. ACS just ignores it and provides no feedback, unless I want to spend an hour on hold on the phone. Kaiser hospital/Hanford issue