

UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

+ + + + +

MEETING

+ + + + +

WEDNESDAY
NOVEMBER 14, 2018

+ + + + +

The Committee met in the Room S-4215,
U.S. Department of Labor, 200 Constitution
Avenue, Washington, D.C., at 8:46 a.m., Steven
Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY

JOHN DEMENT
GEORGE FRIEDMAN-JIMENEZ (via telephone)
MAREK MIKULSKI
KENNETH SILVER

MEDICAL COMMUNITY

MANIJEH BERENJI
VICTORIA CASSANO
STEVEN MARKOWITZ, Chair
CARRIE A. REDLICH

CLAIMANT COMMUNITY

KIRK DOMINA
RON MAHS
DURONDA POPE
CALIN TEBAY

DESIGNATED FEDERAL OFFICER

DOUG FITZGERALD

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P-R-O-C-E-E-D-I-N-G-S

(8:46 a.m.)

MR. FITZGERALD: Good morning, everyone. My name is Doug Fitzgerald and I would like to welcome you to today's meeting of the Department of Labor's Advisory Board on Toxic Substances and Worker Health.

Sorry for the delayed beginning. We just had a few technical difficulties that we've worked out. I'm the Board's designated federal officer or DFO.

And before we begin I'd like to go over some general housekeeping items that, to make sure everyone is safe and comfortable throughout the next two days. First, restrooms are located immediately outside of this room to your right and left.

The restrooms to your right are handicapped accessible. And next to each set of restrooms is a water fountain.

There's also a snack bar on this floor in the C4500 corridor just to your left and

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1 there's also a cafeteria on the sixth floor of
2 the building which is accessible by the elevators
3 just outside this meeting room.

4 In the unlikely event of an emergency
5 you will hear an announcement over the PA system
6 and we will be instructed to use the stairs
7 located both to the right and the left of the
8 conference room. We will guide everyone down and
9 exit through the same building entrance on the
10 first level where you came in until we receive an
11 all-clear announcement.

12 I think that covers the most crucial
13 housekeeping information for now. But before we
14 begin I'd like to express my appreciation for the
15 diligent work of our Board preparing for this
16 meeting and for their upcoming deliberations.

17 I also want to thank my many
18 colleagues here in the Department for all their
19 efforts in preparing for today's meeting, in
20 particular, Carrie Rhoads, our Committee staff
21 and alternate DFO who makes my job so much easier
22 and Kevin Bird and Melissa Schroeder of our SIDEM

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1 contract staff who always do a fantastic job
2 arranging for everyone's travel, preparing
3 briefing materials and running our virtual
4 meetings.

5 I'd also like to thank Zeke Winfred of
6 our conference management center for his
7 assistance in arranging for this room set up and
8 handling much of the A/V logistics. Now I'd like
9 to say a few words about my role as the Board's
10 DFO.

11 As DFO I serve as the liaison between
12 the Department and the Board. I'm responsible
13 for approving meeting agendas and for opening and
14 adjourning meetings while ensuring all provisions
15 of the Federal Advisory Committee Act or the FACA
16 are met regarding the operations of the Board.

17 I'm also responsible for making sure
18 that the Board's deliberations fall within the
19 parameters outlined in the enabling statute and
20 charter.

21 Within that context I work closely
22 with the Board's Chair, Dr. Markowitz, and OWCP

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1 Director Hearthway to ensure that the Board, as
2 an advisory body to the Secretary, is fulfilling
3 that mandate to advise and it's addressing those
4 issues of highest priority and of greatest
5 benefit to the Secretary of Labor who is
6 ultimately responsible for the administration of
7 the Energy Employees Occupational Illness
8 Compensation Program and to the people it serves.

9 And finally, I also work with the
10 appropriate Agency officials to ensure that all
11 relevant ethics regulations are satisfied.
12 You'll note that in the agenda today the Board
13 will receive a briefing on conflict of interest
14 laws as they relate to the Energy Employees
15 Occupational Illness Compensation Program Act.

16 It should also be noted that each
17 Board Member has been asked to file a standard
18 government financial disclosure form.

19 Regarding meeting operations, we have
20 a full agenda over the next two days and you
21 should note that the agenda times are
22 approximate.

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1 So as hard as we may try we may not be
2 able to keep those exact times. Copies of all
3 meeting materials and public comments are or will
4 be available on the Board's website under the
5 heading Meetings.

6 The Board's website can be found at
7 url dol.gov/OWCP/energy/regs/compliance/advisory
8 board.htm, or you can simply Google Advisory
9 Board on Toxic Substances and Worker Health and
10 it's likely to be the first link you would find.

11 If you haven't already visited the
12 Board's website, I strongly encourage you to do
13 so. After clicking on today's meeting link
14 you'll see a page dedicated entirely to this
15 meeting.

16 That page contains all materials
17 submitted to us in advance of the meeting and we
18 will publish any materials that are provided by
19 our presenters throughout the next two days.
20 There you can also find today's agenda as well as
21 instructions for participating remotely in both
22 the meeting and the public comment period at the

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1 end of the day.

2 If you are participating remotely I
3 want to point out that the telephone numbers and
4 links for the WebEx sessions may be different for
5 each day so please make sure you read the
6 instructions carefully.

7 If you're joining by WebEx, please
8 note that the session is for viewing only and
9 will not be interactive. The phones will also be
10 muted until the public comment period opens at
11 4:30 today.

12 During Board discussions and prior to
13 the public comment period, I would request that
14 the people in the room remain quiet as possible
15 since we are recording the meeting to produce
16 transcripts. I would also ask those in the room
17 to put their phones on mute at this time.

18 As I mentioned, we do have a scheduled
19 public comment period that begins at 4:30 today.
20 The Chair will note that this is not a question
21 and answer session but rather an opportunity for
22 the public to provide comments about topics of

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1 interest to the Board.

2 If for any reason the Board Members
3 require clarification on an issue that requires
4 participation from the public, they may request
5 information through the Chair or through me.

6 Regarding meetings and minutes
7 transcripts: the Federal Advisory Committee Act
8 requires that minutes of this meeting be prepared
9 to include a description of the matters discussed
10 over the next two days and any conclusions
11 reached by the Board.

12 As DFO I prepare the minutes and
13 ensure they're certified by the Board's Chair.
14 The minutes of today's meeting will be available
15 on the Board's website no later than 90 calendar
16 days from today, per FACA regulations. But if
17 they're available sooner they'll be published
18 sooner.

19 Also, although formal minutes will be
20 prepared because they are required by FACA
21 regulations, we'll also be publishing verbatim
22 transcripts which are obviously more detailed in

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1 nature. Those transcripts will be available on
2 the Board's website as soon as possible.

3 And in closing and before I turn it
4 over to Dr. Markowitz, I'd like to welcome all of
5 our returning Board Members and all of our new
6 members to the Department of Labor. I'm looking
7 forward to working with all of you in the coming
8 two years and listening to your deliberations
9 over the next two days.

10 I also want to thank you for your
11 dedication to the mission of this Board. And
12 with that, Mr. Chairman, I convene this meeting
13 of the Advisory Board on Toxic Substances and
14 Worker Health.

15 CHAIR MARKOWITZ: Thank you. So I
16 would add to the thanks given to the various
17 people who helped set up this meeting whom Mr.
18 Fitzgerald named so I won't rename them.

19 Before I make some brief introductory
20 remarks I'd like to do introductions including
21 the people actually, everybody in the room. So
22 if you could just state your name and where you

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1 work or your relationship to the DOE complex so
2 people have a sense of where we, what our
3 backgrounds are.

4 I'm an occupational medicine
5 physician, epidemiologist from the City
6 University of New York. And I direct the largest
7 former worker medical screening program in the
8 DOE complex at 14 different sites and have done
9 so since 1998. Kirk.

10 MEMBER DOMINA: My name is Kirk
11 Domina. I'm the employee health advocate for the
12 Hanford Atomic Metal Trades Council in Richland,
13 Washington. HAMTC represents about 2600 active
14 members.

15 I'm the employee health advocate for
16 them and I'm a current worker and I've been out
17 there 35 years.

18 MEMBER BERENJI: Hi there. I'm
19 Manijeh Berenji, Boston Medical Center
20 occupational medicine physician.

21 MEMBER CASSANO: Hi, I'm Victoria
22 Cassano. I'm a retired Navy Undersea and

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1 occupational medicine physician and currently
2 have my own consulting company. And this is my
3 second term on the Board.

4 MEMBER REDLICH: I'm Carrie Redlich.
5 I'm an occupational and pulmonary physician on
6 the faculty at Yale Medical School and I'm
7 director of the Occupational Environmental
8 Medicine Program, and I also was on the prior
9 Board.

10 MEMBER TEBAY: Calin Tebay. I'm the
11 site-wide health advocate at Hanford. I also
12 work at the Hanford Workforce Engagement Center.
13 I've been on site since the early nineties.

14 CHAIR MARKOWITZ: Go ahead, Ken.

15 MEMBER SILVER: Ken Silver, Associate
16 Professor of Environmental Health at East
17 Tennessee State University. Going back to the
18 late nineties, I worked very closely with workers
19 and families at Los Alamos National Laboratory
20 and have continued doing evidence-based advocacy
21 around this program.

22 It's my second term on the Board. I

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1 particularly want to thank the people who put
2 this meeting together for the comfortable seating
3 this time. I don't know who remembers our first
4 meeting. Seriously, thanks.

5 MEMBER MIKULSKI: Marek Mikulski. I'm
6 new to the Board and I'm with the University of
7 Iowa, occupational epidemiologist. I direct the
8 former Iowa Nuclear Weapons Workers Program.

9 MEMBER MAHS: Ron Mahs with the
10 Insulators. I'm representing the building
11 trades.

12 I worked at Oak Ridge on and off over
13 30 years and the last 15 years as the general
14 foreman. And I'm retired and I train for CPWR
15 and sell some real estate, if anybody needs a
16 house.

17 MEMBER POPE: Good morning. My name
18 is Duronda Pope and I work for United Steel
19 Workers. I work currently on the Emergency
20 Response Team responding to fatalities and
21 injuries on behalf of our members.

22 But we also, I also am a second term

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1 and a former worker of Rocky Flats, 25 years.

2 MEMBER DEMENT: I'm John Dement. This
3 is my second term on the Board at the Duke
4 University Occupational Medicine Division. Area
5 of interest is industrial hygiene and
6 epidemiology.

7 I also work with the Building Trades
8 Screening Program and have been for the last 20
9 years.

10 CHAIR MARKOWITZ: Ms. Leiton.

11 MS. LEITON: My name is Rachel Leiton.
12 I'm the director for the Energy Compensation
13 Program at the Department of Labor.

14 MS. QUINN: Hi. I'm Trish Quinn. I'm
15 with the Center for Construction Research and
16 Training as well as the Building Trades National
17 Medical Screening Program, which screens
18 construction trade workers at 35 DOE sites.

19 MS. WHITTEN: Good morning, Diane
20 Whitten with HAMTC.

21 MS. BLAZE: I'm D'Lanie Blaze of CORE
22 advocacy for nuclear workers. I represent

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1 workers of Santa Susana and its related sites
2 near Los Angeles.

3 MS. BARRIE: My name is Terrie Barrie.
4 I'm a founding member of the Alliance of Nuclear
5 Worker Advocacy Groups and the wife of a sick
6 Rocky Flats worker.

7 MR. ARTZER: I'm Josh Artzer. I'm a
8 Hanford Workforce Engagement Center specialist
9 and also the Beryllium Awareness Group Chairman.

10 MS. SPLETT: I'm Gail Splett. I'm the
11 EEOICPA program manager at the Hanford site and
12 I've worked on the Hanford site for 45 years.

13 MR. BALLARD: I'm Chris Ballard. I'm
14 Vice President of Regulatory Affairs for Critical
15 Nurse Staffing. We provide in-home health care
16 under the program.

17 MR. NELSON: Good morning. My name is
18 Malcolm Nelson. I'm the current Ombudsman for
19 the Energy Employees Program. Welcome to
20 Washington.

21 MS. FALLON: Good morning. I'm Amanda
22 Fallon. I'm a policy analyst in the Office of

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1 the Ombudsman.

2 CHAIR MARKOWITZ: Okay. And, George,
3 Dr. Friedman-Jimenez, are you on the phone?

4 (No response.)

5 CHAIR MARKOWITZ: So there is a Board
6 Member, Dr. Friedman-Jimenez from New York who is
7 an occupational medicine physician and an
8 epidemiologist and a prior member of the Board
9 who injured his foot in the last couple of days
10 and wasn't able to physically travel here but I
11 think is listening and watching and hopefully
12 he'll be able to speak at some point.

13 So just a couple of opening remarks
14 really. I want to, there are returning Members
15 of the Board. But a third of the Board is new
16 and I want to make sure that you feel
17 comfortable, to the new Members, asking questions
18 and otherwise learning about the program because
19 you shouldn't think that the returning Members of
20 the Board fully understand this very complex
21 program.

22 We're still on a learning curve, maybe

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1 a little bit ahead of you but maybe not all that
2 much. So I want to encourage your participation
3 and asking questions and the like.

4 So much of these two days was designed
5 actually to try to blend the interest in
6 integrating the new members of the Board so that
7 they are oriented about the program. We have
8 some necessary discussions like the FACA review
9 and the ethics rules.

10 But then we, and we go into an
11 overview that Ms. Leiton will, is going to give
12 for us about the program. And then some updates
13 and modifications which will be of special
14 interest to the returning members of the Board
15 but also instructive otherwise.

16 Later in the day we're going to deal
17 with certain aspects of the Board functioning
18 like whether we want to break into committees, to
19 the extent which we want all of our meetings to
20 be open meetings or not, the work methods of the
21 Board.

22 But I thought we should walk through

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1 much of the day first before we have that
2 discussion. I would ask that Carrie Rhoads, as
3 in the previous Board service, as questions arise
4 that we have for DOL that aren't immediately
5 answered or as requests for information arise
6 that Ms. Rhoads keep a running list of those
7 questions so that we can, we'll call those action
8 items so that we can make sure that we keep track
9 of them and come back to them.

10 We'll also discuss later in the day
11 locations of meetings. Our first meeting of the
12 Board previously was here in D.C. and then
13 afterwards we went out to various sites, in large
14 part to be accessible to the claimants and the
15 DOE workers who have great interest in the
16 program.

17 The binder, we kept the binder
18 intentionally short. There is some necessary
19 information. And then Sections 5 through 8
20 really were just the summary of the prior Board's
21 recommendations and Department of Labor's
22 responses to those recommendations.

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1 There are, for the new Board Members,
2 on the website great many more materials,
3 resources. Some of them are organized by the
4 date of the prior meetings.

5 And so you may need to look around at
6 various places in order to find what you need.
7 But if you have any questions or need some help
8 with that just let us know and we can help you
9 navigate that.

10 Finally, let me just say that the
11 prior Board met five times as a board. We had
12 some 17 subcommittee or working group meetings.
13 So we did a lot of work and hopefully made some
14 useful recommendations to the Department.

15 Some of those recommendations are
16 still under discussion and we're going to
17 summarize and return to those tomorrow. So those
18 are active issues.

19 But even, after we do that, we're
20 going to be addressing new issues. And then
21 just, you know, I always say this and just to put
22 this into perspective that this program really is

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1 a complicated program because it is by statute
2 such an ambitious program.

3 I can't think of another compensation
4 program that takes on the whole universe of
5 occupational diseases and vast numbers of toxic
6 exposures such as occurred in the DOE complex and
7 tries to figure out to what extent those
8 exposures lead to disease and people should be
9 compensated for those programs.

10 I can't think of another federal
11 program that does that, certainly not at the
12 state workers compensation. I'm very familiar
13 with the World Trade Center program and I think
14 this program is unique really in its charge to
15 cover really sort of the encyclopedia of
16 occupational health.

17 And so that's led to a complicated
18 program which we'll learn about and continue to
19 learn about. But it's a program that's achieved
20 a lot in the last like 12, 13 years its existed.

21 It's, according to the website, paid
22 out \$4.5 billion in compensation. Additional

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1 expenses paid for medical expenses. We focus on
2 Part E of the statute and to a lesser extent Part
3 B.

4 Under Part B another five-plus billion
5 dollars has been spent compensating DOE workers.
6 So it's a large program, a complicated program, a
7 program which has performed great service to a
8 lot of DOE workers.

9 And our charge, which I think we'll
10 hear soon, is to provide advice to try to assist
11 the program in various ways. And with that I
12 would, those are my remarks.

13 Any questions or comments at this
14 point? Okay, Ms. Hearthway, I think.

15 MS. HEARTHWAY: Good morning,
16 everyone. I'll just move up here to say welcome.
17 I just wanted to welcome all of you. Am I on
18 now?

19 Okay. I just wanted to welcome
20 everyone. To introduce myself, I'm the new
21 director or not so new anymore. I've been
22 director a little bit over a year, Julia

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1 Hearthway.

2 I will tell you my very first foray
3 into DOL was looking at one of your sets of
4 recommendations that was sitting on my desk when
5 I arrived to go through. And I will echo Dr.
6 Markowitz's words: it is a complicated statute
7 and it's a complicated area scientifically and
8 medically.

9 So I rolled up my sleeves and dug into
10 it and I commend all of you, the past Board and,
11 for your future service, the new Board Members
12 for tackling this area. It's critically
13 important and it is a difficult area. It's an
14 ambitious area.

15 But I thank you for your public
16 service on it. And I wanted to stress that we
17 are looking, myself and the entire program,
18 Energy Program, are looking to have a very
19 productive relationship with the Board.

20 We sat down and spent some significant
21 time going through things that we really are
22 struggling with and we could use your advice and

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1 help on. And Dr. Markowitz and I have met, I
2 think, at least twice if not three times.

3 And we've discussed the Board in
4 general. At the last meeting we discussed some
5 of these things that we are grappling with. And
6 those will be presented to you.

7 But we're hoping for your advice and
8 help on those things. And I look forward to
9 working with all of you looking at what you have
10 to suggest and recommend and delving into this
11 very important work.

12 So just wanted to say those few words.
13 Thank you.

14 CHAIR MARKOWITZ: Thank you. Any
15 comments or questions for Ms. Hearthway? Thank
16 you. So, Mr. Plick, is Mr. Plick here?

17 Actually we have a couple new people
18 in the room if you could just, before when we did
19 introductions everybody was introduced.

20 If you could just introduce
21 yourselves. Mr. Vance.

22 MR. VANCE: Good morning, everybody.

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1 John Vance. I'm sitting in the back of the room.
2 It's nice to see everybody again.

3 MR. GIBLIN: I'm Tom Giblin. I'm the
4 associate solicitor for the Federal Employees and
5 Energy Workers Compensation. I'm on tap for
6 9:45. But if you want I can go now.

7 CHAIR MARKOWITZ: Yes, we do.
8 Accepted.

9 MR. GIBLIN: Good morning. Again, I
10 appreciate the opportunity to come today and
11 welcome the Board. I know a lot of you have been
12 here before and there are a few new folks. So
13 it's, we look forward to working with you.

14 I'm just going to kind of give you
15 just a little bit of an overview of what my
16 office does, a little bit of the statute and a
17 little bit of your -- the provision that applies
18 to you today.

19 As I said, I'm the associate solicitor
20 for Federal Employees and Energy Workers
21 Compensation within the Office of Solicitor.
22 That's, we of course have an acronym. That's

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1 FEEWC or FEEWC, that's how we pronounce it, which
2 is, you know, no easier than EEOICPA.

3 So I guess we're a pretty good match.

4 The division itself provides legal support for
5 the Energy Program. And we do all the legal
6 support except for maybe personnel actions.
7 That's handled by someone else.

8 So we provide legal advice. That
9 includes both formal and informal opinions. We
10 provide, we review all policies and procedures.
11 We do all the regulatory work that's needed and
12 we do any litigation.

13 I should point out that we do not have
14 independent litigation authority. So when OWCP's
15 decisions are appealed to federal court, we have
16 to rely on the Department of Justice to represent
17 us.

18 That doesn't mean it just goes. It
19 means that we're heavily involved obviously with
20 any litigation. We do a lot of the pleadings.
21 You wouldn't be surprised if most DOJ attorneys
22 have never heard of EEOICPA and they actually

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1 welcome our assistance for the most part.

2 So that's really what we do in the
3 division. The statute itself, as you know, was
4 passed in 2000. It was enacted to provide
5 medical benefits and compensation for those
6 workers in the nuclear weapons industry.

7 There are two parts now under the Act
8 that set out the compensation available for
9 covered employees, for their survivors. Part B
10 of the Act provides uniform lump sum payments and
11 medical benefits to covered employees and where
12 applicable to survivors of such employees of the
13 Department of Energy, DOE, its predecessor
14 agencies and certain of its vendors, contractors
15 and subcontractors.

16 Part B of the Act also provides
17 smaller uniform lump sum payments and benefits to
18 individuals found eligible by DOJ for the
19 benefits under Section 5 of the Radiation
20 Exposure Compensation Act or RECA and where
21 applicable to their survivors.

22 Part E of the Act provides variable

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1 lump sum payments based on a worker's permanent
2 impairments and/or qualifying calendar years of
3 established wage loss and medical benefits for
4 covered DOE contractors, employees and where
5 applicable provides variable lump sum payments to
6 survivors of such employees based on the worker's
7 death to a covered illness and any qualifying
8 calendar years of wage loss.

9 Part E of the Act also provides these
10 payments and benefits to uranium miners, millers
11 and ore transporters covered by Section 5 of RECA
12 and also where applicable to their survivors.

13 While these two parts may seem very
14 similar there are a number of differences between
15 who is covered, what illnesses they cover and the
16 amounts of monetary compensation that is
17 available and how it is calculated.

18 As a general rule Part B is broader as
19 to who is covered but is limited in the types of
20 illnesses that are covered. By contrast Part E,
21 as Dr. Markowitz pointed out, is quite extensive
22 as to the type of illnesses that are covered but

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1 is more limited in who is covered.

2 Also the amount of compensation
3 available under Part B is flat and fixed. It's
4 typically \$150,000 or if it's a RECA, it's
5 \$50,000. And under Part E it's variable but it
6 can go up to \$250,000.

7 When EEOICPA was originally passed, it
8 was actually assigned to the President of the
9 United States to administer. By Executive Order
10 13179 issued on December 7, 2000, the President
11 delegated the primary authority to administer
12 EEOICPA to DOL and designated certain specific
13 responsibilities to the Department of Health and
14 Human Services, DOE and DOJ.

15 When Part E was added in 2004 the
16 Secretary of Labor was given direct authority to
17 administer that part.

18 As a general matter, OWCP adjudicates
19 claims and pays benefits under EEOICPA while the
20 National Institute for Occupational Safety and
21 Health, NIOSH, within HHS, estimates the amount
22 of radiation received by employees and alleged to

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1 have sustained cancer as a result of such
2 exposure and established guidelines followed by
3 OWCP when it determines if such cancers are at
4 least as likely as not related to employment.

5 In addition, both DOE and DOJ are
6 responsible for notifying potential claimants and
7 for submitting evidence necessary for OWCP to
8 adjudicate claims under EEOICPA. In December
9 2014 as part of the FY 2015 Defense Authorization
10 Act, EEOICPA was again amended a new provision,
11 Section 7385s-16 which created this Advisory
12 Board.

13 This section was again amended in 2018
14 again under the Defense Authorization Act and
15 extended the Board's time by five years. It will
16 go into 2024.

17 Like the original version of EEOICPA,
18 this Board, the responsibility to establish the
19 Board and appoint the members was given to the
20 President.

21 By Executive Order 13699, dated June
22 26, 2015, the President established the Advisory

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1 Board within the Department of Labor and
2 delegated to the Secretary of Labor the authority
3 to appoint the members of the Board, which is to
4 consist of no more than 15 members, as well as
5 the responsibility of the administration of the
6 Board including funding, staff, administration
7 functions under the Federal Advisory Committee
8 Act or FACA, which Mr. Plick is going to talk
9 about and the designation of senior officials of
10 the Department as the director of the staff to
11 the Advisory Board.

12 Section 7385s-16 specifically sets out
13 the duties of the Board. First, the Board is to
14 advise the Secretary of Labor and that advice is
15 limited to four specified areas.

16 I've got about two more minutes. Is
17 that all right? Okay, no sweat. The Board has
18 really two functions. One is -- or it's been
19 given two duties.

20 One is to advise the Secretary and
21 that advice is limited to four specific areas.
22 The site exposure matrices of DOL, the medical

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1 guidance for claims examiners for claims under
2 Part E with respect to the weighing of the
3 medical evidence of claimants, evidentiary
4 requirements for claims under Part B related to
5 lung disease and the work of industrial
6 hygienists and staff physicians and consulting
7 physicians of the Department and reports of such
8 hygienists and physicians to ensure quality,
9 objectivity and consistency.

10 The second duty of the Board is to
11 coordinate exchange of data and findings with the
12 Advisory Board on Radiation and Worker Health
13 which was established in the original part of
14 EEOICPA, to the extent necessary.

15 As you know, there's also a conflict
16 of interest provision for the Board Members
17 regarding any financial interest related to the
18 provisions and medical benefits under the Act.
19 This was reviewed prior to your appointment.

20 As Dr. Markowitz pointed out, EEOICPA
21 statute is complex and it involves complex
22 development and adjudication and has the unique

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1 challenge of applying these provisions to work
2 that started over 70 years ago.

3 The Department has worked very hard to
4 apply these provisions in a fair and equitable
5 manner and the Solicitor's Office has been there
6 every step of the way to help them with that.
7 The program has gained experience over the nearly
8 20 years it has administered this program and
9 understands the difficulties and challenges that
10 are faced by claimants and the Department.

11 The scope of the Board's authority
12 though limited to the four areas, as I described,
13 can certainly assist in this administration
14 especially with those items identified by the
15 OWCP. That's, does anyone have any questions for
16 me?

17 CHAIR MARKOWITZ: Yes, I have a
18 question about RECA. I know it's not part of our
19 charge.

20 MR. GIBLIN: Right.

21 CHAIR MARKOWITZ: But I think it's
22 been raised at some point in the public comment

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1 section because there are certain specified
2 health conditions under RECA: pneumoconiosis,
3 pulmonary fibrosis, a few of them.

4 And so are the uranium miners
5 mentioned in the Energy Employees Occupational
6 Illness Act and --

7 MR. GIBLIN: Yes.

8 CHAIR MARKOWITZ: So what's the
9 relationship between the way in which they're
10 mentioned there and then the preceding RECA? If
11 you could just clarify that.

12 MR. GIBLIN: Well I don't know if I
13 can answer that question. My --

14 MR. FITZGERALD: Can I interrupt for
15 one second? This is Doug Fitzgerald, DFO. In
16 the interest of time and Joe Plick's scheduling
17 conflict here, can we just suspend questions to
18 Tom Giblin for this moment and have Joe come up
19 and give his presentation and then, Tom, you can
20 --

21 MR. GIBLIN: Sure.

22 MR. FITZGERALD: -- pick up with the

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1 question and answer after Joe's presentation.

2 CHAIR MARKOWITZ: Thank you. So I'd
3 like to welcome Mr. Plick to discuss FACA review
4 rules.

5 MR. PLICK: Good morning, everybody.
6 Thank you for having me. So my name is Joe
7 Plick. I'm the counsel, my title is counsel for
8 FOIA and information law. So I cover a whole
9 bunch of areas including the Federal Advisory
10 Committee Act.

11 And I'm here today just to talk
12 briefly about the Act and its requirements, a
13 little bit of its history so that you understand
14 a little bit more of the rules that you're
15 operating under.

16 The purpose of FACA, it was passed by
17 Congress back in the 70s, Congress understood
18 that there were a lot of councils and committees
19 that were being utilized by the government and it
20 wanted to put some sunshine on them.

21 So it recognized that there was a need
22 for agencies to get balanced outside advice and

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1 expertise. But they wanted some rules, they
2 wanted to make sure that the public and
3 themselves, Congress was aware of what was going
4 on and how this was operating.

5 So they established this law which
6 creates sort of the rules of the road. It
7 governs the establishment, the operation, the
8 termination of committees that are established to
9 give advice and recommendations to the Executive
10 Branch.

11 It requires that the committees give
12 relevant advice, that they act promptly and that
13 there's accountability through cost controls and
14 recordkeeping.

15 So the requirements of the Act.
16 Committees have to be established by statute, by
17 presidential directive or it can be authorized by
18 statute. This obviously is a statutory
19 committee.

20 Once the committee is established it
21 has to be chartered. The General Services
22 Administration is actually the agency that has

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1 government-wide oversight over FACA.

2 I'm not quite sure how they wound up
3 with it. I think they probably missed the
4 meeting that day. But anyway, so they're in
5 charge.

6 And they've issued government-wide
7 rules that we follow in running Federal Advisory
8 Committee Act committees. Committees have to be
9 balanced, that's in terms of points of view and
10 functions, expertise.

11 There may well be additional
12 requirements in statutory committees. I think
13 this committee has some statutory requirements on
14 the membership. Tom has talked about some of the
15 statutory requirements as well.

16 Meetings generally are required to be
17 public. Detailed minutes are required to be kept
18 and have to be certified. Basically any member
19 of the public can file a written statement with
20 the committee before or within a reasonable time
21 following the meeting.

22 The FACA does not require you to take

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1 public comment but you can and I think in this
2 case you guys will. The minutes have to be
3 certified by the Chair within 90 days of a
4 meeting.

5 And it's the minutes, it's not a
6 transcript. For a long time GSA had allowed
7 agencies to use transcripts to fulfill the
8 requirements for minutes.

9 But there were complaints from the
10 public because if you've got a meeting that lasts
11 three or four days and somebody is trying to
12 figure out what happened you don't want them to
13 have to read three or four days' worth of
14 transcripts. So the minutes are a better way to
15 accomplish that goal.

16 A couple of things. We ask that you
17 don't discuss substantive matters outside the
18 meeting unless you're in a subgroup or
19 subcommittee that's been established. If you get
20 together outside the group, it could be seen as a
21 violation of FACA.

22 There is no statutory violation of

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1 FACA contained in the statute itself. Rather
2 courts have said that if there's a violation of
3 FACA, the way that's punished is the Agency is
4 enjoined from taking action based on a
5 recommendation.

6 So it's almost like a nuclear option.

7 A lot of good work could go to waste simply
8 because of some procedural violations.

9 Media inquiries we request be referred
10 to the DFO and the Chair and let them handle
11 those. FACA committees are, we are asking for
12 your independent advice. And the statute
13 requires that we ensure that you provide
14 independent advice.

15 But that has to be in the context of
16 what you're being asked. GSA's regulations say
17 that committee members and staff should be fully
18 aware of the Advisory Committee's mission,
19 limitations if any of its duties and the Agency's
20 goals and objectives.

21 In general, the more specific an
22 advisory committee's tasks and the more focused

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1 its activities are the higher the likelihood will
2 be that the Advisory Committee will fulfill its
3 mission. Committees have to be re-chartered
4 every couple of years.

5 This one is statutory. I know it was
6 recently reauthorized. But there's also this
7 requirement for the charter to be renewed. Any
8 questions on that for anyone?

9 Okay. Agency responsibilities, the
10 statute sets a couple of responsibilities for
11 agencies. There's a committee management officer
12 for the Department who manages all of the
13 Department's committees.

14 And then for this Committee Doug is
15 the designated federal officer and he has certain
16 responsibilities that are enumerated in the
17 statute. He approves the meetings, calls the
18 meetings, he approves the agenda. He's required
19 to attend. He can adjourn it if he determines
20 that it's in the public interest. I've never
21 seen that happen. I'm sure it won't.

22 But there have been some cases where

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1 courts have admonished agencies because a
2 committee went way beyond its scope and then they
3 thought it should have been adjourned. He's
4 required to maintain the records on costs and
5 membership.

6 He has reporting obligations to GSA.
7 He has to ensure efficient operations and
8 provides committee reports that ultimately go to
9 the Library of Congress. He also obviously works
10 with the Chair very closely on making sure the
11 committee runs well and effectively and
12 efficiently and liaisons with the Agency.

13 So overall objectives. Like I said,
14 while the advice received is independent advice
15 the agency can set its priorities and objectives,
16 and it should be a collaborative effort.

17 It's a waste of everybody's time if
18 you're focusing on something that the agency just
19 simply cannot do either because of resource
20 constraints or statutory restraints or whatever.

21 Any questions about that?

22 Okay. As I mentioned, meetings are

1 generally public. There are procedures for
2 closing meetings. We don't generally close
3 meetings here.

4 There is one committee that deals with
5 trade negotiations that does. But you can close
6 it for reasons that sort of track exemptions in
7 the Freedom of Information Act.

8 So if, for example, you were to have
9 testimony from affected workers and you're going
10 to be talking about medical information that
11 might be a reason to close. But there's a
12 process that you would have to go through.

13 The agency head has to approve it. It
14 has to get legal review. The decision has to be
15 made 30 days in advance.

16 Subcommittees. Right now
17 subcommittees if you form them are not subject to
18 the open meeting requirements. That doesn't mean
19 that you can't hold open meetings, but they're
20 not required.

21 The other big thing is to make sure
22 that any subcommittee work is reported back to

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1 the parent committee and the parent committee
2 deliberates on it. If the subcommittee reports
3 directly to the agency it in effect becomes a new
4 committee that's subject to FACA.

5 Meeting, information or things that
6 don't have to take place in a public meeting.
7 Prep work if you task two or more of your members
8 with going off and writing a draft of something,
9 that doesn't have to be done in public as long as
10 they bring the draft back.

11 And administrative matters, you know,
12 if we're talking about how to get you in the
13 building, how to get you your badges or things
14 like that those things don't have to be done
15 publicly.

16 Public availability of records. The
17 Act generally states that the records,
18 transcripts, minutes, appendices, working papers,
19 drafts, studies, agenda and other documents that
20 are available to or prepared for or by the
21 Committee shall be available for public
22 inspection.

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1 The provision is somewhat subject to
2 FOIA. If the Department is providing you with
3 material that would be exempt from FOIA then that
4 wouldn't have to be made public. But any of your
5 materials are public.

6 You should also be aware that Congress
7 for the past several years has been attempting to
8 amend FACA. It's passed the House every year and
9 then it's kind of stalled in the Senate.

10 I don't know obviously with the recent
11 election how that will impact that. But that
12 would impose some additional reporting
13 requirements. It would in fact, I think, make
14 the subcommittee subject to FACA requirements and
15 so you would have to have those subcommittee
16 meetings open to the public.

17 The administration has objected to
18 some of those provisions because they would be
19 really burdensome and really limit the
20 effectiveness, I think, of committees.

21 MR. FITZGERALD: Excuse me, Joe.

22 MR. PLICK: Yes.

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1 MR. FITZGERALD: Doug Fitzgerald, DFO.
2 Could you speak to working groups versus
3 subcommittees?

4 MR. PLICK: In a lot of ways they're
5 not really different. I mean if you're breaking
6 the work down into groups, it's not going to be
7 subject to the FACA requirements whether you call
8 it a work group or a subcommittee.

9 I don't think that matters a whole
10 lot. Subcommittees tend to be a little bit more
11 formal in structure than a work group.

12 A work group could simply be the
13 entire committee is deliberating and you say,
14 well why don't we have a couple people go write
15 this up and bring it back to the next meeting.

16 I think that would be a work group
17 whereas a subcommittee is generally given a task
18 and goes off and maybe does a lot of research and
19 may hold meetings with affected people and then
20 brings their work product back.

21 MR. FITZGERALD: Okay, thank you.

22 MR. PLICK: Again, it's important that

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1 the Committee, when it gets a report from a
2 subcommittee, that it actually deliberates on it
3 and doesn't simply rubberstamp it. Some courts
4 have looked at that and said well it was just a
5 pass-through and it's really the subcommittee
6 reporting directly to the agency.

7 So let's see. That's basically
8 everything I have on this. If you've got any
9 questions, I work closely with Doug and Carrie on
10 this. Other questions?

11 CHAIR MARKOWITZ: Thank you very much.
12 Sure, so we'll return to Mr. Giblin who is here.

13 MR. GIBLIN: Okay. I think I
14 understand your question now. You know, RECA,
15 Section 5 of RECA specifically covers certain
16 uranium miners.

17 And of course by statute they're
18 eligible for benefits under both Part B and E.
19 And when they apply for Part B whatever
20 conditions that have been accepted by DOJ then we
21 accept those conditions and we'll pay them, you
22 know, the \$50,000 and we'll provide medical

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1 benefits.

2 They can also seek, file a claim under
3 Part E for additional health conditions. But
4 obviously they have to meet our statutory
5 requirements.

6 So but for Part B, we accept that
7 they've met their requirements under DOJ and the
8 conditions that DOJ has accepted.

9 CHAIR MARKOWITZ: Okay. So again,
10 we're not charged to deal with RECA so this is
11 just for background information. There are
12 certain conditions, I think, that the miners get
13 compensated, named conditions.

14 I mentioned before pneumoconiosis,
15 fibrosis. I think there's maybe lung cancer. I
16 can't remember. Is that part of the RECA Act or
17 is that part of EEOICPA?

18 MR. GIBLIN: I think it's part of
19 RECA.

20 CHAIR MARKOWITZ: It's part of the
21 original which preceded the EEOICPA, right?

22 MR. GIBLIN: Right, it's been around

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1 for a while.

2 CHAIR MARKOWITZ: Thanks. Any other
3 questions? Yes, sure, Dr. Cassano.

4 MEMBER CASSANO: Hi, Mr. Giblin. I'm
5 Tori Cassano. I have a question, if you could
6 explain for the benefit of everyone we talked
7 about regulatory barriers or procedural barriers
8 to enacting a recommendation and statutory
9 barriers to enacting a recommendation.

10 Could you explain the difference
11 between those two and why one may be more
12 difficult to overcome than the other? Thank you.

13 MR. GIBLIN: Sure. Well the statutory
14 barriers, if there's a recommendation that is not
15 consistent with the statute then we really can't
16 follow it because any agency is, has only the
17 authority granted to it by Congress.

18 And that's what is set out in the
19 statute. So if it conflicts with the statute
20 then we would have to go to Congress and have
21 them amend the statute to give us the authority
22 to implement that recommendation.

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1 If it's inconsistent with their
2 regulation presumably we'll go under the
3 assumption that our regulation was properly
4 issued and we had the authority to issue it, then
5 it's a matter of looking at the regulation and
6 determining whether the recommendation, whether
7 we can make the changes necessary to the
8 regulation.

9 If we can, obviously if it falls
10 within our authority, our regulatory authority
11 then we would engage in rulemaking. That, you
12 know, there's an internal process within the
13 Department to get approval to initiate a reg and
14 then you have to get approval from OMB and then
15 of course once you have that then it goes out for
16 notice and comments.

17 That's, and then once we get those
18 then you have to review the comments and then you
19 have to issue the final rule. It's, you know,
20 it's not a short process but it's, if it's a
21 regulatory issue then it's something that's
22 within our ability to change ourselves.

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1 MEMBER CASSANO: So, thank you. So
2 not totally impossible, just difficult.

3 MR. GIBLIN: Right.

4 MEMBER CASSANO: Thank you.

5 MR. GIBLIN: Any other questions?

6 CHAIR MARKOWITZ: Okay, thank you very
7 much.

8 MR. GIBLIN: Thank you.

9 CHAIR MARKOWITZ: So I don't know if -
10 - we're running ahead of time here. I don't know
11 whether Mr. Mancher is here or -- I'm wondering
12 whether, Ms. Leiton, you want to just give us an
13 overview and then that's, maybe we shouldn't ask
14 Mr. Mancher to come early because that will run
15 us into break, this presentation will run us into
16 break and then we can resume with the schedule.
17 Welcome.

18 MS. LEITON: Good morning. The mic is
19 working fine and everything, good. Okay, so I
20 don't want to, I know a lot of you already know a
21 lot about this program.

22 I'm Rachel Leiton. Again, I'm the

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1 director of the program. I've been the director
2 since 2008. Before that I was the policy chief
3 when the program started back in 2001.

4 So I've been with the program a long
5 time and it is very complicated. There are a lot
6 of factors that make it challenging to adjudicate
7 claims.

8 And part of the reason that we're
9 happy you can help us is we do need scientific,
10 medical help in addition to experienced members
11 from the DOE facility complex. So we're very
12 happy that you're here.

13 Tom already went into some very basics
14 about the program. Mine is a little bit more
15 detailed. For those of you that already know a
16 lot, I apologize, but I do want to make sure that
17 you're aware of kind of the ins and outs of what
18 our expectation is, what we believe Congress
19 intended for us to do and how we kind of go about
20 doing that.

21 So as Tom indicated, the EEOICPA is
22 administered by the Department of Labor. We have

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1 the primary responsibility for providing the lump
2 sum compensation benefits, the medical benefits
3 for adjudicating the claims and undertaking all
4 the development actions in order for those claims
5 to come to a final decision.

6 The Act itself provides lump sum
7 compensation and medical benefits under two
8 different parts of the Act. We do work very
9 closely, however, with the Department of Energy,
10 the Department of Justice and the Department of
11 Health and Human Services. I'll talk a little
12 bit more about their roles.

13 As Tom indicated, there are two paths
14 to eligibility. There's Part B and there's Part
15 E. There are some similarities to how we develop
16 for both parts because there are commonalities in
17 the type of information we need. We need, under
18 Part B and E, we need employment information to
19 verify their employment.

20 We need medical information to verify
21 their diagnosis and causation. And then we need
22 survivor information like marriage certificates,

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1 death certificates to show that there's a
2 relationship there.

3 But there are different criteria for
4 each of those different categories under each
5 part of the Act. So for employee eligibility
6 under Part B, the individual is eligible if they
7 were a DOE contractor and subcontractor, if they
8 were a federal employee, an atomic weapons
9 employee -- that's a term that's defined very
10 specifically in the Act -- a beryllium vendor or
11 a RECA recipient.

12 Under Part E, of those the only ones
13 that are covered are the DOE contractors and
14 subcontractors and the RECA beneficiaries. So
15 the AWEs, the federal employees and the beryllium
16 vendors are not covered under Part E.

17 In terms of medical there are very
18 specific, specified in the Act conditions that
19 are covered under Part B. That would be cancers,
20 chronic beryllium disease, silicosis under very
21 specific circumstances and the RECA Section 5
22 awardees.

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1 Under Part E, however, any condition
2 can be covered, as Dr. Markowitz indicated, as
3 long as we can determine that it was as least as
4 likely as not caused, contributed to or
5 aggravated by their exposure in the workplace to
6 toxic substances.

7 That's where our biggest challenges
8 come in and I think that's what a lot of the work
9 that this Board has done and will probably
10 continue to do is surrounding that area because,
11 as Dr. Markowitz said, there isn't a trail that's
12 been blazed for us to follow when it comes to how
13 do you determine whether or not their exposure
14 was related to their employment.

15 The eligibility criteria for
16 survivorship is also different. Under Part B
17 there's a specific order. It's the spouse as
18 long as that spouse was married to the employee
19 for at least one year, adult children,
20 grandchildren, grandparents in that order.

21 Part E is different. And I think, you
22 know, the history of Part E is that it originally

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1 was given to Department of Energy as Part D.
2 They were trying to adjudicate claims, they were
3 tasked with a panel of doctors that would say
4 whether or not it was related and then they could
5 take that to their state workers comp.

6 So when Part E replaced Part D they
7 modeled it more like a state workers comp
8 survivorship definition type. So the spouse, as
9 long as the death is related to the condition
10 that we've accepted, which is different than Part
11 E which does not require a causal connection, if
12 there is no spouse then it would be children.

13 But the children must be under the age
14 of 18, under the age of 23 and a full time
15 student or any age and incapable of self-support.
16 So again, you're going to have those
17 discrepancies between the two parts.

18 The benefits we provide or that are
19 provided under the statute for Part B and E also
20 are different. Under Part B we provide a lump
21 sum compensation of \$150,000 to the employee or
22 the survivor.

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1 Under RECA if they've been, they've
2 received RECA benefits we pay them an additional
3 \$50,000. Under Part E unlike under Part B where
4 it's an automatic payment if we approve the claim
5 under Part E we approve the claim first.

6 We will pay for medical benefits and
7 then we determine what their compensation might
8 be. That can come in the form of impairment. So
9 a doctor will review, evaluate them, review the
10 American Medical Association guidelines,
11 determine what their percentage of impairment was
12 and then assign that percentage.

13 We take that, and the statute says
14 they get \$2500 for each percentage of impairment
15 they have. We also pay for wage loss. And it
16 can be between \$10,000 and \$15,000 per employee.

17 I'll get into that a little bit more.

18 And then for survivorship if the cause of death
19 was related to the condition we've accepted it's
20 \$125,000 to the survivor. There is a \$400,000
21 cap on any compensation awarded.

22 Okay. So then in terms of our

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1 development actions, the first thing we're going
2 to do is when we're going to verify employment.
3 That employment verification process starts with
4 DOE, Department of Energy.

5 We ask them for, they can oftentimes
6 provide us with verification that an employee
7 worked at a certain facility. Sometimes they
8 don't have the records so we rely on a lot of
9 other resources.

10 We work with ORISE, the Oak Ridge
11 Institute for Science and Education. We work
12 with -- there are corporate verifiers that DOE
13 identified for us that we work directly with.

14 We work with Social Security
15 Administration but mainly for wage loss
16 information. But sometimes they can help us with
17 employment verification.

18 We have other sources. The CPWR is
19 one of them. We also have, we take affidavits
20 and then any other records that the claimant can
21 provide to us.

22 So under Part B the next step is going

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1 to be medical, trying to determine the causation
2 under Part B if it's a Part B case. And that
3 means that there are two paths to getting an
4 acceptance for cancer under Part B.

5 One is Probability of Causation that's
6 conducted by the National Institute for
7 Occupational Safety and Health, NIOSH. They
8 will, we'll refer a case to them for cancer.

9 They will determine the level and
10 extent of exposure to radiation, provide us with
11 that report and then we conduct at the Department
12 of Labor the Probability of Causation
13 calculation.

14 It's a scientific calculation of the
15 likelihood that the radiation exposure is related
16 to cancer. That computer system that we use was
17 developed by NIOSH.

18 If the PoC, the Probability of
19 Causation, is 50 percent or greater then they
20 receive compensation. Again, that is a statutory
21 mandate.

22 The other path in Part B for cancer to

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1 receive coverage is the Special Exposure Cohort.
2 Congress in the Act established four Special
3 Exposure Cohorts, the gaseous diffusion plants
4 plus Amchitka Island.

5 And then they allowed for additional
6 SEC sites, Special Exposure Cohort sites to be
7 established by NIOSH. NIOSH is tasked with
8 looking at petitions for a new special exposure
9 cohort.

10 They also will do, when they're doing
11 dose reconstructions, if they don't have enough
12 records to conduct a PoC, they will sometimes
13 establish them on their own. They have
14 established, I believe it's 124 additional SEC
15 Classes since the beginning of the program.

16 In order to be covered under a Special
17 Exposure Cohort you have to have worked during
18 those periods of time when NIOSH has established
19 it as an SEC. Normally it's, and then you have
20 to work 250 days during that time frame.

21 You also have to have had one of 22
22 cancers that are specified in the Act. If you

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1 don't have one of those cancers and you worked at
2 that site even if you worked during that time
3 period, you will undergo a dose reconstruction.

4 The Department of Labor will, we
5 administer the SEC classes but we don't create
6 them. We have no part and no say in what
7 constitutes an SEC.

8 There are other parts of, there are
9 other conditions under Part B that are covered.
10 Chronic beryllium disease is one of them. There
11 are very specific statutory criteria for CBD
12 under Part B.

13 I'm not going to go into great length
14 about that now because it's part of the
15 discussion we'll have later about Part B lung
16 conditions. But we also cover silicosis under
17 specific circumstances under Part B.

18 Under Part E, we also need to undergo
19 a medical analysis. But this one, as I said,
20 gets a little bit more complicated. So the first
21 thing we have to establish under Part E is that
22 they have the medical condition.

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1 And then we need to determine what
2 toxic substances they might have been exposed to.

3 And then once we've determined that we move to
4 causation to determine whether that level of
5 exposure was related to the condition that has
6 been claimed.

7 The definition itself is slightly
8 complicated also because the way it's laid out in
9 the statute is that the toxic exposure must have
10 been a significant factor in causing,
11 contributing to or aggravating the condition
12 that's been claimed.

13 Figuring out that definition has been
14 a challenge. I think this Board has assisted us
15 some with that as well in trying to break that
16 down into pieces.

17 But there are a lot of different tools
18 that we use to try to get to determine what that
19 exposure level might have been. We have an
20 occupational history questionnaire which is
21 something that the Board has tackled and we may
22 ask them to tackle a little bit more for us.

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1 But that is actually an interview that
2 is conducted by our resource centers. Initially
3 when a person files a Part E claim they'll
4 conduct this interview with the employee or the
5 survivor asking where the person worked, what
6 buildings they might have worked in, what they
7 know.

8 They don't always know a lot. But
9 sometimes they do and we'll take that into
10 consideration in our analysis.

11 We also created the site exposure
12 matrices which we'll get into a lot more detail
13 later today. But basically that is a tool that
14 we use to help the claims examiner determine,
15 okay, if a person, it's in a relational database
16 that contains information about DOE facilities,
17 toxic substances that were at those facilities
18 and the, there's a database called HazMap within
19 that, that talks about the relationship between
20 certain toxic substances and certain conditions.

21 We also rely on what we call document
22 acquisition request records which are Department

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1 of Energy records that sometimes will contain
2 information, industrial hygiene records and
3 things like that, that we can use.

4 We also go to the Former Worker
5 Medical Screening program through Department of
6 Energy to, we'll use those work interviews and
7 any other medical information we can find in
8 those records. And again, we look at affidavits
9 and facility records as well.

10 Okay. So the SEM also, what it
11 contains information about DOE facilities, it
12 also has information about uranium mines and
13 mills. I know that's not part of your task, but
14 just for your information.

15 There is a link on our website. A lot
16 of the information I'm providing you today is on
17 our website. There's procedure manual
18 regulations, statutes, the site exposure
19 matrices, the DOE facility website. There's a
20 lot of information there.

21 Okay, so a little bit, I think I
22 mentioned impairments for Part E. So I'm not

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1 going to go into that a whole lot. Basically
2 it's the, it's something that we obtain from a
3 physician who has evaluated a patient.

4 In some circumstances for impairment
5 we will obtain tests from, like pulmonary
6 function tests or a written examination report
7 from the treating physician. But if a claimant
8 can't find a doctor that can do impairment
9 ratings we rely on a contract medical consultant.

10 I am going to talk a lot more about
11 contract medical consultants as well later. But
12 just as a brief overview of that, so often first
13 we'll go to the claimant to get medical
14 information.

15 We'll go to the claimant to get any
16 other information they have. But when that --
17 when we exhaust that in an effort to help given
18 that not, survivors often don't have information,
19 employees sometimes don't have information, we
20 will go to, we contracted with a company that has
21 access to physicians of all different
22 specialties: oncology, pulmonology, orthopedics,

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1 not orthopedics so much as occupational, we'll
2 say occupational doctors.

3 But anyway we will refer cases to
4 these doctors when a claimant does not have
5 information or if there's other information that
6 we think we can get from a contract medical
7 consultant that we're not getting from the
8 doctor.

9 Sometimes impairment is one of those
10 things, that that physician can provide us with
11 information that maybe a claimant could not.
12 Another contract that we also have and we have on
13 board, we have an on-board medical director as
14 well.

15 And we have several, we have two full
16 time federal industrial hygienists we refer cases
17 to as well. We've, in the last couple of years
18 we've obtained a contract for industrial
19 hygienists to review cases on a case by case
20 specific basis.

21 So if we don't have enough information
22 but we have some information that we can refer to

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1 an industrial hygienist on a case by case basis,
2 we'll send that case with specific information
3 and ask more questions to that doctor.

4 Again, that will be elaborated on more
5 later when we talk about that topic. Wage loss
6 is basically the decreased capacity to work as a
7 result of the accepted medical conditions.

8 There's a pretty complicated
9 definition in the statute for what we pay and how
10 we pay it. But basically for any year that an
11 individual employee made less than 50 percent of
12 their pre-disability annual wage they will
13 receive \$15,000 in compensation.

14 For any year that's between 50 and 75
15 percent of what they used to make they'll get
16 \$10,000 in compensation. And the methods we go
17 about to try to determine that usually rely on
18 Social Security records, what their three-year
19 annual average wage was before they stopped
20 working or had limited capacity to work.

21 So after we've undertaken all of this
22 development what happens is that the, there are

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1 certain responsibilities of the claimant. There
2 are certain responsibilities that we have.

3 First, we expect that the claimant
4 will provide us with whatever they can. And that
5 sometimes is a lot, sometimes it's not a lot.
6 That will determine what development actions we
7 will then take.

8 We expect them to respond to letters
9 from Department of Labor. We've taken on a lot
10 of responsibilities ourselves. As I indicated,
11 first we'll gather the evidence.

12 We have developed these partnerships
13 with other agencies and organizations. We, after
14 we've conducted development the district office,
15 we have four district offices in the country in
16 Seattle, Cleveland, Jacksonville and Denver.

17 And there are claims staff in each of
18 those offices who will issue a recommended
19 decision. That case and that whole decision will
20 then be transferred to our Final Adjudication
21 Branch and it's only a recommendation.

22 At the Final Adjudication Branch

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1 that's where the claimant then has that
2 opportunity to object to the recommended
3 decision. They can, the claimant or their
4 representative can ask for an oral hearing.

5 That can be conducted either in person
6 in their area, by WebEx or by telephone. In the
7 alternate they can ask for a review of the
8 written record which is, they can submit letters
9 or additional information that will be reviewed
10 at the Final Adjudication Branch.

11 The Final Adjudication Branch is
12 separated from the district office. It's made up
13 of hearing representatives who will make that
14 final decision on the case.

15 They are co-located. They have
16 offices co-located with the district offices in
17 the same area, but they're not in the same
18 structure. And then there's a centralized Final
19 Adjudication Branch here in Washington D.C., yes.

20 MEMBER BERENJI: Sorry, question.
21 This is Manijeh Berenji. So who exactly is on
22 that adjudication meeting? I mean is there a

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1 judge? Is there --

2 MS. LEITON: No. So there's the
3 recommended decision that's issued by the
4 district offices. That's claims examiners.

5 And then the Final Adjudication Branch
6 is made up of hearing representatives that work
7 for the Department of Labor also. But they are
8 separated in their chain of command.

9 They are separated in various other
10 ways and independent from what the claims
11 examiner is doing.

12 MEMBER BERENJI: Thank you.

13 MS. LEITON: So once all the
14 objections or in some cases the claimant will
15 waive the right. If it's been accepted they'll
16 waive the right to object and we can issue a
17 decision faster.

18 But every decision is reviewed whether
19 it's an acceptance or a denial by the Final
20 Adjudication Branch before a final decision is
21 issued. They'll issue that final decision.

22 Following the final decision there are

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1 other ways to get, you can get the case. There's
2 a reconsideration option which means that within
3 a certain number of days, 30 days you can ask for
4 reconsideration by a different hearing
5 representative.

6 In addition, cases can go to district
7 court or during, at any time after a final
8 decision a claimant can ask for a reopening of
9 the claim. What that means is if they submit new
10 medicals or they submit information that would
11 suggest that maybe the case could be accepted now
12 they can submit that to us later.

13 Oftentimes we'll reopen cases if there
14 is a new Special Exposure Cohort that's been
15 established. We'll go through all of the cases
16 that could have been affected by it. We'll
17 review them. We'll reopen them and accept them
18 if we can.

19 That same thing applies to new policy
20 that might affect a case that could be ultimately
21 accepted.

22 MEMBER BERENJI: Hi there. This is

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1 Manijeh Berenji again. Sorry I had another
2 question. So how many cases have actually been
3 reopened? Do you have any data on that?

4 MS. LEITON: I do, but I'll have to
5 get it back to you. I don't have it at the tip
6 of my fingers.

7 MEMBER BERENJI: Thank you.

8 MS. LEITON: So once the, if a
9 decision, final decision accepts, well whether
10 it's accepted or denied the case goes back to the
11 district office. If it's accepted the district
12 office will then pay the benefits, especially
13 under B they'll pay them right away.

14 Under Part E, they'll develop for
15 impairment or wage loss or any other benefits
16 they may be eligible for and we'll pay medical
17 benefits for whatever conditions we've accepted.

18 Some pretty broad statistics, program
19 to date we've paid \$15.6 billion, which is
20 pretty, it was surprising to a lot of people who
21 enacted the law originally. They did not expect
22 that we were going to be paying this much money.

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1 They thought it would be kind of a
2 finite amount of people, a finite amount of money
3 and we would be done. But, you know, we do a lot
4 of outreach.

5 We do a lot of, there's still a lot of
6 people out there that we want to reach because
7 while this program is well known to major
8 facilities, Hanford, you know, SRS, Oak Ridge
9 there are still little facilities everywhere that
10 we're still trying to reach out to.

11 There are still survivors. There are
12 still a lot of medical benefits. So this program
13 is not going anywhere and we are continuing to
14 pay benefits.

15 We've paid \$6.5 billion under Part B,
16 \$4.5 under Part E and \$4.5 billion under medical
17 benefits. We do also have resource centers. I
18 mentioned those briefly when I was talking about
19 the occupational history questionnaire.

20 We've got 11 resource centers
21 nationwide. And basically they're contractors
22 that work for us. Many of them have been with

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1 the program since the very beginning.

2 They assist with claimants filing
3 claims. They will help people with walk ins,
4 people who are, they are located in some of the
5 more rural areas and they assist us with a lot
6 of, help claimants with questions, help do
7 outreach with the occupational questionnaire and
8 a lot of other functions that really kind of give
9 claimants, particularly if they're located around
10 these resource centers a face to face
11 conversation, assistance if they need it.

12 And that is my overview. I will, as I
13 said, there is on the agenda there is going to be
14 time later for going into each, delving into each
15 of your mandates so there will be a lot more
16 information.

17 I will talk about chronic beryllium
18 disease. We're going to talk more about the site
19 exposure matrices, weighing of medical evidence
20 and Part B lung conditions.

21 So we'll get into that a lot more
22 later. But if there are questions now I'm happy

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1 to take them.

2 MEMBER BERENJI: I have a question.
3 This is Manijeh Berenji again. So in terms of
4 the education of your claims examiners, I mean is
5 there a certain educational paradigm by which you
6 train these folks because I feel this is very
7 complicated even for occupational medicine
8 physicians, epidemiologists?

9 I feel like there needs to be some
10 sort of baseline education provided at the get
11 go. But I wasn't sure what that procedure was.

12 MS. LEITON: So our claims examiners
13 are given training when they first come on board.
14 And they're trained in how to be claims
15 examiners.

16 They're not medical doctors. They're
17 not industrial hygienists, epidemiologists,
18 experts in those fields. That's why we have
19 experts in those fields to help us.

20 But they are trained in the statute.
21 We have a very, very detailed procedure manual
22 that gives them step by step instructions on what

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1 type of development to do.

2 We also have, we do training modules
3 so they can do online training. We do classroom
4 training, particularly when something new comes
5 up if there is a refresher that needs to be
6 undertaken.

7 And we do a, you know, orientation.
8 Sometimes that consists different, it's different
9 depending on the district office. Sometimes like
10 we might have a mentoring program.

11 One claims examiner will help the
12 other one. Some of them have five to six week
13 kind of orientation moving into a caseload type
14 of thing.

15 But we also have a training lead now
16 in national office. We're working to kind of
17 make that training more robust and more
18 consistent throughout the country.

19 But it's a big part of working with
20 our claims staff to make sure that they
21 understand.

22 MEMBER BERENJI: Thank you.

1 CHAIR MARKOWITZ: Are there other
2 questions? Dr. Silver.

3 MEMBER SILVER: I remember about a
4 decade ago there was a big controversy over
5 Social Security claims administrators having a
6 strong preference for web conferences and
7 telephone hearings to the point where claimants
8 were being denied in-person hearings.

9 I know administrative law
10 professionals across the federal government
11 communicate with each other. Has there been any
12 movement in this program to favor electronic
13 conferences to the disadvantage of in-person
14 conferences?

15 MS. LEITON: So we will do in-person
16 hearings when requested. I have heard from some
17 stakeholders that they've gotten the impression
18 that we are trying to deny those or move towards
19 WebEx or telephone conferences.

20 That's not our intention. We do have
21 that capability because we have resource centers
22 that have WebEx equipment available. We have,

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1 I'll talk a little bit about our centralization
2 of our Final Adjudication Branch assignments
3 recently.

4 And that may be the impetus for some
5 of what I've been hearing about whether or not
6 people are traveling around the country to hold
7 their hearings.

8 But to answer your question plainly,
9 no, we do not have any impetus or requirements
10 that hearing representatives tell claimants that
11 they shouldn't have in-person hearings.

12 They have that right. We want to
13 allow the claimants or their representatives to
14 have that right. But we will entertain telephone
15 conferences or WebEx conferences.

16 Sometimes that easier for some
17 representatives or claimants who don't want to
18 leave the house.

19 MEMBER BERENJI: Hi there, this is
20 Manijeh Berenji again, sorry. I'm new to the
21 Board so I'm just trying to get some
22 understanding.

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1 MS. LEITON: No problem.

2 MEMBER BERENJI: So I understand that
3 you have four regional offices, correct?

4 MS. LEITON: Correct.

5 MEMBER BERENJI: And do you actually
6 have a medical doctor as well as a toxicologist
7 at each one of these branches?

8 MS. LEITON: No. We have a medical
9 director here in the national office. We have a
10 toxicologist here the in national office as well
11 and then we have the industrial hygienists that
12 they can refer cases to.

13 We have the contract medical
14 consultants that can assist with claims. But we
15 do have nurses at the district offices. Some of
16 them are located, we've got a couple in the
17 district offices but they're also available for
18 consultation, et cetera. But they're not co-
19 located necessarily.

20 MEMBER BERENJI: I have a follow up
21 question. So in terms of, you actually have
22 nurses at each of these local branches. If there

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1 is a question that needs to be escalated to the
2 medical director is there a current procedure for
3 that?

4 MS. LEITON: Absolutely. I mean
5 anytime a claims examiner has a question that,
6 you know, isn't either, a nurse can't help them,
7 we have a Policy Branch, John Vance who stood up
8 earlier is our policy chief.

9 And they can refer any questions they
10 have to our Policy Branch. That can be referred
11 to the medical director. And we take any
12 questions or concerns claims examiners have very
13 seriously and we'll help them with them.

14 CHAIR MARKOWITZ: Dr. Redlich.

15 MEMBER REDLICH: Yes, I don't think
16 we've ever met the medical director. Is that
17 possible?

18 MS. LEITON: Yes. I don't know if we
19 can do it this week but we'll definitely make
20 sure that happens.

21 MEMBER BERENJI: And the toxicologist
22 too, I mean that would be great to be able to see

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1 these folks in person.

2 MR. FITZGERALD: This is Doug
3 Fitzgerald. Yes, there was a late request to
4 have Dr. Armstrong speak at the Board but it came
5 in yesterday.

6 Again, it was just a little too late
7 in the agenda setting process. But he did say he
8 would be happy to attend any future subcommittee
9 or committee meetings where he could provide
10 prospective help for the Board.

11 MS. LEITON: And the toxicologist,
12 we'll talk about that as well.

13 CHAIR MARKOWITZ: Steve Markowitz, I
14 have a few questions. Where do you get your
15 epidemiologic expertise from?

16 MS. LEITON: Well basically we rely
17 mostly, when you're talking about expertise we
18 rely on industrial hygienists for the type of
19 toxic substances. We rely on our occupational
20 medicine doctors for the medicine side of it.

21 But when you say, is there something
22 specific you're asking about?

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1 CHAIR MARKOWITZ: Well when a claims
2 examiner is puzzled about a relationship between
3 exposure and disease there's a procedure for them
4 making a request to the toxicologist to review
5 the topic, I think, or at least to receive the
6 question and express an opinion.

7 And toxicology is one thing, it's very
8 useful. But some of the, much of the answer to
9 that question actually relies on epidemiologic
10 expertise.

11 So I'm just wondering where, how that,
12 how you access that expertise.

13 MS. LEITON: Well I believe that she
14 has, our toxicologist has some expertise in
15 epidemiology. But just to be clear a claims
16 examiner will go to the toxicologist when we have
17 a medical article or scientific articles that
18 suggest that there might be a relationship to a
19 disease that could be applied program-wide.

20 She's not to be relied on for a
21 medical determination on causation on specific
22 cases. She's there to help us research any of

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1 these articles that come in, conduct additional
2 research to help us find those links.

3 But right now she's the resource we
4 have for that research side of things.

5 CHAIR MARKOWITZ: Thank you, another
6 question. So we'll hear public comments later
7 and we have access, the Board Members should
8 access the ombudsman's annual reports because
9 they are very informative.

10 But from your point of view, what are
11 the most common frustrations of claimants or what
12 are the active issues that you need, that you're
13 dealing with that seem to be more common at this
14 point because I'm sure they evolve over time?

15 MS. LEITON: I think that causation is
16 the biggest challenge for them. And we hear, you
17 know, it's difficult to establish what they were
18 exposed to. It's difficult to establish what,
19 whether or not this condition was related.

20 They get frustrated if they have a
21 physician that comes in and says, yes, it's
22 related to their radiation or it's related to

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1 their toxic exposure which are very general
2 statements from physicians. And then we ask
3 further questions delving a little bit more
4 deeply.

5 Okay, well this was the length of
6 exposure this person had. This is what we've
7 determined they were exposed to. Can you provide
8 us more information?

9 Doctors get frustrated with that.
10 They feel like, you know, they just want to treat
11 their patients. They don't really want to go
12 into a whole paperwork about whether or not it's
13 related and a lot of doctors don't know.

14 So there's that frustration because
15 claimants can't find a doctor that will provide
16 us with the information we need or we'll go to a
17 contract medical consultant who might have a
18 different opinion from their doctor but they'll
19 rationalize it more or provide us with more
20 information so claimants get frustrated because
21 they say well my doctor says this and you've got
22 this other doctor saying that.

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1 It's a struggle that we continue to
2 battle because where is the line between well
3 rationalized and not well rationalized, seeing a
4 patient, not seeing a patient. So that's a big
5 thing.

6 You know, the use of specialists can
7 be a double edged sword sometimes because well if
8 they say, yes, then it's good but if they don't
9 say what is going to help a claimant's benefits
10 get paid or, you know, there's questions about
11 that it becomes frustrating, I think.

12 I think right now Part E is the most
13 frustrating part. I mean Part B is clear. The
14 statute is clear. There are very specific lines
15 drawn in the sand and Congress laid it out a
16 certain way.

17 That might be a good way or a not very
18 helpful way in some cases. But it can be
19 explained. Part E is a little bit more gray.
20 There is a lot more areas where people become
21 frustrated.

22 I don't know if that helps with any.

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1 But that's where I'm seeing the most difficulty.

2 CHAIR MARKOWITZ: Thank you, that's
3 good. Dr. Cassano.

4 MEMBER CASSANO: Yes, I'm sure I
5 learned this at one point. But I'm of the age
6 where I forget things a lot.

7 If you have a well-rationalized
8 opinion from a personal physician and you get
9 conflicting evidence from your own medical
10 consultant how is that adjudicated?

11 MS. LEITON: Well if they are equal
12 reports we have a process for a referee that we
13 can send the case to another doctor who will
14 examine the patient depending on the type of
15 referral, what the issue is and provide us with a
16 third opinion, and that is considered a referee
17 examination or medical opinion.

18 MEMBER CASSANO: Thank you.

19 CHAIR MARKOWITZ: Dr. Mikulski.

20 MEMBER MIKULSKI: Yes, hi. This is
21 Marek Mikulski. I have a quick question about
22 the Department policy for accepting worker's

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1 affidavits in case there is no employment
2 information existing for the worker.

3 MS. LEITON: So we will accept
4 affidavits. But we usually require additional
5 information. We will look in all of our
6 different, all of our other ways of finding
7 information like Social Security to help us back
8 up an affidavit.

9 As I said, we've got corporate
10 verifiers. We've got the Center for Construction
11 Trades former worker programs. We'll look
12 everywhere to kind of back that up.

13 An affidavit standing all by itself
14 usually we will require additional information.
15 Sometimes if we've got an affidavit from multiple
16 different people, you know, but one affidavit by
17 itself is not usually going to stand alone.

18 CHAIR MARKOWITZ: Yes, Dr. Dement.

19 MEMBER DEMENT: Sort of a follow up
20 question to the one Steve had with regard to the
21 causation which is obviously a major issue for
22 many of the cases. And it really gets back to

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1 the issue of some of these are policy decisions
2 that have come down.

3 Some are presumptions and some are
4 not. It seems that, we've tried to address it in
5 the former Board with certain sets of
6 presumptions.

7 Some of them have been accepted,
8 others not and some I guess have sort of been in
9 the till. But some of the rebuttal of the
10 Board's recommendation has been the causation
11 that is the epidemiology. So where does that
12 expertise come from within the Department?

13 MS. LEITON: Well, as I indicated we
14 do have, we rely on our toxicologist, our
15 industrial hygienists, our health physicists to
16 look at the information.

17 But sometimes when we're reviewing
18 articles and references that have been provided
19 to us we look through it from various different
20 aspects whether it's legal aspect or a scientific
21 one.

22 But we have to determine that the

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1 citation that's provided to us has a connection
2 to the type of work we're looking at. So we're
3 looking at Department of Energy facilities.

4 Obviously there's not going to be a
5 lot of research on that specifically. But that's
6 different from studies that talk about
7 occupational health in general.

8 So we try to look at the articles, the
9 background information from a policy aspect, a
10 legal aspect, scientific aspect and medical
11 aspect. We have physicians as well that review
12 these.

13 And as I said, we have the experts we
14 have on our side. And oftentimes it's just
15 trying to find that link between these articles
16 and the work that we do.

17 And those are the kinds of things we
18 look at when we were looking at those references.
19 We'll summarize a little bit more further the
20 specific recommendations I believe you've got on
21 the agenda tomorrow.

22 CHAIR MARKOWITZ: I have a question.

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1 So the website it's a very nice succinct summary
2 of the number of claims, number of cases, the
3 amount of money paid out Part D, Part E.

4 But what's the difference between a
5 claim and a case and how do they differ between,
6 and there's little asterisks about unique
7 individuals.

8 So I'm sure you've gone over that with
9 us. But if you could just do that again that
10 would be helpful.

11 MS. LEITON: I will do my best. So a
12 case when an employee files a claim we create a
13 case. And that employee's Social Security number
14 used to be the case number.

15 We've changed to case IDs now. But
16 that employee is what we're basing a case on. A
17 survivor could file a claim after that employee
18 has filed a claim or multiple survivors could
19 file a claim for that employee who may be
20 deceased at this point.

21 But it's still, that case consists of
22 any survivor that's filed because of that

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1 employee's employment at a DOE facility. So
2 there could be multiple survivors in a case.

3 In addition, sometimes people will
4 file multiple, they'll file multiple EE1 forms
5 which is a claim for compensation for multiple
6 conditions. Each claim form that they file for a
7 condition is considered a claim.

8 So you can have multiple claims in a
9 case because that case is for an employee. That
10 could mean multiple survivor claims or it could
11 be multiple conditions.

12 So that's, the claims are individual
13 claims that are filed whether it's from different
14 survivors or if it's from, for different
15 conditions. So that's the difference between a
16 case and a claim.

17 When you start mixing B and E into
18 that and you've got a combination of B and E
19 statistics the unique individual employee number
20 becomes relevant because then you're trying to
21 say, or unique individual, I think it says
22 employee unique individual.

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1 I don't have it front of me. But that
2 becomes how many people, I think it's paid I
3 think is under, that asterisk is under paid but I
4 would have to double check, have been paid on a
5 unique individual worker.

6 So the unique individual worker we've
7 got descriptions on the website. I would rather
8 quote that and come back to you with it then try
9 to explain that. But I can very clearly describe
10 case and claim for you.

11 CHAIR MARKOWITZ: But so does that
12 mean a person can be multiple cases? That's what
13 it looks like. Maybe it's in a B versus E, a
14 different case.

15 MS. LEITON: B and E is where that
16 duplication comes from.

17 CHAIR MARKOWITZ: Okay. The other
18 information on the website is the amount of money
19 paid out and it's cumulative over the life of the
20 program.

21 And I couldn't find, maybe it's there
22 if you could point me or if you could provide

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1 this information is over the last three or four
2 years the annual numbers of cases, claims,
3 perhaps individuals and the annual payout under,
4 I guess mostly under E but B to the extent that
5 it's relevant to this Board.

6 And the reason I ask is just so we get
7 a sense of the dynamics of the program, sort of
8 the recent history, the evolution of activity of
9 the program.

10 MS. LEITON: Sure. There are annual
11 reports to Congress which contain that
12 information when we gather it. We're currently
13 in the process of updating that. So I can
14 provide you with what we have.

15 CHAIR MARKOWITZ: Okay, great.
16 Thanks. I have a follow up question and we're
17 going to break in a minute.

18 But on, going back say when a new
19 Special Exposure Cohort comes along or the case
20 of to the extent to which any of our
21 recommendations were accepted and you need to
22 retrospectively go back and reopen cases, does

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1 your data system allow you to do that effectively
2 because I would think that's challenging?

3 MS. LEITON: Well for SECs we've been
4 doing it for a long time and so there's very
5 specific criteria. NIOSH also has information.
6 Oftentimes if we've sent a case to NIOSH and it
7 got denied or it was PoC that was less than 50
8 percent they will help us with the list.

9 We have a list and we can track those.
10 And we pull cases that have been denied at
11 certain sites. Oftentimes we, sometimes we can
12 break it down into periods of time, sometimes we
13 can't.

14 But we will pull any case that could
15 possibly be related to the SEC for your, for the
16 presumptions we are currently pulling that list
17 it's a little bit more complicated because they
18 could be at any site.

19 But if we can pull it by condition.
20 So for the asbestos presumptions that you guys
21 recommended we're pulling cases for asbestos that
22 had been denied and we can do that.

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1 So it depends on the presumption. It
2 depends on the circumstances. Our data isn't
3 perfect by any means. But we can pull
4 information out to reevaluate some things. Other
5 things are more complicated.

6 CHAIR MARKOWITZ: So then you can
7 search by diagnosis?

8 MS. LEITON: Yes.

9 CHAIR MARKOWITZ: Okay. Any other
10 questions because we're due for a break now?
11 Okay, thank you very much.

12 MS. LEITON: Thank you.

13 CHAIR MARKOWITZ: We'll reconvene at
14 10:30.

15 (Whereupon, the above-entitled matter went off the
16 record at 10:21 a.m. and resumed at 10:42 a.m.)

17 CHAIR MARKOWITZ: I would like to
18 welcome Zachary Mancher, the ethics counsel.

19 MR. MANCHER: Thank you. So welcome,
20 everybody to this committee. I'm Zach Mancher.
21 I'm one of the ethics attorneys here at the
22 Department.

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1 And I'm going to talk to you guys for
2 the next half hour or so about the ethics rules
3 as they apply to each of you as an SGE or a
4 special government employee. And likely you are
5 going to be serving under 60 days in the calendar
6 year.

7 And so the way that it works for SGEs
8 is that there are different rules depending on
9 how often you are here, depending on how much you
10 serve in the year.

11 And so there's a bar of 60 days that
12 basically says if you're under that 60 days the
13 rules don't apply to you as much as somebody who
14 is serving more than 60 days in a year or
15 somebody who is a full employee serving, you
16 know, kind of the full year.

17 CHAIR MARKOWITZ: We'll try to keep to
18 the 60 day limit.

19 MR. MANCHER: Sure. So I'm sure
20 you're all glad to hear that, that you won't have
21 to work on it that much. So just on Page 2 you
22 should all have this packet, Ethics for SGEs.

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1 Hopefully everybody received this
2 packet as part of their materials. Just a couple
3 things I want to point out on this page.

4 So every agency has what's known as a
5 designated agency ethics official or DEAO and an
6 alternate designated agency ethics official or
7 ADEAO. And these are the two people who by law
8 are responsible for the Ethics Program at the
9 Department.

10 And so here Kate O'Scannlain, the
11 solicitor of labor is the DEAO and Peter
12 Constantine who is the associate solicitor for
13 legal counsel which is the head of my office, is
14 the ADEAO. And so their contact info is here.

15 In addition, Rob Sadler the counsel
16 for ethics and myself, our contact info is here
17 as well. That is all of the ethics attorneys we
18 have here at the Department so you have all of
19 our contact information.

20 In this presentation what we want to
21 do is make you familiar with the rules. You
22 don't need to know the ins and outs of every

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1 rule. We need to, we just need you to be aware
2 of the types of things that you should come ask
3 us.

4 If you lose our contact information
5 you can contact Carrie and Carrie can get in
6 touch with us. She's your general contact person
7 so she's somebody who can certainly get you in
8 touch with the right people and can help get your
9 questions answered should you have them.

10 If you have any questions kind of
11 throughout the presentation feel free to ask.
12 That's what we're here for.

13 If you have questions that you don't
14 want to ask in the kind of public setting but,
15 you know, it deals with a particular conflict
16 that you may have you can ask me afterwards or
17 send me an email or call me and again, that's
18 what we're here for is to, we're really here to
19 help keep you out of trouble.

20 We're not the got you people. We are
21 here to help make sure that you follow the rules
22 and we're here to help make sure that this

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1 committee is following the rules and that the
2 actions that this committee takes cannot be
3 questioned based off of appearances of any optics
4 issues or any other ethics issues because that is
5 something that often comes up is that people who
6 don't like an agency action will use ethics as a
7 way to try and prevent the agency from taking
8 that action.

9 And so really what we want to do is
10 protect the Committee and protect the
11 Department's actions by making sure that
12 everything you do is above board and everything
13 that you do really is very clearly within the
14 rules and following the ethics rules.

15 So with that I'm going to move on to
16 the actual rules. The first rule which is kind
17 of the main ethics statute, I would say, is the
18 financial conflict of interest rule.

19 And this is a criminal statute, so
20 very important. And this rule says that you may
21 not participate as a government official on a
22 matter that will have a direct and predictable

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1 impact or effect on your financial interests or
2 those that are imputed to you.

3 So your financial interests could be
4 stock holdings or other financial holdings that
5 you have. They could be your job. They could be
6 other types of contractual relationships you
7 have.

8 And also, like I said, those that are
9 imputed to you. There are some people that are
10 so closely related to you that their interests
11 count as your own.

12 And those would be your spouse, your
13 minor children, if you are a part of a general
14 partnership your general partner, your employers
15 if you serve as an officer or director or trustee
16 or employee the business.

17 And there was one other I think. If
18 you are a director or a board member, you have
19 some fiduciary responsibility to some sort of
20 outside organization that organization's
21 interests count as your own.

22 So you are in general not allowed to

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1 work on things that affect, that will have a
2 direct and predictable impact on the financial
3 interests of those outside things.

4 This committee is likely not going to
5 get into the types of specific, certainly not
6 party matters but even specific matters that
7 would really have a direct and predictable impact
8 all that often.

9 If it does, however, these are the
10 things that we are looking for. There are,
11 however, a number of exceptions that will be
12 helpful here.

13 First, holdings that are in a broadly
14 diversified mutual fund. A broadly diversified
15 mutual fund, those do not create a conflict of
16 interest.

17 So if something is in an S&P 500 fund
18 or it's in a large cap fund or something like
19 that, it's broadly diversified across a number of
20 sectors those things will not create financial
21 conflicts for you.

22 So the fact that you're invested in a

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1 mutual fund that has holdings in a particular
2 company and that company could be affected by the
3 work you do, that's not going to create an issue
4 for you.

5 Similarly, for sector mutual funds as
6 long as your holdings and the holdings that are
7 imputed to you, so your spouse and minor
8 children's holdings, add up to less than \$50,000
9 within that sector or within, if it's a regional
10 fund that focuses on particular state.

11 So let's say there's a fund that
12 focuses on companies based in Indiana. As long
13 as there's less than \$50,000 total in holdings in
14 that sector then you're fine and you don't need
15 to worry about any conflicts created by that
16 particular holding.

17 In terms of specific party matters,
18 you are allowed to have stock holdings up to
19 \$15,000 without it creating a conflict. And in
20 terms of policy matters it can be up to \$25,000
21 without creating a conflict under this rule.

22 That being said, you never want to act

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1 on matters that are, if you have holdings that
2 are close to those limits because stock prices
3 change and, you know, in the morning you might
4 have \$24,000 of stock and you act on a matter and
5 that night you go and see that you now have
6 \$26,000 because the price went up.

7 So if you are in a situation where you
8 need to act on a matter and it, you think it
9 could affect the company you should ask us and
10 say, you know, I have "x" amount of stock, right,
11 and we may tell you, you know, either don't act
12 on it or you should, you know, get rid of that
13 stock or sell some of it in order to stay below
14 the limit and make sure that you're not coming in
15 conflict with that rule.

16 MEMBER BERENJI: I have a question.
17 How do you guys come up with these limits, like
18 these dollar amounts?

19 MR. MANCHER: So these limits are
20 either, some of them are statutory and some of
21 them are created by the Office of Government
22 Ethics which puts in the, the Office of

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1 Government Ethics creates the federal regulations
2 that implement the statutes.

3 MEMBER BERENJI: So is this like
4 updated yearly, biannually?

5 MR. MANCHER: So these are government-
6 wide and some of the numbers are updated yearly.
7 Some of the numbers only change whenever the
8 Office of Government Ethics redoes their
9 regulations which can range in time.

10 So some of the numbers are updated
11 yearly. Some of them are more set. One word of
12 advice on this, this rule is not a way to get out
13 of work.

14 My supervisor used to work at the
15 Department of Commerce and under the Department
16 of Commerce they have the Patent and Trademark
17 Office. And there was an employee there who
18 didn't like working on a particular type of
19 patent application.

20 And so any time he saw one of those
21 patent applications come in he would go out and
22 buy \$15,000 worth of stock in the company. If

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1 his boss assigned it to him he would say, sorry,
2 I'm not allowed to work on this.

3 I have a conflict and then they would
4 assign it to somebody else. He would go sell
5 that stock and then wait to see if another one
6 came in and then they quickly picked up on this
7 pattern, as you might imagine, and he lost his
8 job and was prosecuted.

9 Like I said, this is a criminal
10 statute. So I don't imagine anybody here was
11 planning on doing anything like that. But just
12 in case you were, not a good idea.

13 Does anybody have any questions on
14 financial conflicts of interest?

15 CHAIR MARKOWITZ: Why was he
16 prosecuted? He declared his conflict.

17 MR. MANCHER: Because he was
18 prosecuted because there is a rule under the
19 statute that actually says basically that you
20 cannot purposefully create conflicts in order to
21 get out of this rule.

22 MEMBER CASSANO: This was a paid

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1 employee?

2 MR. MANCHER: Yes, yes. So moving on,
3 on Page 4 now we're on the appearance of bias.
4 So where the previous rule talked about conflicts
5 it was talking about financial conflicts this
6 rule is kind of the corollary but talking about
7 relationships.

8 So this rule says that you may not
9 work on a, may not participate on a matter
10 involving specific parties if you have a covered
11 relationship. And kind of the hypothetical
12 person, the hypothetical reasonable person with
13 knowledge of the relevant information would
14 question your impartiality in the matter.

15 And so there are some people that are
16 specifically covered, that the rule specifically
17 mentions. Close family members, your employer,
18 anybody with whom you have a close business or
19 financial relationship and this includes clients.

20 So anybody beyond kind of routine
21 consumer transactions. So if you're an attorney
22 kind of clients, things like that. It also, like

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1 I said, has that catch all of reasonable person
2 test.

3 And so under that we generally say
4 that close friends are covered by this rule. So
5 they're not specifically mentioned. But the
6 catch all says if a reasonable person would think
7 that you couldn't be impartial in the matter.

8 So it's not whether you think you
9 could be impartial. It's whether this kind of
10 reasonable person. And we really use kind of a
11 reasonable reporter test.

12 So if the Washington Post or Fox News
13 or CNN or anybody else was to get a hold of kind
14 of, you know, what you were working on and who it
15 was affecting would they be able to write a story
16 that would make it into the paper that would make
17 it on TV that would be the, you know, talk of the
18 day kind of a thing.

19 And so really, so this is not going to
20 cover, you know, somebody who you had a class
21 with in college and haven't heard from since.
22 But it would cover somebody who, you know, you

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1 see at the holidays every year or you go out to
2 dinner with every couple of months, you know, a
3 close friend.

4 Maybe somebody who is in your wedding
5 party or something like that and now you're
6 working on something that affects them. That's
7 going to be somebody who would be covered by this
8 rule.

9 Additionally, there's a special rule
10 for former employers. For one year generally or
11 two years if you received, basically if you
12 received some sort of severance payment.

13 There are rules for severance payments
14 and some severance payments create an additional
15 two year recusal period. Basically some people
16 leave jobs on good terms. Some people leave jobs
17 on really bad terms.

18 And either way there's a potential for
19 bias against, either in favor of or against that
20 former employer. And so in order to avoid that
21 we have this one or two year cooling off period
22 depending on some of the situations.

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1 And so any work involving anybody you
2 did work for in that previous one to two years
3 come ask us to see whether it would be something
4 that you could work on. Does anybody have any
5 questions on this rule?

6 All right, moving on, non-government
7 activities. So first general rule regarding non-
8 federal employment, for you this is not going to
9 be an issue.

10 You are allowed to keep your outside
11 jobs which is really good because if you're not
12 getting paid here we want to make sure, you know,
13 you can still get paid elsewhere. Again, the
14 only thing is making sure that you're not
15 purposefully creating a conflict.

16 For all of you your financial
17 conflicts have been checked and your outside jobs
18 have been checked ahead of time. And so I know
19 Carrie has worked with our office to make sure
20 that the outside job you have will not create a
21 conflict with this position.

22 So there's not generally something

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1 that you need to worry about there. Outside
2 speaking and writing. This is somewhere where
3 there's a potential for an issue in that you
4 cannot receive pay for outside speaking or
5 writing that is related to your official duties.

6 Now for you as special government
7 employees that rule is somewhat limited versus
8 what it would be for a normal employee. So this
9 covers things that you are asked to do kind of
10 because you are on this committee, because of
11 your government service.

12 So you cannot be paid to speak if they
13 are inviting you there as a member of this
14 committee, the invitation was extended because of
15 your government position or it was extended to
16 you by somebody whose work, you know, whose
17 interests are, you know, very closely affected by
18 your service here and it could be somewhere where
19 they are trying to curry some favor with you
20 based off of your work here or if it, the
21 information that they want you to speak or write
22 about is based off of non-public information that

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1 you have gathered based off of your service here.

2 We will get into that a little bit
3 later on. But clearly non-public information you
4 cannot then go around sharing for your personal
5 gain.

6 Additionally, so something, there's a
7 rule that says that the general subject matter is
8 covered by the area of the operations of your
9 agency.

10 For you as special government
11 employees that rule is narrowed to really the
12 types of, you cannot be paid for speaking on
13 matters that are assigned to you as part of this
14 committee. So it's, you can't go out and speak
15 for pay on things that are assigned to you here.

16 So it's really things that affect your
17 duties here. And that applies to both speaking
18 and writing.

19 There's a somewhat separate rule for
20 teaching that says that you may accept
21 compensation for teaching even if it relates to
22 your official duties as long as it is part of an

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1 accredited, it's part of the regular curriculum
2 at an accredited institution or training program
3 of some kind and you speak on multiple, the
4 teaching is on multiple occasions.

5 So this is really what separates
6 speaking from teaching. So going in as a guest
7 lecturer in somebody else's class is considered
8 kind of speaking and you couldn't be paid for
9 that.

10 But going and teaching a multiple part
11 course, that's considered teaching and that falls
12 within this exception for teaching. Are there
13 any rules, are there any questions on that rule?

14 Yes.

15 MEMBER REDLICH: I apologize. As an
16 occupational lung specialist, I mean I do see
17 patients from all over the country. People have
18 asked me would I be willing to evaluate one of
19 the workers who, you know, has applied for
20 benefits. I have declined in the past.

21 MR. MANCHER: So I might need to think
22 about this a little bit. But so these rules were

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1 really about, I guess about the outside activity
2 rule.

3 I'm not sure. That may apply, have
4 something to do with the special rule for this
5 committee and I can get back to you afterwards
6 about this. I can follow up afterwards.

7 But in general that wouldn't be an
8 issue. I do know that this committee has a
9 special rule that may affect working on
10 particular matters on the outside involving
11 people applying for benefits under this program.

12 So I can get back to you about that.
13 But in general the kind of overarching ethics
14 rules would not prevent you from working on those
15 individual matters on the outside.

16 The next part of the outside
17 activities rule is political activities. So
18 under the Hatch Act you are covered by the Hatch
19 Act which limits the political activities by
20 federal employees.

21 So you are covered by it while you are
22 serving here. So on the days that you are a

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1 federal government employee you may not
2 participate in partisan political activity.

3 And this, partisan political activity
4 is anything aimed at supporting or opposing a
5 current political candidate, a current political
6 party or a political organization. So this is
7 not issues. This is not legislation or a
8 specific bill.

9 It is not some referendum that happens
10 to be in your home state or locality. It is
11 really limited to current partisan political
12 candidates, parties or organizations that support
13 parties or candidates.

14 With the election having just passed
15 there are far, far fewer current candidates right
16 now. That being said, the President, the Office
17 of Special Counsel who enforces this rule has
18 said that the President has officially become a
19 candidate for 2020.

20 So things in support or in opposition
21 to the President's reelection would count as
22 violations under the Hatch Act. So you may not

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1 engage in political activity during government
2 hours or while you are on government premises.

3 So this would involve, this could
4 obviously involve speaking in favor of or against
5 a candidate. It could also involve wearing a
6 pin.

7 We have had this issue in the past
8 with Members of FACA committees who have come in
9 wearing material in favor of or against certain
10 political candidates or parties. So we ask that
11 you do not do that.

12 It would involve kind of having a sign
13 or putting things up in your, I don't think you
14 have government offices so that's not going to
15 create an issue. But in general that's the type
16 of thing that this would prevent.

17 You are not prevented from running
18 from government office which is something that
19 full government employees kind of, every day
20 government employees are prevented from doing.
21 You also may not solicit or accept political
22 contributions on days that you are here as a

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1 government employee.

2 But unlike full government employees
3 you are allowed to do that on other days because
4 you serve on an intermittent basis. Does anybody
5 have any questions on political activities?

6 All right. Services as an expert
7 witness. So this rule does not generally, does
8 not apply to you the same way as it does for
9 people who serve more than 60 days.

10 But you may not serve as, but it still
11 does apply somewhat to you. You may not serve as
12 an expert witness in any proceeding before a
13 federal court or agency if the Department of
14 Labor is a party or has a direct and substantial
15 interest in the case or in the matter unless you,
16 and it affects the work that you do here.

17 So if you are asked to serve as an
18 expert witness in a case you should come check
19 with us ahead of time to make sure. We can kind
20 of go over the rules with you about that. Is
21 there a question, yes?

22 MEMBER CASSANO: Yes, does that

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1 include deposition and attorney work product for
2 cases?

3 MR. MANCHER: Yes. And so come check
4 with us. We can kind of go over the rules. The
5 rule applies differently to employees who are
6 under that 60 day threshold much more narrowly.

7 So it likely will not create an issue
8 unless it's something that's affected by this
9 committee. But certainly you can send us
10 questions and we can go over, you know, certainly
11 a specific individual case or the, and then kind
12 of the more general what cases that would affect.

13 MEMBER MIKULSKI: Does that also
14 affect FAB hearings?

15 MR. MANCHER: Sorry, what was that?

16 MEMBER MIKULSKI: Final Adjudication
17 Branch.

18 MR. MANCHER: If they are before a
19 federal agency, yes. State agencies or local,
20 you know, state or local government agencies are
21 not affected by this rule. But federal agency
22 hearings could be, yes.

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1 MEMBER FRIEDMAN-JIMENEZ: If I may?

2 MR. MANCHER: Sure.

3 MEMBER FRIEDMAN-JIMENEZ: George
4 Friedman-Jimenez, another related question.
5 Would this include a workers' compensation
6 deposition for one of my own patients who is a
7 federal employee, federal workers' comp?

8 MR. MANCHER: Sorry, could you repeat
9 the question?

10 MEMBER FRIEDMAN-JIMENEZ: Would this
11 include a workers' compensation deposition for
12 one of my own patients who is a federal employee
13 with federal workers' compensation?

14 MR. MANCHER: It could. Again, I
15 would need to go to take a look at the specifics
16 for individual cases for you. And I can
17 certainly do that.

18 But, yes, if you are serving as an
19 expert witness and it's a federal court or agency
20 it could be affected by this rule. I'm just
21 going to make a note that I'm going to follow up
22 on the expert witness rule.

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1 MEMBER FRIEDMAN-JIMENEZ: So a
2 treating physician is considered an expert
3 witness then?

4 MR. MANCHER: It depends. It really
5 depends kind of in the case. Often treating
6 physicians sometimes are treated as fact
7 witnesses.

8 But sometimes if they are providing
9 expert testimony as well they could be considered
10 expert witnesses in some cases. But I can
11 certainly follow up with you on that.

12 MEMBER FRIEDMAN-JIMENEZ: Thank you.

13 MR. MANCHER: And I can send some
14 follow up information on this to Carrie to be
15 sent out afterwards to the entire committee.
16 Yes.

17 MEMBER SILVER: I'm not a physician.
18 But in defense of some of the activities of the
19 physicians on this Board I think of ethics as
20 balancing goods against each other.

21 And I think back to maybe the second
22 edition of Industrial Toxicology edited by Dr.

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1 Harriet Hardy who was one of the first doctors to
2 stand up for workers in the atomic industry. The
3 last chapter is all about the ethical duties of
4 physicians to participate in the workers' comp
5 process.

6 So as you look at these issues please
7 keep that in mind. They don't get paid a great
8 deal of money when they're involved in the
9 process. They do it for ethical reasons.

10 And it would really be a shame if
11 their service on this committee were to interfere
12 with their follow through.

13 MR. MANCHER: Certainly. And we
14 certainly take the approach of trying to figure
15 out, you know, we are not here to say, no. We
16 don't like to say, no.

17 We are here to try and find legal ways
18 that protect the Department and that protect the
19 individuals to keep you out of trouble. But if
20 it is possible under the rule we certainly don't
21 kind of, we don't say, no, just to say, no.

22 Some of these rules, you know, like I

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1 said are criminal statutes and so we don't want
2 to put people at risk of violating criminal
3 statutes. But in general we will search for ways
4 to do things if there is such a way.

5 Moving on, next we just want to cover
6 lobbying the federal government. This likely
7 will not affect you very much. But essentially
8 Congress created a rule where they said that they
9 did not want the money that they spent to come
10 back to annoy them.

11 And so basically there's a rule
12 against the federal government spending any money
13 on the encouragement of grass roots lobbying. So
14 the Department has ways of contacting Congress,
15 has formal processes of contacting Congress if
16 the Department wants specific statutory changes
17 of some kind or specific legislation of any kind.

18 But what the Department is prohibited
19 from doing is asking the public to go contact
20 their Congressman, go contact their Senator, go
21 contact their State Representatives about, you
22 know, in order to change a specific law or how to

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1 vote on a specific law.

2 So again, if the Committee decides or
3 Committee Members want to, you know, think that
4 there is some sort of legislative fix that needs
5 to happen in some area there are official ways to
6 do that.

7 And what we need to avoid is basically
8 something where we are telling the public to go
9 contact their Congressman. A question that I
10 often get on this is sometimes members of the
11 public will ask a question at some sort of public
12 hearing where they will say, you know, why don't
13 you make "x" change that would be beneficial.

14 And the answer to that is that it
15 would have to be a legislative change. And so
16 what we have said is allowed is the civics lesson
17 is allowed.

18 So you can say, you know, that is the
19 type of thing that, you know, we don't have the
20 authority to make that change. That type of
21 change would need to be made through legislation.

22 But what you can't do is kind of the

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1 follow up of so then, so you should contact your
2 legislator or you should contact your Senator or
3 something like that.

4 As long as you limit yourself to the
5 civics lesson of that would need to be a
6 legislative change then you're not going to kind
7 of come in conflict with that rule. Are there
8 any questions there?

9 CHAIR MARKOWITZ: I have a question.
10 So I don't think, I would doubt anybody here
11 lobbies the federal government. But if some of
12 us are involved with the Former Worker Program
13 DOE and some Congressional representatives are
14 very interested in that program.

15 And sometimes there is some
16 interaction, not that frequent. If they were to
17 ask an additional question about the compensation
18 program or the activities of this Board that's
19 not, that kind of interaction is not prohibited.

20 We're not representing anyone. We're
21 expressing our own opinion.

22 MR. MANCHER: Right. So you're

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1 talking about not kind of federally registered
2 lobbying.

3 CHAIR MARKOWITZ: Correct.

4 MR. MANCHER: There is not an issue
5 with that. You are not allowed to represent
6 anyone before a federal agency or court in a
7 matter, in a specific party matter that you
8 personally worked on.

9 But again, because you are not working
10 on specific party matters here that's not going
11 to create any issue for you. So if this
12 committee was looking at individual cases and was
13 making some sort of decisions on individual cases
14 you couldn't then go on the outside and represent
15 a client in that particular case.

16 But because this committee is not
17 taking those types of actions and acting in those
18 types of cases there's not an issue there. Are
19 there any other questions there?

20 All right. So the next section,
21 bribes, gifts, salary supplementation. These are
22 a few rules that are somewhat interrelated. And

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1 I'm going to draw some of the distinctions
2 between bribes and gifts and salary
3 supplementations.

4 Bribes are a no. They're not allowed,
5 you might imagine. This is the simple quid pro
6 quo. You know, if you take this action I will
7 give you "x" amount of money.

8 I think we all know this is wrong and
9 that you should report this immediately if
10 somebody offers this to you. I don't think we
11 need to spend any more time on bribes than that.

12 Salary supplementation is where
13 somebody else is paying you for your government
14 service. So it's not that they are specifically
15 saying take this action.

16 But they are saying, you know, we like
17 that you serve on this so we want to give you
18 some sort of pay or it could be like we talked
19 about earlier they are paying you to speak in,
20 when you are also being, you know, also speaking
21 in your government capacity.

22 So generally you cannot be paid by

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1 the, by anybody outside for your service here.
2 There is, however, an exception for SGEs that
3 allows your regular employer to continue to pay
4 you on the days that you are here. And so that
5 is not going to create an issue.

6 Gifts, gifts is actually where we get
7 most of our questions in general. The gift rules
8 should not likely affect you all that much.

9 The general, however, so the general
10 gift rule is that you may not accept a gift that
11 is either because of your official position or
12 from anybody whose interests could be affected by
13 the work of your Agency.

14 Unfortunately here at the Department
15 of Labor that's just about everybody because we
16 regulate all employers, employees, potential
17 employers, retirees. So pretty much everybody is
18 covered.

19 That being said, there are a lot of
20 exceptions and those exceptions will cover really
21 all of the general, all the places that you would
22 expect to receive gifts. So generally if you get

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1 a gift and you think there's nothing kind of
2 ethically wrong with it you can ask us and there
3 will generally be an exception.

4 So the types of gifts, gifts can cover
5 anything of value. So they can be physical
6 items. They could be meals. They could be
7 paying for services. It could be a cab ride. It
8 could be tickets to a show or an event or a
9 sporting event or something like that.

10 It could be a discount. A discount
11 counts as a gift. But there are several, like I
12 said, several exceptions. And I'm just going to
13 go through a few of the exceptions and these are
14 places that you would generally see.

15 So gifts of \$20 or less as long as
16 it's less than \$50 from the same source over a
17 calendar year. So \$20 on a single occasion, \$50
18 over the calendar year from that source are okay.

19 So gifts that are available to the
20 general public. So, you know, your \$10 coupon at
21 Bed Bath and Beyond or some sort of event, you
22 know, promo at a restaurant or something like

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1 that, that's available to everybody that you
2 don't need to worry about.

3 And you don't need to worry about
4 going over that \$50 in the year for something
5 like that. If it's available to the general
6 public, not going to be an issue.

7 So gifts based on a personal
8 relationship. So earlier we talked about the
9 appearance of bias rule. We talked about kind of
10 your family and, close family and friends.

11 Gifts from your close family and
12 friends are going to be okay. Like we said
13 earlier, you shouldn't be working on things that
14 affect them so it's okay to accept gifts from
15 them.

16 But if somebody is reaching out to
17 you, you know, is offering you a gift who has
18 never offered you a gift before and, you know,
19 now that you are on this committee they are
20 offering you a gift you might want to think are
21 they really offering this gift because they're a
22 longstanding friend of mine or are they offering

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1 this gift to me because I am now on this
2 committee.

3 Right, so this is separated from
4 bribes because it's not I'm asking you to take a
5 specific act. This is I'm trying to curry favor
6 with you so if something comes up in the future
7 that you might be able to affect in my benefit
8 you might think, you know, you might fall on my
9 side a little bit more.

10 That's the type of thing that we're
11 trying to prevent with this gift rule. So we
12 really want to look at gifts from people who, you
13 know, generally were not giving you gifts before
14 and now that you're on this committee are
15 offering you gifts now.

16 Free attendance at meals at an event
17 where you are officially presenting, so you're
18 presenting something on behalf of the government,
19 you are speaking you can accept free attendance
20 on that day and any meals that go with that. If
21 you are presenting or speaking on behalf of the
22 Department you need to get that approved from the

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1 Department.

2 Similarly, there's an exception that
3 allows you to accept free attendance at widely
4 attended gatherings.

5 However, widely attended gatherings
6 there must be a diversity of views there and
7 there must be an Agency determination which I
8 assume would come from Carrie, an Agency
9 determination that your, that basically your
10 attendance at that event is in the Agency's
11 interest and that interest outweighs kind of your
12 personal, outweighs the kind of ethical or
13 optical concerns created by accepting that.

14 Items of little intrinsic value again
15 are fine, cards, plaques, trophies, things like
16 that are not going to create an issue. Any
17 meals, lodging, transportation or other things
18 that are offered to you because of your outside
19 business because of the work that you do on the
20 outside or your spouse's outside business are
21 going to be fine.

22 So those types of things you don't

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1 need to worry about. And those are really the
2 exceptions that are going to be covered by the
3 gift rules as they apply to you.

4 One thing, the optics. So this is
5 something that we had long advised and then was
6 actually put into the rules in the last, the last
7 time that they updated these rules a couple of
8 years ago which is basically there's now a part
9 of the rule that says even if a gift is
10 acceptable under an exception, so even if a gift
11 fits an exception and therefore would be legal
12 under the law if the optics of the situation
13 weigh against accepting the gift you should not
14 accept it.

15 I don't foresee that happening in any
16 case with your committee. This generally would
17 happen in the case of employees who again can
18 kind of affect the work, can affect the financial
19 interests of specific parties.

20 But we've had this come up with, you
21 know, attorneys who are in an office even if they
22 are not working on a particular case. But let's

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1 say an attorney is in an office that is in
2 litigation in a big case and they have a friend,
3 a longtime friend who works for, who is the
4 opposing counsel or works for the firm that is
5 the opposing counsel.

6 That friend says, hey, you know, my
7 firm had two extra tickets to tonight's Wizard's
8 game, you know, in our company box, in our firm
9 box. Do you want to come with me?

10 This is the type of thing that
11 generally would be acceptable under the personal
12 relationships gift exception. That being said,
13 while they are in litigation against this firm it
14 could look really bad for this attorney to be
15 seen in the box of the opposing counsel, you
16 know, in the opposing counsel's box at the
17 Wizard's game.

18 Even though it was a gift from the
19 friend that's something where we might say, you
20 know, given the totality of the circumstances the
21 optics weigh against it. We've had some
22 situations also like this with some of our PAS or

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1 Presidential-Appointee Senate-Confirmed employees
2 officials.

3 So these are kind of the highest
4 ranking officials here at the Department who are
5 our public faces. And so sometimes we've told
6 them not to accept gifts or offers to attend
7 certain events because they will be around and,
8 you know, could be photographed or otherwise seen
9 around people who have matters before the Agency
10 that could be affected by their work.

11 And so that's the type of thing. So
12 if you think the optics of accepting a gift might
13 be problematic that might be something where you
14 want to check with us ahead of time even though
15 technically under the rule there is not an issue
16 there. Are there any questions on the gift rule?

17 All right. Next, misuse of government
18 resources or government position. So the general
19 rule here is you may not use your government
20 position or any of the government resources for
21 anything other than authorized government
22 activities.

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1 So I'm not sure how much access you
2 have to government computers or government IT
3 resources, copiers, printers, et cetera here.
4 But if you do those are to be used for the
5 purposes of this committee.

6 They are not to be used kind of for
7 your personal services. The one place we have
8 seen an issue with this is in terms of staff. So
9 there are Department of Labor staff who are here
10 to help you with your service on this committee.

11 They are not here to do personal
12 errands for you. They are not here to do your
13 personal work for you or kind of help you in any
14 ways outside of the business of this committee.

15 They are here, they can set up the
16 logistics as far as those logistics affect the
17 work of this committee. But beyond that they are
18 not here to kind of serve you personally. And
19 that is something that we have seen as a problem
20 in the past.

21 Additionally, you may not use your
22 title as a member of this committee to serve you

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1 personally or your connection to the Department
2 to serve you personally. Another fun story that
3 we've had.

4 We once had a -- a few years ago an
5 employee in the Wage and Hour Division here at
6 Labor whose dog ran away and so the employee put
7 something on social media saying, you know, my
8 dog ran away. If anybody sees my dog please
9 contact me here.

10 And a local business owner happened to
11 find the dog and sent this employee a message
12 over the social media, you know, saying I found
13 your dog. You know, seemed like everything was
14 going well.

15 For whatever reason it didn't, it then
16 went downhill and there was an argument about
17 when the dog was being returned. I think there
18 was something about the business owner wasn't
19 sure about the proper treatment of the dog.

20 Whatever it was it went downhill and
21 then the employee sent in public over this social
22 media something saying I am a Wage and Hour

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1 employee and if you do not return my dog to me by
2 "x" date I will bring an investigation against
3 your company.

4 Clearly this was not allowed. Clearly
5 this employee lost their job and, you know, faced
6 disciplinary action and lost their job because of
7 this action.

8 Do not hold yourself out as a
9 Department of Labor employee or as a Department
10 of Labor official or as having the ability to act
11 on behalf of the Department in any way other than
12 what this committee gives you.

13 You cannot hold yourself out as a
14 member of the Department. You should not be kind
15 of putting it on business cards.

16 You should not be, when you speak at
17 an event if you are speaking at some sort of
18 event that is not related to your service here,
19 you're not speaking officially, it can be
20 included as part of your bio. But it should not
21 be, you know, the thing on your name tag or your
22 main introduction.

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1 You should not be, you know,
2 Department of Labor, FACA Committee Member or
3 Chair or something like that as kind of your
4 position. You shouldn't be, if you were on the
5 board of an outside organization on the website
6 it shouldn't refer to you as representing the
7 Department of Labor or this committee on that
8 board.

9 Again, it can be mentioned as part of
10 a written bio. But it may hold no more weight
11 than any other biographical information.

12 Other misuse of government resources,
13 and I mentioned this earlier, non-public
14 information. You may be privy to non-public
15 information that the Department has in order to
16 assist you with your service here.

17 You may not then go and use that non-
18 public information for your personal benefit
19 whether it is through financial transactions, but
20 for yourself or by telling other people to make
21 financial transactions that you know would be
22 beneficial based on this non-public information.

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1 You may not go, you know, in some way
2 sell that information or sell your access to that
3 information by, you know, some sort of
4 consultancy where you say, you know, I can assist
5 you based off of this information that I know.

6 Non-public information as long as it
7 is non-public must be kept secret. Are there any
8 questions on that?

9 Okay, post-employment restrictions.
10 These won't affect you all that much again, with
11 you not serving in, with you not working on
12 specific party matters. I do want to talk about
13 here a little bit about seeking employment that I
14 didn't talk about earlier.

15 So the financial conflict of interest
16 rule while it covers your current employer it
17 also, if any of you are, you know, for whatever
18 reason seeking new employment either instead of
19 or in addition to the jobs that you currently
20 hold, if you reach out to a potential employer or
21 a potential employer reaches out to you the
22 ethics rules count that employer, count seeking

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1 an employer that you are seeking employment with
2 the same way as they count a current employer.

3 So you could not work on something
4 that would affect the financial interests, that
5 would have a direct and predictable impact on the
6 financial interests of that outside employer or
7 that potential future employer the same way that
8 you can't work on something that would affect
9 your current employer.

10 And so this is if somebody reaches out
11 to you or you reach out to somebody, you know,
12 anything more than kind of asking for an
13 application. So if you send them a resume, you
14 apply for the job, you reach out to them about a
15 potential job there.

16 It does not cover, you know,
17 networking or informational interview type
18 things. So if you reach out to somebody to have
19 really an informational interview to ask them
20 about their field or about their line of work or
21 about the types of things their company does or,
22 you know, but you're not really looking at a

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1 position at that particular company, something
2 like that, that won't create a conflict of
3 interest for you.

4 But if it really is like I am looking
5 for a job at your company, what is available,
6 that would create a conflict. And that conflict
7 runs that, that recusal would run until either
8 they say they are not, you know, the company says
9 they are not interested in you or you say I am
10 not interested in working for your company or I
11 think 60 days pass.

12 So if you send in an application and
13 you don't hear back for 60 days you then can
14 consider it to be the company is saying, no. If
15 the company then later gets back to you and
16 brings you in the recusal period starts up again.
17 Are there any questions on this? Yes.

18 MEMBER CASSANO: Actually, yes. I'm a
19 private consultant. And so if I were to leave
20 the Board or not get renewed obviously if
21 somebody asks me now to write a medical opinion
22 for somebody in this program I say, no, thank

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1 you. I can't do that.

2 How long am I barred from doing that
3 after I would be off the Board?

4 MR. MANCHER: So you would not
5 actually be.

6 MEMBER CASSANO: I would not be, thank
7 you.

8 MR. MANCHER: So the rule basically
9 says that you cannot represent somebody back to
10 the government on a specific party matter that
11 you worked on here.

12 Again, as you guys, you are not
13 working on specific party matters here there
14 aren't going to be then restrictions that prevent
15 you from coming back because there aren't
16 specific party matters that you're working on
17 here.

18 It's again, it's preventing the side
19 switching on those specific matters. It's not
20 preventing you from coming back on future matters
21 that are similar.

22 It's really about the same specific

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1 matters that you were making decisions on here.
2 Are there any questions on that?

3 So that is the end of my presentation.

4 That is the ethics rules as they apply to you.
5 I expect I will be following up with some more
6 information on the expert witness question.

7 If there are any other questions that
8 people have you can either, you know, let me know
9 now so I can kind of go back and follow up.
10 Other than that, if you have any questions about
11 your personal participation in any particular
12 matters or in any instances or situations either
13 officially or personally and you think it might
14 be affected by some of these rules feel free to
15 reach out to me.

16 If you can't find this packet reach
17 out to Carrie and Carrie can put you in touch
18 with me. Are there any questions?

19 CHAIR MARKOWITZ: Did he get his dog
20 back?

21 MR. MANCHER: I'm not sure. That
22 happened, that story happened shortly before I

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1 came on board here.

2 CHAIR MARKOWITZ: Thank you so much.
3 So we're a little bit ahead of schedule. I think
4 we should probably break for lunch instead of
5 starting into the statutory areas for the Board.
6 So it's 11:30 now. Let's return at quarter of
7 one, thank you.

8 (Whereupon, the above-entitled matter went off the
9 record at 11:30 a.m. and resumed at 12:57 p.m.)

10 CHAIR MARKOWITZ: Okay, we are
11 reconvening.

12 There has been some attention paid to
13 the temperature of the room. We don't know how
14 effective it is, but at least there's being
15 attention paid.

16 George, you want to introduce
17 yourself?

18 Give Dr. Friedman-Jimenez -- yes,
19 good.

20 MEMBER FRIEDMAN-JIMENEZ: Hi, yes, I'm
21 George Friedman-Jimenez. I'm an occupational
22 medicine physician and an epidemiologist at

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1 Bellevue NYU Occupational and Environmental
2 Medicine Clinic in New York City.

3 This is my second term as a Board
4 member. And, welcome, everybody.

5 CHAIR MARKOWITZ: So, you know, when
6 you have questions, just feel free to break in,
7 we'll hear you.

8 Also, I'd like to welcome Greg Lewis
9 here from the Department of Energy. Greg, you
10 want to just introduce yourself briefly?

11 MEMBER LEWIS: Sure, I'm Greg Lewis,
12 Director of the Office of Worker Screening and
13 Compensation Support for DOE. So, we provide a
14 reference to DOL and NIOSH as they complete
15 trying to reconstruct dose.

16 And, we also support Dr. Walker in the
17 training program. So, if you all have any
18 questions about how we provide records, what we
19 do out on the sites, I'd be happy to help you
20 out.

21 CHAIR MARKOWITZ: Okay, great. Thank
22 you.

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1 Okay, so, Ms. Leiton?

2 MS. LEITON: Okay, I hope everyone
3 found lunch and, hopefully, the room will warm up
4 a little bit.

5 So, I'm just going to cover a little
6 bit about the four areas that the Board has been
7 tasked to review and provide recommendations on.

8 Tom went into it a little bit earlier,
9 but I'm going to go into it in a little bit more
10 detail.

11 Some of this will be repetitive for
12 you because, those of you who have already been
13 on the Board, we did this the first time. But,
14 so I won't probably go as lengthy as we did the
15 first time.

16 The four areas are the Site Exposure
17 Matrices of the Department of Labor, medical
18 guidance for claims examiners for claims under
19 this subtitle with respect to the weighing of the
20 medical evidence of claimants, evidentiary
21 requirements for claims under Subtitle B related
22 to lung disease and the work of industrial

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1 hygienists and staff physicians and consulting
2 physicians of the Department and reports of such
3 hygienists and physicians to ensure quality,
4 objectivity, and consistency.

5 So, I'm going to go into each one of
6 those individually.

7 The site exposure matrices, I'm not
8 going to go into a lot of detail only because
9 John Vance is going to give a 45 minute
10 discussion about that tomorrow. So, I'm going to
11 just kind of give a brief overview of the SEM
12 itself and he'll go into further detail tomorrow.

13 CHAIR MARKOWITZ: Will there be a
14 demonstration of the SEM also, John?

15 MS. LEITON: We can, yes.

16 CHAIR MARKOWITZ: Great, great.

17 MS. LEITON: Okay, so the SEM was
18 created in 2005 as a tool to help claims staff,
19 our claims examiners research toxic substance
20 data relating to employees working at DOE
21 facilities.

22 And, the reason we found it necessary

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1 and appropriate to do that is to create this
2 database was because simply employees and
3 especially survivors don't always know what they
4 were exposed to in the workplace.

5 So, we wanted to give some sort of a
6 tool that would help our claims staff and the
7 claimants at the end of the day determine what
8 possibilities were out there in terms of
9 exposures at these facilities.

10 And, you know, a lot of the time,
11 without it, we might have found that we had to
12 deny because we didn't have enough information.

13 So, this is an inter-relational
14 database. It contains a large data set relating
15 to evidence that a substance was present or used
16 in operations at a facility.

17 It doesn't provide temporal data on
18 the use of toxic substances. In other words, the
19 use of toxic substances at different times, it
20 doesn't have dates in it.

21 It does have filtering capabilities
22 that allow for searches based on different

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1 variables including health effect, facility, work
2 process, labor category, building area and
3 incident data.

4 This database is more useful,
5 depending on how you search it and what data --
6 the strength of the search results depend on how
7 the evidence, how strong the evidence we have is,
8 if there's information that goes to the building
9 level, there's information that goes to the labor
10 category, that sort of thing in the claims file
11 itself we'll use that to research information on
12 these.

13 We don't use SEM as a decision tool.
14 It is something that is used to help in the
15 development of a claim. It doesn't provide us
16 with extensive exposure, the amount of exposure,
17 but it can provide as a guidepost to use to
18 further develop the claim.

19 When we're looking at this information
20 on a claim-specific basis, the SEM isn't going to
21 provide us with individual information about
22 employees, it will provide us with general

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1 information. When we get to specifics, we refer
2 it to an industrial hygienist.

3 The contractor for this SEM who
4 developed it is called Paragon Technical
5 Services. They have been working on this project
6 for a long time, since it was -- since the
7 beginning of it in 2005.

8 The staff members have extensive
9 experience working at DOE facilities. They have
10 Q clearances. They consist of an engineer,
11 chemist, industrial hygienist and operations
12 management.

13 Keith Stalnaker, you have -- we may
14 have mentioned him the past, but he's the program
15 manager for this.

16 He worked for 32 years in DOE
17 facilities at Portsmouth, Oak Ridge, and Paducah.

18 He's a registered professional
19 engineer, certified safety professional. More of
20 his CV is online and I think we've provided it in
21 the past.

22 In terms of data collection, it's an

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1 ongoing process. There is so much information
2 out there and we have a contract, but we don't
3 have an unlimited amount of resources to do this
4 research.

5 But, at the very beginning, what
6 Paragon did was they held 53 worker roundtable
7 meetings at 37 different DOE facilities, met with
8 about 950 workers requesting input on the SEM in
9 terms of toxins, work processes, labor categories
10 and suggestions for document research.

11 Since that time, Paragon continues to
12 research documents, look for additional
13 information that they can put in terms of toxic
14 substances, alias for toxic substances, labor
15 categories and aliases for labor categories.

16 They work with Department of Energy.
17 They've been able to go to various Department of
18 Energy sites, look through literally boxes of
19 records to find what they can in terms of toxic
20 substance exposures, buildings, labor categories,
21 all of those different types of information that
22 may be available.

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1 As of September of this year, 16,400
2 toxic substances used at 128 DOE sites are in the
3 system. We've got about 4,000 additional RECA
4 sites, they're looking at trade name substances
5 and again, some aliases to those.

6 Recently, we have looked at the CEDR,
7 the DOE Comprehensive Epidemiological Data
8 Resource, taking out of that what we can or what
9 they can to put into the SEM.

10 There's been a lot of gap analysis,
11 so, you know, initial research was done in 2005,
12 2008. We're going back to facilities or going
13 back to DOE to try to obtain more information.

14 In the last year, we've been looking
15 at Pantex, Kansas City plant, Portsmouth,
16 Battelle, LANL and been able to add information.
17 Again, sometimes, it's just labor category
18 information, sometimes it's more toxic
19 substances.

20 Another area that we do obtain
21 information is through the SEM mailbox. We've
22 received information from advocates about various

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1 facilities that we've been able to use in the
2 database.

3 Sometimes, we get information from the
4 document acquisition requests that go into case
5 files. So, if claims examiners find information
6 that may be helpful or useful in the SEM
7 database, they'll forward it to Paragon for their
8 use or research.

9 There is a SEM library that contains
10 the references that have been used in the
11 database.

12 In addition to the toxic effects in
13 the labor category aliases and that sort of
14 thing, there is also health effect data and that
15 is based on HAZMAP, which is -- it's a database
16 that was put together by Dr. Jay Brown based on
17 peer reviewed epidemiological data establishing a
18 causal relationship between a toxic material and
19 a diagnosed illness, for example, asbestos causes
20 asbestosis.

21 The one thing about his database, and
22 we use it in the SEM and we use it as a

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1 reference, is that it's on causation. It does
2 not take into consideration contribution,
3 aggravation, those sorts of things.

4 So, if it's in the database, there's a
5 lot of the research is based on IARC and, you
6 know, even the use of the NIOSH pocket guide,
7 various other resources, peer reviewed
8 literature, that goes through the National
9 Library of Medicine who will then publish it.

10 Once it is published, we use it for
11 our SEM database.

12 Outside of the SEM, the HAZMAP, we
13 have developed our own presumptions of sorts,
14 either a presumption of exposure or presumption
15 of causation.

16 But those are outside of this database
17 which is solely really causation.

18 So, in the adjudication of claims,
19 what a claims examiner will do is go to, in the
20 course of development of the case, obtain as much
21 information as they can from DAR records, from
22 the claimant, and then they'll reference the site

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1 exposure matrices and see, you know, if they're
2 in this building, what toxic substances could
3 have been there, were those linked with any
4 specific conditions.

5 They'll go to an industrial hygienist
6 in some circumstances to find out if there were -
7 - what the extent of that exposure might have
8 been and this is -- they conduct these analyses
9 based on research, the data they have available
10 to them and provide an opinion of high, medium,
11 low levels of exposure at various facilities.

12 And, that report will go into the case
13 file to be used for further assessment on
14 causation.

15 That's the kind of long and short of
16 SEM. But the shorter version of SEM because
17 there will be much more detail provided tomorrow.

18 I'm happy to take questions about that
19 now or we can wait for tomorrow.

20 CHAIR MARKOWITZ: Are there questions?

21 So, I have a question about HAZMAP, so
22 HAZMAP is a library -- a National Library of

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1 Medicine activity linking exposures with
2 diseases.

3 And, do you know to what extent HAZMAP
4 is kept up to date? And, then, as it evolves,
5 how those improvements are integrated into SEM?

6 MS. LEITON: So, it is continually
7 being updated by Dr. Brown and then, once it gets
8 published, it's incorporated into SEM.

9 We did have the latest publication,
10 10/25/18, so that's very recently.

11 I think it's every quarter or so that
12 it's updated or at least published into the --
13 through NLM and, at that point, we just -- we tie
14 it to the SEM and keep those same health links if
15 they're new or additions, they will go into the
16 SEM.

17 CHAIR MARKOWITZ: And, what percentage
18 of -- roughly, what percentage of cases now go to
19 an IH for, you know, exposure refinement?

20 MS. LEITON: I don't have that
21 offhand, I can look --

22 CHAIR MARKOWITZ: Okay.

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1 MS. LEITON: -- and see if we can
2 determine that. But, a good amount of them are
3 now at this point.

4 CHAIR MARKOWITZ: Yes, I mean, the
5 reason I ask is, when we started a couple years
6 ago, the contract was just coming on board.

7 MS. LEITON: Oh, yes, there's a lot
8 more now.

9 CHAIR MARKOWITZ: It was a new
10 activity, because SEM is a guidepost, not a
11 decision making tool. Presumably, some of those
12 decisions are made or there's significant input
13 from the IH and --

14 MS. LEITON: Yes.

15 CHAIR MARKOWITZ: -- wanted to know
16 whether that's 20 percent or 70 percent?

17 MS. LEITON: Of the claims that are
18 Part E claims where an assessment of exposure is
19 required, it's probably up to 50 percent, John?
20 Maybe more than that.

21 CHAIR MARKOWITZ: Oh, okay. Thank
22 you.

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1 MS. LEITON: Mm-hmm.

2 CHAIR MARKOWITZ: Other questions?

3 Comments?

4 Dr. Silver?

5 MEMBER SILVER: What's the DDWLP and
6 how does that relate to the SEM?

7 MS. LEITON: That's called the Direct
8 Disease Work Link Process, I believe. That's
9 Direct Disease Link Work Process, something like
10 that.

11 What that is, is sometimes, we can
12 link certain toxic substance exposures to work
13 processes. Instead of a labor category, we can
14 say this person worked doing a particular process
15 at a facility.

16 That process working on soldering or
17 working with -- there are various examples and
18 I'm sure that we -- he can walk you through that
19 tomorrow.

20 But, a claims examiner can go, and if
21 they've seen in the Occupational History
22 Questionnaire or if they've seen in other

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1 documentation in the case file that somebody did
2 a particular activity, then you can look up that
3 activity in the database and find what types of
4 exposures there may have been versus only being
5 able to look at a labor category or a certain
6 facility or a certain building.

7 Does that help?

8 MEMBER SILVER: But, it has no special
9 advantage in a causation determination, it's
10 still used just for case development?

11 MS. LEITON: It's used for exposure.

12 MEMBER SILVER: Okay. Thank you.

13 CHAIR MARKOWITZ: But, it links the
14 task with the disease directly?

15 MS. LEITON: It links the task with an
16 exposure. The exposure is then where we go into
17 look at linking that with a disease. Correct?

18 Okay, I will move on to the next
19 category, weighing of medical evidence for claims
20 examiners.

21 I'm just going to kind of talk about
22 what the current process for how claims examiners

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1 look at medical evidence in general. So, it will
2 just kind of give you an idea of what we're
3 dealing with when you talk about this particular
4 topic.

5 So, there are various sources of
6 medical evidence that come into the claims
7 examiner. The claimant's doctor, their treating
8 physician is one of them. We have consulting
9 experts and then medical facilities like hospital
10 records, test results, things like that.

11 We do try, first and foremost to go to
12 the attending physician if we can when we have
13 questions.

14 As I indicated earlier, it is not
15 always easy to -- for a physician, just a general
16 practitioner, to provide us with opinions on
17 causation. But we do, first and foremost, go to
18 them when we can.

19 We also review Department of Energy's
20 medical monitoring programs, the screening and
21 former worker programs, ORISE, has -- they have
22 beryllium testing, so sometimes we can get

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1 results from that, contract medical consultants,
2 I'll talk about a little bit more in a minute,
3 second opinion physicians which they're also
4 contracted -- they're on the same contract, but
5 they're actual physicians that can evaluate the
6 claimant in person rather than a medical
7 consultant who just reviews the documentation and
8 case file.

9 And then, there are the referee
10 consultants and they'll provide a rationalized
11 opinion, provide an opinion regarding resolving
12 any conflict of medical evidence that's in the
13 case file.

14 So, in more detail, when a claims
15 examiner is looking at evidence, they'll look at
16 treatment records. These are records made during
17 an evaluation, of diagnosis and treatment of the
18 patient, usually just narrative notes.

19 Sometimes there's chart notes reports,
20 these could include reports from other
21 consultants that were involved in the case,
22 evidence of diagnostic testing. This becomes

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1 very important when we look at chronic beryllium
2 disease particularly.

3 And then, treatment records, as I said
4 from hospitals, hospices, in home healthcare, et
5 cetera.

6 In terms of the medical evaluations,
7 other than to further diagnose or treat the
8 patient, the screening programs are a big part of
9 that.

10 There's also some examinations that
11 are required under state law or federal law like
12 Social Security disability examinations. Those
13 can sometimes help us.

14 And there are other medical
15 documentations that are sometimes submitted with
16 regard to litigation under state or other federal
17 rules of evidence.

18 And then, there are reports provided
19 in response to a DOE referral to CMC, a second
20 opinion or a referee specialist.

21 We also will sometimes look at cancer
22 registry records, death certificates, any other

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1 secondary evidence that we -- that is submitted
2 or we can find and factual affidavits, in some
3 cases.

4 So, with regard to contract medical
5 referrals, we, as I said, we first try to rely on
6 information submitted by the claimant, from their
7 treating physician.

8 We'll first go there, ask that
9 physician for information. If there is follow up
10 to be conducted, we'll follow up with the
11 treating physician is there is one.

12 Sometimes, there isn't a treating
13 physician, there's just old medical records
14 because we're talking about survivors. So, we'll
15 take whatever evidence we can from there.

16 But, if we can't get any information
17 or enough information to really make a decision
18 on the case or we have some information, but it's
19 not very probative or it doesn't really provide
20 us with a lot of assessment, then we'll go to a
21 CMC.

22 The CMC, as I said, will conduct a

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1 review of the case records, the medical evidence
2 that's been submitted from the file and there are
3 certain time frames that they have to submit this
4 -- to review and submit that back to us.

5 We got this contract and primary
6 reason, just as with our primary reason for
7 developing the site exposure matrices was to
8 assist claimants in meeting the burden of proof
9 because, often times, as I indicated, it's not --
10 claims have a difficulty obtaining and providing
11 that evidence to us.

12 They're very case-specific, but
13 there's a lot of different things that they'll
14 look at and a lot of different reasons that we
15 might refer something to a CMC.

16 So, here, just to give you a summary
17 of some of the things that we might refer to at
18 CMC, in some cases, the diagnosis itself is
19 unclear, there's various reports in the case
20 file, but there's no definitive diagnosis. And
21 sometimes, we'll refer those to a CMC so they can
22 provide us with clarifying -- clarification.

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1 As I indicated earlier, our claims
2 examiners are trained to review evidence, but
3 they're not doctors. So, if they have a
4 question, they may refer it to a CMC.

5 Then there's the medical causation
6 side of it, this is, again, based on an
7 individual assessment of a particular case file.

8 We'll refer what we call a statement
9 of accepted facts to the CMC which is a summary
10 of the factual information in a case file like
11 where they worked, what we've accepted as
12 verified employment, if there's any accepted
13 conditions already, we'll list those.

14 We'll provide them with exposure
15 information if it's relevant and appropriate to
16 submit, particularly in a causation request, and
17 any other information.

18 As I indicated earlier, sometimes we
19 refer cases to a CMC for an impairment
20 evaluation. And, that is often because there
21 aren't enough doctors out there that can do them
22 for claimants on their own.

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1 So, but there are various tests
2 depending on the condition that we're -- that the
3 physician is being asked to evaluate, very
4 specific information for breast cancer or lung
5 conditions, PFT results, things like that.

6 So, we'll send a -- there's a sheet of
7 paper that goes to the claimant, saying please go
8 and get these tests, provide us with this
9 information, activities of daily living from
10 their treating physician and we'll submit all of
11 that along with any other relevant information on
12 this condition or the cases that the conditions
13 we've accepted to the CMC for an evaluation of
14 impairment and they'll provide us with a report.

15 Those reports from a treating
16 physician -- from a contract medical consultant,
17 if they're used in a recommended decision in the
18 last several years, we've developed a policy
19 where they are to send those reports to the
20 claimant along with the recommended decision so
21 that, at the final adjudication stage, they can
22 provide additional information if they want to

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1 and see what we relied on for our decision.

2 Sometimes, we'll go to a CMC for a
3 wage loss determination. And, basically, if the
4 evidence is unclear in the case file or there's
5 some information but not really enough, we'll go
6 back to -- we'll go to a treating and provide
7 them with the information we have or a CMC and
8 say, did this person lose wages as a result of
9 the condition that we've accepted?

10 Sometimes we'll go with regard to
11 necessity for certain medical care like durable
12 medical equipment, and home and automobile
13 modifications. More often, it's for home
14 healthcare requests, we get a lot of those.

15 Sometimes we -- often times, we have
16 sufficient evidence from a treating physician or
17 whomever asked for it to move forward with an
18 authorization, but other times, it's in a
19 situation where there's a request for ongoing or
20 increased care. We may go to a CMC for that.

21 We also have consequential conditions
22 that are claimed sometimes and, again, a lot of

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1 times, we'll have sufficient medical evidence for
2 consequentialials from the treating saying, this is
3 definitely related and here's how and here's why.

4 Other times, we don't, but we have
5 some indication it might be related and we'll
6 send that to a CMC.

7 And then, for the second opinions, if
8 we're going to get a home healthcare assessment,
9 we will go for an in person second opinion.
10 Those are usually not record reviews.

11 The referee examinations are also
12 slightly different from a regular CMC referral or
13 a second opinion because we're providing them --
14 they're randomly chosen as impartial examiners to
15 review all the evidence or find an opinion.

16 So, with regard to the development of
17 the medical evidence, it's the claimant's
18 responsibility to provide us with as much
19 information as they can, first and foremost,
20 diagnosis. If we don't have a diagnosis, there's
21 not much further we can go.

22 And, if they're claiming a particular

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1 condition, any evidence they have to support that
2 they actually have that diagnosis is really
3 critical for us to move forward in a case.

4 The claims examiner does go to great
5 lengths, though, to develop the evidence further
6 after that point, try to explain what the
7 deficiencies are in the medical evidence that's
8 been submitted already, requesting additional
9 supporting documentation, communicating with
10 treating physicians.

11 As I indicated earlier, we did
12 recently get nurses. I mean, we've had a couple
13 of nurses on staff for some time, but we've
14 increased that I think to four at this point.

15 And, the role of the nurses is really
16 to help facilitate. Sometimes, when we're trying
17 to get information from a doctor's office, if
18 they get a call from a nurse to a nurse, it's
19 more likely that we're going to get information.

20 A direct conversation can go a long
21 way. And so, our nurses sometimes help with
22 obtaining that type of information.

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1 Then, what will happen, after we've
2 gotten all the information from the treating or a
3 CMC is the claims examiner will review the
4 contents of the medical report to see what type
5 of information is in this documentation,
6 subjective complaints, objective findings,
7 assessment and plan for follow up or treatment.

8 We'll look at any lab findings,
9 diagnostic procedures, physical findings and any
10 assessment that is provided by the physician
11 whether it's opinion, suspicions and diagnosis
12 along with medical rationale, depending on the
13 subject that we're looking at.

14 Weighing of the evidence is always a
15 challenge. But, it is something that claims
16 examiners are trained to do, looking at various
17 documents in the case file whether it's
18 employment records, medical records, et cetera.

19 But, one of the things they're going
20 to look at is was the doctor familiar with this
21 person's history. And, sometimes -- often times,
22 the treating physician, if they've been treating

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1 an employee a long time will.

2 Do they have a factual background to
3 base their opinions on? And, that becomes
4 important when we're talking about somebody who
5 says, well, this person told me they worked at
6 Pantex for 30 years and, therefore, I think
7 there's -- their exposure is related.

8 Now, that may be based on what the
9 claimant's saying, but, in some cases, the
10 evidence is -- shows they were there for, you
11 know, less time or they were -- there's a
12 different work history that we have on file. So,
13 we try to make sure that that information is in
14 the report.

15 And whether it's based on what type of
16 information?

17 We also look at an opinion based on a
18 definitive test and that includes the physician's
19 findings over an opinion based on an incomplete
20 or a subjective or inaccurate information.

21 So, somebody with records, prior
22 history is probably going to have a better or

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1 give us a more thorough assessment than somebody
2 who's only evaluated the patient once and hasn't
3 -- doesn't have any of the records.

4 So, we look at well rationalized,
5 meaning reasoned, basically meaning that the
6 information that's provided is supported by
7 medical findings on examination, a thorough
8 review of the records, in some cases, references
9 to scientific articles where appropriate and a
10 thorough medical explanation.

11 You know, trying to determine whether
12 something's well rationalized or not can be a
13 subjective analysis.

14 However, if somebody's making a plain
15 statement, I believe this condition's caused to
16 his exposure in the workplace versus, I know this
17 person worked there for ten years. They were
18 exposed to asbestos and, you know, silica or
19 whatever else they might have been exposed to and
20 this is the condition that they have.

21 I believe for these reasons that this
22 condition was related to the exposure in the

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1 workplace. That's going to go further than the
2 one statement.

3 And, as I indicated, we are trying
4 more and more to provide things like this
5 Statement of Accepted Facts, the exposure
6 information that we obtain, both in SEM and maybe
7 through an industrial hygienist referral to a
8 treating doctor, if there is one.

9 Because, again, they've got a history
10 of the claimant, they've got a relationship with
11 the claimant and might have a better
12 understanding of that causative analysis.

13 Often times, the opinion of an expert
14 over a general practitioner is going to be
15 weighed more heavily. It, you know, a
16 pulmonologist versus a general practitioner is
17 usually going to carry more weight.

18 We do require board certification for
19 all of our -- in order for it to carry weight at
20 all.

21 And then, there's, you know, an
22 unequivocal opinion over one that's vague or

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1 speculative. It's going to be more probative
2 compared to an opinion that waivers such as
3 could, may or might be.

4 I know we've had this discussion at
5 these board meetings before because, it's not
6 always easy for a doctor to say absolutely I'm
7 sure this is what happened.

8 So, we have to weigh the evidence
9 behind those statements along with the statements
10 themselves to figure out, you know, how this can
11 be used legally in our final determination on the
12 case.

13 Those are the main aspects of what we
14 look at when we're weighing medical evidence, the
15 types of medical evidence we look at, the
16 referrals that we make and why we make them.

17 I'm happy to answer questions.

18 CHAIR MARKOWITZ: Questions? I have a
19 few questions.

20 MS. LEITON: Mm-hmm.

21 CHAIR MARKOWITZ: So, this is an area
22 for the committee. When you talked about

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1 weighing medical evidence, it wasn't just what's
2 the diagnosis, you also talked about the issue of
3 causation. So then, that's within the charge of
4 the committee.

5 MS. LEITON: Yes, I mean, weighing
6 medical -- basically, medical evidence for claims
7 examiners for claims under this Subtitle with
8 respect to the weighing of medical evidence of
9 claimants.

10 CHAIR MARKOWITZ: Right.

11 MS. LEITON: Yes. So, I mean, you're
12 talking about the causation is where we weigh the
13 most evidence, frankly.

14 CHAIR MARKOWITZ: Okay, thanks.

15 The statement of accepted facts, so
16 the claims -- that's what the product of the
17 claims examiner is when -- after they've reviewed
18 the case before they move it forward.

19 That includes a diagnosis. If I were
20 a claims examiner trained but not an expert in
21 health necessarily, I would heavily rely on
22 whatever diagnosis the private personal

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1 physician, the hospital, whatever that they list.
2 And, I would accept that diagnosis.

3 I wouldn't, you know, if a person's
4 labeled as having diabetes, I wouldn't
5 necessarily go look for the evidence their sugar
6 levels or whatever.

7 The same for COPD, I wouldn't
8 necessarily go look for the pulmonary function
9 test if I were in that position.

10 MS. LEITON: Mm-hmm.

11 CHAIR MARKOWITZ: So, is that normally
12 what happens is they rely on a diagnosis --
13 diagnoses of the treating -- I'm not talking
14 about causation, I'm just talking about what's
15 wrong with this person.

16 MS. LEITON: Right.

17 CHAIR MARKOWITZ: Is that what they
18 normally do is rely on those diagnoses or are
19 they customarily digging underneath and looking
20 for the proof that that person has that
21 diagnosis?

22 MS. LEITON: So, there's a very --

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1 there's a lot of -- a fine line there. I mean,
2 sometimes there's conflicting evidence in the
3 case file about what the diagnosis is.

4 You've got one doctor saying this,
5 you've got one medical report saying another
6 thing. And, our claims staff do know some --
7 have some information about PFTs and levels, but
8 we ask them not to do too much analysis of that
9 because they're not doctors.

10 CHAIR MARKOWITZ: Mm-hmm.

11 MS. LEITON: And, I don't want them
12 trying to diagnose, you know, a condition. They
13 need to rely on the treating.

14 That's why if we -- they have
15 questions about diagnoses, they can go to our
16 medical director, the nurses, go back to the
17 treating and say, you know, you've indicated
18 this, there's conflicting evidence in the file.

19 However, we have had instances where
20 we'll go to a physician, a CMC for example,
21 asking about a causation and they'll come back
22 and say, but you're saying this person's

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1 diagnosis is X and I don't think it's X based on
2 the information in the case file and we've seen
3 that happen.

4 And, in those circumstances, we ask
5 them to clarify, the CMC to clarify. You know,
6 if we've accepted a diagnosis already, it's not
7 going to be easy to go back and say it's not the
8 case.

9 But, if we can clarify a diagnosis,
10 make it more precise, that's a different story.

11 You know, once we've gone all the way
12 through a final decision process and said this is
13 the condition that this person has, this is the
14 information we were provided, in order to go back
15 and question that is -- we'd have to have
16 significant evidence to show that it wasn't
17 actually that diagnosis, it's something else.

18 Or we could add a diagnosis if there
19 is evidence to support that diagnosis and that
20 diagnosis is related.

21 We run into this the most when we're
22 dealing with impairments because they're, you

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1 know, different diagnoses are going to come out
2 with different impairment ratings.

3 CHAIR MARKOWITZ: So, when you take a
4 set of finished SOAFs, right, in which the claims
5 examiners are fairly confident they got the
6 diagnosis right, and so they're not asking the
7 CMC any questions about the diagnosis, they may
8 be asking about causation.

9 Have you ever looked at those to see
10 whether the claims examiner -- how often they
11 make a mistake on -- specifically on the medical
12 -- not the causation, just the medical diagnosis?

13 Because they're the ones looking at
14 the record, they're not asking a question further
15 of the CMC. They've decided on what the
16 diagnoses.

17 Have you looked at how -- whether they
18 ever make mistakes or what the rate is?

19 MS. LEITON: Well, we do have an
20 accountability review process which -- and we do
21 have a Part E causation section on that which,
22 you know, the auditors which are -- consist of

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1 policy analysts and other claims staff that
2 didn't work on the case around the country will
3 do annual audits of each office and each claims
4 examiner, or not each claims examiner's work, but
5 claims staff work to determine, you know, what it
6 was -- whether it was done correctly.

7 We haven't found a lot of incidences
8 in those in that area.

9 Now, have we focused on whether or not
10 the diagnosis was wrong, I can't say that we
11 have, I don't know that we could, specifically
12 based on our data.

13 But, we do look overall at causation
14 specifically and the analysis conducted by the
15 claims examiner in their development and in their
16 final or recommended decisions.

17 CHAIR MARKOWITZ: Could we see those
18 reports or those audits?

19 MS. LEITON: The accountability review
20 findings are all on the web, they're on the
21 public reading web.

22 CHAIR MARKOWITZ: Okay, so I guess the

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1 answer is yes. Thanks.

2 MS. LEITON: Yes.

3 CHAIR MARKOWITZ: Any other questions?

4 MEMBER MAHS: I had one for the
5 gentleman from DOE, I forgot your name.

6 MS. LEITON: Greg Lewis.

7 MR. LEWIS: Greg Lewis.

8 MEMBER MAHS: The building trades work
9 their way out of a job all the time so they may
10 be on a project for six months, may be on it for
11 two years at the plant and they go somewhere else
12 and come back when another project comes up.

13 And, they may work for a dozen
14 contractors during the course of their career and
15 work in a 100 different buildings between the
16 three plants.

17 And, they don't remember where they
18 were or what they were a lot of times and they've
19 got an illness and they're trying to remember or
20 they don't know what they worked around because,
21 a lot of times that's classified. We'll let you
22 know if you're in danger.

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1 So, would your office be another
2 resource where they could find some information
3 to go with an affidavit?

4 MR. LEWIS: Well, yes. I mean, my
5 office responds for pretty much all workers who
6 apply to the program. You know, DOL is going to
7 send us a request for information.

8 Subcontractors and building trades
9 workers are our biggest challenge, to be honest.
10 I mean, for all of the reasons you just
11 mentioned, they are a huge challenge when
12 compared to people who worked for a prime
13 contractor or even a subcontractor for the prime,
14 the big subcontractor.

15 So, we do the best we can to find the
16 records that exist. Obviously, things are much
17 better in recent times, historically, it can be a
18 challenge.

19 What we'll do is we'll look at sort of
20 non-traditional employment records, so things to
21 prove site presence, not exactly employment
22 because there's going to be no HR file for these

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1 folks typically.

2 We'll look for like a medical record
3 if they, you know, fell off a ladder. You know,
4 whether it's illness related or just, you know,
5 anything that puts them on site.

6 So, a slip, trip and fall will at
7 least show, hey, they were on site at a
8 particular time. If they wore a dosimetry badge,
9 most times we are, you know, that should be
10 retained by the site.

11 If there's industrial hygiene, that's,
12 you know, particularly the older you go, the less
13 likely it is to find that, but we'll look for
14 that.

15 When we have, you know, at some sites,
16 we've retained site access badge type records,
17 sign in sheets, gate logs, things like that, for
18 the most part, the records retention on those was
19 very short, five to seven years.

20 But, sometimes, just through inertia,
21 it was saved by the site when we do have that, we
22 will incorporate it into the records that we

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1 check for particular claims.

2 But, again, it is a significant
3 challenge for us to find those records. We do
4 everything we can to find them, we are not always
5 able to verify employment or site presence for
6 the building trades type folks.

7 MS. LEITON: We do have a contract or
8 we work closely with CPWR, the Center for
9 Construction and Trades, and they can often do
10 some research to find subcontractors. That is a
11 reference that our claims examiners use to
12 determine whether there was a subcontract at a
13 particular facility and that sort of thing.

14 So, it is another resource that we
15 use.

16 MEMBER MAHS: That's nice. And, a lot
17 of contractors are out of business and, though
18 they're supposed to, don't have the records and
19 it's hard.

20 Like I say, I'm on a learning curve so
21 I didn't know he was involved in that so heavily,
22 I was thinking going along with your affidavits.

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1 MS. LEITON: Sure.

2 MEMBER MAHS: Thank you.

3 CHAIR MARKOWITZ: I have a question,
4 actually, about consequential conditions because
5 the SEM doesn't address that.

6 So, and I haven't looked at the
7 procedure manual around this, but the CE is
8 looking at consequential conditions. They look
9 at whatever the personal physician writes. But,
10 what tools does the CE use to decide whether
11 something's of consequence of another condition
12 or not?

13 MS. LEITON: Well, consequentials
14 basically, it's of the physician's opinion,
15 that's only what we rely on because we don't have
16 to look at whether it's related to toxic
17 substances, because we've already accepted the
18 original diagnosis.

19 So, first and foremost, we're going to
20 go to a treating. Often times, we get it from a
21 treating automatically. They say this is a
22 result of this other condition.

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1 Other times, they'll say it's a result
2 of a medication that was prescribed.

3 Sometimes, claimants will file them on
4 their own and then we develop for it. But, often
5 times, we'll see it in medical evidence before a
6 claimant files for it and then they'll file for
7 it.

8 CHAIR MARKOWITZ: Thank you.

9 Oh yes, Dr. Silver?

10 MEMBER SILVER: I'm a little
11 distressed that this segment never used the word
12 epidemiology. I'm a little distressed that this
13 segment hasn't used the word epidemiology.

14 There are a lot of shreds of evidence
15 in the claimant files that I've seen that make
16 the most coherent sense when one acquires
17 epidemiologic papers and reads the discussion
18 section and looks at things related to the time
19 course of the illness, typical age at onset.

20 I was contacted by a New Mexico legal
21 services after a janitor's case for renal failure
22 had been denied. And, I have special assets in

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1 terms of where uranium was used in his work
2 environment and other renal toxicants.

3 But, what I think really turned the
4 case around on appeal was when I got my hands on
5 five epidemiologic studies of uranium miners and
6 millers and found that there was ambiguity in
7 classification of the disease outcome in the days
8 of old.

9 And, when he was lumped together with
10 all genitourinary diseases, the effect measure
11 was much greater.

12 I found that in reading the discussion
13 that the albumin dipstick test was insensitive
14 back in the day.

15 There was data on the average age of
16 onset after exposure and he fit right in. And,
17 you all awarded the survivor claim on appeal.

18 And, it was only really through the
19 epidemiologic literature that this widow who
20 stuck her neck out even before there was Part E
21 to testify at a public meeting got her claim.

22 So, I think we're going to keep

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1 getting back to the idea that you have to grab
2 the epidemiologic literature by its roots and let
3 a qualified epidemiologist shake the fruit out.

4 CHAIR MARKOWITZ: Thank you.

5 MS. LEITON: Okay, the next topic is
6 Part B lung conditions, diseases, just trying to
7 make sure I'm good on time.

8 CHAIR MARKOWITZ: We're good, we're
9 good.

10 MS. LEITON: Okay.

11 CHAIR MARKOWITZ: We're good, thank
12 you.

13 MS. LEITON: Okay, so Part B lung
14 diseases, beryllium disease and silicosis. I'm
15 first going to talk a little bit about beryllium
16 sensitivity.

17 And, this is something that is a
18 requirement of the statute under Part B in order
19 for a person to be -- for us to accept a
20 beryllium sensitivity, there must be one abnormal
21 beryllium lymphocyte proliferation test or one
22 beryllium lymphocyte transformation test

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1 performed on blood or lung lavage cells which
2 shows abnormal findings.

3 They can also submit beryllium
4 sensitivity or establish that through a beryllium
5 patch test which is old fashioned and usually
6 isn't necessary unless the records are old.

7 But again, this is a statutory
8 requirement which means Congress specifically put
9 in there that they have to have an abnormal.

10 There are -- has been one set of
11 circumstances where we've been able to use a lung
12 biopsy in lieu of a positive beryllium
13 sensitivity test when there is evidence of
14 steroid use.

15 Those -- that was a very specific set
16 of circumstances that allowed us to do that.
17 But, in general terms, this is the test and it's
18 the test that's provided to us under statute.

19 Once we've established beryllium
20 sensitivity under Part B and we've accepted that
21 condition, we will pay for additional test
22 results for the development of chronic beryllium

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1 disease.

2 Medical monitoring which, you know,
3 could be any test for CBD treatment and therapy
4 for the condition effective the date of filing
5 that progresses later to CBD, we can accept the
6 case for CBD.

7 Beryllium sensitivity does not result
8 in a lump sum award, it's just medical monitoring
9 at that stage.

10 So once the -- from beryllium
11 sensitivity or sometimes -- often times chronic
12 beryllium disease is just claimed outright
13 without it first being beryllium sensitivity.

14 But, there are very different
15 criteria, very specific criteria under Part B to
16 accept chronic beryllium disease and these are
17 legal criteria that are also in the statute.

18 And, it makes it a little bit
19 challenging for physicians because of the fact
20 that this is a legal definition, it's not a
21 medical definition.

22 But, I am going to outline what the

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1 law states about chronic beryllium disease.

2 And, we have to make -- there's a
3 determination that we have to make whether it's -
4 - we're going to us a pre-1993 test which is
5 provided by the statute or a post-1993 test.

6 The decision -- we have to make that
7 decision based on the date of the first evidence
8 of a chronic respiratory disorder. Depending on
9 the answer to that question, we'll use either of
10 those tests.

11 So, for a pre-1993 CBD, an individual
12 must have any three of the following criteria,
13 characteristic chest radiography or a computed
14 tomography CT abnormalities.

15 This includes a variety of patterns,
16 conditions such as non-caseating granulomas,
17 nodules, interstitial fibrosis and honeycombing.

18 More clear guidance on chest
19 radiograph abnormalities consistent with CBD is
20 looked for -- the claims examiners will look for
21 that.

22 Restrictive -- the second of the three

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1 criteria is restrictive or obstructive lung
2 physiology testing or diffusing lung capacity
3 defect.

4 The third is lung pathology consistent
5 with CBD.

6 In most instances, a physician's
7 statement that it's with rationale confirming
8 that the tests are consistent with CBD is
9 sufficient.

10 And then, they have to have a clinical
11 course consistent with a chronic respiratory
12 disorder.

13 Oh, I'm sorry, there are actually
14 five, but you only have to have three of the
15 five. So, the first three I just mentioned.

16 The fourth is the clinical course
17 consistent with chronic respiratory disorder.

18 And the fifth is immunologic tests
19 showing beryllium sensitivity like the skin patch
20 test or the abnormal beryllium blood test.

21 The post-1993 CBD criteria, you have
22 to establish beryllium sensitivity as we've

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1 already discussed and a lung pathology consistent
2 with CBD including lung pathology showing
3 granulomas or a lymphocytic process consistent
4 with CBD, computerized axial tomography, a CAT
5 scan showing changes consistent with CBD or
6 pulmonary function or exercise testing showing
7 pulmonary deficits consistent with CBD.

8 A physician's rationalized opinion
9 nothing that biopsy findings are consistent with
10 CBD will take precedence over the diagnostic
11 data.

12 These are challenging diagnostics.
13 The criteria is challenging because we -- for
14 post-1993 we do need a physician to tell us that
15 it's CBD or it's consistent with CBD but it's
16 something that is required by these criteria.

17 The benefits for Part B is the
18 \$150,000 for CBD and it's either to the employee
19 or to the survivor.

20 Under Part E, chronic beryllium
21 disease is different because they didn't give us
22 a legal definition of CBD or criteria for that.

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1 So, we will -- we still -- since there is a legal
2 definition provided in the Act for beryllium
3 sensitivity, we require beryllium sensitivity as
4 defined there and then other information provided
5 by a physician that establishes chronic beryllium
6 disease.

7 And, that's not as specific as it is
8 under Part B. So, we do face challenges there.

9 Beryllium exposure is usually assumed,
10 it's not like some of the other conditions where
11 we have to do extensive research. Beryllium
12 disease comes from beryllium exposure.

13 And then, we have chronic silicosis
14 and this is a -- there are certain very specific
15 criteria for chronic silicosis under Part B as
16 well.

17 The evidence required is, again, it's
18 statutorily set. They have to have been exposed
19 silica in the performance of duty for a aggregate
20 of at least 250 work days during the mining of
21 tunnels at a DOE facility located in Nevada or
22 Alaska.

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1 They have -- there's a latency period
2 of 10 years between the date of initial silica
3 exposure and diagnosis date for chronic
4 silicosis. And, there has to be a written
5 narrative from a qualified physician that
6 includes a diagnosis of silicosis.

7 With regard to diagnostic evidence,
8 any of the following criteria, a chest
9 radiography interpreted by a physician certified
10 by NIOSH as a B reader, classifying the existence
11 of pneumoconiosis of Category 1/0 or higher,
12 results from a CAT scan or other imaging
13 technique that are consistent with chronic
14 silicosis or lung biopsy findings consistent with
15 chronic silicosis.

16 So, again, that's very limited under
17 B, they will get \$150,000 if they meet those
18 criteria, it's only for those two facilities.

19 If you're looking at chronic silicosis
20 under Part E, it's going to be different because
21 you're going to look at it like you would
22 typically look at any other condition.

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1 So, those are the very specific
2 statutory criteria for B lung diseases.

3 Questions?

4 MEMBER TEBAY: Are we going to have
5 time to have this conversation about beryllium at
6 some other point or is it now an appropriate time
7 to have about specific testing?

8 CHAIR MARKOWITZ: We have time, but
9 feel free to ask a question.

10 MEMBER TEBAY: And, Rachel and I have
11 had this conversation before, but just to Hanford
12 at this point, I'll just speak to Hanford and
13 assume it's the same at other complexes as well.

14 We have this, obviously, in the room,
15 this borderline test requirement at this point.

16 At Hanford, I believe we have the most
17 borderline test results of any other site. We
18 have a significant amount of people that have
19 been diagnosed sensitized to be at the borderline
20 test.

21 Which, there's other programs that
22 accept the borderline as a diagnosis criteria for

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1 sensitivity, but what we've seen lately is these
2 people that were diagnosed via borderline test
3 have moved on to chronic beryllium disease.

4 Obviously, that creates a challenge
5 because not only have they been denied at the
6 Department of Labor because they don't meet the
7 abnormal standard, but now they are diagnosed at
8 chronic beryllium disease but they can't get
9 accepted there because they never met the
10 original diagnosis, dose sensitivity.

11 So, we've got these folks stacking up
12 at this point with, you know, diagnosis of
13 sensitivity and chronic beryllium disease that
14 have no other option.

15 It seems to me, whether it's statute
16 or not, your National Jewish, your Cleveland
17 Clinics, I think Dr. Redlich has shared some
18 input as well that the borderline test, whether
19 it be -- I believe the borderline test is
20 abnormal.

21 I think we're talking, if it's not
22 normal, it's abnormal. But, we're kind of in

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1 this hurdle that we can't get over, yet we know
2 the diagnosis criteria and the statute is out of
3 date and it's not accurate, what do we do?

4 Where do we change that? How do we
5 get over that hurdle for these folks?

6 MS. LEITON: I've been advised and
7 we've looked at this in great depth that the
8 statute says what the statute says and we must
9 abide by it as an abnormal.

10 So, in order for us to change it at
11 this point would require a statutory change.

12 MEMBER TEBAY: So, if we keep hinging
13 on this abnormal test result, I mean, it is a
14 borderline test and people that are more educated
15 could help me here, but is a borderline test
16 abnormal?

17 MS. LEITON: And, there are articles
18 and we've received research and various other --
19 I believe the board has a recommendation with
20 this regard and that's why we've had our legal
21 analysis conducted and have been advised that an
22 abnormal has to be an abnormal based on the

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1 statute.

2 CHAIR MARKOWITZ: So, I have a
3 question related to this. If a person doesn't
4 make the criteria on silicosis under Part B, are
5 they eligible to submit under Part E for the same
6 diagnosis.

7 MS. LEITON: If they did -- do not
8 meet the statutory criteria for B?

9 CHAIR MARKOWITZ: Correct.

10 MS. LEITON: Yes, they can file under
11 E.

12 CHAIR MARKOWITZ: So, can the same
13 thing happen for beryllium?

14 ME. LEITON: Absolutely, yes.

15 CHAIR MARKOWITZ: So, a person who has
16 borderline, two borderlines and evidence of lung
17 disease consistent with --

18 MS. LEITON: But, we do have a
19 requirement under or -- under Part E that they
20 have these -- that the requirement for beryllium
21 sensitivity that's under Part B also applies
22 under Part E. This was also under the guidance

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1 of the Solicitor's Office.

2 CHAIR MARKOWITZ: But, that's not in
3 the statute? The statute --

4 MS. LEITON: The Part B criteria is,
5 but being inconsistent in that specific area is
6 something we've been advised against.

7 CHAIR MARKOWITZ: Right, okay, okay.
8 So, the Part E assessment of beryllium is not
9 driven by the statute in the same way, but it's a
10 decision within the Department.

11 Dr. Cassano?

12 MEMBER CASSANO: Yes, going back to
13 the abnormal lymphocyte proliferation test again,
14 the statute says abnormal, correct?

15 MS. LEITON: Yes.

16 MEMBER CASSANO: It doesn't say
17 positive, but so, it is the interpretation of
18 your legal department that borderline is not
19 abnormal, correct?

20 MS. LEITON: That's correct.

21 CHAIR MARKOWITZ: So, we should move
22 on, but we -- unless there are pressing questions

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1 directly on this. We will have time to come back
2 if you want, if that's all right?

3 MS. LEITON: Okay, the last area for
4 review by the Board is the work of industrial
5 hygienists and medical expertise.

6 So, to establish that an employee was
7 exposed to a toxic substance, the evidence on
8 file must show evidence of potential or plausible
9 exposure to toxic substance and evidence of
10 covered DOE contractor, subcontractor or uranium
11 employment at a DOE -- at a covered DOE RECA
12 facility during a covered time period.

13 So, under the regulations, in order to
14 establish an employment related exposure to a
15 toxic substance, we have to have proof of
16 exposure to a toxic substance present and we do,
17 as I said, we use the site exposure matrices
18 where we can to show that there was a toxic
19 substance present.

20 But, we also look at the nature,
21 frequency and duration of that exposure of the
22 covered employee, evidence of the carcinogenic or

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1 pathogenic properties and opinion of a qualified
2 physician with expertise in treating, diagnosing
3 or research the illness, claimed to be caused or
4 aggravated by the alleged exposure and any other
5 evidence that demonstrates a relationship between
6 a particular toxic substance and the claimed
7 illness.

8 The industrial hygiene reviews, I've
9 gone into this a little bit, I'll talk a little
10 bit more about it.

11 But, as I indicated, we have two
12 federal employees that work on this and then we
13 have a contract of industrial hygienists that
14 recently, I guess about two years ago, we hired
15 these contractors to help because we realized
16 there's a lot of these assessments.

17 Probably not going to belabor this
18 since we've talked about it a bit, but the
19 industrial hygienists are certified by the
20 American Board of Industrial Hygiene in the
21 comprehensive practice of industrial hygiene.

22 So, what they will review is

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1 historical occupational safety and health data
2 which may or may not include employee specific
3 industrial hygiene monitoring, depending on
4 whether or not we could get it from a DAR or
5 otherwise along with their application of their
6 specialized knowledge related to the field of
7 industrial hygiene.

8 The IH referral from the district
9 office consists of the CE will first identify an
10 exposure issue. They'll look at the site
11 exposure matrices and everything else in the case
12 file to determine what they need to refer to the
13 industrial hygienist.

14 This could include facility exposure
15 records, DAR information, the occupational
16 history questionnaire, the employment records
17 verified affidavits, former worker program
18 screening records, NIOSH site profiles in some
19 cases, any employee submitted information and
20 other evidence that establishes a toxic presence
21 at the site.

22 And then, we'll put that in a

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1 statement of accepted facts for the industrial
2 hygienist referral.

3 The IH will then review the evidence
4 submitted, review the SOAF, anticipate, recognize
5 and evaluate hazardous conditions in occupational
6 environments and provide their expertise to an
7 evaluation that is then submitted to the claims
8 examiner for review in the case file.

9 Part of the IH's input may include
10 identification of specific chemical or biological
11 toxic substances to which the employee likely had
12 an exposure, work process, presence within a
13 particular work building, area or site or as a
14 result of an occupational accident or incident,
15 identification of specific description of the
16 nature, extent and duration of exposure to
17 specific toxic substance that employee likely
18 encountered because of his or her covered
19 employment.

20 They'll do an evaluation in some cases
21 and comparative analysis of opinions presented by
22 claimant experts that respond to questions of the

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1 nature, extent and duration of employee exposure
2 to toxic substances.

3 The IH will also review SEM to verify
4 searches that may have been conducted by the
5 claims examiner or to verify that they were done
6 correctly.

7 The IH will then render an expert
8 opinion in the form of a memorandum that
9 addresses the issues as specifically as possible.

10 They'll reply to any specific
11 questions that were asked by the CE and then
12 they'll make a determination based on their
13 expertise.

14 The opinion from the industrial
15 hygienist is usually based -- they've identified
16 specific chemical or biological substance,
17 they've been informed by the work history of the
18 employee as accepted by the CE, predicated on the
19 recent application of available data and
20 scientific information. And then they'll
21 communicate that in a clear narrative.

22 I think that we've submitted, and

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1 you've -- and many people on the board have seen
2 examples and we may have examples of an IH
3 opinion on the website.

4 But, basically, they'll talk about, as
5 I said earlier, duration, exposure levels, high,
6 low, intermediate, in passing only, these are the
7 terms that are often used in the IH assessments.

8 The -- I talked quite a bit about the
9 CMC, so I won't go into too much detail about
10 that. But, as I indicated, there are several
11 different reasons we would go to a CMC and they
12 are used when we don't have enough information in
13 the case file or when we can get information that
14 will clarify other information ion the case file.

15 There are some -- there is some
16 oversight of some of these activities. We do
17 have a CMC and second opinion audit that's
18 conducted by a medical director every quarter.
19 Those are now published on our public reading
20 room.

21 And the purpose is to assess the
22 quality of district office and physician work

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1 products and referral packages through the
2 contractor to determine if the CMC review
3 includes all the right information.

4 We'll look at the quality of the
5 medical review and opinion. The questions in
6 this category can -- the medical director will
7 look at various issues.

8 A lot of it, sometimes, if there's a
9 lot of impairment ratings in a quarter, I think
10 he reviews like 60 a quarter, is that right?
11 And, he'll come out with a report at the end of
12 that quarter explaining exactly what he found, if
13 there were deficiencies.

14 We will look at it in policy to make
15 sure that it's consistent, that we don't see any
16 factual inaccuracies in what he was looking at.
17 And then, that will be published.

18 We also do accountability reviews, as
19 I indicated. Part of that accountability review
20 process is looking at whether or not the district
21 office referred it correctly, whether their SOAF
22 was accurate, whether they've submitted the

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1 correct information to the physician, asked the
2 right questions, that sort of thing. And those
3 are also published and put in our accountability
4 review findings.

5 We have done a specific audit, I think
6 it was in February of 2015, I believe we
7 submitted that to the board on just more targeted
8 towards CMC reports and CMC referrals
9 specifically.

10 And, we always are constantly revising
11 our accountability review process every year,
12 pretty much determine what we want to look at in
13 each given year.

14 Sometimes we'll do spot audits and,
15 you know, that is under -- our whole process for
16 accountability reviews is under consideration for
17 this new year whether we want to look at things a
18 little bit differently, whether we want to look
19 at more targeted information. But, it's an
20 analysis that we undergo each year.

21 MEMBER POPE: I have a question.

22 MS. LEITON: That --

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1 MEMBER POPE: Is there data to show
2 during your audit review the number of CMC
3 audits, those cases gone back to be reviewed?

4 MS. LEITON: I'm not sure I understand
5 the question. Are you saying, once we've
6 identified cases, have they been looked at again?

7 MEMBER POPE: Right.

8 MS. LEITON: Every case that were
9 identified an error in will go back to be re-
10 reviewed. In some cases, it'll go back to the
11 CMC to ask follow up questions. In other cases,
12 we have to make a -- take a different path,
13 depending on really what the problem was with it.

14 But, we'll definitely address that case if there
15 were problems with it that we found.

16 MEMBER POPE: Okay, thank you.

17 MS. LEITON: I don't have anything
18 further on the particular issues.

19 CHAIR MARKOWITZ: Dr. Silver?

20 MEMBER SILVER: It's been a few
21 months, would you refresh my memory please as to
22 the accountability and audit procedures for the

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1 work of the industrial hygienists?

2 MS. LEITON: That -- since we've
3 recently gotten the contract, that's something
4 that we're going to do probably quarterly as
5 well, but we have not begun that yet. So, we're
6 going to work out a process for doing quarterly
7 reviews of the IH reports as well.

8 MEMBER SILVER: Would you welcome the
9 board's input into establishing that process?

10 MS. LEITON: Absolutely.

11 CHAIR MARKOWITZ: So, on the website,
12 the up to the third quarter of 2017, the medical
13 audits are available. If it's available, could
14 we look at either the fourth quarter of 2017 or
15 anything into the 2018?

16 MS. LEITON: Yes, if they're not on
17 the website and we have them completed, we will
18 provide them to you.

19 CHAIR MARKOWITZ: And then, when those
20 50 per year, excuse me, per quarter are randomly
21 selected for audit, they seem to be divided 20
22 into causation, 20 impairment and 10 other. So,

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1 that means that you can identify which of the --
2 sort of the main purpose of the CMC reports in
3 that selection?

4 MS. LEITON: Yes.

5 CHAIR MARKOWITZ: Okay, thanks.

6 MS. LEITON: Other questions?

7 CHAIR MARKOWITZ: Has there ever been
8 an exercise looking at consistency between two
9 CMCs or among the CMCs? In other words, if you
10 submitted the same causation question to a
11 different -- one, you know, to multiple CMCs,
12 would they come up with the same decision?

13 MS. LEITON: Since we're usually -- I
14 mean, the purpose of the referrals are to
15 adjudicate claims. We don't -- we're not going
16 to take the time to do that for an individual
17 claim.

18 Now, if we were to go and do it like,
19 I mean, it's possible to do an audit like that
20 that doesn't -- we would want to hold up a claim
21 to do that --

22 CHAIR MARKOWITZ: Sure, sure.

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1 MS. LEITON: -- in other words. But,
2 you know, we have not done that specifically.

3 CHAIR MARKOWITZ: Right, okay. You
4 know, I didn't mean to hold up at all --

5 MS. LEITON: Right, right.

6 CHAIR MARKOWITZ: Questions? Comments?

7 (No response)

8 CHAIR MARKOWITZ: Okay, thank you very
9 much.

10 MS. LEITON: Thank you.

11 CHAIR MARKOWITZ: That was great.

12 Next, I think we have Mr. Vance,
13 Procedure Manual Modifications and Other Changes.

14 MR. VANCE: All right, well, good
15 afternoon everyone. My name is John Vance. I'm
16 the Policy Branch Chief for the program. I'm
17 talking about the procedure manual today, so I
18 see that somebody bribed somebody, I only have
19 ten more minutes according to schedule.

20 CHAIR MARKOWITZ: Yes, but you speak
21 quickly, so that's okay.

22 MR. VANCE: Yes, I do. So, I will

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1 try to be quick so we can get back on schedule
2 here. But --

3 CHAIR MARKOWITZ: No, actually, the
4 schedule -- we have some flexibility.

5 MR. VANCE: All right, well, then I'm
6 just going to talk until I can't talk anymore.

7 CHAIR MARKOWITZ: Okay, okay.

8 MR. VANCE: So, again, I'm the Policy
9 Branch Chief so I oversee the drafting and
10 publication of our procedure manual which is the
11 topic of this conversation.

12 Let me give you a little bit of
13 background about my staff that works on the
14 procedure manual.

15 So, I have seven policy analysts. I
16 have a group of folks working for me in the
17 medical health science group. I have three
18 industrial hygienists, I have two health
19 physicists and I have a toxicologist and nurse
20 consultants.

21 Our working team collaborates on
22 considering, evaluating and deciding how we're

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1 going to make changes to our procedure manual.

2 The procedure manual itself is a very
3 large document, for those folks that have had the
4 opportunity to be exposed to it in the past. It
5 is available on our website so if you just look
6 on our main page and go to policy program
7 procedures and the program manual, it's right
8 there.

9 It is a 600-page document. It is a
10 very lengthy treatise on everything that you need
11 to know about how to process claims through our
12 adjudicatory process.

13 It is essentially an employee
14 handbook. It basically tells staff how they go
15 about doing the job of evaluating cases. So, it
16 is a very detailed description of the work that
17 our staff does in developing cases and evaluating
18 evidence and making judgments in our process.

19 For those folks that have not had
20 exposure to our procedure manual before, there's
21 lots of material that's available in it. For the
22 board, things that I would suggest that you

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1 really want to focus on is Chapter 15, which is
2 our toxic exposure causation analysis chapter.

3 We also have Chapter 18 which talks
4 about non-cancerous conditions. For folks that
5 just want to know our adjudication process,
6 Chapters 24 through 26 is the basic claims
7 adjudication process discussion. So, if you
8 wanted to sort of start somewhere if you're new
9 to this, this is probably the suggestion I would
10 give you.

11 Again, the procedure manual, it's a
12 very large document, it's a PDF. It's available
13 online. The publication of the procedure manual
14 occurs by version, so we are currently in Version
15 2.3. We are working on Version 3.0.

16 The content of our procedure manual is
17 described -- or the changes to our procedure
18 manual is described, when you go to the website
19 and you go to the procedure manual, you will be
20 presented with some different information.

21 You'll have the actual whole working
22 published document of the procedure manual, then

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1 you'll have a transmittal that describes what
2 edits have occurred to the procedure manual for
3 that version.

4 We also have a library of all prior
5 transmittals and then also some archival material
6 that is available online. So we try to be as
7 transparent as we can with the publications of
8 each update to the procedure manual.

9 Some of our publications are very
10 weighty in the sense that we cover a lot of
11 material. Others are very point of fact, we've
12 got a quick change that we have to make. So, we
13 do do substantial edits and then sometimes we do
14 relatively minor changes.

15 MEMBER DOMINA: Can I ask you a
16 question real quick?

17 MR. VANCE: Mr. Domina?

18 MEMBER DOMINA: Because you said
19 you're working on the new version, the 3.0 or
20 whatever, and I don't know if you can comment on
21 this or not, is there anything in that that you
22 can think of that could affect what this Board is

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1 going to work on so that maybe we don't need to
2 work on something in great length that maybe is
3 going to get changed in the next version? Or can
4 you comment on that or not?

5 MR. VANCE: I can't comment on it right now
6 because, let me talk a little bit about how we go
7 about identifying issues for the procedure manual
8 for us to even consider.

9 And, right now, we're in the editing
10 stage. So, let me give you a sense as to how the
11 procedure manual actually operates through
12 publication and that might answer your question.

13 MEMBER DOMINA: Thanks.

14 MR. VANCE: So, a lot of times people
15 will ask, you know, well, this is an employee
16 handbook. This instructs staff as how to do
17 certain things. How do you get guys - decide in
18 policy what you're going to actually change?

19 And, we actually generally make
20 changes based on the input from lots of different
21 sources. The primary source is generally
22 feedback from claims staff that they've run into

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1 case situations that don't generalize very well
2 to the procedure manual.

3 And then we have to look at that and
4 make a decision, is that particular case scenario
5 presenting us with a challenge in our guidance in
6 the procedure manual that requires a change?

7 Is it a one off scenario that we
8 really can't prescribe a solution in the
9 procedure manual, we're going to have to look at
10 the specific nature of that case and resolve it?

11 Or, is there just some issue in the
12 procedure manual that our staff are struggling to
13 understand how to apply? Or that the process is
14 developing in such a way that it's not
15 administrative feasible to continue to do it in
16 that manner anymore?

17 So then we have to take a look at that
18 and make a decision as to, okay, what is the
19 process that we have to go through to evaluate
20 the impact, the language that would fix that and
21 also, you know, are we on solid ground in order
22 to make that determine within the scope of the

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1 law and the regulations?

2 The other sources of feedback that we
3 get is from my policy analyst staff who are
4 basically the principle folks dealing with a lot
5 of incoming policy questions and other issues
6 that come up in case adjudication activities.
7 They will identify items that they think are
8 qualified for inclusion in the editing process
9 and vetting process.

10 We also initiate program initiatives
11 where we're going to go out and do something
12 different than the way we've done before to
13 hopefully create efficiencies and a process or to
14 address other work processes such as input from
15 the Advisory Board. So, I'll talk to you a
16 little bit about some of the things that went
17 into Version 2.3 that are direct consequences of
18 input from the Advisory Board.

19 We also get input from stakeholders
20 just through general correspondence that we get
21 and congressional inquiries or folks that are
22 communicating with the director on concerns or

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1 problems or complaints about the process. So, we
2 also will consider those.

3 We also make changes based on the
4 effect of litigations. It's very rare that that
5 occurs, but it does. And, when we have a policy
6 that's been ruled improper by a judge, we will
7 make those changes.

8 So, we do have one example that
9 occurred in the past few years where we had to
10 make a modification based on the outcome of
11 litigation. And we also take input from the
12 Solicitor's Office where there are issues that
13 come up in ongoing litigation.

14 So, those are generally the sources of
15 changes that we get for changes to the procedure
16 manual. Again, this is an internal document.
17 This is a Department of Labor document that we
18 provide to our staff so it's not something that
19 the public has access to to provide formal
20 comment to. It is something that we will
21 evaluate and consider input from lots of
22 different places and provide guidance to our

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1 staff.

2 The process for evaluating edits is a
3 really cumbersome process. So, we have input
4 that we collect and we make decisions as to what
5 changes and edits need to occur. We will
6 assemble that. I have one staff person who is my
7 Editor in Chief who collects all of the input for
8 changes and edits.

9 We will then assign that out, or I
10 will assign that out to policy analysts who will
11 then do the research necessary to determine what
12 impact that change will have in the procedure
13 manual and to our adjudication process and
14 formulate the language that will convey how the
15 staff is to implement this particular procedure
16 or process.

17 Once that's done, it's got to get
18 through my unit supervisor who is going to
19 evaluate that. I have to evaluate and certify
20 that I feel that that's an appropriate addition
21 for the procedure manual.

22 Then it has to actually go out through

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1 subject matter experts evaluating and determining
2 whether or not the final work product is
3 sufficient.

4 We also have to go through a legal
5 review by our solicitor who's going to evaluate
6 and certify that any content complies with the
7 legal and regulatory standards that exist for the
8 program and that it's a defensible position.

9 We also then have to have other
10 certify it. So, if it's a medical health science
11 issue, we'll have the medical director review and
12 certify it. If we have other types of areas of
13 expertise that we need to have specialists look
14 at, then they will also certify off on that.

15 And then, we're not done. It still
16 then has to go through clearance with the
17 director and then it's on and upwards to the
18 employee union that has to actually evaluate that
19 because this is an employee guidance document.

20 The federal employees union has an
21 opportunity to review that and comment or provide
22 feedback as far as their agreement or

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1 disagreement with any kind of process changes.

2 So, it's a very cumbersome process.
3 It does require lots of effort on the part of our
4 staff. We do a lot of research in conjunction
5 with how processes will change based on edits to
6 our procedure manual.

7 And, I would say one of the big things
8 that I will always say about the procedure manual
9 is that words matter and we take a lot of time in
10 making sure that the words communicate clearly
11 our expectation for processes.

12 So, specificity is very important and
13 we oftentimes get into very long and arduous
14 struggles over wording and phrasing to make sure
15 that people are understanding exactly what we're
16 trying to convey in the procedure manuals.

17 So, that's just something that I
18 always think is important to mention because I've
19 struggled trying to make that work. That's the
20 constant struggle for procedural writing.

21 So, I was asked to just go through a
22 little bit about our last update to the procedure

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1 manual because it encompassed a lot of input from
2 the Advisory Board.

3 The procedure manual -- go ahead.

4 MEMBER REDLICH: Just before you get
5 to that, just clarify one thing. You mentioned
6 in terms of revising the manual --

7 MR. VANCE: Yes?

8 MEMBER REDLICH: -- what expertise you
9 have?

10 You mentioned just in terms of
11 revising the manual, you mentioned the expertise
12 you have in house in terms of industrial hygiene.

13 I didn't hear a physician with
14 expertise in --

15 MR. VANCE: Yes, our medical director
16 will provide approval for things that relate to
17 the field of medicine or the application of
18 medicine.

19 So, he reviews -- and he's actually
20 usually involved up front in the drafting stage
21 because it's not where we're getting to him at
22 the tail end. We usually involve him up front

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1 and say, when the analyst is actually preparing
2 to make a suggested edit, they'll generally be
3 working with the medical director to make sure
4 that he is in agreement with whatever editing
5 that they're proposing before it even gets into
6 the final publication.

7 But then, if there is a medical
8 component that he's got to sign off on, then
9 he'll be part of that formal clearance process.

10 MEMBER REDLICH: Okay. Because, I
11 mean, I realize that the manual is huge.

12 MR. VANCE: Yes.

13 MEMBER REDLICH: And it involves all
14 different areas of expertise. But, having not
15 met the medical expert, does he have expertise
16 in, let's say, chronic beryllium disease?

17 MR. VANCE: He is -- well, he's the
18 physician that we utilize for all issues relating
19 to the field of medicine in the application of
20 this program.

21 So, you know, he would be the one to
22 speak to his different levels of expertise. But,

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1 I -- as far as I am concerned, he is someone that
2 I think is very well versed in all aspects of
3 occupational medicine for the application of this
4 program.

5 MEMBER REDLICH: Okay. And then, you
6 mentioned that you have subject matter experts
7 review individual areas?

8 MR. VANCE: Yes, they're generally
9 going to be involved with the actual formulation
10 of the policy.

11 So, in other words, if I have a policy
12 analyst that's asked to evaluate a recommendation
13 of the board, for example, then we're going to
14 evaluate what that recommendation is. We're
15 going to turn to the person that will evaluate
16 that and give us feedback and thoughts about the
17 information that's been submitted in conjunction
18 with that.

19 And then, once we get a consensus
20 built around that, then they'll propose a change
21 or an edit to the procedure manual. And then
22 that has to get vetted through that entire

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1 clearance process.

2 So, there's basically a drafting stage
3 where we involve the subject matter experts and
4 then there's also a clearance stage where their
5 input is going to be vetted as part of the
6 editing process and certified for publication,
7 public publication.

8 MEMBER REDLICH: Okay. Because, it's
9 just for, you know, some conditions like asthma
10 and COPD, you know, lots of physicians have
11 expertise and experience with that condition.

12 But, something like chronic beryllium
13 disease, there are probably just a handful of
14 physicians in the entire United States who've
15 actually evaluated, diagnosed and in addition to
16 knowing the literature actually have the clinical
17 experience in diagnosing the disease.

18 I happen to be one of them, but I
19 think that for any physician, even a
20 pulmonologist who does not have specialized
21 experience and training in that area, they would
22 not be able to, you know, accurately diagnose it

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1 for an occupational medicine doctor who handles
2 more injuries or other aspects of occupation
3 medicine.

4 So, it really is a very specialized
5 area and I just bring that up because, I mean
6 there are lots of other aspects of, you know,
7 although I'm internal medicine, pulmonary and
8 occupational medicine, you know, I depend on
9 others with more expertise in other areas. So, I
10 am, you know, wondering exactly what is the
11 expertise since it is a big component of this
12 that has to do with chronic beryllium disease.

13 MR. VANCE: Yes, my only comment to
14 that is, I agree. There are lots of areas of
15 expertise needed in this program and I think
16 that's one of the reasons why we turn to the
17 assistance of an advisory board because this
18 program, like Rachael and others have mentioned,
19 is complicated and touches on some very difficult
20 and challenging medical and epidemiological
21 issues that requires a great deal of
22 specialization in lots of different areas and

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1 subject matter.

2 It's hard to have one person that can
3 encompass it all, but, you know, we have to work
4 with what we have and make the best possible
5 decisions we can based on the information that
6 we're presented with.

7 MEMBER REDLICH: Well, you know, maybe
8 moving forward, just to use everyone's time best,
9 we have made some specific recommendations as far
10 as the manual.

11 There may be very good reasons why you
12 can or cannot implement that. Rather than my
13 going, you know, searching through it looking for
14 different words in the text, I think it would be
15 helpful to get feedback, yes, we are able to
16 incorporate this or no for whatever reasons.

17 MR. VANCE: Right.

18 MEMBER REDLICH: And just so that we
19 know where things stand.

20 MR. VANCE: Well, let me just go
21 through the changes that we did agree to because
22 I think some of those were probably a direct

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1 consequence of some of the input you personally
2 had, especially in the asthma area.

3 So, we did make a change in our --

4 CHAIR MARKOWITZ: On this issue?

5 MEMBER REDLICH: Yes, especially on
6 this issue. Yes, and you may be about to answer
7 this, but I remember last year, and I'm a little
8 fuzzy on the details, but you were revising --
9 doing a revision of the old manual at the same
10 time we were reviewing it.

11 And, we had made some recommendations
12 that it sounded like you had accepted at that
13 point, at least verbally, thought it was a good
14 idea but didn't need to go through the whole
15 process.

16 And, yet, when that revision was
17 promulgated, there was stuff in there that was
18 almost diametrically opposed to what we had
19 agreed to.

20 So, I'm wondering if it's not
21 possible, especially for Chapter 15, I think it
22 is, that before it gets promulgated, that this

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1 Advisory Board have -- look at -- I mean, we've
2 looked at the old procedure manuals, you asked us
3 to look at the regulation about before it was
4 going to go out.

5 So, I'm wondering why we couldn't look
6 at that chapter just to make sure that we don't
7 have any tweaks that we might want to make to
8 that.

9 MR. VANCE: Yes, I think that my
10 comment, you know, my response to that is that,
11 you know, we have an internal process for vetting
12 policies and procedures for our program. And,
13 we're looking for input from the board with
14 regard to the areas of its mandate.

15 It's certainly something that I think
16 we can consider, but I don't want to give you a
17 definitive answer on that. So, it's something
18 that I think we're going to consider.

19 MEMBER REDLICH: And one follow up to
20 that. The other thing that we saw was also a
21 dichotomy between what was in the procedure
22 manual and what's in the training documents that

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1 related to that procedure manual.

2 How concurrently do you update the
3 training docs with the procedure manual?

4 MR. VANCE: Yes, generally, when we do
5 updates to the procedure manual, we'll have a
6 sequence of interactions with the field offices
7 in our final adjudication branch talking about
8 changes to our process.

9 And, often times, we are amplifying
10 existing processes that were already there, it's
11 just that the wording is providing more detail
12 and more uniform and consistent guidance as to
13 how they should be doing their job in the first
14 place.

15 So, you know, I think that's my
16 feedback on that.

17 With regard to --

18 MEMBER REDLICH: And, I do --

19 MR. VANCE: Go ahead.

20 MEMBER REDLICH: -- appreciate, I did
21 notice the changed wording --

22 MR. VANCE: Yes.

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1 MEMBER REDLICH: -- as far as the
2 diagnosis of asthma and I do appreciate that.

3 MR. VANCE: So, yes, let me get into
4 some of the changes we actually did take from the
5 board.

6 So, just to give you complete
7 confidence, everything that the board provides to
8 us undergoes a very rigid and very thorough
9 evaluation by many folks. And there are lots of
10 scientific and legal issues that we have to sort
11 of march through in evaluating this.

12 So, it's not a matter of us just
13 offhandedly not accepting recommendations. And,
14 for anyone who is unfamiliar, we have, Carrie, I
15 know, has all of our responses to all the board
16 input we have for responses that the Department
17 of Labor has provided.

18 And, that will provide a little bit of
19 the rationale for some of the things that we have
20 looked at and some of our thoughts on different
21 issues that the board has commented on.

22 With regards to some recommendations

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1 that we did accept, we did make changes and I'm
2 primarily focusing on Exhibit 15-4 in our
3 procedure manual, which is our presumptive
4 standards for evaluation of cases that sort of
5 bypass our normal adjudicatory process for
6 evaluating both exposure and causation.

7 So, these are basically exceptions to
8 the process that gets claimants directly to a
9 positive claim outcome when they meet particular
10 criteria.

11 So, for Exhibit 15-4, one of the
12 changes we made was modifications to our asthma
13 language that the Board recommended. And I
14 believe we changed that word for word.

15 We -- this was not a recommendation of
16 the Board, but I just thought I'd mention it
17 because our industrial hygiene and epidemiologist
18 made this recommendation which is adding
19 Benzedrine to the list of toxins associated with
20 bladder cancer.

21 So, again, the board is working to
22 identify positive health effect features as is

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1 our folks. And so when they identify things that
2 we can add into the procedure manual, we do do
3 that. So, that was added into our presumptive
4 standard for that condition.

5 We added two new toxins to the hearing
6 loss standard, carbon disulfide and n-hexane. We
7 added a series of presumptive changes to
8 pulmonary diseases, so we added a new presumptive
9 standard or criteria for lung cancer. The entire
10 component was added and included evidence
11 relating to the exposure to asbestos latency and
12 duration of exposure.

13 We added and changed latency periods
14 for mesothelioma. We made the same similar type
15 of change to ovarian cancer. We modified latency
16 period for plural plaques.

17 And so, all of those recommendations
18 were direct consequences of input by the board.

19 As far as other changes and
20 recommendations of the board, and there are still
21 things that we are considering. There are still
22 issues that we have encountered that we're still

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1 looking at and that are actually weighing on us
2 as we begin looking at additional edits to the
3 procedure manual.

4 So, it's not a finished work product
5 by any means and I certainly think that the
6 board's going to have plenty more to say with
7 regard to any of the areas that you have
8 commented on before.

9 And also the responses from the
10 Department of Labor.

11 CHAIR MARKOWITZ: So, I have a
12 question, if I could --

13 MR. VANCE: Sure.

14 CHAIR MARKOWITZ: -- about the asthma
15 changes, because I see there are some changes in
16 the language.

17 It says, and this is page 3 of 12,
18 Exhibit 15-4 in the asthma section that the
19 claims examiner doesn't apply a toxic substances
20 exposure assessment to a claim about asthma
21 because any dust, vapor, gas or fume has the
22 potential to affect asthma.

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1 Since the statute requires linkage to
2 a toxic substance, how can you escape that
3 statutory requirement and apply this standard
4 here to asthma?

5 MR. VANCE: So that -- there's
6 actually language in there that does specifically
7 specify that a physician has to identify the
8 triggering agent to that --

9 CHAIR MARKOWITZ: Well, that was my
10 next question.

11 MR. VANCE: Yes.

12 CHAIR MARKOWITZ: But, just sticking
13 with -- and I don't mean to interrupt you, but it
14 does say here, the CE doesn't apply a toxic
15 substance exposure assessment.

16 MR. VANCE: Right. It is strictly a
17 medical question. So, we have a standard in the
18 procedure manual that speaks to -- the standard
19 is basically a question that a physician must
20 answer. That the physician has an understanding
21 of the work history of that patient, has an
22 understanding of their medical status or whatever

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1 medical information exists and is able to offer
2 essentially a rationalized opinion explaining how
3 a specific triggering mechanism of exposure to a
4 toxic substance is associated with either the
5 onset or the development of asthma or an
6 aggravation or contribution to existing asthma.

7 And the standard lays out, and I don't
8 know it off the top of my head, but it's
9 basically, you know, is there evidence that this
10 person was suffering from an aggravation or
11 asthma at the time of their exposure to whatever
12 the triggering mechanism is, or is the physician
13 able to offer some sort of rationalized opinion
14 based on a current understanding of the patient's
15 status and then applying an historical evaluation
16 of exposure or an understanding of that exposure.

17 So, it gets very tricky, but it is up
18 to the physician essentially to make that
19 judgment. The claims examiner would be looking
20 at has the doctor offered what I would argue to
21 be a compelling and convincing argument that
22 identifies the mechanism of exposure at the time

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1 and provide some sort of linkage between that
2 exposure and the asthmatic condition.

3 CHAIR MARKOWITZ: But, that -- the
4 expectation is not that the doctor identify a
5 specific chemical substance, toxic substance that
6 led to the asthma because you acknowledged
7 earlier that any dust, gas, vapor or fume can to
8 do that.

9 The requirement -- it's a question,
10 the requirement is that the physician say there
11 was a workplace contribution in the form of some
12 inhalation exposure that aggravated, contributed
13 or somehow to the -- is that the expectation?

14 MR. VANCE: The expectation, or the
15 way that I understand it is that we recognize
16 that asthma can be affected by so many different
17 things.

18 CHAIR MARKOWITZ: Right.

19 MR. VANCE: It's impossible for us to
20 profile it and say, just look at these things.

21 So, basically, we leave it to the
22 physician but the physician must identify the

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1 toxic substance that they feel is triggering that
2 causal relationship.

3 CHAIR MARKOWITZ: They have to name
4 that it was chlorine or they have to name that it
5 was chromium --

6 MR. VANCE: They have to simply --
7 because the toxic -- the definition of a toxic
8 substance under our statute is that it has to be
9 a chemical, biological or radiological agent.

10 CHAIR MARKOWITZ: Right.

11 MR. VANCE: So, we do have a language
12 that sort of specifies that a triggering exposure
13 to a toxic substance needs to exist. So, the
14 doctor does have to identify it in some way or
15 some explanation of what that mechanism from a
16 toxic substance context is that's associated with
17 that asthmatic condition.

18 CHAIR MARKOWITZ: Well, okay, I'm
19 going to -- it's a little contradictory, but I'll
20 let others step in here.

21 (Off-microphone comments)

22 CHAIR MARKOWITZ: Yes, we can revisit,

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1 I don't mean to pursue it too much, but --

2 MEMBER FRIEDMAN-JIMENEZ: This is
3 George Friedman-Jimenez, I have a related
4 question.

5 In the procedure manual, Section 13(b)
6 on page 123, it says a physician's opinion that
7 relies on inaccurate factual findings, especially
8 speculative exposures not supported by the
9 evidence cannot be considered well rationalized.

10 So, my question is related to this,
11 what information on exposures is available to the
12 treating physician?

13 For example, can they get the site
14 exposure matrix? Can they get employment records
15 for the specific patient? Can they get exposure
16 determinations that were already completed for
17 other coworkers who were in the same job and
18 location?

19 Because since there's so much weight
20 put on identifying a specific exposure, my
21 question is, how can that be done by a physician
22 in the community that's treating this patient and

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1 writing their opinion?

2 MR. VANCE: Yes, and that's one of the
3 challenges of looking at this particular standard
4 is that we have no way of necessarily -- I mean,
5 when you're looking at all the things that can be
6 associated with asthma, we generally rely on the
7 physician to use whatever judgment he or she
8 wants in evaluating that patient and looking and
9 understanding the information that's available.

10 And, that often times relies on the
11 physician's physical examination and interview
12 with the patient. They have access to the site
13 exposure matrices if that's part of the
14 evaluation of the claim.

15 They can certainly ask for any medical
16 records. But, my general sense of it is, is
17 generally it's going to derived from a patient
18 explaining the situation with regard to the work
19 that they were doing and identifying the things
20 that they were encountering that they are feeling
21 is contributing to the asthmatic condition,
22 whether that's either the development of that

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1 condition or the aggravation of that condition at
2 the time of employment.

3 And, often times, you know, where we
4 have cases where the condition is documented to
5 have been affected by something in the workplace,
6 that's a fairly straightforward thing where we
7 can accept that right off the bat.

8 So, asthma is a very interesting and
9 complicated one simply because it's such a --
10 it's so wide open to the type of toxins that can
11 be affecting that kind of a condition.

12 MEMBER FRIEDMAN-JIMENEZ: So, do the
13 physicians have access to those sources of
14 exposure information, the site exposure matrix
15 and exposure determinations done by EEOICPA or
16 other coworkers in the same job and location?

17 Because the number of exposures for
18 which we have tests that we can actually measure
19 from the patient like an antibody, is vanishingly
20 small for asthma and for most other diseases.

21 So, there's the need to have available
22 exposure information for the physicians to make

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1 these judgments.

2 MR. VANCE: Yes, I mean, they would
3 have access to the site exposure matrices, that's
4 a publically available resource.

5 But, again, we're dealing with
6 physicians that are going to have to rely on
7 whatever information they can obtain generally
8 from the patient.

9 If they would ask the Department of
10 Labor to provide any information, we can
11 certainly do that, and we do oftentimes engage
12 with physicians in providing information on these
13 cases.

14 But, from my experience, it's
15 generally left to a physician to make the best
16 possible decision based on whatever information
17 is available.

18 CHAIR MARKOWITZ: Dr. Dement?

19 MEMBER DEMENT: I think, John, I
20 understand the rationale for asthma because it is
21 multi-factorial and complex.

22 However, I would also argue that the

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1 same principles apply to COPD. And it's one of
2 the big ticket items, just one of the large
3 issues facing these workers.

4 The Board made a recommendation on
5 vapors, gas, dust and fumes which wasn't
6 accepted. And, I'm not quite understanding the
7 rationale for rejecting that but also taking the
8 issue of asthma and accepting a more broad
9 definition of exposure.

10 Also, in the SEM, there are mixtures
11 in the SEM. There are many of them in the SEM.
12 COPD, for example, has cement dust, coke oven
13 emissions, they're all complex mixtures just as
14 VGDF is.

15 And, the literature -- the published
16 literature for the last ten years has really
17 supported a broad response -- COPD response to a
18 broad number of different toxins as a mixture.

19 I mean, I get -- I'm trying to
20 understand sort of the big dichotomy and the
21 rationale.

22 MR. VANCE: Yes, I mean, I -- the way

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1 I would respond to that is that, you know, the
2 Department of Labor evaluated -- you know, we
3 have to look at each specific issue that we're
4 presented with.

5 Asthma is its own issue, COPD is
6 something completely and separate in our view.
7 And when we provided our written responses, we
8 explained what our rationale is for our asthmatic
9 condition and we also had a response to how we
10 evaluated and considered the recommendations of
11 the board.

12 So, I mean, we did evaluate and
13 respond to both those things, and that's
14 something that I'm certain that if the board so
15 wishes, we could certainly revisit.

16 CHAIR MARKOWITZ: Sure, probably
17 tomorrow actually.

18 Yes, Dr. Redlich?

19 MEMBER REDLICH: So, I think I want to
20 just clarify one thing I said earlier from my
21 reviewing the most recent version of the
22 procedure manual.

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1 The criteria to diagnose asthma were
2 updated. The criteria to diagnose work related
3 asthma, I think, were the same as before.

4 MR. VANCE: I -- all I can tell --

5 MEMBER REDLICH: I thought maybe --

6 MR. VANCE: -- you is like we did make
7 modifications based on input from the board.
8 And, I thought that it may have been -- I can't
9 be certain, but I do know that we made
10 substantive edits to the language based on input
11 from the board.

12 But, I don't know if it all occurred
13 at one time or based on input from different
14 recommendations. Because I remember there was
15 some recommendations that Dr. Markowitz had made
16 that I think that we accepted at a different
17 point and when we looked at some of the language
18 that you had supplied.

19 MEMBER REDLICH: And I just wanted to
20 just -- I -- in case you're not aware, there is
21 starting on page 533, the matrix for confirming
22 sufficient evidence of noncancerous covered

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1 conditions, and a lot of people look at tables
2 and matrices.

3 My read is that those are -- have not
4 been updated and are not consistent with the
5 text.

6 MR. VANCE: Yes, you are correct and
7 that is actually something on the list for
8 editing.

9 So, our medical director is going to
10 be involved with evaluating and reviewing that.
11 That's something that has been flagged for
12 review.

13 MEMBER REDLICH: Okay. Because I
14 think it is confusing when there are --

15 MR. VANCE: Oh yes.

16 MEMBER REDLICH: -- different
17 versions.

18 CHAIR MARKOWITZ: I know, I think
19 actually, since they -- may of those pertain to
20 some of the outcomes we've been discussing over
21 the last year or two, we could probably be
22 helpful in that process.

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1 MEMBER REDLICH: You know, I think
2 tomorrow the question of mixed exposures for
3 outcome COPD hopefully we'll get back to.

4 CHAIR MARKOWITZ: Sure, we will, yes.
5 Do you have anything else?

6 MR. VANCE: That's it unless there are
7 any other questions.

8 CHAIR MARKOWITZ: Dr. Silver?

9 MEMBER SILVER: Someone asked me
10 recently have I read the updated procedures
11 manual. And my --

12 MR. VANCE: And, you said, absolutely
13 it's the best read I've had in a while. It's
14 almost Stephen King level quality.

15 MEMBER SILVER: Well, my first thought
16 was what do I say to students who are assigned a
17 700-plus page textbook in one of their other
18 courses and that is, contact the publisher and
19 see if there's a workbook that goes along with it
20 so that you can take your mind off the broad
21 generalities and apply them to realistic problems
22 and cases.

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1 You mentioned that you have training
2 materials. To what extent are your training
3 materials approaching a workbook?

4 I mean, I could sit down and read the
5 tax code in the CFR, but without those boldfaced
6 examples that the IRS puts in their tax
7 publications regarding, you know, realistic
8 families and people, I wouldn't learn anything.

9 MR. VANCE: Well, I mean, you know, I
10 hope that the procedure manual is written in a
11 way that conveys information that allows our
12 claims examiners to know exactly what they're
13 role and function evaluating evidence is.

14 I also would say that we write the
15 procedure manual in a way that tries to promote
16 the culture that we want to convey to not only
17 our staff, but to the public, which is that we
18 are actively engaged in trying to find ways
19 through this very complicated process.

20 And, as, you know, to the greatest
21 advantage of our claimants and that we really do
22 apply a lot of different resources and tools to

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1 making sure that our process gives every possible
2 favorable consideration to a claim.

3 It's not something that is easy, and
4 that's why you guys are asked and tasked to help
5 us with that process.

6 We are dealing with some very
7 challenging and difficult epidemiological issues,
8 medical issues, medical health science issues.
9 And the procedure manual is designed to try to
10 give a framework about how claims examiners do
11 their job and I know it's very challenging and
12 complicated.

13 But, often times, we also will find
14 reasons why we don't want to include very
15 specific guidance because we want to leave it to
16 the circumstances of case and the judgment of
17 that examiner in looking at all of the different
18 information in there and making as well of an
19 informed decision as they can based on the
20 specifics of that individual case.

21 CHAIR MARKOWITZ: I would just say
22 that you should -- to the board members, you

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1 should definitely read parts of the manual
2 because that's where the rubber meets the road.

3 Chapter 15, 16 and 18, they're not
4 that long. They're infinitely easier than many
5 things you've read in your lifetime. And they're
6 very informative.

7 And so, if you think that, okay, I'll
8 never get through a 700-page document, just focus
9 in on those chapters because they really address
10 the issues that we care about.

11 MR. VANCE: And I would pay particular
12 attention to Exhibit 15-4, that is our exhibit
13 that talks to the presumptive standards that
14 exist under the program.

15 It's pretty comprehensive. We used to
16 have that fragmented all over the place and we
17 consolidated that on one place. And so that's
18 our one really important resource that we are
19 constantly looking to improve and add to.

20 CHAIR MARKOWITZ: By the way, in that
21 15-4, the only presumption for COPD relates to
22 asbestos, is that right?

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1 MR. VANCE: Yes.

2 CHAIR MARKOWITZ: Okay, thank you.

3 Dr. Dement?

4 MEMBER DEMENT: Just another comment
5 on COPD, there's a direct disease link in there
6 for COPD and it goes over, if you look at it, it
7 has cement dust, coal dust, coke oven divisions,
8 welding fumes --

9 MR. VANCE: Right. Yes, and so, okay,
10 so just to make sure everybody understands what
11 that exhibit is talking about, that exhibit is
12 basically saying that the program has made a
13 determination that if you satisfy those criteria,
14 okay, there are exposure presumptions, but
15 there's also causation presumptions.

16 And I'm talking about causation
17 presumptions. So, in other words, if you meet
18 specific exposure, latency and medical diagnosis
19 criteria, the program is basically saying, then
20 we are accepting that it is at least as likely as
21 not that that exposure was a significant factor
22 in causing, contributing or aggravating that

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1 disease. Okay?

2 Simply because you don't satisfy one
3 of those presumptions does not mean we deny your
4 case. That means that the case goes through the
5 normal adjudicatory process. And we have a lot
6 of information available about known toxins that
7 have a COPD health effect.

8 And so, when I talk a little bit about
9 the site exposure matrices tomorrow, you'll see
10 our assembly of all of the known toxic chemicals
11 that are known to be a health effect for COPD.

12 And then, that plays into the
13 causation analysis and looking at, you know, a
14 physician having to make a judgment as to whether
15 or not the level and extent or exposure as
16 established by the program and evaluated by
17 industrial hygienists is enough to meet that
18 compensable threshold under Part A.

19 CHAIR MARKOWITZ: Dr. Redlich?

20 MEMBER REDLICH: I think that -- I
21 think this point was made before and I just -- I
22 have been reading the different versions of the

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1 procedure manual, in particular, the now Chapter
2 18.

3 And, I realize that you feel that you
4 have experts reviewing the terminology, but my
5 last read of it before this meeting last night,
6 it was still inconsistencies and things that I
7 would say were just medically --

8 MR. VANCE: Right.

9 MEMBER REDLICH: -- inaccurate.

10 And, if you actually go back to the
11 original wording of the congressional act, it
12 doesn't start getting into mediastinal lymph
13 nodes.

14 And, some -- almost feel that in each
15 version sometimes gets more convoluted and
16 complicated than a prior one. And, I -- you
17 know, we have offered our expertise I think just
18 to really be accurate.

19 I still found, yes, there were changes
20 to include, I mean, the lymph node, but whoever
21 edited it really didn't have the understanding
22 fully of I think some of the subtleties in ways

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1 that could actually be worded in a simpler,
2 clearer way that I don't think would not be, you
3 know, opening the doors for every disease but,
4 just sort of internal consistencies.

5 MR. VANCE: I, you know, I'll say two
6 things to that. Okay?

7 The -- as the chief person who looks
8 at all of this stuff coming through this process
9 of drafting and editing and publishing, two
10 things stand out.

11 One, we get input from a lot of
12 different sources, a lot of different physicians
13 over the course of this program. We've had lots
14 of people providing us input.

15 You're now looking at it, you're not
16 the same person that gave us that input.

17 MEMBER REDLICH: And, I realize -- I
18 know I'm not and I know --

19 MR. VANCE: And so --

20 MEMBER REDLICH: -- some people --

21 MR. VANCE: Right. So, you know, my
22 advice and my biggest recommendation for anybody

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1 working on this kind of stuff is specificity.
2 Okay?

3 If you were looking at our procedure
4 manual and you're saying, I don't like that,
5 saying to me, I don't like it, you know, okay,
6 what is it specifically that you think is
7 inappropriate and what would you specifically
8 recommend as a change?

9 You know, specificity is the key thing
10 for our procedure manual.

11 MEMBER REDLICH: Okay, well, you know,
12 I would be happy to spend the time to do that if
13 I felt that it would -- there was a reasonable
14 chance that it would be incorporated or, if it
15 wasn't incorporated that there was just a good
16 reason for that reason.

17 MR. VANCE: Okay, that --

18 MS. LEITON: So, we do -- we looked at
19 the main -- you did provide us very specific
20 information, some of it we took, some of it we
21 didn't.

22 The review process goes through a lot

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1 of different layers. We don't always end up
2 taking exactly what you said word for word.

3 Going back and forth to determine
4 whether the words we used was the words you would
5 have chosen to use, that's not going to be useful
6 time.

7 So, we do have a process. We go
8 through that process, it goes through legal, it
9 goes through our medical director, it goes
10 through a lot of other various administrative
11 functions that need to be -- to be undertaken for
12 our procedure manual chapter to get published.

13 We're not going to be able to go back
14 and forth about why did or did not change a
15 specific thing in our procedure manual. We'll
16 take what we can, we'll incorporate what we can
17 and then we'll publish it based on the guidance
18 and the process that we have and that's as far as
19 we go with it.

20 MEMBER REDLICH: Yes, I understand and
21 I don't want to micromanage, but I think you also
22 just want to be medically accurate.

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1 MS. LEITON: I believe that the
2 process that we have, we are -- I mean, we do
3 have medical people reviewing them. You know,
4 we've had experts, as John indicated, on CBD help
5 us with this.

6 You know, at the end of the day, we
7 can become more vague and then the doctors can
8 tell us. That's our options there. So --

9 CHAIR MARKOWITZ: Okay, thank you very
10 much, Mr. Vance.

11 Let's move on. Ms. Leiton's on again,
12 program updates over the last 12 months or so.

13 Hold on, it's been raised whether we
14 should take our break now. Do people want to
15 take their break now?

16 Okay, we'll go on break, let's -- 3:00
17 we'll resume.

18 (Whereupon, the above-entitled matter
19 went off the record at 2:49 p.m. and resumed at
20 3:10 p.m.)

21 CHAIR MARKOWITZ: We're going to get
22 started. At 4:30 -- a couple minutes before 4:30

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1 actually, we're going to stop because we need our
2 public comments. So, we are going to stick to
3 the schedule here.

4 Well, we're doing well so far, I think
5 we're up to Ms. Leiton to provide program updates
6 over the past 12 months.

7 Thank you.

8 MS. LEITON: Sure.

9 Okay, I'm going to just talk in
10 general about some of the things we've been up
11 to, what we've done policy wise, organizational
12 wise, just in general, not all of these things
13 are going to be specifically related to your
14 tasks, but just so you're aware of some of the
15 things that we're doing.

16 So, one of the main things that we've
17 done in the last year is we've reorganized our
18 national office. John told you a little bit
19 about his branch. His branch used to also
20 include a unit of medical bill processing, a
21 little bit of program integrity.

22 And, what we've done is we've created

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1 a new branch in national office, that is the
2 branch of medical -- the medical branch
3 basically.

4 And, what that consists of is, we're
5 looking -- we've hired people, mostly claims
6 examiners, from taking them away from doing just
7 claims examiners -- their main duties of claims
8 examining, we've created medical benefits
9 examiners.

10 The reason we've done this is we've
11 had a lot of -- an increase as we have an elderly
12 population, we have more and more requests for
13 additional medical equipment, but also
14 specifically home healthcare.

15 And, that increase, it has been kind
16 of overwhelming and taken over in the past couple
17 of years some of the focus on adjudicating claims
18 by claims examiners to now we have a whole other
19 process to adjudicate.

20 So, we've centralized the medical bill
21 processing into one unit, one branch. We've got
22 a unit full of medical benefits examiners. Their

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1 primary focus is to look at ongoing requests for
2 medical care, not typical like if we've got --
3 you know, if we've accepted a condition, we're
4 going to pay for normal, typical treatment of
5 that condition through our treatment suites,
6 through our medical bill processing. But we do
7 require pre-approval for certain things.

8 And so, they're looking specifically
9 at the influx of home healthcare requests that
10 we've received, making sure that we're being
11 consistent in the way that we adjudicate those
12 claims, making sure that we're following up
13 appropriately, that we're doing it timely and
14 that we're doing it accurately and to the benefit
15 of the claimants, ultimately, hopefully, in that
16 when you centralize something like that and give
17 that -- we're writing more and more procedures to
18 make sure that the process for doing that is
19 thorough, consistent and focused.

20 So, that kind of relieves claims
21 examiners who are adjudicating claims to do just
22 that. So that's one thing -- one of the units.

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1 We've got a unit focused on medical
2 bills, assisting with ensuring that the payments
3 are going through, working with the contractor
4 for our medical bills to ensure that the changes
5 or any changes that need to be made that are
6 specific to our program are made, troubleshooting
7 any problems with medical bills.

8 We've had that for some time along
9 with a fiscal section that deals with general
10 payment issues and overpay, things like that.

11 And then we have a program integrity
12 unit. That unit is focused on -- they do some
13 audits of medical bills, make sure they're being
14 submitted properly, paid properly and just
15 looking at overall accuracy and integrity of the
16 way that whole process, whether it's home
17 healthcare or it's other medical bills or
18 whatever it is that they're taking a look at
19 those issues.

20 This is something that is also being
21 done in the federal employees compensation
22 program. They've got medical benefits examiners

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1 that are more focused on that was well due
2 primarily to opioids and that whole issue that's
3 going on in the medical community.

4 So, we do have a new branch chief of
5 that unit, Toni Eason. And then we have branch
6 supervisors for the different units in that
7 branch.

8 So, I think it's going to be a good
9 change. It's, again, we've developed a backlog
10 of some home healthcare requests that we've been
11 able to get through and now we're, you know,
12 streamlining processes.

13 The other thing that we've done this
14 last year is we have centralized our assignment
15 process for our final adjudication branch.

16 In the past, we had -- we've had --
17 and we've developed this from the very beginning.

18 We've had units of FAB examiners and hearing
19 representatives in -- co-located in each of our
20 district offices.

21 We still have those units but the
22 process was a certain percentage of cases that

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1 came out of the district office, say, in
2 Jacksonville would go to that Jacksonville unit,
3 a certain percentage in the Denver would go to
4 Denver, certain percentage in Cleveland, et
5 cetera.

6 As our caseloads in the various
7 regions changes, getting fewer cases in some
8 areas than other areas, it has made sense for us
9 to change the assignment process from a regional-
10 centric assignment process to a centralized
11 assignment process.

12 It also provides more variety for
13 different hearing reps to look at different cases
14 throughout the country instead of just hearing
15 reps in Jacksonville looking at just Jacksonville
16 types of cases.

17 You're going to find perspectives
18 around the country.

19 We've undertaken an extensive training
20 process because one of the reasons we originally
21 did this was there are very specific site
22 interests. There are certain verification

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1 processes that occur at Hanford or Santa Susana
2 that are going to be different from those that
3 are out in Paducah or Oak Ridge.

4 So, we've developed guides for the
5 hearing reps to follow specific information about
6 facilities. We're still in the process of doing
7 that.

8 We've got PoCs in each of our FAB
9 offices that used to be focused on those types of
10 facilities to provide information to the other
11 hearing representatives.

12 But, it will allow us to assign cases
13 more equally, more transparently and have a
14 variety of larger pool of hearing representatives
15 to look at different types of cases throughout
16 the country.

17 And, ultimately, you know, in hiring,
18 we can hire wherever we need to.

19 We have had a national office FAB
20 since the beginning that has looked at all of the
21 different types of cases and that's here in D.C.
22 They're not co-located with any district office.

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1 So, this has been done and it has
2 continually been done but now it's just being
3 done nationwide.

4 I think some of the feedback we've
5 received regarding hearings and scheduling of
6 hearings this last year is a result of this
7 centralization process because we're -- they're
8 still getting used to going from Seattle to, say,
9 Paducah for a hearing instead of just to Hanford
10 to do a hearing.

11 And so, we're working through the
12 logistics of that now, but I think ultimately
13 having this ability to disburse the cases to a
14 wider set of hearing representatives is going to
15 be beneficial to the program and, as I said, the
16 assignment process will be a little bit more -- a
17 little smoother and transparent.

18 We've done a lot of work on outreach
19 in the last year. We have -- well, we started
20 with authorized representative workshops.

21 Denise Brock, who works for NIOSH,
22 she's their Ombudsman, she'd done a couple of

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1 these in the past and they were very small group
2 presentations.

3 Instead of an outreach event where we
4 just provide an hour-long presentation or we work
5 with the joint outreach task force group to do,
6 you know, a couple of different outreach
7 presentations in a day, we're trying to go around
8 the country and do two- to three-day workshops
9 where --

10 And, we are, first, focusing on
11 authorized representatives since sometimes you'll
12 have an authorized representative that will
13 represent multiple people to learn about the
14 process.

15 So, we worked with the joint outreach
16 task force group which consists of Department of
17 Energy employees, former worker program and
18 NIOSH, the Ombudsman for our office, for DOL and
19 then the Ombudsman for NIOSH are all involved in
20 the JOTG.

21 And, we've worked together with them
22 to create these workshops where they'll -- each

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1 of -- each component will provide a presentation
2 on the first day about their roles, what they do,
3 what their resources are.

4 And then, we'll have a more detailed
5 instruction by section. So, for example, we'll
6 have a supervisor provide information about
7 specifically how to file impairment, what that
8 consists of and we'll do for -- we've done it for
9 impairment, wage loss, survivorship.

10 We've got a records, a tool -- a
11 session on how to look for information on our
12 website. We've got a session on specifically
13 hands on session on how to use the SEM, what it
14 looks like, what it means.

15 Stu Hinnefeld from NIOSH has done an
16 hour-long presentation on the dose reconstruction
17 process.

18 And so, we're trying to do them in
19 different areas around the country. We've done
20 three in the last year in Jacksonville,
21 Kennewick, Washington and Cincinnati. And we're
22 looking to probably go another -- maybe out west

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1 in the spring, see how that works.

2 We just feel like if we could -- and
3 it's really 20 to 30 people and it's a little bit
4 more hands on, a little bit more discussions
5 rather than us kind of speaking out at people.

6 Not that we've stopped general
7 outreach. We've done other events, 15 over the
8 year between 17 and 19 about SEC classes, a
9 general JOTG event, and then just general
10 information that we've provided.

11 We also do outreach to the medical
12 community, as I indicated, it's a growing part of
13 our program so we try to target providers in
14 various areas to talk about the medical benefits
15 we provide.

16 That's open to anybody, but it can be
17 doctors, providers, claimants, whoever is
18 interested in that particular topic, we get into
19 a lot more detail about those benefits that we
20 provide.

21 CHAIR MARKOWITZ: And who ends up
22 showing up at those?

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1 MS. LEITON: At the provider ones?

2 CHAIR MARKOWITZ: Right.

3 MS. LEITON: Well, we get various
4 different groups. I mean, we don't get that many
5 physicians because oftentimes they're not going
6 to go to those themselves.

7 But we will have home healthcare
8 companies that will come and listen. Sometimes
9 we'll have administrators for physicians' offices
10 go. And claimants, we still get claimants who
11 are interested to find out what their benefits
12 really are.

13 The authorized representative
14 workshops, they -- you know, we're still -- it's
15 a work in progress. We're still trying to figure
16 out the best way to do that, the best way to
17 reach out to people to do those.

18 Director Hearthway did a stakeholder
19 meeting this year in D.C. this last month to try
20 to reach out to any -- it was open to anybody who
21 could come to D.C. and she did a presentation
22 talking about her mission and her, you know,

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1 direction for the programs.

2 And then, we had individual
3 presentations from myself and John Vance and Toni
4 Eason and our outreach person, Josh Novak, to
5 provide more information about those particular
6 branches.

7 So, that -- those have been our
8 ongoing outreach.

9 Oh, we also have done -- we started
10 email blasts to providers. It's actually to
11 anybody, but they're email blasts specific to
12 medical benefits and particular topics.

13 We've got a lot of subscribers, or
14 hundreds of subscribers to that at this point.
15 And, it's just blasts. If you submit your email,
16 we'll send you information from our medical.

17 We're starting to do that just this
18 year for policies. So, if we have new policy
19 that's out there, we can send email blasts to
20 people who subscribe to give them an update on
21 what new policy is out there, whether there's a
22 new bulletin or circular or whether it's just a

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1 general something that's bigger that we need to -
2 - we'd like to get the word out about.

3 We also hold quarterly conference
4 calls at our -- they're for, again, for medical
5 providers but they're -- and this we do get, if
6 not -- sometimes we get physicians on these
7 calls, sometimes we get nurses from the
8 physicians' offices.

9 But, we'll send out information about
10 the types of -- we'll have a series of questions
11 or a topic that we'll look at, like one of them
12 was conflict of interest in home healthcare, one
13 was about the bulletin for rehabilitation therapy
14 services, one was about ancillary medical
15 services, tips on how to submit prior
16 authorization.

17 So, we'll have these on a quarterly
18 basis as well. They're just phone calls people
19 can call in for.

20 In addition, we've had the electronic
21 document portal out for quite some time, but
22 we've seen a tremendous increase in the use of

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1 that which shows us that the internet is being
2 used more than it was originally.

3 People are looking at the internet
4 more. There's just been -- people are realizing
5 that they -- instead of using mail, they can
6 upload their documents directly into their case
7 file and it'll go directly to the claims examiner
8 for immediate action.

9 And, I've seen that be really
10 beneficial.

11 We've talked about in the past to this
12 Board and we're continuing to work on additional
13 access for claimants specifically to have direct
14 access to their case file and it's a lot more
15 complicated than it seems.

16 Unfortunately, there's levels of
17 privacy, verification of who you are and those
18 sorts of things that really need to go on before
19 we can get that access.

20 I know it's something that has been
21 looked at in our other OWCP programs to get some
22 sort of an access direct to the case file so that

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1 they don't have to ask for paper copies or get
2 them on discs and sent to them.

3 So, that's something we're working on,
4 we're not quite there yet.

5 CHAIR MARKOWITZ: So, what -- I know
6 we discussed this in terms of one of our
7 recommendations and it seemed like it wasn't just
8 EEOICPA, but it was an overall effort.

9 MS. LEITON: Yes.

10 CHAIR MARKOWITZ: Are any of the other
11 compensation programs a little bit further along
12 that the EEOICPA is -- can tag along or --

13 MS. LEITON: Well, we're working with
14 them directly. So, as soon as one of us gets
15 there, we're going to try to --

16 CHAIR MARKOWITZ: When Doug gets
17 there?

18 MS. LEITON: Doug might be able to
19 answer that question.

20 MR. FITZGERALD: I can -- I think I
21 can shed a little light on that.

22 I think that the FECA program, because

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1 it's a closed system, it's a lot easier to manage
2 the personal information easier and know who the
3 users are.

4 For any entities that, and within
5 OWCP, that have external parties involved, you
6 have to make sure that the people are who they
7 are -- who they say they are and that that person
8 actually should have access to the information.

9 So, maintaining that data is very
10 complex when you start going outside of a closed
11 system. So, that's the biggest impediment for
12 where I think the other three programs are in
13 FECA right now.

14 MS. LEITON: Because federal
15 employees, so it makes it a lot easier.

16 CHAIR MARKOWITZ: So, is there any
17 sort of rough time table for success?

18 MS. LEITON: I don't want to give you
19 any promises here. I hope in the next couple of
20 years.

21 The site exposure matrices are
22 continually updated. There have been 15

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1 revisions to the SEM website since March of 2010
2 that we'll talk more about tomorrow, but we've
3 talked about already.

4 We're continuing to do accountability
5 reviews. We -- the results of the last year's
6 reviews, we do them for the district offices. We
7 do them in the final adjudication branch.
8 They've done pretty well in the quality of the
9 cases, the decisions we've reviewed.

10 We have various topics we look at from
11 the quality of the written decision, whether it's
12 a recommended decision or a final decision, to
13 the development process, to the referrals that
14 are being made.

15 Those sorts of things are looked at.
16 I do think there's always room for improvement
17 when you're auditing yourself because, you know,
18 sometimes it's a training issue, but sometimes
19 it's not. And, oftentimes, the fallback is,
20 well, we'll train them more.

21 Sometimes it's just there's a
22 particular person in a unit that's, you know,

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1 that needs to have additional training.

2 And so, we're trying to find ways to
3 enhance or improve that so that we can get to
4 really where any problems might be and how we can
5 address them.

6 We did -- we had a lead training
7 analyst who left at the beginning of last year.
8 And so, we had a lot of plans for enhancing our
9 training which came to a halt and then we had
10 hiring, you know. It's always -- hiring freezes
11 and hiring issues to get new people.

12 But, we did hire a new training
13 analyst who's being tasked with trying to do more
14 -- well, first of all, update current training to
15 make it consistent with our new procedures, our
16 procedure manual.

17 Second of all, to try when there's new
18 procedures to come out to provide a training to
19 go along with it, whether it's a very specific
20 topic or it's a very specific issue that requires
21 a little bit more in-depth discussion, that's
22 where we're trying to focus.

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1 And, I think one of the areas right
2 now that our training lead is working on is the
3 actual presumption changes that we're making as a
4 result of the recommendations from the Board.

5 We are going to -- we've developed a
6 list of cases to be reviewed. We're going to
7 walk them through the best way to review them for
8 these causation analyses that need to be done.

9 And I think that's going to -- it's a
10 big project because, you know, going back and
11 looking at cases that are already adjudicated can
12 take away time from doing incoming cases. But,
13 we're going to work it into the workload, work it
14 into the current process.

15 And so, I think training, we're going
16 to try to build it up more and more as we go
17 forward.

18 Dr. Silver mentioned the procedure
19 manual and one of the -- it's one of the things
20 that we hear about and that it's -- there's a lot
21 of information, claimants and others who are
22 trying to -- they can access -- we've made it

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1 searchable which is helpful.

2 There are, you know, now you can go to
3 a chapter and you can click on the link and it'll
4 take you to the chapter.

5 There are some improvements we've
6 made, but we're working on our website to make it
7 so that it's process-driven.

8 So, for example, if you want to file a
9 claim, you can go to this section, it'll tell you
10 here the forms you're going to need to do that.

11 If you want to do impairment, here's
12 what you, you know, you're going to need. It'll
13 take you to that resource by section.

14 While the procedure manual does that,
15 it's not as easy to navigate. And so, we're
16 trying to come up with a website on our website
17 that will help with that.

18 And that I do hope will be done within
19 this year in the next couple of quarters.

20 Those are the things we've done in the
21 last year that really are the big-ticket items.
22 We continually are looking at our procedure

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1 manual to try to make updates as well.

2 And, there's just -- there's, you
3 know, we do look at what we've -- we try to do
4 and what we've been doing more and more is look
5 at the ombudsman reports and for, you know,
6 issues that have been identified.

7 One of them, of course, that is always
8 recurring is that we're not reaching enough
9 people, so that's why we've been trying to be
10 more robust in our outreach.

11 It's difficult because we don't have
12 lists of current employees; we have lists of
13 current claimants.

14 And so, that's why we're able to work
15 with DOE and the joint outreach task force group
16 to reach some of those people that aren't being
17 reached. They have some lists of former worker
18 programs that we can't take anybody else's lists,
19 that's part of the problem because of the Privacy
20 Act.

21 We can only ask them to help us by
22 mailing things out and getting the word out about

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1 the program.

2 We're trying to do more advertisements
3 as resources allow, more targeted, like, fliers
4 and getting the word out about events.

5 We have one this week I believe it's
6 in Lynchburg maybe where we've done a lot of
7 advertising and kind of trying to get the word
8 out where we can and we'll see how that works
9 out.

10 But, there's also the training issue.

11 Some of these -- whatever comes up, whether it's
12 an ombudsman report or stakeholder meetings or,
13 you know, board meetings, we try to -- we're
14 trying to look at those to see what we can do
15 better.

16 And that's kind of where we are.

17 CHAIR MARKOWITZ: Thank you. Any
18 comments or questions?

19 (No response)

20 CHAIR MARKOWITZ: Okay, great, thanks.

21 I think we're in for a return
22 performance from Mr. Vance.

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1 MS. LEITON: We're both going to stay
2 up here for this one.

3 CHAIR MARKOWITZ: Oh, okay.

4 MR. VANCE: Yes, this is the really
5 fun stuff.

6 CHAIR MARKOWITZ: Uh-oh. For you
7 maybe, John.

8 MS. LEITON: Not really.

9 MR. VANCE: All right, so, we're
10 moving on to some suggestions that the program
11 has with regard to specific areas of needed
12 attention.

13 And we, just to give a little bit of
14 background, so, you know, with my discussion
15 about the policy analysts and the medical science
16 unit, we're privy to lots of issues that come up
17 from case adjudication activities.

18 And so, you know, we made an effort to
19 try to identify areas where we have struggled and
20 identify areas where we really could use some
21 medical health science expertise, epidemiological
22 expertise, medical health science expertise in

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1 evaluating certain topics and subjects.

2 And, I canvassed my staff and I was
3 looking for areas where we really had some
4 issues. And, I was looking for things that would
5 have a direct positive effect if we had better or
6 more clear guidance as to how to apply processes
7 to the evaluations of certain types of cases or
8 certain areas where we could really use some
9 assistance and helping affect positive change for
10 claims, claims that we see, things that we see
11 fairly frequently.

12 And so, I think the Board has been
13 presented with a set of four areas where we have
14 identified a need for assistance.

15 And, the first one is on one that has
16 been around for a long time and it may have been
17 part of the original batch of issues that we had
18 submitted for Board consideration which is this
19 very challenging issue of Parkinson's disease and
20 its association with chemical exposures.

21 And, we have encountered a lot of
22 cases where we are presented with claims for a

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1 variety of problems regarding the interchange
2 between Parkinson's disease, Parkinsonism,
3 manganism and other forms and various types of
4 aliases being utilized by physicians.

5 I've seen Parkinson's syndrome and all
6 these sorts of things.

7 We have created, and it's been out
8 there for quite a while in our presumptive
9 Exhibit 15-4, a presumption relating to
10 Parkinsonism where we're talking about what we
11 had done in the past with looking at exposure
12 criteria, you know, the type of toxins associated
13 with the development of Parkinsonism or
14 Parkinson's disease.

15 And, you know, some of the work
16 processes that are associated with this.

17 This is felt by my team to be woefully
18 out of date and in need of revision. There has
19 been additional epidemiological information that
20 has arisen from this.

21 There is ongoing debates about how to
22 define or categorize this type of disease

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1 process. In other words, is it proper to say
2 that somebody with a true blue diagnosis of
3 Parkinson's disease, is that an occupational
4 disease or is that something that should be
5 reclassified or recharacterized as some sort of
6 occupational disease process such as manganism
7 where you have a direct connection to manganese
8 and then that's what's really the causal factor
9 in the development of that.

10 So, it has presented itself in lots of
11 different ways and we think that our guidance is
12 just out of date and it needs to be looked at and
13 evaluated, particularly with regard to diagnoses.

14 You know, what is the proper diagnosis
15 for an occupational type of Parkinson's syndrome
16 or disease? What are the appropriate aliases?
17 Are we looking at Parkinson's disease as its own
18 entity or should we be separating these out?

19 Manganism is something unique,
20 Parkinsonism, Parkinson's disease is something
21 separate.

22 What are the appropriate linkages,

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1 health effect between particular exposures to
2 specific toxins and the development of these
3 categorizations of Parkinson's disease or any of
4 its associated syndromes?

5 And any, of course, presumptions that
6 we could apply. Our existing presumption has,
7 and I'm not going to spend a lot of time going
8 through the existing presumption, but it does go
9 through a relatively linear set of things that
10 we've done to try to apply a presumptive
11 standard.

12 According to my folks, this is a very
13 challenging area and the epidemiological
14 literature in this area is all over the place.

15 And so, it's -- it would be very
16 helpful for any kind of I think framing of this
17 or some guidance that we could use to apply in a
18 process to generalize from one case to the next.

19 And, when we're presented with claims
20 for this disparate type of stuff associated with
21 these types of conditions.

22 Any questions?

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1 CHAIR MARKOWITZ: Sure. Any sense of
2 how many claims you get per year over the last
3 few years for this spectrum --

4 MR. VANCE: We do --

5 CHAIR MARKOWITZ: -- and how many are
6 accepted or denied?

7 MR. VANCE: I think that we -- when I
8 -- we didn't do a specific statistical analysis
9 and I think we can get that information.

10 MS. LEITON: If we've done it for
11 other Boards.

12 CHAIR MARKOWITZ: So, Carrie, that's
13 on the request list.

14 MR. VANCE: So, this was -- this is
15 the issues that my staff identified as things
16 that they have encountered and they have
17 struggled with.

18 My personal view is that most of these
19 do get through a process where we end up
20 accepting it because it's just so challenging and
21 our process lays out a pretty -- it's a process
22 by which we can, you know, make a presumptive

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1 determination in the case and most physicians
2 understand that, but we don't know whether our --
3 the evolution of science is complying with how we
4 present it.

5 So, and there are challenges when we
6 ask physicians to try to get them to understand
7 their application of the diagnoses and applying
8 it in our process. It's just a challenge for
9 physicians to understand all of this when you're
10 dealing with someone who has a trembling type
11 disease.

12 Are we talking about manganism? Are
13 we talking about Parkinsonism? Are we talking
14 about Parkinson's disease? And what is the
15 association with an occupational exposure or
16 toxin?

17 It's just a very big challenge. And,
18 I think that we've generally -- I think that my
19 view is that we generally accept a lot of these
20 cases but we don't know whether that, you know,
21 whether we should be adjusting our process in any
22 way or making it easier or more difficult or what

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1 based on the current epidemiological literature
2 of medical health science.

3 Other questions?

4 CHAIR MARKOWITZ: Not now, I mean,
5 we're going to turn to these requests tomorrow
6 when we've figured out our agenda. But go ahead.

7 MR. VANCE: Great.

8 Second area of assistance or a
9 suggestion was the re-drafting and editing of the
10 occupational history questionnaire.

11 So, this was a topic that actually the
12 Board had made recommendations on the in the
13 past, but the feedback was viewed as being overly
14 broad and we were hoping for a more encapsulated
15 set of recommendations as far as taking our
16 existing draft occupational history questionnaire
17 and giving specific feedback as far as what
18 changes to that specific draft you would
19 recommend.

20 There was some conversation and input
21 from the Board with regard to assimilating
22 features of the former worker screening program.

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1 That was felt to be very broad, so we're hoping
2 for specific recommendations about what you
3 specifically change in our existing draft.

4 MS. LEITON: Now, I know this has been
5 something that you guys have worked on and have
6 addressed to a certain extent.

7 I think we, you know, we've got such
8 different types -- we've got construction workers
9 and then we've got these other types of workers.

10 And, I don't know if it's something
11 where we should modify it depending on what type
12 of work they're in and have a certain set of
13 questions, what those questions might be.

14 If there is specifics that we could
15 really work with to give to our resource centers
16 and say, these are the types of questions, you
17 know.

18 We don't want to be just -- we don't
19 want to give them a list like we have or we do
20 sometimes of here's these chemicals or substances
21 you might have been exposed to, pick them.

22 But, at the same time, you know, is

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1 there a specific question that'll get them to,
2 this was the work process I was involved with or
3 this is what -- we can lead them to giving us
4 information that will help us get the information
5 we need for toxic substance evaluation.

6 And, just as specific as we can be on
7 that, we have -- we do have a lot of leeway on
8 this one. We just want to make sure, if we need
9 to tailor it more, if we need to do something
10 more specific with it or we can --

11 It's hard to generalize an OHQ, as you
12 know. So, maybe we need to think of different
13 ways to do it, depending on what they're claiming
14 or where they worked or, I don't know.

15 But, those are the kinds of things
16 we're kind of grappling with.

17 CHAIR MARKOWITZ: So right now, you
18 have a draft of a revised questionnaire?

19 MS. LEITON: Mm-hmm.

20 CHAIR MARKOWITZ: So, can we get paper
21 copies of that we can look at by --

22 MS. LEITON: Absolutely.

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1 CHAIR MARKOWITZ: -- mid-tomorrow
2 morning so that we can discuss it and figure out
3 what --

4 MS. LEITON: We have it.

5 CHAIR MARKOWITZ: -- we can do?

6 MS. LEITON: We can get it to Carrie
7 tonight or tomorrow. Tomorrow.

8 CHAIR MARKOWITZ: Okay, thank you.
9 Any comments on this issue?

10 (No response)

11 MR. VANCE: All right, and a third was
12 a recommendation or a seeking for assistance with
13 regard to the radiogenic substances that we often
14 encounter at DOE facilities.

15 We see a lot of, you know, these were
16 atomic weapon production facilities where there
17 was uranium, plutonium and lots of other
18 different types of radiological sources.

19 We have a dose reconstruction process
20 in place and our special exposure cohort analysis
21 process for evaluating radiation as a health
22 effect from those exposures.

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1 But, we have very little information
2 about non-radiogenic health effects. So, in
3 other words, what are the health effects of
4 exposure to those toxins that are not radiogenic
5 in nature?

6 And, the example is we do link uranium
7 with acute tubular necrosis.

8 So, this is something that I think our
9 SEM team was looking for input on. Are there
10 other types of non-cancer conditions that can be
11 associated with radiogenic sources?

12 CHAIR MARKOWITZ: So, you mean sort of
13 the chemical health effects of the --

14 MR. VANCE: Exactly. Yes, struggling
15 to try to figure out how to say it, but yes,
16 basically, you know, what we could do to look at
17 those types of things and link them to other
18 types of medical conditions aside from cancer.

19 Questions?

20 (No response)

21 MR. VANCE: And the reason that's sort
22 of a critical one, just by the way, is that we,

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1 you know, this is a very common set of exposures
2 that people are going to be encountering at these
3 sites where there was production of these atomic
4 weapons, so something you would assume there's a
5 lot of exposure to some mix of workers.

6 CHAIR MARKOWITZ: So, I do have a
7 question I guess, uranium, acute tubular
8 necrosis, how have you previous or dealt with
9 this issue, aside from that connection?

10 MR. VANCE: Well, I mean, once we
11 have, you know, we can talk a little bit more
12 about it tomorrow when we talk about the site
13 exposure matrices.

14 But, you know, once we have an
15 established health effect, we're able to sort of
16 filter and create the framework for which we can
17 then have a physician evaluate that claim for
18 causation.

19 So, if you're looking for, you know,
20 we're looking for the relationship between an
21 exposure to a particular toxin that has the
22 potential to cause disease. We have to profile

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1 that and then get a physician to evaluate that
2 claim and make a judgment of causation.

3 MS. LEITON: But, up to this point,
4 which I think you're asking, we have -- it's been
5 scarce because we just don't have enough
6 information.

7 So, some of those will probably be
8 denied because we don't have information.

9 MR. VANCE: Any other questions?

10 CHAIR MARKOWITZ: Dr. Silver?

11 MEMBER SILVER: Not to complicate
12 things, but it seems like it's somewhat related
13 to another issue which is the non-cancer effects
14 of radiation exposures.

15 MR. VANCE: Yes, I mean that's
16 basically what we're saying is that, you know,
17 the effects of being exposed to uranium other
18 than --

19 MS. LEITON: Yes, that's what Dr.
20 Andrews --

21 MEMBER SILVER: All right, so, let's
22 get clear about this. It's not just the chemical

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1 toxicity of radionuclides; it's non-cancer health
2 effects of radiation exposure.

3 So, it's been a while since I've read
4 the NIOSH regs, but I imagine non-malignant
5 thyroid disease?

6 MS. LEITON: There are a lot of things
7 that radiation caused, but that's -- I'm sorry.

8 Yes, it is non-cancer. Because the
9 cancer ones, we know what we have to do with
10 those. We're required to do those.

11 We have to go to NIOSH for cancer or
12 radiation exposure.

13 It's the ones where we don't have
14 cancer and we don't go through the NIOSH process.
15 But, it is radiation. And so, it's how we handle
16 those particular types of conditions.

17 MR. VANCE: Radiogenic sources.

18 MS. LEITON: Yes.

19 MEMBER CASSANO: So, you want us
20 looking at both then? Both the chemical
21 consequences and the non-carcinogenic effects of
22 radiation?

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1 MS. LEITON: Yes.

2 MR. VANCE: Yes, thank you.

3 CHAIR MARKOWITZ: Any other comments,
4 questions on this issue?

5 (No response)

6 CHAIR MARKOWITZ: Okay.

7 MR. VANCE: The fourth one is a
8 recommendation that came from the SEM team again.

9 So, and I'll demonstrate this a little
10 further tomorrow, but when searching site
11 exposure matrices, we have health effect data
12 relating to specific conditions that basically
13 there is no science associating that particular
14 type of condition with an exposure to a
15 particular toxin.

16 Our site exposure matrices has
17 categorizations of these diseases and one of
18 those things is an alias field.

19 So, in other words, if you are looking
20 at the history of a case and you see that a
21 physician has referenced a particular condition
22 in such a way, we can accept that that is

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1 synonymous with this definition of that
2 particular condition.

3 So, the example in the write-up that
4 we did was for chronic renal failure and some of
5 the aliases are CRF, chronic renal insufficiency,
6 chronic kidney disease unspecified.

7 So this is just an effort to identify
8 in the history of these cases that we see,
9 different terminology that basically is
10 communicating a particular type of diagnosis.

11 So, another example that's pretty
12 familiar for some folks is chronic beryllium
13 disease. A lot of folks refer to that as
14 berylliosis and that's, you know, it's
15 interchangeable. Physicians use those
16 interchangeably, so when our staff are looking at
17 the cases and they see a claim for -- that's
18 referencing either one of those, they know
19 they're dealing with chronic beryllium disease.

20 So, it's just basically a
21 categorization and identification of aliases in
22 the site exposure matrices.

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1 MS. LEITON: Now, I mentioned earlier
2 that that's one of the projects that we have our
3 SEM team working on is looking for aliases.

4 But, it's important in the claims
5 process because, you know, our claims examiners,
6 they have a disease, they go look it up and they
7 see just that disease and nothing, you know, they
8 don't see anything for it.

9 But, if we have an alias for it that
10 says this could also mean this other condition,
11 they might find it there and then they can
12 actually make the links for the exposures that
13 they need to find.

14 CHAIR MARKOWITZ: Mr. Domina?

15 MEMBER DOMINA: Do you see on some of
16 these I guess lack of a better term that from one
17 site to another there might be a cluster of
18 Disease A that you've gone through on a, you
19 know, say, on one of these that you see renal
20 failure, a lot of them coming out of, say,
21 Savannah River, for instance compared to Hanford?

22 So that, do we need to look at maybe

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1 the chemicals or whatever sources or something
2 there? Have you guys broke it down to try and
3 narrow any of those that are just pretty general
4 globally?

5 MS. LEITON: Yes, we don't have -- we
6 haven't been able to do cluster studies or that
7 sort of thing in terms of our current claimant
8 population and where these specifically are
9 coming from.

10 It would require a significant amount
11 of data pull to see where these conditions pop up
12 and what different sites.

13 I mean, it's a project that could be
14 undertaken, but it would just require us to pull
15 a lot of reports and then I don't know that we
16 have the resources, but it's something that we
17 could pull and if you guys wanted to help us look
18 at that, it's something we could think about.

19 MR. VANCE: It's a great research
20 project.

21 MS. LEITON: Yes.

22 MEMBER DOMINA: I guess we won't see

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1 it tomorrow then?

2 (Laughter)

3 MS. LEITON: Not tomorrow.

4 CHAIR MARKOWITZ: So the request on
5 the aliases, synonyms, is only about health
6 effects and you -- the SEM has a lot of these and
7 the request is for us to look -- to review the
8 current aliases and make sure that they're
9 accurate?

10 MR. VANCE: That's correct and then
11 looking as seeing if there are other aliases that
12 we should be applying in some way based on the
13 collective knowledge of the board.

14 MS. LEITON: Yes, I mean, I imagine --
15 I mean, you can look at the various -- obviously,
16 you're not going to look at every single
17 condition that has a health effect in SEM, but,
18 you know, we could tailor it down somehow and
19 look at certain ones. I don't know how you would
20 want to start that project, but we can help you
21 with whatever we can provide.

22 MR. VANCE: And, you know, and then

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1 we, you know, you can always start with the ones
2 that we see the most claims from and that's
3 certainly going to be our pulmonary diseases.

4 So, we have aliases for COPD, and
5 include, like, chronic bronchitis, emphysema and
6 other types of aliases that we use.

7 And so, that's what we're looking for
8 are those appropriate aliases? Are there other
9 aliases that you would apply to that particular
10 classification of disease or that particular
11 disease?

12 CHAIR MARKOWITZ: And, for any given
13 health effect, let's say there's a primary name
14 for it and then you have these aliases, are all
15 of them searchable?

16 MR. VANCE: Yes. And, I'll show
17 everyone tomorrow. You can do an alias search,
18 you can do keyword searches in the site exposure
19 matrices, and that's what you have to put your
20 mind into the head of the examiner when they're
21 sitting down and dealing with this. They're
22 going to be seeing all kinds of things in these

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1 cases starting in as early as 1942.

2 And so, physicians over time are using
3 different terminology in how they evaluate, you
4 know, medical evidence and using different terms
5 and terminology throughout the history of these
6 cases.

7 So, these claims examiners are trying
8 to figure out is this diagnosis the same as this
9 which we have information in the site exposure
10 matrices about. So, they're always trying to get
11 back to that health effect linkage.

12 CHAIR MARKOWITZ: Dr. Cassano?

13 MEMBER CASSANO: I do have -- and it
14 pertains both to the Parkinson's and to this
15 alias because, in some ways, there are similar
16 questions.

17 A lot of these diseases that you
18 mentioned come under an umbrella of broader
19 disease but may have very, almost minuscule
20 differences in either the pathology or in the
21 symptom complex.

22 So, and most of the time, epidemiology

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1 a lot of times doesn't break all of them out.
2 Some epidemiologists will lump them together,
3 some of them will break some of them out.

4 So, would you be looking for the --
5 basically, I'm saying, are you going to be -- do
6 you want us to be lumpers or splitters?

7 Or in other words, are you looking for
8 the umbrella and then which ones would fit under
9 that umbrella, or do you want us to really tease
10 out differences between diseases? Because that
11 makes a difference in how we approach this.

12 MS. LEITON: So, what we're going to
13 be looking for is, in the context of the health
14 effect that we're looking at, and so, if you're
15 looking at health effect, you see chronic renal
16 failure, you're going to see certain toxic
17 substances, right?

18 And so, if you look at that in the SEM
19 and say, okay, they're saying the chronic renal
20 failure and these are linked, if you're going to
21 give us another condition that could be used and
22 linked the same way, that's what we're looking

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1 for.

2 MR. VANCE: So, you have to think of
3 the -- and I'll show you tomorrow -- the site
4 exposure matrices are predicated on the health
5 effect data in the site exposure matrices is
6 predicated on a listing of established, you know,
7 human epidemiological linked conditions.

8 Those are listed out. And, what we're
9 talking about are aliases of those conditions.
10 Okay?

11 CHAIR MARKOWITZ: So, you have a team
12 working on making some corrections in the SEM
13 including working on this task. So, how would
14 our effort --

15 MS. LEITON: Well, they've got a lot
16 of other tasks that they're working on. So, we
17 would definitely pay attention to many other
18 projects that they're trying to -- like gaps in
19 facilities and things like that.

20 CHAIR MARKOWITZ: Okay, any other
21 questions or comments?

22 Oh, yes, Dr. Silver?

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1 MEMBER SILVER: This morning, Dr.
2 Markowitz asked where the program gets its
3 epidemiologic expertise and, Ms. Leiton, I think
4 you mapped it to the epi trending in the
5 toxicologist and the epi trending in the
6 occupational physicians.

7 But, I thought I heard you, John
8 Vance, you referred to the epidemiologist an hour
9 and half ago, and epidemiology is getting
10 mentioned with increasing frequency.

11 So, can we just clear up who that is?

12 MR. VANCE: Okay, so let me just back
13 up a little bit and make sure I -- make sure
14 everybody is clear.

15 So, we had a conversation about health
16 effect data that's reported through HAZMAP that
17 gets translated into the site exposure matrices.

18 That's generally done under the
19 auspices of HAZMAP and Jay Brown. That
20 information is then listed out in the site
21 exposure matrices.

22 Then, when Lynette Stokes, who is our

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1 epidemiologist or toxicologist within the program
2 is looking at an evaluating claim level
3 submissions for new health effects or evaluating
4 case-specific submissions in conjunction with,
5 you know, epidemiology or toxicology.

6 MS. LEITON: I believe we also have
7 epidemiologists on staff on our SEM project at
8 the Paragon that help with these that work on
9 some of these items.

10 They don't go into HAZMAP, but we do
11 have epidemiologists.

12 MEMBER SILVER: All right, so, Dr.
13 Stokes is both the toxicologist and an
14 epidemiologist?

15 MS. LEITON: Yes.

16 MEMBER SILVER: Thank you.

17 CHAIR MARKOWITZ: Okay, thank you.

18 So, there are some issues about Board
19 functioning that we should begin to discuss.
20 Then we'll take a brief break before the public
21 comment period.

22 As we heard this morning in the FACA

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1 presentation, we have the option in our
2 subcommittee meetings of making them open or not.
3 Open means that the subcommittee meetings usually
4 take place over the phone. It means that non-
5 Board members could call in to those discussions
6 and participate.

7 The previous Board elected to do that
8 and the -- both because we thought it was a good
9 thing to make the whole Board work as transparent
10 as possible and also because the Radiation
11 Advisory Board which has been in existence since
12 the early 2000s, also follows that method.

13 The feature of those -- of that
14 process is that you have to schedule such a
15 meeting by Federal Register at least six weeks
16 prior to the meeting.

17 So, let's say there is a subcommittee
18 or a work group that would like to meet and
19 discuss an issue, this is a subset of the Board
20 and, you know, this being mid-November, you could
21 schedule that for some time the first half of
22 January if we decided, you know, by Friday to

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1 start scheduling that because it has to be
2 published in the Federal Register.

3 Actually, it's more the notice goes in
4 six weeks before the meeting but then, the notice
5 actually has to go through the process within
6 DOL. So, we're really talking seven, eight
7 weeks.

8 So, we did that and it wasn't really
9 that much of an obstacle. It kind of diminishes
10 spontaneity a little bit.

11 But, there wasn't -- we don't have
12 that much need for spontaneity in this Board
13 function.

14 So, now, I have to be reminded, when
15 we take a vote, it's a simple majority.

16 MR. FITZGERALD: It should be a,
17 what's the term?

18 MS. LEITON: Consensus.

19 MR. FITZGERALD: Consensus, and that's
20 not well defined but it's certainly more than 50
21 percent plus one.

22 CHAIR MARKOWITZ: Okay, okay.

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1 So, Dr. Friedman-Jimenez, are you on
2 the phone? Can you hear us?

3 MEMBER FRIEDMAN-JIMENEZ: Hello?

4 CHAIR MARKOWITZ: Yes, we're -- yes,
5 we hear you, yes, okay, good.

6 So, I take it you're on mute, so
7 there's a little bit of delay, that's fine.

8 So, let's -- we should --

9 MR. FITZGERALD: One second, excuse
10 me, Mr. Chairman.

11 Just add a couple of other points
12 here, one is with regard to subcommittee
13 meetings. We normally, and the public listens to
14 those; they do not provide public comment at the
15 subcommittee meetings.

16 And, I would just kind of go back to
17 what Joe Plick, our FACA counsel told us today
18 about the spirit of open meetings with regard to
19 the FACA as well.

20 And, kind of the current mood is to
21 move toward more openness rather than less
22 openness.

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1 CHAIR MARKOWITZ: Now, we have, you
2 know, these subcommittees in the past have had
3 four or five members. There have been
4 discussions among one or two or three members
5 short of a full subcommittee which has not been
6 part of the open process. They are --

7 Well, didn't necessarily -- we have a
8 work group, but that work group really functioned
9 more as like a subcommittee in which we scheduled
10 the meeting and there was a significant number.

11 The reason it was called a work group
12 was because it cut across the committees
13 basically.

14 I'm not -- I don't know whether we'll
15 retain that designation for any activity, we'll
16 figure that out.

17 But, just saying that short of a full
18 subcommittee, there can be quote-unquote, closed
19 discussions among smaller numbers of members. It
20 didn't happen much, but just so you know that
21 discussion among one or two people isn't entirely
22 inhibited by the need to schedule such a

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1 discussion six weeks in advance.

2 MR. FITZGERALD: Right, the
3 subcommittee chair could assign some work to a
4 group of people within the subcommittee to go out
5 and some work. They would come back and present
6 to the subcommittee. That would then be
7 discussed in a public forum.

8 CHAIR MARKOWITZ: Right. And so, we
9 did have a one work group on presumptions and it
10 functioned just like the subcommittee, there was
11 no real difference.

12 Yes?

13 MEMBER CASSANO: What about when we
14 went to Seattle? That was a work group.

15 CHAIR MARKOWITZ: So, if you could
16 turn on your mic and just describe what you're
17 talking about.

18 MEMBER CASSANO: We had another work
19 group that looked at cases. We went to the
20 Seattle claims office and looked at cases and
21 that was a subset of a subcommittee and that was
22 not a public meeting because it would have been

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1 logistically impossible.

2 CHAIR MARKOWITZ: So, we need a
3 proposal about whether we want our subcommittee
4 meetings to be open or closed and --

5 MEMBER CASSANO: Motion to make all
6 subcommittee meetings open meetings to the
7 public.

8 CHAIR MARKOWITZ: Is there a second?

9 MEMBER MAHS: Second.

10 CHAIR MARKOWITZ: Okay, open for
11 discussion. Any comments?

12 So, the proposal is to make all the
13 subcommittee meetings open and all those in
14 favor, raise your hand?

15 And so, Dr. Friedman-Jimenez?

16 MEMBER FRIEDMAN-JIMENEZ: Yes.

17 CHAIR MARKOWITZ: Okay. So, it's
18 unanimous, all 12 members vote in favor open
19 processes for subcommittee meetings.

20 Do subcommittees vote at all? And, if
21 so, are -- is there any guidance about that?

22 MR. FITZGERALD: I don't think there's

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1 any particular guidance on voting. Whatever the
2 subcommittee decides to report will be before the
3 full committee.

4 CHAIR MARKOWITZ: Right, okay. And,
5 what I heard this morning from the FACA
6 presentation was that the subcommittee brings
7 whatever the results of their discussion to the
8 full Board, that engenders a full Board
9 discussion and not a simple vote on whatever the
10 subcommittee proposed.

11 So, every meeting, we will have a
12 public comment period. And, I think in some
13 meetings it had been longer than this one. We've
14 had two public comment periods.

15 They usually occur at the end of the
16 day, although, if it's the last day of our
17 meeting, we generally try not to make it at the
18 end of the day.

19 The -- and the people who are present
20 and request time on the public comment period get
21 the time that people can participate by phone.

22 We generally divide the amount of time

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1 by the number of people who make requests. And
2 that, so far, has worked out pretty well.

3 We hear the public comments. We -- in
4 the first Board, I struggled -- my view is we
5 struggled a little bit on how to organize and not
6 really respond to public comments but fully
7 consider some of those comments in our
8 discussions.

9 And, correct me if I have a
10 misimpression about that.

11 And so, I think we did, Carrie, we
12 developed a system where we tracked the public
13 comments by spreadsheet and circulated that among
14 the Board members to make it easier to figure out
15 in summary what was said and then the public
16 comments are available on the website so they can
17 go to the website.

18 So, we need -- we should continue to
19 do that.

20 Part of the problem is that the public
21 comments may or may not pertain to exactly what
22 we're talking about that day or they pertain to

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1 something we talked about yesterday and we're not
2 coming back to that by the next Board meeting, we
3 don't remember what those public comments were.

4 So, if there are ideas beyond what we
5 did last time and we'll replicate which is kind
6 of a spreadsheet with web access to the public
7 comments.

8 If there are ideas that either now or
9 you think of as we go forward to try to
10 accommodate and consider those comments more
11 closely, then please raise those.

12 If anybody has any thoughts now, it
13 would be a good time.

14 (No response)

15 CHAIR MARKOWITZ: Okay, I mentioned
16 before we develop requests and action items from
17 our meetings, not so much today, but we will.

18 And, Carrie keeps track of those. If
19 you do make a request, just -- and if I don't
20 alert Carrie to that, just try to make sure that
21 it's brought to her attention.

22 She keeps -- she will provide us with

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1 a running log of these things and then we get a
2 spreadsheet on the responses or actions taken by
3 DOL, either the information is provided or the
4 decision about access to that information or
5 whatever. Questions, comments about that?

6 (No response)

7 CHAIR MARKOWITZ: Now, locations of
8 meetings, what we'll discuss in our next meeting
9 were tomorrow, but I would say that previous
10 board, we met once in Washington in this room.

11 And then, we went and -- to various
12 sites. First, we went to Oak Ridge, then we went
13 to Hanford, and we went to Los Alamos.

14 And then, we had a phone meeting.
15 And, Greg Lewis and his group very nicely
16 arranged for tours at those facilities which is
17 extremely useful. We would show up a day early
18 and we would see either legacy buildings or
19 legacy processes or we'd see current things going
20 on.

21 But, particularly for people
22 unfamiliar with the complex, it was a very

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1 useful, very informative exercise.

2 So, my preference would be to continue
3 that, but I'd like the sense of people's
4 experience. Yes, Mr. Domina?

5 MEMBER DOMINA: This question might be
6 for John Vance. Because at every Part B board
7 meeting, NIOSH always reports on the most new
8 claims for a four month period prior to or six
9 months, depending on how far apart the meetings
10 are.

11 Because, I guess over the last 30
12 meetings they've had, Hanford's led the complex
13 in new Part B cancer claims.

14 And so, what my question is, is do you
15 guys track on where the most Part E claims come
16 from or is there a way to do that?

17 MR. VANCE: Yes, well, we could
18 definitely go back and look at the Resource
19 Center intake for different regions of the
20 country.

21 I think that we can probably do some
22 sort of basic analysis, see where claims are

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1 coming from and try to provide that information.

2 So, that's going to be a request for Carrie.

3 MEMBER DOMINA: Okay, just because we
4 followed the Part B board the last, you know, few
5 times we went to Oak Ridge, Hanford and then Los
6 Alamos and I just wondered if that might be an
7 appropriate way to do that.

8 CHAIR MARKOWITZ: So, the way the
9 locations were selected was by the number of
10 claims, or cumulative number of claims from those
11 sites. So, the most claimants were from Oak
12 Ridge and secondly Hanford and third, New Mexico.

13 It was either claims where they were
14 from or where the claimants resided, I can't
15 remember.

16 And, I would propose we continue to go
17 -- to do that which would probably Savannah River
18 would be the next.

19 MEMBER REDLICH: I was wondering where
20 Savannah River fell in this.

21 CHAIR MARKOWITZ: Yes, it's number
22 four I think. But, I'm going to -- I check the

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1 website and look at that.

2 MEMBER REDLICH: Okay, because I mean,
3 this is anecdotal, but just from the few cases
4 that we reviewed, it seemed that sort of the
5 level of medical care and was probably not as
6 optimal there as let's say, if Hanford, or
7 Colorado.

8 CHAIR MARKOWITZ: Right.

9 MEMBER REDLICH: Or it just seemed
10 like it would be --

11 CHAIR MARKOWITZ: Right.

12 So, does it make sense to people to
13 just continue by the number of claimants and we
14 only have to pick one ahead of time. We don't
15 have to go to the next. But, I can't remember
16 what number five was, in any case.

17 MEMBER REDLICH: I mean, I think it is
18 important to the claimants in the area, too.

19 CHAIR MARKOWITZ: Yes.

20 MR. FITZGERALD: Steven, I'd like to -
21 - one limiting factor we should consider is that
22 our overall budget just from a fiduciary

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1 standpoint, just managing the resources allocated
2 to the board compared to tours.

3 We just need to weigh that particular
4 opportunity against other things we do.

5 Last year, I know we had a lot of
6 subcommittee meetings that were not necessarily
7 financially -- so, we just have to keep that in
8 mind.

9 CHAIR MARKOWITZ: Okay. And, the
10 expense of the subcommittee wasn't travel but it
11 was transcription and production and all that,
12 right?

13 MR. FITZGERALD: Right. The tours
14 themselves happen the day generally to the travel
15 so, yes, that's the issue.

16 CHAIR MARKOWITZ: Okay.

17 Now, one -- there's an issue that I
18 think we should discuss. I have a hard time
19 finding relevant documents on our website. And
20 I'm wondering other people's experience.

21 Right now, they seem to be organized
22 by our meeting date. So, we had four in person

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1 meetings and then you can go to those particular
2 meeting dates and then I understand you can get
3 the transcription, you can get the minutes, that
4 makes sense because that's date specific.

5 But then, there are the documents that
6 we review at that meeting, for instance, today,
7 actually we just did a -- we kept the briefing
8 book relatively small.

9 But, in our next meeting we'll have
10 relevant documents which we'll put up, that will
11 be useful in our discussions.

12 And, I'm looking for ideas on how to
13 improve the organization of those materials so
14 that -- and particularly the new members, it can
15 be helpful here when you do get to look at them,
16 which is how should we organize them so that
17 they're easy to get to?

18 MEMBER REDLICH: Well, I have one
19 suggestion just as far as our recommendations, I
20 can't keep straight the date of the
21 recommendations, the number.

22 You know, maybe we could just start a

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1 new numbering system that was a continuous one,
2 two, three and also we could have a simple table
3 that would say, okay, this topic, you know, these
4 recommendations address that topic so you could
5 find, you know, whatever that might be, lung
6 disease or --

7 Because, right now, you know, I'm open
8 on both of the ways. Is that this state or that
9 state? And, I think if we simply had a running
10 list of numbers.

11 CHAIR MARKOWITZ: So, consecutive
12 numbering across meetings?

13 MEMBER REDLICH: Yes.

14 CHAIR MARKOWITZ: Yes, that's --

15 MEMBER REDLICH: And --

16 CHAIR MARKOWITZ: We'll do that.

17 MEMBER REDLICH: And that will be easy
18 to have a little table of the recommendation and
19 the topic and then you could immediately find the
20 one that you wanted.

21 CHAIR MARKOWITZ: You know, it's a
22 little complicated as we make a recommendation,

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1 DOL has a response, we have comments on their
2 response. So, sometimes we're --

3 MEMBER REDLICH: But, it still --

4 CHAIR MARKOWITZ: And sometimes
5 revised that recommendation.

6 MEMBER REDLICH: But, even still,
7 still like number three, it was all was related
8 to this --

9 CHAIR MARKOWITZ: Right.

10 MEMBER REDLICH: -- then you could
11 just do that. I don't know, I'm open to any
12 other Board members.

13 CHAIR MARKOWITZ: Right. Yes, we'll
14 do that, that's a good idea.

15 Any other ideas?

16 MEMBER SILVER: Since we came into
17 existence by an act of Congress, we should make
18 our recommendations and DOL's responses and the
19 next round of our responses to their responses
20 available at the fingertips of anyone who goes to
21 the website.

22 We don't need to unlink them from the

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1 meetings where they were voted on, but if we
2 could compile those links in a simpler table on
3 the website, I think that would be of service,
4 not just to people on The Hill, but to people in
5 the claimant community.

6 CHAIR MARKOWITZ: So, for the new
7 Board members, I just want to say that just so
8 you know, the Board has no staff to do work.

9 Obviously, they're DOL staff
10 designated liaison, Mr. Fitzgerald and Ms. Rhoads
11 who help with the meetings, but in terms of
12 either tasks or activities that are requested of
13 us or activities that we take upon ourselves, we
14 have no staff to do that research.

15 Just so you're aware of that. We've
16 never requested it, but it wouldn't -- my take is
17 that -- my understanding is it wouldn't be
18 possible within the current budgeted amount for
19 the board. So, it would require a different kind
20 of budgeting process. So, we've never really
21 made that request.

22 Any other issues on the board that we

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1 need to discuss?

2 (No response)

3 CHAIR MARKOWITZ: Okay, why don't we -
4 - we're not scheduled for public comments until
5 4:30, we can't begin public comments early, so
6 that means we're just going to have to take a
7 break.

8 But, let's come back at 4:25 so we're
9 ready to begin.

10 (Whereupon, the above-entitled matter
11 went off the record at 4:15 p.m. and resumed at
12 4:35 p.m.)

13 CHAIR MARKOWITZ: So, we're going to
14 start in a minute, but 4:30, but I want to just
15 say to the Board members, you know, this public
16 comment is not really a discussion, it's not
17 really a question and answer period.

18 People -- we can make the occasional
19 comment, but in general, it's the opportunity for
20 people to say what they want to say and we
21 listen.

22 With that, I think we can get started

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1 if -- we've got six people who had signed up to
2 speak. I would ask that you speak no longer than
3 ten minutes, of course, you're free to use less
4 than ten minutes if you've exhausted what you
5 want to say. But, it is up to you.

6 Is Michele Jacquez-Ortiz on the phone?

7 (Off-microphone comment)

8 CHAIR MARKOWITZ: Thank you, I'd like
9 to welcome our first speaker which is Michelle
10 Jacquez-Ortiz from Senator Udall's office.

11 (Off-microphone comment)

12 CHAIR MARKOWITZ: So, why don't we
13 move to Terrie Barrie? Oh, she's back. So, Ms.
14 Michelle Jacquez-Ortiz, are you there?

15 MS. JACQUEZ-ORTIZ: Okay, thank you.

16 I'm sorry, Chairman Markowitz and
17 members of the board, can you hear me?

18 CHAIR MARKOWITZ: Yes, we can hear
19 you. You can start, thank you.

20 MS. JACQUEZ-ORTIZ: Okay, thank you,
21 Chairman Markowitz. My name is Michele Jacquez-
22 Ortiz and I work for United States Senator Tom

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1 Udall and have a prepared statement from the
2 Senator to read into the record.

3 And, it starts here. U.S. Senator Tom
4 Udall's statement to the Advisory Board on Toxic
5 Substances and Worker Health, Washington, D.C.
6 November 14th, 2018.

7 As some of you may know, I worked with
8 a bipartisan coalition in Congress to establish
9 the Advisory Board on Toxic Substances and Worker
10 Health.

11 The work of this Board and the
12 recommendations you provide are fundamental to
13 the integrity of the energy employees
14 occupational compensation program, or EEOICPA.

15 Earlier this year, I expressed my
16 concerns to the United States Department of Labor
17 about the long delay in Advisory Board
18 reappointments.

19 I urged the Agency to take quick
20 actions and also secured language in the fiscal
21 year 2019 labor, health and human services
22 appropriations bill formalizing congressional

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1 concerns about board vacancies and directing the
2 Department of Labor to ensure that the Board has
3 sufficient funding and staffing to meeting its
4 obligations.

5 I was pleased when DOL subsequently
6 filled the vacancies. This Board is specifically
7 designed to offer the Department of Labor a
8 unique mix of scientific, medical and claimant
9 expertise on important issues facing the program.

10 The Board thoroughly evaluates the
11 natures for its recommendations and is judicious
12 in the recommendations that are given.

13 As such, the Department of Labor has a
14 responsibility to act on those recommendations in
15 a timely manner.

16 Two and a half years ago, I teamed up
17 with my Republican colleague, Senator Lamar
18 Alexander to express concern that DOL's proposed
19 rule changes for EEOICPA.

20 Claimant advocates have recently
21 reached out to my office to share their request
22 that DOL withdraw its proposed rules and engage

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1 in a negotiated rulemaking process.

2 I encourage the Agency to carefully
3 consider this request which has authority to do
4 so under the Administrative Procedures Act.

5 A negotiated rulemaking will benefit
6 the claimants and best serve the public interest.

7 When Congress enacted EEOICPA, it
8 intended that the program would be science-based
9 and would compensate legitimate claimants in a
10 timely manner without imposing unnecessary
11 bureaucratic requirements. That was the spirit
12 of the law.

13 EEOICPA is complicated and requires
14 expert analysis on many levels. The Advisory
15 Board has a difficult task considering the
16 complex issues associated with this program.

17 I appreciate the hard work and long
18 hours each of you commit as members of this
19 important board and I thank you for your valuable
20 and generous service.

21 Thank you for allowing me time on the
22 agenda for my statement this afternoon.

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1 Tom Udall, United States Senator, end
2 statement.

3 CHAIR MARKOWITZ: Thank you.

4 Ms. Terrie Barrie?

5 MS. BARRIE: Thank you, Dr. Markowitz
6 and members of the Board. My name is Terrie
7 Barrie and I'm the founding member of the
8 Alliance of Nuclear Worker Advocacy Groups.

9 I welcome the new board members and
10 look forward to the continued review of this
11 important compensation program.

12 The previous Board made so many
13 excellent recommendations to improve the program.
14 I applaud the dedication of the previous board
15 members for their outstanding work.

16 I am thankful that DOL accepted some
17 of the recommendations the Board made.
18 Specifically, the criteria to presume workplace
19 exposure resulting in asbestos related diseases.

20 I am a bit concerned about statements
21 made earlier today about why some of the other
22 recommendations the Board made may not be

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1 accepted.

2 It sounds more like a bureaucratic
3 problem than based on the sound science.

4 Ms. Leiton explained earlier that when
5 it comes to a claims examiner reviewing two
6 different doctor's letters, that one may have
7 more probative value because that doctor was an
8 expert in the field, say a pulmonologist, as
9 opposed to a personal physician who is just a GP.

10 And, that's understandable, the
11 specialist letter might hold more weight than
12 GPs.

13 However, the discussion today implied
14 that despite this wonderful group of well-
15 experienced experts, you have the top notch
16 experts here. And, I would think that the
17 opinions and recommendations made by this Board
18 would outweigh the recommendations of the in
19 house DOL experts or site, or whatever, site
20 matter experts.

21 So, I would recommend that Department
22 of Labor accepts all of your recommendations.

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1 You review the problem and the issues from every
2 aspect. You have long deliberations before
3 coming to a consensus.

4 And, they honestly are lucky to have
5 you.

6 I would like to -- it sounds like, you
7 know, for the new Board members, you've seen all
8 the recommendations the previous board made, it
9 seems like that maybe all that there is to do.
10 Well, there isn't, trust me.

11 There is still much work that needs to
12 be done. I still hear complaints about the
13 letters from the industrial hygienists and the
14 CMCs and the toxicologists.

15 Part of your responsibilities is to
16 review those letters and sample them for
17 consistency and accuracy and using the most
18 current science.

19 I recommend that you put this on your
20 agenda for the next coming term. It's important
21 to make sure that claims are decided equitably.

22 Let's see, the statute -- it was

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1 explained that there was a new medical benefits
2 adjudication board, now while the statute doesn't
3 specifically call out and say that you can review
4 that office, it is a new office and it does
5 involve making decisions based on medical
6 documentation.

7 And, I think that clearly falls within
8 your responsibility.

9 The other issue I'd like to suggest is
10 the Site Exposure Matrix, there's a lot more, if
11 you would consider it, a lot more information or
12 a lot more decisions that need to be reviewed for
13 that. The last time I checked, there was
14 processes that didn't have labor categories
15 attached to it and vice versa.

16 So, for instance, there might be a
17 painting process at Iowa, there was no painter
18 listed as a job category. And, that's important
19 because claims are denied, you know, or if they
20 can't prove -- not denied initially, but
21 ultimately, they will be denied if the SEM
22 doesn't list something and the claimant can't

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1 provide documentation that he did -- he was a
2 painter and they did paint at Iowa.

3 The other part is about the RECA
4 program and you did touch on this today with
5 uranium. There's a lot of disease, well, not a
6 lot of disease, but there are some diseases that
7 are covered under RECA and are presumed to be due
8 to the exposure to uranium.

9 The kidney failure, or kidney
10 insufficiency is one of them, lung cancer, a host
11 of other lung conditions.

12 I would see if you can develop a
13 presumption for DOE workers who worked with
14 uranium based on the exposure that is covered
15 under RECA. I don't think it should take too
16 long, but that would just make a lot of claims go
17 right or be expedited a lot quicker.

18 Okay, so, the Secretary -- this is my
19 closing -- the Secretary appointed this Board
20 because of their vast expertise as well as of
21 occupational medicine, epidemiology, pulmonary
22 field as well as a number of the workforce who,

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1 you know, some currently still work there.

2 The Board members are held to great
3 esteem by their peers and by the claimant
4 community.

5 I welcome you and look forward to your
6 continued review and thank you.

7 CHAIR MARKOWITZ: Thank you.

8 Mr. Tee Lea Ong?

9 MR. ONG: Hi, Tea Lea Ong with
10 Professional Case Management. We are a home care
11 agency that works under this EEOICPA program.

12 First of all, thank you to the DOL for
13 allowing me to -- this opportunity to comment and
14 also, thank you to DOL again for the expressed
15 eagerness to renew the collaborative effort to
16 serve the claimants.

17 So, and for the Board, welcome or
18 welcome back for some of you. Thank you so much,
19 your work is very important for helping the
20 special claimant community, sometimes the depth
21 of the work is sometimes underappreciated, so I
22 just want to thank you again for that.

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1 I know a lot of you read the 700-page
2 document, so clearly, that's a lot of work
3 involved, so appreciate that.

4 I really only have one comment but
5 there's probably some themes around the comment
6 that would help add color commentary to it.

7 And, my comment was about the proposed
8 rule changes that was proposed over three years
9 ago.

10 The rules were proposed about three-
11 plus years ago and with over a 100 changes. It
12 is a very substantive proposal authored probably
13 over quite few number of months.

14 So, one can safely infer that it was
15 work that was done quite a bit before and prior
16 to the establishment of this Board with the
17 assembled experts representing different areas.

18 So, with that said, a lot of the
19 comments I heard today, albeit, were directly
20 specific to the procedure manual, a lot of the
21 concept or the themes I think are equally
22 applicable to the proposed rule changes.

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1 For instance, Dr. Markowitz, you
2 mentioned that a lot of things I believe your
3 words, evolved over these past, you know, few
4 years. And, clearly, the same can be said about
5 the proposed rule changes, a lot of things since
6 it was last proposed have evolved, especially as
7 brought on by conversations in meetings like
8 this.

9 And that proposed rule changes
10 elicited over -- about 500 comments. And the
11 question that Dr. Markowitz, you asked, which is
12 that what are some of the most common questions
13 or themes that were raised?

14 I would submit that, in that period of
15 time, it warrants a complete re-think of what are
16 some of the topics that most important to the
17 proposed rule changes so that it can be
18 appropriately addressed.

19 Likewise, in the course of these
20 meetings, and which I've been lucky to
21 participate in most of them, there were a lot of
22 different discussions, themes that were surfaced,

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1 some that accepted, some deliberated and perhaps
2 partially accepted by the DOL and whatnot.

3 And there were rebuttals, as you
4 mentioned, Dr. Markowitz, on some of these
5 themes.

6 Well, those usually bring up new
7 questions. So, to look back at something that
8 were proposed that long ago, it makes a lot of
9 prudent sense to take a step back and say, hey,
10 should we not consider withdrawing that and using
11 the expertise and guidance from the people in
12 this room to rethink and say, what are some of
13 the rules that should be changed to make it more
14 claimant friendly as expressed by the DOL? And
15 start from there.

16 Because I think sometimes what happens
17 is that when you edit and you keep changing the
18 edits that were made, I think Dr. Redlich just
19 mentioned now, sometimes when you try to do that,
20 it makes it even more convoluted than the
21 original topic, if you will.

22 So, with that in mind, it seems to

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1 make sense that in order to start with the
2 expertise in this room and say what are some of
3 the things that ought to be addressed and changed
4 from a rule standpoint, it makes more sense to
5 withdraw it and start from the advice that would
6 be provided from this board as opposed to we keep
7 editing on topics that may not be relevant
8 anymore looking back.

9 So, that is really my comment which is
10 that editing, at some point in terms of its
11 value, probably diminishes as compared to advice
12 from the board that wasn't even established at
13 the time, when the rules came out, this board has
14 been authorized but had not been seated.

15 And, since then, the first meeting
16 which was in this room and Dr. Markowitz, you
17 were sitting in the exact same spot, and we
18 talked about the rule changes at that time.

19 A lot of good conversation took place.

20 And since then, a lot has changed.

21 So, my recommendation for the DOL and
22 I urge DOL to consider this, is to start with

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1 what's relevant and withdraw it and then using
2 the assembled experts to guide that conversation.

3 And then, perhaps, and just one more
4 comment, too, with a third of this board being
5 new and I know there's a lot to learn and
6 obviously, you've spent a lot of time on it, a
7 full third of the Board is new and I think it
8 will take some time for this Board to really
9 coalesce on focus on which are the topics that
10 ought to be addressed in the next round of rule
11 changes.

12 So, I would submit that this is the
13 great time to take a step back and consider and
14 looking forward what should be the rules as
15 opposed to how do we edit what was proposed
16 previously.

17 And, sorry, I said one comment,
18 perhaps this is two, I heard a lot of
19 conversations about the procedure manual today
20 which all really are relevant ones. And I think
21 Kirk, you mentioned, that hey, you know what, can
22 we coordinate, you know, from the DOL folks so

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1 that if you were working on changing the
2 procedure manual, updating it, I think version
3 3.0 was mentioned as an example, let us know so
4 that we don't kind of edit something that you're
5 about to, you know, change anyway.

6 I would submit that with the team
7 here, we heard some really good conversations
8 about expertise, the few experts in the nation,
9 for instance, on beryllium that, perhaps, this
10 should be a more serious thought of not just,
11 hey, let me know what you're changing, rather it
12 should be really tapping into the experts that
13 have volunteered their time to look into it.

14 So, accept the guidance and counsel
15 from this Board rather than, let's coordinate you
16 choose whether you should accept, you know, our
17 help or not.

18 So, with that said, thank you very
19 much for allowing me to speak and I appreciate
20 your time.

21 CHAIR MARKOWITZ: Thank you.

22 I just want to remind the Board that

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1 actually the first time we met, they had -- DOL
2 had reopened the comment period and we did
3 analyze and made comments on the proposed rules
4 at that time. And since that time haven't been
5 involved.

6 So, our next speaker is by phone, it's
7 Ms. Donna Hand.

8 MS. HAND: Yes?

9 CHAIR MARKOWITZ: Hi, you can start
10 now. Thank you.

11 MS. HAND: Well, first, thank you very
12 much and thanks for the Board that you finally
13 got seated and we're all together working on this
14 issue for all the claimants.

15 I wanted to bring attention, you asked
16 about the Radiation Exposure Compensation Act,
17 that Act was used for specified answers in the
18 statute Public Law 107-20 as the overview as well
19 as an edit on a condition on that that the
20 National Cancer Institute said that it's a
21 medical condition or a nomenclature of any of
22 those that are listed, of the 22 cancers and a

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1 submitted as otherwise cancer.

2 So, that's where the Radiation
3 Exposure Act illness got involved with the
4 statute part of the DOL program.

5 The next issue is that first Hearthway
6 on October the 24th and Deputy Solicitor, Tom
7 Giblin today said the statute cannot be changed.

8 The regulations can only be changed
9 through notice and comments. Well, the
10 regulations say that the definition of beryllium
11 sensitivity means that an individual has an, a-n,
12 abnormal beryllium proliferation test performed
13 on blood or lungs.

14 So, nobody knows what is an abnormal
15 other than, yes, it's an abnormal test.

16 Back in 2010, to the beryllium
17 congress with the beryllium compensation
18 community, DOE had an abnormal test to have, too.
19 But, it was brought up that this worker only has
20 to have one.

21 So, if any of those deliberation
22 figures are reacting to beryllium, then they have

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1 an abnormal beryllium test when they seem
2 reasonable.

3 So, really, you know, the Board
4 underlined what has to be an abnormal as not
5 normal. So, and it wasn't defined definitively
6 in a statute or the regulations, you know, it
7 can't be changed by policy.

8 The other issue is that Dr. Armstrong
9 has informed the internist doctors that you can't
10 use the asthma chart with chronic beryllium
11 disease.

12 The issue is with chronic beryllium
13 disease, it has asthma like symptoms. It has
14 symptoms similar to other respiratory conditions.

15 And the beryllium bio today of the
16 beryllium not only goes to the lungs, but into
17 the bone and then it goes to the renal and
18 bladder and large intestines and then it goes out
19 through urine and the lower larger intestines.

20 So this is, you know, from the
21 Washington State University, the medics say the
22 bone and the liver it's well known that the

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1 bones, the skeleton and the liver is all
2 connected with chronic beryllium disease.

3 But, these are never addressed.

4 The other issue I'd like to find out
5 is what is a lymphocyte process that's consistent
6 with or characteristic of CBD?

7 There is a foreman case in the
8 Knoxville, Tennessee federal court where they
9 were saying that you have to have 10 percent.
10 The person had 50 percent and they said that that
11 wasn't enough.

12 The court ruled in favor of the
13 claimant that all they had to show is only the
14 process consistent with CBD.

15 So, there are numbers in this. So,
16 what is a lymphocyte process that's consistent
17 with CBD?

18 Basically, the -- also the medical --
19 the IOH report are reporting significant lows,
20 significant highs, significant middle. Well,
21 that's not what the statute says. It says
22 significant factors. And that's back in 2006 so

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1 the final registry for again the presumption,
2 OWCP said significant factor is any factor.

3 So, the statute applies and the
4 regulations also says, you're going to use any
5 factor. This regulation also proof of exposure
6 is that the employee came into contact with it.

7 And then, the process is in the
8 material that has the potential. They don't have
9 to definitively do it.

10 So, for the statute to say that a
11 physician do a trigger chemical or a trigger
12 exposure, it is an -- it's not even required by
13 the statute or the regulation because that has a
14 potential because of its radiological chemical or
15 biological nature.

16 To be any factor, it's aggravating,
17 contributing or causing and is that exposure
18 regulated?

19 So, in order for me to find out how an
20 expert can determine the level exposure without
21 any data. So, I'd like for the Board to address
22 how can an industrial hygienist go back and do

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1 historical documentation of the levels that the
2 worker was exposed to, to the toxic substance?

3 Thank you.

4 CHAIR MARKOWITZ: Thank you.

5 Next we have Ms. Vina Colley. Are you
6 on the phone?

7 MS. COLLEY: Yes, can you hear me?

8 CHAIR MARKOWITZ: Sure, sure. Welcome.

9 MS. COLLEY: I'm Vina Colley and I'm a
10 former worker at the Portsmouth Gaseous Diffusion
11 Plant and I am the cofounder of the National
12 Nuclear Workers for Justice and I want to thank
13 you for allowing me to speak.

14 And, I'm requesting that the Board
15 comes to Portsmouth and Paducah, Kentucky where
16 all this happened back in 1999 to get the Board
17 all these decisions in the process of getting
18 workers compensated.

19 As a worker, I'm still wondering how
20 does the claims which are being sent to the
21 examiner, how do they know they are our claims?
22 Because I'm getting workers reports on other

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1 workers in my branch and I don't know if these
2 consultants are getting our true records.

3 I have eight records saying that I
4 worked at Paducah and I smoked a pack of
5 cigarettes every day for 20 years and both of
6 those was a lie because I've never worked at
7 Paducah and I never smoked.

8 I listened to you a while ago say that
9 you pick the site by the number of claims that
10 are filed, that is where you hold these meetings.

11 And Oak Ridge was mentioned.

12 I'm wondering if Oak Ridge is used for
13 Paducah and Portsmouth of gaseous diffusion
14 plant? Because, if so, that should be not done
15 that way, because Portsmouth is the largest
16 industry in the world. We do the highest assay
17 of bomb grade material, 99 percent.

18 And not only did we do that, we've
19 done Russian down and we had plutonium at the
20 site since 1953.

21 This compensation bill started out
22 because Portsmouth and Paducah had plutonium at

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1 the gaseous diffusion plant.

2 I was involved in that the night it
3 happened, the hexafluoride at Paducah, Mary Davis
4 and myself who was notified by the media that
5 this is what had happened.

6 Now, the other big chemical in the
7 gaseous diffusion plant that we don't care
8 anything about is the fluoride. Uranium
9 hexafluoride, there is a needs assessment done by
10 the Department of Energy at all of these sites
11 who were scored for Superfund. Tyson submitted to
12 the Superfund test and so did Paducah. Paducah
13 was put on this list but Tyson never was.

14 So, I would like for you to come to
15 Portsmouth. The few of us can take you on a tour
16 and I listened all day long at all this red tape
17 and it's a -- the procedures that they had to go
18 by, who in the world is going to read 700 pages
19 of procedures?

20 I commend the Board for trying to do
21 the right thing and put them in the right
22 direction. But, I'm looking at records from

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1 other workers that work at say Rocky Flats and a
2 lot of electricians at Portsmouth, we are -- our
3 records look the same except for denied, have my
4 name on mine and their name on theirs. But,
5 these records that the Department of Labor are
6 writing are copycats.

7 So, I don't know how to solve this
8 problem. At one time, this was started up and it
9 was a resolution of \$150,000 for each worker and
10 a medical card.

11 That medical card is worth more than
12 any money. And, I don't know what happened to
13 this in 18 years, but we're still fighting. We
14 shouldn't have to be doing that.

15 You know, I really thank the Board for
16 taking on a big project, but I'm scared this is
17 going to be another 18 years down the road and
18 more and more workers are going to have the same
19 suffering. It's time to do the right thing.

20 The other thing is Oak Ridge, there
21 we're getting, when I started the national group,
22 they were getting grant money to go to Washington

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1 state to represent workers that they didn't
2 represent.

3 And, I know that Oak Ridge is not the
4 same site and somehow or another in all of this,
5 Portsmouth and Paducah got lost in the sewer
6 somewhere.

7 I'm asking you to come back to
8 Portsmouth and Paducah to where this all started.

9 And, you had another site there by
10 Paducah which Honeywell in Indianapolis which is
11 starting to have a lot of sick workers that are
12 coming forward.

13 So, we've got to find out how all this
14 fraud is going on in these claims. I mean, it's
15 -- I should be here 18 years later fighting -- I
16 have not ever gotten one consequential illness.

17 Every time the case worker approves my
18 case, they get moved or switched or get fired.
19 But this is happening to me. It's happening
20 nationally and it's a criminal act. It's got to
21 stop.

22 CHAIR MARKOWITZ: Ms. --

1 MS. COLLEY: And I wanted to mention
2 about the local office. We have these offices,
3 they are great. They go in, we go in and they
4 make our allowances for our travel expenses and
5 do all that, but here's the process right here
6 where workers are getting turned down.

7 The people in those offices are not
8 advocates, they don't know the rules and
9 regulations. They don't put our records together
10 before they're sent into the Department of Labor.

11 And so, when the worker goes in there
12 thinking they've got all they need, they don't
13 have all they need and they're turned down.

14 And, once they're turned down, it's
15 hard to make that decision retroactive.

16 So, you may have somebody in those
17 offices, maybe someone from the union or whatever
18 that knows their exposures before these records
19 are sent in to Washington, D.C. to the Department
20 of Labor and then turned down and finally just
21 turned down and denied and denied and denied.

22 And I'd still like to know the answer

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1 about the Oak Ridge site, did those claims get
2 approved or denied or how do you characterize
3 these claims that are going to certain sites?

4 And, I would think that you would want
5 to come when that whole thing started back in '99
6 at Portsmouth. Thank you.

7 CHAIR MARKOWITZ: Thank you, Ms.
8 Colley. And thank you for the invitation to
9 Portsmouth.

10 Our next -- last speaker will be Mr.
11 Josh Artzer.

12 MR. ARTZER: Good afternoon, my name
13 is Josh Artzer and I'm currently the chairman of
14 the Beryllium Awareness Group at Hanford and also
15 appointed by HAMTAC as a workforce specialist at
16 the newly opened up Hanford Workforce Engagement
17 Center.

18 Our office was opened up to help
19 current and former workers and their families
20 kind of navigate these claims processes, whether
21 it's state O&I or the Department of Labor and
22 it's also to provide them with information

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1 regarding to beryllium and also the medical
2 screening programs that are available to them.

3 One of the concerns I have is I know
4 that the board made a recommendation on the
5 borderline BLTPs and I also know that additional
6 information regarding the use and value of the
7 borderline results has been submitted to the
8 Department of Labor by Dr. Maier from National
9 Jewish Health.

10 From the earlier discussions today,
11 it's my understanding that the Department of
12 Labor evaluated this and that their legal team
13 made an interpretation.

14 One question I have is was that
15 interpretation, did it have medical reasoning and
16 was that provided the board and also back to
17 National Jewish?

18 We have quite a few workers affected
19 at -- excuse me -- affected workers that kind of
20 fall into this realm where they're being, you
21 know, medically restricted. Their job
22 classification have been changed based on these

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1 borderline. They're being treated as affected
2 workers, but they can't apply for the Department
3 of Labor programs.

4 As far as what we see at the Hanford
5 Workforce Engagement Center regarding
6 occupational illnesses or diseases related to
7 toxic substance exposure and causal link is that
8 the majority of the time these claims are
9 forwarded on to the CMCs and to IHs for
10 recommendations for claim acceptance or denial.

11 The one question I have is where do
12 the IHs get the data when they're providing these
13 recommendations and opinions?

14 Often we see that the -- excuse me --
15 often we see it's determined that the claimant
16 hasn't been exposed above OELs or PELs.

17 The problem with that is, you know, at
18 Hanford specifically, we're not always being
19 monitored at times.

20 We, as claimants, can't even provide
21 that information. So, when the CMCs and the IHs
22 are making this determination, where are they

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1 getting their information, you know, when they're
2 making that recommendation?

3 Also, to put the burden back on the
4 worker to do that when they know for a fact that
5 this information is not available.

6 So, that's one of the other issues
7 that we have down there.

8 Third thing that I had was, I was glad
9 to hear that Mr. Vance brought up the
10 recommendation to the Board about Parkinson's
11 disease. We see a lot of that down at our
12 centers, especially within the last few months.

13 Again, that, you know, when that's
14 being evaluated through the Department of Labor's
15 process, it does go back to the doctor's
16 diagnosis, documentation providing that causal
17 link.

18 Also, you know, to a known chemical
19 potentially. So, I was glad to see Mr. Vance
20 bring that up and hopefully you guys can come up
21 with some sort of recommendation to help with,
22 you know, that process for these claimants.

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1 So, thank you for your time.

2 CHAIR MARKOWITZ: Thank you.

3 Any other people wish to make public
4 comment?

5 (No response)

6 CHAIR MARKOWITZ: Yes, if anybody's on
7 the phone and they want to make a public comment,
8 you should press star-zero.

9 (No response)

10 CHAIR MARKOWITZ: Okay, so public
11 comment period is closed. Tomorrow we begin at
12 8:30. So, what time shall we meet upon arrival
13 at DOL? 8:15, that's good.

14 So we'll meet downstairs at 8:15 and
15 come in together. So, do I adjourn the meeting
16 or do you?

17 MR. FITZGERALD: I will be happy to do
18 that. So, the meeting is adjourned.

19 (Whereupon, the above-entitled matter
20 went off the record at 5:15 p.m.)

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