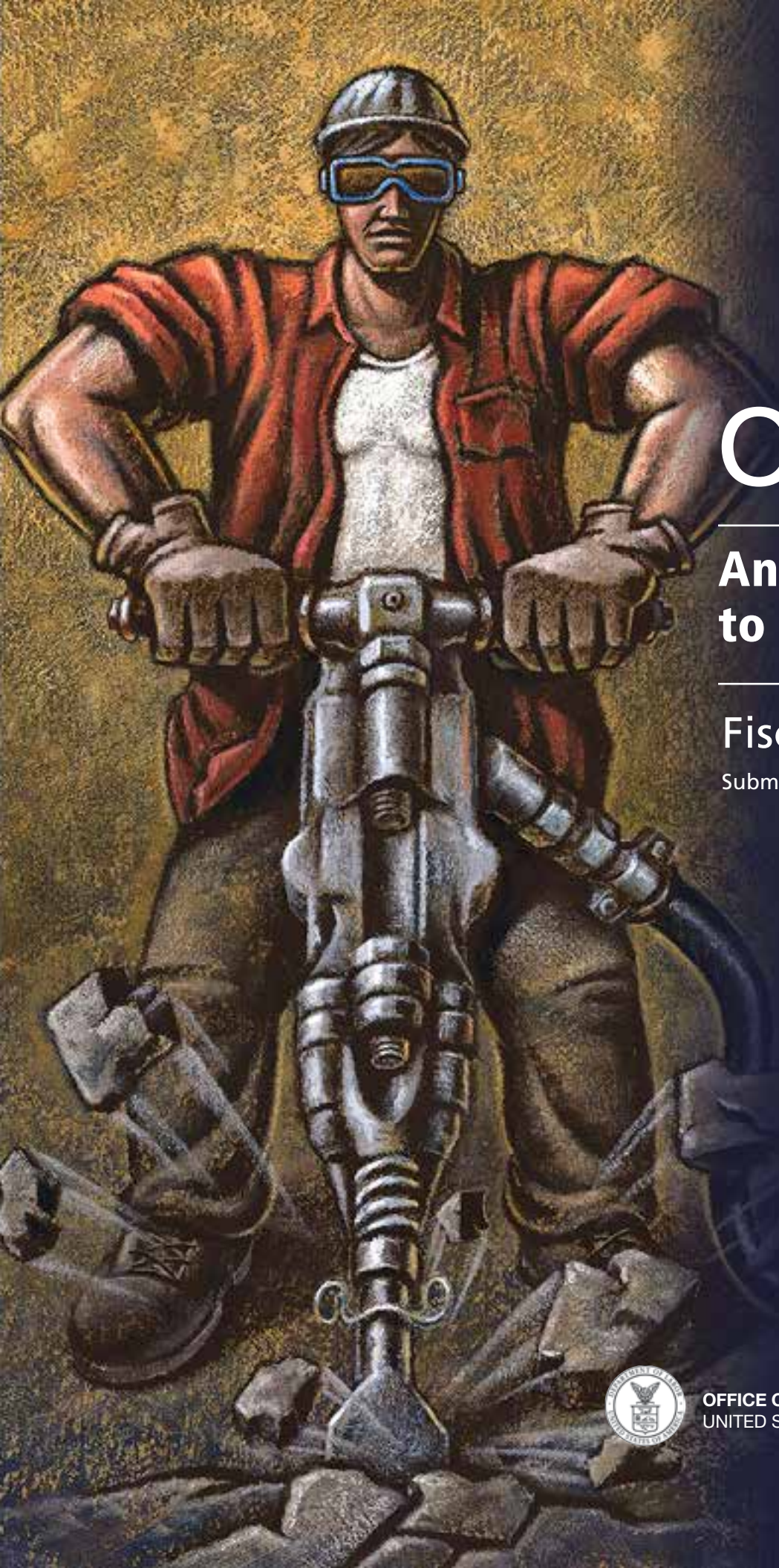

OWCP

Annual Report to the Congress

Fiscal Year 2012

Submitted to the Congress 2014

OFFICE OF WORKERS' COMPENSATION PROGRAMS
UNITED STATES DEPARTMENT OF LABOR

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U.S. Department of Labor

Office of Workers' Compensation Programs
WASHINGTON, D.C. 20210

File Number:

FEB 26 2014

THE HONORABLE PRESIDENT OF THE SENATE
THE HONORABLE SPEAKER OF THE HOUSE OF REPRESENTATIVES

I have enclosed the Department of Labor's annual report to Congress on the FY 2012 operations of the Office of Workers' Compensation Programs. The report covers administration of the Federal Employees' Compensation Act as required by Section 8152 of that Act, the Black Lung Benefits Act as required by Section 426(b) of that Act, the Longshore and Harbor Workers' Compensation Act (LHWCA) as required by Section 42 of that Act, and the Energy Employees Occupational Illness Compensation Program Act, for the period October 1, 2011, through September 30, 2012.

Separate enclosures contain reports on annual audits of the Longshore and Harbor Workers' Compensation Act Special Fund and the District of Columbia Workmen's Compensation Act Special Fund accounts as required by Section 44(j) of LHWCA.

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

Sincerely,

Gary A. Steinberg
Acting Director

Enclosures

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DIRECTOR'S MESSAGE

[1]

Director's Message

The Office of Workers' Compensation Programs (OWCP) had a very productive year in Fiscal Year (FY) 2012. OWCP's mission - "*To protect the interests of workers who are injured or become ill on the job, their families and their employers by making timely, appropriate, and accurate decisions on claims, providing prompt payment of benefits and helping injured workers return to gainful work as early as is feasible*" - was successfully fulfilled by all four OWCP programs. In FY 2012, we met or exceeded our targets for 22 of our 28 Operating Plan performance measures and 23 out of 28 of our annual goals, and established goal teams to improve our operations and assist us in the achievement of the seven goals that represent OWCP-wide priorities supported by the objectives and strategies of the OWCP Strategic Plan (http://www.dol.gov/owcp/owcpstratplan.htm). During this same period, OWCP programs received more than 175,000 claims for workers' compensation benefits and over $3.2 billion in compensation and approximately $1.3 billion in medical benefit payments were made. In addition, all of our programs expanded their communications, outreach, and education activities with claimants, employers, medical providers, insurance companies, and other OWCP stakeholders.

In FY 2012, the Federal Employees' Compensation (FEC) program received approximately 116,000 claims from injured Federal workers or their survivors and provided long-term wage replacement or dependent benefits for work-related injuries or diseases of over $3 billion to more than 240,000 beneficiaries. OWCP, through the FEC program, played an important role in the implementation of the President's Protecting Our Workers and Ensuring Reemployment (POWER) initiative, supporting and enabling the timely submission of claims and assisting injured Federal employees in returning to meaningful jobs as soon as possible. For the 14 largest agencies, FEC helped 91.5 percent of claimants under disability management return to work within 2 years. Also, nearly 97 percent of traumatic injury cases were adjudicated within 45 days of the date of receipt of the notice of injury. Through directed review by FEC staff, $14.3 million in compensation benefit costs were saved. Another of FEC's major accomplishments was the successful deployment of the Employees' Compensation Operations and Management Portal (ECOMP) which is providing employing agencies with a web-based tool to electronically file workers' compensation forms and upload related claims documents directly to the FEC case management system.

Under Part C of the Black Lung Benefits Act (BLBA) the Black Lung program received over 4,800 new claim filings during FY 2012, nearly 5,400 when including survivor conversions. During the year the program paid out $210 million in monthly compensation and medical benefits from the Black Lung Disability Trust Fund for nearly 22,000 Part C beneficiaries. In addition, $166 million in compensation benefits were paid to more than 21,000 beneficiaries under Part B of the BLBA. The Black Lung program also continued to monitor compensation and medical benefits that were disbursed by responsible coal mine operators and insurers to nearly 4,600 miners and survivors. Also in FY 2012, the program reduced the backlog of pending Proposed Decisions and Orders that were over 240 days old by 82 percent.

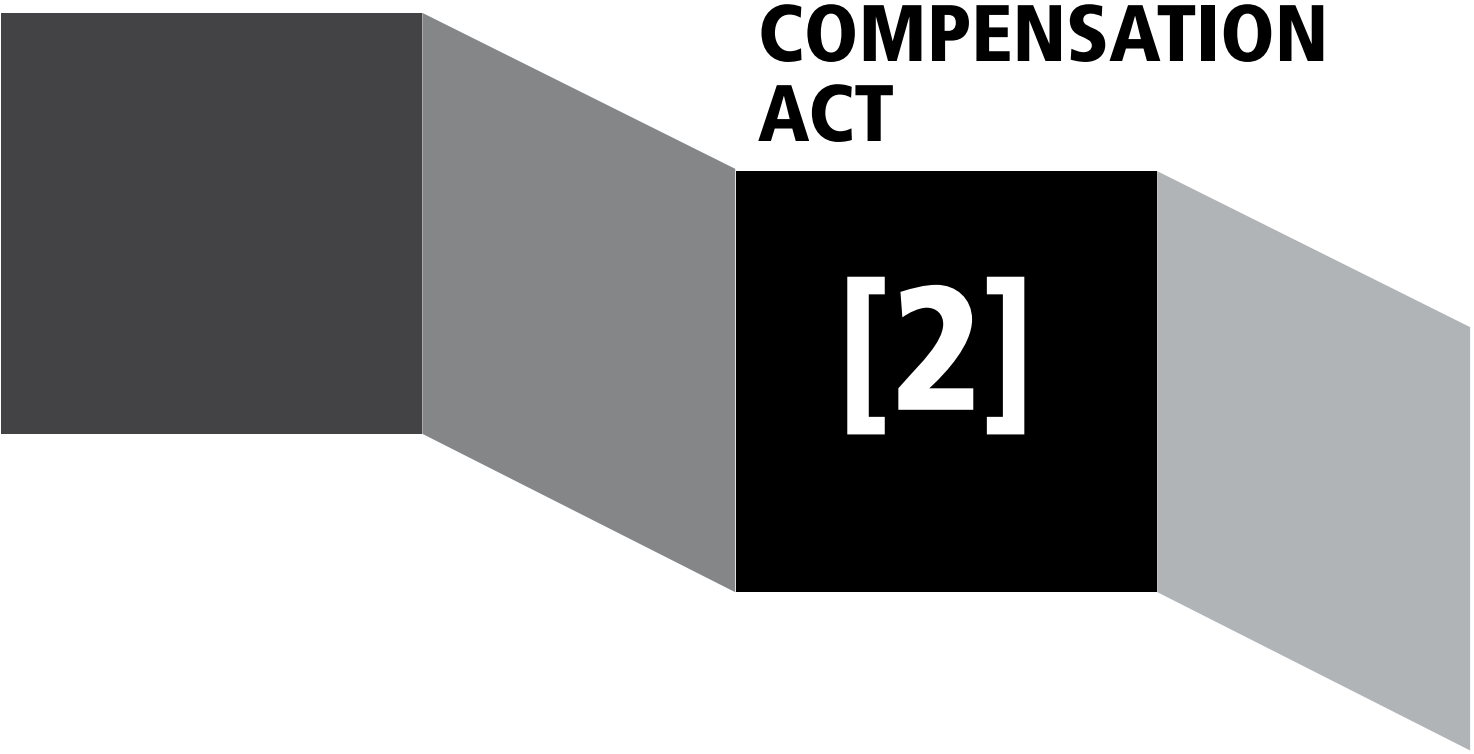
In FY 2012, the Longshore program received over 29,000 new lost-time injury claims and assisted in the return of 300 injured workers to gainful employment. In addition, 12,165 cases of injury and death were reported under the Defense Base Act (DBA). Despite the continuing high number of claims received during FY 2012, the Longshore program maintained its high level of performance by meeting or exceeding its Government Performance Results Act (GPRA) targets for the receipt of First Report of Injury and First Payment of Compensation within 30 days for both DBA and non-DBA cases. In addition, the final rules implementing the amendment to the Longshore Act's recreational vessel exclusion were promulgated in FY 2012.

Under both Parts B and E of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), the Energy program received more than 17,000 new claims during FY 2012 from Department of Energy (DOE) employees or their survivors, contractors and subcontractors who have cancer and other illnesses caused by exposure to radiation and toxic substances. Over $1.1 billion in compensation and medical benefits were provided to these beneficiaries during the year. Outside of its claims adjudication and payment responsibilities, the Energy program focused a large amount of its time and effort on technological improvements that will help the program continue to provide high levels of services to its beneficiaries and other stakeholders. Included in these improvements in FY 2012 was the deployment of an integrated and expanded mission-critical case management system, the Energy Compensation System. Also, and in conjunction with DOE, planning and work was launched on a new method to share and verify employment and other secure claimant information electronically, while the expansion and enhancements continued on both the Site Exposure Matrices and National Library of Medicine Haz-Map Occupational Health databases. All three of the Energy program's GPRA goals were once again achieved. The processing time goal for Part B claims of 100 days was exceeded as only 92 days on average were needed, and for Part E, the program exceeded the 125 day goal as initial claims were processed in an average of 104 days. Also, 92 percent of the Part B and Part E final decisions were issued by the program's Final Adjudication Branch within the program's timeliness standards, in excess of the 90 percent goal.

Each of the four programs under OWCP had many noteworthy accomplishments during FY 2012. These achievements are directly related to the efforts and determination of all of our employees, not just the National Office, but in each and every Region and District Office that makes up OWCP. In meeting or exceeding the majority of our challenging performance goals, while improving the management and efficiency of our programs, OWCP staff has once again demonstrated their expertise and dedication to delivering the best possible services to our customers and stakeholders.

Gary A. Steinberg
Acting Director, Office of Workers'
Compensation Programs

FEDERAL EMPLOYEES' COMPENSATION ACT



Federal Employees' Compensation Act

Introduction

In 1916, President Wilson signed the first comprehensive law protecting Federal workers from the effects of work injuries. Amended several times, the Federal Employees' Compensation Act (FECA) now provides workers' compensation coverage to approximately 2.8 million Federal workers. The FECA also provides coverage to Peace Corps and VISTA volunteers, Federal petit and grand jurors, volunteer members of the Civil Air Patrol, Reserve Officer Training Corps Cadets, Job Corps, Youth Conservation Corps enrollees, and non-Federal law enforcement officers when injured under certain circumstances involving crimes against the United States.

For 96 years, the Federal Employees' Compensation (FEC) program has continuously evolved to meet its commitment to high quality service to employees and Federal agencies, while minimizing the human, social and financial costs of work-related injuries.

Benefits and Services

The primary goal of the FEC program is to assist Federal employees who have sustained work-related injuries or disease by providing financial and medical benefits as well as help in returning to work. FECA benefits include payment for all reasonable and necessary medical treatment for work-related injury or disease. In timely-filed traumatic injury claims, the FECA requires the employer to continue the injured worker's regular pay during the first 45 calendar days of disability. If the disability continues after 45 calendar days, or in cases of occupational disease, the FEC program will make payments to replace lost income. Compensation for wage loss is paid at two-thirds of the employee's salary if there are no dependents, or three-fourths if there is at least one dependent. The FECA provides a monetary award to injured workers for permanent impairment of limbs and other parts of the body and provides benefits to survivors in the event of work-related death. Training and job placement assistance is available to help injured workers return to gainful employment.

In Fiscal Year (FY) 2012, the FEC program provided nearly 243,000 workers and survivors over $3.0 billion in benefits for work-related injuries, illnesses, or deaths. Of these benefit payments, nearly $2.0 billion were for wage-loss compensation, $929 million for medical and rehabilitation services, and $140 million for death benefit payments to surviving dependents.

The FECA is the exclusive remedy by which Federal employees may obtain disability, medical, and/or survivor benefits from the Federal government for workplace injuries. Decisions for or against the payment of benefits may be appealed to the Employees' Compensation Appeals Board (ECAB), an independent body in the Department of Labor (DOL). Program activities are carried out in the 12 program district offices around the country.

Funding

BENEFIT OUTLAYS UNDER FECA FY 2012 Total Benefits: $3,025 Million*		
Long Term Disability (Wage-Loss)	**51.9%**	$1,570 Million
Medical Benefits	**30.7%**	$929 Million
Temporary Disability (Wage-Loss)	**12.8%**	$386 Million
Death Benefits	**4.6%**	$140 Million
*Actual Obligations		

Benefits are paid from the Employees' Compensation Fund. Agencies are billed each August for benefits paid for their employees from the Fund, and most agencies, other than the U.S. Postal Service (USPS) and non-appropriated fund agencies, include those chargeback costs in their next annual appropriation request to Congress. Remittances to the Fund are not made until the first month of the subsequent fiscal year (or later, when an agency's full-year appropriation is enacted after the subsequent fiscal year begins). The annual DOL appropriation makes up any difference between prior year remittances and current year need, which is affected by Federal wage increases and inflation in medical costs.

Expenses for a small number of cases are not charged back to employing agencies, but also are covered by the DOL appropriation. For FY 2012, these non-chargeback expenses were approximately $73.1 million. Non-chargeable costs are attributable to injuries that occurred before December 1, 1960, when the chargeback system was enacted, to employees of agencies that are no longer in existence, or to injuries which have FECA coverage under various "Fringe Acts" such as the Contract Marine Observers Act, Law Enforcement Officers Act, and the War Hazards Compensation Act (WHCA). War Hazards payouts were $54.5 million in FY 2012, significantly higher than in FY 2006 when payouts were only $2 million. The higher costs reflect the increased involvement of contractor staff in Iraq and Afghanistan, which has resulted in a growing volume of claims under the Defense Base Act, leading to reimbursement requests under the WHCA for injuries and deaths caused by hostile action.

For FY 2012, administrative expenditures for the FEC program totaled $173.5 million. Of this amount, $160.2 million, approximately 5.0 percent of total program costs, were direct appropriations to the DOL's Office of Workers' Compensation Programs (OWCP), including $98.0 million in salaries and expenses and $62.2 million in "fair share" expenditures out of the FECA Special Benefits account. These latter funds are specifically earmarked for OWCP capital investments for the development and operation of automated data management and operations support systems, periodic roll case management, and benefit oversight. Another $13.3 million are separately appropriated to the Department for legal, investigative, and other support from the ECAB, Office of the Solicitor, the Office of the Inspector General, and the U.S. Treasury.

Protecting Our Workers and Ensuring Reemployment (POWER) Initiative

Losing skilled employees to injury or illness in the Federal government has numerous costly effects, both direct and indirect. The loss in productivity, increased workers' compensation costs, and loss of professional development for the injured employees strain Federal resources. These costs can be lowered by reducing the number and severity of injuries that occur and facilitating the return to work of employees who sustain a workplace injury or illness. Successive Executive Branch initiatives have designated DOL, through OWCP and the Occupational Safety and Health Administration (OSHA), as the lead in improving government-wide safety and return to work. These include Federal Worker 2000; Safety, Health, and Return to Employment (SHARE); and most recently, Protecting Our Workers and Ensuring Reemployment (POWER) initiatives, which was announced by President Barack Obama in July 2010.

The POWER initiative calls on Federal agencies to establish ambitious but reachable goals aimed at minimizing the impact of workplace injuries. POWER builds on the accomplishments and outreach of prior safety, health and return-to-work initiatives and tasks agencies with the additional objectives of analyzing data, timely filing wage-loss claims, and returning seriously injured employees to the Federal workplace.

POWER goals included three administered by OSHA:

- Reducing total injury and illness case rates.
- Reducing lost time injury and illness case rates.
- Analyzing lost time injury and illness data.

The Division of Federal Employees' Compensation (DFEC) is responsible for four other POWER goals. In FY 2012, the government-wide targets for these goals were:

- Increase the percent of Notices of Injury filed by Federal employers within 10 days to 82 percent.
- Increase the percent of Wage-Loss Claims filed by Federal employers within 5 days to 64 percent.
- Reduce agency Lost Production Day Rates (per 100 employees) to 35.1 days.
- Increase the percent of FECA Disability Management Cases returned to work within two years to 88.4 percent.

Federal agencies have successfully responded and have worked constructively with DOL to improve results. The number of new Federal injury claims filed annually with DOL by Federal agencies has declined and fewer new injury cases, coupled with shorter average time away from work, have dropped gross lost production days.

Timely Submission of Notices of Injury and Wage-Loss Claims. The ability of DFEC to promptly initiate intervention and return-to-work services is improved if Federal employers are timely in the submission of injury reports and wage-loss claims. Earlier receipt of these forms also enables DFEC to begin claims adjudication and payment processing sooner. For these reasons, POWER includes two goals to improve timely submission. In FY 2012, Federal agencies (less the U.S. Postal Service) filed 86.2 percent of Notices of Injury within 10 work days. Agencies also filed 75.9 percent of wage-loss claims within 5 days. Both results exceeded the established targets. Fourteen agencies are using Electronic Data Interchange (EDI) systems to report injuries electronically. Most of these agencies made immediate significant gains in timeliness subsequent to adoption of EDI. To expand electronic filing capability to all agencies, DFEC developed a web-based capability (ECOMP) that extends the electronic submission capability to all employing agencies and further reduces the time of delivery.

Reduce Government-Wide Lost Production Day (LPD) Rates. Under POWER, individual Executive Branch agencies are directed to reduce LPD rates (per 100 employees) by one percent per year through FY 2014. In FY 2012, the government-wide average LPD rate was 34.5 days which exceeded the goal of 35.1 days, but was an increase over the FY 2011 performance of 33.2 days. To support achievement of POWER's four-year LPD and return-to-work goals, DFEC established the POWER Return-to-Work (RTW) Council, with the 14 largest Federal agencies as a forum to review performance results, share best practices, and set individual agency goals that will improve results.

Increase the Share of Federal Employees that Return to Work within Two Years of Entering FECA's Disability Management Program. POWER's four-year target is to increase the overall share of cases that are returned to work by the 14 largest Executive Branch agencies to 92 percent within two years of the cases' start of management by DFEC. Performance during the first two years of the POWER initiative out-paced the set annual goals by several percentage points. As a result, the goals were set against FY 2011 as a new baseline and the new four-year target is to increase the overall share of cases returned to work by these 14 agencies to 95 percent. In FY 2012, 91.5 percent of the injured workers had been returned to work within two years. This performance exceeded the goal of 88.4 percent for FY 2012, but represented a slight decrease from the 91.6 percent of employees returned to work in FY 2011. OWCP, along with DOL's Office of Disability Employment Policy (ODEP) conducted a study in FY 2012 to identify return-to-work best practices used by Federal agencies and document the obstacles that restrict agency return-to-work efforts. Findings were shared through the POWER RTW Council in September 2012. The larger agency community was invited to a public meeting of the Council, and Economic Systems, Incorporated presented the best and most promising practices identified through their research. OWCP/ODEP will continue to evaluate the results of the study in order to determine how to best implement them in return-to-work efforts with Federal agencies.

Achievement of these goals in FY 2012 was due to a combination of earlier identification and delivery of services to new injury cases, Disability Management process and coordination improvements, and effective use of the POWER initiative to focus Federal agencies on performance results.

In support of the POWER initiative, OWCP established the POWER Return to Work Council to serve as a forum for discussion and exchange of best practices in the area of return to work; to review the results of analytical studies on return to work and promote sharing and implementation of best practices identified; and, to form a bridge between the workers' compensation and disability hiring personnel and establish a community of practice for the sharing of information, ideas and experiences.

The Council is composed of representatives of the 14 agencies subject to the return-to-work goal of the POWER initiative, as well as representatives from DOL's Office of Disability Employment Policy, OSHA's Office of Federal Agency Programs and the Office of Personnel Management. The Council met several times during FY 2012 to discuss best practices, share information regarding disability hiring and accommodations in their agencies, and hear the findings of the ODEP return-to-work study. Additionally, the Council participated in discussions with OWCP about increasing the timely filing and return-to-work targets for the final two years of the POWER initiative.

The POWER Council also works in support of Executive Order 13548 on increasing the Federal employment of individuals with disabilities. The reemployment of injured workers in the Federal government is cited in this document and the Secretary of Labor is tasked with proposing specific outcome measures and targets by which each agency's progress is assessed. The goals of the POWER initiative and the Council address this directive. Major implementing strategies include establishing performance targets and providing support to Federal agencies to improve reemployment and retention of injured workers. OWCP is collaborating with the Director of the Office of Personnel Management and DOL's ODEP to pursue innovative reemployment strategies and craft and advance policies, procedures, and structures that foster improved return to work.

Case Adjudication and Management

Approximately 116,000 new injury and illness claims were filed under FECA in FY 2012. Eighty-six percent were for traumatic injuries, such as those caused by slips and falls. The rest were for medical conditions arising out of long-term exposure, repeated stress or strain, or other continuing conditions of the work environment. The program has established varying standards for the prompt adjudication of these claims, depending on the relative complexity of the case, and has met those standards in a high percentage of cases. For traumatic injury claims, 96.7 percent were adjudicated within 45 days of the day OWCP received notice of the injury. In FY 2012, the FEC program also achieved a high rate of timeliness in deciding non-traumatic injury claims despite the complexities involved. For "basic" occupational disease cases with an uncomplicated fact pattern, 94 percent were adjudicated within 90 days. Of the more complex non-traumatic cases, 88.4 percent were adjudicated within 180 days.

The FEC program has reduced time loss in new injury cases under its Quality Case Management (QCM) program since FY 1996. Under QCM every injury case with a wage-loss claim filed and no return-to-work date is reviewed for assignment to an early intervention nurse contracted by the FEC program. As soon after the injury as practicable, the nurse meets with the injured worker and serves as the human face of OWCP. Coordinating medical care and return-to-work issues, the nurse not only works with the injured employee but also the attending physician and the employing agency. If it seems that the injured worker will not return to work soon, the nurse coordinates the transfer of the case for vocational rehabilitation services and/or more aggressive medical intervention.

In FY 2012, 7,935 injured Federal employees returned to work as a result of early nurse intervention. Additionally, vocational rehabilitation counselors arranged training, when necessary, and successfully placed 118 injured workers into non-Federal employment, plus another 278 with previous or new Federal employers. In the past few years, the government-wide average length of disability in QCM cases (lost production days within the first year from the date FECA wage-loss began) has risen due to an increase in USPS cases in QCM and the Postal Service's reduced capacity to offer or maintain return-to-work opportunities. Whereas average LPD in QCM cases was 142 days in FY 2009, average LPD was 168 days in FY 2012.

The FEC program continued to dedicate resources to the thorough review of long-term disability cases. As part of that review, Periodic Roll Management (PRM) staff arranges second opinion medical examinations to reassess changes in medical condition and fitness for work and recommends referral to vocational rehabilitation and placement assistance with a goal of reemploying injured workers. Of the cases that were screened in FY 2012, the disability in 1,195 cases had either resolved or lessened to the point that return to work or adjustment of benefits was possible. Adjustment or termination of benefits resulting from the changes in these cases produced $14.3 million in first year compensation benefit savings.

DFEC is currently exploring new methods for contracting medical advisor, nurse and vocational rehabilitation services to further improve delivery of services.

Services to Claimants and Beneficiaries

Quality customer service and customer satisfaction are key components of DFEC's mission and "Pledge to Our Customers." Over 1.8 million calls were received by the DFEC district offices during FY 2012, many of which were handled by Customer Service Representatives (CSRs) in the 12 district offices. During FY 2012, calls were connected in an average of less than three minutes which is DFEC's service standard. The average wait and response times for callers were below the established targets, and 95 percent of calls were answered in less than two days from receipt.

DFEC began deployment of the new Voice-Over Internet Protocol telephone system in FY 2011. The system replaced antiquated hardware with feature-rich hardware and supporting software. Simultaneously, a self-help call system was devised which allows users to get real-time information about a workers' compensation claim without having to await a call back from claims staff. This automated self-help system is available 24 hours per day. The new system interfaces with the iFECS system, thereby allowing DFEC to automatically capture all telephone messages left for claims staff and associate these calls with a specific case. Deployment of this system was concluded in FY 2012 with DFEC's National Office going live in February 2012.

The new system also allows for much greater flexibility in monitoring calls handled by CSRs. To help ensure quality and to identify areas where additional CSR training is needed, silent monitoring of calls to the district office phone banks continued during the fiscal year. Communications Specialists on DFEC's staff listen to both sides of a conversation and, using a standardized Quality Monitoring scorecard, document the CSRs' performance. The results of quality silent monitoring coupled with local telephone survey results show that 99.1 percent of callers received courteous service in FY 2012. The use of clear and understandable language was reported in 98.7 percent of calls, and 97.7 percent of calls met knowledge and accuracy standards. The goal of 95 percent was exceeded in each of these quality categories.

Across the 12 district offices, more than 76,000 written responses to routine inquiries were provided and 93 percent were sent within 30 days. In addition, over 4,600 written priority inquiries were received and 96 percent of them were answered within 14 days, well above the goal of 90 percent. Over 5,000 pieces of written correspondence were sampled in FY 2012. Ninety-nine percent of them met the standards for courtesy, 99 percent of them were written in clear and understandable language, and 96 percent met knowledge and accuracy standards. The goal of 95 percent was exceeded in all three of these quality categories.

Hearings and Review

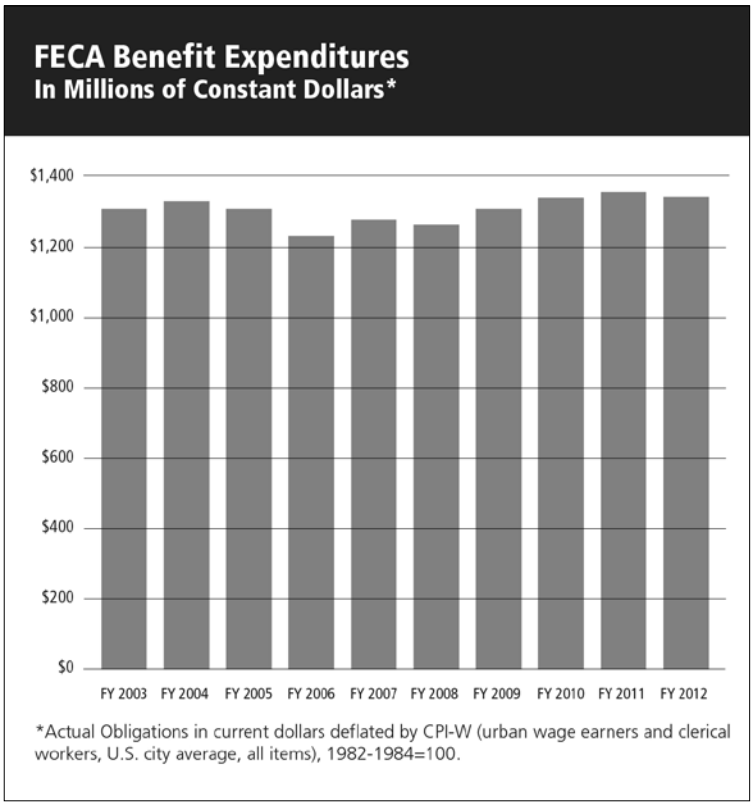
Individuals who disagree with an Office formal decision on a claim may exercise their appeal rights by requesting an oral hearing or a review of the written record from the Branch of Hearings and Review. In FY 2012, the branch received a total of 6,412 incoming requests for reviews of the written record and oral hearings and issued a total of 6,961 decisions.

In FY 2012, customer service and turnaround times remained constant for all of the measured areas. The branch exceeded all established program goals in the three measured categories. The period of time between receipt of an appealed case file and the issuance of a remand or reversal before a hearing in FY 2012 was 54 days. In cases where claimants requested oral hearings, the time period between receipt of an appealed case file and the issuance of decision for FY 2012 was 164 days. For appeals initiated from a review of the written record, the time period for issuance of a decision was 77 days in FY 2012.

In the interest of improving appeal processing times and efficiency, the branch continued to handle hearing requests originating in geographical areas less traveled via telephone hearings; 1,125 telephone hearings were conducted in FY 2012. The branch also continued to conduct proceedings via videoconferencing, increasing productivity associated with hearings. For FY 2012, the branch conducted 728 hearings via teleconferencing. About 14 percent of the approximately 3,800 hearings scheduled during FY 2012 were actually held in person. The use of telephone and video hearings resulted in a speedier appellate process for FECA stakeholders and significant cost savings for the FEC program.

iFECS

DFEC continues to build on its sophisticated information technology claims processing support system: the integrated Federal Employees' Compensation System (iFECS). In FY 2012, DFEC implemented the design, development and implementation of a web portal system for processing forms and submitting documents (ECOMP).



Interactive Voice Response (IVR) Improvements and VOIP Phone System. In January 2011, DFEC implemented the new IVR system in the first district office. The new system automates the process of providing self-service data to every caller via an expanded menu of self help options. Through this significant enhancement of access to case data via telephone, the CA-110 (DFEC call record form) is automatically generated upon the completion of a call. This allows the program to maintain better control of incoming requests for information, and thereby assists with better management of prompt and comprehensive responsiveness to customers and stakeholders. The system provides monitoring and reporting capabilities for tracking workforce performance and supporting workload projections. The system employs a Voice over Internet Protocol (VOIP) phone system that leverages the enterprise system with the Wage and Hour Division of DOL, and as a result reduces toll calls, relieving this cost burden from customers and stakeholders. The IVR system improved and enhanced telephonic access to FECA data for claimants and employing agencies and provides the DFEC staff with the telephonic tools needed to make telework possible for the majority of its workforce. In FY 2012, the DFEC National Office began use of the VOIP phone system. Additionally, enhancements were made to emergency dialing capability.

Centralization of Case-Create/Imaging (3CI). On average, approximately 10,000 new cases are created for DFEC claimants each month, and all documents submitted with these claim forms are imaged into iFECS. DFEC identified a potential for significant cost savings through the centralization of these case-create functions, which had been previously carried out in each of the 12 DFEC district offices.

DFEC launched the central case create facility in late FY 2011 and continued to perfect and refine the processes during FY 2012. New claims for injury and illness, as well as compensation claims, are now submitted to and created by a central case create system run across two facilities. The process of moving 12 case create and data entry operations to two facilities was complex and involved the realignment of personnel, the development of new IT processes, the creation of two new processing sites (Jacksonville and Kansas City), and ongoing outreach and support to external stakeholders impacted by this change – namely injured Federal workers and their employing agencies. In addition to being centralized to one mailing address and fax number, the IT work flow for creating the forms once they have been submitted has been vastly improved through reengineering and automation. The centralization of case-create functions also allow for greater management oversight, leading to more consistent and accurate creation of claims.

Centralized case create provides DFEC with the tools and processes to create claims faster, more consistently, and with a greater degree of accuracy, thus providing superior customer service to all stakeholders. The quicker creation of claims allows injured workers to receive the benefits to which they are entitled in a more timely fashion. It also allows DFEC to identify and manage disability earlier.

Web Portal Forms Processing and Document Submission (ECOMP). In August 2011, DFEC finalized regulations requiring all Federal agencies to provide a method for electronically filing key claim forms by December 31, 2012. In recognition that not all agencies would have the resources needed to develop their own EDI systems, DFEC designed ECOMP, a web-based portal offered free of charge to the entire Federal government. ECOMP supplements the EDI-based system currently available to only a few employing agencies, and provides electronic submission of safety and claims-related documents.

The first component of ECOMP, which was deployed in October 2011, is the Web Enabled Electronic Document Submission feature. This portion of ECOMP provides claimants, employers and medical providers the ability to electronically upload and submit documents to DFEC through its secure web portal. This ability to instantaneously communicate and submit documents to DFEC claims staff instead of mailing or faxing documents will save DFEC the processing fees that are currently associated with scanning mail into the case file system. Stakeholders also save on postage fees, and DFEC and stakeholders alike enjoy a more expeditious exchange of information while still maintaining the security of personal information. Over 30,000 documents are now submitted monthly via this feature.

In addition to the document upload features, ECOMP enables injured workers employed with enrolled agencies to electronically file DFEC and OSHA forms. Supervisors and agency reviewers have the tools to route, review and track claim forms as they are being processed. The system supports Section 508 compliance (accessibility integration for users with disabilities) and allows users to manage their claims during the submission processes in a safe and secure manner. The system also employs a sophisticated workflow process that can be edited and managed by the client agencies in order to deal with potential future requirement changes (such as department and personnel changes). In addition to being able to manage and track the filing of safety and claim forms, enrolled agencies are provided with reporting functionality which allows them to proactively manage their timely filing rates, conduct risk management and injury trends analyses, and compile their OSHA 300/300A log. By the end of FY 2012, 12 departments or agencies were filing their claim forms through ECOMP. These agencies are experiencing the benefits of ECOMP, which include increased timely filing rates and a more transparent claims submission process that provides information on the status of claim forms to the claimant, agency, and DFEC.

Central Medical Bill Processing

OWCP's medical bill processing service continued to achieve improvements in operating efficiencies. During FY 2012, DFEC avoided $72.8 million in additional costs due to further improvements in the editing of bills, which in turn reduced costs charged back to agencies without increasing costs to claimants.

In FY 2012, the bill processing vendor processed 4.7 million bills. Timely and accurate medical bill processing is a critical element in administration of the FECA. Authorizations for medical treatment were processed in an average of 2 workdays and 99.6 percent of bills were processed within 28 days. In FY 2012, the bill processing system was enhanced to include pricing for prescription drugs dispensed in a physician's office. New claimant travel mileage also was implemented to reduce the mileage authorization from 500 miles to 200 miles. Enrollment of 13,281 new providers brought the total of enrolled providers for FECA to 214,321.

FECA BENEFITS CHARGED TO EMPLOYING AGENCIES
Chargeback Year 2012

Chargeback Total: $3,006 Million

Postal Service	$1,320 Million
Defense	$621 Million*
Veterans Affairs	$201 Million
Homeland Security	$178 Million
Justice	$117 Million
Transportation	$102 Million
Agriculture	$74 Million
All Other	$393 Million

*Defense Includes Navy ($240M), Army ($178M), Air Force ($133M), and Dept. of Defense ($70M)

Note: The sum of individual agencies may not equal total due to rounding

Regulatory and Legislative Reform

The FECA regulations were last substantially revised in 1999 and were in need of updating. A Notice of Proposed Rulemaking was published in the Federal Register on August 13, 2010, and the comment period closed on October 12, 2010. After review of all comments submitted, the Final Rule was published on June 28, 2011, effective as of August 29, 2011. During FY 2012, DFEC updated procedural guidance based on the changes conveyed by the new regulations and communicated with stakeholders to enhance understanding of the new rules.

On December 31, 2011, 5 U.S.C. Section 8102a, the law authorizing death gratuities under FECA, was amended by Section 1121 of Public Law 112-81. Pursuant to that amendment, Federal employees may now designate the entire FECA death gratuity to an alternate beneficiary (previously, this designation was limited to 50 percent of the FECA death benefit). Effective with the enactment of this amendment, the employing agency is required to notify the Federal employee's spouse, if one exists, if that employee designates a person other than the spouse to receive all or a portion of the FECA death gratuity. DFEC also updated the form CA-40 (Designation of a Recipient of the Federal Employees' Compensation Act Death Gratuity Payment under 5 U.S.C. Section 8102a) to reflect this change.

As proposed in the President's Budget, DFEC also continues to pursue changes to the FECA that would strengthen the program by enhancing incentives for injured employees to return to work; address retirement equity issues; improve administration; and update and improve benefit payments in certain circumstances. Specifically, the DOL reform proposal includes:

- Converting compensation for new injuries or new claims for disability to a lower benefit at the Social Security retirement age.
- Moving the 3-day waiting period during which an injured worker is not entitled to compensation to the point immediately after an injury.

- Paying schedule awards at a uniform rate concurrent with wage-loss payments.
- Eliminating augmented compensation and raising the basic benefit level for all claimants to 70 percent.
- Allowing OWCP to recover the costs paid by responsible third parties to FECA beneficiaries during the continuation of pay period.
- Increasing outdated funeral expenses from $1,000 to $6,000.
- Increasing benefit levels for facial disfigurement resulting from work injury.
- Identifying unreported earnings and retirement benefits through regular data base matching with the Social Security Administration.
- Creating a return-to-work plan for an employee where appropriate.
- Extending the continuation of pay period to 135 days for employees injured in a Zone of Armed Conflict.

During FY 2012, the House of Representatives and the Senate both passed bills including many of the same FECA reform provisions as in the Administration's proposal.

Program Evaluations and Studies

Throughout FY 2012, DFEC worked with DOL's Office of Disability Employment Policy (ODEP) and Economic Systems, Inc., on a study of the return to work of injured Federal employees with their Federal agencies. The report focused on four agencies for study: Department of Veterans Affairs, Transportation Security Administration, Department of Defense, and Architect of the Capitol. The final report, received at the end of Fiscal Year 2012, identified best and promising practices used by these four agencies to promote the return to work of their employees who sustain serious workplace injury or illness. Economic Systems presented their findings to the POWER Return to Work Council and the larger agency community at an Interagency/POWER Council meeting on September 20, 2012. OWCP will discuss and validate the findings of the report with the POWER Return to Work Council in early FY 2013. DFEC will work with ODEP and the POWER Return to Work Council to determine how to disseminate the best and promising practices identified in this study to the large Federal agency community.

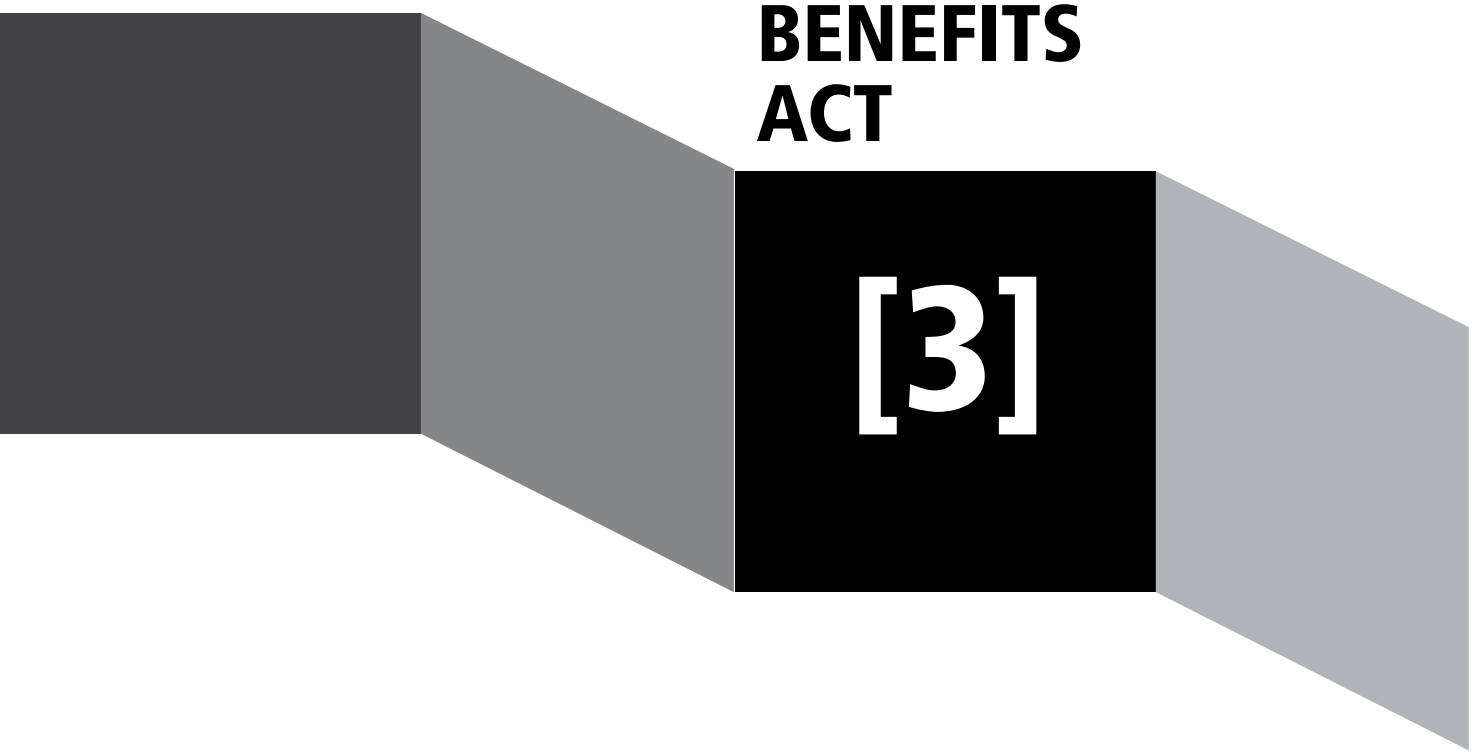
FEDERAL EMPLOYEES' COMPENSATION ACT		
	FY 2011	FY 2012
Number of Employees (FTE Staffing Used)	838	837
Administrative Expenditures[1]	$153.6 M	$160.2 M
Cases Created	121,290	115,697
Wage-Loss Claims Initiated	20,239	19,806
Total Compensation and Benefits (Actual Obligations)[2]	$2,983.9 M	$3,024.9 M
Number of Medical Bills Processed	5,100,000[R]	5,300,000

[1] OWCP expenditures; excludes DOL support costs, but includes "fair share" capital expenditures of $55.4 million in FY 2011 and $62.2 million in FY 2012, respectively.

[2] Compensation, medical, and survivor benefits.

[R] Revised.

BLACK LUNG BENEFITS ACT



Black Lung Benefits Act

Introduction

The Division of Coal Mine Workers' Compensation (DCMWC) completed its thirty-ninth year administering Part C of the Black Lung program in 2012. The initial Black Lung benefits program was enacted as part of the Coal Mine Health and Safety Act of 1969 (the Act). This law created a system to compensate victims of dust exposure in coal mines with public funds initially administered by the Social Security Administration (SSA).

The number of claims filed in the early 1970's greatly exceeded expectations. The Act was amended by the Black Lung Benefits Act of 1972 (BLBA) which simplified interim eligibility criteria for all claims filed with SSA, and transferred processing of new claims to the Department of Labor (DOL) in 1973. OWCP assumed responsibility for processing and paying new claims on July 1, 1973. Further amendments in the Black Lung Benefits Reform Act of 1977 (Public Law 95-239) mandated that all pending and denied claims be reopened and reviewed using interim medical criteria. The Black Lung Benefits Revenue Act of 1977 (Public Law 95-227) created the Black Lung Disability Trust Fund (Trust Fund), financed by an excise tax on coal mined and sold in the United States. The law authorized the Trust Fund to pay benefits in cases where no responsible mine operator could be identified and transferred liability for claims filed with DOL based on pre-1970 employment to the Trust Fund. It also permitted miners approved under Part B to apply for medical benefits available under Part C. These amendments made the Federal program permanent but state benefits continued to offset Federal benefits where they were available.

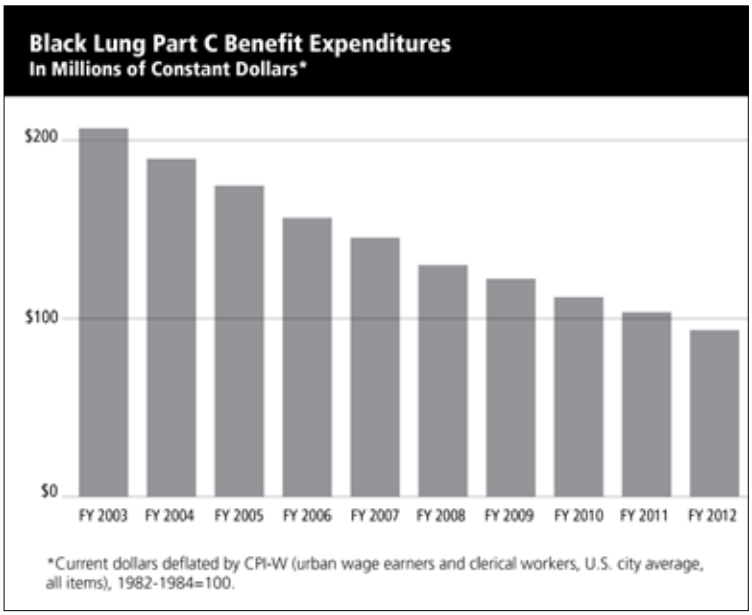
The 1981 Amendments to the Act tightened eligibility standards, eliminated certain burden of proof presumptions, and temporarily increased the excise tax on coal to address the problem of a mounting insolvency of the Trust Fund, which was indebted to the U.S. Treasury by over $1.5 billion at that time.

In 1997, the responsibility for managing active SSA (Part B) Black Lung claims was transferred to DOL by a Memorandum of Understanding between SSA and DOL. This change improved customer service to all Black Lung beneficiaries and was made permanent in 2002 when the Black Lung Consolidation of Administrative Responsibilities Act placed the administration of both programs with DOL.

The Act was most recently amended by several provisions included in the Affordable Care Act which was signed into law in March 2010. These amendments restored two provisions of the Act that had been eliminated by the 1981 Amendments. First, they reinstated the provision that dependent survivors of miners who were receiving benefits at the time of their death were automatically entitled to benefits and did not need to establish that the miner's death was due to pneumoconiosis. Second, they restored a rebuttable presumption that a miner's total disability or death was due to pneumoconiosis upon proof that the miner worked at least 15 years in qualifying coal mine employment and suffered from a totally disabling respiratory or pulmonary impairment. The amendments apply to all claims filed after January 1, 2005, provided that the claim is pending on or after March 23, 2010.

Benefits and Services

The Black Lung Part C program provides two types of benefits: monthly wage replacement and medical services. The program pays a standard monthly benefit (income replacement) to miners who are determined to be totally disabled from black lung disease and to certain eligible survivors of deceased miners. The monthly rate of benefits is adjusted upward to provide additional compensation for up to three eligible dependents. In FY 2012, monthly and retroactive benefit payments totaled $179.4 million.



The Part C program also provides both diagnostic and medical treatment services for totally disabling pneumoconiosis. Diagnostic testing is provided for all miner-claimants to determine the presence or absence of black lung disease and the degree of associated disability. These tests include a chest x-ray, pulmonary function study, arterial blood gas study, and a physical examination. Medical coverage for treatment of black lung disease and directly related conditions is provided for miner-beneficiaries. This coverage includes prescription drugs, office visits, and hospitalizations. Also provided, with prior approval, are durable medical equipment (primarily home oxygen), outpatient pulmonary rehabilitation therapy, and home nursing visits.

Medical expenditures under the Black Lung Part C program during FY 2012 were $31.0 million. This includes payments of $5.7 million for diagnostic services, $24.4 million for medical treatment, and $0.9 million in reimbursements to the United Mine Workers of America Health and Retirement Funds for the cost of treating Black Lung beneficiaries. Approximately 161,000 bills were processed during the year.

Total Black Lung Part C program expenditures for all benefits in FY 2012 were $210.4 million, a decrease of $17.0 million from FY 2011. In FY 2012, benefits were provided from the Trust Fund to approximately 21,500 beneficiaries each month.

In addition to Trust Fund expenditures, self-insured mine operators and insurance companies provided compensation payments of approximately $32 million to about 4,590 miners and survivors. An estimated $5 million also was paid in medical treatment benefits, for an estimated cost to the industry of $37 million during FY 2012. These estimates are an increase over the previous year, as more survivors were eligible for benefits because of the ACA, and because of a presumed increase in medical treatment spending per eligible miner.

State workers' compensation laws require coal mine operators to obtain insurance or qualify as a self-insured employer to cover employee benefit liabilities incurred due to occupational diseases that are covered by state law. If state workers' compensation is paid for pneumoconiosis, any Federal black lung benefit received for that disease is offset or reduced by the amount of the state benefit on a dollar-for-dollar basis. As of September 30, 2012, there were 939 Federal black lung claims being offset due to concurrent state benefits. An additional 66 were being offset due to other Federal benefits, and 20 due to earnings offsets.

As an additional benefit to claimants, the law provides for payment of attorneys' fees and legal costs incurred in connection with approved benefit claims. The fees must be approved by adjudication officers. During the past fiscal year DCMWC processed 163 fee petitions and paid approximately $0.5 million in attorneys' fees from the Trust Fund.

In FY 2012, 1,257 claims were forwarded for formal hearings before the Office of Administrative Law Judges (OALJ) and 459 claims were forwarded on appeal to the Benefits Review Board (BRB). At the end of FY 2012, the OALJ had 2,455 claims pending while 455 were pending before the BRB.

In the Black Lung Part B program, nearly 20,000 active beneficiaries (with more than 1,700 dependents) were receiving nearly $14 million in monthly cash benefits as of September 30, 2012. Part B benefits in FY 2012 totaled $166.1 million. DCMWC completed more than 3,300 maintenance actions on Part B claims during the year, on average less than two weeks from notification.

In order to maintain the integrity of benefit payments and reduce the incidence of improper payments, the Black Lung program continued to match its beneficiary file to the Social Security Administration's Death Master File on a weekly basis in order to be alerted of any deaths in the beneficiary population. DCMWC also continued to maintain the accuracy of payments by updating beneficiary information annually.

Black Lung Disability Trust Fund

The Trust Fund, established in 1977 to shift the responsibility for the payment of black lung claims from the Federal government to the coal industry, is administered jointly by the Secretaries of Labor, the Treasury, and Health and Human Services. Claims that were approved by SSA under Part B of the BLBA are not paid by the Trust Fund, but rather from the general revenues of the Federal government. Because the Trust Fund was established at the same time the Reform Act liberalized eligibility for benefits, and because retroactive benefits far exceeded the collection of excise taxes (which were not applicable retroactively), the Fund soon began to require advances from the Treasury.

These advances were made in the late 1970's and early 1980's when interest rates were high. Consequently, the Trust Fund continued to require advances for the purpose of debt servicing, even though excise tax receipts and benefits eventually stabilized. Despite a moratorium on interest from 1986 through 1990, and several extensions of the excise tax rates set in 1981, by the end of FY 2008 the Trust Fund was over $10 billion in debt to the Treasury. The Congress addressed this debt as part of Public Law 110-343, the Emergency Economic Stabilization Act enacted in FY 2009. The debt was restructured by a one-time allocation from the Treasury and the issuance of zero-coupon Treasury bonds at current interest rates.

Trust Fund revenues consist of monies collected from the industry in the form of an excise tax on mined coal that is sold or used by producers in the United States; funds collected from responsible mine operators (RMOs) for monies they owe the Trust Fund; payments of various fines, penalties, and interest; refunds collected from claimants and beneficiaries for overpayments; and repayable advances obtained from Treasury's general fund when Trust Fund expenses exceed revenues. Excise taxes, the main source of revenue, are collected by the Internal Revenue Service and transferred to the Trust Fund. In FY 2012, the Trust Fund received a total of $629.1 million in tax revenues. An additional $12.5 million was collected from RMOs in interim benefits, fines, penalties, and interest. Total receipts of the Trust Fund in FY 2012 were nearly $856 million, including $214 million in repayable advances from the Department of the Treasury.

Total Trust Fund disbursements during FY 2012 were nearly $809 million. These expenditures included $210.4 million for income and medical benefits, $59.0 million to administer the program ($32.9 million in OWCP direct costs and $26.1 million for legal adjudication and various financial management and investigative support provided by the Office of the Solicitor, the OALJ, the BRB, Office of the Inspector General, and the Department of the Treasury), $107.9 million in one-year obligation payments to Treasury (for FY 2011 advances and interest on those advances), and $431.5 million in bond payments.

In 1981, the Black Lung Benefits Revenue provisions temporarily increased the previous excise tax to $1.00 per ton for underground coal and $0.50 per ton on surface mined coal, with a cap of four percent of sales price. In 1986, under the Comprehensive Budget Reconciliation Act of 1985, excise tax rates were increased again by 10 percent. The rates for underground and surface mined coal were raised to $1.10 and $0.55 per ton respectively, and the cap was increased to 4.4 percent of the sales price. Under current law, these tax rates will remain in effect until December 31, 2018, after which the rates will revert to their original levels of $0.50 underground, $0.25 surface, and a limit of two percent of sales price.

Central Medical Bill Processing

OWCP's medical bill processing service continued to achieve improvements in operating efficiency and effectiveness. Timely and accurate medical bill processing is a critical element in administration of the Black Lung Program. During FY 2012, DCMWC avoided $553,477 in medical costs due to further improvements in the editing of bills.

In FY 2012, the vendor processed 160,689 Black Lung bills. A total of 99.4 percent of bills were processed within 28 days. The number of telephone calls handled was 47,778. Enrollment of 4,485 new providers brought the total of enrolled Black Lung providers to 131,952.

Patient Protection and Affordable Care Act

As a result of the Affordable Care Act, enacted in March 2010, DCMWC experienced an increase of 62 percent in new Federal Black Lung claims filed in FY 2010 compared to FY 2009. Most DCMWC district offices received a major influx of new claims as a result of this new legislation during the third and fourth quarters of FY 2010. This increase of new claims caused an unexpected inventory of pending claims, which was steadily reduced through FY 2012. The filing of new claims declined again in FY 2012, to 4,810 from 5,428 in FY 2011 (widow's conversions not included).

One important consequence of the Affordable Care Act is the reinstatement of the provision that dependent survivors of miners who were receiving benefits at the time of their death do not need to establish that the miner's death was due to pneumoconiosis, but are automatically entitled to benefits. Although many eligible survivors of miner beneficiaries would have been awarded without this provision, they have received benefits sooner because extended case development and litigation was unnecessary.

In March 2012, OWCP proposed rules to implement the Affordable Care Act amendments. Because the Affordable Care Act amended the Black Lung Benefits Act itself, DCMWC had begun to process claims in accordance with the amended BLBA as soon as the Affordable Care Act was enacted.

Government Performance Results Act

In FY 2012, DCMWC continued its efforts to reach DOL's GPRA goal to "minimize the human, social, and financial impact of work-related injuries for workers and their families." At the beginning of FY 2012, DCMWC had set its goal to:

- Reduce the average processing time (APT) required to process a claim from the date of receipt to the issuance of a Proposed Decision and Order (PDO) to no more than 240 days.

Although the processing goal for the previous year had been 250 days, DCMWC had been able to meet it with an APT of 238 days. The new goal was more challenging and DCMWC tried several strategies to meet it, albeit unsuccessfully. However, steady improvement was made throughout the year and by the fourth quarter of FY 2012, the program was only slightly above the goal, at 248 days. New claims declined from 6,059 in FY 2011 to 5,368 in FY 2012. These claim numbers include survivor's conversions that are automatically awarded. Conversion claims numbered 631 in FY 2011 and 558 in FY 2012. The total inventory of claims pending a PDO decreased from 3,605 at the end of FY 2011 to 2,830 at the close of FY 2012.

MANAGEMENT OF SSA PART B BLACK LUNG CLAIMS FY 2012

Professional and Timely Claims Maintenance Services Provided to Part B Claimants by DCMWC Included:

Completing Over 3,300 Maintenance Actions, With Average Completion Time of Less Than Two Weeks from Notification

Managing the Expenditure of Approximately $166 Million in Benefits

DCMWC was Responsible for Nearly 20,000 Active Part B Cases

Recognizing that meeting the GPRA goal for FY 2012 would be challenging, DCMWC focused on it by studying internal timeliness milestones, including a measurement of specific timeframes for medical testing. These measures allow district directors to determine the length of time that claim actions are beyond the control of a district office, and provide more detailed information on case timeliness. At the end of FY 2012, the medical testing timeliness goal was set at 120 days per claim.

Although DCMWC no longer maintains its original GPRA goal of ensuring that 80 percent of claims have no requests for further action pending one year after receipt of the claim, it continues to monitor its performance in resolving claims. In FY 2012, 84.9 percent of claims were resolved with no pending requests for further action. The Black Lung program will continue to work closely with both its stakeholder and authorized provider communities to ensure that delivery of services continues to improve and performance standards are met.

Black Lung Program Evaluation

At the beginning of FY 2010, the Government Accountability Office (GAO) issued a report (GAO-10-7) assessing DOL's policies and procedures regarding the processing and litigation of claims for Black Lung benefits, including some DCMWC procedures. As part of its response to the report, DCMWC took steps to improve physicians' documentation of disease and disability, track claimant utilization of lay and attorney representation while a claim is pending before the district director, and established a mechanism to track complaints about testing practices from stakeholders. At the close of FY 2011, after consultations with a small group of active diagnostic physicians, a new physician's report form had been developed and was pending approval by the Office of Management and Budget. The database regarding complaints about physicians had previously been developed and was maintained throughout FY 2012. DCMWC began reporting on claimant representation at the district office level, and reports indicated that during FY 2011 31.2 percent of claimants were represented by an attorney at the time the claim was adjudicated, and

another 15.3 percent were represented by lay representatives, for a total of 46.5 percent of claimants with representation. In FY 2012, the proportion of represented claimants increased to 48.9 percent, as 28.9 percent of claimants had attorneys and 20.0 percent had lay representatives.

Operation and Maintenance of Automated Support Package

DCMWC's Automated Support Package (ASP) is provided through a contract. The ASP includes a client-server computer system for all black lung claims, statistical and data processing, telecommunications support, and administrative functions.

During FY 2012, DCMWC implemented several changes to the ASP that enhanced available information about coal mine operators, insurers, and self-insured operators, and improved database security.

Stakeholder and Regulatory Assistance

Compliance with Insurance Requirements. Section 423 of the BLBA requires that each coal mine operator subject to the BLBA secure payment of any benefits liability by qualifying as a self insured employer or by insuring the risk with a stock or mutual company, an association, or a qualified fund or individual. Any coal mine operator failing to secure payment is subject to a civil penalty of up to $1,000 for each day of noncompliance.

Under the BLBA, the Secretary of Labor can authorize a coal mine operator to self-insure after an analysis of the company's application and supporting documents. At the close of FY 2012, 77 active companies were authorized by the Secretary of Labor to self-insure. These self-insurance authorizations cover approximately 860 subsidiaries and affiliated companies.

DCMWC continued it Memorandum of Understanding with the National Council on Compensation Insurance (NCCI) that enables the program to receive insurance policy data on individual operators from NCCI for states that mandate such reporting. The reporting system was tested and activated early in FY 2012, and promises to make policy coverage more reliable and accurate than the former paper-based reporting system, which has been almost entirely eliminated. This electronic reporting system allowed DCMWC to collect information on 1,788 policies, with many of these policies having multiple operators.

Compliance with Medical Diagnostic Requirements. Section 413(b) of the BLBA requires DCMWC to provide each individual miner who files a claim for benefits with the opportunity to undergo a complete pulmonary evaluation at no cost to the miner. The project to improve the quality of these medical evaluations and reports continued during FY 2012, with district directors and national office staff making a number of visits to clinics and individual physicians. At these site visits, DCMWC staff reviewed the physicians' written evaluations of the medical information obtained during the complete pulmonary evaluations and made suggestions for improving and standardizing the evaluations and reports. DCMWC officials also met several times with physicians at state and national conferences of the National Coalition of Black Lung and Respiratory Disease Clinics to help improve reporting. The program also continued to update the list of approved diagnostic physicians by requesting accurate certification and specialty information in order to ensure that highly-qualified doctors were available to perform medical evaluations.

DCMWC continued to work closely with the National Institutes of Occupational Safety and Health (NIOSH) regarding digital x-rays, and during FY 2012 regulations addressing the classification of digital images for the coal miner surveillance program were published by NIOSH. At the close of FY 2012, DOL was preparing its own regulations that would permit digital radiology to be used by approved diagnostic providers in the Federal Black Lung program. In the interim, x-ray interpretations must continue to be

classified in accordance with the current guidelines set forth by NIOSH and the International Labour Office (ILO). All x-rays performed for diagnostic testing in Federal black lung claims must conform to the specifications and physicians using the ILO Classification system must continue to use traditional film screen radiographs and standards.

In FY 2012, DCMWC continued its longstanding commitment to ensuring that payments to beneficiaries requiring assistance are properly utilized. DCMWC continued to track district office actions in the appointment of representative payees due to physical or other incapacity and to evaluate these appointments and related expenditure reports within prescribed time frames to verify benefits paid on behalf of the beneficiary were used in his/her best interest. In preparation for FY 2013, DCMWC introduced a measurement called Annual Benefit Evaluation (ABE), in which the program would evaluate its performance in ensuring that benefits are properly paid. The ABE measures the various components of benefit reporting, including annual questionnaires, payment reporting by responsible coal miner operators, and reports by representative payees. This process also serves to minimize erroneous payments.

Regulatory Initiatives

In FY 2012, OWCP proposed rules to implement Black Lung Benefits Act amendments included in the Affordable Care Act. These amendments restored two provisions that were eliminated in 1981: 30 U.S.C. 921(c)(4), which provides a presumption of total disability or death due to pneumoconiosis where the miner had at least 15 years of underground (or comparable surface) coal mine employment and a totally disabling respiratory impairment, and 30 U.S.C. 932(l), which provides automatic entitlement for eligible survivors of miners who were awarded benefits on their lifetime claims. The proposed rules set out standards for determining when the amendments apply; clarify how the 15-year presumption may be invoked and rebutted; clarify automatic survivors' entitlement, including how the amendments affect a survivor whose earlier claim was denied under the law in effect prior to the ACA amendments; and eliminate several obsolete or unnecessary rules in accordance with Executive Order 13536. *See 77 Federal Register* 19456-78 (March 30, 2012).

Litigation

Courts of Appeals

During FY 2012, the courts of appeals published seven decisions in cases arising under the BLBA. Important holdings from these cases are summarized below.

2010 Amendments to the BLBA; Automatic Derivative Entitlement for Survivors – 30 U.S.C. § 932(l). The Affordable Care Act amended the BLBA by providing automatic entitlement for certain survivors of deceased miners if the miner was receiving BLBA benefits at death, the survivor filed a claim after January 1, 2005, and the claim was pending on or after the March 23, 2010. Prior to the 1981 BLBA amendments, section 422(l) provided automatic derivative entitlement for eligible survivors of a miner whose lifetime disability claim was approved. The 1981 amendments restricted this provision to claims filed before January 1, 1982 (the effective date of the amendments), and required an ineligible survivor to prove the miner's death was due to pneumoconiosis. Section 1556 of the Affordable Care Act reinstated automatic entitlement for survivors who met the filing requirements.

In FY 2012, two courts of appeals addressed the interpretation and constitutionality of section 422(l) as amended. In *B & G Construction Co., Inc. v. Director, OWCP*, 662 F.3d 233 (3rd Cir. 2011) (Hardiman, J., concurring), the Third Circuit first addressed the apparent conflict between amended section 422(l)'s grant of automatic entitlement to certain survivors of awarded miners and other, unchanged BLBA provisions

that require a survivor to prove the miner died due to pneumoconiosis to prevail on a claim filed after 1981. The court held that amended section 422(l), as the most recent pronouncement of Congress, controls and impliedly repeals any contrary language in the other provisions. The court then rejected the employer's argument that retroactive application of amended section 422(l) violates the Fifth Amendment's Due Process and Takings clauses. The court rejected the argument that section 422(l) violates procedural due process by creating an irrebuttable presumption of death due to pneumoconiosis. It held that amended Section 422(l) is not concerned with the cause of the miner's death; instead it is intended to compensate survivors for the suffering inflicted on miners, and to provide miners with peace of mind that dependents will be cared for. Moreover, because this purpose is reasonable, the court held the provision does not violate substantive due process. Finally, the court held section 422(l) does not violate the Takings clause. It found the employer did not suffer a disproportionate impact from its increased liability; the employer was only liable for the automatic survivors' benefits if it had employed the miner and he also was entitled to benefits. Similarly, the court concluded the increased liability was foreseeable given the mandatory insurance-policy endorsement making carriers and self-insured operators liable for any obligations arising from BLBA amendments.

In *West Virginia CWP Fund v. Stacy,* 671 F.3d 378 (4th Cir. 2011), the Fourth Circuit similarly rejected an employer's arguments challenging the constitutional validity of amended section 422(l). It held section 422(l) does not violate the Fifth Amendment's Due Process clause because Congress had a legitimate purpose in compensating survivors for deceased miners' disabilities arising out of coal mine employment. Aside from that purpose, the court noted that Congress mitigated the amendment's retroactive effect on employers by limiting the pool of qualified claimants to those survivors who filed after January 1, 2005. The court also held the provision does not violate the Fifth Amendment's Takings clause because an automatic survivor's award is merely an obligation imposed on the employer to pay money and not a deprivation of a specific property interest. The court did not consider such obligations unforeseeable given the BLBA insurance regulations requiring all insurers and self-insurers to assume any benefits liabilities imposed by future statutory amendments. The court also addressed the proper interpretation of amended section 422(l). Agreeing with the Director, the court concluded the "claims" subject to section 422(l) includes claims filed by survivors after January 1, 2005, and not, as the employer argued, only claims filed by miners after that date. Finally, although the issue was not properly raised by the employer, the court agreed with the Third Circuit's holding in *B & G Construction* that the amendments to section 422(l) impliedly repealed any inconsistent language in other BLBA provisions.

Regulatory Preamble as Guide to Physicians' Credibility. The preamble to the regulations implementing the BLBA sets forth the medical and scientific premises upon which DOL relied in promulgating the regulations. During FY 2012, two courts of appeal approved the use of the preamble as an optional guide to assessing physicians' credibility. In *Harman Mining Co. v. Director, OWCP,* 678 F.3d 305 (4th Cir. 2012), the Fourth Circuit rejected the employer's argument that the ALJ violated the Administrative Procedure Act (APA) by consulting the preamble when he weighed conflicting medical reports on a medical issue. The ALJ discounted a physician's opinion that pneumoconiosis does not manifest as an obstructive lung disease because the DOL had rejected the same view in the preamble given substantial medical literature to the contrary. The Fourth Circuit rejected the employer's argument that such reliance is impermissible because the preamble, unlike the regulations, was not subjected to the APA's notice-and-comment procedures during the rulemaking. It concluded the preamble was an appropriate source for the DOL's views and a legitimate tool for assessing a physician's credibility. Consequently, the court held the ALJ acted within her discretion in consulting it. The court also rejected the employer's argument that the preamble must be made part of the administrative record if the ALJ intends to consider it. It held that neither the APA itself nor any other authority required the document's inclusion. Finally, the court noted its decision accorded

with those of the Third and Seventh Circuits. See *Helen Mining Co. v. Director, OWCP,* 650 F.3d 248 (3d Cir. 2011); *Consolidation Coal Co. v. Director, OWCP,* 521 F.3d 723 (7th Cir. 2008).

In *A & E Col Co. v. Adams,* 694 F.3d 798 (6th Cir. 2012), the Sixth Circuit agreed with the Fourth, Third, and Seventh Circuits that an ALJ can consult the preamble in weighing conflicting medical evidence. The ALJ concluded one physician was less credible, in part, because he relied on medical literature the preamble had rejected concerning the effects of coal mine dust exposure on an individual's lungs. The BRB upheld the ALJ's reliance on the preamble as "an authoritative statement of medical principles" accepted by the DOL. The Sixth Circuit agreed. It stated the preamble itself does not purport to be a binding document. Furthermore, the court determined the ALJ did not treat the preamble as binding; rather, he permissibly considered only whether the physicians' reasoning was consistent with the preamble's views. The court also rejected the employer's argument that the preamble must be placed in the administrative record before an ALJ may rely on it, citing the Fourth Circuit's *Harman Mining* decision.

Subsequent Claims – 20 C.F.R. § 725.309(d). A black lung program regulation, 20 C.F.R. 725.309, allows a claimant to file a "subsequent" claim if his first claim has been denied. To avoid the preclusive effect of *res judicata*, which prohibits re-adjudication of a prior denied claim, section 725.309 requires the claimant to prove that his condition has changed by establishing with new evidence an element of entitlement that was decided against him in the prior claim. In *Cumberland River Coal Co. v. Banks,* 690 F.3d 477 (6th Cir. 2012), the Sixth Circuit adopted the Director's interpretation of section 725.309 and held that a claimant may establish the necessary change if the new evidence establishes a previously-unproved element of entitlement. The court rejected the employer's argument that the claimant must also prove that the newly submitted evidence differs qualitatively from the old evidence. Although Sixth Circuit precedent interpreting a prior version of section 725.309 required such a comparison, the court held that the revised rule clearly requires only that the new evidence disprove the continuing validity of the prior denial.

Complicated Pneumoconiosis – 30 U.S.C. § 921(c)(3); 20 C.F.R. § 718.304. The BLBA provides an irrebuttable presumption that a miner is totally disabled by, or died due to, pneumoconiosis that may be invoked with (i) chest X-ray evidence of "large opacities" measuring more than one centimeter in diameter; (ii) autopsy/biopsy evidence of "massive lesions;" or (iii) an equivalent diagnosis by other means. Neither the statute nor the regulations define "massive lesions." In *Bridger Coal Co. v. Director, OWCP,* 669 F.3d 1183 (10th Cir. 2012), the Tenth Circuit considered the quantum of proof necessary for a claimant to establish the existence of massive lesions through autopsy evidence. At the urging of the Director, the court agreed with the Eleventh Circuit's holding in *Pittsburg & Midway Coal Mining Co. v. Director, OWCP,* 508 F.3d 975 (11th Cir. 2007), that a medically reasonable diagnosis of massive lesions/complicated pneumoconiosis is sufficient to invoke the presumption. The court rejected the employer's invitation to adopt the Fourth Circuit's requirement that the claimant must prove that lesions detected by autopsy or biopsy would appear as opacities greater than one centimeter on an X-ray. *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999). The court concurred with the Eleventh Circuit's rationale for rejecting this "equivalency" test: (i) it conflates the X-ray and autopsy/biopsy means for establishing the disease, which Congress intentionally separated by placing the two methods in disjunctive clauses; (ii) by conflating the two distinct methods, the biopsy/autopsy clause is effectively superfluous given the "other evidence" method; (iii) Supreme Court precedent and the BLBA's legislative history note the diagnostic superiority of autopsies compared to X-rays; and (iv) an equivalency test conflicts with the statutory prohibition on denying claims solely based on a negative X-ray. Finally, the court concluded the equivalency test is inconsistent with the plain language of section 411(c)(3), which describes the three invocation methods in the disjunctive, and with the BLBA's requirement that an ALJ must consider "all relevant evidence."

Modification – 33 U.S.C. § 922 as incorporated by 30 U.S.C. § 932(a); 20 C.F.R. § 725.310. A party may petition for modification within one year after a denial of benefits or the last payment of benefits based on a mistake in fact or a change in condition. In *Westmoreland Coal Co. v. Sharpe,* 692 F.3d 317 (4th Cir. 2012) (Agee, J., dissenting), the employer sought to modify a miner's award after the miner's death in order to avoid the award's collateral estoppel effects in the survivor's claim. In a prior proceeding, the Fourth Circuit remanded the claim for the ALJ to consider whether granting modification would render justice; it directed the ALJ to consider the employer's diligence and motivation in requesting modification; the possible futility of granting modification if the employer could not recover the miner's benefits; and the comparative benefits of accuracy versus finality. *Sharpe v. Director, OWCP,* 495 F.3d 125 (4th Cir. 2007). On remand, the Benefits Review Board, reversing the ALJ, held that granting modification would not render justice because the employer could not recover the miner's benefits and because employer's motive – avoiding collateral estoppel – was improper. The Fourth Circuit, with one judge dissenting, affirmed the Board's decision. Emphasizing the employer's improper motive rather than its conduct, a majority gave paramount weight to the fact that modification would allow the employer to circumvent collateral estoppel and "foil" the survivor's "good faith" claim.

Benefits Review Board

During FY 2012, the Benefits Review Board (BRB) issued 623 decisions in cases arising under the BLBA, of which ten were published. Important holdings from several of these cases are summarized below.

2010 Amendments to the BLBA; Automatic Derivative Entitlement for Survivors – 30 U.S.C. § 932(l). The Affordable Care Act amended the BLBA by providing automatic entitlement for certain survivors of deceased miners if the miner was receiving BLBA benefits at death, the survivor filed a claim after January 1, 2005, and the claim was pending on or after the March 23, 2010 enactment date of the ACA. In *Wright v. Eastern Assoc. Coal Corp.,* 25 BLR 1-69 (2012), the Board addressed the nature of amended Section 422(l). Adopting the Third Circuit's holding in *B & G Construction Co., Inc. v. Director, OWCP*, 662 F.3d 233 (3rd Cir. 2011), the Board held that the provision is not intended to compensate survivors for employment-related death, and thus does not create an impermissible irrebuttable presumption of death due to pneumoconiosis. Instead, amended section 422(l) constitutes a rational choice by Congress to compensate survivors for the suffering inflicted on miners, and to provide miners with peace of mind that dependents will be cared for.

In *Dotson v. McCoy Elkhorn Coal Corp.,* 25 BLR 1-13 (2011) (*en banc*), the Board addressed the date from which benefits should be paid when a survivor is entitled to benefits under amended section 422(l). Agreeing with the Director, the Board held that an existing program regulation, 20 C.F.R. § 725.503(c), governs the onset date and provides that survivor benefits commence the month and year the miner died. The Board reasoned that nothing in the Affordable Care Act suggests that Congress intended a different benefits commencement date for claims awarded under amended section 422(l).

In three cases, the Board considered the interplay of amended section 422(l) with statutory and regulatory provisions that allow a claimant's entitlement to benefits to be considered even after the final denial of a claim. Under the BLBA's modification provision, a claimant may, within one year, request reconsideration of a final decision denying benefits. This provision constitutes a statutory waiver of the doctrine of *res judicata*, which generally prohibits re-adjudication of denied claims. If modification is not requested, the program regulations permit the claimant to pursue a "subsequent" claim but only if certain conditions are met. These conditions implement *res judicata* by ensuring that the subsequent claim is not simply a re-adjudication of the denied claim.

In *Mullins v. ANR Coal Co., LLC,* 25 Black Lung Rep. 1-49 (2012), the Board held that amended section 422(l) applies in the case of a survivor who timely requested modification of her denied BLBA claim after the Affordable Care Act was enacted. Agreeing with the Director, the Board held that the survivor was entitled to benefits under amended section 422(l) because her claim met the Affordable Care Act's filing date and pendency requirements: the claim was filed after January 1, 2005 and, because of the timely modification request, was pending after the Affordable Care Act's enactment.

In *Richards v. Union Carbide Corp.,* 25 Black Lung Rep. 1-31 (2012)(en banc), the Board agreed with the Director and held that amended section 422(l) applies to a subsequent claim filed by a survivor whose prior claim was denied for failure to prove death due to pneumoconiosis. The Board reasoned that because, in certain limited circumstances, the BLBA now provides for survivor's entitlement without consideration of the miner's cause of death, applying amended section 422(l) to a survivor's subsequent claim does not constitute re-adjudication of the prior denied claim and does not violate *res judicata*. The Board also held the claimant's entitlement is subject to the regulatory prohibition on the payment of benefits for any period prior to the date on which the order denying the prior claim became final. Accordingly, the Board held that in the case of a claimant who is entitled to survivor's benefits based on a subsequent claim, benefits cannot commence any earlier than the month after the month in which the denial of the prior claim became final.

Finally, in *Surratt v. U.S. Steel Mining Co.,* 25 BLR 1-75 (2012), the survivor filed a request for modification of her denied subsequent claim after Affordable Care Act was enacted. Applying its holdings in *Richards and Mullins*, the Board held the survivor's subsequent claim was awardable under amended section 422(l) because it met the Affordable Care Act's filing date and pendency requirements.

2010 Amendments to the BLBA; Statutory Presumption of Total Disability or Death Due to Pneumoconiosis – 30 U.S.C. § 921(c)(4). The Affordable Care Act amended the BLBA by reinstating section 411(c)(4), which provides a rebuttable presumption that a miner's total disability or death was due to pneumoconiosis upon proof that the miner worked at least 15 years in qualifying coal mine employment and suffered from a totally disabling respiratory or pulmonary impairment. The amended presumption applies to both miners' and survivors' claims filed after January 1, 2005, provided the claim is pending on or after the ACA's March 23, 2010 enactment date. The party opposing entitlement may rebut the presumption by proving either the miner does not have pneumoconiosis or that his respiratory impairment does not arise out of coal mine employment or (in a survivor's claim) that his death was unrelated to his coal mine employment.

In *Owens v. Mingo Logan Coal Co.,* 25 Black Lung Rep. 1-1 (2011), the Board rejected the employer's argument that retroactive application of amended Section 411(c)(4) violates both the due process and takings clauses of the Fifth Amendment. The Board relied on its holding in *Mathews v. United Pocahontas Coal Co.,* 24 BLR 1-193 (2010), in which it rejected similar arguments in the context of amended section 422(l). In addition, the Board rejected the employer's contention that the section 411(c)(4) presumption applies only to cases in which the Black Lung Disability Trust Fund is liable for benefits. Agreeing with the Director, the Board held that the presumption applies to all claims, notwithstanding statutory language outlining how "the Secretary may rebut" the presumption. The Board noted that the courts of appeals have consistently applied section 411(c)(4) to employer claims.

In order to invoke the section 411(c)(4) presumption, a miner must prove he was employed at least fifteen years in an underground coal mine or at a surface coal mine "in conditions substantially similar to conditions in an underground mine." In *Muncy v. Elkay Mining Co.,* 25 Black Lung Rep. 1-21 (2011), the Board held that surface work at an underground coal mine counts as underground coal mine employment for purposes of Section 411(c)(4). The Board relied on its decision in *Alexander v. Freeman United Coal*

Mining Co., 2 Black Lung Rep. 1-497 (1979), in which it held that section 411(c)(4)'s coal mine employment requirement focuses on the type of coal mine where the employee worked rather than the location at which he worked. Thus, a miner employed at an underground coal mine is not required to prove his work on the surface was comparable to conditions underground.

In another decision, the Board addressed the appropriate methods of rebuttal to be used when the section 411(c)(4) presumption is invoked in a survivor's claim. Agreeing with the Director, it held that the presumption may be rebutted either by disproving the existence of pneumoconiosis or by disproving a link between coal mine employment and the miner's death. Recognizing that a survivor who is not eligible under section 422(l) may establish entitlement only by proving death due to pneumoconiosis, the Board reasoned that section 411(c)(4) correspondingly allows survivors only a presumption that the miner's death was due to pneumoconiosis. This presumption can be rebutted in only two ways – by showing that either the miner did not have pneumoconiosis, or that his death was unrelated to his coal mine employment. *Copley v. Buffalo Mining Co.,* 25 Black Lung Rep. 1-81 (2012).

BLACK LUNG BENEFITS ACT

	Part C[1]		Part B[2]	
	FY 2011	**FY 2012**	**FY 2011**	**FY 2012**
Number of Employees (FTE Staffing Used)	161	157	17	17
OWCP Administrative Expenditures[3]	$31.3 M	$32.9 M	$5.1 M	$5.6 M
Total Compensation and Benefit Payments[4]	$227.4 M	$210.4 M	$189.5 M	$166.1 M
Beneficiaries in Pay Status at End of Fiscal Year				
Monthly	22,332	20,640	22,424	19,679
Medical Benefits Only	1,084	901	N/A	N/A
Responsible Coal Mine Operator Beneficiaries in Pay Status at End of Fiscal Year				
Monthly	4,228	4,231	N/A	N/A
Medical Benefits Only	414	359	N/A	N/A

[1] Part C benefits are paid out of the Black Lung Disability Trust Fund or by the liable coal mine operator or insurer.

[2] Part B benefits are paid out of general revenue funds from the U.S. Treasury.

[3] Part C administrative expenditures exclude DOL and Department of Treasury support costs of $26.2 million in FY 2011 and $26.1 million in FY 2012, respectively. Also excludes interest on the Trust Fund debt.

[4] Part C payments include only Trust Fund compensation and benefits (excluding collections from responsible coal mine operators for benefits paid by the Trust Fund on an interim basis, refunds for OWCP administrative costs paid, and other miscellaneous reimbursements). Excluded are self-insured mine operator and insurance carrier payments that totaled approximately $32.6 million in FY 2011 and $37.0 million in FY 2012, respectively.

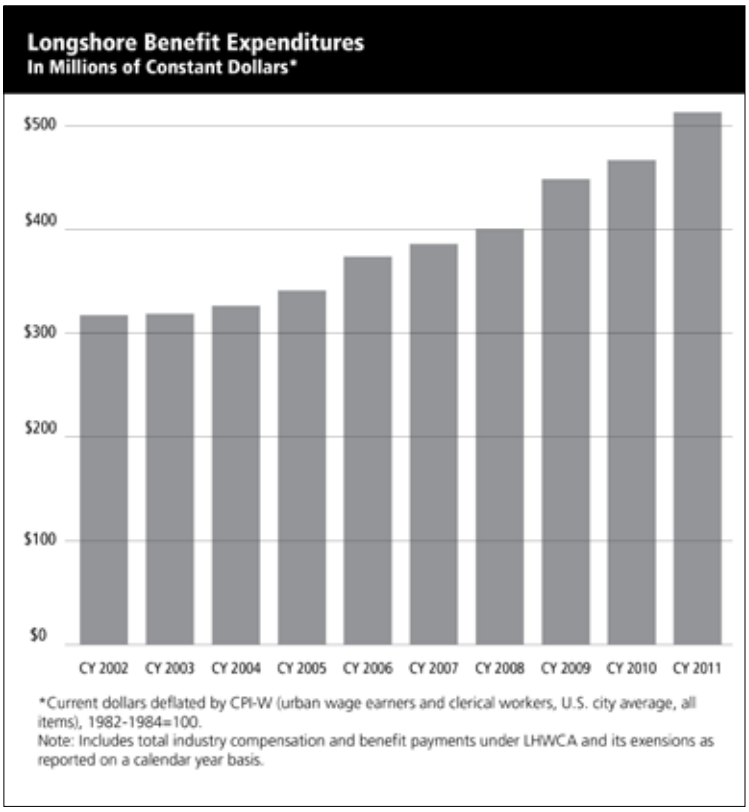
LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT

Longshore and Harbor Workers' Compensation Act

Introduction

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

In addition, LHWCA covers certain other employees through the following extensions to the Act:



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

The original law entitled the Longshoremen's and Harbor Workers' Compensation Act, provided coverage to certain maritime employees injured while working over navigable waters. These workers had been held

excluded from state workers' compensation coverage by the Supreme Court (*Southern Pacific Co. v. Jensen*, 244 U.S. 205 (1917)).

Operations

Disability compensation and medical benefits paid by insurers and self-insurers under LHWCA and its extensions totaled $1,135.9 million in Calendar Year (CY) 2011, a 13.8 percent increase compared to CY 2010, which was largely attributable to continuing increases in payouts under the Defense Base Act.

In Fiscal Year (FY) 2012, total DOL expenditures for program operations and the administration of LHWCA and its extensions were $25.8 million, of which $11.4 million were the direct costs of OWCP. The remaining $14.4 million represent the cost of legal, audit, and investigative support provided by the Office of Administrative Law Judges (OALJ), the BRB, the Office of the Solicitor (SOL), and the Office of the Inspector General (OIG).

At year's end, the Division of Longshore and Harbor Workers' Compensation (DLHWC) employed 96 people in the national office and 11 district offices.

During FY 2012, approximately 600 self-insured employers and insurance carriers reported 29,287 lost-time injuries under the LHWCA. At year's end, 15,226 maritime and other workers were in compensation payment status.

The conflict in Iraq, Afghanistan, and related military activities in the Middle East continued to generate interest in Longshore program operations as they relate to the administration of the DBA in FY 2012. Injuries occurring under DBA are reported to DLHWC District Offices determined by the geographic location of the injury occurrence. During the year, a total of 12,165 cases of injury and death were reported under DBA.

Longshore Special Fund

The Special Fund under the LHWCA was established in the Treasury of the United States pursuant to section 44 of the Act and is administered by the national office of DLHWC. Proceeds of the fund are used for payments under section 10(h) of the LHWCA for annual adjustments in compensation for permanent total disability or death that occurred prior to the effective date of the 1972 amendments, under section 8(f) for second injury claims, under section 18(b) for cases involving employer insolvency, under sections 39(c) and 8(g) for providing rehabilitation assistance to persons covered under the LHWCA, and under section 7(e) to pay the cost of medical examinations.

The Special Fund is financed through fines and penalties levied under the LHWCA; $5,000 payments by employers for each instance in which a covered worker dies and when it is determined that there are no survivors eligible for benefits; interest payments on Fund investments; and payment of annual assessments by authorized insurance carriers and self-insurers. Fines, penalties, and death benefit levies constitute a small portion of the total amount paid into the Special Fund each year. The largest single source of money for the fund is the annual assessment.

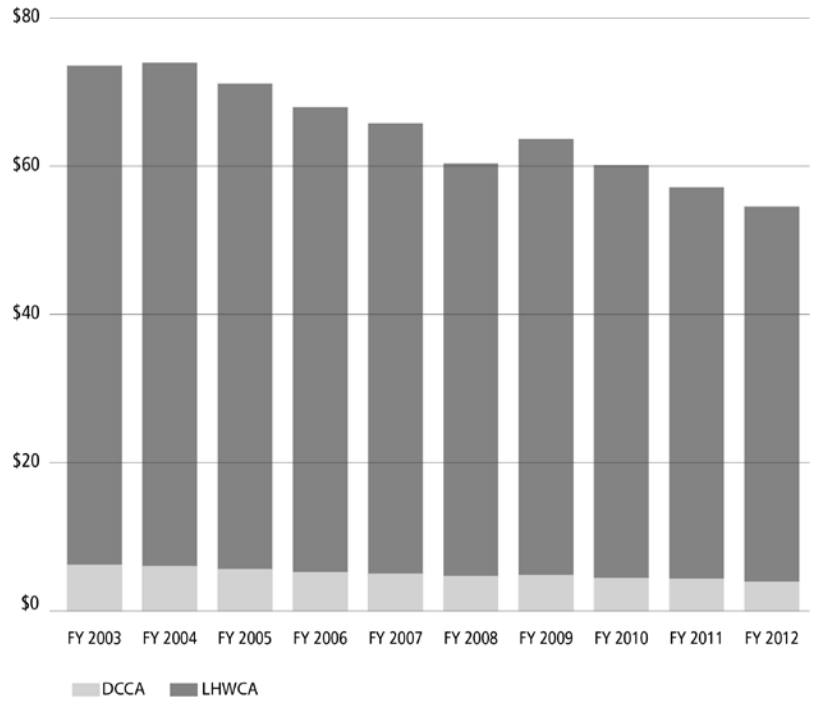
A separate fund under the DCCA is also administered by OWCP. Payments to and from this fund apply only to the DCCA.

The LHWCA Special Fund paid $122.7 million in benefits in FY 2012, of which $111.1 million was for second injury (section 8(f)) claims. FY 2012 expenditures from the DCCA Special Fund totaled $8.7 million, of which $8.0 million was for second injury cases.

Government Performance Results Act

In FY 2012, under the Government Performance Results Act (GPRA), DLHWC measured the percentage of the Employer's First Report of Injury and the First Payment of Compensation for Defense Base Act (DBA) and non-DBA cases filed within 30 days. The First Report of Injury measure tracks the time from the date of injury or death, or the date of the employer's knowledge of the injury and the onset of the disability, to the date the written notice of injury was received by a DLHWC district office. This GPRA goal for injury report timeliness for DBA cases was exceeded as 85 percent of the cases were filed within 30 days against the target of 80 percent. The non-DBA Employers First Report of Injury target also was exceeded. DLHWC's year-end performance was 86 percent filed within 30 days against the target of 85 percent.

LHWCA and DCCA Special Funds' Expenditures
FY 2003-FY 2012
In Millions of Constant Dollars*



*Current dollars deflated by CPI-W (urban wage earners and clerical workers, U.S. city average, all items), 1982-1984=100.

The First Payment of Compensation measure tracks the time it takes the employer or insurance carrier to issue the first payment after the worker becomes disabled or after death. In FY 2012 the GPRA result for DBA cases was 63 percent of the initial payments for compensation were issued within 30 days, versus the 60 percent target. The non-DBA First Payment of Compensation target for cases filed within 30 days remained steady; DLHWC's year-end performance was 85 percent against an annual target of 85 percent.

DBA cases continue to present significant challenges for the Longshore program. Due to language barriers, security issues, and limited access to injured workers and their dependents, DBA claims typically entail lengthy and more resource-intensive development for employers/carriers. Performance goals focus on the role these employers and carriers play in achieving results. The Longshore program will continue to work with large employers and carriers to improve timeliness in both the filing of injury reports and payment of benefits.

While DBA injury and death claims received have decreased from a peak of 15,141 in FY 2007 to 12,165 in FY 2012, this is still well above the pre-Afghanistan and Iraq war total of 347 in FY 2002.

Performance Assessment

In addition to outcomes measured under GPRA, DLHWC monitors program performance in several areas, as indicated in the program's annual Operational Plan. The most noteworthy of these is dispute resolution (previously a GPRA goal in FY 2001 – FY 2009). For example, in FY 2012, DLHWC district offices conducted 3,253 informal conferences that were designed to establish the facts in each case, define the disputed issues and the positions of the parties in respect to those issues, and encourage their voluntary resolution by means of agreement and/or compromise. DLHWC continued to work on its national goal of improving the speed of its dispute resolution system to assist injured workers and employers/carriers in resolving disputed claim issues. Training was provided to staff that mediate and resolve case disputes; improving mediation skills will help to reduce the percentage of cases that move to litigation. Informal dispute resolution is regularly promoted by DLHWC management at the many industry educational events throughout the year. These efforts resulted in the program exceeding their performance targets in this area.

Other outputs include Hearing Referral timeliness, Special Fund Application Review timeliness, Request for Informal Conference Action timeliness, Conference Recommendation timeliness, Congressional Inquiry Response timeliness, and Vocational Rehabilitation Return to Work effectiveness. DLHWC met or exceeded the goals/standards in all of these areas for FY 2012.

Claims Management and Compliance Assistance Activities

The number of DBA injury and death reports of civilian contractors in Iraq and Afghanistan, after a decline from FY 2010 to FY 2011, again increased in FY 2012 to a total of 9,224, of which 261 involved the death of a worker. Between September 1, 2001 and September 30, 2012, a total of 90,680 DBA cases were reported, including 3,187 deaths, of which 68,007 cases (2,850 deaths) originated in Iraq and Afghanistan.

DLHWC continued to handle this high number of DBA claims with initial screening and claim creation in the New York City District Office, then distribution of the domestic claims to the district office nearest the claimant's home, ensuring that the districts with the highest number of claims were staffed with the highest number of claim specialists.

The Longshore program continued its efforts to address challenges presented in DBA claims arising from Iraq and Afghanistan. These challenges include the effective handling of Post-Traumatic Stress Disorder claims, timely payment of benefits to foreign workers and their families in areas with cultural differences, communications obstacles, limited banking and infrastructure, and lack of available medical care. The major stakeholders, including insurance companies and employers, were invited to meetings throughout the year to discuss and resolve those issues, to discuss their performance in the timely reporting of injuries, timely payment of benefits, and to share best practices.

During FY 2012, DLHWC also continued the extraction of various monthly reports from the Longshore data systems to provide assistance in the reviewing of performance results with industry executives on a quarterly basis. The Longshore program also continued the sharing of DBA carrier results with their larger customers. This results in greater compliance with established performance standards.

DBA Program Activities

The number and severity of Defense Base Act claims remain at high levels. Reports of injury and death under DBA increased in FY 2012 after a decline from FY 2010 to FY 2011. During FY 2012, an Interagency Working group composed of DOL, the Department of State, Department of Defense, and the U.S. Agency for International Development continued to meet and discuss ways to address Congress' concerns about costs and claims processing under the Defense Base Act and the War Hazards Compensation Act.

Also, on June 5, 2012, Representative Elijah Cummings (D-MD) introduced H.R. 5891, titled the Defense Base Act Insurance Improvement Act, which would require the Departments of Defense and Labor to develop a strategy to implement a government-wide self-insurance program for DBA claims within six months of enactment, and to implement the strategy within 12 months of enactment. OWCP provided technical assistance to House Committee members and their staff at their request.

Rehabilitation Activities

The slow economic recovery continued to have a negative impact on the Longshore Rehabilitation program during FY 2012. The job market continued in its depressed state throughout the country, making job placement for rehabilitation program participants very challenging. Despite these challenges, DLHWC was largely successful during the year, achieving 99 percent of its placement goal. This success is due to the excellent work of the professional providers and the oversight of DLHWC's district office staff and also to the cooperation of the larger employers in returning their injured workers to modified duties, notably the shipyards and Non-Appropriated Fund Instrumentalities.

Regulatory Initiatives

In FY 2012, OWCP promulgated final rules implementing an amendment to the Longshore Act's "recreational vessel" exclusion in Section 2(3)(F), 33 U.S.C. 902(3)(F). Between 1984 and 2009, workers who repaired or dismantled recreational vessels under 65 feet in length were excluded from coverage if they were covered by a state workers' compensation program. The American Recovery and Reinvestment Act of 2009 expanded this exclusion by eliminating the 65-foot limitation; post-amendment, workers who repair recreational vessels of any length or dismantle them for repair are excluded from LHWCA coverage if they are covered under a state workers' compensation law. The final rules implementing this amendment generally use the U.S. Coast Guard's standards to define a "recreational vessel." OWCP added two provisions to make it easier to apply these standards in the LHWCA context. First, a manufacturer or builder may determine whether a vessel is recreational within the meaning of the regulation based on the vessel's design rather than on its end use. Second, noncommercial vessels that are recreational by design and owned or chartered by the Federal or a state government fall within the recreational vessel definition. The final rule also sets out the amendment's effective date and standards for determining when it applies. See 76 *Federal Register* 82117-29 (Dec. 30, 2011).

Litigation

United States Supreme Court

During FY 2012, the United States Supreme Court issued two decisions in cases arising under the LHWCA and its extensions. These cases are summarized below.

Scope of coverage under the Outer Continental Shelf Lands Act – 43 U.S.C. § 1333(b). The Outer Continental Shelf Lands Act (OCSLA) extends the LHWCA to an employee's injury or death "occurring as the result of operations conducted on the outer Continental Shelf" to extract the natural resources from

the shelf's bed and subsoil. In *Pacific Operators Offshore, LLP v. Valladolid,* __U.S. __, 132 S.Ct. 680 (2012) (Scalia, Alito, JJ., concurring), the Supreme Court addressed a split in the circuits concerning the legal test for determining the scope of OCSLA coverage for injuries occurring outside the geographic confines of the outer continental shelf itself. The Third Circuit extended OCSLA coverage to any work-related injury or death that would not have occurred "but for" the employer's operations on the shelf. The Fifth Circuit limited coverage to injuries or deaths that actually occur on a platform in, or in the waters above, the shelf. The Ninth Circuit, where the case arose, adopted a third test: coverage extends to any worker who establishes a "substantial nexus" between the injury/death and the employer's operations on the shelf. To satisfy this standard, the employee's work must "directly further" and be in the regular course of those operations. In this case, the employee worked almost exclusively on offshore drilling platforms; he spent the negligible remainder of his employment at the employer's onshore processing facility. He died as the result of an accident that occurred while working at the onshore facility consolidating and transporting scrap metal that came from the offshore platforms. The Ninth Circuit remanded the case for application of the "substantial nexus" test to determine whether the deceased employee's survivor was entitled to death benefits under OCSLA. The employer appealed and urged the Supreme Court to adopt the Fifth Circuit's rule. On the Director's behalf, the Solicitor General offered a fourth alternative to the circuit courts' tests: the OCSLA covers off-shelf injuries if the employee's on-shelf work is substantial in duration and nature and the duties the employee was performing when injured contribute to shelf operations. In the alternative, the Director argued that the Court should adopt the Ninth Circuit test as opposed to the Third and Fifth Circuit tests. The Court concluded the Ninth Circuit's "substantial nexus" test best implements section 1333(b). The Court reasoned that this test most faithfully reflects the statutory language and Congress' intent that OCLSA cover any injury regardless of where it occurred provided it occurred "as the result of operations conducted on the" shelf itself. Accordingly, the Court held the employee must establish a "significant causal link" between his injury and the employer's on-shelf extraction operations. The Court remanded the case to the Ninth Circuit for consideration of the survivor's claim under the correct legal standard. The concurring justices agreed with the judgment but disagreed with the majority's standard. They would hold that the OCSLA supplies the workers' compensation remedy if his injury was "proximately caused" by the employer's on-shelf operations.

When is a person "newly awarded compensation" for purposes of determining the applicable maximum weekly compensation rate – 33 U.S.C. § 906(c). Under the LHWCA, upon learning of an injury, employers are required to promptly pay compensation or dispute the obligation to pay. In the vast majority of cases, employers pay voluntarily without contesting liability. If a dispute arises, the statute provides an adjudication process that culminates in a compensation order. Several statutory provisions refer to benefit payments as being made either without an award or pursuant to an award by a compensation order. Disability and death benefits are capped at a maximum of no more than twice the national average weekly wage which is determined each fiscal year by the Secretary of Labor. Under section 906(c), the applicable cap is that of the fiscal year in which the employee is "newly awarded compensation." In *Roberts v. Sea-Land Services, Inc.,* __ U.S. __, 132 S.Ct. 1350 (2012) (Ginsburg, J., concurring in part and dissenting in part), the Court addressed a split in the circuits concerning when an employee is considered "newly awarded compensation" for purposes of section 906(c). The Fifth and Eleventh Circuits held that the fiscal year in which a compensation order issues determines the applicable maximum. The Ninth Circuit, where Roberts arose, utilized the fiscal year in which the employee's disability began and he became entitled to compensation. In this case, the employee sustained a work-related injury in fiscal year 2002; an ALJ awarded his claim in fiscal year 2007. The ALJ, BRB, and Ninth Circuit relied on fiscal year 2002 to determine the maximum allowable compensation under section 906(c). Before the Court, the claimant contended that "awarded" has only one meaning throughout the statute and thus the Fifth and Eleventh Circuits correctly interpreted section 906(c) as meaning that a person is "newly awarded

compensation" when an ALJ issues a compensation order. The Director and the employer supported the Ninth Circuit's view. The majority concluded the Ninth Circuit was correct and held that the phrase is only sensible if construed to mean "statutorily entitled to compensation because of disability." After finding that "newly awarded compensation," in isolation, was ambiguous, the majority identified four reasons for reading it as meaning the date disability entitlement begins: it is logical because employers must know how much compensation is due in order to meet their obligation to voluntarily pay benefits promptly; it is consistent with the statutory purpose to compensate the injured employee for any decrease in the wages he was earning when injured; it avoids disparate treatment for similarly-situated employees who would otherwise receive different compensation rates if their compensation orders issued in different fiscal years; and it discourages "gamesmanship" if employees could otherwise manipulate the administrative process by delaying the entry of a compensation order so as to obtain greater compensation through the application of a more generous 906(c) cap. Accordingly, the majority held an employee is "newly awarded compensation" as of the date he becomes disabled and statutorily entitled to benefits regardless of the date a subsequent compensation order, if any, is issued awarding benefits. The dissent agreed with the majority that the employee's argument was untenable, but would hold the applicable maximum to be that for the fiscal year when an employer voluntarily begins to pay compensation or when the employer is ordered to pay.

Courts of Appeals

During FY 2012, the courts of appeals published seven decisions in cases arising under the LHWCA and its extensions. Important holdings from some of these cases are summarized below.

Exclusivity of Remedies under the Defense Base Act – 42 U.S.C. § 1651(c), 33 U.S.C. § 905(a); Scope of "Injury" under the LHWCA, 33 U.S.C. § 902(2). The increase in defense-related contracting overseas to support the military in Iraq and Afghanistan has resulted in an upsurge of claims under the Defense Base Act (DBA), an extension of the LHWCA. It has also led to increased civil litigation by civilian overseas contractors and their survivors. Recovery under the DBA is generally an employee's exclusive remedy against his or her employer for covered injuries (including death). 42 U.S.C. § 1651(c); 33 U.S.C. § 905(a). Thus, employees cannot sue their employers (but are free to sue third parties) for covered injuries; instead, the employer is obligated to pay LHWCA benefits. Covered injuries include injuries "caused by the willful act of a third person directed against an employee because of his employment." 33 U.S.C. § 902(2).

In *Fisher v. Halliburton,* 667 F.3d 602 (5th Cir. 2012), the court accepted an interlocutory appeal to determine whether a civil suit by employees' survivors against the deceased workers' employer should be dismissed because the LHWCA and DBA provide the plaintiffs' exclusive remedy for the deaths of covered employees. The decedents worked for KBR (a government contractor) as truck drivers in Iraq; they were killed by insurgents while driving a convoy of supplies for the military. The plaintiffs sued KBR in federal district court, alleging several state-law causes of action. KBR moved the district court to dismiss the suit as barred by exclusivity. In determining that the DBA was not the plaintiffs' exclusive remedy, the district court inferred the decedents were killed because of their nationality and not their employment. Thus, the district court found that the deaths did not fall within the definition of an "injury" under the LHWCA because they were not injuries caused by the willful act of a third person directed against an employee because of his employment. Accordingly, the district court denied the motion and certified its order for immediate appeal to the court. The government submitted an amicus brief expressing, as well as concerns from other agencies, the views of the Director, OWCP, regarding the scope of LHWCA exclusivity. The court agreed with KBR and the government that a causal relationship existed between the employees' deaths and their employment. It refused to speculate, as the district court had, on the unknown attackers' subjective intent or motives because the decedents' employment supplied a plausible reason for their deaths. Thus, the court concluded the employees' deaths resulted from the "willful act" of the "third-party"

insurgents "because of [their] employment" by KBR in support of the American military effort in Iraq and therefor qualified as injuries covered by 33 U.S.C. § 902(2). Finally, the court declined to determine whether an exception to exclusivity exists for "intentional torts" because the facts of the case did not present the issue despite the plaintiffs' allegations of intentional harm inflicted on the decedents by KBR. The court vacated the district court's order and remanded the case for dismissal of the plaintiffs' state tort claims.

Special Fund Liability – 33 U.S.C. § 908(f). To encourage employers to hire partially-disabled workers, an employer's liability to pay compensation for additional injuries to such workers is limited to a period of 104 weeks, after which liability shifts to the Special Fund. An employer's right to this relief is, however, limited. One limitation is that the Special Fund is only liable for qualifying claims involving permanent disability; it does not pay for instances of temporary disability. In *Pacific Ship Repair and Fabrication, Inc. v. Director, OWCP (Benge),* 687 F.3d 1182 (9th Cir. 2012), the Ninth Circuit held the Special Fund is not liable for an employee's period of temporary total disability that arises after the Fund has assumed the employer's liability for a claim involving permanent partial disability. The injured employee was receiving permanent partial disability benefits from the Fund under section 908(f) when she underwent surgery for the compensable condition. After a nine-month period of convalescence, her condition stabilized but left her permanently totally disabled. The ALJ and BRB accepted the Director's position that the employer should pay for the nine-month convalescence because it constituted the type of temporary disability from which the Fund is statutorily absolved. The court agreed. Deferring to the Director's statutory interpretation, the court concluded a permanent partial disability is not irrevocably "permanent;" a post-surgical period of healing may be considered a temporary total disability regardless of the surgery's ultimate outcome. Consequently, the court upheld the decisions below imposing liability on the employer for the employee's nine months of temporary total disability, after which liability again reverted to the Fund for the permanent total disability.

Situs and Status, including extraterritorial reach of LHWCA – 33 U.S.C. §§ 902(3), 903(a). The LWHCA covers an employee's injury if he satisfies both the situs and status requirements. "Situs" means the actual navigable waters of the United States and certain areas adjoining the waterfront that are used for maritime activities. For an adjoining area to qualify as a covered situs, it must have both a geographic and a functional nexus with maritime activity. Maritime "status" requires the employee to spend at least some part of his time performing tasks that are essential to maritime commerce.

In *New Orleans Depot Services, Inc. v. Director, OWCP (Zepeda),* 689 F.3d 400 (5th Cir. 2012) (Clement, J., dissenting), the Fifth Circuit considered whether an employee's work repairing maritime shipping containers satisfied the situs and status requirements. The employee sustained work-related hearing loss while repairing shipping containers at the employer's Chef Yard facility. The employer did not contest the geographic nexus of the facility as it was only 300 yards from navigable water, and the ALJ found the facility bore a functional relationship to maritime activity because containers used for marine transportation were stored and repaired at the site. The ALJ further found marine shipping-container repair was covered employment because, consistent with Supreme Court precedent, the work was integral to the loading and unloading process. The ALJ ordered NODSI to pay compensation; the BRB affirmed the decision. Applying a deferential standard of review to the ALJ's factual findings, the majority held substantial evidence supported the ALJ's situs and status findings. The dissenting judge suggested the majority's reasoning improperly extends the reach of the LHWCA to occupations and geographic areas that have only a negligible relationship to maritime commerce. The Fifth Circuit has granted en banc review of the panel's decision.

Keller Foundation/Case Foundation v. Tracy, 696 F.3d 835 (9th Cir. 2012), arose in the context of the "last employer" liability rule, which provides that an injured employee's last employer is liable for all of an

employee's LHWCA compensation even if injuries with previous employers contributed to the present disability. In this case, the employee's last relevant maritime employment with Global International Offshore Ltd. occurred in the waters and ports of Singapore and Indonesia. The ALJ found the employee's disability was the result of cumulative injuries with Global and a previous stateside maritime employer (Keller). The ALJ imposed liability on Keller, however, reasoning that the LHWCA did not cover Tracy's overseas work in foreign ports. The ALJ also rejected the employee's argument that Global should be estopped from denying LHWCA coverage because his employment contract specified that American workers' compensation law would apply. The BRB affirmed, as did the Ninth Circuit. The court refused to extend application of the LHWCA to foreign territorial waters and their adjoining ports in the absence of clear evidence rebutting the "strong presumption that enactments of Congress do not apply extraterritorially." Notwithstanding precedent extending the LHWCA's application to the high seas and the Director's position supporting coverage, the court found nothing in the LHWCA that indicated Congress intended to include the territorial waters of foreign sovereigns as part of the "navigable waters of the United States." Finally, the court concluded the employee could not rely on equitable estoppel to gain LHWCA coverage. It found no evidence the employee had detrimentally relied on a clear promise from Global that the Act covered his employment. The court therefore affirmed the BRB's decision holding that the LHWCA did not apply to the employee's work for Global in foreign territorial waters.

Interest on Past-Due Compensation – 28 U.S.C. § 1961; Judicial Deference to Director's Litigating Position. Although the LHWCA does not expressly authorize interest on an employee's past due benefits, the Director, the Board, and the courts have long accepted that interest is owed. The Ninth Circuit granted rehearing *en banc* to reconsider its panel decision in *Price v. Stevedoring Services of America, Inc.,* 627 F.3d 1145 (9th Cir. 2010) (O'Scannlain, J., concurring). The panel majority had endorsed the Director's position that interest is properly calculated at the rate prescribed by 28 U.S.C. § 1961(a) for interest on judgments in federal civil cases, i.e., a rate equal to the "the 1-year constant maturity Treasury yield . . . for the calendar week preceding the date of judgment." The panel had further held that the Director's policy of calculating interest on a simple, rather than compound, basis was permissible. In its decision, the panel adhered to prior Ninth Circuit law giving significant deference to the Director's interpretation of the LHWCA even where that interpretation was expressed in legal briefs. In *Price v. Stevedoring Services of America, Inc.*, 697 F.3d 820 (9th Cir. 2012) (*en banc*) (O'Scannlain, J., dissenting in part), the *en banc* court reconsidered both the interest issue and the level of deference the Director should receive for his statutory interpretation. The deference issue presented a choice between *Chevron* deference (under which courts generally defer to an agency's interpretation of a statute so long as it is reasonable) and the less-deferential *Skidmore* standard (under which an agency interpretation is only deferred to if the court finds it persuasive). After reviewing Supreme Court precedent on deference, the court concluded that the Director's interpretation of the LHWCA as expressed in litigation briefs (as opposed to regulations or similar pronouncements) was entitled to only *Skidmore* deference. Even applying this lower standard, however, the court agreed with the panel that the Director's application of the section 1961 interest rate was proper in the absence of any congressional guidance or a clear reason to adopt another rate. The court did reverse the panel with respect to the method of calculation holding that interest must be calculated on a compound basis (as section 1961 provides) to adequately compensate employees for the delayed receipt of past-due benefits. The dissenting judge believed proper application of *Skidmore* deference required the court to accept the Director's "long-standing, consistent practice" of allowing only simple interest because the issue presented a policy choice best left to the agency.

Benefits Review Board

During FY 2012, the Benefits Review Board (BRB) issued 204 decisions in cases arising under the LHWCA, of which twelve were published. Important holdings from some of these cases are summarized below.

Maritime Situs – 33 U.S.C. § 903(a). The LWHCA provides for benefits if an employee's injury occurs at a covered "situs," which includes the navigable waters of the United States, one of the "adjoining" areas enumerated in the statutory definition, or any other "adjoining" area customarily used for maritime purposes. In *Ramos v. Container Maintenance of Florida,* 45 BRBS 61 (2011), the BRB considered whether a cargo container repair facility located in a mixed-used area with no connection to maritime activity, and three miles from the nearest deepwater port or terminal, constituted an "adjoining" area customarily used for maritime purposes. Applying controlling court of appeals precedent holding that an "adjoining" area is one that is in geographical proximity to navigable waters and that has a functional relationship to maritime activities, the Board held that the facility was not a covered situs. The Board reasoned that the facility did not have a geographic nexus with the nearest port, given its inland location, and was located in an area that had no functional relationship to maritime activities because it was the only maritime facility in the vicinity. The Board further noted that the geographical nexus was not met simply because it was not feasible to locate the facility any closer to the port. Finally, the Board held that the possibility that the facility's location would, at some future point, develop into a maritime services hub, or that port facilities would be moved farther inland, was not relevant to the situs inquiry. The conditions prevailing at the time of the claimant's injury control.

Maritime Status – 33 U.S.C. § 902(2). An injured employee must also satisfy the "status" requirement to be covered under the LHWCA. Status as a maritime employee requires the employee to spend at least some part of his employment performing tasks essential to maritime commerce. In *Smith v. Labor Finders,* 46 BRBS 35 (2012), the injured employee was hired as a "beach-walker" to clean oil from the Deepwater Horizon spill that washed up on Horn Island, Mississippi, a 20 mile-long federally-protected wilderness preserve and recreational area in the Gulf of Mexico. The employee collected oil residue and other contaminants in bags for removal and disposal, but did not enter the water and was not required to load oil debris onto collection vessels. The BRB affirmed the ALJ's finding that the employee did not satisfy the status requirement. It reasoned that the employee's clean-up work did not have a commercial maritime purpose but was intended to restore the island to a recreational and wildlife area. The employee's ancillary work activities, such as loading and unloading his tools and supplies from a transport vessel or shuttling other beach-walkers and their supplies around the island, did not enable maritime commerce, but merely facilitated the clean-up work. Finally, the loading of oil debris onto collection vessels, which the employee allegedly did on occasion, did not satisfy the status requirement because it was neither an assigned duty nor a responsibility assumed by his employer under its contract.

Average Weekly Wage – 33 U.S.C. § 910(c). The LHWCA makes compensation payable in an amount based upon the worker's average weekly wage (AWW) and provides three alternative methods for calculating AWW. In *Jasmine v. Can-Am Protection Group, Inc.,* 46 BRBS 17 (2012), a case that arose under the Defense Base Act (DBA), the BRB addressed the third method, which affords the adjudicator discretion to determine an amount that reasonably represents the injured employee's annual earning capacity at the time of the injury. The employee was injured in Afghanistan shortly after beginning work under a six-month contract. Prior to his injury, he had alternated regularly between stateside and short-term overseas employment for five years. In calculating the AWW, the ALJ used a blend of earnings received by the employee in work performed stateside and overseas. He declined to consider only the higher overseas earnings in making his calculation. The BRB affirmed the ALJ's "blended" calculation as reasonable based on the facts of the case: the employee's overseas employment was cyclical, the overseas contract was short-

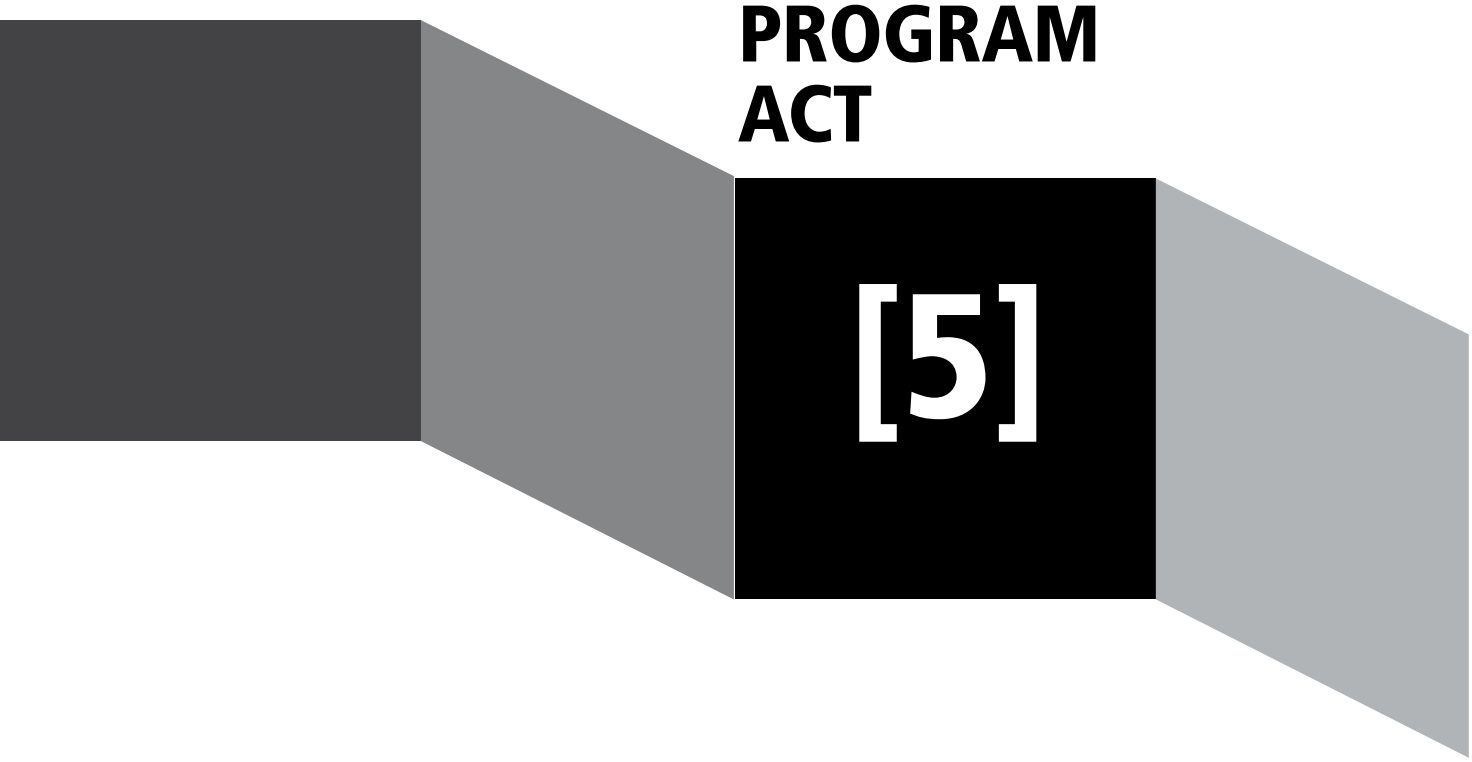
term, and the ALJ's conclusion that the employee lacked a long-term commitment to overseas employment was rational. The BRB noted its prior precedent did not require an ALJ, when calculating AWW in a DBA case, to consider only the employee's overseas earnings at the time of injury.

LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT		
	FY 2011	**FY 2012**
Number of Employees (FTE Staffing Used)	95	96
Administrative Expenditures[1]	$13.5 M	$13.5 M
Lost-Time Injuries Reported	29,169	29,287
Total Compensation Paid[2]	$1,137.5 M	$1,272.7 M
Wage-Loss and Survivor Benefits	$808.6 M	$908.8 M
Medical Benefits	$328.8 M	$363.8 M
Sources of Compensation Paid		
Insurance Companies[2]	$589.4 M	$710.3 M
Self-Insured Employers[2]	$408.5 M	$425.6 M
LHWCA Special Fund	$125.3 M	$122.7 M
DCCA Special Fund	$9.5 M	$8.7 M
DOL Appropriation	$1.9 M	$1.8 M

[1] Direct administrative costs to OWCP only, including Trust Funds; excludes DOL costs of $14.3 million in FY 2011 and $14.4 million in FY 2012, respectively, for support provided by the OALJ, BRB, SOL, and OIG.

[2] Figures are for CY 2010 and CY 2011, respectively. Note: Total compensation paid does not equal the sum of the sources of compensation due to the different time periods (CY v. FY) by which the various data are reported. For Special Fund assessment billing purposes as required by section 44 of LHWCA, compensation and medical benefit payments made by insurance carriers and self-insured employers under the Acts are reported to DOL for the previous calendar year.

ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT



Energy Employees Occupational Illness Compensation Program Act

Introduction

The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) was enacted in October 2000. Part B of the EEOICPA, effective on July 31, 2001, compensates current or former employees (or their survivors) of the Department of Energy (DOE), its predecessor agencies, and certain of its vendors, contractors and subcontractors, who were diagnosed with a radiogenic cancer, chronic beryllium disease, beryllium sensitivity or chronic silicosis as a result of exposure to radiation, beryllium, or silica while employed at covered facilities. The EEOICPA also provides compensation to individuals (or their eligible survivors) awarded benefits by the Department of Justice (DOJ) under Section 5 of the Radiation Exposure Compensation Act (RECA).

Part E of the EEOICPA (enacted October 28, 2004) replaced the former Part D and compensates DOE contractor/subcontractor employees, eligible survivors of such employees, and uranium miners, millers, and ore transporters as defined by RECA Section 5 for any occupational illnesses that are linked to toxic exposures in the DOE or mining work environment.

On July 31, 2012, the Department of Labor (DOL) marked the eleventh anniversary of its administration of the EEOICPA. From the program's inception to the end of Fiscal Year (FY) 2012, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) has awarded compensation and medical benefits totaling over $8.5 billion under both Parts B and E of the EEOICPA. During this time, 81,053 employees or their families have received over $7.3 billion in compensation and over $1.2 billion in medical expenses associated with the treatment of accepted medical conditions. Part B compensation has totaled more than $4.6 billion (since 2001) while Part E compensation has totaled more than $2.7 billion (since 2005).

In FY 2012 alone, 5,803 employees or their families received $510.0 million in Part B compensation. In addition, 3,793 employees or their eligible survivors received $292.8 million in Part E compensation. A total of $340.7 million was paid in covered medical benefits in FY 2012 under both Parts B and E of the EEOICPA, bringing total benefits to over $1.1 billion for the year.

Administration

Implementation of the EEOICPA is a uniquely intergovernmental activity, involving the coordinated efforts of four federal agencies to administer: DOL, DOE, DOJ, and the Department of Health and Human Services (HHS). DOL has primary responsibility for administering the EEOICPA, including adjudication of claims for compensation and payment of benefits for conditions covered by Parts B and E.

DOE designates Atomic Weapons Employer (AWE) facilities and provides DOL and HHS with verification of covered employment and relevant information on exposures including access to restricted data. DOJ notifies beneficiaries who have received an award of benefits under RECA Section 5 of their possible EEOICPA eligibility and provides RECA claimants with information required by DOL to complete the claim development process.

HHS, through its National Institute for Occupational Safety and Health (NIOSH), establishes procedures for estimating radiation doses, develops guidelines to determine the probability that a cancer was caused by workplace exposure to radiation, establishes procedures for designation of new Special Exposure

Cohort (SEC) classes, and carries out the actual dose reconstruction for cases referred by DOL. Under the EEOICPA, Congress established the SEC to allow eligible claims to be compensated without the completion of a radiation dose reconstruction or determination of the probability of causation. To qualify for compensation under the SEC, a covered employee must have at least one of twenty-two **"specified cancers"** and have worked for a certain period of time at a facility designated in the statute or by HHS as a class within the SEC. HHS also provides administrative services and other necessary support to the Advisory Board on Radiation and Worker Health. The Board advises HHS on the scientific validity and quality of dose reconstruction efforts, and receives and provides recommendations on petitions submitted requesting additional classes of employees for inclusion as members of the SEC.

Benefits under the EEOICPA

Part B. To qualify for benefits under Part B of the EEOICPA, an employee must have worked for DOE or a DOE contractor or subcontractor during a covered time period at a DOE facility, or have worked for a private company designated as a covered AWE or beryllium vendor. The worker must have developed cancer, chronic beryllium disease, or beryllium sensitivity due to exposures at a covered work site, or chronic silicosis (for individuals who worked in Nevada and Alaskan nuclear test tunnels). A covered employee who qualifies for benefits under Part B may receive a one-time lump-sum payment of $150,000, plus medical expenses related to an accepted, covered condition. Survivors of these workers may also be eligible for a lump-sum compensation payment. Part B also provides for payment of $50,000 to uranium workers (or their eligible survivors) who received an award from DOJ under Section 5 of the RECA.

For all claims filed under Part B, the employment and illness documentation is developed by claims staff and evaluated in accordance with the criteria in the EEOICPA and relevant regulations and procedures. DOL district offices then issue recommended decisions to claimants. Claims filed under Part B for the $50,000 RECA supplement are the least complex, involving verification by DOJ that a RECA award has been made, and documentation of the identity of the claimant (including survivor relationship). DOL can also move quickly on cases involving "specified cancers" at SEC facilities because the EEOICPA provides a presumption that any of the twenty-two listed cancers incurred by an SEC worker was caused by radiation exposure at the SEC facility. For cases involving claimed cancers that are not covered by SEC provisions (that is, either cancers incurred at a non-SEC facility, a non-specified cancer incurred at an SEC facility, or an employee who did not have sufficient employment duration to qualify for the SEC designation), there is an intervening step in the process to determine causation called "dose reconstruction." In these instances, once DOL determines that a worker was a covered employee and that he or she had a diagnosis of cancer, the case is referred to NIOSH so that the individual's radiation dose can be estimated. After NIOSH completes the dose reconstruction and calculates a dose estimate for the worker, DOL takes this estimate and applies the methodology promulgated by HHS in its probability of causation regulation to determine if the statutory causality test is met. The standard is met if the cancer was "at least as likely as not" related to covered employment, as indicated by a determination of at least 50 percent probability.

Part E. The EEOICPA's Part E establishes a system of Federal payments for employees of DOE contractors and subcontractors (or their eligible survivors) for illnesses determined to have resulted from exposure to toxic substances at a covered DOE facility. Uranium miners, millers, and ore transporters as defined by Section 5 of the RECA may also be eligible to receive Part E benefits. Benefits are provided for any illness if it can be determined that it was "at least as likely as not" that work-related exposure to a toxic substance was a significant factor in causing, contributing to, or aggravating the illness or death of an employee. Additionally, the EEOICPA provides that any determination made under Part B to award benefits (including RECA Section 5 claims) is an automatic acceptance under Part E for causation of the illness, where the employment criteria are also met. The maximum payable compensation under Part E is $250,000

for all claims relating to any individual employee, meaning that a total of $400,000 can be paid in Part B plus E compensation with respect to a single worker.

Under Part E, a covered employee may be eligible to receive compensation for the percentage of impairment of the whole person that is related to a covered illness, as well as any illness, injury, impairment, or disease shown by medical evidence to be a consequence of an accepted Part E illness. The EEOICPA specifically requires that impairment be determined in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment (AMA's Guides). Impairments included in ratings are those that have reached maximum medical improvement (MMI), i.e., they are well-stabilized and unlikely to improve substantially with or without medical treatment. MMI is not required if an illness is in a terminal stage. Eligible employees receive $2,500 for each percentage point of impairment found to be attributable to a covered illness under Part E.

Also under Part E, covered employees may be eligible to receive wage-loss benefits. Wage-loss benefits are paid for each qualifying calendar year (prior to reaching normal Social Security Act retirement age) in which, as a result of the covered illness, an employee's earnings fell a specific percentage below his or her average annual earnings for the 36-month period prior to the month in which the employee first experienced wage-loss (not including periods of unemployment). The EEOICPA provides that covered, eligible employees may receive $15,000 for any year in which they made less than 50 percent of their baseline wage, as a result of a covered illness, and $10,000 for any year in which they made more than 50 percent but less than 75 percent of that baseline wage. Medical benefits for the covered illness are also payable, in addition to monetary compensation.

Part E survivor benefits include a basic lump sum of $125,000 where it is established that the employee was exposed to a toxic substance at a DOE facility and that the exposure was "at least as likely as not" a significant factor in causing, contributing to, or aggravating the illness and death of the employee. Part E also provides $25,000 in additional benefits to eligible survivors, if the deceased employee had, as of his or her normal retirement age under the Social Security Act, at least ten aggregate calendar years of wage loss of at least 50 percent of his or her baseline wage. If an employee had twenty or more such years, the additional amount paid to an eligible survivor may increase to $50,000. The maximum Part E compensation benefit for a survivor is $175,000.

Funding

DOL funding covers direct and indirect expenses to administer the Washington, D.C. National Office; five Final Adjudication Branch Offices; four DEEOIC District Offices in Seattle, Washington; Cleveland, Ohio; Denver, Colorado; and Jacksonville, Florida; and eleven Resource Centers operated by a contractor. A private contractor processes medical bills to reduce overhead and to increase program efficiency. In FY 2012, DOL spent $49.6 million under Part B and $72.4 million under Part E to administer the EEOICPA. These funds supported 227 full-time equivalent (FTE) staff for Part B and 239 FTE for Part E. Additional funds in the amount of $0.3 million under Part B and $0.8 million under Part E supported the Office of the Ombudsman position. Funding for the NIOSH radiation dose reconstruction process and the Advisory Board on Radiation and Worker Health was provided in the Health and Human Services appropriation.

Adjudication of Claims

In FY 2012, DEEOIC continued to receive a substantial number of new claims, creating a total of 6,067 new cases (9,226 claims) for living or deceased employees under Part B, and 5,892 new cases (8,133 claims) under Part E. Each case represents an employee whose illness is the basis for a claim; however, a single case

may contain multiple survivor claims. Under the EEOICPA, workers or their survivors may qualify for Part B benefits only, Part E benefits only, or benefits under both Parts B and E. Claims and cases under Parts B and E are counted separately (that is, if a claimant is potentially eligible under both Parts, his or her claim will be counted under both Part B and Part E).

Under the EEOICPA, the Secretary of HHS is responsible for adding new classes of employees to the SEC where a complete dose reconstruction cannot be performed by NIOSH. The SEC is a mechanism by which claimants, who have one of the 22 cancers identified in the law, receive a presumption that their cancer is the result of their employment; such a presumption expedites the adjudication process by eliminating the need for a dose reconstruction. The EEOICPA initially designated certain employees at four sites (the three gaseous diffusion plants in Oak Ridge, Tennessee; Paducah, Kentucky; and Portsmouth, Ohio; and an underground nuclear test site on Amchitka Island, Alaska) as belonging to the SEC. As of September 30, 2012, NIOSH had added 94 classes of employees to the four statutory classes in the SEC, which combined represent workers at 71 facilities. During FY 2012, NIOSH added 16 classes of employees at the following facilities: Medina Modification Center in San Antonio, Texas; Clarksville Modification Center in Clarksville, Tennessee; Hanford in Richland, Washington; Winchester Engineering & Analytical Center in Winchester, Massachusetts; Feed Materials Production Center in Fernald, Ohio; Electro Metallurgical Corporation in Niagara Falls, New York; Sandia National Laboratories in Albuquerque, New Mexico; Clinton Engineer Works in Oak Ridge, Tennessee; Brookhaven National Laboratory in Upton, New York; Linde Ceramics in Tonawanda, New York; Savannah River Site in Aiken, South Carolina; Pantex Plant in Amarillo, Texas; W.R. Grace in Curtis Bay, Maryland; Y-12 in Oak Ridge, Tennessee; Ames Laboratory in Ames, Iowa; and Vitro Manufacturing in Canonsburg, Pennsylvania.

When a new class of employees is added to the SEC, DOL reviews all affected cases and makes a determination on whether the employee in question meets the criteria for inclusion in the new class. Any previously denied claim with employment meeting the new definition is reopened for additional development and new recommended decisions.

For claims filed under Part E, claims examiners use an array of tools including the Site Exposure Matrices (SEM) database that provides information about substances used in specific DOE facilities and the occupational illnesses and health effects associated with exposure to specific toxic substances. District offices also rely on DOE's records that contain employees' radiological dose records, incident or accident reports, industrial hygiene or safety records, personnel records, job descriptions, medical records, and other records that prove useful in determining causation. Additionally, a referral to a Contract Medical Consultant (CMC) may be required to determine a medical diagnosis, whether or not an illness is indicative of toxic substance exposure versus a natural medical process, whether there is a causal relationship between claimed illnesses and the occupational exposure history, or to evaluate an employee's cause of death. CMC referrals may also be necessary for impairment evaluations and for opinions regarding the causal relationship between a covered illness and claimed wage loss. On February 6, 2012, the program began using CMCs provided by an outside contractor. Claims may also be referred to a health physicist, industrial hygienist, or toxicologist for review when a scientific determination regarding the case is required.

Recommended Decisions and Final Decisions. The DEEOIC district offices process EEOICPA claims to the "recommended decision" stage and for each claim, they issue a recommended decision to approve or deny the claim. Each recommended decision made by the district office must be reviewed by the Final Adjudication Branch (FAB), which ensures that the EEOICPA's requirements, program policies, and procedures are followed, and issues a final decision. Before making a final decision, the FAB considers any challenges brought forth by the claimant through either a review of the written record or an oral

hearing. During FY 2012, the FAB conducted 896 reviews of the written record and oral hearings for 1,043 claimants. (These are not unique claim counts as a claimant may receive one review of the written record or one oral hearing covering both their Part B and Part E claims). For each claim, the FAB reviews the evidence of record, the recommended decision, and any objections/testimony submitted by the claimant or his/her representative, and issues a final decision either awarding or denying benefits. The FAB may also remand a decision to the district office, if further development of the case is necessary. A claimant may challenge the FAB's final decisions by requesting reconsideration or reopening of the claim, or may file a petition for review of a final decision with the appropriate U.S. District Court. While Part B and Part E of the EEOICPA each have unique eligibility criteria, DEEOIC usually adjudicates all claims for benefits under Parts B and E as a unified claim for greater efficiency, and where possible, decisions are issued that address both Parts B and E simultaneously. However, partial decisions may also be issued in cases where benefits under some provisions can be awarded, but claims under other provisions require further development.

During FY 2012, DEEOIC district offices issued 10,686 Part B claim-level recommended decisions and 9,580 Part E claim-level recommended decisions. Further, the FAB issued 11,120 Part B claim-level final decisions and 7,444 Part E claim-level final decisions. DOL approved benefits in 59.3 percent of covered Part B claims and 87.7 percent of covered Part E claims that were issued a final decision during FY 2012. Covered applications are those claims which met the basic eligibility requirements of covered employment and a covered occupational illness under Part B, or for covered employment and survivorship under Part E.

Outreach Activities

DEEOIC's staff continues to sponsor outreach activities to disseminate information about the EEOICPA and provide one-on-one assistance to claimants in applying for benefits.

Resource center and district office personnel supported the collaborative outreach efforts led by DEEOIC's Branch of Outreach and Technical Assistance (BOTA) in the national office. During FY 2012, as additional classes of employees were added by the Secretary of HHS to the SEC, DOL sponsored eight town hall meetings and traveling resource centers in: Albuquerque, New Mexico (meetings in both November 2011 and August 2012); Cincinnati, Ohio; Oak Ridge, Tennessee; Amarillo, Texas; Augusta, Georgia; Amherst, New York; and Hamilton, Ohio. During these town hall meetings and traveling resource centers, DEEOIC staff presented details about new SEC classes at Sandia National Laboratories, General Electric Company (Ohio), Y-12 Plant, Pantex Plant, Savannah River Site, Linde Ceramics Plant, and Feed Materials Production Center. DEEOIC records show that over 1,470 individuals attended these town hall meetings and traveling resource centers, and as a result of these meetings resource center staff submitted 176 new claims to DOL for adjudication. Further, in response to large attendance at past town hall meetings held in the Navajo Nation, DEEOIC conducts quarterly meetings in Shiprock, New Mexico and Kayenta, Arizona, to provide in-person assistance to Navajo and other EEOICPA claimants.

DEEOIC staff continued to participate in a joint outreach task group (JOTG) consisting of representatives from DOE, the Office of the Ombudsman for the EEOICPA, HHS' NIOSH, the Ombudsman to NIOSH for the EEOICPA, and DOE's Former Worker Medical Screening Program, to provide information and clarification regarding the EEOICPA to former nuclear weapons workers and their families. During FY 2012, DEEOIC staff participated in a JOTG town hall meeting and traveling resource center in Upton, New York, which more than 200 individuals attended. The purpose was to provide former employees of the Brookhaven National Laboratory with information about a new class of employees added to the SEC of the EEOICPA. As a result of the event, resource center staff submitted 19 new claims to DOL for adjudication. Further, at the request of the Office of the Ombudsman for the EEOICPA, DEEOIC national office, district office, and resource center staff continued to participate in all Ombudsman-sponsored outreach initiatives by providing claim status updates to claimants, taking new claims, and answering questions as needed.

Other examples of DEEOIC outreach activities conducted during FY 2012 include meetings with local governments and chambers of commerce, presentations to personnel at covered facilities and unions, and other community initiatives. Additionally, during FY 2012 the district offices received 87,731 phone calls and the FAB received 4,276 phone calls. Nearly all calls that required a return call were returned within two business days.

During FY 2012, DEEOIC issued press releases informing individuals in New Jersey and California who worked at covered EEOICPA facilities where less than 50 claims have been filed of the benefits that may be available to them under the EEOICPA. Altogether this effort included notification to potential claimants at 52 facilities.

Services to Claimants

The Departments of Labor, Health and Human Services, Energy, and Justice provide assistance to current and potential claimants and surviving family members, to help them understand the EEOICPA and claimants' rights and obligations under the program. DOL has implemented several strategies to assist workers and survivors in filing claims, collecting evidence to support claims, and understanding the adjudication process from start to finish:

Website. DEEOIC's website provides important information about the statute and regulations governing Parts B and E of the EEOICPA, and gives claimants access to brochures, claim forms, and electronic filing of claims. During FY 2012, two policy bulletins and eighteen final circulars concerning the administration of the EEOICPA were posted to the site. Further, the website also provides DEEOIC's Procedure Manual; the locations and times of town hall meetings; district office and resource center locations and contact numbers; press releases; medical provider enrollment information; and an online web-based page, the Claimant Status Page, which allows claimants access to limited claims information from the Energy Compensation System (ECS), the electronic claims database utilized by DEEOIC claims examiners. The Claimant Status Page allows a claimant to access certain information contained in his or her claim under the EEOICPA, including claimed medical condition(s), worksite locations, most recent claim actions, payment information, and current case location. Claimants are provided with an individual claim identification number to gain access to their claim information and to prevent access by other individuals to a claimant's specific claim information.

Claimants can also view DEEOIC and NIOSH weekly web statistics; payment statistics at the national, state, and facility levels; and the searchable database of DEEOIC final decisions. The website also provides links to DOE, DOJ, and NIOSH's websites and toll-free numbers where additional information and assistance can be obtained.

Procedure Manual. During FY 2012, the DEEOIC continued to evaluate and assess its policies and procedures contained in the EEOICPA Procedure Manual, which contains an overview of the DEEOIC program and provides policies and procedures for the processing and adjudication of claims under the EEOICPA. Throughout FY 2012, the DEEOIC updated portions of the Procedure Manual, incorporating updates in policy directives, when appropriate. The EEOICPA Procedure Manual is available to the public via the DEEOIC website.

Resource Centers. DEEOIC's network of Resource Centers (RCs) at major DOE sites provides an initial point-of-contact for workers interested in the program and in-person and toll-free telephone-based assistance to individuals filing claims under the EEOICPA. In FY 2012, the RC contractor had 61 employees at 11 sites to assist claimants in completing necessary claim forms and gathering documentation that can support their claims.

The RC staff assists with initial claim-filing and Part E occupational history development, and staff forwards all claims and associated documentation to the appropriate district offices. During FY 2012, the RCs helped claimants file 12,083 claims, received more than 82,400 telephone calls, conducted nearly 116,900 follow-up actions with claimants, and completed 5,656 occupational history interviews. RC staff also supported DEEOIC's eight town hall meetings and traveling resource centers as well as the JOTG event in Upton, New York. Additionally, the RC staff continued to assist claimants with the medical bill payment process, preparation of requests for pre-authorized medical travel, and submission of claims for reimbursement related to medical travel. During FY 2012, the RC staff made over 27,400 contacts related to medical bills and enrolled 208 new medical providers into the program.

Web-Ex Video Conferencing System. During FY 2012, the DEEOIC introduced Web-Ex, which is a Cisco systems platform that provides live stream video conferencing capability, as a means of upgrading and modernizing the administration of the EEOICPA. Web-Ex allows the DEEOIC FAB hearing representatives to conduct oral hearings in "real time" with DEEOIC claimants across the country without traveling. DEEOIC has established Web-Ex systems in all four of its district offices, the National Office FAB, and the National Office headquarters in Washington, D.C. In addition, DEEOIC has established Web-Ex systems in seven of the eleven resource centers located in Oak Ridge, Tennessee; Paducah, Kentucky; Portsmouth, Ohio; North Augusta, South Carolina; Amherst, New York; Richland, Washington; and Las Vegas, Nevada with the plans to expand to the Espanola, New Mexico center. Since the FAB hearing representatives are no longer required to travel to locations near Web-Ex sites, substantial savings in terms of travel costs and staff time has resulted. Moreover, DEEOIC also is using the Web-Ex system to conduct its bi-weekly staff meetings (with all district office and FAB managers) and to continue claims examiner training in the areas of medical development, Site Exposure Matrices, and toxicology.

Center for Construction Research and Training. The Center for Construction Research and Training (CPWR), formerly called the Center to Protect Workers' Rights, continued its work under contract with the DEEOIC. The CPWR has been tasked with researching and providing employment information for construction/trade workers (who worked at DOE) in cases where DOL has been unable to obtain reliable information through other available resources. In FY 2012, CPWR provided responses to 1,009 requests for information. CPWR also maintains a website-accessible database that identifies and confirms the existence of contractual relationships between contractor and subcontractor employers and certain covered facilities. This database is available to DEEOIC claims examiners.

Database Systems. DEEOIC's Branch of Automated Data Processing Systems (BAS) is responsible for providing DEEOIC's internal and external customers an entire array of secure and reliable computer services and support. During FY 2012, BAS launched the integrated, modernized and expanded mission-critical case management system. The new unified system, called the Energy Compensation System (ECS), replaced the Energy Case Management System (ECMS) and serves as a repository for data related to claims adjudication activities and compensation benefits. The separate Part B and Part E management systems had supported DEEOIC's users since Part B's (2001) and Part E's (2005) inception. A component of ECMS is still being used, but DEEOIC should be able to transition completely to ECS in FY 2013. These enhancements ensure the effectiveness of administering compensation benefits to claimants to once again meet and exceed strategic and operational goals.

Secure Electronic Record Transfer. During FY 2012, staff from DEEOIC worked with staff from DOE to launch the Secure Electronic Record Transfer (SERT) system. SERT is a HHS-hosted environment where DOL, NIOSH, and other agencies that implement the EEOICPA can send and receive records and data in a secure manner. In addition to effectively securing large volumes of Personally Identifiable Information, the system reduces the time to complete EEOICPA claims and improves transparency between agencies. While the planning for SERT was conducted in FY 2012, the system went live on October 15, 2012.

Ombudsman. Under the Defense Authorization Act for Fiscal Year 2005, Public Law 108-375, 42 U.S.C. § 7385s-15, signed into law on October 28, 2004, an Office of the Ombudsman was created for a period of three years, to provide information to claimants, potential claimants, and other interested parties on the benefits available under Part E of the EEOICPA and how to obtain those benefits. In January 2008, the National Defense Authorization Act of 2008 extended the term of this office to October 28, 2012; on October 28, 2009, the National Defense Authorization Act of 2009 expanded the authority of the Office to also include Part B of the EEOICPA. In FY 2012, the term of the Office of the Ombudsman was again extended to October 28, 2014. The Office of the Ombudsman , within the Department of Labor but independent from OWCP, reports annually to Congress concerning complaints, grievances, and requests for assistance received during the calendar year covered by the report. DEEOIC continues to work directly with the Ombudsman's office to promptly resolve any issues and concerns stemming from the Ombudsman's findings.

Site Exposure Matrices (SEM) Database. DEEOIC continues to enhance its database of "site exposure matrices" to assist claims examiners in determining the types of chemicals and toxic substances that existed at the major DOE facilities, easing claimants' evidentiary burdens and speeding the claims process. In FY 2012, DEEOIC updated the Internet Accessible SEM (IAS) that is viewable by the public. The IAS website contains the same information on each DOE and RECA site that is used by the DEEOIC, delayed by approximately six months for classification reviews by DOE. Working with DOE to achieve those reviews, the DEEOIC updated the IAS twice during FY 2012. Those updates provided the public information on 2,544 additional toxic substances/chemicals. The DEEOIC also responded to 42 inquiries and suggestions received from the public on the IAS website. Major increases in chemical and process information were made using public input for the Portsmouth Gaseous Diffusion Plant and the Mound Plant. During FY 2012, the SEM project team updated 29 of 116 SEM matrices for DOE facilities and added a total of 873 new toxic substances to the SEM database as a result of public and worker input. As of September 30, 2012, SEM housed information on 14,082 toxic substances/chemicals used at 123 DOE sites, 4,252 uranium mines, 49 uranium mills, and 23 uranium ore buying stations covered under the EEOICPA.

In addition to these activities, the National Academy of Sciences/Institute of Medicine (NAS/IOM) began its scientific review of the Site Exposure Matrices during FY 2012 (see the Program Evaluation section of this report). Under an agreement between DEEOIC and NAS/IOM, NAS/IOM convened a panel of experts to review the scientific accuracy of occupational disease links to toxic substances with the SEM.

National Library of Medicine (NLM) Haz-Map Occupational Health Database. DOL continued to provide funding to support further development and expansion of the NLM Haz-Map Occupational Health Database. This database contains information about the possible effects of exposure to hazardous agents that assists DOL in developing and adjudicating claims filed under Part E of EEOICPA by relieving claimants of some of the burden of proof in their claims. The funding provided in FY 2012 allowed NLM to complete 1,442 new and updated health/chemical profiles for its Haz-Map database.

DEEOIC also completed its expansion of the public SEM website, an effort that began in May 2010. By making the information in the SEM public, DEEOIC is making the Part E process more transparent. The final six additions to the public website made this year include the Lawrence Livermore National Laboratory (Livermore, California), the Oak Ridge Gaseous Diffusion Plant (also known as the East Tennessee Technology Park, or K-25, in Oak Ridge, Tennessee), the Y-12 Plant (Oak Ridge, Tennessee), the Paducah Gaseous Diffusion Plant (Paducah, Kentucky), the Pantex Plant (Amarillo, Texas), and the Pinellas Plant (Clearwater, Florida).

Government Performance Results Act

DOL is committed to measuring its outcomes and maintaining accountability for achieving the fundamental goals of the EEOICPA. High performance standards, focusing on moving EEOICPA claims rapidly through the initial and secondary adjudication stages, have been established, and DOL has maintained a strong record of meeting its key performance goals under the Government Performance Results Act (GPRA).

DEEOIC's three indicators achieved under DOL's GPRA goal to "provide good jobs for everyone through income maintenance" were as follows:

- DEEOIC began to measure average days for completion of initial processing of claims in FY 2007, as that measure is a good indicator of overall effectiveness in delivering initial services to claimants. During FY 2011, a goal of 110 days was set for Part B claims and DEEOIC exceeded this goal by taking an average of 91 days to process initial claims. In FY 2012, a goal of 100 days was set, and DEEOIC exceeded this goal by taking an average of only 92 days to process initial claims under Part B of the EEOICPA.
- During FY 2011, a target of 145 days was set for Part E claims, and DEEOIC exceeded this goal by taking an average of 101 days to process initial claims. In FY 2012, a target of 125 days was set. Again, DEEOIC exceeded its goal, as 104 days on average were needed to process initial claims under Part E of the EEOICPA.
- Timely processing also extends to final decisions issued by DEEOIC's FAB. The timeliness standards for both Part B and Part E claims are to complete final decisions within 175 days where there is a hearing and within 75 days where there is no hearing. In the processing of Part B and Part E final decisions through the efforts of the FAB, 92 percent of Part B and Part E decisions in FY 2012 were within the program standards, in excess of the goal of 90 percent.

Central Medical Bill Processing

The OWCP central bill processing service continued to provide a high level of service to eligible claimants and providers in FY 2012. Timely and accurate medical bill processing is critical in the administration of the EEOICPA. In FY 2012, DEEOIC avoided $11.6 million in costs during the year due to further improvements in the editing of bills. These savings were achieved without impacting on services to claimants.

By the end of FY 2012, the bill processing vendor had processed 427,534 EEOICPA bills and handled 48,543 telephone calls. Authorizations for medical treatment were processed in an average of one workday and 98.0 percent of bills were processed within 28 days. Enrollment of 4,038 new providers brought the total of enrolled providers for EEOICPA services to 134,500.

Program Evaluation

On November 10, 2011, the U.S. Department of Labor's Office of Workers' Compensation Programs announced its partnership with the National Academy of Sciences (NAS)/Institute of Medicine (IOM) to further enhance the Site Exposure Matrices website, a tool that aids the adjudication of claims under the EEOICPA. The IOM first convened a panel of experts on January 23, 2012, to review the scientific rigor and organization of the SEM database. The committee also met on March 16, 2012, September 21, 2012, and November 7, 2012. Their focus was on the occupational disease links to workplace chemical usage/exposure; the National Institutes of Health's/NLM's review process with regard to Haz-Map; and the review process used by the Haz-Map developer when including information in the Haz-Map database. The committee will identify strengths and weaknesses of the SEM and make recommendations for addressing any weaknesses. Items to be addressed in a report are:

- What, if any, occupational diseases that might have affected the DOE contractor workforce are missing from SEM?
- What, if any, links between occupational diseases and toxic substances present at DOE sites are missing from SEM?
- Is there additional literature (preferably human epidemiological in nature) that might be incorporated into SEM to strengthen or add to the existing links between toxic substances and occupational diseases? Are the existing links sufficiently robust?
- What, if any, other occupational disease databases might be used to supplement the Haz-Map information in SEM?
- How scientifically rigorous are the disease links contained in SEM and Haz-Map?
- What are the strengths and weaknesses of the NIH/NLM peer review process with regard to Haz-Map? How might this process be improved?
- Can any known (epidemiologically significant) synergistic effects between chemicals/chemicals or chemicals/radiation be placed in SEM? If so, what are the sources of these links and are they occupational in nature?
- What consistent process or approach could be used to consider a disease or cancer established when studies and inconclusive, inconsistent or conflicted in some way?

A report is to be issued in approximately 18 months from the convening of the first meeting.

Litigation

DEEOIC strives in every case to administer the Energy program in accordance with the law and governing regulations. During FY 2012, two U.S. Courts of Appeal issued decisions in cases arising under EEOICPA. Important points from those two cases are summarized below.

Fact-finding and drawing inferences. In *Gomez, et al. v. United States*, 459 Fed.Appx.701 (10th Cir. 2012), three appellants sought to overturn the award of survivor benefits to another claimant under Part B of EEOICPA, because they believed that the factual evidence in the case file was insufficient to support the finding by DEEOIC that she was an adopted child of the deceased employee. This finding of fact by DEEOIC had cut off the potential eligibility of the appellants, who were grandchildren of the deceased employee, since under the statutory order of precedence for Part B, grandchildren are only eligible for

survivor benefits if there is no surviving child. In its opinion, the U.S. Court Appeals for the Tenth Circuit concluded that DEEOIC's finding of fact that the claimant was an adopted child of the employee was neither arbitrary nor capricious, because while the case file did not contain a copy of the actual Order of Adoption, there was enough secondary evidence in the file to enable DEEOIC to properly infer the existence of such an Order. The court concluded, as did DEEOIC, that an official letter from the New Mexico Department of Public Welfare to the employee that referred directly to the Order as having been issued, and to the employee's request for a birth certificate that listed him as the claimant's father, together with some of the ancillary documentation that was needed to complete an adoption at that time in New Mexico, constituted substantial evidence that the claimant was the legally adopted daughter of the employee and thus entitled to the survivor benefits available under Part B of EEOICPA.

Interpretation of the term "incapable of self-support." In *Watson v. Solis*, 693 F.3d 620 (6th Cir. 2012), the appellant had received survivor benefits under Part B of EEOICPA as the child of the deceased employee, but DEEOIC denied her claim under Part E because she did not meet the statutory definition of a "covered child," based on its conclusion that she had failed to prove that she was "incapable of self-support" at the time her father had died, using an interpretation of that statutory term that only appeared in the Federal (EEOICPA) Procedure Manual. The appellant brought suit challenging that interpretation, which requires proof of either a physical or mental incapability, and when she lost in the U.S. District Court for the Eastern District of Tennessee, she appealed to the U.S. Court of Appeals for the Sixth Circuit. In its opinion, the court found that DEEOIC's interpretation of the term "incapable of self-support" as covering only those individuals physically or mentally incapable of self-support was persuasive because it was consistent with other federal statutes and compensation programs. Also, the interpretation was in line with the common definitions of the word "incapable," and avoided making other language within the statutory definition of "covered child" superfluous. And finally, whereas DEEOIC's interpretation created a logical class of identifiable beneficiaries, the court found that the appellant's proposed interpretation, which contained no limiting principle, was not a reasonable alternative. Because she had failed to submit any evidence to DEEOIC of a physical or mental condition that had rendered her incapable of self-support, the court concluded that DEEOIC had not acted arbitrarily or capriciously in denying appellant's claim for survivor benefits under Part E of EEOICPA.

ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT				
	Part B		Part E[1]	
	FY 2011	FY 2012	FY 2011	FY 2012
Number of Employees (FTE Staffing Used)[2]	241	227	230	239
Administrative Expenditures[3]	$51.5 M	$49.6 M	$73.7 M	$72.4 M
Claims Created	9,981	9,226	7,441	8,133
Recommended Decisions (Covered Applications)	13,010	10,686	11,444	9,580
Final Decisions (Covered Applications)	13,337	11,120	10,904	7,444
Number of Claims Approved (Final)	7,264	6,594	5,791	6,529
Total Lump Sum Compensation Payments[4]	$573.5 M	$510.0 M	$338.6 M	$292.8 M
Number of Medical Bill Payments	317,700	331,983	34,007	36,881
Total Medical Payments[5]	$300.0 M	$320.8 M	$18.1 M	$19.9 M

[1] Part E became effective during FY 2005 (October 28, 2004).

[2] The FTE decrease in Part B in FY 2012 was a result of hiring restrictions associated with the extended Continuing Resolution (CR) in 2011 plus a hiring freeze in FY 2012, and does not reflect the required staffing level. The hiring restrictions left the program understaffed in the Final Adjudication Branch (FAB), resulting in a significant backlog in FAB workload. The FTE in Part E, which is funded by an indefinite appropriation, was not affected by the CR in FY 2011, enabling DEEOIC to address staffing needs and maintain a higher FTE usage rate in FY 2012.

[3] Includes Department of Labor expenditures only; beginning in FY 2009, funding for the Department of Health and Human Services responsibilities under the EEOICPA are provided for in that agency's appropriation. During FY 2012, funding of $0.3 million for Part B ($0.2 million in FY 2011) and $0.8 million for Part E ($0.8 million in FY 2011) for the Office of the Ombudsman is excluded.

[4] Excludes payments made by DOL for Department of Justice (DOJ) Radiation Exposure Compensation Act (RECA) Section 5 claims. DOL serves as a pass through and utilizes the compensation fund established under EEOICPA for DOJ's payments of $100,000 to qualifying Section 5 RECA claimants as provided for in 42 U.S.C. § 7384u(d). These payments totaled $30.0 million in FY 2011 and $26.8 million in FY 2012, respectively.

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

APPENDIX

[6]

Appendix

Note: Unless otherwise stated, the financial information in the appendix tables below may differ from what is reported in the Department of Labor's Consolidated Financial Statement. These differences are due to accrual versus cash basis financial reporting requirements and adjustments made during statement compilation.

APPENDIX A. FECA Tables A1-A4

Table A1

Federal Employees' Compensation Rolls

FY 2003 - FY 2012 (Cases at End-of-Year)

	Fiscal Year									
Roll Type	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Total Periodic Roll	58,621	57,817	60,709	50,362	51,125	50,263	49,672	49,517	49,488	49,436
Long-Term Disability	53,099	52,367	55,257	44,910	46,258	45,604	45,162	45,263	45,382	45,490
Death	5,522	5,450	5,452	5,452	4,867	4,659	4,510	4,254	4,106	3,946

Table A2

Federal Employees' Compensation Program Summary of Claims Activity

FY 2003 - FY 2012

	Fiscal Year									
Claim Activity	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
INCOMING CASES										
Cases Created	168,174	162,965	151,690	139,874	134,360	134,013	129,690	127,526	121,290	115,697
Traumatic	142,325	138,521	129,427	119,082	114,592	115,715	112,640	111,121	105,688	99,832
No Lost Time	84,368	80,018	74,071	67,127	64,896	66,812	64,130	61,067	56,412	47,700
Lost Time	57,957	58,503	55,356	51,955	49,696	48,903	48,510	50,054	49,276	52,132
Occupational Disease	25,747	24,320	22,114	20,592	19,633	18,190	16,951	16,300	15,501	15,757
Fatal Cases	102	124	149	200	135	108	99	105	101	108
Wage-Loss Claims Initiated	24,245	24,189	21,455	19,819	19,104	19,187	18,808	19,861	20,239	19,806
HEARINGS AND REVIEW										
Total Requests for Hearing	6,751	8,132	6,757	6,241	6,556	6,584	6,438	6,501	6,739	6,412
Total Hearing Dispositions	6,743	7,682	6,961	7,424	7,581	6,789	7,085	6,758	6,991	6,961

Table A3

Federal Employees' Compensation Program Obligations

FY 2003 - FY 2012 ($ thousands)

	Fiscal Year									
Type of Obligation	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Total Obligations	$2,475,108	$2,568,390	$2,602,815	$2,553,930	$2,707,196	$2,800,284	$2,874,754	$3,015,333	$3,137,445	$3,185,067
Total Benefits	2,345,472	2,434,609	2,476,479	2,418,796	2,563,055	2,657,634	2,732,577	2,857,806	2,983,866	3,024,890
Compensation Benefits	1,556,845	1,600,501	1,664,405	1,621,357	1,684,248	1,736,649	1,747,650	1,807,450	1,931,505	1,955,968
Medical Benefits	658,121	703,571	672,006	668,205	743,124	781,594	847,373	912,796	913,141	928,957
Survivor Benefits	130,506	130,537	140,068	129,234	135,683	139,391	137,554	137,560	139,220	139,965
Total Administrative Expenditures	129,636	133,781	126,336	135,134	144,141	142,650	142,177	157,527	153,579	160,177
Salaries and Expenses	86,358	86,253	86,811	88,435	90,113	89,416	90,049	98,116	98,158	98,029
Fair Share	43,278	47,528	39,525	46,699	54,028	53,234	52,128	59,411	55,421	62,148

Table A4

Federal Employees' Compensation Program Chargeback Costs, by Major Federal Agency

CBY 2003 - CBY 2012 ($ thousands)

	Chargeback Year[1]									
Federal Agency	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Total Costs	$2,323,288	$2,339,782	$2,334,194	$2,440,711	$2,494,096	$2,572,864	$2,669,115	$2,697,107	$2,875,430	**$3,005,857**
U.S. Postal Service	846,876	852,945	840,141	884,078	924,138	978,629	1,055,221	1,101,200	1,240,014	**1,320,011**
Department of the Navy	245,461	245,145	237,791	244,318	244,037	242,440	240,004	234,251	236,471	**239,855**
Department of Veterans Affairs	157,315	155,391	156,170	164,091	166,087	175,637	179,922	182,212	186,254	**200,569**
Department of the Army	181,298	177,250	174,660	180,248	178,993	179,503	181,775	177,236	176,941	**178,289**
Department of Homeland Security	83,975	121,089	138,342	156,734	158,529	161,070	164,611	160,502	166,514	**178,037**
Department of the Air Force	135,509	129,229	124,516	126,663	130,298	131,059	131,301	129,323	135,596	**133,305**
Department of Justice	66,131	74,011	80,090	89,156	94,395	98,825	104,772	104,573	109,850	**117,253**
Department of Transportation	94,682	92,659	92,687	92,830	93,609	97,931	99,251	97,687	97,457	**102,258**
Department of Agriculture	72,312	69,245	68,681	70,185	70,802	72,869	73,670	72,876	72,621	**73,875**
Department of Defense	65,429	63,816	62,996	65,460	62,630	60,737	63,051	63,581	65,331	**69,788**
All Other Agencies	374,299	359,003	358,120	366,948	370,578	374,164	375,537	373,666	388,381	**392,617**

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

APPENDIX B. Black Lung Tables B1-B6

Table B1

Part C Black Lung Claim Decisions at the District Director Level
FY 2003-FY 2012

Year	Total Approvals TF	Total Approvals RO	Total Approvals[1]	Merit Denials[2, 4]	Non-merit Denials TF[3, 4]	Non-merit Denials RO[3, 4]	Total Denials	Total Decisions	Approval Rate
FY 2003	142	531	673	7,943			7,943	8,616	7.81%
FY 2004	126	589	715	5,780			5,780	6,495	11.01%
FY 2005	118	477	595	4,064			4,064	4,659	12.77%
FY 2006	118	521	639	4,109			4,109	4,748	13.46%
FY 2007	146	462	608	3,739			3,739	4,347	13.99%
FY 2008	114	446	560	2,186	473	1,197	3,856	4,416	12.68%
FY 2009	91	397	488	2,086	113	910	3,109	3,597	13.57%
FY 2010	73	432	505	2,096	126	978	3,200	3,705	13.63%
FY 2011	110	645	755	3,298	167	1,961	5,426	6,181	12.21%
FY 2012	97	632	729	2,565	229	1,780	4,574	5,303	13.75%

TF - Black Lung Disability Trust Fund liability

RO - Responsible coal mine operator liability

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

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

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

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

Table B2

Distribution of Part C Black Lung Claims and Disbursements, by State

FY 2012

State	Total Claims Received[1]	MBO Claims[2]	In Payment[3]	Total Benefits ($ 000)[4]
Alabama	35,483	18	579	$4,851
Alaska	153	0	4	34
Arizona	2,192	2	82	687
Arkansas	3,863	1	101	846
California	6,512	1	136	1,140
Colorado	7,140	4	245	2,053
Connecticut	1,010	0	30	251
Delaware	789	1	7	59
District of Columbia	287	0	33	276
Florida	12,075	23	470	3,938
Georgia	1,720	2	106	888
Hawaii	16	0	0	0
Idaho	254	0	12	101
Illinois	32,428	10	663	5,555
Indiana	18,345	12	476	3,988
Iowa	5,161	0	110	922
Kansas	2,185	1	29	243
Kentucky	99,963	337	3,955	33,138
Louisiana	357	0	6	50
Maine	45	0	1	8
Maryland	6,731	8	186	1,558
Massachusetts	249	1	14	117
Michigan	10,556	6	221	1,852
Minnesota	148	0	6	50
Mississippi	371	1	15	126
Missouri	4,685	0	101	846
Montana	864	2	14	117
Nebraska	130	0	2	17
Nevada	447	1	28	235
New Hampshire	27	0	2	17
New Jersey	4,321	4	136	1,140

Table B2 (continued)

Distribution of Part C Black Lung Claims and Disbursements, by State

FY 2012

State	Total Claims Received[1]	MBO Claims[2]	In Payment[3]	Total Benefits ($ 000)[4]
New Mexico	2,472	1	67	561
New York	4,055	0	111	930
North Carolina	3,737	12	270	2,262
North Dakota	160	0	2	17
Ohio	54,868	32	1,603	13,431
Oklahoma	3,810	2	80	670
Oregon	629	0	14	117
Pennsylvania	138,915	190	5,953	49,879
Rhode Island	40	0	2	17
South Carolina	1,015	3	93	779
South Dakota	54	0	4	34
Tennessee	22,206	50	755	6,326
Texas	1,781	4	80	670
Utah	4,291	5	155	1,299
Vermont	50	0	3	25
Virginia	47,067	207	2,728	22,857
Washington	1,594	2	36	302
West Virginia	118,546	316	5,271	44,165
Wisconsin	458	0	15	126
Wyoming	2,671	0	89	746
All Other	451	1	5	42
TOTAL	**667,377**	**1,260**	**25,106**	**$210,358**

[1] All filings since July 1, 1973, including terminated, nonapproved, and Medical Benefits Only (MBO) claims.

[2] Active MBO claims as of 9/30/12.

[3] Active claims in payment status, excluding MBO claims, as of 9/30/12.

[4] Disbursements of income and medical benefits for all claims, including claims paid by the Trust Fund and claims in interim pay status. Does not include benefits paid by responsible coal mine operators and insurers.

Note: Data in column no. 1 may not be consistent with changes from previous years due to a change in computer systems.

Table B3

Part C Black Lung Claims, by Class of Beneficiary

FY 2003 - FY 2012[1]

	Number of Beneficiaries[2]									
Class of Beneficiary	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Primary Beneficiaries:										
Miners	14,773	13,398	12,012	10,857	9,744	8,654	7,699	6,967	6,633	6,375
Widows	32,615	30,810	29,110	27,366	25,556	23,690	21,913	20,495	19,014	17,553
Others	1,238	1,247	1,248	1,258	1,241	1,230	1,214	1,209	1,182	1,178
Total Primary Beneficiaries	48,626	45,455	42,370	39,481	36,541	33,574	30,826	28,671	26,829	25,106
Dependents of Primary Beneficiaries:										
Dependents of Miners	11,131	10,020	9,004	8,088	7,205	6,442	5,726	5,202	5,028	4,939
Dependents of Widows	1,052	1,006	944	874	840	777	723	681	647	593
Dependents of Others	353	238	213	146	140	132	122	113	110	106
Total Dependents	12,536	11,264	10,161	9,108	8,185	7,351	6,571	5,996	5,785	5,638
Total, All Beneficiaries	**61,162**	**56,719**	**52,531**	**48,589**	**44,726**	**40,925**	**37,397**	**34,667**	**32,614**	**30,744**

[1] As of September 30 of each year.

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

Table B4

Part C Black Lung Benefits Program Obligations

FY 2003 - FY 2012 ($ thousands)

	Fiscal Year									
Type of Obligation	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Total Obligations	$1,046,303	$1,053,246	$1,061,698	$1,060,006	$1,068,295	$1,070,958	$7,152,627	$661,798	$754,975	$808,713
Total Benefits[1]	370,389	346,864	329,933	307,067	291,310	273,232	254,987	238,423	227,397	210,358
Income Benefits[2]	307,371	292,555	279,965	265,365	252,020	235,347	221,298	207,801	193,038	179,404
Medical Benefits[3]	63,018	54,309	49,968	41,702	39,290	37,885	33,689	30,622	34,359	30,953
Administrative Costs[4]	55,332	55,803	56,872	57,975	59,772	58,257	57,712	58,618	57,513	59,006
Interest Charges[5]	620,582	650,579	674,894	694,964	717,214	739,469	0	0	0	0
Bond Payments[6]							341,939	364,757	400,905	431,486
Principal							337,472	353,424	379,286	394,287
Interest							4,467	11,333	21,619	37,199
One-Yr. Obligation Pmts.[7]									60,160	107,863
Principal									60,000	107,749
Interest									160	114
Repayable Advances[8]	525,000	497,000	446,000	445,000	426,000	426,000	6,497,989	60,000	107,749	214,000
Cumulative Debt[9]	8,243,557	8,740,557	9,186,557	9,631,557	10,057,557	10,483,557	6,370,580	6,289,746	6,163,077	6,064,860
Principal							6,158,245	5,864,821	5,533,284	5,245,248
Capitalized Interest							212,335	424,925	629,793	819,612

[1] Excludes collections from responsible mine operators for benefits paid by Trust Fund on an interim basis, refunds for OWCP administrative costs paid, and other miscellaneous reimbursements.

[2] Monthly and retroactive benefit payments.

[3] Includes diagnostic and treatment benefits, and reimbursements to the UMWA Health and Retirement Funds.

[4] Administrative costs include support for DCMWC, Office of the Inspector General, Office of the Solicitor, Office of Administrative Law Judges, and Benefits Review Board within DOL, and reimbursements to the Department of Treasury and the Social Security Administration.

[5] Interest charges on repayable advances to the Trust Fund from the Department of Treasury.

[6] Scheduled repayments of principal and interest on zero-coupon bonds issued to refinance the BLDTF debt as mandated under the Emergency Economic Stabilization Act of 2008 (EESA).

[7] Repayment of prior year advances, and interest on those advances, to the Treasury as required under EESA.

[8] Advances from the Department of Treasury. FY 2009 is a one-time non-repayable appropriation under the EESA. Beginning in FY 2010, EESA classifies these advances as one-year obligations that must be repaid to the Treasury.

[9] Shows the cumulative debt of the Trust Fund to the Department of Treasury. Starting in FY 2009, this debt includes principal and capitalized loan interest related to the zero-coupon bonds issued under EESA and payable to the Bureau of Public Debt.

Note: Detail may not add to totals due to rounding.

Table B5

Funding and Disbursements of the Black Lung Disability Trust Fund

FY 2012 ($ thousands)

	Funding				Disbursements								
						MEDICAL BENEFITS							
Month	Coal Excise Tax Revenue	Treasury Advances	Reimburse.[1]	**Total**	Income Benefits[2]	Diagnostic	Treatment[3]	Total Benefits	Admin. Costs	Interest on Advances	Bond Payments[4]	One-Year Oblig. Payments[5]	**Total**
Oct. 2011	$13,754	$0	$685	$14,439	$15,220	$492	$1,908	$17,619	$3,853	$0	$0	$0	$21,473
Nov. 2011	57,980	0	686	58,666	15,176	564	2,133	17,873	4,077	0	0	0	$21,950
Dec. 2011	55,417	0	1,091	56,508	15,682	387	2,573	18,642	3,668	0	0	0	$22,309
Jan. 2012	46,648	0	401	47,049	15,052	504	1,970	17,526	7,586	0	0	0	$25,113
Feb. 2012	70,934	0	869	71,803	15,159	533	2,638	18,330	4,918	0	0	0	$23,247
March 2012	58,730	0	545	59,275	15,512	444	2,045	18,001	5,238	0	0	0	$23,239
April 2012	61,901	0	1,375	63,276	14,365	498	2,053	16,916	4,881	0	0	0	$21,796
May 2012	60,930	0	2,683	63,613	14,951	552	3,088	18,591	5,074	0	0	0	$23,665
June 2012	49,682	0	874	50,556	14,732	413	1,514	16,658	4,881	0	0	0	$21,539
July 2012	53,463	0	924	54,387	14,674	393	1,795	16,861	4,976	0	0	0	$21,837
August 2012	30,796	0	1,331	32,127	14,397	506	2,158	17,061	5,072	0	0	0	$22,133
Sept. 2012	68,866	214,000	1,038	283,903	14,486	385	1,410	16,281	4,782	0	431,486	107,863	$560,412
TOTALS	**$629,101**	**$214,000**	**$12,500**	**$855,601**	**$179,405**	**$5,670**	**$25,284**	**$210,358**	**$59,006**	**0**	**$431,486**	**$107,863**	**$808,713**

[1] Reimbursements include collections from RMOs, and fines, penalties, and interest.

[2] Includes monthly and retroactive benefit payments.

[3] Treatment expenditures include reimbursements to the United Mine Workers' Health and Retirement Funds.

[4] Repayment of principal and interest on principal for the zero-coupon bonds issued to refinance the BLDTF debt under the Emergency Economic Stabilization Act of 2008 (EESA).

[5] Repayment of prior year advances, including interest on those advances, to the U.S. Treasury as mandated by the EESA.

Table B6

Claims filed under Part C of the Black Lung Benefits Act

FY 2003-FY 2012

Fiscal Year[1]	New Claims	Refiled Claims	Successor Claims	Survivor Conversions	Total
2003	2,594	1,926	704	982	6,206
2004	1,992	1,832	665	856	5,345
2005	2,087	1,869	611	804	5,371
2006	1,720	1,837	563	642	4,762
2007	1,873	1,889	570	581	4,913
2008	1,670	1,598	522	480	4,270
2009	1,597	1,807	506	444	4,354
2010	2,683	3,088	636	637	7,044
2011	2,410	2,383	635	631	6,059
2012	2,176	2,140	494	559	5,369

[1] Current regulations became effective January 19, 2001.

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

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

Conversion: some dependent survivors are automatically entitled to benefits.

APPENDIX C. LHWCA Tables C1-C5

Table C1

Total Industry Compensation and Benefit Payments Under LHWCA[1]

CY 2002 - CY 2011[2] ($ thousands)

	Calendar Year									
Payments By:	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Self-Insured Employers	$310,940	$309,843	$322,520	$325,694	$368,744	$325,544	$340,336	$388,088	$408,534	$425,581
Insurance Carriers	246,603	262,753	278,887	325,027	367,625	456,773	504,348	551,716	589,387	710,330
Total Payments	$557,543	$572,596	$601,407	$650,721	$736,369	$782,317	$844,684	$939,804	$997,921	$1,135,912

[1] Includes disability compensation and medical benefit payments under LHWCA, DCCA, and all other extensions to the Act.

[2] Industry payments are reported to the Department of Labor on a calendar year basis.

Table C2

National Average Weekly Wage (NAWW) and Corresponding Maximum and Minimum Compensation Rates and Annual Adjustments Pursuant to Sections 6(b), 9(e), and 10(f) of LHWCA

Period	NAWW	Maximum Payable[1]	Minim Payable	Annual Adjustment (% Increase in NAWW)[2]
10/01/02-9/30/03	498.27	996.54	249.14	3.15
10/01/03-9/30/04	515.39	1,030.78	257.70	3.44
10/01/04-9/30/05	523.58	1,047.16	261.79	1.59
10/01/05-9/30/06	536.82	1,073.64	268.41	2.53
10/01/06-9/30/07	557.22	1,114.44	278.61	3.80
10/01/07-9/30/08	580.18	1,160.36	290.09	4.12
10/01/08-9/30/09	600.31	1,200.62	300.16	3.47
10/01/09-9/30/10	612.33	1,224.66	306.17	2.00
10/01/10-9/30/11	628.42	1,256.84	314.21	2.63
10/01/11-9/30/12	647.60	1,295.20	323.30	3.05

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

[2] Five percent statutory maximum increase under section 10(f) of LHWCA, as amended. Maximum increase not applicable to DCCA cases (see note 1/, above).

Table C3

LHWCA and DCCA Special Funds' Expenditures[1]

FY 2003 - FY 2012 ($ thousands)

	LHWCA						DCCA					
	Expenditures ($)					Number of Second Injury Cases	Expenditures ($)					Number of Second Injury Cases
CY	Total	Second Injury Cases[2]	Pre Amend. Cases[3]	Rehab.[4]	Ohter[5]		Total	Second Injury Cases[2]	Pre Amend. Cases[3]	Rehab.[4]	Ohter[5]	
2003	$131,589	$119,965	$2,153	$4,628	$4,844	4,778	$11,184	$9,997	$664	$0	523	572
2004	135,247	122,358	2,081	4,990	5,818	4,694	10,920	9,867	645	0	408	544
2005	134,549	122,418	1,973	5,002	5,156	4,588	10,604	9,767	597	0	240	527
2006	133,270	123,412	1,811	2,749	5,298	4,908	10,246	9,418	588	0	240	621
2007	131,920	117,524	1,796	6,715	5,885	4,728	10,087	9,260	613	0	214	603
2008	126,933	116,894	1,673	2,330	6,035	4,533	9,960	9,104	630	0	226	582
2009	132,688	121,203	1,656	2,832	6,996	4,378	10,094	9,197	590	0	306	550
2010	128,110	116,703	1,484	3,183	6,740	4,201	9,388	8,598	548	0	241	516
2011	125,329	112,876	1,389	2,821	8,243	4,089	9,528	8,265	504	4	755	497
2012	122,667	111,143	1,341	2,323	7,861	3,946	8,726	8,005	475	1	245	473

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

[2] Section 8(f) payments to employees who sustain second injuries that, superimposed on a pre-existing injury, result in the employee's permanent disability or death.

[3] Section 10(h) of the Act requires that compensation payments to permanent total disability and death cases, when the injury or death is caused by an employment event that occurred prior to enactment of the 1972 amendments, be adjusted to conform with the weekly wage computation methods and compensation rates put into effect by the 1972 amendments. Fifty percent of any additional compensation or death benefit paid as a result of these adjustments are to be paid out of the Special Fund accounts.

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

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

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

Table C4

LHWCA and DCCA Special Funds' Assessments[1]

CY 2003 - CY 2012 ($ thousands)

	LHWCA			DCCA		
CY	Total Industry Assessments[2]	Preceding Year Total Industry Payments[3]	Assessment Base Yr.	Assessment[2]	Preceding Year Total Industry Payments	Assessment Base Yr.
2003	$125,000	$364,194	CY 2002	$10,800	$4,746	CY 2002
2004	137,000	368,671	CY 2003	11,500	4,286	CY 2003
2005	135,000	388,258	CY 2004	11,500	5,402	CY 2004
2006	125,000	418,714	CY 2005	10,500	4,277	CY 2005
2007	125,000	471,133	CY 2006	10,000	4,185	CY 2006
2008	124,000	495,148	CY 2007	8,500	4,758	CY 2007
2009	125,000	564,798	CY 2008	11,500	3,598	CY 2008
2010	124,000	621,671	CY 2009	7,500	3,437	CY 2009
2011	123,000	666,985	CY 2010	8,000	3,540	CY 2010
2012	124,000	770,364	CY 2011	8,000	3,085	CY 2011

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

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

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

Table C5

Summary of Case Processing Activities Under LHWCA[1]

FY 2003 - FY 2012

Adjudication Level and Case Status	Fiscal Year 2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
District Offices										
Pending Inventory of Cases	5,495	6,051	6,375	6,338	8,563[3]	7,726	8,075	7,700	12,974	9,294
OALJ										
Carryover from Previous FY	2,980	2,517	2,355	2,318	1,984	2,123	2,168	2,324	2,410	2,502
New Cases	3,036	2,926	2,763	2,413	2,614	2,657	2,696	2,884	3,068	2,967
Total Docket	6,016	5,443	5,118	4,731	4,598	4,780	4,864	5,208	5,478	5,469
(Dispositions)	3,499	3,088	2,800	2,747	2,475	2,612	2,540	2,798	2,976	2,974
Pending Inventory	2,517	2,355	2,318	1,984	2,123	2,168	2,324	2,410	2,502	2,495
BRB										
Carryover from Previous FY	208	267	222	211	182	152	134	114	130	148
New Cases	332	297	288	248	241	226	229	200	201	166
Total Docket	540	564	510	459	423	378	363	314	331	314
(Dispositions)	282	355	304	288	282	260	256	195	198	204
Pending Inventory	267[2]	222[2]	211[2]	182[2]	152[2]	134[2]	114[2]	130[2]	148[2]	114[2]

[1] Beginning in FY 1988, DCCA cases are excluded from DLHWC's District Offices' inventory as administration of these cases was delegated to the District of Columbia government effective July 18, 1988. Case processing and adjudication activities at the Office of Administrative Law Judges (OALJ) and Benefits Review Board (BRB) levels continue to include both LHWCA and DCCA cases.

[2] Data adjusted by BRB to account for misfiled, duplicate, or reinstated appeals.

[3] The increase in pending inventory compared to FY 2006 was due to the large number of new Defense Base Act cases created in the second quarter of FY 2007. The total number of new cases increased by 42 percent during FY 2007.

APPENDIX D. EEOICPA Tables D1-D5

Table D1 PART B

Status of All EEOICPA Applications at the End of FY 2012[1]

Case Status/Claims Activity	CASE[2]	CLAIM[3]
Total Applications Received-Program Inception Through 9/30/2012	83,513	133,540
Total Covered Applications Received-Program Inception Through 9/30/2012	67,797	113,451
Final Decisions Completed by Final Adjudication Branch (FAB)[4]	62,066	95,669
Final Approved	38,507	59,672
Final Denied	23,559	35,997
Recommended Decisions by District Offices[5]	1,456	3,238
Outstanding Recommended Decision to Approve	573	1,360
Outstanding Recommended Decision to Deny	883	1,878
Completed Initial Processing - Referred to NIOSH	1,484	6,169
Pending Initial Processing In District Office[6]	2,791	8,375
Lump Sum Compensations	35,620	55,610
Total Payment Amounts		**$4,601,639,477**

[1] Statistics show the status of all applications filed from program inception through September 30, 2012.

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

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

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

[5] Each case or claim still pending final decision by FAB.

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

Table D1 PART E

Status of All EEOICPA Applications at the End of FY 2012[1]

Case Status/Claims Activity	CASE[2]	CLAIM[3]
Total Applications Received-Program Inception Through 9/30/2012	73,507	112,335
Total Covered Applications Received-Program Inception Through 9/30/2012	61,422	84,351
Final Decisions Completed by Final Adjudication Branch (FAB)[4]	54,428	64,205
Final Approved	32,406	38,936
Final Denied	22,022	25,269
Recommended Decisions by District Offices[5]	1,702	2,721
Outstanding Recommended Decision to Approve	680	1,036
Outstanding Recommended Decision to Deny	1,022	1,685
Completed Initial Processing - Referred to NIOSH	1,082	7,493
Pending Initial Processing In District Office[6]	4,210	9,932
Compensation Payments (Unique Cases and Claims)[7]	23,552	25,443
Total Compensation Payment Amts.		$2,730,336,673
Lump Sum Allocations (Unique Cases and Claims)	12,895	13,901
Total Lump Sum Payment Amts.		$1,549,500,714
Wage Loss Allocations (Unique Cases and Claims)	2,646	3,186
Total Wage Loss Payment Amts.		$127,011,638
Impairment Allocations (Unique Cases and Claims)	11,525	11,530
Total Impairment Payment Amts.		$1,053,824,321

[1] Statistics show the status of all applications filed from program inception through September 30, 2012.

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

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

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

[5] Each case or claim still pending final decision by FAB.

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

[7] A Case or Claim that has payment in more than one category is counted in each category, so the total number of unique Cases or Claims with compensation payment will not equal the total number of unique Cases or Claims in each payment category.

Table D2 PART B

Processing Activity During FY 2012 on All EEOICPA Cases/Claims[1]

Processing Activity	CASE[2]	CLAIM[3]
Total Cases/Claims Received-FY 2012	6,067	9,226
Total Cases/Claims (Covered Applications) Received-FY 2012	5,803	8,945
Final Decisions by FAB Offices in FY 2012	7,302 [4]	11,120
Final Approved	4,380	6,594
Final Denied	2,922	4,526
Modification Orders in FY 2012	0	0
Recommended Decisions by District Offices in FY 2012	7,010	10,686
Recommended Decision only, to Approve	4,521	6,933
Recommended Decision only, to Deny	2,489	3,753
Referrals to NIOSH in FY 2012	1,547	2,454
Lump Sum Compensation Payments in FY 2012	3,738	5,803
ECMS-Generated Payments	3,638	5,667
Non ECMS-Generated Payments	100	136
Remands	474	767

[1] Activity statistics capture actions made during FY 2012 only, therefore the number of activities reported do not add up to the total number of cases/claims received during FY 2012. (Many activities recorded occurred on cases/claims received prior to FY 2012).

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

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

[4] Total includes cases with recommended decisions in FY 2012.

Table D2 PART E

Processing Activity During FY 2012 on All EEOICPA Cases/Claims[1]

Processing Activity	CASE[2]	CLAIM[3]
Total Cases/Claims Received-FY 2012	5,892	8,131
Total Cases/Claims (Covered Applications) Received-FY 2012	5,675	7,711
Final Decisions by FAB Offices in FY 2012	6,519 [4]	7,444
Final Approved	5,752	6,529
Final Denied	767	915
Modification Orders in FY 2012	0	0
Recommended Decisions by District Offices in FY 2012	8,191	9,580
Recommended Decision only, to Approve	5,970	6,854
Recommended Decision only, to Deny	2,221	2,726
Referrals to NIOSH in FY 2012	1,279	1,337
Compensation Payments in FY 2012 (Unique Cases and Claims)[5]	3,636	3,797
Total Compensation Payment Amts. (ECS and Non-ECS)		$292,754,044
Non-ECS Generated Payments	75	76
Total Compensation Payment Amts. (Non-ECS)[6]		$6,306,488
ECS Generated Payments	3,561	3,721
Total Compensation Payment Amts. (ECS)		$286,447,556
Lump Sum Allocations (Unique Cases and Claims)	1,255	1,376
Total Compensation Payment Amts. (ECS only)		$136,050,145
Wage-Loss Allocations (Unique Cases and Claims)	374	439
Total Wage-Loss Payment Amts. (ECS only)		$13,104,439
Impairment Allocations (Unique Cases and Claims)	2,132	2,134
Total Impairment Payment Amts. (ECS only)		$137,292,972
Remands	893	1,055

[1] Activity statistics capture actions made during FY 2012 only, therefore the number of activities reported do not add up to the total number of cases/claims received during FY 2012. (Many activities recorded occurred on cases/claims received prior to FY 2012).

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

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

[4] Total includes cases with recommended decisions in FY 2012.

[5] A Case or a Claim that has payment in more than one category is counted in each category, so the total number of unique Cases or Claims with compensation payment will not equal the total number of unique Cases or Claims in each payment category.

[6] Non-ECS generated payments are not separated out by Lump Sum, Wage Loss, and Impairment categories.

Table D3 Part B

EEOICPA Cases With Approved Decisions and Payments by Category, Program Inception Through September 30, 2012

Category	Number of Approved Cases[1]	Percentage of Total Final Approvals	Number of Paid Claimants[1]	Total Compensation Paid[2] ($ thousands)	Percentage of Total Compensation Paid
Radiation Exposure Comp. Act (RECA)[3]	7,247	20.5%	10,897	$363,533	8.5%
Special Exposure Cohort Cancer (CN)	15,374	43.6%	25,343	2,291,602	53.5%
Dose Reconstructed Cancer (CN)	8,457	24.0%	11,903	1,263,837	29.5%
Beryllium Disease (CBD)[4]	2,071	5.9%	2,728	307,744	7.2%
Beryllium Sensitivity-Only (BS)	1,773	5.0%	N/A	N/A	N/A
Silicosis (CS)	90	0.3%	116	12,850	0.3%
Multiple Conditions[5]	288	0.8%	307	43,050	1.0%
TOTAL	35,300	100.0%	51,294	$4,282,616[6]	100.0%

[1] There is not a direct correlation between number of approved cases and number of paid claimants for two reasons: (1) more than one claimant can receive payment on a single approved case, and (2) some cases were approved prior to 9/30/2012, but payments were not issued.

[2] Represents total lump sum compensation payments from EEOIC program inception through September 30, 2012.

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

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

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

[6] Total compensation paid does not include 10 cases that could not be attributed to the designated categories.

Table D4 Part B

EEOICPA Cases With Final Decision to Deny, Program Inception Through September 30, 2012

Reason for Denial	Number of Cases[1]
Employee Did Not Work at a Covered DOE Facility, Atomic Weapons Employer, or Beryllium Vendor During a Covered Time Period 2/	5,070
Alleged Survivor Not an Eligible Beneficiary 2/	1,667
Claimed Condition Not Covered Under Part B of EEOICPA 2/	10,639
Dose Reconstruction Reveals the Probability that the Cancer is Related to Employment is Less Than 50 Percent	15,869
Medical Evidence is Insufficient to Establish Entitlement	6,030
TOTAL	39,275

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

[2] Non-covered applications.

Table D4 Part E

EEOICPA Cases With Final Decision to Deny, Program Inception Through September 30, 2012

Reason for Denial	Number of Cases[1]
Employee Did Not Work at a Covered DOE Facility and/or Did Not Work During Covered Time Period, or the Employee Worked for an Atomic Weapons Employer (AWE) or Beryllium Vendor[2]	4,089
Alleged Survivor Not an Eligible Beneficiary[3]	7,996
Migrated Denials from ECMS to ECS	14,445
Cancer Not Work Related[4]	880
Medical Evidence is Insufficient to Establish Entitlement	6,697
TOTAL	34,107

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

[2] Non-covered applications. Part E of the EEOICPA covers DOE contractor or subcontractor employees only. Employees who worked for an AWE or beryllium vendor are not eligible for benefits under Part E of the EEOICPA.

[3] Non-covered applications. Per EEOICPA Amendments of 2004, adult children are not covered under Part E.

[4] Probability of Causation is less than 50 percent.

Table D5 Part B

Most Prevalent Non-Covered Medical Conditions, EEOIC Program Inception Through September 30, 2012

Non-Covered Medical Condition	Percentage of All Denials For This Condition[1]
Other Lung Conditions	21%
Heart Condition/Failure/Attack/Hypertension	10
Chronic Obstructive Pulmonary Disease & Emphysema	9
Asbestosis	9
Renal Condition or Disorder (Kidney Failure, Kidney Stones)	6
Hearing Loss	6
Benign Tumors, Polyps, Skin Spots	4
Diabetes	4
Neurological Disorder	3
Thyroid Conditions (e.g., Hypothyroidism)	2
Anemia	1
Back or Neck Problems	1
Parkinson's Disease	1
Psychological Conditions	1
All Other Non-Covered Conditions (Each Less Than 1%) or Other (Not Listed)	20
No Condition Reported on Claim Form or Blank Condition Type	2

[1] Based on cases that were denied because claimed condition was not covered under Part B of EEOICPA. These figures exclude cases that have a "covered" condition, whereas Table D-4 Part B includes these cases.

Note: The sum of individual items may not equal 100 percent due to rounding.

OFFICE DIRECTORY

[7]

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202-693-0031
www.dol.gov/owcp

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Gary A. Steinberg, Acting

Deputy Director, Office of Workers' Compensation Programs
Gary A. Steinberg

Division of Administration and Operations
Michael Tyllas, Director

Division of Financial Administration
Joseph Shellenberger, Director

Division of Federal Employees' Compensation
(www.dol.gov/owcp/dfec)
Douglas C. Fitzgerald, Director
Julia Tritz, Deputy Director
Tirzah Leiman-Carbia, Deputy Director

Division of Coal Mine Workers' Compensation
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Michael Chance, Director
Gerald Delo, Deputy Director

Division of Longshore and Harbor Workers'Compensation
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Antonio Rios, Director
Richard Stanton, Chief, Branch of financial Management, Insurance and Assessments
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Division of Energy Employees Occupational Illness Compensation
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Rachel P. Leiton, Director
Christy A. Long, Deputy Director

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OWCP/DCMWC
Mine Safety & Health Academy, Rm. G-100
139 Airport Road
Beckley, WV 25802
304-252-9514

Benefit Counselors
Bluestone Health Center
3997 Beckley Road
Princeton, WV 24740
304-431-5499

U.S. Department of Labor
OWCP/DCMWC
1103 George Kostas Drive
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U.S. Department of Labor
OWCP/DCMWC
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1664 Pond Fork Road
Madison, WV 25130
1-800-347-3749

U.S. Department of Labor
OWCP/DCMWC
604 Cheat Road
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National Operations Office

(District of Columbia, Maryland, Virginia)

Angella Winn, District Director
U.S. Department of Labor
OWCP/DFEC
National Operations Office
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Washington, DC 20211
202-513-6800

ADDENDUM

[8]

Addendum

FECA Benefit Expenditures
In Millions of Constant Dollars*

FY 2003	$1309.3
FY 2004	$1330.8
FY 2005	$1309.2
FY 2006	$1232.1
FY 2007	$1277.2
FY 2008	$1263.4
FY 2009	$1309.2
FY 2010	$1340.5
FY 2011	$1358.6
FY 2012	$1343.2

*Actual Obligations in current dollars deflated by CPI-W (urban wage earners and clerical
workers, U.S. city average, all items), 1982-1984=100.

Black Lung Part C Benefit Expenditures
In Millions of Constant Dollars*

FY 2003	$206.6
FY 2004	$189.6
FY 2005	$174.4
FY 2006	$156.4
FY 2007	$145.2
FY 2008	$129.9
FY 2009	$122.2
FY 2010	$111.8
FY 2011	$103.5
FY 2012	$93.4

*Current dollars deflated by CPI-W (urban wage earners and clerical workers, U.S. city average, all items), 1982-1984=100.

Longshore Benefit Expenditures
In Millions of Constant Dollars*

CY 2002	$317
CY 2003	$318.5
CY 2004	$326
CY 2005	$340.7
CY 2006	$373.6
CY 2007	$385.8
CY 2008	$400.2
CY 2009	$448.3
CY 2010	$466.4
CY 2011	$512.7

*Current dollars deflated by CPI-W (urban wage earners and clerical workers, U.S. city average, all items), 1982-1984=100.

Note: Includes total industry compensation and benefit payments under LHWCA and its exensions as reported on a calendar year basis.

LHWCA and DCCA Special Funds' Expenditures FY 2003-FY 2012
In Millions of Constant Dollars*

FY	DCCA	LHWCA
2003	$6.2	$73.5
2004	$6.0	$73.9
2005	$5.6	$71.1
2006	$5.2	$67.9
2007	$5.0	$65.7
2008	$4.7	$60.3
2009	$4.8	$63.6
2010	$4.4	$60.1
2011	$4.3	$57.1
2012	$3.9	$54.5

*Current dollars deflated by CPI-W (urban wage earners and clerical workers, U.S. city average, all items), 1982-1984=100.

www.dol.gov/owcp