

DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES
AND WORKER HEALTH

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MEETING

+ + + + +

MONDAY
NOVEMBER 8, 2021

+ + + + +

The Board met via Videoconference, at
1:00 p.m. EST, Steven Markowitz, Chair,
presiding.

MEMBERS

SCIENTIFIC COMMUNITY

AARON BOWMAN
MARK CATLIN
KENNETH Z. SILVER
MIKE VAN DYKE

MEDICAL COMMUNITY

GEORGE FRIEDMAN-JIMENEZ
ROSE GOLDMAN
STEVEN MARKOWITZ
MAREK MIKULSKI

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CLAIMANT COMMUNITY

JIM H. KEY
DURONDA M. POPE
CALIN TEBAY
DIANNE WHITTEN

DESIGNATED FEDERAL OFFICIAL

MICHAEL CHANCE

ALSO PRESENT

KEVIN BIRD, SIDEM
RACHEL POND, DOL
CARRIE RHOADS, DOL
JOHN VANCE, DOL

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

1:03 p.m.

MR. CHANCE: Thank you. Before I begin, I want to confirm that you can hear me.

CHAIR MARKOWITZ: Yes.

MS. POND: We can hear you.

MR. CHANCE: Okay. All right, because I need to read through my script. Okay, thank you.

Good afternoon, or morning, depending on where you are everyone. Today is November 8th, 2021. And welcome to Day 1 of the teleconference meeting of the Department of Labor's Advisory Board on Toxic Substances and Worker Health. My name is Michael Chance, and I'm the Board's Designated Federal Officer, or DFO.

We appreciate the Board Member's participation in this meeting today. We are scheduled to meet today from 1:00 p.m. Eastern time to 5:00 p.m. Eastern time. And today there will be a public comment period. I believe

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commencing around 4:15.

Today, this meeting is completely virtual, as a precaution against the COVID-19 pandemic. I hope everyone is staying safe out there, taking the proper precautions as this format is designed to ensure.

On my team, as the DFO, I'm joined virtually by Ms. Carrie Rhoads from the Department of Labor, and Mr. Kevin Bird from SIDEM, our contractor.

A few notes regarding meeting operations, timing, there's an agenda to the meeting that has been posted. We will break as needed throughout the day, as proceedings can be lengthy. And so, please consult the agenda and generally, Dr. Markowitz does a nice job of keeping that moving.

Copies of all meeting materials and any written public comments are or will be available on the Board's website through the heading, meetings. And the listing there for this, for any subcommittee meetings.

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The documents will also be up on the Webex screen, so everyone can follow along with the discussion. So, please log in order to see that. You can enter the Board webpage for additional information, where after clicking on today's meeting date, you'll see a page dedicated entirely to today's meeting.

The webpage contains publicly available materials submitted to us in advance of the meeting. We will publish any materials that are provided to the subcommittee. There you will also find today's agenda, as I mentioned, as well as instructions for participating remotely.

If you are having a problem, please email us at EnergyAdvisoryBoard@DOL.gov. If you're joining by Webex, please note that the session is for viewing only, and will not be interactive. I think this was mentioned before, but it's important to note that phones will be muted for non-Advisory Board Members.

For those of us who are on the

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speaking group, make sure to mute yourself in and out as needed. If you are running into any kind of problems, you may contact Ms. Rhoads or Mr. Bird at both systems throughout the meeting.

A few notes on the minutes and the transcription, a transcript and minutes will be prepared from today's meeting. During Board discussions today, as we are on a teleconference line, please speak clearly enough for the transcriber to understand.

When you begin speaking, especially at the start of the meeting, please try to remember to state your name, so we can get an accurate record of the discussion, and who was participating.

Also, they've asked our transcriber to please let us know if you are having trouble hearing anyone, or understanding anyone, and that is hampering the recording in any way.

As DFO, I see that the minutes are prepared, and ensure they are certified by the Chair. The minutes of today's meeting will be

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available on the Board's website no later than 90 calendar days from today per FACA regulation. But if available sooner, we will post them before that 90-day mark.

Also, although formal minutes will be prepared, we'll also be publishing verbatim transcripts, which are obviously more detailed in nature. Those transcripts should be available on the Board's website within 30 days.

I'd also like to remind Advisory Board Members that there are some materials that have been provided to you in your capacity as a Special Government Employee and Members of the Board, which are not for public disclosure, and cannot be shared or discussed publicly, including in this meeting. Please, be aware of this as we continue with the meeting today.

And it's important to remember these materials can be discussed in a general way, which would not include any personal identified information, PII, such as names, addresses, specific facilities, if a case is being

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discussed, or the use of a doctor's name specifically.

And finally, more germane to our times. I also want to note for everyone's information that the two-year terms of all of our Board Members will expire July 2022. And in the spring, OWCP will conduct another membership nomination process. Current Board Members would be eligible for renomination as always. OWCP will announce that process sometime in the spring.

And as I mentioned, more germane to our times, I also want to remind that the Board Members who have not completed their financial disclosure forms, they're required. Please complete them as soon as possible.

And this is also true about COVID vaccine information. That is required of federal workers, including Special Government Employees, which all the Board Members are. If you've not submitted your COVID vaccination information, please submit it to us as soon as possible.

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So, I appreciate you bearing with me as I read all of that into the record. And with that, I now convene this meeting of the Advisory Board on Toxic Substances and Worker Health, and turn the opening of the discussion over to Dr. Steven Markowitz. Dr. Markowitz.

CHAIR MARKOWITZ: Yes, all right. Thank you, Mr. Chance. And I add to Mr. Chances' welcome to everybody, the Board Members.

Also, we have DOL OWCP leadership here, I see. Ms. Pond, Mr. Vance, and perhaps others by phone, although I don't see any Webex indication.

I want to welcome everybody. Welcome the members of the public who are participating. And I know Mr. Chance gave you the website, or where you could find some of the documents, both the agenda and some of the documents that we will be looking at today.

If for some reason, you aren't able to get into Webex, where we will be looking at these documents, almost all of the documents are

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also available on our website. So, you could, if you're looking at a screen, find the same documents that way. And I'll try to indicate which ones they are so you can find them.

Let's do -- I'm going to review the agenda in a few minutes, but let's do some introductions. Although, I would like to thank Kevin Bird, and whoever is assisting Mr. Bird today, and tomorrow, for your work in making all this happen. It's much appreciated.

So, introductions. What I'm going to do is I think I'll just call people's names. That'll be easiest. By the way, during this meeting, if you want to say something, if you look on the Webex, at the bottom right, you'll see an oval that says Participants.

And if you click on that, you'll see a list of the participants, and you'll see at the bottom right, there's a little hand. You can click on the hand to indicate that you want to speak. And then after you're done, if you wouldn't mind clicking the hand again, to lower

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your hand. That would be helpful.

So, I will start, I'm Steven Markowitz. I'm an occupational medicine physician and epidemiologist at the City University of New York. I've been involved with the Board since 2016. And I run the largest former worker medical screening program, you know, for DOE workers. Dr. Bowman.

MEMBER BOWMAN: Yes, I'm Aaron Bowman, I am professor and head of the School of Health Sciences at Purdue University. I am also a toxicologist, and I do work related to environmental health as well. Thank you.

CHAIR MARKOWITZ: Mr. Tebay.

MR. TEBAY: Calin Tebay, Hanford Workforce Engagement Center. Beryllium health advocate site-wide, at Hanford.

CHAIR MARKOWITZ: Thank you, Ms. Whitten.

MS. WHITTEN: Good morning. This is Dianne Whitten. I'm the Hanford Atomic Metal Trades Council, Health Advocate and a member of

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the IBEW, like Local 984.

CHAIR MARKOWITZ: Ms. Pope.

MEMBER POPE: Hello, my name is Duronda Pope. I am a retired Rocky Flats worker. Worked there 25 years. I am currently, United Steel Workers Director of the Emergency Response Team.

CHAIR MARKOWITZ: Dr. Friedman-Jimenez.

MEMBER FRIEDMAN-JIMENEZ: Hi. I'm George Friedman-Jimenez. I'm an occupational medicine physician, and an epidemiologist at Bellevue NYU Occupational Medicine Clinic in New York City.

CHAIR MARKOWITZ: Dr. Silver.

MEMBER SILVER: Hi, Ken Sliver. I've spent the last couple of decades on the environmental health faculty at East Tennessee State University in the College of Public Health, before that my dissertation work.

I was on historical emissions and exposures at DoD sites. A big focus on Los

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Alamos National Laboratory and worked there closely with workers and families when the compensation initiative was kicked off by New Mexico's former Congressman, and Energy Secretary, Bill Richardson, and our friend, David Michaels.

CHAIR MARKOWITZ: Dr. Mikulski.

MEMBER MIKULSKI: Good afternoon, Marek Mikulski, I'm an occupational epidemiologist, and an adjunct faculty of the University of Iowa, Occupational and Environmental Health. I direct a former worker program for workers from two sites in Iowa.

CHAIR MARKOWITZ: And Mr. Catlin.

MEMBER CATLIN: Hello. I'm Mark Catlin. I'm an industrial hygienist. I retired in 2018 from, as Health and Safety Director for the Service Employees International Union. I'm now consulting part-time. Thanks.

CHAIR MARKOWITZ: And Dr. Goldman.

MEMBER GOLDMAN: Hi. I'm Rose Goldman. I'm an academic occupational

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environmental medicine physician with a practice at Cambridge Health Alliance. And an academic appointment as associate professor at Harvard Medical School, and environmental health at Harvard T.H. Chan School of Public Health.

CHAIR MARKOWITZ: Okay, thank you. And then for the sake of the public, I just want to call on Ms. Pond and Mr. Vance to introduce yourselves. Although everybody knows who you are. Ms. Pond.

MS. POND: Hello everyone. I'm Rachel Pond. I'm the Director of the Energy Program at Department of Labor.

MR. VANCE: And good afternoon, everyone. My name is John Vance. I'm the Policy Branch Chief for the Energy Compensation Program.

CHAIR MARKOWITZ: Okay, great. Thank you. So, let me just --

MEMBER VAN DYKE: Mike Van Dyke, you forgot me, but that's all right.

CHAIR MARKOWITZ: You know --

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MEMBER VAN DYKE: Mike Van Dyke, associate professor University of Colorado.

CHAIR MARKOWITZ: Yes, thanks. You know, I don't see you on the list, the participant list. And so, I apologize for that. But I'm not, I'm concerned that I'm not seeing you, because then I don't know how I'm going to see you raise your hand to make a comment.

Is anybody else seeing Mike on the list?

MR. BIRD: Yes, just added. You should see him in a second here.

CHAIR MARKOWITZ: Oh, okay. Oh, yes, okay, okay. Well, yes, welcome.

Okay. So, let me go through the agenda. And if there are questions, comments or additions let me know. This meeting is going to be a little bit more of, I would say information exchange, report back, more of a brain stormings and planning session, than a vote on recommendations to the OWCP.

We're going to hear from the

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Department of Labor on program highlights first, as we always do. I'm going to spend just a few minutes reviewing our charter, and the selection plan, because it was renewed since the last meeting. And actually, a few minutes will help remind us of the purpose of this Board.

We're going to discuss the department's responses to our recommendations from the last meeting, including a couple of questions that they, really clarifications that they requested from us. Having to do with aldrin, dieldrin and one on styrene.

And then after a break, we're going to look at generic profiles briefly. We have requested that we have the opportunity to look at these. They've been referred to and I'll explain more when we get to that point in the agenda.

And then in -- we're going to discuss department's responses to requests for information that were made by the two working groups that met over the summer, the Industrial

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Hygienist Medical Working Group and also the Public Comment Working Group.

We don't really have or need report backs from those groups. What we have are questions that we submitted to the department, and we've received responses to those. And so, we'll discuss that. And then we'll have a public comment period.

Now, I can't recall, Mr. Chance, did you actually announce instructions for public commenters if they want to add their names to the public comment session?

MR. CHANCE: I admit it, Steven, I did not. And it might be better for Kevin or Carrie to take that.

MR. BIRD: Sure, absolutely. So, Carrie, correct me if I'm wrong. But I believe they should contact you at the moment, correct?

MS. RHOADS: That's right. The best way is to send an email to the Energy Advisory Board inbox. Let me know that you want to comment today during the public comment session.

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There's also, there will also be a way to make yourself known during the public comment session, to our moderator. So, either way of those, either one of those we're fine.

CHAIR MARKOWITZ: So, Carrie, could you give them the email address if they want to email you?

MS. RHOADS: Yes, it's posted on the website as well.

It's EnergyAdvisoryBoard@DOL.gov.

CHAIR MARKOWITZ: Okay. And you said they could contact the moderator. How would they do that during the public comment period?

(Simultaneous speaking.)

MS. RHOADS: Uh --

MR. BIRD: Dr. Markowitz.

CHAIR MARKOWITZ: Yes.

MR. BIRD: Yes, I think we will push people to contact Carrie with that email address ahead of time, but once we get to the public comment period, if there's a last-minute request, you would notify the moderator by

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pressing *1. But we, I think, would like to try to get as many of these noted, ahead of time so that we can plan everything out.

CHAIR MARKOWITZ: Okay, great. And then, so just to continue on. The agenda actually, and if you could, Kevin, go to Page 2 on the agenda, Day 2. So, we're, yes.

So, we're going to review the Board's request for resources from the department in order to do our work more effectively. And part of that request is to get some help with reviewing claims.

So, I thought it would be a good time for us to begin to talk about what kind of information we would want to get from claims. And actually, I realize that some Board Members have looked at some claims, others have not. And we should do some consideration to actually requesting a limited number of claims between now and the spring, so that we can approach claim review with a little bit more knowledge.

And then we'll talk about, brainstorm

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really, we'll look at the kind of data that department posts in the public reading room, which is ample. But think through whether there are other indicators or other data that the Board might want to take a look at?

I don't know that we're going to come to any conclusions at this meeting, but I thought it would be a good thing to kick off that discussion. And then if you could scroll up a little bit, Kevin? We have whatever new business arises during the meeting. And then we'll do a little bit of planning for the next meeting.

And that's about it. Any questions, comments or additions?

Okay. And by the way, if I, I don't always look at the participant list in terms of hand raising, so if you want to say something, just unmute yourself and break in. That's just fine.

Okay. So, let me turn it over to Ms. Pond and Mr. Vance for program highlights,

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updates regarding the overall compensation program.

MS. POND: Great. Thank you, Dr. Markowitz. This is Rachel Pond. I'm going to run through some overall program updates. Just kind of what we've been up to in the last year. And then I'm going to turn it over to John to go into a little bit more detail about some of the policy changes we've had, and procedure matter updates.

I just do want to first thank you all for being here. I know that this takes time out of your days and your, the overall projects that you're all working on. And so, I appreciate the time and effort that you put in to the recommendations that you make and the actual meetings that you attend biannually. So, thank you for that.

So, I'm just going to start with, I wanted to talk a little bit about our quality review process. I think I've mentioned this in prior meetings. But I wanted to kind of talk

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about the fact that this year, we've gone, we're going into a little bit more detail.

We set some quality review processes up in place prior to this year, in 2021. And this year we've been following up even more to make sure that we are reviewing everything that we can.

So, there are four different ways that we review our work. The first is, and this is the newest way that we've been doing this, and that is we have a branch, from a standard branch, made up of analysts to review work on an ongoing basis.

Meaning, they'll review cases every -- throughout the year. And they'll just like two weeks after something's been done and action's been taken on a case, they'll review it. And then they do these quarterly reports.

So, while they're reviewing the case, they're going to be looking for multiple different kinds of things for each section of the work that we do. So, we have the work of our

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claim examiners, which includes development and recommended decisions. Then we have the work of our final adjudication branch. They do the final decisions. And then we have the work of our medical benefits examiners, who do the employee medical benefits and home health care.

So, what they're going to be looking at when they do this sampling, is they look at the various stages of development. They look for quality. And then at each quarter, this branch will provide a quarterly report to the management of the programs to kind of say, here's what our recommendations are, here's what we found.

The supervisors can also look throughout the year at the spreadsheet that's put in this particular system that we recently created. That they can kind of check and see what kinds of mistakes they're making on a regular basis.

And then there's a whole presentation of this report with the managers of each of

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these different sections. And there's a feedback loop, for here's what we think, here's what the recommendations are.

And a lot of times those recommendations are training, individual case reviews as appropriate, and any changes that they think should happen in policy, based on the reviews that they're undertaking. We found this to be very helpful in managing our work throughout the year.

We also in the last couple of years, we started a more robust sampling process. Our supervisors throughout the country, review a sample every single month of every claim the examiners work. And that again is for the offices, our final adjudication branch, and our medical benefits examiners.

These samples, when they meet with the claimants, or I'm sorry, the employee, they will kind of go over, here's what we found this month and talk through that feedback with the employee. That process and the items that they

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review is the development, decisions, payments, coding, all those sorts of things.

We also review, our supervisors review about 10 percent of our recommended and final decisions before they're issued. So, we can catch errors before those decisions go out the door. And then we, this year we did eliminate the accountability review. We used to do accountability review every year on a variety of different subjects.

But that was eliminated because of the fact that we're doing this ongoing quality quarterly review, except for the payment process. We continue to do the accountability review for the payments, to make sure that those are being processed properly.

The next thing I just to briefly touch on, is this last year we eliminated, totally, all of our paper files. We had started that process and made significant progress in 2020. In 2021, we finally finished all of the paper files. We are completely digital now,

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which has allowed for us to have greater telework capabilities.

We've been able, we're working on eliminating some space in the federal buildings. And just moving space around because of the fact that we will be able to telework greater, more so in, even when things turn to normal, and federal offices are open. Our OWCP has been able to show that we can telework successfully. And so, part of that is this elimination of paper case files.

I also wanted to, I'm really excited that we have started the process of providing electronic case files to claimants. In 2021, at the very end we were able to finalize allowing employees claimants, meaning it has to be a living employee, can have access to their case file, electronically.

Instead of having us go through and copy all the case files, we are going to be able to allow these individuals to go into a multifactor authentication process, to look at

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their case files. That is something that, one of the things the Board had recommended, so I'm really excited that we're starting that process.

Now, we will continue that throughout this year and next year to make it so that authorized representatives will be able to have that access through this same multifactor authentication process. And then we're going to move to sole survivors, and they will be able to access the case files also. That's a little bit more complicated just because of privacy concerns.

And looking at other claim survivors in a case file, we have to make sure that we're restricting it to only the survivor who filed the claim. So, that's going to be a little bit more complicated. And we're hoping to have that, that piece of it for at least sole survivors by the end of the fiscal year.

Outreach has been a challenge this year, and past because of the pandemic. We have not been able to go out and do in person

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outreach. So, we've been modifying basically what we do, to at least try to reach out to who we can. And that is based a mailing list that we actually started creating a couple years ago.

People can sign up to get policy updates or, I think, on medical benefits. And when people sign up for that, they will see and get an invitation to, well basically our website will let them sign up for any, for the outreach that we're doing. All of our outreach events are on our website, posted on our website. Anybody in the public can attend them.

We've been doing virtual since the beginning of the pandemic pretty much. We've been doing about one session a month. We actually found that we're getting about 150 to 200 plus people attending these virtual events. So, that's a good thing. They're mostly events that will just talk about different pieces of the process, the adjudication process.

And within the department we've also worked with the Joint Network Taskforce Group.

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And we've had the ombudsman from, our ombudsman at DOL, as well as the ombudsman from NIOSH. We've had the Resource Center speak. We've also had sessions on the Site Exposure Matrices. So, we're trying to change it up as much as we can.

Department of Energy did a session, NIOSH did a session. Just to kind of continue to inform the program -- the public, about what we're doing, what direction we're going. And even just to detail processes.

I am hoping, you know, when the world opens up a little bit more, I'm hoping that we'll be able to do some in-person outreach again. You know, the benefit of that is those who don't know about the program, that's where we try to reach out to them.

Go out to the areas where the DOE sites are and, you know, provide information about the program to people who are not aware of the program. So, we're hoping to get there when we can. When everything kind of gets a little bit, hopefully, back to normal.

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And then we've done a lot of employee training this year. You know, we've had some new staff, especially in our Medical Benefits Examination Units. We've added some factor five and some one factor in district offices just to handle all of the work that is going on with regard to medical benefits, consequential conditions, and just in general.

We, since we've had that additional staff, we've been making sure that our training opportunities are up to date. We've had virtual training also, mainly through what we call Learning Link, we've got a whole set of modules, that I know some of the Board Members have seen before, kind of going through the basics of how to do these claims. How to adjudicate them at all stages of the program.

And then we are also working on kind of more individual ongoing training for those who've been around in the program, but there's new topics. For example, this last summer, our Medical Health Science Unit did a training

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session on exposures again, for different sessions throughout the different regions.

So, individuals could sign up for this training at different times throughout the week. And it was conducted, you know, kind of face to face. Well, if face to face can happen through Webex. Through, you know, other mechanisms like Microsoft Teams to kind of have actual conversations about, you know, exposures, and with them, and various other aspects of exposure analysis.

So, that was actually really well received. And we're hoping to do more that style. So, we'll have a little bit of virtual, or have a little bit of classroom kind of stuff, and even it's remote classroom training, coming up this year. Hopefully, to look at, you know, recommended and final decisions, those sources, just quality reviews. Maybe walking through case files, which we've found to be very successful in the past.

We also had a pretty extensive

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training this year on customer service: how to answer phone calls, how to record those phone calls, you know, the proper way to talk to claimants and other stakeholders. So, we also had soft skills training, which included things like civility in the workplace, how to work through, you know, at home, various things that are kind of relevant to what employees are encountering on a regular basis.

So, that's just kind of the general overview. What I can do, is I can, if you have any questions for me, or what I was thinking actually, is I'll just have John Vance go through his. And then if you have questions for either of us on the content of what we've just said, then we'll take them at that point, if that works for you, Dr. Markowitz?

CHAIR MARKOWITZ: Yes, that's fine. Thank you.

MS. POND: Okay. I will turn it over to John. Thank you all for your attention.

MR. VANCE: Well, thank you Rachel.

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This is John Vance. I'm the Policy Branch Chief for the Energy Compensation Program. Good afternoon.

So, what I'll do, is I'm going to just run through some updates for the Board, regarding some of our policies and procedures. And also, I'll just go through some of the work that we've been doing in conjunction with the last set of recommendations from the Board.

But I do want to start off by just pointing out that with regard to the Webinars, that Rachel mentioned before, if anybody does have an interest in just seeing the past events. If you go to our upcoming events link on our website, there's actually a link that will take you to our outreach presentations.

It's not a recording of the presentations, but it's the material that was used. And again, we've been trying to keep up with that. And I think the next session of the Webinars will be reinstated in January. So, we're taking a part and we'll start up again in

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the beginning of the year.

So, let me get into, just giving an overview of some of the important updates from a procedural standpoint, that I think the Board might be interested in. And I'm just going to start in with our bulletins that were issued in 2021.

One of the first ones I'll mention, was a bulletin, 2104, which is actually a product of a recommendation of the Board, with regard to instructing our staff on how to handle and adjudicate cases for COVID-19, as a consequential illness. So, that was published and that has now been put into production. And that was a direct consequence of a Board recommendation.

We have two bulletins that were issued in 2021 that are, is continuing to extend allowances by the program for providers to utilize telemedicine for routine and home residential health care examinations and interactions with patients. And that's going to

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continue through March of 2022. And then would be reevaluated around that time.

We also had a new Special Exposure Cohort Class that was designated by NIOSH, that we actually issued a circular for, Circular 2103, put into production. A review of those cases potentially impacted by that Special Exposure Cohort Class, and that was instituted over the summer.

Our big update, from a procedural standpoint, was our publication of our staff procedure manual. Again, this is a document that is designed to provide instruction and guidance to our staff on how to adjudicate cases, that are presented under the act.

Version 5.1 was released for our staff in the late summer, early fall. And it provides substantial edit throughout our procedure manual. I'm just going to highlight big ticket items I think you might be interested in. And I'm just going to run through my bullet points here.

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There were a ton of administrative updates and other technical issues that we have updated the procedure manual on. All of the changes that we report, as far as the administrative and technical, and actually any content changes in the procedure manual, are going to be reported out in a transmittal document.

Will be available for review on our website, if you view our policies and procedures section, and just go to the most recent addition of our procedure manual. You'll see a document that sort of will highlight and summarize all the changes in each addition.

So, this transmittal notified our staff about lots of little updates with regard to administrative changes. We also had updated two chapters throughout.

We did an update to reflect current credentialing for impairment raters. We added a reference to the allowance of a six-minute-walk test, in our impairment chapter. This was

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specific to a Board recommendation. So that has now been incorporated into the staff procedure manual.

We also, had a rather substantial change to our instructions for Claims Examiners, and how they go about evaluating impairment ratings from physicians and CMCs. Clarified the weighing of evidence to support ratings that are submitted by physicians, and to ensure that those ratings conform to the explicit guidance in the AMA Guides, 5th edition.

The major changes that we had for this past publication, occurred to two chapters in the procedure manual, Chapter 28, our medical bill processing instructions, and also, Chapter 28, our ancillary medical benefits chapter.

I'm not going to run through all of them, but the medical bill pay process chapter, you know, we had a lot of changes that updated guidance and provided new qualifications for our Medical Bill Processing Unit. How they engage with our staff. How they conduct oversight for

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the medical bill processing systems. How they handle transaction coding and interact with our bill processing contractor.

So, very technical stuff, but very important instructions for how our Medical Bill Processing Unit functions to support bill processing.

For our ancillary medical benefits procedures, we provided really substantial updates to consolidation on how we go about developing medical evidence, and documentation of medical necessity for the various types of things that folks request in conjunction with their accepted work-related illnesses.

So, we really did try to simplify and clarify. So, we got rid of a lot of redundancy. We tried to incorporate clear instructions on how to handle different kinds of adjudication engagements over different kinds of services that folks request, such as durable medical equipment, ops unit equipment, all kinds of therapeutic services, massage therapy, speech

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therapy, occupational therapy.

All of those things are now better communicated as far as how do you go about evaluating and weighing evidence to support those requests.

And then we have just an update to our payment processing chapter. We had a lot of minor, I would say relatively minor change and clarifications about how we process payments and verify and validate payments to ensure that we have an accurate payment going out, in response to a decision that's been issued in a case. So, those are our main updates as far as our procedures are concerned.

Moving over to the recommendations from the Board. I've already touched on a few of these, but I'm just going to run through them relatively quickly here. So, there had been a recommendation of the Board to add a group of health effects based upon information from an organization that makes recommendations for the carcinogenicity of cancers.

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That is IARC. There was a recommendation from the Board to add a series of health-effect -- recommendations with regard to adding health-effect added to the Site Exposure Matrices. We agreed to do that. And that did occur.

As Dr. Markowitz mentioned, we did have two items that are being returned to the Board for clarification. Because when we had, Paragon and DOL were engaging in how to make this change happen, we just had questions about some of the wording and terminology, and the science behind a couple of those recommendations on two of the cancer categories. So, I think, Dr. Markowitz has mentioned that he's going to be discussing that at a later time today.

There was a recommendation to add some wording with regard to IARC and the National Toxicology Program. There was a recommendation that we make it more clear, that we do accept those kinds of organizational input. And we did, we actually added language to

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our Site Exposure Matrices webpage that specifically makes reference to both organizations, International Association for Research on Cancer, and National Toxicology Program and Health. Both referenced as sources of health-effect data on our SEM webpage.

The recommendation with regard to just the continuing collaboration between the Board and DOL with regard to utilizing IARC and the National Toxicology Program. And the Department of Labor does agree that we will continue to do that. And as updates are occurring, we will be, or evaluating that for updates to help perfect data that is communicated in the Site Exposure Matrices.

As I mentioned before, there had been a recommendation for adding a presumptive standard for the evaluation of COVID-19 as a consequential illness, to an accepted work-related illness. We did agree to that and we did issue a bulletin that has been published, and is available for our staff to implement.

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There was also a series of questions, I think it's two questions, that regarded, that were in regards to how the Department of Labor would evaluate job titles, and different kinds of exposure information. And the Board had recommended that we ask Paragon to evaluate changes based on the recommendations of the Board.

Department of Labor and Paragon did engage on that, and we have submitted feedback to the Board. There was no changes that we could make, but we did provide some feedback that I think will be a topic of discussion by the Board. And I've provided all of the feedback from Paragon to Dr. Markowitz.

That also includes a request for a generic profile data that had been requested by the Board. So, that is in the possession of Dr. Markowitz. And I think it's been shared with the group.

And then finally, I mentioned this earlier, we did make a change for our procedure

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manual, identifying explicitly, that the six-minute walk test would be a viable method for calculating, or assisting in the calculation of impairments for respiratory disorders.

So, those are the main updates from the last set of recommendations. I just have one highlight here. That the addition of the IARC Group 2A, listed health effect data, will likely be updated as far as our next release of the public SEM, which will be occurring in November. It looks like that process begins November 16th. So, that become publicly available, but it has already been changed for the employee variation of the Site Exposure Matrices.

So, our internal staff are utilizing that, that new health-effect data. But it will be publicly available in the next public release, that should start, that process, on November 16th.

And those are the updates that I had for everyone.

MS. POND: Thanks, John, appreciate

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it. And just if you have any questions let us know. Also, John or I, or both of us, will be here throughout the rest of today, and tomorrow, for any questions that you may have throughout the couple of days.

CHAIR MARKOWITZ: Okay, great, great. Thank you very much. So, any Members of the Board, have any comments or questions?

I don't see any hands, but I have a few. So, let me start off and maybe people will come up with some.

So, one comment on the digitization of the claims, materials and making it available to the claimants. That's a great thing, I know it's taken years, but that's the nature of that kind of work. So, it's great that you've gotten there.

MS. POND: Thank you.

CHAIR MARKOWITZ: It would be really interesting to see, to get some feedback from some claimants to see how much it's actually used. It may be easier when the authorized reps

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come on board, but the ease of use, whether it's organized in a way that's understandable to people. And I don't know if there's a mechanism to get feedback from your customer, so to speak, but that would be a good thing to do at some point.

MS. POND: Yes, we just started it. So, I mean literally we, at the very end of September 30th it went live. So, we're still going to be working and doing some outreach. Make sure that people are aware of it. You know, make sure that we're sending them communication about how to access it, and all of that.

So, it's going to be, you know, we're ramping it up now. This year should be the test. And we'll, we are doing a lot of, stakeholder engagement in terms of, we've done some surveys.

The last, we've actually done one survey over the summer, and we're working on another one. We've hired a couple of, our experienced individual, and we have a stakeholder's strategist now. And we hired those

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two individuals last year.

So, they're really going to help us with some of that, obtaining feedback. We've got really good results from our, or at least we got a pretty substantial result of people responding to the last survey, which we sent out after they received, I believe it was a recommended decision.

Kind of saying, how was your communication? Please provide us with feedback. And then we were able to make phone calls to anybody who left their phone number and asked to be called. Our folks here in national office called them up and tried to get additional feedback.

So, we're really hoping with this new kind of more robust stakeholder engagement part of the national office, we're going to get some pretty real feedback from the employees, I mean the claimants and stakeholders from the program. So, we will keep you informed as we move forward with getting those kinds, that kind of feedback.

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CHAIR MARKOWITZ: Okay, great. So, the, you know, for a couple of Board meetings now, actually let me turn it over to Ms. Pope. She may have a follow-up question to that. Ms. Pope.

MEMBER POPE: Yes, I'm also pleased to hear about the electronic or digital capability for the claimants. I was curious as to, is this program, view only, or interactive?

MS. POND: Well, in terms of getting access to the case file, it's going to be view only. But what you can do, part of our process is, right now people can upload documents to their case files.

So, we have a system called the, Energy Document Portal where even -- we've been able to do this for a while, anybody associated with the claim, can upload documents. Then for the viewing the actual case files, you'll just have view only. As if you were receiving a copy of your case file.

We don't have the ability right now

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to like have chats or anything in that system, but basically this provides you with the entire case file, so that you will be able to see it.

MEMBER POPE: Is that part of the plan? To be able to have a chat, so to speak?

MS. POND: I don't think we're there yet. I think right now, we're just --

(Simultaneous speaking.)

MEMBER POPE: Okay, I was just curious. I know it's in the beginning stages but it sounds great. Thank you.

MS. POND: All right, thank you.

CHAIR MARKOWITZ: I'm sorry, can you hear me now?

MS. POND: Yes.

MR. BIRD: Yes, we can.

CHAIR MARKOWITZ: Yes, okay, sorry. I got my mute mixed up. It's Steven.

So, a couple of Board meetings now actually, there's been discussion of the changes in the quality review organization process, tools et cetera. And I'm wondering if any of the

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results of those, of that work are currently or could be made available to the Board?

Perhaps, on our public reading room page, so that we can look at some of that?

MS. POND: Yes, we're working on ways to organize it in such a fashion that it would be beneficial, or you guys could look at it. And I hope to have it, we should have something this quarter pulled together for how you can look at those results. At least for the quality reviews, the quarterly.

Obviously, we can't do that with the sampling, because that gets into individual employee's performance. But we can definitely provide you with some of that, in terms of the quarterly reports that we're doing.

CHAIR MARKOWITZ: And could you also make, and it's possible that you've done this in the past, but I don't recall. Can you make available the methodology that you're using for these quality review processes?

MS. POND: We can probably do that.

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I'll need to, I'll talk to you about it.

CHAIR MARKOWITZ: Okay.

MS. POND: But we can, we have documents that kind of lays out how we do them. So, that probably shouldn't be a problem.

CHAIR MARKOWITZ: Okay, okay, great. So, you know, one of the Board's tasks is to look at, weigh in, help on the quality assessment of the industrial hygienist work, and the medical physician input into the claims process. So, is any of this quality review, modifications that you've made, have any of them addressed the issue of the industrial hygienist, or the physicians?

MS. POND: The quality review will look at the reports themselves and make sure they're in compliance with the processes. But we, that is not a part of the process where we're doing the actual reviews. We are still working, John and I working on a methodology, a different, a new methodology for reviewing the work of the CMC.

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You know, the work of the industrial hygienist, the contract -- every single report that's done by a contract medical, or a contract industrial hygienist, is reviewed by a federal employee, at least one. It might even be two. John, correct me if I'm wrong.

So, you know, given that they're reviewed already, so that process we're still kind of trying to figure out the best way to do that. But we will share it with you as soon as we come up with our methodology.

CHAIR MARKOWITZ: Okay, thank you. Mr. Vance, some of the pages on the transmittal, of the changes in the new version of the PM, related to impairment. And I'm just wondering if there's anything significant? Significant changes that the Board should know about with relation to whatever was changed on impairment.

I can't quite, couldn't quite tell what was different. But if you, if you know offhand, that would be helpful.

MR. VANCE: Yes, I have some. I'm

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very familiar actually.

So, a few of the things that we did was the changes that were incorporated, were a consequence of some of the actual engagement we had with the Board before. Where we were asking about the conformity of ratings that are being presented to the department, that are interpretations of the AMA Guides.

So, in other words, you know, what should the department's role be in evaluating medical documentation and rationale that's being submitted in support of an impairment rating?

And, you know, this was a discussion we had had about the role of our medical directorate, and that sort of thing. And so, what the procedures now do, is make it very clear that the Department of Labor is going to evaluate impairment ratings based solely, or very explicitly on what is the words in the AMA Guides?

So, if there is something that is specifically communicated in the guide, saying

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this is a requirement of the guide, that is how the examiner is to evaluate the sufficiency of an impairment rating. So, the instruction gives the Claims Examiner the ability to weigh information that's being submitted in support of an impairment rating.

It gives instructions for how that Claims Examiner is to do their comparative analysis between what the rating position is stating, the information in the case file that supports that rating, and then also the communication that's in the AMA Guides.

The update also made it very clear that this is not going to be something that we will engage with our internal physician. We are no longer referring to our medical director, as a medical director. We're calling that individual now, just a medical officer.

But that person, who will no longer have a role in our impairment process, if there would be development issues or concerns with the sufficiency of an impairment rating. We would

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give the rating physician the opportunity to clarify if that was an option. And then if that does not overcome whatever defect presents in the case file, that would be a standard referral to a contract medical consultant.

And so, the procedure is basically stipulating that our staff is really going to have to take a look at the words that are being presented by a rating physician to make sure that it conforms to the explicit instruction and guidance from the AMA Guides.

And where it does not, and we've given that doctor the opportunity to, to clarify their opinion, we will refer the matter to a CMC. And then we'll be in a position to weigh those competing opinions to decide which carries the weight of medical evidence in determining the final outcome on an impairment rating.

CHAIR MARKOWITZ: Okay. Great, yes, that's very helpful actually. So, actually what you're describing sounds like it conforms with the routine process you used for --

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MR. VANCE: Yes.

CHAIR MARKOWITZ: -- sticking points, when the claims examiner encounters sticking points, what they do, where they get help.

MR. VANCE: Right, and that the preeminent reference is going to be the AMA Guides. Where the AMA Guides does not clearly provide guidance as to what it expects, then we're going to generally defer to the judgment of the rating physician.

CHAIR MARKOWITZ: Okay, great. By the way, I, this is Steven again. Have you had many COVID claims? I know we, you know, the Board discussed the criteria and made a recommendation, but I was just curious whether the extent to which COVID claims have come in. Do you have any sense?

MS. POND: Yes, some --

(Simultaneous speaking.)

MR. VANCE: I know that we -- well, I know that we've gotten sporadic cases. But I'm not sure, I don't have a count. But I've heard

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of them coming through the process. I'm not sure if Rachel has additional updates on that.

MS. POND: Yes, actually I think we've only had like less than five. We really haven't had a lot that come through. Because they normally would just come through as consequential to other conditions. And it is, I guess, it's a little bit defining given the fact that, you know, we have so many lung conditions. But we haven't gotten a lot of claims for them yet.

MR. VANCE: I will say that of the ones that I know, that COVID-19 was a direct factor in individuals that passed away. So, that did play, that circular has, or bulletin has played a very large role in getting benefits out on those cases that it has affected.

CHAIR MARKOWITZ: Yes, okay. Thank you. So, to the Board Members, anybody else have any comments or questions?

Okay. Some of, a few of these issues may arise again when we go through our agenda

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items. Let's move on then.

Kevin, we want to look at the charter. And while John brings it up, the language of the charter looked very familiar to me. So, let me ask Ms. Pond or Mr. Vance, were there any changes? Offhand do you know of any --

(Simultaneous speaking.)

MS. POND: This is Rachel. I think that's a question for Mike or Carrie.

MS. RHOADS: Yes, this is Carrie. There are only changes in, like the standard language that's required of all the charters. We didn't change any of terms that are specific to our Board.

CHAIR MARKOWITZ: That's fine.

MR. CHANCE: Yes, otherwise it's pretty, it is pretty much the way it was.

CHAIR MARKOWITZ: Okay. That's great. And Kevin, if you could scroll up, I just want to skim through this to highlight the important things to Board Members.

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MR. BIRD: And Dr. Markowitz, you have control. So, I have control over the page, but you have control over --

CHAIR MARKOWITZ: Oh, yes, okay.

MR. BIRD: -- where on the page you --

CHAIR MARKOWITZ: Okay, great.

MR. BIRD: -- you view.

CHAIR MARKOWITZ: Okay, great, perfect. Thank you.

So, yes, there's the preamble. The rationale for the entire program, actually. And then set out the five or so tasks that we have. The first, to look at the SEM and make recommendations. The second, medical guidance for claims examiners for claims within the program. Third, is an issue that we, that the Board addressed earlier on, earlier versions of the Board. The lung disease covered under Part B, less so in the last couple of years or so.

And Kevin, can I go to the second page, or -- I'll hold on. Something I need to

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do?

MR. BIRD: Yes, you're able to do it, but if I do it, it helps keep everyone on the same page.

CHAIR MARKOWITZ: Oh, so okay. And then we need to provide advice on quality, objectivity, and consistency of the work of industrial hygienists, physicians.

And then a task that was added more recently, although not in the past six months, that we get to provide advice on the claims adjudication process generally, including reviewing procedure manual changes prior to incorporation, and then additional matters that the Secretary of Labor deems to be appropriate.

Support that the OWCP provides, administrative support to us under FACA. The operating cost, 2.5 person-years of staff support, DFO. Okay, let me see, next page.

Okay. Meet twice per year and otherwise as needed. And then there was some clarification, actually. This has to do with

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membership, but we're going to go over a different document, which repeats the same things, actually.

And that we are Special Government Employees, high degree of independence is important to maintain trust. Offer opinions independently of the DOL compensation program. Two years terms -- oh, we form subcommittees and informal work groups that are governed by the, governed by FACA. And those entities have to report back to the entire Board, not directly to the Secretary.

Okay. So, that's it, unless there are any questions about any of these things. And Kevin, if you could just pull up the next document, the membership, which to me looks like a new document. But maybe I just hadn't seen it before. But it's worth taking a look at.

What it does actually, is just describes how the meeting should be composed, Membership Balance Plan. And here the basic idea is that there's a nice balance between the

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claimant community, scientific community, medical community, and it just goes through our functions again.

The relative distribution balance. A total 12-15 members, and also considerations which are listed here, with relation to demography, ethnicity, geography, economic aspects and the like. And I think there is a Page 3. No, this is just the process for identifying candidates et cetera.

So, just wanted to remind you -- I don't know why it flipped back to Page 2, but here's Page 3 again. And we, okay --

Okay. Any questions or comments on this? Okay, fine. Let's move on then.

We're going to go to the, Kevin, you need to bring up DOL response to our Board recommendations. That should be on our, our page for this meeting.

MR. BIRD: Yes, sorry. Just pulling it up now.

CHAIR MARKOWITZ: Yes, that's fine,

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that's fine.

MR. BIRD: You should be seeing it in a second here, just confirm it was the correct document.

CHAIR MARKOWITZ: Yes, and -- yes, June 29th. And Mr. Vance went over some of this, but I, I just wanted to, we should just together look at the responses from the department, and if there are any points of discussion, clarification.

But basically, we recommended that agents that qualified as 2A carcinogens under IARC, and for which there was some limited human epidemiological evidence, that those be included in the SEM. And that's been agreed to by the department.

And then we recommended that the SEM should specify that IARC and NTP evaluations have been used in updating the SEM links between exposure and disease. And that has been done. I mean, it's been explicitly stated, that that's been done.

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And then there's on, an annual basis, at least, that any new 2A carcinogens, or the equivalent in their NTP, should be evaluated and added to the SEM. And in case everybody doesn't know, actually the 2A carcinogen designation is IARC. NTP doesn't -- it has a text version of those. We, and the Board focused on the IARC 2As rather than the NTP per se. They're very similar, but just for clarification.

The next -- oh, and I see, I can operate the page here. Yes. So --

MR. BIRD: Sorry, just a head's up, that when you change the page, it doesn't change it for everybody. So, I'm happy to follow along with you, if you just want to prompt me.

CHAIR MARKOWITZ: Well, okay. Okay, yes, thanks for telling me. And so, the department agreed to continue regular collaboration with the Board on evaluating updated health-effect data from different scientific organizations including IARC and the NTP.

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Which suggests to me that -- and Ms. Pond or Mr. Vance can give me an interpretation. Is that an invitation for the Board to periodically look at these? Or do you think, are you going to do that in-house, and bring us your thinking about that?

MS. POND: John, do you want to address that?

MR. VANCE: I think the response is, that we would be happy if the Board could continue to make recommendations with regard to anything that it thinks is of scientific merit to evaluate. And that's exactly why we had gone to the Board requesting a look at this, the Group 2A from IARC. Because that was something that we felt that the Board was perfectly positioned to be able to look at, and make a recommendation on.

So, our in-house toxicologist and epidemiologist continue to look. But, you know, we're always looking for additional input from the Board on these health-effect connections.

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CHAIR MARKOWITZ: Okay, so, Ms. Rhoads, if you could just include that on an action list for this meeting. I think that, well, I would open that up to the Board for comment. It does look like sometime in 2022, the Board will hopefully have access to a contractor that could do some of that work.

Not thinking so much of that IARC and NTP, because I think those are, all that frequently updated, so there's not that much new. But if there were additional scientific organizations that were to be included, that would constitute some work.

But are there any Members of the Board that have any comments or observation about this.

MEMBER GOLDMAN: This is Rose Goldman. Can I comment or ask a question?

CHAIR MARKOWITZ: Sure.

MEMBER GOLDMAN: This seems like a huge expectation because I don't know if this just relates to cancer or the way it's written

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or that the Board should take it upon itself to, sort of, be responsible for updating or calling attention to the Department of Labor, maybe some advances in any of the things they have.

So I mean, that's, sort of, an enormous expectation so I just wanted to clarify. Is this just on 2A that we're going to update people or on carcinogens or on all of the outcomes that are currently in the booklet?

MS. POND: So I'm not sure if that was a question for us or for Dr. Markowitz, but basically, you know, we do look at health effects on a regular basis. I mean, we don't have a, we don't have a research arm, though, to do a lot of research.

So that's why when Dr. Markowitz mentioned your contractor that you're hopefully going to get them to be able to help with some of that. You know, it really, it's, kind of, broad like you said, but you guys could maybe come up with certain particular conditions or types that you want to look at to help, you

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know, kind of, narrow it down, you know, whether it's a particular lung disease or something like that.

And then, you know, we could work with you on whatever you guys come up with. Again, we do, we have a toxicologist. We have -- but that's about what we have. We don't have a series of scientists or positions that go through this because our mandate is really to adjudicate claims and, you know, as they come up.

So as John said, we would be looking toward whatever recommendations you guys might have, but it could be as narrow or as broad as, I guess, the Board would define it.

(Pause.)

MR. BIRD: Is anyone on mute maybe --

CHAIR MARKOWITZ: I'm sorry, was I just on mute? This is Steven.

MR. BIRD: Yes, you are.

CHAIR MARKOWITZ: Yeah, yeah, sorry. Yeah, I agree with Dr. Goldman that for us to

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take on non-cancer outcomes would be an enormous task but, I mean, it is doable to look at selected things, for instance, when we looked at Parkinsonism.

And I think with having a contractor to help us that it will facilitate that. I think, you know, going, I mean, I'd like to hear other people's opinion. IARC and NTP don't really add that much new on an annual basis.

They don't change designations all that frequently of various agents. So I think that's something we probably could take on to assist, to advise the department. But if, you know, if other people differ please speak up but to go beyond IRC and NTP to some of the other consensus organization, driven organizations about carcinogens that that might be a bit much for us to take on.

MEMBER GOLDMAN: This is Rose again. But what about the non-carcinogenic effects? That's what I was also asking about. Who's looking to see if there's something new coming

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up with one of the other things?

Do we wait for somebody who makes a claim or are we or is somebody supposed to be surveying the various exposures and that there are some new findings? I mean, how is that happening?

CHAIR MARKOWITZ: No, well, that's a question for the department that relates to whether Haz-Map is updated or whether the SEM's underlying effects, health effects data are updated.

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez. I'd like to respond to that question that Rose just asked.

CHAIR MARKOWITZ: Yeah.

MEMBER FRIEDMAN-JIMENEZ: Yeah, IRC and the National Toxicology Program are expert review panels that include multidisciplinary experts, toxicologists, molecular mechanism experts, epidemiologists, biostatisticians, clinical positions.

And so the real advantage of using

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IRC and NTP evaluations for carcinogens that you have this multidisciplinary review panel that weighs in on all of these disciplines together and discusses the interaction of them and comes up with a final conclusion. And there not too many diseases for which there exist these kind of expert review panel.

IRC doesn't do non-cancer outcomes. However, the National Toxicology Program does. While I was on their Board they started doing reproductive outcomes, neurological outcomes. So they have started using the same concept of a multidisciplinary review panel to branch out, so there is some possibility.

However, I'm not aware of another organization that has such a deep multidisciplinary expert panel for non-cancer outcomes. The NTP is the only one that I know of and it's not really very well systematized because there's so few. They can only do a few reviews in a year.

So I think there is some possibility

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but I don't think there's going to be much that you can find for non-cancer outcomes.

MS. POND: Yeah, this is Rachel. You know, that's our dilemma overall with this program is there just aren't -- there's not a lot of information out there that's been peer-reviewed or there's a panel that, kind of, reviews in general these conditions.

And that's why we have to realize so often on those individual case files. We, you know, for each state Haz-Map we update the SEM when we get more information. You know, there are some contractor reviews. They are consistently and constantly reviewing DOE records but that's for exposure, causation or cause effects. That's become more of a challenge because, you know, there isn't this broad-based, you know, scientific community that's evaluating these sorts of conditions other than they do at -- Dr. Jimenez -- Friedman-Jimenez has mentioned.

So, you know, while we're happy to,

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you know, work with you or, you know, help you guys hone-in on particular areas you might want to have a contractor look at once you have one, but that is the current dilemma.

CHAIR MARKOWITZ: This is Steven. Is Haz-Map updated and by, you know, the author and the National Library of Medicine contract with them? And are those updates integrated into the SEM?

MS. POND: When there are updates they are integrated into the SEM. It is not -- I don't think that there's as much work going into that right now, so we try to incorporate other reviews. Like, we have a series, a set of cases that goes to our toxicologist, a lot of times we'll do that through policy or sometimes we'll be able to add it to the SEM.

John, do you have any additional information on that?

MR. BIRD: No. I mean, the way Rachel is describing it is correct. You know, as we do have new information that becomes available

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showing humanistic health effects, you know, that's something that we would review and update into the Site Exclusion Matrices, but those kinds of consensus viewpoints on established new humanistic health effects, you know, that takes a lot to get to that point.

And, you know, we have our epidemiologists and looking at these things, but again, it's like as I heard some comments before it's there's a lot out there.

And you could pick and choose whatever you want to take a look at but it's, and that's the challenge is that, you know, you could spend a lot of time looking at this information to decide whether it's going to be enough to trigger an update under the Site Exposure Matrices as a generalization of health effect.

And that's, sort of, the problem that we have. So I think the answer is, yes, we will update it when we have that kind of information become available, but again, it's few and far

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between when we see that type of information that's actionable.

CHAIR MARKOWITZ: Yeah, this is Steven. Yeah, it's a problem in the field. And Dr. Friedman-Jimenez is right that, you know, it's really done routinely mainly for cancer and then, you know, sporadically for other, either other diseases or other systems. So it's a challenge.

Any other comments from Board members
Okay, so Dr. Friedman-Jimenez --

MEMBER FRIEDMAN-JIMENEZ: This is George Friedman-Jimenez, one more comment. The legal profession does it by precedent. In other words, when they decide a case that's on the legal record and it's a precedent that other lawyers can look at later.

It's not very applicable to our situation because determining the causal relationship for an individual really requires understanding their exposure and every individual is going to be different for their

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exposure.

The review of the literature may be similar unless new articles come out in between, but the actual process requires assessing the exposure to see if they had enough exposure for long enough, enough latency period, the timing was right, et cetera, to be able to call it a causal relationship.

So it's quite complicated and unfortunately I think a lot of these cases are still going to have to be decided either one-on-one, case-by-case or as presumptions in groups based on years of exposure as we're doing with asbestos-related diseases.

MS. POND: That's right, so absolutely that is, you said that very well because that is the dilemma that we face and that's why we do have so many individual reviews by, you know, of the exposure of that individual person and then the review by the physician.

MR. BIRD: Dr. Markowitz, are you muted?

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CHAIR MARKOWITZ: Yeah, I'm sorry. Yeah, the -- I remember you brought Parkinson's disease to us and I assume that was because you had a fair number of claims and you were puzzling over what to do with it.

So I suspect, you know, you have aggregation of certain claims in the future on common outcomes that you were puzzled about that those will probably come to the Board.

And from the Board side, you know, if there are salient issues in occupational medicine where there are, you know, noncancer consensus on important illnesses, those kind of things we could, we could bring to the program, too, as something that should be updated.

It's not a substitute for, you know, routine updating of Haz-Map, but it is, it should help to keep the program more current.

Dr. Freidman-Jimenez, if you don't have a -- your hand's up so I can't tell if you -- another commenter or what.

Okay. So let's continue. The next

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recommendation was about COVID as a consequential condition. The department accepted our recommendation. I just advanced the page there, Kevin, the six-minute walk test.

They accepted our recommendation around the six-minute walk test, so basically -- and that's the end of that letter. Basically they accepted all of our recommendations that were included, so that's good.

There were couple questions that had been brought to us and Kevin, there are two emails that I sent you or Carrie sent you earlier today. So let me just, while he brings them up, that this came out of the IRQA discussion.

One was around aldrin and dieldrin and the question has to do with aldrin as a metabolite. If I remember it correctly, aldrin is metabolized to dieldrin, okay.

So here's the query to us. At Line 3, the Board mentions two toxins when discussing breast cancer health effects. We're not sure

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whether both toxins listed by the Board should be included, aldrin and dieldrin.

Both are listed in the SEM as occupational toxins but not, I take it not linked to breast cancer.

MEMBER GOLDMAN: Do you want me to answer that?

CHAIR MARKOWITZ: I'm sorry, unclear what we are to do about reference to dieldrin being a metabolite of aldrin. And so skipping down a few lines, the reference from the Board that connects dieldrin to breast cancer, the question is what toxin from an occupational exposure connects to breast cancer?

Is an occupational exposure to dieldrin the same as having the body produce it from aldrin uptake -- intake, excuse me.

And we are also not quite sure what the reference to inadequate evidence for aldrin means. So they didn't want to make any assumptions. They wanted -- they brought it back to us and then here it's in our table, the Table

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1 that we included, the aldrin metabolite dieldrin, inadequate evidence for aldrin but limited evidence for dieldrin, cancer of the breast.

So are there comments from the Board members on this issue?

R: This is Rose as I'm speaking for our group, so the challenge here is that there was reasonable evidence. So the evidence depends on what studies you're doing and what's available.

So if IRC did the review there was enough evidence both, you know, they look at animal, human and mechanistic data for dieldrin being a carcinogen. And enough of the evidence pointing to an increased risk for human breast cancer.

Now, the problem with aldrin is there wasn't really as much human data. There was some animal data that it was a carcinogen so it was marked down as inadequate. It doesn't mean that it's not a carcinogen. It's just that there was

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inadequate data.

However, they do make a point of knowing that anytime you have exposure to aldrin, you metabolize to create dieldrin. So then the issue then is if every time you get exposure to aldrin you basically have exposure to dieldrin.

So it just seemed that from a compensation point of view, if somebody had exposure to aldrin one could assume that they did have exposure to dieldrin. So that's why I think, and I'll also ask the other people on the 2A committee, I think we were thinking that actually we would put forth both of them just because whenever you have aldrin exposure you're going to have dieldrin.

So I'll stop there and see if anybody else wants to comment.

CHAIR MARKOWITZ: Yeah, Dr. Bowman?

MEMBER BOWMAN: Yes, thank you. Let me put down my hand, too, so I don't leave it up accidentally. I would concur with Rose. In fact,

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just taking from the IRC monograph on this, the statement that, quote, "However, since aldrin rapidly converts to dieldrin in the body, exposure to aldrin inevitably entails internal exposure to dieldrin."

I'm guessing part of the limited evidence in humans is the fact that it is converted so rapidly. So if you needed to secure doing an internal exposure assessment, you would never detect the aldrin because it's metabolized so rapidly.

So I would concur as a member of that subgroup as well that both should be included.

CHAIR MARKOWITZ: Are there other comments? This is Steven. I agree that what matters to the target tissue is what it's actually seeing, not what's ingested or absorbed through the skin but what actually makes it to the target tissue.

And if that's dieldrin and it's carcinogenic then there's no distinction actually, or not much distinction between having

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dieldrin being absorbed into the body or ingested and it being converted from aldrin.

And there's another example. There's actually benzidine-based dyes. Benzidine causes bladder cancer. Dyes when ingested or absorbed are rapidly broken down to benzidine, which then causes bladder cancer.

So it's a well-known, kind of, a well-known mechanism.

So I think that, any other comments?

Otherwise I think that should answer your question. But my question to Mr. Vance, does it?

MR. VANCE: I'm following along and all I can say is that remember that the Site Exposure Matrices, and I don't know the science and that's where I can be happy to say that. Our concern is that from an occupational exposure standpoint, so that means if you're encountering one of these toxins in an occupational setting, are we talking about both of these having the same health effect?

So whether you're, you know, exposed

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to aldrin or dieldrin in an occupational setting are -- is that mechanism going to be triggering that breast cancer health effect? Because that's -- and that's people are confusing those with metabolite reference.

CHAIR MARKOWITZ: And the answer, I think I'm representing the answer, the answer is yes. So both aldrin and dieldrin separately should be linked to breast cancer in the SEM.

MS. POND: Right, so we can take that response and probably use the transcript discussion that you guys just had back to the contractor for their review. And that should -- I would imagine that that would clarify things.

MR. VANCE: Yes, I agree.

CHAIR MARKOWITZ: Okay, great. The next one, Kevin, is the other email regarding styrene. And so let me, if I remember the issue correctly, so styrene in our table, we -- oh, I'm sorry. Actually, yeah, this is fine.

So a proposed disease to be added to the SEM under styrene was lymphohematopoietic

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malignancies. These are blood and lymph cancers.

And with relation to styrene they're not in the SEM or Haz-Map at present. And the question, I think, to us was are diseases limited to acute myelogenous leukemia and T-cell lymphoma or is the linkage broader than that?

And I think in the fourth column, the middle column is what we had submitted to the department, which is that the lymphohematopoietic malignancies were linked but the evidence was stronger, more consistent for acute myelogenous leukemia and T-cell lymphoma.

So the department is asking us whether a recommendation on disease titles and ICD-9, 10 diagnostic codes would apply.

Now, I'm not sure we're able to do that at this meeting because I failed to circulate this request in time, but the floor is open if people have thoughts or recollection from when you looked at styrene.

So I looked back at the report that we prepared that the working group, the 2A

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working group, prepared and it was a very nice, kind of, summary report that didn't in and of itself go into, sort of, this level of detail. And so I couldn't find an answer from that report to this.

But there, I think there is some underlying review that that working group did when you looked at these studies. And so if there's time, if we -- if some people have a chance to look at this maybe we could revisit this tomorrow afternoon and see if we can provide an answer? Otherwise, you know, we can do it after the meeting and then get back, I think, to the department relatively quickly.

Any thoughts? Okay.

MR. VANCE: And I think that sounds fine to come back to that.

CHAIR MARKOWITZ: And when you get into lymphomas it's a complicated topic. So we'll see. Okay.

So let's move on. We actually are at -- we're supposed to be at break but let me just

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continue with the generic profiles because this is not a long, this is not a long topic. Unless do people want to break now or do you want to spend 15 more minutes?

PARTICIPANT: Let's spend 15 more minutes.

CHAIR MARKOWITZ: Okay, good, so the majority rules. So the generic profiles, and Kevin, I think you have these and I think these were also on our meeting website. So these were provided by, just to give you the history here, the Board and the department have gone back and forth on asbestos issues.

And the department's contractor, Paragon, had referred to in their response to the Board's recommendation they had referred to generic profiles. And we had never seen these going back to 2016.

And so we requested to take a look at these to see what they are and how they're used. And to me it looks like part of what goes into the SEM. So now these are, this is -- Mr. Vance,

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this is an updated version, right?

MR. VANCE: Yeah, so there was a set that I had gotten over the summer and then when we were just checking with Paragon I got an updated submission from them, so I forwarded that to Carrie. So Carrie, I'm assuming that's the most up-to-date one?

MS. RHOADS: Yeah, this is -- this should be the most up-to-date one.

CHAIR MARKOWITZ: Yeah.

MR. VANCE: Okay.

MS. RHOADS: That's the update.

MR. VANCE: Yeah, so that should be up there.

CHAIR MARKOWITZ: Yeah. So you can see what this does here. It matches up work processes with labor categories with particular toxins, and when you go into the SEM you can go in through any of these routes by DOE site.

And so I assume that these linkages are what exist in the SEM. The reason why we were interested, aside the fact that it helps us

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understand the SEM better and what the thinking in the program is, is when we have a particular question around asbestos and Paragon's response to us, they -- there was some note that certain workers like laundry workers, janitors and one other I'm forgetting were exposed to asbestos.

And but they're not in the procedure manual on the presumptive list of people exposed to asbestos. So that was puzzling.

You go to that presumptive list you may remember in Exhibit 15-4 there's a list of about 25 job titles, plumbers, carpenters, painters and the light who, for whom it's presumed that they have significant exposure to asbestos.

And there were, there are other workers, like laundry workers, janitors and I think there were power cable workers for whom the generic profile we're looking at recognizes that they have exposure to asbestos, but they don't make it to that presumption list.

And I think the Paragon's response to

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this was it's one thing to recognize that they had exposure to asbestos, but it's quite another thing to have a level of certitude that allows you to presume that they had significant exposure to asbestos. That was, I think, the thinking that I took away from the Paragon response.

But I have to say that this version of the generic profile which I think we received today, I'm not quite used to looking at, so I'm not sure I actually -- maybe I'll take a look at it overnight and see if we come back to it tomorrow.

I wanted to look, for instance, at now I'm changing. I'm moving pages. Are you seeing the page change? I'm up to Page 6, for instance. Is that happening on your --

MR. BIRD: No, Dr. Markowitz, if you want to change the page just let me know or I can just make you the presenter here.

CHAIR MARKOWITZ: Well, no. I'm looking for the page that includes the janitors

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and the laundry workers in the like.

MR. BIRD: And there are two documents. One is the generic profile DOL closure and the other is the generic profile DOL operations. We're currently viewing the generic profile DOL closure document. I don't know if that's the correct one.

CHAIR MARKOWITZ: Okay, yeah. Okay, yeah, thanks. So yeah, let's move to the operations not the closure. But actually while we're on that, Mr. Vance, what's the difference between the closure profiles and the operations profiles?

MR. VANCE: It's just after the sites shut down there was a period where they were doing maintenance or remediation activities. So the closure profile is relating to the closure of a particular site or facility, whereas operations is just that.

That's when there was actual production and operations occurring at the site.

CHAIR MARKOWITZ: Okay, so Mound,

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Fernald, K-25, these are closure sites --

MR. VANCE: Right.

CHAIR MARKOWITZ: -- and that would apply to them. And ORNL and Idaho, INL, et cetera, these are operational sites. Okay. So yeah, this, so if we look and I can't see how many pages there are in this document, but if we look, the --

MR. BIRD: I think there's 60, 60 something pages to the document.

CHAIR MARKOWITZ: Yeah, okay. But now that is looking -- could you put the page right side up? I don't know what you're seeing, but I'm looking at a page on its side.

MR. BIRD: Which -- that's going to have to be done manually. Which page are you on?

CHAIR MARKOWITZ: Oh, okay. Well, yeah, but let's try Page 3, for instance.

MR. BIRD: Give me one second. I'm going to share it in a different way that might help.

CHAIR MARKOWITZ: Okay. Yeah, now

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it's right side up. That's nice. It's also a very small --

MR. BIRD: You do have control over the Zoon, just so you know.

CHAIR MARKOWITZ: Yeah, yeah, yeah, I got that. Okay. And now I can't figure out how to, oh, how to change the pages.

MR. BIRD: So it won't work with the way I'm currently sharing, and I have control now. I don't know if you have a problem.

CHAIR MARKOWITZ: Okay. Well, so let me just summarize what I saw when I looked at it earlier, which is I looked for the janitors and the laundry workers to see how they were dealt with in this generic profile since that's what Paragon had referred to.

And what it said in the last version of the generic profile was that up until 1981 laundry workers had exposure to asbestos. However, that was in the notes column, same for the janitors and no comment on after 1981.

So presumably those job titles don't

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make the presumption list, and we're not arguing. We don't -- we didn't argue that they necessarily should make the presumption list. We just wanted to understand how the department was making decisions about that.

So I'm going to take a look at this and if you can -- is this version, Carrie, on our website now for the meeting?

MR. VANCE: Yes, this is --

MS. RHOADS: Yes, I did it.

MR. VANCE: -- this is what's on the website.

CHAIR MARKOWITZ: Okay, okay. So I'll take a look overnight and see if there's anything else, and if anybody else wants to take a look and see if there's anything else that we can learn from this.

But I take it, Mr. Vance, that these connections we're looking at here between job category, work process and toxin, these are entirely built into the SEM?

MR. VANCE: Yes because this is what

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would be informing the toxicological connections to these activities. So in other words, yes, these activities and those toxins are what would be reported out in the Site Exposure Matrices.

CHAIR MARKOWITZ: Okay. Okay, good. Fine, so let's take a break. It's 2:40. Let's take a break for 15 minutes and we'll resume at 2:55.

(Whereupon, the above-entitled matter went off the record at 2:40 p.m. and resumed at 2:59 p.m.)

CHAIR MARKOWITZ: Okay, welcome back. Can you hear me okay?

MR. BIRD: Yes, we can.

CHAIR MARKOWITZ: Okay. So if, we're going to pick up where we left off. This is -- so what we're looking at now is response to one of our recommendations on asbestos. And this response was drafted, written by the Paragon Technical Services which is the DOL contractor that deals with the SEM and these issues.

And so if you scroll up a little bit,

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okay. No, we want to go back to the previous page. The first point in the response is that the department agreed to coordinate a re-evaluation of the noted job titles with the PTS and make agreed-to alterations to the list of Labor categories with a presumption of significant exposure to asbestos.

So as far as I can tell, the re-evaluation hasn't been completed yet and so this is, kind of, an ongoing thing but let's, we're going to review the response to see how far PTS or Paragon has got.

So the first item we're looking at is this generic profile that included information about asbestos. And if you can scroll down a little bit without changing the page? Yeah, there we go. Okay, that's good, yeah.

So we raised the issue of the janitors and laundry workers and power communication line maintenance. And, in fact, they do appear in the generic profile, and Paragon's response was that in the generic

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profile it's acknowledged that those job titles had potential exposure to asbestos but that they weren't subject to presumptions as the other job titles in Exhibit 15-4, the carpenters, the insulators, et cetera, due to this issue of nature, frequency and duration of exposure.

And the generic profile doesn't really provide information about those details around exposure, and that's the reason why there is on a surface level a discrepancy between the generic profile and this presumptive list that occurs in the procedure manual.

And that's understandable. If you see in the second paragraph there, the one that starts with addition of asbestos prior to 1981, the sum profiles was made by DOL direction in March 2010.

And I think that's what we see next to the janitors and the laundry workers in the generic profiles but that is not the same as sufficient evidence to make the presumption list. So at least what they've done is a little

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bit clearer.

Okay, I want to move on to item Number 2 and so let me give you the background, remind you really of the background here. Dr. Jonathan Mends and I had looked at national information on mesothelioma a couple of years ago, and this is from the NIOSH database that they keep.

And we saw a lot of job titles that showed significant risk of mesothelioma and mesothelioma is synonymous with having asbestos exposure. And so we proposed that that kind of information, since it was high quality, it was a national database very specific to asbestos, could be used to modify the presumption list that the DOL keeps in the procedure manual.

And so this provoked a back and forth with Paragon and they made the point, and correctly I think, actually, that there are certain job titles in this national database where there were relatively small numbers of deaths and not much of an increased risk.

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And it's reasonable that those job titles don't appear in the DOE complex. And I thought that we've reviewed this before, that we thought that actually was persuasive.

And so the Board came back and said, okay, but there are some job titles, and these are listed in this paragraph we're looking at if you look down at the bottom two lines, three lines, chemical engineers, industrial health and safety engineers and mechanical engineers, for whom the increase in risk in the national databases is very significant. It's with a PMR 449 means a four and a half -- that the chemical engineers had four and a half times the risk of general population, more or less and same with the industrial health and safety engineers.

And so, yeah, okay, we're looking at a slightly different version. This is the same version. I just highlighted certain things.

So the risks were increased for those, and furthermore, there were a lot of deaths in the national database, at least 30

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deaths for each of those job titles. The point being that what that meant to us was that the risk of asbestos that this indicates is probably broadly shared across industries for these job titles, meaning chemical engineers in general demonstrated they likely had significant exposure to asbestos, given the level of increase in risk and given the number of deaths, mesothelioma deaths.

And so we made that point to PTS and here's the PTS response, if you're with me, was actually that, oh, their recommendation that the department or some entity look at death certificates for three occupations, the layout workers, molding and casting machine operators and materials engineers.

So that was one way of figuring out whether that's applicable to DOE or not. Actually, the Board already conceded that those, there were two few deaths in those particular job titles to really bring to a presumption by the department.

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And so PTS is saying actually, you know, you could look at these death certificates for this. It wouldn't be a real big problem with PII. There aren't that many deaths, et cetera, but frankly, there's no reason to move ahead with looking at the death certificate if we agreed, the Board agrees with the logic that these particular job titles with just not enough information from this national database to justify including them.

So I'm not sure what Paragon was pushing back against because we had already agreed on those job titles, that there wasn't enough there.

So if we can scroll up to item Number 3? Okay, and then just one last issue here which is that the Board, and actually this is a PTS restatement of the Board's own recommendation or comments, which is that the Board stated uncertainty of the SEM routinely recognizes bystander exposures.

This issue has come up, and it is,

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for instance, could be that the three occupations we're insistent on, the chemical engineers, the mechanical engineers and the industrial safety engineers, that it's possible that their predominant or even exclusive asbestos exposure is through bystander exposure.

And so the Paragon's response is, and I want to read this because I need some help here understanding this response. "The SEM does recognize bystander exposure when documentation such as industrial hygiene sampling demonstrates that potential asbestos exposure exists."

"SEM does not rely solely on Labor categories to decide to include or exclude asbestos in the profile. Further asbestos work usually establishes boundaries within which all workers, regardless of Labor category, have to wear proper PPE to protect against asbestos."

So what I don't understand about that response is that the SEM recognizes bystander exposure when industrial hygiene sampling provides evidence. But what I wonder is who is

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ever doing any bystander exposure industrial hygiene sampling?

And if you look at the asbestos literature, you're hard-pressed to find much in, you know, in the academic study of asbestos. The idea that it's actually being done in the field looking at what bystanders are exposed to in terms of asbestos. It seems a little implausible.

And then the second point I want to make is just that establishing boundaries within which all workers -- I think they're talking about essentially asbestos abatement -- and our concern is not really with the abatement workers here. It's really with other kind of workers who, you know, prior to, you know, better awareness and DOE policy directives had less controlled exposure to asbestos, but who, frankly, you know, even after the policy directives continue to have incidental or unknowing exposure to asbestos.

So anyway, I'm interested in what

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other people think of this? Yeah, Dr. Goldman?

MEMBER GOLDMAN: Well, this is very interesting. The thing about mesothelioma, which is really different from other things, as Steve mentioned, is almost always if you look hard enough linked to asbestos exposure.

And you're right, it could be a janitor, somebody walking by pipes that are just flaking and just in that area for a long time. And so I'm just wondering, and maybe this is, sort of, simplistic that almost anybody who comes forward with a diagnosis of mesothelioma, I mean, it would be assumed that it would be related to some level of asbestos exposure, you know, whether it's, you know, bystander or whatever, as long as you've excluded that they didn't get it specifically from another job.

So to me, maybe this again is oversimplistic, the presumption would be if anybody got mesothelioma the presumption is it's due to asbestos. And if they didn't get it somewhere else and they're even around anywhere,

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a janitor or firefighter whatever and working at in these settings here, that it would be assumed to be work-related.

CHAIR MARKOWITZ: This is Steven. Yeah, that's an excellent point. And so let me ask Mr. Vance to respond to either as a matter of policy or whether you just know offhand, because I can't recall how the procedure manual, what it specifically says about mesothelioma.

But and I'm sure you don't have many cases because it's a rare disease but do you know? Are the mesotheliomas routinely compensated because the process concludes that they likely had asbestos exposure in the complex?

MR. VANCE: Yeah, it would be compensated. It would be compensable because it's a known health effect of asbestos exposure, so the likelihood of someone showing up with mesothelioma and some sort of asbestos exposure on the sites would likely mean that case, if they had a long enough exposure.

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And I don't know at the top of my head with the duration of exposure is required for the presumption, but more than likely that case would be approved. You would see that with mesothelioma and asbestos. That's, sort of, following in that same, sort of, category.

So but it's generally a highly compensable situation with mesothelioma.

MEMBER GOLDMAN: And actually it's not a huge dose. It's much more an issue, my understanding, is of latency, that, you know, they had the exposure long enough ago. Even a summer exposure working in construction has been related in some people to getting mesothelioma. So it's much more an issue of latency.

CHAIR MARKOWITZ: Yeah. I mean, my hunch is that the claims examiner, if they find asbestos in the SEM as being an exposure for the person with mesothelioma that it's likely going to be compensated without necessarily going to the official presumption route.

If they're not on the list of 20 or

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25 occupations for whom significant exposure to asbestos is assumed but if it merely exists in the SEM, my hunch is that, particularly if it makes it through the CMC that it's going to be compensated.

But that's then, you know, that's, kind of, an empirical question whether it is or not. Mr. Catlin?

MEMBER CATLIN: Yeah, thanks. As byer -- and I may be wrong, as I recall we were looking at the trying to identify the potential asbestos exposure issue. So and I think that was broader than just looking at mesothelioma because if someone comes in with mesothelioma that's an easier case to make.

But I think we were concerned also about lung cancer and maybe some other cancers that wouldn't be recognized by the SEM because these bystander exposures weren't tested.

CHAIR MARKOWITZ: Yeah, I agree that it's a broader issue than just mesothelioma. And lung cancer is much more common and much and

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more difficult to address, I think, in the claims evaluation process I would guess. And where it says, where that presumption list really, probably really matters.

MEMBER CATLIN: Yeah. Yeah, this is Mark Catlin again. And I think we used the mesothelioma as a surrogate for some, you know, cases where we knew there was likely enough asbestos exposure for to show up as disease. But so I think what, so that we're really trying to get them to look at is to identify asbestos exposure, right, in some of these categories that they're not currently there.

CHAIR MARKOWITZ: This is Steven. That's exactly the point, which is that it was a proxy for a high level of confidence that the person had asbestos exposure. And so if the chemical engineers and the mechanical engineers and the safety industrial hiking engineers make it to the presumption list for asbestos, then it would cover mesothelioma, lung cancer, asbestosis and pleural plaques.

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And that that would, you know, make decision-making on those job titles a little bit easier. But, you know, the, I'm wondering about this bystander exposure issue where documentation such as industrial hygiene sampling demonstrates exposure.

For those of you who do industrial hygiene, is it, do you feel like it's likely that there was bystander, documentation of bystander exposure? I mean, it would be very unusual in any industrial setting to do that except if you were doing some sort of special study.

MEMBER SILVER: This is Ken Silver. As you mentioned, there is a special case of asbestos abatement and there's a cottage industry of firms, and if it fits within the regulations there is often area monitoring going on on the perimeter of the job site.

My impression of the way they operate in this part of the country is always that if they get a hit they wouldn't report it to the

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facility. And I can't imagine DOE back in the day was any better.

So I wouldn't wait for evidence from the asbestos abatement industry. It's probably -

-

CHAIR MARKOWITZ: And Dr. Van Dyke?

MEMBER VAN DYKE: Well, I think that, I mean, I think that assumes that all the exposure was due to asbestos abatement, which there's lots of exposures to asbestos that were likely not recognized early on.

And they didn't even recognize it in the people doing the jobs, much less the bystanders. So I think the -- the odds of there being any sort of IH measurements of bystanders is really low for asbestos or anything else.

So I would agree with what you're saying, Steve.

CHAIR MARKOWITZ: Yeah, yeah. Mr. Catlin, did you have another comment because -- or you just took your hand down.

MEMBER CATLIN: Yeah, I was going to

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repeat what was just said, so --

CHAIR MARKOWITZ: Yeah. Well, the -- it's Steven -- I think for us what the unresolved issue is that we would wait to hear back from the department is about those job titles and what Paragon's position is on those three job titles.

We don't have to resolve the issue of the how much bystander exposure documentation there was, although I have to say as a side comment I think bystander exposure is a really challenging, would be a really challenging issue for the SEM to address, given the lack of data, really, around this.

So it's not unimportant. Others? So other comments on this issue before we move on?

Okay. So, Carrie, the action item is, you know, awaiting additional response on the asbestos job titles.

Okay, then let's move on.

MS. POND: Dr. Markowitz, this is Rachel. Can I just clarify? Is this something -

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- do you want us to respond to it based on the transcript or are we going to get something else or --

CHAIR MARKOWITZ: Well --

MS. POND: I just want to make sure we can respond the right way to the questions.

CHAIR MARKOWITZ: No, the -- but at the beginning of this killer, Kevin, if you could go up to the top of this Page 1? Yeah, okay.

What's highlighted is that the department agrees to coordinate a re-evaluation of the noted job titles with PTS and make agreed-to alterations to the list.

MS. POND: Okay, great.

CHAIR MARKOWITZ: And what is still outstanding is the opinion of PTS on our recommendation that chemical engineers, mechanic engineers and industrial safety engineers be added to the presumption list in Exhibit 15-4 of the procedure manual.

MS. POND: Okay, that's helpful,

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thank you.

CHAIR MARKOWITZ: Yeah. Okay, so let's move on to next agenda item, which is another -- this is on our website meeting page, and it -- Kevin, let me give you the name of it because there's several items actually listed there. It's the IH/CMC and public comment DOL responses to those information requests. If you could bring that up?

So by way of, while he's doing that, by way of background, since the last meeting we've had two working groups looking at, okay. So looking at --

MR. BIRD: Sorry, Dr. Markowitz, are you looking for the response to this from DOL?

CHAIR MARKOWITZ: Yes, let's go to the response.

MR. BIRD: Okay.

CHAIR MARKOWITZ: Because the response has the questions.

MR. BIRD: And I believe this is it, correct?

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CHAIR MARKOWITZ: Yes, yeah. Okay. So by way of background, two working groups, one looking at talking through issues of industrial hygiene, medical input into the claims process and the Board's potential advice on that objectivity, consistency and quality of those.

That was one working group, and the second one had to review, looked at public comments over the last 24 months, which we had not systematically done and Ray brought forward certainly questions that we thought we could get some clarification on from the department.

I should say that part of the public comment working group was there were some aspects limited, but some aspects of the questions raised by the public that we couldn't quite understand from the written comments.

And so we asked the department whether we could ask those public commenters for to clarify their questions or their comments to us. And that was an issue that, I think, the department was going to get back to us on

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because normally on these committees there's just not a lot of back and forth between the public commenters and members of the Board.

So I don't know what the status of that is from the department's perspective, but if there's no answer yet today, maybe tomorrow we can revisit that.

But in any event, there were questions that we directed to the department and so we wanted to just go through it, and this document actually has both the questions from the IH/CMC working group and from the public comment working group.

And I think we start off with, I think it's the CMC/IH working group or vice versa. I'm not quite sure because it's not labeled. But in any event, it probably doesn't matter.

So we were, there was a question about the timeliness of claims involving impairment evaluation over the past several years. And so we asked for information on counts

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by year, resident state of the claimant and by consulting impairment MD.

And so the responses to the question was unclear. Clarification, different ways of measuring timeliness endpoints, what two endpoints are we talking about?

So I -- if anybody on one of the working groups who that came up with this question wants to chime in?

So this is Steven. I -- the issue was, and this may have come from public commenters, I'm not quite sure where it came from, but that for some period of time there was a lot of time between when the impairment evaluation was submitted and when the claim finally moved forward.

And so the Board's interest was on particular claims that involved impairment evaluations was or is the -- whatever time metric is used for advancing claims was it different from other claims? Or was there an inordinate delay in impairment evaluations

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during that, setting aside the issue of the pandemic, of course, in the impairment evaluations?

And was this in certain parts of the country or certain areas, certain types of claimants? What's known about that?

And the question, I guess, for Mr. Vance is is there any -- do you have any sense of the issues with impairment that could shed light on this for us?

MR. VANCE: Well, are you talking about, like, the timeliness of case adjudication involving impairments?

CHAIR MARKOWITZ: Right.

MR. VANCE: I mean, you know, it's going to be dependent on lots of different variables and how you'd want to look at it. And that's what makes data requests so complicated is because it really depends on the context and the framework of the, of what it is that you're trying to get to.

I mean, you and I, and I'm sure the

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Board is aware, you know, we do collect a lot of information and sometimes it can be evaluated and analyzed to provide data that may be -- may be useful in responding to or informing a particular issue.

But, you know, it would really depend on what it is specifically that you're looking for and then, sort of, negotiating over, you know, what data do we have that could even be used as, sort of, that benchmark for when do you want to start versus when you want to end?

It really is a challenge, and that's why this is, that our response is like that because we just need to have a better understanding of exactly what it is, A, you're asking for and then once we look at it, whether we're going to be able to, B, provide that data in a way that can be useful.

So and that's what, that's why this is difficult. We just -- I just didn't understand nor did we understand what the context was for this.

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MS. POND: Yeah, this is Rachel.

CHAIR MARKOWITZ: Sure.

MS. POND: I think that this set of questions are the ones that came from the public. So I mean, I, kind of, imagine that maybe you got the questions from the public and there wasn't a whole lot of context. So it makes it a little bit more challenging for us to answer it.

I mean, there's various stages of an impairment. You know, we send out a notice right after final decision to accept something under Part E, and we say you can file and this is how you file for impairment.

Then they can come back with a claim for impairment. Then they can choose whether they want they have their own physician do it or they want to have a claim, a CMC do it. And sometimes when they have their own claimant do it, I mean, their own physician do it, that physician is backlogged. So they will wait until that physician that they want to go to is ready

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and so that can take time.

We will give, you know, extensions and say, well, you know, typically just to work on the letter to that doctor and say here's what we need from you in order to make this calculation. And sometimes the doctors will get right on it. Sometimes they'll wait. The appointments have been spread out for, you know, months sometimes because claimants want to go to a particular doctor.

So that's going to affect timeliness. Now, you know, there is a certain point which we'll say, well, you know, if we don't get a response we're going to go ahead and either, you know -- they'll sometimes withdraw it or they'll come back and say I want to do this later or we'll deny it and then they, you know, appeal it.

So there's just a lot of different -- there's different things that could happen in an impairment. If it's a CMC, we have very specific timelines. The CMC has to provide us with the

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report, but we also need to get test results from the claimant that we can send to the doctors.

So and that's where the timeline can change. Now, we do have specific ops plan goals to have, you know, an initial decision done on an impairment. I think it's, like, 200 days or something.

But again, it's really sometimes they'll withdraw, they'll pull back. They'll say, oh, it hasn't been two years. I want to, you know, wait and it -- so it gets challenging. That's why this question's a little bit open-ended for us to, kind of, give you anything objective.

CHAIR MARKOWITZ: Okay, so I think that if -- I think we should that the committee, the working group that raised this question, if we want to drill into it further and reconvene and try to get more specific about what's being requested? I think that's reasonable.

And let me just ask Carrie to make

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notes about it, aside from the transcript, about what we're doing with these questions and we're pursuing them or not?

So okay, that's just the overall timeline of claims evaluations over the past two years. And the question is big and requires clarification, what is meant by claims evaluation.

So the -- you -- the program has goals around timeliness of the various steps of the claims process. Is that right?

MS. POND: Yes, absolutely. We have operational plan goals that outline all the different timeframes that we expect that the district offices will make then, that that trickles down to what is put in performance evaluations.

But we've, you know, so that's pretty much outlined but in a lot of the different steps so we have the time it takes from the time we get a claim to the time we issue a recommended decision or it goes to NIOSH is that

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the time it takes between a recommended decision and a final decision.

We've got a timeline for impairment and wage loss. We've got timelines for, you know, evaluation of home healthcare. So really there's a lot of different steps that we have timelines for which we can provide you, too, but we just need to know what particular piece you're looking for.

CHAIR MARKOWITZ: Well, so can you -- this is Steven -- can you share, not on this call, but I mean, can you share with us what your goals are in terms of timeliness? What periods of time, what percentage reaching that those periods of time for the various steps so we have a better understanding of what's actually looked at?

So we're not asking for data per se. We're asking for just --

MS. POND: You're asking for the operational angles, right?

CHAIR MARKOWITZ: Yeah, yeah.

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MS. POND: I don't think that should be a problem. I will double-check. I don't want to make a solid commitment unless there's some reason that there's an issue with it, but I don't think that should be a problem and we'll get back to you.

CHAIR MARKOWITZ: Okay. Because if, you know, at least need to understand what, you know, what the goals process are and if we -- if there's more information requested then we can request from --

MS. POND: Yes.

CHAIR MARKOWITZ: -- or inform the inform position.

MS. POND: Absolutely.

CHAIR MARKOWITZ: Question three, and I'm going to try to unsuccessfully to move the page down, but maybe Kevin you can do it? So this was -- is addressed to medical providers accepting the EEOICPA benefit medical card. I think the perception was that medical providers were decreasing, the ones who accepted the card.

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And so this question had to do with the last several years of the count of providers who accepted it over time so we could look at the trend and if it -- and what are the reasons why providers drop out of the program.

So again, the scene I'm looking at -- okay. Can you all see the answer to that now on the screen?

MR. BIRD: Dr. Markowitz, everyone should be able to scroll on the page down.

CHAIR MARKOWITZ: I see. I mean, individually we can all scroll?

MR. BIRD: That's correct.

CHAIR MARKOWITZ: Okay. Okay, so basically it sounds like the department doesn't really have this information directly. They have an inventory of medical providers enrolled in the program who may receive payment, but that's there's a lag between those that receive payment and those that drop out of a program. So that it wouldn't permit a timely look at trends. I think that's what -- that's the way I read this as the

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reason.

If the providers who drop out, the department has no real way of knowing why they would drop out.

MS. POND: Dr. Markowitz, this is Rachel. I just got confirmation that we can provide you with the ops plan goals, our operational plan goals, so we will do that.

CHAIR MARKOWITZ: Okay. So let me ask then, is it the impression, Mr. Vance or Ms. Pond, that that there are decreasing numbers of medical providers who accept the card? Or it's clearly no?

MS. POND: I mean, I think that there's sometimes might be a perception of that. There are some that have indicated that they're frustrated with the process, but I haven't noticed a trend where we're seeing a whole lot of people just dropping out of the program.

You know, I think that with any bureaucracy it can be a frustrating process for doctors when they're being asked, especially for

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with this comp limiting being asked a lot of questions, like, about causation, follow-up questions.

So, you know, there are physicians that might not want to, you know, be involved with the program for that reason but there's, you know, overall I haven't noticed a huge drop in the participation rate of doctors.

CHAIR MARKOWITZ: Okay. By the way, if any Board members want to chime in feel free. We ask how many claimant occupational health interviews have the contractor and federal IH has done over the past two years? And the answer is two, so that's a pretty easy calculation, one per year.

So by way of background, this was a recommendation from the Board some years ago that this mechanism be developed to try to improve the exposure information that is used by the industrial hygienist for when they evaluate a claim and trying to make, trying to fair weigh in on the significance of the exposure that the

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person might have had.

And so my question, since it's rarely occurring, is is it -- presumably that's because claimants are not requesting to have an interview and the industrial hygienists are not initiating an interview? I think it's from both ends that that's not happening. Is that right?

MS. POND: That's correct.

CHAIR MARKOWITZ: Yeah.

MR. VANCE: Well, and I'd like -- this is John Vance -- let me just add, you know, the mechanism that we describe in our procedure manual is one where the claims examiner can initiate the review of this when there's a purpose or a reason for wanting to have additional information.

And we certainly communicate it to our staff the importance of having this option available, but it's related to the claims examiner to make a judgment as to whether or not there's some issue or concern in the case file that they think will be rectified by having

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these kinds of interviews.

And so it does not seem to be something that claims examiners are initiating. And I know that we've covered this, and in fact, when Rachel did her introduction we had had a training session with all of our staff over this summer, and we were making it clear that this is an option if there were concerns being raised about exposure that we wanted to explore further.

And it's just not producing the kind of referrals that we would have thought,

CHAIR MARKOWITZ: You know, that's -- this is Steven -- and I can understand why the claims examiner might want not initiate the interview, but there's, when they send over a claim to an industrial hygienist with a statement of accepted facts and then they have questions for that industrial hygienist, essentially about the relevance and significance of the claimant's exposures, and then the industrial hygienist sifts through whatever

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available records there are from the claim file or more generally and then weighs in with their report, it's that industrial -- I would think it's the industrial hygienist who might realize, hey, I'm getting a picture of what this claimant might have been exposed to but not a complete picture.

And not a good enough picture that lets me really describe appropriately their exposure. And so it's the industrial hygienist who might want to conduct that interview now, because they would -- they are the ones who realize what's, you know, what they don't have in order to weigh in here.

And so is that offer of an interview made also to the industrial hygienist, not just the -- the claims examiner?

MR. VANCE: The conceptual framework for that procedure is driven by the claims examiner's need for additional information. So it really is the impetus of the claims examiner to communicate to an industrial hygienist the

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need for some sort of engagement to get clarifying evidence.

It's not really the IH that, or the industrial hygienist that would be triggering or initiating that kind of development. What they would be looking at is whatever documentation that they had available to them in writing to profile their exposures that they're doing.

Now, if there would be some reason for that, that -- I don't think the IHs are prevented from doing that, but it's just not a common occurrence if we've only done two over the past few years.

MS. POND: Yeah, and I think also the extent was that the IHs could do that if they want to. You know, if they, like, Dr. Markowitz was saying, if they see, oh, well, it would be helpful to have more information, they can do -- they can initiate that interview.

CHAIR MARKOWITZ: Yeah, okay. Any comments any Board members want to make on this?

MS. WHITTEN: This is Diane Whitten.

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CHAIR MARKOWITZ: Go ahead.

MS. WHITTEN: It's not really surprising to me that there's only been two. I have seen, you know, a lot of claims from co-workers, retirees and it's just corny when the IH data says the CMC will report that, you know, they weren't exposed to toxic substances over a known amount when in reality they haven't even called the claimant to ask them if and when they were exposed and to what.

So I hope we can fix this.

MS. POND: Well, the OHQ is used for that purpose, the occupational history questionnaire used to try to get as much information as we can from the claimant in addition to the records that we get from DOE.

CHAIR MARKOWITZ: Yeah. Any other comments? Mr. Catlin, yeah.

MEMBER CATLIN: Thanks, this is Mark. Yeah, I just recall from my experience in Washington State as -- I did a lot of these interviews in my work at the University

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Washington for a number of years and it's, you know, it's the if the claims examiner is probably not really the best one to be looking to say that these have got to be done.

It would be useful to maybe have a process where of claims managers or claims examiners decide there's -- they don't need to have an interview done and a certain number of those get done anyway by the industrial hygienist to see if there's -- how much additional information can be pulled out and whether or not that's going to be helpful.

So some way to, sort of, look at this to try to help increase the number of interviews, because I was actually shocked to see this number of only one per year.

CHAIR MARKOWITZ: I want it on the record that that's not New York City. Yeah, go ahead.

MEMBER SILVER: Here's a devil's advocate benign interpretation. Out there at the Resource Centers the new occupational health

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questionnaire is capturing much better data than in years past.

So the contractor in federal IHs have less reason to go back and plug the claimant for more details is a possible interpretation of reality or way off base.

MS. POND: No, that's correct. I would agree with that assessment.

MEMBER SILVER: Well, it would be interesting to have some empirical data to see if that's really true. I mean, I'm skeptical but, you know, logically the thought hopped into my head.

CHAIR MARKOWITZ: Well, yeah, this is -- I don't know if people who still have their hands up want to say something else here or what.

This is Steven. My hunch is that the routine, the claims have a customary level of exposure information and not a ton and hopefully not too frequently very little, and that the industrial hygienists are producing their

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reports given what the customary amount of information they get is.

And then it's they don't really see the occasion to pursue additional specific information from individuals. I can understand that.

I think that actually Mr. Catlin's idea of essentially a pilot project where, you know, say, 20 interviews are done by the IHs and to see if well, you know, see if it's a useful thing or not. You know, a limited effort that wouldn't take a ton of time, but to see whether in fact it does improve the quality is something that I don't know the Board can think about a little bit more.

But I think we should move on unless there are other comments on this?

MEMBER SILVER: I just wanted to second Mark's idea.

CHAIR MARKOWITZ: Go ahead. What's that?

MEMBER SILVER: Ken Silver. I second

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Mark's idea.

CHAIR MARKOWITZ: Yeah. Okay, so the next question is the more detailed role the EEOICPA Medical director and the program being added to the procedure manual, and the answer is that in the procedure manual, specifically around Chapter 29, Ancillary Medical Benefits, that the Medical Officer reviews organ transplant and experimental treatment requests, which hopefully is pretty infrequent.

So I take that to mean that -- and I've looked at the procedure manual to look for the specific language around the medical director's role in it, and it's there's very little actually given to the medical director.

And I said, and this is -- this is a question. The procedure manual is for -- is a guide for the claims examiners and it's the fact that the medical director doesn't appear very frequently in the procedure manual means that the fact the medical director or Medical Officer has a very small role specifically in claims

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evaluations. Is that correct?

RP Yes, that's correct. The medical director is a medical, I mean, the Medical Officer, he's of DEEOIC. He looks at more of the broad space, I mean, overall. He's looking at the, you know, how we are getting billed and how we're processing overall, you know, medical issues related to all of our EEOICPA programs. So we're a piece of it.

He's had, you know, less. Sometimes we will go to him with specific questions like VLC organ transplants and things like that in there that we need to have him look at for, from a program perspective. But it is rare and it's becoming more and more rare because we're using CMCs or going back to the treating physician more often.

CHAIR MARKOWITZ: And while we're on this topic, actually, because the language is between Medical Officer versus medical director. Is that the same person?

MS. POND: Yeah, that title changed

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in the last year or two years --

CHAIR MARKOWITZ: Okay.

MS. POND: -- there, so --

CHAIR MARKOWITZ: And is there a second physician in the office that's dealing with some of these issues?

MS. POND: I think the state keeps (audio interference) to work with him for other OWCP as well, but that's recent and so I'm not exactly sure what that role is going to be for us.

There's also a pharmacist who looks at other types of issues for OWCP overall. Again, that's for all of the workers compensation programs at Labor.

CHAIR MARKOWITZ: Thank you.

MR. VANCE: Yeah, and this is John Vance, and let me just clarify as well, because one of the things that we have been doing in the procedure manual is making it very clear that the position of our Medical Officer is that of an interpretation of the evidence by a medical

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physician.

And that represents his or her interpretation of the evidence, and then that would be something we would compare to other opinions in the case and have to weigh.

So I think it's part of the contention may have been that we were giving some sort of special weight to the interpretation of the evidence by the medical director, and we're trying to make it clear that his or her opinion is just that.

It's an opinion that the department letter obtains in some these cases and would have to be considered in comparison to other medical input that we get from other physicians.

CHAIR MARKOWITZ: But this is Steven, let me just say that what you just described I couldn't find in the procedure manual. I think it's --

MR. VANCE: Actually it's -- Dr. Markowitz, it's in -- I know it's in Chapter 29 now, but when we are assessing, especially for

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these organ transplants and the experimental medication, there's now specific language that the opinion of our Medical Officer serves as an interpretation that must be weighed against other information being obtained by the Department of Labor.

CHAIR MARKOWITZ: But is that only relevant to the issue of organ transplant and experimental treatments? Or is it you're saying -- or is that true in general?

MR. VANCE: In general that's the way that we're going to approach this because that's the way the procedure that -- we're trying to consolidate all of our procedures so that when we're weighing medical evidence that's the way that the claims examiner would approach it.

But if there are conflicting medical opinions that the opinion of a Medical Officer from the Department of Labor is just that. It's another interpretation of the evidence.

I can send Carrie the language so you can take a look at it.

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CHAIR MARKOWITZ: Yeah, that would be great. That would be great. Not that I get lost in the 711 pages of the procedure manual, but --

MS. RHOADS: I can't imagine why you would. It's so simple.

CHAIR MARKOWITZ: Okay. So the next question, again, if there's Board members who want to chime in and just feel free, but here it is is that there's been an attempt to aggregate data from prior claims decisions to ensure consistency in decision-making.

For example, one could look at decisions on beryllium sensitivity, you know, for different job titles to see if there's variation in claims outcomes for the same job titles.

And the short answer to this is that, no, that they don't, the department really doesn't do that kind of data aggregation, which is useful to know because I think that it's one of -- it's something that the Board with resources could look at, talking about it

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sometime in 2022.

But could look at it to address the issue of consistency. But any comments or questions?

Okay, question seven, what are current and future changes in occupational medicine at the EEOICPA? I guess it's really, someone had mentioned I think at one of the Board meetings that you were going to hire another physician. I think that was where this question came from.

MS. POND: Yeah, we're not. We're not hiring any energy per se. The Medical Officer for the (audio interference). And that's what we've got in terms of the -- the medical expertise at DOL, but that's why, as I said, we're trying to make sure that we're relying more on the treating doctors and if there's some question or concern on a particular case that we go through to a CNC.

CHAIR MARKOWITZ: Okay, next question, for what percentage of claims through

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its CMCs and IHs recommend denial? And the answer is zero because they only provide professional advice to the claims examiner that the claims examiner uses to weigh in adjudicating a claim.

They don't recommend a denial or not, so that is -- was a misconception, I think, on our part.

Although, I think, you know, when we get to look at some claims and drill in on IH and CNC, I think maybe we'll get a better, more refined question.

Same with the next one, question nine, for what percentage of claims do we see CNC writes is fine minimal exposure provided by GM -- by individual CMC and IH. And the department doesn't keep that kind of data.

Okay, so the second set of questions came from the CMC IH working group and first question was about the National Office's Medical Director's role in claims evaluation.

And we've already discussed this.

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We're going to look at Chapter 29 and see what it says. Well, essentially there's a very limited role in individual claims evaluations.

What procedures does the medical director follow? I think that question, too, actually is derivative from question one. So if there's little role in claims evaluation then procedures aren't really relevant.

Question three, how does the medical director communicate his or her input into the claims evaluation process? And so when the program requests a case-specific review from the Medical Officer, the Medical Officer will communicate a response in writing and the department then uploads that written response into the information system for it to be part of the permanent case record.

Okay. So then when we look at claims in the future, we may on occasion see these communications. Is that right?

MR. VANCE: Yes, but it would be very

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rare.

CHAIR MARKOWITZ: Okay. But we don't, hopefully we won't look at that many claims that we'll find very rare events.

Question for --

MS. POND: I just want to say we did change some of that, as you'll see here. We in the most recent part of the procedure manual, so there, you know, we might have more input in the past. We've evaluated some of that and make, we want to make sure that we're putting it more, putting any specific claims evaluations, like this next question on impairment, to either treating or the CNC folks.

So you may have seen some of that. That's probably where question came from, but you will see that.

CHAIR MARKOWITZ: Right, and then, in fact, that's what Mr. Vance said earlier regarding the changes in the transmittal document with the PM 5.1 around impairment.

Okay. So then what triggers an

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impairment claim review by medical director and going forward very little it seems.

And okay, so I think, so those are the questions that we had posed and so let me just ask on this other issue of about getting some clarification on limited number of public comments about whether there's a way in which we can do that.

This came out of an information request, and I had to do it with FACA and the rules and all that, and I think the department was going to --

MR. BIRD: Yes, Steven, we're probably going to have to talk about that offline.

CHAIR MARKOWITZ: Okay. Okay, fair enough.

MR. BIRD: So Carrie and I will set up a time that works for you to talk about that, okay?

CHAIR MARKOWITZ: Sure, sure.

MR. BIRD: Thank you.

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CHAIR MARKOWITZ: Okay. We have 15 minutes until the public comment period. Dr. Silver,?

MEMBER SILVER: Yes, the last 30 minutes of discussion or so around these questions makes me feel a hole in my heart for the lack of it an ombudsman. None of the data-related questions, you know, might be answerable through an iterative process of someone right there in the department going back and forth with the program staff to frame the question, you know, the one about to refine the hypothesis and, you know, eventually get hands on the data to answer it.

And similarly when the public comments and the Board feels the need to get clarification and it becomes a big, complicated thing in FACA, it would be nice to have someone in the ombudsman's office to, you know, deal with it a little more promptly and directly.

So I know it's not exactly in our charter but the personnel of the ombudsman's

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office brought a lot of high-quality commentary to our meetings, and it would be nice to have someone in that role participating again.

CHAIR MARKOWITZ: Okay. Speaking of the ombudsman, actually, is there a timetable or a plan to replace the ombudsman or what exactly is the status?

MS. POND: This is Rachel. We don't have -- that's a separate office from us so we don't really have any control or say of whatever happens over there.

I know there's currently an acting. That's all I really know, sorry.

CHAIR MARKOWITZ: Yeah, that's okay. So, Carrie, you just sent the language from Mr. Vance around, the Medical Officer. I'm wondering whether if you could send that to Kevin and we could take a look at it, just to close out that discussion?

MS. RHOADS: Yep, I'm sending it to Kevin right now.

CHAIR MARKOWITZ: And so let me also

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ask how many public commenters do we have so far? Do we know?

MS. RHOADS: I still have two.

CHAIR MARKOWITZ: Two? Okay.

MS. RHOADS: Yes.

MR. BIRD: Thank you, Carrie. I received your email. I am pulling it up in a second. Hold on one second.

(Pause.)

CHAIR MARKOWITZ: Okay. Now if you could -- yeah, great. Okay, that's good. That's good.

So just to walk through this, this is from the Procedure Manual Chapter 29 of Part B, Disapproval by the DEEOIC Medical Officer. In the event that the DEEOIC Medical Officer does not agree with a medical necessity for the requested organ transplant procedure or opines that the medical evidence is insufficient to support proposed experimental treatment for an accepted condition, the Medical Officer returns the case to the MBPU with a memorandum

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explaining his or her decision.

And depending upon the opinion of the Medical Officer, the MBE takes one of the following actions: One, Medical Officer requests further information, the MBE proceeds with development to obtain the information needed for the opinion from the Medical Officer; or two, when the Medical Officer provides an opinion that the medical evidence does not support the medical need for an organ transplant or experimental treatment, the MBE treats the matter as a conflict of medical opinion between the prescribing physician and the Medical Officer, the MBE must assess competing opinions to determine the one that the MBE can assign the weight of the medical evidence to decide to claim.

If the MBE assigns equal weight to the opposing opinion, the MBE is to obtain a refereed medical opinion. Okay.

So that sounds reasonable, to me anyway, but more to the point all this applies

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to organ transplant requests and experimental treatment and appears to only apply to those occasions. Is that right?

MR. VANCE: Yes. Yes, for this procedure chapter this is what this relates to. Now, the Medical Officer within MBE has lots of other functionality but for our purposes this is what we are asking the Medical Officer to participate in with reviews.

CHAIR MARKOWITZ: Okay, okay. So are these the only claim types in which when we look at claims we're likely to see the Medical Officer actually have a written, some sort of written opinion that makes it into the record?

MR. VANCE: Yes.

CHAIR MARKOWITZ: Okay, okay. Okay, thank you. That clarifies. Comments from the Board, questions?

Okay.

MEMBER FRIEDMAN-JIMENEZ: Yes, this is Dr. Friedman-Jimenez. What is meant by experimental treatment? Does that refer

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strictly to medical experiments, i.e., randomized clinical trials where there is a treatment group and a placebo group or a standard care group and it's an actual experiment?

Or is that referring, sort of, loosely to treatments that haven't yet been approved by insurance companies?

MR. VANCE: I think it's more of the second. It's more of a loose standard that it's something unusual or not particularly falling within a routine type of medical care.

So the ones that I've seen that I know about are generally going to be involving, like, medical marijuana and those types of, you know, CBD oils and that sort of thing where it's some, sort of, treatment that is not recognized as a normal and routine type of treatment modality for a particular condition.

MS. POND: Or we have to have them weigh in because of the federal rules and whatever, particularly when testing medical

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marijuana.

But I think it's bad in itself and it's also just, you know, something that they've even, the doctor himself has said this is not a particular, this is something we, that we don't normally do but here's the reason behind it so we get our Medical Officers to take a look at it.

MEMBER FRIEDMAN-JIMENEZ: Okay. If that's the case, I think that that word experimental can be potentially problematic because that could be changed depending on the opinion of the Medical Officer.

I think it would make sense to change that to a different word. Experimental has a pretty precise medical meaning and it means generally in a medical experiment, a randomized trial.

And I think you should either say unapproved treatment or some other word beside experimental because otherwise I think there are going to be problems of differing

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interpretations of that word.

MR. VANCE: Yeah, this is John Vance. I think we define it earlier in that section somewhere. I hope to go back, I just -- and, of course, I just closed it, but I'm pretty sure that we do have some sort of description of what is meant by experimental treatment. So I'll have to -- I will pull that up and -- and circulate that.

MEMBER FRIEDMAN-JIMENEZ: Okay, because we've similar problems coming up in the World Trade Center program that people actually have, you know, a cancer treatment that they feel their life depends on and it's denied because it's so-called experimental. And it can really lead to problems.

MR. VANCE: Yeah, this is John again, so obtaining evidence for evaluation of requests to participate in experimental treatments, also known as investigational protocols or clinical trials, experimental treatment.

So this is wording from our procedure

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manual, experimental treatment is a treatment that is not generally accepted by the medical community that has a proven efficacy.

So again, it's a very, a relatively loose definition. But that's how it's defined in the procedure manual.

MEMBER FRIEDMAN-JIMENEZ: I think you should consider looking for another word there because I know it may not be that often but it can lead to pretty, pretty bad problems and bad feelings.

MS. POND: Okay, we can look into it.

CHAIR MARKOWITZ: Okay, so let's -- I'm sorry, Dr. Goldman, do you have another comment?

MEMBER GOLDMAN: Just to go along with George, like, that is confusing. What about somebody who might have cancer or something where they're part of a, you know, drug trial where the only way you can get treatment is that you participate in one of those, you know, drug trials that they're doing with cancer, with

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cancer patients. Would that be considered experimental?

Because that's not that uncommon that people, you know, sign up for those kinds of drug trials with chemo.

MR. VANCE: Well, I think what you're talking about is all of these are basically exception processes that involve a special level of review. And so what you're calling it, you know, like, an experimental treatment or I think in that particular case what you're talking about it is an exception process for a prescription medication, it's going to have to really be dependent on the specific issues that are involved with that particular case.

You know, so we do have exception processing procedures for drug, for prescription medications. I think this is separate from that, this discussion of experimental treatment.

MEMBER GOLDMAN: But those type of things would probably not be something that would be automatically paid for in a medical

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bill system and would raise a flag that they would have to look at and then determine, you know, is there something more we need or whatever?

And so it really will depend on the specific request, but if it is not paid at the bill pay level it will raise a flag for our medical benefits during its review.

CHAIR MARKOWITZ: Okay, any other comments, questions? Okay, so we're done this. We have just a couple minutes before we start the public comment period.

We have two commenters, so the public comment period is not going to last that long. And my question to the Board members is if the public comment period is relatively short whether we should continue with one 15-minute item, the first 15-minute item from tomorrow?

Or whether we should just finish for the day and resume tomorrow 1:00 p.m.

MEMBER BOWMAN: This is Aaron. I would vote for finishing with the agenda as is

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and resuming tomorrow. It would give a little bit of time for some Board members on the -- for us to think about the issue with the IARC, for example.

CHAIR MARKOWITZ: Okay, other comments?

MEMBER GOLDMAN: I agree.

CHAIR MARKOWITZ: So the vocal minority wins. And what we'll do is after the public comment period we will adjourn for the day and then resume tomorrow at 1 o'clock.

So with that, I turn it over to I guess Carrie or the moderator? I'm not quite sure.

MS. RHOADS: Kevin, can you tell if the FRC's public commenters are online?

MR. BIRD: Yes, so right now I believe it's only Terrie Barrie is on the line. I do not see D'Lanie Blaze.

MS. RHOADS: Okay.

CHAIR MARKOWITZ: Well, why don't we have a couple of -- we have a couple in a couple

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minutes to break until 4:15 probably, to be fair.

MS. RHOADS: That's right. Does the moderator have to change something in the format so we can hear the public comments?

MR. BIRD: Nope, just whenever you're ready just ask for that person and we will put them through.

MS. RHOADS: Okay.

CHAIR MARKOWITZ: So while we're waiting, for tomorrow's discussions on looking at data that's available from DOL and whether additional data might of interest, Carrie's sending around an email with the link to the program's public reading room.

And that has various files and it won't take very long, but in about 20 minutes or so you can open a number of those and see what kind of data the program routinely provides. And so that we can work from there and see whether there's additional data that might be of interest.

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And it's 4:15 so we can get started with the public comment period.

MR. BIRD: And Dr. Markowitz, I already jumped in but I just would remind everyone on the line that if you were not scheduled to make a public comment but would like to please press star one to make that known. I will go back to you, Dr. Markowitz for jumping in.

CHAIR MARKOWITZ: Okay. Okay, so we can start with Ms. Barrie.

MS. BARRIE: Hello, this is Terrie Barrie. Can you hear me?

MR. BIRD: Yes, we can.

CHAIR MARKOWITZ: Yes, we can.

MS. BARRIE: You can. All right. Well, good afternoon, Dr. Markowitz and members of the Board this is Terrie Barrie and I'm the founding member of the Alliance of Nuclear Worker Advocacy Group. I want to thank you for your continued service and for the opportunity to provide these comments.

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I provided a letter from ANWAG, oh, earlier this summer concerning the cancers that were rescinded, and I'd like to clarify why this request would fall under this Board's purview instead of the Advisory Board on Radiation and Worker Health.

First, under the statute, the Radiation Board is not permitted to provide advice to the DEEOIC, but this Board can. I guess they could provide advice, but, you know, the department wouldn't consider it, I imagine, but this Board can.

It was DEEOIC that initiated the dialogue with the National Cancer Institute on whether cancers could be considered a specified cancer and therefore compensable if a claimant qualified under the special exposure cohort.

When NCI came back with a positive answer and the reasons behind it, DEEOIC began processing SEC claims to include this subset of cancer. Then someone at DOL noticed that the statute only allowed DEEOIC to consult with NCI

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only about the names and nomenclature of potential cancers, not if a type of cancer can be considered a specified cancer.

I guess I can almost understand DEEOIC's reasoning. However, the fact remains that NCI had determined that the five cancers in question are specified cancers. The statute allows this Board to provide advice on the claims adjudication process generally.

For example, I've noted earlier today the Board provided the recommendation that parkinsonism should be treated as Parkinson's disease. Respectfully, I ask the Board to review the original and rescinded final circulars and consider recommending to DEEOIC that the five cancers identified in those circulars, as well as the SLL/CLL issue Ms. D'Lanie Blaze raised in her written comments do qualify as a specified cancer.

NCI has already done the heavy lifting. DEEOIC, of course, can reject your recommendation, which I hope they do not, but at

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least they will know that if they do they will not be violating the statute if they accept this Board's recommendation.

I am hoping the discussion tomorrow will reveal that DEEOIC has finally issued a request for proposal which will provide a support contractor to the Board. The Board has mentioned the need many times over the years but wasn't informed that a formal recommendation was necessary until about 2019.

Still, it's astounding that it has taken almost three years just to issue a request for proposal. I cannot understand why it has taken so long to provide the Board with the resources they need and requested.

The Department of Labor had the personnel and infrastructure in place and the interim rules, the interim final rules to process claims a mere eight months after Congress passed the law in -- on October 30th, 2000.

I don't understand why they're having

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such a difficult time with finding an appropriate contractor for the Board.

From today's conversation and discussion, I would recommend, or suggest, not recommend, but I would suggest that the Board ask for the number of cases that were filed for mesothelioma. That will give you an idea of how frequently the cases were approved or disapproved.

When it comes to the impairment rating decisions, I'd be curious to find out how long it takes for a recommended decision should be issued from the time the impairment rating physician submits everything to DEEOIC and when the final decision is finally issued.

I'm hearing still that these claims are being delayed by months and months. So that would help figure out that there's a problem with claims examiners issuing these decisions.

And that's all I have for today, and I thank you again for this opportunity.

CHAIR MARKOWITZ: Okay, thank you.

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The -- did Ms. Blaze get on the line?

MR. BIRD: Not yet, no.

CHAIR MARKOWITZ: Okay, okay, fine.

So let's move to Ms. Donna Hand?

MS. HAND: Yes, can you hear me?

CHAIR MARKOWITZ: Yes.

MS. HAND: Okay. My issues are the same as Ms. Blaze, as well as Ms. Barrie according to the, you know, specified diseases or specified cancer. That has been defined in the act as you know, you know, and they list certain cancers that are listed as specified.

But part of the option is is the specified diseases designated in this section means a physiological condition or conditions that are recognized by the National Cancer Institute under those names or nomenclature or under any previous accepted or commonly used names or nomenclature.

So whenever that was added in there, that gave the duty for Department of EEOICPA to, you know, assist the claimant in developing or

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going to the National Cancer Institute and say, well, since CLL is a leukemia it, does that -- is that nomenclature?

Is the spinal cord cancer the same thing is a brain cancer because they did that with the myelodysplasia syndrome, and the policy, you know, says random.

You know, so again is the parathyroid and the thyroid, is it the same underneath the recognized condition for the National Cancer Institute? That, you know, so that right there is what we need to have done is that the National Cancer Institute is to be addressed or to be asked, you know, to add these into.

I know that the CLL is in the statute that says it's not a radiogenic cancer, but then the (audio interference) changed that. So that may be a technical or, you know, a legal thing that may have to be changed as well.

The other issue is the impairment that's being done. A lot of the activities of daily living are not being addressed and not

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being added into the impairment. So (audio interference) before they would get an impairment of 35 percent, now they have home health care and they're only 36 percent.

And so the consistency of adding those impairments in addressing activities of daily living needs to be addressed and be consistent as well as in all the reports.

The -- before they would also give a three percent for chronic pain and the fifth guide does allow three percent for chronic pain, and they do not do that for the impairment anymore.

Also the depression and anxiety, the fifth guy has it listed at three percent also for that, and that's not even addressed because they said there's nothing there to give the impairment for.

The other issue that I have is that Haz Map is no longer part of the National Institute of Health so why can't we use and address the environmental health perspective and

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their database, the Collaborative on Health, because it is very claimant friendly.

You can put in a health effect or you can put in a disease or you can put in a toxic substance and they list three separate categories of, you know, good evidence, of medium evidence or limited evidence. And they use the same studies and everything for occupational to, like, you know, environmental reports and studies that is used in the CMC report.

So that should be, you know, addressed as too, so then the non-cancer illnesses are in that database and they list the toxic substances.

So thank you very much for your time.

CHAIR MARKOWITZ: Thank you. This is Steven Markowitz, a point of clarification. So I know you've mentioned this in previous public comment. What is this database that you're referring to? What is it specifically?

MS. HAND: The Collaborative of

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Health and it's within the Environmental Health Perspectives. I sent you an email with a link to it.

CHAIR MARKOWITZ: Environmental Health Perspectives is a journal, so you're saying that the Collaborative on Health is a --

MS. HAND: A toxic diseases database within their website.

CHAIR MARKOWITZ: Okay. Well, I don't know if you -- I'll take a look, but if you wouldn't mind sending in the details as a written comment so in case we have trouble finding it. That would be helpful.

MS. HAND: Will do.

CHAIR MARKOWITZ: Yeah, thank you. Okay, Ms. Carroll is next?

MS. CARROLL: This is Stephanie Carroll. I am an authorized rep here in Denver and I specialize in beryllium disease claims, and I just have a few comments just from hearing the meeting today. Thank you so much for accepting my comments today.

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So what I would like to first just point out is the Act was and Congress were very clear and unambiguous in the language when discussing medical benefits for this program. Under medical benefits in the Act, the commencement of benefits reads, an individual receiving benefits under this section shall be furnished those benefits as of the date on which that individual submitted the claim for those benefits in accordance with this subchapter.

In other words, when they put in a claim for Part B or Part E that's when they're putting in a claim for medical benefits and that's when they shall be furnished.

Also medical benefits that are provided, quote, "the United states all furnish to an individual receiving medical benefits under the section for an illness the services, appliances and supplies prescribed or recommended by a qualified physician for that illness, which the president considers likely to cure, give relief or reduced the degree or the

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period of that illness.

I think it's very important to pay attention to the clear and unambiguous language of the Act when determining if workers are going to be furnished the medical benefits that their physician orders or recommends.

I think that the language by saying recommends and that the president considers likely to not just cure or treat, but to give relief or to reduce the degree or the period of that illness should be paid attention to because, you know, changing the meaning of the Act in a procedure manual by saying that if a doctor recommends a lung transplant we all have to determine if it will reduce the degree or the period of that illness. I think it would and why are we accepting this very steep criteria to get authorization for treatment? Now, to be consistent, if they're relying on the fact that a lung transplant is experimental, yet they are approving the drug treatment for COVID right now, which those drug treatments are often

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experimental at this point, then it's not consistent to say that they're going to run people through mill here if they want a lung transplant but if they have COVID they're going to allow them to get this experimental treatment.

So I think it has to be consistent no matter the cost of the treatment.

The other thing is when it comes to nomenclature with the NCI, of course, the Act has been very clear on that which, thank you Donna for reading the Act's language into the record today, something has changed in the program.

My grandfather was actually approved for secondary bone cancer but it wasn't called secondary bone cancer. He was actually approved for prostate cancer metastatic to the bone.

When I contacted right now, they are not treating the underlying cancer. It's secondary bone cancer is approved in this program. Before they used to count the primary

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cancer which would be prostate or blast or melanoma that has gone to the bone, they would actually include that cancer as an approved cancer in this program.

They don't do that anymore. They only approve something called secondary bone cancer. When I called, contacted NCI and said I'd like some treatment record or treatment papers for secondary bone cancer, there is no such thing. Secondary bone cancer is not a cancer that can be treated. It is only treated when it is referred to as metastatic from another primary area.

So it's prostate cancer secondary to the bone or melanoma and so forth. So that is a very big concern because I've been having problems getting people that have secondary bone cancer related to the prostate covered for their treatments. And it's really been awful.

So that's something that's changed and the law has not changed, but the procedure manual has changed on that.

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And then, let's see, I'm having a problem still with Dr. Hoffman. He is actually being asked questions by the claims examiners concerning chronic beryllium disease which the Act actually does not -- it does address using physicians, but not for Part B because it's a statutory diagnosis.

So Dr. Hoffman is being asked questions about the statutory criteria for chronic beryllium disease and if workers meet that criteria. And then when you look at his references, his reference is the procedure manual.

So he is actually weighing in on an approval for statutory disease or not. He's not getting questions such as does his PFP show obstruction. No, he's getting asked does this person have pre-93 or post-93 CBD.

I don't think a doctor should weigh in on that. I think the doctor is not a claims examiner and if they are going to start using him as such then we should, you know, actually

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list him as part of the program as a claims examiner, because he is weighing in on people getting their claims approved or not. And nothing seems to be done about that physician.

And then one more thing is Econometrica in 2005 addressed so many of the issues that you are being asked to address. And what I'm concerned about is when we do these illnesses that are presumed, sometimes they are, well, the presumption is more stringent than the Act ever intended.

So you have to pay really close attention to what the Act and Congress intended. And then also all of the work that was done by Econometrica you may be doing work right now chasing after this very big projects that they're giving, maybe to distract you from the stuff that's more important.

But go back to Econometrica, I think a lot of your work was done in that report in 2005 when it comes to presumptions or exposures that are expected to be at the site.

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The other thing, when it comes to Rocky Flats and the dates of production until 1989, yes, production, official production stopped at 1989 but after '89 they were processing waste. They were doing all kinds of processes that were the same as during production.

So I'm very concerned about those then changing in the sun based on that, and also the SEM does have in library of documents that have already been used to verify that those, that those exposures are on site and the DOE gave over those documents. I can't get copies of them, but asbestos has a library full of documents that there, that's provide exposure information.

So you could ask for that library index from Department of Labor. There is a SEM library, all of the documents that support each part of SEM have SEM or have DOL library numbers connected to them if you look at the old SEM.

So that's all I have to say but thank

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you so much for listening. I appreciate all of the work that you do. Thank you, bye-bye.

CHAIR MARKOWITZ: Okay, thank you. Are there other public commenters?

MR. BIRD: There are not, no.

CHAIR MARKOWITZ: Okay. So let me then, I think we've done our business for today. Let me turn it over to Mr. Chance.

MEMBER CATLIN: Yes. Yes, thank you, Dr. Markowitz and all the public commenters, everyone who took part in the meeting today. We will adjourn at 4:34 and resume at 1 o'clock Eastern Time tomorrow.

Everyone enjoy your evening.

CHAIR MARKOWITZ: Okay, thank you very much.

(Whereupon, the above-entitled matter went off the record at 4:34 p.m.)

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