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June 17, 2016

Rachel Leiton, Director
Energy Employees Occupational Illness Compensation Program
Office of Workers Compensation Programs
US Department of Labor
Via email

Re: EEOICPA Bulletin No: 16-02
Adjudication of COPD Claims
<http://www.dol.gov/owcp/energy/regs/compliance/PolicyandProcedures/finalbulletinshtml/EEOICPABulletin16-02.htm>
December 28, 2015

Dear Ms. Leiton:

A newly issued Bulletin 16-02 recently came to our attention. As we understand it, the intent is to improve upon the efficiency of adjudication of COPD claims by providing a presumption specific to asbestos exposures, and includes a provision for re-adjudication of COPD claims previously declined. For this we are thankful.

However, we also think it is not up-to-date in terms of the science and may be misleading. It contains a number of technical errors about COPD risks, and historical inaccuracies. Together, these deficiencies could impede claims adjudication. Further, we think the state of science can be used to expand upon the presumption for COPD, and help expedite claims review for a much broader class of COPD claimants.

Problems with the Current Presumption

1. OWCP claims to have reviewed the available scientific literature and that the guidance in this Bulletin is consistent with it. It cites five published studies to support this claim. [Am J Epi 156:738-746, 2002; Am J Respir Crit Care Med 170: 691-715; 2004; JOEM 43(7): 623-629, 2001; Am J Ind Med 53: 224-240, 2010; J Occ Med Tox 5(12): 1-7, 2010.] Only one of these studies is specific to DOE employment. [See Am J Ind Med 53: 224-240, 2010.] It should also have included two recent studies published on occupational risks in DOE facilities, including one specific to COPD. They focus on construction workers, which are the predominant labor categories listed in Attachment 1 of the Bulletin. We have included copies of these studies in this submission.
 - a. Ringen K, Dement J, Welch LS, Bingham E, Quinn P, Chen A, Haas S. Mortality of older construction and craft workers



- b. employed at Department of Energy (DOE) nuclear sites: Follow-up through 2011. Am J Ind Med 58:152–167, 2015 [hereafter referred to as “study cited in 1.a”].
 - c. Dement J, Welch L, Ringen K, Quinn P, Chen A, Haas, S. A case-control study of airways obstruction among construction workers. Am J Ind Med 58:1083-1097, 2015 [“hereafter referred to as study cited in 1.b”].
2. The subject matter line of this Bulletin is “*Presumptions Available for Accepting Chronic Obstructive Pulmonary Disease (COPD) Under Part E...*” This may be misleading in that it fails to note that it only covers asbestos exposures.
 3. The Bulletin’s sole focus on asbestos suggests that asbestos is a predominant occupational risk for COPD, which is wrong, and could lead a claims examiner to believe that other toxic exposures that also aggravate, contribute to or cause COPD are less important or not important.
 - a. One of the studies cited in the Bulletin notes, “Increased COPD risk was observed for exposures to asbestos, silica, welding, cement dust, and some tasks with exposures to solvents, paints, and dust/fumes from paint removal.” [See Am J Ind Med 53: 224-240, 2010.]
 - b. The recent study cited above in 1.b, which is the most comprehensive study of COPD in relation to DOE employment, shows that exposures to a broad range of vapors, gasses, dusts and fumes (VGDF) cause COPD. Asbestos by itself instills about the same risk as silica, caustics, wood dust etc. Most importantly, however, in most occupational settings involving the labor categories in Attachment 1 of the Bulletin, workers are exposed regularly to a mixture of these VGDFs.
 4. The Bulletin gives the appearance that asbestos exposures mainly occurred before 1980 when it states: “*The 1980 reference to the exposure standard derives from the fact that the majority of the referenced studies applied analysis of occupational asbestos exposure occurring prior to this year.*” This is a wrong interpretation of the published literature, and could lead claims examiners to believe that any exposures claimed to have occurred after 1980 would be unlikely and should not be considered.
 - a. While installation of new asbestos may have ended by the early 1980s, handling of asbestos in place, including its removal, has continued since then and will continue into the foreseeable future. For instance, in 2014, the EPA fined DOE and two DOE contractors for asbestos abatement violations at the Hanford site. [See <http://yosemite.epa.gov/opa/admpress.nsf/0/370E71F8FC43470E85257CAF005A426E>.]
 - b. There have been hundreds of papers published on the non-malignant health effects of asbestos that can inform decision making; we cannot review all of that literature here. There is a minimum latency between first exposure to asbestos and the development of asbestosis which makes it hard at this point to determine risks from asbestos exposures after 1980, and most available studies rely on populations with exposure prior to 1980. The reason for that is that it takes a long time to develop asbestos disease from the time of first exposure. This long delay between exposure and disease manifestation is known as “latency.” One recent analysis from 2014 reported that the mean latency for non-malignant asbestos related disease (NMARD) was 46 years with a range of 25-66 years.” There has

not been sufficient time elapsed since 1980 to conclude exposures were reduced sufficiently that NMARD will not develop. To this point, it appears that one of the papers cited in Bulletin 16-02 [JOEM 43(7): 623-629, 2001] included workers who started work in the 1950s based on their ages and years of exposure.

- c. More importantly, the studies cited in both 1.a and 1.b note that excess occupational risks have been found in workers who started their DOE or construction-related employment after 1980. Although occupational regulations promulgated by OSHA for asbestos went into effect around 1980, there is no evidence that they had a marked effect on occupational COPD risk among workers employed in DOE facilities after 1980.
5. The following statement in the Bulletin is confusing and misleading: "*The consensus of scientific data present in epidemiological studies document that a 20-year significant asbestos exposure threshold is associated with increased incidence of pulmonary dysfunction, including asbestosis.*"
- a. There is no evidence to support a requirement of 20 years of exposure, even for asbestosis. Risk is a function of many factors, including duration of exposure, intensity of exposure, and breathing rate. The study cited in Bulletin 16-02 [Occ Med Tox 5(12); 1-7, 2010] reported a 2.5 fold increase in obstructive airways disease among asbestos exposed workers, with a mean exposure of 16 years, but the study size is not large enough to stratify by different exposure groups. Another study cited in the Bulletin [Am J Epi 156:738-746, 2002] reported a trend associated with working 15 or more years in risky occupations. Neither study supports an exposure requirement of 20 years for simple causation, and much less so for the standard required by EEOICPA for acceptance of a claim.
 - b. More importantly, studies looking at exposure dose and latency for asbestosis should not be used to infer risk for COPD, or for COPD attributed to other types of exposures.
 - c. The study cited in 1.b (see in particular table IV) shows that even in the lowest quartile of exposure, there is significant occupational risk for developing COPD from a number of VGDF sources (as noted in point 3, above).
 - d. These data translate to a worker *with as little as five years of employment* with exposures to VGDFs can have a ten (10) percent increased risk of developing COPD, and this increased risk can be attributed to those occupational exposures.

Evidence in Support of an Expanded Presumption COPD Claims

We find that the data presented in the study cited in 1.b justifies an expansion of the presumption for compensation of COPD claims for the labor categories listed in Attachment 1 of the Bulletin 2016-02 in three major ways:

- a. **Covered exposures:** the following exposures should be considered to be presumptive because they impose a risk for COPD that is as great as the risk found in Bulletin to be presumptive for asbestos: Asbestos; silica; cement dust; engine exhausts; acids and caustics; welding, thermal cutting, soldering, brazing; metal cutting and grinding; machining aerosols; isocyanates, organic solvents, wood dust, molds and spores; and particulates not otherwise regulated (PNORⁱⁱⁱ).
- b. **Mixed exposures:** Further, because each of the labor categories identified in Attachment 1 of Bulletin 16-02 has been exposed to a mixture of toxic agents in the category of

- VGDFs that aggravate, contribute to, or cause COPD, it should be presumed that any claimant in one of these labor categories has had exposures to such agents.
- c. **Time of exposure:** Because these exposures continue to take place on DOE sites and many of them are unregulated, it should be presumed that any claimant in one of these labor categories has experienced exposures to toxic substances that cause, contribute to or aggravate COPD at any time period of employment covered by EEOICPA, up to the present time.
 - d. **Commonness of exposure:** For the labor categories in Attachment 1 of Bulletin 16-02, exposures to VGDFs are common and ubiquitous. In the study cited in 1.b, which includes these labor categories, only 1.4% of cases and 2.5% of controls reported no VGDF exposures (see Supplemental Materials, Table IV-S.)
 - e. **Duration of exposure.** Based on the evidence presented in the study cited in 1.b a duration of employment in a covered DOE facility of at least five years and with reported exposures to VGDF can be presumed to aggravate, contribute to, or cause COPD.
 - f. **Time since first exposure.** Based on the evidence presented above, a period of fifteen (15) years from first exposure to date of diagnosis of COPD can be presumed sufficient to aggravate, contribute to or cause COPD.

Proposed Alternative Presumption for Adjudication of COPD

We ask that OWCP consider replacing the presumption it has established in Bulletin 16-02 with the following alternative presumption:

1. Any claimant with a physician's diagnosis of COPD who worked in any covered facility and in any of the labor categories in Attachment 1 of Bulletin 16-02 for a period which in aggregate totals at least five years with reported VGDF exposure, and the time period from time of first reported exposure to VGDFs until date of diagnosis is at least fifteen (15) years, is presumed to have experienced sufficient exposure to toxic agents to aggravate, contribute to, or cause COPD.
2. Additionally, claims examiners should not rule out accepting claims for COPD even if the worker had less than 5 years of exposure or if the time period from first reported exposure until diagnosis is less than 15 years if a claimant has experienced high intensity exposures to VGDFs during work in a covered facility.

A Final Word of Caution

Professor Leslie Boden has pointed out that while presumptions lead to more efficient administration of claims that fall within them, they can also lead to claims examiners adopting a more severe attitude about claims that fall outside them (see attached, especially highlighted section on p. 328).

The Bulletin opens the door for a such an unintended bias on two levels for COPD claims with asbestos exposures after 1980 by stating: "*Alternatively, an Industrial Hygienist has provided a well-rationalized discussion of case-specific evidence opining that an employee (in any labor category) has had 20 years of significant asbestos exposure (any time period).*" Firstly, claims examiners will be more likely to reject any claim with *less than* 20 years of exposure, and second, will be more likely to require a greater burden of exposure evidence to fulfill the requirement of *significant exposure*. We urge you to offer training to your claims examiners on this potential bias.

Thank you for your consideration of these suggestions.

Sincerely,



Erich J. Stafford
Director of Safety and Health
North America's Building Trades Unions

Attachments:

Ringen K, Dement J, Welch LS, Bingham E, Quinn P, Chen A, Haas S. *Mortality of older construction and craft workers employed at Department of Energy (DOE) nuclear sites: Follow-up through 2011*. *Am J Ind Med* 58:152–167, 2015

Dement J, Welch L, Ringen K, Quinn P, Chen A, Haas, S. *A case-control study of airways obstruction among construction workers*. *Am J Ind Med* 58:1083-1097, 2015

Dement J et al. *A case-control study of airways obstruction among construction workers: supplemental materials*.

Boden L. Presumptive standards: Can they improve occupational disease compensation? In J.S. Lee and W.N. Rom, eds., *Legal and Ethical Dilemmas in Occupational Health*. Ann Arbor Sciences Press. 317-330, 1982.

¹ The referenced studies are:

Am J Epi 156:738-746, 2002: Hnizdo E, Sullivan PA, Bang KM, Wagner G. *Association between chronic obstructive pulmonary disease and employment by industry and occupation in the US population: a study of data from the Third National Health and Nutrition Examination Survey*.

Am J Respir Crit Care Med 170: 691-715; 2004; Guidotti TL, Miller A, Christiani D, Wagner G, Balmes J, Harber P, Brodtkin CA, Rom W, Hillerdal G, Harbut M, Green FYM. *American Thoracic Society Statement: Diagnosis and initial management of nonmalignant diseases related to asbestos*

JOEM 43(7): 623-629, 2001; Wang XR, Yano E, Wang M, Wang Z, Christiani DC. *Pulmonary function in long-term asbestos workers in China*.

Am J Ind Med 53: 224-240, 2010: Dement JM, Welch L, Ringen K, Bingham E, Quinn P. *Airways obstruction among older construction and trade workers at Department of Energy nuclear sites*.

Occ Med Tox 5(12); 1-7, 2010: Abejie BA, Wang X, Kales SN, Christiani DC. *Patterns of pulmonary dysfunction in asbestos workers: a cross-sectional study*.

² Fujimoto N1, Kato K, Usami I, Sakai F, Tokuyama T, Hayashi S, Miyamoto K, Kishimoto T. *Asbestos-related diffuse pleural thickening*. *Respiration*. 2014;88(4):277-84. doi: 10.1159/000364948. Epub 2014 Aug 28.

³ PNOR includes all mineral and inorganic "inert or nuisance dusts" without specific individual U.S. Occupational Safety and Health Administration Permissible Exposure Limits (PEL). See OSHA. *Chemical Sampling Information: Particulates Not Otherwise Regulated (Total Dust)* Washington, DC. 2015; NIOSH *Pocket Guide to Chemical Hazards: Particulates not Otherwise Regulated*. Atlanta, GA, 2015.