Testimony of

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On Asbestos Related Diseases and Senate Bill 852
and the Bates-White Analysis of Future Claims
Before the Senate Judiciary Committee
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Chairman Specter, Senator Leahy, and members of the committee, thank you for the opportunity to appear before the committee to testify on asbestos-related diseases. I had the honor of testifying before this committee both in June 2003 and earlier this year on this important public health matter, and appreciate the chance to again assist in the development of legislation to establish a trust fund to compensate workers with these diseases.

The specific questions being addressed are raised by a recent report from Bates and White, LLC: Analysis of S. 852 Fairness in Asbestos Injury Resolution (FAIR) Act. . This report, prepared on behalf of the American Legislative Exchange Council (ALEC), sets forth a series of estimates on projected claims and costs of the proposed Asbestos Trust Fund that are significantly higher than other estimates prepared by other groups. The report's sponsors, including ALEC, have been strong advocates of very restrictive medical criteria bills that would bar many seriously ill asbestos disease victims from even bringing forward a claim for injury in the tort system. One of the key conclusions of this report is that compensating lung cancers among individuals with pleural scarring will cause the trust to fail. However, individuals who have lung cancer with pleural plaque in combination with substantial occupational exposure to asbestos must be compensated under this trust fund. These are asbestos-related lung cancers; the scientific literature is very clear on this. If current level of the trust is insufficient to compensate these individuals, we must increase the funding. Eliminating this group of workers from compensation under the trust would undermine the principles on which the trust is founded.

There are several problems with the Bates and White report I want to highlight:

? The population at risk used by Bates and White includes many individuals without exposure to asbestos, thus overstating the potential number of cancers eligible for compensation
? A great number of the individuals in the Bates and White population at risk who have had asbestos exposure are not eligible for compensation under S. 852, again overstating the potential number of cancers eligible for compensation
? The estimates of the prevalence of pleural disease in the occupationally exposed population too high, which leads to an overstatement of the number of cancers eligible.

By way of background, I am a physician with board certification in both Occupational and Environmental Medicine and Internal Medicine. I received my medical degree from the State University of New York at Stony Brook, and have held faculty positions at the Schools of Medicine at Albert Einstein, Yale, and George Washington Universities. I have extensive experience in diagnosis and treatment of asbestos-related diseases. I have been in occupational medicine practice for more than 20 years, and a substantial part of my practice has always been devoted to examination of workers exposed to asbestos.

In addition, I have many years of experience in medical surveillance programs for asbestos. Since 1987, I have been the medical advisor to the Sheet Metal Occupational Health Institute Trust (SMOHIT), a joint labor-management organization within the sheet metal industry established to provide medical examinations for sheet metal workers exposed to asbestos and other respiratory hazards. To date, SMOHIT has provided medical examinations for more than 30,000 workers. It is the largest epidemiological database of asbestos-exposed workers in the country. I also developed similar medical screening programs for the Laborers National Health and Safety Fund and other construction trades, in conjunction with the Occupational Health Foundation. I currently serve as medical director for a Department of Energy-funded medical screening program to provide medical examinations for former construction workers at a number of former atomic weapons production facilities. In each of these programs, I have designed programs to detect asbestos-related disease, and designed algorithms for the examining physicians to use in interpretation of the results. In addition, I have been active in efforts to improve validity and reliability of x-ray reading to detect asbestos related disease in the United States; this work included publication of a paper on variability between readers' classification of x-rays using the International Labor Organization Guide to Classification of Pneumoconiosis, based on an analysis of results from these screening programs.

I currently am medical director at The Center to Protect Workers Rights, a research institute devoted to improving health and safety in the construction industry.

However, before I address specific criticisms of the Bates and White report, let me re-state the rationale for the trust fund, the process that lead to the development of the medical criteria, and some key scientific facts about asbestos and cancer.

? All parties involved in development of the bill agreed that the fund's goal is to provide compensation to those who are sick from asbestos-related diseases.

? Individuals who have lung cancer with pleural plaque and substantial occupational exposure to asbestos must be compensated under this trust fund. These are asbestos-related cancers, and those individuals who develop these cancers are certainly sick. If the current funding is insufficient to compensate these individuals it should be increased.

? The medical criteria that were originally agreed upon by the Judiciary Committee in 2003 in conjunction with S. 1125 were developed carefully, in a bipartisan manner, and were based on sound science. The criteria took into account the uncertainty inherent in determining causation for each individual case. The criteria included compromises by all parties that limit compensation to a subset of all the cases of pleural plaque, asbestosis, lung cancer and other cancers that occur in asbestos-exposed groups. In my view those criteria were conservative. This

year, during the mark-up on the current bill, S. 852, those criteria were changed to be more restrictive, in particular eliminating the category of lung cancers with significant asbestos exposure, but no x-ray changes. This change is contrary to the scientific evidence and will exclude many victims of asbestos related lung cancers from being compensated. The cancers now excluded are asbestos-related cancers, and those individuals who develop these cancers are also sick. Again, if the current funding is insufficient to compensate these individuals, it should be increased.

? The compensation set for each level under the fund takes into account the uncertainty in determining causation for each individual case of cancer. For example, the values for lung cancer compensation are 25-50% of those for mesothelioma not because a death from lung cancer is worth less than a death from mesothelioma, but because there is more uncertainty in the causation of each lung cancer than for mesothelioma.

Specific comments on Bates and White report: Analysis of S. 852 Fairness in Asbestos Injury Resolution (FAIR) Act.

(1) Overestimation of the population eligible under S. 852:

The Bates and White estimate of the number of projected claims among people with lung and other cancers occupationally exposed to asbestos is much higher than other estimates developed for this legislation by Goldman Sachs, the Congressional Budget Office, and others. This difference arises because the Bates and White estimate of the population exposed to asbestos is larger than previous ones derived from William Nicholson's estimates in his 1982 publication. This is so because their approximation assumes the entire exposed population qualifies for compensation under the fund, and because this estimate assumes that everyone with a cancer in this population will file a claim. There may be many workers who develop asbestos-related lung cancer or other cancer as defined by S. 852, but I cannot accept Bates and White's estimate of how many that will be.

In his answer to Senator Specter's questions, Mr. Bates described that his population at risk included the 283 occupations in 142 industries classified as having potential asbestos exposure in the Cocco and Dosemeci analysis , supplemented by some additional exposure information available to Bates and White. The list of occupations and industries used by Cocco and Dosemeci is a list of jobs with potential exposure to asbestos, but we cannot and should not assume that every worker in every one of those jobs had such exposure. For example, Cocco and Dosemeci consider all machine operators and mechanics to have potential exposure to asbestos; some machine operators or mechanics may have worked in plants with friable asbestos in place, worked in asbestos manufacturing facilities, or otherwise have had exposure to asbestos; many others would not have had occupational exposure. Occupations with a lower likelihood of exposure are included in the Bates and White model, such as architects, foresters, cooks, barbers and manicurists. S. 852 will provide compensation to specific claimants exposed to asbestos, not to every person who ever worked in an occupation with potential exposure to asbestos.

S. 852 requires that claimants meet several criteria before being compensated, and the criteria differ for each level of disease and compensation. Levels II and higher (except for mesothelioma)

all require, at a minimum, five years of substantial occupational exposure, defined in the bill as follows:

The term `substantial occupational exposure' means employment in an industry and an occupation where for a substantial portion of a normal work year for that occupation, the claimant--
(i) handled raw asbestos fibers;
(ii) fabricated asbestos-containing products so that the claimant in the fabrication process was exposed to raw asbestos fibers;
(iii) altered, repaired, or otherwise worked with an asbestos-containing product such that the claimant was exposed on a regular basis to asbestos fibers; or
(iv) worked in close proximity to other workers engaged in the activities described under clause (i), (ii), or (iii), such that the claimant was exposed on a regular basis to asbestos fibers.

In addition to documentation of substantial occupational exposure, the claimant must provide supporting medical documentation, such as a written opinion by the examining or diagnosing physician that (1) establishes asbestos exposure as a substantial contributing factor in causing the pulmonary condition in question; and (2) excludes other more likely causes of a pulmonary condition when that condition is asbestosis. By ignoring these requirements of S. 852, Bates and White have overstated the population eligible for compensation.

It can not be stated too strongly that all workers exposed to asbestos have a risk of asbestos-related disease, as Dr. Nicholson clearly shows. Today, we are not talking about risk for asbestos-related disease, but compensation for asbestos-related diseases according to specific requirements and criteria as set forth in S. 852. As noted in the introduction, many workers with serious asbestos-related disease are not eligible for compensation under this bill, due to changes in the medical criteria that are contrary to the scientific evidence.

I agree with the assessment from Bates and White that asbestos exposure has been identified in many other occupations in addition to those identified in Dr. Nicholson's report, and that Dr. Nicholson did not include all workers in all exposed occupations and industries in his estimates. I also agree that the potential number of individuals with lung cancers and other cancers eligible for compensation under this bill is large. However, the Bates and White estimates push the limits of the available information to the highest end of that potential population and substantially overstate the cost to the fund. I am not saying Dr. Nicholson's estimates include all workers exposed to asbestos, or all cancers caused by asbestos exposure. For the purpose of S. 852, it is less important how many workers were exposed to asbestos than how many workers will meet the medical criteria set forth in the bill and, in the final analysis, file a claim. All estimates of this latter number have a great deal of uncertainty to them, as highlighted by the Congressional Budget Office (CBO) in its cost estimate on S. 852. However, the Bates and White population exposed estimate includes millions of workers who were or may have been exposed to asbestos but who would not likely be eligible for compensation under S. 852.

(2) Overestimation of the population eligible for Level VI, VII, and VIII:

The Bates report substantially errs since it assumes that all individuals in the exposed population are eligible for compensation for lung cancer if they have pleural disease. The report also ignores

the requirement for a specific number of weighted years of substantial occupational exposure for Level VII.

Weighted exposure is determined by adjusting the number of years required in any specific occupation to account for different intensities of exposure in that occupation. To being with, substantial occupational exposure means that each year that a claimant's primary occupation, during a substantial portion of a normal work year for that occupation, involved working in areas immediate to where asbestos-containing products were being installed, repaired, or removed under circumstances that involved regular airborne emissions of asbestos fibers, counts as one year of substantial occupational exposure. Substantial occupational exposure is adjusted for occupations that had heavy or very heavy exposure as follows: heavy exposure: Each year that a claimant's primary occupation involved the direct installation, repair, or removal of asbestos-containing products counts as 2 years of substantial occupational exposure; very heavy exposure: means that for each year that a claimant's primary occupation, was in primary asbestos manufacturing, a World War II shipyard, or the asbestos insulation trades counts as 4 years of substantial occupational exposure.

In addition to the intensity of exposure, the weighting takes into account reduction in asbestos exposure over time. Each year of exposure that occurred before 1976 is counted at its full value, each year from 1976 to 1986 is counted as 1/2 of its value, and years after 1986 are counted as 1/10 of its value

This concept of weighted years is then applied to each Level as follows:

? For Level VI, primary colorectal, laryngeal, esophageal, pharyngeal, or stomach with bilateral asbestos related disease, a claimant must have evidence of 15 or more weighted years of substantial occupational exposure to asbestos. In addition, these cases are also sent for individual review to determine compensability.
? For Level VII, lung cancer with pleural disease, a claimant must have evidence of 12 or more weighted years of substantial occupational exposure to asbestos.
? For Level VIII, lung cancer with asbestosis, a claimant must have evidence of either 8 or 10 or more weighted years of substantial occupational exposure to asbestos, depending on the severity of the asbestosis.

Bates and White assume that a barber who started work in 1970 has the same risk of asbestos related lung cancer or other cancer as an insulator who worked in a shipyard during World War II, and both have the same eligibility under S. 852 . Clearly this is not the case.

(3) Overestimation of the prevalence of pleural disease in eligible population

Although I think I have made it clear that S. 852 will not compensate all asbestos-exposed workers with pleural disease, I still want to address the estimates in the Bates and White report on the prevalence of pleural disease in eligible population. The report estimates the number of lung cancers with pleural disease (Level VII) based in part on an estimate of the proportion of his eligible population with pleural scarring. The intensity of the exposure required for the eligible population determined the proportion of pleural disease expected. The tables supplied would allow an estimate of pleural disease ranging from 4% in the "low" exposure group to 50% among

insulators, so clearly the overall mean rate of pleural disease will depend on what proportion of the eligible population is drawn from each group. As the estimated prevalence of pleural disease increases, the number of eligible workers must decrease; Bates and White does not do this as he increases his estimate of the prevalence of pleural disease from 10% to 25%. There is not sufficient data to estimate the prevalence of asbestos-related pleural disease in the Bates and White "population at risk."

I have been involved with screening sheet metal workers for asbestos related disease since 1986. Over time, I have seen a decline in the proportion of participants who have asbestos-related disease. Those sheet metal workers first exposed after 1970 have lower rates of pleural disease than those exposed in prior years , an observation in keeping with the reductions in asbestos exposure through the 1970s and 1980s. The occupational studies cited by Bates and White describe prevalence of pleural disease found in screenings between 1965 and 1988. These estimates are likely to be higher than what we would see in current population-based data. Because of the wide range of estimates for prevalence of pleural disease, the variation among exposed groups, and potential changes over time, there is not sufficient data to estimate the overall prevalence of asbestos-related pleural disease in the Bates and White "population at risk." Such an estimate would require information on each occupation included in the population and a weighting of the estimate by the proportion of each occupation to be anything more than a guess.

(4) Uncertainty in the estimates

As stated earlier, the Bates-White estimates are significantly higher than other estimates on projected claims and costs for an asbestos trust fund legislation prepared by CBO and experts on behalf of the insurance industry, defendants and trial lawyers. The main reasons for these differences appear to be incorrect assumptions about the size of the eligible population and then also about the level of claims filing in a new administrative system.

There is uncertainty about the number of claims that may be filed under an asbestos trust fund and the funding that will be needed to compensate individuals suffering from asbestos-related diseases. The AFL-CIO and its Building and Construction Trades Department have had and continue to have concerns that the level of funding will be sufficient, particularly in the early years when the number of claims will be the greatest. The original legislation had provided for contingent funding from defendants and insurers if needed. But the present legislation instead provides for a return to the tort system in the event that funding is inadequate. In my view, it would be far preferable for the bill to include a mechanism to ensure that adequate funding was available to compensate all eligible claims. It is in no one's interest, particularly for claimants, for the trust fund to be underfunded and fail. But at a minimum the return to the tort system in the current bill must be maintained so that victims do not bear the risk of uncertainty and possible underfunding of the legislation.

(5) It is essential to retain compensation of Level VI and Level VII under the Asbestos Trust Fund

The Bates-White Report focuses much of its analysis on the cost of compensation of victims with lung cancer and pleural disease (Level VII) and those with "other cancers" including

gastrointestinal, esophageal and laryngeal cancers (Level VI). The thrust of the Bates report is that these asbestos related diseases are not being compensated in the current tort system, but they would be compensated in the new asbestos trust fund. While not explicitly stated, the report implies that these asbestos related diseases should not be compensated. Indeed, the report's sponsors, including ALEC, have been strong advocates of very restrictive medical criteria bills that would bar many seriously ill asbestos disease victims from even bringing forward a claim for injury in the tort system.

It is important to point out that asbestos-related lung cancers with pleural disease and "other" asbestos-related cancers are being compensated in the current system. Indeed all of the asbestos bankruptcy trusts that have been established to compensate victims for these diseases, and for most of these trusts, the criteria are not as stringent as those in S. 852.
These diseases are being compensated in the current system and are eligible under S. 852 because the scientific evidence establishes that significant exposure to asbestos greatly increases the risk of lung cancers and other cancers. These findings were established through numerous scientific studies which were utilized by Dr. William Nicholson in his original estimates of future asbestos-related cancers. These findings - that asbestos exposure significantly increases the risk of lung cancer and other cancers - have also been endorsed by government scientific and regulatory agencies.

Recent epidemiological studies of asbestos-exposed workers conducted by Dr. Mark Cullen of the Yale School of Medicine and other researchers have reinforced these earlier findings. A large intervention study that examined and followed more than 3,000 heavily exposed asbestos workers found significant increased lung cancer risk. Controlling for smoking and other factors, Cullen found that both increased years of exposure and pleural disease were strong independent predictors for the development of lung cancer. The increased risk of lung cancer was similar in workers with pleural disease and workers with asbestosis, and those workers with more than 10 years of asbestos exposure. A recently published paper, which examined the incidence of colo-rectal cancer in this same group of asbestos-exposed workers, found that the risk of such cancers was significantly increased among those workers with pleural disease or asbestosis .

As I stated at the outset of my testimony, one of the underlying rationales behind the asbestos trust fund legislation was that the current system historically has not equitably compensated victims of asbestos related disease. The goal was to create a system that compensated individuals who were sick from asbestos-related disease and not compensate individuals who were not sick or not impaired. To that end, medical criteria were agreed to that provided no monetary compensation to those individuals with non-malignant asbestos-related diseases, but with no impairment. The medical criteria and awards focused on compensating individuals with the most serious asbestos-related diseases. The Bates-White analysis incorrectly objects to this basic premise of the legislation and suggests that in addition to eliminating monetary compensation for those individuals without impairment, there should be no compensation for victims with clear asbestos-related cancers. This is unacceptable and contravenes the basic foundation on which the fund is established.

Conclusion:

My analysis of the Bates and White estimates of claims finds the assumptions used result in a large over-estimate of the claims and costs for S. 852. As I have described, a great number of the individuals in the population at risk as defined by Bates and White are not eligible for compensation under S. 852. Many of these workers may be at risk for asbestos-related disease, but not all asbestos-related disease is eligible for compensation from this fund. The estimate of claims is also inflated by the assumption that 100% of individuals with cancer in his population at risk will file claims under S. 852.

Many Americans will die of asbestos-related cancer over the next 25 years. Even though exposure to asbestos has been reduced due to product substitution and exposure controls, exposures over past decades will continue to cause lung cancer, mesothelioma, and other cancers well into this century. By proposing S. 852, the Senate Judiciary Committee has acknowledged this legacy of disease. There is a good deal of uncertainty in any estimate of the number of these cancers that will end up as a claim under S. 852, and the fund needs to take this uncertainty into account. The Bates and White analysis provides nothing useful in this regard.