

**H.R. 2561, IMPROVING ACCESS TO WORKERS'
COMPENSATION FOR INJURED FEDERAL WORKERS
ACT AND H.R. 697, FEDERAL FIRE FIGHTERS
FAIRNESS ACT OF 2005**

HEARING

BEFORE THE
SUBCOMMITTEE ON WORKFORCE PROTECTIONS
OF THE
COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED NINTH CONGRESS

FIRST SESSION

May 26, 2005

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**H.R. 2561, IMPROVING ACCESS TO WORKERS'
COMPENSATION FOR INJURED FEDERAL
WORKERS ACT AND H.R. 697, FEDERAL FIRE
FIGHTERS FAIRNESS ACT OF 2005**

Thursday, May 26, 2005

U.S. House of Representatives

Subcommittee on Workforce Protections

Committee on Education and the Workforce

Washington, DC

The Subcommittee met, pursuant to notice, at 10:33 a.m., in room 2175, Rayburn House Office Building, Hon. Charlie Norwood [Chairman of the Subcommittee] presiding.

Present: Representatives Norwood, Kline, Marchant, Price, Drake, Owens, Kucinich, Woolsey, and Bishop.

Staff present: Kevin Frank, Professional Staff Member; Ed Gilroy, Director of Workforce Policy; Donald McIntosh, Legislative Assistant; Jim Paretto, Workforce Policy Counsel; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Deborah L. Emerson Samantar, Committee Clerk/Intern Coordinator; Kevin Smith, Senior Communications Advisor; Margo Hennigan, Legislative Assistant/Labor; Marsha Renwanz, Legislative Associate/Labor; Peter Rutledge, Senior Legislative Associate/Labor.

Mr. NORWOOD. A quorum being present, the Subcommittee on Workforce Protections of the Committee on Education and the Workforce will now come to order.

We are meeting today to hear testimony on H.R. 697, the Federal Fire Fighters Fairness Act of 2005, and H.R. 2561, the Improving Access to Workers Compensation for Injured Federal Employees Act.

Under Committee Rule 12(b), opening statements are limited to the Chairman and Ranking Minority Member. If other Members have statements, they, of course, will be included in the record.

With that, I ask unanimous consent for the hearing record to remain open for 14 days.

This will allow Members' statements and other extraneous material referenced during the hearing to be included in the hearing record.

Without objection, so ordered.

STATEMENT OF HON. CHARLIE NORWOOD, CHAIRMAN, SUB-COMMITTEE ON WORKFORCE PROTECTIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Both of these bills would amend the Federal Employees' Compensation Act, otherwise known as FECA. FECA is the comprehensive workers' compensation program for Federal employees. The program provides important benefits and services to Federal workers who have suffered economic hardship from a work-related injury or death.

The Subcommittee has held a number of oversight hearings on the FECA program over the past several years. The last hearing, held in May of last year, provided a broad overview of the FECA program.

We looked at what could be done to maximize the benefits for workers and improve the efficiency and effectiveness of the program.

Today's hearing reinforces those themes and will focus on two proposals that would increase access to the program for injured Federal workers.

Our first panel of witnesses will testify on H.R. 697, a bipartisan bill introduced by Representative Jo Ann Davis. The bill would create a presumptive disability under the law such that certain diseases incurred by a Federal firefighter would be presumed to be work-related.

Our second panel of witnesses will testify on H.R. 2561, a bipartisan bill that Rob Andrews, my colleague on the Full Committee, and I introduced earlier this week. H.R. 2561 would allow injured Federal workers to submit medical documentation signed by a physician assistant or a nurse practitioner in support of a claim for benefits.

This is an important bill that would improve access to compensation benefits for injured Federal workers, especially those in rural areas with limited options for medical treatment.

I would like to thank the witnesses for making themselves available to share their expertise with us today. We appreciate you taking time out of what we know is a busy schedule to appear before the Subcommittee, and we look very forward to your testimony.

I now yield to the distinguished gentleman from New York, the Ranking Member on the Subcommittee, Major Owens, for his opening statement.

[The prepared statement of Chairman Norwood follows:]

Statement of Hon. Charlie Norwood, Chairman, Subcommittee on Workforce Protections, Committee on Education and the Workforce

The Subcommittee is meeting today to hear testimony on two bills: H.R. 697, the "Federal Firefighters Fairness Act of 2005," and H.R. 2561, the "Improving Access to Workers' Compensation for Injured Federal Workers Act."

Both bills would amend the Federal Employees' Compensation Act, otherwise known as "FECA." FECA is the comprehensive workers' compensation program for federal employees. The program provides important benefits and services to federal workers who have suffered economic hardship from a work-related injury or death.

This Subcommittee has held a number of oversight hearings on the FECA program over the past several years. The most recent hearing, held in May of last year, provided a broad overview of the FECA program. We looked at what could be done to maximize the benefits for workers and improve the efficiency and effectiveness

of the program. Today's hearing reinforces those themes, and will focus on two proposals that would increase access to the program for injured federal workers.

Our first panel of witnesses will testify on H.R. 697, a bipartisan bill introduced by Representative Jo Ann Davis. The bill would create a "presumptive disability" under the law, such that certain diseases incurred by a federal firefighter would be presumed to be work-related.

Our second panel of witnesses will testify on H.R. 2561, a bipartisan bill that my colleague on the full committee, Rob Andrews, and I introduced earlier this week. H.R. 2561 would allow injured federal workers to submit medical documentation signed by a physician assistant or a nurse practitioner in support of a claim for benefits. This is an important bill that will improve access to compensation benefits for injured federal workers, especially those in rural areas with limited options for medical treatment.

I would like to thank the witnesses for being available to share their expertise with us today. We appreciate you taking time out from your busy schedules to appear before the Subcommittee. We look forward to your testimony.

I now recognize the gentleman from New York, the Ranking Member on the Subcommittee, Major Owens, for his opening statement.

**STATEMENT OF HON. MAJOR R. OWENS, RANKING MEMBER,
SUBCOMMITTEE ON WORKFORCE PROTECTIONS, COM-
MITTEE ON EDUCATION AND THE WORKFORCE**

Mr. OWENS. Thank you very much, Mr. Chairman. I appreciate the fact that today the task before us is a bipartisan and positive one.

As we approach Memorial Day, I really thought that we are going to do some positive things for working families. Working families, of course, bear the brunt of the sacrifices in the battlefields of the world for our nation. They are bearing that burden in Iraq now, and they did so in Vietnam and on D-Day and the Battle of the Bulge. Ninety-five percent of the people in the armed forces are from working families, and we look forward to the day when we have a Department of Labor and a government and administration which cares more for our working families.

Certainly today is an unusual and very much appreciated step in the direction of trying to improve things for working families.

I am very pleased that this hearing focuses on bills designed to strengthen protections for American workers, in contrast to legislation that we often have which subverts or undermines such safeguards. Both bills before us this morning would enhance worker protections afforded by the Federal Employees' Compensation Act, FECA.

The immediate aftermath of the devastating terrorist bombing attacks on the Murrah Federal Building in Oklahoma City and the World Trade Center in New York City remind us all of just how crucial the FECA program can prove to be. Services provided under FECA, for example, proved invaluable in assisting surviving family members of those killed in the Oklahoma City bombing.

Likewise, medical care tied to the FECA program helped make the difference for some of the workers wounded during the tragic events of 9/11 between a faster recovery and a series of risky health setbacks.

In addition to providing critical assistance in the case of national emergencies, over the years FECA has helped countless other Federal works injured or made ill in the course of carrying out their duties, as well as surviving family members in the event of worker deaths.

Let me turn now to H.R. 697, the first bill before us at this morning's hearing.

This bill would give Federal firefighters the same presumptive disability protections already afforded firefighters in 40 states. In other words, the disability or death of Federal firefighters from a range of specified diseases would be presumed as a direct result of occupational exposure.

The exposure of firefighters to certain infectious diseases include tuberculosis, HIV, hepatitis, rabies, has received more press attention that some of the other diseases specified in this bill.

Yet, the connections between the day-to-day duties of fire protection personnel, including firefighters, paramedics, emergency medical technicians, rescue workers, as ambulance and hazardous materials workers, and there are increased risks of exposure to infectious illnesses, a range of cancers, and heart and lung diseases, have already been well documented.

I understand that the lead sponsor of H.R. 697, Representative Jo Ann Davis, will testify on the first panel of witnesses, and I ask her to add me as a cosponsor to this important bill. The lead cosponsor of H.R. 697, Representative Lois Capps, also wanted to be here today to testify, but she had a scheduling conflict.

Mr. Chairman, I ask that a written statement by Representative Capps be included in the record in its entirety.

Mr. NORWOOD. So ordered.

Mr. OWENS. At this juncture, I would like to acknowledge Mr. Joe Shufro, who is Mr. Occupational Health and Safety himself in New York State, Mr. Shufro of the New York Committee on Safety and Health, and I want to welcome him as an important witness to this hearing.

Mr. Shufro and NYCOSH have played a pivotal role in addressing the critical health problems for workers and residents that emerge and are still emerging as a result of the devastation wrought by the attacked of 9/11. The clean-up workers of Ground Zero deserve the same presumptive disability protections that H.R. 697 would grant to Federal firefighters.

We need to do much more than just wax eloquently about the debt we owe these brave workers, many of whom volunteered to clean up Ground Zero at great personal risk to themselves and their families.

We need to provide these workers, a number of whom will never be able to work again, with real medical relief and wage replacement.

It is absolutely unconscionable that the Bush administration in the fiscal 2006 budget request is attempting to rescind more than \$120 million in workers compensation funds for the 9/11 workers. Furthermore, it is a disgrace that Governor Pataki, Governor of New York, is refusing to sign bills to afford presumptive disability protections to 9/11 workers. I do not know any issues that have more to do with morality than these.

Until we address the critical needs of these brave workers, as well as all the residents of Manhattan, Brooklyn, and other New York City burroughs affected, we have failed to meet our moral responsibility.

So, I commend Mr. Shufro and his great organization for remaining on the front lines of this important fight.

I further ask, Mr. Chairman, that a New York Post article of May 8, 2005, which was posted on the NYCOSH website, be entered into the record its entirety. The article is entitled "W plan stiff heros."

[The article referred to is on page 48 of this document.]

Mr. NORWOOD. Do we get a chance to look that over? I am sure—

Mr. OWENS. Yes.

Mr. NORWOOD [continuing]. That will not be any problem, just give us a chance to look it over.

Mr. OWENS. It is from the New York Post. It's a great paper.

Mr. NORWOOD. I do not read any New York papers, you know. I have enough trouble with the Atlanta Journal.

Mr. OWENS. My time is almost up, but I would like to make a few comments about H.R. 2561 before closing.

Mr. Chairman, your bill is an important piece of legislation, as you know. I cosponsored it during the 108th Congress.

However, the American Nurses Association and Service Employees International Union recently pointed out to me that the bill would be improved immeasurably by substituting a broader category of, quote "advanced practice registered nurses" for the narrow subset of nurse practitioners.

For example, certified nurse anesthetists administer some 65 percent of all anesthetics delivered to U.S. patients every year, but they are precluded from FECA coverage in your bill.

Mr. Chairman, I request that a forthcoming written statement by the American Nurses Association about this issue be later included in the record.

In closing, I applaud you for holding this hearing.

I look forward to hearing the testimony of all the witnesses.

Mr. NORWOOD. Thank you very much, Mr. Owens.

I am, frankly, delighted that you approve of this hearing.

I feel it incumbent upon me to make sure you got home for this vacation in a good mood, so maybe this will start us off.

We, today, have two panels of witnesses.

Our first panel will testify on H.R. 697. We will begin with testimony offered by the gentlelady from Virginia, the Honorable Jo Ann Davis, the first elected female Republican to the U.S. House of Representatives from the Commonwealth.

Representative Davis has represented the First District of Virginia since she was elected in November of 2000. In addition to her Committee work on the House Armed Services Committee, International Relations, and the Permanent Select Committee on Intelligence, Representative Davis serves as Chair of the Intelligence Committee's Subcommittee on Intelligence Policy. We look forward to hearing her insight, and as the sponsor of H.R. 697, on the need for this important legislation.

Next, we will hear from Mr. James Johnson, 16th District Vice President of the International Association of Fire Fighters, located right here in Washington, D.C., and the final witness on our first panel is Mr. Joel Shufro, executive director of the New York Committee on Safety and Health.

Before the gentlelady from Virginia begins her testimony, I would like to remind our Members that we will impose a 5-minute limit on all questions. I understand Ms. Davis can only be with us for a limited time today and must excuse herself after offering her testimony. Therefore, if any of our Members have questions for her, we will forward them to her and include the answers and questions in the hearing record.

I would like to point out the timer system up there. Red means time's up. Green means it's time to start. Yellow gives you a little notion that we are getting close.

We all have a copy of your testimony.

I would ask you to summarize in that 5-minute period so we can run a orderly hearing here.

Representative Davis, you are recognized for 5 minutes.

**STATEMENT OF HON. JO ANN DAVIS, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF VIRGINIA**

Ms. DAVIS. Thank you, Mr. Chairman, and Mr. Owens, we will make sure you are a cosponsor right away.

Mr. Chairman and Members of the Subcommittee, I want to thank you for the opportunity to discuss with you an issue that is very important to me and even more important to the brave men and women who defend Federal installations around the country.

As the wife of a now-retired municipal battalion fire chief, I know the dangerous work that our firefighters do, and we owe them a tremendous debt of gratitude. That is why I am proud to sponsor H.R. 697, the Federal Firefighters Fairness Act of 2005.

Federal firefighters risk their lives protecting our nation's most vital interest.

They face some of the most difficult and hazardous working conditions in the country, guarding military installations, nuclear facilities, VA hospitals, and the like.

As such, they are daily exposed to stress, smoke, heat, toxic substances that greatly increase their chances to contract heart disease, lung disease, and various types of cancer. May I point out that many times they do not even know when they are being exposed to these hazardous materials.

A paper by the International Association of Fire Fighters states that during the latest 10-year period, professional firefighters experienced 342 line-of-duty deaths, 502 occupational disease deaths, 343,861 injuries, and 6,632 forced retirements due to occupationally induced diseases or injuries, and almost monthly, my husband calls me to tell me about a young fellow or a young woman from our local fire department that has either contracted cancer or heart disease or some disease that they should not have contracted at an early age, and we are losing firefighters much more quickly than we should be.

The IFF report continues that, of the injuries reported, approximately 80 percent occur while at the emergency scene. Data shows that more than 40 percent of all firefighters can be expected to be injured at least once during the course of the year. Occupational diseases such as heart disease and cancer constitute more than 90 percent of all reported firefighter deaths when their occurrences are combined. Additionally, the IFF reports that technology has

created a distinct difference in the modern firefighting environment. The report explains that firefighters are often exposed to extremely high concentrations of a large number of toxic and carcinogenic chemical compounds.

Chemicals such as carbon monoxide and soot are natural products of combustion and have always been present at fires. However, the combustion of modern synthetic and plastic material produces many highly toxic and carcinogenic compounds that were not found in fires three or four decades ago.

As a result, the modern firefighter faces a number of potentially serious new health threats, including many that can develop over several years of exposure.

Currently, 40 states have presumptive disability laws that presume that cardiovascular diseases, certain cancers and infectious diseases are job-related for purposes of workers compensation and disability retirement unless proven otherwise, but our Federal firefighters' compensation and retirement benefits are not provided with the same benefits that these 40 states provide.

This requirement places a substantial burden on Federal firefighters who suffer from occupational diseases, because they have to, by Federal law, prove that they came into contact with these substances, which is—and specify where the precise cause of the injury or illness comes from. It is very hard to do, because firefighters do not know, many times, when they are exposed to these substances.

To give you a for-instance, when I was pregnant with our first child, my husband contracted hepatitis. It has stayed with him forever, and it has caused a lot of problems for him, and he contracted it, we think, on an ambulance. We do not know from who, what, when, where.

This happens even more so to our Federal firefighters because of the types of buildings and types of fires and incidences that they have to go on.

The burden of proof is unacceptably high for firefighters to meet, because they are constantly exposed to a myriad of harmful substances and dangerous conditions. Working in such a hazardous environment, it is often impossible to precisely identify when and where a firefighter contracted a certain disease.

My legislation, H.R. 697, simply creates the presumption that Federal firefighters who become disabled by heart and lung disease, certain cancers, and certain other infectious diseases contracted the illness on the job. Additionally, if a firefighter contracts an illness that is clearly not caused by his or her firefighting duties, my bill recognizes that the Federal Government should not be responsible for covering those costs, and I have much more to say here, Mr. Chairman, but I know how important and how vital the time is, and like you say, you have my written statement.

I just cannot stress enough how important it is that our Federal firefighters get the same benefits that are offered to firefighters in 40 other states.

Our Federal firefighters, in my opinion, are put at much more risk, especially since 9/11, than many of our state and local firefighters.

I hope that the Committee will read my complete statement, that you will listen carefully to the testimonies today, and that if you have any questions, you will contact me, and I may be a little prejudiced, because I'm married to a firefighter, but after 30 years of being married to him, I have seen what happens with our firefighters, and I just ask for your consideration of the bill.

Thank you, Mr. Chairman.

[The prepared statement of Hon. Davis follows:]

Statement of Hon. Jo Ann Davis, a Representative in Congress From the State of Virginia

Mr. Chairman, and Members of the Subcommittee, I want to thank you for the opportunity to discuss with you an issue that is very important to me, and even more important to the brave men and women who defend federal installations around the country. As the wife of a now-retired municipal battalion fire chief, I know firsthand the vital and dangerous work that our nation's firefighters perform every single day. We all owe them a tremendous debt of gratitude. That is why I am proud to sponsor H.R. 697, the Federal Firefighters Fairness Act of 2005.

Federal firefighters risk their lives protecting our nation's most vital interests. They face some of the most difficult and hazardous working conditions in the country guarding military installations, nuclear facilities, and VA hospitals. As such, they are daily exposed to stress, smoke, heat, and toxic substances that greatly increase their chances to contract heart disease, lung disease, and various types of cancer.

A paper by the International Association of Fire Fighters (IAFF) states that during the latest ten year period, professional firefighters experienced 342 line-of-duty deaths, 502 occupational disease deaths, 343,861 injuries and 6,632 forced retirements due to occupationally induced diseases or injuries. The IAFF report continues that of the injuries reported, approximately 80 percent occur while at the emergency scene. Data shows that more than 40 percent of all firefighters can be expected to be injured at least once during the course of a year. Occupational diseases such as heart disease and cancer constitute more than 90 percent of all reported firefighter deaths when their occurrences are combined.

Additionally, the IAFF reports that technology has created a distinct difference in the modern firefighting environment. The report explains that firefighters are often exposed to extremely high concentrations of a large number of toxic and carcinogenic chemical compounds. Chemicals such as carbon monoxide and soot are natural products of combustion and have always been present at fires. However, the combustion of modern synthetic and plastic materials produces many highly toxic and carcinogenic compounds that were not found in fires even three or four decades ago. As a result, the modern firefighter faces a number of potentially serious new health threats, including many that can develop over several years of exposure.

Currently, 40 states have presumptive disability laws that presume that cardiovascular diseases, certain cancers and infectious diseases are job-related for purposes of workers compensation and disability retirement unless proven otherwise. However, under federal law, compensation and retirement benefits are not provided to federal employees who suffer from occupational illnesses unless they can specify the precise cause of a disease in order for it to be considered job-related. This burden of proof is unacceptably high for firefighters to meet because they are constantly exposed to a myriad of harmful substances, and dangerous conditions. Working in such a hazardous environment, it is often impossible to precisely identify when and where a firefighter contracted a certain disease.

My legislation, H.R. 697, simply creates the presumption that federal firefighters who become disabled by heart and lung disease, certain cancers, and certain other infectious diseases contracted the illness on the job. Additionally, if a firefighter contracts an illness that is clearly not caused by his or her firefighting duties, my bill recognizes that the federal government should not be responsible for covering those costs. However, in the case of the vast majority of federal firefighters who contract certain illnesses, it should be presumed that their illness is a result of their service to our country by running into burning buildings while others are running out of them.

The Federal Firefighters Fairness Act will bring federal law in line with state laws that afford a majority of municipal firefighters a presumptive disability benefit. This bill will help our nation's federal firefighters receive fair and equitable compensation or retirement benefits as a result of workplace illnesses. There is no reason why the federal government cannot treat its firefighters with the same respect as 40 states now treat their municipal firefighters. We owe our federal first responders the same occupational safeguards and benefits our civilian firefighters enjoy.

Mr. Chairman, thank you for holding this hearing today on legislation pertaining to compensation for injured federal workers, and for including the Federal Firefighters Fairness Act of 2005. As I have stated before, the unique hazards associated with firefighting demand that federal firefighters are afforded a presumptive disability benefit similar to laws already on the books in 40 states. As you consider these issues, I urge you and your fellow Committee Members to act on H.R. 697, in order to provide our brave federal firefighters with the support that they deserve. Thank you again for including this important issue with today's hearing.

Mr. NORWOOD. Thank you, Ms. Davis.

It is all right for you to be prejudiced if you are married to a firefighter.

I think that makes sense.

We appreciate your coming this morning, and you are now excused.

Ms. DAVIS. Thank you.

Mr. NORWOOD. Mr. Johnson, you are now recognized for 5 minutes.

STATEMENT OF JAMES B. JOHNSON, 16TH DISTRICT VICE PRESIDENT, INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS, WASHINGTON, DC

Mr. JOHNSON. Thank you, Mr. Chairman, Ranking Member, Members of the Committee.

I am James Johnson, and I am the 16th District vice president of the International Association of Fire Fighters. I represent the Federal firefighters for the IFF. On behalf of General President Jake Berger and the 267,000 men and women of the IFF, it is my honor to testify before you today regarding H.R. 697, a bipartisan bill which was introduced by Representatives Jo Ann Davis and Lois Capps. This bill would bring a much needed benefit to the firefighters that I represent in the Federal sector.

Federal firefighters, although not as visible to the public eye as their counterparts in the municipal sector, play an essential role in protecting the vital interests of the United States.

Over 15,000 Federal firefighters face some of the most difficult and hazardous working conditions in the country guarding military installations, VA hospitals, and other Federal assets and lands.

Without their dedicated service, our nation would be less secure.

The job of a Federal firefighter is unique in many ways. When compared to other occupations in the Federal civil service, they are routinely exposed to carcinogens, infectious diseases, and other occupational hazards. Federal firefighters respond to all the same types of emergencies as their counterparts in the cities, including medical emergencies, hazardous materials incidents, structural fires, and aircraft emergencies, but they also face unique hazards involving incidents at weapons depots, facilities that conduct classified work and research, and emergencies aboard naval vessels.

They respond to these incidents often without adequate information about the dangers they may encounter. For instance, an EMS

call can involve a chemical spill, and a structural fire can actually be the result of an ammunition test failure. Although firefighters take precautions and wear protective gear, as with all aspects involving occupational hazards, exposures do and can happen. As a result, they are far more likely to suffer from heart disease, lung disease, and cancer than other workers, and as firefighters, increasingly assume the role of the nation's leading providers of emergency medical services, they are also exposed to infectious diseases. These illnesses are now among the leading causes of death and disability for firefighters.

Mr. Chairman, in the interest of time, I will not go into great detail, but as my written testimony will indicate, there is an abundance of medical reasons why firefighters acquire these illnesses and diseases at a higher level and a higher rate than the average person.

It is important, however, to note that, under the Federal Employees' Compensation Act, compensation and/or retirement benefits are not provided to Federal employees who suffer from occupational illnesses unless they can specify the conditions and the exact situation in their employment to which the disease is attributed.

In order to qualify for these benefits under current law, Federal firefighters must be able to pinpoint the precise incident or exposure that caused the disease in order for it to be determined job-related.

This burden of proof is extraordinarily difficult for firefighters to meet, because they respond to a variety of emergency calls, constantly working in different environments under varied conditions.

H.R. 697 was named the Federal Firefighter Fairness Act because the main reason for the legislation is to treat Federal firefighters fairly.

H.R. 697 would create a presumption that firefighters who become disabled because of heart or lung disease or certain cancers or infectious diseases contracted their illness on the job. H.R. 697 would shift the burden of proof from the employee to the employer to prove that the illness was caused by some factor other than the duties of a firefighter.

It is important also to note that Congress has enacted legislation with presumptive benefits in the past. The 108th Congress passed the Hometown Heroes Act, and under this law, the public safety officers benefit is paid to families of firefighters who died as a result of a heart attack or a stroke while they are on duty.

So, we are assuming that the death was a direct and proximate result of their duties.

However, currently, if a firefighter does not succumb to a heart or stroke on duty, it is presumed not to be job-related.

In conclusion, Mr. Chairman, while we believe the merits of H.R. 697 warrant Congressional action, we are also mindful that, in this tight budget environment, we must be sensitive to the cost of even the most compelling initiatives. Although no formal cost estimate has been done by the Congressional Budget Office, we believe the cost of implementing H.R. 697 will be minimal.

Mr. Chairman, that concludes my statement, and I would like to thank you and the Committee for the opportunity to be here today, and would welcome any questions you may have.

[The prepared statement of Mr. Johnson follows:]

Statement of James B. Johnson, 16th District Vice President, International Association of Fire Fighters, Washington, DC

Mr. Chairman, Ranking member and members of the committee, my name is James Johnson, and I am the 16th District Vice-President of the International Association of Fire Fighters (IAFF), representing federal fire fighters.

On behalf of General President Harold A. Schaitberger and the 267,000 men and women of the IAFF it is my honor to testify before you today on H.R. 697, The Federal Fire Fighters Fairness Act, a bipartisan bill introduced by Representatives Joann Davis and Lois Capps. The bill would bring a much-needed benefit to the fire fighters that I represent in the federal sector.

Introduction

Since the events of September 11, 2001, Americans have become increasingly aware of the role that fire fighters serve as our nation's domestic defenders. These courageous men and women protect the lives and property of their neighbors in communities throughout the country.

Federal fire fighters, although not as well known as their counterparts in the municipal sector, play an essential role in protecting the vital interests of the United States. The over 15,000 federal fire fighters face some of the most difficult and hazardous working conditions in the country guarding military installations, nuclear facilities, and VA hospitals. And their 72 hour work week is unparalleled. Without their dedicated service, our nation would be less secure.

The job of federal fire fighters is unique in many ways. Far more often than other occupations within the federal sector, they are routinely exposed to carcinogens, infectious diseases, and other occupational hazards.

Federal fire fighters respond to all of the same types of emergencies as their counterparts in the municipal sector including medical emergencies, hazardous material incidents, structural fires, and aircraft emergencies. But they also face unique hazards involving incidents at weapons depots, facilities conducting classified work and research, and emergencies aboard naval vessels.

And they respond to these incidents often without adequate information about the dangers they may encounter. An EMS call can actually turn out to involve a chemical spill, and a structural fire can be the result of a research or ammunition test failure. Although fire fighters take precautions and wear protective gear, as with all aspects involving occupational protection, exposures happen.

Fire fighters are exposed on an almost daily basis to stress, smoke, heat and various toxic substances. As a result, they are far more likely to contract heart disease, lung disease and cancer than other workers. And as fire fighters increasingly assume the role of the nation's leading providers of emergency medical services, they are also exposed to infectious diseases.

Heart disease, lung disease, cancer, and infectious disease are now among the leading causes of death and disability for fire fighters, and numerous studies have found that these illnesses are occupational hazards of fire fighting.

Under the Federal Employees' Compensation Act (FECA), compensation and/or retirement benefits are not provided to federal employees who suffer from occupational illnesses unless they can specify the conditions of employment to which the disease is attributed. In order to qualify for these benefits under current law, federal fire fighters must be able to pinpoint the precise incident or exposure that caused a disease in order for it to be determined job-related.

As I will explain further in my testimony, this burden of proof is extraordinarily difficult for fire fighters to meet because they respond to a wide variety of emergency calls, constantly working in different environments under varied conditions.

As a result, very few cases of occupational disease contracted by fire fighters have been deemed to be service connected.

State Laws

In recognition of the linkage between firefighting and certain diseases, 40 states have enacted some sort of "presumptive disability" laws, which presume that cardiovascular diseases, certain cancers and infectious diseases are job-related for purposes of workers compensation and disability retirement unless it can be shown otherwise.

For example, Mr. Chairman, in your home state of Georgia fire fighters are protected by a presumptive disability law that covers heart disease, lung disease, and certain infectious diseases.

Many of the illnesses covered by state presumptive disability laws are debilitating and often fatal. They place a great strain on the fire fighter and his/her family. Knowing that they will not have to fight their state Worker's Compensation offices during trying times for them and their families provides a degree of security for those who place themselves in harm's way to protect the rest of us.

While presumptive laws are now the norm for municipal fire fighters, no such protection exists for fire fighters employed by the federal government.

Fairness

HR 697 was named the Federal Fire Fighters Fairness Act because the main impetus for the legislation is to treat federal fire fighters fairly. It is simply not right that federal fire fighters are denied an important workplace protection that is routinely provided in the municipal sector. This inequity is especially egregious in communities where federal fire departments maintain a mutual aid agreement with a neighboring municipality.

In such instances, federal fire fighters work side-by-side with municipal fire fighters during mutual aid responses and are subject to the same occupational hazards as the municipal fire fighter. However, if two fire fighters both contract an illness due to their mutual exposure at an incident, the municipal fire fighter in most instances would be covered by workers compensation but the federal fire fighter would not.

There simply is no valid justification for denying federal fire fighters comparable protections.

Recruitment and Retention

In order for the federal government to adequately protect our nation's domestic military installations, nuclear facilities and other sensitive agencies, the government must offer fire fighters benefits that are competitive with those that are provided by municipalities. Often, federal fire fighters leave the federal service for work in a municipal department because the benefits are superior. For those same reasons, municipal departments also have a competitive advantage over the federals in the recruitment of new hires.

Being at a competitive disadvantage to recruit and retain fire fighters harms the federal government in two ways. First, it makes it more difficult to recruit and keep the very best our profession has to offer. Considering the vital national security role played by the nation's fire fighters, it is important that the federal government is able to recruit and retain the elite of the firefighting world.

Second, the federal government invests a significant amount of money to uniquely train federal fire fighters, and it costs taxpayer dollars each time a federal fire fighter leaves for the municipal sector. High turnover is costly and wasteful.

In order to address these problems, the federal government must offer a competitive benefits package, and that includes having occupational illness covered by workers compensation.

Case Studies

Admittedly, there are few examples of the Department of Labor's Office of Worker's Compensation (OWCP) rejecting applications for occupational illnesses, but that is due to the fact that fire fighters simply do not apply for benefits they have been told are not available to them.

When a fire fighter contracts a career-ending illness, they are given paperwork by their local personnel office and told what benefits they are or are not eligible to receive. Those who are suffering from diseases that have been linked to fire fighting are informed that such illnesses are not considered duty-related for Workers Comp purposes.

For example, Fire Fighter Leon Tukes of Warner Robins Air Force Base in your home state of Georgia suffered a heart attack while on duty. After his heart attack, Fire Fighter Tukes went to the Personnel Office at Warner Robins to enquire about receiving a presumptive disability retirement. He was told to not even bother because no claim has ever been granted for a heart attack. He never filed a claim and accepted the retirement benefits provided to people who retire for non-work related reasons.

Unable to work and with no protection under FECA, Fire Fighter Tukes had to rely on his fellow fire fighters to donate leave to him so he could retire with a full pension. He was lucky to be near retirement age; most are not when they are stricken with these occupational illnesses.

Occasionally an instance occurs in which the service connection is so apparent that OWCP has little choice but to award benefits. But the absence of a presumptive disability law means that in even these cases the fire fighter must spend years fighting the bureaucracy to get what they are rightfully entitled to.

Fire Fighter Rick LeClair provides a tragic example of this delay. LeClair spent his career protecting the critical naval facility in San Diego, California until he was diagnosed with lung cancer. Doctors discovered that his cancer was caused by mesothelioma, which was attributed to the asbestos suits that fire fighters once wore. Fire Fighter Leclair filed a claim with the Office of Workers' Compensation. Before the claim was decided fire fighter LeClair succumbed to the cancer that was ruled to be caused by an occupational hazard. If this law would have been in place for fire fighter Leclair, his illness would have been presumed and he would have received the benefit he died waiting years to receive.

It is for fire fighters Tukes, LeClair, and many others whose names we don't know, that we urge passage of the Federal Fire Fighters Fairness Act.

Firefighter Health and Safety

The IAFF has been actively involved in the health and safety of fire fighters for more than seventy years. Each year the IAFF conducts an annual death and injury survey with the cooperation and participation of various fire department administrators. This survey has shown that fire fighting is the most hazardous occupation in the United States. During the latest ten-year period (1990–2000), the Death and Injury Survey has found that professional fire fighters experienced 342 traumatic-injury deaths, 502 occupational disease deaths, 343,861 injuries and 6,632 forced retirements due to occupationally induced diseases or injuries.

Occupational diseases such as heart disease and cancer constitute a majority of all reported fire fighter deaths.

Heart Disease

The very nature of firefighting places extraordinary strain on cardiovascular systems. Fire fighters are constantly making transitions from the calm, peaceful environment of the firehouse to the hostility presented by fire. Within 15–30 seconds after the fire alarm sounds, research studies have found that a fire fighter's heart rate can increase by as much as 117 beats per minute. In addition, a fire fighter's heart can beat at twice its normal rate throughout the entire fire fighting operation. These extreme physiological stresses lead to severe coronary problems, which have been documented by numerous authorities.

Fire fighting involves stressful and strenuous physical activity that is made more burdensome by the fact that the protective clothing and breathing apparatus a fire fighter wears adds 45 to 65 pounds. The working environment can also mean a transition from below freezing temperatures to temperatures between 100 degrees and 500 degrees Fahrenheit at the fire itself.

The strain placed on the heart by this unique combination of factors is unlike that of any other occupation, and leads to heightened risk of heart disease.

Cancer

Technology has created a distinct difference in the modern fire environment. Fire fighters are exposed in their work to extremely high concentrations of a large number of toxic and carcinogenic chemical compounds.

Some of these chemicals—for example, carbon monoxide and soot containing polycyclic aromatic hydrocarbons—are natural products of combustion and have always been present at fires. However, the combustion of modern synthetic and plastic materials produces many highly toxic and carcinogenic compounds that were not found in fires even three or four decades ago. Exposures today commonly include benzene, formaldehyde, polycyclic aromatic hydrocarbons (PAH), asbestos and the complex mix of carcinogenic products that arise from combustion of synthetic and plastic materials.

These chemical compounds are commonplace ingredients in our environment as components of household furniture, plastic pipes, wall coverings, automobiles, buses, airplanes, and coverings for electrical and other insulation materials.

While the initial health effects of such exposures can be short-term or even non-existent, these exposures can and do result in long-term illnesses involving the cardiovascular system, the respiratory system, the central nervous system and other body organs.

Practically every emergency situation encountered by a fire fighter has the potential for exposure to carcinogenic agents. However, fire fighters can also be exposed to carcinogenic agents when the protective clothing they wear is exposed to high heat or burns. Fire fighters have even been exposed to carcinogens through the fire-extinguishing agents they utilize. The list of potential carcinogenic agents that fire fighters can be exposed to is almost as long as the list of all known or suspected carcinogens. Nevertheless, fire fighters constantly enter potential toxic atmospheres without adequate protection or knowledge of the environment.

Research has clearly shown the following specific linkages established between cancer and chemicals encountered in fire fighting:

- Leukemia is caused by benzene and 1,3-butadiene.
- Lymphoma and multiple myeloma are caused by benzene and 1,3-butadiene.
- Skin cancer is caused by soot containing PAH.
- Genitourinary tract cancer is caused by gasoline and PAH.
- Gastrointestinal cancer is caused by PCBs and dioxins.
- Angiosarcoma of the liver and brain cancer are caused by vinyl chloride.

Leukemia, lymphoma, multiple myeloma, cancer of genitourinary tract, prostate cancer, gastrointestinal cancer, brain cancer and malignant melanoma are among the cancers that have been observed consistently with increased frequency in epidemiologic studies of fire fighters. It is likely that additional associations will be identified between chemicals encountered in the fire environment and cancer in fire fighters. Nevertheless, the available data are sufficient to conclude that excess risk of cancer is a distinct hazard of fire fighting.

Lung Disease

In the course of their work, fire fighters are exposed to numerous substances that irritate the respiratory tract—ammonia, chlorine, formaldehyde, hydrogen sulfide and hydrogen chloride to name just a few. Toxic substances can cause acute (immediate) effects, chronic effects noted months or years afterwards, or both. The acute effects of inhaling smoke are familiar to every fire fighter. Some of these agents may not cause immediate irritation, but instead, cause damage that doesn't become apparent until years later when it may be difficult to prove cause and effect.

Infectious Diseases

Infectious diseases have become a hazard to fire fighters too big to ignore. Fire fighters and emergency medical responders can be exposed during motor vehicle accidents in which blood and sharp surfaces often are present, by rescuing burn victims, and through the administration of emergency care. The victim may require extrication from a difficult-to-access accident scene, such as a motor vehicle accident or poorly accessible building. There may be broken glass or other sharp objects at the scene that are poorly visualized, and the lighting at the scene may be minimal. In addition, if the victim is exsanguinating and needs to be extricated quickly to save his life, the emergency provider may act in haste, with disregard for his or her own safety. Fire fighters are also involved in emergency medical treatment at the scene, including intravenous line insertion and blood drawing. The fire fighter almost never knows the infectious disease status of the victim while he or she is rendering emergency services. All of these factors combine to place the fire fighter at increased risk of contracting a blood borne contagious disease through a puncture wound, skin abrasion or laceration that becomes contaminated with infected blood from the victim.

Every fire fighter's education now includes use of Universal Precautions, such as the wearing of protective gloves, safety glasses, and masks. But in the chaotic environment of an emergency scene, these precautions can and do fail. Exposures happen. A government study conducted during the development of the federal OSHA Blood borne Pathogen Standard found that 98 % of EMT's and 80% of fire fighters are exposed to blood borne diseases on the job.

Next Steps

Mr. Chairman, as I have previously stated, nearly 40 states have some form of a presumptive disability law on the books. There is no such law for federal fire fighters.

In order to qualify for a disability retirement, a fire fighter who suffers from an occupational illness must specify the precise exposure that caused their illness. As my testimony indicates those are nearly insurmountable odds.

H.R. 697, The Federal Fire Fighters Fairness Act would create a rebuttable presumption that fire fighters who become disabled by heart and lung disease, certain cancers and infectious diseases contracted the illnesses on the job. H.R. 697 would shift the burden of proof to the employer to prove that the illness was caused by some factor other than the duties of the fire fighter.

This does not mean that every fire fighter who contracts a disease named in the legislation automatically would qualify for benefits under FECA. For example, lung cancer is unlikely to be determined to be occupational if it is contracted by a fire fighter who was also a long-term smoker. But the burden of proof would no longer be placed on the fire fighter to prove the cause of the disease.

Precedent

Although FECA currently does not provide presumptive disability benefits, Congress has enacted such presumptions in other benefit programs. Peace Corps volunteers, military veterans, and public safety officers who die in the line of duty are all covered by presumptive laws.

Service-connected disability is provided to Vietnam veterans whose cancers are presumed to be caused by herbicide exposure. Like fire fighters, Vietnam Veterans found it extremely difficult to pinpoint precise exposures, and as a result, thousand of veterans were denied a benefit to which they were entitled. After years of lobbying by veteran groups, Congress responded by enacting a law that established a presumption of service-connection for certain diseases.

More recently, the Congress passed and President Bush signed into law the Hometown Heroes Act (PL 108-182). Under the new law, Public Safety Officer Benefit (PSOB) will be paid to the families of fire fighters and police officers who die as a result of heart attack or stroke suffered within twenty-four hours of responding to an emergency call or participating in a training exercise involving "unusual physical exertion." It is now presumed that the death was "a direct and proximate result" of the emergency response.

Cost

While we believe that the merits of the Federal Fire Fighters Fairness Act warrant congressional action, we are mindful that in this tight budget environment we must be sensitive to the cost of even the most compelling initiatives. Although no formal cost estimate has been done by the Congressional Budget Office, we believe the cost of implementing H.R. 697 will be minimal.

The number of federal fire fighters is relatively small compared with other occupations in the federal sector, and the vast majority do not retire due to an illness. Based on the experience of states with similar presumptive disability laws, as few as 15-20 people are likely to qualify for the benefit each year.

Moreover, because fire fighters are generally on the lower end of the GS pay scale, benefits based on their salary would not have a significant impact on FECA's balance sheet.

In short, an important protection can be provided to the nation's federal fire fighters at little expense to the federal treasury.

In conclusion, Mr. Chairman, I would like to thank you and the Committee for holding this hearing today. I look forward to working with the committee to see this legislation move forward.

Mr. NORWOOD. Thank you very much, Mr. Johnson, and now, Mr. Shufro, you are recognized for 5 minutes.

STATEMENT OF JOEL A. SHUFRO, EXECUTIVE DIRECTOR, NEW YORK COMMITTEE FOR OCCUPATIONAL SAFETY AND HEALTH (NYCOSH), NEW YORK, NY

Mr. SHUFRO. Thank you very much. I appreciate the opportunity to testify.

The New York Committee for Occupational Safety and Health is a nonprofit educational organization composed of 200 local unions and 300 individual members dedicated to promoting every worker's right to a safe and healthful work place.

I am here to support H.R. 697, which creates the legal presumption that certain diseases are considered work-related when they cause the disability or death of Federal fire protection employees.

Many states, including New York, have created such presumptions as a reasonable and rational method of providing those workers who are routinely exposed to hazardous substances and conditions at work and who are disabled as a result with medical and financial benefits.

This year, the New York State legislature, in its current session, passed legislation establishing presumptions that disability is work-related among certain public employees who were exposed to

hazardous conditions in connection with the World Trade Center tragedy of September 11, 2001. The bill, which provides disability retirement, is currently sitting on Governor Pataki's desk, and we are hoping that he will sign the bill this year. The need, however, goes far beyond public sector workers and disability retirements.

It is estimated that 30 to 35 thousand workers worked directly on the pile at Ground Zero. Countless others worked to clean up the buildings of lower Manhattan and Brooklyn.

Six thousand of the 12,000 workers who have been seen at the World Trade Center worker and volunteer medical screening program at Mt. Sinai Medical Center have respiratory symptoms that require medical treatment.

For some, symptoms have abated. Others have symptoms that have reemerged after abating, and still others have symptoms that are appearing only now, nearly 4 years after exposure.

Similar numbers of workers have been diagnosed with mental problems requiring psychological counseling, and of course, it is too early to know how many workers will develop diseases such as cancers with latency periods as long as 40 years.

To receive medical treatment, workers and volunteers must apply for workers compensation.

In the aftermath of 9/11, Congress allocated \$175 million over 4 years to assist New York State's workers compensation board.

In his latest budget proposal, the President eliminates \$125 million which has not yet been spent. If the funding is not restored, there will be no source of funds to pay future claims of volunteers and uninsured workers who have been made ill as a result of their exposure at Ground Zero, as well as the ongoing claims of those workers who have already been able to establish them.

This is extremely unfortunate.

While we do not know how many workers are eligible for benefits, we do know that there are many impediments for workers to file and that large numbers of individuals who should receive medical attention and possibly wage replacement are not receiving them.

For example, many immigrant workers and volunteers who participated in the rescue efforts and cleanup of office buildings in lower Manhattan were never informed of their right to access the New York State workers compensation program.

My organization, through funding from the Red Cross and the United Church of Christ World Services, has been reaching out to the immigrant organizations and has begun to identify large numbers of workers who are sick and have not received any benefits.

In addition, we have a case known as medical-only cases, claims where workers need medical treatment but have not lost time at work, and they cannot get legal representation. Lawyers do not get paid in this process, and so, our system, which is very arcane and complicated, especially for immigrant workers, to navigate without a lawyer—many of the workers just drop out.

Many workers' compensation claims have been contested and remain unresolved.

Many workers who participated in the rescue and clean-up at the World Trade Center site, who have experienced the onset of respiratory illness and other diseases, have not been able to establish

claims, thereby preventing them from receiving timely medical treatment and medication, as well as receiving wage replacement benefits. This has meant real hardship for the many who heroically attempted to rescue those who were buried in the rubble of the collapse or who worked in the vicinity of Ground Zero.

There are many reasons workers have not received benefits. In part, the difficulty has arisen because there are no presumptions in the law.

In the remaining time, I would just like to say that we urge that the Congress restore the funding for workers' compensation payments to workers who were made ill in New York City.

[The prepared statement of Mr. Shufro follows:]

Statement of Joel A. Shufro, Executive Director, New York Committee for Occupational Safety and Health, New York, NY

My name is Joel Shufro. I am the executive director of the New York Committee for Occupational Safety and Health, a non-profit educational organization. We are a coalition of 200 local unions and 300 individual members dedicated to promoting every worker's right to a safe and healthful workplace. We have a twenty-six year history of providing safety and health training and technical assistance to working people, community organizations and employers in the New York Metropolitan area.

I am here to support H.R. 697, which creates the legal presumption that certain diseases are considered work-related when they cause the disability or death of federal fire protection employees. Many states, including New York, have created such presumptions to as a reasonable and rational method of provide those engaged in hazardous activities with medical and financial benefits to workers who are routinely exposed to hazardous substances and conditions at work and who are disabled as a result.

This year the New York state legislature, in its current session passed legislation establishing the presumption that disability is work-related among certain public employees who were exposed to hazardous materials presumptive accidental disability in connection with the World Trade Center tragedy of September 11, 2001. The legislature passed the same bill last year and the year before that, but the first two times it was vetoed by Governor Pataki. In so doing, the legislature recognized that public employees including police, fire, correction and sanitation rendered rescue, recovery and clean up at and around the World Trade Center site and were exposed to numerous hazards which may have, and may, impact their health in years to come.

The bill is currently sitting on Governor Pataki's desk. We are hoping that he will not veto the bill for the third time.

The need, however, goes far beyond public sector workers and disability retirements. It is estimated that 30-45,000 workers worked directly on the pile at Ground Zero; countless others worked to clean up the buildings of Lower Manhattan. Still others returned to work and live in buildings which were either not or inadequately cleaned up and still contaminated after the EPA and OSHA assured the public that the air was safe. The consequence has been that workers and community residents are sick—and in large numbers.

Six thousand of the 12,000 workers who have been seen at the World Trade Center Worker and Volunteer Medical Screening Program at Mt. Sinai Medical Center have respiratory symptoms that require medical treatment. For some, symptoms have abated; others have symptoms that re-emerge after abating and still others have symptoms that are appearing only now, nearly four years after exposure. Similar numbers of workers have been diagnosed with mental problems requiring psychological counseling. Many of the workers will never be able to work again; others will not be able to pursue their chosen careers. And, it is, of course, too early to know whether and how many workers will develop diseases such as cancers with latency periods as long as 40 years.

To receive medical treatment workers and volunteers must apply for workers' compensation. In the aftermath of 9/11, Congress allocated a total of \$175 million over four years to the New York State Workers' Compensation Board. Of the money allocated, \$125 million was earmarked for the processing of claims; \$50 million to reimburse the state Uninsured Employers Fund for benefits paid to volunteers and to employees of companies that did not have workers' compensation insurance.

According to a recent GAO report (GAO-04-1013T) entitled "September 11, Federal Assistance for New York Workers' Compensation Costs," the New York State Workers' Compensation Board has spent \$50 million of the \$175 million that has been provided by the federal government. In his latest budget proposal, the President calls for taking back the remaining \$125 million. If the president's proposal is agreed to there will be no source of funds to pay future claims of volunteers and uninsured workers who have been made ill as a result of exposure to toxic substances during the September 11th cleanup.

This is extremely unfortunate. While we do not know how many workers are eligible for benefits, we do know that there are many impediments for workers to file and that large numbers of individuals who should receive medical attention and possibly wage replacement are not receiving them.

For example, many immigrant workers and volunteers who participated in the rescue efforts and cleanup of office buildings in Lower Manhattan were never informed of their right to access the New York State Workers' Compensation System. NYCOSH has recently received grants from the Red Cross and the United Church of Christ World Services to inform organizations that are active in the immigrant community about the eligibility of workers who have developed occupational disease related to work at the World Trade Center.

In addition, many workers have what are known as "medical-only cases"—claims where the worker needs medical treatment but has not lost time at work. In these cases, lawyers in New York State most lawyers are unwilling to take medical-only cases, because there is no mechanism to pay lawyers for work on such cases. The Workers' Compensation System in New York State is too complicated and arcane for any worker, but especially an immigrant worker, to navigate workers' compensation system without a lawyer. As a result, far too many workers who would be entitled to medical treatment do not pursue their cases.

Many workers' compensation claims have been contested and remain unresolved. Despite a request from the then chair of the New York State Workers' Compensation Board, Robert Snashall, that claims for workers' compensation arising out of the World Trade Center tragedy be expedited, many workers who participated in the rescue and cleanup at the World Trade Center site and have experienced the onset of respiratory illness and other diseases have been unable to establish claims thereby preventing them from receiving timely medical treatment and medication as well as receiving wage replacement benefits. This has meant real hardship for many who heroically attempted to rescue those who were buried in the rubble of the collapse or who worked in the vicinity of Ground Zero cleaning up the toxic dust which covered Lower Manhattan.

There are many reasons workers have not received benefits. In part, the difficulty has arisen because there are no presumptions in our workers' compensation law that associate the adverse health effects that workers at the Trade Center experienced with their exposure to the toxic substances. Given the witches brew of toxic substances and chemicals to which workers were exposed, it is virtually impossible for a worker to prove the onset of symptoms was caused by any given chemical or combination of chemicals. However, there is evidence that insurance companies are contesting claims of 9/11 victims, according to some sources, at a rate ten times greater than that of the normal population of injured workers. This has led programs that have provided needed medicines to injured workers while their cases are being adjudicated, to stop providing assistance until workers claims have been established, leaving workers without access to prescribed medications while they await a determination.

Consequently, we are here to urge Congress should restore funding to cover the future workers' compensation costs associated with illnesses arising out of the rescue, cleanup of Ground Zero and return to workers to workplaces throughout Lower Manhattan. This is particularly important since we have do not know whether additional workers will develop illnesses in years to come nor do we know how long the symptoms workers are currently experiencing will persist. The funding should be used to:

- 1) create a medical trust fund so workers can get needed medical treatment while they are waiting for their claims to be established;
- 2) finance a outreach campaign to special populations such as immigrant workers and volunteers to inform them of their rights to benefits under New York State's Workers' Compensation Law.
- 3) fund Medical Centers of Excellence which would develop expertise in dealing with the complex, multiple medical issues which workers who worked at the World Trade Center site are experiencing.

As our state legislature noted in passing its bill for disability retirements for public-sector workers who participated in the rescue and clean up at the World Trade

Center, "It is beyond question that the State must recognize the services that these individuals provided not only to the victims and their families, but to all citizens of the City and the State of New York and the United States of America." We believe that all workers who participated in the rescue and clean up or have become ill as a result of exposure to the toxic substances from the collapse of the World Trade Center should receive appropriate benefits and that the funding should be restored to the President's budget.

Mr. NORWOOD. Thank you, Mr. Shufro.

I recognize Mr. Kline for 5 minutes.

Mr. KLINE. Thank you, Mr. Chairman.

Thank you, gentlemen, for being here today.

I want to try to get a better handle in my own mind on the scope of the problem in terms of numbers, and I know, Mr. Johnson, you mentioned the number of Federal firefighters. Could you give that to us again and tell us what percentage of that that your union represents?

Mr. JOHNSON. Overall, there are approximately—depending on at which time you actually work, because of the hiring processes, between—approximately 15,000 Federal firefighters.

That includes overseas sites, Guam, Puerto Rico, and throughout the continental United States.

A portion of those Federal firefighters are also—are military, however.

My understanding is there's about 4,000 military firefighters between the different agencies, and then the remainder are civilians.

Mr. KLINE. How many of those are in the union?

Mr. JOHNSON. The IFF represents approximately 4,000 Federal firefighters.

There are several other unions that represent a number of firefighters, also.

Mr. KLINE. OK. Thank you very much.

Continuing on the—getting a handle on the scope of the problem, the—looking at my notes here, the FECA is set up as a non-adversarial program, and according to my notes here, the Department of Labor has told us that approximately 65 percent of all claims for occupational diseases are ultimately approved.

Is the issue with firefighters out of proportion with that, or is there a higher number approved or disapproved? Do you know?

Mr. JOHNSON. We feel that there are a higher number disapproved.

As an example, I will use hepatitis exposures, which Jo Ann Davis mentioned.

The problem that we're seeing specifically with those type of exposures, infectious diseases, is the employees are being told that unless they can specifically point out the patient that they acquired the disease from, they are not going to be covered, their claims are denied, and basically—it comes down to basically a blood test issue, and OWCP is looking for something that they can actually sink their teeth into and say, OK, you acquired this infectious disease from this person, and it's nearly impossible for a firefighter to be able to pin that down, because a firefighter may go on 25 or 30 calls a month, medical calls, and—and obviously we do not know who is carrying those diseases when they respond.

Mr. KLINE. OK.

One final question, then I will yield back, but along the same lines as trying to get a feel for the difference between the firefighters population and the general population, obviously in the general population, people die from cancer and heart disease and so forth. On an age-equal basis, could you give me a sense of the percentage or number of deaths from heart disease, for example, for firefighters versus the general population, say, for 45-year-olds?

Mr. JOHNSON. I believe we have that data in the full testimony that we submitted, and I cannot recall it off the top of my head, but it is in the report that we submitted. Overall, from my experience working in the Federal sector for 27 years, there is, I believe, a higher rate of heart attack and strokes specifically with Federal firefighters because of the exposures and the stress in the job. There are also—I've been actually witness to several instances with employees I have worked with where they have tried to file claims through OWCP related to these incidences, and they have been denied.

Mr. KLINE. I see, and those numbers are in the testimony?

Mr. JOHNSON. Yes.

Mr. KLINE. OK.

Thank you very much.

Mr. Chairman, I yield back.

Mr. NORWOOD. The gentleman yields back.

Mr. Bishop, you are recognized for questioning for 5 minutes.

Mr. BISHOP. Thank you, Mr. Chairman, and thank you for holding this hearing.

I have a written statement, and I would ask unanimous consent that it be inserted into the record.

Thank you, Mr. Chairman.

First, let me start by commending Representatives Davis and Capps for filing this legislation.

I think it is very good and very important legislation. I am proud to be a cosponsor of it, and I hope that we can see that this legislation becomes law.

Mr. Johnson, several states already have the presumption of disability, and my question is, what experiences can you cite for us that would help inform the Federal Government with respect to how that presumption has worked? For example, how often is the presumption challenged? How often is that challenge successful?

Mr. JOHNSON. From the data that we reviewed involving the separate states that have presumptive-type disability for firefighters, we actually find that there are relatively few firefighters that actually apply for disability under the presumption.

So, I do not think the numbers are really that great for us to actually look at.

Most of the instances that we see are related to heart attack and stroke issues, and I think a lot of that was channeled into the Public Safety Officers Death Benefit, which was a lot of the impetus behind that.

Mr. BISHOP. If we are successful in passing this law, do you have any sense of what its impact would be on the ability to both recruit or retain Federal firefighters? Is this something that would be attractive?

Mr. JOHNSON. It would definitely be a benefit. As we see right now, we have a lot of problems in the Federal sector as far as Federal firefighters currently, as far as recruiting new hires and retaining those individuals throughout their career. Obviously, when the cities are offering better pay and better benefits, better compensation, and better health care and this presumptive disability that most of them offer, it becomes a challenge for the Federal sector to recruit and retain employees through an entire career. We do experience, as I have seen, employees coming into the system, gaining experience, and then seeing an opportunity to move to the municipal sector, and they definitely will take that road if they get the opportunity. So, improving the benefits within the Federal sector, I think, would be a great help.

Mr. BISHOP. One more question for Mr. Shufro. You cited that at least \$125 million that is proposed to be cut from workers' compensation claims. Can you walk us through the human implications of that if we are unsuccessful in having that money restored? How many people are we talking about? What types of disabilities would go uncompensated?

Mr. SHUFRO. Well, workers who worked on the pile are suffering from respiratory problems, many of whom are no longer able to work at all, many of whom go in and out of experiencing symptoms.

We have large numbers of workers who worked on the pile who currently are not able to work.

To eliminate this funding will mean that workers who are currently collecting will not be able to collect, and in New York, the maximum benefit level is the lowest of any state in the country, \$400 a week, and—but more importantly—and I guess as importantly, I would say—workers who will become ill—there will be no funding for them, and especially for those people who are—were volunteered to work on the pile, for whom our workers compensation system has no provision. So, this will mean very real hardship for workers.

It is hardship enough to live on \$400 a week, let alone if there is no funding at all.

Mr. BISHOP. Thank you very much.

Thank you, Mr. Chairman. I yield back.

Mr. NORWOOD. Thank you very much. The gentleman yields back.

Dr. Price of Georgia, you are recognized for 5 minutes for questioning.

Dr. PRICE. Thank you, Mr. Chairman.

I, too, want to thank you all for coming and giving your testimony today, and just simply want to echo what others have said, and that is that we certainly, all of us, appreciate the work that firefighters do, our Federal firefighters, and want to recognize that and recognize that they are true heroes on the front lines.

As a physician, I know that firefighters are oftentimes the first folks there on medical tragedies and crises when, in fact, there is no fire around. They get involved in many medical emergencies.

So, I appreciate the work that they do.

I would like to ask a couple specific questions. I am interested in the list in the bill of diseases, and understand through your

statement, Mr. Johnson, about some of the correlation of exposure to certain chemicals and the like.

How did you all come up with this list?

Mr. JOHNSON. The data that is included in the report is obviously the result of years and years of research and statistical studies that the IFF and medical professionals have developed over a period of time. The IFF itself conducts annual surveys regarding deaths and injury for firefighters, and we tried to delve in detail into what the causes of injuries in firefighters are, and based on that data, we maintain a reporting system that we can extract that data from and come up with the diseases and specific illnesses that are affecting firefighters.

Dr. PRICE. That gets to, I think, the crux of the issue that I think Mr. Kline tried to touch on, and that is whether the actuarial data will give any difference—show any difference between firefighters and the general public, and you mentioned that the numbers were in your testimony, and I may have missed it, but I did not see it.

Mr. JOHNSON. I will check to see. If it is not, then we will make sure that that is provided to you.

Dr. PRICE. I think that would be of great help to all Members of the Committee to see that.

I also wanted to just point out one item in your—and ask you to comment on it, one item in your—in your written testimony, Mr. Johnson. That is in the area of cancer, and it lists the exposure and the—and how certain leukemias and lymphomas and skin cancers can be a result of certain exposure, but the final line in this paragraph here is that, “Nevertheless, the available data are sufficient to conclude that the excess risk of cancer is a distinct hazard of firefighting,” and that is the kind of data that I think we are interested in, and I do not see that here.

Finally, I would like to have each of you comment on the cost.

Your summary says that this would probably affect 15 to 20 people a year.

So, I am curious about that, given the scope of what you all seem to say today is much larger than that, but your written testimony is 15 to 20 a year.

So, would you comment on the cost—I know CBO has not scored it, but what you all believe is the cost?

Mr. JOHNSON. Just briefly to try to summarize that, I think what we were looking at is what we actually see from the states currently that have this type of presumption, and we tried to look at how many claims are actually filed and go through the system successfully, because it is still important to remember that, even in the states that have a presumptive disability, there is still the ability on the states’ part, or the employer, to controvert that claim. So, it is not a given that just because the presumption is there initially that the employee is going to receive the benefit permanently.

So, we looked at those numbers, and based off those numbers from the states, we tried to equate what we thought is a best estimate.

Dr. PRICE. Have you got a guess?

Mr. JOHNSON. Pardon me?

Dr. PRICE. Do you have a guess?

Mr. JOHNSON. Within the Federal sector?

Dr. PRICE. Yes.

Mr. JOHNSON. My best guess would probably be 30 to 40 employees a year.

We really do not see that many—

Dr. PRICE. In a line item per—

Mr. JOHNSON. Well, it is also important to remember that this is broken down into different categories.

Some employees may acquire a disease that only requires two or 3 months of treatment and they are back on the job, and that is what we see the majority of the time, are limited illnesses to where the employee is off for a short duration.

Occasionally there will be—obviously there is occasions when an employee's illness requires a disability retirement.

Dr. PRICE. If I may, Mr. Chair, do Federal firefighters have access to any other disability that they can purchase on their own for those kinds of instances?

Mr. JOHNSON. There are private avenues that—obviously, they could pursue private disability-type insurance or something of that nature.

The only other compensation that they can receive is directly through OWCP.

Dr. PRICE. Thank you, Mr. Chairman.

Mr. NORWOOD. Thank you very much. The gentleman's time is expired.

Ms. Woolsey, you are now recognized for 5 minutes for questioning.

Ms. WOOLSEY. Thank you, Mr. Chairman, and this is a great bipartisan bill. It is good to be working on something like this.

I was a city council member in Petaluma, California, for 8 years, and the mayor used to say, oh, do not even ask Woolsey about her vote on the—for our local firemen, because she is always going to say yes, because you are absolutely my heroes, and he is right, I always did say yes, and the same thing goes here.

So, I do not understand why we have left the firefighters out of this disability coverage, and if you have some—you know, if you want to tell us why you think that happened, that is fine, that and I would like you both to look at both of these ideas.

You know, your list of dangerous chemicals and all that, which is important to have, but we are finding that our world changes so quickly, and we manufacture new products, and we do not even have any idea what is in the product, like in our carpeting, where you go—you know, when it starts burning, and then our furniture, and you are in there saving people, and the furniture is setting off gases and things. Whoever knew that that is what we would be up against?

I hope, in your lists, that it is not all inclusive. You have got to leave room for what is coming up next, because you know, we sometimes react backwards and get rid of things that are toxic, but we are always adding more. So, please—OK.

Mr. JOHNSON. I think that is also important to remember.

The list is as concise as it can be at this point in time, because it basically covers those incidences or those diseases that we see affecting firefighters the majority of the time.

There are always unknowns out there that we do not know about, and they will continue, and the firefighters respond to incidences, especially on Federal installations, and I think that is important to point out, because you clued in on some of the hazards that are out there that we know about. The Federal firefighters on some of these Federal installations get involved in things that they have no idea what it is, and in some cases, they will not be told what it is, because it is classified, and I have personally been in incidences that involve classified issues and materials, and it is really an unknown, and it is an unknown that you will never get any information on, and that is, you know, important to note.

Ms. WOOLSEY. Joel, do you want to respond?

Mr. SHUFRO. No.

Ms. WOOLSEY. OK.

You know, in private—as long as I have a couple of seconds left, in private industry—I was a human resources professional, and we have our protocols in manufacturing. We knew what—our local firefighters knew if they came into our plant—it was an electronics company—and there was a fire, which we never had one, but if there was, they would know what they were looking for. You do not have that, do you, in Federal buildings.

Mr. JOHNSON. Most of the Federal installations have inspection procedures and parameters, and inspections are conducted.

So, in most of your administrative-type buildings, the firefighters are well aware of what are in those buildings, the office-type buildings and things of that nature. When you get into the facilities that are involved in research and depot work and things of that nature, there are a lot of instances where we are prohibited from actually even touring the building or having any idea whatsoever what is in there.

So, when you show up, if there is an incident on the scene, you really are at peril, because you have no idea whatsoever what you're getting into or what is in the building or what is involved.

Ms. WOOLSEY. Well, we ought not to be treating you as our stepchildren because you are Federal, and I think this bill is a step in the right direction, Mr. Chairman.

Mr. NORWOOD. The gentlelady's time is expired.

Mrs. Drake, you are recognize for 5 minutes for questioning.

Mrs. DRAKE. Thank you, Mr. Chairman.

First of all, I would like to thank both of you for being here.

I think this is an important discussion, and we certainly are very grateful for the work of our firefighters.

I have many friends who are firefighters, and I did serve in the Virginia legislature when we passed what we called the heart-lung bill to deal with what you have just mentioned about heart and lung diseases, and in Virginia, we have a much more limited list of cancers that are covered with a presumption. We cover no infectious diseases, and a big part of my concern is how we determine where they actually got exposed to that disease.

I have family members who have died of meningitis. I have family members who have had hepatitis that had nothing to do with any occupation at all. What I wonder is, when you treat someone who might have a disease—hepatitis, HIV, any of the diseases—is

there any reporting system back to you that you would know you had had that exposure, or is that allowed to take place?

Mr. JOHNSON. Well, the first step is that you would have to be aware that the patient you were treating was infected.

In some instances, the patient may state to the responder that they are carrying an illness or a disease such as hepatitis or something of that nature. In most cases, they do not state that, or they may not even be aware themselves.

Mrs. DRAKE. I mean from the medical facility that you are transporting them to, is there a reporting back to you that there may have been an exposure?

Mr. JOHNSON. Normally not. Because of patient privacy issues, normally the firefighters themselves will not get any type of notification back from a medical facility that a patient was or was not carrying an infectious disease.

Mrs. DRAKE. I mean I think you can understand the concern that we may giving someone a presumption that, by their own particular lifestyle, has caused themselves to be exposed to certain diseases, and maybe that is an avenue we need to look at for these infectious diseases, is some sort of reporting requirement.

Mr. JOHNSON. I would say that is a possibility. I think from my position, I think because of the nature of the job and the work that the firefighters are doing, that at the very least they deserve the benefit of the doubt.

Mrs. DRAKE. OK. I would like to thank you. I know we have to go vote.

Thank you, Mr. Chairman. I yield back my time.

Mr. NORWOOD. Thank you. The gentlelady yields back.

Mr. Owens, you are now recognized.

Mr. OWENS. That last questions—have any patterns been established showing that firefighters do come down with an appreciable number of infectious diseases, any kind of research done to document that, more so than other occupations, you have a pattern where large numbers of firefighters have some of these infectious diseases?

Mr. JOHNSON. Yes, we do.

Mr. OWENS. Documented?

Mr. JOHNSON. Yes.

Mr. OWENS. Mr. Shufro, thank you again for being here, Joel. The Mount Sinai Medical Center study was financed by the Federal Government, right?

Mr. SHUFRO. Yes, that is correct. It financed screening but not medical treatment. All the workers who are going through the program were screened, but they rely on workers' compensation for treatment. There is no treatment funded by the Federal Government.

Mr. OWENS. You say 6,000 of 12,000 who were screened were found to have problems related to 9/11.

Mr. SHUFRO. That is correct.

Mr. OWENS. That is 50 percent, a pretty high rate.

Mr. SHUFRO. It is a very high rate.

Mr. OWENS. Then the old moribund inefficient workers' compensation board was given the money, Federal money, also, right, to deal with the problems of individual workers, correct?

Mr. SHUFRO. The workers' compensation board is giving Mount Sinai money?

Mr. OWENS. No.

Mr. SHUFRO. I am sorry.

Mr. OWENS. The Federal Government gave \$175 million, and part of that went to the New York State workers' compensation board.

Mr. SHUFRO. Yes, that is correct. The Federal Government—

Mr. OWENS. That is the money that the President, the administration is seeking to take back, is money that that workers' compensation board did not spend, correct?

Mr. SHUFRO. That is correct.

Mr. OWENS. So, we are penalizing future workers because of the lack of efficiency of that board. I mean they have a reputation for being slow, and they have a mind-set of sort of suspecting workers and safeguarding employers, and all that went into play, I am sure, and so, you have unspent \$120 million.

Mr. SHUFRO. Unspent \$120 million. Some of it I would not lay totally at the foot of the board. I think that the board worked to try and deal with many cases that came in front of it.

The Chairman of the workers' compensation board at that time, Robert Snashall, put out a statement urging that the insurance carriers expedite all the cases, but really, what has happened has been that the carriers have treated this as business as usual and contested an extremely high rate of—high number of the cases.

In fact, one of the companies, called IWP, has been providing free medicine to workers while their cases have been adjudicated in front of the board, because workers were not entitled to medication until their cases were established.

That company has just written a letter deciding not to provide anymore medicine, because the—it has not been—they have found that the cases that are being contested are contested at a rate 10 times higher than the normal rate of contest for other workers.

So, it may not be the board's fault here but the insurance companies' fault.

Mr. OWENS. Are we getting any help from OSHA and EPA in terms of scientific technical assistance? That 9/11 situation produced something that never existed before, ashes which consist of glass, lead, metal. All kinds of things were in that toxic brew that the workers were breathing. Are we getting any kind of help to pinpoint the fact that, you know, this is an ongoing mystery, they are still trying to sort it out, and not enough time has passed for us to be dismissing workers as having no relationship between what happened.

Mr. SHUFRO. The EPA is yet to finalize a sampling program for—to determine the extent and scope of contamination of lower Manhattan. That battle is still going on, and they put forth one plan which was found totally inadequate, and now they have proposed a second, which members of the community and many of the unions representing workers in lower Manhattan have criticized, also.

So, we are still not at a point where the dust—the toxic nature of that dust has been characterized, and so, we do not know the exposures of all that people were subjected to.

Mr. OWENS. Thank you.

Mr. NORWOOD. Well, I think everybody has asked questions but the Chairman.

I would like to ask a few and then put a number of them in writing.

Mr. Johnson, you mentioned that 40 states, which I find very interesting, have enacted presumptive disability laws.

Can you provide the Subcommittee with a list of those states?

Mr. JOHNSON. Absolutely, yes.

[The information referred to appears on page 35 of this document.]

Mr. NORWOOD. Can you clarify for me whether these presumptive disability laws have been added to the various state workers' compensation systems, or are these presumptive disability laws that is part of a separate disability and retirement program for firefighters, or are there states out there, for example, that have multi-purpose broad disability retirement programs that are specific to firefighters?

Mr. JOHNSON. My understanding is that it varies, that some states have included the presumptive issue for firefighters into their current programs and that there are also states that have created a separate program just for public safety or firefighters.

So, there is both.

Mr. NORWOOD. So, like in so many other things, states do things separately.

I guess that would—the presumptive disability provisions would vary, you know, the types of illnesses or disease.

I guess that would vary state by state, too?

Mr. JOHNSON. It is my understanding, yes, it does.

Mr. NORWOOD. Well, one more little question about that.

These disability—presumptive disability laws have been added to various state workers' compensation systems, or are these presumptive disability laws part of a separate disability?

You are telling me that all the states do this differently in so many different ways.

Mr. JOHNSON. There are differences out there, yes. I think the norm is for them to be included in the current programs, but there—there are also states that have created a separate program just for firefighters that covers just workman's comp for firefighter issues.

Mr. NORWOOD. I presume that information or, certainly, we could get that information.

Mr. JOHNSON. We can get that information, yes, sir.

Mr. NORWOOD. Yes. We would love to take a really good look at that.

I thank both of you for your time and your valuable testimony, and we will dismiss you as a panel, and I will ask that the second panel of witnesses come forward and take your seats at the table.

Mr. JOHNSON. Thank you.

Mr. NORWOOD. Thank you very much.

The second panel will address H.R. 2561, the Improving Access to Workers' Compensation for Injured Federal Workers Act.

Our first witness today will be Professor William Kohlhepp, associate director of the physician assistant program at Quinnipiac

University in Hamden, Connecticut. Professor Kohlhepp is testifying on behalf of the American Academy of Physician Assistants.

Our final witness today is Dr. Jan Towers. Dr. Towers is the director of health policy at the American Academy of Nurse Practitioners, located right here in Washington, D.C.

I would like for you both to know we truly appreciate you taking the time and coming to help teach us something.

With that, Mr. Kohlhepp, I will recognize you for 5 minutes.

STATEMENT OF WILLIAM C. KOHLHEPP, MHA, PA-C, ASSISTANT PROFESSOR AND ASSOCIATE DIRECTOR, PHYSICIAN ASSISTANT PROGRAM, QUINNIPIAC UNIVERSITY, HAMDEN, CT

Mr. KOHLHEPP. Good morning. Thank you, Chairman Norwood, for the opportunity to present testimony this morning on behalf of the American Academy of Physician Assistants.

I am here to discuss the need to update the Federal Employees' Compensation Act to allow PAs to diagnose and treat Federal workers who are injured on the job.

I request that my written statement be included in the hearing record.

Mr. NORWOOD. So ordered.

Mr. KOHLHEPP. My name is Bill Kohlhepp, as you said, and I have been a physician assistant for 25 years. As you said, I am the associate director of the Quinnipiac University physician assistant program.

For the past 15 years, I have continued my clinical practice at Saint Raphael's Occupational Health Plus in New Haven, Connecticut.

I am a past president of the AAPA and current chair of the National Commission on Certification of PAs, which is the certifying body for PAs.

What I would like to do this morning is to provide a brief overview of PA education, and I would like to share our perspective on why it is important to update FECA to allow PAs to diagnose and treat Federal employees who are injured on the job.

PA programs are located at schools of medicine or health sciences, universities, teaching hospitals, and the armed services.

All PA programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant, an organization composed of representatives from national physician groups and PAs.

The average PA program is 26 months and is characterized by a rigorous competency-based curriculum with both didactic and clinical components.

The first phase of the program consists of an intensive classroom and laboratory study providing students with an in-depth understanding of the medical sciences.

The second year of PA education consists of clinical rotations.

On average, PAs devote more than 50 to 55 weeks to clinical education.

The overwhelming majority of PA programs offer master degrees. After graduation, PAs must pass a national certifying exam.

PAs maintain their certification through required CME and recertification by exam every 6 years.

PAs are licensed health-care professionals who practice medicine, as delegated by and with the supervision of a physician.

PAs are legally regulated in all states.

Forty-eight states, the District of Columbia, and Guam authorize physicians to delegate prescriptive privileges to PAs.

In 2004, an estimated 206 million patient visits were made to the 55,000 PAs in clinical practice. Approximately 250 million medications were prescribed or recommended by those PAs.

PAs always work with physicians. However, this does not mean that the physician is necessarily onsite, nor does it suggest that PAs do not make autonomous medical decisions. For example, PAs employed by the State Department may be—may work with a physician who is a continent away and available for consultation by telecommunication.

It has been said that every workers' compensation case is a failure of prevention, and PAs as a profession have a particular focus in prevention. PAs' versatility, competencies, and interpersonal skills are well suited to the demands of occupational medicine.

PAs participate in the promotion of employee health, including the treatment of occupational injuries and illnesses, preventive and pre-placement exams, health maintenance activities, immunization programs, Department of Transportation exams, workers' compensation case management follow-up, and health and safety education.

What does it mean for my practice that I cannot sign FECA claim forms as a PA? The bottom is that, unless the physician signs the form, the claim is not paid.

In letters responding to Congressional inquiries on PAs and FECA, the DOL's Office of Workers' Compensation has taken the position that claims or reports are not acceptable if they have been signed by a PA, because PAs are not included in the FECA's definition of physician.

PAs currently jump through hoops to ensure that physicians sign the workers' compensation claims in order to make the system work for the injured employee and the practice.

Waiting for a physician's signature is not the best use of the physician's time, my time, or the time of the injured worker, and physicians are not always available, particularly in rural and urban medically under-served communities where PAs may be the only licensed health care professionals serving the community or in clinics staffed by PAs that provide care during evenings and weekends or at other times without a physician present.

We believe that it makes good sense and good public policy to update FECA to allow PAs to diagnose and treat Federal employees who are injured on the job. The current restriction limiting PAs' abilities to provide care to Federal workers adds unnecessary cost to the system, limits Federal workers' access to quality medical care, restricts Federal workers' choice of a preferred health care professional, and may result in problems related to continuity of care.

There is another good reason to update FECA to allow PAs the ability to diagnose and treat injured workers, the shortage of physicians in occupational medicine. The 1,500 to 1,800 occupational medicine physicians in practice today falls far below the need.

We believe these are compelling reasons to update FECA to recognize PAs.

Thank you for the opportunity to present testimony before the Subcommittee. I look forward to responding to your questions.

[The prepared statement of Mr. Kohlhepp follows:]

Statement of William C. Kohlhepp, MHA, PA-C, Assistant Professor and Associate Director, Physician Assistant Program, Quinnipiac University, Hamden, CT

Good Morning. Thank you, Chairman Norwood and Representative Owens, for the opportunity to present testimony this morning before the Subcommittee on Workforce Protections. On behalf of the American Academy of Physician Assistants (AAPA), I also wish to thank you for your interest and leadership in updating the Federal Employees' Compensation Act (FECA) to allow PAs to diagnose and treat federal workers who are injured on the job.

My name is Bill Kohlhepp. I am a graduate of the University of Medicine and Dentistry of New Jersey's PA Program, and I have been a physician assistant for the past 25 years. I hold a master's degree in health administration and am currently enrolled in a doctoral program in health science.

I am the Associate Director of the Quinnipiac University Physician Assistant Program, where I am also a professor. For the past 15 years, I have practiced clinically on a part-time basis for Saint Raphael's Occupational Health Plus, which is an occupational medicine practice affiliated with Saint Raphael's Hospital in New Haven, Connecticut. I was the founding Administrative Director of the practice. I am also a co-author of an article on the role of PAs in occupational medicine that was published in the *Journal of the American Academy of Physician Assistants*.

I am a member of the AAPA and the American Academy of Physician Assistants in Occupational Medicine (AAPA-OM). I am a former president of AAPA, as well as a former Speaker of the AAPA's House of Delegates. I am the current Chair of the National Commission on Certification of Physician Assistants (NCCPA), which is the certifying organization for PAs in the United States.

On behalf of the more than 55,000 clinically practicing physician assistants in the United States who are represented by the American Academy of Physician Assistants, I am pleased to submit comments on the need to update the Federal Employees Compensation Act (FECA) to allow PAs to diagnose and treat federal workers who are injured on the job.

Overview of Physician Assistant Education

Physician assistant programs provide students with a primary care education that prepares them to practice medicine with physician supervision. PA programs are located at schools of medicine or health sciences, universities, teaching hospitals, and the Armed Services. All PA educational programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant, an organization composed of representatives from national physician groups and PAs.

The average PA program is 26 months and is characterized by a rigorous, competency-based curriculum with both didactic and clinical components. The first phase of the program consists of intensive classroom and laboratory study, providing students with an in-depth understanding of the medical sciences. More than 400 hours in classroom and laboratory instruction are devoted to the basic sciences, with over 70 hours in pharmacology, more than 149 hours in behavioral sciences, and more than 535 hours of clinical medicine.

The second year of PA education consists of clinical rotations. On average, students devote more than 2,000 hours or 50–55 weeks to clinical education, divided between primary care medicine and various specialties, including family medicine, internal medicine, pediatrics, obstetrics and gynecology, surgery and surgical specialties, internal medicine subspecialties, emergency medicine, and psychiatry. During clinical rotations, PA students work directly under the supervision of physician preceptors, participating in the full range of patient care activities, including patient assessment and diagnosis, development of treatment plans, patient education, and counseling.

After graduation from an accredited PA program, the physician assistant must pass a national certifying examination jointly developed by the National Board of Medical Examiners and the independent National Commission on Certification of Physician Assistants. To maintain certification, PAs must log 100 continuing medical education credits over a two-year cycle and reregister every two years. Also to maintain certification, PAs must take a recertification exam every six years.

A growing number of PAs possess master's degrees, and the majority of PA educational programs now offer master's degrees. According to data collected by the AAPA, 61.7 percent of PAs graduating from a PA educational program in 2004 received a master's degree. Approximately 80 percent of the 137 PA educational programs currently offer master's degrees.

Physician Assistant Practice

Physician assistants are licensed health care professionals educated to practice medicine as delegated by and with the supervision of a physician. In all states, physicians may delegate to PAs those medical duties that are within the physician's scope of practice and the PA's training and experience, and are allowed by law. Forty-eight states, the District of Columbia, and Guam authorize physicians to delegate prescriptive privileges to the PAs they supervise.

PAs always work with physicians. However, this does not mean that the physician is necessarily on site, nor does it suggest that PAs do not make autonomous medical decisions. PAs employed by the State Department, for example, may work with a physician who is a continent away and available for consultation by telecommunication.

PAs are located in almost all health care settings and in every medical and surgical specialty. Nineteen percent of all PAs practice in non-metropolitan areas where they may be the only full-time providers of care (state laws stipulate the conditions for remote supervision by a physician). Approximately 41 percent of PAs work in urban and inner city areas. Approximately 44 percent of PAs are in primary care. Nearly one-quarter practice in surgical specialties. Roughly 80 percent of PAs practice in outpatient settings. In 2004, an estimated 206 million patient visits were made to PAs and approximately 250 million medications were prescribed or recommended by PAs.

PAs are covered providers within Medicare, Medicaid, Tri-Care, and most private insurance plans. Additionally, PAs are employed by the federal government to provide medical care, including the Department of Defense, the Department of Veterans Affairs, the Public and Indian Health Services, the State Department, and the Peace Corps. PAs are designated as covered providers in the overwhelming majority of State workers' compensation programs. (A chart is attached to the testimony, summarizing coverage of medical services provided by PAs in the State workers' compensation programs.)

Physician Assistants in Occupational Medicine

Physician assistant versatility and interpersonal skills are well suited to the demands of occupational medicine. Working as part of a medical team, physician assistants participate in the promotion of employee health, including the treatment of occupational injuries and illnesses, preventive and pre-placement examinations, health maintenance activities, immunization programs, Department of Transportation exams, workers' compensation case management follow-up, and health and safety education.

PAs deliver employee health services in diverse settings—corporate medical offices, occupational medicine clinics, private physician offices, hospital employee health departments, clinics for production plants or mines, remote pipeline locations, aboard ship, on military bases, and on the White House medical staff.

The US Department of Transportation allows PAs to perform and sign truck driver physicals. The regulations identify the responsibilities of the medical examiner in performing and recording the physical examination (49 CFR, Part 391.43) and define physician assistants as medical examiners. PAs are employed in occupational medicine roles by numerous federal agencies, including the Department of Veterans Affairs and the Department of Defense. OSHA recognizes PAs as qualified occupational medicine providers able to “perform physical examinations, identify health problems, and plan therapeutic interventions.”

Following are a few examples of PAs who practice in occupational medicine.

PA Fills Diverse Role with Occupational Med Company

A PA working for Mercy Occupational Health—a clinic providing occupational medicine services to a diverse range of employers including General Motors, Wal-Mart, Lear Jet, local school districts, and service industry employers—treats patients with a wide range of work-related injuries, including strains, lacerations, and repetitive stress ailments. After diagnosis, she equips employees with detailed written instructions concerning all aspects of their recovery, including the use of prescribed medications and how to best protect injured areas against further damage. She consults with managers about lighter duty assignments during employee recovery. Follow-up visits help to ensure a full and well-coordinated recovery.

The PA administers a range of pre-placement physicals for employers, including fitness tests and drug screenings tailored to reflect the physical demands of the work to be performed. In addition, she performs DOT physicals for employers including the local school district and Federal Express.

This physician-PA team effectively increases patient access to care by sending the PA off-site to provide care at a laboratory equipment factory four hours a week. The physician is available for consultation by phone if necessary while the PA sees the workers, many of whom have no other medical provider. By answering their medical questions and providing general health education, the PA helps keep the factory workers well and able to work in a physically demanding setting.

PA Care at Los Alamos

The workers and researchers of Los Alamos Nuclear Laboratory receive their occupational health services from a physician assistant. This PA specializes in the prevention, diagnosis, and referral of radiation-related conditions. To help Los Alamos fulfill strict Occupational Safety and Health Administration (OSHA) regulations concerning radiation exposure, he conducts rigorous medical exams for employees on a yearly basis. The PA also treats the researchers employed by the facility who travel to remote locations and return with ailments related not only to radiation exposure but also more mundane problems such as stomach ailments. A physician is always on-site at the facility and coordinates care with the PA.

PA Versatility Shows at New York Presbyterian Hospital

A PA employed by New York Presbyterian Hospital treats a diverse population of hospital employees and Cornell University researchers. Her versatility is impressive, ranging from pre-placement exams to developing preventive worker safety measures. In conducting pre-placement examinations for candidates offered employment by the hospital, she tests for TB, illegal substances, and HIV, and gauges applicants' physical fitness to perform job duties. This PA also serves as a main contact person for impaired employees, making referrals to drug and alcohol treatment centers.

As a certified New York state HIV educator, the PA at New York Presbyterian Hospital conducts employee safety training for hospital employees at risk for HIV exposure through blood or body fluid exposure. This PA also oversees a program addressing the special health needs of Cornell researchers working in a Biosafety Level 3 Lab. Here researchers are exposed to a variety of health risks through their contact with lab animals, including rare viruses. To protect against these hazards, the PA has devised and implemented lab safety measures in cooperation with the New York State Department of Health and laboratory and hospital officials.

CDC Employs Occupational Medicine PAs

At the federal Centers for Disease Control and Prevention (CDC), a PA cares for researchers who typically spend a month at a time in "hot spots" or disease outbreak areas around the world. His practice combines travel medicine with infectious disease medicine. Researchers generally return with at least one ailment, ranging in seriousness from digestive problems to malaria. One of the PA's specialty areas is the testing of researchers' fitness for the use of physically demanding protective gear. Cardiopulmonary tests gauge employees' fitness for use of protective gear used in highly toxic environments. Working closely with his supervising physician, he coordinates the annual bioterrorism fitness exams required of CDC researchers.

His other large patient base consists of CDC office workers who typically suffer from carpal-tunnel syndrome and similar repetitive stress injuries. In these cases, the PA collaborates with the CDC's industrial hygienist to restructure employees' workstations along ergonomic standards and trains employees in preventive measures against repetitive stress.

State Department Counts on Versatility

The U.S. Department of State employs occupational medicine PAs to provide medical care to State Department employees and their families overseas. For example, a PA working for the State Department manages family medicine as well as emergency medical crises. In addition, he serves as the medical liaison between employees and host country medical personnel and facilities, inspecting local hospitals to determine their quality of care. In countries where acceptable inpatient care is not available, he has developed alternative sites where patients can be stabilized prior to airlift to hospital. This PA's work epitomizes the clinical range and organizational versatility of PAs in occupational medicine.

PA Practice at Saint Raphael's Occupational Health Plus

The hospital-based occupational medicine practice where I work has 300 clients. For our federal clients, like the FBI and the Post Office, we perform pre-employment physicals and treat injuries that are covered by FECA. With respect to the workers on the merchant ships arriving in New Haven Harbor, virtually all illnesses and injuries are covered under workers' compensation. We do a lot of work with employees who have back, shoulder, and knee injuries. In order to be most effective as a clinician, it is important for me to be familiar with the workplace and know about the workers' compensation system so that informed decisions can be made about returning employees to work.

My day at Saint Raphael's Occupational Health Plus is typically divided between seeing employees with work-related injuries and doing examinations on individuals who are being hired or employees who need periodic screening. Injuries are generally musculoskeletal sprains and strains, but may also involve lacerations, burns, fractures, or eye injuries. Evaluating and treating employee exposures to infectious agents like tuberculosis or bloodborne pathogens (i.e., Hepatitis B or HIV) may also be involved. Pre-placement examinations are performed immediately before the employee is hired. Periodic examinations are performed to evaluate potential health effects of exposures to chemicals or other things in the worker's environment. They are also completed to evaluate the worker's continuing ability to safely perform their jobs, such as DOT physicals for truck drivers or respirator examinations for fire-fighters.

What does it mean for my practice that I can not sign FECA claims forms as a PA? The bottom line is that unless the physician signs the form, the DOL's Office of Workers' Compensation will not honor the FECA claim. At a minimum, this means that the physician can not make the maximum use of my skills and must sign every workers' compensation form. Quite frankly, this is not the best use of the physician's time and expertise. The problem is exacerbated when I'm performing on-call services for the practice or if I'm providing after-hours care at the practice. Physicians hire PAs to extend their reach and to extend access to care. Many physicians also hire PAs to make life a little easier for them—to share on-call duties and to provide after-hour care.

The Problem with the Federal Employees Compensation Act

In letters responding to congressional inquiries on PAs and FECA, the Office of Workers' Compensation has taken the position that claims or reports are not acceptable if they have been signed by a PA, because PAs are not included in FECA's definition of "physician" (section 8101 (2)).

In a December 2001 letter to Senator Gramm, the Director of the Office of Workers' Compensation Program wrote:

OWCP is responsible for the administration of the Federal Employees' Compensation Act (FECA). In Section 8101(2) of this Act, physicians are defined as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law.

Since Physician's [sic] Assistants are not included in this definition, we are unable to accept their clinical reports as medical evidence unless these reports are countersigned by a physician.

Why It Makes Good Sense and Good Public Policy to Update FECA to Allow PAs to Diagnose and Treat Federal Employees who are Injured on the Job

Simply put, the current restriction limiting PAs ability to provide care to federal workers who are injured on the job results in added costs to the system, unnecessarily limits federal workers' access to quality medical care, restricts federal workers' choice of preferred health care professional, and may result in problems related to continuity of care.

PAs currently jump through hoops to ensure that physicians sign the workers' compensation claim in order to make the system work for the injured employee and the practice. However, physicians aren't always available—particularly in rural and urban medically underserved communities where PAs may be the only health care professional serving the community or in clinics staffed by PAs that provide care during evenings and weekends. Following are a few of the personal examples that we've heard from PAs regarding the FECA problem.

- A PA in Georgia informed us that federal workers were advised to use hospital emergency rooms for non-emergency care, rather than receiving care after-hours at local clinics where PAs were the only health care professional on-site. Ironically, the care provided in the emergency room could be provided by a PA—at 4-5 times the cost.

- A federal worker in Massachusetts recently asked a PA in a surgical practice where he had undergone surgery to suture a laceration on his leg that occurred while on the job. The physician was not in the office that day, and the PA had two choices—to send her patient to the emergency room or to provide the care, knowing that the practice wouldn't be reimbursed. She chose continuity of care and sutured his leg.
- Every rural community in the nation has at least one employee of the U.S. Postal Service. A PA from Iowa commented that it made no sense that she could provide medical care to this employee on an ongoing basis, but not be able to collect reimbursement for attending to a dog bite or other injury that occurred on the job.

We also understand that the FECA issue is particularly troublesome in the Peace Corps and State Department where many injuries and illnesses are covered under the Federal Workers' Compensation Program.

As federal employees, Subcommittee Members and staff have the option of seeing a PA through your Federal Employee Health Benefit Plan. But, you may not be able to see the PA if you're injured during working hours.

There is also another very good reason to update FECA to allow PAs the ability to diagnose and treat injured workers—the shortage of physicians in occupational medicine. According to the American Board of Preventive Medicine, only 3,332 physicians have been certified in occupational medicine since 1955, and only 1,500 –1,800 of these physicians are actually in practice today. This number falls far below the Bureau of Health Professions' estimated need of 4,830 physicians certified in occupational medicine or the Institute of Medicine's need estimate of 3,100 –5,500 occupational medicine physicians.

We believe that expanded access to care and continuity of care for federal workers are compelling reasons to update FECA to recognize PAs, as are potential cost savings and meeting the need that is created by the physician workforce shortage in occupational medicine. After all, that's why the physician-PA team concept was created—to expand the physician's ability to provide care.

Thank you for the opportunity to present testimony before the Subcommittee. I look forward to responding to your questions.

[An attachment to Mr. Kohlhepp's statement follows:]

STATE WORKERS' COMPENSATION PROGRAMS

State	PA Covered Provider	Services Covered
ALABAMA	Yes	Determined in pre-authorization. PA limited to 99201, 99211 evaluation and management codes; 12.5% reimbursement for first assisting
ALASKA	Yes	All medical services cited in PA law except assisting at surgery
ARIZONA	Yes	Same as PA law, first assist 10%
ARKANSAS	*	
CALIFORNIA	Yes	Insurer authorizes PA services, first assist 10%
COLORADO	Yes	Insurer authorizes PA services, first assist 10%
CONNECTICUT	Yes	Same as PA law
D. C.	No	
DELAWARE	*	
FLORIDA	Yes	75% of physician allowable
GEORGIA	Yes	Same as PA law
HAWAII	Yes	Maximum 15% for first assisting
IDAHO	*	Same as PA law
ILLINOIS	*	
INDIANA	*	Check with individual company
IOWA	*	
KANSAS	Yes	All practitioners limited to \$500 unless pre-authorized by employer
KENTUCKY	Yes	20% reimbursement rate for first assisting
LOUISIANA	Yes	Same as PA law
MAINE	Yes	50% for first assisting
MARYLAND	Yes	All services cited in PA law except first assisting at surgery
MASSACHUSETTS	Yes	All medical services cited in PA law except administration of anesthesia and ionizing radiation
MICHIGAN	Yes	13% reimbursement rate for first assisting
MINNESOTA	Yes	Same as PA law. Reimbursement for assisting in surgery depends on facility type.
MISSISSIPPI	No	
MISSOURI	*	
MONTANA	Yes	Same as PA law
NEBRASKA	Yes	Same as PA law
NEVADA	Yes	Rural PA contacts physician daily when treating workers comp patient, 14% for first assisting
NEW HAMPSHIRE	Yes	Same as PA law
NEW JERSEY	*	
NEW MEXICO	Yes	First assisting determined by insurance carrier
NEW YORK	Yes	Same as PA law
NORTH CAROLINA	Yes	All medical services cited in PA law except first assisting at surgery
NORTH DAKOTA	Yes	10% reimbursement for first assisting
OHIO	Yes	Same as PA law
OKLAHOMA	Yes	10 % reimbursement rate for first assisting
OREGON	Yes	
PENNSYLVANIA	Yes	Same as PA law
RHODE ISLAND	Yes	16% reimbursement rate for first assisting
SOUTH CAROLINA	Yes	Same as PA law
SOUTH DAKOTA	Yes	10% reimbursement rate for first assisting
TENNESSEE	Yes	
TEXAS	Yes	Same as PA law, 10% for first assisting
UTAH	Yes	PA cannot take anyone off work
VERMONT	Yes	Same as PA law
VIRGINIA	Yes	Same as PA law
WASHINGTON	Yes	Same as PA law
WEST VIRGINIA	Yes	Same as PA law, 15% for first assisting
WISCONSIN	Yes	
WYOMING	Yes	Same as PA law, 15% for first assisting

*Individual workers' compensation insurance carriers determine coverage policy. The state has no specific policy regarding medical services provided by PAs.

This chart is based on information gathered from phone calls made to workers' compensation offices throughout the country. Blank spaces indicate incomplete information provided by state agencies. It is best to call the state workers' compensation offices for specific information about their policies regarding coverage of medical services provided by physician assistants. In most cases (except when the reimbursement rate is less than 100%) services provided by PAs are billed under the physician's name and provider number.

5/9/03

Mr. NORWOOD. Thank you very much.
Having spent 45 days in the hospital last year, I got to know your crowd pretty well.

I know what you guys do.

Mr. KOHLHEPP. I am happy to hear that we played an important role in your recovery.

Mr. NORWOOD. They did, indeed.

Dr. Towers, you are now recognized for 5 minutes for testimony.

STATEMENT OF JAN TOWERS, PhD, NP-C, CRNP, FAANP, DIRECTOR OF HEALTH POLICY, AMERICAN ACADEMY OF NURSE PRACTITIONERS, WASHINGTON, DC

Dr. TOWERS. I am here representing the American Academy of Nurse Practitioners, which is the full-service organization that represents over 90,000 nurse practitioners of all specialties throughout the United States. I am the director of health policy, but I am also a family nurse practitioner, and I am here to speak to the proposed amendment to the Federal Employees' Compensation Act.

Certified registered nurses are advanced practice nurses who have completed a formal nurse practitioner program culminating in a minimum of a Master's education beyond their 4-year baccalaureate education in professional nursing. This means they have a total of 6 years of preparation in the medical and health care field.

Most, in addition, are seasoned nurses before they go back for their graduate degree to become a nurse practitioner, and we then become educated by specialty, and our specialties follow along the same lines as the physician specialties, with family, internal medicine, pediatrics, gerontology, etcetera.

Nurse practitioners are prepared to be primary care providers in today's health care arena, and they have been recognized as medical providers in the Federal employee health insurance program since the 1980's.

As the Committee knows, nurse practitioners are highly qualified health care providers who have demonstrated their skill in providing primary care to individuals in both rural and urban settings, regardless of age, occupation, or income. The quality of their care has been well documented over the years.

With their advanced preparation, they are able to manage the medical and health problems seen in the primary care and acute care settings in which they work.

Nurse practitioners constitute an effective body of health care providers that may be utilized as a cost savings in both fee-for-service and managed care arenas in the country.

Recent managed care data reports an aggregate patient-per-month cost savings of over 50 percent among patients seen by nurse practitioners when compared to similar patients being seen by physicians, and I did bring a document here that has a number of citations that speaks to similar kinds of findings and studies.

Other cost savings realized when nurse practitioners are properly utilized include savings due to reductions in emergency room visits and hospitalizations.

In relation to cost, not recognizing nurse practitioners as attending providers for Federal employees in the Federal employees compensation program actually creates a cost for the Federal Government, because the patient is required to see a physician for any work related to a work-related medical problem.

This potentially increases the number of medical encounters incurred by patients who will continue to see their regular health care provider for other medical problems while seeing the required physician provider for the problem coming under the aegis of the Federal employees compensation program.

Nurse practitioners diagnose and treat patients of all ages and walks of life. This includes taking patient histories, conducting physical examinations, ordering and interpreting their diagnostic tests, and prescribing medications and other treatments for their medical problems.

Nurse practitioners are often the only provider in a particular health care setting. In rural areas, it means that patient have to travel distances to see other providers when that is required.

The inability of nurse practitioners to serve their patients when an occupationally related injury or illness occurs not only creates additional cost by forcing patients to go elsewhere for the care of these conditions, often to the more expensive emergency rooms, but also creates fragmentation of care that can have implications for other health care outcomes.

Nurse practitioners are covered medical providers in Medicare, Medicaid, Tricare, and private insurance plans, as well as the Federal employees health insurance program. They serve as medical providers in the VA, the Department of Defense, and the Indian Health Service.

They are capable of performing services for workman's compensation patients in state programs but are still excluded from doing the same for Federal employees who are under their care.

Nurse practitioners are licensed to practice in all 50 states and the District of Columbia.

They are authorized to diagnose, treat, and prescribe medications under their own signatures.

They are board-certified.

They carry malpractice insurance.

They are capable of making medical judgments related to occupational hazards, diseases, and injuries.

They have an outstanding record for providing high-quality care, and they are cost-effective.

According to the current statute, Federal employees come under the jurisdiction of the Federal Employees' Compensation Act, have the right to choose their own health care provider for the treatment of their condition. Yet if their health care provider is a nurse practitioner, they are forced to go elsewhere for that part of their medical care, even though the nurse practitioner is perfectly qualified to provide the care they need.

It is for this reason that we are asking the Federal Employees' Compensation Act be amended to include nurse practitioners as medical providers in that act, and we thank you for the opportunity to speak with you, and I will be glad to answer any questions.

[The prepared statement of Dr. Towers follows:]

Statement of Jan Towers, PhD, NP-C, CRNP, FAANP, Director of Health Policy, American Academy of Nurse Practitioners, Washington, DC

My name is Jan Towers. I am here representing the American Academy of Nurse Practitioners, the full service organization representing over 90,000 nurse practitioners of all specialties throughout the United States. I am the Director of Health

Policy and a family nurse practitioner. I am here to speak to the proposed amendment to the Federal Employees' Compensation Act that would allow nurse practitioners and physician assistants to be covered providers under that act.

Certified registered nurse practitioners are advanced practice nurses who have completed a formal nurse practitioner program culminating in a minimum of a Master's education beyond their four-year baccalaureate education in professional nursing. They are prepared to be primary care providers in today's health care arena. As the committee knows, nurse practitioners are highly qualified health care providers who have demonstrated their skills in providing primary care to individuals in both rural and urban settings regardless of age, occupation or income. The quality of their care has been well documented over the years. With their advanced preparation, they are able to manage the medial and health problems seen in the primary care and acute care settings in which they work.

Nurse practitioners constitute an effective body of health care providers that may be utilized at a cost savings in both fee for service and managed care arenas in this country. Recent managed care data reports an aggregate patient per month cost savings of over 50% among patients seen by nurse practitioners when compared to similar patients being seen by physicians. Other cost savings realized when nurse practitioners are properly utilized include savings due to reductions in emergency room visits and hospitalizations.

Not recognizing nurse practitioners as attending providers for federal employees in the Federal Employees' Compensation Program actually creates a cost for the federal government because the patient is required to see a physician for any work related medical problem. This potentially increases the numbers of medical encounters incurred by patients who will continue to see their regular health care provider for other medical problems while seeing the required physician provider for the problem coming under the aegis of the Federal Employees' Compensation Program.

Nurse practitioners diagnose and treat patients of all ages and walks of life. This includes taking patient histories, conducting physical examinations, ordering and interpreting their diagnostic tests and prescribing medications and other treatments for their medical problems. Nurse practitioners are often the only provider in a particular health care setting. In rural areas this means that patients have to travel distances to see other providers. The inability of nurse practitioners to serve their patients when an occupationally related injury or illness occurs, not only creates additional costs by forcing patients to go elsewhere for the care of these conditions (often to more expensive emergency rooms), but also creates fragmentation of care that can have implications for other health care outcomes.

Nurse practitioners are covered medical providers in Medicare, Medicaid, Tri-care and private insurance plans. They serve as medical providers in the Veterans Administration, the Department of Defense and the Indian Health Service. They are capable of performing services for worker's compensation patients in state programs, but are still excluded from doing the same for federal employees who are under their care.

Nurse practitioners are licensed to practice in all fifty states and the District of Columbia. They are authorized to diagnose, treat and prescribe medications under their own signature. They are Board certified. They carry malpractice insurance. They are capable of making medical judgments related to occupational hazards, diseases and injuries. They have an outstanding record for providing high quality care.

According to the current statute, federal employees coming under the jurisdiction of the Federal Employees' Compensation Act, have the right to choose their own health care provider for the treatment of their condition. Yet, if their health care provider is a nurse practitioner, they are forced to go elsewhere for that part of their medical care, even though the nurse practitioner is perfectly qualified to provide the care they need. It is for this reason that we are asking the Federal Employees Compensation Act be amended to include nurse practitioners as medial providers in the act.

We thank you for the opportunity to discuss this issue with you. I will be glad to answer questions or provide you with further information that you may need.

Mr. NORWOOD. Thank you, Dr. Towers.

Mr. Kline, you are recognized for 5 minutes for questions.

Mr. KLINE. Thank you, Mr. Chairman.

I would like to thank the witnesses for being here today.

We discovered in the earlier panel that the occupation of one's spouse may sometimes indicate a level of interest. I would have to

admit that my spouse has spent 30 years as a registered nurse, so I have been following the testimony of Dr. Towers very closely, and it does seem to me we have a serious disconnect here. I have got a couple of notes here, and some questions, and I will direct them to you, if I could, Dr. Towers.

You mention that the nurse practitioners are board certified and carry liability insurance. Is there a difference in that insurance between a nurse practitioner and a physician both in coverage and cost?

Dr. TOWERS. In coverage, we cover 1 million/3 million, generally, which is about the same as a physician, and the cost right now is considerably less than a physician. We still pay less than \$1,000 a year for malpractice insurance. So, we have been very well protected.

Our malpractice rate is quite low, less than 1 percent, and that has not changed.

We did studies in 1989 and in 1999 and just completed another study, national study, last year, and that rate is just about the same as where it was in 1989.

Mr. KLINE. Thank you.

You also mentioned that nurse practitioners are covered medical providers under Medicare, Medicaid, Tricare, I think you said, and some others. Do you know—are nurse practitioners and physicians treated the same, exactly the same, in those programs, and if not, what the differences might be?

Dr. TOWERS. The difference in some of the programs, such as Medicare, is a difference in reimbursement. For every 100 percent of the physician payment, where you have \$100, the nurse practitioner's reimbursement would be 85. It's 85 percent of the physician cost. The activities are the same within the primary care piece. Nurse practitioners are not in surgery, but they do work in sub-specialties in relation to things like orthopedics.

Mr. KLINE. OK. Thank you.

I will ask one more question and yield back.

Do you know, yourself, if state workers' compensation programs allow nurse practitioners to be designated as medical providers?

Dr. TOWERS. Yes, they do, and this is not 100 percent at this point, but I think one of the reasons this came to the surface, because we were doing workman's comp for other things in the state, and then you would get a Federal employee in your practice come to you, and suddenly you could not sign something that you have been signing for everybody else, and that is how we became aware that we were beginning to have a problem with this.

Mr. KLINE. That there was a discrepancy?

Dr. TOWERS. Yes.

Mr. KLINE. Would you say that was true in most of the states?

Dr. TOWERS. I would say, at this point, we are probably around half or over half.

We are doing it—it is something that has grown over the past several years.

More and more states are recognizing nurse practitioners to do this.

I certainly do it in Maryland.

Mr. KLINE. Well, thank you for the questions. I do see a very serious disconnect here, and I was interested in your testimony talking about how you have someone whose primary care provider is a nurse practitioner, they are injured, and suddenly they have to go someplace else, and it looks like we ought to be able to fix that.

Thank you, Mr. Chairman.

I yield back.

Mr. NORWOOD. The gentleman yields back.

Dr. Price, you are recognized.

Dr. PRICE. Thank you, Mr. Chairman, and I want to thank you all for coming, as well. I am sorry that I was not here for your testimony. We had a vote on the floor, and I apologize.

As you may know, I am an orthopedic surgeon from Georgia, and we have some interesting scope-of-practice issues in that state, as you know. It is always a challenge, and the challenge that we have as policymakers is to make certain that patients are provided quality care, and I know that you concur with that.

Dr. TOWERS. That is correct.

Dr. PRICE. That is your goal, as well.

Professor, I am interested in—and I am sorry I did not hear your testimony, but I am interested in kind of the history of PAs and how they relate to physicians and how you see that relationship changing, if at all, if we were to adopt this legislation.

Mr. KOHLHEPP. Well, thank you very much for that question.

Certainly, the history of the physician assistant profession started in the mid-1960's at a time of significant shortage of particularly primary care physicians, was the specialty that was really lacking, and physician assistants that came out of the Duke University system—Dr. Eugene Stead started the profession, and it started with three Navy corpsmen.

So, it has a long history both with physician education, physician educators, a commitment to the physician-PA team, and I do not see that commitment ever changing, and certainly, this legislation will allow physicians to better use PAs and to more efficiently and seamlessly see a series of patients in their practice, rather than trying to say which patient has what kind of insurance when they are coming in the door. That makes a great deal of difficulty for a practice.

Dr. PRICE. As a physician extender, if you will? Is that fair to say?

Mr. KOHLHEPP. Personally, I like to refer to both professions as physician assistants and advanced practice registered nurses and nurse practitioners, whatever they prefer, but it certainly is a role that we play, where we extend the ability of physicians to provide access, quality of care, and cost-effective care.

Dr. PRICE. How close is the physician physically to PAs when they are practicing?

Mr. KOHLHEPP. As I mentioned in my testimony—

Dr. PRICE. I am sorry.

Mr. KOHLHEPP. I recognize that you needed to vote.

PAs are in a variety of settings, and the presumption is that supervision is active and that the physician is supervising the PA, providing conversations before patient care, quality checks after patient care, and availability during patient care, but availability can

be via telecommunication, particularly in rural sites or inner city communities, was the two examples I used in my testimony, where a physician may not be physically present. That does not mean that supervision is not effective.

Dr. PRICE. I understand.

Dr. TOWERS—and again, I am sorry, I missed the beginning of your statement, but tell me about the numbers of APNs across the nation.

Dr. TOWERS. There are 106,000 nurse practitioners at this point in time in the United States.

Dr. PRICE. Is there any evidence that they practice in settings—any objective evidence where—that they practice in settings where physicians do not?

Dr. TOWERS. Oh, yes.

Dr. PRICE. Is that in your testimony?

Dr. TOWERS. I do not know that we put it quite that way, but nurse practitioners are often utilized in areas, and your state is one of them, where there are no physicians available, and you have got one of the most interesting states in terms of how they manage to function with some of the things they have to deal with in the state as far as statute and regulation is concerned, but nurse practitioners will be sole providers in consultation with other health care providers, including physicians in many areas, and in our rural areas, it is particularly prevalent.

Dr. PRICE. I suspect you all have data on that, do you not?

Dr. TOWERS. Yes, we do.

Dr. PRICE. Would you be able to provide that?

Dr. TOWERS. We certainly can, and we can tell you there are some states that do not have requirements for physicians to be hooked into—for them to be hooked into a physician in a formal manner.

That does not mean that they do not consult and that they do not have their network of health care providers, which include physicians, that they utilize regularly, and so, we have about 13 states that—where nurse practitioners actually function that way at this point in time.

Dr. PRICE. Do you see this legislation resulting in a collaborative relationship between APNs and physicians in a structured way or just—

Dr. TOWERS. I think it would be according to how the state laws establish the relationship. What would be required of them in the state in terms of their license and how they function under their license would be the way that—it would be consistent with this. In terms of collaborating with physicians—if you are thinking about are there things that get out of their scope, every nurse practitioner has to have a way to deal with things that are outside their scope, and so, you have a referral network that you utilize, or consulting network. That is what the collaboration word means for us.

Dr. PRICE. Us, as well.

Thank you so much.

I yield back.

Mr. NORWOOD. The gentleman yields back.

Mr. Owens, you are recognized.

Mr. OWENS. Mr. Chairman, I just have one brief question, and that is for Dr. Towers.

Would you agree that nurse anesthetists should be able to provide services under FECA as part of an advanced practice category?

Dr. TOWERS. Yes. We do not see any problem with that. The reason this became—was a nurse practitioner issue is because we are the ones that are generally hit with not being able to function with our patients in relation to this. When a patient can choose a—their attending provider, why that attending provider is generally not going to be an anesthetist or, you know, some of the other advanced practice groups.

The nurse practitioners are the ones that are sitting in the position where, when it comes to documenting and recognizing that someone has a problem and determining what needs to be done about it, they are the ones that are finding that they cannot provide that service, unless they want to do it free, and even then it does not work, even if they do it for free, because you have to have that physician's signature on these documents, which means you have to go find a physician to do it.

So, that is why this has been focused mainly on nurse practitioners, but we have no problems with other kinds of advanced practice nurses being included. We need to look and see how they would fit into the pattern.

Mr. OWENS. I have no further questions, Mr. Chairman.

I want to thank the witnesses and apologize for the fact that we had to go to vote, but I have your written testimony. Thank you.

Mr. NORWOOD. Thank you, Mr. Owens.

I will just quickly follow up. Is there anybody who opposes that, that Mr. Owens just suggested?

Dr. TOWERS. I do not think so.

Mr. NORWOOD. Mrs. Drake, I think you are recognized next.

Mrs. DRAKE. Thank you, Mr. Chairman, and again, thank you for being here.

I am just trying to understand the issue in my mind, because in Virginia, nurse practitioners do work under a physician, and I have used a nurse practitioner. It was a wonderful person, did a good job.

I am not familiar with physician assistants personally, but when you reference these 13 states that—where nurse practitioners can work, do you mean they are completely on their own?

There is no physician overseeing them in any form at all?

Dr. TOWERS. According to state statute, that is correct, yes, and they function in rural areas. They are in rural health clinics, and if you have Federal clinics—I mean there is always a physician around some way, but not in a formalized manner, and in those states, they could have their own practices, and they do.

Mr. OWENS. Medicaid/Medicare would pay them directly with no physician in the middle.

Dr. TOWERS. Right.

Mr. OWENS. I had wondered if part of the reason that their liability insurance was so low was because there was a physician also responsible, but the answer to that would be no.

Dr. TOWERS. No. That is right.

Mr. OWENS. All right. Well, thank you very much.

I yield back, Mr. Chairman.

Mr. NORWOOD. The lady yields back.

I have a question for one of the Members.

Dr. Price, do physicians usually only cover themselves up to a million dollars in malpractice?

Dr. TOWERS. 1 million/3 million.

Dr. PRICE. It depends on the state or the hospital in which they practice. Many hospitals have their own levels.

1/3 is customary, 2/6 in some areas, but depending on your style of practice—

Mr. NORWOOD. Surgeons get it up as high as they can.

Dr. PRICE. We, at one point, had 15 million/30 million, because we had a fellow who was taking care of professional athletes.

Mr. NORWOOD. Would any Members like to ask additional questions?

We thank you very much for the time that you have given us and your expertise on this subject. You have done very well, and we appreciate it. We may follow up with some written questions, if that is all right, that we would like to put in the record, and with that, this hearing is now adjourned.

[Whereupon, at 11:55 a.m., the Subcommittee was adjourned.]

[Additional material submitted for the record follows:]

[The prepared statement of Mrs. Capps follows:]

**Prepared Statement of Hon. Lois Capps, a Representative in Congress
From the State of California**

Thank you for holding this hearing.

Mr. Chairman, America's fire fighters are the best trained and best equipped in the world. And they provide unparalleled service to our communities.

They do their job as well in large part because of their bravery and skill. And, they are helped along in this job by some of the prevention measures for which they have tirelessly advocated. With the help of better safety equipment, such as flame retardant suits, fire fighters can get to the heart of fires quicker and pull more victims to safety.

All Americans benefit from that.

But I don't need to tell anyone that fire fighting continues to be extremely dangerous. More than ever, fire fighters are working longer, harder hours, uncertain of what dangers lay ahead.

After September 11th, America needs its firefighters to be better prepared to respond to deliberate acts of terror and destruction. The fire service needs to be better prepared to deal with bioterrorism and it needs to be prepared to help save people who have been attacked with toxic chemical weapons.

In short, America's fire departments need to be prepared for what once seemed unthinkable.

I think most people don't understand—until they go through a fire or an emergency—exactly how many roles firefighters play, and how dangerous their job often is.

As a public health nurse, I know it is critical to provide adequate presumptive disease coverage, especially coverage that extends beyond respiratory disease.

Science tells us that when we combine high levels of stress with environmental exposure to toxins, serious ailments can result. Fire fighting is hazardous enough—the least we can do is to extend presumptive coverage to these work-related illnesses.

For that reason, my colleague Jo Ann Davis and I have introduced H.R. 697, the Federal Fire Fighters Fairness Act of 2005.

This legislation creates a presumptive disability for Federal fire fighters who become disabled by heart or lung disease, cancers such as leukemia or lymphoma, and infectious diseases like tuberculosis and hepatitis.

We introduced this bipartisan legislation on behalf of thousands of Federal fire fighters.

At great personal risk, these men and women protect America's defense installations, our veterans, Federal wild lands, and other national treasures. Yet when they present with work-related illnesses, Federal law denies them compensation and retirement benefits unless they can point to the specific conditions that caused their disease.

This onerous requirement makes it nearly impossible for Federal fire fighters to receive fair and just compensation or retirement benefits. The bureaucratic nightmare they must endure is burdensome, unnecessary, and in many cases, overwhelming.

It's ironic and unjust that the very people we call on to protect us are not afforded the health care and retirement protection that they deserve.

Too frequently, the poisonous gases, asbestos and other hazardous substances that Federal fire fighters and emergency response personnel come in contact with, rob them of their health, livelihood, and professional careers.

The Federal Government should not rob them of necessary benefits.

The Federal Fire Fighters Fairness Act will help protect the lives of our fire fighters and it will provide them with a vehicle to secure their health and safety.

In recent years, there has been a greater appreciation for the risks fire fighters and emergency response personnel face every day. Thirty-eight states have already enacted similar disability presumption laws for state and local fire fighters. It's time to provide the same protection for Federal fire fighters.

Recently, I learned of a case involving one of the Federal fire fighters in my district at Vandenberg Air Force Base. He's been fighting brain cancer for the past six months and continues radiation treatment. This father of three is responsible for \$14,000 in co-pays for his treatment.

Without presumptive care protection he has only limited Federal insurance coverage and must rely on the support of his fellow firefighters. I applaud his fellow firefighters for stepping up to the challenge—but it's the Federal government's responsibility.

We need to secure presumptive rights for Federal Firefighters now.

This bill is the right thing to do and we should make every effort to pass it.

Thank you again for having this hearing, and I wish to thank all of our nation's firefighters and emergency response personnel for everything they do.

[The prepared statement of Mr. Bishop follows:]

Prepared Statement of the Hon. Timothy H. Bishop, a Representative in Congress From the State of New York

Mr. Chairman, thank you for calling this important hearing to examine how we can make the Federal Employees' Compensation Act a better law.

In particular, I think it's important that we are taking this opportunity to acknowledge how fire fighters who have sustained injuries or illnesses in the line of duty—while protecting federal property—have experienced difficulty receiving disability benefits.

Federal fire fighters have some of the most dangerous responsibilities in the country. Protecting our national interests on military bases, nuclear plants, and other federal facilities often expose them to toxic substances, temperature extremes and stress.

Since September 11, they have assumed a greater responsibility to prepare for emergencies and stand ready to place their lives on the line to protect our families and our communities.

It's regrettable that while 38 states have passed laws shifting the burden to the government to disprove a fire fighter's claim that he or she was disabled on the job, this same standard does not apply to claims filed by federal fire fighters.

Cutting through the red tape in order to receive the compensation they deserve is a tremendous burden, unnecessary, and in many cases, overwhelming.

It's ironic that the very people we call on to protect our Nation's interests are not afforded the very best health care and retirement benefits our government has to offer.

That is why yesterday I cosponsored the legislation introduced by our colleague from Virginia, Mrs. Davis (H.R. 697, the Federal Fire Fighters Fairness Act)—to shift the burden of proof in disability claims to the federal government and make it easier for our brave fire fighters to claim the fair and just compensation they deserve.

I am very pleased to add my name to H.R. 697, and once again thank our fire fighters for their courage and service to our country.

[The American Nurses Association statement follows:]

Advanced Practice Registered Nursing: A Solution for FECA

Thank you for the opportunity to provide a statement for the record regarding the Federal Employees Compensation Act (FECA). ANA is the only full-service national association representing registered nurses (RNs). Through our 54 constituent nursing associations, we represent RNs across the nation in all practice settings. Our membership includes advanced practice registered nurses who have been unable to treat patients covered by FECA.

The mission of American College of Nurse-Midwives is to promote the health and well-being of women and infants within their families and communities through the development and support of the profession of midwifery as practiced by certified nurse-midwives, and certified midwives.

The American Psychiatric Nurses Association (APNA) represents approximately 4900 psychiatric nurses in 50 states, with one international chapter. Our mission is to promote psychiatric-mental health nursing, improve mental health care for individuals, families and communities, and to inform health policy for the delivery of mental health services. APNA represents the largest group of psychiatric nurses serving as direct care providers, researchers, educators, and administrators. Our members specialize in the full range of mental health care and substance abuse treatment to adults, children, adolescents, and the elderly in rural and urban healthcare settings.

The National Association of Clinical Nurse Specialists, founded in 1995, exists to enhance and promote the unique, high value contribution of the clinical nurse specialist to the health and well-being of individuals, families, groups, and communities, and to promote and advance the practice of nursing. Members of NACNS benefits from national, regional, and local efforts of the Association to make the contributions of CNSs more visible.

Innovative advances in health care make frequent headlines, but there is an equally innovative, if somewhat misunderstood, treatment for the cost and accessibility woes plaguing the Federal Employees Compensation Program. The Health Resources and Services Administration reports that 196,279 advanced practice registered nurses (APRNs) are prepared to serve the American populace. These APRNs are carving out a new role in delivering timely, cost-effective, quality health care, especially to chronically underserved populations such as the elderly, the poor, and those in rural areas.

Some 60 to 80 percent of primary and preventive care traditionally done by doctors can be done by a nurse for less money. This is not to say nurses work cheaper, but their cost-effectiveness reflects a variety of factors related to the employment setting, liability insurance, and the cost of education.

With an emphasis on health promotion and disease prevention and a proven record of providing excellent primary care in diverse settings, advanced practice nurses form a critical link in the solution to America's health care crisis. Removing the barriers to APRNs would pay a healthy dividend now and in the future.

Who Are APRNs?

The advanced practice registered nurse (APRN) is an umbrella term given to a registered nurse (RN) who has attained advanced expertise in the clinical management of health problems. Typically, an APRN holds a master's degree with advanced didactic and clinical preparation beyond that of the RN. Most APRNs have extensive practice experience as RNs prior to entering graduate school. Practice areas include, but are not limited to: family, gerontology, pediatrics, women's and adult health, neonatology, mental health, midwifery, and anesthesiology. Beginning in 2003, APRNs must hold a master's degree to bill Medicare for their services. Under this umbrella fall four principal types of APRNs.

Nurse Practitioner (NP)

- Number: 102,829; of which 14,643 are also trained as CNSs.
- Education: According to the American Association of Colleges of Nursing, there are 329 schools in the US offering a master's or post-master's level NP programs.
- What they do: Working in clinics, nursing homes, hospitals, or their own offices, NPs are qualified to handle a wide range of basic health problems. Most have a specialty—for example, adult, family, pediatric, psychiatric health care. NPs conduct physical exams, take medical histories, diagnose and treat common acute minor illnesses or injuries, order and interpret lab tests and X-rays, and counsel and educate clients. In all 50 states, and D.C., they may prescribe medication according to state law. Some work as independent practitioners and can be reimbursed by Medicare

or Medicaid for services rendered. Others work for hospitals, health maintenance organizations (HMOs), or private industry.

Certified Nurse Midwife (CNM)

- Number: 9,232.
- Education: An average one and one-half years of specialized education beyond nursing school, either in an accredited certificate program, or like NPs, increasingly at the master's level. There are currently 43 nurse-midwifery programs in the U.S. accredited by the American College of Nurse-Midwives. Four of these are post-baccalaureate certificate programs and 39 are graduate programs.
- What they do: CNMs provide well-woman gynecological and low-risk obstetrical care including prenatal, labor and delivery, and post-partum care. In 2002, the most current year which data is available from the National Center for Health Statistics, there were 307,527 CNM-attended births in the U.S. This accounts for over 10 percent of all vaginal births that year. An ANA meta-analysis of CNM care found that nurse-midwives performed fewer fetal monitors, episiotomies, and forceps deliveries, administered fewer IVs, delivered fewer low birth weight and premature infants, and had shorter patient hospital stays. CNMs have prescriptive authority in 48 states, D.C., American Samoa, and Guam.

Clinical Nurse Specialist (CNS)

- Number: 69,017; of which 14,643 are also prepared as NPs.
- Education: Registered nurses with advanced nursing degrees—master's or doctoral—who are experts in a specialized area of clinical practice defined in terms of population (e.g. pediatrics, geriatrics, women's health), type of problem (e.g. pain, wound management, stress), setting (e.g. critical care unit, operating room, community clinic, emergency room) type of care (e.g. rehabilitation, end-of-life) or disease (e.g. diabetes, oncology, psychiatry). There are 218 U.S. schools offering master's or post-master's degrees for CNSs.
- What they do: CNSs practice in hospitals, clinics, nursing homes, their own offices, and other community-based settings, such as industry, home care and HMOs. CNSs have clinical nursing expertise in diagnosis and treatment to prevent, remediate or alleviate illness and promote health within a defined specialty population. Besides delivering direct patient care, CNSs work in consultation, research, education, and administration. Some work independently or in private practice and can be reimbursed by Medicare, Medicaid, Tri-Care, and private insurers.

Certified Registered Nurse Anesthetist (CRNA)

- Number: 29,844.
- Education: Registered nurses who complete 2-3 years higher education beyond the required four-year bachelor's degree, as well as meeting national certification and recertification requirements.
- What they do: In this oldest of the advanced nursing specialties, CRNAs administer more than 65 percent of all anesthetics given to patients each year, and are the sole providers of anesthetics in 85 percent of rural hospitals. Working sometimes with an MD anesthesiologist, but frequently independently, these nurse specialists work in almost every setting in which anesthesia is given: operating rooms, dentist's offices, and ambulatory surgical settings.

APRNs Are Accessible

They provide pre-employment physicals for employers, home health care to the elderly, health education in hospitals, schools, and community clinics, geriatric care in nursing homes, infectious disease control in prisons, pre- and post-natal care in inner-city and rural clinics, and psychotherapy in public and private practices. A study published in the July/August 2003 issue of the *Annals of Family Medicine* found that physician assistants, nurse practitioners and nurse midwives are more likely to work in underserved communities than are general internists, pediatricians, and obstetricians. This held true in both rural and inner city areas.

APRNs Deliver High Quality Health Care

All advanced practice registered nurses must meet rigorous education, certification, and continuing education requirements. Standards of practice are set and monitored by nursing professional organizations. APRNs work collaboratively with physicians and other health professionals to coordinate health services for the best outcome for the patient.

More than three decades of research have documented the high quality of care provided by APRNs. In 1986, The Congressional Office of Technology Assessment released a report requested by the Senate Appropriations Committee. This report, "Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives: A Policy

Analysis,” stated that NPs are “especially valuable in improving access to primary care and supplementary care in rural areas and in health programs for the poor, minorities and people without health insurance.” OTA found the quality of NP care to be “as good as or better than care provided by physicians,” and found NPs had “better communication, counseling and interviewing skills than physicians have.”

A study published in the January 5, 2000 *Journal of the American Medical Association* attests to the high quality services provided by APRNs. This study, entitled “Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians,” compared the outcomes of patients randomly assigned to MDs and NPs within the same managed care organization. The authors found that patient outcomes and satisfaction were equivalent for NPs and MDs.

A large-group study of patients seeking care for minor emergencies was published in the *Lancet* in 1999. The study compared the outcomes of patient’s whose care was managed by NPs and physicians. The authors found that NPs were better than MDs in recording medical histories and that fewer patients seen by an NP sought unplanned follow-up for advice about their injury. There were no significant differences between NPs and MDs in the accuracy of examinations, adequacy of treatment, planned follow-up or requests for medical imaging.

In June of 2002, the Medicare Payment Advisory Committee (MedPAC’s) issued a report titled “Medicare Payment to Advanced Practice Nurses and Physician Assistants.” In its recommendation to Congress, MedPAC’s reported that, “research studies show quality and outcomes of care [provided by CNMs] at least comparable to obstetricians and gynecologists.”

A case in point is a May 1998 study from the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC) that was published in the *Journal of Epidemiology and Community Health*. It examined all single, vaginal births in the United States in 1991 delivered at 35-43 weeks of gestation by either physicians or CNMs. After controlling for a wide variety of social and medical risk factors, the risk of experiencing an infant death was 19 percent lower for births attended by CNMs than for births attended by physicians. The risk of neonatal mortality (an infant death occurring in the first 28 days of life) was 33 percent lower, and the risk of delivering a low birth weight infant was 31 percent lower. Mean birth weight was 37 grams heavier for the CNM attended than for the physician-attended births. Low birth weight is a major predictor of infant mortality, subsequent disease, or developmental disabilities.

The study also found that CNMs attended a greater proportion of women who are at higher risk for poor birth outcome: African Americans, American Indians, teenagers, unmarried women, and those with less than a high school education. Physicians attended a slightly higher proportion of births with medical complications. However, birth outcomes for CNMs were better even after socio-demographic and medical risk factors were controlled for in statistical analyses.

APRNs Are Cost-Effective

Advanced practice nurses aren’t low-priced doctor substitutes. They are first and foremost registered nurses, a profession with its own educational and licensing requirements, overseen by boards of nursing in all 50 states, that meet competency standards and continuing education requirements. APRNs are skilled in performing a wide range of health services, especially screening and preventive services, that if ignored, can lead to far more serious and costly health problems.

A seminal study published in the *Yale Journal on Regulation* in 1992 reviewed two decades of research on APRN services. The author found that the evidence is clear that APRNs provide care of comparable quality and lower cost than physicians. The study asserts that APRNs tend to prescribe fewer drugs, use less expensive tests, and select lower-cost treatments than MDs.

In 1995, the *Journal of the American Academy of Nurse Practitioners* published the results of a year-long study that compared a family physician’s managed practice with an NP’s practice within the same managed care organization. The authors found that the NP’s total annualized per member cost was approximately 50 percent less than the physician’s. The NP practice resulted in far fewer emergency room visits and inpatient days.

A study published in the June, 2003 issue of the *American Journal of Public Health* contained the results of a two and one-half year cohort study funded by the Agency for Health Care Research and Quality (AHRQ). The AHRQ researchers found that low-risk patients receiving midwifery care had birth success rates comparable to those who saw only physicians. In addition, the patients who received midwifery care experienced fewer cesarean sections, spent fewer days in the birth center/hospital, experienced less induction of labor, and received less technical inter-

vention. The study also revealed similar morbidity, preterm birth, and low-birth weights among women receiving midwifery care and those seeing physicians.

Based on a comparison of 1988 data from St. Paul Fire and Marine Insurance Company (then the country's largest provider of liability insurance for CRNAs), and 2004 data from CNA Insurance Company (currently the largest insurer of CRNAs) insurance premiums for nurse anesthetists have decreased nationally a total of 39 percent in the 88-'04 time span. The decrease in CRNA malpractice insurance premium rates demonstrates the superb anesthesia care that CRNAs provide. The rate drop is particularly impressive considering inflation, an increasingly combative legal system, and generally higher jury awards.

Conclusion

The Federal Employees Compensation Program is one of the last major health care programs to deny patients' access to APRNs. APRNs are covered medical providers in Medicare, Medicaid, Tri-Care and private insurance plans. They serve as medical providers in the Veterans Administration, the Department of Defense and the Indian Health Service. In fact, most federal employees have access to APRNs through their federal employee health benefit plan.

Decades of research have shown that APRNs provide high quality services that often incur fewer costs than care provided by physicians alone. In addition, APRNs are more likely to provide services in medically underserved areas.

For these reasons, the undersigned organizations urge the Committee to support efforts to provide Federal workers full access to the wide compliment of services provided by APRNs.

American College of Nurse-Midwives.
American Nurses Association.
American Psychiatric Nurses Association.
National Association of Clinical Nurse Specialists.

[From the New York Post, May 8, 2005]

W. Plan Stiffs Heroes; Nixes WTC Comp Pay

By SAM SMITH

The Bush administration is renegeing on its pledge of \$175 million to fund workers' compensation claims for uninsured Ground Zero responders, The Post has learned.

In its proposed 2006 budget, the administration says it will take back \$120 million in funds granted in 2002 that have yet to be spent.

"These particular funds were set aside for workers' compensation needs that have not turned out to be as large as expected," said federal Office of Management and Budget spokesman Scott Milburn. "The initial need for the funds has been met."

But advocates say the federal decision will leave workers in the lurch as they continue to get sick from their time at Ground Zero, and that the money may well be needed to pay future claims.

"I'm disgusted," said Joseph Pecuro, 38, of Toms River, N.J., a Ground Zero volunteer who filed for workers' compensation last August and is worried that the Bush administration's proposal will leave him without benefits.

"I can't even believe they would actually do that. They should be ashamed," he said.

Pecuro, an ironworker, says his ailments forced him to quit working two years ago. "I can't afford to buy my groceries," he said.

Health professionals were concerned about the government's decision.

"We don't know what the long-term health effects will be," said Dr. Robin Herbert, director of Mount Sinai hospital's World Trade Center health-monitoring program.

So far, the New York Workers' Compensation Board has paid out roughly \$52 million in benefits to 113 claimants from the federal funding. Of those, 37 are receiving biweekly payments because of the severity of their injuries.

All those payments—along with 94 claims currently being processed, another 400 filed with the state in anticipation of future health problems, and any future complaints—are jeopardized by the Bush administration's proposal.

