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H.R. 6594, THE JAMES ZADROGA 9/11 HEALTH AND COMPENSATION ACT OF 2008

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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H.R. 6594, THE JAMES ZADROGA 9/11 HEALTH AND COMPENSATION ACT OF 2008

THURSDAY, JULY 31, 2008

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:10 a.m., in room 2322 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman) presiding.

Members present: Representatives Pallone, Towns, Green, Capps, Engel, Solis, Weiner, Deal, Burgess, Barton (ex officio), and Fossella.

Staff present: Jack Maniho, Brin Frazier, Lauren Bloomberg, Melissa Sidman, Chad Grant, and Aarti Shah.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. The meeting of the subcommittee is called to order. And today we are having a hearing on the James Zadroga 9/11 Health and Compensation Act of 2008. And the Chair now recognizes himself for an opening statement.

The bill, as you know, has been introduced by Ms. Maloney, Mr. Nadler, Mr. King, and Mr. Fossella on a bipartisan basis and I want to thank all of you for your hard work on this legislation. I know how hard all of you have been working, not only in the last few weeks, in particular, but also in the last few years.

Last year the subcommittee held a hearing to examine the ongoing medical monitoring and treatment programs related to 9/11 health defects and I am proud to be able to hold the second hearing today on legislation designed to bolster current efforts and provide adequate monitoring and treatment services.

I have to say, none of us will ever forget the horrible events of 9/11, and 7 years later, we simply cannot forget about the thousands of people who helped at Ground Zero in the days and months afterwards. I remember, in particular, coming there a few days later when the President visited the Ground Zero and I also remember going with Mr. Nadler to, I guess, the Federal Court or the Federal building where we had a hearing—field hearing, specifically, on the health effects. I don't remember when that was, Jerry, a couple weeks or a couple months later, but I remember you, in particular, very concerned about the health effects at a time when many of the—those in Washington, including then—or former Gov-

ernor Whitman, who were sort of downplaying the impact of it and saying that it really wasn't a problem. But we have to do everything in our power to protect the responders, the clean-up crews, the volunteers, and the victims of the World Trade Center attacks.

Thousands of first-responders, rescue workers, and local residents now suffer from chronic medical conditions that are directly related to the tons of dust, glass fragments and other toxins that were released into the air in lower Manhattan when the Twin Towers collapsed. Studies have shown that nearly 70 percent of the rescue workers currently suffer from complex respiratory conditions that were caused or worsened by the September 11 terrorist attacks. One-third have abnormal pulmonary function tests and one in every eight responders has experienced symptoms of post-traumatic stress disorder.

Studies have also examined the effects on local residents, showing a three-fold increase in lower respiratory diseases, as compared to controlled populations, low pregnancy rates and an increase in the variety of mental health disorders.

OK. Is that better? OK. I will put it back on you. All right.

And these brave men and women who were present during one of our Nation's darkest hours are in need of our help. In my district alone, there are 1400 known individuals who were exposed to the toxins released by the 9/11 attacks. It is now our turn to step up to the plate and help ensure that they can access the medical care they need and deserve.

The James Zadroga 9/11 Health and Compensation Act is an important step in this direction. The bill is named for James Zadroga, who I should mention was a New Jersey hero who responded on 9/11 and spent hundreds of hours digging through the World Trade Center debris. Mr. Zadroga died in 2006 from pulmonary disease and respiratory failure after his exposure to toxic dust at the World Trade Center.

The bill would establish a permanent program to monitor and screen eligible residents and responders and provide medical treatment to those who are suffering from World Trade Center-related diseases. It would direct the Department of Health and Human Services to conduct and support research into new conditions that may be related to the attacks and to evaluate different and emerging methods of diagnosis and treatment for these conditions. And it would build upon the expertise of the Centers for Excellence, which are currently providing high quality care to thousands of responders and insuring ongoing data collections and analysis to evaluate health risks.

Now, one of these centers, as Jerry knows, is located in my district and is headed by Dr. Iris Udasin. That program is a joint institute of Rutgers and the UMDNJ-Robert Wood Johnson Medical School, serves over one thousand rescue and recovery workers. Last year, I had the opportunity to visit that program, at Rutgers, to see how it provides the opportunity for early detection and intervention to lessen the severity of the illnesses that many rescue and recovery workers are experiencing.

We are really faced with a large undertaking. But it is crucial that we step up and share these costs. The responders, volunteers, workers, and community members should not be left to bear the

burden of their health care costs after risking their lives to come to our Nation's rescues. And I will also say to the Mayor, I don't think that New York should have to bear as much of the costs as they have. The Federal Government has the overwhelming responsibility.

Again, I want to thank all the sponsors of this bill, but I do want to voice my displeasure that Dr. Howard, the former Director of the NIOSH, is not present today to testify. While I greatly appreciate Dr. Gerberding being here today to testify and recognize her accomplishments as Director of the CDC, Dr. Howard has been the one overseeing the World Trade Center Medical Monitoring and Treatment Program since its inception. And I believe he is by far the most informed person in this administration to speak on these programs, and it is unfortunate that the Bush Administration refused to allow Dr. Howard to testify this morning.

I am also dismayed by the Administration's decision to not reappoint Dr. Howard for another term. Dr. Howard has done an exceptional job and has earned the respect and praise from industry and labor alike for his commitment to this cause. So, his expertise will be greatly missed. But, again, thank all of you and I now would recognize our ranking member, Mr. Deal.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you Mr. Chairman for holding this hearing on this important issue to discuss H.R. 6594 and the health concerns associated with the terrorist attacks of September the 11th. I want to thank our distinguished witnesses who have agreed to share their insight and perspective on this issue, which of course is of great importance to our entire country.

We can certainly all agree that men and women who first responded to the call for help are true heroes. Thousands of fire fighters, police officers, emergency medical service personnel and other government and private sector workers heroically responded to the call of duty, not only on September the 11th, but for many weeks and months to follow as the recovery efforts and cleanup continued to persist.

In the midst of a Nation rocked by the attacks, which left thousands of innocent people dead and many more seriously injured, these brave men and women came from across the Nation to lend their hands to a unified recovery effort. As we are all aware, those involved in these efforts and the residents of New York City were unavoidably exposed to toxic mixtures of dust, smoke, and various chemicals. Many of these individuals continue to experience persisting health issues as a result.

This legislative hearing today, of course, is to focus on H.R. 6594, The James Zadroga 9/11 Health and Compensation Act and the assessment of current monitoring and treatment efforts being provided to the affected individuals. I look forward to continuing to work with the committee as we work on this issue and address it. And I, especially, appreciate the input of the panelists that we will hear from today. Thank you Mr. Chairman for holding the hearing and I would yield back my time.

Mr. PALLONE. Thank you, Mr. Deal. Next for an opening statement is Mr. Green, the gentleman from Texas.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, for calling this hearing on H.R. 6594, The James Zadroga 9/11 Health and Compensation Act. As a member of Congress from Houston and very close to my first responders, both firefighters and police officers, that tragic event on September the 11th, claiming 2,974 lives, hit everyone. In New York City, the attack on the World Trade Center, claiming nearly 2700 lives on September 11, but these individuals and their family were not the only people impacted by the terrorist attack.

In the weeks and months following the attacks, 40,000 responders from Federal, State, and private organizations, other volunteers came to the World Trade Center site to aid with recovery and cleanup. We usually think of the victims of the 9/11 attacks as those who lost their lives on that terrible day, but in reality, many of these victims are still among us, suffering from the attacks.

When the World Trade Center collapsed, asbestos, smoke, and other potential hazardous material was released into the air. As a result of the release of asbestos and smoke, the cleanup in general went first responders, area workers, students, residents, office workers have suffered physical ailments such as sinus asthma and The World Trade Center Cough. These individuals are also suffering from mental ailments, including post-traumatic stress disorder and increased alcohol use.

The brave men and women who worked on the cleanup and recovery were not just from the New York area and those who were in New York at the time, many no longer live there. It is safe to say that individuals from all 50 States are suffering from adverse health effects related to the September 11 attacks. It is clear we need to establish a permanent program to provide medical monitoring for the responders and individuals in the community who were exposed to toxins released by the collapse of the World Trade Center. We also need to reopen the 9/11 Victim Compensation Fund and allow those who wish to seek compensation for their economic losses and harm.

Currently, these individuals have to go to the court system for compensation even though they may have been eligible for the 9/11 Compensation Fund or would now be considered eligible. H.R. 6594 addresses these issues by establishing World Trade health center program and it provides a medical monitoring treatment program for responders and community members in the direct area of the attacks in New York and the United States.

The bill reopens the 9/11 Victims Compensation Fund, establishes a research program, through HHS, to evaluate the World Trade Center conditions. The bill would help those individuals. I am proud to be a co-sponsor of this bill and, again, Mr. Chairman I am glad you called the hearing. On and on I thank our New York members for making sure those of us understand that we all share in this. And, coming from Houston, we will have a hurricane some time and I appreciate everyone considering our situation, just like we are doing this, so thank you.

Mr. PALLONE. Thank you, Mr. Green. Next for an opening statement, the gentlewoman from California, Ms. Capps.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. CAPPS. Thank you, Chairman Pallone, for holding this hearing. I thank my colleagues for testifying and also to the Honorable Mayor of New York. I thank all of the witnesses who will be testifying today. Quite frankly, though, I wish the testimonies that we will hear today would paint a rosier picture. A picture of us having risen above and beyond to ensure that every individual whose health was adversely affected by the attacks on 9/11 and subsequent cleanup has had access to any and all necessary medical treatment, one where we had done a better job of assessing the environmental impact of the attacks, the rescue missions and the cleanup.

Unfortunately, we find ourselves, today, 7 years later with so much work still to do, to ensure that victims, heroes, and neighbors of the World Trade Center are being properly cared for. Though I don't represent New York City, I do represent many Californians who volunteered themselves quickly to assist and come to the site, and to assist in the aftermath of that horrific day, and they are also having a difficult time assessing the care they also, rightly, deserve.

I am afraid this is largely due to a very weakened Environmental Protection Agency and OSHA under the current administration, but it is not too late to take the right steps now to correct what has gone wrong. I am proud to co-sponsor the legislation introduced by our colleagues Congressmen Nadler, Fossella, King, and Congresswoman Maloney that will take the positive steps to treat all affected individuals.

We have a lot to learn from the experience, even including today, as we prepare for future scenarios that present public health emergencies. Failing to learn from past experiences and taking steps to prevent problems in the future is unacceptable to our way of life. I am confident that my colleagues and I share a commitment to better prepare ourselves in the future. For today, though, we must be strong in our resolve to care for every individual who is still suffering physically or psychologically as a result of 9/11.

And I, particularly, welcome the opportunity to hear directly from the witnesses who were there that day, who have a great deal to tell us about how we can, in fact, help them. I yield back.

Mr. PALLONE. Thank you Ms. Capps, and next for an opening statement, the gentleman from New York, Mr. Weiner.

OPENING STATEMENT OF HON. ANTHONY D. WEINER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. WEINER. Thank you Mr. Chairman and I want to thank you and Ranking Member Deal for taking this issue so seriously. Congressman Nadler, Congressman King, Congresswoman Maloney, who have, just about, in every opportunity when there was a chance to talk to our colleagues about this issue, have done it. I also want to take a moment to pay tribute to Congressman

Fossella, who championed this program for so long, almost from the moment it was conceived, was looking to expand it, has really moved this committee towards a place where we are now, hopefully, on the final steps on passing this legislation. I wanted to thank him for his service to this Congress and also for his sponsorship of this legislation.

But, while we are going to have this hearing it is very important, to some degree, the major, the macro issues that we are going to discuss here have been discussed and, frankly, ruled upon by this Congress and by the American people. Shortly after September 11 everyone agreed the responsibility for the heroes that walked into those buildings, ran into those buildings to save so many people in the largest civil evacuation in American history, no one disputed this was the responsibility of the Federal Government to pay tribute to them, to take care of them, to take care of their families.

This Congress decided, in an overwhelming fashion, when we created the Victims Compensation Fund. Never once was it uttered here in Congress or around the country that, "ah, that is New York's problem, let them worry about it." Even in the context of a partisan country and a partisan Congress, everyone came together and realized this was the responsibility of the Federal Government to help the people of the city of New York.

When Mayor Giuliani and Mayor Bloomberg called upon the resources of the city and contractors and volunteers and everyone to come down to Ground Zero and help us with the process of rebuilding and restoring and healing our city, nobody for a moment thought that was the responsibility of the city or those individual contractors. Everyone understood this was the responsibility of the Federal Government, as part of the obligation of the Federal Government to respond when we were attacked as a country and New York City just happened to be the point of that attack.

So, to a large degree, the only question is how we decide who it is that we are going to be compensating and taking care of. Frankly, if we in this House knew that years and years after September 11 there would be people dying by degrees, dying day by day because of the impact of the attack, we would have written the original laws to take into the account the idea that this might be a process that should go on for 10, 12 years.

So the only issue we have today, I think, is the details. How we make sure the city is compensated, how we make sure the contractors are compensated and how we make sure individuals are made whole to the greatest extent possible. And I should make it very clear, Mr. Chairman, New York is not being asked to be repaired. We can never be repaired. The attack that was suffered by so many—has left a scar on so many. All we are asking is for a natural continuation of the discussion that we had in a bipartisan fashion shortly after September 11 when we said, "you know what, we are all going pitch in."

The Victims Compensation Fund, only by oversight, only for lack of a clause that said "for those who have passed away or those who, as a result of this, are sick, injured or dying by degrees." If it were not for that language, the addition of that language, we would have no real dispute here today.

And I want to thank you, Mr. Pallone and thank the witnesses and thank Mayor Bloomberg for reminding us every day of the responsibility that we have. If we get this wrong, I say to my colleagues, here is the scenario that we face. We face the possibility, the very real possibility, in any number of cities, in any town, or in any part of this country being attacked and people say, "you know what, I don't want to be involved because the Federal Government, while encouraging us to do so is not taking care of us once we do."

This Congress is not going to let that happen and if we hearken back to the substance of that debate, let us hearken back to one other thing. This was a bipartisan agreement. We had all decided we were going to come together as part of a package of restoring our country. We were going to restore New York City. We were going to help to pave the way for New York City to get back on its feet. Today, in living rooms and dining rooms and in hospital rooms, frankly, all around the New York City area are people who are dying because of September 11. This legislation honors them, it does our best to make it whole and it lives up to the commitment we made after September 11, and I thank you Mr. Chairman for holding this hearing.

Mr. PALLONE. Thank you Mr. Weiner. Next is the gentlewoman from California, Ms. Solis.

OPENING STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. SOLIS. Thank you, Mr. Chairman, and I also want to welcome our witnesses, our colleagues, as well as the Mayor from New York, Mr. Bloomberg. It is an honor to have you here. I will be brief. I just want to say that I have often wondered why our government takes so long to address catastrophes like this. And we know that as a result of the toxins and the exposure, we see higher rates of asthma now in individuals that were around the World Trade Center and especially among our first-responders. California, as was noted, did send a number of our emergency responders to help out in that situation, and I believe that we have a responsibility to help provide the best healthcare assessments and access that they need in their recovery. In addition to asthma rates going up, care for post-traumatic stress and mental health assistance needs to be provided as well. So I agree, in part, with all that has been said by my colleagues. This is a bipartisan issue, one that all of us would never want to have placed upon us at any time in our lives. And there is an urgency for us to help people, and not just the first-responders, but anyone that was affected by the fallout of the hazardous material that spread throughout that city in that particular time. So, with that, I yield back the balance of my time.

Mr. PALLONE. Thank you. The gentleman from New York, Mr. Towns, is recognized for an opening statement.

OPENING STATEMENT OF HON. EDOLPHUS TOWNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. TOWNS. Thank you very much Mr. Chairman, and of course thank you Ranking Member Deal, for convening this important hearing. This bill recognizes and addresses the rising health problems among the brave citizens who were exposed to unknown health risks as a result of the terrorist attack of 9/11. I would also like to thank the author of the bill, my friend and colleague from New York, Carolyn Maloney, in her diligence and leadership on this issue, and other members of our New York delegation who have really been very involved in pushing this bill forward: Congressmen Weiner, Engel, Fossella, Nadler, and King. And I would especially like to thank the Honorable Mayor of the city of New York for joining us this morning to offer his testimony. I would also like to thank the New York State Department of Labor Commissioner, Patricia Smith, for joining us.

As we approach the seventh anniversary of the 9/11 attacks, I hope we can work together to bring effective medical treatment and financial assistance to those affected on that fateful day. I have held several 9/11 hearings in my Government Reform Subcommittee and this has been a long and painstaking process. But I look forward to a successful passing of this legislation before us today and moving toward a solution we can all be proud of. Now, we need to encourage people to be supportive of each other. We need to encourage people to, in times of crisis, that if you respond and go beyond the call of duty, we will be there for you. I think the Federal Government has that responsibility. So I come today to say that I hope that we will assume that responsibility to respond in a positive way. Again, I thank the Chairman and the Ranking Member for holding this hearing. I look forward to the testimony, and on that note I yield back.

Mr. PALLONE. Thank you Mr. Towns. Next, another gentleman from New York, Mr. Engel recognized for an opening statement.

OPENING STATEMENT OF HON. ELIOT L. ENGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. ENGEL. Thank you very much Mr. Chairman. I appreciate it and we—those of us who are New Yorkers appreciate this hearing. It is one of the reasons why I am proud to serve on the Energy and Commerce Committee and on the Health Subcommittee. I can think of nothing more topical and more important to New Yorkers than this hearing and to try to help, based on the tragedy of 9/11. I would like to welcome our witnesses here today, including our Mayor Michael Bloomberg, my colleagues Jerry Nadler and Pete King and I would also like to welcome the New York State Commissioner of Labor, Patricia Smith and the New York State AFL-CIO representative Suzy Ballentine, who are with us in the audience today.

As devastating as September 11 was, there are few days I have been more proud to be an American than on 9/11. Within minutes of crashes into the Twin Towers New York's first responders mobilized to save those trapped within the World Trade Center, putting

themselves in unspeakable danger and too many lost their life that day, including many of my constituents. Within days over 40,000 responders from across the Nation descended upon Ground Zero to do anything possible to help with the rescue, recovery, and cleanup.

I remember those bittersweet days. I was there in New York City where I was born and bred and remember seeing Americans lined up around blocks to donate blood. I remember the chaos as we didn't know quite what to do. People knew they had to do something, anything to help our Nation rise up from the assault by the terrorists.

The past 6 years have not been kind to so many of the first responders who put themselves in harm's way. It is estimated that up to 400,000 people in the World Trade Center area on 9/11 were exposed to extremely toxic environmental hazards, including asbestos, particulate matter, and smoke. Years later this exposure has left a significant number of first responders with severe respiratory ailments, including asthma, at a rate that is 12 times the normal rate of adult onset asthma.

Also common are mental health problems, including PTSD and depression. This has all been well documented in the scientific peer-reviewed published work regarding the long-term health effects of 9/11 by Mount Sinai, the Fire Department of the city of New York, and the World Trade Center Health Registry.

While these illnesses should sadden all of us, what is more outrageous is that our Nation has failed to provide the first responders with anything more than a fragmented and unreliable health care monitoring and treatment program that forces those who fearlessly volunteered for our country to fight within a myriad of bureaucracy to receive care that should be given, and yet in a struggle.

It is outrageous that officials like Christine Todd-Whitman told us that the air was fine and we should go about our business and we should just continue to do what ever is necessary when that was not the case. And there are many people in the area, not only first responders who were exposed to these deadly toxins—and I know my colleague, Jerry Nadler, in whose district the World Trade Center is, is making a very forceful case that we ought to not only help first responders, but we ought to help the communities around and people who were exposed to that. And I am very sympathetic to what Jerry Nadler has said in that regard.

So I am proud to join with my New York colleagues, led by Representatives Maloney, Nadler, Fossella, and King and Ed Towns and Tony Weiner, as well, in introducing the revised 9/11 Health and Compensation Act.

This comprehensive bill would ensure that first responders and community residents exposed to the Ground Zero toxins have a right to be medically monitored and all that are sick have a right to treatment.

It would also rightfully provide compensation for loss by reopening the 9/11 Compensation Fund. No more fragmented healthcare. No more excuses. We must and shall do what is right.

In this vein, it is troubling to me that just before the July 4 holiday CDC Director, Julie Gerberding informed Dr. John Howard, Director of The National Institute for Occupational Safety and Health, that he would not be reappointed to a second term, even

though he had asked to be reappointed. This effective termination came despite universal praise regarding Dr. Howard's service of protecting American workers, accolades for his outstanding work on behalf of the heroes of 9/11 in his capacity as 9/11 Health Coordinator and strong support from Labor Employers, the public health community, and Congress for his reappointment. I would like to enter into the record an editorial from the New York Times criticizing the administration for this action.

I still feel great sorrow in our remembrance of the tragedy of 9/11. We will never forget what happened that day, but we must look forward and right the wrongs that our Nation has perpetrated against our own heroes and provide them with the care and compensation they so desperately deserve.

Mr. Chairman, I urge all Americans to pause and reflect on this tremendous loss of life that day and how so many sacrificed so much for their fellow Americans and make sure that our future actions are driven by these memories and I again thank you for the hearing.

Mr. PALLONE. Thank you Mr. Engel. Now, you had a unanimous consent request there?

Mr. ENGEL. Yes, Mr. Chairman.

Mr. PALLONE. All right, without objection, so ordered.

Mr. ENGEL. Thank you.

Mr. PALLONE. You have your hand up, Mr. Towns.

Mr. TOWNS. Yes, I also have one.

Mr. PALLONE. What is yours?

Mr. TOWNS. I ask for unanimous consent to submit the testimony of Dr. Reibman, Associate Professor of Medicine and Environmental Medicine, Director of NYU Bellevue Asthma Center.

Mr. PALLONE. Without objection, so ordered.

[The prepared statement of Dr. Reibman follows:]

Statement of

Joan Reibman, MD

Associate Professor of Medicine and Environmental Medicine
Director NYU/Bellevue Asthma Center
Director of Health and Hospitals Corporation WTC Environmental Health Center

Bellevue Hospital
New York University School of Medicine

H.R. 6594 James Zadroga 9/11 Health & Compensation Act of 2008

Before the

Committee on Energy and Commerce
Sub-committee on Health
U.S. House of Representatives

July 31, 2008

Good morning, Chairman Pallone, Ranking Member Deal, Congressmen Towns, Engel, Weiner and Fossella, Members of the committee. My name is Joan Reibman, and I am an Associate Professor of Medicine and Environmental Medicine at New York University School of Medicine, and an Attending Physician at Bellevue Hospital, a public hospital on 27th Street in NYC. I am a specialist in pulmonary medicine, and for the past 16 years, I have directed the NYU/Bellevue Asthma Center. I am pleased to be able to testify today on behalf of the workers, residents and students of downtown New York, and the clean-up laborers, all of whom were exposed to World Trade Center dust and fumes.

I am very pleased to be here today to support H.R. 6594 James Zadroga 9/11 Health & Compensation Act of 2008, which will provide needed long-term funding for the monitoring and treatment of WTC-exposed members of the community. Many of these individuals, unfortunately, have become patients with critical health needs related to physical, respiratory and mental health illness.

First, I would first like to thank this Committee and the Members of Congress who have shown their continuing and extraordinary support for our patients and our program, especially Members Nadler, Maloney, Fossella and King, and Senators Clinton and Schumer. Congress has generously provided funding for the community programs but unfortunately these funds have not been released by the Department of Health and Human Services at this time. The Department did announce an RFP last week for $30 million - $10 million each year – for three years. This will be a competitive grant process and we will apply.

Populations at risk

Let me now tell you about the people I serve, the area workers, residents and students exposed to World Trade Center dust and fumes. On the morning of 9/11 over 300,000 individuals were at work in the area, or in transit to their offices. Many were caught in the initial massive dust cloud as the buildings collapsed – these are the thousands whom we saw in video and still photographs coated in white, running for their lives. In the great outpouring of pride and patriotism after 9/11, many area workers returned to work one week later, the massive WTC clean-up and rescue operation still in full force, and not all buildings completely cleaned or decontaminated.

As you know, Lower Manhattan is also a dense residential community; almost 60,000 residents of diverse racial and ethnic backgrounds live south of Canal St. (US census data). They are economically diverse; some living in large public housing complexes, others in newly minted coops. Lower Manhattan is also an educational hub; there are some 15,000 school children, and large numbers of university students. Some were locked in their buildings; others were let out and told to run. The dust of the towers settled on streets, playgrounds, cars, and buildings. Dust entered apartments, schools and office buildings through windows, building cracks, and ventilation systems. The WTC buildings continued to burn through December.

Each of these groups had potential for exposure to the original dust cloud, to the re-suspended outdoor dust that remained or was generated by the clean up, to indoor dust and to fumes from the fires that continued to burn. As pulmonologists in a public hospital, we sought to determine whether the collapse of the buildings posed a health hazard.

What we know

Our first step was to monitor the effect on the local residents. With funds from the Centers for Disease Control, and in collaboration with the New York State Department of Health, we looked at the rate of new respiratory symptoms in local residents after 9/11. It was the first such study, completed just over a year after 9/11. The results have been reported in three peer-reviewed publications (Reibman et al. The World Trade Center residents' respiratory health study; new-onset respiratory symptoms and pulmonary function, Environ. Health Perspect. 2005; 113:406-411. Lin et al. Upper respiratory symptoms and other health effects among residents living near the world trade center site after September 11, 2001, Am. J. Epidemiol. 2005; 162:499-507, Lin et al., Reported respiratory symptoms and adverse home conditions after 9/11 among residents living near the World Trade Center. J. Asthma 2007; 44:325-332).

We surveyed residents in buildings within one mile of Ground Zero, and, for purposes of control, other lower-risk buildings approximately five miles from Ground Zero. From an epidemiologic perspective, the exposed population was over sampled because at that time, this was the only study of the residents. Analysis of 2,812 individuals revealed that new-onset and persistent symptoms such as eye irritation, nasal irritation, sinus congestion, nose bleed, or headaches were present in 43% of the exposed residents, more than three times the number of exposed compared to control residents. New-onset and persistent lower respiratory symptoms of any kind were present in 26% versus 8% of exposed and control residents respectively; a more than three fold increase in symptoms. This included an increase in cough, shortness of breath, and a 6.5-fold increase in wheeze (10.5 % of exposed residents versus 1.6% of control residents respectively). These respiratory symptoms resulted in an almost two-fold increase in unplanned medical visits and use of medications prescribed for asthma in the exposed population compared to the control population.

Our most recent analysis of the data also suggest that residents reporting longer duration of dust or odors or multiple sources of exposure had greater risk for symptoms compared to those reporting shorter duration. Data from the NYCDOHMH WTC Registry administered by the New York City Department of Health and Mental Hygiene, further document adverse health effects in additional populations, including building evacuees and school children, and confirm our original findings.

Treatment

After 9/11, we began to treat residents who felt they had WTC-related illness in our Bellevue Hospital Asthma Clinic. We were then approached by a community coalition

and together began an unfunded program to treat residents. We were awarded an American Red Cross Liberty Disaster Relief Grant in 2005 to set up a medical treatment program for WTC-related illness in residents and responders. A year later, we received additional philanthropic funding, and major funding from the City of New York to provide evaluation and treatment of individuals with suspected World Trade Center-related illnesses. This program was initially awarded $16 million over 5 years to Bellevue Hospital.

In 2006, Mayor Bloomberg appointed a panel to make recommendations about the sufficiency of resources available to those whose health has been affected by the September 11, 2001 terrorist attacks. The panel recommended that the Mayor expand the Bellevue program and seek federal funds to support it. Although the Bellevue program has yet to receive any federal funding, the Mayor committed to implement the Panel's recommendation and added another $33 million in 2007, allowing for expansion of the program to two additional sites. But the City cannot afford to be the lone supporter of a treatment program to address this national problem indefinitely. For now, the WTC Environmental Health Center is funded by the City with a commitment that will average nearly $10 million per year over five years—but we need federal support to sustain and enhance the program over the long term.

We now have an interdisciplinary medical and mental health program that has evaluated and is treating approximately 2700 patients. We continue to receive inquiries each week; while most come from local people, we have received calls from individuals living in about 20 other states. To enter our program, an individual has to have a medical complaint; we are not a screening program for asymptomatic individuals. To date, our patients are almost equally men and women, of diverse race/ethnicity and many, although not all, are uninsured. Some have never sought medical care, some have been unable to seek care for lack of insurance, others have been seeing doctors for years, with a history of recurrent bronchitis, pneumonia, and sinusitis. These individuals have a complex of symptoms that include persistent sinus congestion (40%), asthma-like symptoms of cough (47%), shortness of breath (66%) or wheeze (26%) for which they continue to need care more than 6 years after 9/11. One third of our population has lung function that is below the lower limit of normal; 40% have shortness of breath at a level that is consistent with significant activity limitation, 10% have the highest score on a standardized scale of breathlessness used for disability assessment.

These are people who were previously normal, working and functional. We have heard from many individuals who were highly physically active – even training for marathons -- who now require daily medication to allow them to walk a few city blocks. The lung function abnormalities have varied patterns consistent with what we see clinically; while many of our patients can be treated aggressively as if they have asthma, the sickest among them show a process in their lungs that may consist of a type of inflammation, a granulomatous process, that is like an illness called sarcoid. Others have lung diseases that affect not only their airways, or breathing tubes, but also the air sacs that allow for the exchange of oxygen and carbon dioxide. Some have pulmonary fibrosis, characterized as scarring or permanent damage in the lungs, and are now so sick

that they are waiting lung transplants. Over 50% of our patient population has concurrent mental health issues, including PTSD, depression and/or anxiety.

Unanswered questions

Many challenges remain and it is clear that we need to maintain our commitment to treatment as well as research.

How can we determine whether an illness is WTC-induced? We have no simple test to determine whether any individual illness is related to WTC exposure. What we have is six years of clinical experience in Centers that have seen so many cases that we can now recognize a set of symptoms associated with the World Trade Center dust. Our tools are the history of exposure, the temporal sequence of illness and a particular constellation of symptoms that are by now sadly familiar. Armed with these tools, we can more effectively differentiate such cases from illnesses that are unrelated. The Registry provides us with the larger epidemiological picture and context that inform our daily clinical practice.

Why are some people sick, while others are well? We now suspect that while the level of exposure plays a role, so does individual susceptibility. This is similar to tobacco-induced disease: some smokers remain healthy, while for others, tobacco causes lung disease, cancer, and heart disease. Only through the existence of Centers will there ever be sufficient data collected to attack such medical puzzles.

What are these disorders, and will they respond to treatment? Will there be late emergent diseases, with cancers? For patients, these are the paramount questions and I wish I could clearly answer them. Without Centers, we will never have answers.
We now know from peer-reviewed published literature as well as our clinical experience, that large numbers of residents and workers were subjected to environmental insults on a large and unprecedented scale and that these insults had measurable medical consequences. These men, women and children will require continued evaluation, screening and treatment for years to come.

H.R. 6594, The 9/11 Health and Compensation Act of 2008.

The bill before this committee today, provides much needed long-term stability for our program and for our patients. Many of the residents, area workers and students exposed to the dust and debris of September 11 are sick. We have peer-reviewed articles demonstrating respiratory and mental health illness in residents and local workers.
The bill provides long-term, sustained funding to monitor and treat those who are sick or who could become sick because of 9/11, and it funds critical research so that we can understand what the medium and long-term health impacts of the terrorist attacks.
Importantly, the bill includes federal funding to monitor and treat residents, area workers and community members who to this point, have not received any federal funding for treatment. The WTC Health Center at the City's Health and Hospitals Corporation is

treating approximately 2700 patients for WTC-related conditions, and the City is currently funding the entire program.

The bill defines specific groups, including area workers and residents and delineates specific geographic areas that people must have been in on September 11 or immediately following to be eligible for treatment. These boundaries reflect the best data we have available at this time but, because we do not know with certainty everyone who could have or could contract a 9/11-related illness was exposed within these boundaries, the bill also provides limited funding to treat people who may—on a case-by-case basis—be diagnosed with a 9/11-related condition but was outside the designated area. This recognizes that we do not know the full extent of the health impacts of the disaster.

People who meet these criteria are "eligible" for treatment but then a doctor with experience treating WTC-related conditions must determine, based on a medical examination, that exposure to airborne toxins or other hazards caused by the 9/11 attacks is substantially likely to be a significant factor causing, contributing to or aggravating the patient's condition. The doctor's assessment of the patient's exposure to toxins and symptoms will be based on standardized questionnaires; and even after a condition is deemed to be WTC-related, that decision is subject to review and certification by the federal WTC administrator. These are tough standards that are very similar to the protocols we already have in place at the WTC Environmental Health Center. These protocols ensure that only those who are sick due to 9/11 will be treated under the WTC health program.

Finally, the bill caps the number of responders and community members who can get monitoring or treatment. Again, these limitations are based on the best available information about how many people could potentially seek treatment, and while we think they will be sufficient to provide treatment to anyone who may need it, there are reporting requirements in the bill so that Congress will be told if those caps are approached.

The bill also mandates the establishment of Quality Assurance and Fraud Prevention programs to prevent funds from being used for any purpose other than to monitor and treat those affected by the 9/11 attacks. And the City has its own incentives to contain costs because the City has agreed to be responsible for paying 5% of the cost to treat anyone treated at a WTC Environmental Health Center serving the residents, area workers and other community members. Finally, the federal program will be secondary payor to both Workers Compensation payments and to applicable health insurance available to an eligible recipient with a WTC-related condition.

Research on WTC-related diseases is essential. The bill ensures that critical 9/11-related research continues. Long-term research is the only way that we're going to be able to develop a full understanding of the health Impacts of 9/11. The Centers of Excellence have all contributed to research efforts. The research funded in the bill will make it possible for both patients and clinicians to have the necessary information to

make informed decisions about health treatment and to make available the best science to determine what conditions qualify for treatment under this bill.

We need the full and predictable sources of federal funding which this bill provides. I urge you to support this bill to help us ensure first-rate care for all of those who desperately need it.

I thank you for the opportunity to testify today and would be glad to take any questions.

Pertinent funding to Joan Reibman, MD.

2001-2002	CDC, World Trade Center Residents Respiratory Survey (Institutional P.I, Lin P.I.)
2001-2003	NIH, NIEHS, World Trade Center Residents Respiratory Impact Study: Physiologic/Pathologic characterization of residents with respiratory complaints (P.I.)
2004-2005	CDC, NIOSH WTC Worker and Volunteer Medical Monitoring Program (P.I.)
2005-2007	American Red Cross Liberty Disaster Relief Fund (P.I.)
2006-2011	New York City funding for WTC Environmental Health Center (Linda Curtis, Bellevue Hospital, PI)

Mr. PALLONE. And next for an opening statement, the gentleman—I was going to say New York, I will say Staten Island, because we think that Staten Island is closer to New Jersey, but thank you for all your efforts.

OPENING STATEMENT OF HON. VITO FOSSELLA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. FOSSELLA. It is closer to New Jersey. And thank you, Chairman Pallone and Ranking Member Deal, thank you for extending me the courtesy of sitting on your subcommittee for today's hearing, and at the outset I ask unanimous consent to submit, for the record, the testimony of Representative Carolyn Maloney, and without her we wouldn't be here today. She has been the most tireless advocate, so I submit that. In addition, unanimous consent to submit the testimony of Dr. David Prezant, M.D., Chief Medical Officer, Office of Medical Affairs and the Co-Director of the World Trade Center Medical and Monitoring Treatment Programs of New York City Fire Department.

Mr. PALLONE. Without objection, so ordered.

[The prepared statement of Ms. Maloney follows:]

STATEMENT OF HON. CAROLYN MALONEY

Chairman Pallone, Ranking Member Deal, members of the Health Subcommittee, I want to thank you for inviting me to testify here today on H.R. 6594, the James Zadroga 9/11 Health and Compensation Act, which I introduced with Representatives Nadler, Fossella, and King, with the support of the entire New York Delegation. I am pleased to be here with Mr. Nadler, Mr. King, and Mayor Bloomberg, and I am grateful that the Committee is taking up the important issue of health care for the heroes of 9/11—the World Trade Center rescue, recovery and clean up workers, residents, area workers, school children and others who have become sick because of exposures to the toxins of Ground Zero.

On 9/11, our Nation was brutally attacked at the hands of terrorists. Nearly 3,000 people lost their lives that day. But as we now know, many more have lost their health.

The James Zadroga 9/11 Health and Compensation Act would ensure that those brave Americans who have lost their health have a right to medical monitoring and treatment for their WTC-related illnesses and the opportunity to get compensation for economic loss and harm. We need to pass this bill because responders came to the aid of our nation after 9/11 and many are sick as a result. If we don't take care of them now, what will happen in the event of another disaster?

Now, some here today might say that this is a very expensive endeavor and, truth be told, they would be right. Thousands of people from all 50 states were exposed to the toxins and many of them are sick. Monitoring, treating, and compensating all of them carries a hefty price tag. And it's a price tag that the Federal Government is going to have to pay.

Because the truth is that this is a national problem that needs a federal solution. We all wish the terrorist attacks had never happened, we wish all those lives weren't needlessly lost, and we wish that there weren't so many people sick because of the air as caustic as Drano, but that won't change the facts. People are sick because our Nation was attacked. Not just New York City, not just New York State, but our Nation as a whole. In the aftermath of 9/11, Americans everywhere cried for our losses, prayed for our country, and found that patriotic spirit within. And people acted: first responders traveled from every single state in the Nation to help.

Early on, some in Congress and in the Administration didn't think that 9/11 health issues were a real problem. They questioned the science. They questioned the need for funding. But hearing after hearing and GAO report after report made clear what we know today: that thousands of people are sick from 9/11 and they need and deserve our help.

So we in Congress went to work to drum up the funding that was needed. Over 6 years, we have provided $335 million for screening, monitoring, and treatment for

responders and community members. This funding allowed the Director of NIOSH, Dr. John Howard, to provide medical monitoring for 40,000 Responders and treatment for 16,000 sick responders. Furthermore, NIOSH made arrangements for a national program for those who live outside the New York area, and has started the process toward helping non-responders who are sick and need treatment.

And what happens in this Administration to an official who does what Congress directs and helps the heroes of 9/11? Unfortunately, he gets fired. That's right, although Dr. Howard asked to be reappointed as Director of NIOSH, Secretary Leavitt and CDC Director Gerberding refused to reappoint him to his post. There was absolutely no reason given for his dismissal. In fact, at a meeting just this morning with Secretary Leavitt and Dr. Gerberding, they refused to offer any grounds for terminating Dr. Howard.

The program that Dr. Howard supervised, the WTC Medical Monitoring and Treatment Program, is playing a very important role in the lives of so many heroes of 9/11, and the facilities that are a part of this program are truly Centers of Excellence. The FDNY has a program of over 16,000 firefighters who are being monitored, and a Consortium of providers led by Mt. Sinai is monitoring about 24,000 other responders. Combined, the responder programs are treating about 16,000 responders for WTC-related illnesses. For all the good work that the WTC Medical Monitoring and Treatment Program is doing, it constantly faces the challenge of uncertain funding, never knowing when they may need to close their doors or cut back on their medical personnel. Notably, year to year funding makes it very difficult to recruit and keep the high quality doctors and other care providers that make this Center of Excellence what it is.

Today, residents, area workers, school children, and others are being screened and treated at a WTC Center of Excellence which receives no federal funding whatsoever. The City of New York is picking up the bill for the WTC Environmental Health Center at Bellevue Hospital, which has about 2,700 community members currently enrolled.

H.R. 6594 will build on these current Centers of Excellence, expanding what's working and filling in the gaps left by what's missing. It will provide the steady funding that people need to know their care will continue and provide the funding to recruit and keep doctors who are experts in their field. It will make care for Responders and others mandatory. The care for sick heroes of 9/11 should not be left to the discretion of the year-to-year appropriations process.

As I mentioned earlier, this is not an inexpensive proposition. Handling a big problem usually has a big cost. But, as some of you know, hand-in-hand with the City of New York and the AFL-CIO, we have sharpened the scope of our previous bill, H.R. 3543, allowing us to save billions of dollars in our newly introduced bill, H.R. 6594. We were able to do this because our original bill didn't match the problem it was trying to solve on the ground. It was too broad in its scope. In drafting H.R. 6594, we brought the bill in line with the real problem that needed to be solved: monitoring only those were exposed and treating only those who are sick.

For example, H.R. 3543 included a radius of 2 to 5 miles within which community members would be covered. In the new bill, we create a smaller geographic area-south of Houston Street in Manhattan and up to a 1.5 mile radius in Brooklyn-which more closely mirrors where the dust cloud blew. Then, for anyone outside that smaller radius, we set up a capped contingency fund which could screen and treat only those community members who are determined to have WTC-related conditions. We made a number of changes like this so that the bill targeted the problem that needed solving and helped the people who need to be helped.

This morning, I hope that my testimony has set the stage for you to hear more from the other panelists about H.R. 6594, the James Zadroga 9/11 Health and Compensation Act.

In closing, I'm pleased to say to the Committee what I've told thousands of people before-I will not rest, we here at this table will not rest-until everyone at risk of illness from Ground Zero toxins is monitored and all those sick receive treatment for the WTC-related illnesses. This is the very least we can do, as a grateful nation.

[The prepared statement of Dr. Prezant follows:]

Statement of

David Prezant, MD

Chief Medical Officer, Office of Medical Affairs

Co-Director WTC Medical Monitoring & Treatment Programs

New York City Fire Department

H.R. 6594 James Zadroga 9/11 Health & Compensation Act of 2008

July 31, 2008

Committee on Energy and Commerce

Sub-committee on Health

U.S. House of Representatives

Good morning Chairman Pallone, Ranking Member Deal and New York Committee Members Towns, Engel, Fossella and Weiner and Members of the Subcommittee. My name is Dr. David Prezant, and I am the Chief Medical Officer, Office of Medical Affairs, for the New York City Fire Department (FDNY). I am also a Professor of Medicine in Pulmonary Diseases at the Albert Einstein College of Medicine. Along with Dr. Kerry Kelly, who could not be here today, I am the Co-Director of the FDNY World Trade Center (WTC) Medical Monitoring and Treatment Program. I am delighted to be here today to support this legislation, which will provide needed long-term funding for the monitoring and treatment of WTC-exposed responders and specifically for FDNY responders. Many of these responders, unfortunately, have become patients with critical health needs related to physical, respiratory and mental health illness.

I would first like to thank this Committee and the Members of Congress who have shown their extraordinary support for our patients and our program, especially Members Maloney, Nadler, Fossella and King, and Senators Clinton and Schumer. The funding that Congress has generously provided has helped the FDNY to provide needed monitoring and treatment, analyze our results, develop treatment protocols and share this information with other healthcare

providers so that our experience could be used to help other patients with similar WTC-related problems.

The FDNY is operating under a federally funded NIOSH WTC five-year grant program for monitoring, treatment and data analysis. We anticipate that we will run out of funding in February 2009, six months before the official end-date for this grant on June 30, 2009. Congress has appropriated additional funding, but the Department of Health and Human Services (HHS) has not yet released that funding. Beyond that, we need a long-term solution – a commitment from Congress and the President that matches the commitment FDNY firefighters and EMS workers made on 9/11, the day our nation was attacked and 2,751 innocent victims were killed. The day when 341 FDNY firefighters and two FDNY paramedics made the ultimate sacrifice. The day that began a ten-month long rescue/recovery effort during which nearly every FDNY member was exposed to WTC dust and chemicals, risking their life and health.

I am often asked, how many have been exposed, how many are in the monitoring and treatment program and will there be funding left to allow this program to continue? The FDNY-WTC Center of Excellence, its clinical and data center components, is uniquely capable of providing this information because, as a group, our exposure was the most intense and our group is the

only one with pre-9/11 baseline health data. So, the effects of WTC exposure on the health of our members can be objectively measured. The following data will help to answer these questions and allow you to better understand the FDNY's WTC-related healthcare needs.

- More than 11,500 firefighters and fire officers, 3,000 EMTs and Paramedics and 1,000 FDNY retirees took part in the WTC rescue, recovery and fire suppression efforts. So far, arrival time at the WTC site has been the best predictor of health outcomes. Nearly 2,000 members -- or 15 percent of our workforce -- arrived in the morning on 9/11, 54 percent arrived during the remainder of that day, 14 percent on day two, 15 percent during days three through 14, and the rest thereafter.
- 14,962 FDNY WTC-exposed rescue/recovery workers (active and retired fire and EMS) have received at least one FDNY WTC Monitoring Exam for a 97 percent compliance rate.
- 12,116 FDNY WTC-exposed rescue/recovery workers have received a second FDNY-WTC Monitoring Exam for an 81 percent retention rate.
- 9,141 FDNY WTC-exposed rescue/recovery workers have received at a third FDNY-WTC Monitoring Exam for a 75 percent

retention rate. These compliance and retention rates are unmatched and indicate how enormously successful this joint labor-management program has been for the FDNY and why this cohort needs to be maintained. Outreach continues and a fourth round of exams has just started.

- Disease surveillance is a critical part of our program. In the first year post-9/11, the average annual decline in pulmonary function, for symptomatic and asymptomatic FDNY-WTC responders, was 372 ml, or 12 times greater than the average annual decline noted five years before 9/11. Further testing has indicated that the predominant problem is obstructive airways diseases such as airway hyperactivity, asthma, Reactive Airway Dysfunction Syndrome (RADS) and chronic bronchitis. Over the next six years, pulmonary functions of many of our members have leveled off, improved or, unfortunately for a few, declined still further. More than 25 percent of the members who participated in follow-up WTC medical monitoring exams continue to report respiratory symptoms.
- Sarcoidosis is an auto-immune disease that can affect any organ but primarily affects the lungs. In the first year after 9/11, FDNY

identified 13 Sarcoidosis cases, as compared to an annual rate of only two to three cases per year in the 15 years before 9/11. While the numbers have leveled off -- we now see about four cases a year -- these Sarcoidosis cases continue to have more serious clinical presentation than we saw prior to 9/11. Before 9/11, they were nearly always asymptomatic. Now the majority of the Sarcoidosis cases we see have airway obstruction and a few have disabling systemic inflammation involving joints, bones, muscles and other organs.

- Unrelated to Sarcoidosis, we have also seen several cases of pulmonary fibrosis, one of which has been fatal, one has just received a lung transplant and is doing well and another will need a lung transplant in the future.
- In a mental health study, 76 percent of our FDNY-WTC firefighters reported at least one psychological symptom post-WTC. The most frequent symptoms reported are insomnia, irritability and anxiety, and 12 percent met criteria for Post Traumatic Stress Disorder (PTSD). We are now seeing more cases of chronic depression.

- Monitoring for late-emerging illnesses, such as cancer and autoimmune disease, is ongoing and critical if we are to understand the results of WTC exposure and provide early diagnosis and treatment.
- Since 9/11, the FDNY WTC Medical Monitoring Program has provided treatment for WTC-related physical health (majority being asthma, rhinosinusitis, GERD) and mental health (majority being PTSD, depression, prolonged grief and anxiety) conditions to 7,484 and 9,153 members, respectively. In the last 12 months, our program has provided WTC-related physical health and mental health treatment to 3,157 and 2,174 members, respectively.
- Nearly all of the patients in our treatment program report improvement in symptoms. Many have been able to return to work but others have had to retire with documented disability based on serious reductions in lung function. Between 2002 and 2006, 728 FDNY firefighters have qualified for lung disability benefits, averaging 146 cases per year, as compared to 49 cases per year in the three years before 9/11.
- In addition to publishing over 20 peer-reviewed articles on WTC medical conditions (see attachment), the FDNY distributed a

summary data publication to every FDNY-WTC member, a copy of which is provided to you today and is available on-line for anyone with interest at:

http://www.nyc.gov/html/om/pdf/2007/wtc_health_impacts_on_fdny_rescue_workers_sept_2007.pdf

What are the costs of running this program? On July 1, 2004, the National Institute of Occupational Safety and Health (NIOSH) awarded FDNY a five-year grant, totaling $25 million for clinical monitoring and data analysis. We are now in the final year of this grant. We anticipate that when NIOSH approves our year 5 budget, the annual cost for our monitoring program will be $12.4 million and that we will run out of money by approximately February 2009. In 2006, NIOSH awarded FDNY $20 million as a treatment supplement to replace funding initially provided by FDNY, Project Liberty, the American Red Cross September 11th Fund and other agencies and philanthropies. In this current grant year, we anticipate that we will spend $18.4 million -- $7 million of which is for medications -- and that we will run out of treatment dollars by approximately February 2009.

These numbers only begin to express the real healthcare needs of our exposed members and patients. They provide the basis for understanding the extent of this disaster and our future funding needs, but they do not speak to the

heart and soul of the matter -- to the special commitment that was made on 9/11 between those in need of help and those who could provide the help. On 9/11, when the towers were burning, FDNY firefighters ran into those buildings. By the time the second plane hit, most realized that this was not just a fire, but an attack and they were in the middle of a war zone. In a tower that morning, one senior firefighter told a young firefighter to search the right hallway while he searched the left. At the time he could not have realized that he would come home and the younger man would not. But, because he is my patient, I can tell you that there are still nights when he wakes up screaming in a cold sweat reliving that decision. Thankfully, this happens less often than before we started treatment, but still too often to claim a medical victory.

One fire officer was buried in the first collapse and was rescued by a group of firefighters who, without a second thought, ran in to pull him out. Many of the members of that unit are my patients today. They have asthma and sinusitis that prevents them from being firefighters or from living anything that resembles the life they once took for granted. But, like every patient I have, they all shared a common commitment that remains unshaken, no matter how ill they are or might become. They would not have done anything different. They wish they could have done more, and they would all do it again. They were the lucky ones because that morning their efforts were rewarded. They found that

fire officer with the top part of his skull hanging off to the side and barely breathing. One of those firefighters told me that "we had no choice but to push it back on as if it was his helmet, pick his heavy ass up and run for our lives." He got to the hospital alive, but was suffering severe head trauma, and airway and lung injuries. The next few days were tough ones for him and his family. He was saved many times over. I spoke to his wife and tried to explain to her how critical his condition was and what decisions she needed to make. She looked up at me and said I am counting on you and the others here to make the decisions. Thankfully, he eventually recovered. He continues to have a daily cough, vertigo, headaches and a host of other problems. But, the treatment that this program provides him has gotten him back on his feet and he remains hopeful that the monitoring and treatment that we have promised him will continue and may allow him the chance to see his children and grandchildren grow and prosper.

Others were not so lucky. They could not be rescued. But, it was not for lack of effort or commitment. Nearly every FDNY member suffered significant and repeated exposures and they were not alone in these efforts. Members of the Police and Sanitation Departments, and construction and communication workers, and others helped in every way possible. A perfect example is a firefighter who was not there during the collapse, but arrived the day after. He

worked at the site all day on days two and four, trying in whatever way he could to find someone. His cough became so severe that he could not return. Years later, increasingly short of breath, he was diagnosed with severe pulmonary fibrosis. He was advised that he would need a lung transplant to survive. Tears of joy came to his eyes when I told him that the FDNY WTC Treatment Program was created for people just like him. A commitment was made on 9/11 and we would not abandon him. Earlier this month, he received a double lung transplant, is doing well and just recently was discharged from the hospital.

This program needs to continue for him, for the other patients I talked about today, for every FDNY WTC rescue/recovery worker and for all the others who were exposed at the World Trade Center. This legislation will provide long-term funding so that the FDNY and other Centers of Excellence can continue monitoring and treatment programs for our exposed workforce (both active and retired firefighters and EMS workers), and use lessons learned to inform lesser exposed groups (and their healthcare providers) of the illnesses seen and the treatments that are most effective. Most importantly, I am proud to say that this legislation will allow all of us to fulfill the commitment we all made on 9/11 – to help those lucky enough to survive and to help those who

helped us survive. *Thank you for your past efforts, and your continued support of our members, patients and Department and I urge you to support H.R. 6594.*

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Mr. FOSSELLA. Another gentleman who has spent the last, almost, 7 years committed to helping those in need. And I highlight why we are here because of the many advocates who haven't given up, the Union officials, the FLC, I know has been mentioned, Susan and Dennis Hughes, the first responders, New York City Fire Department, Police Department, healthcare professionals, among them, Mount Sinai who just have not let us forget what happened, in particular, the witnesses, Congressman Nadler, Congressman King, I mentioned Congresswoman Maloney, my colleagues of the New York delegation, Mr. Towns, and one, in particular, Mr. Weiner who has been a vocal advocate to ensure that something get done. And above all is our Mayor from the great city of New York, Mike Bloomberg. He could have easily walked away from this issue, but there has been no one who has been more tireless and more vocal in support of those who suffered greatly on 9/11 and we couldn't have a better advocate in City Hall. So thank you, Mr. Mayor, for coming.

And let me just also add something Mr. Green said earlier about if there is a hurricane in Houston, the Federal Government is there to help. Frankly, if there is a hurricane anywhere in this country or fire or flood, the Federal Government is there to help and that is what the American people do. They will respond through their Representatives, through their Congress to help. And, frankly, the people who responded in New York City and 9/11 still need help, and we haven't fulfilled the obligation to all of them. So we are here to talk about the legislation, which is a culmination of many long hours of work and even longer hours of compromise from the offices of Ms. Maloney, Mr. Nadler, Mr. King, and the Mayor's office.

Their staffs have worked tirelessly to ensure that the bill we are set to discuss provides the best and most effective care to those still suffering. These individuals believe, as I do, that when we started working on this issue, it was for the right reasons and to help those still suffering. Those reasons remain the same today. We will continue pushing for the legislation till we finally see that all those who continue to suffer receive the treatment they deserve.

It has been exactly 6 years, 10 months, and 20 days since the Nation suffered the horrible attacks. While much progress has been made to address the residual health effects, many of our Nation's citizens are still suffering and much is left to be done.

The bill before us is our best chance to fulfill that obligation. Most of all, this bill represents our joint commitment to those who continue to suffer and deserve the monitoring treatment that has been deferred to them far too long.

We cannot continue to stress enough the national health impact that these attacks have had. Currently, there are individuals from every congressional district in our country enrolled in the World Trade Center Health Registry. On this subcommittee alone, Democrats and Republicans combined represent roughly 10,000 individuals affected by these attacks.

I, sadly, represent nearly 5,000 individuals enrolled in the registry. It is hard to imagine the public outrage we would see if there was an attack today on our country and the Federal Government did not provide adequately for those injured. Yet, this is exactly

what we are experiencing today, as those who were exposed to these toxins from 9/11 continue to grow sick.

The updated 9/11 Health and Compensation Act represents many significant changes from the original bill and much has been done to ensure that the best possible care is provided while minimizing the size of the program, specifically the geographic areas when patterned on the most likely affected population areas. Standards of association for those claiming health conditions related to 9/11 have a refined and cost-share with the city of New York for medical monitoring and treatment has been included. Our bill has been improved in ways unrelated to health.

As much as possible, it makes whole the companies that brought the equipment and know-how to the rescue and recovery operation at the World Trade Center site. The Good Samaritan contractors and subcontractors performed a federal function by dealing with the aftermath of the attack. The bill indemnifies those companies so that they and others, who wish to help our Nation in a similar situation in the future, will do so without fear of losing everything. This is a significant improvement in our bill.

This is a national health issue that needs to be addressed as such. Numerous studies have documented the illnesses of those exposed to the deadly ash and smoke mixtures from these terrorist attacks are at risk of developing. And many who suffer from these sicknesses face the added financial strain of no longer being able to work and having to bear the brunt of their medical costs without a federally funded national program to incur the costs.

The Federal Government has an obligation to come to the aid of both the first responders who answered the call when their Nation needed them most and the innocents whose health continue to suffer from these devastating attacks. Any failure on our part to address this urgent issue now can have far reaching implications on our future response efforts.

To those exposed to the sickening cloud of ashes and chemicals, the suffering continues long after the physical remains of the taxed have been addressed. I applaud the work of my colleagues in coming together to help those whose health at risk due to their exposure at Ground Zero on that fateful day, and we should pledge our support never to forget. Thank you Mr. Chairman.

Mr. PALLONE. Thank you. The ranking member, the gentleman from Texas, Mr. Barton, recognized for an opening statement.

OPENING STATEMENT OF HON. JOE BARTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BARTON. Thanks, Mr. Chairman. I am conflicted by this hearing. We all want to take care of the first-responders at the World Trade Center. We want to take care of the individuals who were in those buildings. We want to take care of the volunteers who risked their lives to try to help the professionals. And we also want to help our congressional friends from New York. I am glad to have the mayor here. It is a privilege to have you here, sir.

It is good that we are having a hearing. I mean, I have spent a fair amount of time complaining to Mr. Pallone and Mr. Dingell that things that should go through the committee are taken to the floor on the suspension calendar so I can't complain that we are

having a hearing. Having said that, this is a bill that was introduced, I think, last Thursday. We have tried to get a minority witness to appear but we haven't had time to make that happen.

This bill is well-intended but it appears, on the surface, to be somewhat, to be as polite as I can about it, somewhat more comprehensive and beneficial than it really needs to be to solve the immediate problem. It is certainly something that needs to be addressed. I am told that there are several state and national initiatives trying to address it right now, Mr. Chairman, so I am a little bit perplexed that a bill that was introduced last Thursday, we are having a hearing on today.

Again, I am glad that you have a lot of witnesses, that is a good thing, but if I had to vote on this legislation today, I would vote no. If we can narrow the legislation down, if we can target it to those that are most in need of help, there is certainly some gold in the legislation. But there are also, as it is currently drafted, some hidden costs that don't necessarily need to be borne, in my opinion, by the federal taxpayers. So, I have another hearing, as you know, going on downstairs. It is good that we are having the hearing. It is good that we need to address the problem.

Again, Mr. Fossella has been an absolute champion on this issue for a number of years, and we know that he is sincere about it, and I can say the same thing for Mr. Nadler and Mrs. Maloney and Mr. King but sometimes haste does make waste and this particular bill may be an example of that. So with that, Mr. Chairman, I am going to be happy—if we can yield during an opening statement, I will be happy to yield. I am willing to, sure.

Mr. FOSSELLA. Only because you say you have to leave and thank you for yielding. I have the deepest respect for Mr. Barton and concluding with haste makes waste—almost 7 years, to me, is not haste. The fact is that we have tried, desperately, to have an adequate federal response and it has been lacking. And many people who have suffered, and their advocates, people who care deeply—I am not suggesting you don't—could have walked away and left the city of New York and the city taxpayers and the State taxpayers assume that burden, which has been tremendous. And we have tried desperately to get the Federal Government and its appropriate agencies to do what it should have done years ago. And I would just, respectfully, request that if anyone has anything to add, expeditiously, they should do so now.

As you know, the congressional calendar is coming to a close, Congress is going on recess for the month of August. We come back for all of, probably, several weeks. In order to get something achieved this year, it will have to be done sooner rather than later and today is perhaps the last day we will have one of these hearings. So haste does not make waste in some respects. No, I should say—let me be clear—yes it does, but 7 years is far from haste, so I say that and if anyone has something to add that makes this program better and put in place now, I think we are all ears.

Mr. BARTON. Well, I don't know how much time I still have, Mr. Chairman. I have probably consumed it. But my concern, Mr. Chairman, and I am not going to belabor this because I know we need to get forward with the hearing, is that some of the eligibility requirements we are giving people, that apparently—and I say ap-

parently—were not truly first responders. It appears to be drafted in such a way that somebody that just happened to be in the vicinity could be eligible and I think that we need to look at that.

We are giving some folks that have signed waivers a second opportunity and I think that is where having a second look—I am not opposed to the concept. Don't misunderstand me. I just want to try to narrow the scope and make sure that we target the benefits to those that are truly needy and truly eligible. And that is not being Attila the Hun, that is just trying to be responsible, but with that, Mr. Chairman, it is good that you are holding a hearing on the subject.

I have a number of bills I would like hearings held on too if you are in the market for bills. So, with that, we appreciate your concern and we know that the New York delegation is grateful that you are doing this.

Mr. PALLONE. Thank you, Mr. Barton. I see Mr. Burgess is sort of hesitating to sit down. Would you like to be recognized for an opening statement? I recognize the gentleman from Texas.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman, for the recognition. I apologize for being late. I am trying to work between two hearings. I do believe this country has a solemn obligation to those who selflessly responded to the World Trade Center after the attacks on September 11, 2001. They didn't know the risks. These Americans went down to a site that, probably, more closely resembled Dante's inferno than any disaster site they had ever seen before. In lower Manhattan the fires went on for weeks. The plume of smoke and ash covered downtown and surrounding boroughs. We watched on the news, from down in Texas, hour after hour.

Those working on the site were exposed to numerous toxins. Some may result in long-term medical conditions. The psychological impact of the event can't be overcalculated for those that will never recover the bodies of their comrades, for those that knew someone who may have been in the building that day or just affected by the sheer magnitude of this tragic act. Their mental health needs could persist for years to come.

I appreciate the members of the New York delegation that are here today. Thanks to the Mayor for being in attendance. I hope as we move forward that this committee can work with you to improve H.R. 6594 and bring a bill to the floor. I think it would be a welcome commemoration and recognition for the sacrifice for those who responded to the worst terrorist attack ever to take place in the United States of America.

We do need to be certain the program is a response to those who face an occupational illness because of their service. We need to ensure that past federal investments have been prioritized to then determine if improvements can be made and make them. This is a complicated issue. It is an emotional issue, but I commit to the Chairman that my staff and I are ready and willing to work with you to produce a bill, a better bill if one can be attained, but a bill nevertheless, one that we can all be proud of and one that will

make people in this country proud of the sacrifice exhibited by all of those who answered the call to service on 9/11. I will yield back.

Mr. PALLONE. Thank you and I believe that concludes the opening statements by members of the subcommittee, so we will now turn to our witnesses in our first panel.

Let me welcome all of you. Let me say to the Mayor, we are certainly honored that you are here with us today, not only because of what you have done on this issue, but also what you do for the great city of New York. I will note that Carolyn Maloney, who is the prime sponsor of legislation, wasn't able to be here because she has a mark-up on another bill in financial services. But I do want to welcome all of you.

Let me say, well—nobody here needs any introduction, but I will do it anyway because that is what we normally do. First, we have the Honorable Jerry Nadler. I have to say, Mayor, and this is not in any way commenting on the Republican members, but I have never seen anybody work harder on an issue than I see in Jerry and Carolyn. They have been relentless. Not only from the very beginning, when you had that hearing and called attention to this issue Jerry and I came to the courthouse in Manhattan, but also in terms of you and Carolyn constantly coming to the floor and demanding that we move this bill and have hearings and try to come up with something that is workable with the leadership. So, I want to commend you for that. And we also have with us Peter King, also from New York, and of course the Mayor of New York, Michael Bloomberg. We will start with Congressman Nadler.

STATEMENT OF HON. JERROLD NADLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. NADLER. Thank you very much. Let me begin by extending my thanks to Chairman Pallone, Ranking Member Deal, and the members of the subcommittee for convening this hearing and inviting my colleagues and me to testify here this morning. I want to thank Speaker Pelosi for her ongoing leadership and I also want to thank the chairmen of the Committees of Jurisdiction, the bipartisan members of the New York, New Jersey, and Connecticut congressional delegations, in particular Carolyn Maloney who is not here, about whom I will have more to say in a moment, and Vito Fossella and Peter King, the Mayor of the City of New York, and the Governor of New York, the AFL-CIO, numerous local community groups for working with us intensively over the past several weeks to sharpen the focus of the legislation before us today.

As you know, Congresswoman Maloney and I, and let me say that, again, Carolyn has been working—we have been working together and she has been a leader on this since very early on and I am very sorry that she can't be here this morning because of the mark-up in the Financial Services Committee, but everyone who knows anything about this issue knows of her leadership role. And along with our colleagues Congressman King and Congressman Fossella have introduced H.R. 6594, the James Zadroga 9/11 Health and Compensation Act of 2008, which is not in one sense a brand new bill. It is a modification of a bill introduced a year ago, which in turn is a combination of several bills introduced over the years. We have bills going back 6 years on this topic and contin-

ually refining them on the basis of new knowledge and new experience.

And the purpose of the bill is to ensure that the living victims of the September 11th terrorist attacks have a right to health care for their World Trade Center-related illnesses and a route to compensation for their economic losses. Although the Victims Compensation Fund part of the bill is not before this committee, today.

We believe the current version of this bill represents our collective best efforts to provide that critical support for those affected by the attacks, our heroic first responders, area workers, resident, students or others—through a stable, long-term approach that builds on successful, existing programs. And it does all of this in a fiscally responsible manner. We are hopeful that today's hearing marks the beginning of the end of our collective 7-year struggle in pressing this case.

Beginning shortly after 9/11 we were warned that the air wasn't safe and that our courageous first responders were not being afforded the proper protection from dangerous toxins as they worked on the rescue, recovery and cleanup operation. We spent years trying to convince public officials that the asbestos, fiberglass, and other toxins had traveled far and settled into the interiors of residences, workplaces and schools, and that a proper testing and cleanup program was required to eliminate the health risks to area residents, workers, and students. We asked that the government acknowledge the fact that thousands of our Nation's citizens were becoming sick from 9/11 and that many more could become sick in the future.

We explained to whomever would listen that our 9/11 heroes were struggling to pay health care costs because they could no longer work and no longer had health insurance, or because they have had their workers' compensation claims controverted, and we argued vigorously that the federal response, to date, has been dangerously limited, piecemeal, and unstable.

Thankfully, we believe that we have now finally achieved a much more widespread recognition of many of these problems, and nearly 7 years after the attacks, we believe and hope that Congress will do what is right for our heroes and our living victims, and pass H.R. 6594.

Though the devastating 9/11 attacks on the World Trade Center occurred within my congressional district, we know that these were really attacks on our Nation as a whole—figuratively and literally. The President has repeatedly referred to them as such. The members of the New York delegation represent thousands of people who were exposed to contamination in lower Manhattan and then affected parts of Brooklyn. Indeed, every member in this room represents a state that has people suffering the health effects of 9/11.

And as this is unquestionably a national problem, it has always required a national response. But despite our sustained efforts to get the administration to develop a comprehensive plan to deal with this growing public health problem the New York delegation has instead found itself, year after year, coming to Congress with its hat in hand to test its luck at the annual appropriations process.

Thankfully, with growing bipartisan support for that funding, and with dedicated public servants like Dr. John Howard, we have had some key successes. But this is simply no longer a tenable course of action. Neither our heroes nor the excellent health care programs that are now in place to serve them should have to rely on such an unpredictable and unreliable funding source as annual appropriations.

Passage of the James Zadroga 9/11 Health and Compensation Act would mark an end to this entire problematic approach and ensure that a consistent source of funding is available to monitor and treat the thousands of first-responders and community members who have been or will become ill because of World Trade Center related illnesses. And it would make sure that no matter where an affected individual were to live in the future, he or she could get care.

The bill would also require substantial data collection regarding the nature and extent of World Trade Center illnesses, a critical step in learning more about these illnesses and then preparing for future natural or man-made disasters.

And finally, as you know, this legislation would provide an opportunity for compensation for economic losses by reopening the 9/11 Victim Compensation Fund, and would indemnify the contractors who dropped everything and rushed to help the rescue and recovery operations.

The needs here are abundantly clear. We now have 16,000 first-responders being treated for World Trade Center related illnesses and another 40,000 being monitored through a consortium of providers led by Mount Sinai and by the Fire Department of New York. And we have nearly 3,000 sick community members being treated in an entirely city-funded program with countless others being treated elsewhere.

But unfortunately these are just today's numbers. In a February 2007 report to Mayor Bloomberg, the City of New York estimated that there were nearly 90,000 first-responders and about 318,000 heavily exposed community members, who were living or working within an even more narrowly drawn radius than is used in this bill, an unknown number of whom may ultimately become sick as a result of the effects of the 9/11 attacks.

As you may know, the preliminary cost estimates of the original version of this bill, last year's version, were substantially higher than our expectation. Therefore, we have redesigned the bill in order to bring those costs down dramatically by many billions of dollars. We made many different cuts in the bill, and some of them were very difficult to swallow. With respect to the community program, a variety of cuts were required.

First, this new bill dramatically shrinks the radius within which individuals who reside, go to school or work would be eligible for services.

Mr. PALLONE. Jerry, I apologize, but you are 2 minutes over so you need to wrap up a little.

Mr. NADLER. OK, I will try to wrap it up quickly. Second, it caps the number of new treatment slots for the community members to 35,000. It places strict dollar limits on various contingency funds. Concerns have been raised that with these limits and caps some in-

dividuals who were or are still being exposed to 9/11 toxins and who may become sick in the future may be excluded from help. These fears arise because although we do not have—because we have a good deal of data about toxicity there has never been a systematic testing program to determine the geographic extent of indoor contamination, as was recommended by the EPA Inspector General.

And individual cap levels in the bill were determined in part by looking to the current number of people being treated in each of the existing programs. And as has been previously noted, we know that the population in the community program at Bellevue underrepresents the total population that is currently sick.

Nonetheless, I am hopeful these fears are unfounded. Our goal has been to use the best available data and knowledge to estimate the number of people who could eventually get sick and craft a bill whose price tag allowed a real chance of passage. Our goal was not to deny any deserving individual care or compensation.

Today we must decide if we are going to be a part of, in an effort to honor the heroes and victims of 9/11 and to provide for their health and for compensation for losses in a reasonable and responsible manner. I urge you to come to the aid by enacting this bill.

You would not be alone. The broader, original, more expensive version of this bill had more than 100 bipartisan co-sponsors. It stands to reason that we will see even more support for this bill, which is strongly supported by the governor, the mayor, the national AFL-CIO, the contractors, numerous environmental and community advocacy groups and is essential if this Nation is going to redeem its honor and begin to behave properly toward the victims and the heroes of the 9/11 attacks on the United States.

I urge you to give favorable consideration to this bill. I thank you for your attention and for your indulgence for the overtime statement.

[The prepared statement of Mr. Nadler follows:]

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TESTIMONY OF U.S. REPRESENTATIVE JERROLD NADLER (D-NY 08)

Before the Energy and Commerce Subcommittee on Health

The James Zadroga 9/11 Health and Compensation Act of 2008

July 31, 2008

I want to extend my thanks to Chairman Pallone, Ranking Member Deal, and the members of the Subcommittee for convening this hearing and inviting my colleagues and me to testify before you today. I also want to thank Speaker Pelosi, the Chairmen of the Committees of jurisdiction, the bi-partisan members of the New York, New Jersey, and Connecticut Congressional delegations, the Mayor of the City of New York, and the Governor of New York, the AFL-CIO, and numerous local community groups for working with us intensively over the past several weeks to sharpen the focus of the legislation before you today.

As you know, Congresswoman Maloney and I, along with Congressman Fossella and Congressman King have introduced H.R. 6594, the James Zadroga 9/11 Health and Compensation Act of 2008, to ensure that the living victims of the September 11th terrorist attacks have a right to health care for their World Trade Center-related illnesses and a route to compensation for their economic losses. We believe that the current version of this bill represents our collective best efforts to provide that critical support for those affected by the attacks – regardless of whether they are our heroic first responders, area workers, resident, students or others – through a stable, long-term approach that builds on successful, existing programs. And it does all of this in a fiscally responsible manner.

We are hopeful that today's hearing marks the beginning of the end of our collective seven-year struggle in pressing this case. Those of us sitting on these panels have held so many press conferences, testified at so many hearings and released so many memos and reports about the environmental impacts and health effects of 9/11, that we can hardly keep track anymore.

We warned that the air wasn't safe and that our courageous first responders were not properly protected from dangerous toxins as they were toiling on the pile to rebuild. We spent years working to try to convince public officials that the asbestos, fiberglass and other toxins had travelled far and settled into the interiors of residences, workplaces and schools, and that a proper testing and cleanup program would be required to eliminate the health risks to area residents, workers and students. We demanded that the government acknowledge the fact, supported by a mountain of peer-reviewed research, that thousands of our nation's citizens are today sick from 9/11 and that many, many more could become sick in the future. We explained to whomever would listen that our 9/11 heroes were struggling to pay health care costs because they could no longer work and no longer had health insurance, or because they have had their worker's compensation claims controverted, and we have argued vigorously that the federal response to date has been dangerously limited, piecemeal and unstable – both in terms of preventing further health impacts from potentially persistent indoor contamination and, most notably, in terms of a lack of comprehensive, long-term approach to providing health care and compensation for those already affected.

Thankfully, we believe that we have now finally achieved a much more widespread recognition of many of these problems, and nearly seven years after the attacks, we believe that Congress will do what is right for our heroes and our living victims, and pass H.R. 6594.

Though the devastating 9/11 attacks on the World Trade Center occurred within the bounds of my Congressional district, we know that these were really attacks on our nation as a whole – figuratively and literally. The President has repeatedly referred to them as such. The victims can be found throughout the country. Every member in New York's downstate delegation represents hundreds, if not thousands, of people who live, work, attend school, or were otherwise present in Lower Manhattan and the affected parts of Brooklyn, and were exposed to a toxic brew of contamination. Indeed, every member in this room represents a state that has people suffering from the negative health effects of 9/11.

And as this is unquestionably a national problem, it has always required a national response. But despite our sustained efforts to get the Administration to develop a comprehensive plan to deal with this growing public health problem that they themselves now finally acknowledge, the New York delegation has instead found itself, year after year, coming to Congress with its "hat in hand" to test its luck at the annual appropriations process. Thankfully, with growing bi-partisan support for that funding, we have had some key successes. And with those monies we have seen some critical first steps in federally-funded health care programming, thanks to dedicated public servants like Dr. John Howard. But this is simply no a longer a tenable course of action. Neither our heroes nor the excellent health care programs that currently serve them should have to rely on such an unpredictable funding process.

Passage of the James Zadroga 9/11 Health and Compensation Act would mark an end to this entire problematic approach and ensure that a consistent source of funding is available to monitor and/or treat the thousands of responders and community members and others already affected by WTC-related illnesses as well as those who are most likely to become sick in the future. And it would make sure that no matter where an affected individual were to live in the future, he or she could get care. Building on the expertise of the Centers of Excellence, the bill would fill key gaps in how we are currently providing treatment and monitoring. The bill would also require substantial data collection regarding the nature and extent of WTC-related illnesses. This is a particularly critical provision as there is still so much we have to learn about these illnesses and how they may have affected different exposure populations. And finally, as you know, this legislation would provide an opportunity for compensation for economic damages and losses by reopening the 9/11 Victim Compensation Fund.

The needs here are abundantly clear. We already have 16,000 first responders currently being treated for WTC-related illnesses and another 40,000 being monitored through a Consortium of providers, led by Mt. Sinai Hospital, and by the FDNY. And we have 3,000 sick community members being treated in an entirely City-funded program – the World Trade Center Environmental Health Program at Bellevue Hospital – with countless others being treated elsewhere either because they don't know about the Bellevue program or for a host of other reasons. Indeed, without a single federal dollar going to the Bellevue program thus far, it hasn't even had the means to do any real outreach and marketing as of yet.

But unfortunately, these are just today's numbers. In a February 2007 report to Mayor Bloomberg, entitled *"Addressing the Health Impacts of 9/11,"* The City of New York estimated, conservatively in my opinion, that there were nearly 90,000 first responders (who were by definition heavily exposed to WTC toxins) and about 318,000 "heavily exposed" community members, who were living or working within an even more narrowly drawn radius than is used in this bill, who could ultimately become sick as a result of the effects of the 9/11 attacks.

As you may know, the preliminary cost estimates of the original version of the bill were far higher than our expectation of what would be needed to treat everyone who might be affected. As such, it was required that we redesign the bill in order to bring those costs down dramatically, by many billions. We made many different kinds of cuts, and some of these were tremendously difficult to swallow.

With respect to the community program, a variety of cuts were required. First, this new bill fundamentally shrinks the radius within which individuals who reside, go to school or work (including commuters from throughout the Tri-state area) would be eligible for services. Second, it caps the total number of new treatment slots to 35,000 (which, incidentally, is the same level as the responder program). It also creates contingency funds with strict dollar limits, and caps other kinds of spending.

With this necessity of cost cutting, concerns have been raised about the fact that we may have already mistakenly excluded some individuals who may have been or are still being exposed to 9/11 toxins and who may become sick. This is because although we do have a good deal of data about toxicity levels of the plume at certain distances from the WTC site, there has never been a systematic testing program to determine the geographic extent of indoor contamination, in concentric circles out from the site, as was prescribed by the EPA Inspector General. The concern arises as well because individual cap levels in the bill were determined in part by looking to the current number of people being treated in each of the existing programs. And as has been previously stated, we know that the population in the community program at Bellevue underrepresents the total population that is currently sick.

Nevertheless, I am hopeful that these fears are unfounded. Beyond the obvious goal in making sure we could provide this Committee with a bill whose price tag allowed for a real chance a passage, our aim was to use our best data and knowledge to date to estimate the actual numbers of people we believe are currently or will likely get sick. Our goal was not to deny any deserving individual care or compensation. Though it was a very difficult challenge, I believe the City of New York, using its World Trade Center Registry and other available data, has done a very good job at advising us regarding the community cap level. We are all obviously hopeful that there will be far fewer people who ultimately become sick than are eligible for care under this bill. And if we are wrong in the other direction, it will be for future Congresses to consider.

But today, you must decide if you are going to be a part of the beginning of an effort to honor the heroes and victims of 9/11 and to provide for their health and compensation for losses in a reasonable and responsible manner. Your decision is to begin a program that will benefit thousands of people who are now struggling to pay their medical bills and keep their families together. Your decision is about how you will respond to the September 11th attacks. I urge you to come to the aid of those who helped our country in its most desperate hour by supporting this legislation.

You would not be alone. The broader, original version of this bill had more than 100 bi-partisan co-sponsors. It stands to reason that we will see even more support for this new bill. This legislation is also strongly supported by Governor Paterson, Mayor Bloomberg, Speaker Pelosi, the national AFL-CIO, Building and Construction Trades Council, the Contractors' Association of Greater New York, the Building Trades Employers' Association, and numerous environmental and community advocacy groups.

Please join us in finally doing the right thing before the seventh anniversary of the 9/11 attacks. Support the James Zadroga 9/11 Health and Compensation Act.

I thank you for holding this hearing and look forward to the testimony of my colleagues and other witnesses today. Thank you.

Mr. PALLONE. Thank you. Congressman King.

STATEMENT OF HON. PETER KING, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. KING. Thank you, Mr. Chairman. Mr. Chairman, I would ask unanimous consent to have my prepared statement made part of the record.

Mr. PALLONE. Without objection, so ordered.

Mr. KING. Mr. Chairman, let me thank you and Ranking Member Deal for holding this hearing and let me commend Congresswoman Maloney and Congressman Nadler, who, as you rightly pointed out, have fought very hard on this issue very valiantly and, of course, Congressman Fossella who has been there from the start and that just works tirelessly on it. And, of course, Mayor Bloomberg whose—that he and his administration have dedicated themselves to addressing this issue. And it really is a human issue and it is not just a New York issue and I am glad that that has been pointed out by a number of people.

Now Congressman Green mentioned the fact that if there is a hurricane in Houston, or it could also be a terrorist attack in Houston—in this year's Homeland Security Funding additional funds went to Houston because of its ports, there is a prime terrorist target, so there is virtually no—whether it is Houston or Los Angeles, whether it is New York, whether it is Boston, Chicago, the fact is there are any number of terrorist targets in this country—prime terrorist targets—Washington, DC—and we as a Nation have an obligation to come together and stand together as one.

My own district, I had over 150 people killed, over 1,200 first-responders. Congressman Fossella, I believe, had over 400 people in his district killed. Congressman Nadler had, of course, thousands and thousands of residents who were affected by this, but as has been pointed out every—I think virtually every congressional district in this country sent volunteers to Ground Zero, so it truly is a national effort. And at the time, I believe that Congress and the administration, everyone did what they felt was the right thing to do.

We did not anticipate that when we passed, for instance, the Victims Compensation Fund just a week after September 11, that the dust, debris, and the toxins would cause all of these terrible illnesses later on. And Dr. Burgess is the medical expert, but I can tell him there are constituents in my district, neighbors of mine, people in their 40s and 50s with very rare cancers, very unusually severe respiratory illnesses. And, again, it could be anecdotal. It could be coincidental, but you have such a large number of people who worked there coming down with these rare illnesses.

To me, there is definitely a cause and effect. I think that that debate should almost be over, so we need a permanent monitoring system, a permanent system of treatment. We have to open up the Victims Compensation Fund and it has to be done for those who responded, those who came down, those who spent weeks and months, really going into the following year, working at Ground Zero.

You have the contractors who showed up without signing any liability agreements, who really put their businesses on the line for

this and they could be on the hook right now for many lawsuits and for many actions. So it is important that they be indemnified. And it is really vital we just set a tone and set a program in place, for if, God forbid, another attack does happen anywhere else in this country, we wont be going through this uncertainty for 6 or 7 years, not knowing exactly who to treat and how to treat them, how it is going to be paid, what the protocols are going to be.

So, this is a bipartisan bill. It is a vital bill. It is one which we owe to those who responded. We owe it to those who did work there. I can remember Barton mentioning, he said people just happened to work there. Well, the fact is, downtown Manhattan was attacked because of the people that worked there. It was attacked because it is the financial center of the world. And so, to me those people just went to work, innocent people, on a Tuesday morning not knowing what is in store for them, but they were killed for a reason and those who were wounded and damaged and were suffering illnesses today, it is for a reason. They just didn't happen to be there, they worked in an area which is a prime target of Islamic terrorism.

So we have an obligation to defend those who were attacked, to work with those to provide whatever health and medical care we can for them. So I thank the subcommittee for having this hearing. I certainly hope we can get this on the floor for a vote. It should not be caught up in partisan politics.

I know those of us on the Republican side will do all we can to work with the Administration, to work with Republican leadership to ensure that this is not a New York bill, it is not a Democrat bill, it is not a Liberal bill, this is an American bill for real Americans who suffered, who died and, really, in memory of those who put their lives on the line and we should never ever forget them.

So with that, I thank you for holding the hearing, I certainly urge the adoption of H.R. 6594 and, again, thank Congressman Nadler, Congresswoman Maloney, Vito Fossella, of course, and Mayor Bloomberg for being such a champion of this issue, and I yield back.

[The prepared statement of Mr. King follows:]

STATEMENT OF HON. PETER T. KING

Chairman Pallone, Ranking Member Deal, and members of the Subcommittee on Health, thank you for inviting me to speak on this important issue. I would like to thank my colleagues, Mrs. Maloney, Mr. Nadler, and Mr. Fossella, for their hard work and dedication to the James Zadroga 9/11 Health and Compensation Act, H.R. 6594, and am pleased to have the opportunity to explain why such legislation is so crucial.

On September 11th, 2001, the Nation sustained the greatest attack on our homeland in history. I am sure that everyone in this room remembers the exact moment they found out about this tragedy and where they were as they watched the towers finally succumb and collapse. In New York City, as the towers burned and civilians were evacuating the buildings, brave men and women were rushing into the World Trade Center. These men and women, the members of the FDNY, NYPD, Port Authority, and other emergency services, gave their lives to save others. Moreover, in the weeks and months following the attack, after having already lost so many friends and colleagues, these same people worked diligently in the cleanup and recovery effort. Their work was an inspiration not only to me and my fellow New Yorkers, but to the nation as a whole. I am proud to say that over 1,200 of my constituents are among those that responded to the 9/11 attacks.

However, the devastation of 9/11 did not end once the cleanup was complete. Those that responded are now becoming ill due to the dust, debris, and toxins they were exposed to on 9/11 and during the recovery effort. These individuals sustained not only serious physical harm, but also extreme emotional and mental trauma as a result of their work.

As you heard from my colleagues, Congress has appropriated some funds for an ongoing medical monitoring and treatment program for 9/11 first responders. This program has resulted in a number of medical studies showing the detrimental effects that exposure to toxins at Ground Zero have had on first responders, volunteers, and area residents and workers. It is a scientific fact that those who worked in the recovery efforts have decreased pulmonary function, have developed adult onset of lower and upper respiratory conditions, and have experienced worsened symptoms of asthma and other conditions.

With limited resources, the WTC Centers of Excellence in the New York metropolitan area have done an outstanding job of monitoring and caring for responders, but funding for this program should not be an annual battle. These men and women are very sick and they are so because they rose to the occasion and did the hard work that the Federal Government asked them to do. While I have been supportive of all current efforts, more must be done for the heroes of 9/11. We must come to the aid of those who selflessly responded to the 9/11 attacks by creating a permanent program of treatment and monitoring. The list of ailments currently being endured by those who had 9/11 exposures may only grow longer as the years since the attacks pass. We must ensure that these individuals receive adequate preventive care in the present, but we must also create an infrastructure and be prepared to care for these individuals in the future.

The program that would be established by H.R. 6594 would put in place a structure under which all those affected by 9/11, both responders and residents, can receive that healthcare. The cost of this program is a small price to pay given the sacrifice these courageous individuals have made.

Furthermore, it was not only New Yorkers that responded to the attacks. Every district in this country has at least one responder that answered the call of duty on 9/11. H.R 6594 would establish a national treatment and monitoring program so that those responders who either came from out-of-state to help New York in our time of need or who have since moved can receive quality medical treatment for their 9/11-related illnesses even if they do not live in the New York metropolitan area. I am extremely grateful to those that traveled from Texas, Florida, California, Pennsylvania, North Carolina, and across the country to help their fellow citizens in need. The national program established by H.R. 6594 would show that the Federal Government is also grateful for what these compassionate and patriotic individuals did.

The reality is that the FDNY, NYPD, and others who responded to the attack on New York were on the front lines of the first battle in the War on Terror. Just as they were there for us when our country was challenged, these heroes now need our help. The Federal Government has the responsibility to care for all those who responded to the attack on the World Trade Center, just as those who responded at the Pentagon have been protected by the Federal Government. The men and women in New York—without question, without protest—worked tirelessly for months on the burning pile; the least we can do is to ensure they are receiving medical treatment for the ailments they have as a result of this work. This is truly a national problem and Congress must act now to help the heroes of 9/11.

Mr. PALLONE. Thank you. Mayor Bloomberg.

STATEMENT OF MICHAEL BLOOMBERG, MAYOR, CITY OF NEW YORK

Mr. BLOOMBERG. Chairman Pallone, Ranking Member Deal, Congresswoman Solis and Congressmen Towns, Weiner, Burgess, I wanted to thank all of you and particularly the New York delegation, Vito Fossella, Carolyn Maloney, who couldn't be here, Congressman Nadler and King who have worked so hard on this. I understand that my presence on this panel, along with members of the Congress defies the normal procedures and I would like to thank Speaker Pelosi for her strong commitment to moving this bill

forward. And I think it underscores the historic importance of this measure.

Passing this bill would, at long last, fully engage the Federal Government in resolving the health challenges created by the attack on our entire Nation that took place on September 11. The destruction of the World Trade Center was an act of war against the United States. Now people from every part of the country perished in the attack and people from 50 States took part in the subsequent relief and recovery efforts and I might point out that planes went into a field in Pennsylvania and into the Pentagon, right here in Washington.

And that makes addressing the resulting and ongoing health effects of 9/11, I think, a national duty by any standard. Members of the committee, nearly 2 years ago on the fifth anniversary of 9/11, I directed New York City Deputy Mayors Ed Skyler and Linda Gibbs to work with the city health experts and agencies to make a thorough investigation of the health problems created by the terrorist attack. And their report, published 6 months later, established beyond question that many people suffered physical and mental health effects as a result of the World Trade Center attacks and its aftermath and they included fire fighters and police officers, community residents, school children, and owners and employees of neighborhood businesses. And also, and most importantly, construction workers and volunteers from across America that took part in the historic task of clearing the debris from the World Trade Center site.

The report made clear that the ultimate scope of these health effects is still unknown. It also identified the two most important challenges presented by these health problems. And the great strength of this bill is that it addresses both of them. First, it would establish consistent federal support for monitoring, screening and treatment of health related problems among eligible 9/11 responders and community residents. It would also fund essential ongoing medical research so that we can better understand what the health impacts of 9/11 are and what the resources we need in order to address them. The Federal Government has provided ad hoc appropriations for monitoring treatment for first-responders and workers who answered the call on 9/11. As you know, Congress has also, in the past, appropriated funds for residents, area workers and other community members whose health was affected by the attack, but until last week the Federal Department of Health and Human Services had not released those funds and only now has issued a request for proposals.

And now you should know that New York City has not waited for federal funds to address this unmet need. In fact the city has budgeted nearly $100 million for 9/11 health initiatives. About half of that will be used to treat residents, workers, and others at the World Trade Center and Environmental Health Centers in our Health and Hospitals Corporation.

But providing long-term treatment to those who are sick or who could become sick because of 9/11, really, is a national responsibility. And to date, uncertain and insufficient federal support of treatment efforts has jeopardized the future of these programs and

the passage of this bill would make those funds—that future secure.

Similarly, the World Trade Center Health Registry that we created and that we maintain, in partnership with the Federal Government, is the most comprehensive nationwide database on 9/11 health related issues and consistent federal support for the registry, made possible by this bill, will guide essential research and treatment for Americans whose health was effected by 9/11.

The bill also incorporates strict cost containment standards for spending on treatment. For example, it requires that New York City, itself, and its city taxpayers to pay five percent of the cost of treatment provided at our public hospitals and clinics. And we accept this obligation. It gives us a powerful incentive to work with federal health officials, to ensure that expensive and finite medical resources only go to those who truly need them.

The second key element of this bill, and I will close in a minute, is that it would reopen the Victims Compensation Fund. This is an essential act of fairness for those whose 9/11 related injuries or illnesses had not emerged before the fund was closed in December of '03, or who couldn't be compensated because of the overly narrow eligibility requirements in place at that time.

It would also heal rifts that have needlessly emerged since 9/11. Today, the Victims of 9/11, the city of New York and the construction companies that carried out the cleanup at the World Trade Center site are being forced into expensive legal procedures. This bill would stop those needless and costly court cases. It would allow the city to help, rather than litigate against those who are ill. It would end misplaced efforts to assign blame to the city and the companies who worked to bring New York back from 9/11 instead of to the terrorists who attacked our Nation. It would create a mechanism for converting $1 billion now available to the Captive Insurance Company for this purpose. It would indemnify the city and its contractors from future liabilities in such cases and it would send the clear message that if, God forbid, terrorists strike us again contractors and responders can meet the challenge urgently and unselfishly, knowing their government stands behind them.

In summary, this bill directly addresses the current and the future health problems created by 9/11 and also provides important relief for past injuries and illnesses. Members of the committee, we will observe the anniversary of 9/11 just 6 weeks from today, and let us work together to pass this bill and ensure that the brave men and women, who bravely answered the call of duty, when our Nation was attacked, receive the health care that they deserve. Thank you very much for having me.

[The prepared statement of Mr. Bloomberg follows:]

STATEMENT OF MICHAEL R. BLOOMBERG

Chairman Pallone; Ranking Member Deal; Congressmen Towns, Engel, and Weiner; members of the subcommittee. I want to thank you for this extraordinary invitation to testify on this panel along with the bipartisan sponsors of the "9/11 Health and Compensation Act."

I understand that my presence on this panel along with Members of Congress breaks with the normal procedures of Congress. And like Speaker Pelosi's strong commitment to moving forward on this bill, that strongly underscores the historic

importance of this measure. Passing this bill would, at long last, fully engage the Federal Government in resolving the health challenges created by the attack on our entire nation that occurred on 9/11.

The destruction of the World Trade Center was an act of war against the United States. People from every part of the country perished in the attack, and people from all 50 states took part in the subsequent relief and recovery efforts. And that makes addressing the resulting and ongoing health effects of 9/11 a national duty.

Members of the Committee: Nearly 2 years ago, as the fifth anniversary of 9/11 approached, I directed Deputy Mayors Edward Skyler and Linda Gibbs to work with City health experts and agencies to make a thorough investigation of the health problems created by that terrorist attack. Their report, published 6 months later, established beyond question that many people suffered physical and mental health effects as a result of the World Trade Center attack and its aftermath. They include firefighters and police officers, community residents, schoolchildren, and owners and employees of neighborhood businesses, and also construction workers and volunteers from across America who took part in the heroic task of clearing the debris from the World Trade Center site.

The report made clear that the ultimate scope of these health effects is still unknown. It also identified the two most important challenges presented by these health problems. The great strength of this bill is that it addresses them both.

First, it would establish much-needed year-in, year-out Federal support for monitoring, screening, and treatment of health-related problems among eligible 9/11 responders and community residents. It would also fund essential ongoing medical research so that we can better understand what the health impacts of 9/11 are, and what resources we need in order to address them.

To date, the Federal Government has provided ad hoc appropriations for monitoring and treatment for first responders and workers who answered the call on 9/11. Congress also appropriated funds for residents, area workers, and other community members whose health was affected by the attack. But until last week, the Federal Department of Health and Human Services had not released those funds, and only now has issued a request for proposals.

New York City has long recognized this unmet need; we have not waited for Federal funds to address it. In fact, the City has budgeted nearly $100 million for 9/11 health initiatives. About half that will be used to treat residents, workers, and others at the WTC Environmental Health Center in our Health and Hospitals Corporation. But providing long-term treatment to those who are sick, or who could become sick, because of 9/11 is rightly a national responsibility.

And while Federal funds have supported important research and treatment efforts, the uncertain and insufficient nature of that support has needlessly jeopardized the future of these programs. Passage of this bill would make that future secure.

Similarly, the World Trade Center Health Registry that we created and that we maintain in partnership with the Federal Government is the most comprehensive nationwide database on 9/11 health-related issues. Consistent Federal support for the Registry will guide essential research and treatment for Americans affected by 9/11-related health problems—who live in all but four of the nation's 435 congressional districts—for years to come.

The bill also incorporates strict cost-containment standards for spending on treatment. For example, it requires the City of New York to pay 5% of the cost of treatment provided at our public hospitals and clinics. We accept this obligation. It will give us a powerful incentive to work with Federal health officials to ensure that expensive and finite medical resources only go to those who truly need them.

The second key element of this bill is that it would re-open the Victim Compensation Fund. This is an essential act of fairness for those whose 9/11-related injuries or illnesses had not emerged before the fund was closed in December 2003, or who couldn't be compensated because of the overly narrow eligibility requirements in place at that time. It also would heal rifts that have needlessly emerged since 9/11.

Today, the victims of 9/11, the City of New York and the construction companies that carried out the clean-up at the World Trade Center are being forced into expensive legal proceedings. This bill would stop these needless and costly court cases. It would allow the City to help, rather than litigate against, those who are ill. It would end misplaced efforts to assign blame to the City and the companies who worked to bring New York back from 9/11, instead of to the terrorists who attacked our Nation.

It would also create a mechanism for converting $1 billion now available to the Captive Insurance Company for this purpose. And it would indemnify the City and its contractors from future liability in such cases.

And it would send the clear message that if—God forbid—terrorists strike us again, contractors and responders can meet the challenge urgently and unselfishly, knowing that their government stands behind them.

In summary: This bill directly addresses the current and future health problems created by 9/11, and also provides important relief for past injuries and illnesses.

Members of the committee: We will observe the anniversary of 9/11 just 6 weeks from today.

Let's work together to pass this bill and ensure that men and women who bravely answered the call of duty when our nation was attacked receive the health care that they deserve.

Mr. PALLONE. Thank you, Mayor. It is the tradition not to ask questions of the members panel and unless someone has a problem with that, I am going to release you and thank you very much for being here, and have you know that, as I have mentioned to Jerry and Carolyn, that it is not our intention to just have a hearing. We do want to move a bill and we are very much cognitive of the fact that——

Mr. BLOOMBERG. Mr. Chairman, can I say one more thing? I am sorry Congressmen Green and Barton aren't here, but Congressman Burgess from Texas is. Texas, in particular, of all the States in this country, is a state that should know just how much of a burden it is to come to the relief of other parts of our country. I have always had great admiration for the city of Houston and its people and its Mayor, Bill White, who had came to the aid of the terrible—the people who were involved in the terrible tragedy of Katrina. I was in New Orleans last week. Their population has gone from 500,000 to 250,000; 150,000 of those went to the city of Houston, that continues to try to provide jobs and education and healthcare and housing to them. So it is a State that really does understand that we all have an obligation to help each other. It is a State that also could use some help from other States who—which should be a part of that, and if you would express my views to your associates in Texas and particularly the Mayor of Houston, who I have great admiration for.

Mr. BURGESS. Thank you. We will have that hearing when——

Mr. PALLONE. I didn't commit anything.

Mr. BLOOMBERG. What is fair is fair.

Mr. PALLONE. I am not committing anything, but we do want to move the bill that is before us. Let me tell you that, and again thank you very much. Thank you all. I would ask the second panel—I guess it is just one person, the panelist to come forward.

OK, on our second panel, we have but one witness, and I want to welcome Dr. Gerberding. Is that the correct spelling, what we have there on your—G-e-r-e-b-e-r—no. OK, it is G-e-r-b-e-r-d-i-n-g. All right, thank you. Well, welcome. Thank you for being with us today. Dr. Julie L. Gerberding is Director of the Centers for Disease Control in Atlanta. You know we have 5-minute opening statements that become part of the record, and each witness, in the discretion of the committee, may submit additional brief and pertinent statements in writing. So we may, depending on the questions, ask you to submit additional material. I thank you for being here and I now recognize you.

STATEMENT OF JULIE GERBERDING, M.D., M.P.H., DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION

Dr. GERBERDING. Thank you. I appreciate the opportunity to provide information for the committee, relevant to CDC and NIOSH's activities related to the World Trade Center catastrophe. I was thinking this morning, probably every American knows exactly where they were the morning of 9/11, and I know when I saw the plane hit the tower, my first thought wasn't "oh, we are under a terrorism attack." It was basically "where is my daughter?" because our stepdaughter was working in Manhattan at that time, and as the events unfolded many CDC workers were there, in the pit at Ground Zero, helping with a variety of different issues and the safety for those people that I care for and those people that I am responsible for at CDC was something that has been on my mind ever since the attacks occurred. So, what I thought I would try to do in my remarks this morning was to just give you, kind of, an umbrella picture of what we see the health concerns are and what we see the likelihood of ongoing need for monitoring and treatment of these individuals, maybe both the responder community as well as those in the community that were adjacent to the Trade Centers when they collapsed.

The first thing is to recognize that there is a lot of uncertainty about this. We have never experienced any kind of an event of this nature or this scale. But when we think about what was the nature of the work that people were doing with such passion and such dedication, what was the nature of the exposure that they may have received in this environment and what are the long-term health effects. There is no precedent. We know something about the dust. We know something about the combustibles. We can predict what kinds of toxins and chemicals were inhaled. We know that there is likely to be variability in the dose that people receive, both because of the time that they were first exposed and the duration of their exposure, and perhaps the respiratory protection that they used. But nevertheless, there is a great deal of uncertainty.

What we can say, right now, thanks to the New York Fire Department and their annual screening effort where about 14,500 fire workers are undergoing monitoring and evaluation, is that a significant proportion of those responders did experience respiratory symptoms following the collapse of the Towers and a significant proportion of them are continuing to experience respiratory symptoms and signs out of proportion with what we would expect for a comparable cohort of people of the same age or the same smoking history or their overall similar health histories.

Of the people who have conditions, the majority of them are experiencing what we would call aerodigestive disorders or respiratory problems. Another significant proportion are reporting chronic mental health related issues along the lines of post-traumatic stress disorder. The people who have respiratory complications have been assessed and have had data published in several publications, which I can submit for the record, but which are also available on the CDC Web site.

About one-third of people get better over time. About one-third of people are staying the same, and about one-third of people are getting worse. So when we have the challenge of assuring that peo-

ple receive the appropriate monitoring care and treatment that they deserve and need we have very little background data to go on, in terms of assessing costs or requirements.

We have to admit that we are learning as we go here. We have made good faith estimates. Health and Human Services has allocated about $925 million so far for the support of responders, and more recently non-responders, in the community. We think we have done a pretty good job of accurately assessing what the projections are, but we could be wrong and if we need more than what we are prepared to invest right now, we will tell you because we all want the same thing. We want the best possible treatment, a fair deal for the people who gave so much to really help America during that very challenging time.

I think we also need to know more about these health effects. One of the things we have been very careful about is to not use the appropriation that Congress has provided us for research of activities that weren't directly linked to the support and treatment of the people who were affected. But now that we have some information, we are now raising questions and there is a need to know more to do some science work in the laboratory, to do some work in cohorts of people and to really get as much information as we can. Not just for the sake of the people who were affected in the New York environment, but for people who, sometime in the future, may find themselves in a similar situation.

We have learned a lot of lessons about worker protection. I think we have learned a lot of lessons about what communities are going to need and we need to make sure that we have the science and the evidence to apply those lessons to protect people in a more proactive manner in the future than we have been able to do this time out.

So we are committed. We want to do the very best we can and we will continue to try to do our job in supporting the responders and the non-responders who were affected. Thank you.

[The prepared statement of Dr. Gerberding follows:]

Testimony
Before the Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

World Trade Center Health Effects

Statement of
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Director
Centers for Disease Control and Prevention
U.S. Department of Health and Human Services

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Good morning, Chairman Pallone and other distinguished Members of the Subcommittee. My name is Dr. Julie Gerberding, and I am the Director of the Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services (HHS). Mr. Chairman, I would like to express my appreciation to you and to the Members of the Subcommittee for holding this hearing and for your support of our efforts to assist those who are at risk or have experienced adverse health outcomes from their 9/11 exposures. I am pleased to appear before you today to report on the progress we have made in addressing the health needs of those who served in the response effort after the World Trade Center (WTC) attack on 9/11 and those in the affected communities. HHS would like to note that the Administration is currently reviewing H.R. 6594, the James Zadroga 9/11 Health and Compensation Act of 2008, and HHS cannot offer a view or position on the bill at this time.

WTC Responder Health Program – Monitoring and Treatment

Since 2002, agencies and offices within HHS have been dedicated to tracking and screening WTC rescue, recovery and clean up workers and volunteers (responders). HHS has allocated $925 million for WTC-related efforts since September 11, 2001.

In 2004, CDC's National Institute for Occupational Safety and Health (NIOSH) established the national WTC Worker and Volunteer Medical Monitoring Program to continue baseline screening (initiated in 2002), and provide long-term medical

monitoring for WTC responders. In FY 2006, Congress appropriated $75 million to CDC to further support existing HHS WTC programs and provide screening, monitoring and medical treatment for responders. Since these funds were appropriated, NIOSH has established a coordinated WTC Responder Health Program to provide periodic screenings, as well as diagnosis and treatment for WTC-related conditions (e.g. aerodigestive, musculoskeletal, and mental health) identified during monitoring exams. Current spending rates indicate that there are sufficient resources to continue supporting health care treatment and monitoring for World Trade Center responders through FY 2009 and potentially longer (as of April 30, 2008, $185 million of the $323 million appropriated from FY2003 through FY2008 remains unexpended). The WTC Responder Health Program consists of a consortium of clinical centers and data and coordination centers that provide patient tracking, standardized clinical and mental health screening, treatment, and patient data management.

As of April 30, 2008, more than 51,000 responders from across the country have enrolled in the WTC Responder Health Program from the estimated 91,469 responders who were involved in the rescue, recovery and cleanup. Approximately 41,000 responders have had an initial medical screening via the New York City Fire Department (FDNY), the Mt. Sinai clinical consortium, or the national network of clinics outside the NYC-NJ metropolitan area.

FDNY manages the clinical center that serves FDNY firefighters and emergency medical service personnel enrolled in the program. As of April 30, 2008, FDNY had conducted 14,816 initial examinations and 20,376 follow-up examinations.

The Mt. Sinai School of Medicine's Center for Occupational and Environmental Medicine coordinates a consortium of clinics that serve other response workers and volunteers who were active in the WTC rescue and recovery efforts. According to data provided by the grantee in April 2008, these clinics have conducted 23,780 initial examinations and 13,021 follow-up examinations.

Of the 38,596 responders that have received an initial screening via a clinical center in the New York City-New Jersey metropolitan area, 10,545 have received treatment for aerodigestive conditions, such as asthma, interstitial lung disease, chronic cough, and gastro-esophageal reflux, and 5,502 have been treated for mental health conditions.

In conjunction with these activities, CDC/NIOSH has funded the NYC Police Foundation's Project COPE and the Police Organization Providing Peer Assistance to continue providing mental health services to the police responder population. The availability of treatment for both physical and mental WTC-related health conditions has encouraged more responders to enroll and continue participating in the WTC Responder Health Program, which will enable us to better understand and treat the long-term effects of their WTC exposures.

Nationwide Scope

Many rescue and recovery workers traveled from other states to New York City to participate in the response efforts and following their service, and have since returned to their states of residency. HHS is working with its partners to ensure that the benefits of all federally-funded programs are available to eligible responders across the nation. As of April 30, 2008, approximately 4,000 responders residing outside the NYC-NJ metropolitan area have enrolled in the WTC Responder Health Program and 2,393 have had an initial medical screening. These responders, including current and former Federal employees, receive monitoring and treatment services via a national network of clinics.

On May 31, 2008, CDC contracted with Logistics Health, Inc. (LHI) to manage the WTC National Responder Health Program to monitor and treat responders outside of the NYC-NJ metropolitan area. These responders were previously served by Mt. Sinai, the Association of Occupational and Environmental Clinics, and Federal Occupational Health Services. LHI is working with each of these organizations to transition the responders into the new structure. During this transition period, responders who are currently receiving treatment are having their care continued without interruption.

Non-Responder Population

From September 11, 2001 to present, HHS/CDC has provided health care services solely to WTC responders. In the Consolidated Appropriations Act,

2008, Congress appropriated funding "to provide screening and treatment for first response emergency services personnel, residents, students, and others related to the September 11, 2001, terrorist attacks on the World Trade Center." In response, on July 24, 2008, CDC published a funding opportunity announcement (FOA) to provide access to screening, diagnosis and treatment services for residents, students, and others in the community (the non-responder population). Applications for this FOA will be received through August 25, 2008, and CDC anticipates making award decisions September 29, 2008. The NIOSH-administered competitive grants would provide up to $10 million per year for three years for health screenings and assessments, health monitoring and tracking and improved access to health care services. The grant money would be used to help cover gaps when individuals' public or private insurance is insufficient to fully cover the costs associated with care or treatment.

WTC Health Registry

In addition to the WTC Responder Health Program, the Agency for Toxic Substances and Disease Registry (ATSDR) maintains the World Trade Center Health Registry. In 2003, ATSDR, in collaboration with the New York City Department of Health and Mental Hygiene (NYCDOHMH), established the WTC Health Registry to identify and track the long-term health effects of tens of thousands of residents, school children and workers (located in the vicinity of the WTC collapse, as well as those participating in the response effort), who were

the most directly exposed to smoke, dust, and debris resulting from the WTC collapse.

WTC Health Registry registrants will be interviewed periodically through the use of a comprehensive and confidential health survey to assess their physical and mental health. At the conclusion of baseline data collection in November 2004, 71,437 interviews had been completed, establishing the WTC Health Registry as the largest health registry of its kind in the United States. The NYCDOHMH launched the WTC Follow-up survey in November, 2006. As of August 31, 2007, 39,703 adult paper and web surveys had been completed for nearly a 60% response rate. NYCDOHMH has begun a third phase of the follow-up survey to reach the registrants through direct interviewing by telephone and has initiated a separate mailed survey of registrants who are younger than 18 (approximately 2,200).

The WTC Health Registry findings provide an important picture of the long-term health consequences of the events of September 11th. Registry data are used to identify trends in physical or mental health resulting from the exposure of nearby residents, school children and workers to WTC dust, smoke and debris. Last year, two journal articles published findings on 9/11-related asthma and post-traumatic stress disorder (PTSD) among rescue and recovery workers (*Environmental Health Perspectives*, 8/27/2007; and *American Journal of*

Psychiatry, 2007; 164:1385-1394). Newly diagnosed asthma after 9/11 was reported by 926 (3.1%) workers, a rate that is 12 times the norm among adults. Similarly, the overall prevalence of PTSD among rescue and recovery workers enrolled on the WTC Health Registry was 12.4%, a rate four times that of the general U.S. population. By spotting such trends among participants, we can provide valuable guidance to alert Registry participants and caregivers on what potential health effects might be associated with their exposures.

The WTC Health Registry also serves as a resource for future investigations, including epidemiological, population specific, and other research studies, concerning the health consequences of exposed persons. These studies will permit us to develop and disseminate important prevention and public policy information for use in the unfortunate event of future disasters. And the findings can assist those working in disaster planning who are proposing monitoring and treatment programs by focusing their attention on the adverse health effects of airborne exposures and the short- and long-term needs of those who are exposed.

Conclusion

Since 9/11, HHS has worked diligently with our partners to best serve those who served their country, as well as those in nearby communities affected by the tragic attack. We have had great success in expanding our monitoring program to include treatment, which has encouraged more responders to enroll and

receive needed services. We will continue to forge ahead in providing medical monitoring and treatment services to responders, regardless of their location, as well as to residents, students and others most directly affected by the WTC attack. Likewise, the WTC Health Registry continues to paint a picture of the overall health consequences of 9/11, including the effects experienced by the residents, school children and office workers located in the vicinity of the WTC.

Thank you for this opportunity to update you on our progress. I am happy to answer any questions you may have.

Mr. PALLONE. Thank you Doctor, and we will have some questions now, and I will begin by recognizing myself for some questions. Mr. Barton, of course, mentioned that this bill was just introduced, I guess, about a week ago. But we have had other legislation that this was based on around for some time. I know that you state in your written statement that you are not ready to comment on the bill before us, but my problem, of course, is the session is running out. We have a month between now and when we come back, I guess, on September 8 and then 3 weeks. And we would like to move to mark-up the legislation, so I am hoping that we can get your feedback within the next few weeks or so, so that we could have it to look at over the August recess. What is your time table for giving us feedback on the bill? One week, 2 weeks, hopefully not much longer.

Dr. GERBERDING. I don't know how big the bill is or everything that is in it, but obviously we want to be able to express our perspectives and our voice and we will do everything we can to respect your timetable, so we will make it a priority.

Mr. PALLONE. Let me just say that we do intend, over the August recess, to look this over, to talk, both Democrats and Republicans, and see if we can come up with a consensus so we really would like to have input from you within the next couple weeks if possible. We are not going to wait until we come back.

Dr. GERBERDING. I understand.

Mr. PALLONE. Thank you. At the last hearing that we had on the larger issue, including some of the precursor legislation to this, there was a lot of criticism of the administration, either because not enough money had been expended for these centers, or because the administration, frankly, hadn't come up with its own legislative initiative or long-term solution, if you will, regardless of whether it was legislative or not, to deal with the problem. In other words, the sense was that we are operating on an ad hoc basis, we are operating on contingency funding and that we need to do something permanent, which is why this bill is before us. So what is the reason why the Administration hasn't submitted its own long-term proposal, if you will?

Dr. GERBERDING. I can't really comment on the broader administrative perspective, but what I can say is that, as a doctor, what I am seeing—and I have read the literature in detail. I am seeing what is going to be an ongoing need. How long, how bad, I don't think we know, but we need to prepare for a sustainable——

Mr. PALLONE. But what I am saying, and you understand I am not trying to be difficult, is that what this bill tries to do is to not just look at this ad hoc, the way we have, but say OK this—we are going to set up a federal program that is long-term and that deals with this problem. Is there any talk with the administration of doing that, or even at least supporting such a long-term solution whether or not it is this bill?

Dr. GERBERDING. I am hesitant to speak for the broader administration, but from the standpoint of NIOSH and CDC we know that a long-term broad program is needed and I think we would welcome authorization that moves us out of the appropriations process and into something that creates some consistency. I am, as an agency head, very well aware of the congressional intent around

making sure that there was a care and treatment program for these individuals. That has not been part of CDC, NIOSH's traditional mission, so part of the reason this has been difficult for us is because we don't really provide insurance or provide care and treatment. We are a research agency, in this sense, and so this has been something that, again, we would look forward, during the authorization process, to really look at who should be doing what and how can we assure that the research needs are met as well as the care and treatment needs.

Mr. PALLONE. OK. Now, the other aspect, of course, is that the criticism which again we had at the previous hearing about the funding not being forthcoming, not that Congress wasn't appropriating it, but that it wasn't forthcoming, even though it had been appropriated. And my understanding is that the money that was appropriated for this fiscal year, which I guess began last October, but I don't know exactly when it was finalized, probably a few months after that, was just released last week. I mean, can you explain why the CDC would delay taking action until this past week and what are the administrations plans to make sure that this $108 million appropriated for the fiscal year is utilized?

Dr. GERBERDING. If you ask me how would we go about spending x amount of money to build the gulf standard surveillance system——

Mr. PALLONE. No. I am just trying to find out why it took so long. I mean, it is July, and this money was available as early as January, February, as far as I remember.

Dr. GERBERDING. The challenge that we were facing is how do we provide a program for non-responders. Is that everyone who lives in Manhattan? Is that a few thousand people who are right next to the pit. I mean, with tremendous variability in who should be included and how we would go about planning for a medical program for an——

Mr. PALLONE. Do you know, Doctor, and I know I am interrupting you. My time has run out, but when I go to the center at Rutgers, which is the one that I am familiar with in my district, and—she is not here today, Dr. Udasin, because she wasn't able to be here, who is in charge or it. All they did was tell me how they needed more money for this, they needed more money for that, they have all these people that they want to do things for and they can't because of limited resources, so there doesn't seem to be any reason to wait 6 months to release funding that we have already appropriated. That is all I am asking. Why 6 months and how do we make sure this money gets out there? I mean, we appropriate it, but it doesn't seem to get out there.

Dr. GERBERDING. I think we have mechanisms to cover all the groups that were included in the congressional intent, right now. But I got to tell you, it is hard and that is why I brought up the issue that this is not something we do at CDC, we are starting from scratch here, to try to figure out how do we build a care and treatment program for non-responders when we have never done anything even close to this before, so it took us longer than you would have liked. And believe me, I wish we had done it faster because it would have satisfied your constituents, but also because we would have less question about what our intent really was. We

are committed. I think the mechanisms are there. These are long standing opportunities, now, to renew and continue funding. And I think you will see a better time line in the future.

Mr. PALLONE. All right, thank you. Mr. Deal.

Mr. DEAL. Before I ask Dr. Gerberding the questions, Mr. Chairman, I would like to ask you in response to your statement that you have intentions of moving a bill on this. Could you give us some idea of the timeline that you have in mind?

Mr. PALLONE. Mr. Deal, I don't have a timeline. I am hoping that you and I and Mr. Barton and Mr. Dingell and our staff can spend some time over the August recess so that when we come back we have a consensus. Obviously, since we are going to only be here, probably a short time in September—I don't even know if we go into October. We would have to do something in September, but I think what I would ask is that we spend the time during the August recess, get the Administration's input, meet on a bipartisan basis with the staff and try to see if we can come to a consensus by the time we come back.

Mr. DEAL. Welcome to the committee. I think I understand the concern that you have about being asked to do something that is not traditionally within the role of CDC, and I can understand that haste, in that regard, would probably result in a lot of criticism for money that might be misspent, and so I appreciate the complexity that you have outlined that you are facing. And that is one of the concerns that all of us, I think, should share. We know that there have been fraudulent claims submitted under the Victims Compensation Fund and so there are those who wish to take advantage of this catastrophe for purposes that are not intended by either Congress or anyone else, to be reimbursed for those kinds of things. So I commend caution and I think that is what you have done.

As I understand your written testimony, there is about $138 million that still is appropriated that is available for healthcare monitoring, et cetera. Is that about correct?

Dr. GERBERDING. This is a moving target so my testimony was reflecting on what we understood in April when we submitted a report to Congress, but obviously people have been treated and seen and costs are accumulating and money has been spent since that time so I would have to give you a refreshed understanding of where we actually are with the spending right now.

Mr. DEAL. OK. Obviously, you have learned a lot in terms of trying to administer the funds that have, currently, been appropriated. Will you, as an agency, be in a better position now to administer any future appropriations for programs such as the one outlined in this bill than you were initially?

Dr. GERBERDING. Yes, I am not sure what is outlined in the bill, but if it is expectation of continuing what we are doing right now, I mean, I think we are on a good track. We are still challenged and that is one of the areas, I think, we would like to consult and confer both within the department, but also with the committee because we might not be the best place to do all of the things that the bill is asking us to do. And we feel strongly that there are some things that only we should be doing and we would like to make sure that we are playing to everybody's strengths. But the really important thing is, we want to make sure that there is a care and

treatment program for both the responders and the affected non-responders.

Mr. DEAL. Because traditionally, CDC has not been the agency that supervises what is really a large entitlement program for healthcare.

Dr. GERBERDING. Exactly.

Mr. DEAL. That is not your traditional role.

Dr. GERBERDING. That is our challenge.

Mr. DEAL. And I think that is a legitimate concern as to where, if we are going to do this, where is the appropriate place for that kind of oversight and administration to take place. Would you give us a brief idea, though—I know you summarized rather quickly, but could you give us a brief idea how the CDC and NIOSH have been working with the city of New York to deal with this issue?

Dr. GERBERDING. There have been several activities within the department and specifically within CDC and NIOSH. One is the registry program where people who believe that they were exposed or affected are welcome to register so that we can monitor and track them over time. Right now, there are about 75,000 people, mainly from the metropolitan New York area, who are included in that registry.

We have also funded quite a few of the hospital—well, we funded all the hospital facilities that are seeing patients through these Centers of Excellence concept, and the Mount Sinai consortium. About 24,000 visits have occurred for the first visit and about 13,000 follow-up visits have occurred. In the national program, there are about 4,000 people who are being followed that are not in New York. They are—this is happening around the country. And the fire department is following about 14,800 people and has done more than 20,000 follow-up visits. So there have been a lot of base line and follow-up visits and that is where we are beginning to get the accumulated knowledge that this problem is not going to go away, that people have been affected and there will be ongoing health issues for those, particularly, who were exposed early or exposed for a long period of time, at Ground Zero.

We also believe there are going to be some health effects in the people who surrounded that area, but we know a little bit less about the long-term durability of those. And when you look at this dust, this material and you think about how deep it was and how dark it was when it was contaminating the air, you just have to appreciate that peoples lungs have been affected by their exposure to these materials that may include chemical and metal toxins, but also just particulates including asbestos.

So there is a legitimate concern here and I am emphasizing that because sometimes I have—not here, but in other environments, I have seen a tendency for some people to be dismissive about the long-term seriousness of these effects and I wanted to be very clear and on the record as a physician and as a CDC Director that this is very credible evidence to me that this requires a long-term health monitoring program.

Mr. DEAL. Thank you Dr. Gerberding.

Mr. PALLONE. Thank you, Mr. Deal. Ms. Capps.

Ms. CAPPS. Thank you, Mr. Chairman, and thank you Dr. Gerberding for your testimony today and for taking questions. One

issue of worker safety that has come up is that workers at Ground Zero were not required to wear fit-tested respirators during clean-up. As a public health nurse, I know it is well documented that the tested respirators are an effective tool to reduce inhalation of asbestos and hazardous materials, as well as to prevent the transmission of disease.

I find it no surprise that workers at the Pentagon site, who were required to wear them, have experienced fewer negative health effects. In fact, I understand that even some of the workers at Ground Zero itself, who wore respirators, have not suffered as much as those who did not. I don't know if this is scientifically demonstrated, but there has been some documentation. So without going back to revisit what happened that day, what steps are the CDC and other federal agencies that you are associated with, taking to ensure greater usage or mandatory usage of fit-tested respirators and any other protective equipment for future emergencies. In other words, as you prepare pre-mitigation planning, including the possibility of Avian Flu or other pandemic?

Dr. GERBERDING. I wanted to address two points very quickly. One is there is a big difference between what happened in New York and what happened at the Pentagon in terms of the kinds of exposures and so forth, so it is not just a matter of respiratory protection, but that is likely. I mean, it is common sense that it would make a difference, so I agree with your overall principle.

NIOSH has published, now, four volumes of guidance based on the lessons that we have learned from these experiences for protecting responders in situations of various kinds of emergencies, including an emergency such as an implosion or an explosion of a building, and it certainly does emphasize the importance of respiratory fitting and required use.

We are also initiating a process of going State by State and examining the statutes and regulations on a State basis to assure that it isn't just a matter of guidance that we are supporting that with effective regulatory and statutory language where that is required at a state level because not all states function the same way. So we think this is very important and we are doing everything that we can, as a government agency, to support that.

Ms. CAPPS. So if there was an emergency, God forbid, in the next few days, would there be more of these fit-tested respirators——

Dr. GERBERDING. Absolutely.

Ms. CAPPS [continuing]. Available and would they be deployed? I mean, nothing can happen 100 percent overnight, but——

Dr. GERBERDING. There are several issues here. One is availability, absolutely availability and access to testing. Those things can and will be done effectively. But there is a practical aspect of wearing one of these masks. I mean, what I remember in those early days is the fire personnel were there searching for their colleagues that were missing. And they were not thinking about themselves. They were thinking about rescuing people that they cared about. In that environment it is hard to breathe in a mask when you are working that hard and exerting that much, these masks get very—the work of breathing goes up. You get exhausted and they take the mask off, so there is a practical issue as well as a kind of infrastructure issue.

Ms. CAPPS. And as we all do here, there is drilling and preparation so that instinctively you know, just like on a plane, you put your own oxygen mask on before you assist——

Dr. GERBERDING. And the supervisors in the field have to plan on the fact that people will get tired of breathing with these masks on and work out schedules and rests and other administrative procedures to assure that workers can continue to work and wear their masks. I have many poignant photographs of masks hanging on pieces of concrete or beams, not because they weren't there, but because people, just simply, couldn't tolerate using them for as long as they were working.

Ms. CAPPS. Thank you. If I have time, I want to address another issue. I am a member of Congress from California and I am disturbed to learn that there are only a small number of clinics in a very few States nationwide that are equipped to respond—provide screening and monitoring services for World Trade Center responders. Can you tell me where some of these are located? I represent the Central Coast of California and know personally and was so proud to say that a group of very brave talented, specially trained, first-responders responded very quickly to the call for help and now they are not sure where they can go for assessment and so forth. And shortly after we had Katrina, and so we know now that an event of that magnitude that happened on 9/11 is going to bring people from all over the country.

Dr. GERBERDING. Some weeks ago we announced an award to an organization that operates national occupational health clinics, and they will assume the responsibility for providing care to the people who are outside the areas of New York and New Jersey where the Centers of Excellence are currently operational. So this award has been made. These clinics are scaling up. They want to be able to create a continuity of care so that there isn't, "you had everything here and now you got to start all over." So there is a transition period.

Ms. CAPPS. Right.

Dr. GERBERDING. But I think you are going to see, over the next year, a significant improvement in access.

Ms. CAPPS. And this is now just beginning?

Dr. GERBERDING. Several weeks ago the award was——

Ms. CAPPS. But all these years have gone by.

Dr. GERBERDING. But we awarded the money the year we got it, so it is—we could have——

Ms. CAPPS. Used it earlier.

Dr. GERBERDING. I have heard we should have been faster based on people's need, but we did make that award available, and I think it is an expansion of what we were doing before and a broadening of the scale and scope of the reach. I hope it will be successful. We will have to monitor carefully to make sure that we are not missing people that need to be treated in that program.

Ms. CAPPS. Thank you.

Mr. PALLONE. Thank you. Mr. Weiner.

Mr. WEINER. Thank you, Doctor, appreciate your testimony. Can you help us clear up a couple of concerns that some of our colleagues have had about the bill. You have spent some time in your testimony and response to questions to Mr. Pallone talking about

why it has taken so long to, kind of, come up with a foundational system to, kind of, deal with this problem. That is in stark contrast to what the ranking member, Mr. Barton, said earlier about us being hasty. In your view, have we been hasty in providing services to those in need?

Dr. GERBERDING. I don't think anyone would characterize our response as hasty.

Mr. WEINER. Can I ask? You have been very frank about the long-term need for monitoring and the complexities of what is in peoples bodies at this point. Is there any question, in your mind, that the affliction that these people have is a direct result of 9/11?

Dr. GERBERDING. On any given individual basis, I think that is always going to be impossible to say for sure, if a person has a problem was it attributed to the exposure or not attributed to the exposure, but the scientific information, looking at the population of exposed people, suggests that there is a significant attributable impact from the exposures at Ground Zero.

And two lines of evidence support that. One is the proportion of people with respiratory and mental health issues is much greater than it was before 9/11, especially among the people who were enrolled in annual screening. But, in addition, compared to controls in the community who weren't exposed that have higher rates and then finally, to the best of peoples ability to estimate dose of exposure. There is a dose response, so the earlier you were in, the longer you were there, the more likely you are to have significant symptoms and that has been documented with pulmonary function tests, independent of whether people also use tobacco products or not.

Mr. WEINER. Right, but if—I mean, not expecting you to drill down to metaphysical certitude. As a medical professional, is there any doubt in your mind that the attack of September 11 and exposure to the after effects of that attack has led to the debilitating illness, in many cases, of thousands of people?

Dr. GERBERDING. That is what the scientist says is the truth.

Mr. WEINER. Well, I appreciate that. Can I also ask you this question, there is this question about how it is you define the universe of who we are going to cover, and you have touched on, in your testimony—I mean, I am concerned we must not let the perfect be the enemy of the necessary. We might never know with absolute precision every single human being and be able to issue them a card, you are affected, and then they come in and flash it.

But, all that being said, there are some indicators that physicians can see and say, "you know what, this isn't someone who just got off the bus from Kansas City trying to fill the gaps in their health insurance plan, and are trying to get into this." This notion that we are creating, that there is a danger of creating this wide open system—there are markers that doctors can see. There is a way to separate, at least in the broadest sense, the wheat from the chaff.

I think that what is truly mysterious is there is some opposition to saying, "Oh, you don't want to create this open-ended health care plan."

By the way, that should be the worst thing we ever do, Mr. Chairman, is create an open-ended health care plan where people

can get healthcare. That should be—like people say that what a crime that would be to create healthcare for Americans.

But there is this idea that, oh, we are going to create this process that the port authority and JFK and La Guardia are going to be filled up with people, I want to get a piece of this program. There are ways that physicians would some—we can acknowledge whether someone is showing the signs of the elements of asbestos, the elements of the dust, the elements of precedent that has been set from people who have been monitored. I can't imagine that this is a process that needs to go on another 2, 3, 4, 7 years. I mean, there has got to be some, not universal consensus, but some sense of physicians who have been down there, have been taking a look at the files of people affected to be able to say, "you know what? This is clearly a case. Let us get on with providing the care." Isn't that the case?

Dr. GERBERDING. Well, I have not personally been involved in the care of any of these people, so I can't answer you from my own personal perspective, but obviously for some people it is easy. It is a no-brainer. They were there. They have the classic presentation that we were describing in this literature and it is very clear, but I think what we are trying to do here is balance the importance of being inclusive and acknowledging our uncertainty that we have got a lot to learn.

There may be other things that emerge that we haven't predicted or haven't thought of yet, so you can't exclude something because you haven't seen it yet. At the same time we have to be accountable for the investment that we are making and that is an important part of this too.

Mr. WEINER. Well, I think that is right, and my time is up, but I think that the most important part of your testimony is the notion that we need to be inclusive. We need to make sure that if we are going to create a program, it includes people in the community, it includes, I mean—the much more desirable mistake to make is to include two larger universes of people than it is to draw a line that includes too few people. And I think that that needs to be the defining ethos of people who take a look at this bill. We can always take an imaginary line and constrict it and make it smaller if it turns out OK.

But I have to tell you something, I was standing on the deck of my office on Emmons Avenue in Sheepshead Bay, not exactly in the neighborhood. And we literally had dust and ember falling there—pieces of paper falling there. I can imagine how much fine and particulate matter that wasn't written on a piece of paper I couldn't see, how far that was going. I would encourage your office—we will try to deal with the fiscal constraints that we are handed, but your job as a medical professional is to think of the most expansive universe that we can and then, as we get through time, as you learn a little bit more, maybe you do draw the lines in.

But that last thing we should do is draw such a tiny bubble then say, well, this is the only absolute certitude that we know and we wind up excluding thousands or tens of thousands of people who really do need this care simply because of our desire to find the perfect line. We are not going to find that. I acknowledge that, but

right now, inertia is the enemy because there are people, right now, that need care and people, right now, tragically, as you know, are dying because of the effects of 9/11 air.

Dr. GERBERDING. And I think that the—at least our understanding of the congressional intent and the appropriation that was made was to be inclusive of the various groups. And we, as I admit, we were not as fast as you would like us to have been, but we have made a good faith effort to be inclusive of both the responders and now the community. And yes, there is uncertainty over what we will ultimately need to be doing, but we intend to reflect your intent.

Mr. WEINER. Well, I thank you. You are the living, breathing speaking rebuttal to Mr. Barton's notion that we are being hasty. And I have to tell you, if there is any benefit from your not being so quick, it is clear that Mr. Barton's——

Mr. PALLONE. We have to move on, but thank you, Mr. Weiner. And, oh, Mr. Engel is here, so we have Mr.—the gentleman from New York is recognized.

Mr. ENGEL. Thank you, Mr. Chairman. Doctor, I said in my opening statement that I was disappointed with your not reappointing Dr. Howard, and I would like to ask you if you could tell us why not, why you did not choose to reappoint him. I don't agree that 12 years is too long. I don't think that is an acceptable answer. There were others, Donald Miller, who served for 12 years, from '81 to '93. Linda Rosenstock was reappointed and served eight years. I know you have said it is a personal issue and you don't want to discuss it. That is not acceptable.

CRS tells us that there is no legal reason for you not to answer to Congress about a secretary level appointment. You have said you have given him a job in Atlanta to finish out his time before retirement. I don't find that acceptable. It is not about finishing his tenure, it is about the great work he has done that you are putting an end to and you have said he had a problem with horizontal management. I don't find that acceptable. I don't know what it means. And does it mean that he was doing what Congress told him to do and not allowing things to be dissolved into CDC.

And let me just say, if you won't reappoint Dr. Howard to another 6-year term, I believe that you should keep him on as acting director through the end of the year or extend his term for a period of 1 year to provide continuity and give the new administration time to determine the appropriate leadership, as Chairman Obey, Chairman Harkin and ranking member Specter have called on you to do. And at a minimum, I think Dr. Howard should be retained as an advisor to Secretary Leavitt and the Office of the Secretary to oversee, and be a liaison on the World Trade Center Health Program. So I would like to ask you those things.

I have put the New York Times editorial "A Pointless Departure" into the record. There are quotes praising Dr. Howard's work from so many different organizations, including the Chamber of Commerce, the AFL, CIO and the American Industrial Hygiene Association, so obviously I am quite worked up about this and I would like to ask you to comment.

Dr. GERBERDING. Thank you. It has been heartening, I think, to understand and respect how much Dr. Howard's work on the World

Trade Center has been to the New York delegation and to those who are concerned about the overall situation with care and treatment for the responders and the non-responders who were affected.

And I also think I need to be very clear that we appreciate Dr. Howard's service. Dr. Howard has accepted a new position at CDC where he is actually going to be involved in working on issues related to worker protection around emergency response in our public health law program where his law degree will be serving him well, I think. As I mentioned to the Congresswoman, we are interested in making sure that we have statutes and regulations that protect workers generically on these kinds of disasters and that is going to be the focus of his ongoing work. And he has committed to making himself available to me and to his successor, Dr. Christine Branch, who is here in the room today. The deputy that he selected a year, or so, ago who has been also working on these issues and is a credible and credential scientist in her own right.

We are taking away from this an acknowledgement of your expectation that you want a comparable level of support and service from CDC and NIOSH that you have come to enjoy with Dr. Howard. And so, I take it as a personal challenge to assure that we continue to focus on the World Trade Center efforts, that we make ourselves available, that we are responsive.

I, this morning, had a chance to meet with some members of the delegation and gave them my personal cell number and my card and if there is ever an issue that you feel that CDC, NIOSH, HHS, or the administration are not responsive, I want you to please contact me directly because that is not my intent. I hope you would support us meeting in New York, having stakeholder conversations and really building on Dr. Howard's successful engagement on the World Trade Center as we go forward.

Mr. ENGEL. Well, let me just say, and this is nothing against the current deputy who I am sure is doing a fine job and will do a fine job, but it is very aggravating that you have been adamant in, just, not listening to all of us who feel so strongly in the New York region about what has happened. There is no reason whatsoever for Dr. Howard not to be reappointed, and this is not just my opinion. It is my strong opinion, but it is the opinion of the vast overwhelming majority of those of us and I—it is very disheartening that our wishes were not respected. It is just very, very disheartening. Let me ask you one other question.

Mr. PALLONE. Time is expired. I will allow one more because I have let other people go over, but let us have the one and that is it.

Mr. ENGEL. OK, thank you, Mr. Chairman. I am forever in——

Mr. PALLONE. You don't have to be. Go ahead.

Mr. ENGEL. Thank you. Why was Mount Sinai Hospital, the largest clinical center of the New York/New Jersey consortium, not allocated the original budget request and will additional funds be available to provide necessary services to this population of heroes? Why was it allocated $1 million dollars less than what they actually spent last year when they had expected growth in treatment from 5,000 to 6,000 patients?

They were awarded $24 million and can't under the grant update that they got last night, can submit a supplement for up to $6.4

million, which is still considerably less than they feel they will spend based on cohort size and continued growth and treatment and monitoring, plus inflation. So I wonder if you could explain this because even if awarded the supplemental later in the year, it still wont get them to what they expect will be the cost of $32 million plus.

Dr. GERBERDING. My understanding from the NIOSH team and conversations that I had, both with Dr. Howard as well as his deputy for management, is that the Mr. Sinai request, as it originally came in, was for $32 million and the senior grant managers in both sides of that equation looked at some of the projections and the estimates and said, "no, 30 was the more appropriate request amount." So there was already a negotiation that $30 million dollars was what they were projecting they would need.

We have looked at last year's resource utilization. We have looked at money that has not been obligated and that is carried over as of April. Significant dollars had not yet been spent. It is impossible to say exactly what they are going to need. And I acknowledge a great deal of uncertainty, so we made sure that—we knew they would need at least $24 million, let us get that out. If there is evidence through our better monitoring programs, now, that the spend rate is going to continue to go up, as I wont be surprised if it does, we will need to make sure that they have the additional resources and if that doesn't cover it or we don't have what we need, we are going to have to come back and tell you we need more.

So I am prepared to update these investments if the information and the experience suggests that there is a greater requirement than we are projecting today. But I am also clear that there is a lot of uncertainty here and we have never done this before and we don't really know what people are going to need and we just have to make sure that you know that we will come back and ask if we need it and that our goal here is not to attenuate needed services, it is to try to support them, but also in an accountable and cost effective way that—we don't want to end up in a situation where we have not been fiscally accountable and then we would have to come back to this committee and explain why we hadn't been managing the money effectively. So we want them to get what they need.

Mr. PALLONE. All right. Thank you very much, and thank you Eliot. And we appreciate your testimony. It has been very helpful. Thanks again, and I will ask the third panel to come forward.

OK, welcome to the third panel, today. Let me introduce you. Starting on my left is Ms. Margaret Seminario, who is Director of Safety and Health for the AFL-CIO. Then we have Dr. Jacqueline Moline, who is Vice Chair and Associate Professor of the Department of Community and Preventive Medicine at Mount Sinai School of Medicine, in New York City. And, finally, Mr. Cas Holloway, who is Chief of Staff to the Deputy Mayor for Operations Counsel and Special Advisor to Mayor Bloomberg.

And I will just say, I think you know the drill. We have 5-minute opening statements that become part of the record, and each witness may, in the discretion of the committee, submit additional brief and pertinent statements in writing. We may ask you addi-

tional questions in writing, and we will start with—from my left, with Ms. Seminario.

STATEMENT OF MARGARET SEMINARIO, DIRECTOR, SAFETY AND HEALTH, AFL-CIO

Ms. SEMINARIO. Thank you very much, Chairman Pallone and ranking member Deal and members of the committee. I appreciate the opportunity to testify today to express the AFL-CIO's strong support for the 9/11 Health and Compensation Act of 2008. This legislation will provide much needed and long overdue help to thousands of brave responders, recovery and clean-up workers and residents who are now sick as a result of exposures to toxins and other hazards that resulted from the attacks on the World Trade Center in 2001.

We have already had a lot of testimony this morning reviewing what has happened and what we know. we know, with respect to the 9/11 attacks and the resulting collapse of the Trade Center, that we had, really, a level of unprecedented exposures to very large numbers of individuals, both on the day of the attack with the collapse of the towers and in the days and months that followed with the fires that burned and the dust exposures that continued.

We also know that these exposures were made much worse by the fact that EPA pronounced that the air was safe and that for 10 months on the clean-up of that site that the Occupational Safety and Health Administration did not enforce the law. As the committee has heard, last September and today, there is wide spread disease that has occurred as a result of these exposures and that we have thousands of workers who are now sick. Many of these people are disabled and they can no longer work, and a number of individuals have died.

We have also heard that these problems, indeed, are serious and they are persistent. They are long term. And we have also heard that despite the fact that we have known about these serious health problems for some time, that still we have no action by the Bush Administration to put in place a comprehensive plan or a comprehensive response to what is a very, very large public health catastrophe.

So today we are here to talk about H.R. 6594, a legislation that has been introduced that would establish such a comprehensive program and plan. This legislation has been under development for some time. A bill was introduced last September that actually formed the basis for this legislation. The new bill is a refinement on that piece of legislation. So we have not moved hastily on this at all. In fact, we in the labor movement, and others with the involvement, obviously, in leadership of Congresswoman Maloney, Congressman Nadler, Congressman Fossella, and the city of New York, we have been working on this for a very, very long time. First, with respect to putting in place the programs that are in place, as a result of funding that has been appropriated, but also tried to come up with a long-term legislative solution. And we think that H.R. 6594 is a very responsible measure, a much needed measure to address the problems that have been identified.

Let me just briefly review what the bill would do and what has been done to try and address some of the concerns about the cost

of this program. The legislation attempts to build on the successful existing programs, so it builds on the Centers of Excellence at the Fire Department of New York and at the Mount Sinai Medical Consortium, because those programs have been successful and have been working. So that is the basis for this legislation. It also would establish a community program to finally provide, in an ongoing basis, the services, the medical treatment to those in the community who have been affected. It would provide monitoring to those who are eligible and it would provide medical care and medical treatment to those who have been determined to have a World Trade Center related condition.

We have now refined the bill to include provisions to address the concerns that many have expressed about cost. But let me just state, because the problems are extensive, we have 18,000 responders who we know are sick, who have been in medical treatment. Because the problems are extensive and serious, the cost will be large. There is no getting around that. What has been done to try to address these costs in the bill are a number of things.

First of all, the program is based at these Centers of Excellence and designated providers by including and limiting the care to these particular centers, it will both provide the high quality care, but it will also constrain cost by having people seen by individuals who know these conditions and can diagnose them and treat them effectively.

The legislation also now includes particular provisions that raise the standard of proof and causality that is required for these to be considered World Trade Center related diseases. There are offsets included in the bill where workers compensation payments are made and those claims are accepted, the workers' comp reimbursement cost will be reimbursed and offset to the program.

For individuals who don't have a work related problem, health care will be the primary payer with the federal program being the secondary payer. And New York City has also, in the bill, been designated to be responsible for a five percent cost share on the community program.

And to deal with the questions of uncertainty, the bill now includes a cap on the number of participants in the program, that being set at 35 additional responders and 35 additional individuals in the community program. And so we think these measures are sound, they are responsible and that they have addressed the concerns that have been raised by individuals and Members of Congress about the potential large cost of this program.

In conclusion, let me just say that on September 11, 2001 and the days that followed, tens of thousands of brave firefighters, police, emergency workers, and construction workers answered the call when the Nation was attacked. They toiled for days, weeks, and months trying to save lives, recover victims and repair a broken city, and now thousands of these workers and others are now sick. Some are disabled and many have died. These brave responders have received the Nation's gratitude, but now they need the Nation's help. The September 11 attacks were an attack on the Nation and the Federal Government has a moral obligation to assist those who responded just as it would assist others who have defended our country.

And now 7 years after the September 11 attacks, it is time for the Congress to make a commitment and establish a long-term permanent program to provide these responders and all who are sick the ongoing medical care and compensation they need and deserve. The AFL-CIO urges the Committee to move with all speed to support and favorably report the 9/11 Health and Compensation Act of 2008 so that this long overdue measure can be enacted into law. Thank you.

[The prepared statement of Ms. Seminario follows:]

STATEMENT OF MARGARET SEMINARIO

Chairman Pallone, Ranking Member Deal and Members of the Committee, I appreciate the opportunity to testify today to express the AFL-CIO's strong support for the James Zadroga 9/11 Health and Compensation Act of 2008 (H.R. 6594). This legislation will provide much needed and long overdue help to the thousands of brave responders, recovery and clean-up workers and residents who are now sick as a result of exposures to toxins and other hazards that resulted from the attacks on the World Trade Center in 2001.

Nearly 7 years ago, the September 11, 2001, terrorist attacks claimed the lives of 3,000 individuals, injured thousands more and brought unparalleled grief and anguish to the nation. But soon after the 9/11 attacks it became clear that those who died and were injured on that day were not the only victims. Tens of thousands rescue and recovery workers—including firefighters, police, emergency medical technicians, workers in the building and construction trades, transit workers and others—and hundreds of thousands of other workers and residents near Ground Zero were exposed to a toxic mix of dust and fumes from the collapse of the World Trade Center. The scale and scope of these exposures was massive and extraordinary, with tons of glass, pulverized concrete, asbestos, lead, and burning jet fuel forming a dust and smoke cloud that engulfed the WTC site and lower Manhattan and spread throughout the area. The exposures continued for months as the fires at the WTC burned, rescue, recovery, and clean-up operations ensued, and toxic dust contaminated the area. The exposures were made much worse by EPA's pronouncements that the environment was safe and OSHA's failure to enforce workplace safety and health requirements during the entire 10-month period of rescue, recovery, and clean-up operations at the WTC site.

As this committee heard at a hearing last September, the exposures resulting from the attacks on the World Trade Center and its aftermath have caused significant and widespread health problems among rescue, recovery, and clean-up workers, residents, and others who were exposed. Peer reviewed studies by the New York City Fire Department (FDNY) show that 90 percent of FDNY rescue workers suffered new respiratory problems, experiencing an average loss of 12 years of lung capacity. A study of Ground Zero responders, recovery and clean-up workers conducted by the Mount Sinai Medical Center found that 69 percent had new or worsened upper or lower respiratory symptoms and one-third had abnormal pulmonary function tests. Similar findings have been reported by researchers from the Penn State University College of Medicine and Johns Hopkins in studies of police and other recovery and clean-up workers. These and other studies have also documented a high incidence of gastrointenstinal and mental health problems.

While those who responded on September 11 and the days that followed had the highest exposures, other groups of workers and residents were exposed to the toxic dusts and also suffer similar health problems. A study of clean-up workers conducted by researchers from the Johns Hopkins University found that workers who started working at the WTC site after January 2002 also experienced significant respiratory health problems. And studies and surveys of residents and area workers conducted by the New York City Department of Health World Trade Center Registry have found similar patterns of reported respiratory and mental health problems in these populations.

Despite the fact that serious health problems among World Trade Center responders have been documented and recognized for several years, it has been a struggle to get these brave workers and others affected the help and the care they need Since September 11, 2001, the Bush Administration has failed to provide leadership or take action. The administration has opposed reprogramming already appropriated funds for medical treatment, and dragged its feet on funding and establishing monitoring and treatment programs for responders outside the NY area, for federal

workers, and for residents and area workers. Repeatedly, the administration has failed to request the level of funding needed to support these programs. And most recently, the administration failed to reappoint Dr. John Howard as Director of NIOSH, also terminating his appointment as Director of the World Trade Center Health Program, despite widespread universal support from labor, industry, and the occupational health community and bipartisan support from Members of Congress.

Largely at the initiative of Congress, in 2002, a federally funded screening program for firefighters, police, rescue and clean-up workers was established which identified serious health problems among these workers. This screening program was conducted by the FDNY and a consortium of medical centers with expertise in occupational health coordinated by the Mt. Sinai Medical Center. In 2004 this program was expanded to provide more comprehensive medical monitoring, which confirmed significant respiratory and gastrointestinal problems as a result of exposure to the toxic dust and fumes. But the workers' compensation claims of many workers who were sick and disabled were contested by the city of New York and private contractors, leaving them nowhere to turn for medical treatment. Due to their health conditions, many of these sick responders are unable to work and have lost their health insurance. And even for those who have insurance, health insurance policies generally do not cover work-related conditions since they are supposed to be covered by workers' compensation. None of these insurance policies provide coverage for ongoing medical monitoring for individuals who have been exposed and are at risk of developing disease.

In FY 2006, through the efforts of the New York delegation and the unions, the Congress appropriated $75 million to further support these programs and to provide medical treatment to workers sick as a result from their exposures from the World Trade Center attacks and its aftermath. This medical treatment was provided through the same medical centers that had conducted the earlier screening and monitoring and had first identified and documented the health problems in responders, recovery and clean-up workers. In FY 2007, $50 million for medical treatment was included in a supplemental spending measure, and in FY 2008 a total of $158 million was appropriated. The National Institute for Occupational Safety and Health (NIOSH) has coordinated and overseen these monitoring and treatment initiatives through the WTC Medical Monitoring and Treatment Program, which until recently was headed by NIOSH Director Dr. John Howard.

In 2006, the city of New York announced and established the WTC Environmental Health Center at Bellevue Hospital to provide medical treatment to residents, clean-up workers and area workers who were not covered by the federally funded treatment programs. In the FY 2008 Consolidated Appropriations Act, Congress designated that some of the appropriated funds should be used to fund medical treatment for residents, students and area workers with World Trade Center Health problems. But HHS has yet to distribute these funds for this purpose.

As of December 2007, 39,368 responders had received at least one examination in the FDNY or Mt. Sinai Consortium programs, according to the April 2008 Department of Human Services "Report to Congress: Providing Monitoring and Treatment Services for those Experiencing Injuries or Illnesses as a Result of the World Trade Center Exposures." The FDNY conducted 14,620 of these initial exams and the Mt. Sinai consortium conducted 22,748 initial exams. HHS reports that of among the responders and recovery workers examined, 9,744 received medical treatment for a combination of respiratory and gastrointestinal conditions such as asthma, interstitial lung disease, chronic cough, and gastroesophageal reflux disease (GERD), and 5,674 received treatment for mental health conditions such as post-traumatic stress disorder (PTSD). According to FDNY and Mt. Sinai between 40 to 45 percent of the responders in the monitoring program have been treated for WTC-related health conditions, with some individuals being treated for both physical and mental health problems.

The number of individuals in monitoring and treatment continues to grow as more responders have enrolled in the program, many of whom are sick as a result of their WTC exposures. It should be noted that these numbers do not include approximately 4,000 responders who live outside of the NY-NJ area who have also received screening or monitoring or the approximately 2,700 residents, area and clean-up workers who have received medical treatment for WTC-related health conditions through the WTC Environmental Health Center at the Bellevue Hospital. Nor do they include individuals who are not enrolled in existing programs or receiving treatment from other health care providers.

In November 2007, in a Congressional briefing on the WTC responder monitoring and treatment program, NIOSH estimated the cost of the responder medical monitoring and treatment program at approximately $218 million for FY 2008. Of this amount, the estimated cost of treatment is $149 million, the cost of monitoring is

$37.5 million, and the cost of program coordination, data collection and other support is $32 million.

As more responders become sick, as is still the case, these costs will likely increase. Since many of the WTC-related health problems are chronic conditions, these individuals will need medical treatment for years to come. Moreover, due to the massive and complex exposures that occurred, there is concern that new conditions with longer latencies, including cancer, fibrosis, and auto-immune diseases will also emerge.

The medical monitoring and treatment programs that have been established at the FDNY, Mt. Sinai Consortium, and Bellevue Hospital have been vital for the thousands of workers and others who are now sick as a result of their exposures. But nearly seven years after the collapse of the World Trade Center towers, these efforts are still temporary and piecemeal; and there is no comprehensive permanent program to provide ongoing guaranteed medical monitoring to those who were exposed and medical treatment to responders, recovery and clean-up workers and members of the community who are suffering from WTC-related health problems.

THE JAMES ZADROGA 9/11 HEALTH AND COMPENSATION ACT OF 2008 (H.R. 6594)

The 9/11 Health and Compensation Act of 2008 (H.R. 6594) would establish a comprehensive program to provide medical monitoring to those who have been exposed to WTC toxins and medical treatment and compensation to those who are sick. It would also fund ongoing research on WTC-related health conditions and reopen the Victim Compensation Fund (VCF) to provide compensation to those who have been harmed or suffered economic loss.

Specifically H.R. 6594 would amend the Public Health Service Act to establish the World Trade Center Health Program within the National Institute for Occupational Safety and Health, to be administered by the NIOSH director or his or her designee.

The legislation would establish a monitoring and treatment program for responders, a program for the community and a national program for those eligible individuals who reside outside the NY Metropolitan area.

The legislation builds on the successful monitoring and treatment programs that have been providing services to these populations. The responder program would be delivered through Clinical Centers of Excellence at the FDNY and the Mt. Sinai coordinated consortium, in which five medical institutions currently participate. The community program would be delivered through Clinical Centers of Excellence at the Bellevue Hospital. This delivery system will ensure that workers and community members are evaluated and treated by physicians who have expertise in diagnosing and treating World Trade Center related conditions, and will receive high quality care. Additional clinical centers and providers may be designated by the program administrator, providing they have the necessary expertise and meet other program requirements.

Steering committees of providers and representatives of the affected populations would be established to help guide and coordinate the responder and community programs.

Coordination of these clinical center programs is to be overseen by Coordinating Centers of Excellence at the FDNY, Mt. Sinai and Bellevue Hospital which will collect and analyze uniform data, develop medical monitoring and treatment protocols, coordinate outreach and oversee the steering committees for the responder and community health programs.

The bill sets forth eligibility criteria for inclusion in the program, which are based upon exposure to World Trade Center toxins and hazards, and are defined in geographic and temporal terms. For the responder program, the eligibility criteria are based upon work at the World Trade Center site and related disposal and support facilities. These criteria are based on those that have been utilized in the existing WTC Medical Monitoring and Treatment Program for responders and have been approved by NIOSH. Responders who meet the eligibility criteria qualify for the medical monitoring program. As stated earlier, approximately 40,000 responders have received monitoring exams in the current program. Estimates of the total population of responders who may qualify range from 50,000 to 100,000 individuals.

Responders who are in the monitoring program are eligible for medical treatment, if an examining physician at a clinical center of excellence diagnoses a condition that is on the list of identified WTC-related health conditions included in the bill, and the physician determines that exposure to WTC toxins or hazards is substantially likely to be a significant factor in causing the condition. The list of conditions included in the bill is the same list utilized in the current responder monitoring and treatment program that has been approved by NIOSH.

Under the bill, the NIOSH Administrator is responsible for making final eligibility determinations and certifying individuals for participation in the monitoring program and their eligibility for medical treatment.

Recognizing that the scientific and medical evidence on WTC-related health problems continues to evolve, the bill provides for the addition of conditions to the list of identified WTC-related conditions, with the review and input of a Scientific and Technical Advisory Committee. It also provides for special independent expert medical review procedures for the consideration of medical treatment claims of individuals diagnosed with WTC-related conditions that are not yet on the list.

While we do not know the full extent of WTC-related disease among responders, we do know that in the current program approximately 40 0945 % of those in the monitoring program have been treated for a WTC-related health condition, and the number of sick responders continues to increase.

For the community program, the bill also sets forth geographic and exposure criteria for defining the potential population that may be eligible for the program. The bill designates the geographic area covered by the bill as lower Manhattan South of Houston Street and the area in Brooklyn within a 1.5 mile radius of the World Trade Center site, and sets various time limits for residing, working, or being present in the designated area. In addition the bill requires the WTC Program Administrator to develop and adopt more refined eligibility criteria within 90 days taking into account the period and intensity of exposures, based upon the best available evidence, in consultation with the Bellevue Hospital, the Community Steering Committee and affected populations.

For the community program, the bill includes provisions for making determinations of eligibility for medical treatment similar to those as for the responder program. The major difference in the programs is the expectation that the community program will not provide a comprehensive monitoring program but rather will focus on more limited screening and treatment of individuals with World Trade Center-related health conditions.

For those eligible responders, residents or non-responders who reside outside the NY metropolitan area, the bill directs the WTC Program Administrator to establish a national program with services to be provided by health care providers designated and approved by the administrator. These providers must have expertise and experience in treating the type of medical conditions included on the list of identified WTC-related conditions and agree to follow the established medical treatment and data collection protocols set forth in the bill.

PROVISIONS TO ADDRESS PROGRAM COSTS

The AFL-CIO recognizes that many in Congress are concerned about the costs associated with this legislation, particularly since the bill is structured as an entitlement to ensure ongoing funding for medical treatment for those who are sick as a result of World Trade Center exposures. Unfortunately, due to the massive exposures that occurred and the failure to protect workers and residents, the health problems that have resulted are serious, persistent and extensive.

While we do not know the full extent of the health problems that have resulted or will result from WTC exposures, nearly seven years after the September 11 attacks, we do have substantial knowledge and experience, particularly concerning responder health problems and related treatment costs. As stated earlier, there are approximately 40,000 responders who have received monitoring and 18,000 individuals who have received medical treatment for WTC-related physical and/or mental health conditions. According to NIOSH, the current cost of WTC Responder Monitoring and Treatment Program is approximately $218 million a year.

For the community program, there is less experience and less information since the WTC Environmental Health Program at the Bellevue Hospital was just initiated in 2006. To date, approximately 2,700 individuals have received medical treatment for World Trade Center-related health problems similar to those seen in the responder population. While the exposures of most residents and area and clean-up workers were not as great as responders who worked at the WTC site, many of these individuals had significant exposures and are suffering from serious health problems. Moreover, the number of individuals seen in the Bellevue program does not represent the full populations of those who are eligible or sick with WTC-related health conditions. In a September 2007 report, "Addressing the Health Impacts of 9-11: Report and Recommendations to Mayor R. Bloomberg," an expert panel of New York City officials estimated the potential costs of treatment for residents and area workers for 9/11 conditions at approximately $200 million a year.

While the costs of WTC-related health problems will be large, the legislation includes a number of provisions to constrain these costs. First the program is limited

to the Centers of Excellence or providers designated by the administrator who have experience with WTC-related health conditions. Eligible individuals must receive monitoring or treatment through these designated providers.

Evaluations of exposures and health conditions are to be made utilizing standardized questionnaires approved by NIOSH, and treatment provided according to medical protocols established by the program.

For conditions that are work-related, the medical treatment costs are offset by any workers' compensation payments and the Centers of Excellence are required to assist eligible individuals to file for these and other available benefits. Unfortunately, since the city of New York and other employers continue to contest these claims, to date the workers' compensation benefits for these conditions have been limited and delayed.

For those conditions that are not work-related and are covered by existing health insurance, the legislation designates the WTC treatment program as the secondary payor, with private or public insurance having the primary obligation to pay for treatment.

In addition, for individuals receiving treatment in the community program at Bellevue Hospital or other facilities of the Health and Hospitals Corporation, the city of New York is responsible for a 5 percent cost share of treatment costs.

But because the numbers of individuals who may be affected is indeed uncertain, the legislation imposes a mandatory cap on participation. For the responder program this cap is set at 35,000 additional responders to the number currently enrolled in the monitoring program, bringing the total program participation to approximately 75,000 responders. For responders this cap applies to the number of responders in monitoring, of which, based on current experience, approximately 40 0945% or 30,000 to 34,000 individuals can be expected to require some type and level of medical treatment.

For the community program, the cap is also set at 35,000 participants in addition to the approximately 2,700 individuals who are currently enrolled in the Bellevue program. Because of the design of the Bellevue program, which only enrolls those with diagnosed WTC-related conditions, all of those certified as eligible for the community program are expected to receive medical treatment.

Because the geographic area for the community program has been limited and due to the uncertainty about the extent of exposures and disease, the bill provides for a contingent fund of $20 million a year to provide medical treatment to residents and non-responders who are diagnosed with WTC-related conditions, but fall outside the scope of the bill's exposure and geographic eligibility criteria. For example, this contingent fund would be available to pay the cost of medical treatment for individuals diagnosed with WTC related conditions in New Jersey, Staten Island and other locations in the NY metropolitan area who were exposed outside the geographical boundries set in the bill.

In order to track the program's progress and experience, the legislation requires the WTC Program Administrator to provide an annual report to Congress setting forth the experience with claims, the nature of the diseases treated, the results of new research, program costs and other information. In addition, if and when 80 percent of the cap in either the responder or community program is reached, the administrator is required to notify Congress, so a determination can be made if further congressional action should be taken.

THE CONGRESS SHOULD ACT NOW TO PROVIDE ONGOING MEDICAL TREATMENT TO RESPONDERS, RESIDENTS AND OTHERS WHO ARE SICK FROM WORLD TRADE CENTER EXPOSURES AND ENACT THE 9/11 HEALTH AND COMPENSATION ACT OF 2008 (H.R. 6594)

On September 11, 2001 and the days that followed tens of thousands of brave firefighters, police, emergency workers, and construction workers answered the call when the nation was attacked. They toiled for days, weeks and months trying to save lives, recover victims and repair a broken city.

Now thousands of these workers and others are sick as a result of World Trade Center exposures, many are disabled and some have died. For the past several years, the Federal Government has provided monitoring and medical treatment for responders who are ill through a series of temporary short term funding measures. But many more who are ill have yet to receive the care they need, and there is no long term plan or funding to ensure that medical treatment will continue.

These brave responders have received the nation's gratitude but now they need the nation's help. The September 11 attacks were an attack on the nation and the Federal Government has a moral obligation to assist those who responded just as it would assist others who have defended our country.

Seven years after the September 11 attacks it is time for the Congress to provide these responders and all who are sick as a result of the World Trade Center attacks the ongoing medical care and compensation they need and deserve. The AFL-CIO urges the Committee to move will all speed to support and favorably report the James Zadroga 9/11 Health and Compensation Act of 2008 (H.R. 6594) so that this long overdue measure can be enacted into law.

Thank you.

Mr. PALLONE. Thank you. Dr. Moline.

STATEMENT OF JACQUELINE MOLINE, M.D., M.SC., VICE CHAIR AND ASSOCIATE PROFESSOR, DEPARTMENT OF COMMUNITY AND PREVENTIVE MEDICINE, MOUNT SINAI SCHOOL OF MEDICINE

Dr. MOLINE. Good afternoon. I am a board certified specialist in Occupational Medicine and in Internal Medicine and I am the Director of the Mount Sinai Clinical Center for the World Trade Center Medical Monitoring and Treatment Program. Our center is the flagship of a regional and national consortium that has been supported by NIOSH, and since July 2002 has seen over 25,000 responders in the New York metropolitan area and across the United States.

In the days, weeks, and months that followed September 11, an estimated 50,000 to 100,000 people from across the country responded selflessly without concern for their own lives or well-being when our Nation needed them. Workers and volunteers, traditional first-responders, firefighters, police officers, paramedics, the National Guard, and the not so traditional—a diverse force of operating engineers, laborers, iron workers, telecommunication workers, transit workers, sanitation workers, building cleaners and many more. They came from across America, tens of thousands from the metropolitan New York area, but from every state in the Nation. They toiled for days, weeks, and months in and around Ground Zero, at the Staten Island landfill, engaged in rescue and recovery work, the restoration of critical services, debris removal, and clean-up. Their hard work and bravery got New York back on its feet and we owe them tremendous gratitude.

While they were there, they were exposed to a complex and unprecedented mix of toxic chemicals. Ninety thousand liters of jet fuel created a dense plume of black smoke with volatile compounds in it, such as benzene, metals, and polycyclic aromatic hydrocarbons. The collapse of the Twin Towers, and later that day a third tower, World Trade Center seven, produced an enormous dust cloud filled with pulverized cement that was 60 to 65 percent of that dust mass. Trillions of microscopic glass particles and fibers, asbestos, lead, hydrochloric acid, PCBs, pesticides, furans, and dioxins were in the air. Levels of airborne dust, estimated by the U.S. Environmental Protection Agency, range from—up to 100,000 micrograms per cubic meter creating a thick airborne soup that turned a bright sunny day into night. The high content of pulverized cement made the dust extremely caustic with a pH similar to lye. Fires burned both above and below ground until December. Rubble removal operations continued until May, continuously reexposing individuals to this dust.

In addition to the physical exposures there were extreme psychological stressors. Responders lost friends and family and during the desperate search and rescue operations; thousands of them came upon human remains. Stress was compounded by fatigue as these dedicated workers remained at the site working for hour on hour. Among those most affected are the non-traditional responders, those not trained for any emergency, but who responded when our Nation needed them.

Mount Sinai, through its Center for Occupational and Environmental Medicine has taken a leading role in treating these workers. This work began days after the attack, many months before any Federal program was in place. We designed and developed what stands as the Federal Government's health response to 9/11, a model based on experience and expertise of academic physicians who are trained in Occupational Medicine, surrounded by specialists in Pulmonary Medicine, Psychiatry, Rehab Medicine, and other healthcare workers.

We have been proud to work as a partner with all of you, legislators, agencies, and the stakeholders, to represent them to provide a program that brings experience and excellence. We have a regional consortium that you have heard of earlier today: Mount Sinai, SUNY Stony Brook, University of Medicine and Dentistry of New Jersey, in your region Chairman, the Queens College Center for Biology of Natural Systems and Bellevue. Together with the national program that we, until recently, coordinated has provided, as of the end of May, nearly 40,000 examinations to over 25,000 responders from all 50 states.

In that time, we have also provided 70,000 treatment services in our consortium. At Mount Sinai alone we have provided over 53,000 treatment services and over 24,000 of those services have been since federal funding was in place. Earlier we had philanthropy that covered many of the costs.

Much of what we know about the health effects has been learned through our program and our sister program at the Fire Department of New York. Our physicians have diagnosed and carefully documented diseases and responders and linked these conditions to the exposures at the World Trade Center. We have provided expert medical, mental health and social work treatment, as is needed, to all who come in our doors. We remain constantly vigilant for newly emerging diseases and trends in the 9/11 population. People are still coming in. In the past year, almost seven years after September 11, an average of over 160 new, eligible responders come in every month.

Adverse health effects are suffered by a large percentage of our responders. There have been social and financial impacts which have added to the problems they face. Respiratory conditions have been well documented in peer reviewed literature. In 2006 we published a paper that showed that among monitoring responders new or worsened respiratory symptoms were experienced by 63 percent; lower respiratory symptoms, such as asthma, COPD in 47 percent. One quarter had objective measures of decreased pulmonary function and rates were higher, five times higher, in some tests than in comparably non-smoking, non-exposed Americans.

Mental health consequences also afflict a large percentage of 9/11 responders. We recently published a paper that shows that PTSD, or post-traumatic stress disorder, rates are at rates similar to returning veterans from Afghanistan, with 11 percent.

Mr. PALLONE. I am sorry, but I just wanted you to know you are a minute-and-a-half over, so you have to wrap up.

Dr. MOLINE. Oh my goodness, I will talk faster.

Mr. PALLONE. Right, or summarize.

Dr. MOLINE. I will summarize. We continue to see health effects, gastrointestinal problems in the folks we treat. Four thousand people in the past 6 months have been treated. Mental health problems in one-third, lower respiratory conditions in nearly half, 25 percent of our folks are on disability and out of work as a result of their health problems, and over 60 percent have multiple World Trade Center conditions.

The medical literature from all the programs, whether it is the Mount Sinai consortium, the Fire Department, Bellevue's Environmental Health Clinic, we have all published. We have all found the same percentages of illnesses. These illnesses are real. They are persistent and we need a long-term stream of funding in order to ensure that people can get adequate healthcare going forward, without concerns about interruption in the care so that we can learn and be prepared for diseases that may come in the future. We know there are carcinogens and other health hazards that will manifest in the future and we need to be prepared through our Centers of Excellence to be able to cover these.

[The prepared statement of Dr. Moline follows:]

MOUNT SINAI
SCHOOL OF
MEDICINE

TESTIMONY

before

The United States House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

Hearing on

HR 6594 " James Zadroga 9/11 Health and Compensation Act of 2008"

Washington, D.C.

July 31, 2008

Presented By

Jacqueline Moline, M.D., M.Sc.

Vice Chair and Associate Professor

Department of Community and Preventive Medicine, Mount Sinai School of Medicine

Director

World Trade Center Medical Monitoring and Treatment Program at Mount Sinai

Good morning. Mr. Chairman and Members of the Committee, I thank you for inviting me to present testimony.

My name is Jacqueline Moline, MD. MSc. I am Vice Chair and an Associate Professor in the Department of Community and Preventive Medicine and also an Associate Professor of Internal Medicine at the Mount Sinai School of Medicine in New York City. I am a board certified specialist in Occupational Medicine and in Internal Medicine. I serve as Director of Mount Sinai's Clinical Center of Excellence within the World Trade Center Medical Monitoring and Treatment Program. This Center is the flagship of a regional and national consortium that is supported by the National Institute for Occupational Safety & Health (NIOSH), and that since July 2002 through May 31, 2008 has diagnosed and treated over 25,000 WTC responders in the New York metropolitan area and across the United States.

I am here today to testify in support of HR 6594. I will update you on the health status of the 9/11 responders and on the current extent of WTC-related illnesses in these brave men and women. I will discuss with you the critical need for continuing to provide medical care for the responders. I will emphasize the importance of stable, long-term federal support for the Centers of Excellence, where the necessary expertise and unique experience have been developed to provide the complex, high-quality medical follow-up and treatment that the 9/11 responders need and so rightfully deserve.

The Diverse Population of 9/11 Responders

In the days, weeks, and months that followed September 11, 2001 an estimated 50,000 to 100,000 people from across the U.S. responded selflessly – without concern for their own lives or well-being – when our nation needed them. Workers and volunteers, they included traditional first responders - firefighters, law enforcement officers, paramedics, the National Guard - and the not so traditional, including a large and

highly diverse force of operating engineers, laborers, ironworkers, telecommunications workers, transit and sanitation workers, building cleaners and more. They came from across America – tens of thousands of men and women from New York, New Jersey, and Connecticut, and from every state in the nation. They toiled for days – for weeks and months, in and around Ground Zero, the Staten Island landfill and adjacent areas -- engaged in rescue and recover operations, the restoration of critically needed essential city services, and debris removal and clean up. Their hard work and bravery got New York and our nation back on its feet, and we owe them tremendous gratitude.

The Exposures

These heroes were exposed to a complex and unprecedented mix of toxic chemicals. The combustion of 90,000 liters of jet fuel created a dense plume of black smoke containing volatile organic compounds - benzene, metals, and polycyclic aromatic hydrocarbons. The collapse of the Twin Towers and then of a third building (WTC 7) produced an enormous dust cloud – filled with pulverized cement comprising 60 to 65% of the total dust mass. Trillions of microscopic glass fibers and glass shards, asbestos, lead, polycyclic aromatic hydrocarbons, hydrochloric acid, polychlorinated biphenyls or PCBs, organochlorine pesticides, furans and dioxins were also included. Levels of airborne dust were highest immediately after the attack, at estimated concentrations of 1,000 to > 100,000 $\mu g/m^3$ according to the US Environmental Protection Agency – creating the thick airborne "soup" as a bright sunny day turned into night. The high content of pulverized cement made the dust extremely caustic, with a pH similar to lye (pH 10–11). Fires burned both above and below ground until December of 2001. Rubble-removal operations continued until May 2002 repeatedly re-aerosolized the dust, creating continuing (intermittent) exposures over many months.

In addition to these extraordinary physical exposures, the 9/11 responders suffered extreme psychological stress. Responders lost friends and family in the attack, and during the desperate search and rescue

operations, thousands of them came upon human remains. Stress was compounded by fatigue as these dedicated workers remained at the site, working for hour upon hour. Among those most affected are the non-traditional responders - those not previously trained for any emergency, let alone a disaster of the scale posed by 9/11.

Centers of Excellence

Mount Sinai, through its Center for Occupational and Environmental Medicine, took a leading role in medically evaluating and treating affected workers and volunteers in the wake of the disaster. This work began within days after the attack, many months before any federal program was in place. Our dedicated physicians and staff designed and developed what stands today as the federal government's health response to 9/11, a model based on the experience and expertise of academic physicians with specialty training in occupational medicine, surrounded by a team of specialists in disciplines ranging from pulmonary medicine, to psychiatry to rehabilitation medicine as well as nurses, social workers and support staff. We have been proud to work as a partner with all of you – legislators, federal agencies, and importantly the stakeholders, the affected responders and many organizations that represent them to provide a program that brings experience and excellence in its provision of service. We have striven to assure to the best of our ability the same quality of care for every responder, regardless of where they live.

Our regional consortium of Clinical Centers of Excellence – Mount Sinai School of Medicine, SUNY Stony Brook, Queens College/Center for Biology of Natural Systems, University of Medicine and Dentistry of New Jersey and Bellevue Hospital, together with a national program for responders that until recently we coordinated, has provided, as of May 31, 2008, over 39,915 monitoring examinations to 25,303 responders in all 50 states. Mount Sinai alone has provided over 28,000 of those medical evaluation services – to almost 17,000 responders. Since the New York and New Jersey Metropolitan area consortium treatment

programs began, we have provided over 70,000 physical health, mental health, and social work services consortium-wide[1]. At Mt. Sinai alone, we have provided 53,509 treatment services - some through our privately-supported program, before federal funding was in place; 24,367 of these have been provided since federal funding began in the fall of 2006.

Much of what we know today about the health effects of the attacks on the WTC has been learned through this program. Our physicians have diagnosed and carefully documented diseases in responders and linked these conditions to exposures sustained at the World Trade Center. We provide expert medical, mental health and social work treatment that is unfortunately needed by tens of thousands of affected responders, and we provide this wide range of services regardless of patients' ability to pay. We remain constantly vigilant for newly emerging diseases and for trends of illness in the 9/11 responder population.

Demand for our Medical Monitoring and Treatment Program remains strong. Even now, almost 7 years after 9/11, an average of 161 new eligible registrants join the program each month.

Health Effects

Adverse health effects continue to be suffered by a large percentage of 9/11 responders. In addition, there have been social and financial impacts experienced by those who have become ill and which add to a list of loss and devastation for many responders, magnifying the problems they face.

Respiratory conditions, including both upper and lower respiratory diseases, remain prominent among the health effects that we continue to see in responders. We documented these effects in a report published in

[1] Most of the clinical centers began treatment programs for WTC responders with philanthropic funding. The first such program was initiated at MSSM in January 2003.

2006 in *Environmental Health Perspectives,* the respected peer-reviewed medical journal of the National Institute of Environmental Health Sciences. That report highlighted the following observations:

- New or worsened upper respiratory symptoms were experienced by 63% of program participants;
- New or worsened lower respiratory symptoms were experienced by 47% of participants, conditions such as asthma, RADS and COPD;
- Over one-quarter of responders had abnormal pulmonary function test results;
- Decreased forced vital capacity, a particular breathing abnormality, was found 5 times more frequently in non-smoking WTC responders than in the general, non-smoking population of the United States.

Mental health consequences also afflict a large percentage of 9/11 responders enrolled in the monitoring program. A paper that we published earlier this year in *Environmental Health Perspectives* documents, among over 10,000 Medical Monitoring patients, the presence of post-traumatic stress disorder (PTSD) in 11% of responders and depression in 9%, up to five years after September 11th. These rates are comparable to rates of PTSD among our veterans returning from Afghanistan.

Physical and mental health problems persist to the present time in a substantial proportion of the 9/11 responders. Statistics among patients actually in treatment in the New York/ New Jersey Consortium Clinical Centers – as evident by a six month snapshot of conditions seen among 4,144 patients between October 1, 2007 and March 31, 2008, highlight additional concerns:

- Gastrointestinal conditions affected 48% - most cases of GERD or gastro-esophageal reflux disorder.
- 33% were affected by mental health problems – including PTSD, seen in 21%, and major depression seen in 22%.

- While lower respiratory conditions affected 47% of patients; upper respiratory conditions affected 65% .
- Social disability was unfortunately common, with over 27% of responders being unemployed/laid off, or on sick leave/disability during the observation period.
- 24% had no medical insurance at some point during the period.
- 61% suffered from multiple WTC-related covered conditions.

Because most of our patients are being treated for more than one WTC-covered condition, it is critical that they receive this care in Centers of Excellence where providers understand the complexity of the physical and emotional needs of the responders. A majority of patients in our program receive treatment on an outpatient basis, but we have also had several inpatient admissions for conditions such as asthma attacks, complicated sinus surgeries, and for treatment of the mental health consequences, such as severe depression and attempted suicides.

These medical findings in the 9/11 responders fit with scientific understanding of the exposures that the responders sustained at Ground Zero. These findings are consistent also with the results of studies undertaken by the FDNY, the New York City Department of Mental Health and Hygiene, the Bellevue WTC Environmental Clinic and other independent researchers. The percentage of individuals afflicted by physical and mental health problems has been remarkably consistent across the various published studies, whether they are examining firefighters, construction workers, police officers, or office clean-up workers. Some responders have, of course, recovered. Many have been helped by the treatments that the Centers of Excellence provide. But the persistence of WTC-related physical and mental illness in thousands of responders nearly 7 years after the attack is no longer in question.

The possibility is real that new conditions – diseases marked by longer latency – will also emerge among the 9/11 responders. We know that responders were exposed to carcinogens such as asbestos and benzene, neurotoxins, and chemicals toxic to the respiratory tract in concentrations and in combinations that never before have been encountered. Longer term conditions we might see may include cancers, auto-immune disorders, and pulmonary fibrosis. The future health outlook for responders remains uncertain. The long-term consequences of such unique exposures are not fully known. It is for these reasons that all of us in the Centers of Excellence remain constantly vigilant.

Conclusion

The medical findings in the 9/11 responders that I have summarized this morning, and most importantly, the persistence of WTC-related illness in a substantial proportion of the responders, underscore the critical importance and the urgent need for stable, predictable, multi-year federal support for a medical program for the responders. The complexity of these conditions and the difficulty of their treatment strongly support the need for provision of this care in the setting of an established medical monitoring and treatment program that is based in Centers of Excellence, and led by experienced physicians with specialty training in Occupational Medicine.

Data coordination is a second very powerful reason to sustain the Centers of Excellence model for provision of medical care to the 9/11 responders. The Centers of Excellence are highly skilled and experienced in the medical tracking and epidemiological monitoring of the responders' health as well as in overseeing the quality and in monitoring the outcomes of the care provided to the responders. Through the work of the epidemiologists and statisticians in our WTC Data and Coordination Center at Mount Sinai we have tracked medical trends and patterns of disease in responders. We have assured, as best we are able, uniform quality in services for all program participants. We have assessed the efficacy of our treatments. All

of the data collected through the Data and Coordination Center are analyzed. Key findings are regularly disseminated to the medical community, policy-makers and the public through publication in major, peer-reviewed biomedical journals. This dissemination of findings and recommendations for diagnosis and treatment permits us to share our knowledge and to optimize medical care. This shared knowledge and experience provides invaluable guidance in preparing for disaster planning for the future.

All of this good work would be impossible in the absence of Centers of Excellence. These Centers of Excellence are a national treasure. They are providing state-of-the-art medical care to the men and women who risked everything for all of us in a time tantamount to war. This bill will ensure that the work of the Centers of Excellence can continue. Passage of HR 6594 will ensure that the heroes of 9/11 are never forgotten.

Thank you.

I am pleased to answer any questions

Mr. PALLONE. Thank you, and your full statement will be put in the record too. Thank you, Doctor. Mr. Holloway.

STATEMENT OF CASWELL HOLLOWAY, CHIEF OF STAFF TO THE DEPUTY MAYOR FOR OPERATIONS COUNSEL, SPECIAL ADVISOR TO MAYOR BLOOMBERG

Mr. HOLLOWAY. Thank you very much, Mr. Chairman. Can you hear me? Thank you very much.

Mr. PALLONE. Maybe bring it closer.

Mr. HOLLOWAY. There we go. Sorry about that.

Mr. PALLONE. That is good.

Mr. HOLLOWAY. Thank you, Chairman Pallone and the members of the committee who were here. I want to reiterate Mayor Bloomberg's thanks to Speaker Nancy Pelosi, to the New York delegation, particularly Representatives Nadler, King, and Fossella for making this legislation a priority. My name is Cas Holloway and I am Chief of Staff to New York City's Deputy Mayor for Operations, Edward Skyler and a Special Advisor to Mayor Bloomberg. Along with my colleague, Rima Cohen, who is also here behind me today, I served as Executive Director of the Panel convened by Mayor Bloomberg at the fifth anniversary of the attacks to assess the health impacts of 9/11 and what needed to be done to ensure that those who are sick or could become sick get the treatment that they need.

I also want to acknowledge Dr. Joan Reibman and Dr. David Prezant, who are also sitting behind me as back-up. Dr. Reibman runs the Bellevue Center, which is the only center open to residents and community members and is currently treating 2,700 patients. And, of course, Dr. Prezant, who I think is known to everybody involved with this issue, who runs the Fire Department's program. Both of these doctors have submitted testimony to the committee, which details the same effects and treatment information. For example, in the community program they are fielding 100 calls a week and admitting as many as 25 patients a week over the last 6 months, so the need is clearly there.

And as the Mayor said when he testified, just a short while ago, this bill establishes two critical things. It provides the long-term funding that we need to meet the health needs. It also reopens the Victim Compensation Fund.

I don't want to go back over all of that. What I would like to do though is focus on some of the controls that are in the bill, some of the changes that have been made over time, that working with the people sitting with me here, we think, will do a lot to control the costs and make sure everybody who needs care gets care, because we recognize that these are public dollars and Mayor Bloomberg is as committed to fiscal responsibility as anybody on the committee.

First, the bill defines specific groups, for example, firefighters and recovery workers and specific geographic areas the people must have been in or on or within a defined period after 9/11 to be eligible for treatment. Now, there is a defined specific contingency fund for people who would be outside that area because, the fact is, we don't know the full extent of the problem and the goal of this bill is to cover anybody who could be sick.

Second, although people who meet these criteria are eligible for treatment under the bill, to actually get treatment a doctor with experience treating WTC related conditions must determine, based on medical examination, that the exposure was caused or exacerbated by 9/11. That assessment has to be based, in part, on standardized questionnaires. And even after a condition is deemed to be WTC-related, it is subject to review and certification by the World Trade Center administrator under the bill.

Now, these are tough standards, and they are based to a large extent on protocols already in place at the Environmental Health Center at Bellevue at HHC, and I know that there are lengthy questionnaires that are used for the responder programs.

The bill also caps the number of responders and community members who can get monitoring and treatment. These limitations are based on the best available information. And to make sure that we don't get it wrong, there is a provision in the bill to notify Congress if those caps are reached, which is critical to making sure, again, that anybody who is ill gets covered.

In addition to these controls, which apply to every potential patient, the bill mandates the establishment of quality assurance and fraud prevention programs that act as further safeguards against the misuse of these funds for any purpose other than to monitor and treat those who were affected by the 9/11 terrorist attacks.

The bill also ensures important provisions to contain costs and make sure that federal dollars are used wisely. As Peg Seminario mentioned, there is an offset for workers' compensation if it has been paid. The program acts as the last payer if there is health insurance that covers the conditions that people present for.

And finally, as Mayor Bloomberg pointed out, under the bill, the City is responsible for paying 5 percent of treating anyone treated at a Center of Excellence that is within the Health and Hospitals Corporation. Currently, by the way, that is everybody in the community program because it is only an HHC program that is open to community members. We accept this responsibility because Mayor Bloomberg thinks that it is critical for the city to have an investment in making sure that these dollars are spent wisely and that that is fully consistent with this being a national obligation.

I do want to mention one issue that we would like addressed as the bill moves forward. The bill establishes steering committees for both the responder and the community programs and we would like to make sure that there are representatives from the Police Department and another responder agency on the responder committee and that the Department of Health is represented on both of the committees because we think that is important institutionally, as we move forward. We are actually working together to resolve those issues, but I wanted to just mention it.

The bill also ensures that critical 9/11 related research is expanded and existing efforts like the World Trade Center Health Registry are continued because long-term research is the only way that we are going to be able to develop a full understanding of the health impacts of 9/11.

And finally, this bill fulfills another core recommendation of Mayor Bloomberg's World Trade Center Health Panel, the urgent need for Congress to reopen the VCF. The VCF was fair and effi-

cient and it provided a means of relief for the victims of the attacks and their families. It is imperative that the fund be reauthorized to take care of those who were not eligible to benefit before it closed in December of 2003. The fact that their injuries were slower to emerge or that the initial criteria were too narrow should not disqualify them from getting the help they need.

The reason we need this is that the city and the contractors need the indemnity that the bill also provides, is to ensure that, God forbid another attack like this is to happen again, the private sector and the public sector would respond knowing that they had the full backing of the Federal Government. And, in addition, the way the bill is structured once these things are in place, the one billion dollars that is currently available in the Captive Insurance Company would be made available to pay out claims under the VCF.

So, in sum, this bill achieves two critically important things to help complete the recovery from 9/11, the health funding and reopening the VCF. That is why it has gained such strong support in the New York delegation and that is why Mayor Bloomberg has come down here many times and was down here today, in support of the bill. We are pledged to working with you to do everything in our power to make sure that it moves forward and is ultimately enacted. Thank you.

[The prepared statement of Mr. Holloway follows:]

Statement of Caswell F. Holloway

Chief of Staff to New York City Deputy Mayor for Operations Edward Skyler
and
Special Advisor to Mayor Michael R. Bloomberg

H.R. 6594: 9/11 Health & Compensation Act of 2008

July 31, 2008

Committee on Energy and Commerce
Sub-committee on Health
U.S. House of Representatives

Good morning. I want to thank Chairman Pallone, Ranking Member Deal, and the other distinguished members of the Committee for convening this hearing on H.R. 6594, *The 9/11 Health and Compensation Act of 2008.*

I also want to reiterate Mayor Bloomberg's thanks to House Speaker Nancy Pelosi, and to the New York delegation-- particularly representatives Maloney, Nadler, King and Fossella for making this legislation a priority. As we approach the seventh anniversary of the worst terrorist attack on American soil, it is critical to ensure that the unmet health needs and lingering harm that people have suffered as a result of the attacks are finally addressed.

My name is Cas Holloway and I am Chief of Staff to New York City's Deputy Mayor for Operations Edward Skyler and a Special Advisor to Mayor Bloomberg. Along with my colleague Rima Cohen, who is also here today, I served as Executive Director of a Panel convened by Mayor Bloomberg at the fifth anniversary of the attacks to assess the Health Impacts of 9/11 and what needed to be done to ensure that those who are sick or could become sick get the treatment they need.

The Committee has already heard a great deal about this bill today, including from Mayor Bloomberg, so I'll keep my remarks limited to a few key issues.

As the Mayor said, this bill achieves two things critical to completing the nation's recovery from 9/11: First, it provides long-term, funding to monitor and treat those who are sick or who could become sick because of 9/11, and continues to fund and expand critical research. Second, the bill reopens the Victim Compensation Fund so that people who were harmed by the terrorist attacks can get compensation fairly and quickly without having to prove that the City, the contractors, or anyone else but the terrorists were at fault.

More than 90,000 (and by some estimates, well more than 100,000) New York City firefighters, police officers, other first responders and recovery workers responded to ground zero and participated in the rescue, recovery and clean-up at ground zero. As the Committee has heard, today, tens of thousands are being monitored and treated for 9/11-related conditions at the Fire Department and the other Centers of Excellence, including at Mt. Sinai Medical Center. Federal funding to meet this critical health need has been ad-hoc, and this bill will finally provide the long-term, sustained funding that is needed to ensure that we care for those who answered the nation's call on 9/11.

And hundreds of thousands of residents, area workers, school children and other community members were directly impacted by the attacks. Although Congress has appropriated money to treat these groups, the only Center of Excellence open to these groups has not yet received any federal funding, and the City of New York is currently paying the entire cost to treat approximately 2,700 patients for WTC-related conditions. As Mayor Bloomberg said, the City has not waited for the federal government to address this unmet need—but this is clearly a national obligation that, under this bill, will finally be met.

We recognize, however, that these are still public dollars and in keeping with Mayor Bloomberg's commitment to fiscal responsibility and accountability this bill incorporates protections to ensure that the funds will go to those who are injured as a result of the terrorist attacks and that the funds will be spent responsibly.

There are, of course, many important provisions in this bill, but I want to say a few words about those controls.

First, the bill defines specific groups (for example, firefighters or recovery workers) and specific geographic areas that people must have been in on, or within a defined time period after 9/11 to be eligible for treatment.

I should note that there is specified funding to treat people outside the designated areas or groups who may—on a case-by-case basis—be eligible for treatment for a 9/11-related condition. This is necessary because we do not know the full extent of the health impacts of the disaster and want to provide a means for anyone sick because of 9/11 to get treatment.

Second, while people who meet these criteria are "eligible" for treatment, to actually get treatment, a doctor with experience treating WTC-related conditions must determine <u>based on a medical examination</u>, that exposure to airborne toxins, trauma or other hazards caused by the 9/11 attacks is substantially likely to be a significant factor causing, contributing to or aggravating the patient's condition.

That assessment must be based in part on standardized questionnaires; and even after a condition is deemed to be WTC-related, it is subject to review and certification by the WTC administrator.

These are tough standards that are based to a large extent on the protocols already in place at the WTC Environmental Health Center in the New York City Health and Hospitals Corporation. They are necessary to ensure that only those who are sick due to 9/11 are treated under this program.

The bill caps the number of responders and community members who can get monitoring or treatment. These limitations are based on the best available information about how many people were exposed and could potentially be ill, and while we think they will be sufficient to provide treatment to anyone who may need it, there are reporting requirements in the bill so that Congress will be told if those caps are approached.

In addition to these controls—which apply to every potential patient—the bill mandates the establishment of Quality Assurance and Fraud Prevention programs that will act as further safeguards against the misuse of these funds for any purpose other than to monitor and treat those affected by the 9/11 attacks.

The bill also includes important provisions to ensure that federal dollars go <u>only to cover costs that the federal government should pay</u>. For example, there is an offset for any Workers'

Compensation payments that have been made. For non-work related conditions, the program acts as the payer of last resort if an eligible recipient has applicable health insurance.

Finally, as Mayor Bloomberg pointed out, under the bill, the City is responsible for paying 5% of the cost of treating anyone treated at a Center of Excellence within the City's Health and Hospitals Corporation (This currently includes all of the residents, area workers and other community members in treatment at a WTC-specific program because it is the only program available for them).

9/11 was an attack on the nation and the obligation to provide treatment for these individuals is a national one—but requiring the City to pay 5% of these costs is an obligation we accept because it ensures that we have a strong incentive to monitor these programs and make sure that these health care dollars are spent wisely.

I want to mention one issue that should be addressed as this bill moves forward. To assist in coordinating the responder and community programs, the bill establishes a Steering Committee for each program that, among other things, will advise the WTC Administrator on what conditions are WTC-related and will assist with outreach to affected populations. The City would like a representative from the Police Department and at least one other responder agency on the Steering Committee for the responder program, and a representative from the Department of Health on both Steering Committees. This representation is critical to ensure that the City agencies whose employees and retirees are affected participate in the administration of the WTC program and that the Department of Health—which is the home of the WTC Health Registry—also has an institutional role.

The bill also ensures that critical 9/11-related research is expanded, and existing efforts, like the World Trade Center Health Registry based in the City's Department of Health, continue. Long-term research is the only way that we're going to be able to develop a full understanding of the Health Impacts of 9/11 and dedicate resources appropriately to treat them.

The Registry is a partnership between the City and the federal government. It is largest effort of its kind in history, with more than 71,000 exposed people in it from every state in the country and from all but 4 Congressional Districts. Over 20 percent of the people in the Registry are from outside the New York Metropolitan region. This is a reflection of the numbers of people from throughout the country who were in New York at the time of the attacks, or who came to New York afterwards.

Finally, this bill will fulfill another core recommendation of Mayor Bloomberg's World Trade Center Health Panel, the urgent need for Congress to reopen the Victim Compensation Fund (VCF).

Between 2001 and 2004, the VCF provided compensation to a combined total of nearly 5,700 victims' families and individuals injured in the attacks.

It was a fair and efficient process that provided a measure of relief to the victims of the attacks and their families.

Now it's imperative that the fund be reauthorized to take care of those who were not eligible to benefit from it before it closed in December 2003. The fact that their injuries have been slower to emerge, or that the initial eligibility criteria were too narrow should not disqualify them from getting the help they need.

The bill also provides indemnity to the City and the contractors for the historic recovery and clean-up that helped bring New York City and the country back after 9/11. And it will make the $1 billion currently in the Captive Insurance Company available to much more quickly pay claims—so that people can be compensated for losses rather than trying to prove that the City, or the contractors, or anyone but the terrorists was responsible for the devastating harm caused by 9/11.

Reopening the Fund would help assure that if another terrorist attack were to take place, our first responders and the private sector could respond with the same purpose and dedication that we saw on 9/11, knowing that their government will always stand by them.

In sum, the Health and Compensation Act of 2008 is a vital lifeline to the men and women who risked everything, and helped lift our nation back onto its feet during our time of greatest need. That's why it has gained the support of New York's Congressional delegation. And it's why Mayor Bloomberg and his Administration are pledging to work with you all and do everything possible to make it a reality.

Thank you for your attention. I'd be happy to answer any questions you might have.

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Mr. PALLONE. Thank you and thank you to all of you. I am going to recognize myself for questions. Initially, I am trying to get one in for each of you in my time, so let me start with Ms. Seminario, and I understand you were actively involved in the drafting of this new version of the bill and I am going to be very parochial on this one.

I am curious about how the changes from the first bill to this one might affect my constituents and the citizens of New Jersey. I mean, I am sure you are aware that many New Jerseyans were affected by the attacks. Most of the people who live in the—and who worked on one of the top floors from—what was it Cantor, they mostly were—most of those people that died were in my district, actually.

So, specifically, the way that you did this with the radius so that it is south of Houston and within one-and-a-half miles of Brooklyn, would the previous bill, in terms of—not first-responders, but the people that actually lived or worked there—would the previous bill have included parts of New Jersey that would not be included the way it has been struck now. I mean, I know now it wouldn't include Staten Island or New Jersey because you have to be Manhattan or Brooklyn. I mean, is there a reason for that and is it because the cloud didn't go over New Jersey or Staten Island? That would be my first question.

And then, with regard to the Centers for Excellence, obviously the site in New Jersey has been very important for the State. Is there any way that the legislation guarantees that we continue to have the site in New Jersey? I am being very parochial here, as you can see. And I also assume that Staten Island is part of New Jersey too, but go ahead.

Ms. SEMINARIO. That is fine. Let me address the first question with respect to the coverage under the bill. From the initial bill, 3543 to this bill, the criteria, essentially for the responders, remained the same, so that didn't change at all, but what did change were some of the criteria with respect to the residents and area workers, those who would be affected by the community program.

The original bill, essentially, set a 2-mile radius from the World Trade Center site as the area in which those who were residents, working and meeting certain criteria would be potentially eligible. It, then, left it to the World Trade Center administrator, working with Bellevue and others in the community to tighten up those criteria to try to determine who, exactly——

Mr. PALLONE. Well, was the 2 miles—would that have included, say, New Jersey and Staten Island?

Ms. SEMINARIO. It would have included Staten Island, definitely, and I believe from my recollection looking at the map, it would have included parts of New Jersey. As far as the present bill, the geographic criteria were changed to make is south of Houston, within lower Manhattan, and a radius of 1-and-a-half miles into Manhattan. That population——

Mr. PALLONE. No, from Brooklyn, I thought.

Ms. SEMINARIO. I am sorry, Brooklyn, correct.

Mr. PALLONE. So what is the justification for that other than the money?

Ms. SEMINARIO. The money was the driver on this because in looking at the bill, it starts with a pool of potentially eligible people from where they live or where they work and with that number being pretty large—Manhattan and the New York area is a very densely populated area. There were a very, very large number of people who it potentially affected. In structuring the bill as an entitlement, that meant that anybody who was in that area, that presented with possibly a World Trade Center related——

Mr. PALLONE. But what I am asking you is, was there some reason to believe that the people in Brooklyn, for example, were affected greatly and those in Staten Island, New Jersey were not?

Ms. SEMINARIO. Yes, in terms of where the cloud went.

Mr. PALLONE. Yes, I mean, that is what I want to know.

Ms. SEMINARIO. We really tried to look at where the greatest exposure was and put those individuals in the area that were in the potentially eligible pool. But we also did—recognizing that there may be other individuals because we don't know who were exposed but aren't in that defined area. We created a contingent fund, and essentially what the bill does is it allows those people to come forward just like anybody else. Come forward and to be evaluated and for a determination made that they have a World Trade Center related condition. The only difference is, essentially, which pocket it gets paid out of. One would be an entitlement. The other is, essentially, a contingent fund that would provide payment for those individuals.

Mr. PALLONE. What I would ask you to do, if you could get back to us and explain this phenomenon of the cloud and how——

Ms. SEMINARIO. Sure.

Mr. PALLONE. It is true that if you are in Brooklyn or Manhattan, you are much more likely to be exposed than somebody that might have been to the west or to the—I don't know, sand house to the south and west, I guess. New Jersey's to the west.

Ms. SEMINARIO. Right, but let me just make——

Mr. PALLONE. If you could get back to us with that.

Ms. SEMINARIO. Be happy. One point, though, as far as the individuals. If they worked in Manhattan, if they worked in that area, they are covered.

Mr. PALLONE. Right, no I——

Ms. SEMINARIO. The only people who aren't are the people who, essentially, were residing outside of that area.

Mr. PALLONE. Right.

Ms. SEMINARIO. They would not——

Mr. PALLONE. Well, you have to give us some information on that.

Ms. SEMINARIO. We would be happy to, and then the next question you asked, just very quickly.

Mr. PALLONE. The center.

Ms. SEMINARIO. The center, yes. The center is specifically covered in the bill as one of the Centers of Excellence. It is established, as a matter of statute, as one of the ongoing Centers of Excellence to provide treatment and care for these individuals.

Mr. PALLONE. The one in New Jersey?

Ms. SEMINARIO. That is correct.

Mr. PALLONE. OK. We will come back. Let me yield to the gentleman from New York. Well, I have more, but we can go back and forth—

Mr. HOLLOWAY. Chairman, do you mind if I just add one or two points on the——

Mr. PALLONE. On that? Sure.

Mr. HOLLOWAY. The radius, as Peg first pointed out, there are categories of people in the bill, including for responders and nonresponders, where if you were downtown working in Manhattan, if you worked on the pile. If you are in those groups, you are covered.

Mr. PALLONE. Right.

Mr. HOLLOWAY. The radius really covers—we were looking at this more from the community perspective and working with Dr. Reibman and HHC we said, OK we have 2,700 people in our program now. Based on who we have seen, where are they falling, what is the scatter plot? What is the reasonable line drawing we can do based on what we know now, recognizing that it is so difficult to draw lines in this context, period. But it is important to note, I think, that those—so that was part of the calculus here. In terms of the cloud, we also, if you look there has been some research done on this.

Mr. PALLONE. Well, I will ask any of you to get back to me in writing on—to respond to that. It may very well be that the literature out there shows that it is primarily people or even exclusively people who were in Manhattan south of Houston and in that radius around Brooklyn, but I just would like to have whatever you have on that to get back to us, and I will yield to the gentleman from New York.

Mr. FOSSELLA. Well, thank you, and I am sorry I missed your testimony, but thank you again for appearing, in particular Mr. Holloway for representing the Mayor's office. Obviously, you heard today, still some skepticism and perhaps some education that still needs to take place regarding what happened on that day and what we need to do to respond.

Evidently, at the core, I think we can easily talk away the money, but clearly, impediment, to getting this legislation passed to date has been the cost. So, to follow up on the Chairman's point, if I am not mistaken it is the research and the science and other, sort of critical, elements that have minimized the scope of this initial area as opposed to, if you will, the broad brush of the first go around—the first iteration of this legislation, is that correct?

And in part, while you still may become eligible, in part it was to move this process forward, given the potential cost, which was clearly an obstacle to getting it beyond where we currently are. Is that a fair point? We have had to strike a compromise, if you will.

Mr. HOLLOWAY. Yes.

Ms. SEMINARIO. Yes. That is absolutely correct and we tried to do that based upon the evidence, based upon the information, based upon what we know.

Mr. FOSSELLA. Right.

Ms. SEMINARIO. We don't know everything, but based upon what we do know, that is how we have tried to structure this bill and come up with something that we think is—it will cover people, but also is reasonable and responsible.

Mr. FOSSELLA. And Dr. Moline, there are people out there who question whether people are really sick because of the Ground Zero toxins. In short and in plain English, what do you say to those who are skeptical?

Dr. MOLINE. I say, come to our clinical center or any of our clinical Centers of Excellence. Come talk to an iron worker who used to climb up 20, 30 flights of stairs, who can barely climb up one. Come meet someone who used to run marathons that can't walk a mile. Come look at someone who used to work two jobs and now has to rely on others. Come see the people that are sick. We have people that have upper and lower respiratory problems, they have gastro esophageal reflux disease. Those are the three main physical categories of diseases, and we have people who have post-traumatic stress disorder and depression.

We have people at Mount Sinai and the Mount Sinai consortium, the Fire Department at Bellevue's program. We have all published and we all have the same numbers, the same diseases, independently arrived at it, everyone has the same types of disorders, and remarkably consistent numbers. The police department did a study. They found 28 percent have abnormal pulmonary function tests. We did a study, exact same number in a much larger group of individuals. The numbers are out there. The diseases are consistent. It is in the medical literature, but they should look at the human faces. They should come meet these responders.

These are people—the average age of our population is about 42, people in the prime of their earning lives. These are people who are in physically demanding jobs who were well on September 10. From September 11 on, they were no longer able to do what they used to do. They were in physically demanding jobs. They were the healthy workers, and now they are ill. They have respiratory problems. They have gastrointestinal problems and they have mental health conditions, and they are suffering, and they continue to suffer.

We have moved into a chronic phase, now. We see people—some have gotten better, some were able to maintain on a variety of medications, the cost of which can be astronomical for many of these folks. Some have not gotten better and some are getting worse and we are also concerned that others will continue to get worse in the future or new diseases.

Mr. FOSSELLA. Let me just thank you for that, and Mr. Holloway, you get the sense of the opposition to this and some of it is, I think, maybe you still need to educate more. For example, the questions come, well, of first-responders—responded, aren't they taken care of? Well, we know by now that it wasn't just—there weren't just first-responders who responded and suffered. The whole group of people, construction workers, iron workers, carpenters, residents, who don't fit the technical definition of a first-responder, who should be treated equally. So you sort of get that issue of, evidently, we still need to educate those who don't seem up to speed on what happened.

But having said that, there is another—the tact is well, why should we do it, I mean the Federal Government? Why should the Federal Government assume this? Aren't there existing programs in place? Aren't there existing compensation programs in place?

Isn't there the family doctor that one can see? Why is it our responsibility, meaning the Federal Government? Mr. Holloway, how would you best address that?

Mr. HOLLOWAY. Well, first I think—and as Mayor Bloomberg testified earlier we think it is beyond doubt and I think Congress' reaction immediately after the attacks, reinforces this in the strongest way possible that 9/11 was an attack on the Nation, that people came from all 50 states. If you look at the registry, which only has 71,000 of the estimated more than 400,000 people who were the most heavily affected by the attacks, but that is still a huge number. They come from every congressional district in the country but four.

The response was immediate and the response was national. The attack was against the Nation and to say that one particular locality should bear the cost, happening to have been the unlucky target of that attack simply is just not—it doesn't make sense.

And so, in terms of conceptualizing it as being a national issue, this includes responders and non-responders, then that means the community, the residents, the schoolchildren, the office workers, the people who were doing what they do in lower Manhattan on 9/11 and after. And those are also the people who, whether they were volunteers or doing other things, who helped to bring the city back and finish the work on the recovery which was historically quick and unprecedented in its nature that way.

And what you see when we have looked at the data is that for those most heavily exposed, that includes about, up to 100,000 or some say even more responders, people who were there doing the work. That includes contractors. But then about 320,000 residents, office workers, community members, that is just within the narrow area of the most heavily exposed in the registry. If you look at the area under the bill, you are talking about approximately 630,000 people and, you know, for the city, and I think really based on the fact that the bill is out and how Congress has acted in the past, there is just no question that this is a national problem.

And the city, though, recognizing that these are—dollars are scarce today in the current economic environment, but this is really a program for over the long run, so it is not a short-term question, but the city is putting in 5 percent of the cost to cover for those treated at HHC. That will cover responders and non-responders because the city recognizes we needed incentives to make sure that these dollars are spent wisely.

Let us just talk about the third thing that you mentioned. What are the other mechanisms? Well, I guess you could describe those as, kind of—you could have health insurance. You could have workers compensation, and the first thing to recognize, and this was not in the earlier version of the bill, is that for workers compensation that has been paid, that is an offset of what would be paid under the bill.

For health insurance, the program acts as the payer of last resort, if a person has health insurance for an injury that is not work related, and so that coverage would cover first. So those mechanisms, to the extent that they will cover, are actually being brought to bear under the bill.

I should note, though, that a lot of people don't have health insurance. The community members at Bellevue—50 percent and up to 60—50 percent or more of people don't have health insurance or they are under insured. Their co-pays and deductibles and what we are trying to do here is make sure that where those gaps exist, we fill them so that people who are injured, because of these attacks on the country, that those gaps are filled. And I think that this bill does that in a responsible way, plus the city has skin in the game, so to speak. The city is on the hook.

Ms. SEMINARIO. Could I——

Mr. PALLONE. Thank you. Sure, go ahead.

Ms. SEMINARIO. I wanted to add to that. I think it is important. We have tried with this revised version, to call upon the other resources that might be available to bear some of the cost.

But that being said, we also think it is really important to structure this program so that first and foremost it is designed in a way that people get the quality care they need, and that is why we developed it and delivered these services through the Centers of Excellence. So there will be an attempt to recoup money. We think it is really important that Dr. Moline and Dr. Reibman and Dr. Prezant have the ability and the program is structured in a way that first and foremost they are able to develop and deliver the services for these people in a timely way and not have to wait for the comp claim to be resolved three years later for that individual or to fight it out with the insurance companies necessarily.

And I just wanted to make that very, very clear and that is why we think it doesn't make sense just to turn this into a health insurance program that people go off to their own doctor who don't have the qualifications and have to fight with them about getting coverage. So it is a hybrid but it is put together that way for a very important reason and that is to take care of those who are sick.

Mr. PALLONE. Dr. Moline.

Dr. MOLINE. And just why shouldn't someone go to their family doctor rather than a center of excellence? I can't tell you how many patients I saw who were treated with antibiotics in the fall of 2001 for a cough, who didn't have a cough that was related to an infection. They had the World Trade Center cough. That was due to inflammation, and if they had gotten appropriate treatment earlier, perhaps they wouldn't have long-term health consequences.

If people are—if their care is fractionated and they are not going to centers, one other critical element will be lost, which is we will never know what exactly has happened to the group of responders who worked at the World Trade Center site because we will never know who got sick where. We won't have a systematic way of collecting it and reporting after our colleagues to better prepare us in the future.

We also are the ones—the centers have seen collectively, literally, 50,000 individuals with World Trade Center exposures. We can treat them. We do a good job. We talk to each other. If someone has seen an unusual condition, we say "hey, have you seen any of these?" Just last month on a conference call that we have we were talking about a potential new condition. That is going to be lost and people won't recognize and know to look for new diseases unless there are centers where this care can be delivered.

Mr. PALLONE. Thank you. Mr. Engel.

Mr. ENGEL. Thank you, Mr. Chairman. Let me start with Dr. Moline. Since you are at Mount Sinai, and I am sure you were here before when I questioned Dr. Gerberding on the fact that Mount Sinai is the largest clinical center in the New York/New Jersey consortium and it was not allocated the original budget request. I am wondering if you would care to comment on that.

Dr. MOLINE. Well, every year we have put in budget requests and we have been able to refine our requests as we have had more experience and we know what our expenses have been for the past time intervals and our budget request that we put in for the fifth year, which we got notice of just yesterday, for a budget year that started July 15, was for about $8½ million less than we asked with the ability to supplement it up by about 25 percent. It wont make us up to the exact amount we asked, but the—we have spent all the money we have been provided and then some. We have to ask for supplemental funds. We have to ask for them every year to cover the costs as the treatment expenses come in.

I would like to be spending a lot more time dealing with the medical aspects rather than the budgetary aspects. We do have an absolute fiduciary responsibility to make sure that we are spending this money wisely, we are spending it on the responders, but it is frustrating to be asked to put in a budget that is based on real numbers and your best estimates and then be given a number that is significantly less with the expectation, come back and ask us if you need more. Well, our track record is such that we know we are going to need more. So it is just a matter of coming in with a budget now that is for one third less than we asked and then having to supplement it when we will need it and it is a matter of, just, which month we will need it in.

Mr. ENGEL. I couldn't agree with you more, and I think we need to keep pushing that point. Let me ask you a question—your take on why it is necessary to make the World Trade Center Medical Monitoring and Treatment Program into a long-term entitlement program rather than just funding it year to year as Congress has done over the past few years. Give us your take on that.

Dr. MOLINE. There are a variety of reasons why long-term funding would be beneficial. Some of the toxins that I was mentioning earlier in my testimony—many of the diseases that may occur are going to take years to manifest so we need a long-term program to ensure monitoring to look for the health effects that may develop so that we can diagnose diseases early and treat them. That is the ultimate goal.

Year to year funding—we never know if we are going to have to send that letter out saying, "I don't have any more money, I am going to have to try to provide you with another physician or another critical center or if I am going to have enough money to treat you." The year to year funding, while we have been absolutely appreciative of all that we have been given, it makes it difficult to run a stable program. People don't necessarily want to come to a place where they might only have a job for a year. Getting a physician credentialed takes a minimum of 3 months. The turn over, the expertise that we have amassed, you don't want to lose that by

having people worried are they going to have a job in 9 months, do I have to start looking for a new position?

But we want to make sure the resources are available, going forward, to take care of all who need the help. We know that these conditions are going to last. People are going to continue to need that medication for asthma or for reflux or their PTSD meds and we don't want to have to worry about, is there going to be enough to cover this med this year and that med that year.

Long-term funding, as an entitlement, would allow people to get the care they need without concern about interruptions and allow the centers to be able to provide that care without worries that we are not going to be able to deliver it in a manner in which the responders deserve.

Mr. ENGEL. Let me ask Ms. Seminario, why does—any relation to Tony Seminario, by the way?

Ms. SEMINARIO. I have been told that he is a distant cousin.

Mr. ENGEL. OK. I served with him in the New York State Assembly many years ago. Why does this bill task NIOSH with the administration of a WTC health program? Isn't that outside the scope of what NIOSH usually does? And let me also ask you if you could explain why there are so many different committees created in this bill.

Ms. SEMINARIO. NIOSH is tasked because they are the agency that stepped up to the plate and actually has the experience in dealing with these problems and so they have been the lead agency. This program started, initially, as a screening program and a monitoring program. And that is exactly what is NIOSH's responsibility under the OSHA law and what they have done under the Mine Safety Law, so they have a long experience in conducting and overseeing monitoring and screening programs.

Those screening programs and monitoring programs found that people were sick, and so they needed to be treated. So now we are in a position where we need programs to provide medical treatment, so NIOSH is tasked with this because they have the expertise in dealing with occupational health problems and that they have been overseeing it, but I think it is important to understand that there is the expectation and it is in the bill itself that NIOSH will work with other agencies and other entities to provide and administer this program. It is provided for in the bill that NIOSH can enter into contracts and arrangements with other agencies, for example, to provide reimbursement for the health costs. And so they could look to a private insurer. They could look to CMS. They could look to the Department of Labor, FICA, workers' comp program that routinely process claims and provide reimbursement for these kind of services.

So that is actually envisioned in the bill, but we want a lead agency that has expertise in the issue and not just an administrative agency that, essentially, is cutting checks for medical care.

With respect to the committees in the bill, there are three committees that are set up under the bill. One is a scientific technical advisory committee to the program administrator that is tasked at looking at the scientific data to make determinations, first of all, if there should be additional diseases added to the list of what are identified World Trade Center related conditions, and also tasked

with looking at the scientific data to see if the eligibility criteria in populations that are covered under the bill should be modified or changed. And so that is a technical committee.

Then there are two committees set up, one for the responder program and one for the community program that, essentially, are advisory committees comprised of providers and the affected communities to help coordinate and oversee the program. The program delivered through the Mount Sinai consortium and the FDNY, the responder program and similar for the community program. There is already an existing committee and the bill builds upon it.

We think it is really, really important that there be mechanisms for those who are affected to have a role and participate in input into the programs that are affecting them, and so these are committees built on, again, the existing model, which are comprised of the providers and those who are affected to look at what is happening, try to coordinate the care and improve it so that those who are affected can get better services.

Mr. PALLONE. Mr. Engel, I am going to—I hesitate to say this but I am actually going to have a second round because I—so, if you want to wait, we will just do a second round. All right. And I don't want to keep people too long, but I have to ask these two additional questions so I am going to recognize myself and then we will go back to the other two members. I will try to put them together, although not related. What I wanted to ask Dr. Moline is if you just tell us a little more about why these Centers of Excellence are so important as opposed—I know you got into it a little, in responding to Congressman Fossella's question about why not just go to your family practitioner—why the expertise and the knowledge is so important.

And then, I wanted to ask Mr. Holloway, after that, I still don't understand how people are treated if they are first-responders versus if they are people that happen to be working there or living in the area. Is there a difference in treatment? Is there a difference in where they go? Because, again, in terms of this being more narrowly focused in the new bill, there may be some—there obviously are going to be more limitations on the people who are not first-responders.

So let me start with you, and you don't have to go on too long, but I just think that we need to have a little more on the record about why these centers are crucial.

Dr. MOLINE. The centers have been in existence since 2002 monitoring the healthcare. We have seen between the Fire Department Center and Mount Sinai Center, and I am speaking for the responder consortium, we have seen 40,000 individuals and monitored their health. About 40 percent of those are in treatment at our centers.

Individuals have complex medical conditions. They have a constellation of findings that we are seeing and also are beginning—we are concerned that there may be new conditions emerging. We have developed the expertise in dealing with the complex physical and mental health conditions that the responders have. They have them together, often. Sixty percent of our folks have more than one World Trade Center related condition and they are getting comprehensive care for all of these conditions at one center that has

seen thousands of other cases similar to this and knows how to develop best practices, find the most cost effective delivery of care and provide the best care possible.

Another critical reason for these Centers of Excellence is the data coordination. We are able to collect the data through these Centers of Excellence using standardized instruments so that we can report out to the public, the medical community and the public at large what we have been able to find. We also can put into place quality assurance programs to make sure that the care is most effective and is most appropriate and also is elastic enough to move to meet the needs as they change over time. And also, through these centers, this is the way we are going to find out what new diseases might be emerging. Without those centers, you are going to lose that ability. You are going to lose the ability to tell whether rates of diseases are increased over the general population.

Mr. PALLONE. All right, that is fine. Thank you, and either Mr. Holloway or Ms. Seminario, you know you have these two defined universes, I guess. One is the first-responders that can be anybody who came there and then the second is, this now more narrowly defined radius or whatever of people who work there, lived in the area, whatever. Is there a difference in terms of where they go or how they are treated now and under the bill? Or they are all treated the same, to where they can go to the same places, they can go to the centers or——

Mr. HOLLOWAY. Well, under the bill they can go to the centers that exist, and by the way the bill also sets criteria to establish additional centers that the point is to make sure that you have the expertise at treating WTC related conditions and the city has actually expanded its program from Bellevue to other HHC facilities, Elmhurst and Gouverneur.

I think it is important to note before drawing distinctions between the programs that there is a lot about them that are the same and everybody works in collaboration to see what are we seeing. Bellevue and the Mount Sinai program and the FDNY work together to develop treatment protocols. They meet all of the time. People who come in, once you are determined to be eligible for the program, you go through and you receive a detailed medical workup and then you are treated and a lot of the conditions that are being seen, there are some variations which is really important and interesting for learning, what are the effects of the attacks, but the respiratory ailments, lower intestinal GERD—I am not a doctor so I am not going to go too deeply into that except to say that a lot of the things that are seen are the same.

In terms of the mechanics of the programs, there are some differences right now. The Mount Sinai FDNY programs—first if you are in the FDNY you are eligible for the program. About 95 percent, or more, of FDNY active members who and retired members, who came and worked on the site, are now in that program. They have had an incredible rate of retention for both monitoring and treatment, so they are monitored on a cyclical basis.

For the community program the standards are a little different in terms of getting in. You present with a symptom and then once you are in, you are monitored periodically and then you are treated. And what they have found is about one-third get well, about

one-third will probably be there for the long-term and then one-third will be there over some medium period, but Dr. Reibman is also here.

Mr. PALLONE. What I guess I am trying to say—maybe I should ask you. Let me give you an example, I live in my hometown, Long Branch, New Jersey, OK. I may have been working in the World Trade Center on the day, on 9/11, or I may have left the Fire Department at Long Branch and went up there to help for a week or two. In either case, under this legislation, can I go to the place at Rutgers and be treated or what if I am in San Francisco and I am in one or two of those categories, where do I go?

Ms. SEMINARIO. That is a very good question. The way the program is structured right now is it builds on what exists, and so for the responders, what that means is the program at FDNY in the Mount Sinai consortium is the base program, all right? For the community, for people who are not in the responder population, the base program is the World Trade Center Environmental Health Center at Bellevue. But what the program—and then also there is provisions in the bill to have a program of national providers for those individuals who are outside the New York/New Jersey area where the program administrator essentially designates and finds providers that have the qualifications, who have expertise in these kinds of diseases and they become designated providers that participate in the program.

The bill also provides for the program administrator to add additional clinical Centers of Excellences to these base programs. So, in moving forward, the bill provides for the head of the program to say "well we don't have enough capacity here at Bellevue because this program is growing and we have also got a number of individuals who are in this area who are, they are living in Staten Island, so we want to start a center there." And so, again, the bill uses the bases that are established but it doesn't limit it to this.

Mr. PALLONE. In other words, just to get going back to my example, if I am in Long Branch, New Jersey and I was working at the World Trade Center on 9/11 or I went there as a fireman for a week or two, I can definitely go to the Rutgers center, right, in either case?

Ms. SEMINARIO. Yes, right.

Mr. PALLONE. And if I am in San Francisco and I happen to have work there and move to San Francisco or first-responded and moved to San Francisco I could certainly travel back to the New York/New Jersey metropolitan area, but if I can't do that, you are going to have somebody in San Francisco that would be, hopefully, eligible to take me and attend to my concerns.

Ms. SEMINARIO. Yes, absolutely, and that was one of the questions that was raised by Representative Capps as a concern in California. One of the frustrations in the current system is that HHS has been very, very slow to get that national program up and going. There was a system of clinics that were in place, trying to provide some of these services, but it was recognized it needed to be more robust and wide spread and it is only in the last couple of weeks that, finally, a contract has been let to provide those services. So this is an area that really needs to be expanded under the

legislation, and actually needs to be expanded under the current program, as well.

Mr. PALLONE. OK, thank you. Do you have any questions?

Mr. FOSSELLA. Yes, again, just to dispel the notion that it is concentrated exclusively in New York City, and or New Jersey, for example. And ironically, those who may be skeptical of the legislation are the ones whose constituents will probably suffer the most. By that I mean the reference to just go see a family doctor. If you are in the middle of California or in the middle of Texas and you went and responded and you are suffering just as someone else was suffering, say who lives in Staten Island, who has access to some of the programs that exist in New York City, or live in New Jersey and have access to Rutgers, but if you are in the middle of Texas, you are on your own, or more likely that you are on your own. You go to see a family doctor and they may treat you with antibiotics, not knowing the true harm that is being done to one's body.

I would like you just to, for the record, let me know as a healthcare professional—anyone else? I know Cas, you are not, but—is that something that we should consider as this national scope as Ms. Capps pointed out earlier, and others who may be unaware of the implications of their own constituent's plight.

Dr. MOLINE. Well I think one of the points you raise is that going to your family physician, if you are outside the New York area, they may not even know to ask. And that is something that we hope to do a better job of providing continuing education and actually have been asked by NIOSH to develop some medical education materials that we can provide throughout the country through various venues, so that providers throughout the country will have a better understanding of World Trade Center related health effects through our New York/New Jersey Education and Research Center, which we will be doing in the next several months to make sure that there is greater awareness of the healthcare problems.

But we do need, for the national responders, those who aren't living in the metropolitan area, to have a place they can go to where they are, essentially, satellites of our Centers of Excellence. They are using similar diagnostic tools. They have ways of finding out what may—what to look for, and how they should be treated. What are the best practices? There has to be a robust program that isn't piecemeal, that isn't stopped and started, switched—you can go here, but wait you have to wait awhile to get in treatment. You responded, you came to New York City from, whether it was from a construction site on 23rd Street in Manhattan or from San Francisco as part of a USAR team. You came, you responded, everyone should be able to have access to the same type of healthcare regardless of their environment. And it is important that the national program—there is a national program that is tied in, very closely, to the metropolitan area program that provides the same level of care as those folks in New York are able to get.

Ms. SEMINARIO. Could I just add to that? I think over time this is going to become more important because as people age and these health problems continue and they retire and they move—I mean there is mobility in the population, and so insuring that there is a very high quality national program and that people know how to access it, that we don't keep it secret as to who these providers are,

so that people have some knowledge and they also have some confidence that when they go to those providers, they are going to get care that is going to be part of the integrated care—an overall program is really, really critical and important, and that hasn't happened to date.

Mr. HOLLOWAY. And to add an additional detail—I mean, we know from the Fire Department, the Police Department, the agencies that responded that those populations migrate toward retirement. A lot stay in the area, but as, I am sure you know, they move all over the place—down to Florida and other places and 15,000 people have retired in the Police Department who actually are in the World Trade Center database at the Department, of the 34,000 who participated in some way in the operations, so this is critically important for the city, as well.

Mr. PALLONE. Mr. Engel.

Mr. ENGEL. Thank you, Mr. Chairman. I just have two questions. Let me start with Mr. Holloway. You heard Mr. Nadler's testimony and I said in my opening statement that I was persuaded that, while we need to, obviously, help the first-responders the greatest way we can, there are community people who were told, erroneously, that the air quality was fine after the days of 9/11 and stayed in the community and may not even know that they are going to get sick in the future.

There is a cap of 35,000 people on the number of new community members who can come into the program. I am concerned about that. I would like your take on that. Do you think it is enough, not enough? How do you explain the number? I know we are all trying to keep costs down, but it just would seem to me if someone is legitimately sick, as a result of breathing in that air, why would we devise a program to deny them, at some point, if they get sick after the cap has—the number of people—the claims have happened.

I mean, we really just don't know. Some people have gotten sick immediately. Some people have gotten sick many years later and we don't know, in years to come, if people will get sick and I am very troubled by formulas that keep people out of a system who are legitimately—who have legitimately gotten sick as a result of 9/11.

Mr. HOLLOWAY. Let me start by saying, as I noted earlier, line drawing and making limitations in this context is clearly a very difficult thing to do. I think what the city tried to do, in working with people here and all of the people who have been working on this bill is to say, "well what do we know now and can we reasonably make an estimation to set this kind of a limitation." And so, let me just talk a little bit about what we did.

Building on a methodology we used in the Mayor's report, which—and I can—we did a full write up on this, which I will make sure I circulate so that the whole members of the committee can get it. We looked at——

Mr. PALLONE. If the gentleman would yield. I mean, I have to admit guilt or responsibility here because you should know that, the leadership of the committee, we obviously asked them to cut back on the cost, so you understand that they are trying to address this because we told them that they have to. I just want you to know that.

Mr. ENGEL. No, I know and I am sympathetic if we are going to sell this program to the rest of the country and the rest of the Congress, we need to be mindful of trying to cut back on costs I certainly am, but my difficulty and my problem is that we are really going into uncharted waters here and we really just don't know how many people have gotten sick immediately and how many people have yet to get sick.

And my concern is that there seems to be a lack of flexibility in terms of people who are legitimately sick as a result of 9/11, of being shut out of the process. I mean, I fully understand that we don't want to give help to everyone who may claim that they are ill as a result of 9/11, when, indeed, some people may not have been ill as a result of 9/11, but conversely we don't want to shut anybody out who may get sick years down the road, so that is the point I was——

Mr. PALLONE. No, I agree, and if the gentleman would yield. I mean, I want you to tell us how you figured this out, but I also think that in the same way that I asked you to give us some background on the radius and how you decided to make it Brooklyn and Manhattan that maybe you could give us some written information. Because the kinds of questions that Mr. Engel are asking are going to be asked by everybody as we move forward. How did we get to these caps? How did we limit the radius, but go ahead.

Mr. HOLLOWAY. Absolutely, so I will be very brief, just a few sentences. We looked, and by we I mean Dr. Reibman, Dr. Prezant, health experts on the city side, looked at what are the rates that we are seeing for treatment in the—what do we know from the World Trade Center registry? What are the rates that we are seeing, in terms of in the underlying population, make some assumptions about how many of those people—how many of who are where the prevalence is there. How many of those people would actually present for treatment? And it is a methodology that, clearly, is based on a set of assumptions, and it is challenging to do, but I will send a full analysis of how we did it.

There is a method to that number that we looked at the entire group of who would be eligible, potentially, under the New York City Disaster Area defined in the bill, and then walk through each of the conditions and made a series of assumptions. I will make sure you get that.

I want to also note, importantly, though the overall goal is to make sure that nobody, whether you are inside those areas, because that is another problem—issue with the bill, not a problem with the bill. It is line drawing and what if you are outside? What if you are north of Houston Street? Is that—are you shut out? The short answer to that is, there is a mechanism for you if you have a WTC-related condition that you are diagnosed with, to get treated, there is this defined fund. So that is a safety valve in the bill, and then there are reporting requirements.

We could be wrong, you know we made assumptions and came up with an estimate that is reflected in the bill, but there are also reporting requirements in the bill. There is an annual reporting requirement on the program, who is being treated, how many people. And then the administrator is required to report to Congress if we hit or exceed 80 percent of the caps in the bill and then we are

going to need to address that because we could be off. There is no question about it.

Mr. ENGEL. Thank you. Thank you, Mr. Chairman.

Mr. PALLONE. I just wanted to say, again, I know I am not—maybe I am prolonging this unnecessarily, but, obviously all of us who represent the New York metropolitan area, at some point, are going to have to agree on some kind of consensus as to the radius and the numbers. And that is not going to be an easy thing. I know it wasn't an easy thing for Carolyn and Jerry Nadler to agree on in presenting this bill. But this is part of the consensus that we are going to have to work on over the August recess. I would like to, if we can, come to a consensus that when we come back in September, we can all sign off and say, "look, this is what we can live with, and this is what will sell, financially, as well as in terms of covering people the way they should be."

It is not an easy task and I appreciate the fact that all of you have been involved in this, and helped us get to where we are today. But it is important that we do this and come to a consensus that we can all agree on and that we do it as quickly as possible if we are going to move something before the session ends, so I just want to thank you all again. You have done a great job, you really have.

We appreciate it and we have a process whereby we may submit additional questions to you. You should hear—if we have any you will probably get those within the next 10 days so that you can respond and the clerk would notify you of those procedures. But, again, thank you again and without objection, this meeting of the subcommittee is adjourned.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

New York Times

July 11, 2008

Editorial

A Pointless Departure

Just why John Howard was denied reappointment as head of the National Institute for Occupational Safety and Health is a mystery that deserves to be cleared up. But whatever the reasons for it, the timing of his departure — in the waning months of the Bush administration — could hardly have been worse. Programs often slip badly as an administration winds down, and we fear that without Dr. Howard's leadership, the agency's exemplary work on behalf of ground zero workers will stall.

Dr. Howard's six-year term as director of the institute, part of the Centers for Disease Control and Prevention within the Department of Health and Human Services, expires on Monday. He had asked to be reappointed, but just before the long July Fourth weekend Dr. Julie Gerberding, director of the disease control centers, let him know that she was beginning a search for a new director.

Dr. Howard has gained particular renown over the past two years for coordinating and championing health programs for workers who were sickened at ground zero, including screening, monitoring and treatment.

Both the A.F.L.-C.I.O. and the Chamber of Commerce urged his reappointment, at least on an interim basis. So did the American Society of Safety Engineers and the American Industrial Hygiene Association, which called him "the most respected leader in NIOSH's history." Several House members from New York, both of New York's senators and the state's governor, David Paterson, all want Dr. Howard kept on.

Some members of Congress believe that the White House or the health and human services secretary, Michael Leavitt, wanted him out because he was pushing for 9/11 health programs that they deemed too costly. Others believe that he simply ran afoul of Dr. Gerberding, who had tried to oust him in a reorganization plan four years ago but failed.

A C.D.C. spokesman's explanation — that Dr. Gerberding had decided to "go in a different direction" — makes no sense with so little time left to go in any new direction. Surely it would make more sense to reinstate Dr. Howard for the rest of this year so that he can continue his important work. Then the next president could decide whether to give him another six-year term.

I

110TH CONGRESS
2D SESSION

H. R. 6594

To amend the Public Health Service Act to extend and improve protections and services to individuals directly impacted by the terrorist attack in New York City on September 11, 2001, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 24, 2008

Mrs. MALONEY of New York (for herself, Mr. NADLER, Mr. FOSSELLA, Mr. KING of New York, Mr. RANGEL, Mr. ENGEL, Mr. TOWNS, and Mr. WEINER) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on the Judiciary and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Public Health Service Act to extend and improve protections and services to individuals directly impacted by the terrorist attack in New York City on September 11, 2001, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 "James Zadroga 9/11 Health and Compensation Act of
6 2008".

1 (b) TABLE OF CONTENTS.—The table of contents of
2 this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Findings.
Sec. 3. Emergency funding.

TITLE I—WORLD TRADE CENTER HEALTH PROGRAM

Sec. 101. World Trade Center Health Program.

"TITLE XXX—WORLD TRADE CENTER HEALTH PROGRAM

"Subtitle A—Establishment of Program; Advisory and Steering Committees

"Sec. 3001. Establishment of World Trade Center Health Program within NIOSH.
"Sec. 3002. WTC Health Program Scientific/Technical Advisory Committee.
"Sec. 3003. WTC Health Program Steering Committees.
"Sec. 3004. Community education and outreach.
"Sec. 3005. Uniform data collection.
"Sec. 3006. Centers of excellence.
"Sec. 3007. Programs regarding attack at Pentagon.
"Sec. 3008. Entitlement authorities.
"Sec. 3009. Definitions.

"Subtitle B—Program of Monitoring and Treatment

"PART 1—FOR WTC RESPONDERS

"Sec. 3011. Identification of eligible WTC responders and provision of WTC-related monitoring services.
"Sec. 3012. Treatment of eligible WTC responders for WTC-related health conditions.

"PART 2—COMMUNITY PROGRAM

"Sec. 3021. Identification of eligible WTC residents and other non-responders and provision of WTC-related monitoring services.
"Sec. 3022. Treatment of eligible WTC residents and other non-responders for WTC-related health conditions.
"Sec. 3023. Treatment of other individuals with WTC-related health conditions.

"PART 3—NATIONAL ARRANGEMENT FOR BENEFITS FOR ELIGIBLE INDIVIDUALS OUTSIDE NEW YORK

"Sec. 3031. National arrangement for benefits for eligible individuals outside New York.

"Subtitle C—Research Into Conditions

"Sec. 3041. Research regarding certain health conditions related to September 11 terrorist attacks in New York City.

"Subtitle D—Programs of the New York City Department of Health and Mental Hygiene

"Sec. 3051. World Trade Center Health Registry.
"Sec. 3052. Mental health services.

TITLE II—SEPTEMBER 11 VICTIM COMPENSATION FUND OF 2001

Sec. 201. Deadline extension for certain claims under September 11 Victim Compensation Fund of 2001.
Sec. 202. Exception to single claim requirement in certain circumstances.
Sec. 203. Immediate aftermath defined.
Sec. 204. Eligible individuals to include eligible WTC responders and eligible WTC residents and other non-responders.
Sec. 205. Limited coverage for additional individuals.
Sec. 206. World Trade Center collapse and disaster rescue, recovery, debris removal, cleanup, remediation, and response indemnification.

1 **SEC. 2. FINDINGS.**

2 Congress finds the following:

3 (1) Thousands of rescue workers who responded
4 to the areas devastated by the terrorist attacks of
5 September 11, local residents, office and area work-
6 ers, and school children continue to suffer significant
7 medical problems as a result of compromised air
8 quality and the release of other toxins from the at-
9 tack sites.

10 (2) In a September 2006 peer-reviewed study
11 conducted by the World Trade Center Medical Moni-
12 toring Program, of 9,500 World Trade Center re-
13 sponders, almost 70 percent of World Trade Center
14 responders had a new or worsened respiratory symp-
15 tom that developed during or after their time work-
16 ing at the World Trade Center; among the respond-
17 ers who were asymptomatic before 9/11, 61 percent
18 developed respiratory symptoms while working at the

1 World Trade Center; close to 60 percent still had a
2 new or worsened respiratory symptom at the time of
3 their examination; one-third had abnormal pul-
4 monary function tests; and severe respiratory condi-
5 tions including pneumonia were significantly more
6 common in the 6 months after 9/11 than in the
7 prior 6 months.

8 (3) An April 2006 study documented that, on
9 average, a New York City firefighter who responded
10 to the World Trade Center has experienced a loss of
11 12 years of lung capacity.

12 (4) A peer-reviewed study of residents who lived
13 near the World Trade Center titled "The World
14 Trade Center Residents' Respiratory Health Study:
15 New Onset Respiratory Symptoms and Pulmonary
16 Function", found that data demonstrated a three
17 fold increase in new-onset, persistent lower res-
18 piratory symptoms in residents near the former
19 World Trade Center as compared to a control popu-
20 lation.

21 (5) Previous research on the health impacts of
22 the devastation caused by the September 11 terrorist
23 attacks has shown relationships between the air
24 quality from Ground Zero and a host of health im-
25 pacts, including lower pregnancy rates, higher rates

of respiratory and lung disorders, and a variety of post-disaster mental health conditions (including posttraumatic stress disorder) in workers and residents near Ground Zero.

(6) A variety of tests conducted by independent scientists have concluded that significant WTC contamination settled in indoor environments surrounding the disaster site. The Environmental Protection Agency's (EPA) cleanup programs for indoor residential spaces, in 2003 and 2005, though limited, are an acknowledgement that indoor contamination continued after the WTC attacks.

(7) The United States Geological Survey (USGS) reported on November 27, 2001 that certain outdoor dust samples collected by the agency in September 2001 at Varick and Houston Streets (approximately 1.2 miles north of Ground Zero) registered higher than 11 on the pH scale, a level the USGS characterized as being "as caustic as liquid drain cleaners".

(8) According to both the EPA's own Inspector General's (EPA IG) report of August 21, 2003 and General Accountability Offices's (GAO) report of September 2007, no comprehensive program has ever been conducted in order to characterize the full

1 extent of WTC contamination, and therefore the full
2 impact of that contamination—geographic or other-
3 wise—remains unknown.
4 (9) Such reports found that there has never
5 been a comprehensive program to remediate WTC
6 toxins from indoor spaces. Thus, area residents,
7 workers and students may continued to be exposed
8 to WTC contamination in their homes, workplaces
9 and schools.
10 (10) Because of the failure to release federally
11 appropriated funds for community care, a lack of
12 sufficient outreach, the fact that many community
13 members are receiving care from physicians outside
14 the current City-funded World Trade Center Envi-
15 ronmental Health Center program and thus fall out-
16 side data collection efforts, and other factors, the
17 number of community members being treated at the
18 World Trade Center Environmental Health Center
19 underrepresents the total number in the community
20 that have been affected by exposure to Ground Zero
21 toxins.
22 (11) Research by Columbia University's Center
23 for Children's Environmental Health has shown neg-
24 ative health effects on babies born to women living

1 within 2 miles of the World Trade Center in the
2 month following 9/11.
3 (12) Federal funding allocated for the moni-
4 toring of rescue workers' health is not sufficient to
5 ensure the long-term study of health impacts of Sep-
6 tember 11.
7 (13) A significant portion of those who have de-
8 veloped health problems as result of exposures to
9 airborne toxins or other hazards resulting from the
10 September 11, 2001, attacks on the World Trade
11 Center have no health insurance, have lost their
12 health insurance as a result of the attacks, or have
13 inadequate health insurance.
14 (14) The Federal program to provide medical
15 treatments to those who responded to the September
16 11 aftermath, and who continue to experience health
17 problems as a result, was finally established more
18 than five years after the attacks, but has no certain
19 long-term funding.
20 (15) Rescue workers and volunteers seeking
21 workers compensation have reported that their appli-
22 cations have been denied, delayed for months, or re-
23 directed, instead of receiving assistance in a timely
24 and supportive manner.

1 (16) A February 2007 report released by the
2 City of New York estimated that approximately
3 410,000 people were the most heavily exposed to the
4 environmental hazards and trauma of the September
5 11 terrorist attacks. More than 30 percent of the
6 Fire Department of the City of New York first re-
7 sponders were still experiencing some respiratory
8 symptoms more than five years after the attacks and
9 according to the report, 59 percent of those seen by
10 the WTC Environmental Health Center at Bellevue
11 Hospital (which serves non-responders) are without
12 insurance and 65 percent have incomes less than
13 $15,000 per year. The report also found a need to
14 continue and expand mental health services.
15 (17) Since the 5th anniversary of the attack
16 (September 11, 2006), hundreds of workers a month
17 have been signing up with the monitoring and treat-
18 ment programs.
19 (18) In April 2008, the Department of Health
20 and Human Services reported to Congress that in
21 fiscal year 2007 11,359 patients received medical
22 treatment in the existing WTC Responder Medical
23 and Treatment program for WTC-related health
24 problems, and that number of responders who need

1 treatment and the severity of health problems is ex-
2 pected to increase.
3 (19) The September 11 Victim Compensation
4 Fund of 2001 was established to provide compensa-
5 tion to individuals who were physically injured or
6 killed as a result of the terrorist-related aircraft
7 crashes of September 11, 2001.
8 (20) The deadline for filing claims for com-
9 pensation under the Victim Compensation Fund was
10 December 22, 2003.
11 (21) Some individuals did not know they were
12 eligible to file claims for compensation for injuries or
13 did not know they had suffered physical harm as a
14 result of the terrorist-related aircraft crashes until
15 after the December 22, 2003, deadline.
16 (22) Further research is needed to evaluate
17 more comprehensively the extent of the health im-
18 pacts of September 11, including research for
19 emerging health problems such as cancer, which
20 have been predicted.
21 (23) Research is needed regarding possible
22 treatment for the illnesses and injuries of September
23 11.
24 (24) The Federal response to medical and fi-
25 nancial issues arising from the September 11 re-

1 sponse efforts needs a comprehensive, coordinated
2 long-term response in order to meet the needs of all
3 the individuals who were exposed to the toxins of
4 Ground Zero and are suffering health problems from
5 the disaster.

6 (25) The failure to extend the appointment of
7 Dr. John Howard as Director of the National Insti-
8 tute for Occupational Safety and Health in July
9 2008 is not in the interests of the administration of
10 such Institute nor the continued operation of the
11 World Trade Center Medical Monitoring and Treat-
12 ment Program which he has headed, and the Sec-
13 retary of Health and Human Services should recon-
14 sider extending such appointment.

15 **SEC. 3. EMERGENCY FUNDING.**

16 Amounts appropriated pursuant to this Act (other
17 than amounts appropriated for the WTC Health Program
18 Steering Committees or for the WTC Health Program Sci-
19 entific/Technical Advisory Committee) are designated as
20 emergency requirements and necessary to meet emergency
21 needs pursuant to section 204(a) of S. Con. Res. 21
22 (110th Congress) and section 301(b)(2) of S. Con. Res.
23 70 (110th Congress), the concurrent resolutions on the
24 budget for fiscal years 2008 and 2009.

TITLE I—WORLD TRADE CENTER HEALTH PROGRAM

SEC. 101. WORLD TRADE CENTER HEALTH PROGRAM.

The Public Health Service Act is amended by adding at the end the following new title:

"TITLE XXX—WORLD TRADE CENTER HEALTH PROGRAM

"Subtitle A—Establishment of Program; Advisory and Steering Committees

"SEC. 3001. ESTABLISHMENT OF WORLD TRADE CENTER HEALTH PROGRAM WITHIN NIOSH.

"(a) IN GENERAL.—There is hereby established within the National Institute for Occupational Safety and Health a program to be known as the 'World Trade Center Health Program' (in this title referred to as the 'WTC program') to provide medical monitoring and treatment benefits—

"(1) to eligible emergency responders and recovery and clean-up workers (including those who are Federal employees) who responded to the September 11, 2001, terrorist attacks on the World Trade Center; and

"(2) to residents and other building occupants and area workers in New York City who were di-

1 rectly impacted and adversely affected by such at-
2 tacks.
3 "(b) COMPONENTS OF PROGRAM.—The WTC pro-
4 gram includes the following components:
5 "(1) MEDICAL MONITORING.—Medical moni-
6 toring under sections 3011 and 3021, including
7 screening, clinical examinations, and long-term
8 health monitoring and analysis for individuals who
9 were likely to have been exposed to airborne toxins
10 that were released, or to other hazards, as a result
11 of the September 11, 2001, terrorist attacks on the
12 World Trade Center.
13 "(2) TREATMENT FOR WTC-RELATED CONDI-
14 TIONS.—Provision under sections 3012, 3022, and
15 3023 of treatment and payment, subject to the pro-
16 visions of subsection (d), for all medically necessary
17 health and mental health care expenses (including
18 necessary prescription drugs) of individuals with a
19 WTC-related health condition.
20 "(3) OUTREACH.—Establishment under section
21 3004 of an outreach program to potentially eligible
22 individuals concerning the benefits under this title.
23 "(4) UNIFORM DATA COLLECTION.—Collection
24 under section 3005 of health and mental health data

1 on individuals receiving monitoring or treatment
2 benefits, using a uniform system of data collection.
3 "(5) RESEARCH ON WTC CONDITIONS.—Estab-
4 lishment under subtitle C of a research program on
5 health conditions resulting from the September 11,
6 2001, terrorist attacks on the World Trade Center.
7 "(c) NO COST-SHARING.—Monitoring and treatment
8 benefits are provided under subtitle B without any
9 deductibles, copayments, or other cost-sharing to an eligi-
10 ble WTC responder or any eligible WTC resident or other
11 non-responder.
12 "(d) PAYOR.—
13 "(1) IN GENERAL.—Except as provided in para-
14 graphs (2) and (3), the cost of monitoring and treat-
15 ment benefits provided under subtitle B shall be
16 paid for by the WTC program.
17 "(2) WORKERS' COMPENSATION PAYMENT.—
18 Payment for treatment under subtitle B of a WTC-
19 related condition in an individual that is work-re-
20 lated shall be reduced or recouped to the extent that
21 a payment is made under a workers' compensation
22 law or plan of the United States or a State for such
23 treatment.
24 "(3) HEALTH INSURANCE COVERAGE.—

1 "(A) IN GENERAL.—If an individual has a
2 WTC-related condition that is not work-related
3 and has health coverage for such condition
4 through any public or private health plan, the
5 WTC program shall be secondary payor with
6 respect to the payment for items and services
7 for such condition to the extent such items and
8 services are covered under such plan and such
9 plan has an arrangement with the health care
10 provider or facility allowing such payment.
11 "(B) BILLING HEALTH PLAN.—In the case
12 described in subparagraph (A), the Clinical
13 Center of Excellence providing the items or
14 services involved shall bill the public or private
15 health plan for such items or services. The
16 health plan shall be responsible for payment for
17 such items or services to the extent that the
18 health plan has or had a responsibility under
19 the terms of coverage of that health plan to
20 make such payment with respect to such items
21 or services. If the health plan refuses to make
22 such payment to such Clinical Center, the WTC
23 Program Administrator shall seek to recover
24 such payment with respect to the item or serv-
25 ice involved to the extent it is demonstrated

1 that the health plan has or had a responsibility
2 to make payment with respect to such item or
3 service.
4 "(C) REMAINING COSTS UNDER TITLE.—
5 Any costs for such covered items and services
6 that are not reimbursed by such health plan,
7 due to the application of deductibles, copay-
8 ments, coinsurance, other cost-sharing, or oth-
9 erwise, are reimbursable under this title to the
10 extent that they are covered under the WTC
11 program.
12 "(4) WORK-RELATED DESCRIBED.—For the
13 purposes of this subsection, a WTC-related condition
14 diagnosed in an eligible WTC responder, or in an in-
15 dividual who qualifies as an eligible WTC resident or
16 other non-responder on the basis of being a rescue,
17 recovery, clean-up worker, or area worker, shall be
18 treated as a condition that is work-related.
19 "(e) QUALITY ASSURANCE AND MONITORING OF
20 CLINICAL EXPENDITURES.—
21 "(1) QUALITY ASSURANCE.—The WTC Pro-
22 gram Administrator working with the Clinical Cen-
23 ters of Excellence shall develop and implement a
24 quality assurance program for the medical moni-
25 toring and treatment delivered by such Centers of

1 Excellence and any other participating health care
2 providers.
3 "(2) FRAUD PREVENTION.—The WTC Program
4 Administrator shall develop and implement a pro-
5 gram to review the program's health care expendi-
6 tures to detect fraudulent or duplicate billing and
7 payment for inappropriate services. Such program
8 shall be similar to current methods used in connec-
9 tion with the Medicare program under title XVIII of
10 the Social Security Act. This title is a Federal
11 health care program (as defined in section 1128B(f)
12 of such Act) and is a health plan (as defined in sec-
13 tion 1128C(c) of such Act) for purposes of applying
14 sections 1128 through 1128E of such Act.
15 "(f) WTC PROGRAM ADMINISTRATION.—The WTC
16 program shall be administered by the Director of the Na-
17 tional Institute for Occupational Safety and Health, or a
18 designee of such Director.
19 "(g) ANNUAL PROGRAM REPORT.—
20 "(1) IN GENERAL.—Not later than 6 months
21 after the end of each fiscal year in which the WTC
22 program is in operation, the WTC Program Admin-
23 istrator shall submit an annual report to the Con-
24 gress on the operations of this title for such fiscal

1 year and for the entire period of operation of the
2 program.
3 "(2) CONTENTS OF REPORT.—Each annual re-
4 port under paragraph (1) shall include the following:
5 "(A) ELIGIBLE INDIVIDUALS.—Informa-
6 tion for each clinical program described in para-
7 graph (3)—
8 "(i) on the number of individuals who
9 applied for certification under subtitle B
10 and the number of such individuals who
11 were so certified;
12 "(ii) of the individuals who were cer-
13 tified, on the number who received medical
14 monitoring under the program and the
15 number of such individuals who received
16 medical treatment under the program;
17 "(iii) with respect to individuals so
18 certified who received such treatment, on
19 the WTC-related health conditions for
20 which they were treated; and
21 "(iv) on the projected number of indi-
22 viduals who will be certified under subtitle
23 B in the succeeding fiscal year.

1 "(B) MONITORING AND TREATMENT
2 COSTS.—For each clinical program so de-
3 scribed—
4 "(i) information on the costs of moni-
5 toring and the costs of treatment and on
6 the estimated costs of such monitoring and
7 treatment in the succeeding fiscal year;
8 and
9 "(ii) an estimate of the cost of med-
10 ical treatment for WTC-related conditions
11 that have been paid for or reimbursed by
12 workers' compensation, by public or private
13 health plans, or by the City of New York
14 under section 3012(c)(4).
15 "(C) ADMINISTRATIVE COSTS.—Informa-
16 tion on the cost of administering the program,
17 including costs of program support, data collec-
18 tion and analysis, and research conducted under
19 the program.
20 "(D) ADMINISTRATIVE EXPERIENCE.—In-
21 formation on the administrative performance of
22 the program, including—
23 "(i) the performance of the program
24 in providing timely evaluation of and treat-
25 ment to eligible individuals; and

1 "(ii) a list of the Clinical Centers of
2 Excellence and other providers that are
3 participating in the program.
4 "(E) SCIENTIFIC REPORTS.—A summary
5 of the findings of any new scientific reports or
6 studies on the health effects associated with
7 WTC center exposures.
8 "(F) ADVISORY COMMITTEE REC-
9 OMMENDATIONS.—A list of recommendations by
10 the WTC Scientific/Technical Advisory Com-
11 mittee on additional WTC program eligibility
12 criteria and on additional WTC-related health
13 conditions and the action of the WTC Program
14 Administrator concerning each such rec-
15 ommendation.
16 "(G) RESEARCH RESULTS.—The findings
17 research conducted under section 3041(a).
18 "(3) SEPARATE CLINICAL PROGRAMS DE-
19 SCRIBED.—In paragraph (2), each of the following
20 shall be treated as a separate clinical program of the
21 WTC program:
22 "(A) FDNY RESPONDERS.—The benefits
23 provided for eligible WTC responders described
24 in section 3006(b)(1)(A).

1 "(B) OTHER ELIGIBLE WTC RESPOND-
2 ERS.—The benefits provided for eligible WTC
3 responders not described in subparagraph (A).
4 "(C) ELIGIBLE WTC RESIDENTS AND
5 OTHER NON-RESPONDERS.—The benefits pro-
6 vided for eligible WTC residents and other non-
7 responders.
8 "(h) NOTIFICATION TO CONGRESS WHEN REACH 80
9 PERCENT OF ELIGIBILITY NUMERICAL LIMITS.—The
10 WTC Program Administrator shall promptly notify the
11 Congress—
12 "(1) when the number of certifications for eligi-
13 ble WTC responders subject to the limit established
14 under section 3011(a)(5) has reached 80 percent of
15 such limit; and
16 "(2) when the number of certifications for eligi-
17 ble WTC residents or other non-responders subject
18 to the limit established under section 3021(a)(5) has
19 reached 80 percent of such limit.
20 **"SEC. 3002. WTC HEALTH PROGRAM SCIENTIFIC/TECH-**
21 **NICAL ADVISORY COMMITTEE.**
22 "(a) ESTABLISHMENT.—The WTC Program Admin-
23 istrator shall establish an advisory committee to be known
24 as the WTC Health Program Scientific/Technical Advisory
25 Committee (in this section referred to as the 'Advisory

1 Committee') to review scientific and medical evidence and
2 to make recommendations to the Administrator on addi-
3 tional WTC program eligibility criteria and on additional
4 WTC-related health conditions.

5 "(b) COMPOSITION.—The WTC Program Adminis-
6 trator shall appoint the members of the Advisory Com-
7 mittee and shall include at least—

8 "(1) 4 occupational physicians, at least two of
9 whom have experience treating WTC rescue and re-
10 covery workers;

11 "(2) 2 environmental medicine or environmental
12 health specialists;

13 "(3) 2 representatives of eligible WTC respond-
14 ers;

15 "(4) 2 representatives of WTC residents and
16 other non-responders;

17 "(5) an industrial hygienist;

18 "(6) a toxicologist;

19 "(7) an epidemiologist; and

20 "(8) a mental health professional.

21 "(c) MEETINGS.—The Advisory Committee shall
22 meet at such frequency as may be required to carry out
23 its duties.

24 "(d) REPORTS.—The WTC Program Administrator
25 shall provide for publication of recommendations of the

1 Advisory Committee on the public website established for
2 the WTC program.

3 "(e) AUTHORIZATION OF APPROPRIATIONS.—For the
4 purpose of carrying out this section, there are authorized
5 to be appropriated such sums as may be necessary, not
6 to exceed $100,000, for each fiscal year beginning with
7 fiscal year 2009.

8 "(f) DURATION.—Notwithstanding any other provi-
9 sion of law, the Advisory Committee shall continue in op-
10 eration during the period in which the WTC program is
11 in operation.

12 "(g) APPLICATION OF FACA.—Except as otherwise
13 specifically provided, the Advisory Committee shall be sub-
14 ject to the Federal Advisory Committee Act.

15 **"SEC. 3003. WTC HEALTH PROGRAM STEERING COMMIT-**
16 **TEES.**

17 "(a) ESTABLISHMENT.—The WTC Program Admin-
18 istrator shall establish two steering committees (each in
19 this section referred to as a 'Steering Committee') as fol-
20 lows:

21 "(1) WTC RESPONDERS STEERING COM-
22 MITTEE.—One steering committee, to be known as
23 the WTC Responders Steering Committee, for the
24 purpose of facilitating the coordination of medical

1 monitoring and treatment programs for the eligible
2 WTC responders under part 1 of subtitle B.
3 "(2) WTC COMMUNITY PROGRAM STEERING
4 COMMITTEE.—One steering committee, to be known
5 as the WTC Community Program Steering Com-
6 mittee, for the purpose of facilitating the coordina-
7 tion of medical monitoring and treatment programs
8 for eligible WTC residents and other non-responders
9 under part 2 of subtitle B.
10 "(b) MEMBERSHIP.—
11 "(1) INITIAL MEMBERSHIP OF WTC RESPOND-
12 ERS STEERING COMMITTEE.—The WTC Responders
13 Steering Committee shall initially be composed of
14 members of the WTC Monitoring and Treatment
15 Program Steering Committee (as in existence on the
16 day before the date of the enactment of this title).
17 "(2) INITIAL MEMBERSHIP OF WTC COMMUNITY
18 PROGRAM STEERING COMMITTEE.—
19 "(A) IN GENERAL.—The WTC Community
20 Program Steering Committee shall initially be
21 composed of the following:
22 "(i) The Medical Director of the WTC
23 Environmental Health Center.
24 "(ii) The Executive Director of the
25 WTC Environmental Health Center.

1 "(iii) Three physicians, one each rep-
2 resenting the three WTC Environmental
3 Health Center treatment sites of Bellevue
4 Hospital Center, Gouverneur Healthcare
5 Services, and Elmhurst Hospital Center.
6 "(iv) Three physicians or specialists,
7 including a pediatrician, an epidemiologist,
8 a psychiatrist or psychologist, with experi-
9 ence with non-responder WTC diseases.
10 "(v) One environmental/occupational
11 specialist with WTC experience.
12 "(vi) One social worker with experi-
13 ence treating non-responders at a WTC
14 Environmental Health Center treatment
15 site.
16 "(vii) 10 representatives of the af-
17 fected populations of residents, students,
18 area workers, and other non-responders.
19 Such Committee shall also include, as nonvoting
20 members, members of the WTC Environmental
21 Health Center Community Advisory Committee
22 (as in existence on the day before the date of
23 the enactment of this title) who are not other-
24 wise appointed under clause (vii).
25 "(B) APPOINTMENTS.—

1 "(i) NYC HEALTH AND HOSPITALS
2 CORPORATION.—The New York City
3 Health and Hospitals Corporation shall
4 nominate members for positions described
5 in clauses (iii) through (vi) of subpara-
6 graph (A).
7 "(ii) WTC EHC COMMUNITY ADVISORY
8 COMMITTEE.—The WTC Environmental
9 Health Center Community Advisory Com-
10 mittee as in existence on the date of the
11 enactment of this title shall nominate
12 members for positions described in sub-
13 paragraph (A)(vii).
14 "(iii) TIMING.—Nominations under
15 clauses (i) and (ii) shall be recommended
16 to the WTC Program Administrator not
17 later than 60 days after the date of the en-
18 actment of this title.
19 "(iv) APPOINTMENT.—The WTC Pro-
20 gram Administrator shall appoint members
21 of the WTC Community Program Steering
22 Committee not later than 90 days after the
23 date of the enactment of this title.

1 "(v) GENERAL REPRESENTATIVES.—
2 Of the members appointed under subpara-
3 graph (A)(vii)—
4 "(I) the representation shall re-
5 flect the broad and diverse WTC-af-
6 fected populations and constituencies
7 and the diversity of impacted neigh-
8 borhoods, including residents, hard-to-
9 reach populations, students, area
10 workers, school parents, community-
11 based organizations, Community
12 Boards, WTC Environmental Health
13 Center patients, labor unions, and
14 labor advocacy organizations; and
15 "(II) no one individual organiza-
16 tion can have more than one rep-
17 resentative.
18 "(3) ADDITIONAL APPOINTMENTS.—Each
19 Steering Committee may appoint additional mem-
20 bers to the Committee, subject to the approval of the
21 WTC Program Administrator.
22 "(4) VACANCIES.—A vacancy in a Steering
23 Committee shall be filled by the Steering Committee,
24 subject to the approval of the WTC Program Ad-
25 ministrator, so long as—

1 "(A) in the case of the WTC Responders
2 Steering Committee, the composition of the
3 Committee includes representatives of eligible
4 WTC responders and representatives of each
5 Clinical Center of Excellence and each Coordi-
6 nating Center of Excellence that serves eligible
7 WTC responders; or
8 "(B) in the case of the WTC Community
9 Program Steering Committee, the composition
10 of the Committee includes representatives in-
11 cludes representatives of eligible WTC residents
12 and other non-responders and representatives of
13 each Clinical Center of Excellence and each Co-
14 ordinating Center of Excellence that serves eli-
15 gible WTC residents and other non-responders.
16 "(5) CO-CHAIRS OF WTC COMMUNITY PROGRAM
17 STEERING COMMITTEE.—The WTC Community Pro-
18 gram Steering Committee shall have two Co-Chairs
19 as follows:
20 "(A) ENVIRONMENTAL HEALTH CLINIC CO-
21 CHAIR.—A WTC Environmental Health Clinic
22 Co-Chair who shall be chosen by the WTC En-
23 vironmental Health Center members on the
24 Steering Committee.

1 "(B) COMMUNITY/LABOR CO-CHAIR.—A
2 Community/Labor Co-Chair who shall be chosen
3 by the community and labor-based members of
4 the Steering Committee.
5 "(c) RELATION TO FACA.—Each Steering Com-
6 mittee shall not be subject to the Federal Advisory Com-
7 mittee Act.
8 "(d) MEETINGS.—Each Steering Committee shall
9 meet at such frequency necessary to carry out its duties,
10 but not less than 4 times each calendar year and at least
11 two such meetings each year shall be a joint meeting with
12 the other Steering Committee for the purpose of exchang-
13 ing information regarding the WTC program.
14 "(e) DURATION.—Notwithstanding any other provi-
15 sion of law, each Steering Committee shall continue in op-
16 eration during the period in which the WTC program is
17 in operation.
18 **"SEC. 3004. COMMUNITY EDUCATION AND OUTREACH.**
19 "(a) IN GENERAL.—The WTC Program Adminis-
20 trator shall institute a program that provides education
21 and outreach on the existence and availability of services
22 under the WTC program. The outreach and education
23 program—

1 "(1) shall include the establishment of a public
2 website with information about the WTC program;
3 and
4 "(2) shall be conducted in a manner intended—
5 "(A) to reach all affected populations; and
6 "(B) to include materials for culturally and
7 linguistically diverse populations.
8 "(b) PARTNERSHIPS.—To the greatest extent pos-
9 sible, in carrying out this section, the WTC Program Ad-
10 ministrator shall enter into partnerships with local govern-
11 ments and organizations with experience performing out-
12 reach to the affected populations, including community
13 and labor-based organizations.
14 **"SEC. 3005. UNIFORM DATA COLLECTION.**
15 "(a) IN GENERAL.—The WTC Program Adminis-
16 trator shall provide for the uniform collection of data (and
17 analysis of data and regular reports to the Administrator)
18 on the utilization of monitoring and treatment benefits
19 provided to eligible WTC responders and eligible WTC
20 residents and other non-responders, the prevalence of
21 WTC-related health conditions, and the identification of
22 new WTC-related medical conditions. Such data shall be
23 collected for all individuals provided monitoring or treat-
24 ment benefits under subtitle B and regardless of their

1 place of residence or Clinical Center of Excellence through
2 which the benefits are provided.
3 "(b) COORDINATING THROUGH CENTERS OF EXCEL-
4 LENCE.—Each Clinical Center of Excellence shall, under
5 section 3006(d)(3), collect data described in subsection (a)
6 and report such data to the corresponding Coordinating
7 Center of Excellence for analysis by such Coordinating
8 Center of Excellence under section 3006(a)(2)(A).
9 "(c) PRIVACY.—The data collection and analysis
10 under this section shall be conducted in a manner that
11 protects the confidentiality of individually identifiable
12 health information consistent with applicable legal require-
13 ments.
14 **"SEC. 3006. CENTERS OF EXCELLENCE.**
15 "(a) IN GENERAL.—
16 "(1) CONTRACTS WITH CLINICAL CENTERS OF
17 EXCELLENCE.—The WTC Program Administrator
18 shall enter into contracts with Clinical Centers of
19 Excellence specified in subsection (b)(1)—
20 "(A) for the provision of monitoring and
21 treatment benefits under subtitle B;
22 "(B) for the provision of outreach activities
23 to individuals eligible for such monitoring and
24 treatment benefits and follow-up to individuals
25 who are enrolled in the program;

1 "(C) for the provision of counseling for
2 benefits under subtitle B, with respect to WTC-
3 related health conditions, for individuals eligible
4 for such benefits;
5 "(D) for the provision of counseling for
6 benefits for WTC-related health conditions that
7 may be available under Workers' Compensation,
8 health insurance, disability insurance, or other
9 insurance plans or through public or private so-
10 cial service agencies and assisting eligible indi-
11 viduals in applying for such benefits;
12 "(E) for the provision of translational and
13 interpretive services as for program participants
14 who are not English language proficient; and
15 "(F) for the collection and reporting of
16 data in accordance with section 3005.
17 "(2) CONTRACTS WITH COORDINATING CEN-
18 TERS OF EXCELLENCE.—The WTC Program Ad-
19 ministrator shall enter into contracts with Coordi-
20 nating Centers of Excellence specified in subsection
21 (b)(2)—
22 "(A) for receiving, analyzing, and report-
23 ing to the WTC Program Administrator on
24 data, in accordance with section 3005, that has
25 been collected and reported to such Coordi-

1 nating Centers by the corresponding Clinical
2 Centers of Excellence under subsection (d)(3);
3 "(B) for the development of medical moni-
4 toring and treatment protocols, with respect to
5 WTC-related health conditions;
6 "(C) for coordinating the outreach activi-
7 ties conducted under paragraph (1)(B) by each
8 corresponding Clinical Center of Excellence;
9 "(D) for establishing criteria for the
10 credentialing of medical providers participating
11 in the nationwide network under section 3031;
12 and
13 "(E) for coordinating and administrating
14 the activities of the WTC Health Program
15 Steering Committees established under section
16 3003(a).
17 The medical providers under subparagraph (D) shall
18 be selected by the WTC Program Administrator on
19 the basis of their experience treating or diagnosing
20 the medical conditions included in the list of identi-
21 fied WTC-related conditions for responders and of
22 identified WTC-related conditions for residents and
23 other non-responders.
24 "(b) CENTERS OF EXCELLENCE DEFINED.—

1 "(1) CLINICAL CENTER OF EXCELLENCE.—In
2 this title, the term 'Clinical Center of Excellence'
3 means the following:
4 "(A) FOR FDNY RESPONDERS IN NEW
5 YORK.—With respect to an eligible WTC re-
6 sponder who responded to the 9/11 attacks as
7 an employee of the Fire Department of the City
8 of New York and who resides in the New York
9 Metropolitan area, such Fire Department (or
10 such entity as has entered into a contract with
11 the Fire Department for monitoring or treat-
12 ment of such responders).
13 "(B) OTHER ELIGIBLE WTC RESPONDERS
14 IN NEW YORK.—With respect to other eligible
15 WTC responders who reside in the New York
16 Metropolitan area, the Mt. Sinai coordinated
17 consortium, Queens College, State University of
18 New York at Stony Brook, University of Medi-
19 cine and Dentistry of New Jersey, and Bellevue
20 Hospital.
21 "(C) WTC RESIDENTS AND OTHER NON-
22 RESPONDERS IN NEW YORK.—With respect to
23 eligible WTC residents and other non-respond-
24 ers who reside in the New York Metropolitan
25 area, the World Trade Center Environmental

1 Health Center at Bellevue Hospital and such
2 hospitals or other facilities, including but not
3 limited to those within the New York City
4 Health and Hospitals Corporation, as are iden-
5 tified by the WTC Program Administrator.
6 "(D) ALL ELIGIBLE WTC RESPONDERS
7 AND ELIGIBLE WTC RESIDENTS AND OTHER
8 NON-RESPONDERS.—With respect to all eligible
9 WTC responders and eligible WTC residents
10 and other non-responders, such other hospitals
11 or other facilities as are identified by the WTC
12 Program Administrator.
13 The WTC Program Administrator shall limit the
14 number of additional Centers of Excellence identified
15 under subparagraph (D) to ensure that the partici-
16 pating centers have adequate experience in the treat-
17 ment and diagnosis of identified WTC-related med-
18 ical conditions.
19 "(2) COORDINATING CENTER OF EXCEL-
20 LENCE.—In this title, the term 'Coordinating Center
21 of Excellence' means the following:
22 "(A) FOR FDNY RESPONDERS.—With re-
23 spect to an eligible WTC responder who re-
24 sponded to the 9/11 attacks as an employee of

1 the Fire Department of the City of New York,
2 such Fire Department.
3 "(B) OTHER WTC RESPONDERS.—With re-
4 spect to other eligible WTC responders, the Mt.
5 Sinai coordinated consortium.
6 "(C) WTC RESIDENTS AND OTHER NON-
7 RESPONDERS.—With respect to eligible WTC
8 residents and other non-responders, the World
9 Trade Center Environmental Health Center at
10 Bellevue Hospital.
11 "(3) CORRESPONDING CENTERS.—In this title,
12 a Clinical Center of Excellence and a Coordinating
13 Center of Excellence shall be treated as 'cor-
14 responding' to the extent that such Clinical Center
15 and Coordinating Center serve the same population
16 group.
17 "(c) REIMBURSEMENT FOR NON-TREATMENT, NON-
18 MONITORING PROGRAM COSTS.—A Clinical or Coordi-
19 nating Center of Excellence with a contract under this sec-
20 tion shall be reimbursed for the costs of such Center in
21 carrying out the activities described in subsection (a),
22 other than those described in subsection (a)(1)(A), subject
23 to the provisions of section 3001(d), as follows:

1 "(1) CLINICAL CENTERS OF EXCELLENCE.—
2 For carrying out subparagraphs (B) through (F) of
3 subsection (a)(1)—
4 "(A) CLINICAL CENTER FOR FDNY RE-
5 SPONDERS IN NEW YORK.—The Clinical Center
6 of Excellence for FDNY Responders in New
7 York specified in subsection (b)(1)(A) shall be
8 reimbursed—
9 "(i) in the first year of the contract
10 under this section, $900 per participant in
11 the medical treatment program, and $400
12 per participant in the monitoring program;
13 and
14 "(ii) in each subsequent contract year,
15 subject to paragraph (3), at the rates spec-
16 ified in this subparagraph for the previous
17 contract year adjusted by the WTC Pro-
18 gram Administrator to reflect the rate of
19 medical care inflation during the previous
20 contract year.
21 "(B) CLINICAL CENTERS SERVING OTHER
22 ELIGIBLE WTC RESPONDERS IN NEW YORK.—A
23 Clinical Center of Excellence for other WTC re-
24 sponders in New York specified in subsection

1 (b)(1)(B) shall be reimbursed the amounts
2 specified in subparagraph (A).
3 "(C) CLINICAL CENTERS SERVING WTC
4 RESIDENTS AND OTHER NON-RESPONDERS.—A
5 Clinical Center of Excellence for eligible WTC
6 residents and other non-responders in New
7 York specified in subsection (b)(1)(C) shall be
8 reimbursed—
9 "(i) for each participant in a medical
10 treatment program enrolled at a non-hos-
11 pital-based facility, the amount specified in
12 subparagraph (A) per participant in a
13 medical treatment program; and
14 "(ii) for each participant in a medical
15 treatment program enrolled at a hospital-
16 based facility, ⅔ of the amount specified
17 in clause (i).
18 "(D) OTHER CLINICAL CENTERS.—A Clin-
19 ical Center of Excellence or other providers not
20 described in a previous subparagraph shall be
21 reimbursed at a rate set by the WTC Program
22 Administrator.
23 "(E) REIMBURSEMENT RULES.—The reim-
24 bursement provided under subparagraphs (A),
25 (B) and (C) shall be made for each participant

1 in the WTC program per year, regardless of the
2 volume or cost of services required.
3 "(2) COORDINATING CENTERS OF EXCEL-
4 LENCE.—A Coordinating Centers of Excellence spec-
5 ified in section (a)(2) shall be reimbursed for the
6 provision of services set forth in this section at such
7 levels as are established by the WTC Program Ad-
8 ministrator.
9 "(3) REVIEW OF RATES.—
10 "(A) INITIAL REVIEW.—Before the end of
11 the fifth contract year of the WTC program,
12 the WTC Program Administrator shall conduct
13 a review to determine whether the reimburse-
14 ment rates set forth in this subsection provide
15 fair and appropriate reimbursement for such
16 program services. Based on such review, the
17 Administrator may, by rule beginning with the
18 sixth contract year, may modify such rates, tak-
19 ing into account a reasonable and fair rate for
20 the services being provided.
21 "(B) SUBSEQUENT REVIEWS.—After the
22 sixth contract year, the WTC Program Admin-
23 istrator shall conduct periodic reviews to deter-
24 mine whether the reimbursement rates in effect
25 under this subsection provide fair and appro-

1 priate reimbursement for such program serv-
2 ices. Based upon such a review, the Adminis-
3 trator may by rule modify such rates, taking
4 into account a reasonable and fair rate for the
5 services being provided.
6 "(C) GAO REVIEW.—The Comptroller
7 General of the United States shall review the
8 Secretary's determinations regarding fair and
9 appropriate reimbursement for program services
10 under this paragraph.
11 "(d) REQUIREMENTS.—The WTC Program Adminis-
12 trator shall not enter into a contract with a Clinical Center
13 of Excellence under subsection (a)(1) unless—
14 "(1) the Center establishes a formal mechanism
15 for consulting with and receiving input from rep-
16 resentatives of eligible populations receiving moni-
17 toring and treatment benefits under subtitle B from
18 such Center;
19 "(2) the Center provides for the coordination of
20 monitoring and treatment benefits under subtitle B
21 with routine medical care provided for the treatment
22 of conditions other than WTC-related health condi-
23 tions;

1 "(3) the Center collects and reports to the cor-
2 responding Coordinating Center of Excellence data
3 in accordance with section 3005;
4 "(4) the Center has in place safeguards against
5 fraud that are satisfactory to the Administrator;
6 "(5) the Center agrees to treat or refer for
7 treatment all individuals who are eligible WTC re-
8 sponders or eligible WTC residents and other non-
9 responders with respect to such Center who present
10 themselves for treatment of a WTC-related health
11 condition; and
12 "(6) the Center agrees to meet all the other ap-
13 plicable requirements of this title, including regula-
14 tions implementing such requirements.

15 **"SEC. 3007. PROGRAMS REGARDING ATTACK AT PENTAGON.**

16 "The Secretary may, to the extent determined appro-
17 priate by the Secretary, establish with respect to the ter-
18 rorist attack at the Pentagon on September 11, 2001, pro-
19 grams similar to the programs that are established in sub-
20 titles B and C with respect to the September 11, 2001,
21 terrorist attacks on the World Trade Center.

22 **"SEC. 3008. ENTITLEMENT AUTHORITIES.**

23 "Subtitle B constitutes budget authority in advance
24 of appropriations Acts and represents the obligation of the
25 Federal Government to provide for the payment for moni-

1 toring and treatment in accordance with such subtitle and
2 section 3006(c) constitutes such budget authority and rep-
3 resents the obligation of the Federal Government to pro-
4 vide for the payment described in such section.

5 **"SEC. 3009. DEFINITIONS.**

6 "In this title:

7 "(1) The term 'aggravating' means, with re-
8 spect to a health condition, a health condition that
9 existed on September 11, 2001, and that, as a result
10 of exposure to airborne toxins, any other hazard, or
11 any other adverse condition resulting from the Sep-
12 tember 11, 2001, terrorist attacks on the World
13 Trade Center requires medical treatment that is (or
14 will be) in addition to, more frequent than, or of
15 longer duration than the medical treatment that
16 would have been required for such condition in the
17 absence of such exposure.

18 "(2) The terms 'Clinical Center of Excellence'
19 and 'Coordinating Center of Excellence' have the
20 meanings given such terms in section 3006(b).

21 "(3) The term 'current consortium arrange-
22 ments' means the arrangements as in effect on the
23 date of the enactment of this title between the Na-
24 tional Institute for Occupational Safety and Health

1 and the Mt. Sinai-coordinated consortium and the
2 Fire Department of the City of New York.
3 "(4) The terms 'eligible WTC responder' and
4 'eligible WTC resident or other non-responder' are
5 defined in sections 3011(a) and 3021(a), respec-
6 tively.
7 "(5) The term 'list of identified WTC-related
8 health conditions' means—
9 "(A) for eligible WTC responders, the
10 identified WTC-related health condition for eli-
11 gible WTC responders under section
12 3012(a)(3); or
13 "(B) for eligible WTC residents and other
14 non-responders, the identified WTC-related
15 health condition for WTC residents and other
16 responders under section 3022(b)(1).
17 "(6) The term 'Mt.-Sinai-coordinated consor-
18 tium' means the consortium coordinated by Mt.
19 Sinai hospital in New York City that coordinates the
20 monitoring and treatment under the current consor-
21 tium arrangements for eligible WTC responders
22 other than with respect to those covered under the
23 arrangement with the Fire Department for the City
24 of New York.

1 "(7) The term 'New York City disaster area'
2 means the area within New York City that is—
3 "(A) the area of Manhattan that is south
4 of Houston Street; and
5 "(B) any block in Brooklyn that is wholly
6 or partially contained within a 1.5-mile radius
7 of the former World Trade Center site.
8 "(8) The term 'New York metropolitan area'
9 means an area, specified by the WTC Program Ad-
10 ministrator, within which eligible WTC responders
11 and eligible WTC residents and other non-respond-
12 ers who reside in such area are reasonably able to
13 access monitoring and treatment benefits under this
14 title through a Clinical Centers of Excellence de-
15 scribed in subparagraphs (A), (B), or (C) of section
16 3006(b)(1).
17 "(9) The term 'September 11, 2001, terrorist
18 attacks on the World Trade Center' means the ter-
19 rorist attacks that occurred on September 11, 2001,
20 in New York City and includes the aftermath of
21 such attacks.
22 "(10) The term 'WTC Health Program Steer-
23 ing Committee' means such a Steering Committee
24 established under section 3003.

"(11) The term 'WTC Program Administrator' means the individual responsible under section 3001(d) for the administration of the WTC program.

"(12) The term 'WTC-related health condition' is defined in section 3012(a).

"(13) The term 'WTC Scientific/Technical Advisory Committee' means such Committee established under section 3002.

"Subtitle B—Program of Monitoring and Treatment

"PART 1—FOR WTC RESPONDERS

"SEC. 3011. IDENTIFICATION OF ELIGIBLE WTC RESPONDERS AND PROVISION OF WTC-RELATED MONITORING SERVICES.

"(a) ELIGIBLE WTC RESPONDER DEFINED.—

"(1) IN GENERAL.—For purposes of this title, the term 'eligible WTC responder' means any of the following individuals, subject to paragraph (5):

"(A) CURRENTLY IDENTIFIED RESPONDER.—An individual who has been identified as eligible for medical monitoring under the current consortium arrangements (as defined in section 3009(3)).

1 "(B) RESPONDER WHO MEETS CURRENT
2 ELIGIBILITY CRITERIA.—An individual who
3 meets the current eligibility criteria described in
4 paragraph (2).
5 "(C) RESPONDER WHO MEETS MODIFIED
6 ELIGIBILITY CRITERIA.—An individual who—
7 "(i) performed rescue, recovery, demo-
8 lition, debris cleanup, or other related serv-
9 ices in the New York City disaster area in
10 response to the September 11, 2001, ter-
11 rorist attacks on the World Trade Center,
12 regardless of whether such services were
13 performed by a State or Federal employee
14 or member of the National Guard or other-
15 wise; and
16 "(ii) meets such eligibility criteria re-
17 lating to exposure to airborne toxins, other
18 hazards, or adverse conditions resulting
19 from the September 11, 2001, terrorist at-
20 tacks on the World Trade Center as the
21 WTC Program Administrator, after con-
22 sultation with the WTC Responders Steer-
23 ing Committee and the WTC Scientific/
24 Technical Advisory Committee, determines
25 appropriate.

1 "(2) CURRENT ELIGIBILITY CRITERIA.—The
2 eligibility criteria described in this paragraph for an
3 individual is that the individual is described in either
4 of the following categories:
5 "(A) FIRE FIGHTERS AND RELATED PER-
6 SONNEL.—All members of the Fire Department
7 of the City of New York (whether fire or emer-
8 gency personnel, active or retired) who partici-
9 pated at least one day in the rescue and recov-
10 ery effort at any of the former World Trade
11 sites (including Ground Zero, Staten Island
12 land fill, and the NYC Chief Medical Exam-
13 iner's office) for any time during the period be-
14 ginning on September 11, 2001, and ending on
15 July 31, 2002.
16 "(B) OTHER WTC RESCUE, RECOVERY,
17 AND CLEAN-UP WORKERS.—The individual—
18 "(i) worked or volunteered on-site in
19 rescue, recovery, debris-cleanup or related
20 support services in lower Manhattan (south
21 of Canal St.), the Staten Island Landfill,
22 or the barge loading piers, for at least 4
23 hours during the period beginning on Sep-
24 tember 11, 2001, and ending on Sep-
25 tember 14, 2001, for at least 24 hours

1 during the period beginning on September
2 11, 2001, and ending on September 30,
3 2001, or for at least 80 hours during the
4 period beginning on September 11, 2001,
5 and ending on July 31, 2002;
6 "(ii) was an employee of the Office of
7 the Chief Medical Examiner of the City of
8 New York involved in the examination and
9 processing of human remains, or other
10 morgue worker who performed similar
11 post-September 11 functions for such Of-
12 fice staff;
13 "(iii) was a worker in the Port Au-
14 thority Trans-Hudson Corporation tunnel
15 for at least 24 hours during the period be-
16 ginning on February 1, 2002, and ending
17 on July 1, 2002; or
18 "(iv) was a vehicle-maintenance work-
19 er who was exposed to debris from the
20 former World Trade Center while retriev-
21 ing, driving, cleaning, repairing, and main-
22 taining vehicles contaminated by airborne
23 toxins from the September 11, 2001, ter-
24 rorist attacks on the World Trade Center

1 during a duration and period described in
2 subparagraph (A).
3 "(3) APPLICATION PROCESS.—The WTC Pro-
4 gram Administrator in consultation with the Coordi-
5 nating Centers of Excellence shall establish a proc-
6 ess for individuals, other than eligible WTC respond-
7 ers described in paragraph (1)(A), to apply to be de-
8 termined to be eligible WTC responders. Under such
9 process—
10 "(A) there shall be no fee charged to the
11 applicant for making an application for such
12 determination; and
13 "(B) the Administrator shall make a deter-
14 mination on such an application not later than
15 60 days after the date of filing the application.
16 "(4) CERTIFICATION.—
17 "(A) IN GENERAL.—In the case of an indi-
18 vidual who is described in paragraph (1)(A) or
19 who is determined under paragraph (3) (con-
20 sistent with paragraph (5)) to be an eligible
21 WTC responder, the WTC Program Adminis-
22 trator shall provide an appropriate certification
23 of such fact and of eligibility for monitoring
24 and treatment benefits under this part. The Ad-
25 ministrator shall make determinations of eligi-

1 bility relating to an applicant's compliance with
2 this title, including the verification of informa-
3 tion submitted in support of the application,
4 and shall not deny such a certification to an in-
5 dividual unless the Administrator determines
6 that—
7 "(i) based on the application sub-
8 mitted, the individual does not meet the
9 eligibility criteria; or
10 "(ii) the numerical limitation on eligi-
11 ble WTC responders set forth in paragraph
12 (5) has been met.
13 "(B) TIMING.—In the case of an individual
14 who is determined under paragraph (3) and
15 consistent with paragraph (5) to be an eligible
16 WTC responder, the WTC Program Adminis-
17 trator shall provide the certification under sub-
18 paragraph (A) at the time of the determination.
19 "(5) NUMERICAL LIMITATION ON ELIGIBLE
20 WTC RESPONDERS.—
21 "(A) IN GENERAL.—Notwithstanding any
22 other provision of this title, the total number of
23 individuals not described in subparagraph (C)
24 who may qualify as eligible WTC responders for
25 purposes of this title, and be certified as eligible

1 WTC responders under paragraph (4), shall not
2 exceed 35,000.
3 "(B) PROCESS.—In implementing subpara-
4 graph (A), the WTC Program Administrator
5 shall—
6 "(i) limit the number of certifications
7 provided under paragraph (4) in accord-
8 ance with such subparagraph; and
9 "(ii) provide priority in such certifi-
10 cations in the order in which individuals
11 apply for a determination under paragraph
12 (3).
13 "(C) CURRENTLY IDENTIFIED RESPOND-
14 ERS NOT COUNTED.—Individuals described in
15 this subparagraph are individuals who are de-
16 scribed in paragraph (1)(A).
17 "(b) MONITORING BENEFITS.—
18 "(1) IN GENERAL.—In the case of an eligible
19 WTC responder, the WTC program shall provide for
20 monitoring benefits that include medical monitoring
21 consistent with protocols approved by the WTC Pro-
22 gram Administrator and including screening, clinical
23 examinations, and long-term health monitoring and
24 analysis. In the case of an eligible WTC responder
25 who is an active member of the Fire Department of

1 the City of New York, the responder shall receive
2 such benefits as part of the individual's periodic
3 company medical exams.
4 "(2) PROVISION OF MONITORING BENEFITS.—
5 The monitoring benefits under paragraph (1) shall
6 be provided through the Clinical Center of Excel-
7 lence for the type of individual involved or, in the
8 case of an individual residing outside the New York
9 metropolitan area, under an arrangement under sec-
10 tion 3031.

11 **"SEC. 3012. TREATMENT OF ELIGIBLE WTC RESPONDERS**
12 **FOR WTC-RELATED HEALTH CONDITIONS.**

13 "(a) WTC–RELATED HEALTH CONDITION DE-
14 FINED.—
15 "(1) IN GENERAL.—For purposes of this title,
16 the term 'WTC-related health condition' means—
17 "(A) an illness or health condition for
18 which exposure to airborne toxins, any other
19 hazard, or any other adverse condition resulting
20 from the September 11, 2001, terrorist attacks
21 on the World Trade Center, based on an exam-
22 ination by a medical professional with experi-
23 ence in treating or diagnosing the medical con-
24 ditions included in the applicable list of identi-
25 fied WTC-related conditions, is substantially

1 likely to be a significant factor in aggravating,
2 contributing to, or causing the illness or health
3 condition, as determined under paragraph (2);
4 or

5 "(B) a mental health condition for which
6 such attacks, based on an examination by a
7 medical professional with experience in treating
8 or diagnosing the medical conditions included in
9 the applicable list of identified WTC-related
10 conditions, is substantially likely be a signifi-
11 cant factor in aggravating, contributing to, or
12 causing the condition, as determined under
13 paragraph (2).

14 "(2) DETERMINATION.—The determination of
15 whether the September 11, 2001, terrorist attacks
16 on the World Trade Center were substantially likely
17 to be a significant factor in aggravating, contrib-
18 uting to, or causing an individual's illness or health
19 condition shall be made based on an assessment of
20 the following:

21 "(A) The individual's exposure to airborne
22 toxins, any other hazard, or any other adverse
23 condition resulting from the terrorist attacks.
24 Such exposure shall be—

"(i) evaluated and characterized through the use of a standardized, population appropriate questionnaire approved by the Director of the National Institute for Occupational Safety and Health; and

"(ii) assessed and documented by a medical professional with experience in treating or diagnosing medical conditions included on the list of identified WTC-related conditions.

"(B) The type of symptoms and temporal sequence of symptoms. Such symptoms shall be—

"(i) assessed through the use of a standardized, population appropriate medical questionnaire approved by Director of the National Institute for Occupational Safety and Health and a medical examination; and

"(ii) diagnosed and documented by a medical professional described in subparagraph (A)(ii).

"(3) LIST OF IDENTIFIED WTC-RELATED HEALTH CONDITIONS FOR ELIGIBLE WTC RESPONDERS.—For purposes of this title, the term 'identified

1 WTC-related health condition for eligible WTC re-
2 sponders' means any of the following health condi-
3 tions, and any condition specified under paragraph
4 (4):
5 "(A) AERODIGESTIVE DISORDERS.—
6 "(i) Interstitial lung diseases.
7 "(ii) Chronic respiratory disorder-
8 fumes/vapors.
9 "(iii) Asthma.
10 "(iv) Reactive airways dysfunction
11 syndrome (RADS).
12 "(v) WTC-exacerbated chronic ob-
13 structive pulmonary disease (COPD).
14 "(vi) Chronic cough syndrome.
15 "(vii) Upper airway hyperreactivity.
16 "(viii) Chronic rhinosinusitis.
17 "(ix) Chronic nasopharyngitis.
18 "(x) Chronic laryngitis.
19 "(xi) Gastro-esophageal reflux dis-
20 order (GERD).
21 "(xii) Sleep apnea exacerbated by or
22 related to a condition described in a pre-
23 vious clause.
24 "(B) MENTAL HEALTH CONDITIONS.—

1 "(i) Post traumatic stress disorder
2 (PTSD).
3 "(ii) Major depressive disorder.
4 "(iii) Panic disorder.
5 "(iv) Generalized anxiety disorder.
6 "(v) Anxiety disorder (not otherwise
7 specified).
8 "(vi) Depression (not otherwise speci-
9 fied).
10 "(vii) Acute stress disorder.
11 "(viii) Dysthymic disorder.
12 "(ix) Adjustment disorder.
13 "(x) Substance abuse.
14 "(xi) V codes (treatments not specifi-
15 cally related to psychiatric disorders, such
16 as marital problems, parenting problems,
17 etc.)
18 "(C) MUSCULOSKELETAL DISORDERS.—
19 "(i) Low back pain.
20 "(ii) Carpal tunnel syndrome (CTS).
21 "(iii) Other musculoskeletal disorders.
22 "(4) APPLICATION FOR ADDITIONAL IDENTI-
23 FIED WTC-RELATED HEALTH CONDITIONS FOR ELI-
24 GIBLE WTC RESPONDERS.—

1 "(A) APPLICATION.—Any individual or or-
2 ganization can apply to the WTC Program Ad-
3 ministrator for an illness or health condition
4 not described in paragraph (3) to be added to
5 the list of identified WTC-related conditions for
6 eligible WTC responders.
7 "(B) REVIEW.—The WTC Program Ad-
8 ministrator shall establish a public process for
9 receiving public input and comments on any ap-
10 plication under subparagraph (A).
11 "(C) CONSIDERATIONS.—In making deter-
12 minations on such applications, the WTC Pro-
13 gram Administrator shall give deference to the
14 findings and recommendations of Clinical Cen-
15 ters of Excellence published in peer reviewed
16 journals in the determination of whether an ad-
17 ditional illness or health condition, such as can-
18 cer, should be added to the list of identified
19 WTC-related health conditions for eligible WTC
20 responders.
21 "(D) CONSULTATION.—The WTC Pro-
22 gram Administrator shall consult with the WTC
23 Responders Steering Committee and the WTC
24 Scientific/Technical Advisory Committee in
25 making a determination on whether an addi-

1 tional health condition should be added to the
2 list of identified WTC-related conditions for eli-
3 gible WTC responders.
4 "(E) DETERMINATION.—The WTC Pro-
5 gram Administrator shall add an illness or
6 health condition to the list of identified WTC-
7 related health conditions for eligible WTC re-
8 sponders if, based on a review of the evidence
9 and consultations conducted under subpara-
10 graphs (B), (C), and (D), the Administrator de-
11 termines that exposure to airborne toxins, other
12 hazards, or other adverse conditions resulting
13 from the September 11, 2001, terrorist attacks
14 on the World Trade Center is substantially like-
15 ly to be a significant factor in aggravating, con-
16 tributing to, or causing the illness or health
17 condition.
18 "(b) COVERAGE OF TREATMENT FOR WTC-RELATED
19 HEALTH CONDITIONS.—
20 "(1) DETERMINATION BASED ON AN IDENTI-
21 FIED WTC-RELATED HEALTH CONDITION FOR ELIGI-
22 BLE WTC RESPONDERS.—
23 "(A) IN GENERAL.—If a physician at a
24 Clinical Center of Excellence that is providing
25 monitoring benefits under section 3011 for an

1 eligible WTC responder determines that the re-
2 sponder has an identified WTC-related health
3 condition, and the physician makes a clinical
4 determination that exposure to airborne toxins,
5 other hazards, or adverse conditions resulting
6 from the 9/11 terrorist attacks is substantially
7 likely to be a significant factor in aggravating,
8 contributing to, or causing the condition—
9 "(i) the physician shall promptly
10 transmit such determination to the WTC
11 Program Administrator and provide the
12 Administrator with the medical facts sup-
13 porting such determination; and
14 "(ii) on and after the date of such
15 transmittal and subject to paragraph (2),
16 the WTC program shall provide for pay-
17 ment under subsection (c) for medically
18 necessary treatment for such condition.
19 "(B) REVIEW; CERTIFICATION; AP-
20 PEALS.—
21 "(i) REVIEW.—A Federal employee
22 designated by the WTC Program Admini-
23 trator shall review determinations made
24 under subparagraph (A)(i) of a WTC-re-
25 lated health condition.

"(ii) CERTIFICATION.—The Administrator shall provide a certification of coverage of the treatment of such condition based upon reviews conducted under clause (i). Such a certification shall be provided unless the Administrator determines that the responder's condition is not an identified WTC-related health condition or that exposure to airborne toxins, other hazards, or adverse conditions resulting from the 9/11 terrorist attacks is not substantially likely to be a significant factor in significantly aggravating, contributing to, or causing the condition.

"(iii) APPEAL PROCESS.—The Administrator shall provide a process for the appeal of determinations under clause (ii).

"(2) DETERMINATION BASED ON OTHER WTC-RELATED HEALTH CONDITION.—

"(A) IN GENERAL.—If a physician at a Clinical Center of Excellence determines pursuant to subsection (a) that the eligible WTC responder has a WTC-related health condition that is not an identified WTC-related health condition for eligible WTC responders—

1 "(i) the physician shall promptly
2 transmit such determination to the WTC
3 Program Administrator and provide the
4 Administrator with the facts supporting
5 such determination; and
6 "(ii) on and after the date of such
7 transmittal and pending a determination
8 by the Administrator under subparagraph
9 (B), the WTC program shall provide for
10 payment under subsection (c) for medically
11 necessary treatment for such condition.
12 "(B) REVIEW; CERTIFICATION.—
13 "(i) USE OF PHYSICIAN PANEL.—The
14 WTC Program Administrator shall provide
15 for the review of each determination made
16 under subparagraph (A)(i) of a WTC-re-
17 lated health condition to be made by a
18 physician panel with appropriate expertise
19 appointed by the WTC Program Admini-
20 trator. Such a panel shall make rec-
21 ommendations to the Administrator on the
22 evidence supporting such determination.
23 "(ii) REVIEW OF RECOMMENDATIONS
24 OF PANEL; CERTIFICATION.—The Admini-
25 trator, based on such recommendations

1 shall determine whether or not the condi-
2 tion is a WTC-related health condition
3 and, if it is, provide for a certification
4 under paragraph (1)(B)(ii) of coverage of
5 such condition. The Administrator shall
6 provide a process for the appeal of deter-
7 minations that the responder's condition is
8 not a WTC-related health condition.
9 "(3) REQUIREMENT OF MEDICAL NECESSITY.—
10 The determination under paragraphs (1)(A)(ii) and
11 (2)(A)(ii) of whether treatment is medically nec-
12 essary for a WTC-related health condition shall be
13 made by physicians at the appropriate Clinical Cen-
14 ter of Excellence, taking into account, for identified
15 WTC-related health conditions, medical treatment
16 protocols established under subsection (d).
17 "(4) SCOPE OF TREATMENT COVERED.—
18 "(A) IN GENERAL.—The scope of treat-
19 ment covered under such paragraphs includes
20 services of physicians and other health care pro-
21 viders, diagnostic and laboratory tests, prescrip-
22 tion drugs, inpatient and outpatient hospital
23 services, and other medically necessary treat-
24 ment.

1 "(B) PHARMACEUTICAL COVERAGE.—With
2 respect to ensuring coverage of medically nec-
3 essary outpatient prescription drugs, such drugs
4 shall be provided, under arrangements made by
5 the WTC Program Administrator, directly
6 through participating Clinical Centers of Excel-
7 lence or through one or more outside vendors.
8 "(5) PROVISION OF TREATMENT PENDING CER-
9 TIFICATION.—In the case of an eligible WTC re-
10 sponder who has been determined by an examining
11 physician under subsection (b)(1) to have an identi-
12 fied WTC-related health condition, but for whom a
13 certification of the determination has not yet been
14 made by the WTC Program Administrator, medical
15 treatment may be provided under this subsection
16 until the Administrator makes a decision on such
17 certification. Medical treatment provided under this
18 paragraph shall be considered to be medical treat-
19 ment for which payment may be made under sub-
20 section (c).
21 "(c) PAYMENT FOR MEDICAL MONITORING AND
22 TREATMENT OF WTC-RELATED HEALTH CONDITIONS.—
23 "(1) MEDICAL TREATMENT.—
24 "(A) USE OF MEDICARE PAYMENT
25 RATES.—

1 "(i) IN GENERAL.—Subject to sub-
2 paragraph (B), the WTC Program Admin-
3 istrator shall reimburse costs for medically
4 necessary treatment under this title for
5 WTC-related health conditions provided
6 under this title in a facility for which a
7 payment rate is established under the
8 Medicare program under title XVIII of the
9 Social Security Act at the applicable per-
10 centage of such Medicare payment rate.
11 "(ii) APPLICABLE PERCENTAGE.—For
12 purposes of this subparagraph, the term
13 'applicable percentage' means—
14 "(I) 115 percent for treatment
15 provided by a hospital or an ambula-
16 tory care facility; or
17 "(II) 130 percent for other treat-
18 ment.
19 "(B) PHARMACEUTICALS.—
20 "(i) IN GENERAL.—The WTC Pro-
21 gram Administrator shall establish a pro-
22 gram for paying for the medically nec-
23 essary outpatient prescription pharma-
24 ceuticals prescribed under this title for

1 WTC-related conditions through one or
2 more contracts with outside vendors.
3 "(ii) COMPETITIVE BIDDING.—Under
4 such program the Administrator shall—
5 "(I) select one or more appro-
6 priate vendors through a Federal com-
7 petitive bid process; and
8 "(II) select the lowest bidder (or
9 bidders) meeting the requirements for
10 providing pharmaceutical benefits for
11 participants in the WTC program.
12 "(iii) TREATMENT OF FDNY PARTICI-
13 PANTS.—Under such program the Admin-
14 istrator may enter select a separate vendor
15 to provide pharmaceutical benefits to eligi-
16 ble WTC responders for whom the Clinical
17 Center of Excellence is described in section
18 3006(b)(1)(A) if such an arrangement is
19 deemed necessary and beneficial to the
20 program by the WTC Program Adminis-
21 trator.
22 "(C) OTHER TREATMENT.—For treatment
23 not covered under a preceding subparagraph,
24 the WTC Program Administrator shall des-
25 ignate a reimbursement rate for each such serv-

1 ice based upon the rates of reimbursement spec-
2 ified in the preceding subparagraphs.
3 "(2) MEDICAL MONITORING.—The WTC Pro-
4 gram Administrator shall reimburse the costs of
5 medical monitoring provided under this title at a
6 rate set by the Administrator.
7 "(3) ADMINISTRATIVE ARRANGEMENT AUTHOR-
8 ITY.—The WTC Program Administrator may enter
9 into arrangements with other government agencies,
10 insurance companies, or other third-party adminis-
11 trators to provide for timely and accurate processing
12 of claims under this section.
13 "(4) PARTICIPATION BY NEW YORK CITY IN
14 TREATMENT COSTS.—
15 "(A) IN GENERAL.—The amount of the
16 covered treatment payment (as defined in sub-
17 paragraph (B)) for a fiscal year shall be re-
18 duced by an amount equal to 5 percent of the
19 amount of the covered treatment payment that
20 would be made for the fiscal year but for this
21 paragraph.
22 "(B) COVERED TREATMENT PAYMENT DE-
23 FINED.—For purposes of this paragraph, the
24 term 'covered treatment payment' means pay-
25 ment under paragraph (1), including under

1 such paragraph as applied under section
2 3022(a), for items and services furnished by a
3 Clinical Center of Excellence within the New
4 York City Health and Hospitals Corporation to
5 eligible WTC responders and to eligible WTC
6 residents or other non-responders. Such pay-
7 ment shall be determined after the application
8 of paragraphs (2) and (3) of section 3001(d).
9 "(d) MEDICAL TREATMENT PROTOCOLS.—
10 "(1) DEVELOPMENT.—The Coordinating Cen-
11 ters of Excellence shall develop medical treatment
12 protocols for the treatment of eligible WTC respond-
13 ers and eligible WTC residents and other non-re-
14 sponders for identified WTC-related health condi-
15 tions under subsection (b).
16 "(2) APPROVAL.—The WTC Program Adminis-
17 trator shall approve the medical treatment protocols,
18 in consultation with the WTC Health Program
19 Steering Committees.

1 **"PART 2—COMMUNITY PROGRAM**

2 **"SEC. 3021. IDENTIFICATION OF ELIGIBLE WTC RESIDENTS**
3 **AND OTHER NON-RESPONDERS AND PROVI-**
4 **SION OF WTC-RELATED MONITORING SERV-**
5 **ICES.**

6 "(a) ELIGIBLE WTC RESIDENT AND OTHER NON-
7 RESPONDER DEFINED.—

8 "(1) IN GENERAL.—In this title, the term 'eligi-
9 ble WTC resident and other non-responder' means,
10 subject to paragraph (3), an individual who is not an
11 eligible WTC responder and is described in any of
12 the following subparagraphs:

13 "(A) A person who was present in the New
14 York City disaster area in the dust or dust
15 cloud on September 11, 2001.

16 "(B) A person who worked, resided or at-
17 tended school, child care or adult day care in
18 the New York City disaster area for—

19 "(i) at least four days during the 4-
20 month period beginning on September 11,
21 2001, and ending on January 10, 2002; or

22 "(ii) at least 30 days during the pe-
23 riod beginning on September 11, 2001,
24 and ending on July 31, 2002.

25 "(C) Any person who worked as a clean-up
26 worker or performed maintenance work in the

1 New York City disaster area during the 4-
2 month period described in subparagraph (B)(i)
3 and had extensive exposure to WTC dust as a
4 result of such work.
5 "(D) A person who was deemed eligible to
6 receive a grant from the Lower Manhattan De-
7 velopment Corporation Residential Grant Pro-
8 gram, who possessed a lease for a residence or
9 purchased a residence in the New York City
10 disaster area, and who resided in such residence
11 during the period beginning on September 11,
12 2001, and ending on May 31, 2003.
13 "(E) A person whose place of employ-
14 ment—
15 "(i) at any time during the period be-
16 ginning on September 11, 2001, and end-
17 ing on May 31, 2003, was in the New
18 York City disaster area; and
19 "(ii) was deemed eligible to receive a
20 grant from the Lower Manhattan Develop-
21 ment Corporation WTC Small Firms At-
22 traction and Retention Act program or
23 other government incentive program de-
24 signed to revitalize the Lower Manhattan
25 economy after the September 11, 2001,

1 terrorist attacks on the World Trade Cen-
2 ter.
3 "(F) A person who was receiving treat-
4 ment as of the date of the enactment of this
5 title at the World Trade Center Environmental
6 Health Center operated by the New York City
7 Health and Hospitals Corporation.
8 "(2) ELIGIBILITY CRITERIA.—In establishing
9 eligibility criteria for purposes of subparagraphs (A)
10 through (C) of paragraph (1) and for purposes of
11 section 3011(a)(1)(D), the WTC Program Adminis-
12 trator shall—
13 "(A) take into account the period, and, to
14 the extent feasible, intensity, of exposure to air-
15 borne toxins, other hazard, or other adverse
16 condition;
17 "(B) base such criteria on best available
18 evidence of exposure and related adverse health
19 effects; and
20 "(C) consult with the WTC Community
21 Program Steering Committee, Coordinating
22 Centers of Excellence described in section
23 3006(b)(1)(C), and affected populations.

1 The Administrator shall first establish such criteria
2 not later than 90 days after the date of the enact-
3 ment of this title.
4 "(3) APPLICATION PROCESS.—The WTC Pro-
5 gram Administrator in consultation with the Coordi-
6 nating Centers of Excellence shall establish a proc-
7 ess for individuals to be determined eligible WTC
8 residents and other non-responders. Under such
9 process—
10 "(A) there shall be no fee charged to the
11 applicant for making an application for such
12 determination; and
13 "(B) the Administrator shall make a deter-
14 mination on such an application not later than
15 60 days after the date of filing the application.
16 "(4) CERTIFICATION.—
17 "(A) IN GENERAL.—In the case of an indi-
18 vidual who is determined under paragraph (3)
19 and consistent with paragraph (5) to be an eli-
20 gible WTC resident or other non-responder, the
21 WTC Program Administrator shall provide an
22 appropriate certification of such fact and of eli-
23 gibility for monitoring and treatment benefits
24 under this part. The Administrator shall make
25 determinations of eligibility relating to an appli-

1 cant's compliance with this title, including the
2 verification of information submitted in support
3 of the application and shall not deny such a
4 certification to an individual unless the Admin-
5 istrator determines that—
6 "(i) based on the application sub-
7 mitted, the individual does not meet the
8 eligibility criteria; or
9 "(ii) the numerical limitation on eligi-
10 ble WTC residents and other non-respond-
11 ers set forth in paragraph (5) has been
12 met.
13 "(B) TIMING.—In the case of an individual
14 who is determined under paragraph (3) and
15 consistent with paragraph (5) to be an eligible
16 WTC resident or other non-responder, the WTC
17 Program Administrator shall provide the certifi-
18 cation under subparagraph (A) at the time of
19 such determination.
20 "(5) NUMERICAL LIMITATION ON ELIGIBLE
21 WTC RESIDENTS AND OTHER NON-RESPONDERS.—
22 "(A) IN GENERAL.—Notwithstanding any
23 other provision of this title, the total number of
24 individuals not described in subparagraph (C)
25 who may qualify as eligible WTC residents and

1 other non-responders for purposes of this title,
2 and be certified as eligible WTC residents and
3 other non-responders under paragraph (4),
4 shall not exceed 35,000.
5 "(B) PROCESS.—In implementing subpara-
6 graph (A), the WTC Program Administrator
7 shall—
8 "(i) limit the number of certifications
9 provided under paragraph (4) in accord-
10 ance with such subparagraph; and
11 "(ii) provide priority in such certifi-
12 cations in the order in which individuals
13 apply for a determination under paragraph
14 (3).
15 "(C) INDIVIDUALS CURRENTLY RECEIVING
16 MONITORING OR TREATMENT NOT COUNTED.—
17 Individuals described in this subparagraph are
18 individuals who, before the date of the enact-
19 ment of this title, have received any monitoring
20 described in subsection (b)(1) or have received
21 any treatment described in section 3022(a) for
22 an identified WTC-related condition for eligible
23 WTC residents and other non-responders.
24 "(b) MONITORING BENEFITS.—

1 "(1) IN GENERAL.—In the case of an eligible
2 WTC resident or other non-responder, the WTC pro-
3 gram shall provide for monitoring benefits that in-
4 clude medical monitoring consistent with protocols
5 approved by the WTC Program Administrator, in
6 consultation with the World Trade Center Environ-
7 mental Health Center at Bellevue Hospital and the
8 WTC Community Program Steering Committee, and
9 including screening, clinical examinations, and long-
10 term health monitoring and analysis.
11 "(2) SOURCE OF BENEFITS.—The monitoring
12 benefits under paragraph (1) shall be provided
13 through a Clinical Center of Excellence with respect
14 to the individual involved.

15 **"SEC. 3022. TREATMENT OF ELIGIBLE WTC RESIDENTS AND**
16 **OTHER NON-RESPONDERS FOR WTC-RE-**
17 **LATED HEALTH CONDITIONS.**

18 "(a) IN GENERAL.—Subject to subsection (b), the
19 provisions of section 3012 shall apply to the treatment of
20 WTC-related health conditions for eligible WTC residents
21 and other non-responders in the same manner as such pro-
22 visions apply to the treatment of identified WTC-related
23 health conditions for eligible WTC responders, except that
24 an eligible WTC resident or other non-responder need not
25 be receiving monitoring benefits to receive treatment for

1 a WTC-related health condition for eligible WTC residents
2 and other non-responders.
3 "(b) LIST OF IDENTIFIED WTC-RELATED HEALTH
4 CONDITIONS FOR WTC RESIDENTS AND OTHER NON-RE-
5 SPONDERS.—
6 "(1) IDENTIFIED WTC-RELATED HEALTH CON-
7 DITIONS FOR WTC RESIDENTS AND OTHER NON-RE-
8 SPONDERS.—For purposes of this title, the term
9 'identified WTC-related health conditions for WTC
10 residents and non-responder' means any of the fol-
11 lowing health conditions, and any condition specified
12 under paragraph (2):
13 "(A) AERODIGESTIVE DISORDERS.—
14 "(i) Interstitial lung diseases.
15 "(ii) Chronic respiratory disorder—
16 fumes/vapors.
17 "(iii) Asthma.
18 "(iv) Reactive airways dysfunction
19 syndrome (RADS).
20 "(v) WTC-exacerbated chronic ob-
21 structive pulmonary disease (COPD).
22 "(vi) Chronic cough syndrome.
23 "(vii) Upper airway hyperreactivity.
24 "(viii) Chronic rhinosinusitis.
25 "(ix) Chronic nasopharyngitis.

1 "(x) Chronic laryngitis.

2 "(xi) Gastro-esophageal reflux dis-
3 order (GERD).

4 "(xii) Sleep apnea exacerbated by or
5 related to a condition described in a pre-
6 vious clause.

7 "(B) MENTAL HEALTH CONDITIONS.—

8 "(i) Post traumatic stress disorder
9 (PTSD).

10 "(ii) Major depressive disorder.

11 "(iii) Panic disorder.

12 "(iv) Generalized anxiety disorder.

13 "(v) Anxiety disorder (not otherwise
14 specified).

15 "(vi) Depression (not otherwise speci-
16 fied).

17 "(vii) Acute stress disorder.

18 "(viii) Dysthymic disorder.

19 "(ix) Adjustment disorder.

20 "(x) Substance abuse.

21 "(xi) V codes (treatments not specifi-
22 cally related to psychiatric disorders, such
23 as marital problems, parenting problems,
24 etc.)

1 "(2) APPLICATION FOR ADDITIONAL IDENTI-
2 FIED WTC-RELATED HEALTH CONDITIONS FOR WTC
3 RESIDENTS AND OTHER NON-RESPONDERS.—The
4 provisions of paragraph (4) of section 3012(a) shall
5 apply with respect to an addition to the list of iden-
6 tified WTC-related conditions for eligible WTC resi-
7 dents and other non-responders under paragraph (1)
8 in the same manner as such provisions apply to the
9 addition to the list of identified WTC-related condi-
10 tions for eligible WTC responders under section
11 3012(a)(3).

12 **"SEC. 3023. TREATMENT OF OTHER INDIVIDUALS WITH**
13 **WTC-RELATED HEALTH CONDITIONS.**

14 "(a) IN GENERAL.—Subject to subsection (c), the
15 provisions of section 3022 shall apply to the treatment of
16 WTC-related health conditions for eligible WTC residents
17 and other non-responders in the case of individuals de-
18 scribed in subsection (b) in the same manner as such pro-
19 visions apply to the treatment of WTC-related health con-
20 ditions for WTC residents and other non-responders.

21 "(b) INDIVIDUALS DESCRIBED.—An individual de-
22 scribed in this subsection is an individual who, regardless
23 of location of residence—

24 "(1) is not a eligible WTC responder or an eli-
25 gible WTC resident or other non-responder; and

1 "(2) is diagnosed at a Clinical Center of Excel-
2 lence (with respect to an eligible WTC resident or
3 other non-responder) with an identified WTC-related
4 health condition for WTC residents and other non-
5 responders.
6 "(c) LIMITATION.—
7 "(1) IN GENERAL.—The WTC Program Admin-
8 istrator shall limit benefits for any fiscal year under
9 subsection (a) in a manner so that payments under
10 this section for such fiscal year do not exceed the
11 amount specified in paragraph (2) for such fiscal
12 year.
13 "(2) LIMITATION.—The amount specified in
14 this paragraph for—
15 "(A) fiscal year 2009 is $20,000,000; or
16 "(B) a succeeding fiscal year is the
17 amount specified in this paragraph for the pre-
18 vious fiscal year increased by the annual per-
19 centage increase in the medical care component
20 of the consumer price index for all urban con-
21 sumers.

1 **"PART 3—NATIONAL ARRANGEMENT FOR BENE-**
2 **FITS FOR ELIGIBLE INDIVIDUALS OUTSIDE**
3 **NEW YORK**

4 **"SEC. 3031. NATIONAL ARRANGEMENT FOR BENEFITS FOR**
5 **ELIGIBLE INDIVIDUALS OUTSIDE NEW YORK.**

6 "(a) IN GENERAL.—In order to ensure reasonable ac-
7 cess to monitoring and treatment benefits under this sub-
8 title for individuals who are eligible WTC responders or
9 eligible WTC residents or other nonresponders and who
10 reside in any State, as defined in section 2(f), outside the
11 New York metropolitan area, the WTC Program Admini-
12 strator shall establish a nationwide network of health care
13 providers to provide such monitoring and treatment bene-
14 fits near such individuals' areas of residence in such
15 States, or to establish a mechanism whereby individuals
16 who are entitled to benefits for such monitoring or treat-
17 ment can be reimbursed for the cost of such monitoring
18 or treatment. Nothing in this subsection shall be construed
19 as preventing such individuals from being provided such
20 monitoring and treatment benefits through a Clinical Cen-
21 ter of Excellence.

22 "(b) NETWORK REQUIREMENTS.—Any health care
23 provider participating in the network under subsection (a)
24 shall—

25 "(1) meet criteria for credentialing established
26 by the Coordinating Centers of Excellence;

"(2) follow the monitoring and treatment protocols developed under section 3006(a)(1); and

"(3) collect and report data in accordance with section 3005.

"Subtitle C—Research Into Conditions

"SEC. 3041. RESEARCH REGARDING CERTAIN HEALTH CONDITIONS RELATED TO SEPTEMBER 11 TERRORIST ATTACKS IN NEW YORK CITY.

"(a) IN GENERAL.—With respect to individuals, including eligible WTC responders and non-responders, receiving monitoring under subtitle B, the WTC Program Administrator shall conduct or support—

"(1) research on physical and mental health conditions that may be related to the September 11, 2001, terrorist attacks;

"(2) research on diagnosing WTC-related health conditions of such individuals, in the case of conditions for which there has been diagnostic uncertainty; and

"(3) research on treating WTC-related health conditions of such individuals, in the case of conditions for which there has been treatment uncertainty.

1 The Administrator may provide such support through con-
2 tinuation and expansion of research that was initiated be-
3 fore the date of the enactment of this title and through
4 the World Trade Center Health Registry (referred to in
5 section 3051).

6 "(b) TYPES OF RESEARCH.—The research under
7 subsection (a)(1) shall include epidemiologic studies on
8 WTC-related conditions or emerging conditions—

9 "(1) among WTC responders, residents, and
10 non-responders under treatment; and

11 "(2) in sampled populations outside the New
12 York City disaster area in Manhattan as far north
13 as 14th Street and in Brooklyn, along with control
14 populations, to identify potential for long-term ad-
15 verse health effects in less exposed populations.

16 "(c) CONSULTATION.—The WTC Program Adminis-
17 trator shall carry out this section in consultation with the
18 WTC Health Program Steering Committees and the WTC
19 Scientific/Technical Advisory Committee.

20 "(d) APPLICATION OF PRIVACY AND HUMAN SUB-
21 JECT PROTECTIONS.—The privacy and human subject
22 protections applicable to research conducted under this
23 section shall not be less than such protections applicable
24 to research otherwise conducted by the National Institutes
25 of Health.

1 "(e) AUTHORIZATION OF APPROPRIATIONS.—For the
2 purpose of carrying out this section, there are authorized
3 to be appropriated $15,000,000 for each fiscal year, in
4 addition to any other authorizations of appropriations that
5 are available for such purpose.

6 "Subtitle D—Programs of the New
7 York City Department of Health
8 and Mental Hygiene

9 **"SEC. 3051. WORLD TRADE CENTER HEALTH REGISTRY.**

10 "(a) PROGRAM EXTENSION.—For the purpose of en-
11 suring on-going data collection for victims of the Sep-
12 tember 11, 2001, terrorist attacks on the World Trade
13 Center, the WTC Program Administrator, shall extend
14 and expand the arrangements in effect as of January 1,
15 2008, with the New York City Department of Health and
16 Mental Hygiene that provide for the World Trade Center
17 Health Registry.

18 "(b) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated $7,000,000 for each fis-
20 cal year to carry out this section.

21 **"SEC. 3052. MENTAL HEALTH SERVICES.**

22 "(a) IN GENERAL.—The WTC Program Adminis-
23 trator may make grants to the New York City Department
24 of Health and Mental Hygiene to provide mental health
25 services to address mental health needs relating to the

1 September 11, 2001, terrorist attacks on the World Trade
2 Center.
3 "(b) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated $8,500,000 for each fis-
5 cal year to carry out this section.".

6 TITLE II—SEPTEMBER 11 VICTIM 7 COMPENSATION FUND OF 2001

8 SEC. 201. DEADLINE EXTENSION FOR CERTAIN CLAIMS 9 UNDER SEPTEMBER 11 VICTIM COMPENSA- 10 TION FUND OF 2001.

11 Section 405(a)(3) of the Air Transportation Safety
12 and System Stabilization Act (49 U.S.C. 40101 note) is
13 amended to read as follows:
14 "(3) LIMITATION.—
15 "(A) IN GENERAL.—Except as provided by
16 subparagraph (B), no claim may be filed under
17 paragraph (1) after December 22, 2003.
18 "(B) EXCEPTIONS.—
19 "(i) IN GENERAL.—A claim may be
20 filed under paragraph (1) by an individual
21 (or by a personal representative on behalf
22 of a deceased individual) during the period
23 described in clause (ii), if the Special Mas-
24 ter determines that—

1 "(I) the individual first knew
2 that the individual had suffered a
3 physical harm as a result of the ter-
4 rorist-related aircraft crashes of Sep-
5 tember 11, 2001, or the aftermath of
6 such attacks, after December 22,
7 2003, and before the date that is 5
8 years after the date of the enactment
9 of the James Zadroga 9/11 Health
10 and Compensation Act of 2008;
11 "(II) the individual did not for
12 any reason other than as described in
13 subclause (I) know that the individual
14 was eligible to file a claim under para-
15 graph (1) until after December 22,
16 2003;
17 "(III) the individual filed a claim
18 under this title before, on, or after
19 December 22, 2003, and suffered a
20 significantly greater physical harm as
21 a result of the terrorist-related air-
22 craft crashes of September 11, 2001,
23 or the aftermath of such attacks, than
24 was known to the individual as of the
25 date the most recent previous claim

1 was filed, and before the date that is
2 5 years after the date of the enact-
3 ment of the James Zadroga 9/11
4 Health and Compensation Act of
5 2008; or
6 "(IV) the individual was not eli-
7 gible to file a claim under this title be-
8 fore December 22, 2003, but who be-
9 comes so eligible because of the
10 amendments made by the James
11 Zadroga 9/11 Health and Compensa-
12 tion Act of 2008.
13 "(ii) PERIOD.—
14 "(I) IN GENERAL.—Except as
15 provided in subclause (II), the period
16 described in this clause is the two-
17 year period beginning on the date of
18 the enactment of the James Zadroga
19 9/11 Health and Compensation Act of
20 2008.
21 "(II) EXCEPTION.—In the case
22 of an individual who first knew on a
23 date after such date of enactment that
24 the individual had suffered physical
25 harm described in subclause (I) of

clause (i) or a significantly greater harm, described in subclause (III) of such clause, the period described in this clause is the two-year period beginning on the date the individual first acquired such knowledge.".

SEC. 202. EXCEPTION TO SINGLE CLAIM REQUIREMENT IN CERTAIN CIRCUMSTANCES.

Section 405(c)(3)(A) of the Air Transportation Safety and System Stabilization Act (49 U.S.C. 40101 note) is amended to read as follows:

"(A) SINGLE CLAIM.—

"(i) IN GENERAL.—Except as provided by clause (ii), not more than 1 claim may be submitted under this title by an individual or on behalf of a deceased individual.

"(ii) EXCEPTION.—A second claim may be filed under subsection (a)(1) by an individual (or by a personal representative on behalf of a deceased individual) if the individual is an individual described in clause (i)(II), (i)(III), or (ii)(II) of subsection (a)(3)(B).".

1 **SEC. 203. IMMEDIATE AFTERMATH DEFINED.**

2 Section 402 of the Air Transportation Safety and
3 System Stabilization Act (49 U.S.C. 40101 note) is
4 amended by adding at the end the following new para-
5 graph:

6 "(11) IMMEDIATE AFTERMATH.—In section
7 405(c)(2)(A)(i), the term 'immediate aftermath'
8 means any period beginning with the terrorist-re-
9 lated aircraft crashes of September 11, 2001, and
10 ending on July 31, 2002.".

11 **SEC. 204. ELIGIBLE INDIVIDUALS TO INCLUDE ELIGIBLE**
12 **WTC RESPONDERS AND ELIGIBLE WTC RESI-**
13 **DENTS AND OTHER NON-RESPONDERS.**

14 Section 405(c)(2) of the Air Transportation Safety
15 and System Stabilization Act (49 U.S.C. 40101 note) is
16 amended—

17 (1) in subparagraph (A)(i), by striking "at the
18 World Trade Center, (New York, New York), the
19 Pentagon (Arlington, Virginia), or"and inserting
20 "within the New York City disaster area (as defined
21 in section 3009 of the Public Health Service Act) or
22 any area (such as marine transport stations, barges,
23 trucks in transit, and Fresh Kills in Staten Island,
24 and including loading, unloading, sorting, and sifting
25 areas) at which debris from the former World Trade

1 Center was handled, at the Pentagon (Arlington,
2 Virginia), or at";
3 (2) in subparagraph (A)(ii), by inserting "or
4 the handling of such debris" after "such an air
5 crash";
6 (3) in subparagraph (B), at the end by striking
7 "or";
8 (4) in subparagraph (C), by striking "subpara-
9 graph (A) or (B)" and inserting "subparagraph (A),
10 (B), or (C)";
11 (5) by redesignating subparagraph (C) as sub-
12 paragraph (D); and
13 (6) by adding after subparagraph (B) the fol-
14 lowing new subparagraph:
15 "(C) an individual who is an eligible WTC
16 responder or an eligible WTC resident or other
17 non-responder, as defined in sections 3011(a)
18 and 3021(a), respectively, of the Public Health
19 Service Act; or".

20 **SEC. 205. LIMITED COVERAGE FOR ADDITIONAL INDIVID-**
21 **UALS.**

22 (a) ADDITIONAL INDIVIDUALS.—Section 405(c) of
23 the Air Transportation Safety and System Stabilization
24 Act (49 U.S.C. 40101 note) is amended—

1 (1) in paragraph (2), by inserting ", or is de-
2 scribed in paragraph (4)" before the semicolon at
3 the end; and
4 (2) by adding at the end the following new
5 paragraph:
6 "(4) ADDITIONAL INDIVIDUALS.—An individual
7 described in this paragraph is an individual who—
8 "(A) is diagnosed at a Clinical Center of
9 Excellence (with respect to an eligible WTC
10 resident or other non-responder) under title
11 XXX of the Public Health Service Act with an
12 identified WTC-related health condition for
13 residents and or other non-responders; and
14 "(B) but for this paragraph would not be
15 a claimant described in paragraph (2).".
16 (b) LIMITATION.—Section 406 of the Air Transpor-
17 tation and Safety Stabilization Act (49 U.S.C. 40101
18 note) is amended by adding at the end the following new
19 subsection:
20 "(d) LIMITATION ON FUNDING FOR CERTAIN CLAIM-
21 ANTS.—
22 "(1) IN GENERAL.—Notwithstanding any other
23 provision of this title, in the case of claimants de-
24 scribed in section 405(c)(4)—

1 "(A) the total payments that may be made
2 under this title for such claimants shall not ex-
3 ceed $50,000,000; and
4 "(B) no such payment shall be made to
5 compensate for items and services for which
6 payment is made under title XXX of the Public
7 Health Service Act.
8 "(2) CRITERIA FOR DISTRIBUTION.—If the Spe-
9 cial Master determines that the amount provided
10 under paragraph (1)(A) is not adequate to pay
11 claims under this title for all such claimants, the
12 Special Master shall establish criteria for the dis-
13 tribution of such amount among such claimants.".

14 **SEC. 206. WORLD TRADE CENTER COLLAPSE AND DIS-**
15 **ASTER RESCUE, RECOVERY, DEBRIS RE-**
16 **MOVAL, CLEANUP, REMEDIATION, AND RE-**
17 **SPONSE INDEMNIFICATION.**

18 Section 408 of the Air Transportation and Safety
19 Stabilization Act (49 U.S.C. 40101 note) is amended by
20 adding at the end the following new subsection:
21 "(d) INDEMNIFICATION.—
22 "(1) IN GENERAL.—Notwithstanding any other
23 provision of Federal, State, local, or other law, the
24 United States hereby indemnifies and shall defend
25 and hold harmless all contractors and subcontractors

1 (at any tier), including any general contractor, con-
2 struction manager, prime contractor, or any parent,
3 subsidiary, affiliated company, or joint venture
4 thereof, and the City of New York, for any and all
5 pending or future claims and actions and for any
6 and all liability arising from or related to the rescue
7 and recovery efforts and the debris removal, cleanup,
8 remediation, and response to the World Trade Cen-
9 ter collapse and disaster subsequent to the terrorist-
10 related aircraft crashes of September 11, 2001,
11 whether such claims and actions and liability are for
12 compensatory or punitive damages, for contribution
13 or indemnity, or for any other form or type of relief.
14 The indemnification provided herein shall apply to
15 any and all liability, damages, or other obligation to
16 pay any sums (including attorneys fees, other litiga-
17 tion costs, fines, penalties, or other assessments) of
18 the aforementioned parties, except conduct held to
19 be intentionally tortious in nature, regardless of
20 whether such liability, damages, or obligation to pay
21 arises from a finding of liability by a court of com-
22 petent jurisdiction, through arbitration or another
23 method of dispute resolution, through settlement of
24 claims, or any other method of resolution. No such
25 indemnification payment shall be made to the extent

1 such payment would duplicate payments made under
2 title XXX of the Public Health Service Act.
3 "(2) RECOVERY OF PAYMENTS.—To the extent
4 that insurance coverage exists that is applicable and
5 available to cover a claim, action, or liability for
6 which the indemnification provided under paragraph
7 (1) applies, the United States shall have the right to
8 seek recovery for any payments made under this
9 subsection from any insurer that provided such in-
10 surance coverage.
11 "(3) CONTINGENCY.—Paragraph (1) shall not
12 apply with respect to the City of New York unless,
13 within 30 days after the date of the enactment of
14 this subsection, the City provides for the dissolution
15 of the WTC Captive Insurance Company and the
16 payment to the Treasury of the United States of all
17 remaining funds of such company. Payment of such
18 funds shall be credited against expenditures made
19 under this title as a result of amendments made by
20 title II of the James Zadroga 9/11 Health and Com-
21 pensation Act of 2008. The previous sentence shall
22 not be construed to limit the funds available to carry
23 out such amendments.".

○

○