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Selected Federal Compensation Programs for Physical Injury or Death

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Summary

Congress has established a number of programs to compensate or assist victims of certain specific circumstances, including negligence, terrorism, and "acts of God." Federal compensation programs can be described by certain common attributes. These include aspects of program administration; requirements for and determination of individual eligibility; eligibility of healthcare providers; types of benefits provided; whether certain diseases are presumed to be eligible for compensation; and the means by which the program is financed.

Though federal compensation programs display considerable diversity in these attributes, most can be classified into one of three categories: (1) programs that primarily limit compensation or assistance to *specified groups of people*, with little or no limitation of the types of injury that may be compensated; (2) programs that primarily limit compensation or assistance for *specified types of injuries*, with little or no limitation of the classes of individuals who may be compensated; and (3) hybrid programs, which limit both the classes of eligible individuals and the compensable injuries or diseases.

This report describes a number of federal programs that Congress established to compensate or assist individuals who have suffered physical or psychological harm as a consequence of specific events (including the actions of others), or who have suffered specific types of physical or psychological harm. First, several program attributes — which are used to describe specific programs — are discussed in general. Next, selected compensation programs are presented in three groupings, as mentioned above. Next, three veterans' compensation programs are presented. Veterans' disability compensation is based on establishing a connection between an illness or injury and military service. Congress has on three occasions granted a presumption of a service-connection for a specific group of veterans. Finally, an **Appendix** describes three additional federal assistance programs that do not fit into the above classifications, but that may nonetheless be of interest to policymakers: The Federal Tort Claims Act, emergency and disaster assistance, and the Breast and Cervical Cancer Treatment Program.

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Selected Federal Compensation Programs for Physical Injury or Death

Introduction

In many instances, people who suffer physical or psychological injury, disease or death due to the actions of others may gain compensation through civil actions in the courts. In addition, Congress has established a number of programs to compensate or assist victims of certain specific circumstances, including negligence, terrorism, and "acts of God." The programs fall, broadly, into three categories: (1) those that primarily limit compensation or assistance to *specified groups of people*, with little or no limitation on the types of injury that may be compensated (e.g., workers' compensation systems); (2) those that primarily limit compensation or assistance for *specified types of injuries*, with little or no limitation of the classes of individuals who may be compensated (e.g., the Vaccine Injury Compensation Program); and (3) hybrid programs, which limit both the classes of eligible individuals, and the compensable injuries or diseases (e.g., the Black Lung Program).

These compensation programs display considerable diversity in program design and implementation. In the context of considering compensation for asbestos exposure, the Government Accountability Office (GAO) reviewed four federal programs designed to compensate individuals injured by exposure to harmful substances. GAO found that design of the programs, the agencies that administer them, their financing mechanisms, benefits paid, and eligibility criteria, including their standards of proof (the evidence claimants must provide to support their claims), differed significantly.[1]

To assure responsible stewardship of available funds, a variety of approaches are used to determine whether conditions stated in claims are actually related to the relevant employment or incident, and should, therefore, be compensated. This matter is more easily resolved in the case of acute injuries, such as a broken leg sustained from a fall, than it is for illnesses that emerge some time following an exposure (often termed a *latent period*). Some programs, such as those for workers' compensation, evaluate claims administratively on a case-by-case basis, offering claimants the opportunity to appeal denied claims. Other programs, particularly those dealing with ionizing radiation or other hazardous exposures that may cause a number of different health conditions, develop lists (often called tables) of

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[1] Government Accountability Office (GAO), "Federal Compensation Programs: Perspectives on Four Programs," GAO-06-230, Nov. 2005. GAO evaluated the Black Lung Program, the Vaccine Injury Compensation Program (VICP), the Radiation Exposure Compensation Program (RECP), and the Energy Employees Occupational Illness Compensation Program (EEOICP).

compensable conditions. It is presumed that when an eligible individual develops a listed condition, the condition is related to the exposure, and compensation is provided. This is called a *disease presumption.*

Vaccine injury compensation programs incorporate both an injury table and a time window following vaccination. Listed conditions that arise within the time window are presumed to be causally related to vaccination, and are compensated. Time limitations may not be applicable in many other circumstances, either because exposures did not occur at discrete or known times, or because some conditions (e.g., some cancers) may arise decades after exposure, but still be causally related to an exposure. When a program does not stipulate time limitations, there is nonetheless often the requirement that a claimant provide evidence that the onset of the condition did not precede the relevant exposure or incident.

Burdens to demonstrate or refute the eligibility of individuals, or causality for health conditions, vary among programs. Disease presumptions help shift the burden of proof from the claimant to the program administrator, in what is an intrinsically adversarial system. Disease presumptions ideally flow from scientific evidence showing a causal relationship between an exposure and a subsequent disease. But there is no bright line in medical science beyond which a causal relationship has been demonstrated, and a presumption should be provided. Further, it is not generally possible to know, for a specific individual, whether a condition is causally related to the exposure of interest, or arose for some other reason. Rather, when evidence suggests that exposed populations face an increased risk of developing certain conditions, the presumption of causality may be extended to all individuals in that population, in accordance with the compassionate intent that underpins many of these programs.

This report describes a number of federal programs that Congress established to compensate or assist individuals who have suffered physical or psychological harm as a consequence of specific events (including the actions of others), or who have suffered specific types of physical or psychological harm. First, several program attributes — which are used subsequently to describe specific programs — are discussed in general. Next, selected compensation programs are presented in three groupings, as mentioned above: (1) programs to compensate specified groups of individuals; (2) programs to compensate for specified types of illness or injury; and (3) hybrid programs. Next, three veterans' compensation programs are presented. Veterans' disability compensation is based on establishing a connection between an illness or injury and military service. Congress has on three occasions granted a presumption of a service-connection for a specific group of veterans. Finally, an **Appendix** describes three additional federal assistance programs that do not fit into the above classifications, but that may nonetheless be of interest to policymakers: the Federal Tort Claims Act, emergency and disaster assistance, and the Breast and Cervical Cancer Treatment Program.

Program Attributes

Each of the program descriptions in subsequent sections of this report include discussion of certain program attributes. Following a background discussion of each program, including the basis for congressional action, program attributes that are described include:

Program Administration. This section describes the program's statutory authority and supporting regulations, if not already mentioned in the background discussion; the agency or agencies responsible for its administration; and relevant topics such as: how payment decisions are made, how denials may be appealed (including whether agency decisions are subject to judicial review), and whether attorneys fees are covered.

Individual Eligibility. This section describes individuals who are potentially eligible for compensation or assistance, based upon factors such as employment, exposure to a hazard, or the development of a specific disease.

Eligibility of Healthcare Providers. Some of the programs discussed will reimburse individuals or their healthcare providers for the costs of eligible healthcare services. Of these programs, some will reimburse any licensed healthcare provider, unless that provider has been excluded, for cause, from participation. Others restrict, up front, the types of providers that may be reimbursed, in an effort to improve the quality of services provided.

Congress required, in the Black Lung Program, the establishment of a network of black lung clinics, to provide specialized care for black lung in areas where miners typically live. (This program is discussed further in a subsequent section of this report.) Some state workers' compensation programs also establish *specialized provider networks*, staffed by occupational medicine physicians and other specialists. Specialized provider networks can improve the quality of care by assuring that providers have experience in treating rare conditions, such as Black Lung and several other conditions discussed in this report. Such networks can serve as centers for clinical research, and sources of outreach and training to general practitioners, who may see these conditions very rarely. Requiring the exclusive use of in-network providers could limit access to care, if providers are not geographically well-placed with respect to the individuals they serve. On the other hand, a recent study found that use of a specialized provider network by the Louisiana workers' compensation system reduced lost work time, and was less costly, compared with traditional case management.[2]

Benefits. This section describes the benefits (typically cash) that eligible individuals may receive. These include one or more of the following: (1) a benefit for death or disability; (2) replacement of lost income; and (3) payment or reimbursement of healthcare costs. Compensation may be provided as one-time or

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[2] Edward J. Bernacki, et al., "A Preliminary Investigation of the Effects of a Provider Network on Costs and Lost-Time in Workers' Compensation," *Journal of Occupational & Environmental Medicine*, vol. 47(1), pp. 3-10, Jan. 2005.

lump-sum payments, as payment or reimbursement for needs as they accrue, or a combination of mechanisms. For most of the programs described in this report, compensation for healthcare costs, if provided, is limited to those health conditions that are related to the employment or incident being addressed. These programs do not, therefore, constitute general health insurance.

In some cases, the program serves as a *secondary payor*, and any comparable benefits paid by third parties are deducted from the program benefit. The program may also be considered as a third party payor by other benefits programs, which may reduce their payments accordingly, unless the primary program's benefits are protected from recoupment by statute. Benefits also vary in terms of whether they are considered as taxable income, and whether they are considered in determining eligibility for public benefit programs such as Medicaid and Food Stamps.

Disease Presumptions. For those programs with lists (or "tables") of presumed diseases, this section discusses the presumptive conditions, and the approach or approaches used to develop the list. Lists may be developed through a variety of mechanisms. Lists may be provided in statute (e.g., some radiation exposure programs). They may be developed through rulemaking (e.g., the vaccine injury compensation programs). Scientific advisory groups may be tasked with identifying diseases for possible inclusion in a presumptive list (e.g., veterans' compensation following exposure to Agent Orange).

Disease presumptions may be rebuttable. For example, many state workers' compensation laws provide rebuttable presumptions that lung cancer in firefighters who don't smoke be considered occupationally related. Program administrators could rebut the presumption — saying that other behaviors on an individual's part, or other factors, were more likely to have caused the cancer — and deny the claim.

Financing. The section describes the mechanism(s) by which the program is financed. Examples include annual appropriations, special appropriations, and payroll and excise taxes.

In its evaluation of four federal compensation programs,[3] GAO found that:

> ... the federal role in all four programs has expanded significantly over time. All four have expanded to provide eligibility to additional categories of claimants, cover more medical conditions, or provide additional benefits. As might be expected, as the federal role for these four programs has grown, so have their costs. Beyond the costs associated with expanded eligibility, increasing medical costs and new research on exposure levels and medical conditions associated with that exposure that could lead to expanded eligibility may further increase program costs. The difficulty in estimating the actual cost of these programs may be due to the inherent difficulty of estimating the number of claimants and anticipating expansions of the programs. However, because these programs may expand significantly beyond the initial cost estimates, policymakers must

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[3] The Black Lung Program, the Vaccine Injury Compensation Program (VICP), the Radiation Exposure Compensation Program (RECP), and the Energy Employees Occupational Illness Compensation Program (EEOICP).

carefully consider the cost and precedent-setting implications of establishing any new federal compensation programs, particularly in light of the current federal deficit.[4]

Programs for Specified Classes of Individuals

Workers' Compensation Systems

Background. Workers' compensation systems have been established in every state in accordance with state laws. Together, these cover the vast majority of private sector workers in the United States. Longshore and harbor workers are covered by a special federal law.[5] U.S. government employees are covered by the Federal Employees' Compensation Act (FECA).[6] These compensation systems vary in particulars, but are characterized in general by the following principles. When employees suffer injuries on the job, their employers are obligated to pay the cost of their medical care and (partial) replacement of wages during the period of disability. The system is administrative rather than court-oriented, as fault need not be determined. In view of the relatively prompt and guaranteed benefits, workers do not have standing to sue their employers for injuries, except in very special circumstances.

Program Administration. Employees apply for benefits through their employers or the employer's insurer. The Federal Employees Compensation Program and the Longshore and Harbor Workers' Compensation Program are administered by the Department of Labor, Employment Standards Administration, Office of Workers' Compensation Programs. These federal programs, and state governments, have appeal systems available in cases of disputes.

Individual Eligibility. The vast majority of employees in the United States are covered by workers' compensation. Benefits become available in cases of (in typical statutory language) "personal injury or death by accident arising out of and in the course of employment."

Eligibility of Healthcare Providers. Regulations for the Federal Employees Compensation program define physicians, hospitals and other providers as any such parties currently licensed under state law, and provide procedures for exclusion of providers under certain circumstances. "Qualified" providers are those that have not been excluded under these procedures. Grounds for exclusion include certain criminal conduct, exclusion from participation in other federal or state

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[4] GAO, "Federal Compensation Programs: Perspectives on Four Programs," GAO-06-230, pp. 4-5, Nov. 2005.

[5] The Longshore and Harbor Workers' Compensation Act (33 U.S.C. §§ 901 *et seq.*). Railroad and maritime (high seas) workers can make use of special federal laws, but these are court-oriented liability laws rather than true workers' compensation schemes.

[6] 5 U.S.C. Chapter 81.

programs, fraud, and certain billing irregularities.[7] Most states give the employee the choice of physician, at least in the first instance.

Benefits. Medical costs are fully covered. Wage replacement for total disability (whether temporary or permanent) is most often at a rate of two-thirds of the employee's wage, but limited to a maximum percent of the state's average wage for all workers. Benefits in many states are subject to offset for Social Security or unemployment insurance. Permanent partial disability may be compensated according to "percentage" of disability and may be limited by time or cumulative dollar amount. Some specific types of injuries, especially loss of certain body parts or functions, are compensated by a set schedule of dollar amounts or weeks-equivalent of wages.

Disease Presumptions. Not applicable. In principle, occupational diseases are covered as well as occupational injuries. In practice, though, disease claims are much more difficult to sustain. The difficulty arises most often because it is usually hard to prove that a disease was caused by a particular employment. Also, long-latency diseases may be manifested after the period allowed for filing claims has ended. In many states, moreover, explicit restrictions are placed on benefits for specific diseases, especially of the respiratory type. These may require a certain minimum exposure to the hazard, or a maximum period between exposure and disability, or they may require that there be total disability.

Financing. In 2004, the latest year tabulated, benefits nationwide totaled $56 billion, of which $29.9 billion was wage replacement and $26.1 billion was for medical care. Employer costs (which include insurance premiums and administration) were $87.4 billion. This was the equivalent of $1.76 for each $100 of payroll. Larger employers tend to "self-insure," i.e., pay benefits directly out of their own resources. Smaller employers[8] meet their obligations through insurance. Some state governments operate workers' compensation insurance funds; of these, some are legal monopolies, others allow competition with private insurers.

Additional Note. Various rehabilitation and training benefits must be made available under certain circumstances. Employees may be subject to loss of part or all of their wage replacement if they do not cooperate with the rehabilitation program.

Public Safety Officers' Benefits Program

Background. The Public Safety Officers' Benefits Act (P.L. 94-430)[9] established the Public Safety Officers' Benefits (PSOB) program to provide one-time compensation for line-of-duty death or permanent and total disability.[10] The program

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[7] 20 C.F.R. §§ 10.815 *et seq*.

[8] These terms are loosely defined, but "small" employers would commonly be those with less than 1,000 employees.

[9] 42 U.S.C. §§ 3796 *et seq*.

[10] Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, "Public (continued...)

also provides financial assistance for higher education, and certain additional support services, for the spouses and children of eligible public safety officers.

Program Administration. The PSOB program is administered by the Bureau of Justice Assistance ("the Bureau") in the Department of Justice. Claims are managed administratively. The Bureau is authorized to use appropriated funds to conduct appeals of public safety officers' death and disability claims. This includes capped reimbursement of claimants' attorneys' fees, for those claimants who obtain these services during the initial claims and/or appeals processes.

Individual Eligibility. The Public Safety Officers' Benefits Act initially covered state and local law enforcement officers and firefighters. Subsequently, Congress added federal law enforcement officers and firefighters; members of federal, state, and local public rescue squads and ambulance crews; Federal Emergency Management Agency personnel; state, local and tribal emergency management and civil defense agency employees; and chaplains serving public agencies in an official capacity. The law states that such individuals are eligible if "serving a public agency in an official capacity, *with or without compensation.*"[11] (Emphasis added.)

Eligibility of Healthcare Providers. Not applicable. The program does not provide a healthcare benefit.

Benefits. The PSOB program provides *death benefits* in the form of a one-time financial payment to the eligible survivors of public safety officers whose deaths are the direct and proximate result of a traumatic injury sustained in the line of duty, and provides *disability benefits* for public safety officers who have been permanently and totally disabled by a catastrophic personal injury sustained in the line of duty, if that injury permanently prevents the officer from performing any substantial and gainful work. Medical retirement for a line-of-duty disability does not, in and of itself, establish eligibility for benefits. For each death and disability claim, the award amount is solely determined by the actual date of the officer's death or disability.

At its 1976 inception, the PSOB program provided only a death benefit; in 1990, the program added the permanent, total disability benefit. The act established the payment level at $50,000 in 1976. The benefit level was increased to $100,000 in November 1988, and to $250,000 in October 2001, retroactive to January 1, 2001. The amount is pegged to the Consumer Price Index and is adjusted each fiscal year. As of October 1, 2006, the benefit amount is $295,194. The act requires the Bureau to expedite payments made for line-of-duty deaths or disabilities related to a terrorist attack. Benefits are reduced for individuals receiving certain other death or disability benefits; certain other benefit programs reduce benefits if PSOB program compensation is received.

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[10] (...continued)
Safety Officers Benefits Program," at [http://www.ojp.usdoj.gov/BJA/grant/psob/psob_main.html].

[11] 42 U.S.C. § 3796b.

Disease Presumptions. The act and program regulations do not limit the types of compensable injuries, but stipulate only the compensable outcomes. The act provides the benefit for individuals who have "died as the direct and proximate result of a personal injury sustained in the line of duty," or who have become "permanently and totally disabled as the direct result of a catastrophic injury sustained in the line of duty."[12] The law also provides, though, that an otherwise eligible individual shall be eligible for the death benefit as a result of a fatal heart attack or stroke suffered within 24 hours of "nonroutine stressful or strenuous physical ... activity" performed while on duty.[13] (This presumption is not rebuttable.) Otherwise, the program is not designed to compensate public safety officers for chronic diseases, although events associated with progressive disease may be covered if trauma (e.g., carbon monoxide poisoning) is a substantial contributing factor in causing a death.

Financing. The program received appropriations of $73 million in FY2006, including $3 million for its administration. The death benefits (about 88% of the total) are classified as a mandatory expenditure, and the disability and educational benefits as discretionary.

September 11th Victim Compensation Fund[14]

Background. The September 11th Victim Compensation Fund of 2001 (P.L. 107-42) was signed into law on September 22, 2001, establishing a program to compensate any individual (or the personal representative of a deceased individual) who was physically injured or killed as a result of the terrorist attacks. A victim (or personal representative) could seek no-fault compensation from the program, or could bring a tort action against an airline or other party, but could not do both (unless naming a terrorist as the other party).

Administration. On November 26, 2001, Attorney General Ashcroft appointed Kenneth R. Feinberg as special master to distribute the fund that Congress created without any financial cap. The Special Master developed and promulgated regulations governing the administration of the fund.[15] The deadline for filing a claim was December 22, 2003.

Individual Eligibility. Eligible claimants included individuals present at the World Trade Center, Pentagon, or Shanksville, Pennsylvania site at the time or in the immediate aftermath of the crashes and who suffered physical harm, as the direct result of the terrorist-related aircraft crashes.[16] A *personal representative*, in general, was an individual appointed by a court of competent jurisdiction as the personal

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[12] 42 U.S.C. § 3796.

[13] Ibid.

[14] This section was written by Celinda Franco, Domestic Social Policy Division. See CRS Reports: RL31716, *Homeland Security: 9/11 Victim Relief Funds,* by Celinda Franco; and RL31179, *The September 11th Victim Compensation Fund of 2001,* by Henry Cohen.

[15] 67 *Federal Register* 11233-11247, March 13, 2002, (28 C.F.R. § 104).

[16] 28 C.F.R. §104.2.

representative of the decedent or as the executor or administrator of the decedent's will or estate.[17] If no personal representative was appointed by a court, the Special Master was authorized to determine who would be the personal representative for purposes of compensation under the Fund.

Eligibility of Healthcare Providers. Not applicable. The program did not provide a healthcare benefit.

Benefits. Of the 2,973 eligible families of dead victims, 2,880 filed claims.[18] The average award for families of victims killed in the attacks exceeded $2 million. In addition, 2,682 valid injury claims were filed and processed. The average award for injured victims was nearly $400,000. The overall payout of the program was over $7.1 billion.[19] Determinations were final and were not subject to judicial review.

The fund has issued awards for personal injury claims that are quite varied, reflecting the varied nature of the injury, the recovery, the existence or lack of existence of a disability or incapacity, the long-term prognosis, and the ongoing pain and suffering or lack thereof for each victim. To date, awards have ranged from a low of $500 to a high of over $8.6 million after offsets.[20]

Congress mandated that awards be offset by life insurance and other collateral source compensation. In the regulations the Special Master defined "collateral sources" as not including tax benefits received from the federal government as a result of the Victims of Terrorism Tax Relief Act. He also determined that the amount of offsets for pension funds, life insurance, and similar collateral sources be reduced by amounts of self-contributions made, or premiums paid by, the victim.

Disease Presumptions. The program provided compensation for physical injury or death, from any cause, that resulted from an individual's presence at the sites at the time of the crashes or in their immediate aftermath. For all claimants other than rescue workers, the *immediate aftermath*[21] was defined as the period of time that included 12 hours after the time of the crashes. For rescue workers, the

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[17] 28 C.F.R. §104.4.

[18] Seventy people chose to file law suits naming airlines and government agencies and thereby rejected the federal government's offer of compensation. Twenty-three eligible families of dead victims took no action. These families are no longer eligible to receive compensation from the fund.

[19] U.S. Department of Justice, *Final Report of the Special Master for the September 11th Victim Compensation Fund of 2001*, vol. 1, p.1.

[20] Department of Justice, September 11th Victim Compensation Fund of 2001: Compensation for Personal Injury Victims, Award Payment Statistics, as of January 28, 2005, at [http://www.usdoj.gov/archive/victimcompensation/payments_injury.html]; and Compensation for Deceased Victims, Award Payment Statistics, as of January 28, 2005, at [http://www.usdoj.gov/archive/victimcompensation/payments_deceased.html].

[21] 28 C.F.R. §104.2(b).

immediate aftermath included the 96-hour period after the crashes. *Physical harm*[22] was defined as a physical injury to the body treated by a medical professional within 24 hours of the sustaining the injury, or within 24 hours of rescue, or within 72 hours of injury or rescue for victims who were unable to realize immediately the extent of their injuries or whose treatment by a medical professional was not available on September 11, or within a time period determined by the Special Master for rescue personnel who did not or could not obtain treatment by a medical professional within 72 hours. The program was not intended to provide compensation for illnesses or injuries that manifested after the stipulated time periods.

Financing. The overall payout of the program was more than $7 billion. Funding for the program was authorized under the 2001 Emergency Supplemental Appropriations Act for Recovery From and Response to Terrorist Attacks on the United States (P.L. 107-38). The law provided that not less than $20 billion be available for disaster recovery activities and assistance related to the terrorist acts in New York, Virginia, and Pennsylvania.

Programs for Specified Illnesses or Injuries

National Vaccine Injury Compensation Program[23]

Background. The National Childhood Vaccine Injury Act of 1986, as amended, provides compensation to persons who suffer injury or death from specified vaccines. It establishes a National Vaccine Injury Compensation Program (VICP) to provide prompt, no-fault, but limited, recovery.[24] Claimants who are denied an award under the program, or are dissatisfied with an award, may sue vaccine manufacturers and administrators under state tort law, as modified by the federal statute.[25] Persons injured by a vaccine administered after October 1, 1988, with claims of more than $1,000, may not sue a vaccine administrator or manufacturer without first applying for compensation under the program.

Program Administration. The program is jointly administered by the Department of Health and Human Services (HHS), the Department of Justice (DOJ), and the United States Court of Federal Claims. Claims for compensation under the program are served on the Secretary of HHS and filed in the United States Court of Federal Claims. HHS (through HRSA, the Health Resources and Services Administration) reviews the medical information in the claim, and this review is sent to DOJ, which represents the Secretary of HHS. DOJ reviews the legal aspects of the claim.

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[22] 28 C.F.R. §104.2(c).

[23] This section was written by Henry Cohen, American Law Division.

[24] See HHS, Health Resources and Services Administration (HRSA), National Vaccine Injury Compensation Program (VICP), at [http://www.hrsa.gov/vaccinecompensation/].

[25] 42 U.S.C. §§ 300aa-1 *et seq.*

Individual Eligibility. Any person who has been injured or who has died as a result of the administration of a vaccine set forth in the Vaccine Injury Table contained in the statute may file a petition for compensation under the program. To be eligible to file a claim, the effects of the person's injury must have: lasted for more than six months after the vaccine was given; or resulted in a hospital stay and surgery; or resulted in death.

Eligibility of Healthcare Providers. No restrictions.

Benefits. Compensation under the program is limited to: (1) actual nonreimbursable and reasonable projected nonreimbursable expenses for medical and custodial care and rehabilitation, and related expenses; (2) in the event of a vaccine-related death, $250,000 for the estate of the deceased; (3) actual and anticipated loss of earnings; (4) up to $250,000 for actual and projected pain and suffering and emotional distress; and (5) reasonable attorneys' fees and other costs.

Disease Presumptions. A Vaccine Injury Table is established in statute, and may be modified by the Secretary of HHS through rulemaking. Individuals may petition the Secretary to amend the table. The table currently lists specified compensable adverse events, which must occur within specified time frames, for nine different types of vaccines.[26] Four types of vaccines which were recently added to the list do not yet have specified compensable conditions or time frames.[27] The table also includes "[a]ny new vaccine recommended by the Centers for Disease Control and Prevention for routine administration to children, after publication by Secretary, HHS of a notice of coverage."[28] Compensable adverse events typically include anaphylaxis or anaphylactic shock, infections caused by certain live-virus vaccines, any acute complications (including death) that result from these events, and a number of conditions that are specific to certain vaccines.

Financing. Compensation under the program is paid from the Vaccine Injury Trust Fund, which is funded by a manufacturers' excise tax on certain vaccines. In FY2006, $54 million in claims were paid, $277 million in deposits were received, and the trust fund ended the year with a balance of $2.37 billion.

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[26] Vaccines for which compensable conditions have been established are: tetanus toxoid-containing vaccines; pertussis antigen-containing vaccines; measles, mumps and rubella virus-containing vaccines in any combination; rubella virus-containing vaccines; measles virus-containing vaccines; polio live virus-containing vaccines; polio inactivated-virus containing vaccines; Hepatitis B antigen-containing vaccines; and vaccines containing live, oral, rhesus-based rotavirus.

[27] Listed vaccines without specified compensable conditions are: Hemophilus influenzae (type b polysaccharide conjugate vaccines); varicella vaccine; rotavirus vaccine; and pneumococcal conjugate vaccines.

[28] HRSA, Vaccine Injury Table, at [http://www.hrsa.gov/vaccinecompensation/table.htm].

Smallpox Vaccine Injury Compensation Program

Background. In January 2003, the Secretary of Health and Human Services (HHS) declared that the potential for a bioterrorist incident made it advisable to administer, on a voluntary basis, smallpox vaccine and related countermeasures to certain individuals — such as healthcare workers and public safety officers — who may be called upon to respond in the event of a smallpox attack.[29] At that time, liability protections were already in place for parties who manufacture and who would be involved in distribution and administration of smallpox countermeasures, but there was not yet a mechanism to compensate individuals who may be harmed by the indemnified products. Based on historical information, 1% of those who receive the smallpox vaccine may suffer non-life-threatening adverse reactions, and one or two people per million may die as a result of vaccine-related adverse reactions.[30] In April 2003, Congress passed the Smallpox Emergency Personnel Protection Act of 2003 (SEPPA, P.L. 108-20), requiring the federal government, through the Secretary of HHS, to establish a program to provide to eligible individuals or their survivors, for covered injuries, payment for related medical care, lost employment income, and death benefits.[31] The program covers injuries that the Secretary finds to be vaccine-related, occurring in individuals who volunteered for vaccination, or those who were infected after contact with those individuals (so-called "vaccinia contacts").

Program Administration. The Smallpox Vaccine Injury Compensation Program is administered by HRSA.[32] The program borrows certain elements from the PSOB program, including the amount of the death benefit, and the categorization and prioritization of survivors. SEPPA establishes that the government is a secondary payor for most benefits available under the program. Thus, benefits are generally secondary to any obligation of any third-party payor. Requesters generally must provide the names of all other third-party payors that have already provided benefits, that are expected to do so in the future, or that may have a duty to do so. These payers include, but are not limited to: insurance companies, workers compensation programs, the Federal Employees Compensation Program, or the PSOB program. The law does not permit judicial review of the Secretary's actions.

Individual Eligibility. Eligible individuals are: (1) those who were vaccinated in the context of a covered occupation (including health care workers, law enforcement officers, public safety personnel, and supporting personnel), who received a smallpox vaccine as a participant in an approved smallpox emergency response plan, and who sustained a compensable injury (described below); (2) certain vaccinia contacts, namely, those individuals who are infected as a result of contact

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[29] 68 *Federal Register* 4212-4213, Jan. 28, 2003. The declaration has been extended several times, and remains in effect. See 72 *Federal Register* 4013-4014, Jan. 29, 2007.

[30] Centers for Disease Control and Prevention, smallpox information at [http://www.bt.cdc.gov/agent/smallpox/].

[31] See CRS Report RL31960, *Smallpox Vaccine Injury Compensation*, by Susan Thaul.

[32] See HRSA, Smallpox Vaccine Injury Compensation Program information, at [http://www.hrsa.gov/smallpoxinjury/]. Program regulations are at 42 C.F.R. Part 102.

with individuals described in (1); and, (3) certain survivors and representatives of the estates of deceased individuals described in (1) and (2).[33]

Eligibility of Healthcare Providers. No restrictions.

Benefits. The benefits available under the program include compensation for medical care, lost employment income, and survivor death benefits. There are no deductibles, caps or cost-sharing requirements for medical benefits. However, the Secretary may limit the payment of such benefits to the amounts he considers reasonable for those services and items he considers reasonable and necessary. In addition, payment of medical benefits or reimbursement of costs for medical services and items by the program is secondary to the obligations of any third-party payor. The death benefit is in the amount specified by the PSOB program. (As of October 1, 2006, the benefit amount is $295,194.) Any death benefit to survivors is reduced by the amount that the smallpox vaccine injury compensation program had paid as lost employment income benefits to the deceased. The death benefit may not be in addition to a PSOB disability or death benefit. The death benefit may, however, be made in addition to any payment or reimbursement for medical care made to that person prior to death.

Disease Presumptions. Smallpox vaccine recipients are eligible for compensation for 12 covered conditions. Vaccinia contacts are eligible for compensation for 11 of these conditions.[34] The onset of each compensable condition must occur within a specified time following vaccination.

Financing. In April 2003, coincident with passage of SEPPA, Congress provided, in the Emergency Wartime Supplemental Appropriations Act, 2003 (P.L. 108-11), $42 million in no-year funds for the Secretary of HHS to compensate eligible individuals who were injured as a result of smallpox vaccination. Congress has since rescinded $30 million of that amount.[35] As of January 2007, HRSA has received 62 claims, and has paid one death claim of $262,100, 10 medical expense and injury claims totaling $1,616,000, and five claims for lost employment income totaling $94,352. Additional claims are pending.[36] The agency also reports spending

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[33] Eligibility was restricted to individuals who were vaccinated as part of an approved smallpox response plan, and their contacts. However, since smallpox vaccine is not commercially available, it is likely that most or all of the individuals who received the vaccine would have met this definition.

[34] Compensable conditions are: significant local skin reaction; Stevens-Johnson Syndrome; inadvertent inoculation; generalized vaccinia; eczema vaccinatum; progressive vaccinia; postvaccinial encephalopathy, encephalitis or encephalomyelitis; fetal vaccinia; secondary infection; anaphylaxis or anaphylactic shock (vaccinia contacts not covered); vaccinial myocarditis, pericarditis, or myopericarditis; and, death resulting from any of the above injuries when the injury arose within the specified time.

[35] P.L. 108-447, Section 224 (Dec. 8, 2004), rescinded $20 million, and P.L. 109-149, Section 220 (Dec. 30, 2005), rescinded an additional $10 million.

[36] The Centers for Disease Control and Prevention reports that as of January 2007, approximately 45,000 civilian volunteers have received smallpox vaccinations. CDC (continued...)

slightly more than $2 million in administrative costs, including the costs of identifying third-party payors and establishing annuities.[37] As the smallpox threat declaration remains in force, and vaccines may continue to be administered, the compensation program remains in effect.

Hybrid Programs

Black Lung Program

Background. As an alternative to benefits under state workers' compensation programs, which were found to be rarely accessible to coal miners suffering from pneumoconiosis (black lung), the Black Lung Benefits Act provides cash compensation and medical care benefits to black lung victims, and cash payments to their survivors.[38]

Program Administration. The program is administered by the Office of Workers Compensation Programs in the Department of Labor. Prior to 2003, the Part B benefit (pertaining to the oldest claims) was administered by the Social Security Administration.

Individual Eligibility. Coal miners totally disabled by black lung disease and their surviving dependents are eligible for benefits. A claim must meet three general conditions: (1) the miner must have (or if deceased, must have had) black lung disease; (2) the miner must be totally disabled by the disease; and (3) the disease must have arisen out of coal mine employment. Certain statutory presumptions of eligibility may come into play in establishing qualification for benefits, in addition to medical evaluations. For example, if a miner with pneumoconiosis worked in coal mines for more than 10 years, there is a presumption that the disease arose out of that employment. Claimants who filed through June 1973 (December 1973 in the case of survivors) were judged eligible under Part B program definitions; later claims are determined under somewhat more stringent Part C definitions. Coverage under Part B vs. Part C also differs depending on the date of claimants' last coal mine employment.

Eligibility of Healthcare Providers. There are no restrictions for miners receiving treatment for pneumoconiosis. However, in establishing the diagnosis of pneumoconiosis, an essential element of individual eligibility, providers who submit certain evidence such as chest X-rays may require special certifications (e.g., board certification in radiology.)

Congress created the Black Lung Clinics Program (BLCP) to provide specialized pulmonary and respiratory care to coal miners who otherwise could not

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[36] (...continued)
Washington Office, March 5, 2007.

[37] HRSA Office of Legislation, Feb. 26, 2007.

[38] 30 U.S.C. §§ 901-945; 26 U.S.C. §§ 4121 and 9501.

access specialized health care.[39] Eligible individuals are not required to receive care through a Black Lung Clinic. The BLCP is administered by HRSA.[40]

Benefits. Part B and Part C benefits are the same amount. Basic monthly cash compensation is equal to 37.5% of a base GS-2 federal salary, increased to as much as 75% of a GS-2 salary for those with dependents (or if there are multiple survivors). The current range of rates is from $584 to $1,168 per month.

The program pays for the full cost of any medical treatment and care of eligible disabled miners related to black lung disease, including reasonable transportation costs. The program provides two types of medical services related to black lung disease: diagnostic testing for all miner-claimants to determine the presence or absence of black lung disease and the degree of associated disability; and, for miners entitled to monthly benefits, medical coverage for treatment of black lung disease and disability. Diagnostic testing includes a chest x-ray, a pulmonary function study (breathing test), an arterial blood gas study, and a physical examination. Medical coverage includes (but is not limited to) costs for prescription drugs, office visits, and hospitalizations. Also provided, with specific approval, are items of durable medical equipment, such as hospital beds, home oxygen, and nebulizers; outpatient pulmonary rehabilitation therapy; and home nursing visits.[41]

Black lung beneficiaries also may receive benefits under state workers' compensation or black lung laws, social security or other disability or retirement systems, or unemployment compensation programs. Part B benefits are reduced by comparable payments received under workers' compensation, disability insurance, or unemployment compensation laws; they also are subject to a reduction for earnings. Part C benefits are reduced by comparable workers' compensation payments, but not by disability insurance or unemployment compensation payments; a reduction for earnings applies to claims made after 1981, and the receipt of Part C benefits can cause a reduction in social security disability benefits.

Disease Presumptions. Black Lung Program regulations require that certain medical evidence must be established to support a diagnosis of pneumoconiosis. Then, regulations establish certain presumptions in extending eligibility to miners with pneumoconiosis, including a rebuttable presumption that a miner who is suffering or suffered from pneumoconiosis, and who was employed for 10 or more years in one or more coal mines, developed pneumoconiosis as a

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[39] The Black Lung Benefits Reform Act of 1977 (Public Law 95-239), as amended, February 27, 1985, authorized support of the BLCP to evaluate and treat coal miners with respiratory impairments.

[40] HRSA, Black Lung Clinics Program, at [http://ruralhealth.hrsa.gov/funding/BLCP/]. See also, White House Office of Management and Budget, Program Assessment, Black Lung Clinics, 2006, at [http://www.whitehouse.gov/omb/expectmore/detail/10003534.2006.html].

[41] Department of Labor, Compliance Guide to the Black Lung Benefits Act, at [http://www.dol.gov/esa/regs/compliance/owcp/blbenact.html].

result of such employment; and an irrebuttable presumption that the death or total disability of a miner with pneumoconiosis is due to pneumoconiosis.[42]

Financing. The costs of the Part B program (cash compensation and related administrative expenses) are financed by federal appropriations from general revenues. Part C costs (cash payments, medical costs, and federal administrative costs) are largely funded by the Black Lung Disability Trust Fund, which in turn is financed by: (1) an excise tax on coal; (2) loans from the federal Treasury, if necessary because coal tax revenues are not sufficient; and (3) small amounts attributable to interest on trust fund investments in government securities, certain fees and penalties collected by the trust fund, and recoupment of some beneficiaries' payments. Some Part C benefits are paid directly by individual coal mine operators who have been identified "responsible" under specified rules.

In FY2004, the black lung trust fund paid $344 million in Part C benefits to some 44,000 recipients. About 5,000 new claims are being received each year. As the trust fund was inadequate to meet claims in the early years, it borrowed substantially from the Treasury and currently owes $9 billion. In recent years, coal tax receipts have been approximately equal to benefit payments, but the fund has had to borrow from the Treasury to meet its interest obligations to the Treasury. Proposals have been made for retiring this debt (e.g., H.R. 3915 in the 109th Congress).

Radiation Exposure Compensation Program

Background. The Radiation Exposure Compensation Act (RECA) of 1990 established a trust fund to provide compassionate lump-sum payments to individuals who have contracted certain cancers and other serious diseases that are presumed to be the result of their exposure to ionizing radiation from above-ground nuclear weapons testing or from various activities in connection with uranium mining.[43]

Program Administration. The Radiation Exposure Compensation Program (RECP) is administered by the Department of Justice, Civil Division.[44]

Individual Eligibility. As originally enacted, RECA established two categories of claimants: (1) downwinders (i.e., civilians who lived in specified counties in Nevada, Arizona, and Utah downwind from the Nevada Test Site in the 1950s and early 1960s) who developed one of 13 types of cancer; and (2) uranium miners in certain western states who worked in underground mines between 1947 and 1971 and who developed lung cancer or certain nonmalignant respiratory diseases. Immediately after its enactment, RECA was amended to include a third category of claimant: government employees and others who participated on-site in an above-ground test, and who developed one of the same 13 cancers for which downwinders

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[42] 20 C.F.R. §§ 718.301 *et seq*.

[43] P.L. 101-426 (Oct. 15, 1990), 42 U.S.C. § 2210 note.

[44] Information on RECA is available at [http://www.usdoj.gov/civil/torts/const/reca/index.htm].

may be compensated.[45] RECA was more substantially modified and expanded in 2000.[46] The changes included creating two new claimant populations (i.e., uranium mill workers and uranium ore transporters) and adding six types of cancer to the list of 13 cancers for which downwinders and on-site participants may be compensated.

Eligibility of Healthcare Providers. No restrictions; however, RECA authorizes grants for programs to screen potential claimants, provide referrals for treatment, help with claims documentation, and develop public information and education programs about radiogenic diseases. Under this authority, HRSA funds seven health care institutions in five western states (AZ, CO, NV, NM, and UT).

Benefits. The benefits for each of the RECA claimant categories are as follows: (1) downwinders who have contracted one of the 19 compensable cancer types receive a payment of $50,000; (2) on-site participants who have contracted one of the 19 compensable cancer types receive a payment of $75,000; (3) uranium miners who meet the exposure criteria or mined for at least a year during the relevant time period, and who have contracted lung cancer or certain nonmalignant respiratory diseases receive a payment of $100,000; and (4) uranium mill workers and ore transporters who worked during the relevant time period and have contracted lung cancer, certain nonmalignant respiratory diseases, kidney cancer, or certain other chronic kidney diseases receive a payment of $100,000. These benefits are offset (reduced) by any amounts received under private litigation, and acceptance of the benefits constitutes settlement of all claims against the federal government and its contractors. RECA payments are not subject to federal income tax and are not considered income for the purposes of computing eligibility for state or federal benefit programs.

Since the inception of the program, 25,696 claims have been filed, and more than $1.1 billion has been awarded to 16,867 claimants (as of January 3, 2007).

Disease Presumptions. The 19 compensable cancers established in statute are: leukemia (other than chronic lymphocytic leukemia); multiple myeloma; lymphoma (other than Hodgkin's disease); and primary cancer of the thyroid, breast, esophagus, stomach, pharynx, small intestine, pancreas, bile ducts, gall bladder, salivary gland, urinary bladder, brain, colon, ovary, liver (except if cirrhosis or hepatitis B is indicated), or lung.

Financing. In the past, Congress made annual appropriations to the RECA trust fund, from which compensation was paid to eligible claimants. Any money remaining in the trust fund at the end of the fiscal year was carried forward to the next fiscal year. Passage of the RECA Amendments of 2000 led to a dramatic increase in the number of claims filed and processed. Congress initially appropriated $11 million to the trust fund for FY2001, but followed that up with a supplemental appropriation for such sums as may be necessary to pay claims through the end of

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[45] P.L. 101-510 (Nov. 5, 1990). On-site participants are individuals who were present above or within the official boundaries of the Nevada, Pacific, Trinity, or South Atlantic Test Sites during a period of testing and who participated in the test.

[46] P.L. 106-245 (Jul. 10, 2000).

that fiscal year. The trust fund paid out a total of $108 million in approved claims in FY2001. The National Defense Authorization Act for FY2002 mandated the appropriation of such sums as may be necessary for the RECA trust fund for a 10-year period — FY2002 through FY2011 — up to a specified maximum amount each fiscal year.[47] The Consolidated Appropriations Act for FY2005 amended that language and made funding for the RECA trust fund mandatory and indefinite beginning in FY2006.[48] Also, beginning in FY2005, the trust fund only pays downwinder and on-site participant claims. Pursuant to the Ronald W. Reagan National Defense Authorization Act for FY2005, the claims of uranium miners, millers, and ore transporters are paid by the Energy Employees Occupational Illness Compensation Program (described below).[49] Furthermore, under this program uranium miners, millers, and ore transporters who receive RECA compensation may also be eligible to receive an additional $50,000 and future medical benefits related to the condition for which they received compensation under RECA.

Energy Employees Compensation Program

Background. The Energy Employees Occupational Illness Compensation Program Act (P.L. 106-398, Title XXXVI, October 30, 2000) provides monetary compensation and medical care to workers in the "nuclear weapons complex," the industrial operations involved in producing nuclear weapons.[50] Many of these workers have been exposed to radiation, beryllium and other toxic substances, in a context of official secrecy that may have impeded proper protection or compensation.

Program Administration. The lead agency is the Department of Labor (DOL), Office of Workers' Compensation Programs, with auxiliary roles played by the National Institute of Occupational Safety and Health (NIOSH) and the Department of Energy (DOE). NIOSH makes certain technical estimates, such as radiation dose reconstruction. Under amending legislation in October 2004,[51] management of Title E (see below) was transferred from DOE to DOL. The remaining duties of DOE consist mainly of providing employment and exposure information and assuring the cooperation of government contractors in furnishing such information.

Individual Eligibility. The general rule is that employees of covered facilities in the nuclear weapons complex (primarily government contractors) who were significantly exposed to one of the specified hazards (beryllium, silica and ionizing radiation) become eligible for benefits under Subtitle B if they develop a specified

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[47] P.L. 107-107 (Dec. 28, 2001). The act capped the appropriations for the RECA Trust Fund as follows: FY2002, $172 million; FY2003, $143 million; FY2004, $107 million; FY2005, $65 million; FY2006, $47 million; FY2007, $29 million; FY2008, $29 million; FY2009, $23 million; FY2010, $23 million; FY2011, $17 million.

[48] P.L. 108-447 (Dec. 8, 2004).

[49] P.L. 108-375 (Oct. 28, 2004).

[50] 42 U.S.C. § 7384 *et seq.*

[51] Title 31 of the Ronald W. Reagan National Defense Authorization Act for FY2005, P.L. 108-375.

illness (berylliosis, silicosis and certain types of cancer). In addition, Subtitle E benefits are available to: (1) Subtitle B recipients, (2) weapons complex workers who develop any other illness caused by any toxic substance at these facilities, and (3) uranium miners and millers who are compensated under RECA (see section above). Survivors may claim benefits in lieu of deceased workers.

Eligibility of Healthcare Providers. No restrictions. Providers register with the Department of Labor's contractor (currently Affiliated Computer Services). Eligible claimants receive a document describing their accepted medical conditions. Fees limited to region-specific schedules (with no balance billing). Some services require preauthorization.

Benefits. The Subtitle B benefit (i.e., cases of beryllium, silica and radiation) is a lump sum of $150,000 and necessary medical treatment. The Subtitle E benefit was intended to provide a substitute for state workers' compensation in recognition of the difficulty these workers have had in getting workers' compensation. (Beginning early in 2005, it replaced a Subtitle D program which, rather than paying federal benefits, assisted workers in making claims under the workers' compensation laws of their states.) It consists of a one-time payment equal to the sum of two amounts: (1) for impairment, $2,500 times the claimant's percentage of permanent physical impairment (e.g., loss of all functional capabilities would receive the maximum of $250,000); and (2) for wage loss, $15,000 for each year up to normal retirement age that the worker was able to earn less than one-half his/her normal wage pre-injury (or $10,000 for each year of earnings between 50 and 75% of normal). The Subtitle E benefit is capped at $250,000. Also, the E benefit (unlike the B benefit) is subject to offset for any workers' compensation payments received.

Disease Presumptions. Diagnostic criteria for beryllium disease (including *beryllium sensitivity*) and silicosis are explicitly defined in the authorizing statute. Eligibility depends on the diagnosis combined with documented exposure in a covered work facility.

As for cancer (one of the 19 compensable types listed *supra* under RECA), each claimant's degree of exposure to radiation must be estimated and a determination made that the cancer was "more likely than not" caused by the radiation. This involves the use of radioepidemiological tables (discussed in more detail in the section on veterans' compensation, below), and takes into consideration the type of cancer, non-work exposures (such as smoking), and other relevant factors.

Such determinations based on dose reconstructions are not required for certain groups of workers in a category called the *Special Exposure Cohort* (SEC). Members of the SEC qualify for the presumption that their cancer was caused by their occupational exposure if they worked sufficiently long in certain facilities.

The act designated four specific groups of workers as members of the SEC.[52] In addition, Section 7384q of the act authorizes additional classes of workers to be

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[52] Certain workers at the gaseous diffusion plants at Paducah KY, Portsmouth OH and Oak Ridge TN, and at the Alaska underground test site.

included in the SEC upon designation by the President with the advice of a special advisory board appointed by NIOSH. These groups must be such that (1) "it is not feasible to estimate with sufficient accuracy the radiation dose that the class received," while at the same time, (2) "there is a reasonable likelihood that such radiation dose may have endangered the health of members of the class." As membership in the SEC greatly simplifies the process of qualifying for benefits, the process of designating SEC classes has become controversial. For example, there have been allegations of bias or other irregularities in appointing members of the advisory board, issuing contracts, and other matters.[53] At the same time, some Members of Congress have introduced bills to designate particular groups statutorily rather than relying on the Section 7384q process.

Financing. The authorizing statute made a permanent appropriation of such amounts as may be necessary to pay benefits. Administrative costs for Subtitle B require annual appropriation. As of January 28, 2007, 55,545 Subtitle B cases had been filed and 43,287 final decisions reached, of which 16,685 were approvals. Monetary compensation totaled $1.837 billion. At the same time, under Subtitle E, 44,250 cases had been filed, 21,724 decided (9,121 approved) and $567 million paid.[54]

Marshall Islands Nuclear Claims Tribunal[55]

Background. From 1946 to 1958, the United States conducted 67 atmospheric atomic and thermonuclear weapons tests on or near the Marshall Islands atolls of Bikini and Enewetak. During that time, the Marshall Islands, located east of Guam in the Southwest Pacific, was a district of the United Nations Trust Territory of the Pacific Islands administered by the United States. The Compact of Free Association, enacted in 1986, terminated the Trust Territory status of the Marshall Islands and Micronesia and provided a "full measure of self-government" for the peoples of the two island countries.[56] Section 177 of the Compact and the Agreement for the Implementation of Section 177 (the "177 Agreement") extended $150 million in the form of a trust fund (Nuclear Claims Fund) as compensation for the four "most affected" Marshall Islands atolls. According to U.S. government estimates, between 1958 and 2004, the United States spent $531 million on nuclear test-related compensation and assistance in the Marshall Islands. The Compact provided that the Nuclear Claims Fund constituted a "full and final settlement" of legal claims against the U.S. government, but provided for possible additional compensation, if loss or damages to persons or property arose or were discovered that

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[53] A number of hearings on these matters were held during 2006 by the House Judiciary Subcommittee on Immigration, Border Security and Claims.

[54] There were many cases where a claimant filed under both subtitles. The above figures reflect claims by a total of 59,671 workers.

[55] This section was prepared by Thomas Lum, Foreign Affairs, Defense and Trade Division.

[56] The Compact was negotiated and agreed to by the governments of the United States and the Marshall Islands and approved by plebiscite in the Marshall Islands and by the U.S. Congress in 1985 (P.L. 99-239). Portions of the Compact were renewed in 2003 (P.L. 108-188).

could not reasonably have been identified as of the effective date of the agreement, and if such injuries rendered the provisions of the Compact "manifestly inadequate." In September 2000, the Republic of the Marshall Islands (RMI) government submitted to the United States Congress a *Changed Circumstances Petition* requesting additional compensation pursuant to the Compact.

Program Administration. The 177 Agreement established a Nuclear Claims Tribunal (NCT) to adjudicate claims related to the nuclear testing program and allocated $45.75 million from the Nuclear Claims Fund for payment of personal injury and property damages awards. The Tribunal is made up of three judges for terms of three years, and is organized into three operational divisions — Administration, the Office of the Defender of the Fund, and the Office of the Public Advocate, all of which are under the supervision of the Chairman.[57] The Nuclear Claims Fund is now nearly exhausted and the NCT reportedly may soon cease operation for lack of funds.

Individual Eligibility. The Tribunal's system of personal injury compensation, implemented in 1991, is modeled after the Radiation Exposure Compensation Act (RECA). As with RECA, the Tribunal does not require the claimant to prove a specific causal link between his or her exposure to ionizing radiation and the claimant's injury. The claimant must simply provide proof of residency in the Marshall Islands during the years of nuclear testing (July 1, 1946 to August 19, 1958) and have one of the listed medical conditions (i.e., compensable diseases), which the Tribunal presumes to be caused by radiation exposure.

Eligibility of Healthcare Providers. No restrictions.

Benefits. Unlike RECA, which pays the same amount for all downwinder claims (i.e., $50,000), the Tribunal awards differing amounts for the various diseases on its list of compensable diseases.[58] Awards range from $12,500 for certain benign tumors and non-cancerous conditions to $125,000 for certain types of malignant cancer. For biological children of a mother who was physically present at the time of the testing, the NCT provides 50% of amounts offered to first-generation claimants.

Disease Presumptions. Initially, the Tribunal adopted a list of 25 compensable diseases, including the cancers listed under RECA, and other conditions for which there was credible evidence showing a significant statistical relationship between exposure to ionizing radiation and the subsequent development of the disease. In determining which diseases to include on the list, the Tribunal referred to the findings of the Radiation Effects Research Foundation in Japan and the U.S. National Academy of Sciences, and sought recommendations from Dr. Robert Miller, an expert in the field of radiation health effects. The Tribunal reviewed the list of

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[57] Nuclear Claims Tribunal, Republic of the Marshall Islands, at [http://www.nuclearclaimstribunal.com/].

[58] Ibid. See also CRS Report RL32811, *Republic of the Marshall Islands Changed Circumstances Petition to Congress*, by Thomas Lum, Kenneth Thomas, C. Stephen Redhead, David Bearden, Mark Holt, and Salvatore Lazzari.

compensable diseases each year and considered any new scientific evidence on diseases linked to exposure to ionizing radiation. As a result of that review process, the list has been amended on several occasions since 1991 and now includes a total of 36 medical conditions.[59]

Financing. The RMI government hired a U.S. investment management firm to act as trustee and manage the Nuclear Claims Fund, which was intended to generate a perpetual source of income for potential claimants. However, the NCT's personal injury awards alone (not counting property damages awards) have exceeded the $45.75 million allocation from the Nuclear Claims Fund. Furthermore, according to the NCT, the Fund has underperformed, growing to only $160 million between 1986 and 2001 rather than $270 million as expected when the Compact was negotiated. The NCT has awarded nearly $90 million for compensable injuries to nearly 2,000 individuals; however, pending additional money for the Nuclear Claims Fund, many claimants have received only partial payments.

Ricky Ray Hemophilia Relief Fund Program

Background. The Ricky Ray Hemophilia Relief Fund Act of 1998 established a five-year trust fund to provide compassionate lump-sum payments to hemophiliacs who became infected with the human immunodeficiency virus (HIV) during the early 1980s as a result of using HIV-infected antihemophilic (blood clotting) factor.[60] The act authorized appropriations to the trust fund totaling $750 million.

Program Administration. The Ricky Ray Hemophilia Relief Fund program was administered by HRSA. Pursuant to the act, the trust fund terminated on November 12, 2003. The administrative close-out of the program occurred on October 31, 2005.[61]

Individual Eligibility. The Ricky Ray program covered individuals with blood-clotting disorders, such as hemophilia, who used blood clotting factor between July 1, 1982, and December 31, 1987, and contracted HIV, as well as certain persons who contracted HIV from these individuals. In the event individuals eligible for payment were deceased, the program also provided payments to certain survivors of these individuals. In addition to hemophiliacs who contracted HIV from their treatments, their spouses and children are also eligible if infected.

Eligibility of Healthcare Providers. Not applicable. The program did not provide a healthcare benefit.

Benefits. The act provided for a payment of $100,000 to each eligible claimant. Some petitions resulted in a payment of less than $100,000. In all, the Ricky Ray program paid out more than $559 million to almost 7,200 eligible individuals and survivors. Ricky Ray payments were not subject to federal income

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[59] See Nuclear Claims Tribunal at [http://www.nuclearclaimstribunal.com/].

[60] P.L. 105-369 (Nov. 12, 1998), 42 U.S.C. §§ 300c — 22 note.

[61] Information on the Ricky Ray Relief Fund program is available at [http://bhpr.hrsa.gov/rickyray].

tax and did not affect eligibility for Medicaid or other federal benefits, nor were they subject to recoupment by insurers.[62]

Disease Presumptions. The act provided that any eligible individual (i.e., an individual who had a blood clotting disorder, who used clotting factors within the specified time period, and who had an HIV infection) would receive compensation. Eligible individuals were not required to offer evidence that HIV infection was caused by their use of clotting factors.

Financing. In three separate appropriations, the trust fund received a total of $655 million, which was more than sufficient to pay all the eligible claims.[63] All remaining funds were returned to the U.S. Treasury.

Veterans' Disability Compensation

Background. The Department of Veterans Affairs (VA) pays monthly cash benefits to veterans who are physically or mentally disabled by injury or disease as a result of military service. These disabilities need not have occurred in the line of duty, or even be related to active duty. For a condition to be regarded as service-connected — and, therefore, eligible for compensation — veterans need show only that the condition occurred (or was aggravated) as a result of military service, or arose during that period. The severity of a veteran's disability is evaluated by the VA, which assigns a disability rating, in increments of 10%, from 0 to 100%. In order to receive disability compensation, a veterans must be rated at least 10% disabled. The rate of compensation depends on the degree of disability and follows a payment schedule that is adjusted annually and applies to all veterans.[64]

To receive compensation for a service-connected disability, veterans are required to document that their condition is related to their service. The claim is often clearly documented by pertinent military records. However, with some medical conditions, evidence of a service-connection is inconclusive. Since 1988, Congress has on three occasions granted a *presumption* of a service-connection for a specific group of veterans, making these individuals potentially eligible for disability compensation in the absence of conclusive evidence linking their medical conditions to military service.

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[62] The act also specified that payments arising from the successful class action lawsuit brought by the hemophilia community against the manufacturers of blood clotting factor were not to affect eligibility for Medicaid or Supplemental Security Income.

[63] The Ricky Ray fund initially received $75 million in the FY2000 Labor-HHS-Education appropriations bill (P.L. 106-113). The FY2001 omnibus consolidated appropriations bill (P.L. 106-554) included $105 million for the fund. P.L. 106-554 incorporated the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, which provided an additional appropriation of $475 million for Ricky Ray. All funds were to remain available until expended.

[64] See CRS Report RL33113, *Veterans Affairs: Basic Eligibility for Disability Benefit Programs,* by Douglas Reid Weimer.

The following sections describe the VA's presumptive compensation programs for (1) atomic veterans, (2) Vietnam veterans, and (3) veterans of the 1991 Persian Gulf War. All VA cash payments are financed through federal appropriations.

Atomic Veterans: Non-presumptive claims. In 1984, Congress enacted legislation (P.L. 98-542) to establish a program to provide disability compensation to the so-called atomic veterans (i.e., radiation-exposed veterans who participated in the U.S. atmospheric atomic tests or in the U.S. occupation of Hiroshima and Nagasaki, Japan). The law instructed the VA to write regulations setting out the criteria for adjudicating claims. Under the program, the VA awards compensation if it determines that a veteran's disability is "at least as likely as not" the result of exposure to radiation while in service.[65] Although P.L. 98-542 only mentioned the atomic test participants and the occupation forces in Japan, the regulations cover all veterans who were exposed to radiation from any source while on active duty.

Each claim must be accompanied by an estimate of the radiation dose received by the claimant. Dose estimates are provided by the Defense Threat Reduction Agency (DTRA) using a variety of sources of data, including radiation badges worn by service personnel. Because many individuals were not issued badges and historical records are incomplete, inaccurate, or missing, DTRA often has to perform a dose reconstruction. A veteran may also submit an alternative dose estimate from a credible source. VA officials determine whether it is at least as likely as not that the veteran's disease is the result of service-connected radiation exposure using a set of radioepidemiologic tables developed by the National Cancer Institute. These tables allow an investigator to look up the probability that the development of a particular cancer at age T was caused by a radiation dose, D, at age t. In order to satisfy the VA's criterion (i.e., "at least as likely as not"), the probability of causation (POC) must be at least 50%. Current VA regulations state that all cancers and four non-malignant conditions (e.g., thyroid nodules) are potentially radiogenic. The agency will also consider evidence that diseases other than those listed in the regulations may be caused by radiation exposure.

Atomic Veterans: Presumptive claims. In response to atomic veterans' complaints about the difficulty of getting compensation under P.L. 98-542, Congress in 1988 enacted the Radiation-Exposed Veterans' Compensation Act (P.L. 100-321), which established a presumption of a service connection for 13 specified types of cancer. Unlike the earlier law, P.L. 100-321 does not require an estimation of radiation dose. If a veteran participated in one of three specified radiation-risk activities[66] and has one of the listed cancers, that veteran is presumed to have a

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[65] 38 C.F.R. § 3.311.

[66] P.L. 100-321 defined a radiation-risk activity as: on-site participation at an atmospheric atomic test; occupation of Hiroshima or Nagasaki; and internment as a POW in Japan during World War II, resulting in an opportunity for exposure. The VA subsequently expanded the definition of radiation-risk activities to include service at Amchitka Island, AK, prior to January 1, 1974, if a veteran was exposed while performing duties related to certain underground nuclear tests; and service at gaseous diffusion plants located in Paducah, KY, Portsmouth, OH, and an area known as K25 at Oak Ridge, TN.

service-connected condition and is eligible for compensation.[67] P.L. 102-578 amended P.L. 100-321 by adding two more cancers to the presumptive list, and P.L. 106-117 added one additional cancer. In 2002, the VA announced the addition of five more cancers, bringing the total number of compensable cancers to 21.[68]

Atomic veterans suffering from one of the 21 presumptive cancers have their claims adjudicated under P.L. 100-321. Veterans seeking radiation compensation for other types of cancer or non-cancer diseases must submit to a dose estimate or reconstruction and are considered under the non-presumptive program (i.e., P.L. 98-542).

Vietnam Veterans. In 1991, the Agent Orange Act (P.L. 102-4) established for Vietnam veterans a presumption of a service connection for diseases associated with exposure to Agent Orange and other herbicides that the U.S. Air Force sprayed over South Vietnam between 1962 and 1971. Under the act, veterans seeking disability compensation for diseases they claimed to be associated with herbicide exposure no longer were required to provide proof of such exposure. P.L. 102-4 authorized the VA to contract with the Institute of Medicine (IOM) to conduct, every two years, a scientific review of the evidence linking certain medical conditions to herbicide exposure. The VA was instructed to use the IOM's findings, and other evidence, to issue regulations establishing a presumption of a service connection for any disease for which there is scientific evidence of a positive association with herbicide exposure. Currently, the VA presumptively recognizes the following diseases as connected with military service in Vietnam: chronic lymphocytic leukemia; soft-tissue sarcoma; non-Hodgkin's lymphoma; Hodgkin's disease; chloracne; multiple myeloma; type II diabetes; acute and subacute peripheral neuropathy; prostate cancer; respiratory cancers and porphyria cutanea tarda. Additionally, Vietnam veterans' children with the birth defect spina bifida are eligible to receive a monthly monetary allowance in addition to certain health care services. The Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) authorized similar benefits and services for children with certain birth defects who were born to female Vietnam veterans.[69]

Persian Gulf War Veterans. The Veterans' Benefits Improvements Act of 1994 (P.L. 103-446) created a presumption of a service connection for Gulf War veterans with certain chronic disabilities resulting from illnesses that VA could not diagnose, and that appeared during active duty in the Gulf War or within a specified time period after Gulf War service. The Veterans' Education and Benefits Expansion

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[67] 38 C.F.R. § 3.309.

[68] The 21 cancers presumed to be service-connected for veterans who participated in radiation-risk activities are: leukemia (all forms except chronic lymphocytic leukemia); cancer of the thyroid, breast, pharynx, esophagus, stomach, small intestine, pancreas, bile ducts, gall bladder, salivary gland, urinary tract (renal pelvis, urethra, urinary bladder, and urethra), brain, bone, lung, colon, and ovary; bronchiolo-alveolar carcinoma; multiple myeloma; lymphomas (other than Hodgkin's disease); and primary liver cancer (except if cirrhosis or hepatitis B is indicated).

[69] See CRS Report RS22481, *Veterans and Agent Orange: Eligibility for Health Care and Benefits*, by Jacqueline Rae Roche and Sidath Viranga Panangala.

Act of 2001 (P.L. 107-103) expanded the definition of chronic disability under P.L. 103-446 to include the following three specific conditions: fibromyalgia, chronic fatigue syndrome, and irritable bowel syndrome.

Appendix: Selected Additional Federal Assistance Mechanisms

Federal Tort Claims Act[70]

Background. The Federal Tort Claims Act (FTCA) allows suits against the United States for torts committed by federal employees. With exceptions, it makes the United States liable "under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred."[71]

Program Administration. An injured person must first present an administrative claim to the responsible federal agency.[72] If the agency denies the claim, the injured person may file suit in a federal district court,[73] which will hear the case without a jury.[74]

Individual Eligibility. Any person may file a claim with the appropriate federal agency within two years after the claim accrues.[75] Federal employees injured on the job, however, whether military or civilian, may not recover under the FTCA.[76] Alternative compensation for work-related injury to these employees is available under the Federal Employees' Compensation Act and the veterans' compensation systems.

Eligibility of Healthcare Providers. No restrictions.

Benefits. Successful plaintiffs may recover economic and noneconomic damages, to the extent allowed by applicable state law, except that punitive damages may not be awarded, and attorney's fees may not be awarded unless the United States acts in bad faith.[77] Awards must be in lump-sum payments, but the parties may agree to structured settlements (i.e., periodic payments).

Disease Presumptions. Not applicable.

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[70] This section was written by Henry Cohen, American Law Division.

[71] 28 U.S.C. § 1346(b).

[72] 28 U.S.C. § 2675(a).

[73] 28 U.S.C. § 1346(b).

[74] 28 U.S.C. § 2402.

[75] 28 U.S.C. § 2401.

[76] 5 U.S.C. § 8116(c); *Feres* v. *United States*, 340 U.S. 135 (1950).

[77] 28 U.S.C. §§ 2674, 2412(b), 2412(d)(1)(A).

Financing. Awards and settlements of $2,500 or less are paid out of appropriations available to the agency whose employee committed the tort. Awards and settlements in excess of $2,500 are paid out of general revenues.[78]

Stafford Act Emergency and Disaster Assistance[79]

Background. In response to catastrophes, the President can provide funding to both state and local governments, and to individuals, to assist them in response and recovery. Assistance is provided under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (the Stafford Act), upon a presidential declaration of an emergency (providing a lower level of assistance) or a major disaster (providing a higher level of assistance).[80] Pursuant to a Stafford Act emergency or major disaster declaration, federal assistance may be provided to assist individuals either in a congregate setting through state and local governments, or directly to individuals, in covering the costs of healthcare for related injuries or illnesses. Additionally, if requested specifically by the Governor, a counseling program may also be made available under a Presidential declaration.

Administration. Stafford Act assistance programs are administered by the Federal Emergency Management Agency (FEMA) in the Department of Homeland Security (DHS).

Individual Eligibility. Individual eligibility is strictly based on residence in an area subject to a presidential emergency or major disaster declaration, pursuant to the Stafford Act.

Eligibility of Healthcare Providers. No restrictions.

Benefits. Pursuant to section 408 of the Stafford Act, the FEMA Individuals and Households Program (IHP) provides cash assistance for uninsured, disaster-related medical, dental, and funeral expenses.[81] The amount available is the same for an individual or a household, and is capped in statute, with an annual adjustment based on the Consumer Price Index. The current ceiling (for FY2007) is $28,200.[82] Recipients might have to use the funds to meet other needs concurrently, such as rent and other costs of living. FEMA evaluates individual eligibility, and

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[78] 28 U.S.C. § 2672. Specifically, awards and settlements over $2,500 are paid from the judgment fund, 31 U.S.C. § 1304, which is a permanent (i.e., not annually appropriated) fund for the payment of judgments not otherwise provided for.

[79] This section was written by Francis X. McCarthy, Government and Finance Division. See also, "Federal Assistance for Disaster-Related Healthcare Costs," in CRS Report RL33579, *The Public Health and Medical Response to Disasters: Federal Authority and Funding*, by Sarah A. Lister.

[80] 42 U.S.C. §§ 5121 *et seq*. See CRS Report RL33053, *Federal Stafford Act Disaster Assistance: Presidential Declarations, Eligible Activities, and Funding*, by Keith Bea.

[81] 44 C.F.R. § 206.119.

[82] 71 *Federal Register* 59514, Oct. 10, 2006.

whether claimed medical, dental and funeral costs are disaster-related, on a case-by-case basis.

Section 416 of the Stafford Act authorizes the President, pursuant to a major disaster declaration, to provide financial assistance to state and qualified tribal mental health agencies for professional counseling services, or training of disaster workers, to relieve disaster victims' mental health problems caused or aggravated by the disaster or its aftermath. The Substance Abuse and Mental Health Services Administration (SAMHSA) in HHS, and FEMA, jointly administer the Crisis Counseling Assistance and Training Program (CCP).[83]

Pursuant to Stafford Act sections 403 (for a major disaster declaration) and 502 (for an emergency declaration), states may receive federal assistance in providing for victims' healthcare needs, but such assistance is not provided directly to individuals.

Disease Presumptions. Not applicable.

Financing. Activities undertaken under authority of the Stafford Act are funded through appropriations to the Disaster Relief Fund (DRF), administered by FEMA. The DRF is a no-year account in which appropriated funds remain available until expended. Supplemental appropriations legislation is generally required each fiscal year to replenish the DRF to meet the urgent needs of particularly catastrophic disasters.[84]

Breast and Cervical Cancer Treatment Program

Background. In 1990, Congress established, in CDC, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which provides low-income, uninsured, and underserved women access to screening and diagnostic services to detect breast and cervical cancer at an early stage.[85] Women in the program who were found to have breast or cervical cancer often faced access barriers to treatment, for the same reasons that made them eligible for the screening program.[86] On October 2000, Congress passed the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354). (In 2001, in the Native American Breast and Cervical Cancer Treatment Technical Amendment Act, P.L. 107-121, Congress amended the act to also apply to American Indians/Alaska Natives who are eligible for health services provided by the Indian Health Service or by a tribal organization.) The act gives states the option to provide medical assistance, through Medicaid, to

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[83] See CRS Report RL33738, *Gulf Coast Hurricanes: Addressing Survivors' Mental Health and Substance Abuse Treatment Needs*, by Ramya Sundararaman, Sarah A. Lister, and Erin D. Williams.

[84] See CRS Report RL33053, *Federal Stafford Act Disaster Assistance: Presidential Declarations, Eligible Activities, and Funding*, by Keith Bea.

[85] CDC, National Breast and Cervical Cancer Early Detection Program, at [http://www.cdc.gov/cancer/nbccedp/].

[86] In 2005, between 1 and 2% of women who were screened for each condition were found to have cancer.

eligible women who were screened through the NBCCEDP and found to have breast or cervical cancer, including pre-cancerous conditions. All 50 states and the District of Columbia now offer such coverage.

Program Administration. The Medicaid program is administered by the states under broad federal guidelines and the oversight of the Centers for Medicare and Medicaid Services (CMS) in HHS.[87]

Individual Eligibility. In order for a woman to be eligible for Medicaid under this program, she must: (1) have been screened for and found to have breast or cervical cancer, including precancerous conditions, through the NBCCEDP; (2) be under age 65; and (3) be uninsured and otherwise not eligible for Medicaid. A woman remains eligible as long as she requires treatment for breast or cervical cancer, and continues to meet the other two criteria.

Eligibility of Healthcare Providers. CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to receive reimbursement through the Medicaid program. These conditions are the minimum health and safety standards that providers and suppliers must meet in order to be Medicaid certified. (These conditions apply equally for Medicare.) There are no additional provider restrictions applied to the Breast and Cervical Cancer Treatment program.

Benefits. Eligible individuals are entitled to the full range of Medicaid services as specified in the state plan.[88] Benefits are not limited to services for breast or cervical cancer. As is the case with Medicaid coverage in general, states may use administrative mechanisms, such as prior review and approval requirements, to determine that care and services furnished to women in this program are medically necessary.

Disease Presumptions. Not applicable.

Financing. States and the federal government share the cost of Medicaid. States are reimbursed by the federal government for a portion of a state's Medicaid program costs. Because Medicaid is an open-ended entitlement, there is no upper limit or cap on the amount of federal funds a state may receive.[89] The federal share of Medicaid is funded through general revenues.

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[87] CMS, Breast and Cervical Cancer: Prevention and Treatment, at [http://www.cms.hhs.gov/MedicaidSpecialCovCond/02_BreastandCervicalCancer_PreventionandTreatment.asp].

[88] For more information, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

[89] Ibid.