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The Public Health and Medical Response to Disasters: Federal Authority and Funding

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Summary

When catastrophes overwhelm the response capability of state and local authorities, the President can provide certain assets and personnel to aid stricken communities, and can provide funding to individuals, government and not-for-profit entities to assist them in response and recovery. Aid 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). The Secretary of Health and Human Services (HHS) also has both standing and emergency authorities to assist state and local governments, not-for-profit entities, and others in response to public health and medical emergencies.

The flawed response to Hurricane Katrina and preparedness efforts for an influenza ("flu") pandemic have each raised concerns about existing federal response mechanisms for incidents in which there are overwhelming public health and medical needs. In addition, some concerns have been expressed about federal leadership and delegations of responsibility for the public health and medical response to incidents, as carried out according to the National Response Plan (NRP).

While there is precedent for presidential authority to declare an infectious disease threat an emergency, pursuant to the Stafford Act, there is not corresponding precedent for the authority to declare such a threat a major disaster. Many of the needs likely to result from a flu pandemic could not be met with the types of assistance provided pursuant to the Stafford Act, even if a major disaster declaration applied. For example, in a severe pandemic, the healthcare system may have to provide care for seriously ill victims who are uninsured or underinsured, or sustain the loss of revenue if more lucrative but non-essential procedures are postponed during a pandemic. In addition, potential adverse economic impacts of a flu pandemic, such as losses in trade, travel and tourism, are not generally eligible for Stafford Act assistance. In the course of the public health and medical response to Hurricane Katrina, numerous federal aid mechanisms in addition to those in the Stafford Act assistance were developed administratively or in statute. Some of these mechanisms may be applicable during a flu pandemic.

This report examines: (1) the statutory authorities and coordinating mechanisms of the President (acting through the Secretary of Homeland Security) and the Secretary of HHS in providing routine assistance, and in providing assistance pursuant to emergency or major disaster declarations and/or public health emergency determinations; (2) mechanisms to assure a coordinated federal response to public health and medical emergencies, and overlaps or gaps in agency responsibilities; and (3) existing mechanisms and potential gaps in financing the costs of a response to public health and medical emergencies. A listing of federal public health emergency authorities is provided in the **Appendix**.

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The Public Health and Medical Response to Disasters: Federal Authority and Funding

Introduction

In response to catastrophes, the President can provide certain additional assets and personnel to aid stricken communities, and can provide funding to individuals and to government and not-for-profit entities to assist them in response and recovery.[1] This aid 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).[2]

While there is precedent for presidential authority to deem an infectious disease threat (i.e., West Nile virus) an emergency, there is not corresponding precedent regarding the authority to declare such a threat a major disaster. In addition, there are some concerns about federal leadership and delegations of responsibility for the public health and medical response to incidents, as carried out according to the National Response Plan (NRP), Emergency Support Function 8 (ESF-8).

Many of the needs likely to result from a flu pandemic could not be met with the types of assistance provided pursuant to the Stafford Act, even if a major disaster declaration applied. For example, in a severe pandemic, the healthcare system may confront the challenge of providing care for seriously ill victims who are uninsured or underinsured, as well as the loss of revenue from more lucrative but non-essential procedures that may be canceled as a result of the pandemic. In addition, potential adverse economic impacts of a flu pandemic, such as losses in trade, travel and tourism, or costs associated with changes in the demand for services, are not generally eligible for Stafford Act assistance.

In the course of the public health and medical response to Hurricane Katrina, numerous federal assistance mechanisms other than Stafford Act assistance were developed administratively or in statute. Some of these mechanisms may be

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[1] The terms *emergency* and *major disaster* have specific meanings in the Stafford Act. To avoid confusion, in this report the terms *event*, *incident*, and *catastrophe* will be used in general reference to events, whether or not Stafford Act assistance applies. The term *public health emergency* is also commonly used in both a generic manner and to describe one or more specific authorities in law. This is discussed further in the Appendix.

[2] Information on the Stafford Act is provided, in part, by Keith Bea of the Government and Finance Division of the Congressional Research Service (CRS). For background on the Stafford Act, see CRS Report RL33053, *Federal Stafford Act Disaster Assistance: Presidential Declarations, Eligible Activities, and Funding*, by Keith Bea.

applicable in response to a flu pandemic. Information regarding the overall cost of these one-time assistance mechanisms is not publicly available, however.

This report examines (1) the statutory authorities and coordinating mechanisms of the President (acting through the Secretary of Homeland Security) and the Secretary of Health and Human Services (HHS) in providing routine assistance, and in providing assistance pursuant to emergency or major disaster declarations and/or public health emergency determinations; (2) mechanisms to assure a coordinated federal response to public health and medical emergencies, and overlaps or gaps in agency responsibilities; and (3) existing mechanisms and potential gaps in financing the costs of a response to public health and medical emergencies. A listing of federal public health emergency authorities is provided in the **Appendix**.

Federal Authority and Plans for Disaster Response

Federal Statutory Authorities for Disaster Response

Stafford Act: Major Disaster Declaration. A major disaster declaration issued pursuant to the Stafford Act authorizes the President to provide a variety of types of assistance to eligible entities.[3] A major disaster declaration must meet three tests — *definition, need,* and *action*. First, the statute defines a major disaster as follows:

> "Major disaster" means any natural catastrophe (including any hurricane, tornado, storm, high water, winddriven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this chapter to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby."[4]

Second, the incident must result in damages significant enough to exceed the resources and capabilities not only of the affected local governments, but the state as well. The requirement is set forth as follows:

> All requests for a declaration by the President that a major disaster exists shall be made by the Governor of the affected State. Such a request shall be based on a finding that the disaster is of such severity and magnitude that effective

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[3] 42 U.S.C. § 5170(a)-5189. For more information, see CRS Report RL33053, *Federal Stafford Act Disaster Assistance: Presidential Declarations, Eligible Activities, and Funding*, pp. 7-9, by Keith Bea.

[4] 42 U.S.C. § 5122(2).

> response is beyond the capabilities of the State and the affected local governments and that Federal assistance is necessary.[5]

Third, the state must implement its authorities, dedicate sufficient resources, and commit to meet its share of the costs, as follows:

> As part of such request, and as a prerequisite to major disaster assistance under this chapter, the Governor shall take appropriate response action under State law and direct execution of the State's emergency plan. The Governor shall furnish information on the nature and amount of State and local resources which have been or will be committed to alleviating the results of the disaster, and shall certify that, for the current disaster, State and local government obligations and expenditures (of which State commitments must be a significant proportion) will comply with all applicable cost-sharing requirements of this chapter. Based on the request of a Governor under this section, the President may declare under this chapter that a major disaster or emergency exists.[6]

Stafford Act: Emergency Declaration. By comparison with a major disaster declaration, considerably less assistance is authorized under an emergency declaration.[7] However, the Stafford Act gives the President considerably broader discretion in issuing an emergency declaration. First, the definition of "emergency" does not include the specific causal events listed in the definition of "major disaster." The President instead may determine whether circumstances are sufficiently dire for the affected state to call for an emergency declaration. Also, of importance to the issue of an influenza pandemic or other mass health threat, the protection of public health is to be considered by the President, as seen in the following:

> "Emergency" means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.[8]

The statutory provisions concerning the procedures by which an emergency declaration will be considered by the President, like those for a major disaster, also contain requirements pertaining to *need* and *action*. However, as is the case with the definition of "emergency," the procedures section provides for a wider degree of discretion on the part of the President. While governors requesting assistance must take required actions, they do not have to identify that state and local resources have been committed. Governors must, however, identify the type and extent of federal aid required. The President also has discretion to act in the absence of a gubernatorial request if the emergency creates a condition that primarily or solely

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[5] 42 U.S.C. § 5170.

[6] Ibid.

[7] 42 U.S.C. § 5192-5193. For more information, see CRS Report RL33053, *Federal Stafford Act Disaster Assistance: Presidential Declarations, Eligible Activities, and Funding*, p. 9, by Keith Bea.

[8] 42 U.S.C. § 5122(1).

constitutes a federal responsibility. The Stafford Act procedure for an emergency declaration follows:

> (a) Request and declaration. All requests for a declaration by the President that an emergency exists shall be made by the Governor of the affected State. Such a request shall be based on a finding that the situation is of such severity and magnitude that effective response is beyond the capabilities of the State and the affected local governments and that Federal assistance is necessary. As a part of such request, and as a prerequisite to emergency assistance under this chapter, the Governor shall take appropriate action under State law and direct execution of the State's emergency plan. The Governor shall furnish information describing the State and local efforts and resources which have been or will be used to alleviate the emergency, and will define the type and extent of Federal aid required. Based upon such Governor's request, the President may declare that an emergency exists.
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> (b) Certain emergencies involving Federal primary responsibility. The President may exercise any authority vested in him by Section 5192 of this Title or Section 5193 of this Title with respect to an emergency when he determines that an emergency exists for which the primary responsibility for response rests with the United States because the emergency involves a subject area for which, under the Constitution or laws of the United States, the United States exercises exclusive or preeminent responsibility and authority. In determining whether or not such an emergency exists, the President shall consult the Governor of any affected State, if practicable. The President's determination may be made without regard to subsection (a) of this section.[9]

The emergency declaration authority in the Stafford Act has previously been used by a President to respond to a public health threat. In the fall of 2000, President Clinton issued two emergency declarations for New York and New Jersey to help the states contain the threatened spread of the West Nile virus.[10]

Public Health Emergency Authorities. Section 319 of the Public Health Service Act grants the Secretary of HHS broad authority to determine that a public health emergency exists. Pursuant to such a determination, the Secretary may waive certain administrative requirements, provide additional forms of assistance, and take certain other actions to expand federal aid to state and local governments, not-for-profit entities, and others. The Secretary's statutory authority to determine a public health emergency is as follows:

> If the Secretary determines, after consultation with such public health officials as may be necessary, that — (1) a disease or disorder presents a public health emergency; or (2) a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists, the Secretary may take such action as may be appropriate to respond to the public health

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[9] 42 U.S.C. § 5191. Examples of emergencies involving Federal primary responsibility include the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City, and the 2001 attack on the Pentagon, both federally owned facilities.

[10] For background, see Federal Emergency Management Agency (FEMA) notices at [http://www.fema.gov/news/disasters.fema?year=2000#em].

> emergency, including making grants, providing awards for expenses, and entering into contracts and conducting and supporting investigations into the cause, treatment, or prevention of a disease or disorder as described in paragraphs (1) and (2).[11]

The Secretary has a variety of additional authorities to provide assistance. Some of these authorities require a concurrent determination of public health emergency pursuant to the Section 319 authority above, some require a concurrent Stafford Act declaration, and some are independent of any other authority. A listing of various federal public health emergency authorities is provided in the **Appendix**.

The emergency authorities of the Secretary of HHS are not strictly comparable to authorities in the Stafford Act. Stafford Act major disaster assistance is intended to assist states and individuals with needs that exceed the scope of assistance routinely provided by federal agencies, and is often triggered by large-scale damage to public and private infrastructure. In contrast, the response to public health emergencies, such as infectious disease outbreaks, involves technical assistance for epidemiologic and laboratory investigation, workforce assistance, the provision of special drugs or tests, and a variety of other extensions of routine program activities.

The Secretary of HHS can provide a considerable degree of assistance to states, upon their request, without the restrictions of cause or the requirement to demonstrate need as with the Stafford Act. For example, simply upon the request of a State Health Official, and without the involvement of the President, the Centers for Disease Control and Prevention (CDC) can provide financial and technical assistance to states for outbreak investigation and disease control activities. These activities are carried out under the Secretary's general authority to assist states, pursuant to Section 311 of the Public Health Service Act.[12] Public health emergency determinations have been made considerably less often than have disaster or emergency declarations pursuant to the Stafford Act. The Secretary of HHS has determined that a public health emergency exists on only three occasions since 2000: (1) nationwide, in response to the terrorist attacks on September 11, 2001; (2) in several states affected by Hurricane Katrina in August and September 2005; and (3) in several states affected by Hurricane Rita in September 2005.[13] The rarity of public health emergency declarations may reflect the wide latitude that may be exercised by the Secretary of HHS through standing authority. Compared to authorities in the Stafford Act, the Secretary of HHS appears to have considerably more discretion in dedicating federal resources, whether he has determined there to be a public health emergency or not.

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[11] 42 U.S.C. § 247d(a), as amended in P.L. 106-505, the Public Health Improvement Act.

[12] 42 U.S.C. § 243c.

[13] More information regarding these determinations is available in CRS Report RL33096, *2005 Gulf Coast Hurricanes: The Public Health and Medical Response,* by Sarah A. Lister. The 2001 determination applied to the September 11 attacks and not to the subsequent anthrax attack (66 *Federal Register* 54998, Oct. 31, 2001). Stafford major disaster and emergency declarations may be found on FEMA's website at [http://www.fema.gov/hazard/index.shtm].

Intersection of Stafford Act and Public Health Emergency Authority. Disaster and emergency authorities pursuant to the Stafford Act are generally independent of public health emergency authorities. Only one provision in current law — allowing for the waiver of a number of HHS statutory, regulatory and program requirements — requires simultaneous Stafford Act and public health emergency declarations. (See "Waiver of certain requirements" in the **Appendix** for more information.) However, when all three types of declarations are issued as a result of a specific incident, as they were following Hurricane Katrina, it poses a greater challenge for officials in understanding the altered scope of their response authorities.[14]

Federal Coordinating Mechanisms for Disaster Response

National Response Plan. Pursuant to congressional mandate, the Department of Homeland Security (DHS) released the National Response Plan (NRP) in December 2004 to establish a comprehensive framework for the coordination of federal resources under specified emergency conditions.[15] The NRP, which is under the overall coordination of the Secretary of Homeland Security, and delegated to the Federal Emergency Management Agency (FEMA), sets forth the responsibilities and roles of federal agencies, identifies tasks to be undertaken by specified federal officials, and includes annexes that provide detail on support resources and mechanisms that are integral to the Plan's implementation. The Plan is to be invoked after the President issues a major disaster or emergency declaration under authority of the Stafford Act.

In addition to emergencies that result in Stafford Act declarations, federal officials implement the NRP during domestic incidents that, among other factors, satisfy any one of four criteria set out by President Bush in Homeland Security Presidential Directive (HSPD) - 5.[16] These include:

- a federal agency, under its own authority, requests DHS assistance;

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[14] For example, for Hurricane Katrina, Louisiana received an emergency declaration on Aug. 27, 2006, prior to landfall, which was superceded by a major disaster declaration on Aug. 29, 2006, the day of landfall. The Secretary of HHS also determined that a public health emergency existed in Louisiana, effective Aug. 29, 2006. To further complicate matters, at least two types of assistance to Louisiana citizens — Medicaid and Crisis Counseling Program grants — were based on their evacuation status *from* Stafford major disaster areas, and were available to them in host areas (including other states), some of which did not themselves have major disaster declarations.

[15] 6 U.S.C. § 312(6). See Department of Homeland Security, National Response Plan, December 2004, hereafter called the NRP, at [http://www.dhs.gov/interweb/assetlibrary/NRP_FullText.pdf]. The NRP superseded the Federal Response Plan that had been used since 1992. See also CRS Report RL32803, *The National Preparedness System: Issues in the 109th Congress*, by Keith Bea.

[16] White House, "Homeland Security Presidential Directive/HSPD-5, Subject: Management of Domestic Incidents," Feb. 28, 2003, at [http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html].

- state and local governments overwhelmed by an emergency request federal aid not only through Stafford Act declarations but also through "catastrophic incidents" that, whether caused by natural or human actions, result in "extraordinary" mass casualties or disruptions of functions that might threaten national security;
- more than one federal agency is involved in incident response; and,
- the President directs the Secretary of DHS to assume management of an incident.[17]

National Response to an Influenza Pandemic. In addition to the NRP, which guides a coordinated federal response to a variety of catastrophes, key federal planning documents specific for an influenza pandemic include:

- The *National Strategy for Pandemic Influenza,* November 2005: outlines general responsibilities of individuals, industry, state and local governments, and the federal government in preparing for and responding to a pandemic.[18]
- The *HHS Pandemic Influenza Plan,* November 2005: provides guidance to national, state and local policy makers and health departments, outlining key roles and responsibilities during a pandemic and specifying preparedness needs and opportunities. This plan emphasizes specific preparedness efforts in the public health and healthcare sectors.[19]
- *Department of Defense Influenza Pandemic Preparation and Response Health Policy Guidance,* January 2006: provides policy and instructions for Department of Defense (DOD) military assets regarding influenza pandemic preparedness and response, with the goal of maintaining operational effectiveness by minimizing death, disease and lost duty time of military members.[20]

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[17] Modifications to the NRP were issued by DHS on May 25, 2006, that replaced the phrase "Incidents of National Significance" with more general, and undefined terms such as "incident," "actual or potential domestic incidents," or "domestic incident management." The impact of such a change might be significant, as the criteria for invoking the NRP might change from situations not envisioned to be "Incidents of National Significance." See DHS, *Notice of Change to the National Response Plan,* May 25, 2006, at [http://www.dhs.gov/dhspublic/display?theme=15&content=4269].

[18] White House Homeland Security Council, *National Strategy for Pandemic Influenza,* Nov. 1, 2005, at [http://www.whitehouse.gov/homeland/nspi.pdf].

[19] Department of Health and Human Services, *HHS Pandemic Influenza Plan,* November 2005, at [http://www.hhs.gov/pandemicflu/plan/pdf/HHSPandemicInfluenzaPlan.pdf].

[20] Assistant Secretary of Defense for Health Affairs William Winkenwerder, Jr., "Department of Defense Influenza Pandemic Preparation and Response Health Policy Guidance," memorandum to the Joint Services, Jan. 25, 2006, at [http://www.vaccines.mil/documents/ 886PandemicFluPolicy.pdf]. The guidance assumes that DOD: (1) will support the HHS in pandemic response by conducting medical and laboratory surveillance and diagnostic testing through DOD assets; (2) may, under applicable authorities, assist civil authorities by providing logistical and medical support; and (3) may, upon a civilian request,

(continued...)

- *National Strategy for Pandemic Influenza, Implementation Plan,* May 2006: assigns more than 300 preparedness and response tasks to departments and agencies across the federal government; includes measures of progress and timelines for implementation; provides initial guidance for state, local, and tribal entities, businesses, schools and universities, communities, and non-governmental organizations on the development of institutional plans; provides initial preparedness guidance for individuals and families.[21]

Would the Stafford Act Apply in a Flu Pandemic?

Each of the pandemic influenza plans listed earlier is written with the premise that the NRP could be triggered by a flu pandemic, thereby guiding a coordinated federal response to problems within the health sector and other affected sectors through routine, non-emergency, federal assistance mechanisms.[22] According to the Pandemic Implementation Plan, the Secretary of Homeland Security may declare a pandemic an Incident of National Significance early in the event, perhaps while foreign countries were affected, but before the disease had reached the United States.[23] Given that emergency declarations pursuant to the Stafford Act were made in response to West Nile virus in 2000, there is precedent for a presidential emergency declaration in response to an infectious disease threat. The matter of presidential authority to declare a major disaster (providing a higher level of federal assistance) in response to an infectious disease threat generally, and a flu pandemic specifically, is less clear. FEMA has in the past, in the context of the national TOPOFF exercises, interpreted biological disasters as ineligible for major disaster assistance pursuant to the Stafford Act.[24] However, the Administration view is that

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[20] (...continued)
respond immediately to save lives, mitigate human suffering, minimize property damage, or restore essential operations and services.

[21] Homeland Security Council, *National Strategy for Pandemic Influenza: Implementation Plan,* May 2006, hereafter called the Pandemic Implementation Plan, at [http://www.whitehouse.gov/homeland/pandemic-influenza-implementation.html].

[22] The NRP Biological Incident Annex notes that "Actions described in this annex take place with or without a presidential Stafford Act declaration or a public health emergency declaration" by the Secretary of HHS. See NRP, Biological Incident Annex, p. BIO-1. While this annex addresses intentional bioterrorism events, it also addresses naturally occurring biological threats, and explicitly mentions pandemic influenza. In contrast, the NRP Catastrophic Incident Annex does not explicitly mention pandemic influenza. While this annex is designed to address disasters with "extraordinary levels of mass casualties" such as could occur with a pandemic, it is also explicitly focused on "no-notice or short-notice incidents of catastrophic magnitude," a definition that would not likely apply to an influenza pandemic. See NRP, Catastrophic Incident Annex, p. CAT-1, and DHS, Notice of Change to the National Response Plan, May 25, 2006, pp. 9-10, at [http://www.dhs.gov/dhspublic/display?theme=15&content=4269].

[23] Pandemic Implementation Plan, p. 37.

[24] See DHS, Office of the Inspector General, *A Review of the Top Officials 3 Exercise,* Office of Inspections and Special Reviews, OIG-06-07, November 2005, p. 30, at (continued...)

the President's authority to declare a major disaster pursuant to the Stafford Act could be applied to an influenza pandemic.[25]

NRP Emergency Support Function 8: Roles and Challenges

Overview

Hurricane Katrina demonstrated the scope of *public health* and *medical* activities needed in response to a large-scale catastrophe. A successful public health response — which involves the monitoring and assurance of the safety of food and water, prevention of injury, control of infectious diseases, and a host of other activities — is carried out by a variety of entities, primarily government and not-for-profit agencies. A successful medical response is perhaps more challenging, requiring the coordination of several elements, which are variously based in federal, state or local authority, or in the private sector. These elements are (1) patients, who may be inaccessible and require rescue or medical evacuation; (2) a treatment facility, which may be an existing hospital or a field tent with cots; (3) a competent healthcare workforce; (4) appropriate non-perishable medical supplies; (5) appropriate drugs, vaccines, tests and other perishable medical supplies; (6) a system of medical records; and (7) a healthcare financing mechanism. A flu pandemic would not likely impose the mass dislocations and destruction of healthcare infrastructure seen following Hurricane Katrina. But, as a pandemic would affect all areas of the nation simultaneously, responders could not necessarily count on the state-to-state mutual aid that was critical to the hurricane response.

According to the NRP, the Secretary of HHS is tasked with coordinating *Emergency Support Function 8* (ESF-8), the public health and medical response to incidents.[26] The 15 ESFs in the NRP are coordinating mechanisms, not funding mechanisms. The response to an influenza pandemic is likely to be primarily an ESF-8 response, in which public health and medical needs could be substantial. Less onerous burdens might be expected on other ESFs such as transportation, public works and energy, compared to those imposed following hurricanes and other weather-related disasters. Nonetheless, planners note that a severe pandemic could still constitute a multi-sector incident. Staffing shortages and supply chain

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[24] (...continued)
[http://www.dhs.gov/interweb/assetlibrary/OIG_06-07_Nov05.pdf].

[25] Pandemic Implementation Plan, Appendix C, "Authorities and References," p. 212.

[26] NRP, Annex ESF#8, at [http://www.dhs.gov/interweb/assetlibrary/NRP_FullText.pdf]. See also HHS, "HHS Maintains Lead Federal Role for Emergency Public Health and Medical Response," press release, Jan. 6, 2005. Many ESF-8 responsibilities and activities are delegated to the Assistant Secretary for Public Health Emergency Preparedness. See HHS, Office of the Secretary, Office of Public Health Emergency Preparedness, "Statement of Organization, Functions, and Delegations of Authority," 71 *Federal Register* 38403, July 6, 2006.

disruptions could affect the continuity of services, and possibly the integrity of infrastructure, in the transportation, public works and energy sectors, among others.

The Secretary of HHS is responsible for coordinating the following activities under ESF-8, and may request assistance from 14 designated support agencies and the American Red Cross as needed:

- Assessment of public health and medical needs;
- Health surveillance;
- Medical care personnel;
- Health and medical equipment and supplies;
- Patient evacuation;
- Patient care;
- Safety and security of human drugs, biologics, and medical devices, veterinary drugs, and other HHS-regulated products;
- Blood and blood products;
- Food safety and security;
- Agriculture safety and security (principally with regard to food-producing animals and animal feeds and drugs);
- Worker health and safety;
- All-hazard public health and medical consultation, technical assistance and support;
- Behavioral health care;
- Public health and medical information;
- Vector control (e.g., control of disease-carrying insects and rodents);
- Potable water, wastewater and solid waste disposal;
- Victim identification and mortuary services; and
- Protection of animal health (principally with regard to HHS-regulated animal feeds and drugs).

HHS does not bear primary responsibility for *mass care*, which is the coordination of non-medical services such as shelter, feeding, emergency first aid, and efforts to reunite displaced family members. Mass care is the responsibility of DHS and is carried out by the FEMA and the American Red Cross according to ESF-6. HHS is also not responsible for *urban search and rescue*, which is also the responsibility of DHS and FEMA pursuant to ESF-9. Furthermore, HHS may depend on numerous other agencies to carry out certain of their ESF activities (e.g., public safety, road clearing and power restoration) before some ESF-8 activities can commence.

ESF-8 Leadership

Some have questioned whether the NRP clearly defines federal ESF-8 leadership, or whether the respective roles of the Secretaries of Homeland Security and Health and Human Services could conflict during a response. Some, including congressional investigators, felt this conflict was in evidence during the response to

Hurricane Katrina.[27] Others are concerned that the respective roles are insufficiently clear to guide a coordinated response to a flu pandemic. Several pending bills in the 109th Congress propose to clarify federal responsibilities for ESF-8 response. These include H.R. 5438 (reported in House) and S. 3678 (reported in Senate), which provide that HHS shall lead the federal public health and medical response to incidents, and H.R. 4632 (introduced in the House) and H.R. 5814 (reported in the House), which would delegate certain ESF-8 preparedness and response functions to the Chief Medical Officer in DHS. There has been particular concern about the clarity of authority with respect to the deployment of two federal response assets, the National Disaster Medical System (NDMS, discussed further below), and the Strategic National Stockpile (SNS) of drugs and medical supplies, which would likely be deployed in response to a flu pandemic. Under current law, both the Secretary of Homeland Security and the Secretary of HHS have authority to deploy the SNS, as well as certain joint authorities regarding procurement.[28]

Unclear Federal Leadership for Certain Response Functions

In the response to Hurricane Katrina, it became apparent that federal responsibility to coordinate certain support activities was not clear in the existing ESF assignments in the NRP. Some of these problems are discussed below.

It is not essential that an ESF lead agency have direct control of all of the federal assets needed for the relevant response. The NRP, in fact, assumes that federal agencies retain control over their assets and that NRP mechanisms ensure that resource delivery from multiple federal agencies is coordinated. However, there has been considerable discussion regarding whether ESF-8 can function effectively when one of its key assets, the National Disaster Medical System (NDMS), is based at FEMA rather than at HHS. (NDMS consists of a number of medical response teams that can deploy to a scene rapidly and set up field operations that are self-sustaining for up to 72 hours, until additional federal support arrives.[29]) Congressional and White House investigators each found that NDMS deployments in response to Hurricane Katrina were made by FEMA without the involvement of personnel at HHS, undermining the intent of the NRP and the ability of HHS to coordinate the overall ESF-8 response effectively.[30] In FY2007 appropriations for DHS (P.L. 109-

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[27] See U.S. Senate, Committee on Homeland Security and Governmental Affairs, *Hurricane Katrina: A Nation Still Unprepared*, chap. 24, p. 28ff, May 2006, online at [http://hsgac.senate.gov/], hereafter called *A Nation Still Unprepared*; and the White House, *The Federal Response to Hurricane Katrina: Lessons Learned*, p. 47, Feb. 2006, at [http://www.whitehouse.gov/reports/katrina-lessons-learned/], hereafter called *Lessons Learned*.

[28] The authority of the Secretary of DHS to deploy the SNS is codified at 6 U.S.C. § 312. The authority of the Secretary of HHS to deploy the SNS is codified at 42 U.S.C. § 247d-6b, as are certain procurement authorities provided jointly to the two secretaries.

[29] Additional information about NDMS is available in CRS Report RL33096: *2005 Gulf Coast Hurricanes: The Public Health and Medical Response*, by Sarah A. Lister.

[30] See U.S. House of Representatives, *A Failure of Initiative: The Final Report of the Select Bipartisan Committee to Investigate the Preparation for and Response to Hurricane* (continued...)

295, signed October 4, 2006), Congress transferred NDMS to HHS, effective January 1, 2007. The transfer was supported by the Administration.[31] (NDMS was originally transferred from HHS to DHS in P.L. 107-296, the Homeland Security Act, effective in 2003.)

(The role of NDMS in a flu pandemic is a matter of some discussion as well. As a pandemic would be a near-simultaneous national incident, the value of a mobile medical force is less apparent than it would be in a localized event. Some planners have suggested that NDMS personnel should remain within their home communities. The Pandemic Implementation Plan envisions the strategic use of NDMS teams, when available, to support a variety of federally coordinated disease-control activities.)

The NRP does not clearly delegate responsibility for the retrieval of human remains in mass fatality events. HHS is responsible for the ESF-8 function of coordinating federal assistance to identify victims and determine causes of death. NDMS Disaster Mortuary Assistance Teams (DMORTs) comprise medical examiners, pathologists, dental technicians and other medical personnel. These teams are not skilled in the safe retrieval of remains from hazardous sites such as waterways or collapsed buildings. Other responders, including Urban Search and Rescue teams and the Coast Guard, are trained to work safely in such dangerous conditions, but their mission is to rescue the living, not recover the dead.[32] The matter of mass fatality management is of considerable concern to pandemic planners, and this gap could be problematic during such a disaster.

The NRP does not clearly delegate federal responsibility for the well-being of pets during disasters.[33] It is well established that some people are reluctant to abandon their pets and will remain at home during an evacuation order if they cannot take pets with them: therefore, the absence of coordinated mechanisms to assure the safety of pets in disasters may jeopardize human safety as well.[34] Several states (e.g.,

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[30] (...continued)
Katrina, p. 297, Feb. 2006, at [http://katrina.house.gov/], hereafter called *A Failure of Initiative*; *A Nation Still Unprepared*, chap. 24, p. 29; and *Lessons Learned*, p. 47.

[31] Office of Management and Budget, "Statement of Administration Policy: H.R. 5441 — Department of Homeland Security Appropriations Bill, FY2007," Senate version, July 12, 2006, p. 2, at [http://www.whitehouse.gov/omb/legislative/sap/109-2/hr5441sap-s.pdf].

[32] Further discussion of the difficulties in coordinating body retrieval following Hurricane Katrina is available in *A Failure of Initiative*, p. 299.

[33] A search of the NRP for the terms "pets" and "companion animals" yields references only to FDA's responsibilities to assure the safety of animal drugs, and USDA's responsibilities to control animal diseases affecting livestock and to advise on decontamination procedures for pets exposed to radioactive material. See also, R. Scott Nolen and Allison Rezendes, "Summit Works Toward National Animal Disaster Plan," *Journal of the American Veterinary Medical Association*, news article, June 15, 2006, at [http://www.avma.org/onlnews/javma/jun06/060615a.asp].

[34] See DHS: "Nationwide Plan Review, Phase 2 Report," June 16, 2006, p. 53, at [http://www.dhs.gov/interweb/assetlibrary/Prep_NationwidePlanReview.pdf]; and (continued...)

Florida, Louisiana, and Texas) have incorporated pet-friendly shelters or other arrangements in their disaster plans, to address this concern. In FY2007 appropriations for DHS (P.L. 109-295, signed October 4, 2006), Congress included a provision requiring the department, in approving standards for state and local emergency plans, to account for the needs of individuals with household pets and service animals before, during, and following a major disaster or emergency. The act does not, however, address the broader matter of federal leadership for the needs of pets in disasters.

Finally, as was evident in the response to Hurricane Katrina, the distinction between ESF-6 (mass care) and ESF-8 (public health and medical) may be blurred, such as when evacuees in Red Cross shelters required medical care, when large numbers of hospital patients evacuated to ESF-8 field hospitals required food and water, or when crisis counseling services were required to address victims' mental health needs. This problem is likely amenable to an administrative solution, and is being considered by FEMA, HHS and the American Red Cross in their reviews of the hurricane response and their ongoing preparedness activities.

Federal Funding to Support an ESF-8 Response

Hurricane Katrina represented the greatest test of ESF-8 since the creation of the Department of Homeland Security and the publication of the NRP. A variety of public health and medical activities were undertaken in the hurricane response. The costs of these activities were borne by agencies at the federal, state and local levels, not-for-profit groups, businesses, healthcare providers, insurers, families, and individuals. Private insurance covered some of the property damage, healthcare and other costs resulting from the disaster. Congress provided additional assistance through emergency appropriations to cover expanded federal agency activities and a portion of uninsured healthcare costs. Some other costs, such as the costs of rebuilding the devastated healthcare infrastructure in New Orleans, have not been fully met at this time, either through existing assistance mechanisms or mechanisms developed since the storm.[35] The response to Hurricane Katrina, and ongoing pandemic preparedness efforts, each offer a glimpse of the complexity and adequacy of existing mechanisms to fund the costs of an ESF-8 response.

Funding Sources and Authorities

The Disaster Relief Fund. Activities undertaken under authority of the Stafford Act are funded through appropriations to the Disaster Relief Fund (DRF), administered by FEMA. Federal assistance supported by the DRF is used by states,

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[34] (...continued)
"Ready.gov," preparedness information for pet owners, at [http://www.ready.gov/america/getakit/pets.html].

[35] See HHS, "Louisiana Health Care System Focus of Redesign," press release, July 17, 2006; and Bruce Alpert, "GAO Says Hospitals not Worth Salvaging," Times-Picayune, Mar. 30, 2006.

localities, and certain non-profit organizations to provide mass feeding and shelter, restore damaged or destroyed facilities, clear debris, and aid individuals and families with uninsured needs, among other activities. Federal agencies that receive *mission assignments* from DHS and provide assistance pursuant to the NRP are also reimbursed through funds appropriated to the DRF. 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.[36]

The Public Health Emergency Fund. In 1983, Congress established authority for a no-year public health emergency fund to be available to the HHS Secretary.[37] In 2000, Congress reauthorized the fund, clarifying that it could only be used when the Secretary had made a determination of a public health emergency pursuant to 42 U.S.C. § 247d(a), as follows:

> (1) In general. There is established in the Treasury a fund to be designated as the "Public Health Emergency Fund" to be made available to the Secretary without fiscal year limitation to carry out subsection (a) only if a public health emergency has been declared by the Secretary under such subsection. There is authorized to be appropriated to the Fund such sums as may be necessary.
> (2) Report. Not later than 90 days after the end of each fiscal year, the Secretary shall prepare and submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Commerce and the Committee on Appropriations of the House of Representatives a report describing — (A) the expenditures made from the Public Health Emergency Fund in such fiscal year; and (B) each public health emergency for which the expenditures were made and the activities undertaken with respect to each emergency which was conducted or supported by expenditures from the Fund.[38]

Prior to 2000, the fund was authorized for annual appropriations sufficient to have a balance of $45 million in the fund at the beginning of each fiscal year. Despite this prior authorization of annual appropriations, the fund received appropriations only in response to a few public health threats (e.g., the emergence of hantavirus in the Southwest in 1993-1994), but did not receive an appropriation for its intended use as a reserve fund for unanticipated events. The fund has not received an appropriation since it was explicitly linked to the public health emergency authority in 42 U.S.C. § 247d(a) in 2000. As a consequence, the fund was not utilized during three public health emergency determinations made subsequently: (1) nationwide, in response to the terrorist attacks on September 11, 2001; (2) in several states affected by Hurricane Katrina in August and September 2005; and (3) in several states affected by Hurricane Rita in September 2005.[39]

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[36] For more information, see CRS Report RL33053, *Federal Stafford Act Disaster Assistance: Presidential Declarations, Eligible Activities, and Funding*, by Keith Bea.

[37] P.L. 98-49.

[38] 42 U.S.C. § 247d(b), as amended by P.L. 106-505.

[39] More information regarding these determinations is available in CRS Report RL33096, (continued...)

In 2002, Congress reauthorized the National Disaster Medical System (NDMS) in language suggesting that the emergency fund could be used to support NDMS activities, as follows:

> ... For the purpose of providing for the Assistant Secretary for Public Health Emergency Preparedness and the operations of the National Disaster Medical System, other than purposes for which amounts in the Public Health Emergency Fund under Section 319 are available, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2002 through 2006.[40]

The Public Health and Social Services Emergency Fund. The Public Health and Social Services Emergency Fund (PHSSEF) is an account at HHS that has been used to provide annual or emergency supplemental appropriations for one-time or short-term public health activities in a variety of agencies and offices. Providing funding to the PHSSEF, which does not have an explicit authority in law, separates these amounts from an agency's annual "base" funding. Recent activities funded through the PHSSEF include preparedness activities for a flu pandemic, one-time purchases for the Strategic National Stockpile (SNS), and funding for state public health and hospital preparedness. Amounts appropriated to the PHSSEF may or may not be designated as emergency spending. Because the PHSSEF has been used only to fund certain planned activities, it is not a reserve fund for unanticipated events.

In FY2006, Congress appropriated certain amounts that had previously been provided through the PHSSEF directly to the various agencies overseeing the programs. These included funding for the SNS and grants for upgrading state and local public health capacity, amounts now appropriated in CDC's "Terrorism and Public Health Preparedness" budget line,[41] and state grants for hospital preparedness, now appropriated in the budget line for bioterrorism programs of the Health Resources and Services Administration (HRSA).[42]

Funding the ESF-8 Response to Hurricane Katrina

In response to the widespread destruction caused by Hurricane Katrina, the 109th Congress enacted two FY2005 emergency supplemental appropriations bills (P.L. 109-61 and P.L. 109-62), which together provided $62.3 billion for emergency response and recovery needs. The FY2006 appropriations legislation for the Department of Defense (P.L. 109-148) reallocated $23.4 billion in funds appropriated in the two emergency supplemental statutes, and an additional amount from a government-wide rescission, primarily to pay for the restoration of damaged federal facilities. In June 2006, Congress provided an additional $6 billion to the DRF in

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[39] (...continued)
2005 Gulf Coast Hurricanes: The Public Health and Medical Response, by Sarah A. Lister.

[40] 42 U.S.C. § 300hh-11, as amended by P.L. 107-188.

[41] More information on CDC's budget is available at [http://www.cdc.gov/fmo/fmofybudget.htm].

[42] More information on HRSA's budget is available in the FY2007 budget justification at [http://www.hrsa.gov/about/budgetjustification07/].

P.L. 109-234, Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006.[43]

A portion of supplemental appropriations to the DRF supported federal ESF-8 response activities. FEMA reports expenditures for mission assignments to both HHS and separately to CDC (an agency within HHS) for the responses to Hurricanes Katrina, Rita and Wilma.[44] A number of HHS agencies in addition to CDC were involved in the response to the hurricanes, and their activities, when requested by FEMA, were presumably reimbursed through the DRF.[45]

There were likely other HHS activities carried out in response to the hurricanes that would not fall within the scope of activities reimbursable by the DRF. For example, on September 16, 2005, CDC issued guidance to state grantees permitting them to redirect funds from a number of grant programs to their hurricane relief efforts as needed.[46] According to CDC, funds could be used for alternate activities within the state, or to support state-to-state mutual aid pursuant to the Emergency Management Assistance Compact (EMAC).[47] States were permitted to redirect funds from the following federal grant programs: infectious diseases (including immunization, sexually transmitted disease prevention, tuberculosis, West Nile virus, hepatitis, HIV, emerging infections and laboratory programs); environmental health; injury prevention; and, terrorism and emergency preparedness. CDC noted at the time that "No supplemental appropriations have been provided to CDC for Katrina relief, so any existing CDC funds used for relief will reduce the overall amount available to work non-relief grant issues."[48] HRSA also advised state grantees that some redirection of funds provided by the National Bioterrorism Hospital

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[43] For more information, see CRS Report RS22239, *Emergency Supplemental Appropriations for Hurricane Katrina Relief*, by Keith Bea; and CRS Report RL33298, *FY2006 Supplemental Appropriations: Iraq and Other International Activities; Additional Hurricane Katrina Relief*, coordinated by Paul M. Irwin and Larry Nowels.

[44] See, for example, DHS, FEMA, "Weekly Disaster Relief Fund (DRF) Report," Congressional Weekly Report, July 12, 2006, at [http://appropriations.house.gov/_files/HurricaneKatrinaLink.htm].

[45] For information regarding the activities of HHS agencies in response to the 2005 hurricanes, see CRS Report RL33096, *2005 Gulf Coast Hurricanes: The Public Health and Medical Response*, by Sarah A. Lister; and HHS, Centers for Medicare and Medicaid Services (CMS), "Summary of Federal Payments Available for Providing Health Care Services to Hurricane Evacuees and Rebuilding Health Care Infrastructure," Jan. 25, 2006, at [http://www.hhs.gov/katrina/#hhs].

[46] CDC, letter from William P. Nichols, Director, CDC Procurement and Grants Office, to CDC directors and grants management personnel, regarding "Treatment of Grants under Emergency Conditions due to Hurricane Katrina," Sept. 16, 2005, hereafter referred to as the Nichols letter, at [http://www.bt.cdc.gov/disasters/hurricanes/katrina/pdf/grantuse.pdf].

[47] The Emergency Management Assistance Compact is a congressionally approved interstate mutual aid agreement that provides a legal structure by which states affected by a catastrophe may request emergency assistance from other states. For more information, see CRS Report RS21227, *The Emergency Management Assistance Compact (EMAC): An Overview*, by Keith Bea.

[48] Nichols letter.

Preparedness Program was also permissible to support the hurricane response.[49] Information regarding the overall amount of funds that may have been redirected by HHS agencies to support Hurricane Katrina response activities, and, for those expenditures that were not reimbursable by the DRF, whether there were alternate mechanisms to "backfill" the accounts, is not publicly available.

Federal Assistance for Disaster-Related Healthcare Costs

Existing Mechanisms. Several federal assistance mechanisms are available to cover the costs of healthcare services that are rendered during, or required as a result of, a catastrophe. Examples include:

- Services provided by the National Disaster Medical System (NDMS) or other federalized employees while carrying out mission assignments requested by FEMA may be reimbursed by the DRF, though efforts are made to seek reimbursement from patients' insurers when possible. This assistance may be provided under both major disaster and emergency declarations that involve the provision of health and safety measures and the reduction of threats to public health and safety.[50]
- The FEMA Individuals and Households Program (IHP) provides cash assistance that may be used for uninsured medical expenses. Recipients might have to use the funds to meet other needs concurrently, such as rent and other costs of living. The amount available is the same for an individual or a household, and is capped in statute, with an adjustment based on the Consumer Price Index.[51] The maximum amount available for Hurricane Katrina relief was $26,200,[52] and the current ceiling is $27,200.[53]
- 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 administers the Crisis

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[49] See notice posted by the Association of State and Territorial Health Officials at [http://www.astho.org/templates/display_pub.php?pub_id=1681&admin=1].

[50] 42 U.S.C. § 5170b (major disaster) and 42 U.S.C. § 5192 (emergency).

[51] 42 U.S.C. § 5174(h).

[52] For more information on the FEMA Individuals and Households Program, see DHS, Office of Inspector General, "A Performance Review of FEMA's Disaster Management Activities in Response to Hurricane Katrina," OIG-06-32, Appendix B, pp. 149 ff., March 2006, at [http://www.dhs.gov/interweb/assetlibrary/OIG_06-32_Mar06.pdf].

[53] 70 C.F.R. 58735.

Counseling Assistance and Training Program (CCP). Financing for this assistance is drawn from the DRF.[54]

- Certain medications and supplies may be provided to patients from pre-paid stockpiles for which reimbursement is not expected. Examples may include supplies used in Red Cross first aid stations or distributed to states from the CDC's Strategic National Stockpile.
- Public Health Service agencies in HHS may provide support to states and other entities through existing non-emergency mechanisms to assist in managing surges in healthcare needs for specific populations. In some cases, agencies have received supplemental appropriations to support these activities. Examples include SAMHSA Emergency Response Grants (SERG) to states, territories, and federally recognized tribal authorities for crisis mental health and substance abuse services,[55] and expanded federal support, including personnel, for health centers in disaster-affected areas.[56]

These programs provide a patchwork of coverage that in some cases fails to optimally match services with need (e.g., the Crisis Counseling Program), or in other cases fails to meet the magnitude of need (e.g., the FEMA individual assistance program). In any case, these programs are not generally coordinated with each other at the federal level, though programs that support state activities to finance or deliver healthcare services may be coordinated at that level.

Financing Healthcare Needs Following Hurricane Katrina. Hurricane Katrina was one of the worst natural disasters in the nation's history, and the largest mass casualty incident in recent memory. Many of Katrina's victims were dislocated to different states, separated from their documentation of health insurance, or both. Others lost employer-based health insurance due to the destruction or closure of businesses. In many cases, care was rendered without definitive financing mechanisms, while federal, state and private entities worked to retrofit these mechanisms in the disaster's aftermath.

In response to Hurricane Katrina, HHS expanded a number of existing programs to assist state and local agencies, healthcare providers and the storms' victims with

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[54] 42 U.S.C. § 5183. For more information, see CRS Report RS22292, *Hurricanes Katrina and Rita: Addressing the Victims' Mental Health and Substance Abuse Treatment Needs,* by Erin D. Williams.

[55] Ibid.

[56] Health centers provide healthcare services regardless of ability to pay. For more information, see HRSA, Bureau of Primary Health Care, Health Center Program, at [http://bphc.hrsa.gov/chc/]; and Hurricane Relief and Recovery, at [http://www.hrsa.gov/katrina/].

a variety of health and public health needs.[57] Information regarding the overall cost of these expansions is not publicly available.

In 2002, Congress gave the Secretary of HHS authority to waive certain administrative requirements for provider participation in Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP) when there has been both a Stafford Act declaration by the President and a determination of public health emergency by the Secretary of HHS.[58] This authority was exercised in a number of affected and host states following Hurricane Katrina. While this authority may improve access to healthcare services in affected areas, it does not directly address the financing of services.

A significant challenge following Hurricane Katrina involved setting up or re-establishing healthcare financing mechanisms for displaced individuals. Ultimately, the Medicaid program became the mechanism by which affected and host states financed certain healthcare costs that were not compensated through other public or private insurance sources. After several months of debate over a number of proposals, Congress provided authority and funding to cover, for certain states through January 31, 2006, the Medicaid and SCHIP matching requirements for individuals enrolled in these programs, and the total cost of uncompensated care for the uninsured, for eligible individuals who had been displaced from declared major disaster areas.[59] Congress provided up to $2 billion for these activities. This was in addition to $100 million earlier provided in supplemental appropriations to NDMS to cover expenses related to the response to Hurricane Katrina.[60] Through an interagency agreement, most of the $100 million was transferred from FEMA to the HHS Centers for Medicare and Medicaid Services (CMS), which is also administering the $2 billion amount.[61]

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[57] HHS, Centers for Medicare and Medicaid Services (CMS), "Summary of Federal Payments Available for Providing Health Care Services to Hurricane Evacuees and Rebuilding Health Care Infrastructure," Jan. 25, 2006, at [http://www.hhs.gov/katrina/#hhs].

[58] 42 U.S.C. § 1320b-5, enacted in P.L. 107-188.

[59] Section 6201 of P.L. 109-171, the Deficit Reduction Act of 2005, enacted Feb. 8, 2006. This arrangement was designated for those states covered under a Medicaid and SCHIP waiver developed specifically for Hurricane Katrina relief. For more information, see CRS Report RL33083: *Hurricane Katrina: Medicaid Issues*, by Evelyne P. Baumrucker, April Grady, Jean Hearne, Elicia J. Herz, Richard Rimkunas, Julie Stone, and Karen Tritz. FEMA had previously determined, regarding a Medicaid waiver proposed by New York state in response to the terror attack of Sept. 11, 2001, that the DRF may not be used to reimburse a state for a federal matching requirement. FEMA cited its grant regulations at 44 CFR § 13.24(b)(1), which say that "Except as provided by Federal statute, a cost sharing or matching requirement may not be met by costs borne by another Federal grant." (Letter from Joseph F. Picciano, Acting Regional Director, FEMA Region II, to Edward F. Jacoby, Jr., Director, New York State Emergency Management Office, Jan. 13, 2003.)

[60] P.L. 109-62, *Second Emergency Supplemental Appropriations Act to Meet Immediate Needs Arising From the Consequences of Hurricane Katrina, 2005*, Sept. 8, 2005, 119 Stat. 1991.

[61] HHS, Centers for Medicare and Medicaid Services, *Justification of Estimates for* (continued...)

ESF-8 Funding Needs During a Flu Pandemic

While a severe flu pandemic may constitute a national catastrophe, requiring a robust ESF-8 public health and medical response, the types of funding needs may not be readily addressed through existing assistance mechanisms pursuant to the Stafford Act (to the extent that they apply), and could outstrip existing government and private resources. While the need for public health and medical services could be considerable, extensive damage to public or private infrastructure is not anticipated. Costs associated with workforce surge capacity (e.g., overtime pay) and consumption of certain supplies (e.g., for public health laboratory tests) could increase substantially. Presuming a surge of patients in the healthcare system, non-urgent procedures could be postponed for weeks or months at a time. This has raised questions regarding whether there would be shifts in overall revenue to providers for services rendered during a pandemic, and how such shifts could affect providers and insurers. Finally, the cost of providing healthcare services during a pandemic, when almost 46 million Americans lack health insurance, is of concern to many. Americans' concerns about equity and fairness tend to be heightened during catastrophes. Also, some are concerned that disease control efforts could suffer if some subgroups of the population were unwilling, because of their uninsured status or for other reasons, to seek care or otherwise interact with disease control authorities during a pandemic.

As previously noted, following Hurricane Katrina, Congress provided $2.1 billion to states to cover the states' usual share of Medicaid and SCHIP costs for storm victims for a defined time period, and the cost of uncompensated care for the uninsured. This federal assistance mechanism required legislative action and took nearly six months to enact, in the absence of a pre-existing mechanism to provide such federal assistance. Whether this could serve as a model for federal assistance during a flu pandemic is unclear. An important element of the discussion regarding the Katrina assistance was the desire to help both states that had been directly affected, and states that had assumed fiscal liability by accepting evacuees. While the element of victim displacement would not likely be seen during a pandemic, Congress may nonetheless debate the merits of expanding federal assistance for healthcare costs during a flu pandemic, and the model developed following Hurricane Katrina may serve as a useful starting point for discussion.

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[61] (...continued)
Appropriations Committees, FY2007, p. 192.

Appendix: Federal Public Health Emergency Authorities[62]

Broad Authority in Section 319 of the Public Health Service Act

In 2000, in P.L. 106-505, the Public Health Improvement Act, Congress gave the Secretary of HHS[63] broad authority to determine that a public health emergency[64] exists, as follows:

- "If the Secretary determines, after consultation with such public health officials as may be necessary, that — (1) a disease or disorder presents a public health emergency; or (2) a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists, the Secretary may take such action as may be appropriate to respond to the public health emergency, including making grants, providing awards for expenses, and entering into contracts and conducting and supporting investigations into the cause, treatment, or prevention of a disease or disorder as described in paragraphs (1) and (2)."[65]

This authority, found in Section 319 of the Public Health Service Act (PHSA) and codified at 42 U.S.C. § 247d, is the basis for much, but not all of, the Secretary's authority to waive or streamline administrative requirements and certain statutory requirements, and to take certain other actions, when needed, to prepare for or respond to non-routine threats to public health.

Also in P.L. 106-505, Congress reauthorized a no-year public health emergency fund to be available to the HHS Secretary during a public health emergency determined pursuant to the authority above, as follows:

- "There is established in the Treasury a fund to be designated as the 'Public Health Emergency Fund' to be made available to the Secretary without fiscal year limitation to carry out subsection (a) only if a public health emergency has been declared by the Secretary under such subsection. There is authorized to be appropriated to the Fund such sums as may be necessary. ... Not later than 90 days after the end of each fiscal year, the Secretary shall prepare and submit to

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[62] Kathleen S. Swendiman, legislative attorney in the American Law Division of CRS, contributed to this section.

[63] In this appendix, unless otherwise stated, "the Secretary" refers to the Secretary of HHS.

[64] Federal statute contains numerous authorities relating to instances of public health emergency. In some cases the term is defined, such as for the HHS Secretary's key emergency authority in Section 319 of the Public Health Service Act, though definitions vary. In other cases the term is not defined, or does not refer explicitly to related authorities.

[65] 42 U.S.C. § 247d, as amended by P.L. 106-505, the Public Health Improvement Act.

> the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Commerce and the Committee on Appropriations of the House of Representatives a report describing — (A) the expenditures made from the Public Health Emergency Fund in such fiscal year; and (B) each public health emergency for which the expenditures were made and the activities undertaken with respect to each emergency which was conducted or supported by expenditures from the Fund."[66]

Subsequently, Congress expanded or clarified the Section 319 emergency authority, as follows:

- **Duration of emergency, notification of Congress:** "Any such determination of a public health emergency terminates upon the Secretary declaring that the emergency no longer exists, or upon the expiration of the 90-day period beginning on the date on which the determination is made by the Secretary, whichever occurs first. Determinations that terminate under the preceding sentence may be renewed by the Secretary (on the basis of the same or additional facts), and the preceding sentence applies to each such renewal. Not later than 48 hours after making a determination under this subsection of a public health emergency (including a renewal), the Secretary shall submit to the Congress written notification of the determination."[67]
- **Data submittal and reporting deadlines:** "In any case in which the Secretary determines that, wholly or partially as a result of a public health emergency that has been determined pursuant to subsection (a), individuals or public or private entities are unable to comply with deadlines for the submission to the Secretary of data or reports required under any law administered by the Secretary, the Secretary may, notwithstanding any other provision of law, grant such extensions of such deadlines as the circumstances reasonably require, and may waive, wholly or partially, any sanctions otherwise applicable to such failure to comply. Before or promptly after granting such an extension or waiver, the Secretary shall notify the Congress of such action and publish in the Federal Register a notice of the extension or waiver."[68]
- **Requirement for notification:** During the period in which the Secretary of HHS has determined the existence of a public health emergency under 42 U.S.C. § 247d, the Secretary "shall keep relevant agencies, including the Department of Homeland Security,

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[66] 42 U.S.C. § 247d, as amended by P.L. 106-505. This fund has not received a recent appropriation.

[67] 42 U.S.C. § 247d, as amended by P.L. 107-188, the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.

[68] Ibid.

the Department of Justice, and the Federal Bureau of Investigation, fully and currently informed."[69]

- **Emergency use of countermeasures:** The Secretary may declare an emergency justifying expedited use of certain medical countermeasures on the basis of: (1) a determination by the Secretary of Homeland Security that there is a domestic emergency, or a significant potential for a domestic emergency; or (2) on the basis of a determination by the Secretary of Defense that there is a military emergency, or a significant potential for a military emergency; or (3) on the basis of a "determination by the Secretary of a public health emergency under Section 247d of Title 42 that affects, or has a significant potential to affect, national security, and that involves a specified biological, chemical, radiological, or nuclear agent or agents, or a specified disease or condition that may be attributable to such agent or agents."[70] This provision in the Federal Food, Drug and Cosmetic Act is referred to as the *Emergency Use Authorization*.
- **Waiver of certain requirements:** In order to assure "that sufficient health care items and services are available to meet the needs of individuals in ... (an emergency, and) ... that health care providers ... that furnish such items and services in good faith, but that are unable to comply with one or more requirements ... may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse," the Secretary may modify or waive certain statutory or regulatory requirements following a determination of public health emergency pursuant to 42 U.S.C. § 247d *and* an emergency or disaster declaration by the President pursuant to the National Emergencies Act (50 U.S.C. § 1601) or the Stafford Act (42 U.S.C. § 5121 et seq.).[71] Requirements that may be waived or modified pursuant to this section include (1) conditions of participation and certain other requirements in the Medicare, Medicaid and SCHIP programs;[72] (2) federal requirements for state licensure of health professionals; (3) certain provisions of the Emergency Medical Treatment and Active Labor Act of 1985 (EMTALA); (4) certain sanctions prohibiting physician self-referral (so-called "Stark" provisions); (5) modification, but not waiver, of deadlines and timetables for performance of required activities; (6) limitations on certain payments for health care items and services furnished to individuals enrolled in a Medicare + Choice plan; and (7) sanctions and penalties that arise from noncompliance with certain patient

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[69] 6 U.S.C. § 467, authorized in P.L. 107-296, the Homeland Security Act of 2002.

[70] 21 U.S.C. § 360bbb-3, authorized in P.L. 108-276, the Project BioShield Act of 2004.

[71] 42 U.S.C. § 1320b-5, as amended by P.L. 107-188 and P.L. 108-276.

[72] For more information on the use of these waivers following Hurricane Katrina, see CRS Report RL33083, *Hurricane Katrina: Medicaid Issues*, by Evelyne P. Baumrucker, April Grady, Jean Hearne, Elicia J. Herz, Richard Rimkunas, Julie Stone, and Karen Tritz.

privacy requirements of the Health Insurance Portability and Accountability Act of 1996.

- **Alternate Medicare drug reimbursement method:** In situations where a public health emergency has been determined to exist under 42 U.S.C. § 247d, and "there is a documented inability to access drugs and biologicals," the Secretary may, under certain circumstances, use an alternative methodology for determining payments of certain drugs under the Medicare program.[73]

Pursuant to the authority in Section 319, the Secretary of HHS has determined that a public health emergency exists on three occasions: (1) nationwide, in response to the terrorist attacks on September 11, 2001; (2) in several states affected by Hurricane Katrina in August and September, 2005; and (3) in several states affected by Hurricane Rita in September, 2005.[74]

Other Public Health Emergency Authorities of the HHS Secretary

The following is a list of statutory authorities or requirements of the Secretary or others within HHS to take certain additional actions during public health emergencies that are not explicitly defined or linked to an emergency determination pursuant to Section 319 authority. In some cases these actions flow from federal emergency or major disaster declarations pursuant to the Stafford Act. In other cases reference is made to a situation of public health emergency, but such emergency is not defined.

- **Assistance to states:** Pursuant to Section 311 of the Public Health Service Act, the Secretary of HHS has broad authority to assist state and local governments in their disease control efforts, upon their request, as follows: "The Secretary may, at the request of the appropriate State or local authority, extend temporary (not in excess of six months) assistance to States or localities in meeting health emergencies of such a nature as to warrant Federal assistance. The Secretary may require such reimbursement of the United States for assistance provided under this paragraph as he may determine to be reasonable under the circumstances. Any reimbursement so paid shall be credited to the applicable appropriation for the Service for the year in which such reimbursement is received."[75] The term "health emergencies" is not defined in this context, but this authority underpins a variety of unanticipated activities which are undertaken each year such as CDC's deployment of Epidemic Intelligence Service officers to assist states affected by an ongoing mumps outbreak.

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[73] 42 U.S.C. § 1395w-3a(e), authorized in P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

[74] More information regarding these determinations is available in CRS Report RL33096, *2005 Gulf Coast Hurricanes: The Public Health and Medical Response*, by Sarah A. Lister.

[75] 42 U.S.C. § 243c.

- **National preparedness plan:** "The Secretary shall further develop and implement a coordinated strategy, building upon the core public health capabilities established pursuant to Section 319A [42 U.S.C. § 247d-1], for carrying out health-related activities to prepare for and respond effectively to bioterrorism and other public health emergencies, including the preparation of a plan under this section."[76]
- **HHS exemption from "Select Agent" regulation:** The Secretary maintains regulatory control over certain biological agents and toxins which have the potential to pose a severe threat to public health and safety. The Secretary may temporarily exempt a person from the regulatory requirements of this section if "the Secretary determines that such exemption is necessary to provide for the timely participation of the person in a response to a domestic or foreign public health emergency (whether determined under Section 247d(a) of this Title *or otherwise*)." (Emphasis added).[77]
- **USDA exemption from "Select Agent" regulation:** The Secretary, after granting an exemption under 42 U.S.C. § 262a(g) (relating to regulation of certain biological agents and toxins) pursuant to "a finding that there is a public health emergency" may request the Secretary of Agriculture to "temporarily exempt a person from the applicability of the requirements of this section with respect to an overlap agent or toxin, in whole or in part, to provide for the timely participation of the person in a response to the public health emergency."[78]
- **Activation of NDMS:** The Secretary may activate the National Disaster Medical System (NDMS) to "provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims of a public health emergency (*whether or not determined to be a public health emergency* under Section 247d of this Title)" (emphasis added). NDMS was subsequently transferred to the Department of Homeland Security in P.L. 107-296, the Homeland Security Act, without any other amendment to its authorizing language.[79]
- **Authority for the Strategic National Stockpile:** "The Secretary, in coordination with the Secretary of Homeland Security, shall maintain a stockpile or stockpiles of drugs, vaccines and other biological products, medical devices, and other supplies in such numbers, types, and amounts as are determined by the Secretary to

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[76] 42 U.S.C. § 300hh. This provision, in Section 2801 of the PHSA, refers to Section 319A of the PHSA.

[77] 42 U.S.C. § 262a, as amended by P.L. 107-188. Additional information regarding the regulation of so-called "Select Agents" may be found at [http://www.cdc.gov/od/sap/index.htm] and CRS Report RL31719: *An Overview of the U.S. Public Health System in the Context of Emergency Preparedness,* by Sarah A. Lister.

[78] 7 U.S.C. § 8401, as amended by P.L. 107-188.

[79] 42 U.S.C. § 300hh-11, as amended by P.L. 107-188.

be appropriate and practicable, taking into account other available sources, to provide for the emergency health security of the United States, including the emergency health security of children and other vulnerable populations, in the event of a bioterrorist attack or other public health emergency."[80]

- **Authority for the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP):** "The Secretary shall, ... establish and maintain a system for the advance registration of health professionals for the purpose of verifying the credentials, licenses, accreditations, and hospital privileges of such professionals when, during public health emergencies, the professionals volunteer to provide health services." ... "The Secretary may encourage each State to provide legal authority during a public health emergency for health professionals authorized in another State to provide certain health services to provide such health services in the State."[81]
- **Federal quarantine authority:** The Secretary has the authority to "make and enforce such regulations as in his judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession." These regulations may "provide for the apprehension and examination of any individual reasonably believed to be infected with a communicable disease in a qualifying stage." The term "qualifying stage" means that the disease is "in a communicable stage" or is "in a precommunicable stage, if the disease would be likely to cause a public health emergency if transmitted to other individuals."[82]
- **Authority for the administration of smallpox countermeasures:** The Secretary may issue a declaration "concluding that an actual or potential bioterrorist incident or other actual or potential public health emergency makes advisable the administration of" certain countermeasures against smallpox for Public Health Service employees.[83]
- **Liability protection for certain countermeasures:** If the Secretary "makes a determination that a disease or other health condition or other threat to health constitutes a public health emergency, or that there is a credible risk that the disease, condition, or threat may in

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[80] 42 U.S.C. § 247d-6b, as amended by P.L. 108-276, the Project BioShield Act of 2004.

[81] 42 U.S.C. § 247d-7b. Additional information regarding the ESAR-VHP program is available at [http://www.hrsa.gov/esarvhp/].

[82] 42 U.S.C. § 264. There are other sections dealing with quarantines such as 42 U.S.C. § 243, assistance to States in the enforcement of quarantine regulations and public health plans; § 249, medical care for quarantined persons; and § 267, dealing with quarantine stations. For more information, see CRS Report RL33201, *Federal and State Quarantine and Isolation Authority*, by Kathleen S. Swendiman and Jennifer K. Elsea.

[83] 42 U.S.C. § 233(p). See also sections immediately following this section, including 42 U.S.C. §§ 239 et seq.

the future constitute such an emergency, the Secretary may make a declaration, through publication in the Federal Register, recommending, under conditions as the Secretary may specify, the manufacture, testing, development, distribution, administration, or use of one of more covered countermeasures....” Liability protection is provided for certain persons with respect to claims resulting from the administration of covered countermeasures following a declaration of a public health emergency under this authority.[84]

- **Disaster relief for aging services organizations:** The Assistant Secretary for Aging, in HHS, “may provide reimbursements to any State (or to any tribal organization receiving a grant under Title VI [42 U.S.C. §§ 3057 et seq.]), upon application for such reimbursement, for funds such State makes available to area agencies on aging in such State (or funds used by such tribal organization) for the delivery of supportive services (and related supplies) during any major disaster declared by the President in accordance with the Robert T. Stafford Disaster Relief and Emergency Assistance Act.”[85]
- **Authority to expedite research:** If the Secretary “determines, after consultation with the Director of NIH, the Commissioner of the Food and Drug Administration, or the Director of the Centers for Disease Control and Prevention, that a disease or disorder constitutes a public health emergency, the Secretary, acting through the Director of NIH,” shall expedite certain review procedures for applications for research grants on diseases relevant to the disease or disorder involved in the emergency and take other specified administrative measures to assist relevant grants or contracts. (NIH is the National Institutes of Health.)[86]
- **Fisheries management:** The Secretary of Commerce may take certain measures relating to the national fishery management program in case of an emergency. If the emergency is a public health emergency, then the Secretary of HHS is to “concur” with the “emergency regulation or interim measure promulgated” by the Secretary of Commerce.[87]
- **ATSDR assistance for exposure to toxic substances:** The Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR, an agency within HHS) shall, “in cases of public health emergencies caused or believed to be caused by exposure to

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[84] 42 U.S.C. § 247d-6d. Additional information regarding this authority is available in CRS Report RS22327, *Pandemic Flu and Medical Biodefense Countermeasure Liability Legislation: P.L. 109-148, Division C (2005)*, by Henry Cohen.

[85] 42 U.S.C. § 3030.

[86] 42 U.S.C. § 289c.

[87] 16 U.S.C. § 1855(c).

toxic substances, provide medical care and testing to exposed individuals."[88]

- **Mosquito-borne diseases:** The Secretary has enhanced budget authority for the response to public health emergencies related to mosquito-borne diseases as follows: "In the case of any control programs carried out in response to a mosquito-borne disease that constitutes a public health emergency, the authorization of appropriations (in this provision) is in addition to applicable authorizations of appropriations under the Public Health Security and Bioterrorism Preparedness and Response Act of 2002."[89]

Additional Public Health Emergency Authorities

The following are public health emergency authorities of individuals other than the HHS Secretary.

- **Authority of the Attending Physician to Congress:** "The Attending Physician to Congress shall have the authority and responsibility for overseeing and coordinating the use of medical assets in response to a bioterrorism event and other medical contingencies or public health emergencies occurring within the Capitol Buildings or the United States Capitol Grounds. This shall include the authority to enact quarantine and to declare death. These actions will be carried out in close cooperation and communication with the Commissioner of Public Health, Chief Medical Examiner, and other Public Health Officials of the District of Columbia government."[90]
- **Crisis counseling assistance and training during a disaster:** "The President is authorized to provide professional counseling services, including financial assistance to State or local agencies or private mental health organizations to provide such services or training of disaster workers, to victims of major disasters in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath."[91] This provision in the Stafford Act is administered by the Substance Abuse and Mental Health Services Administration in HHS.[92]
- **Notification during potential public health emergencies:** "In cases involving, or potentially involving, a public health emergency, but in which no determination of an emergency by the Secretary of

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[88] 42 U.S.C. § 9604.

[89] 42 U.S.C. § 247b-21.

[90] 2 U.S.C. § 121g, first authorized in P.L. 108-199, the Consolidated Appropriations Act, 2004.

[91] 42 U.S.C. § 5183, Section 416 of the Stafford Act.

[92] For more information, see CRS Report RS22292: *Hurricanes Katrina and Rita: Addressing the Victims' Mental Health and Substance Abuse Treatment Needs*, by Erin D. Williams.

> Health and Human Services under Section 319(a) of the Public Health Service Act (42 U.S.C. 247d(a)), has been made, all relevant agencies, including the Department of Homeland Security, the Department of Justice, and the Federal Bureau of Investigation, shall keep the Secretary of Health and Human Services and the Director of the Centers for Disease Control and Prevention fully and currently informed."[93]

Methodology

The above listing of federal public health emergency authorities was developed by reviewing the results of a search of the U.S. Code for the terms "public health emergency," or "health threat" or "disaster," or for citations to the public health emergency authority at 42 U.S.C. § 247d. Not included in the listing are references to the suspension of certain routine activities in the event of a disaster, requirements for disaster planning in healthcare facilities, or other provisions not directly related to the declaration or determination of a federal public health emergency or the activities authorized or required when such a declaration or determination is made.

[93] 6 U.S.C. § 467, authorized in P.L. 107-296, the Homeland Security Act of 2002.