Order Code RL33579

# CRS Report for Congress

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

**Updated June 23, 2008**

Sarah A. Lister
Specialist in Public Health and Epidemiology
Domestic Social Policy Division


Prepared for Members and
Committees of Congress

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


## Summary

When there is a catastrophe in the United States, state and local governments are principally responsible for response activities, and state and local legal authorities are the principal means to support these activities. When catastrophes overwhelm state and local response capabilities, the President (acting through the Secretary of Homeland Security) can provide assistance to stricken communities, individuals, governments, and not-for-profit groups to assist 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. The Secretary of Health and Human Services (HHS) also has both standing and emergency authorities in the Public Health Service (PHS) Act by which he can provide assistance in response to public health and medical emergencies. At this time, he has limited means, however, to finance activities that are ineligible, for whatever reason, for Stafford Act assistance.

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 that result in overwhelming public health and medical needs. These concerns include the delegation of responsibilities among different federal departments, and whether critical conflicts or gaps exist in these relationships. In particular, there are some concerns about federal leadership and delegations of responsibility as laid out in the recently published National Response Framework (NRF).

There is no federal assistance program designed purposely to cover the uninsured or uncompensated costs of individual health care that may be needed as a consequence of a disaster, nor is there consensus that this should be a federal responsibility. However, following Hurricane Katrina, Congress provided short-term assistance to host states, through the Medicaid program, to cover the uninsured health care needs of eligible Katrina evacuees. Some have proposed establishing a mechanism to cover certain uninsured health care costs of responders and others who are having health problems related to exposures at the World Trade Center site in New York City following the 2001 terrorist attack.

This report examines (1) the authorities and coordinating mechanisms of the President and the Secretary of HHS in providing routine assistance, and 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**. This report will be updated as needed.

## Contents

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

## Introduction

When there is a catastrophe in the United States, state and local governments are principally responsible for response activities, and state and local legal authorities are the principal means to support these activities. 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]

Recent incidents — in particular the September 11 and anthrax attacks of 2001, and several Gulf Coast hurricanes in 2005 — have shown the limitations of existing funding mechanisms in supporting public health and medical incident responses. First, it is not clear that Stafford Act major disaster assistance is available for the response to infectious disease threats, whether intentional (bioterrorism) or natural (e.g., pandemic influenza, or "flu"). Second, the Secretary of Health and Human Services (HHS) has authority to draw upon a special fund to support departmental activities in response to unanticipated public health emergencies, but there is at present no money in the fund. Finally, there is no existing comprehensive mechanism to provide federal assistance for uninsured or uncompensated individual health care costs that may be incurred as a result of a natural disaster or terrorist incident, though there is not general agreement that such assistance should be a federal responsibility.

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

---

[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, and CRS Report RL34146, *FEMA's Disaster Declaration Process: A Primer*, by Francis X. McCarthy.

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**. This report will be updated as needed.

For more information on aspects of public health and medical preparedness and response in general, and in the context of specific disasters or threats, see the following CRS Reports:

- RS22602, *Public Health and Medical Preparedness and Response: Issues in the 110th Congress*;
- RL33589, *The Pandemic and All-Hazards Preparedness Act (P.L. 109-417): Provisions and Changes to Preexisting Law*;
- RL33927, *Selected Federal Compensation Programs for Physical Injury or Death*;
- RL31719, *An Overview of the U.S. Public Health System in the Context of Emergency Preparedness*;
- RL33096, *2005 Gulf Coast Hurricanes: The Public Health and Medical Response*;
- RL33083, *Hurricane Katrina: Medicaid Issues*;
- RL33738, *Gulf Coast Hurricanes: Addressing Survivors' Mental Health and Substance Abuse Treatment Needs*;
- RL33145, *Pandemic Influenza: Domestic Preparedness Efforts*; and
- RL34190, *Pandemic Influenza: An Analysis of State Preparedness and Response Plans.*

# 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

---

[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*, by Keith Bea, under the section titled "Types of Assistance and Eligibility."

> 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 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 a flu pandemic or other public 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

---

[4] 42 U.S.C. § 5122(2).

[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*, by Keith Bea, under the section titled "Emergency Declaration Assistance."

> 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 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 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.
>
> (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 specifically to a public health threat. In the fall of 2000, President Clinton issued emergency declarations for New York and New Jersey to help the states contain the threatened spread of the West Nile virus.[10]

---

[8] 42 U.S.C. § 5122(1).

[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].

**Public Health Emergency Authorities.** State and local governments, rather than the federal government, are the seats of responsibility and authority for public health activities, both in general, and in response to public health and medical emergencies. As with catastrophes in general, the federal government may provide various forms of assistance to state and local governments, non-profit entities, families, and others, in response to public health threats. 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 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 declaration pursuant to the Stafford Act and/or the National Emergencies Act,[12] 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) often involves extensions of routine program activities, such as technical assistance for epidemiologic and laboratory investigation, workforce assistance, or the provision of special drugs or tests.

In response to public health threats, the Secretary of HHS can provide a considerable degree of assistance to states, upon their request, through the Secretary's standing (i.e., non-emergency) authorities. There is neither a defined threshold, nor a 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

---

[11] 42 U.S.C. § 247d(a).

[12] For more information regarding the National Emergencies Act, see CRS Report 98-505, *National Emergency Powers*, by Harold C. Relyea.

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.[13]

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 four 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 (including states that were directly affected, and a number of states that hosted evacuees); (3) in Texas and Louisiana, affected by Hurricane Rita in September 2005; and (4) in Iowa and Indiana, as a result of severe flooding in June 2008.[14]

Two factors may explain the rarity of public health emergency determinations. First, the Secretary of HHS has standing (non-emergency) authority to render many forms of aid to state and local governments and others, without the need to meet a defined threshold of need or impact. Also, although making such a determination authorizes the Secretary to draw from a Public Health Emergency Fund (PHEF), the fund has not had a balance in it for many years.[15] Consequently, none of the determinations issued since 2000 had the effect of mobilizing any additional funds beyond those that would otherwise have been available. It is possible that if funds were available to the Secretary in the PHEF, it could influence his decision to make a public health emergency determination, or the pressures put upon him to do so.[16] Given that, the Congress may consider whether the degree of discretion afforded to the HHS Secretary in making such a determination, and the accompanying reporting requirements, are appropriate.

Although the Secretary of HHS does not, at this time, have access to additional funding if he makes a public health emergency determination, the authority appears to have be useful, nonetheless, in addressing the widespread evacuations that resulted from Hurricanes Katrina and Rita in 2005, and the Midwest floods in 2008. When a public health emergency determination is made, the Secretary has authority to

---

[13] 42 U.S.C. § 243c.

[14] The 2001 determination applied to the September 11 attacks, and not to the subsequent anthrax attack (66 *Federal Register* 54998, October 31, 2001). More information about the 2005 hurricane determinations is available in CRS Report RL33096, *2005 Gulf Coast Hurricanes: The Public Health and Medical Response*, by Sarah A. Lister. More information about the 2008 flood determinations is available on the website of the HHS Centers for Medicare and Medicaid Services (CMS), at [http://www.cms.hhs.gov/emergency/20_midwestflooding.asp]. Stafford major disaster and emergency declarations may be found on FEMA's website at [http://www.fema.gov/hazard/index.shtm].

[15] See the subsequent section "Federal Funding to Support an ESF-8 Response."

[16] FEMA's administration of the Disaster Relief Fund (DRF), which supports the response to Stafford Act emergency and major disaster declarations, may offer an instructive comparison. The DRF is discussed further in a subsequent section of this report. See also CRS Report RL34146, *FEMA's Disaster Declaration Process: A Primer*, by Francis X. McCarthy.

waive a number of requirements that typically apply to health care providers as a condition of their receipt of federal reimbursement (through the Medicare program, for example.) Among other things, these waivers allow beneficiaries to receive services despite having lost their documentation of eligibility, and providers to provide services in alternate temporary facilities.[17]

**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, as mentioned above — requires a simultaneous public health emergency determination, *and* a declaration pursuant to either the Stafford Act or the National Emergencies Act. However, when multiple declarations are in effect as a result of a specific incident, as they were following Hurricane Katrina, it poses a greater challenge for officials in understanding the scope and interaction of their response authorities.[18]

## Federal Coordinating Mechanisms for Disaster Response

**National Response Framework.** 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.[19] In January 2008, the NRP was replaced by the *National Response Framework* (NRF),[20] following a lengthy stakeholder engagement intended, among other things, to capture lessons learned from the flawed response to Hurricane Katrina. The NRF is under the overall coordination of the Secretary of Homeland Security, and its implementation is delegated to FEMA. The NRF sets forth the responsibilities and roles of federal agencies; identifies tasks to be performed by specified federal officials; and includes annexes with details on support resources and mechanisms that are integral to its implementation. It is not a source of new authority for incident

---

[17] Applicable waiver authorities are described in "Waiver of certain requirements" in the Appendix. For more information about waivers applied in response to the Midwest floods of 2008, see HHS, "HHS Takes Action to Help Medicare Beneficiaries and Providers in Iowa and Indiana," press release, June 16, 2008.

[18] For example, as Hurricane Katrina approached, Louisiana received an emergency declaration on August 27, 2006, prior to landfall. This was superceded by a major disaster declaration on August 29, 2006, the day of landfall. The Secretary of HHS also determined that a public health emergency existed in Louisiana, effective August 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 were not themselves subject to major disaster declarations.

[19] 6 U.S.C. § 312(6). Department of Homeland Security (DHS), National Response Plan, December 2004. The NRP was mandated in the Homeland Security Act, P.L. 107-296, and superceded the earlier Federal Response Plan.

[20] DHS, *National Response Framework,* (NRF) January 2008, hereinafter referred to as NRF, at [http://www.fema.gov/emergency/nrf/].

response. While it may be used to guide response activities that flow from Stafford Act declarations, it is not a source of funding for these activities.[21] It is applicable to incidents whether or not they have led to a Stafford Act declaration.[22] Finally, it is intended to be a *national* coordinating blueprint, laying out and integrating roles for state, local, territorial and tribal governments, and the private sector, in addition to federal agencies.

**National Response to an Influenza Pandemic.** In addition to the NRF, which guides a coordinated national *all-hazards* response (i.e., to a variety of catastrophes), numerous federal and other planning documents that are specific for a flu pandemic have been published. Selected planning documents are listed below. Unless otherwise noted, they can be found on a government-wide pandemic flu website managed by HHS.[23]

- 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.
- *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.
- 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 health care sectors.
- *Department of Defense Implementation Plan for Pandemic Influenza*, August 2006: provides policy and guidance for the following priorities: (1) force health protection and readiness; (2) the continuity of essential functions and services; (3) Defense support to civil authorities (i.e., federal, state, and local governments); (4) effective communications; and (5) support to international partners.

---

[21] See the subsequent section on "The Disaster Relief Fund" for an explanation of how activities authorized by the Stafford Act may be funded.

[22] Implementation of the NRF represents a departure from the earlier NRP, which required certain triggers. In contrast, the NRF "is always in effect, and elements can be implemented at any level at any time." (NRF, p. 7) As a result, while the NRF serves as the blueprint for coordinated national response actions following Stafford Act declarations, such declarations are not required in order for the NRF to be in effect. Consequently, the NRF serves also to guide and coordinate homeland security activities during special events such as the Super Bowl and political conventions.

[23] See [http://www.pandemicflu.gov/].

- *VA Pandemic Influenza Plan*, March 2006: provides policy and instructions for Department of Veterans Affairs (VA) in protecting its staff and the veterans it serves, maintaining operations, cooperating with other organizations, and communicating with stakeholders.
- *Pandemic Influenza Preparedness, Response, and Recovery Guide for Critical Infrastructure and Key Resources*, September 2006: provides business planners with guidance to assure continuity during a pandemic for facilities comprising critical infrastructure sectors (e.g., energy and telecommunications) and key resources (e.g., dams and nuclear power plants).
- *State pandemic plans:* All states were required to develop and submit specific plans for pandemic flu preparedness, as a requirement of grants provided by HHS.[24]

## Would the Stafford Act Apply in a Flu Pandemic?

Each of the pandemic influenza plans listed above was written with the premise that the NRP would have been applicable to guide a coordinated federal response to a flu pandemic. The NRF, which was published subsequently, similarly notes that it could serve as the blueprint for a coordinated national response to this incident.[25]

As noted earlier, the NRF serves as a coordinating mechanism, but it does not confer any additional executive authorities, or serve as a source of funding for response activities. When a Stafford Act emergency or major disaster is declared, the Disaster Relief Fund may be used to pay for authorized response activities and assistance.[26] There is precedent for a Stafford emergency declaration in response to an infectious disease threat: as noted earlier, emergency declarations pursuant to the Stafford Act were made in response to West Nile virus in 2000. However, there is no relevant precedent regarding whether Stafford Act major disaster assistance could be provided in response to a flu pandemic. 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.[27] However, the Administration's view is that the President's authority to declare a major disaster pursuant to the Stafford Act could be applied to a flu pandemic,[28] and FEMA has

---

[24] For more information, see CRS Report RL34190, *Pandemic Influenza: An Analysis of State Preparedness and Response Plans*, by Sarah A. Lister and Holly Stockdale.

[25] NRF, p. 73.

[26] See the subsequent section on "The Disaster Relief Fund" for an explanation of how activities authorized by the Stafford Act may be funded.

[27] 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 [http://www.dhs.gov/xoig/rpts/mgmt/editorial_0334.shtm]. Also, the anthrax attack in 2001 did not result in a Stafford Act declaration.

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

issued a Disaster Assistance Policy regarding major disaster assistance that may be provided in response to this threat.[29]

The matter of the applicability of a Stafford major disaster declaration to a flu pandemic is important for two reasons. First, the level of funding that may be available to support federal activities, and provide assistance to state and local governments and individuals, is substantially greater following a major disaster declaration than it is for an emergency declaration.[30] Second, the federal leadership structure for incident response may be different depending on whether the incident results in a Stafford Act declaration, or is a "non-Stafford" incident. The Stafford Act requires the President, upon making an emergency or major disaster declaration, to appoint a Federal Coordinating Officer (FCO) to operate in the affected region.[31] This individual has historically reported to the head of FEMA, who in turn reports to the President and assumes overall operational control of the federal government's incident response. The NRF, and the NRP before it, established the role of Principal Federal Official (PFO), a different individual who reports directly to the Secretary of Homeland Security during an incident response. Confusion about the respective roles and authorities of these individuals was identified following Hurricane Katrina, and has remained a matter of concern to Congress.[32] It is reported that in December 2006, the Secretary of Homeland Security predesignated, in the event of a response to a flu pandemic, one national and five regional FCOs, *and* one national and five regional PFOs.[33] The respective roles of these individuals — all of whom would presumably be involved in response activities if a Stafford Act declaration were made — have not been clarified in any publicly available pandemic planning document.[34]

---

[29] FEMA, "Emergency Assistance for Human Influenza Pandemic," Disaster Assistance Policy 9523.17, March 31, 2007, at [http://www.fema.gov/pdf/government/grant/pa/policy.pdf].

[30] Even so, the types of activities for which assistance is authorized pursuant to a Stafford major disaster declaration are not necessarily well aligned to the types of activities that would be needed during a pandemic response, or during an incident with a substantial public health and medical response component in general. This is discussed further in a subsequent section on "Federal Funding to Support an ESF-8 Response."

[31] 42 U.S.C. § 5143.

[32] In FY2008 appropriations for DHS, Congress prohibited the use of appropriated funds for "any position designated as a Principal Federal Official" for any disasters or emergencies declared pursuant to the Stafford Act. P.L. 110-161, the Consolidated Appropriations Act, 2008, § 541, 121 Stat. 2079, December 26, 2007. See also, DHS Office of Inspector General, "FEMA's Preparedness for the Next Catastrophic Disaster," OIG-08-34, March 2008, at [http://www.dhs.gov/xoig/].

[33] See Government Accountability Office (GAO), "Influenza Pandemic: Further Efforts Are Needed to Ensure Clearer Federal Leadership Roles and an Effective National Strategy," GAO-07-781, p. 18, August 14, 2007.

[34] Ibid. GAO reported that DHS was developing a "Federal Concept Plan for Pandemic Influenza," which would clarify these roles, but such plan has not been published.

# NRF Emergency Support Function 8: Roles and Challenges

## Overview

The Hurricane Katrina response, and planning for a flu pandemic, each demonstrate the scope of *public health* and *medical* activities needed in response to a large-scale catastrophe. A flu pandemic would not likely impose the mass dislocations and destruction of health care 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.

A successful *public health response* involves such things as monitoring and assurance of the safety of food and water, prevention of injury, control of infectious diseases, and a host of other activities, and is carried out by a variety of entities, primarily government and not-for-profit agencies. A successful *medical response* is perhaps more complicated, 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 require rescue or medical evacuation; (2) a treatment facility, which may be an existing hospital or a field tent with cots; (3) a competent health care workforce; (4) appropriate medical equipment and non-perishable medical supplies; (5) appropriate drugs, vaccines, tests and other perishable medical supplies; (6) a system of medical records; and (7) a health care financing mechanism.

According to the NRF (and the earlier NRP), the Secretary of HHS is tasked with coordinating *Emergency Support Function 8* (ESF-8), the public health and medical response to incidents.[35] (ESF-8 is one of 15 ESFs in the NRF. Other functions include public safety, energy supplies, and transportation, for example.) ESFs are coordinating mechanisms, not funding mechanisms. The response to a flu 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 disruptions could affect the continuity of services, and possibly the integrity of infrastructure, in the transportation, public works, and energy sectors, among others.

---

[35] NRF, Annex ESF #8, at [http://www.fema.gov/emergency/nrf/]. See also HHS, "HHS Maintains Lead Federal Role for Emergency Public Health and Medical Response," press release, January 6, 2005. Many ESF-8 responsibilities and activities are delegated to the HHS Assistant Secretary for Preparedness and Response (ASPR, formerly called 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.

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/medical/veterinary equipment and supplies;
- patient evacuation;
- patient care;
- safety and security of human and veterinary drugs and medical devices, and human biologics;[36]
- blood and blood products;
- food safety and security;
- agriculture safety and security;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;
- mass fatality management, victim identification and decontaminating remains; and
- veterinary medical support.

Depending on the incident, HHS may need other agencies to carry out certain of their ESF activities (e.g., public safety, road clearing, and power restoration) before some ESF-8 activities could begin. Some specific concerns resulting from overlaps or gaps in defined ESF duties are discussed below.

## 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. The NRF has addressed some of these concerns, left others unclear, and possibly raised some new concerns.

Some had questioned whether the NRP clearly defined federal ESF-8 leadership, or whether the respective roles of the Secretaries of Homeland Security and HHS could conflict during a response. Some, including congressional investigators, felt this conflict was in evidence during the response to Hurricane Katrina.[37] Others were concerned that the respective roles were insufficiently clear to guide a coordinated response to a flu pandemic. In October 2006, the President signed P.L. 109-295, the

---

[36] These are products regulated by HHS's Food and Drug Administration (FDA).

[37] See U.S. Senate, Committee on Homeland Security and Governmental Affairs, *Hurricane Katrina: A Nation Still Unprepared*, chap. 24, p. 28ff, May 2006, 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, February 2006, at [http://www.whitehouse.gov/reports/katrina-lessons-learned/].

Post-Katrina Emergency Management Reform Act of 2006 (called the "Post-Katrina Act"; included in DHS appropriations for FY2007), which reauthorized and reorganized programs in FEMA.[38] Among other things, the law also codified the position of Chief Medical Officer (CMO) at DHS, the individual who coordinates all departmental activities regarding medical and public health aspects of disasters. The Post-Katrina Act provided that the CMO "shall have the primary responsibility *within the Department* for medical issues related to natural disasters, acts of terrorism, and other man-made disasters."[39] (Emphasis added.) Subsequently, in December 2006, the President signed P.L. 109-417, the Pandemic and All-Hazards Preparedness Act, which provided that "The Secretary of Health and Human Services shall lead all *Federal* public health and medical response to public health emergencies and incidents covered by the National Response Plan...."[40] (Emphasis added.) The Government Accountability Office (GAO) has recommended, in the context of pandemic flu planning, that the two departments (DHS and HHS) conduct rigorous testing, training and exercises to ensure that these roles are clearly defined.[41]

Responsibility for the health and safety of disaster response workers was a matter of concern in the NRP, and remains so in the NRF. The Government Accountability Office (GAO) found that OSHA's efforts during the response to Hurricane Katrina were hampered by confusion about the agency's role. GAO noted in particular that disagreements between FEMA and OSHA regarding OSHA's role delayed FEMA's authorization of mission assignments to fund OSHA's response activities.[42] Some Members of Congress and others sought to have worker health and safety elevated to an Emergency Support Function in the NRF, which would give OSHA more autonomy in commencing its response activities.[43] Instead, the NRF contains a revised Worker Safety and Health Support Annex.[44]

Although both the NRP and the NRF address mass fatality management, the NRP did not, and the NRF 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.

---

[38] See CRS Report RL33729, *Federal Emergency Management Policy Changes After Hurricane Katrina: A Summary of Statutory Provisions*, by Keith Bea, Barbara L. Schwemle, L. Elaine Halchin, Francis X. McCarthy, Frederick M. Kaiser, Henry B. Hogue, Natalie Paris Love and Shawn Reese.

[39] P.L. 109-295, 120 Stat. 1409.

[40] P.L. 109-417, § 101.

[41] GAO, "Influenza Pandemic: Further Efforts Are Needed to Ensure Clearer Federal Leadership Roles and an Effective National Strategy," GAO-07-781, August 14, 2007.

[42] GAO, "Disaster Preparedness: Better Planning Would Improve OSHA's Efforts to Protect Workers' Safety and Health in Disasters," GAO-07-193, March 28, 2007.

[43] Katherine Torres, "DHS Denies OSHA Power to Invoke Emergency Response Plan, Official Says," *Occupational Hazards*, vol. 70, March 1, 2008; and Anon., "Despite Lawmakers' Concerns, OSHA's Role in NRF Remains Unchanged," *Inside OSHA*, vol. 15, February 4, 2008.

[44] NRF, ESF-8 Annex and Worker Safety and Health Support Annex, at [http://www.fema.gov/emergency/nrf/].

Federal Disaster Mortuary Assistance Teams (DMORTs) comprise medical examiners, pathologists, dental technicians and other medical personnel.[45] 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 U.S. Coast Guard, are trained to work safely in such dangerous conditions, but their mission is to rescue the living, not recover the dead.[46] The matter of mass fatality management is of considerable concern to pandemic planners, and this gap could be problematic during such an incident.

At times the distinction between ESF-6 and ESF-8 may be blurred. Emergency Support Function 6 (ESF-6), *Mass Care*, under the leadership of FEMA, lays out the coordination of emergency shelter, feeding, and related activities for affected populations. As was evident in the response to Hurricane Katrina, the ESF functions overlapped when evacuees in Red Cross shelters required medical care, or when large numbers of hospital patients evacuated to ESF-8 field hospitals required food and water. The revised ESF-6 and ESF-8 annexes accompanying the NRF provide substantially more detail regarding the coordination of these functions than did the corresponding NRP annexes. Also, this problem was reportedly considered by FEMA, HHS, and the American Red Cross in their reviews of the hurricane response, and in their subsequent preparedness planning.

In the NRF, as with the NRP, leadership for the federal coordination of mental and behavioral health services following a disaster appears to be split between ESF-6 and ESF-8. "Crisis counseling" is among the responsibilities delegated in ESF-6, while federal coordination of "behavioral health care" — including assessing mental health and substance abuse needs, and providing disaster mental health training for workers — is delegated in ESF-8. Hence, federal leadership for disaster mental health in the NRP is delegated to both FEMA and to HHS.[47] (When the disaster involves terrorism or other forms of violence, the Department of Justice may also become a key federal partner, as was seen following the Oklahoma City bombing.[48])

Finally, the NRF resolves a gap in the NRP regarding federal responsibility for pets during disasters. It is well established that some people are reluctant to abandon their pets and will remain at home, despite an evacuation order, if they cannot take pets with them. Hence, the absence of coordinated mechanisms to assure the safety of pets in disasters may jeopardize human safety as well. In the Post-Katrina Act,

---

[45] DMORTs are a component of the National Disaster Medical System (NDMS), which comprises teams of medical professionals who are pretrained, and are "federalized" to deploy and provide medical services in the immediate aftermath of a disaster before other federal assets arrive. NDMS is administered by the HHS ASPR. For more information, see [http://www.hhs.gov/aspr/opeo/ndms/index.html].

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

[47] For more information, 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.

[48] The Department of Justice shares leadership responsibilities with DHS for ESF-13, *Public Safety and Security*. ESF-13 does not explicitly mention mental health.

Congress required DHS, in developing standards for state and local emergency plans, to account for the needs of individuals with household pets and service animals before, during, and after a major disaster or emergency, in particular with regard to evacuation planning and planning for the needs of individuals with disabilities. In addition, the act authorized the President to make Stafford Act assistance available to states and localities to carry out pet rescue and sheltering activities in the immediate response to a major disaster.[49] Congress passed similar provisions in P.L. 109-308, the Pets Evacuation and Transportation Standards Act of 2006, though neither act addressed the matter of federal leadership for the needs of pets in disasters. The NRF, however, clearly assigns this responsibility under ESF-6 (Mass Care) and ESF-11 (Agriculture and Natural Resources). FEMA, when coordinating federal efforts to provide human sheltering services per ESF-6, is to ensure that the needs of pets can also be accommodated (various approaches to this are often referred to as "co-sheltering"), while USDA's Animal and Plant Health Inspection Service, per ESF-11, is to ensure that the sheltering needs of the pets are met.

# Federal Funding to Support an ESF-8 Response

Hurricane Katrina was the greatest test of ESF-8 since the establishment of DHS 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, health care providers, insurers, families, and individuals. Private insurance covered some of the property damage, health care 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 health care costs. Some other costs, such as the costs of rebuilding the devastated health care infrastructure in New Orleans, have not been fully met at this time, either through existing assistance mechanisms or mechanisms developed since the storm.[50] The response to Hurricane Katrina, and ongoing pandemic preparedness efforts, each offer a glimpse of the complexity of the challenge, and the adequacy of existing mechanisms to fund the costs of an ESF-8 response.

## Funding Sources and Authorities

**The Disaster Relief Fund.** Activities undertaken pursuant to 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, 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 also receive *mission*

---

[49] P.L. 109-295, §§ 536, 653 and 689.

[50] See Government Accountability Office (GAO), "Status of the Health Care System in New Orleans," GAO-06-576R, March 28, 2006; the Louisiana Health Care Redesign Collaborative, at [http://www.hhs.gov/louisianahealth/]; and Bruce Alpert, "GAO Says Hospitals not Worth Salvaging," Times-Picayune, March 30, 2006.

*assignments* from FEMA to provide assistance pursuant to the NRF, and are reimbursed through funds appropriated to the DRF. Through mission assignments, the DRF supported a variety of federal public health activities in the response to Hurricane Katrina, including activities to assure the safety of food and water, monitor population health status (including mental health), control infectious diseases and mosquitoes, and evaluate potential health threats associated with chemical releases. However, the DRF is not generally available to pay or reimburse the costs of health care for affected individuals, though it may pay such costs to a limited extent. (See "Federal Assistance for Disaster-Related Health care Costs," below.)

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.[51]

**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.[52] 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.[53]

Between 1988 and 2000, the fund was authorized for annual appropriations sufficient to have a balance of $45 million at the beginning of each fiscal year.[54] 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

---

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

[52] P.L. 98-49.

[53] 42 U.S.C. § 247d(b), as amended by P.L. 106-505.

[54] P.L. 100-607, § 256(a).

authority in 42 U.S.C. § 247d(a) in 2000. As a consequence, the fund was not available for the response to four 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 (including states that were directly affected, and a number of states that hosted evacuees); (3) in Texas and Louisiana, affected by Hurricane Rita in September 2005; and (4) in Iowa and Indiana, as a result of severe flooding in June 2008.[55]

In 2002, Congress reauthorized the National Disaster Medical System (NDMS) in language suggesting that the emergency fund could be used to support additional activities of the HHS Secretary, including NDMS deployments, 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.[56]

Depending on the availability of funds, this mechanism could be used to fund NDMS deployments that occurred in the absence of Stafford Act declarations.

**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 grants 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

---

[55] The 2001 determination applied to the September 11 attacks, and not to the subsequent anthrax attack (66 *Federal Register* 54998, October 31, 2001). More information about the 2005 hurricane determinations is available in CRS Report RL33096, *2005 Gulf Coast Hurricanes: The Public Health and Medical Response*, by Sarah A. Lister. More information about the 2008 flood determinations is available on the website of the HHS Centers for Medicare and Medicaid Services (CMS), at [http://www.cms.hhs.gov/emergency/20_midwestflooding.asp]. Stafford major disaster and emergency declarations may be found on FEMA's website at [http://www.fema.gov/hazard/index.shtm].

[56] 42 U.S.C. § 300hh-11, as amended by P.L. 107-188. Pursuant to P.L. 109-417, the HHS Assistant Secretary for Public Health Emergency Preparedness is now designated as the HHS Assistant Secretary for Preparedness and Response (ASPR).

Public Health Preparedness" budget line,[57] and grants to states for hospital preparedness, previously administered by the Health Resources and Services Administration (HRSA, an agency in HHS), and transferred to the HHS Assistant Secretary for Preparedness and Response (ASPR) in the Pandemic and All-Hazards Preparedness Act.[58]

## 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) subsequently 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 P.L. 109-234, the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006.[59]

A portion of supplemental appropriations to the DRF supported federal ESF-8 response activities. FEMA reports to Congress on expenditures for mission assignments to both HHS, and separately to CDC, for the responses to Hurricanes Katrina, Rita and Wilma.[60] 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.[61]

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

---

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

[58] See HHS, the Hospital Preparedness Program, at [http://www.hhs.gov/aspr/opeo/hpp/index.html].

[59] 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.

[60] DHS, FEMA, "Disaster Relief Fund (DRF) Report," Congressional Monthly Report, as of June 1, 2008.

[61] 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," January 25, 2006, at [http://www.hhs.gov/katrina/#hhs].

efforts as needed.[62] 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).[63] 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."[64] HRSA also advised state grantees that some redirection of funds provided by the National Bioterrorism Hospital Preparedness Program (which HRSA administered at the time) was also permissible to support the hurricane response.[65]

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. HHS received limited direct supplemental appropriations for its response to Hurricane Katrina, namely $8 million to CDC for mosquito abatement and other pest control activities, and $4 million to HRSA to re-establish communications capability in health departments, community health centers, major medical centers, and other entities that would continue to provide health care in areas affected by Hurricane Katrina.[66]

## Federal Assistance for Disaster-Related Health Care Costs

**Overview.** When Stafford major disaster assistance is available, as it was following Hurricane Katrina, it can be invaluable in supporting public health response activities under ESF-8. Typically, these activities are inherently governmental, and are generally reimbursable from the DRF. But even when a Stafford major disaster declaration applies, it does little to meet the uninsured or uncompensated costs of health care for disaster victims, or to reimburse institutions

---

[62] 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," September 16, 2005, hereafter referred to as the Nichols letter.

[63] 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.

[64] Nichols letter.

[65] 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].

[66] P.L. 109-234, the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 120 Stat. 463. See also CRS Report RS22239, *Emergency Supplemental Appropriations for Hurricane Katrina Relief*, by Keith Bea.

and providers who may have provided care without compensation. There is no federal assistance program designed purposely to cover the uninsured or uncompensated costs of individual health care that may be needed as a consequence of a disaster.

In a typical year, there are dozens of Stafford Act major disaster declarations (most resulting from weather-related events), potentially affecting millions of people. Given that some U.S. uninsured health care needs go unmet under normal circumstances, there is not consensus that the costs of health care for these disaster victims should be a federal responsibility. However, policy debates following two recent disasters, and concerns about pandemic flu, suggest that some Members of Congress and others are interested in exploring possible mechanisms to provide such assistance, at least in certain situations.

Following Hurricane Katrina, Congress provided $2.1 billion through the Medicaid program to assist states in providing for the health care needs of Katrina evacuees for five months following the storm. Katrina's victims continue to experience mental health problems in disproportionate numbers, however. These problems, and possibly others resulting from the storm and its aftermath, may linger beyond the duration of assistance programs that may be available to the storm's victims.

While there is not consensus that the costs of health care for disaster victims should be borne by the federal government, there has nonetheless been considerable discussion about the needs of victims of the terrorist attack of September 11, 2001, and whether terrorism should place upon the federal government a different responsibility for its victims than for victims of non-terrorist disasters.

**Existing Mechanisms.** Several federal assistance mechanisms are available to provide *limited* coverage for the costs of health care services that are rendered during, or required as a result of, a catastrophe. 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 Individuals and Households program). Furthermore, these programs are not generally coordinated with each other at the federal level, though programs that support state activities to finance or deliver health care services may be coordinated at that level. These programs include:

- Services provided by the National Disaster Medical System (NDMS) or other federalized employees while carrying out mission assignments requested by FEMA, pursuant to a Stafford Act declaration, 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.[67]

---

[67] 42 U.S.C. § 5170b (major disaster) and 42 U.S.C. § 5192 (emergency).

- The FEMA Individuals and Households Program (IHP) provides, pursuant to a Stafford Act declaration and reimbursed from the DRF, 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 annual adjustment based on the Consumer Price Index. The maximum amount available for Hurricane Katrina relief was $26,200, and the current ceiling is $28,800.[68]
- 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. FEMA and the Substance Abuse and Mental Health Services Administration (SAMHSA) in HHS jointly administer the Crisis Counseling Assistance and Training Program (CCP). Financing for this assistance is drawn from the DRF.[69]
- 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 first aid stations or distributed to states from the CDC's Strategic National Stockpile. Agencies' costs may be reimbursed from the DRF if the incident resulted in a Stafford Act declaration.
- 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 health care needs for specific populations.[70] 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,[71] and expanded federal

---

[68] 72 *Federal Register* 57341, October 9, 2007. 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/xoig/rpts/mgmt/OIG_mgmtrpts_FY06.shtm].

[69] 42 U.S.C. § 5183. For more information, 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.

[70] For more information on Public Health Service agencies and their functions, see CRS Report RL34098, *Public Health Service (PHS) Agencies: Background and Funding*, Pamela W. Smith, Coordinator.

[71] For more information, 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.

support, including personnel, for health centers in disaster-affected areas.[72]

- Certain federal compensation programs may cover some or all health care costs for certain disaster victims, though these programs generally flow from the individual's employment status rather than from their status as disaster victims. Such programs include workers' compensation programs, for federal workers whose injuries are related to employment,[73] and benefits for federal, state, and local public safety officers (including police officers and firefighters) who are killed or permanently disabled while performing their duties.[74]

**Health Care Needs of 9/11 Responders.** Within two weeks of the terrorist attack on the World Trade Center (WTC) in New York City, Congress established the September 11th Victim Compensation Fund (VCF).[75] 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.[76] The deadline for filing a claim was December 22, 2003.

Thousands of responders worked on the site in a rescue, recovery, and cleanup operation that lasted more than a year. Many of these workers, and others who lived in the area, are experiencing, many years later, various respiratory, psychological, gastrointestinal, and other problems felt to be related to their exposures at the site.[77] Physical hazards to which these individuals were potentially exposed include asbestos and other particulates, heavy metals, volatile organic compounds, and dioxin.

Congress provided funding to the CDC to establish the World Trade Center Health Registry, an effort to identify and periodically survey people who were exposed at the site or in the general vicinity, to track their health status over a 20-year period.[78] In addition, several medical monitoring programs were established to develop and deliver initial, and sometimes follow-up, health examinations to groups

---

[72] Health centers provide health care services regardless of ability to pay. For more information, see HRSA, Bureau of Primary Health Care, Health Center Program, at [http://bphc.hrsa.gov/].

[73] State and private workers' compensation programs generally provide similar benefits.

[74] For more information on these programs, see CRS Report RL33927, *Selected Federal Compensation Programs for Physical Injury or Death*, by Sarah A. Lister and C. Stephen Redhead, hereinafter referred to as CRS Report RL33927.

[75] P.L. 107-42, signed into law on September 22, 2001.

[76] For more information, see CRS Report RL33927, the section "September 11th Victim Compensation Fund."

[77] See CDC/National Institute for Occupational Safety and Health (NIOSH), "World Trade Center Response," at [http://www.cdc.gov/niosh/topics/wtc/].

[78] For more information, see New York City Department of Health and Mental Hygiene, World Trade Center Health Registry site, at [http://www.nyc.gov/html/doh/html/wtc/index.html].

of individuals potentially at risk of future illness. While recruitment for both activities continues, the monitoring programs have identified a number of people with serious health problems presumably related to their WTC exposures, some of whom have died. Congress has provided intermittent appropriations to support the costs of medical treatment for some of these individuals, through treatment programs established after the terrorist attack.[79]

The VCF is not available to assist individuals whose symptoms arose after the fund's closing date. Routine sources of health care coverage may also elude these individuals. Some may have lost employer-based health insurance coverage, if they have become too sick to work. For some with health insurance, the plan may not cover needed prescription drugs or specialty care, or coverage may be denied if an insurer asserts that an illness is work-related and should be covered by workers' compensation. Some workers, such as volunteers or immigrants, may lack workers' compensation coverage. Others who have this coverage may still find that employers and insurers contest their claims on the basis that an illness is not work-related.[80]

Congressional interest in this issue has focused on matters of short- and long-term financing and accountability for the registry, monitoring, and treatment programs, and whether or how financial responsibility for the long-term needs of affected individuals should be shared, if at all, among the federal government, local governments, private insurers, and others. Bills introduced in the 110th Congress have proposed establishing programs to pay health care or other costs for workers and others who may be ill as a result of their exposures following the WTC incident, or providing eligibility for these individuals in existing programs.[81] None of these bills has advanced.

**Financing Health Care Needs Following Hurricane Katrina.** Hurricane Katrina was the largest mass casualty incident in recent times. Many of the storm'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, HHS expanded a number of existing programs to assist state and local agencies, health care providers and the storms' victims with a variety of health and public health needs.[82] Information regarding the overall cost of these expansions is not publicly available.

---

[79] See CRS Report RL33927, section on "World Trade Center Medical Monitoring and Treatment Program."

[80] See, for example, the House Committee on Energy and Commerce, Subcommittee on Health, hearing on, "Answering the Call: Medical Monitoring and Treatment of 9/11 Health Effects," September 18, 2007, 110th Cong., 1st Sess., Washington, DC.

[81] See, for example, H.R. 1247, H.R. 1414/S. 201, and H.R. 3543.

[82] 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," January 25, 2006, at [http://www.hhs.gov/katrina/#hhs].

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 are in effect, concurrently, a Stafford Act declaration by the President, and a determination of public health emergency by the Secretary of HHS.[83] This authority was exercised in a number of affected and host states following Hurricane Katrina. While this authority may improve access to health care services in affected areas, it does not directly address the financing of these services.

A significant challenge following Hurricane Katrina involved setting up or re-establishing health care financing mechanisms for displaced individuals. Ultimately, the Medicaid program became the mechanism by which affected and host states financed certain health care costs that were not compensated through other public or private insurance sources. After several months of debate, Congress provided, in the Deficit Reduction Act of 2005, 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.[84] Congress provided up to $2 billion for these activities.[85] This was in addition to $100 million earlier provided in supplemental appropriations to NDMS to cover expenses related to the response to Hurricane Katrina.[86] (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.[87]) According to HHS, as a result of this mechanism, eight states were able to reimburse providers that incurred uncompensated care costs as a result of serving an estimated 325,000 evacuees, and 32 states were able to provide continuity of coverage for up to five months for

---

[83] 42 U.S.C. § 1320b-5, enacted in P.L. 107-188.

[84] P.L. 109-171, the Deficit Reduction Act of 2005, § 6201, enacted February 8, 2006. This arrangement was designated for those states covered under a Medicaid and SCHIP waiver developed specifically for Hurricane Katrina relief. 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 September 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, January 13, 2003.)

[85] See GAO, "Hurricane Katrina: Allocation and Use of $2 Billion for Medicaid and Other Health Care Needs," GAO-07-67, February 28, 2007.

[86] P.L. 109-62, 119 Stat. 1991, September 8, 2005.

[87] HHS, Centers for Medicare and Medicaid Services, *Justification of Estimates for Appropriations Committees*, FY2007, p. 192.

displaced low-income individuals by temporarily enrolling them in a host state's Medicaid program through a simplified enrollment process.[88]

Individuals, institutions, providers, and others affected by Hurricane Katrina continue to face challenges that are beyond the scope of the nation's disaster assistance mechanisms. The Louisiana Health Care Redesign Collaborative was established in 2006 to develop a health care system that would integrate Gulf Coast and greater New Orleans rebuilding into a broader statewide plan.[89] A key funding strategy for the Collaborative is the development and approval by CMS of a comprehensive Medicaid waiver and Medicare demonstration proposal.[90]

**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, 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 health care system, non-urgent procedures (which are often more lucrative) 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 health care services during a pandemic, when about 47 million Americans currently lack health insurance, is of concern to many. Some are concerned that disease control efforts could suffer if some subgroups of the population were unwilling, because of their insurance status or for other reasons, to seek care or otherwise interact with disease control authorities during a pandemic.

In March 2007, FEMA issued a Disaster Assistance Policy for pandemic flu, outlining, among other types of assistance, the types of health care services that would be reimbursable through the Disaster Relief Fund, presuming that a Stafford major disaster declaration were made.[91] Assistance would be provided to eligible entities (including state and local government agencies) to support a number of ESF-8 activities, including establishing temporary medical facilities, public communication, and mass fatality management. With respect to the costs of medical care provided to individuals, the policy states that the following services may be eligible for reimbursement, for a period of time to be determined by the Secretary of

---

[88] HHS, "HHS Participation in the Recovery of the Gulf Coast," at [http://www.hhs.gov/louisianahealth/background/].

[89] Louisiana Health Care Redesign Collaborative, at [http://www.dhh.state.la.us/offices/?ID=288].

[90] Ibid. See also the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, hearing on "Post Katrina Health Care: Progress and Continuing Concerns — Part II," August 1, 2007, 110th Cong., 1st Sess., Washington, DC.

[91] See the earlier section of this report, "Would the Stafford Act Apply in a Flu Pandemic?"

Homeland Security or his designee: "Emergency medical care (non-deferrable medical treatment of disaster victims in a shelter or temporary medical facility and related medical facility services and supplies, including emergency medical transport, X-rays, laboratory and pathology services, and machine diagnostic tests....)"[92] Neither "emergency medical care" nor "non-deferrable medical treatment" are defined. Given the potential for there to be many casualties of a flu pandemic who require extended critical medical care, the extent to which the Disaster Relief Fund would be tapped to support the costs of such care is not entirely clear.

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 health care costs during a flu pandemic, and the model developed following Hurricane Katrina may serve as a useful starting point for discussion.

## Conclusion

Both the Secretaries of Homeland Security and HHS have statutory authority to provide additional assistance to state and local governments, and others, in response to catastrophes. Following Hurricane Katrina, Congress defined in statute the respective roles of the Secretaries with respect to the public health and medical response to catastrophes. Numerous specific aspects of these relationships are yet to be sorted out, through specific planning, exercises, and other approaches. In carrying out the federal response to public health and medical emergencies and disasters, the Secretary of HHS has broad authority and considerable discretion in providing assistance. But he lacks a sound funding source to support the response to these unanticipated events. In contrast, the President, acting pursuant to the Stafford Act, has, in the Disaster Relief Fund (DRF), a ready source of funds to support an immediate response to emergencies and disasters. Stafford Act assistance is, however, not especially well-tailored for the response to public health and medical threats. Indeed, some of these threats (e.g., bioterrorism) may not even trigger Stafford Act major disaster assistance.

---

[92] FEMA, "Emergency Assistance for Human Influenza Pandemic," Disaster Assistance Policy 9523.17, March 31, 2007, at [http://www.fema.gov/pdf/government/grant/pa/policy.pdf].

# Appendix. Federal Public Health Emergency Authorities[93]

## Broad Authority in Section 319 of the Public Health Service Act

The Secretary of HHS[94] has broad authority to determine that a public health emergency exists. Congress reauthorized this authority in 2000, 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).[95]

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 2000, Congress reauthorized a no-year public health emergency fund that is available to the HHS Secretary for use 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 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

---

[93] Kathleen S. Swendiman, legislative attorney in the American Law Division of CRS, contributed to this section. Federal law contains numerous authorities relating to instances of public health emergency. In some cases the term "public health emergency" is defined in statute, 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.

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

[95] 42 U.S.C. § 247d, as amended by P.L. 106-505, the Public Health Improvement Act.

activities undertaken with respect to each emergency which was conducted or supported by expenditures from the Fund.[96]

Subsequent to the 2000 reauthorization, 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."[97]
- **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."[98]
- **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, the Department of Justice, and the Federal Bureau of Investigation, fully and currently informed."[99]
- **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

---

[96] 42 U.S.C. § 247d, as amended by P.L. 106-505. This fund has not received a recent appropriation.

[97] 42 U.S.C. § 247d, as amended by P.L. 107-188, the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.

[98] Ibid.

[99] 6 U.S.C. § 467, authorized in P.L. 107-296, the Homeland Security Act of 2002.

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."[100] 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 *et seq*.) or the Stafford Act (42 U.S.C. § 5121 *et seq*.).[101] 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;[102] (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 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

---

[100] 21 U.S.C. § 360bbb-3, authorized in P.L. 108-276, the Project BioShield Act of 2004.

[101] 42 U.S.C. § 1320b-5, as amended by P.L. 107-188, P.L. 108-276, and P.L. 109-417.

[102] 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.

circumstances, use an alternative methodology for determining payments of certain drugs under the Medicare program.[103]

- **Deployment of the Public Health Service Commissioned Corps:** The Secretary may deploy officers in the Commissioned Corps of the U.S. Public Health Service to respond to an "urgent or emergency public health care need," as determined by the Secretary, arising as the result of (1) a national emergency declared by the President under the National Emergencies Act (50 U.S.C. § 1601 *et seq.*); (2) an emergency or major disaster declared by the President under the Stafford Act (42 U.S.C. § 5121 *et seq.*); (3) a public health emergency declared by the Secretary pursuant to 42 U.S.C. § 247d; or (4) any emergency that, in the judgment of the Secretary, is appropriate for the deployment of members of the Corps.[104]

Pursuant to the authority in Section 319, the Secretary of HHS has determined that a public health emergency exists on four recent 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; (3) in several states affected by Hurricane Rita in September 2005; and (4) in Iowa and Indiana as a result of severe flooding in June 2008.[105]

## 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

---

[103] 42 U.S.C. § 1395w-3a(e), authorized in P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

[104] 42 U.S.C. § 204a, as amended by P.L. 109-417, the Pandemic and All-Hazards Preparedness Act.

[105] The 2001 determination applied to the September 11 attacks, and not to the subsequent anthrax attack (66 *Federal Register* 54998, October 31, 2001). More information about the 2005 hurricane determinations is available in CRS Report RL33096, *2005 Gulf Coast Hurricanes: The Public Health and Medical Response*, by Sarah A. Lister. More information about the 2008 flood determinations is available on the website of the HHS Centers for Medicare and Medicaid Services (CMS), at [http://www.cms.hhs.gov/emergency/20_midwestflooding.asp]. Stafford major disaster and emergency declarations may be found on FEMA's website at [http://www.fema.gov/hazard/index.shtm].

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."[106] 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.

- **National Health Security Strategy:** "Preparedness and response regarding public health emergencies: Beginning in 2009 and every four years thereafter, the Secretary shall prepare and submit to the relevant committees of Congress a coordinated strategy (to be known as the National Health Security Strategy) and any revisions thereof, and an accompanying implementation plan for public health emergency preparedness and response. Such National Health Security Strategy shall identify the process for achieving the preparedness goals described in subsection (b) and shall be consistent with the National Preparedness Goal, the National Incident Management System, and the National Response Plan developed pursuant to section 502(6) of the Homeland Security Act of 2002 [6 U.S.C. § 314(6)], or any successor plan."[107]
- **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).[108]
- **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

---

[106] 42 U.S.C. § 243c.

[107] 42 U.S.C. § 300hh-1, as established in P.L. 109-417.

[108] 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.

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."[109]

- **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).[110]
- **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 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."[111]
- **Authority for the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP):** "Not later than 12 months after the date of enactment of the Pandemic and All-Hazards Preparedness Act, the Secretary shall link existing State verification systems to maintain a single national interoperable network of systems, each system being maintained by a State or group of States, for the purpose of verifying the credentials and licenses of health care professionals who volunteer to provide health services during a public health emergency."[112] "Public health emergency" is not defined.
- **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

---

[109] 7 U.S.C. § 8401, as amended by P.L. 107-188.

[110] 42 U.S.C. § 300hh-11, as amended by P.L. 107-188.

[111] 42 U.S.C. § 247d-6b, as amended by P.L. 108-276, the Project BioShield Act of 2004.

[112] 42 U.S.C. § 247d-7b, as amended by P.L. 109-417.

likely to cause a public health emergency if transmitted to other individuals."[113]

- **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.[114]
- **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 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.[115]
- **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."[116]
- **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

---

[113] 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.

[114] 42 U.S.C. § 233(p). See also sections immediately following this section, including 42 U.S.C. §§ 239 et seq.

[115] 42 U.S.C. § 247d-6d. Additional information regarding this authority is available in CRS Report RS22327, *Pandemic Flu and Medical Biodefense Countermeasure Liability Limitation*, by Henry Cohen and Vanessa K. Burrows.

[116] 42 U.S.C. § 3030.

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.)[117]

- **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.[118]
- **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 toxic substances, provide medical care and testing to exposed individuals."[119]
- **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."[120]

## 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,

---

[117] 42 U.S.C. § 289c.

[118] 16 U.S.C. § 1855(c).

[119] 42 U.S.C. § 9604.

[120] 42 U.S.C. § 247b-21.

and other Public Health Officials of the District of Columbia government."[121]

- **Health and medical monitoring following a disaster**: The President, acting through the Secretary of HHS, is authorized to carry out a program for the coordination, protection, assessment, monitoring, and study of the health and safety of individuals (including but not limited to responders) who may have had hazardous exposures as a result of a disaster declared pursuant to the Stafford Act (42 U.S.C. § 5121 *et seq*.). If the President carries out such a program, it must be commenced in a timely manner to ensure the highest level of public health protection and effective monitoring.[122]
- **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."[123] This provision in the Stafford Act is administered by the Substance Abuse and Mental Health Services Administration in HHS.[124]
- **Authority of the Secretary of DHS to deploy the Strategic National Stockpile:** "The [DHS] Secretary [Secretary's responsibilities] ... shall include ... coordinating other Federal response resources, including requiring deployment of the Strategic National Stockpile, in the event of a terrorist attack or major disaster ...."[125]
- **Authority of the Secretary of Veterans Affairs to provide care:** The Secretary of Veterans Affairs is authorized to furnish hospital care and medical services to individuals, including non-veterans, affected by (1) a major disaster or emergency declared by the President under Stafford Act (42 U.S.C. § 5121 *et seq.*) or (2) a disaster or emergency in which NDMS is activated.[126]

---

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

[122] 42 U.S.C. § 300hh-14, as amended by P.L. 109-347, the SAFE Port Act.

[123] 42 U.S.C. § 5183, Section 416 of the Stafford Act.

[124] For more information, 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.

[125] 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. The deployment authority of the Secretary of DHS is codified at 6 U.S.C. § 314. 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.

[126] 38 U.S.C. § 1785, as established in P.L. 107-287, the Department of Veterans Affairs (continued...)

- **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 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."[127]

## 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," "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 health care 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.

---

[126] (...continued)
Emergency Preparedness Act of 2002. Activation of NDMS may be done at the discretion of the Secretary of HHS, and does not require any type of federal emergency or disaster declaration. The VA has proposed regulations to implement this authority at 72 *Federal Register* 38042-38045, July 12, 2007.

[127] 6 U.S.C. § 467, authorized in P.L. 107-296, the Homeland Security Act of 2002.