



Public Health Emergency Response Act (PHERA)

This legislation would help ensure that victims of catastrophic public health emergencies have meaningful and immediate access to medically necessary healthcare services. The proposed legislation would establish a “turn-key” process at the federal level that the Secretary of the Department of Health and Human Services could choose to implement immediately in times of catastrophic public health emergencies.

Summary of Problem

Recent catastrophic events, such as the 9-11 attacks and Hurricanes Katrina and Rita, have highlighted the need for rapid and effective access to a full range of healthcare services during and immediately following a public health emergency. The possibility of a future influenza pandemic or biologic attack also has drawn attention to the importance of ensuring that the uninsured do not face impediments to accessing healthcare services during a public health crisis, as well as that providers are not unfairly burdened by uncompensated services provided as part of the medical surge.

Despite a number of federal and state initiatives designed to improve the national and local infrastructure for responding to catastrophic events, a glaring gap remains in our Nation’s ability to ensure that the American public has access to medically necessary healthcare services following a catastrophic event.

For example, although the federal government provided reimbursement for medically necessary healthcare services for some individuals following Hurricane Katrina, coverage of these services was not made available in a timely manner. Following Katrina, the federal government had to establish a vehicle for providing the services (as a temporary “1115 waiver” expansion under the Medicaid program), and subsequently, individual states had to apply to participate in these waiver programs. Many states faced an excessive burden of paying for care for individuals who were not eligible for Medicaid or had inadequate or no private insurance coverage. For future catastrophes, it is vital to make certain reimbursement issues do not prevent providers from offering care for uninsured victims and individuals from seeking necessary healthcare services.

Ensuring timely and orderly access to healthcare services is critical to the initial victims of a catastrophic event, and potentially, to the Nation’s overall public health in the case of an infectious disease outbreak. Seeking immediate treatment for an infectious agent – either naturally occurring or manmade – may be critical for early identification and containment.

Conversely, the absence of such coverage could have a chilling effect on the provision of medically necessary services, placing unfair financial burdens on the most dedicated healthcare providers. In fact, the lack of timely access to medical care could jeopardize regions of the United States located far away from the initial epicenter in public health emergencies involving infectious disease.

Current Law

Although the federal government has established a number of initiatives to aid in the response to natural and man-made disasters, the current inventory of programs does not adequately address the need to ensure access to medically necessary healthcare services. For example, current federal initiatives include (but are not limited to) the following:

- **The Pandemic and All-Hazards Preparedness Act:** In late 2006, Congress enacted the Pandemic and All-Hazards Preparedness Act (P.L. 109-417), which focuses on public health emergency preparedness and response activities. This legislation supports surveillance initiatives, hospital infrastructure and other activities, but the law does not address the need to cover and reimburse for healthcare services for victims of catastrophic events.
- **The Public Health Improvement Act:** The Secretary of the Department of Health and Human Services has broad authority to determine that a public health emergency exists under Sec. 319 of the Public Health Service Act. In addition, the Secretary is charged with administering the Public Health Emergency Fund under the Act for use in response to such a declared emergency. The fund has not received appropriations since 2000 and was not used in response to September 11th, Hurricane Katrina, or Hurricane Rita.

Summary of PHERA's Key Provisions

Temporary Emergency Healthcare Coverage

The legislation would allow the Secretary of the Department of Health and Human Services to activate the coverage of catastrophic emergency healthcare services if specific criteria are met.

As a prerequisite to activating the coverage of catastrophic emergency healthcare services, the Secretary must find that a public health emergency exists under the existing terms of the Public Health Service Act. In addition, to limit the application of this benefit to truly extraordinary events, other criteria must be met for the Secretary to activate coverage.

The legislation would not quantify the number of victims or potential victims necessary to trigger use of this authority, although the scale of the catastrophe must be extraordinary. The Secretary would be directed to consider a range of factors, including: the degree to which the catastrophe is likely to overwhelm healthcare providers in the region; the opportunity to minimize morbidity and mortality through intervention under the program; the estimated number of direct casualties of the catastrophe; the potential number of casualties in the absence of intervention under this program (such as in the case of infectious disease); the potential adverse financial impacts on local healthcare providers in the absence of activation of the program; and such other factors as

the Secretary may deem appropriate. The need for healthcare services must be of sufficient severity and magnitude to warrant major assistance.

Termination of Benefit

Coverage of healthcare services under this legislation would terminate upon the earlier of the following: the Secretary's determination that a catastrophic public health emergency no longer exists; or 90 days following the initiation of the catastrophic public health emergency. The Secretary would have the authority to extend the catastrophic public health emergency for a second 90-day period. Prior to such an extension, the Secretary would set forth in a report to Congress the nature of the catastrophic public health emergency and the expected duration of the event. In addition, the Secretary would provide recommendations in the report to Congress, if deemed appropriate, regarding a further extension of the public health emergency period. Such an extension would require authorization by Congress. The Secretary's report would include a discussion of the healthcare needs of catastrophic event victims and affected individuals, including the likely need for follow-up care over a two-year period.

Medical Monitoring Program

The Secretary would establish a medical monitoring system for tracking and reporting on healthcare needs of the affected population over time. At least annually for a period of 5 years, the Secretary would report to Congress on the affected population's continuing and/or new health care needs related to the catastrophic public health emergency. These reports would include recommendations on how to ensure that catastrophic event victims and affected individuals have access to needed healthcare services.

Eligibility for Coverage of Catastrophic Emergency Healthcare Services

Eligibility for coverage of catastrophic emergency healthcare services would be limited to (a) uninsured or otherwise qualified emergency victims or (b) uninsured affected individuals.

For the purposes of this section, "uninsured" refers to individuals with no healthcare insurance, and "otherwise qualified" refers to individuals whose insurance coverage the Secretary determines is not actuarially equivalent to benchmark coverage. An individual is an "emergency victim" if the individual needs healthcare services due to injuries or disease resulting from the public health emergency. An "affected individual" resides in an assistance area designated for the emergency (or whose residence was displaced by the emergency) or, in the case of such an emergency constituting a pandemic flu or other infectious disease outbreak, who resides in the area affected by the outbreak (or whose residence was displaced by the emergency); and whose ability to access care or medicine is disrupted as a result of the emergency.

The legislation would provide for a streamlined process for determining eligibility, recognizing that in the context of a catastrophic event, individuals may be unable to provide identification cards, healthcare insurance information or other documentation. The primary method for determining eligibility for services would be an attestation provided to the healthcare provider (with a standard alternative for unattended minors and adults without the capacity to sign an attestation form).

Providers would commence with treatment for an individual in the absence of any centralized “enrollment process” as that term typically is used in the context of public and private insurance programs. However, providers would be required to collect basic information, including the individual’s name, address, social security number and existing health insurance coverage, if any.

Emergency Healthcare Services.

The definition of emergency healthcare services would be based on the national and local coverage policies used by fee-for-service Medicare (Title XVIII of the Social Security Act) under Medicare A and B for the applicable setting of care (hospital, physician office, community health clinic, etc.).

In the case of prescription drugs falling outside of the scope of Medicare coverage policies under Part B, the Secretary would establish a process through rulemaking for adapting the formularies of two or more of the largest Part D prescription drug plans.

The Secretary would have the authority to cover drugs, devices, biologics and other healthcare products, if such products are authorized for use by the Food and Drug Administration pursuant to an alternate authority, including the emergency use authority.

Not Medicare, Medicaid, or SCHIP Benefits

The emergency healthcare services provided under this section are not benefits under Medicare, Medicaid or SCHIP.

Completion of Treatment

The Secretary may identify a subgroup of emergency victims to continue receiving coverage of emergency healthcare services that are medically necessary to treat an injury or disease resulting directly from the public health emergency for up to an additional 60 days.

Covered Providers

Providers that have valid Medicare, Medicaid or SCHIP provider numbers and that are in good standing with these programs and not excluded from participation in a Federal health care program would be deemed covered providers.

Under rulemaking, the Secretary also may waive certain requirements for provider enrollment that otherwise apply to Medicare, Medicaid or SCHIP to ensure an adequate supply of healthcare providers and services. For example, the Secretary could specify a process to ensure that an adequate supply of nurses and other providers who may not typically have valid Medicare, Medicaid or SCHIP provider numbers, but who would be needed in a catastrophic public health emergency. The Secretary also may waive certain requirements to increase the number of available providers.

Report on Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

The Secretary must submit a report to Congress on the number of volunteers enrolled in the ESAR-VHP Program that will be available in the event of a public health emergency. If the Secretary determines that the number of volunteers is not adequate, then the Secretary must

include in the report recommendations for actions to ensure adequate surge capacity for public health emergencies.

Payments to Providers and Claims Administration

In general, payment to providers for catastrophic emergency healthcare services would equal 100 percent of the payment level for the corresponding service under fee-for-service Medicare (Title XVIII of the Social Security Act). Claims for the covered services would be submitted to one or more designated Medicare contractors using the claim forms, codes and nomenclature in effect under Medicare at the time of the catastrophic event. Providers would not balance-bill patients.

For eligible persons with some health insurance coverage, payment equal to 100 percent of the payment under the Act would be made to the provider. The designated claims contractors would then submit a claim to the eligible person's insurer to recoup partial or full payment for the services, reflecting whatever amount the insurer would normally reimburse for each covered service.

Before receiving payments, providers would have to attest that they notified the administrative contractor of any third-party payment received or claims pending for the services rendered; the recipient of the services has attested that he/she is an uninsured or otherwise qualified emergency victim or an uninsured affected individual; and the services were medically necessary.

Funding; Fraud and Abuse Provisions

The funding mechanism for this benefit is the Public Health Emergency Fund, a no-year fund established in 1983 that is available to the Secretary of Health and Human Services. There would be no Medicare funds used to pay for this benefit.

Providers and recipients of emergency healthcare services would be subject to the federal fraud and abuse protections that apply to Federal health care programs as defined in the Social Security Act.

Rulemaking

The Secretary would use a Negotiated Rulemaking Committee to advise on key issues regarding the implementation of the Public Health Emergency Response Act.

Emergency Planning and the Education of Healthcare Providers and the Public

The Secretary would conduct an outreach and public education campaign prior to a catastrophic public health emergency to inform healthcare providers and the general public about the availability of the temporary benefit during a public health emergency. An outreach effort to healthcare providers should include an explanation of the catastrophic emergency healthcare coverage program, as well as claim forms and instructions for healthcare providers to use when providing covered services during a catastrophic event. Special outreach initiatives to vulnerable and hard-to-reach populations would be undertaken by the Secretary prior to a catastrophic public health emergency. Seven million dollars is authorized to be appropriated for each fiscal year for administration of the Public Health Emergency Fund and the outreach and public education campaign.