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After the Catastrophe: Disaster Relief for Hospitals

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AFTER THE CATASTROPHE: DISASTER RELIEF FOR HOSPITALS

ELIZABETH WEEKS*

Disaster planning for health care providers following the September 11, 2001, terrorist attacks and, more recently, Hurricane Katrina, focuses on preparing hospitals and other emergency services to respond to victims' medical needs. But little attention has been paid to the challenges that providers would face resuming normal operations after the catastrophe. A large-scale disaster could create unprecedented demand for health care and emergency services. Hospitals already struggle to meet the high demand for and high costs of emergency care, and they would face additional challenges in the aftermath of a catastrophic event. Strained capacity and financial reserves may force hospitals to close, just as occurred with the two largest public hospitals in New Orleans following Katrina. To prevent the initial terrorist-related or natural disaster from spiraling into a lasting access-to-care crisis, this Article proposes a government disaster relief plan to stabilize the health care industry before the next catastrophe and prevent interruption of services during the recovery.

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INTRODUCTION

Since September 11, 2001, policymakers have devoted substantial resources to preparing the Nation's essential facilities to respond to future catastrophes. Hurricane Katrina in September 2005 tragically tested the shortcomings of those preparedness efforts and revealed the substantial additional work that needs to be done. But even less attention has been paid to ensuring that key industries and emergency responders are able to resume normal operations after the crisis has passed. Hospitals, in particular, face considerable challenges recovering payment and returning to normal operations after the disaster victims are treated.

Contrary to the expected economic effect of increased demand producing increased revenue, in the health care context, demand surge could threaten providers' overall solvency. Hospitals could anticipate delayed payment from private and government payers, which face their own demand surge in processing the sudden, unprecedented volume of claims; claims denials due to unusual clinical presentation of patients; and increased levels of uncompensated care costs as victims' private and government health

coverage and personal finances are disrupted or lost in the disaster.¹ Given typically thin financial reserves, existing emergency care burdens, and other unique characteristics of health care financing, hospitals may be unable to sustain those additional burdens.² As a result, they may be forced to close their doors, depriving already ravaged communities of essential medical care. To prevent the initial crisis of a terrorist attack or natural disaster from spiraling into a lasting access-to-care crisis, this Article proposes a government disaster relief plan to stabilize the health care industry before the next catastrophe and prevent interruption of services during the recovery.

Hurricane Katrina left many challenges and troubles in its wake, including a regional health care crisis. That disaster amply demonstrates the need to consider a relief plan for emergency medical service providers before the next catastrophe. New Orleans's two large public hospitals were severely damaged and closed indefinitely after the storm.³ Essential medical records have been lost or destroyed. Pre-Katrina, fifty percent of the Gulf Coast population lacked health insurance.⁴ The numbers of uninsured and destitute

1. See Sara Rosenbaum et al., *New Models for Prevention Systems: Public Health Emergencies and the Public Health/Managed Care Challenge*, 30 J.L. MED. & ETHICS 63, 65–67 (2002) (describing various private insurance payment challenges likely during a public health emergency).

2. See Elizabeth Belmont et al., *Disaster Checklist: Emergency Preparedness, Response & Recovery Checklist: Beyond the Emergency Management Plan*, 37 J. HEALTH L. 503, 547 (2004) (noting that “[r]egardless of whether they are operated on a for-profit or nonprofit basis, healthcare institutions depend upon regular cash flow to remain operational” and anticipating difficulties from interruption in “usual revenue flow cycle” during emergency).

3. See *Two New Orleans Hospitals Beyond Help*, CNN.com, Oct. 5, 2005, <http://www.cnn.com/2005/US/10/05/neworleans.hospitals/index.html>; see also Sara Rosenbaum, *US Health Policy in the Aftermath of Katrina*, 295 JAMA 437, 437 (2006) (reporting that Charity Hospital was “devastated and dysfunctional, furloughing nearly 2600 employees as of November 7, 2005”).

4. See Ruth E. Berggren & Tyler J. Curiel, *After the Storm—Health Care Infrastructure in Post-Katrina New Orleans*, 354 NEW ENG. J. MED. 1549, 1549 (2006) (describing various concerns, namely that hospitals “have no surge capacity” and “must deliver even greater amounts of uncompensated health care”); Claudia Kalb & Andrew Murr, *The Cost of the Katrina Effect*, NEWSWEEK, Dec. 12, 2005, at 66, 66 (discussing lasting health care crisis, including hospital closures); Todd Zwillich, *Sens. Back Full Katrina Medical Payments*, United Press Int'l, Sept. 12, 2005, <http://www.upi.com/archive/view.php?archive=1&StoryID=20050912-044709-9283r> (describing public health and health care delivery challenges and quoting National Governors Association director: “We’ve got to go in and almost rebuild and [sic] entire infrastructure, a health infrastructure, in that particular area.”); *New Orleans’ Emergency Rooms Overtaxed* (National Public Radio broadcast Jan. 27, 2006) (transcript on file with the North Carolina Law Review) (describing ongoing emergency care crisis in New Orleans); see also KAISER COMM’N ON MEDICAID & THE UNINSURED, KAISER FAMILY FOUND., REPORT NO. 7387, ADDRESSING THE HEALTH CARE IMPACT OF HURRICANE KATRINA 1–5 (2005),

rose dramatically as many residents' employers were wiped out and, with them, their employer health insurance.⁵ Without accessible medical care or health insurance, residents may forego necessary treatment. Untreated medical conditions may become worse and the need for care even more acute.⁶ For health care providers, the impact is not limited to physical destruction of facilities and buildings. Increased demand for care and increased numbers of uninsured patients create a severe financial strain, particularly for emergency services.⁷ The financial strain extends beyond providers in the flood zone to providers in neighboring states, which have taken in the storm's victims. Those host states bear additional burdens caring for destitute, newly uninsured patients and out-of-state health plan enrollees.⁸

Even before Katrina, September 11, 2001, and biological threats from anthrax, sudden acute respiratory syndrome ("SARS"), and other agents tested the readiness of the Nation's hospitals and health care financing system to respond to a major public health emergency.⁹ Post-9/11 studies and response drills revealed a troubling lack of preparedness.¹⁰ Those reports prompted legislation, appropriations,

<http://www.kff.org/uninsured/upload/7387-2.pdf> [hereinafter KAISER REPORT 7387] (detailing poverty levels and levels of uninsured pre- and post-Katrina).

5. See KAISER REPORT 7387, *supra* note 4, at 1 (estimating 400,000 jobs lost, meaning people lost not only income but also employer health insurance coverage).

6. See MICHAEL PERRY ET AL., KAISER FAMILY FOUND., REPORT NO. 7538, VOICES OF THE STORM: HEALTH EXPERIENCES OF LOW-INCOME KATRINA SURVIVORS 7–13 (2005), <http://www.kff.org/uninsured/upload/7538.pdf> [hereinafter KAISER REPORT 7538] (describing flood survivors' serious and persistent gaps in care and barriers to accessing care).

7. See KAISER REPORT 7387, *supra* note 4, at 2 (noting closure of "Big Charity" Hospital, the largest New Orleans public hospital and regional Level I trauma center).

8. See Rosenbaum, *supra* note 3, at 437–38 (discussing problems of uninsured and lack of portability as major limitation to Medicaid); KAISER REPORT 7538, *supra* note 6, at 11–12 (discussing coverage and enrollment problems of uninsured); KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., REPORT NO. 7420, A COMPARISON OF SEVENTEEN APPROVED KATRINA WAIVERS 1 (2006), <http://www.kff.org/medicaid/upload/7420.pdf> [hereinafter KAISER REPORT 7420] (noting that displaced victims have to enroll in Medicaid and the State Child Health Insurance Program in host states and that host state providers are not compensated by patients' home states).

9. See, e.g., Rosenbaum et al., *supra* note 1, at 67–68 (discussing one private insurer's experience with 2001 anthrax outbreak); *id.* at 65 (describing insurance and public health conflicts during Milwaukee's 1980s measles outbreak).

10. See U.S. GEN. ACCOUNTING OFFICE, HOSPITAL PREPAREDNESS: MOST URBAN HOSPITALS HAVE EMERGENCY PLANS BUT LACK CERTAIN CAPACITIES FOR BIOTERRORISM RESPONSE 2 (2003) [hereinafter HOSPITAL PREPAREDNESS], available at <http://www.gao.gov/new.items/d03924.pdf> (noting hospitals' deficiencies in response to potential large-scale bioterrorism or mass casualty events); Phillip O'Connor, *Crisis Could*

and other plans to improve hospitals' ability to fulfill their crucial first-responder roles in treating victims and protecting the public's health.

Emergency preparedness remains policymakers' focus, but the financial aftermath and post-catastrophe return to normal operations also needs to be considered.¹¹ Preparedness measures require hospitals to create disaster contingency plans, staffing arrangements, communication systems, and stockpiles of supplies and pharmaceuticals. Those efforts increase hospitals' direct-care costs as well as indirect recordkeeping, compliance, and administrative costs.¹² To the extent that policymakers have considered the issue of hospital reimbursement for disaster response, they believe that existing payment approaches would provide adequate and prompt reimbursement.¹³ Hospital administrators, however, anticipate that unique payment difficulties that would likely follow a major disaster and already are attempting to identify potential reimbursement sources before the next disaster.¹⁴

Swamp Hospitals Here; Medical Centers Look to Federal Aid To Boost Their Ability To Deal with Mass Casualties, ST. LOUIS POST-DISPATCH, June 25, 2003, at A1 (“[H]omeland security experts view the health care system’s inability to quickly handle a surge in patients as one of the nation’s major vulnerabilities in responding to a terrorist attack.”).

11. See, e.g., Marc Santora, *When a Bug Becomes a Monster*, N.Y. TIMES, Aug. 21, 2005, at 29 (comparing possible avian flu outbreak to smallpox pandemic and noting that “the most significant problem in 1918, as it would most likely be today, was the sheer inability of hospitals to deal with a sudden surge in patient demand”); see also Jeffery N. Rubin, *Recurring Pitfalls in Hospital Preparedness and Response*, J. HOMELAND SECURITY, Jan. 2004, <http://www.homelandsecurity.org/newjournal/articles/rubin.html> (“[M]ost hospitals are still unprepared to effectively manage the results of a major incident—whether due to mishap, terrorism, natural disaster, or infectious disease outbreak An incident . . . will not only magnify hospital and shortcomings, it will further hamper effective hospital response and hospital community recovery.”).

12. See *infra* Part I.D (outlining preparedness statutes and model legislation).

13. See, e.g., *infra* notes 187–90 and accompanying text (describing post-Katrina Medicaid waiver approach).

14. See, e.g., E-mail from John Casey, Hillcrest Health System, to Elizabeth Weeks, Associate Professor of Law, University of Kansas School of Law (Aug. 5, 2005, 09:50 CST) (on file with the North Carolina Law Review) (requesting assistance “to determine what types of post event funding will be available, and what type of information will need to be gathered during (and after) the event [in order to] develop an accounting system”); E-mail from John Casey, Hillcrest Health System, to Elizabeth Weeks, Associate Professor of Law, University of Kansas School of Law (Aug. 8, 2005, 09:22 CST) (on file with the North Carolina Law Review) (noting dearth of literature “on recovery/returning to normal operations” and difficulty advising “various organizations on what (and how) information needs to be captured so that reimbursement will even by [sic] an option,” concluding, “I applaud your efforts”). See generally Belmont et al., *supra* note 2, at 539 (listing a comprehensive checklist for emergency preparedness, response, and recovery, including provisions related to documentation required “for insurance reimbursement,

A catastrophic event could spiral into a lasting national health care crisis if hospitals cannot remain operational and capable of providing routine emergency care after the immediate crisis has passed. The Article begins by explaining the need for government intervention to support the health care system following a catastrophe. Next, the Article examines previous government responses to industry-specific financial crises, including post-9/11 legislation designed to shore up the airline and insurance industries and Medicare laws assuring payment for emergency care costs of undocumented immigrants.¹⁵ Borrowing lessons from those programs, the Article concludes by proposing the broad outlines of a federal hospital relief plan.

The proposal has three parts: first, immediate cash assistance to hospitals to cover operating costs during and immediately after the crisis. Cash infusion would avert a secondary crisis in access to medical services by ensuring that facilities remain open and able to provide not only emergency but also routine care. Second, hospitals would receive “loans” to sustain ongoing operations as they await reimbursement from private insurers, government health care programs, charitable donations, patients, and other sources. That assistance would be loaned to the extent that providers would be required to return any government payments for which reimbursement from other sources is eventually recovered. Finally, a federal backstop, similar to stop-loss insurance, would cover hospitals’ unusually high uncompensated care costs resulting from the crisis.¹⁶

The Article proposes the broad outlines of a government relief plan because estimating the precise financial requirements and mechanics of the program would be impossible. Hospitals may be called to respond to a range of scenarios, depending on the nature and source of the disaster, geographic area affected, immediate or

subsequent loans, funding from the Federal Emergency Management Agency (FEMA), payor funding, and/or other emergency funding”).

15. See *infra* Part III (discussing four models for proposed methodology).

16. See Saul Levmore, *Coalitions and Quakes: Disaster Relief and Its Prevention*, 3 U. CHI. L. SCH. ROUNDTABLE 1, 30–32 (1996) (comparing problem of uninsured emergency care patients as argument in favor of ex ante approach); Sara Rosenbaum, *New Directions for Health Insurance Design: Implications for Public Health Policy and Practice*, 31 J.L. MED. & ETHICS 94, 95 (2003) (“How to assure the availability of accessible, timely and quality medical care in the face of terrorism and other public health emergencies represents an enormous public health challenge.”). See generally VICTOR R. FUCHS, WHO SHALL LIVE? HEALTH, ECONOMICS, AND SOCIAL CHOICE 13–14 (expanded ed. 1998) (discussing access-to-care problems by various segments of society).

sustained impact, and other factors.¹⁷ The variability in potential disaster scenarios, however, does not counsel in favor of leaving the entire issue to ex post legislation. An unfortunate lesson of Katrina is the importance of immediate, unhesitating response to prevent the initial crisis from worsening into a much broader, more severe catastrophe.¹⁸ Accordingly, an essential feature of the proposal is ex ante assurance of government support for the Nation's health care providers.¹⁹

I. DEFINING THE PROBLEM

To make the case for federal hospital disaster relief, the Article first explains why hospitals would likely face financial strain under a large-scale disaster.²⁰ In defining the problem and explaining the need for government intervention, this Part begins with a broad overview of characteristic features of hospital financing. Next, the Part explains the pressures that hospital emergency departments face

17. See *infra* Part II.A (comparing financial impact of various recent catastrophes).

18. See U.S. GOV'T ACCOUNTABILITY OFFICE, FEDERAL EMERGENCY MANAGEMENT AGENCY: FACTORS FOR FUTURE SUCCESS AND ISSUES TO CONSIDER FOR ORGANIZATIONAL PLACEMENT 2 (2006), available at <http://www.gao.gov/new.items/d06746t.pdf> (describing FEMA's performance during Hurricane Katrina and raising questions regarding the Agency's organizational placement); Letter from David M. Walker, Comptroller Gen., to Thomas Davis, Chairman, Select Bipartisan Comm. To Investigate the Preparation for & Response to Hurricane Katrina (Feb. 1, 2006) [hereinafter Walker Letter], available at <http://www.gao.gov/new.items/d06365r.pdf> (suggesting need for clear, decisive leadership, in single individual accountable to the President); Pam Fessler, *Fragmented Government Slowed Katrina Response* (National Public Radio Broadcast Feb. 1, 2006), available at <http://www.npr.org/templates/story/story.php?storyId=5183478> (reporting on Comptroller Walker's GAO report).

19. For further justification for the ex ante approach, see *infra* Part IV.D (discussing TRIA analogy). Compare LLOYD DIXON & RACHEL KAGANOFF STERN, COMPENSATION FOR LOSSES FROM THE 9/11 ATTACKS xxxii (2004) (discussing merits of ex ante, ex post, or combined approach and noting that "[s]etting up government compensation programs in advance of a terrorist attack may encourage individuals and firms to determine how they will cover losses that would not be covered by government programs") with Holman W. Jenkins Jr., *Defy Terrorist, Not Nature*, WALL ST. J., Sept. 28, 2005, at A17 ("Sometimes a little moral hazard is a good thing. After Sept. 11, we didn't want business and homeowners to reorganize their lives around the threat of terrorism."). See also Posting of Saul Levmore to The Univ. of Chi. Law Sch. Faculty Blog, http://uchicagolaw.typepad.com/faculty/2006/01/katrina_a_cash_.html#more (Jan. 26, 2006 09:25 CST) (suggesting that post-disaster aid allocation "is likely to be more error prone, politically difficult, and even corrupt"). See generally George L. Priest, *The Government, the Market, and the Problem of Catastrophic Loss*, 12 J. RISK & UNCERTAINTY 219, 219 (1996) ("Virtually all approaches to the problem of catastrophic loss conclude that the magnitude and character of such losses compels some form of government solution, whether in the form of ex post disaster assistance or ex ante regulation to reduce exposure to the loss.").

20. See *infra* Part I.A.

under normal operating conditions.²¹ The description of the complex Medicare reimbursement methodology provides an illustration of the existing approach to hospital reimbursement and suggests the need for a less cumbersome, more streamlined approach following a catastrophe.²² Finally, the Part describes several post-9/11 preparedness laws that expand health care providers' responsibilities in disaster response, further burdening the Nation's already strained health care infrastructure.²³

A. *Features of Hospital Financing*

The increased demand for medical care resulting from a catastrophic event seemingly would be a boon to health care providers, at least to the extent that patients have insurance coverage and insurers honor the claims. Hospitals typically provide medical care to patients up front and seek payment from third-party payers after the fact.²⁴ Higher demand for services should mean higher collections. But due to a combination of factors discussed below, including existing financial strain on hospital emergency departments, higher-than-normal levels of uninsured patients, and claims-submission challenges, a major disaster is more likely to produce financial liabilities than lucrative revenue streams for hospitals.

In the current health care climate of declining reimbursement and rising costs, many hospitals already teeter on the brink of insolvency.²⁵ According to one report, approximately thirty percent

21. See *infra* Part I.B.

22. See *infra* Part I.C.

23. See *infra* Part I.D.

24. See DAVID DRANOVE, *THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE* 31–32 (2000) (describing third-party payment structure and noting that “[n]o one should expect patients to consider the cost of medical care when insurance is paying for it,” and that they “will consent to almost any treatment recommendation”); SHERMAN FOLLAND ET AL., *THE ECONOMICS OF HEALTH AND HEALTH CARE* 13 (2001) (noting that over eighty percent of health care payments are from third-party payers); FUCHS, *supra* note 16, at 81 (discussing reasons for expensive hospital care, including “[o]nly a small fraction . . . is paid for directly by patients; the bulk comes from so-called third parties, of which the government is the most important, picking up over half the total bill”); JOSEPH NEWHOUSE, *PRICING THE PRICELESS* 9–13 (2002) (describing patient control over provider choice and minimal insurer control over price); Belmont et al., *supra* note 2, at 547 (“The majority of income for most healthcare institutions comes from patient insurance reimbursement.”); Thomas Bodenheimer & Kevin Grumbach, *Paying for Health Care*, 272 *JAMA* 631, 635–36 & fig.2 (1994) (describing third-party payment structure).

25. See, e.g., James J. Unland, *Can Community Hospitals Survive Without Large Scale Health Reform?* *J. HEALTH CARE FIN.*, Spring 2004, at 49, 49 (noting community hospital emergency services remain “too often, the last line of defense for people who are uninsured or underinsured”); see also Seth Borenstein, *GAO Calls U.S. Unready in Event*

of hospitals in the United States operate in the red, with many more close to the edge of insolvency.²⁶ Hospital emergency rooms, in particular, are squeezed by declining reimbursement and increased utilization by uninsured patients seeking nonemergency care and managed care enrollees circumventing gatekeepers.²⁷ Federal law requires hospitals to provide emergency care to patients regardless of ability to pay.²⁸ Health care consumers, even those with insurance, but particularly the uninsured, often rely on emergency rooms for primary care.²⁹ As a result, emergency departments tend to be losing cost centers.³⁰ Hospitals typically employ a strategy of cost-shifting to

of SARS Outbreak, CONTRA COSTA TIMES (Cal.), May 9, 2003, at 4 (quoting GAO health care director's observation that "we're way behind" in terms of preparedness and observing that "[e]mergency rooms are now near the breaking point"); *Know When To Visit ER, and When Not To*, L.A. DAILY NEWS, Mar. 22, 2004, at AV2, available at 2004 WLNR 2852730 (discussing hospital overcrowding and long waits); O'Connor, *supra* note 10 (quoting homeland security expert as saying, "If you're the CEO of a hospital, you're just struggling to keep your doors open"); Joe Stinebaker, *Report Urges Overhaul of Emergency Medicine; County Facing Healthcare "Collapse,"* HOUSTON CHRON., June 29, 2004, at 1 (quoting county emergency medical care report that "already overburdened emergency system is likely to continue to decay to the point of collapse without corrective action in the near term"); Tracy Wheeler, *Bioterror Front Lines Not Funded*, BEACON J. (Akron, Ohio), Apr. 23, 2003, at B1 (quoting emergency room physician's observations that emergency rooms "don't have the capacity to deal with day-to-day challenges . . . so how are they going to be ready for a biological attack?").

26. AM. HOSP. ASS'N, HOSPITAL PREPAREDNESS FOR MASS CASUALTIES, FINAL REPORT 10 (2000); see also AM. HOSP. ASS'N, THE FRAGILE STATE OF HOSPITAL FINANCES 2, <http://www.ahapolicyforum.org/ahapolicyforum/resources/content/05fragilehosps.pdf> (last visited November 13, 2006) (noting that 60% of hospitals lose money on patient-care costs and 30% lose money overall); MARSHA REGENSTEIN & JENNIFER HUANG, KAISER FAMILY FOUND., REPORT NO. 7329, STRESSES TO THE SAFETY NET: THE PUBLIC HEALTH PERSPECTIVE 7 & nn.22-23 (2005), <http://www.kff.org/medicaid/upload/Stresses-to-the-Safety-Net.pdf> [hereinafter KAISER REPORT 7329] (describing public hospital safety net as "intact but endangered" and "fragile yet resilient").

27. See FOLLAND ET AL., *supra* note 24, at 408-09 (noting "growth of managed care and the introduction of reimbursement methods that discourage inpatient care and long lengths of stay"); KAISER REPORT 7329, *supra* note 26, at 14 (documenting "effects of increasingly lower payments for underinsured patients or patients whose coverage provides underpayment for care" and hospitals providing care to "extremely large numbers of uninsured patients").

28. 42 U.S.C. § 1395dd (2000 & Supp. III 2003); see *infra* Part I.B (describing EMTALA requirements).

29. See Rubin, *supra* note 11, at n.3 (citing S.M. Schneider et al., *Emergency Department Crowding: A Point in Time*, 42 ANNALS OF EMERGENCY MED. 167-72 (2003)); U.S. GEN. ACCOUNTING OFFICE, EMERGENCY CARE: EMTALA IMPLEMENTATION & ENFORCEMENT ISSUES 9 & nn.15-16 (2001) [hereinafter EMTALA IMPLEMENTATION & ENFORCEMENT ISSUES], available at <http://www.gao.gov/new.items/d01747.pdf> ("[M]any emergency department visits are for primary care services and treatment of nonurgent conditions.").

30. See Bryan Ford, *The Uncertain Case for Market Pricing of Health Insurance*, 74 B.U. L. REV. 109, 130 (1994) ("Those without health insurance are often turned away by

balance out revenue-losing departments against revenue-generating departments. Similarly, the cost of caring for uninsured or underinsured patients is balanced out against increased charges to private insurers and, to the extent allowable, government payers.³¹ If uncompensated or under-reimbursed costs cannot be balanced or shifted, hospitals could face insolvency.³²

In addition, hospitals face substantial administrative burdens complying with complex reimbursement systems from multiple payment sources, insurers, and government programs. For Medicare reimbursement alone, hospitals must comply with over 130,000 pages of regulations. A recent study concluded that for every hour of patient care, hospitals spend one-half hour completing paperwork.³³ The task of collecting payment for the exceedingly high number of claims likely to result from a terrorist attack, natural disaster, or other public health emergency under existing payment methodologies would severely strain hospital billing departments. In addition, the unprecedented volume and novelty of claims would likely cause payment delays and denials, requiring hospitals to carry

health care providers or restricted to receiving inadequate and expensive care in emergency rooms.”); Phil Galewitz & Mary Ellen Klas, *The State of Health Insurance: How Did It Get This Bad?*, PALM BEACH POST, Oct. 12, 2003, at 14A, available at 2003 WLNR 2803326 (“People who don’t have insurance often wait until they have an emergency to seek care and then rely on hospital emergency rooms. This causes a financial drain on hospitals, which raise rates for paying patients.”).

31. See DRANOVE, *supra* note 24, at 25 (“The idea that hospitals could raise prices to their privately insured patients to generate the revenues necessary to pursue their [nonprofit] mission became known as ‘cost-shifting.’ ”); FOLLAND ET AL., *supra* note 24, at 406–08 (discussing uncompensated care costs and third-party payer discounts being shifted to other patients); Ray Carter, *Lower Reimbursement Rates Lead to More Cost-Shifting*, J. REC. (Okla. City, Okla.), July 30, 2003, at 1 (describing practice of shifting uninsured patient care costs to increased insured patients’ charges; noting trend of declining reimbursement).

32. See Ruth E. Bergognen and Tyler J. Curiel, *After the Storm—Health Care Infrastructure in Post-Katrina New Orleans*, 354 NEW ENG. J. MED. 1549, 1550 (2006) (quoting hospital CEO in response to question regarding government relief: “We have asked and asked [authorities] for fair compensation, and perhaps we will get it eventually, but we cannot go on indefinitely providing uncompensated care.”).

33. See David Gratzner, *Health of the Union*, WALL ST. J., Jan. 26, 2006, at A10 (citing recent American Hospital Association study); see also AM. HOSP. ASS’N, CRACKS IN THE FOUNDATION: AVERTING A CRISIS IN HOSPITALS 7 (2002), <http://www.aha.org/aha/content/2002/pdf/cracksreprint08-02.pdf> [hereinafter CRACKS IN THE FOUNDATION] (noting that every hour of emergency department care requires “one hour of preparation”). Medicare hospitals must comply with at least five distinct reimbursement methodologies, not to mention other payers’ billing requirements. See *infra* Part I.C (describing Medicare payment system).

unreimbursed costs for extended periods of time. Hospitals may be unable to float those losses on typically thin operating margins.³⁴

Consumers require convenient physical access to health care providers. For emergency care, access and proximity are even more important because the urgency of the patient's condition demands immediate attention and minimal travel time. Recent corporate reorganization trends have resulted in fewer local, independent hospitals and increasing numbers of large corporate conglomerates.³⁵ But even national conglomerates need local markets for their hospital business.³⁶ If a community hospital closes, patients are constrained to consider geographic proximity in choosing another hospital, whereas if a hometown airline, insurance company, or car manufacturer goes out of business, consumers may replace that local supplier on a national market. For health care, the relevant market is necessarily local, not national.³⁷ If patients cannot readily receive medical care close to home, they may forego treatment, exacerbating their underlying medical conditions. Therefore, maintaining a local infrastructure of easily accessible health care providers should be a central objective of a government relief program.³⁸

34. See Rosenbaum et al., *supra* note 1, at 65–66 (discussing potential conflicts between insurance and public health and noting that certain services “may be either completely excluded or covered only with higher cost-sharing or the prior approval of the insurer”); cf. Belmont et al., *supra* note 2, at 547–54 (describing cash flow, billing, and patient-coverage challenges during emergencies and offering practical suggestions).

35. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 430–36 (1982) (discussing hospital consolidation trend and rise of for-profit operations).

36. One approach to the locality problem is certificate of need, or “CON,” laws, which were introduced in the 1940s to address a recognized shortage and misdistribution of hospitals. See MARK A. HALL ET AL., *HEALTH CARE LAW & ETHICS* 1082–83 (6th ed. 2003) (discussing history of CON regulation). Before opening a new facility, CON laws require a showing of community need, “financial feasibility, and other criteria.” *Id.*; see also Clark Havighurst, *Regulation of Health Facilities and Services by “Certificate of Need,”* 59 VA. L. REV. 1143, 1153 (1973) (critiquing CON regulation of health care markets).

37. See FOLLAND ET AL., *supra* note 24, at 409 (discussing problem of rural hospital closings and challenges of maintaining access for rural populations); cf. FUCHS, *supra* note 16, at 87 (noting rural areas’ lack of nonprofits but markets for small, proprietary hospitals); STARR, *supra* note 35, at 420–49 (discussing decline in local control of health care delivery).

38. Kalb & Murr, *supra* note 4, at 66 (quoting LSU hospital executive as saying, “[w]e’re a bus wreck or a plane crash away from another catastrophe”); cf. KAISER REPORT 7387, *supra* note 4, at 2–3 (discussing hospital closures in New Orleans and overflow demand in localities such as Houston); *id.* at 8–9 (proposing federal grants to repair health care infrastructure).

B. Emergency Medical Care Burden

Even before certain post-9/11 legislation increased the burden on hospital “first responder” roles,³⁹ emergency departments struggled with high patient demand and financial strain under existing laws. In particular, the Emergency Medical Treatment and Active Labor Act (“EMTALA”) imposes a duty to provide treatment, with no promise of payment.⁴⁰ EMTALA was enacted in 1985 in response to reports of widespread “patient-dumping,” or denying treatment to patients needing emergency services, especially indigent and uninsured patients.⁴¹ Rather than bear the considerable cost of treating uninsured or indigent patients, some hospitals immediately diverted them, without even a cursory medical examination, to public or charity hospitals that provide free care.⁴² Patients were transferred in unstable, even life-threatening, conditions.⁴³

Under EMTALA, Medicare-participating hospitals are required to provide appropriate, nondiscriminatory medical screenings to all individuals presenting with emergency medical conditions, without regard to the patients’ ability to pay, insurance status, or Medicare eligibility.⁴⁴ Specifically, hospitals must screen “any individual

39. See *infra* Part I.D.

40. 42 U.S.C. § 1395dd (2000 & Supp. III 2003).

41. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 164 (codified as amended at 42 U.S.C. § 1395dd (2000 & Supp. III 2003)); H.R. REP. NO. 99-241, pt. 3, at 27 (1986) (discussing “increasing number of reports” of hospitals refusing to provide treatment or transferring patients in unstable conditions); see also Maria O’Brien Hylton, *The Economics and Politics of Emergency Health Care for the Poor: The Patient Dumping Dilemma*, 1992 BYU L. REV. 971, 1013 (noting dumping of underinsured, including patients discharged when insurance runs out and AIDS patients); Bley W. Rose, *Emergency Rooms Get Federal Relief: Relaxation of 1986 Rules Intended To Help Hospitals Deal with Financial Burden of Uninsured May Cut Losses*, PRESS DEMOCRAT (Santa Rosa, Cal.), Nov. 3, 2003, at D1 (noting EMTALA enactment “in response to allegations, chiefly from public hospitals, that for-profit facilities were ‘dumping’ uninsured patients on their emergency rooms”).

42. See EMTALA IMPLEMENTATION & ENFORCEMENT ISSUES, *supra* note 29, at 1; Robert Schiff et al., *Transfers to a Public Hospital*, 314 NEW ENG. J. MED. 552, 552 (1986) (analyzing transfer of patients in Chicago area and concluding transfers were made for economic reasons).

43. Am. Acad. of Pediatrics, *Overcrowding Crisis in Our Nation’s Emergency Departments: Is Our Safety Net Unraveling?*, 114 PEDIATRICS 878, 879 (2004) [hereinafter *Overcrowding Crisis*] (citing EMTALA legislative history). Various factors, including incentives built into the new Medicare Inpatient Prospective Payment System (“IPPS”), caused increased patient-dumping. See H.R. REP. NO. 99-241, pt. 3, at 27 (1986) (noting impact of new payment system); see *infra* Part I.C (describing Medicare payment methodology).

44. 42 U.S.C. § 1395dd(b)(1) (2000); see Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53,222, 53,222 (Sept. 9, 2003) (to be

regardless of diagnosis (e.g., labor, AIDS), financial status (e.g., uninsured, Medicaid), race, color, national origin (e.g., Hispanic or Native American surnames), handicap, etc.”⁴⁵ EMTALA defines an “appropriate” screening examination as one reasonably calculated to determine whether an emergency medical condition exists.⁴⁶ The hospital must provide screening and stabilizing treatment in a nondiscriminatory manner, meaning that services must be the same as the hospital would provide to any patient, “within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department.”⁴⁷ EMTALA does not require hospitals to provide more or different care than they otherwise would, but they cannot provide less. Consistent with EMTALA’s antidiscrimination mandate, implementing regulations expressly prohibit hospitals from delaying screening or stabilization services to inquire about payment method or insurance status.⁴⁸ After screening a patient, the hospital must provide stabilizing treatment or an appropriate transfer to another facility.⁴⁹ Transfer is permitted if

codified at 42 C.F.R. pts. 413, 482, 489) (summarizing EMTALA requirements); Sara Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J.L. MED. & ETHICS 590, 590 (2003) (“EMTALA imposes on all Medicare-participating hospitals a singular, legally enforceable duty of care, entitling all individuals who seek care at hospital emergency departments to an appropriate (i.e., nondiscriminatory) examination and to either stabilizing treatment or a medically appropriate transfer if an emergency medical condition is identified.”).

45. U.S. DEP’T OF HEALTH & HUMAN SERVS., STATE OPERATIONS MANUAL, APPENDIX V—INTERPRETIVE GUIDELINES—RESPONSIBILITIES OF MEDICARE PARTICIPATING HOSPITALS IN EMERGENCY CASES, pt. II, tag A406 (2004), http://cms.hhs.gov/manuals/Downloads/som107ap_v_emerg.pdf [hereinafter INTERPRETIVE GUIDELINES]; see Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145, 151 (2004).

46. 42 C.F.R. § 489.24(a) (2005); see Rosenbaum & Kamoie, *supra* note 44, at 592 (summarizing “appropriate medical screening” requirements).

47. 42 C.F.R. § 489.24(a); see INTERPRETIVE GUIDELINES, *supra* note 45, at pt. II, tag A400 (suggesting conditions, such as HIV, which might subject patients to discriminatory treatment).

48. 42 C.F.R. § 489.24(c)(3); INTERPRETIVE GUIDELINES, *supra* note 45, at pt. II, tag A400. *But see infra* notes 59–60 and accompanying text (summarizing EMTALA amendments).

49. Rosenbaum & Kamoie, *supra* note 44, at 590 (regarding medically appropriate transfers); Joan M. Stieber & Linda J. Spar, *EMTALA in the '90s—Enforcement Challenges*, 8 HEALTH MATRIX 57, 59–60 (1998) (noting that EMTALA “requires hospitals to do three basic things”: screening examination, stabilizing treatment, and medically appropriate transfer).

the benefits of the transfer outweigh the risks or if the patient makes an informed written request for transfer.⁵⁰

EMTALA imposes significant financial burdens on hospitals and physicians. Providing the statutorily required screening, treatment, and transfers involves considerable direct costs in terms of professional services and medical supplies. In addition, the statute imposes significant liability, management, and administrative burdens on hospitals.⁵¹ EMTALA requires hospitals to maintain on-call lists of physicians, including specialists, available to respond to emergencies on a twenty-four-hour basis.⁵² Both the hospital and

50. Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53,222, 53,223 (Sept. 9, 2003) (to be codified at 42 C.F.R. pts. 413, 482, 489) (preamble to final rule amending EMTALA regulations).

51. Rosenbaum & Kamoie, *supra* note 44, at 590 (discussing costs); *Overcrowding Crisis*, *supra* note 43, at 879 (suggesting that “[n]ationwide, EMTALA requirements are estimated to cost emergency care professionals more than \$425 million annually” and that “direct expense for emergency physician services provided to uninsured patients approximated \$1 billion” in 1998); *id.* at 883 (urging that “[e]xcessive clinical demands on an already saturated [emergency department] often lead to medical errors and poor outcomes” and that overcrowding through increased capacity has led to “increased utilization of hallways and other suboptimal, poorly equipped locations as patient treatment areas, challenging patient comfort, care satisfaction, and confidentiality and adding additional risk for error”).

52. See 42 U.S.C. § 1395cc(a)(1)(I)(iii) (2000) (requiring hospitals “to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition”). The on-call requirement creates tension between hospital management, staff, and physicians. See, e.g., Letter from John Horthy, Horthy, Springer & Mattern, P.C., to Tommy G. Thompson, Sec’y of Health & Human Servs. (Apr. 18, 2002) [hereinafter Horthy Springer Letter], available at http://www.hortyspringer.com/Data/Misc/HSM_EMTALA_Comments.htm (comments to proposed rule, noting that EMTALA “pits physicians against hospitals” and imposes “unreasonably burdensome on-call requirement”). Physicians object to on-call duty because, like hospitals, they may not receive compensation for providing emergency care. The management struggle arises, in part, because EMTALA does not require physicians to accept call duties but requires hospitals to maintain on-call lists, leaving the enforcement burden on hospitals. See Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. at 53,251 (summarizing comments and declining to adopt proposed on-call changes); Horthy Springer Letter, *supra* (proposing amendment requiring Medicare-participating physicians to take call). To secure an adequate roster of physicians and specialists, hospitals employ various strategies, including conditioning medical staff privileges on physicians’ agreeing to take call or paying them for on-call coverage. Those strategies further strain hospitals’ limited resources. See Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. at 53,251 (discussing burdens on hospitals, including physician compensation for call coverage); *id.* at 53,225 (regarding trend of specialty physicians, severing staff privileges, resulting in hospitals having no specialty physician coverage); Rosenbaum & Kamoie, *supra* note 44, at 590 (noting that EMTALA is “major contributor to hospital

physician face sanctions up to \$50,000 per EMTALA violation if they fail to provide the required screening and stabilization or, for physicians, if they fail to respond to call.⁵³ In addition, the statute provides a private cause of action to patients injured by EMTALA violations.⁵⁴ One recent source estimated that EMTALA costs health care providers more than \$425 million annually. In 1998, total direct expense for emergency physician services provided to uninsured patients approached \$1 billion, and hospital facility costs exceeded \$2 billion.⁵⁵ Responding to emergency calls also distracts and takes time away from physicians' own patients.

Health care providers may be left holding the bag for uncompensated care if third-party payers retrospectively deny payment for enrollees on the grounds that emergency treatment was not medically necessary.⁵⁶ Even when reimbursement comes, it may be inadequate to cover the costs of care. Hospitals complain that the EMTALA burden, among other pressures, place them in the red and force unavoidable emergency room closures.⁵⁷ Some commentators suggest that EMTALA operates as an "unfunded mandate" and advocate government subsidies or grants to cover the costs of providing emergency care.⁵⁸

emergency department overcrowding and cost"); Horthy Springer Letter, *supra* (describing pressure on hospitals to compensate physicians for call coverage).

53. 42 U.S.C. § 1395dd(d)(1) (2000) (providing sanctions up to \$50,000 on hospital and physician for negligently violating EMTALA requirements).

54. 42 U.S.C. § 1395dd(d)(2) (2000) (providing patients' cause of action for EMTALA noncompliance).

55. See *Overcrowding Crisis*, *supra* note 43, at 879; see also Lee, *supra* note 45, at 155 (discussing problem of managed care retrospective denial of claims for emergency medical treatment); Horthy Springer Letter, *supra* note 52 (describing same concern); Am. Coll. of Emergency Physicians, Costs of Emergency Care, <http://www.acep.org/webportal/PatientsConsumers/critissues/CostsofEmergencyCare/default.htm> (last visited Nov. 13, 2006) (citing American Medical Association May 2003 study finding that emergency physicians lost average \$138,000 revenue annually providing EMTALA care). Under most third-party compensation arrangements, hospitals and physicians each receive reimbursement for services provided to emergency room patients.

56. See Lee, *supra* note 45, at 155; see also EMTALA IMPLEMENTATION & ENFORCEMENT ISSUES, *supra* note 29, at 12 (citing American Hospital Association report that uncompensated care represented approximately 6.2% of total hospital expenses in 1999); *id.* at 9 (noting that emergency department visits rose from 90.5 million to 94.8 million, or about 5%, from 1994 to 1998).

57. See Rubin, *supra* note 11, at n.1 (citing Joseph A. Barbera et al., *Ambulances to Nowhere: America's Critical Shortfall in Medical Preparedness for Catastrophic Terrorism*, J. HOMELAND SECURITY (Mar. 2002)); see also CRACKS IN THE FOUNDATION, *supra* note 33, at 4 (suggesting that 62% of hospitals and 79% of urban emergency departments are "at" or "over" capacity and numbers continue to rise).

58. See Lee, *supra* note 45, at 166 (noting that hospital industry is facing financial crisis); *id.* at 170 (proposing increase in disproportionate share hospital ("DSH") subsidy

Recent regulatory amendments mitigate some of the EMTALA burdens, including on-call coverage, prior authorization, and other requirements.⁵⁹ Those amendments relieve some EMTALA compliance challenges, but preserve the core requirement to provide screening, stabilization, and appropriate transfer to any patient who requests emergency services regardless of payment or insurance status. EMTALA and other financial pressures place hospital emergency departments in dire straits even before enlisted as first responders for a major terrorist strike or natural disaster.⁶⁰ Post-9/11

and additional federal subsidy to fund EMTALA mandate); *Overcrowding Crisis*, *supra* note 43, at 879 (“EMTALA poses a profound economic challenge for hospitals and emergency care professionals, because this mandate for care does not carry with it a mandate for reimbursement for services rendered.”); *see also* STARR, *supra* note 35, at 436 (quoting hospital representative regarding patient who died one day after transfer: “These freebies [EMTALA services] cost \$2000 or \$3000 a day. Who’s going to pay for them?”).

59. Regulators suggest that the amendments clarify hospitals’ responsibilities under EMTALA and improve quality and access to care. Other clarifications relate to EMTALA’s restriction on inquiring about patients’ insurance status. *See* Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53,222, 53,224 (Sept. 9, 2003) (to be codified at 42 C.F.R. pts. 413, 482, 489) (background to proposed EMTALA amendments); Press Release, Ctr. for Medicare and Medicaid Servs., U.S. Dep’t of Health & Human Servs., Medicare Announces Final Rule on Hospital Responsibilities to Patients Seeking Treatment for Emergency Conditions (Aug. 29, 2003), <http://www.cms.hhs.gov/apps/media/press/release.asp?counter=837> (quoting CMS Administrator: “The rule will improve people’s access to emergency care by encouraging physicians to be on call and by permitting hospitals to take the most effective steps for getting emergency treatment for patients who need it.”). In response to proposed amendments, hospitals and other constituents pointed out that patients may be unaware that insurers or hospitals will charge them for emergency room treatment. As those costs can be substantial, the commenters urged that patients have a right to know about the possibility of charges before receiving treatment. *See* Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. at 53,227; *see also id.* at 53,225–27 (codified at 42 C.F.R. § 489.24(d)(4) (2005)) (regarding prior authorization provisions). The final rules affirm that a hospital cannot delay treatment to inquire about a patient’s ability to pay or to seek prior authorization. *See* 42 C.F.R. § 489.24(d)(4) (2005). But they may follow reasonable registration processes, including asking whether a patient is insured, as long as the inquiry does not “delay screening” or “unduly discourage” individuals from receiving emergency medical treatment. *See id.* § 489.24(d)(4)(i)–(ii) (regarding treatment or examination delay to inquire about payment or insurance status); *id.* § 489.24(d)(4)(iv).

60. *See Ambulances Find Overwhelmed ERs “at Breaking Point,”* WALL ST. J., June 15, 2006, at D6 (describing Institute of Medicine study, noting that the “nationwide crisis comes from just day-to-day emergencies. Emergency rooms are far from ready to handle the mass casualties that a bird-flu epidemic or terrorist strike would bring.”); Inst. of Med. of the Nat’l Acad., *The Future of Emergency Care in the United States*, <http://www.iom.edu/?ID=16107> (last visited Nov. 13, 2006) (reporting results of three related studies).

homeland security legislation helped to equip hospitals to respond to victims' medical needs but did little to help them recover payment and resume normal operations after the crisis has passed.

C. *Reimbursement for Emergency Care*

The September 11, 2001, attacks and September 2005 Katrina flooding tested the Nation's emergency response capabilities, revealing the need for substantial improvements. Katrina in particular showed that, especially for health care providers, remaining challenges extend beyond responding to the initial crisis to resuming normal operations after the episode. The existing approach to hospital reimbursement is technical, time consuming, and resource-intensive. The policy choices and competing concerns that underlie the design of those payment systems, such as ensuring adequate payment without creating moral hazard or perverse incentives for unnecessary care, lose salience under disaster scenarios.⁶¹ Cost-containment and efficiency concerns must yield to the exigencies of crisis response. Accordingly, the disaster response payment approach should emphasize prompt, adequate financial support with minimal administrative costs.⁶²

The following description of the Medicare program exemplifies the complexity typical of hospital reimbursement. Health insurers use a broad array of strategies and methodologies to pay hospitals for medical care provided to subscribers. An exhaustive description of the various payment arrangements exceeds the scope and purpose of

61. See David M. Frankford, *The Medicare DRGs: Efficiency and Organizational Rationality*, 10 YALE J. ON REG. 273, 293–96 (1993) (disputing purported efficiency and cost-containment improvements under Medicare DRG system); Elizabeth A. Weeks, *Gauging the Cost of Loopholes: Health Care Pricing and Medicare Regulation in the Post-Enron Era*, 40 WAKE FOREST L. REV. 1215, 1267–68 & n.255 (2005) (describing intended and unintended incentives created by Medicare IPPS methodology); see also Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, in EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 52, 63–67 (Tom Baker & Jonathan Simon eds., 2002) (noting that insurance coverage may stimulate increased provision of services); *id.* at 69 (discussing Medicare coverage for home health services, as an example: within five years, “[t]he number of Medicare-certified agencies almost doubled,” and within ten years, “home health care had become the new ‘cost crisis’ in health”). Compare Bodenheimer & Grumbach, *supra* note 24, at 637 (discussing difficulty controlling costs in third-party payment arrangement because both patients and providers are shielded from direct costs), with Malcom Gladwell, *The Moral-Hazard Myth*, NEW YORKER, Aug. 29, 2005, at 44 (disputing moral hazard as cause of health care crisis).

62. See DIXON & STERN, *supra* note 19, at xxi–xxii (describing post-9/11 other compensation schemes and importance of “economic efficiency,” meaning “making sure that benefits are distributed with low administrative and other transaction costs”).

this Article.⁶³ Understanding the challenges hospitals would face receiving timely, adequate reimbursement following a mass casualty or other demand surge, under even a single payment system, such as Medicare, amply demonstrates the need for an alternative approach. Medicare is a particularly relevant example because virtually all full-service hospitals accept Medicare patients. Government health care program payments comprise a substantial portion of most hospitals' total revenue.⁶⁴ In addition, the EMTALA duty is tied to Medicare-program participation.⁶⁵

1. Inpatient Services

Under Medicare, hospital emergency room services may be considered "Part A" services and reimbursed under the Inpatient Prospective Payment System ("IPPS").⁶⁶ Under IPPS, hospitals receive predetermined, fixed payments for Medicare patients, based on the diagnosis, or "diagnosis related group" ("DRG") assigned at discharge.⁶⁷ The DRG "bundled" payment accounts for all hospital services and supplies provided during the patient's stay, including but not limited to room and board, nursing and other health services, laboratory and diagnostic testing, operating room expenses, and medications.⁶⁸ Also, outpatient diagnostic services furnished to patients during the three days preceding the hospital admission are included in the DRG payment for the inpatient stay.⁶⁹

63. See generally KAISER REPORT 7329, *supra* note 26, at 4–6 (describing typical public hospital payer mix for inpatient and outpatient services).

64. The U.S. government is the single largest purchaser of health care services in the world. See, e.g., Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Statements for the Record to the House Budget Committee Health Care Task Force, Medicare Program: Improper Payments & Fraud. (July 12, 2000), <http://www.oig.hhs.gov/reading/testimony/2000/00712fin.htm> (describing Health Care Financing Administration as the largest health care purchaser in the world); see also Thomas R. McLean, *Crossing the Quality Chasm: Autonomous Physician Extenders Will Necessitate a Shift to Enterprise Liability Coverage for Health Care Delivery*, 12 HEALTH MATRIX 239, 255 (2002) (Federal Government is the largest purchaser of health care services).

65. See *supra* Part I.B (describing EMTALA requirements).

66. 42 U.S.C. § 1302 (2000); 42 U.S.C. § 1395hh (2000 & Supp. III 2003); 42 C.F.R. § 412.60 (2005).

67. 42 U.S.C. §§ 1302, 1395hh; 42 C.F.R. § 412.60. See generally *Inpatient Hospital PPS*, 1 Medicare & Medicaid Guide (CCH) ¶¶ 4202–4299 (2006) (explaining IPPS methodology).

68. HALL ET AL., *supra* note 36, at 1009 (defining DRGs).

69. 42 U.S.C. §§ 1302, 1395hh; 42 C.F.R. § 412.2(c)(5); see *Services Subject to PPS*, 1 Medicare & Medicaid Guide (CCH) ¶ 4210 (Mar. 28, 2006) (discussing three-day, or seventy-two-hour payment rule).

An “inpatient,” for purposes of IPPS, is a patient formally admitted to the hospital with the expectation of occupying an inpatient bed and remaining at least overnight, even if the patient is later discharged or transferred to another hospital and does not actually occupy an inpatient bed.⁷⁰ Any part of a day, including the admission day, counts as a full day.⁷¹ If a patient is admitted and dies, or is discharged on the same day, the day counts as an inpatient day.⁷² If a patient is transferred to another hospital, the transferee hospital receives the DRG payment, while the transferring hospital is paid a per diem rate for each day of the patient’s stay.⁷³

2. Outpatient Services

Some emergency services provided to victims of a terrorist attack or natural disaster might be considered outpatient, or “Part B,” services.⁷⁴ Part B services are reimbursed under the Medicare Outpatient Prospective Payment System (“OPPS”).⁷⁵ OPPS has distinct fixed payment rates from IPPS, based on “ambulatory

70. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., PUBL’N NO. 100-02, MEDICARE BENEFIT POLICY MANUAL ch. 1, § 10.1 & ch. 3, § 20.1.3, <http://www.cms.hhs.gov/Manuals/IOM/list.asp> (follow “100-02” hyperlink) (last visited Nov. 26, 2006) [hereinafter MEDICARE BENEFIT POLICY MANUAL] (providing subregulatory interpretive guidance on Medicare regulations and policies); see *Definition of “Inpatient,”* 1 Medicare & Medicaid Guide (CCH) ¶ 1209 (May 24, 2005).

71. see *Definition of “Inpatient,”* *supra* note 70.

72. *Id.*

73. 42 U.S.C. §§ 1302, 1395hh; 42 C.F.R. § 412.4; see *Discharges and Transfers*, 1 Medicare & Medicaid Guide (CCH) ¶ 4235 (Oct. 3, 2006) (explaining distinction between discharges and transfers and transfer payment methodology). Normally, Medicare will not pay for services at nonparticipating hospitals. To participate in the Medicare program, a hospital must sign a participation agreement and comply with Medicare conditions of participation (“COPs”) and other regulations. But Medicare will pay for emergency services provided to Medicare beneficiaries at nonparticipating hospitals if the services otherwise would be covered by Medicare and the nonparticipating hospital signs a special payment agreement. See 42 U.S.C. § 1395f(d)(1) (2000); 42 C.F.R. § 424.103 (2005) (listing conditions for payment for emergency services by nonparticipating hospitals and terms of election to claim payment); see *Emergency Inpatient Services in Nonparticipating Hospitals*, 1 Medicare & Medicaid Guide (CCH) ¶ 1239 (May 9, 2006) (summarizing same). To qualify for payment, the hospital must be the most accessible hospital available equipped to furnish services that the patient requires. Services at the nonparticipating hospital are covered only during the period of time the patient could not be safely discharged or transferred to a Medicare-participating hospital. For purposes of the special payment rule, “emergency services” are inpatient services necessary to prevent death or serious impairment of the health of the patient. 42 C.F.R. § 424.103(a)(4); see *Emergency Inpatient Services in Nonparticipating Hospitals*, *supra*.

74. 42 U.S.C. §§ 1302, 1395hh; 42 C.F.R. § 424.103.

75. *Ambulatory Payment Classification System*, 1 Medicare & Medicaid Guide (CCH) ¶ 4310 (Nov. 22, 2005).

payment categories” (“APCs”), instead of DRGs.⁷⁶ APCs are groupings of various Healthcare Common Procedure Coding System (“HCPCS”) or International Classification of Diseases (“ICD-9-CM”) codes. Hospital payment rates and patient coinsurance amounts are based on the APC to which the codes are assigned.⁷⁷ An emergency room patient who receives same-day services, such as sutures to close a wound or a cast to stabilize a broken bone, is billed as an outpatient, using the appropriate HCPCS or ICD-9-CM code, which is then keyed to the appropriate APC to determine the payment amount.⁷⁸ OPSS also applies to day patients, meaning patients admitted with the expectation of receiving same-day hospital services, including specific services such as renal dialysis treatment.⁷⁹

Another aspect of the Medicare payment methodology implicated in emergency care is “evaluation and management” (“E & M”) services.⁸⁰ Often, emergency rooms evaluate patients and hold them for observation before making a final disposition.⁸¹ For patients evaluated in the emergency room and admitted to the hospital for treatment, surgery, or testing, E & M services are bundled into the DRG payment.⁸² In certain cases, however, patients receiving only E & M services are billed as outpatients under OPSS. Recent Medicare regulations authorize payment for E & M services for particular conditions, including chest pain, asthma, and congestive heart failure, using special HCPCS codes.⁸³ Those conditions, especially

76. *Id.*

77. 42 C.F.R. §§ 419.31, 419.32; see *Ambulatory Payment Classification System*, *supra* note 75.

78. *Ambulatory Payment Classification System*, *supra* note 75.

79. See MEDICARE BENEFIT POLICY MANUAL, *supra* note 70, at ch. 6, § 20.1; CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., PUBL’N NO. 100-04, MEDICARE CLAIMS PROCESSING MANUAL, ch. 8, § 10, <http://www.cms.hhs.gov/Manuals/IOM/list.asp> (follow “100-04” hyperlink) (last visited Nov. 26, 2006) [hereinafter MEDICARE CLAIMS PROCESSING MANUAL]; *Definition of “Inpatient,” Medicare & Medicaid Guide (CCH)* ¶ 1209.74 (May 9, 2006) (describing exceptions).

80. See ANNE B. CASTO & ELIZABETH LAYMAN, PRINCIPLES OF HEALTHCARE REIMBURSEMENT 38–39 (2006) (discussing “Evaluation and Management Facility coding in the Emergency Department”).

81. *Id.* at 203.

82. See *supra* notes 67–72 and accompanying text (describing DRGs and same-day admission and transfer policies).

83. CMS, Medicare Program; Changes to the Hospital Outpatient Prospective Payment System for Calendar Year 2002, 66 Fed. Reg. 59,855, 59,856 (Nov. 30, 2001) (to be codified at 42 C.F.R. pts. 413, 419, 489); Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2003 Payment Rates and Changes to Payment Suspension for Unfiled Cost Reports, 67 Fed. Reg. 66,717, 66,718 (Nov. 1, 2002) (to be codified at 42 C.F.R. pts. 405, 419); MEDICARE CLAIMS PROCESSING

nonspecific chest pain, could be prevalent during terrorist incident or sudden calamity, such as Katrina, due to stress and anxiety.

Hospitals with limited experience with the intricate Medicare reimbursement methodology, or even experienced hospitals facing unprecedented patient demand, would likely experience delay, confusion, and errors in filing claims for disaster response. Some emergency patients would be considered inpatients, while others would be considered outpatients, calling billing personnel to follow separate, distinct payment rules. Moreover, appropriate DRG, HCPCS, or ICD-9-CM codes may not exist or may inadequately describe patients with novel or unprecedented clinical presentations. Coding system deficiencies could increase the inevitable payment delays and produce inadequate reimbursement or claims denials.

3. Physician and Ambulance Services

Under Medicare regulations, physicians and ambulances are reimbursed separately from hospitals, requiring providers to interpret and apply additional sets of regulations during the chaos of disaster response. Physicians' professional services are not included under Medicare Part A. Instead, they submit separate claims and receive separate reimbursement under Medicare Part B, based on the Medicare Physician Fee Schedule ("PFS").⁸⁴ The PFS is a uniform list of Medicare rates for physicians' professional services.⁸⁵ The PFS is based on a "relative value scale" ("RVU") that rates the value of a particular physician service relative to other services, based on the resources (i.e., physician work, practice expense, and malpractice expense) required to provide the service.⁸⁶

Medicare pays the lesser of the physician's actual charges or the PFS amount. Medicare-participating physicians may "balance bill," or collect additional payment from, Medicare beneficiaries up to fifteen percent above the Medicare allowable charge.⁸⁷ Some physician services not directly related to patient care, such as teaching, research, supervision, and committee service are considered

MANUAL, *supra* note 79, ch. 4, § 290.4; *Ambulatory Payment Classification System*, *supra* note 75 (describing observation services and requirements for OPSS claims and payment).

84. 42 U.S.C. § 1395x(b)(4) (2000); see *Exclusion of Physicians' Professional Services*, 1 Medicare & Medicaid Guide (CCH) ¶ 1281 (May 24, 2005) (discussing IPPS treatment of physician services).

85. 42 U.S.C. § 1395w-4(a) (2000). See generally *Physician Fee Schedule*, 1 Medicare & Medicaid Guide (CCH) ¶¶ 3401–3473 (2006).

86. 42 U.S.C. § 1395w-4(c)(2) (2000); see *Relative Values*, 1 Medicare & Medicaid Guide (CCH) ¶ 3408 (Jan. 31, 2006) (explaining physician fee schedule and RVUs).

87. 42 U.S.C. § 1395w-4(g)(2)(C) (2000).

hospital costs and included in hospital reimbursement. Also, professional services of interns and residents participating in an approved graduate medical education (“GME”) program are covered under Part A and included in hospitals’ DRG payments.⁸⁸

Disaster response could also call for ambulances to transport victims from the scene of attack or injury to appropriate medical facilities. Generally, emergency transportation, or ambulance services, are reimbursed under Medicare Part B, separately from hospital and physician services.⁸⁹ Medicare pays for both ground and air transportation, as long as medically necessary.⁹⁰ Ambulance providers are paid the lower of their actual charges or the applicable Medicare ambulance fee schedule amount.⁹¹ Ambulance fee schedule payments are based on HCPCS codes, similar to OPPS.⁹² If a patient is transferred to another hospital after admission, the transportation services are included in the hospital’s DRG inpatient payment and may not be billed separately by the ambulance provider.⁹³

The Medicare reimbursement methodology is complex, cumbersome, and filled with potential pitfalls even for savvy providers filing routine levels of claims.⁹⁴ Emergency services fall under various rules depending on the service and service provider. Despite the complexity, Medicare-participating hospitals are

88. See MEDICARE BENEFIT POLICY MANUAL, *supra* note 70, at ch.1, § 60; *Exclusion of Physicians’ Professional Services*, *supra* note 84; *Interns and Residents-in-Training*, 1 Medicare & Medicaid Guide (CCH) ¶ 1235 (May 9, 2006) (discussing GME coverage).

89. 42 C.F.R. § 414.610 (2005); *Ambulance Service*, 1 Medicare & Medicaid Guide (CCH) ¶ 3148 (Nov. 16, 004) (summarizing coverage and payment for ambulance services under Medicare); see also CASTO & LAYMAN, *supra* note 80, at 148–52 (describing reimbursement for services).

90. 42 C.F.R. §§ 414.605, 414.610(a) (2005); *Ambulance Service*, *supra* note 89 (summarizing coverage and payment for ambulance services under Medicare).

91. 42 C.F.R. § 414.610(a) (2005); *Ambulance Service*, *supra* note 89 (summarizing coverage and payment for ambulance services under Medicare).

92. 42 C.F.R. § 414.610; Medicare Program; Fee Schedule for Payment of Ambulance Services—Update for CY 2003, 67 Fed. Reg. 70,442, 70,443 (Nov. 22, 2002) (to be codified at 42 C.F.R. pts. 414); see *Ambulance Service*, *supra* note 89 (summarizing coverage and payment for ambulance services under Medicare).

93. MEDICARE CLAIMS PROCESSING MANUAL, *supra* note 79, at ch. 15, § 10; see *Ambulance Service*, *supra* note 89. Similarly, transfers of patients in Medicare-certified skilled nursing facilities or other sites to or from the hospital, or to another Medicare facility, are included in the appropriate facility’s payment and may not be billed separately by the ambulance supplier. *Id.*

94. *Cf. Stephenson v. Shalala*, 87 F.3d 350, 356 (9th Cir. 1996) (“Medicare and Medicaid are enormously complicated programs. The system is a web; a tug at one strand pulls on every other.”).

accustomed to receiving relatively prompt payment.⁹⁵ But the huge volume of claims likely to accumulate from a major catastrophe would hamper the system's normal functioning. Also, emergency response may require enlisting volunteer medical professionals and administrative staff inexperienced with Medicare and other payment requirements.⁹⁶ These volunteers' unfamiliarity with system requirements could increase incidences of coding and claims-filing errors.

The Medicare program is just one of various reimbursement systems with which hospitals must comply to collect payment for emergency medical treatment. Hospitals face similar complexity complying with Medicaid and other government programs, not to mention an array of private insurance and patient self-pay arrangements, each with unique billing challenges. The potentially high volume of claims in the event of a major disaster would severely tax the present reimbursement scheme. As the patient demand surge moves up the line into billing and payment demand surges, third-party payers, including private insurers and government health care programs, would also be burdened in processing the claims through existing channels. Meanwhile, hospitals could fall into financial distress awaiting payment.

D. Hospital First Responders

Following the September 11, 2001, attacks, Congress quickly passed several measures to prepare the country to better predict and respond to future homeland terrorist attacks. The Homeland Security Act of 2002 ("HSA") radically reorganized the Federal Government and created a new agency to coordinate a wide range of functions. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 ("Bioterrorism Preparedness Act") specifically aimed at health care preparedness.⁹⁷ Project BioShield of

95. MEDICARE CLAIMS PROCESSING MANUAL, *supra* note 79, at ch.1, §§ 80.2.1.1, 80.2.2; see *Claims Processing Timeliness*, 2 Medicare & Medicaid Guide (CCH) ¶ 10,195.01 (July 11, 2006); see also Thomas H. Stanton, *The Administration of Medicare: A Neglected Issue*, 60 WASH. & LEE L. REV. 1373, 1377-78 (2003) (noting that "Medicare is required to pay virtually all claims within thirty days").

96. See U.S. DEP'T OF HEALTH & HUMAN SERVS., EMERGENCY SYSTEM FOR ADVANCE REGISTRATION OF VOLUNTEER HEALTH PROFESSIONALS (ESAR-VHP)—LEGAL AND REGULATORY ISSUES 24 (2006) (draft report) [hereinafter ESAR-VHP DRAFT], available at ftp://ftp.hrsa.gov/bioterror/May_06_Legal_Report.pdf (outlining recommendations for volunteer response during public health emergencies).

97. Public Health Security Bioterrorism Preparedness and Response Act of 2002, Pub. L. No. 107-188, 116 Stat. 594 (codified as amended in scattered sections of 42 U.S.C.).

2004 addressed the threat of chemical, biological, radiological, or nuclear attacks.⁹⁸ At the state and local level, a comprehensive Model State Emergency Health Powers Act (“MSEHPA”) was drafted by the Centers for Disease Control (“CDC”) and public health experts.⁹⁹

Those laws explicitly define hospitals’ first responder roles in a terrorist attack or other public health emergency, prepare them to meet the patient demand surge, and ease certain compliance burdens to facilitate the response. But after the crisis has passed, as hospitals attempt to resume normal operations, nothing in the laws assures hospitals that they will recoup the overhead and direct-care costs of providing essential emergency care to unprecedented numbers of disaster victims. Without compensation, disaster response hospitals may be unable to recover, creating a crisis for the health care infrastructure, much as occurred in the Gulf Coast following Hurricane Katrina.

1. Federal Legislation

The events of the fall of 2001 highlighted the need for coordinated emergency planning and preparedness for future terrorist attacks. Authorities had already committed resources to bioterrorism preparedness before the September 11 attacks but made substantial additional appropriations following the airline hijackings and bioterrorism threats that followed.¹⁰⁰ In 2001, Congress passed the Public Health Threats and Emergencies Act, allocating \$500 million to the Department of Defense (“DOD”) for grants and cooperative agreements with states and local governments for emergency and bioterrorism preparedness.¹⁰¹ In addition, the CDC’s bioterrorism preparedness funding jumped from negligible to \$194 million in fiscal year 2001. In October 2001, President Bush signed the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act

98. Project Bioshield Act of 2004, Pub. L. No. 108-276, 118 Stat. 835 (codified as amended in scattered sections of 42 U.S.C.).

99. MODEL STATE EMERGENCY HEALTH POWERS ACT (Ctr. for Law & the Public’s Health, Discussion Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

100. See James G. Hodge, Jr., *Bioterrorism Law and Policy: Critical Choices in Public Health*, 30 J.L. MED. & ETHICS 254, 254 (2002) (noting previous commitments).

101. Public Health Threats and Emergencies Act, Pub. L. No. 106-505, § 319C, 114 Stat. 2314, 2317–18 (2000); see also NAT’L CONFERENCE OF STATE LEGISLATURES, AFI HEALTH COMMITTEE SUMMARY: PUBLIC HEALTH THREATS & EMERGENCIES ACT (2002), <http://www.ncsl.org/statefed/health/PHTEAS.htm> (summarizing Pub. L. No. 106-505).

(“PATRIOT Act”), aimed at preventing and prosecuting terrorism.¹⁰² In addition to increasing the federal surveillance authority, the PATRIOT Act contained the First Responders Assistance Act, which designated ambulance companies and hospitals as “first responders,” eligible for federal preparedness grants.¹⁰³ Also, in January 2002, President Bush signed a \$2.9 billion bioterrorism appropriations bill, providing \$1.1 billion to states to improve terrorism-related public health emergency response preparedness.¹⁰⁴

The central piece of post-9/11 legislation was the HSA, which brought more than 100 agencies, including some functions of the U.S. Department of Health and Human Services (“HHS”), the Federal Emergency Management Agency (“FEMA”), and DOD, under the new cabinet-level Department of Homeland Security (“DHS”).¹⁰⁵ HSA involved the largest restructuring of the Federal Government since the creation of the DOD in 1947.¹⁰⁶ DHS oversees the Nation’s preparedness and defense initiatives for future terrorist attacks. Hospitals, public health agencies, and other health care entities receive funding for response planning.¹⁰⁷ In addition, drills and mass

102. See *Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act*, Pub. L. No. 107-56, 115 Stat. 272 (codified in scattered sections of 18 U.S.C., 28 U.S.C., 50 U.S.C., 47 U.S.C., 2 U.S.C., and 31 U.S.C.).

103. See *id.*; Edward F. McArdle, *Survey of New York Law: Health Law*, 53 SYRACUSE L. REV. 629, 633 (2003) (describing PATRIOT Act provisions relevant to health care providers).

104. See Hope Reeves, *School Gets Bioterror Grant*, N.Y. TIMES, Feb. 18, 2002, at B4 (summarizing federal responses to 9/11); see also Lee, *supra* note 45, at 173–74 (discussing post-9/11 priorities, including food safety and hospital capacity).

105. Homeland Security Act of 2002, Pub. L. No. 107-296, §§ 503, 201, 116 Stat. 2135, 2145, 2213 (codified at 6 U.S.C. §§ 121(g), 313 (Supp. III 2003)); see Wendy K. Mariner, *Law & Public Health: Beyond Emergency Preparedness*, 38 J. HEALTH L. 247, 263 (2005) (“After September 11, 2001, as part of the war on terror, the federal government has asserted even greater influence in matters that affect public health—as a matter of national security.”); see also U.S. GOV’T ACCOUNTABILITY OFFICE, *supra* note 18, at 1 (describing FEMA’s performance during hurricane Katrina and raising questions regarding Agency’s organizational placement).

106. See Kristi L. Koenig et al., *The Evolution of Protecting the U.S.: Transition from Civil Defense to Homeland Security*, June 8, 2005, http://www.acep.org/webportal/MemberCenter/Templates/Default_Primary.aspx?NRMODE=Published&NRORIGINALURL=%2fwebportal%2fMemberCenter%2fSectionofMembership%2fDisasterMedicine%2fNewsletterArticles%2fTheEvolutionofProtectingtheUSTransitionFromCivilDefense%2html&NRNODEGUID=%7b18F10303-B24-F1B-A7EE-10C210092AC2%7d&NRCACHEINT=NoModifyGuest (last visited Sept. 3, 2006) (describing legislation and impact); see also WHITE HOUSE, *PROGRESS REPORT ON THE GLOBAL WAR ON TERRORISM 7* (2003), available at http://www.whitehouse.gov/homeland/progress/progress_report_0903.pdf.

107. See 6 U.S.C. § 101 (Supp. IV 2004) (defining “emergency response providers”); Homeland Security Presidential Directive No. 8, § 2(d) (Dec. 17, 2003) [hereinafter

destruction exercises were conducted in major cities to test the response readiness of public health and other essential services.¹⁰⁸

HSA calls for the creation of a fully integrated national emergency response system, or National Response Plan (“NRP”), adaptable to any domestic terrorist attack or natural disaster.¹⁰⁹ The NRP is to include a National Incident Management System (“NIMS”) to allow coordination among federal, state, and local authorities’ prevention, preparedness, response, and recovery plans.¹¹⁰ The President’s declaration of an “Incident of National Significance” would invoke special federal powers and coordinated assistance under the NRP.¹¹¹ For example, in the case of a public health emergency (“PHE”), as declared by the HHS Secretary, local hospitals could draw staff from other hospitals, including Federal Veterans Affairs facilities, and other states, as state licensing requirements would be waived.¹¹² Although not providing any payment for medical care, the NRP envisions memoranda of understanding (“MOUs”) to allow cross-reimbursement among emergency responders and governmental entities.¹¹³

In addition to HSA, Congress passed legislation aimed directly at health care preparedness. The Bioterrorism Preparedness Act appropriated \$1.6 billion in federal grants to state and local governments to implement state plans and conduct preparedness activities.¹¹⁴ Specifically, local authorities and first responders were encouraged to improve communications infrastructure, train

Presidential Directive], available at <http://www.whitehouse.gov/news/releases/2003/12/20031217-6.html> (including hospitals within “first responders”).

108. See Presidential Directive, *supra* note 107, at §§ 1–9 (regarding “Training and Exercises”); Thomas May, *Political Authority in a Bioterror Emergency*, 32 J.L. MED. & ETHICS 159–63 (2004) (describing May 2000 “TOPOFF” exercise for “top officials,” simulating bioterrorism attack in Denver, Colorado); Cynthia P. Schneider & Michael D. McDonald, *“The King of Terrors” Revisited: The Smallpox Vaccination Campaign and Its Lessons for Future Biopreparedness*, 31 J.L. MED & ETHICS 580, 581–82 (2003) (describing 2001 “tabletop” exercise and “Dark Winter” simulated smallpox attack). See generally Christian W. Erickson & Bethany A. Barratt, *Prudence or Panic? Preparedness Exercises, Counterterror Mobilization, and Media Coverage—Dark Winter, TOPOFF 1 and 2*, 1 J. HOMELAND SEC. & EMERGENCY MGMT. 1 (2004) (describing various exercises).

109. See Presidential Directive, *supra* note 107.

110. *Id.*

111. *Id.*

112. *Id.*

113. *Id.* (describing NRP); U.S. DEPT’ OF HOMELAND SECURITY, NATIONAL RESPONSE PLAN 5 (2004), http://www.dhs.gov/xlibrary/assets/NRP_FullText.pdf (implementing NRP, based on Presidential Directive).

114. See Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Pub. L. No. 107-188, § 143(a), 116 Stat. 594, 627 (codified at 42 U.S.C. § 1320b-5 (Supp. III 2003)).

laboratory and other health care professionals to screen for novel medical conditions, enhance surveillance and detection activities, stockpile medical equipment and supplies, and develop bioterrorist countermeasures or antidotes.¹¹⁵

The Bioterrorism Preparedness Act expressly authorizes federal authorities, in an emergency area, during an emergency period, as defined in the Act, to waive or modify for sixty days certain health care laws and requirements on health care providers.¹¹⁶ An “emergency period” must be declared by either the President, under the Federal Robert T. Stafford Disaster Relief and Emergency Assistance authority, or the Secretary of HHS, under section 319 of the Federal Public Health Service Act (“PHSA”).¹¹⁷ Secretary of Health and Human Services Michael Leavitt acted under section 319 to declare a PHE in the Gulf Region states of Alabama, Florida, Louisiana, Mississippi, and Texas after Hurricane Katrina.¹¹⁸ A federal emergency declaration allows authorities to waive or modify Medicare and Medicaid COPs, including EMTALA requirements and sanctions; state licensure requirements for professionals and facilities; and limitations on payments for certain Medicare enrollees.¹¹⁹ But the Act does not waive or relax billing procedures or

115. *See id.* (ensuring “sufficient health care items and services” and waiving sanctions for “furnish[ing] such items and services in good faith,” even if “unable to comply with one or more requirements” under EMTALA); Jason W. Sapsin, *Introduction to Emergency Public Health Law for Bioterrorism Preparedness and Response*, 9 WIDENER L. SYMP. J. 387, 398–99 (2003) (summarizing Bioterrorism Preparedness Act).

116. *See* Public Health Security and Bioterrorism Preparedness and Response Act § 143(a) (authorizing HHS Secretary “to temporarily waive or modify” certain laws, ensuring “to the maximum extent feasible . . . that sufficient health care items and services are available to meet the needs of individuals” in “any emergency area and during any emergency period”); *id.* (regarding “Duration of Waiver”).

117. *See id.* § 143(g)(1). The Bioterrorism Preparedness Act also amended section 319 of the Public Health Service Act, regarding the Secretary of HHS’s authority to declare and terminate a PHE at the federal level. *See id.* § 144(a).

118. *See* Determination that a Public Health Emergency Exists (U.S. Dep’t of Health & Human Servs. Aug. 31, 2005), <http://www.hhs.gov/emergency/determination.html> (declaring PHE under section 319 of the Public Health Services Act in Alabama, Florida, Louisiana, and Mississippi as a consequence of Hurricane Katrina); Determination that a Public Health Emergency Exists (U.S. Dep’t of Health & Human Servs. Sept. 4, 2005), <http://www.hhs.gov/emergency/determination1.html> (declaring same in Texas).

119. *See* Public Health Security and Bioterrorism Preparedness and Response Act § 143(a) (authorizing HHS Secretary to waive or modify certain laws); Project Bioshield Act of 2004, Pub. L. No. 108-276, § 9, 118 Stat. 835, 863 (to be codified at 42 U.S.C. § 1320b-5(b)) (amending Social Security Act § 1135(b) on EMTALA sanctions, and adding Social Security Act § 1135(b)(7), on Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) privacy provision); *see also* 42 C.F.R. § 489.24(a)(2) (2005) (providing that sanctions “for inappropriate transfer . . . do not apply to a hospital with a dedicated emergency department located in an emergency area”).

assure reimbursement for the cost of care provided to victims of the public health emergency.¹²⁰

Hospitals expressed concern that certain preparedness laws may be inconsistent with EMTALA responsibilities.¹²¹ EMTALA would hamper coordinated community response plans. For example, to contain an infectious disease outbreak, a community might agree to confine all infected patients at a single hospital. But EMTALA's requirement to screen and stabilize all patients before diverting them would seem to preclude immediate transfers to a designated infectious disease facility, thereby undermining efforts to control the outbreak. In response to those and similar concerns, federal regulators confirmed that, "in the event of a national emergency or crisis (e.g., bioterrorism) State or local governments may develop community response plans that designate specific entities (hospitals, public health facilities, etc.) with the responsibility of handling certain categories of patients during these catastrophic events."¹²² Similarly, the Bioterrorism Preparedness Act waives EMTALA sanctions and other laws to facilitate community response plans.¹²³ Although they provide flexibility in community response plans and patient diversion, the preparedness laws do not alleviate the demand surge and essential EMTALA burden to treat emergency patients irrespective of payment or insurance status.

Project BioShield, jointly administered by DHS and HHS, aims to improve pharmacological interventions against chemical,

120. See Rosenbaum, *supra* note 16, at 100 (noting that the Bioterrorism Preparedness Act "authorize[d] a federal legal framework for planning and executing public health and medical care activities" but "did not specify provisions for funding reforms on a mandatory basis").

121. See Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53,222, 53,257 (Sept. 9, 2003) (to be codified at 42 C.F.R. pts. 413, 482, 489) (summarizing comments).

122. INTERPRETIVE GUIDELINES, *supra* note 45, at pt. II, tag A406 (emphasis omitted); see also *id.* (suggesting that hospital could transfer patient to specified community screening site without violating EMTALA); Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. at 53,257 (clarifying EMTALA policies under Interpretive Guidelines); *Ambulances Find Overwhelmed ERs "at Breaking Point," supra* note 60 (describing IOM report recommendations for overburdened ERs, including directing hospitals "not necessarily to the nearest ER, but to the one best equipped to treat each patient's condition").

123. See Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. at 53,257 (describing Act's impact on EMTALA).

biological, radiological, or nuclear attacks.¹²⁴ The legislation authorized \$5.6 billion over ten years and streamlined government procurement processes for purchasing and stockpiling of vaccines and drugs to treat anthrax, smallpox, botulism, and other biological agents as well as radiation and chemical weapons exposures.¹²⁵ Grants for biodefense medical research, including \$1.5 billion per year for National Institutes of Health studies on treatments for smallpox, anthrax, Ebola, and other pathogens, were made available.¹²⁶ Project BioShield also creates incentives for pharmaceutical companies to research and develop new vaccines and treatments, including professional or expedited Food and Drug Administration (“FDA”) new drug approval. In addition, pharmaceutical companies and health care providers are authorized, under certain conditions, to distribute “best available” drugs and devices before final FDA approval.¹²⁷ The law also supports improved surveillance, intelligence, and law enforcement methods, environmental detectors, and disease surveillance techniques.¹²⁸

2. Model State Emergency Health Powers Act

Policymakers and academics urge that emergency preparedness requires more than funding. Public health authorities also need special, broader powers to respond adequately to emergencies.¹²⁹ With that goal in mind, the CDC initiated the Model State Emergency Health Powers Act (“MSEHPA” or “Model Act”), drafted in collaboration with scholars, governors, legislators, public health commissions, and attorneys general, in consultation with major

124. See Project Bioshield Act of 2004, Pub. L. No. 108-276, 118 Stat. 835 (to be codified at 42 U.S.C. § 247d-6); Press Release, White House, President Bush Signs Project Bioshield Act of 2004 (July 21, 2004), <http://www.whitehouse.gov/news/releases/2004/07/20040721-2.html>.

125. See Project Bioshield Act §§ 1–3 (to be codified at 42 U.S.C. § 247d-6a, 6 U.S.C. § 320) (listing policies and strategies and amending section 319F of the Public Health Service Act and section 510 of the Homeland Security Act of 2002).

126. See Press Release, White House, Fact Sheet: Progress on the War on Terror, (July 21, 2004), <http://www.whitehouse.gov/news/releases/2004/07/20040721-9.html>; Press Release, U.S. Dep’t of Health & Human Servs., HHS Fact Sheet—Project Bioshield (July 21, 2004), <http://www.hhs.gov/news/press/2004pres/20040721b.html>.

127. See Project Bioshield Act § 4 (to be codified at 21 U.S.C. § 360bbb-3) (amending section 564 of the Federal Food, Drug, and Cosmetic Act and authorizing use of medical products in emergencies).

128. See Press Release, U.S. Dep’t of Health & Human Servs., *supra* note 126 (summarizing key provisions).

129. See, e.g., Lawrence O. Gostin and James G. Hodge, *Public Health Emergencies and Legal Reform: Implications for Public Health Policy and Practice*, 118 PUB. HEALTH REP. 477, 477–79 (2003) (explaining need for Model Act).

stakeholders, including businesses, civil liberties organizations, and medical practitioners.¹³⁰ MSEHPA expands state and local authorities' powers to protect the public's health during public health emergencies.

MSEHPA incorporates five basic public health powers: "preparedness, surveillance, management of property, protection of persons, and public information and communication."¹³¹ The Model Act grants the state governor the power to declare a state of "Public Health Emergency," defined broadly as "an occurrence or imminent threat of an illness or health condition that . . . is believed to be caused by bioterrorism or the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin" that poses a high probability of a large number of deaths or serious disabilities in the population.¹³² The governor may terminate the declaration by executive order, and the declaration terminates automatically after thirty days, unless renewed.¹³³ In addition, the state legislature may terminate the declaration by a majority vote in both houses.¹³⁴

The public information and communication provisions of MSEHPA are intended to facilitate authorities' ability to detect and track public health emergencies.¹³⁵ Health care providers, coroners, and medical examiners are required to collect and report, within twenty-four hours of an encounter, detailed patient information, including name, date of birth, sex, race, occupation, home and work addresses, and "any other information needed to locate the patient for follow-up."¹³⁶ MSEHPA attempts to safeguard individual privacy and liberty interests, providing that information-sharing "shall be restricted to the information necessary for the treatment, control, investigation, and prevention of a public health emergency."¹³⁷ But

130. Lawrence O. Gostin, *Public Health Law in an Age of Terrorism: Rethinking Individual Rights and Common Goods*, HEALTH AFF., Nov.–Dec. 2002, at 79, 83 (summarizing MSEHPA). The Center for Law & the Public's Health at Georgetown & Johns Hopkins Universities, of which Lawrence O. Gostin is the director, spearheaded the drafting effort.

131. *See id.* at 83.

132. MODEL STATE EMERGENCY HEALTH POWERS ACT § 104(m) (Ctr. for Law & the Public's Health, Discussion Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

133. *Id.* § 405(b).

134. *Id.* § 405(a)–(c).

135. *Id.* §§ 301 (reporting), 302 (tracking), 303 (information sharing).

136. *Id.* § 301(c) (regarding manner of reporting).

137. *Id.* § 303(c) (regarding information sharing on "reportable illnesses, health conditions, unusual clusters, or suspicious events").

that “necessary” language may provide little assurance against improper disclosure.

As of July 15, 2006, thirty-eight states and the District of Columbia enacted statutes incorporating at least some MSEHPA or similar provisions.¹³⁸ Despite wide acceptance, the Model Act has been sharply criticized.¹³⁹ The proposed laws implicate constitutional questions about the degree to which governmental power should intrude on individual rights.¹⁴⁰ Various constituents, including physicians, public health authorities, and civil libertarians, suggest that MSEHPA “treats American citizens as if they were the enemy.”¹⁴¹ Provisions authorizing the governor to possess or destroy private property, including medical facilities, implicate property rights. Authorities may conscript medical providers and other emergency workers into service against their will, implicating liberty interests.¹⁴² The Model Act also includes strict law enforcement

138. CTR. FOR LAW AND THE PUBLIC'S HEALTH, THE MODEL STATE EMERGENCY HEALTH POWERS ACT (MSEHPA) STATE LEGISLATIVE ACTIVITY, <http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Leg%20Activity.pdf> (last visited Nov. 16, 2006) (maintaining information about MSEHPA).

139. See Daniel M. Fox, *Populations and the Law: The Changing Scope of Health Policy*, 31 J.L. MED. & ETHICS 607, 611 (2003) (discussing objections to broad public health powers); Edward P. Richards et al., *Legislative Alternatives to the Model State Emergency Health Powers Act (MSEHPA)* (LSU Program in Law, Sci., & Prob. Health, White Paper No. 2, 2003), available at http://biotech.law.lsu.edu/blaw/bt/MSEHPA_review.pdf. See generally Lawrence O. Gostin, *When Terrorism Threatens Health: How Far Are Limitations on Personal and Economic Liberties Justified?*, 55 FLA. L. REV. 1105, 1106 (2003) (noting that the issue is “politically charged because it affords the state enhanced powers to restrict personal and economic liberties”).

140. See Daniel S. Reich, *Modernizing Local Responses to Public Health Emergencies: Bioterrorism, Epidemics, and the Model State Emergency Health Powers Act*, 19 J. CONTEMP. HEALTH L. & POL'Y 379, 388 (2003) (discussing “balance between individual's legitimate expectation of privacy and the public health benefits to society as a whole”). But see Lawrence O. Gostin, *The Model State Emergency Health Powers Act: Public Health & Civil Liberties in a Time of Terrorism*, 13 HEALTH MATRIX 3, 25 (2003) (disagreeing that MSEHPA threatens civil liberties and could be triggered for any epidemic, such as HIV/AIDS); Hodge, *supra* note 100, at 259 (discussing individual liberties and bioterrorism); Ken Wing, *Preparing for the Next Public Health Emergency*, 13 HEALTH MATRIX 71, 75–77 (2003) (suggesting that governors need broad powers to act in previously unimaginable scenarios).

141. See, e.g., Ass'n of Am. Physicians and Surgeons, Inc., AAPS Analysis: Model Emergency Health Powers Act (MEHPA) Turns Governors into Dictators, (Dec. 3, 2001), <http://www.aapsonline.org/testimony/emerpowers.htm> (quoting George Annas); Naturodoc, *The Emergency Health Powers Act Turns Governors into Dictators*, <http://www.naturodoc.com/library/News/MEHPA.htm> (last visited Nov. 16, 2006) (urging readers to sign petition against MEHPA).

142. MODEL STATE EMERGENCY HEALTH POWERS ACT § 608(a) (Ctr. for Law & the Public's Health, Discussion Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf> (authorizing state “[t]o require in-state health care providers to assist”).

provisions, authorizing threats or use of deadly force to take property and compel vaccination or quarantine, despite the firmly rooted constitutional and common law rights to refuse medical treatment.¹⁴³ Opponents charge that MSEHPA, “in effect, empowers the Governor to create a police state by fiat” and “[u]nder this Act, any governor could appoint himself dictator by declaring a ‘public health emergency’ ”¹⁴⁴ Specifically, MSEHPA gives governors broad powers to declare and terminate an emergency, with only limited checks on that power from the state legislature.¹⁴⁵ Adding potential for abuse, public health authorities acting under MSEHPA are immune from liability in state courts.¹⁴⁶

State laws modeled on MSEHPA increase health care providers’ financial and administrative burdens, including information collection, patient tracking, electronic recordkeeping, communications, and community response planning. In addition, MSEHPA authorizes states to compel treatment and seize medical facilities during an emergency.¹⁴⁷ A governor’s executive order might even compel physicians and other medical professionals to assist in a disaster.¹⁴⁸ If the government employs all these strategies, hospitals would experience increased patient volume and demand for medical care. Despite its comprehensive delineation of emergency powers, MSEHPA does not address state budgetary powers or authorize governors to compensate providers for the additional preparedness and direct patient care costs they will incur in meeting the demand surge. Model law drafters next should turn their attention to developing a compensation plan to ensure that hospitals and other health care providers are not left with the unsustainable financial burden of disaster response.

143. See Reich, *supra* note 140, at 401–02 & nn.103–04 (citing cases). *But see* Jacobson v. Massachusetts, 197 U.S. 11, 37–38 (1905) (upholding state law on mandatory vaccination).

144. Ass’n of Am. Physicians and Surgeons, Inc., *supra* note 141.

145. See Gostin, *supra* note 130, at 87 (rebutting concerns).

146. See MODEL STATE EMERGENCY HEALTH POWERS ACT § 804(a) (Ctr. for Law & the Public’s Health, Discussion Draft 2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf> (providing immunity for governor, public health authority, or any other state official, except in cases of “gross negligence or willful misconduct”).

147. *Id.* §§ 501, 603(b).

148. See ESAR-VHP DRAFT, *supra* note 96, at 24 (noting that states adopting MSEHPA framework for public health emergencies, e.g., District of Columbia, may “require health care providers within the District to reasonably assist with the emergency response”).

II. LESSONS LEARNED

Even after federal and state lawmakers have enacted a broad package of laws designed to prepare the Nation to respond to the next major attack or natural disaster, questions remain whether we are any better prepared than we were pre-9/11. In addition, we do not yet know how the operation of those laws will affect the Nation's economy, infrastructure, and essential services, not only during the disaster but afterwards, as the Nation regroups and tries to return to normal. For hospitals, simply keeping doors open to patients may be a major challenge. It is impossible to predict the timing, scope, and impact of the next episode and, therefore, to tailor plans or legislation precisely. But one of the lessons of Katrina is that we cannot afford to wait and see, developing a response *ex post* as the crisis unfolds and throwing money and personnel at whichever problem seems to be bleeding most profusely.¹⁴⁹ Instead, we should take advantage of calmer times to think through the range of problems that are not only likely but certain to arise, both during and after the catastrophe.¹⁵⁰

In 2003, the U.S. General Accounting Office ("GAO") surveyed over 2,000 urban hospitals' preparedness for bioterrorism, including the status of planning activities, staff training, and response capacity.¹⁵¹ The GAO report suggested that, despite additional funding and special legislation, hospitals remained inadequately prepared for homeland security, bioterrorist threats, or other public health emergencies.¹⁵² Although most hospitals had conducted basic

149. See, e.g., U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 18, *passim* (raising questions regarding FEMA's Katrina response); Robert Block, *Hearings To Shape FEMA's Future*, WALL ST. J., Sept. 15, 2005, at A12 ("FEMA has become synonymous with the government's bungled response to the hurricane, with a number of politicians saying part of the problem is that the agency is no longer cabinet-level but rather a small cog in the mammoth Department of Homeland Security."); Walker Letter, *supra* note 18 (suggesting need for clear, decisive leadership, in single individual accountable to the President); Fessler, *supra* note 18.

150. Cf. GUIDO CALABRESI & PHILIP BOBBITT, *TRAGIC CHOICES* 21 (1978) (asking "why, for instance, the United States will spend a million dollars to rescue a single, downed balloonist but will not appropriate a similar sum to provide shore patrols" and concluding that "[b]y making the choice seem necessary, unavoidable, rather than chosen, it attempts to convert what is tragically chosen into what is merely a fatal misfortune").

151. See *HOSPITAL PREPAREDNESS*, *supra* note 10, at 20-24.

152. *Id.*; see also Borenstein, *supra* note 25 (summarizing GAO findings and quoting emergency room doctor: "I liken the SARS problem right now to a two-acre fire in a tinder-dry forest We don't have the capacity in any city in my mind to handle a real outbreak of the disease."); Hodge, *supra* note 100, at 254 (noting lack of "infrastructure, resources, knowledge, or tools to effectively respond to mass exposure to diseases"); O'Connor, *supra* note 10 ("[Area hospitals] acknowledge being woefully unprepared to

response planning and coordination activities, they lacked adequate staff and specialized medical equipment (e.g., ventilators and isolation facilities) required to handle significant increases in patient volume and prevent the spread of infectious disease.¹⁵³ Most hospitals reported that they provided some staff training in disease identification and diagnosis, but fewer than half had conducted drills or response simulations. The GAO report and other sources suggested that legislative efforts failed to ready the Nation's emergency health care providers to respond to a homeland security emergency. Katrina made that reality painfully clear.¹⁵⁴ Additional funding and support for preparedness is needed to improve hospitals' ability to fulfill their essential first responder roles, but lawmakers also need to address post-disaster financial recovery.

A. *Cost of Catastrophes*

Given the severity and devastation of recent disasters, it is almost unthinkable to imagine what catastrophe we might next face. It is equally difficult to estimate the potential costs in human life, insured losses, and government expenditures for various disaster scenarios. A natural disaster impacts society and the economy differently than a terrorist attack. A sudden, single-strike attack imposes different costs and burdens than an emerging or episodic crisis, such as an infectious disease outbreak. Moreover, the effect on society depends on the particular financial, government, and public health resources of the affected geographic area. Although cold numbers may not have the same salience as the tragic images of the World Trade Towers or the Ninth Ward, a brief survey of economic figures for recent disasters gives some context for thinking about the potentially severe costs of the next catastrophe.

Hurricane Katrina and the flooding of New Orleans was an unprecedented catastrophe, resulting in more insurance claims than any other United States disaster. Initial loss estimates in the days immediately after the storm were as high as \$26 billion.¹⁵⁵ Later

deal with a mass-casualty incident, especially in the first hours. . . . The lack of resources, training, and personnel mean some victims will die from a lack of adequate treatment.”).

153. See Laura Landro, *The Informed Patient: Hospitals Step Up Disaster-Preparedness*, WALL ST. J., Sept. 6, 2006, at D4 (“But for all the progress in improving readiness, experts warn there is still a long way to go.”).

154. See *supra* note 108 and accompanying text (citing sources describing results of disaster response drills).

155. See, e.g., Mike Comerford, *Allstate Mobilizes Adjusters for Hurricane Claims*, CHI. DAILY HERALD, Aug. 30, 2005, at B1 (citing initial storm damage estimates, before levees broke, ranging from \$10 billion to \$26 billion); Scott Miller, *Katrina Damages Piling Up*;

estimates ranged from \$70 billion to \$130 billion.¹⁵⁶ Even the early, grossly underestimated \$26 billion figure would have exceeded the costs of any previous U.S. natural disasters. Combined with the losses of Hurricane Rita, Katrina's financial toll far exceeds that of Hurricane Andrew (the costliest hurricane previously on record) the 9/11 terrorist attacks, and the Northridge earthquake.¹⁵⁷

Other recent natural disasters, including the Asian tsunami and Pakistani earthquake, produced staggering losses in terms of human life. But the estimated financial impact of those catastrophes was far lower than similar U.S. disasters, given those regions' weak economies. The tsunami that struck eleven countries in South Asia on December 26, 2004, caused a devastating human toll of 300,000 dead or missing but only \$8.4 billion in damages.¹⁵⁸ Six hundred ninety hospitals and health care clinics were destroyed.¹⁵⁹ The relatively modest economic loss figure reflects the fact that the insurance market in the region is relatively underdeveloped, and many of the property owners were uninsured.¹⁶⁰ The death toll from

Some Estimates as High as \$16 Billion; State Farm Ready, PANTAGRAPH (Bloomington, Ill.), Aug. 30, 2005, at C1 (reporting various estimates, from low of \$4 billion to high of \$16 billion).

156. *After the Hurricanes: Impact of Hurricane on 2007 Budget: Hearing Before the H. Comm. on the Budget*, 109th Cong. 10 (2005) (statement of Douglas Holtz-Eakin, CBO Director) [hereinafter *Hurricane Hearing*]; see also Jesse Westbrook, *Hurricane Could Cost Insurers \$60 Billion*, ORLANDO SENTINEL, Sept. 10, 2005, at C1 (citing estimates); David Wyss, *A Second Look at Katrina's Cost*, BUS. WK. ONLINE, Sept. 13, 2005, http://www.businessweek.com/bwdaily/dnflash/sep2005/nf20050913_8975_db082.htm ("The damage done by Katrina . . . is still unknown, but it's clearly more than first expected, with estimated costs now as high as \$200 billion.").

157. Westbrook, *supra* note 156 (comparing previous disaster costs, including Hurricane Andrew in 1992, \$20.8 billion; 1994 Northridge earthquake, \$16 billion; and 2004 Central Florida hurricanes, \$22 billion). See *Hurricane Hearing*, *supra* note 156, at 1-5 (statement of Douglas Holtz-Eakin, CBO Director) (noting that total insured and uninsured losses from Hurricanes Katrina and Rita approach \$140 billion, which far surpasses recent disasters, even converted to today's dollars).

158. See Michael VanRooyen & Jennifer Leaning, *Perspective: After the Tsunami—Facing Public Health Challenges*, 352 NEW ENG. J. MED. 435, 435 (2005) (noting that "the devastation wrought by the tsunami was catastrophic—more than 150,000 people dead, tens of thousands of people missing, thousands of miles of destroyed coastline, and loss of livelihood for millions of distraught survivors"); Amy Waldman & James Brooke, *Disaster's Damage to Economies May Be Minor*, N.Y. TIMES, Jan. 3, 2005, at A1.

159. See Peter Fritsch, *Cleaning Up After the Tsunami, an ACEH Surprise: Good Government*, WALL ST. J., Nov. 2, 2005, at A1 (regarding tsunami aftermath); Denise Gracy, *Even Good Health System Is Overwhelmed by Tsunami*, N.Y. TIMES, Jan. 9, 2005, at 10 (discussing public health outreach following destruction of clinics and hospitals).

160. See Insurance Information Institute, *Catastrophes: Insurance Issues*, INS. ISSUES UPDATE, Aug. 2006, available at 1995 WL 628905 (noting that Indonesians spent average of \$8 per capita on non-life insurance in 2003, compared to \$1,980 per capita in the United States).

the Pakistani earthquake in October 2005, initially as low as 16,000, increased to 73,000 in the following month.¹⁶¹ The Pakistani Prime Minister estimated rebuilding costs at \$5 billion.¹⁶²

Until Katrina, the September 11, 2001, terrorist attacks were the costliest U.S. disaster.¹⁶³ Total costs of the World Trade Center attack alone are estimated between \$33 billion and \$36 billion, including lost earnings, property damage, and Ground Zero cleanup and restoration.¹⁶⁴ Close to 3,000 people lost their lives in the attack.¹⁶⁵ Tragically, direct health care costs were negligible because there were no survivors of the attacks. Some disaster-related medical costs were incurred for rescue workers, including smoke inhalation, treatment and mental health and substance abuse treatment for victims' families, rescue workers, and others.¹⁶⁶

Biological, chemical, or other infectious disease-causing agents bring different challenges than a single-episode natural disaster or terrorist attack. Data on the health care financial impact for a bioterrorism scenario were compiled following the recent SARS outbreak in Ontario, Canada.¹⁶⁷ The 108-day outbreak in the summer

161. See *Quake Toll Jumps*, HERALD SUN (Melbourne, Austl.), Nov. 4, 2005, at 47 available at 2005 WLNR 17766911 (citing current estimate and noting that "officials warned it was likely to rise further as relief supplies fail to reach thousands of stranded victims"); see also *Pakistan Predicts Sharp Jump in Quake Toll*, CHINA DAILY, Oct. 17, 2005, available at http://www.chinadaily.com.cn/english/doc/2005-10/17/content_485517.htm (quoting official statement: "Some people fear that the death toll could be 100,000 and they might be right.").

162. See *Post-Quake Reconstruction To Cost 5 Bln USD: Pakistani PM*, XINHUA GEN. NEWS SERVICE, Oct. 15, 2005; see also Farhan Bokhari, *Pakistan to Plead Special Exports Case After Quake*, FIN. TIMES, Oct. 18, 2005, at 2 (citing \$5 billion estimate and quoting Pakistani cabinet member on plans to seek preferential access to U.S. and European markets: "We want to build our case on the ground that there are sudden new pressures on our economy following the earthquake, and the reconstruction task ahead is gigantic.").

163. See Westbrook, *supra* note 156 (comparing disasters and describing 2004 hurricanes as most costly pre-9/11 disaster, with insured property loss at \$20 billion).

164. See Jason Bram et al., *Measuring the Effects of the September 11 Attack on New York City*, FRBNY ECON. POL'Y REV., Nov. 2002, at 5 (estimating losses as of June 2002).

165. See *id.* at 14 (summarizing loss estimates by Federal Reserve Bank of New York). "Privately insured losses [from the terrorist attacks] are estimated to total \$35.2 billion and include \$11.9 billion in business-interruption losses, \$10.4 billion in property losses, \$3.8 billion in aviation liability, \$1.9 billion in workers' compensation benefits, and \$1.1 billion in life insurance payments." See *Hurricane Hearing*, *supra* note 156, at 16.

166. See DIXON & STERN, *supra* note 19, at xxiv (estimating that approximately 425 emergency responders were killed or seriously injured in 9/11 attacks); Bram et al., *supra* note 164, at 12 (identifying "[a]ttack-related productivity effects," including "increase in post-traumatic stress disorder and alcohol and drug use three months after attack").

167. *Ontario Presses Ottawa To Foot SARS Bill*, CBC NEWS, June 27, 2003, http://www.cbc.ca/canada/story/2003/06/27/sars_compensation030627.html [hereinafter

of 2003 cost Ontario's health care facilities \$945 million, according to the Minister of Health.¹⁶⁸ Those costs included \$395 million in hospital costs, including staff and supplies; \$330 million in health care worker costs, including wage replacement for quarantined workers; and \$100 million in lost revenues to hospitals affected by the SARS outbreak.¹⁶⁹ In addition, \$120 million was spent on disease-tracking, rapid-response teams, and other preparedness for future attacks.¹⁷⁰

The Canadian Government initially provided only \$150 million to offset the Province's costs.¹⁷¹ Ontario authorities sought a national emergency declaration and additional compensation.¹⁷² Subsequently, the Federal Government approved \$330 million in compensation for the outbreak, based on a separate report and reexamination of Ontario's books, lowering the total health care cost estimate to \$660 million.¹⁷³ But costs of a full-blown, sustained chemical or biological attack or infectious disease pandemic could be much higher. With that possibility in mind, the Bush administration in 2005 committed \$7.1 billion over three years for avian flu preparedness.¹⁷⁴ The international community pledged \$1.9 billion in international aid to prepare for an avian flu pandemic.¹⁷⁵

Ontario Presses Ottawa] (tabulating recovery costs, including quarantine compensation, job recovery, and tourism).

168. *Id.*

169. *Id.*

170. *Id.*; see also ONTARIO MINISTRY OF FIN., QUARTERLY ONTARIO FINANCES: FIRST QUARTER 2003–2004 (2003), <http://www.fin.gov.on.ca/english/finances/2003/ofin031.html> (reporting financial impact of SARS at Can. \$1,073,000,000); Kristin Choo, *The Avian Flu Time Bomb*, A.B.A. J., Nov. 2005, at 36, 39 (comparing emerging avian flu threat to SARS, which was contained due to quick action by public health authorities in affected countries and noting that “SARS, unlike most human influenza viruses, was not very contagious”).

171. *Ontario Presses Ottawa, supra* note 167.

172. See *id.* (quoting Ontario Minister of Health: “Every hour we have waited for help and for every hour that we have had to waste, begging the federal government to help the people it is supposed to serve and protect, is an hour wasted in the battle against SARS.”).

173. *Ottawa Ups Ontario SARS Aid*, LONDON FREE PRESS, Nov. 19, 2003, at A3 (noting figure was higher than government's initial \$250 million offer but still below \$1 billion request).

174. See Choo, *supra* note 170, at 36 (suggesting that avian flu outbreak “is likely to be a lot worse” than World War I, which killed 10 million people in four years of fighting and 1918 Spanish flu outbreak, which killed 40 million people”); Sarah Lueck & Anna Wilde Mathews, *Bush Proposes \$7.1 Billion Outlay To Fight Pandemic-Flu Threat*, WALL ST. J., Nov. 2, 2005, at A6 (discussing administration's plan, including stockpiling, international monitoring, and local response plans); Santora, *supra* note 11 (comparing avian flu threat to 1918 smallpox epidemic and describing New York City preparedness plan); *Bush Unveils \$7.1 Billion Plan To Prepare for Flu Pandemic*, CNN.com, Nov. 2, 2005, <http://www.cnn.com/2005/HEALTH/conditions/11/01/us.flu.plan> (noting that Bush plan includes \$251 million for detection and training, \$1.2 billion for vaccines, \$2.8 billion for

The above survey of recent catastrophes shows that all types of catastrophes wreak economic devastation on affected individuals and nations, the effects of which should be considered in advance. But the precise impact varies widely, making it difficult to anticipate the extent and nature of financial relief that might be required to stabilize particular industries, markets, or economies. Accordingly, any ex ante government disaster relief plan should be broadly defined and adaptable to a range of scenarios.

B. Katrina

Hurricane Katrina and the New Orleans levee collapse tragically and starkly demonstrate the Nation's inadequate disaster preparation.¹⁷⁶ The catastrophe provides still-emerging lessons for health care response and recovery. Authorities quickly authorized emergency funding and waivers to assist health care providers in responding to health care needs during and immediately after the catastrophe. Federal authorities debated and eventually enacted additional financial and other assistance for patients and providers. But the impact on the region's economy generally, and on the health care system specifically, will be severe and lasting.¹⁷⁷ Hospitals as far away as Houston and Atlanta struggled to collect payment, return to normal operations, and remain solvent after the flood water receded.¹⁷⁸

vaccine production "crash program," and \$1 billion for stockpiling existing antiviral drugs); *see also* CAL. DEPT OF HEALTH SERVS., DRAFT PANDEMIC INFLUENZA PREPAREDNESS AND RESPONSE PLAN (2006), [http://www.dhs.ca.gov/ps/dcdc/izgroup/pdf/update/Mini%20\(0206\).pdf](http://www.dhs.ca.gov/ps/dcdc/izgroup/pdf/update/Mini%20(0206).pdf); Dorsey Griffith & Edie Lau, *State Readies Pandemic Response*, SACRAMENTO BEE, Jan. 19, 2006, at A1, available at <http://dwb.sacbee.com/content/news/ongoing/flu/story/14090823p-14920808c.html> (describing California's proposed avian flu plan).

175. *Playing Chicken with Bird Flu*, N.Y. TIMES, Feb. 21, 2006, at A18.

176. *See* Choo, *supra* note 170, at 39 ("Anyone looking for lessons about the value of preparedness does not need to look far. A good place to start is the U.S. Gulf Coast, still reeling from the devastation caused by Hurricane Katrina when it hit on Aug. 29.")

177. *See generally* Kalb & Murr, *supra* note 4, at 66 (discussing effects on region's health care system); *New Orleans' Emergency Rooms Overtaxed*, *supra* note 4 (same); KAISER REPORT 7538, *supra* note 6, at 19–35 (describing lasting health experiences of low-income Katrina survivors).

178. *See* KAISER REPORT 7387, *supra* note 4, at 3 (noting that "[h]ospitals located in communities receiving large inflows of individuals displaced by Katrina are facing increased demand"; Houston's Harris County hospital district, in particular, has assumed care of 23,000 evacuees living in the Astrodome, and Baton Rouge's population has doubled); Andy Miller, *Evacuees' Access to Medicaid Eased*, ATLANTA J.-CONST., Sept. 7, 2005, at 4F (noting public health official's "warn[ing] that treating Katrina's victims on top of metro Atlanta's perennially packed emergency rooms may finally break the system").

After the levees broke, the Federal Government quickly appropriated \$62.3 billion in emergency assistance funds, most of which went to FEMA.¹⁷⁹ Soon, concern arose that the FEMA money was being put to questionable use.¹⁸⁰ Both Democrats and Republicans called for an investigation into spending of the hurricane relief funds, and subsequent relief packages were scaled back under budget and other pressures.¹⁸¹ As far as health care providers were concerned, FEMA offered little assistance.¹⁸² The federal disaster relief program pays only for the cost of rebuilding disaster-damaged facilities and expressly excludes direct-care and administrative costs.¹⁸³ Some New Orleans hospitals that were physically damaged may qualify for FEMA funds for rebuilding. In addition, under certain circumstances, FEMA authorizes up to \$26,500 per patient to cover health care costs, but the amounts are paid directly to patients and still would have to be collected from patients by health care providers.¹⁸⁴

179. See *Congress Responds to Hurricane Katrina*, U.S. FED. NEWS, Sept. 12, 2005, (reporting Katrina relief appropriations); *Hurricane Hearing*, *supra* note 156, at 21.

180. See Angie C. Marek & Edward T. Pound, *A Flood of Money*, U.S. NEWS & WORLD REP., Oct. 10, 2005, at 24 (describing \$236 million, six-month contract with Carnival cruise lines to shelter and feed evacuees and emergency workers, and \$2 billion contract to buy 120,000 trailers as emergency housing for flood victims).

181. See *id.* (describing DHS response, establishing Office of Hurricane Katrina Oversight, and appointing former FEMA top official, Matthew Jadacki, as auditor); David Rogers, *White House To Trim Katrina Spending Request*, WALL ST. J., Oct. 19, 2005, at A8 (reporting plans to scale back “Katrina spending requests to keep the next relief package in the \$20 billion range and offset the costs with equivalent savings”); see also Block, *supra* note 149 (reporting on Congress’s FEMA hearings).

182. Fla. Hosp. Ass’n, *FHA Primer on FEMA Assistance for Hospitals 3*, <http://www.fha.org/fhafemaprimer.doc> (last visited Nov. 26, 2006) (noting that “FEMA generally does not reimburse” medical facilities in disaster area for costs of increased patient loads and operating costs); *Health Workers Struggling To Meet Needs a Year After Katrina*, NATION’S HEALTH, Oct. 2006, at 1.

183. See 42 U.S.C. § 5172(a)(1)(A) (2000) (authorizing President to make contributions to state or local governments to help repair, restore, reconstruct, or replace public facilities belonging to such state or local governments which were damaged or destroyed by a major disaster); *id.* § 5133(c) (authorizing funding for rebuilding costs). *But see* Medical Care and Evacuations, Response and Recovery Directorate Pol’y No. 9525.4, § 7(B)(2) (Fed. Emergency Mgmt. Agency, (Aug. 17, 1999)), in FED. EMERGENCY MGMT. AGENCY, PUBLIC ASSISTANCE: POLICY REFERENCE MANUAL [hereinafter *Response and Recovery Directorate Pol’y No. 9525.4, § 7(B)(2)*], available at <http://www.fema.gov/government/grant/pa/policy.pdf> (defining facilities’ “ineligible costs” as “[c]ost of emergency medical treatment of any kind,” “[c]ost of follow-on treatment of disaster victims,” “[i]ncreased administrative and operational cost to the hospital due to increased patient load,” and “[c]osts associated with loss of revenue”).

184. See 42 U.S.C. § 5172(a)(1)(A) (authorizing President to make contributions to state or local governments to help repair, restore, reconstruct, or replace public facilities belonging to such state or local governments which were damaged or destroyed by a major

Consistent with the post-9/11 legislation, the administration's focus after Katrina was ensuring that providers could meet the immediate health care needs of the victims. But the relief package stopped short of providing lasting financial stabilization to the fragile health care infrastructure. Between August 31, 2005 and September 4, 2005, Secretary Leavitt declared a state of public health emergency in six states.¹⁸⁵ The declaration authorized the affected states to waive certain Medicare, Medicaid, State Child Health Insurance Program ("SCHIP"), and Health Insurance Portability and Accountability ("HIPAA") patient privacy requirements.¹⁸⁶

HHS promised full payment and exemption from noncompliance sanctions for providers furnishing medical services in good faith but unable to fully comply with government program requirements due to the hurricane.¹⁸⁷ CMS pledged to pay hospitals the DRG rate plus a special add-on payment for treatment provided until appropriate transfer could be arranged.¹⁸⁸ EMTALA sanctions were waived for patient transfers to less hazardous locales. Standard preauthorization requirements for Medicaid, Medicare, and SCHIP were waived.¹⁸⁹ Medicare and Medicaid claims processors were instructed to

disaster). *But see* Response and Recovery Directorate Pol'y No. 9525.4, § 7(B)(2), *supra* note 183 (defining facilities' "ineligible costs" as "[c]ost of emergency medical treatment of any kind," "[c]ost of follow-on treatment of disaster victims," "[i]ncreased administrative and operational cost to the hospital due to increased patient load," and "[c]osts associated with loss of revenue"). For FEMA's description of individual assistance, see Press Release, Fed. Emergency Mgmt. Agency, Emergency Assistance Flowing to Gulf Coast: FEMA Distributes \$450 Million to Victims of Hurricane Katrina (Sept. 9, 2005), *available at* <http://www.fema.gov/news/newsrelease.fema?id=18738> (reporting initial household payments for "emergency needs of food, shelter, clothing, personal necessities and medical needs" of \$2000 each and maximum of \$26,500).

185. *See supra* note 118 and accompanying text.

186. *See* Waiver Under Section 1135 of the Social Security Act (U.S. Dep't of Health & Human Servs. Sept. 4, 2005), <http://www.hhs.gov/katrina/ssawaiver.html> (listing waivers under section 1135 of SSA); Office for Civil Rights, U.S. Dep't of Health & Human Servs., Hurricane Katrina Bulletin: HIPAA Privacy and Disclosures in Emergency Situations (Sept. 2, 2005), <http://privacyruleandresearch.nih.gov/pdf/HurricaneKatrina.pdf> (regarding policy on patient information sharing in disaster relief situations); Press Release, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs. CMS Takes Emergency Steps To Ease Health Care Access to Katrina Victims, (Sept. 9, 2005), <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1551> (reporting SCHIP and Medicaid changes).

187. *See* Thomas Dowdell, Fulbright & Jaworski, Client Alert: Hurricane Katrina; HHS Policy (Sept. 7, 2005) http://www.fulbright.com/index.cfm?fuseaction=publications.detail&pub_id=2010&site_id=494&detail=yes.

188. *Id.* Crisis services provided to qualified beneficiaries receiving treatment in nonqualified facilities and ambulance transfers were covered by Medicare and Medicaid. *Id.*

189. *Id.*

prioritize disaster response hospitals' requests for accelerated or interim payments.¹⁹⁰ In addition, state professional and facility licensing requirements and some HIPAA rules were waived.

Like government payers, private health insurers took steps to reduce coverage interruption for their enrollees.¹⁹¹ Private health plans extended due dates or granted grace periods for premium payments and waived certain medical and pharmacy refill restrictions. Many plans suspended prior authorization, precertification, referral, or notification requirements for hospital admission. Some companies deemed all physicians caring for affected members as in-network providers regardless of their actual status. Other plans allowed patients early refills of prescription medications and facilitated mail-order refills to replace damaged or lost medications.¹⁹²

Accommodations by public and private insurers partially addressed patients' treatment and access-to-care concerns and providers' emergency response and payment needs. But the measures failed to fully address the health care crisis resulting from Katrina. Storm-damaged facilities and evacuation of health care providers exacerbated existing access-to-care challenges.¹⁹³ Chronic-disease patients could not find providers to provide necessary care, or patients themselves could not be located.¹⁹⁴ Mental health needs rose for victims facing loss of homes, life, property, and employment.¹⁹⁵

For providers, the problems were likewise multifaceted.¹⁹⁶ In addition to damaged facilities and increased patient demand, Katrina had a unique financial impact on health care providers by

190. *Id.*

191. Gloria Gonzalez, *Health Insurers Waive Rules for Katrina Victims*, BUS. INS., Sept. 12, 2005, at 51, available at 2005 WLNR 14499470 (listing insurers providing coverage despite nonpayment).

192. *Id.*

193. KAISER REPORT 7387, *supra* note 4, at 2 ("The capacity of primary care providers to serve low-income populations . . . has been reduced or eliminated.").

194. KAISER REPORT 7538, *supra* note 6, at 7.

195. *See id.* at 9 (describing impact on low-income victims); Berggren & Curiel, *supra* note 4, at 1550 (describing post-Katrina health care infrastructure); Kalb & Murr, *supra* note 4, at 66 (noting region's "nickname: 'the stroke belt'" and describing chronic disease, mental health, and public health needs of Gulf Coast residents).

196. *See* KAISER REPORT 7538, *supra* note 6, *passim* (describing impact on low-income victims of pre-Katrina health and poverty problems, physical damage to health care facilities, staffing shortages, lost medical data, disaster-related health and mental health care needs, and other factors); *see also* KAISER REPORT 7387, *supra* note 4, at 3 (discussing effects of "Big Charity" closing, which "served as the primary safety net hospital for thousands of New Orleans residents," with 51% uninsured and 32% Medicaid patients); *Two New Orleans Hospitals Beyond Help*, *supra* note 3 (reporting that two main public hospitals were damaged beyond repair and will close).

dramatically increasing the level of uninsured patients in the region. Many victims' employers, along with their employer health insurance, were swept away by the flood.¹⁹⁷ The loss of jobs and health insurance increased the numbers of destitute and uninsured people in the Gulf Coast region.¹⁹⁸ Yet some newly uninsured patients retained sufficient assets that prevented them from qualifying for federal health insurance under Medicaid, which has strict income-eligibility limits.¹⁹⁹ Other flood victims were sufficiently destitute to qualify for Medicaid but could not meet residency requirements in the "host" states to which they temporarily migrated.²⁰⁰ The increased level of uninsured patients translates into increased patient-care costs for which hospitals may never receive compensation.

To address those problems, a U.S. Senate bill proposed a five-month disaster relief Medicaid program for all flood victims.²⁰¹ The Emergency Health Care Relief Act of 2005 sought to ensure immediate access to medical care and Medicaid coverage.²⁰² Income, residency, and other eligibility requirements were waived, and other application requirements streamlined and simplified.²⁰³ In addition,

197. See KAISER REPORT 7387, *supra* note 4, at 1 ("An estimated 400,000 jobs have been lost; many of those who lost their jobs have lost not only their source of income but also the health insurance coverage that their former employees offered."); Miller, *supra* note 155 (quoting State Farm employee: "I've had people call and say they're not only homeless, but they're also jobless because the place they worked is just gone.").

198. See Ricardo Alonso-Zaldivar, *A Long Road to Recovery; Shut Out on Healthcare After the Storm*, L.A. TIMES, Oct. 9, 2005, at A1 (discussing paradox of workers losing employer health insurance yet not qualifying for government health care programs, such as Medicaid); Dana P. Goldman & Mark A. Schuster, RAND Corp., *Commentary: Health Costs of Katrina* (Oct. 11, 2005), available at <http://www.rand.org/commentary/101005UPI.html> (noting victims "deprived of paychecks and employer-sponsored health insurance" are "[s]uddenly unable to pay their medical bills"); KAISER REPORT 7387, *supra* note 4, at 1 ("Katrina has raised both the number of people in poverty and the number of uninsured living in the States hit by Katrina as well as in the States of refuge"); *Health Workers Struggle To Meet Needs a Year After Katrina*, *supra* note 182 ("Already home to a large poor and uninsured population before the storm, Hurricane Katrina altered the health care landscape in New Orleans, exacerbating the problem.").

199. See Alonso-Zaldivar, *supra* note 198 ("Under present rules for Katrina victims, if you are destitute, the government will pay your medical bills But if you're an adult who had a job that included health benefits and you lost the job because of the storm, the government can't seem to help.").

200. See Rosenbaum, *supra* note 3, at 438 (describing Medicaid's lack of portability).

201. Emergency Health Care Relief Act of 2005, S. 1716, 109th Cong. (2005); S. Comm. on Fin., Grassley-Baucus Emergency Health Care Relief Package Summary (Sept. 14, 2005), <http://finance.senate.gov/press/Gpress/2005/prg091405asumm.pdf>; see Zwillich, *supra* note 4.

202. See Zwillich, *supra* note 4.

203. See *MH Coalition Supports Health Care Bill for Katrina Survivors*, MENTAL HEALTH WKLY., Sept. 26, 2005, at 1 [hereinafter *MH Support*]; Editorial, *Katrina Care; Speedy Coverage for Evacuees*, MINNEAPOLIS STAR TRIB., Oct. 8, 2005, at 18A

the Federal Government would pick up the entire tab for the special Medicaid coverage, unlike traditional Medicaid, which is jointly funded by states and the Federal Government.²⁰⁴ Similar emergency Medicaid was extended to 9/11 victims.²⁰⁵

The Bush administration, however, implemented an alternative approach, authorizing states in the flood region and neighboring states facing an influx of victims to apply individually for Medicaid waivers.²⁰⁶ The White House opted to negotiate “directly with governors, one state at a time,” believing it more efficient to support the state programs already in place rather than build major new systems.²⁰⁷ Critics suggested that requiring individual negotiations was inefficient and would delay coverage to needy beneficiaries.²⁰⁸ The Medicaid waiver programs eventually allowed displaced and newly uninsured victims of the flood to obtain Medicaid in the states to which they evacuated under streamlined application processes.²⁰⁹ The waivers were temporary and not intended to become a permanent, new federal entitlement.²¹⁰ Six states’ waivers include

[hereinafter Editorial, *Katrina Care*]; Zwillich, *supra* note 4 (quoting Grassley: “You’re entitled to Medicaid regardless of your income Don’t worry about your healthcare.”).

204. Editorial, *Katrina Care*, *supra* note 203 (noting full federal reimbursement to states); *MH Support*, *supra* note 203, at 6 (detailing Grassley proposal to assist Louisiana, Mississippi, and Alabama by paying 100% of Medicaid and State Child Health Insurance Program costs through 2006).

205. See DIXON & STERN, *supra* note 19, at 94–95 (describing disaster relief Medicaid necessitated by damage to New York City’s Medicaid computer system and eligibility records, which program eased eligibility cutoffs); Rosenbaum, *supra* note 16, at 99 (describing post-9/11 emergency health care funding).

206. See Rosenbaum, *supra* note 3, at 439 (describing Bush plan).

207. Editorial, *Katrina Care*, *supra* note 203 (noting that “negotiating waivers state by state is crazy,” time-consuming, “risks wild variation,” and imposes unsustainable costs on states); see also David S. Broder, *Waiting for Action; Right Words but Little Practical Help for Poor*, WASH. POST, Sept. 22, 2005, at A25 (quoting CMS official: “The best and fastest way to provide help to evacuees is to support the state programs in place and support the local health care providers already in place, not to take time to build new systems.”).

208. See Broder, *supra* note 207 (suggesting that “the Bush Administration, rather than backing this simple and effective measure, is insisting on a slower, more cumbersome approach, requiring each state to negotiate its own waiver from the rules limiting eligibility for Medicaid benefits”); Editorial, *Katrina Care*, *supra* note 203 (summarizing Grassley-Baucus bill as “call[ing] for a fast, streamlined application process”).

209. See Press Release, *supra* note 186 (discussing temporary Medicaid and SCHIP eligibility and application); Press Release, U.S. Dep’t of Health & Human Servs., Estimates Show More than 40 Percent of Hurricane Evacuees Now Receiving HHS Benefits or Services (Sept. 29, 2005), available at <http://www.hhs.gov/news/press/2005pres/20050929a.html> (listing states receiving waivers); KAISER REPORT 7420, *supra* note 8, at 1 (describing approved waivers and details of enrollment and coverage).

210. See Editorial, *Katrina Care*, *supra* note 203 (noting that the Grassley-Baucus plan is temporary, suggesting that “[a]nyone can understand the administration’s reluctance to create a big new federal entitlement, especially in the costly field of health care”).

block-grant uncompensated care pools of funds, in addition to temporary Medicaid.²¹¹

Temporary emergency Medicaid was intended to address both the uninsured patient coverage and provider payment problems. Compensation was tied to the patient, rather than paid directly to states or health care providers, leaving providers to track patients' bills and collect Medicaid reimbursement through existing claims-filing procedures.²¹² But details have not been developed regarding funding levels or sources for the pools or methodologies for prioritizing or paying providers.²¹³

The Nation remains unprepared to respond to a major disaster, as evidenced by post-9/11 reports and drills, and, most saliently, actual experience with Hurricane Katrina. It is difficult to predict the timing, nature, and impact of the next major catastrophe. But the dire threat to the health care infrastructure in the aftermath of a large-scale disaster calls for anticipatory planning. To that end, this Article proposes a government relief program that assures short-term cash assistance and long-term financial stability to emergency medical care providers.

III. DESIGNING THE SOLUTION

To develop a proposed hospital disaster relief plan, this Part considers four pieces of legislation that addressed similar industry insolvency, disaster relief, or compensation concerns. First, the package of financial assistance and loan guarantees to airlines following September 11 is a useful model of immediate cash grants

211. KAISER REPORT 7420, *supra* note 8, at 2 (noting that pool funds are available for expenses incurred between August 24, 2005, and January 31, 2006).

212. *See* KAISER REPORT 7387, *supra* note 4, at 7 (advocating temporary Medicaid because funds “follow the person” and such an approach is “the most accurate mechanism for targeting federal assistance to the areas, providers, and low-income individuals who most need it”); Rosenbaum, *supra* note 3, at 437–38 (noting that “[f]or decades the Gulf Region population has lived daily with the consequences of the nation’s gap-ridden approach to health care financing” and “[d]espite Medicaid’s strengths, it lacks Medicare’s nationwide, uniform coverage potential and interstate portability”).

213. *See* KAISER REPORT 7420, *supra* note 8, at 2 (noting that “critical components,” including funding and payment mechanisms for uncompensated care pools, are not specified); Editorial, *Health Care for Katrina Victims*, N.Y. TIMES, Oct. 4, 2005, at A26 (“The White House has said it will reimburse health care providers who treat victims who are not covered by Medicaid. But it has not said how much the payments would be or how providers could access the so-called uncompensated care fund.”); *see also* Berggren & Curiel, *supra* note 4, at 1550 (quoting New Orleans Oschner Clinic CEO, when asked what government had contributed: “Nothing. We have asked and asked [authorities] for fair compensation, and perhaps we will get it eventually, but we cannot go on indefinitely providing uncompensated care.”).

effectively stabilizing a vulnerable, essential industry.²¹⁴ The second model is the 9/11 Victims' Compensation Fund ("VCF"), which replaced traditional tort liability with a no-fault administrative compensation scheme.²¹⁵ A third useful example is the Medicare Modernization Act's provision for paying hospitals for emergency care to undocumented immigrants.²¹⁶ Finally, useful lessons emerge from the Terrorism Risk Insurance Act ("TRIA"), which establishes a government reinsurance program for property and casualty insurers.²¹⁷

A. *Air Transportation Safety and System Stabilization Act*

Within days of the 9/11 attacks on the Pentagon and World Trade Center, Congress passed the Air Transportation Safety and System Stabilization Act ("ATSSSA"),²¹⁸ providing financial assistance to the entire airline industry and shielding the airlines used in the hijackings from tort liability arising out of the episode.²¹⁹ There is precedent for the Federal Government bailing out major, single companies on the brink of bankruptcy.²²⁰ But the ATSSSA was unprecedented in two ways. First, the government promised assistance in anticipation of financial distress, even before airlines faced insolvency. Second, government assistance was extended to an entire industry, not just a single troubled company.²²¹

214. See *infra* Part III.A.

215. See *infra* Part III.B.

216. See *infra* Part III.C.

217. TRIA is analytically distinct from the other three models in that it does not compensate or reimburse insurers for costs resulting from a disaster that has already struck. Instead it provides a government backstop to insurance industry exposure in the next catastrophe. Accordingly, insurers are better able to manage risks and continue providing coverage for terrorism, without fearing massive, unpredictable exposure. Likewise, the plan proposed in this Article would assure hospitals before the next episode that they would not be left holding the entire bag of disaster response costs, ensuring their continued operations.

218. Air Transportation Safety and System Stabilization Act of 2001, Pub. L. No. 107-42, 115 Stat. 230 (2001) (codified at 49 U.S.C. § 40101 note (Supp. II 2002)).

219. Air Transportation Safety and System Stabilization Act §§ 101, 408. Airline industry lobbyists initially sought a broad package of legislation, including immunity from liability, low-interest loans, antitrust relief, additional compensation for Department of Defense contracts, and fuel tax relief. See Robert S. Peck, *Victim Compensation Fund: Born from a Unique Confluence of Events Not Likely To Be Duplicated*, 53 DEPAUL L. REV. 209, 216 (2003).

220. See Margaret M. Blair, *The Economics of Post-September 11 Financial Aid to Airlines*, 36 IND. L. REV. 367, 382-84 (2003) (comparing ATSSSA to Chrysler bailout).

221. See *id.* at 369-70 (listing prior bail-outs, including Lockheed, Chrysler, Continental-Illinois Bank, Amtrak, the savings and loan industry, and long-term capital markets).

The ATSSSA package included \$10 billion in federal loan guarantees and \$5 billion in direct compensation to stabilize the already struggling U.S. airline industry.²²² For three days following the September 11 attacks, the government closed U.S. airspace and grounded all flights, resulting in considerable loss of revenue. In subsequent months, business and vacation travel remained slow because of travelers' fears and alternative travel arrangements.²²³ Also, the increased airport security and passenger screening costs fell heavily on airlines.²²⁴ The Iraqi war further exacerbated the industry's crisis, with passenger bookings in early 2003 down twenty to thirty percent from the previous year.²²⁵

The first line of ATSSSA support to the battered airline industry was cash payouts. Those payments were made quickly and generously to offset losses and prevent the collapse of air travel.²²⁶ Immediate, post-disaster cash infusion to hospitals likewise would ensure that the emergency health care system remains operational and able to respond to victims' urgent medical needs.

The second line of ATSSSA support was government loan support to ensure long-term stability. Airlines found that part of the relief package much less accessible and harder to qualify for than the cash grants. To access government loans, airlines had to meet several

222. See Air Transportation Safety and System Stabilization Act § 101(a) (loan assistance and direct compensation provisions); see also DIXON & STERN, *supra* note 19, at 119–21 (describing post-9/11 airline loans and grants); Peck, *supra* note 219, at 216 & n.42 (identifying rising oil prices and declining business travel as contributing factors to “worst losses in a decade” (quoting Marilyn Adams, *Airlines Edge Near Bankruptcy, Cut Flights*, USA TODAY, Sept. 17, 2001, at B1)); Scott McCartney et al., *As War Deepens Airline Crisis, a Split over Federal Rescue Plan*, WALL ST. J., Mar. 24, 2003, at A1 (identifying labor costs and noting that “[t]he industry, already swimming in red ink, fears losses will widen by \$10 billion this year because of the war”).

223. See Peck, *supra* note 219, at 216 (suggesting that holiday travelers avoided flying and businesses used video conferencing); see also Richard P. Campbell, *The September 11th Attack on America: Ground Zero in Tort and Insurance*, 9 CONN. INS. L.J. 51, 53 (2002) (“Without passengers and cash flows, the resultant dislocations from the attack credibly threatened to bring the entire commercial airline industry down in an apocalyptic crash like the four aircraft that disintegrated in New York, Washington and Pennsylvania.”).

224. See Amy Schatz & Susan Carey, *Airlines Take Their Problems to Congress*, WALL ST. J., June 3, 2004, at B2 (discussing airlines' share of passenger screening costs and inability to pass costs onto passengers due to fervent price competition).

225. See McCartney et al., *supra* note 222.

226. See Blair, *supra* note 220, at 380 (reporting that government paid over \$2 billion to ten largest airlines within twenty days of attacks and \$3 billion additional over next few months); see also *id.* at 379 (noting that air travel was halted entirely for only four days but resumed very gradually, with domestic travel down thirty-four percent by end of September 2001).

prerequisites: substantial importance to the air transportation system, necessity of financial support to remain operational,²²⁷ a viable business plan,²²⁸ inability to obtain commercial credit,²²⁹ and losses caused directly by the September 11 attacks.²³⁰ In essence, the airline had to be “sick” enough to not qualify for commercial loans but “well” enough to remain a going concern after government support. After witnessing the hurdles that some of the first applicants faced, only a handful of small carriers even bothered to apply. The few airlines that managed to navigate the application process received assistance only after substantial concessions.²³¹ Ultimately, only \$1.5 billion of the \$10 billion appropriation was tapped.²³² One lesson to be drawn from the ATSSSA for a proposed hospital relief program is that an overly arduous application process and administrative or claims-filing burdens could threaten the effectiveness of the entire program.

227. See Air Transportation Safety and System Stabilization, Pub. L. No 107-42, § 102(c)(1)(C), 115 Stat. 230, 231 (2001) (codified at 49 U.S.C. § 40101 note (Supp. II 2002)) (requiring that “such agreement is a necessary part of maintaining a safe, efficient, and viable commercial aviation system in the United States”).

228. Blair, *supra* note 220, at 385–86 (suggesting that America West’s “precarious financial position” made it more difficult to receive financial aid under the ATSSSA and quoting airline representative: “The message was: You need to prove you have a viable business plan and need to be willing to pay taxpayers for the risk they are taking.”); see also Schatz & Carey, *supra* note 224 (discussing Frontier Airline’s financial situation post-9/11).

229. See Air Transportation Safety and System Stabilization Act § 102(c)(1)(A) (requiring that “obligor is an air carrier for which credit is not reasonably available”).

230. See *id.* § 101(a) (listing actions President shall take “to compensate air carriers for losses incurred by the air carriers as a result of the terrorist attacks on the United States that occurred on September 11, 2001”); see also Schatz & Carey, *supra* note 224 (discussing factors for federal loan backing).

231. See Blair, *supra* note 220, at 385 (listing America West, Frontier, Vanguard, and Spirit as applicants and detailing America West’s concessions, including reducing \$400 million request by \$20 million, granting compensation in form of common stock to government and vendors, and instituting labor cost controls, payment schedules, and executive compensation limits); Schatz & Carey, *supra* note 224 (on Frontier and America West approvals).

232. See Blair, *supra* note 220, at 384–87 (recounting America West’s arduous path and noting that other airline companies watched as a “rough guide” and “[didn’t] like what they saw” (quoting Micheline Maynard, *Airlines Shy Away from Loan Guarantees by U.S.*, N.Y. TIMES, Jan. 3, 2002, at C1)); see also Susan Carey et al., *UAL Again Fails To Get Loan Aid, Hurting Airline’s Chapter 11 Plan*, WALL ST. J., June 29, 2004, at A3 (noting that United’s third denial “effectively closes the book on the loan-guarantee program” after only \$1.56 billion was paid out).

B. Victims' Compensation Fund

In addition to the cash and loan support, the ATSSSA also provided relief to the airline industry through the Victims' Compensation Fund ("VCF" or "the Fund").²³³ Airlines feared that their already precarious financial stakes would be toppled by civil liability for the massive loss of life, personal injury, and property damage resulting from the hijackings.²³⁴ Trial lawyers eventually called a moratorium on all 9/11-related lawsuits.²³⁵ But the potential exposure was massive and real.²³⁶ The VCF shielded airlines from private lawsuits while providing government compensation to victims for physical injury or death resulting from the terrorist attacks.²³⁷

The VCF was unique among government compensation schemes for mass torts, natural disasters, or similar episodes because payments were made directly to victims by the Federal Government, rather than as grants to states to be distributed to victims by the state. The

233. See Air Transportation Safety and System Stabilization Act §§ 401–407; Peck, *supra* note 219, at 217 (noting plaintiffs' lawyers' urging that victim compensation "had to be a part of any relief package Congress might enact for the airlines"); see also DIXON & STERN, *supra* note 19, at 20–21 (describing political backdrop for VCF provision of ATSSSA); Elizabeth M. Schneider, *Grief, Procedure, and Justice: The September 11th Victim Compensation Fund*, 53 DEPAUL L. REV. 457, 460 (2003) (discussing impetus for victims compensation); Georgene Vairo, *Remedies for Victims of Terrorism*, 35 LOYOLA L.A. L. REV. 1265 (2002).

234. See Peck, *supra* note 219, at 214 (noting some victims' families immediately sought legal representation for claims based on airline security or safety lapses that allowed hijackers to commandeer aircraft); see also Josh Romero, *A Victim's Eye View of the September 11th Victim Compensation Fund*, 71 DEF. COUNS. J. 64, 66–67 (2004) (noting victims could prevail on negligence theory that airline failed to take adequate measures to prevent hijackers from boarding or provoked them once on board); Jack B. Weinstein, *Compensation for Mass Private Delicts: Evolving Roles of Administrative, Criminal and Tort Law*, 2001 U. ILL. L. REV. 947, 955 (suggesting that Congress enacted ATSSSA in response to "likelihood of tens of thousands of suits in state and federal court with tens of billions of dollars in potential recoveries").

235. See Peck *supra* note 219, at 214–15 (citing statements by Association of Trial Lawyers of America); see also Campbell, *supra* note 223, at 56 & n.13 (quoting the President of the Association of Trial Lawyers: "After all, 9/11 was a mass murder, not a mass tort.").

236. By July 2004, 450 families filed notices of intent to sue. See DIXON & STERN, *supra* note 19, at 19.

237. See *id.* at 20–21 ("The program was the result of a political compromise that balanced aid to victims with billions in aid to the airlines and set up a quid pro quo for the liability restrictions."); Romero, *supra* note 234, at 64; Schneider, *supra* note 233, at 460 (summarizing ATSSSA as limiting exposure of airlines in civil litigation and providing no-fault alternative to litigation for victims); Hillel Sommer, *Providing Compensation for Harm Caused by Terrorism: Lessons Learned in the Israeli Experience*, 36 IND. L. REV. 335, 352 (2003) (comparing Israeli terrorism compensation scheme as "primarily intended to compensate the victims" to VCF scheme as "primarily intended . . . to defend the two major airlines involved in the 9/11 events from lawsuits by victims and their families").

VCF was criticized, on the one hand, for treating all victims as the same, by calculating damages from presumed amounts within fixed parameters. On the other hand, the Fund seemed to treat victims unfairly by allowing certain individual adjustments such as lost earnings. The general approach to compensating victims was to replace the time-consuming disputes over and damages characteristic of civil litigation with less than perfect but assured compensation. Despite the criticism, the “rough justice” approach is a useful approach to efficiently and fairly process a high volume of claims and protect a key industry from insolvency. Accordingly, the VCF analogy to hospitals is apt.

Under the VCF, 9/11 victims and their survivors had two options for recovery: private litigation with caps on recovery or Fund compensation. Under the first option, the ATSSSA created an exclusive federal cause of action for all injuries “arising out of the hijacking and subsequent crashes” of September 11.²³⁸ Jurisdiction for those lawsuits was vested in the Southern District of New York, and choice of law principles from the state in which the crash occurred applied.²³⁹ Victims who chose litigation would bring a traditional civil lawsuit and bear the burden of proving all elements of the claim against the airline. Recovery in any civil lawsuit was capped at the defendant-airline’s pre-9/11 liability insurance limit.²⁴⁰

Under the second option, victims could forfeit all rights to recover in tort against the airlines and receive Fund compensation instead.²⁴¹ Fund claimants were not required to prove fault by the airline.²⁴² They merely had to state the “factual basis for eligibility for compensation” and provide support for damages by describing physical harm suffered and identifying economic and noneconomic losses.²⁴³ Unlike under traditional tort principles, victims’ collateral sources of compensation, such as private insurance, death benefits, and pension funds, were applied to offset the Fund compensation

238. Air Transportation Safety and System Stabilization Act § 408(b)(1).

239. *Id.* § 408(b)(2)–(3).

240. *See id.* § 408(a) (“liability for all claims, whether compensatory or punitive damages, arising from the terrorist-related aircraft crashes of September 11, 2002, against any carrier shall not be in an amount greater than the limits of the liability coverage maintained by the air carrier”).

241. *See id.* § 405(c)(3)(B)(i) (by submitting claim under this title, claimant waives right to file civil action in any federal or state court for 9/11-related damages).

242. *See id.* § 405(b)(2) (“With respect to a claimant, the Special Master shall not consider negligence or any other theory of liability.”).

243. *See id.* § 405(a) (requiring Special Master to develop claims form and listing information required to be submitted by claimant).

award.²⁴⁴ A two-year statute of limitations applied to all VCF claims.²⁴⁵ The civil liability waiver did not extend to suits against the hijackers, terrorists, their estates, or any conspirators.²⁴⁶

Under the VCF, the minimum total compensation per victim, including economic and noneconomic damages, before collateral source offsets, was \$500,000 for a victim with a surviving spouse or dependent, or \$300,000 for a single victim with no dependents.²⁴⁷ Economic loss awards were calculated based on individual characteristics of the victim and the claimants, similar to damages calculations in traditional tort suits.²⁴⁸ Specifically, the special master could consider the victim's age, life expectancy, marital status, number of dependents, lost earnings, and medical costs and then applied those factors to the presumed damages to calculate the award.²⁴⁹ The VCF's reliance on individualized factors to determine economic loss awards drew criticism because younger or higher-earning victims received larger awards than older or lower-income victims who suffered though the same disaster.²⁵⁰ Variability of

244. *Id.* § 405(b)(6); see Kenneth P. Nolan & Jeanne M O'Grady, *The Victim Compensation Fund—Looking A Gift Horse in the Mouth*, 53 DEPAUL L. REV. 231, 245–46 (2003) (describing collateral source offset as “the most controversial aspect of the [VCF] program, and the most damaging to potential claimants”); see also 28 C.F.R. § 104.47 (2006) (listing life insurance, pension funds, death benefits, and other government payments as collateral sources). See generally MARSHALL S. SHAPO, PRINCIPLES OF TORT LAW 407–08 (2003) (defining collateral source rule, under which “courts have refused to permit a defendant to subtract from a damages award payments that a plaintiff received from third parties”).

245. See Air Transportation Safety and System Stabilization § 405(a)(3) (providing two-year statute of limitations from date of final implementing regulations). The statute of limitations provision also was criticized because it could preclude latent injury claims, such as exposure to toxic substances. See Graham Rayman & Nia-Malika Henderson, *Controversies Persist; All Not Over for 9/11 Fund*, NEWSDAY, June 17, 2004, at A4 (quoting firefighters' attorney seeking compensation for latent respiratory disease: “Nobody told their lungs to show symptoms of disabling asthma by Dec. 22.”).

246. See Air Transportation Safety and System Stabilization § 408(c) (“Nothing in this section shall in any way limit any liability of any person who is a knowing participant in any conspiracy to hijack any aircraft or commit any terrorist act.”); see also Nolan & O'Grady, *supra* note 244, at 235–36 (summarizing same).

247. See 28 C.F.R. § 104.41 (2005) (establishing minimum compensation levels).

248. See September 11th Victim Compensation Fund of 2001, 67 Fed. Reg. 11,233 (Mar. 13, 2002) (codified at 28 C.F.R. pt. 104); 28 C.F.R. § 104.43 (2005) (listing factors); U.S. Dep't of Justice, Explanation of Process for Computing Presumed Economic Loss (Aug. 27, 2002), http://www.usdoj.gov/archive/victimcompensation/vc_matrices.pdf.

249. See September 11th Victim Compensation Fund of 2001, 67 Fed. Reg. 11,233 (Mar. 13, 2002) (codified at 28 C.F.R. pt. 104); 28 C.F.R. § 104.43 (2005) (listing factors); U.S. Dep't of Justice, Explanation of Process for Computing Presumed Economic Loss (Aug. 27, 2002), http://www.usdoj.gov/archive/victimcompensation/vc_matrices.pdf.

250. See DIXON & STERN, *supra* note 19, at 31–33 (discussing equities of individually evaluating economic loss for victims); Nolan & O'Grady, *supra* note 244, at 240–41

awards seemed unfair to some, especially because the government, rather than the purported tortfeasor, was providing the compensation. It seemed only fair that a no-fault compensation program, funded with taxpayer dollars, should treat all victims the same.

Other rules on Fund compensation restricted victims' recovery. Economic loss was limited to the types and categories of damages that would be compensable under applicable state law in a civil tort suit.²⁵¹ Noneconomic loss compensation was a presumed, fixed amount, not individualized to victims or claimants.²⁵² The presumed noneconomic damages amount was \$250,000 for decedents, plus \$100,000 for the spouse and each dependent, with applicable deductions for collateral sources of compensation.²⁵³

By the special master's account, the VCF was a success of both administrative efficiency and victim compensation. The deadline for submitting claims was December 22, 2003. By that date, 98 percent of eligible claimants had elected Fund compensation over private litigation.²⁵⁴ Fewer than 100 families opted out of the VCF and proceeded with private lawsuits against airlines and other defendants.²⁵⁵ The Fund was shut down on schedule, on June 15, 2004, with all claims paid or authorized for payment within twenty days of shutdown.²⁵⁶ Over 7,300 claims, totaling \$7.1 billion, were

(discussing Cantor Fitzgerald families' compensation and special master's individual determinations).

251. See Air Transportation Safety and System Stabilization Act, Pub. L. No. 107-42, § 402(b), 115 Stat. 230, 237 (2001) (authorizing economic recovery "to the extent recovery for such loss is allowed under applicable State law"); 28 C.F.R. § 104.42 (2005) (interpreting statute as not permitting compensation for "those categories or types of economic losses that would not be compensable under the law of the state that would be applicable to any tort claims brought by or on behalf of the victim").

252. See 28 C.F.R. § 104.44 (2005).

253. See *id.* (presumed noneconomic losses); see also DIXON & STERN, *supra* note 19, at 34-35 (regarding whether presumed damages were adequate).

254. See U.S. Dep't of Justice, Closing Statement from the Special Master, Mr. Kenneth R. Feinberg, on the Shutdown of September 11th Victim Compensation Fund, <http://www.usdoj.gov/archive/victimcompensation/closingstatement.pdf> (last visited Nov. 26, 2006) [hereinafter Closing Statement].

255. See Douglas McLeod, *September 11 Compensation Fund Closes; Fewer than 100 Suits To Proceed*, BUS. INS., June 21, 2004, at 3, available at 2004 WLNR 1765921 (noting that fewer than 100 civil lawsuits against the World Trade Center's owner, airlines, and other defendants went forward after 9/11 fund closed); see also *Court Partially Grants, Partially Denies Dismissal of Suits Arising from Terrorist Aircraft Crashes*, N.Y. L.J., June 21, 2004, at 17 (reporting some plaintiffs waived right to civil suits by not timely withdrawing VCF claims while others were timely withdrawn and proceeded as lawsuits).

256. Closing Statement *supra*, note 254.

processed by the VCF.²⁵⁷ Individual awards ranged from \$250,000 to \$7.1 million.²⁵⁸ Despite the criticism, the VCF scheme, including direct compensation and the “rough justice” approach, provides useful models for a proposed hospital disaster relief plan.

C. Medicare Modernization Act Section 1011

EMTALA’s “unfunded mandate” is particularly burdensome on hospitals that treat high numbers of undocumented aliens. For example, California hospitals provided an estimated \$500 million in emergency care to undocumented immigrants. Arizona hospitals spent an estimated \$91 million for emergency services to undocumented immigrants.²⁵⁹ Nonlegal residents typically do not qualify for coverage through employer health plans or most government health care programs.²⁶⁰ Estimating the proportion of services provided to undocumented aliens is difficult because hospitals do not routinely ask patients’ immigration status and undocumented aliens may be reluctant to self-identify.²⁶¹

Until passage of section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“Medicare Modernization Act” or “MMA”),²⁶² hospitals looked to three

257. *See id.*

258. *See* McLeod, *supra* note 255 (citing statistics).

259. *See* Nathanael J. Scheer, Note, *Keeping the Promise: Financing EMTALA’s Guarantee of Emergency Medical Care for Undocumented Aliens in Arizona*, 35 ARIZ. ST. L.J. 1413, 1422–24 (2003) (citing United States/Mexico Border Countries Coalition study).

260. *See* 8 U.S.C. § 1611(a) (2000); *see also* Kaiser Comm’n on Medicaid & the Uninsured, Kaiser Family Foundation, *Immigrants’ Health Care Coverage and Access 1–2* (Mar. 2001), available at <http://www.kff.org/medicaid/upload/Fact-Sheet-Immigrants-Health-Care-Coverage-and-Access.pdf> (discussing immigrants’ disproportionate lack of health coverage). *But see* 8 U.S.C. § 1611(b)(1)(A) (2000) (providing Medicaid benefits for care and services necessary for treatment of emergency medical conditions).

261. *See* U.S. GEN. ACCOUNTING OFFICE, *UNDOCUMENTED ALIENS: QUESTIONS PERSIST ABOUT THEIR IMPACT ON HOSPITALS’ UNCOMPENSATED CARE COSTS 3* (2004) [hereinafter *UNDOCUMENTED ALIENS*], available at <http://www.gao.gov/new.items/d04472.pdf> (discussing lack of reliable data); Frederick Isasi, *New Source of Federal Funds for Emergency Care Presents Novel Challenges to Providers*, J. HEALTH CARE COMPLIANCE, Sept.–Oct. 2005, at 25, 25–26 (discussing difficulty estimating costs but reporting “that they have increased steadily over the last decades and may run into the billions of dollars each year”); *cf.* JOHN HOLAHAN & ALLISON COOK, KAISER FAMILY FOUND. REPORT, NO. 7411, *ARE IMMIGRANTS RESPONSIBLE FOR MOST OF THE GROWTH OF THE UNINSURED?* 9, available at <http://www.kff.org/uninsured/upload/Are-Immigrants-Responsible-for-Most-of-the-Growth-of-the-Uninsured-issue-brief.pdf> (concluding that immigration trends are not responsible for increased uninsured in U.S.).

262. Pub. L. No. 108-173, § 1011(a)(1), 117 Stat. 2066, 2432–35 (2003) (codified at 42 U.S.C. § 1395dd (Supp. III 2003)). The MMA attracted considerable attention for certain major revisions to the Medicare program, including prescription drug coverage (“Medicare Part D”) and beneficiary health plan choice. *See* Press Release, Ctrs. for

principal sources of federal funding to cover the costs of caring for undocumented aliens.²⁶³ First, undocumented immigrants with serious medical conditions may qualify for short-term, emergency Medicaid.²⁶⁴ Second, the federal disproportionate share hospital (“DSH”) program provides supplemental payments to hospitals that treat a disproportionate share of low-income patients.²⁶⁵ Finally, the Balanced Budget Act of 1997 provided \$25 million annually to be distributed among the twelve states with the highest shares of undocumented aliens to cover emergency care costs of patients who are not eligible for Medicaid under state requirements.²⁶⁶

Section 1011 appropriated \$1 billion over three years to compensate hospitals and other providers for the costs of emergency services provided to undocumented and certain other aliens, based on Immigration and Naturalization Service (“INS”) statistics.²⁶⁷ The total \$1 billion was divided into \$25 million allotments for years 2005 through 2008. Two-thirds of the money was divided proportionately among all fifty states and the District of Columbia based on relative percentages of undocumented aliens. The remaining one-third was divided among the six states with the highest proportion of

Medicare & Medicaid Servs., U.S. Dep’t of Health & Human Servs., Proposed Regulations to Implement the New Medicare Law: The Next Step Toward Prescription Drug Coverage, Better Benefits and Lower Costs for Medicare Beneficiaries (July 26, 2004), available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1129> (summarizing MMA and implementing regulations).

263. See UNDOCUMENTED ALIENS, *supra* note 261, at 3; Scheer, *supra* note 259, at 1422–24.

264. See 42 U.S.C. § 1396b(v)(2)(A) (2000) (regarding reimbursement for “emergency medical condition”); see, e.g., Utah Dep’t of Health, Emergency Medicaid Services (2004) (brochure), available at <http://health.utah.gov/eol/forms/pdffiles/pm921.pdf>; S.C. Appleseed Legal Justice Ctr., Emergency Medicaid for Immigrants (brochure), available at <http://www.scjustice.org/pdfs/Emergency%20Medicaid%20brochure.pdf>.

265. 42 U.S.C. § 1396r-4 (2000 & Supp. III 2003).

266. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4723(a), 111 Stat. 251, 515 (“for each of the 4 consecutive fiscal years (beginning with fiscal year 1998) \$25,000,000 for payments to certain states”); Press Release, Ctrs. for Medicare and Medicaid Servs., U.S. Dep’t of Health & Human Servs., CMS Implements \$1 Billion Program To Help Hospitals, Others Recoup Unpaid Emergency Room Costs (July 22, 2004), available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1123> (announcing “new program to support all aspects of emergency treatment—including hospital, physician, and ambulance services—that have been strained by providing uncompensated care for undocumented immigrants”); see also Scheer, *supra* note 259, at 1422–23 (citing border state study on emergency care costs).

267. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173 § 1011(a)(1), 117 Stat. 2066, 2432 (2003) (codified at 42 U.S.C. § 1395dd (Supp. III 2003)).

undocumented aliens.²⁶⁸ The legislation authorized CMS to establish the payment methodology and other implementing regulations for section 1011.²⁶⁹

CMS defined the term “alien” to include undocumented and certain other immigrants entering the United States under special visa categories.²⁷⁰ Various issues arose regarding how hospitals would determine patient eligibility and immigration status without violating other federal statutes and discouraging necessary medical care.²⁷¹ CMS initially proposed that providers make a good faith effort to verify citizenship status for section 1011 payment purposes.²⁷² That provision drew sharp criticism because it would have imposed excessive administrative burdens on hospitals and discouraged patients from seeking medical treatment.²⁷³ CMS initially insisted that documentation was necessary to ensure that section 1011 compensation was provided consistently with the statutory purpose.²⁷⁴ The Agency reminded providers that under EMTALA they could not

268. See Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget, 70 Fed. Reg. 25,578, 25,578 (U.S. Dep’t of Health & Human Servs. May 13, 2005).

269. See Medicare Prescription Drug, Improvement and Modernization Act § 1011(c)(2)(A)(ii) (regarding payment determinations and authority to establish different methodologies for different providers); see also § 1011(d)(1)(B) (requiring Secretary “to ensure that inappropriate, excessive, or fraudulent payments are not made from the allotments”). CMS published the proposed implementation approach and solicited public input through written comments and two live, open-door forums. See Ctrs. for Medicare & Medicaid Servs., U.S. Dept. of Health & Human Servs., Proposed Implementation Approach: Federal Funding of Emergency Health Services to Undocumented Aliens: Federal Fiscal Years 2005 Through 2008 (July 21, 2004) [hereinafter Proposed Implementation], available at http://www.nilc.org/immspbs/health/Issue_Briefs/Sec1011_Reimbrsmnt.pdf. CMS then sought emergency review and approval in compliance with statutory timeframes. See Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget, 70 Fed. Reg. at 25,578.

270. See Proposed Implementation, *supra* note 269, at 9 (including those authorized to enter for medical services and “laser visas”); see also 8 U.S.C. § 1011(a)(6) (2000).

271. See Mary Beth Sheridan, *Hospitals Won’t Have To Ask Immigrant Status*, WASH. POST., Oct. 5, 2004, at B3.

272. See Proposed Implementation, *supra* note 269, at 17–18 (proposing “patient based documentation approach” and asking providers “to make a good faith effort to obtain citizenship information”). Patient information requests could also implicate HIPAA.

273. *But see id.* at 18 (rejecting view that request “could inappropriately discourage persons from seeking needed emergency medical services” and suggesting that paperwork burden “is minimal”).

274. See *id.* at 17 (stating that “section 1011 funds are limited” and noting importance of ensuring that funds are used for purpose authorized by the statute).

delay treatment to inquire about citizenship status or otherwise discriminate against patients based on citizenship status.²⁷⁵

But CMS later softened its stance and proposed a method for determining a patient's eligibility for section 1011 coverage through "indirect documentation."²⁷⁶ Hospitals may inquire about a patient's eligibility at discharge but only after the patient is identified as self-pay or Medicaid-eligible. If a patient provides a border-crossing card or other eligible visa, a copy of that documentation may be submitted. Otherwise, documentation based on a foreign place of birth plus additional verification, such as a foreign birth certificate, voting card, passport, driver's license, or other identification card could be used. Other acceptable documentation includes an expired visa, invalid border crossing card, or invalid U.S. Social Security number.²⁷⁷

Various health care providers, including hospitals, physicians, and ambulances, may qualify for compensation under section 1011. Hospitals' EMTALA-required screening and stabilization treatment is covered along with, in some cases, inpatient or outpatient services beyond the emergency room. Section 1011 payment eligibility begins when the EMTALA duty begins, or when a patient presents at the emergency room or other defined areas requesting emergency care.²⁷⁸ If an undocumented alien requires inpatient admission to stabilize the emergency medical condition, those additional services are covered, but only to the extent necessary for stabilization. Ongoing treatment for any underlying condition is not covered.²⁷⁹ CMS "presumes" that stabilization will occur within two days following the emergency room

275. See *id.* (suggesting that documentation could be obtained consistent with EMTALA requirements).

276. See Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget, 70 Fed. Reg. 25,587, 25,587 (May 13, 2005) (recognizing the burdens of verifying documentation and that "asking a patient to state that he or she is an undocumented alien in an emergency room setting may deter some patients from seeking needed care").

277. See *id.* at 25,586-87 (describing indirect patient-based documentation approach and acceptable verification methods); Ctrs. for Medicaid & Medicare Servs., U.S. Dep't of Health & Human Servs., Form CMS 10130A Section 1011 Provider Payment Determination 2 (Jan. 2006), available at <http://www.CMS.hhs.gov/cmsforms/downloads/cms10130a.pdf> ("A provider should not ask a patient if he or she is an undocumented alien. However, if a patient voluntarily informs you that he or she is, [then section 1011 payment is available].").

278. See Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget, 70 Fed. Reg. at 25,583 ("For hospital services, we are adopting a position that payment will be made for covered services that would begin when the hospital's EMTALA obligation begins.").

279. See *id.* ("To be considered stable, a patient's emergency medical condition must be resolved, even though the underlying medical condition may persist.").

visit and may review all claims extending beyond two days of inpatient care.²⁸⁰ Similarly, outpatient treatment deemed necessary for stabilization, such as setting a broken bone or providing sutures, performed in a hospital outpatient department is covered. Physician services after discharge are not covered, even if the services are followup or related to the original emergency.²⁸¹ Medically necessary ambulance transports, including transfers, are covered.²⁸²

To qualify for section 1011 reimbursement, Medicare-participating hospitals and other providers may submit abbreviated applications.²⁸³ Non-Medicare providers are not required to enroll fully in Medicare to receive section 1011 payments but must complete the Medicare enrollment application and meet Medicare COPs.²⁸⁴ In addition, providers must attempt to collect payment from all other available payment sources, including private insurance, other government health care programs, and patients before claiming section 1011 reimbursement.²⁸⁵ Any section 1011 overpayments must be refunded if compensation from other sources is later received.²⁸⁶ Traditionally Medicare rules prohibit hospitals from “balance-billing,” or requesting additional payment from patients above the Medicare-approved amount. The balance-billing prohibition is

280. *Id.* (stating that “we believe that most patients are stabilized within 2 calendar days” and announcing plan “to review inpatient admissions that go beyond 2 calendar days”).

281. *Id.* at 25,584 (discussing coverage for outpatient and physician services).

282. *See id.* at 25,584 (describing coverage for ambulance services). The proposed methodology covered all inpatient and outpatient treatment, as well as treatment “related” to the emergency medical condition. *See Proposed Implementation, supra* note 269, at 9–10 (interpreting “related” treatment more broadly than emergency clearance).

283. *See Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget*, 70 Fed. Reg. at 25,584–85 (describing enrollment process).

284. *Id.* at 25,585 (describing process for non-Medicare providers). CMS relied on the existing Medicare application process to facilitate electronic claims payment and reduce fraud and abuse. *See Proposed Implementation, supra* note 269, at 12–14; *see also Privacy Act of 1974: Report of a New System of Records*, 70 Fed. Reg. 45,397, 45,397–98 (U.S. Dep’t of Health & Human Servs. Aug. 5, 2005).

285. *See Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget*, 70 Fed. Reg. at 25,585–86 (“adopting a position that each provider seek reimbursement from all available funding sources”); *see also Proposed Implementation, supra* note 269, at 14–15 (discussing reimbursement from other payers). Grants and gifts to hospitals do not affect section 1011 reimbursement. *Id.*

286. *See Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget*, 70 Fed. Reg. at 25,586 (stating that “if a hospital or other provider receives a payment from a third-party payer subsequent to a section 1011 payment[,]” the provider must notify CMS and “overpayment may occur”).

designed to avoid creating inequities among Medicare beneficiaries.²⁸⁷ Under section 1011, by contrast, the legislation requires hospitals to collect payment from other available sources, including patients, contrary to the traditional balance prohibition. The change from the otherwise applicable Medicare reimbursement rule is consistent with the objective of section 1011 as a government compensation fund for truly uncompensated, “free” care provided to undocumented immigrants.²⁸⁸ A similar “payer of last resort” approach would be appropriate for a government compensation fund for care provided to disaster victims.

With respect to the payment methodology, section 1011 generally follows the Medicare methodology to calculate payment.²⁸⁹ CMS elected to use the Medicare payment methodology, tying funding to specific patients, rather than extending lump-sum payments to hospitals, similar to DSH funds. Accordingly, providers must submit claims following the intricate hospital, physician, ambulance, and other payment methodologies and fee schedules to recover section 1011 reimbursement.²⁹⁰ The traditional Medicare reimbursement methodology may be workable for section 1011 but is not appropriate for catastrophe scenarios involving a sudden demand surge for emergency medical services. The expected patient demand and related administrative burdens for section 1011 hospitals likely would be steady and routine, similar to normal patient flow. By contrast, hospitals responding to a major disaster would face a sudden, unprecedented demand surge and related difficulty filing timely and accurate claims for payment. The extraordinary number of claims would quickly overwhelm government and private contractor claims processors, resulting in payment delays and

287. *See id.* at 25,585 (allowing providers to balance-bill eligible self-pay patients “for the appropriate costs after a section 1011 payment has been made”); HALL ET AL., *supra* note 36, at 921–22 (comparing Medicare and Medicaid policies on balance-billing, defined as prohibition on charging more than program’s payment); RAND ROSENBLATT ET AL., *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 485–87 (1997) (describing Medicare mandatory assignment and balance-billing prohibition for hospitals).

288. *See* Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget, 70 Fed. Reg. at 25,585 (suggesting approach “is consistent with the statutory intent of this provision and will limit reimbursement to only those instances where no other reimbursement is likely to be received”).

289. *See id.* at 25,589.

290. *See id.* at 25,591 (listing specific, applicable payment rules); *see also supra* Part I.C (describing Medicare reimbursement methodology).

denials.²⁹¹ Meanwhile, hospitals would be left bearing substantial uncompensated care costs until they eventually were paid.²⁹² A hospital disaster relief plan, therefore, should rely on a less onerous payment approach than the existing Medicare methodology.

D. *Terrorism Risk Insurance Act*

The Terrorism Risk Insurance Act of 2002 (“TRIA”) was enacted a year after the 9/11 attacks, on November 26, 2002.²⁹³ TRIA establishes a government reinsurance program for future terrorism losses.²⁹⁴ It does not compensate insurers for payments made under policies in effect at the time of the 9/11 attacks.²⁹⁵

TRIA provides a federal backstop for property and casualty insurers and policyholders by sharing a portion of terrorism losses up to a fixed cap.²⁹⁶ Health, life, automobile, homeowners’, and other individual consumer policies are not covered.²⁹⁷ Therefore, patients, health care providers, and health insurers are not insulated under TRIA from full losses or costs for medical treatment and services incurred during a terrorist attack. TRIA was scheduled to sunset on December 31, 2005, but Congress was urged to extend the deadline or make the law permanent.²⁹⁸ Those suggestions took on greater force

291. See Stephen Franklin & Bruce Japsen, *No Rush To Claim Cash for ER Bills; Hospitals Cite Ethics, Red Tape as Obstacles*, CHI. TRIB., Sept. 17, 2006, at C1 (“The biggest deterrent to applying for the money, [experts] explain, is concern about time-consuming paperwork that can offset any money gained.”).

292. See Belmont et al., *supra* note 2, at 538–39, 547 (discussing administrative challenges of traditional payment arrangements); Rosenbaum et al., *supra* note 1, at 65–66 (discussing tension in public health emergencies and traditional contract-based insurance).

293. Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 101(a)–(b), 116 Stat. 2322, 2322–23 (2002) (regarding enactment).

294. See Saul Levmore & Kyle D. Logue, *Insuring Against Terrorism—and Crime*, 102 MICH. L. REV. 268, 277 (2003) (explaining that under TRIA “the federal government will provide reinsurance for ninety percent of all property casualty losses attributable to ‘acts of terrorism’”); Robert L. Rabin & Suzanne A. Bratis, *Financial Compensation for Catastrophic Loss in the United States*, in DANIEL A. FARBER & JIM CHEN, *DISASTERS AND THE LAW* 195, 195 (2006) (describing TRIA as “exemplif[y]ing] the federal government assuming the role of excess liability insurer, in effect providing a cap on the losses for which the private insurance industry will be responsible in the event of a major act of terrorism”).

295. See Levmore & Logue, *supra* note 294, at 276 (describing how life and property insurers were “able to meet their financial obligations arising out of the events of 9/11”).

296. See PETER CHALK ET AL., *TRENDS IN TERRORISM: THREATS TO THE UNITED STATES AND THE FUTURE OF THE TERRORISM RISK INSURANCE ACT* 5–9 (2005); Robert J. Rhee, *Terrorism Risk In a Post-9/11 Economy: The Convergence of Capital Markets, Insurance, and Government Action*, 37 ARIZ. ST. L.J. 435, 454–59 (2005).

297. See Levmore & Logue, *supra* note 294, 306–07 (on exclusions).

298. See Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 108(a), 116 Stat. 2322, 2322–23 (2002) (regarding sunset provision); see, e.g., William R. Berkley, *Expand*

after Katrina and included proposals to expand the program to natural disasters.²⁹⁹ Just days before the scheduled sunset, the President signed a two-year extension, but limited the coverage to terrorism.³⁰⁰

Before 9/11, the insurance industry generally estimated the probability of a homeland terrorist attack as very remote. Accordingly, policy premiums reflected little incremental increase to cover possible terrorism losses. Therefore, when policyholders sought recovery for terrorist-related losses, the insurance industry was severely underfinanced to cover the enormous volume and value of claims, amounting to over \$30 billion at the low end of estimates.³⁰¹ In the aftermath of 9/11, insurers reacted by charging enormous premiums for new terrorism coverage, limiting coverage, or refusing to cover terrorism altogether.³⁰² All but five states passed legislation allowing insurers' to sell policies with terrorism risk exclusions following 9/11.³⁰³ TRIA nullified those state laws and required insurers to offer property and casualty coverage for loss due to terrorism that does not "differ materially from the terms, amounts, and other coverage limitations applicable to losses arising from events

the Terror Insurance Safety Net, WALL ST. J., Sept. 20, 2005, at B2 (urging TRIA extension and suggesting that Federal Government should be ultimate responder to terrorism); Holman Michael Schroeder, *Insurers Fight To Save Terrorism Safety Net, Opponents Say Taxpayers Shouldn't Underwrite Industry's Exposure to Losses from Attacks*, WALL ST. J., May 5, 2005, at A4 (noting bipartisan divide).

299. See, e.g., Jenkins, *supra* note 19 (arguing that "[w]hat was tolerable government subsidy for terrorism insurance would be unalloyed madness if extended to natural disasters"); see also Jeffery R. Brown et al., *An Empirical Analysis of the Economic Impact of Federal Terrorism Reinsurance*, 51 J. MONETARY ECON. 861, 867 (2004) (discussing "differences between terrorism risk and other types of natural and man-made catastrophes" and justifications for government reinsurance).

300. See Robert J. Rhee, *Catastrophic Risks and Governance After Hurricane Katrina: A Postscript to Terrorism Risk in a Post-9/11 Economy*, 38 ARIZ. ST. L.J. 581, 600 (2006) (discussing extension and market impact of TRIA); Mark A. Hofmann, *Just-in-Time Extension for Terror Coverage Backstop*, BUS. INS., Jan. 2, 2006, at 12 (discussing controversy over extension and final resolution).

301. See Brown et al., *supra* note 299, at 868–69 (reporting insurance loss estimates between thirty billion dollars and seventy billion dollars and industry reaction); Levmore & Logue, *supra* note 294, at 269 ("Insured loss estimates range from 30 to 100 billion dollars . . ."); see also Rhee, *supra* note 296, at 442–59 (describing pre- and post-9/11 insurance markets and government response).

302. See Brown et al., *supra* note 299, at 871–73 (describing proliferation of terrorism exclusions by primary and reinsurers following 9/11 and states' reactions).

303. See *id.*; Rhee, *supra* note 296, at 451 n.69 (citing Jeffery E. Thomas, *Exclusion of Terrorist-Related Harms from Insurance Coverage: Do the Costs Justify the Benefits?* 36 IND. L. REV. 397 (2003)).

other than acts of terrorism.”³⁰⁴ TRIA does not require policyholders to purchase terrorism insurance, but insurers’ participation is mandatory.³⁰⁵

TRIA operates prospectively for any future terrorism losses. It does not provide ex post subsidies for insured losses incurred in the 9/11 attacks or other possible terrorism-related events,³⁰⁶ such as the anthrax episode, prior to the Act’s passage. Coverage is activated when the Secretary of Treasury certifies, with confirmation by the Attorney General, an “act of terrorism”³⁰⁷ resulting in insured losses. The insurance industry is fully responsible for the first \$5 million in annual losses. After the \$5 million level is reached, the Secretary of Treasury is authorized to release TRIA support.³⁰⁸ Insurers cover a portion of the remaining claims as a “deductible,” based on a fixed percentage of each company’s direct earned premiums, meaning that large insurance companies pay a proportionately larger share of the aggregate deductible than smaller companies.³⁰⁹ The deductible was 7% of direct earned premiums in 2003, the first year of TRIA., 10% for 2004, and 15% for 2005.³¹⁰ Above the applicable deductible, the government bears 90% of the loss up to a maximum \$100 billion per year.³¹¹ The government’s portion is paid out of general revenues and, thus, operates as a taxpayer subsidy to the insurance industry.³¹²

304. Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 103(c)(1)(B), 116 Stat. 2322, 2322–23 (regarding enactment); *see* Levmore & Logue, *supra* note 294, at 276–77 (discussing industry concerns, including widespread reports that “reinsurers were planning to insert broad terrorism exclusions” in new and renewal policies).

305. *See* Terrorism Risk Insurance Act § 103(a)(3); Brown et al., *supra* note 299, at 874 (noting that “[t]hrough the end of 2004, insurers are required to ‘make available property and casualty insurance coverage for insured losses that does not differ materially from the terms, amounts, and other coverage limitations applicable to losses arising from events other than acts of terrorism’ ” (quoting Terrorism Risk Insurance Act § 103(c)(1)(B)).

306. *See supra* notes 294–95 and accompanying text.

307. “[A]n act that is dangerous to human life, property, or infrastructure . . . [committed] to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.” Terrorism Risk Insurance Act § 102(1)(A); *see also* 31 C.F.R. § 50.5(b) (2006) (providing similar definition).

308. Terrorism Risk Insurance Act § 102(1)(B)(ii).

309. *See* CHALK et al., *supra* note 296, at 6 (noting that “[i]n effect, for large insurance groups, this deductible can be quite high—well over \$1 billion); Rhee, *supra* note 296, at 455 & n.97 (describing premiums and citing examples).

310. Terrorism Risk Insurance Act § 102(7) (defining “Insurer Deductible”).

311. *Id.* § 103(e)(1)(A) (regarding ninety percent share); § 103(e)(2) (regarding one hundred billion dollar cap).

312. *See* Brown et al., *supra* note 299, at 865 (describing funding debates and variations in proposed and finally enacted versions); Rhee, *supra* note 296, at 456 (characterizing programs as federal subsidy).

If annual losses exceed the government's \$100 billion cap, the government will no longer provide any subsidy.³¹³

TRIA also authorizes the government to require insurance policyholders to subsidize the relief program. Up to specified thresholds, the government bears all losses and is not allowed to recoup any payment from policyholders.³¹⁴ If annual terrorism losses exceed the applicable threshold, the government may recoup the payouts through "surcharges" on individual insurance policies, which may not exceed 3% of the policy's annual premium.³¹⁵

The first, immediate objective of TRIA was to correct post-9/11 market disruptions and ensure continued availability and affordability of terrorism insurance. The second, long-term objective was to allow a transitional period for the market to stabilize, resume pricing, and build capacity to cover future losses.³¹⁶ A GAO study of TRIA implementation, presented to the Senate Committee on Banking, Housing and Urban Affairs, on May 19, 2004, suggested that TRIA had generally met the first goal by ensuring that terrorism insurance continues to be available and affordable for commercial policyholders.³¹⁷ By the end of 2004, nearly half of large and midsize U.S. insurers carried terrorism property insurance, up 27% from the previous year.³¹⁸

313. Terrorism Risk Insurance Act §§ 102(7), 103(e); *see also* Brown et al., *supra* note 299, at 874–75; Levmore & Logue, *supra* note 294, at 277; Rhee, *supra* note 296, at 455; Richard R. Stedman II, Comment, *Of Hurricanes and Airplanes: The Congressional Knee-Jerk Reaction to September 11*, 49 LOY. L. REV. 997, 1009–12 (2003).

314. The threshold was \$10 billion in 2003; \$12.5 billion in 2004; \$15 billion in 2005. Stedman, *supra* note 313, at 1011 n.106.

315. Terrorism Risk Insurance Act §§ 103(e)(6)(A), 103(e)(8)(C); *see* Brown et al., *supra* note 299, at 874–75 (describing "mandatory recoupment of the federal share of losses up to . . . \$10 billion in the first year of the program" through "a premium surcharge on property-casualty insurance policies"); Stedman, *supra* note 313, at 1011–12 & nn.111–12 (describing recoupment provisions). For example, annual TRIA-covered losses for 2005 would be fully federally funded (from general revenue and insurer deductibles), with no policyholder subsidy, up to \$15 billion. Between \$15 billion and \$100 billion, the Federal Government would pay 90% of the claims. Above \$100 billion, insurers would be responsible for 10% of claims.

316. *See* Terrorism Risk Insurance Act § 101(b).

317. U.S. GEN. ACCOUNTING OFFICE, TERRORISM INSURANCE: EFFECTS OF THE TERRORISM RISK INSURANCE ACT OF 2002, at 1 (2004) [hereinafter GAO TRIA REPORT], available at <http://www.gao.gov/new.items/d04307.pdf> (providing statement of Richard J. Hillman, Director of Financial Markets and Community Investment, before the Senate Committee on Banking, Housing and Urban Affairs).

318. *See* Schroeder, *supra* note 298 (citing statistics from the insurance company Marsh, Inc.).

TRIA's second goal of encouraging development of a viable private market has not been as successful.³¹⁹ Despite increased availability, most policyholders have not purchased terrorism insurance, perhaps perceiving a low threat of terrorism relative to purchase premiums.³²⁰ In addition, terrorism-risk insurance premiums remain high because primary insurers cannot obtain private reinsurance for their own risks. Reinsurers remain unwilling to sell terrorism coverage without a federal backstop. In addition, the uncertainty about the future of TRIA, alleviated somewhat by the recent two-year extension, undermines industry stability.³²¹

Insurers also expressed concern about the Act's actual operation, such as the length of time the Secretary of Treasury may take to certify a terrorist event and potential inefficiencies and time lags in processing and paying claims.³²² Delay in payment of claims "might seriously impact insurer cash flows or, in certain circumstances, solvency."³²³ TRIA does not specify a timeframe for the Secretary to certify a triggering "act of terrorism." Most states, however, have laws requiring prompt payment of insurance claims. Accordingly, insurers may be required to pay insurers' claims in full while indefinitely awaiting government reinsurance under TRIA, which could create a cash flow problem for insurers.³²⁴ In sum, TRIA has received mixed reviews as an insurance industry stabilization effort.³²⁵

319. See GAO TRIA REPORT, *supra* note 317, at 15 (concluding that insurance industry has not yet achieved Congress's second objective); Schroeder, *supra* note 298 (citing GAO TRIA REPORT observing little industry coordination to establish private system); see also Rhee, *supra* note 296, at 456-60 (questioning achievement of either of Congress's two objectives).

320. See GAO TRIA REPORT, *supra* note 317, at 3, 9-10 (noting low take-up rates and high concentration of purchases in urban areas perceived most at risk); CHALK ET AL., *supra* note 296, at 25 (estimating "terrorism insurance take-up rates at approximately one-half of insured commercial assets" and recommending permanent government program with "policies that encourage increased purchase . . . such as tax subsidies and reduced deductibles"); Levmore & Logue, *supra* note 294, at 304 (discussing problems of noncompulsory program).

321. See CHALK ET AL., *supra* note 296, at 58 (suggesting that TRIA's sunset would slow industry recovery); GAO TRIA REPORT, *supra* note 317, at 12-14 (suggesting that reinsurers have cautiously returned to market); Schroeder, *supra* note 298 ("Industry backers say making the law permanent would lead to more stability in the insurance and real estate markets.").

322. GAO TRIA REPORT, *supra* note 317, at 2.

323. *Id.* at 6.

324. *Id.* at 6-7.

325. See CHALK ET AL., *supra* note 296, at 55 (suggesting that TRIA has been "moderately successful in . . . encouraging insurers to reenter the market"); Brown et al., *supra* note 299, at 878-80 (providing empirical results indicating generally negative effect of TRIA on insurance industry); Mark A. Hofmann, *AIA Chief Aims for Consensus*;

Nevertheless, the law provides useful approaches for addressing the potentially dramatic effects of the next disaster on the health care industry.

IV. PROPOSED HOSPITAL DISASTER RELIEF PROGRAM

As first responders in the next 9/11, Katrina, or other previously unimaginable disaster, hospitals play an essential role in providing emergency treatment to potentially unprecedented numbers of patients. The Nation's emergency health care system already is on financially shaky ground, without the added burdens and costs of preparing for and responding to the next disaster.³²⁶ Policymakers have devoted considerable attention and funding to disaster preparedness but have given little consideration to the challenges presented after hospitals treat victims and attempt to return to normal operations. Accordingly, *ex ante* consideration should be given those unique administrative and financial pressures to ensure that hospitals are promptly and adequately compensated for their crucial first responder roles in the next disaster.

A. ATSSSA Analogy

The economic pressure that hospitals would likely face responding to a major public health emergency is similar to the airline industry's post-9/11 financial crisis.³²⁷ Hospitals, like airlines before

Public Understanding Is Key Goal, BUS. INS., Jan. 2, 2006, at 3, available at 2006 WLNR 365865 (quoting AIA president's comment that extension "is just a temporary solution, so we will have some significant responsibilities throughout the course of that two-year period of time addressing from a policy perspective what we do on a permanent basis"); Levmore & Logue, *supra* note 294, at 269 ("provid[ing] a skeptical view of government intervention in property-insurance markets generally and of the particular federal terrorism-reinsurance regime that Congress recently adopted"); Rhee, *supra* note 300, at 600 (discussing economic impact of TRIA and other government insurance); Schroeder, *supra* note 298 (discussing controversy over extending TRIA).

326. See Inst. of Med. of the Nat'l Acad., *The Future of Emergency Care in the United States*, <http://www.iom.edu/?ID=16107> (last visited Nov. 13, 2006) (reporting results of three related studies); *Ambulances Find Overwhelmed ERs "at Breaking Point," supra* note 60 (describing IOM study and noting that "nationwide crisis comes from just day-to-day emergencies" and "[e]mergency rooms are far from ready to handle the mass casualties that a bird-flu epidemic or terrorist strike would bring").

327. See Blair, *supra* note 220, at 379 (noting that "[b]y almost any measure, the airline industry suffered a huge economic cost in the wake of the events of September 11"); Campbell, *supra* note 223, at 53 ("The commercial airlines were the first industry brought to the brink of complete failure. Without passengers and cash flows, the resultant dislocations from the attack credibly threatened to bring the entire . . . industry down in an apocalyptic crash like the four aircraft that disintegrated in New York, Washington and Pennsylvania.").

9/11, are already suffering serious financial shortfalls and market pressures.³²⁸ The analogy between the airline and hospital industries is not entirely apt, however. Specifically, the post-9/11 financial pressures for airlines derived from severely reduced passenger demand for air travel, whereas hospitals, following a disaster, would face exploding demand, especially for urgent care. Hospital emergency rooms should expect a demand surge, not reduced patient loads.³²⁹ That unprecedented utilization creates inherent financial exposure, especially in the health care industry, in which services typically are provided upfront with payment expected later.

In both cases, however, the problem is cash flow: for airlines, revenues were down because passengers were afraid or reluctant to fly; for hospitals, revenues would be down because unprecedented demand for care and higher than normal numbers of uninsured patients would lead to payment delays and under-reimbursement.³³⁰ Therefore, just as ATSSSA cash grants helped prevent industry-wide insolvency for airlines, similar immediate cash infusion into the health care industry would ensure that hospitals would not collapse under the financial pressures of disaster response. As with airline relief under the ATSSSA, the government relief should be extended before hospitals become insolvent, to prevent them from going out of business.

One justification for government relief to an industry is that the Government caused or exacerbated the industry's financial straits.³³¹ The Government partially caused the airlines' troubles by mandating a three-day grounding order and increased security requirements. Likewise, the Government, in part, would be responsible for causing financial distress for hospitals in disaster response. As a matter of federal law, hospitals are required to provide emergency screening

328. See *supra* Part I.B (describing EMTALA burden).

329. See Santora, *supra* note 11 (“[T]he most significant problem in 1918 [at the height of the Nation’s major smallpox epidemic], as it would most likely be today, was the sheer inability of hospitals to deal with a sudden surge in patient demand.”); see also *Ambulances Find Overwhelmed ERs “at Breaking Point,” supra* note 60 (quoting Emory’s chief of Emergency Medicine: “If you can barely get through the night’s 911 calls, how on Earth can you handle a disaster?”).

330. See Blair, *supra* note 220, at 380 (noting that initial cash payouts “prevented the cash flow crisis from turning into a rash of bankruptcies at a number of small airlines and even a few large airlines”); see also Campbell, *supra* note 223, at 57 (describing \$5 billion payouts).

331. For a similar argument, see Jeffrey Manns, *Insuring Against Terror?* 112 *YALE L.J.* 2509, 2520 (2003) (“The close interplay between the federal government’s foreign policy decisions and the existence of terrorist threats suggests that the federal government may be at least partly responsible for ‘creating’ many of the risks posed by terrorism.”).

and stabilization for any patient on their doorstep, with no assurance of payment. EMTALA creates an emergency care safety net for the uninsured, funded by hospitals and insured patients, to the extent hospitals shift uncompensated care costs.³³² Certain 9/11 preparedness laws expand hospitals' emergency response duties and, accordingly, expand their financial exposure to providing uncompensated care to uninsured patients. To the extent that the Government's first responder orders contribute to hospitals' financial strain, government financial support is justified.

The airline analogy also is useful because a terrorist attack affected the entire industry. Likewise, a major disaster would likely affect the entire health care industry, or at least a major geographical region, as volunteer health care workers from outside the disaster area would be called to respond and patients transferred to distant, safer hospitals. Therefore, in both cases, it seems appropriate that government relief should be aimed at the entire industry, rather than targeted to particular businesses or hospitals.³³³

Airlines and hospitals are also analogous because they both provide essential services to the public. Air travel has become an essential part of modern business and personal interactions. Health care, to an even greater degree, is an industry that we quite literally cannot live without. Both industries are key components of the Nation's economy and provide vital services to consumers. Lack of access to emergency health care could produce costly externalities and increase health care costs overall, as patients' conditions become increasingly acute or infectious disease spreads. Therefore, health care, like air transportation or national security, may be considered a "public good," calling for collective response and government support to ensure that essential care continues to be available.³³⁴

332. See *supra* note 40 and accompanying text.

333. See Blair, *supra* note 220, at 382–84 (explaining the similarities between the ATSSSA and the federal bailout of the Chrysler corporation).

334. See *id.* at 371–72 (discussing economic rationale for airline assistance, including externalities, "public goods," and highly valued services that the market otherwise would not adequately provide, such as education); see also Ford, *supra* note 30, at 133–34 (observing that "current public policy requires assuring that all Americans will receive adequate medical care" and "[b]ecause medical care is so important" the government "pays much of the medical expense for selected populations" that lack private health insurance). But see Priest, *supra* note 19, at 235 (rejecting view that catastrophic losses "generate public goods problems" and suggesting "government is particularly ineffective as an insurance provider and even as a regulator"). See generally Lawrence O. Gostin, *Preface to PUBLIC HEALTH LAW AND ETHICS: A READER* xix, xxiv–xxv (Lawrence O. Gostin ed., 2002) (discussing public health externalities, collective goods, and government responsibility and power).

The argument for government relief for hospitals is even stronger than for airlines because hospitals already provide an uncompensated “public good” under the EMTALA mandate.³³⁵ Airlines are not similarly compelled to offer free flights to passengers who claim an urgent need to travel. In that context, government relief for hospitals could be viewed not as a “bailout” or gratuitous handout, but as “earned compensation” for public services already rendered.

The ATSSSA also offers specific implementation lessons. First, the most successful part of the program, cash grants to shore up a struggling industry immediately after the disaster, would also be important to a hospital relief plan. The ATSSSA’s long-term loan support program was not effective, however, in large part due to the overly rigorous, complex application process.³³⁶ Though intended to ensure the most efficient allocation of scarce government resources, the prerequisites and other hoops that airlines were required to jump through ultimately undermined the program.

B. VCF Analogy

The VCF provides a useful “rough justice” model for balancing efficiency concerns against payment accuracy. Victims electing Fund compensation gave up the risks and expense of private litigation—even though successful litigants could enjoy full, “make whole” compensation—in favor of assured payment under a streamlined, albeit less individualized, process.³³⁷ Similarly, disaster response hospitals likely would be willing to accept assured government compensation and reduced administrative burdens, even if the amount is less than they could have collected by filing individual patient reimbursement claims.

Doctrinally, the VCF is an awkward analogy for hospital compensation, in that it replaces tort compensation, which is

335. See *supra* notes 51–58 and accompanying text (describing costs of EMTALA compliance).

336. See Blair, *supra* note 220, at 394 (suggesting that ATSSSA terms “are nearly as stringent as (and maybe more stringent than) the airline would face in the private financial markets”); see also *supra* Part III.A (describing ATSSSA).

337. See DIXON & STERN, *supra* note 19, at 6–7 (stating that one compensation system objective is economic efficiency, which includes “transactional efficiency,” or transferring resources “using the least resources possible”); Sommer, *supra* 237, at 351 (comparing Israeli approach of choice between government compensation and rights under other laws with U.S. “carrot and stick” approach requiring waiver of personal injury claim to opt into VCF).

premised on a “wrong” for which the tortfeasor owes damages.³³⁸ Part of the justification for the government paying VCF awards was as an expression of sympathy.³³⁹ While we were all “damaged,” at least emotionally, by the terrorist attacks, the direct victims suffered even greater harm. Government compensation, as a collection of taxpayer contribution to the victims especially affected seemed appropriate.

Another way of justifying VCF awards is under the tort law expectation that where there is a wrong, there is a remedy.³⁴⁰ With the terrorists themselves casualties of the plane crashes and the conspirators’ identities unknown, the domestic airlines on which the hijackings occurred became the most likely defendants in victims’ lawsuits. To protect airlines from insolvency while still allowing victims to recover for the wrong done to them, the government stepped in to provide compensation.³⁴¹

Likewise, government compensation for hospitals could be considered “damages” to the disasters’ “victims,” in the sense that the losses and extreme financial exposure would not have occurred if the government had taken adequate steps to protect us or prevent the disaster from occurring.³⁴² Moreover, hospitals might be especially affected “victims,” in their essential emergency care capacity. The “government failure” justification for special compensation might be

338. See Campbell, *supra* note 223, at 54–55 (comparing traditional tort laws that “provide compensation for injured people and those who suffer property damage through normative decision-making by jurors, roughly allocating responsibility along lines of fault and causation” with VCF, which “will also raise questions about the role of fault, and the need for lengthy and costly litigation to adjudicate it, in compensating individuals for injuries and damages suffered in tragic events”). See generally John G. Culhane, *Tort, Compensation, and Two Kinds of Justice*, 55 RUTGERS L. REV. 1027 (2003) (arguing that VCF confuses theories of corrective justice, i.e., tort law, and distributive justice, i.e., allocation of goods in society, and discussing the government’s proper role with respect to the separate theories).

339. See DIXON & STERN, *supra* note 19, at 20–21.

340. See generally Ernest J. Weinrib, *Corrective Justice*, 77 IOWA L. REV. 403, 403 (1992) (“At private law the sufferers of wrongful harm can recover compensation from those who have wronged them.”).

341. Congress authorized appropriation of “such sums as may be necessary to pay the administrative and support costs,” and specified that this appropriation “represented the obligation [of] the Federal Government to provide for the payment of the amounts.” Air Transportation Safety and System Stabilization Act of 2001, Pub. L. No. 107-42, §§ 404(b), 406(b), 115 Stat. 230, 238, 240 (2001) (codified at 42 U.S.C. § 40101 note (Supp. II 2002)); Campbell, *supra* note 223, at 61 (quoting same).

342. See Levmore & Logue, *supra* note 294, at 279 (justifying VCF as government compensation for national security failure); Manns, *supra* note 331, at 2521 (suggesting that “[t]he rationale that the federal government should internalize the costs from terrorist attacks that its foreign policies may have helped to provoke has remained unspoken”).

stronger for a terrorist attack rather than a natural disaster, which is less clearly the government's "fault."³⁴³ Even if the government is not at fault for the initial natural disaster, it could be blamed for failing to adequately warn, predict, or respond, as Katrina starkly illustrates.³⁴⁴ Moreover, the public collectively experiences the economic and emotional impact of major disasters, no matter who is to blame. This shared loss justifies government response.³⁴⁵

Alternatively, government relief for hospitals perhaps is more analogous to contract than to tort law. Perhaps they are not "victims" of a disaster, but rather providers of services that "unjustly enriched" the government and the public. The government would provide compensation to hospitals not as injured "victims" deserving damages, but as government contractors providing a service for which payment is due. The government has a preexisting obligation under Medicare, Medicaid, and other government health care programs to pay for the services provided to program beneficiaries.³⁴⁶ The

343. See Brown et al., *supra* note 299, at 867–68 (comparing terrorism and natural disasters to justify government response, including magnitude of loss, ability to predict occurrences, and government's role in preventing and mitigating magnitude of losses); Levmore & Logue, *supra* note 294, at 278–79 (suggesting that public reaction and demand for government relief may be stronger for terrorist attack than natural disaster because the former "draws in the entire nation in a way that natural disasters do not" whereas "natural disasters typically hit only a well-defined fraction of the country and of the economy, creating the quintessential concentrated and politically effective interest group"). "In Israel, where every restaurant and bus has become a potential frontline in terror's war," government compensation for terrorism is justified on the same grounds as benefits to victims of the armed forces and their families, i.e., viewing civilian victims of terrorism as "involuntary soldiers." Sommer, *supra* note 237, at 339.

344. See, e.g., Levmore & Logue, *supra* note 294, at 299 (suggesting government may have superior information-gathering capabilities than private industry); Spenser S. Hsu, *Chertoff Vows To 'Re-Engineer' Preparedness*, WASH. POST, Oct. 20, 2005, at A2.

345. See Levmore & Logue, *supra* note 294, at 288 (describing Winston Churchill's argument for government compensation for World War II property damage as "reflect[ing] the conviction that the entire nation was joined in the struggle as one"); Deborah M. Mostaghel, *Wrong Place, Wrong Time, Unfair Treatment? Aid to Victims of Terrorist Attacks*, 40 BRANDEIS L.J. 83, 86 (2001) (noting that Congress justified an Oklahoma City memorial since survivors' "losses and struggles" were "shared with a community, a Nation, and the world").

346. See 42 U.S.C. § 1395g (2000) (regarding Medicare payment), *id.* § 1396b (2000) (regarding Medicaid grants and payment to providers under state plans). See generally 42 C.F.R. § 482 (2005) (Medicare conditions of participation); U.S. Dep't of Health & Human Servs., Medicare Enrollment for Institutional Providers (May 2006), available at <http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/providers.pdf>; U.S. Dep't of Health & Human Servs., Form CMS-855A Medicare Enrollment Application: Institutional Providers (June 2006), available at <http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf>. Medicaid enrollment varies under state-specific plans. Despite Medicare and Medicaid programs' social welfare origins, they are increasingly operated

exigencies of the disaster situation would not change or nullify that standing contractual agreement to pay. Likewise, private insurers are contractually obligated to pay for medical services provided to plan enrollees.³⁴⁷ But for uninsured or underinsured patients, there is no preexisting promise to pay hospitals.³⁴⁸ Hospitals typically bear the cost of providing care to the uninsured and offset the losses through cost-shifting or other strategies.³⁴⁹ But a terrorist attack or natural disaster is anything but “typical.” The extraordinary circumstances justify extraordinary government financial support for hospitals.³⁵⁰ The contract analogy also makes sense in a broad “social contract” sense, in that health care may be considered a community need appropriately and most effectively provided by the central government.³⁵¹ If securing the Nation’s health is appropriately a government function, then the government should pay hospitals that provide those services for the community on the government’s behalf.

Setting aside the tort or contract rationales for government compensation, the VCF provides other useful ideas for a hospital disaster relief plan. First, the VCF demonstrates the merits of a

under commercial insurance and contract principles. See Rosenbaum, *supra* note 16, at 97–98 (comparing private insurance arrangements and government programs).

347. See Bodenheimer & Grumbach, *supra* note 24, at 635 (describing private health insurance transaction as “a reimbursement payment from insurance plan to provider” and third-party payment agreement); Ford, *supra* note 30, at 11–15 (tracing history of health insurance and noting that “hospitals developed programs in which they agreed to provide certain services in exchange for a set annual fee”); Rosenbaum et al., *supra* note 1, at 64 (describing private insurers’ obligations as “contractually defined and limited to enrolled members and sponsors” and that “[p]ublic insurers such as Medicare and Medicaid . . . are governed by laws that operate in a manner similar to the insurance contract”).

348. For limited exceptions, see *supra* Part I.C (listing government funding for uninsured care). See also KAISER REPORT 7329, *supra* note 26, at 8 (suggesting that a bigger problem than uncompensated care is “unreimbursed [care], meaning the payments received for services provided do not cover the full costs of providing these services” and that “hospitals often lose money on Medicare and Medicaid patients”).

349. See *supra* note 31 and accompanying text (discussing “cost-shifting”); Brad Delong’s Semi-Daily Journal, Problems with the Market for Health Insurance, http://econ.161.berkeley.edu/movable_type/ (Nov. 15, 2005 14:19 EST) (quoting Paul Krugman and noting that patients unable to obtain private health insurance or qualify for Medicaid may “receive ‘uncompensated’ treatment, which ends up being paid for either by the government or by higher medical bills for the insured”).

350. Public hospitals face a similar crisis under economic downturn and funding cuts. See KAISER REPORT 7329, *supra* note 26, at 12 (“As the number of uninsured in the country climbs, our safety net hospitals . . . will continue to be called on to fill the gaps, stretching resources and services that are already nearly stretched to the breaking point.”).

351. See Michael Walzer, *Security and Welfare*, in PUBLIC HEALTH LAW AND ETHICS, *supra* note 334, at 69, 69–76 (positing that government forms to serve community needs and that health care, like security and welfare, is a community need); see also Levmore, *supra* note 16, at 30 (suggesting that “the subset of citizens in need of extensive health care is more difficult to organize”).

rough justice or quid pro quo approach, i.e., trading payment accuracy for efficiency.³⁵² Most 9/11 victims readily gave up the risks of tort litigation and the potential for full compensation in favor of speedy, certain less-than-make-whole awards. Likewise, hospitals would likely be willing to forgo intricate, highly technical claim-by-claim filing requirements in exchange for prompt, assured payment, even if the amount was less than they might otherwise have received under normal circumstances.

The VCF also instructs that different circumstances may call for different rules. For example, under traditional tort law, victims' recovery is not reduced for collateral sources whereas Fund awards were.³⁵³ The different approach served as an effective way to ration limited government funds and ensure that payments were made only for losses not otherwise compensated.³⁵⁴ Similarly, a workable plan for hospital compensation should relax the traditional, cumbersome approach to provider reimbursement. Complexity and accuracy should yield to flexibility to ensure that hospitals respond quickly to unforeseen circumstances.³⁵⁵

C. Section 1011 Analogy

Section 1011 is a close analogy for a hospital disaster relief fund in purpose, if not in operation. Both programs are designed to alleviate the financial burden of providing emergency care to uninsured patients. A significant portion of the U.S. population lacks health insurance or is inadequately covered.³⁵⁶ Even if hospitals fairly

352. Workers' compensation is another example of a no-fault, quid pro quo compensation scheme. See MARC A. FRANKLIN & ROBERT L. RABIN, TORT LAW AND ALTERNATIVES: CASES AND MATERIALS 793 (7th ed. 2001) (noting that the "heart of workers' compensation is a basic quid pro quo," in which employers provide workers medical and income benefits for workplace injuries and illnesses, regardless of fault, and employees treat workers' compensation benefits "as their exclusive remedy . . . and give up any common law tort claims").

353. See *supra* note 244 and accompanying text.

354. See Robert A. Katz, *Too Much of a Good Thing: When Charitable Gifts Augment Victim Compensation*, 53 DEPAUL L. REV. 547, 548 (2003) (discussing rationale for VCF collateral source reduction and whether VCF awards should be reduced similarly by amount of charitable gifts claimants received); see also Campbell, *supra* note 223, at 62 (characterizing special master's attitude towards the "Fund as precious government monies that should be controlled and dispersed with caution and circumspection" and Department of Justice's view that "society generally and the bar specifically should not look at the Fund as it would ordinary tort recoveries").

355. See Rosenbaum et al., *supra* note 1, at 64 (discussing private insurers' response to public health emergencies).

356. See John Holahan & Allison Cook, *MarketWatch: Changes in Economic Conditions and Health Insurance Coverage, 2000-2004*, HEALTH AFF. (web exclusive),

may be expected to bear the costs of providing uncompensated emergency care under routine circumstances, section 1011 and the proposed disaster relief program recognize that they should not have to bear the entire burden when the demand for uncompensated care is unusually high.³⁵⁷ The unusual financial burden on hospitals in disaster relief areas and locales with high levels of undocumented immigrants justifies government relief.

The section 1011 compensation approach, like the VCF, reflects a policy decision that government, as opposed to private, funds should be available only to the extent that other funding sources are exhausted. Just as the VCF changes the traditional collateral source rule, section 1011 changes the traditional “balance-billing” prohibition, preserving government funds as a “last resort” for hospitals unable to collect from other insurers or payment sources.³⁵⁸ Likewise, the proposed disaster relief plan should be a last resort fund. Hospitals should be required to collect from all other available sources, including private insurance, government health care programs, DSH adjustments, workers compensation, and private charity pools before receiving government disaster relief.³⁵⁹ Hospitals that receive upfront government funding for care provided to disaster victims, for which they are subsequently reimbursed through other sources, should refund the government assistance “overpayment.”

Despite the close analogy between section 1011 compensation and disaster relief for hospitals, one key feature of the section 1011 approach should be rejected. Section 1011 adopts the complex

Nov. 1, 2005, at W5-498, W5-498, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.498v1> (citing 2005 Census Bureau data on 45.8 million uninsured Americans, an 850,000 person increase from 2003 to 2004); Rosenbaum, *supra* note 16, at 96 & n.9 (citing a 2003 Congressional Budget Office report finding that “40 million Americans are uninsured on a full-year basis” or “60 million if a point-in-time measurement system is used”). *But see* CATHERINE HOFFMAN & JOHN HOLAHAN, KAISER FAMILY FOUND., REPORT NO. 7384, WHAT IS THE CURRENT POPULATION SURVEY TELLING US ABOUT THE NUMBER OF UNINSURED? 1 (2005), available at <http://www.kff.org/uninsured/upload/7384.pdf> (critically examining census bureau statistics on levels of uninsured and suggesting numbers may be lower than indicated).

357. *See supra* notes 277–90 and accompanying text (discussing allocation of section 1011 funds); *cf.* Rosenbaum et al., *supra* note 1, at 64–65 (describing commercial insurers’ lack of coverage, exclusions, denials, and delays for public health emergencies). *See generally* Levmore & Logue, *supra* note 294, at 281, 291–94 (stressing importance of limiting assistance to uninsured losses).

358. *See supra* Part III.B–C (describing VCF and section 1011).

359. *See* Levmore & Logue, *supra* note 294, at 291 (“[The terrorism relief program should] provide only for uncompensated or uninsured losses. This structural spine of any relief system—the limitation of benefits to uninsured losses—is what sustains public sympathy for the relief effort, even as it serves the function of reducing moral hazard.”).

Medicare reimbursement methodology to determine provider payments for care provided to undocumented immigrants.³⁶⁰ Borrowing that approach for the disaster relief fund would not address the essential challenge of responding to a sudden demand surge and obtaining prompt payment on the massive numbers of claims.³⁶¹ A disaster relief fund would be more effective in the form of block grants, rather than compensation tied to individual patients. For similar reasons, states' Medicaid programs failed to provide adequate coverage for patients or payment for providers in the wake of Katrina.³⁶² Instead, direct grants or lump-sums to providers, similar to the uncompensated care pools included in some states' Medicaid waiver programs, would be better suited to assist hospitals struggling to remain operational after responding to a major catastrophe.³⁶³

D. *TRIA Analogy*

TRIA, like the ATSSSA, was a government program aimed at industry-specific stabilization after 9/11. Property and casualty insurers, like airlines, faced potential insolvency following the terrorist attacks.³⁶⁴ But the financial threat for insurers was not loss of customers, like airlines, but unprecedented demand for collections on terrorism insurance policies and requests for new coverage. Likewise, hospitals' financial burden following a disaster is not loss of business but increased demand.

360. See *supra* notes 289–90 and accompanying text.

361. See Berggren & Curiel, *supra* note 4, at 1550 (describing demand surge and reimbursement challenges post-Katrina). But see Franklin & Japsen, *supra* note 291 (suggesting that paperwork burdens have also deterred providers from enrolling in section 1011).

362. See *supra* notes 202–13 and accompanying text (describing disaster relief Medicaid waiver programs).

363. See Rosenbaum et al., *supra* note 1, at 65 (noting that “government may elect to bypass the issue of coverage and directly bear the costs, out of general or dedicated revenues”); Rosenbaum, *supra* note 16, at 99–100 (comparing expanded public insurance approach to direct financing approach); *supra* note 211 and accompanying text (describing uncompensated care pools under Katrina Medicaid waivers). Another option would be for the government to “subsidize through a demand-side deduction, credit, or direct cash transfer, all property insurance that covers terrorism risk.” Levmore & Logue, *supra* note 294, at 309.

364. See Brown et al., *supra* note 299, at 868–69 (noting that while the industry vowed that they “would not invoke ‘acts of war’ exclusions” after 9/11, it also asserted that it was “not in a position to continue to insure additional large terrorism losses going forward, and that some form of federal assistance was needed”); cf. Levmore & Logue, *supra* note 294, at 277 (suggesting that insurance industry may have overstated financial impact of 9/11).

September 11 represented the largest insured losses from a single event in the Nation's history,³⁶⁵ causing concern that the industry was undercapitalized to cover the magnitude of losses resulting from future major terrorist attacks. Although virtually all of the claims were paid, insurers were anxious to avoid similar exposure in the future.³⁶⁶ Insurers needed government assistance not as compensation for costs or losses already incurred, as in the three foregoing models, but rather, as prospective market stabilization to ensure continued availability of terrorism insurance. Similarly, health care providers would benefit from *ex ante* assurance that government support will protect them from insolvency resulting from the high demand for services in the next disaster, so that they can keep their doors open to patients.³⁶⁷

Health care providers' major task in disaster response is responding to victims' immediate medical needs. But they also face serious challenges during recovery resuming normal operations and providing essential care to the affected community. Various post-9/11 terrorism laws extend some financial support for hospitals' disaster preparedness efforts, in terms of staffing, stockpiling, and communications. Other laws allow federal, state, and local authorities to invoke special powers to ensure that essential medical care is available by waiving licensing requirements, taking control of health care facilities, and, in some cases, conscripting medical professionals into emergency service.³⁶⁸ The laws allow, and may compel, hospitals to meet the patient demand surge but do not address the cost of providing care to those unprecedented numbers of patients. Like insurers, hospitals are understandably concerned about

365. See Brown et. al., *supra* note 299, at 868 (citing insured loss estimates from \$30 billion to \$70 billion).

366. See CHALK ET AL., *supra* note 296, at 1–2 (noting that TRIA “was intended to stabilize insurance markets reeling from the enormity of claims” after 9/11 and to address the industry’s concern that “they would not be able to cover additional strikes”); Brown et al., *supra* note 299, at 865–68 (discussing challenges predicting “low frequency, high severity events” but suggesting that government intervention in terrorism insurance may not have been necessary); Levmore & Logue, *supra* note 294, at 276 (noting that “[d]espite the vast magnitude of the insured life and property losses, there seems to be little doubt that most life insurers and property insurers will be able to meet their financial obligations arising out of the events of 9/11”); Rhee, *supra* note 296, at 463 (suggesting that the industry could “absorb as much as a \$100 billion loss”).

367. See Rosenbaum, *supra* note 16, at 100 (suggesting that TRIA model “could be adapted to health care through legislation that combines broadened coverage with federal reinsurance guarantees” and “financed through a combination of special premium fees and [government] stop-loss coverage”); cf. Sommer, *supra* note 237, at 343 (describing an Israeli system that includes state-funded medical care for injured victims).

368. See *supra* Part I.D (describing federal preparedness laws and MSEHPA).

how to recover those costs, as they balance their books in the relative calm that follows the storm.

TRIA assured the insurers that they would not have to bear the cost of terrorism coverage without a backstop. That assurance allowed the industry to stabilize and continue providing terrorism coverage without fear of unlimited exposure. Similarly, stability in the health care industry would be well served by enacting a relief plan before the next disaster, assuring hospitals that federal financial support would be available to backstop the extraordinarily high uncompensated care costs.

Ex ante assurance of payment also could prevent hospitals from taking steps to plan for the disaster response financial exposure in ways that could be harmful to patients and the public. Without assurance of government support, hospitals might try to build up reserves or otherwise “self-insure” against the potential losses. For example, through the typical cost-shifting strategy, they might increase charges for insured patients now to build up revenue reserves to cover uninsured patient losses later.³⁶⁹ To prevent their own profit margins from being depleted by providers’ higher charges, insurers, in turn, likely would increase subscribers’ premiums. As health care premiums rise, fewer people could afford insurance, exacerbating the country’s existing uninsured crisis.³⁷⁰ A TRIA-style government backstop for hospitals facing unprecedented demand surge could avert such a spiral.³⁷¹

In addition, ex ante assurance of financial support would encourage health care providers to continue providing essential medical services despite the mounting financial toll. As the Gulf Coast Region experienced in Katrina, a major catastrophe could result in emergency room closures as hospitals facilities are damaged or destroyed, medical personnel residing in the disaster area are forced to seek refuge elsewhere, and financial losses become

369. See generally Weeks, *supra* note 61, at 1255–65 (describing market and regulatory incentives and restrictions on hospital charge inflation).

370. See *supra* note 356 (citing studies and statistics on current level of uninsured in U.S. population). See generally Rhee, *supra* note 296, at 461 (tracing economic “domino effect” of a potential failure to provide insurance for future terrorist attacks, including rising costs, “prohibitively expensive” premiums, higher prices elsewhere in economy, and overall “damaged economy”).

371. Cf. Katherine Swartz, *Government as Reinsurer for Very-High-Cost Persons in Nongroup Health Insurance Markets*, HEALTH AFF. (web exclusive), Oct. 23, 2002, at W380, W381–82, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.380v1> (discussing merits of government health care reinsurance and describing precedent in other contexts, including catastrophe reinsurance and secondary mortgage markets).

unsustainable. Even if hospitals were not legally obligated to provide emergency care, we might hope that altruism, patriotism, communitarian values, or other moral or nonlegal considerations would prevent them from refusing to treat disaster victims despite economic losses. But the staggering costs, liability exposure, fear of infectious disease, or other injuries could rationally limit the amount of voluntary free care extended by even the most altruistic providers.³⁷² After Katrina, private charities and churches sought FEMA reimbursement for the extensive aid provided to flood victims.³⁷³ Despite strong criticism, the government extended FEMA funds to many charity rescue organizations.³⁷⁴ To the extent that the unprecedented demand and staggering uncompensated costs threaten charitable, health care, and other facilities' financial solvency, *ex ante*

372. See ESAR-VHP DRAFT, *supra* note 96, at 17 (proposing comprehensive approach to issues facing volunteer health care providers with goal of ensuring adequate response); James G. Hodge, Jr. et al., *Volunteer Health Professionals and Emergencies: Assessing and Transforming the Legal Environment*, 3 BIOSECURITY & BIOTERRORISM: BIODEFENSE STRATEGY, PRAC. & SCI. 216, 216–17 (2005) (explaining background and need for ESAR-VHP).

373. Joyce Howard Price, *Keep the Faith, and They Will Come; Religious Folk Step Forward To Clean Up After Katrina*, WASH. TIMES, Oct. 27, 2005, at A1, available at 2005 WLNR 17408153 (reporting on charities' aid and FEMA reimbursement).

374. Charities expressed concern that government compensation was incompatible with charitable purposes and would discourage private donations. Civil rights advocates suggested that financing faith-based charities violated separation of church and state. See Baird Helgeson & Gretchen Parker, *Emergency Officials Plan To Get Religion: Churches, Others Asked for Help*, TAMPA TRIB., Oct. 9, 2005, at 1, available at 2005 WLNR 16796685 (FEMA plans "for the first time [to] use taxpayer money to reimburse churches and other religious organizations that provided shelter, food and supplies"); see also Alan Cooperman & Elizabeth Williamson, *FEMA Plans To Reimburse Groups for Hurricane Aid*, WASH. POST, Sept. 27, 2005, at A1 (explaining that some civil liberties groups "accept the need for the government to coordinate with religious groups in a major disaster, but not to 'pay for their good works'"); Annie Laurie, *As Usual, Churches Get Credit, Taxpayers Get the Bill; FEMA Church Give-Away Sets Egregious Precedent*, FREETHOUGHT TODAY, Nov. 2005, at 3 ("FEMA's messy plan to reimburse churches is financially and constitutionally a river of no return."); Richard Walden, *Too Much Generosity Goes to Red Cross*, NEWSDAY, Sept. 26, 2005, at A42 (Red Cross continued to collect private donations while receiving government compensation). But see *The Bad Samaritan*, INVESTOR'S BUS. DAILY, Oct. 3, 2005, at A18 ("To some liberal groups, separation of church and state means churches and faith-based groups shouldn't be paid back for helping hurricane evacuees. How is aiding flood victims an establishment of religion?"); Linda Chavez, *Reimburse Faith Groups Aiding Hurricane Victims*, GRAND RAPIDS PRESS, Sept. 29, 2005, at A17 ("[W]hat really angers the anti-religion Left is how much more effective private and religious groups are in getting things done than Big Government ever can be."); *Paying for Charity; FEMA Storm Aid Is Justified*, MINNEAPOLIS-ST. PAUL STAR-TRIB., Oct. 1, 2005, at A16 ("[G]iven the extraordinary human needs generated by the disasters, this one-time compensation program is demonstrably necessary."). For an argument for "supercharged subsidy for charitable gifts over direct government relief," see Levmore & Logue, *supra* note 294, at 308–09.

promise of compensation assures that they do not hesitate to respond to victims' needs the next time around.³⁷⁵

Additional lessons from Katrina suggest the importance of an ex ante approach. We saw that the government, when compelled, can act quickly to provide necessary financial and other support.³⁷⁶ Ex post programs, however, may be cluttered by political special interests, sympathy, and overestimation of risks.³⁷⁷ In addition, a program implemented in haste may not coordinate effectively with existing laws.³⁷⁸ Moreover, laws driven by sympathy in the wake of a catastrophe, rather than by cooler heads in calmer times, might work injustice by extending compensation for persons or entities affected by one particularly dramatic or salient catastrophe while denying similar compensation to victims of a less dramatic or more localized event.³⁷⁹ Accepting the rationale that the government, rather than health care providers alone, should bear some of the costs of disaster

375. See Levmore & Logue, *supra* note 294, at 291–95 (discussing merits of permanent versus episodic government relief and moral hazard, sympathy, delays, and uncertainty).

376. See *supra* Part II.B (describing post-Katrina response).

377. See Levmore & Logue, *supra* note 294, at 296 (describing “apparent, or perhaps opportunistic, panic in the insurance industry following the attacks of 9/11 and the claim that those attacks had rendered terrorism risks . . . ‘uninsurable’ ”); Rhee, *supra* note 296, at 440 (suggesting that one ex post drawback, is that it is “often subject to a mix of political motivations, sympathy, and perceived (if not always correct) economic needs”); Sommer, *supra* note 237, at 335 (describing U.S. approach as “ad hoc quick fix arrived at under severe time constraints in the emotional aftermath of major terrorist attacks and causing multiple issues of inequity”); see also Brown et al., *supra* note 299, at 864 (stating that “government intervention . . . results primarily from rent-seeking behavior of special interest groups” and programs such as TRIA “may be viewed as opportunistic attempts to secure an ex ante wealth transfer for taxpayers”); *id.* at 877 (suggesting that life insurers were left out of TRIA because of less active lobbying).

378. See Mostaghel, *supra* note 345, at 83 (suggesting that Congress tends to pass terrorism legislation in response to individual episodes and that in “emotional aftermath,” lawmakers “are not necessarily concerned with how, or even whether, these laws coordinate with other similar laws”); Sommer, *supra* note 237, at 359–60 (discussing ad hoc versus permanent compensation systems).

379. See Levmore & Logue, *supra* note 294, at 282–86 (describing factors prompting greater government relief for 9/11 than previous attacks, such as earlier World Trade Center bombing, Oklahoma City bombing, or attack on U.S.S. *Cole*); Sommer, *supra* note 237, at 360 (advocating permanent terrorism compensation and noting the “first and most intriguing problem in the American scheme of case-by-case legislation is the evident inequality between victims similarly situated”); Posting of Saul Levmore to The University of Chicago Law School Faculty Blog, http://uchicagolaw.typepad.com/faculty/2006/01/katrina_a_cash_.html#more (Jan. 26, 2006 09:25 CST) (discussing problems with ex post aid allocation and suggesting that “[p]oliticians take the temperature of the country’s taxpayers and send more money to a desperate locality the more the people are sympathetic”); Rosenbaum, *supra* note 16, at 99 (discussing how the “sheer magnitude” of 9/11 disaster minimized political disputes about financing emergency).

response, the relief should be available in all instances, regardless of magnitude, scope, or source.³⁸⁰

E. Proposed Hospital Disaster Relief Plan

Drawing lessons from four legislative models that addressed similar industry financial pressures, my proposed hospital relief plan includes three parts: First, hospitals should receive immediate cash grants to ensure that they remain operational both during and after the disaster. This aspect of the plan could be modeled on the ATSSSA airline cash assistance program. The funds should be available without unduly burdensome procedural requirements that would delay, deter, or undermine hospitals' access to the funds.

Second, the plan should provide funding, in the form of block grants, to cover direct care costs for treating disaster victims. Even though many patients may carry insurance, the volume of claims and other administrative demands on providers, billing clerks, and claims processors working in a disaster scenario would likely cause payment delays and denials. Hospitals struggle to "float" unreimbursed costs, even at normal volumes, much less the unprecedented volumes to be expected in a major disaster. Therefore, they would benefit from government "loans," until payment is made from other sources. If payment is forthcoming, the government funds that were advanced should be returned as an overpayment. Government compensation would be a "last resort," as under the VCF's collateral source offset rule or section 1011's balance-billing allowance. The loan assistance should be provided as grants or subsidies, directly to the provider, not as reimbursement that is tied to the patient, because one of the central problems for hospitals in a demand surge situation would be compliance with traditional, complex reimbursement methodologies.

The third part of the plan should provide a government pool of funds for uninsured care. This uncompensated care "backstop," modeled on TRIA, would be triggered only in a declared public health emergency when uninsured losses reach a specified, catastrophic level. Hospitals would be expected to bear some routine level of uncompensated care, even in a disaster. But the government

380. See *supra* note 334 and accompanying text (describing "public goods" notion of health care); *supra* note 343 and accompanying text (suggesting that "government failure" justifies intervention); see also Sommer, *supra* note 237, at 360 ("If we are to accept a rationale that the society, rather than the individual innocent victim, should bear some of the cost of the terrorist attack, this rationale should apply to all victims of terrorism, regardless of the number of victims in a specific attack, and regardless of the external motive to bail out the airline industry.").

should share the burden during major disasters, when the numbers become staggeringly high.

The proposed hospital disaster relief program should be temporary, with its aim to provide financial relief from the immediate crisis. Although many of the challenges health care providers face in disaster response exist even in normal operating circumstances, this program should not be extended as a permanent approach to fill the gaps and flaws in health care financing.³⁸¹ Disaster response planning provides insights into those larger issues but should not be used as a quick fix to address a more complex problem, which is well beyond the scope of both this proposal and Article.

CONCLUSION

Existing federal law requires Medicare-participating hospitals to provide emergency medical services to the community without regard to payment. Homeland security preparedness laws enacted following the September 11, 2001, terrorist attacks define hospitals as “first responders” and expand their responsibilities in providing emergency services to the disaster-affected community. Post-9/11 laws addressed the costs of disaster preparedness but not the costs of disaster recovery. And measures have not been implemented to ensure compensation and industry stability following the crisis.

Emergency medical care for victims of a national catastrophe or major public health emergency is an essential community service. Therefore, it should be expected that the government would bear at least some of the cost of providing that care, rather than leaving health care providers bearing the costs of disaster relief. Moreover, government support is essential to ensure that hospitals do not buckle under the financial strain. If hospitals cannot bear the costs and are forced to close, the immediate challenge of responding to disaster victims’ needs could spiral into a lasting access-to-care crisis. To avert those results, this Article examines four different government programs that provided financial support and stabilization to essential service industries threatened by unusual demands. The Article then draws on those models to develop the broad outlines of a government relief plan for hospitals, to be enacted before the next disaster.

381. See Brown et al., *supra* note 299, at 869 (noting concerns that TRIA “would turn into a permanent fixture in the insurance industry”); Sommer, *supra* note 237, at 364 (noting drawback of permanent system is creating “untouchable rights,” which, once in place, are “very hard, politically, to reduce”); see also Levmore & Logue, *supra* note 294, at 287–91 (comparing permanent compensation systems in Israel and Great Britain).