March 25, 2009

The Honorable Ray LaHood  
Secretary  
Department of Transportation  
400 Seventh Street, SW  
Washington, D.C. 20590

The Honorable Janet Napolitano  
Secretary  
Department of Homeland Security  
U.S. Department of Homeland Security  
Washington, D.C. 20528

The Honorable Charles E. Johnson  
Acting Secretary  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, D.C. 20201

Dear Secretary LaHood, Secretary Napolitano and Acting Secretary Johnson:

On behalf of our airline and airport members, we welcome the opportunity to work with the Obama administration to address the challenges facing our industry. Preparing for a pandemic was a focus of the Bush administration, and efforts to implement the National Strategy for Pandemic Influenza are still underway. While this work has valuable benefits in strengthening our overall emergency preparedness and public health infrastructure, some aspects of the plans as they relate to international air transportation appear to have been developed without sufficient scientific basis or understanding of airline or airport operations. This administration now has the opportunity to revisit and refine these plans, based on what we have learned to date. In particular, there are three decisions regarding implementation of Risk-Based Border Screening (RBBS), made without stakeholder input or public debate, that we believe merit careful reconsideration: funneling flights to a small number of U.S. airports, segregating and detaining passengers after deplaning (“cohorting”), and limiting federal resources to 19 airports.
Flight Funneling

The current plan for screening arriving international flights\(^1\) involves funneling these flights to a subset of airports to screen them. This will:

- disrupt international and connecting domestic airline operations;
- impose significant burdens on airports receiving flights to be screened while depriving other airports of basic operating revenue; and
- create extreme delays and inconvenience for passengers.

The initial decision to limit arrivals to just 19 out of 82 U.S. airports with international air service was based on an early assumption that federal resources would be insufficient to mount screening programs at every airport. However, it has not been demonstrated that shifting health screening to a small subset of international airports would produce any efficiencies – in fact, there is evidence that the congestion, confusion and delay that would result could actually increase the federal resources required. Moreover, resource needs are driven largely by another policy-based decision – to require segregation or “cohorting” of passengers from each flight until every passenger has been cleared of disease. Streamlining the process and deploying federal resources more efficiently would allow effective screening to occur wherever it is needed.

Passenger Cohorting

After going through a primary screening process, passengers from a given flight would be segregated in a “cohort” and held in a waiting area until the last passenger has been cleared prior to being allowed to proceed to Customs. This requirement will add a \textit{minimum} of 30 minutes to passenger processing, and easily could result in passenger delays of an hour or more. Furthermore, detaining and segregating passengers at this stage in the screening process increases space and personnel needs exponentially. Whereas primary health screening can be conducted at the arrival gate with half a dozen people (including one public health/medical official), “cohorting” entails holding an entire planeload of passengers (over 400 people on a full B 747 and more than 550 on an A380) in a secure area, and requires approximately 14 people to staff each arriving flight, including 10 public health or medical officers. This means that JFK International Airport, which has 26 international flights arriving in a peak hour, would need 364 people to staff just this part of the screening process, 260 of whom would need to be public health or medical officers. Airports may also need to provide law enforcement personnel to assist in crowd control if delays prompt passengers attempting to leave the cohort area prior to being cleared.

\(^1\)See Standard Operating Procedure for U.S. Public Health Entry Screening of Arriving International Travelers at Airports During an Influenza Pandemic, Version 1.0 (March 13, 2009). This document is based on the Department of Homeland Security and Department of Health and Human Services (HHS) “Entry Procedures for Travelers at Airports of Entry in the Event of a Severe Influenza Pandemic – Concept of Operations, Final” (undated), which was provided to us for the first time along with the Standard Operating Procedure. According to the Concept of Operations, it in turn was based on a framework approved by a Homeland Security Council Policy Coordination Committee (PCC) on January 24, 2006.
cleared by federal authorities. Despite the obvious burdens that cohorting would impose, there has been no attempt to scientifically evaluate or quantify the public health benefit, if any, of detaining and segregating passengers at this stage of the screening process, nor have alternatives been given serious consideration.

**Limiting Federal Resources to 19 Airports**

As originally conceived, the screening plan would have limited international arrivals to just 19 out of the 82 U.S. airports that currently have scheduled international service. The plan was revised to include six more airports, with the condition that screening be conducted at these additional airports using primarily nonfederal resources. The decision to limit federal resources to 19 specific airports is based on the premise that these airports already have a federal public health presence in the form of Quarantine Stations operated by the Centers for Disease Control and Prevention (CDC). However, despite their name, these Quarantine Stations are essentially administrative offices with limited space, and are not the type of facilities that could handle mass screening or cohorting, much less be used to quarantine passengers. The public health and medical personnel assigned to airport Quarantine Stations likewise are not sufficient to conduct mass screening, and would have to be supplemented by a surge force of public health and medical experts from the U.S. Public Health Service Commissioned Corps, other CDC and HHS staff, and state and local health departments. Similarly, the 19 airports, like every airport with scheduled international service, have a permanent Customs and Border Protection (CBP) presence but this workforce would need to be increased to handle the additional duties and workload under the current screening plan.

The possibility of sending at least some of these surge forces to other airports, where they could work with local resources to implement screening as needed, has not been seriously considered. Instead, an arbitrary decision was made to confine federal resources to 19 airports that have not been objectively analyzed as the best locations for catching pandemic influenza before it enters the United States.

**Now is the Time to Revisit These Decisions**

Airports and airlines are indispensible partners in the national effort to prepare for the possibility of a pandemic and in the execution of any plan to prevent the spread of a pandemic. However, some of the choices made in the last administration present significant obstacles to developing feasible implementation plans. The decisions to include flight funneling and passenger cohorting and limit federal resources to only 19 airports as elements of the RBBS plan were made without stakeholder or public input and are not supported by objective analysis. For these reasons, they demand a closer look before any additional resources are used to further develop plans for public health entry screening at airports in the United States.
Our comments in this letter do not necessarily reflect all of our concerns, but highlight the need for review by the Obama administration. We ask that you immediately convene a process to review these policy implementation decisions, with input from aviation stakeholders and experts in public health. We would be pleased to meet with you or your staff to discuss these issues further and provide our views on how to improve the RBBS to achieve the dual goals of slowing the spread of a pandemic to the United States while mitigating impact to the economy and the functioning of society.

Sincerely,

James C. May
President and CEO
Air Transport Association of America, Inc.

Greg Principato
President
Airports Council International - North America

cc: Vice Admiral Thomas Barrett, USCG (Ret.), Deputy Secretary, DOT
R. Rand Beers, Acting Deputy Secretary, DHS
Calvin Johnson, Acting Deputy Secretary, HHS
Susan McDermott, Acting Assistant Secretary for Aviation and International Affairs, DOT
Dr. Jon R. Krohmer, Acting Assistant Secretary for Health Affairs and Chief Medical Officer, DHS
Rear Admiral W. Craig Vanderwagen, M.D., Assistant Secretary for Preparedness and Response, HHS
Lynne A. Osmus, Acting Administrator, FAA
Michael Lowder, Director, Office of Intelligence, Security and Emergency Response, DOT
Joan Harris, Pandemic Flu Coordinator, DOT
Laura Valero, Pandemic Flu Coordinator, FAA
Dr. Til Jolly, Acting Associate Chief Medical Officer for Medical Readiness, DHS
J. Bradley Dickerson, Senior Policy Advisor, Office of Policy Development, DHS
Clay Evans, Senior Program Manager, Pandemic Planning Program and Public Health Issues, Office of Field Operations, CBP
Philip P. Carey, Health Security Coordinator, Office of Health Affairs, DHS
Zhoolan Jackson, Senior Program Analyst, Office of the Assistant Secretary for Preparedness and Response, HHS
Dr. Martin Cetron, Director, Division of Global Migration and Quarantine, CDC
Dave McAdam, Associate Director for Policy, Division of Global Migration and Quarantine, CDC
Lisa Koonin, Senior Advisor, Division of Global Migration and Quarantine, CDC
Todd Wilson, Associate Chief for Preparedness, Division of Global Migration And Quarantine, CDC