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U.S. Repatriation Program for Citizens Returned from Abroad

Introduction

Section 1113 of the Social Security Act (42 U.S.C. §1313) permanently authorizes the U.S. Department of Health and Human Services (HHS) to provide temporary aid to certain repatriated U.S. citizens and their dependents. To be eligible, citizens must (1) be without available resources *and* (2) be identified by the Department of State (DOS) as having returned or been brought back from a foreign country because the citizen was destitute, because the citizen (or a dependent) was ill, or because of war, threat of war, invasion, or a similar crisis. Temporary aid is generally provided as a loan. The Social Security Amendments of 1961 (P.L. 87-64) established the program following the repatriation of a "substantial number of American citizens from Cuba" (S.Rept. 87-425). Jurisdiction for the program has traditionally been exercised by the House Ways and Means Committee and the Senate Finance Committee.

Federal Administration

Since August 2018, the program has been operated by the Office of Human Services Emergency Preparedness and Response within the HHS Administration for Children and Families (ACF). (Previously, the program was administered elsewhere within ACF.) ACF coordinates with DOS in operating the program. Under its own statutory authorities, DOS assists U.S. citizens abroad by providing for their evacuation or return when their lives are endangered (22 U.S.C. §4802) or when they are destitute (22 U.S.C. §2671). This is generally done via loans. Once individuals arrive in the United States, ACF assumes responsibility for providing temporary aid under Section 1113 to eligible repatriates referred by DOS. Some responsibilities for the reception, temporary care, or transportation of eligible repatriates may be carried out by states through repatriation agreements with ACF or by a nongovernmental organization under a cooperative agreement with ACF.

Eligible Costs and Services

The program provides temporary assistance to eligible repatriates and may also cover administrative costs incurred by states or other entities. *Temporary assistance* is defined as money payments, temporary billeting, transportation, medical care, and other services (e.g., counseling) needed for the health or welfare of an individual. The resource test for eligibility looks at whether resources are "immediately accessible" to meet an individual's needs. In general, temporary assistance may not be provided for more than 90 days. An exception may be made if an individual is "handicapped in attaining self-support or self-care for reasons such as age, disability, or lack of vocational preparation." In such cases, aid may be extended by nine months with prior approval. In addition to providing aid to repatriates, HHS is also authorized to engage in a process, in consultation with DOS and other agencies, to develop plans and make arrangements for the provision of temporary assistance.

Repayment of Temporary Assistance

Section 1113 generally requires recipients of temporary assistance to repay the federal government. However, the law also gives HHS the authority to waive repayment. Federal regulations establish factors for such waivers. For instance, repayment may be waived due to financial hardship or if recovering funds would be "against equity and good conscience." ACF reports that relatively few waivers are granted each year (typically fewer than a dozen) and that loans are generally repaid in full. In the event costs are not recovered within 30 days of billing, loans begin accruing interest; further penalties may apply to debts delinquent by over 90 days. Costs recovered via loan repayments do not directly offset program expenditures.

Emergency Repatriations

In addition to routine repatriations (e.g., for individuals or families due to destitution or illness), the program responds to emergency repatriation events, often resulting from war or natural disasters. For example, the program supported mass repatriations from Lebanon amidst the Hezbollah-Israel War in 2006. During a mass emergency repatriation, ACF or participating states or other entities typically set up a processing reception center at applicable ports of entry. This is done in coordination with DOS, as well as states selected to receive repatriates. At these centers, repatriates who do not have immediate access to resources complete an intake form and loan repayment agreement. Repatriates are interviewed to determine what assistance they need (e.g., travel costs, cash assistance). Later, states or other entities submit claims for the administrative costs incurred and for temporary assistance provided directly to repatriates.

Funding Cap for Temporary Assistance

The repatriation program receives mandatory funding in annual HHS appropriations acts. Statute caps the amount of funding that may be used for temporary assistance at $1 million per fiscal year. Statute does not explicitly apply this cap to other program costs (e.g., HHS planning activities, administrative costs incurred by states). The current cap was put in place in FY1990 (P.L. 101-382). It has been temporarily waived or raised multiple times since then, usually in response to emergency repatriation events (see **Table 1**). In most cases, Section 1113 was amended to raise or waive the cap in its entirety, not for limited purposes (i.e., extra funds were not limited to a particular event or activity, regardless of what prompted the cap adjustment). In two cases, however, the cap was effectively waived by provisions in supplemental appropriations acts that allowed for additional spending *notwithstanding* the cap. In both cases, spending in excess of the cap was restricted to

assistance in response to specified incidents (an earthquake in Haiti in FY2010 and an Ebola outbreak in FY2015). Raising or waiving the cap does not mean additional funds will be used; it means the funds may be available if needed.

Table 1. Adjustments to Assistance Cap Since FY1990

Affected Year(s)	Treatment of the Funding Cap and Related Context
FY1990, FY1991	Cap effectively waived (P.L. 101-508) Context: conflict in Persian Gulf
FY2003	Cap effectively waived (P.L. 108-11) Context: conflict in Iraq
FY2006	Cap raised to $6 million (P.L. 109-250) Context: conflict in Lebanon
FY2010	Cap raised to $25 million (P.L. 111-127) Cap later effectively waived *for assistance provided in response to the Haiti earthquake* (P.L. 111-212) Context: earthquake in Haiti
FY2015	Cap effectively waived *for assistance provided in the response to the Ebola outbreak* (P.L. 113-235) Context: Ebola outbreak
FY2017, FY2018	Cap raised to $25 million (P.L. 115-57) Context: Hurricanes Irma, Jose (in Caribbean)
FY2020	Cap raised to $10 million (P.L. 116-148) Context: COVID-19 pandemic
FY2021, FY2022	Cap raised to $10 million (P.L. 117-39) Context: U.S. withdrawal from Afghanistan

Source: Table prepared using bill text searches from 101st Congress to present. Context is from various documents (e.g., conference reports). From P.L. 111-212 onward, these provisions have designated funds as an emergency requirement.

Budget Proposals to Increase the Cap

Several administrations have proposed permanent increases to the temporary assistance funding cap. Most recently, the FY2025 Biden Administration budget proposed setting the cap at $10 million and indexing it for inflation to "better position the program to respond when a mass evacuation of U.S. citizens is necessary." Trump Administration budget requests for FY2020-FY2021 had also proposed increasing the cap to $10 million using the same rationale. Previously, the FY2006-FY2009 budget requests from the George W. Bush Administration had proposed increasing the cap to $5 million, stating that $1 million was "no longer sufficient."

Additional Repatriation Authorities

In addition to the main repatriation authorities discussed above, HHS is also authorized to serve certain repatriates returned to U.S. soil as a result of mental illness (24 U.S.C. §§321 et seq.). These authorities were established in 1960 by P.L. 86-571 and are separate from authorities in Section 1113 (e.g., funds are not subject to the Section 1113 cap). To be eligible, a repatriate must be (1) certified as a U.S. national by DOS *and* (2) certified as having a mental health condition (e.g., deemed legally insane, in need of treatment) by an appropriate authority. Lack of resources is not a condition of eligibility. ACF may provide temporary care, treatment, and assistance in the form of hospitalization, other medical and remedial care, food, lodging, money, transportation, and other goods and services. In limited cases, continuing care and treatment in a hospital may also be provided. With few exceptions, the repatriates are expected to repay the government for services received.

Funding History and People Served

Table 2 displays the temporary assistance cap, total funding, and the number of people served since FY2014. Most people served are adults; children account for about a quarter to a third of those served annually by the routine program. Funds may be used for the main program and the program for mentally ill repatriates. Statute authorizes HHS to accept gifts to carry out the main program, but gifts may only be used to the extent provided in appropriations acts.

Table 2. 10-Year History: Temporary Assistance Cap, Total Funding, and People Served ($ in thousands)

Fiscal Year	Assistance Cap	Total Funding	People Served
2015	$1,000*	$927	615
2016	$1,000	$932	617
2017	$25,000	$24,931	670 + 3,195
2018	$25,000	$2,937	789
2019	$1,000	$938	751
2020	$10,000	$1,444	478 + 324
2021	$10,000	$8,660	442 + 626
2022	$10,000	$10,600	606
2023	$1,000	$12,238	925
2024	$1,000	$18,199	not available

Sources: Laws and HHS materials. *The FY2015 cap was waived *for limited purposes*, but HHS did not use this authority. People are those served by the routine programs, *plus* mass repatriations. Total funding is for temporary assistance and for activities not subject to the cap. Funding reflects sequestration. FY2024 data are preliminary.

Recent Issues

According to ACF, the COVID-19 pandemic marked the first time a mass emergency repatriation occurred due to an infectious disease outbreak. In 2020, a whistleblower raised concerns that some deployed ACF staff were not properly trained or outfitted before meeting quarantined repatriates. P.L. 116-148 later prohibited ACF staff from having direct contact with repatriates, except for uniformed members of the Public Health Service Corps or the Ready Reserve Corps with appropriate training and equipment. This prohibition expired with the COVID-19 public health emergency. A 2021 GAO report examining the COVID-19 repatriation response recommended that HHS (1) revise or develop new emergency repatriation response plans, and (2) conduct regular exercises with federal, state, and local partners to test and inform plans. A House Appropriations Committee Report (H.Rept. 117-96) directed HHS to comply with these recommendations. Since FY2021, HHS data suggest more than 80% of annual funding has gone to planning costs, including a new training and technical assistance center. HHS notes that such activities had not

historically been funded. Accounting for these costs, total funding in recent years has been higher than average.

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