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March 5, 2020

Coronavirus: Legal Aspects of the Public Health Response, and What Employers Should Be Doing Now

Operator: Ladies and gentlemen, thank you for standing by and welcome to the Coronavirus: Legal Aspects of the Public Health Response, and What Employers Should Be Doing Now. At this time, all participants' lines are in a listen-only mode. Please be advised that today's conference is being recorded. If you require further assistance, press *0. I would now like to hand the conference over to our first speaker today, Mark Barnes. Thank you. Please go ahead, sir.

Mark Barnes: Thank you, Operator. Good afternoon everyone. This is Mark Barnes speaking from the Boston office of Ropes & Gray. I'm here in Boston with my colleagues Doug Brayley and also Michael Lampert and in our Washington office, we have Valerie Bonham and Jeremiah Williams. We're here today, as the operator said, to talk about some of the more pressing legal issues, both background issues as well as our issues regarding employment and labor issues, and also issues regarding public companies.

We have a slide presentation that should have been sent to you. If it has not been sent to you, then you should please write to Marnine.Copeland@ropesgray.com and Marnine will be kind enough to send them to you. A copy of the slides today will also be included in the thank you follow-up email that we'll circulate probably tomorrow.

You'll have an opportunity to ask questions during this presentation. While the phone line won't open up for questions, please feel free to submit questions by email actually to me, Mark.Barnes@ropesgray.com and we will try to weave your question into the presentation if time permits.

We actually have hundreds of cites on the conference call today, and so I'm relatively sure there will be a ton of questions. We might not get to all of them. Those questions that look to us to have great significance that we don't get to, we will put answers together with those questions and we will send them out in the thank you that goes out to all of you as a follow-up, together with another copy of the slides that we're going to be going through today.

Today's presentation is for educational and informational purposes only. Nothing we say, not our slides, not our comments, not our answers to your questions, should be construed as legal advice or legal opinion on any specific facts or circumstances. Today's presentation is not intended to create a lawyer-client relationship between the listeners and us, and we urge you to consult with your own in-house or external counsel concerning your particular situation and any specific questions that you have about very specific factual scenarios.

If you want to receive CLE credit, you can do that. You need to fill out the attorney affirmation form that was linked for download in the confirmation email that you received today. At the end of the presentation we will give you a code. I will announce a code so that you can add that to the form so that you can receive CLE credit.

After the audio conference is finished, and after you have put the code onto that attorney affirmation form, please send the completed form to cle.team@ropesgray.com as directed on the form.

So I'm a partner in the Healthcare and Life Sciences Group. I'm joined today, as I said, by Doug Brayley, who's a partner in Boston in our Labor and Employment Group. Michael Lampert is a partner in our Healthcare Group, Val Bonham in Washington, counsel in the Healthcare and Life Sciences Group, and Jeremiah Williams, who's a partner in Litigation and Enforcement Practice, also in Washington.

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So with all that out of the way, let's go to the slides.

I will start with some of the public health background, then you'll hear a bit from Val Bonham, and then back to me and we will go to the others who are here with us in Boston and in Washington.

As the speakers go through the slides, we're going to cite the number of the slide so that you will be able to follow along with us, and we will go through the entire presentation, and then I will go to the questions and we'll take all that we can take at that point.

We do have this scheduled, if you want to stay on the line for a total of two hours, up until 6:00 pm Eastern, so we should have a good deal of time at the end to handle a lot of questions, and I will try when the other speakers are talking to try to weave some questions that come in while they are talking into their presentations by asking them at pauses when they talk.

So if you go to Slide 2, the agenda today is we're going to talk about the public health background of this. We're going to talk about infectious disease control measures, and then we're going to talk finally about considerations for healthcare providers, both individual providers, but especially for group providers and institutional providers, for employers and also the implications for public companies. That's the agenda.

If you turn to slide 4, first we're going to talk for just a second about some facts and figures and some background as to where we are today. Some of the early slides I'm going to go through extremely quickly, because I think that most of you are quite learned about the basics of what we're talking about.

If you go to slide 5, the virus that we're talking about has been abbreviated as COVID-2. The disease that it causes is typically referred to as "coronavirus disease 2019." It's a betacoronavirus, like MERS and SARS. Research suggests that all three of them actually originated with a cross-over to the human population from a wild animal population, probably a bat.

The exact method it spread to humans is still undetermined, although it's being researched. We note that there has been an international health regulations emergency declared by the WHO, declaring this a public health emergency of international concern, and also Alex Azar, the HHS Secretary, has also declared this a public health emergency for the U.S., which is important in terms of triggering public health authority of the federal government.

The travel restrictions on Slide 6, just to be clear about the way that this occurred, the chronology of it, on February 2, the entry of foreign nationals who have been in China for the past 14 days has been suspended in all ports of entry into the U.S. However, U.S. citizens, residents, and immediate family members who have been in Hubei province, where Wuhan is, and other parts of mainland China, are allowed to enter, subject to health monitoring and possible quarantine in the U.S., after they've entered, for up to 14 days.

And then on February 29, the US suspended the entry of foreign nationals who have been in Iran during the past 14 days, because that plus Italy are really the sites of the major outbreaks so far, where it looks like actual community spread has occurred on at least a modest scale.

Facts and figures on slide 7. You have the countries here that have been classified by CDC according to their risks of travel to those locations. Again, it is classified by our own Centers for Disease Control in Atlanta. China, Level 3; Iran, Italy, Level 3; South Korea, Level 3, Hong Kong Level 1 and Japan Level 2. This is as of this afternoon.

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Total cases in the U.S. is being updated daily and so I can't swear that the figures here are absolutely accurate. The CDC updates them regularly, and there is vaccine development underway. Tony Fauci from the NIH has talked in public briefings as head of NIAD, the National Institute of Allergy and Infectious Disease at NIH, who is one of the most eminent infectious disease physicians and researchers in the U.S., has talked in public about vaccine and drug development.

There is a Phase I vaccine trial, that's multi-site, it's estimated for 3-4 months duration, with 45 subjects, and there is a Phase II drug trial, single site, which is not a vaccine, it's a treatment drug, but with an estimated multi-year duration. So, as Dr. Fauci said in his various briefings that he's given, we're probably talking about many months from now that either a vaccine or a defined treatment is actually available. The treatment could very well come before the Phase I trial has even necessarily concluded.

Now we're going to talk for a minute about legal authority for federal and state issues. So if you look on Slide 10, the headlines in regard to preparedness for COVID-19, you see the many headlines that approach us every day when we open our computer or laptop or we open the newspapers.

But let's talk for a minute about the legal landscape here, because this I think is something that is important for everyone to know as citizens, and as managers, as administrators, but also as employers, because it really forms the backdrop for some of what Doug Brayley and others are going to be talking about today.

The federal agency's authority, the federal authorities do have the authority to control infectious disease. They have the ability to quarantine, to isolate, to surveil, and we'll talk about that in a minute. The FDA has been offering emergency use authorization for test kits, that is test kits with the reagents that will allow laboratories to test for the coronavirus and whether someone actually has been infected with it or not.

And the FDA has, of course, expedited the trials, in our case, the trial for the vaccine and the trial for the Phase II treatment. And there is grant funding being offered. There is emergency funding being pushed out by NIH, by other authorities, NIAD, BARDA, to allow mostly university researchers but also potentially researchers in the private pharma space to have seed money to conduct very quick, very rapid research. And then there is state and local law, which we will talk about as well, including the tribal law of the Native American reservations.

The federal law on slide 12, what one looks to in regard to the federal authority and what's most important here to keep in mind is that the federal authority and the state and local authorities really are kind of on two separate tracks. They cross over. That is, the federal crosses over into the state, the state doesn't really cross over into the federal except insofar as the state authority assists the federal government in whatever measures the federal government wants to take. But the statutory basis for the public health service for CDC, to take action is founded in Section 361 of the Public Health Service Act, Control of Communicable Diseases. This has been strengthened over time, especially after the SARS and MERS episodes. There have been various small amendments that are nevertheless significant that have gone through Congress in 2006, 2013, and 2019, that basically strengthen the federal authority.

Traditionally the way it worked is that before these various acts is that the federal government exercised its authority generally at ports of entry into the U.S. to keep people out or to quarantine people or even goods or animals that were being shipped into the U.S. that the federal government, especially the CDC, thought would be a potential significant risk to the population of the public health of the U.S.

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That has expanded over time, but still today and actually from the beginning of our republic, that is really going back all the way to the case of *Gibbons vs. Ogden*, there was a dicta in that Supreme Court case I believe in 1822 or 23, which basically stated that quarantine powers were reserved to the state and that that was part of the state police power. It's always been therefore part of the state police power. The states have plenary authority over public health measures, and the states delegate that authority according to their own state codes to counties, municipalities, towns, cities, that are organized as corporate entities within those states.

The public health service authority, however, has been delegated primarily to CDC. It used to actually reside in large part at FDA, and that was shifted over about 20 years ago to CDC. And there is a statute that authorizes fines for disobedience to federal laws.

So looking at Slide 13, the way that this is implemented in the CFR is that there is federal quarantine authority that extends across the states that is located at the limit of the federal boundaries, but also that authority extends to quarantine of goods and people and animals who go between the states, and that's based, of course, on the commerce power.

The federal authorities do under these powers which are both in regard to the borders and also in regard to interstate commerce, they are authorized to detain, to medically examine and to release, persons arriving in the U.S. and also traveling between states, who are suspected of carrying these illnesses. The way that it is implemented according to the regulatory scheme, is that there is a presidential order which has been updated over the years, especially after SARS and MERS, and the conditions that allow the CDC to invoke the quarantine powers, they must fall into one of the categories that has been articulated in the executive order, which has the list of quarantinable communicable diseases, and you can find that in Executive Order 13295. It includes respiratory diseases of unknown origin, which certainly would be the category in which the coronavirus would fall.

On Slide 14, the CDC quarantine regulation was put forward in a final rule after a lengthy rulemaking process with an ANPRM and NPRM and then the final rule. This refined the CDC's quarantine regulations. What this did not do, however, it allowed for isolation, it allowed for traveler health screening, it required commercial airlines to report illnesses that occur on the flights when they bring people into the U.S., and between the states as well, and so all these kinds of public health measures were included in that.

It did not actually authorize compulsory medical testing, vaccination or treatment without informed consent. So the federal government actually doesn't really have that authority clearly. That authority, however, rests at the state level, in the state police power, which we'll get into in a second.

And what really happens here, however, if you turn to Slide 15, is that CDC, through revenue sharing, gives grants to all fifty states, the Commonwealth of Puerto Rico, the various American territories, and also it gives grants and aid directly to six city health departments, including Washington, New York, Boston, San Francisco and I believe Los Angeles. And those are direct grantees, and CDC conditions the receipt of those funds, which are substantial – they support a substantial part of the public health infrastructure at the state level and in these six major municipalities, it puts a condition on the funding which says that if you want to continue to receive funding you will assist CDC in its disease-control efforts, and you will implement its recommendations and so state health departments and local health departments simply don't turn that down, because they frankly need the money for their infrastructure support. So there is federal authority, as I've set forth here, there is also the conditionality of federal funding that flows to the states and cities through the CDC.

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If you look on Slide 15, there was a final rule that was issued on February 12 of this year, direct response to COVID to improve the CDC's ability to identify and evaluate and it did have certain airline requirements in regard to reporting not only illnesses, but also reporting passenger information and contacts of passengers, so that the CDC and other health authorities would actually be able to assess contacts and trace family contacts and find people once they arrived in the U.S.

On Slide 16, the state authority, as I said before, derives from the police powers. Police powers are inherent in the constitutional structure, but they're also set forth and there is judicial authority to indicate that they're based on the 10th Amendment, with the powers reserved to the states that are not articulated for the federal government, and the police power is definitely one of those. That has been interpreted by the Supreme Court, first and foremost in *Jacobsen v. Massachusetts*, in which the Supreme Court upheld the ability of Cambridge Massachusetts to enforce its smallpox vaccination penalties -- the penalties for failing to undergo smallpox vaccination, and the Supreme Court articulated that this was based cleanly and clearly on the police power of Massachusetts, which was delegated to the City of Cambridge.

Various states have different approaches to exercising and implementing their police power in an epidemic. What they do all over is they require that individual providers, healthcare providers, hospitals, laboratories, nursing homes, and individual physicians, as a condition of continued licensure within the state, must report unusual manifestations of new diseases to the local health department and/or the state health department, and they must report those by name, with identifying information of the individuals who are afflicted with the condition.

There also is a list in some jurisdictions of up to about 75 conditions or incidents, such as gunshot wounds, animal bites, mumps, rubella, etc., that also must be reported. These are typically reported by hospital emergency rooms and also by laboratories, because many of the reportable conditions are actually the result of laboratory tests. So states may enact these measures, but they also have enacted, state by state, other measures, such as the ability to isolate, the ability to quarantine individuals, isolate people who are suspected of having a transmissible illness. They can quarantine people who are confirmed to have a transmissible illness. States also under their various state laws, have the ability to *detain* people, to test them, to see whether they do have an illness, and in some cases to mandate, and make mandatory treatment for the condition, for example for tuberculosis. But these take different forms in different states, because every state has found its own pathway.

I've given you on Slides 17, 18 and 19 examples of these state laws. Each state has one. California, Massachusetts, Illinois. Some are old, they go back to days of tuberculosis, such as the one in Massachusetts, and there is a law in New York City, that I was frankly involved in writing about 30 years ago, that tried to update the quarantine isolation provisions and mandatory treatment and testing provisions in order to control multi-drug-resistant tuberculosis.

This was the first of its kind that was passed. Many of the states that revised or enacted laws after the New York City ordinance actually they followed the New York City law. There is this variation in quarantine laws, which I have a couple of quotes on Slides 21 and 22. Now the problem here, and part of the complexity is that the federal government has this ability to issue quarantine and isolation orders, as I said, both into the states as well as between or among the states. However, the federal government, especially the CDC, doesn't really have a mechanism of enforcing these things other than at the borders, where the federal authorities who control the border can help the CDC enforce these things. Therefore, the CDC when it decides that it must do something, that the locality or the state is not already doing, the CDC really relies on the state and city authorities, including the law enforcement authorities to assist it in implementing the CDC's orders for isolation, for quarantine, etc. In most cases, that's not really necessary. The heavy-hand of CDC is not necessary because CDC simply advises the local health department or state health department of what CDC wants to be done, and there generally is a concurrence between the local health officials, the state health officials and CDC. These

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are people who are physicians, they are trained either in schools of public health or in medical schools or in both, and they are people who know each other, who have worked together in most cases for decades, because this is a career civil service at the federal, state and local level. These are not really political appointments, and therefore they do work hand-in-glove, and they tend to work extremely well together, and that's been the experience over the years.

Now, before I pass this on to Val Bonham for Slide 23, and then after Val, on to Doug Brayley, I do want to say that the trick here is trying to understand if you actually have COVID in your workplace, if you have COVID in your home, if you have it in your healthcare facility, if it actually is confirmed, or even if it's strongly suspected, the interaction with these public health authorities, especially at the local and state level, is absolutely crucial. Because those are the people ultimately who have the plenary control over what to do, how to advise, and how to advise everyone in terms of taking their own measures within the workplaces, within the hospitals, within the nursing homes, to control the spread of the virus.

So with that, Val, I'm going to turn this over to you to talk a bit about the infection control measures and we'll go on to Slide 24.

Valerie Bonham: Thanks, Mark. As it was clear from what Mark talked about, there's a long history in our country of responding to threats from infectious disease and other public health crises or issues. And I'm going to speak about what will be familiar to many of you and if not, hopefully, at least, useful as an overview so that if you encounter some of these things or you deal with them, they're not new and you recognize that it is part of a continuum of efforts to protect the public health and as Mark noted, in the last ten to fifteen years, we've seen several expansions in efforts to deal with preparedness in response to an array of public crises and emergency situations including SARS, including Ebola, and including issues that arose out of 9/11.

So we have, in many respects, a stronger federal government today than we did 20 years ago in this space, certainly with regard to funding as well, but we have a tradition of efforts and authorities that lie largely with the state and efforts of control and quarantine and isolation, for example, that we don't *normally* encounter in our day-to-day lives, but which are not ... there's nothing really *novel* about the strategies that are available and are both being undertaken and we would expect in the future to be undertaken.

So as you see on Slide 24, there's sort of a range of public health interventions that are available to both the Feds and the states and municipalities to try to deal with a perceived threat. I think everyone knows that the concerns about the spread of the disease are very high and the sensitivity in the public is very high, and steps are occurring to reduce the risk.

But the incidence of, notwithstanding, that the numbers are a little bit shaky because the CDC, for example, is not quite as direct as it was a few days ago, for examples, in the numbers and they are changing rapidly. Nevertheless, in the main, the incidence still remains, relatively speaking, a bit *low* in our country, thought, obviously, that is expected to change.

But we start with education. Disease reporting. Providers have disease reporting duties, as well as public health employees, particularly of the state, have duties to obtain information and do contact tracing, etc. Mandatory examinations and lab testing are available and are being used in some context, narrow.

Mandatory treatment is a little trickier for states to enforce, but I think what we see, it's available, but what we're seeing is a lot of efforts to *voluntarily* encourage individuals to either agree to treatment, agree to testing, or agree to quarantine or self-quarantine. For example, I read just earlier today, I think Rhode Island has asked that within its state folks

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voluntarily agree not to go to nursing homes or bring children into to nursing homes or sick people into nursing homes. So it's still on the level of the state *asking* what would be available to it as a mandatory opportunity or authority should it choose to do so, but you see an effort to utilize the *available* tools without necessarily pressing the mandatory obligations and mandatory tools, by instead asking people to voluntarily agree to things.

So, real quick, just for clarification, the difference between quarantine and isolation, these terms are used often interchangeably, and there's nothing wrong with that per se, but it's useful, particularly when we're thinking about the legal limits that the state or the feds might face, to keep the difference straight in our heads. Quarantine is about separating and restricting people who were exposed to a disease to see if they become sick, that's the 14-day waiting period we hear a lot about, and isolation is when we're separating somebody who we *know* to be sick from the broader community, until they are no longer infectious and healthy again.

As we've spoken about and as the legal history that Mark walked through explicates, it's a *balancing* act. Quarantine and isolation are both a *balancing* of individual rights, the autonomy of an individual to exercise free choice with regard to their movements and their activities, vs. the interests of the whole, and in public health, in situations like we find ourselves in *today*, that gets tested and it becomes a little bit more acute and more visible to all of us. That's part of why we're all seeing this in the news as much as we are.

Now, when it comes to court challenges to the exercise of authority to quarantine. as Mark has already described, it exists, given it's an old one, but collectively the different challenges that might be brought with regard to the ability of the state or the federal government to a degree, to exercise these public health *measures* -- these long-standing tools to protect the public health -- in the main, they've been tested. They don't get tested a lot. We see some of these cases are quite old, actually, but they have been tested and, in the main, they have withstood challenges.

The future issues, Mark I don't know if you want to weigh in on 28? Buy here we're just previewing what we can all see in the paper about some of the *challenges* that are starting to come up. States or cities not wanting to let individuals be isolated or quarantined within their boundaries. What is the government responsibility to provide for the care of people who are voluntarily home quarantined? These issues, I think, are getting worked through, but we would anticipate that they continue to arise particularly as the risk of infection spreads and municipalities, states and, to some degree, the federal government seek to utilize the tools that we've talked about to reduce those risks.

So there will be these challenges of "can an area refuse to allow people to stay?" To some degree, hopefully that won't get much worse. Hopefully the incidence will level off, or what have you. But these two are not new issues. They have been seen over centuries in terms of how we as a public take the interest of the public in comparison to the interests of an individual. So I think the takeaway here is that there's a lot of tools, they're time-tested tools, they're judicially-validated tools, and there's a give-and-take, and what we're seeing today is a lot of effort to try to exercise them through a largely voluntary effort rather than mandatory effort.

So Mark I don't know if you want to add on that?

Mark Barnes: That's fine, Val, thank you very much. We're going to move to Michael Lampert, who's going to talk to us for just a minute about some of the healthcare facility and healthcare delivery issues.

Michael Lampert: Terrific. Thank you. I'll begin on Slide 30, there. Obviously this is an event and a virus that is affecting every part of the economy globally. That obviously includes healthcare providers, healthcare organizations. Many on the phone today are those -- we recognize that many are not those two -- but for both the healthcare

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organizations represented on the phone today, and for the investors, the equity sponsors in those healthcare organizations, some points quickly for the legal issues that face them, and then we turn to the broader legal issues for employers for public companies.

We begin just with a quick observation on liability. Healthcare organizations saw after Katrina, for example, liability to some healthcare providers for insufficient emergency preparation; saw a claim that nurses brought, a class action that nurses brought in Toronto after the SARS crisis there; saw a whistleblower claim recently brought or alleged against HHS for improper preparation that HHS had undertaken. The requirements that healthcare organizations face are largely set forth in rules that are relatively new. Rules around emergency preparation that were adopted in 2016, were last amended, ironically, last September, September 2019, so they are fresh, in Appendix Z for those who deal with it in the State Operations Manual for how organizations and particularly healthcare institutions, hospitals are assessed for compliance with their emergency preparation.

Now update, hot off the press *yesterday*, CMS issued three notices. One of the CMS notices stated, which is *unprecedented*, I believe, that CMS is suspending all survey activity except for highly-prioritized survey activity of hospitals for compliance and other institutions for the compliance with their conditions of participation. CMS is *prioritizing* survey activity only for “immediate jeopardy”, for infection-related compliance and then for a few other categories.

Two bottom-lines on that. Number one, that obviously this is a clear focus by the agency on emergency preparation of healthcare organizations. Number two, which is going in an entirely different organization, for organizations that are undergoing transactions right now that require the engagement of CMS survey. This is hot off the presses of yesterday, but a significant question that we’ll have to address is what that means for transactions that require CMS surveyors to pass muster for that to go through.

Moving on quickly: EMTALA. EMTALA is the obligation of hospitals to screen and to stabilize all patients who arrive. There are significant questions that came up in the Ebola crisis for how hospitals should care for or provide for, have access to Ebola patients to ensure access for them.

Going again to yesterday’s CMS notices, they focus on — again, there were three notices. Forgive me. There were three notices. One of them focused on discharges by hospitals. Hospitals discharges of patients and another focus on nursing homes’ acceptance of patients, all assessing whether the patient can be discharged out of a hospital into an environment where that patient is not going to pose a danger to others, where that patient can comply with isolation requirements.

Now that’s not directly an EMTALA point, but it is again a strong point for healthcare providers’ consideration on assuring that when they take a patient in the door, and see that that patient may be infected, that there are responsibilities for making sure that that patient doesn’t infect others.

Staffing shortages. The CDC has issued a lot of guidance around quarantine and isolation for exposed providers. That may pose, for healthcare organizations questions of facing reduced staffing volumes, as they may have exposed providers and enhanced needs to care for populations. Planning that healthcare organizations are currently undertaking for flexible staffing, including emergent screening and credentialing of personnel are then coming to the fore now.

Questions of what to do with healthcare organizations employees who may be exposed and they’re wondering what to do with those employees.

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I'll defer to Doug in just a couple of minutes.

Government authority over healthcare institutions is something that generally healthcare institutions have accepted, anyway, but there has been significant guidance coming out of HHS, coming out of CMS within HHS. Obviously, reporting obligations that institutions know, visit access limitations and recommendations on facilities' adoption of limited access to patients for visits, and so, just a note, that there is, of course, significant new guidance, or at least reminders of guidance and focus, that a number of different parties are giving.

Organizations certainly know their HIPAA obligations around privacy. There was guidance a week or so ago that reminded them of that. Of course, the bottom lines are that organizations certainly can -- healthcare organizations -- notify family members and other caregivers of a patient's diagnosis, subject to the patient's opportunity to object. Obviously there is no need for consent to give notice to public health authorities, and then subject to *state* law, there are HIPAA provisions to addressing disclosure to other potentially exposed people including potentially exposed co-patients that healthcare organizations will be facing and ought to be, if they haven't been, refreshing on those protocols.

Turning quickly to Slide 31. These are some operational points and really commercial points for a number of healthcare organizations. The first is diagnostics. Now, obviously we have all read in the newspaper about limited access to testing kits, and that being a problem that patients are encountering. That also obviously being a challenge that the manufacturers of testing kits may face.

There was FDA guidance that was released on February 29, not even a week old now, that gave authority to CLIA-certified high-complexity labs that developed their own diagnostic tests for COVID-19 to use those tests before obtaining and even seeking approval for an emergency use authorization or at least obtaining that approval. It's just for a period of 15 days. But that is FDA's indication that it will act on those applications within 15 days, and that high-complexity labs that have developed those tests can deploy them before receiving approval, which is obviously immediate access to the market.

Clinical trials. There are over 80 clinical trials are now running or pending in China. Of course, vaccine development is moving in the U.S. We read about Moderna, for example, a couple of days ago. The NIH has clinical trials running. Providers I anticipate will face questions from patients about getting access to clinical trials, particularly patients who will seek access to vaccines in clinical trial testing. Now, providers face that all the time in cancer, for example, settings, but these will be questions that may be coming to different parts of medical staffs or different offices that haven't experienced those before and that providers will be sharing information certainly within their organizations of how to deal with those.

Telehealth and remote care. Very quickly. CDC has indicated and the recent guidance yesterday from CMS that directed users to that CDC guidance that certainly patients who are not in an acute state but who are infected or may be infected in many cases can simply remain at home, provided that they have a private space, a private bedroom where they won't affect others. Now that is going to impose, particularly if it becomes broader in need, a need for broader access to telehealth perhaps than organizations have been providing because it will be necessary to check in, to monitor, to not minister to but to measure the performance of those patients.

Now, reimbursement for telehealth has been changing dramatically, which organizations currently have seen, although the historic rules are that a patient cannot really be at home and have their telehealth visit be reimbursed. There have been some changes for commercial payers, Medicare is lagging. There was recently, just a few days ago, a bill proposed in, this is in Arizona, but for full coverage by Arizona Medicaid for virtual visits that relate to COVID-19.

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Now if organizations *can't* get coverage for providing telehealth services to patients in quarantine or in isolation, they may be then facing the question of providing free care to those patients because that's the right thing to do. That will present for some of their lawyers questions around beneficiary inducement, because those are free services certainly to patients.

Now certainly the advances promotes access to care and poses a low risk of harm exception that was adopted in the Affordable Care Act, may be a good fit there, I think that organizations may be looking toward, but one step that organization can certainly take as they face the potential need to provide broader telehealth coverage, remote care coverage, is at least adding this to their protocol and analysis, if you will, ready to go, so they have their clear view on exactly how they want to approach that.

Just a few more points. One, considerations under payor risk deal. Obviously, a broad number of providers throughout the, really, industry have, over the past decade moved toward risk deals in which providers bear risk for the cost of care delivered to a population. Those risk deals, by and large, including the Medicare Shared Savings program, may include trimming of outlier expenditures, but are not really built to isolate and insulate provider organizations that have assumed risk from broad-based increases in expenditure across the population. And so for *financial* operators within ACOs, clinically integrated networks, and others, there may be a question to say *how* are your risk deals going to deal with what could be a broad base of increased expenditures that may not yield significant outliers, because you may not have an awful lot of high acuity patients that come in-house, more than you've had otherwise, but nonetheless with broad infection, would have an increase in expenditures across the board. Also certainly questions for any payor deals currently under negotiation.

Really, the last thought here is somewhat of a grab-bag, and we will be sending an invitation to another webinar that we'll be having in about a week and a half that will be focused on issues for healthcare providers, in which we'll do a deeper dive, and address a broader swath of these, but the last point quickly, considerations for teaching programs for medical students and for medical residents. Obviously for medical *students*, the LCME requires that medical schools and their teaching hospital affiliates coordinate with regard to care for medical students who are exposed to infection.

The ACGME has taken an approach recognizing that part of advanced training is certainly advanced training with pandemics, but different institutions, different training institutions have been taking different approaches for their medical residents. Some have been, for at least residents in some specialties, requiring that medical residents not enter the room of patients who have been diagnosed or are suspected to be infected. Others have simply prioritized medical residents for N-95 masks. And so there is a diversity in practice certainly occurring with medical training needs. But certainly for academic medical centers that could be the locus, if you will, of some higher points of acuity, the questions and sort of advance planning for how to deal with medical residents and students will be at the fore.

Mark Barnes: Michael, thank you very much. We've gotten several questions that really lead into Doug's presentation.

One, Doug, is that we've gotten one question, and by the way, those of you who send questions, your identity and your affiliation will not be disclosed when we go over the questions, so feel free to write in knowing that it will remain for the purposes of the call anonymous.

We have a question about whether an employer has an obligation to report to the public health authorities an employee who is known to the employer to have tested positive COVID. And then there is a related question, which is — I'll answer that in just a second, but just so you'll know what's coming, Doug, there's a related question: "Can we ask

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employees to let us know where they are traveling on personal trips? Can we require them to stay at home if they have traveled to a Level 1, 2 or 3 country?"

In regard to the reporting, I'll answer that then I'll turn it over to Doug. The reporting obligations under disease reporting laws apply to healthcare providers. They don't apply to the public at large or to employers, and I can tell you that I think that this is sort of a null set, that you're talking about. The reason for that is that if someone has actually been diagnosed with COVID, it means that they've had their physician or their healthcare provider has had access to a test kit. Those test kits are rare, they're hard to find, they're hard to get, they're hard to get access to. They're only given to patients who fit the clinical criteria for having a very high risk of having coronavirus. And so the health care provider that administered the test, whether you as an employer know it or not, that provider has almost certainly immediately reported that person, that patient to the public health authority. In fact, it may well be the public health authority's laboratory, where each state and major city has its own public health laboratory run by the city or the state health department, those are the laboratories that are actually in most cases right now running the tests, so they already know that which they know. They have the name of the person whom they're testing, so the disease reporting obligation is not really on the employer.

If for some odd reason you had reason to believe that the person with diagnosed, confirmed coronavirus was completely unknown to the public health authorities, then I'll tell you what I would do. Before I said anything to the public health authority, I think I'd call my attorney, my external or in-house attorney, and I think that in that case the decision probably would be to report, but I think that is going to be a null set.

With that I'm going to turn it over to Doug, and he's going to tell us all about employers.

Doug Brayley: Thanks, Mark.

I'm very happy to have this opportunity to talk over some of the employment issues that are raised by this. I think it is important, though, to lead off with the observation that at a fundamental level, the employer's response and obligations with regard to COVID-19 infection is not different from an employment law perspective than with respect to the seasonal flu or any other infectious disease, even one that we think of as common and part of our everyday lives.

That said, there are some unique aspects to this. And one of those is with respect to travel. As we discussed earlier in the session, the CDC has put out travel recommendations to certain geographies, China, South Korea, Italy, among others and the federal government is blocking entry from foreign nationals from those geographies. What we recommend and what we are seeing fairly widespread among our client base is employer policies of cancelling or restricting non-essential travel to geographies that the CDC has identified and, in some cases, restricted all travel to those geographies.

We are also seeing some limitations on travel, generally – non-essential travel, *generally* – though that is certainly beyond what the CDC is recommending and what the circumstances require, but we are seeing some employers take that prophylactic step.

Generally speaking, modern technology is very helpful in this situation where at least for white collar professionals a great deal of our work can be performed remotely whether it is video conferences in lieu of travel to high risk jurisdictions, or work from home, for folks who have recently returned from one of those jurisdictions and have been asked to self-quarantine.

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By the same token, we are seeing a lot of employers in line with CDC guidance instruct their employees who are returning from high risk locations to stay at home, not to come into the workplace for fourteen days after they've returned. And that is fine. That is allowed, that is a permissible instruction. It is permissible to ask your employees where they have been travelling for this purpose, whether it was for business travel or personal travel. That is not a protected piece of information.

You know I think you may face some morale problems if you start to ask invasive questions about where people travelled, particularly if you are going beyond the geographies identified in the CDC alerts. You know they'll say, "well, why does it matter whether I was in France just because France is near Italy?" But that is more of a morale problem than a legal problem.

Moving on to Slide 33, we've been getting questions about "What do we do if an employee shows symptoms." You know, of course, a challenging fact here is that at least as I understand it being thoroughly not a medical expert, some of the initial symptoms of COVID-19 are similar to those of the common seasonal flu, or the common cold. Notwithstanding that fact, and this is true of the common cold and seasonal influenza just like COVID-19, an employer has a right to ask visibly [missing word?] employees to stay away from the work place or work remotely. That is not an infringement on anyone's rights. When employer's instruct an employee to go home, and to work from home, or just to go home and recuperate, whether or not they need to be *paid* for that time off is a different question. Unfortunately, I can't give you a one-size-fits-all answer because there is actually a patchwork of state and local laws that answer that question, and more significantly actually for our client base, there is a patchwork of policies and insurance plans that answer that question.

I will say, though, that from having talked to a number of organizations and hearing kind of through the grapevine through industry groups, the vast majority of employers are taking a fairly generous approach with regard to paying people during periods of self-quarantine or when they've been sent home because they are exhibiting symptoms. And the theory there I think is that number one the fiscal cost of paying someone for fourteen days is not particularly high and that is particularly true because higher paid *white collar employees* from the fiscal costs of two weeks away be higher are also generally those who can be pretty productive from home.

Secondly, offsetting that relatively low fiscal cost of paying someone during a self-quarantine is the fact that if you are going to send someone off on unpaid leave or dock their vacation days when you ask them to stay away from the workplace, you might reduce compliance and reduce people's willingness to raise their hand, which of course has all sorts of other public health consequences. And my advice would be to try to stay on the right side of the public health issues even at the cost of the pain of a little bit of paid time off for self-quarantined or ill employees.

Some are asking whether they can screen employees themselves. Doing temperature tests or otherwise asking for medical exams. I suggest that you talk to your lawyer before you do anything like that. In general, I think that you want to not get too far out ahead of the CDC and local health authority recommendations on what sort of screening measures are called for. Particularly where you don't have any reason to believe that your work place has been exposed to an infectious disease. One way to think about it is that if you start going out there and testing your employees for the disease and let's say your testing fails, and an infection gets through anyway, you have now put yourself in the cross hairs for getting out ahead of the public health authorities and done something in an unsanctioned, unsupervised manner.

Moving on to Slide 34, there's a list of a number of *types* of employment laws that are implicated here. Anti-discrimination laws. This is becoming a little bit less of an issue actually this week than it was a few weeks ago. But you do want to make sure that your response to the coronavirus if any, doesn't distinguish among people based on, for

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example, national origin. You know, there was a time a few weeks ago where it might have been tempting for some employers to single out their employees of Asian ancestry or Chinese ancestry for special scrutiny. That would be inappropriate and unlawful.

You can certainly base it on employees' recent travel history. That is not a protected characteristic and if it happens to dovetail with national origin, so be it. But you shouldn't be targeting employees based solely on protected characteristics.

The Americans with Disabilities Act prohibits disability-related inquiries and puts limits on what is allowable medical *testing* by employers and it also requires that reasonable accommodations be made for disabilities. So that is another set of laws that can be implicated here. I think that the application of those laws can be pretty case-specific and so may be beyond the scope of this presentation, but it is a suite of laws to be aware of as you think about this.

OSHA is another body of law. This is the Occupational Safety and Health Act. Basically requiring employers to provide a safe working environment for you from recognized hazards. Again, it is going to be specific to your work place but I think that the employers who need to be paying the most attention to OSHA, probably those on the call already know you who you are, but as places like medical health centers or perhaps airlines where there is a reason to believe that your employees are unusually vulnerable to or unusually likely to be exposed to the coronavirus. That said, if you know that your work place had a problem, an outbreak, of the infectious disease, there may be reason to think about OSHA.

Mark Barnes: Doug, Can I ask you a question that has come in that relates to a couple things that you just talked about? This is in regard to whether there is any guidance from the EEOC or any other federal agency on religious accommodations in regard to facial hair in terms of the fitting and the wearing of the N-95 mask, which is the mask that actually is useful for preventing primary infection with COVID-19.

Doug Brayley: That is a fascinating question. Not one that I have researched. That is pretty specific. I *can* say that there is guidance from the EEOC about responses to the H1N1 pandemic and most of that analysis I think would be relevant here to the coronavirus outbreak, so I think that you can look at that. In fact, if you look at the Ropes & Gray FAQ that we have put up on our coronavirus mini-page, we have a link to that EEOC guidance. And, you know the one thing that the EEOC does talk about with regard to religious accommodation is that an employer should not be forcing employees to, for example, get a vaccine if it violates their religious beliefs.

Mark Barnes: Okay. Great.

Doug Brayley: Moving onto Slide 35, two other categories of laws that may apply here and for any employer who lived through H1N1 in 2009, and frankly any large employer that is used to dealing with employees' sick leave requests, these are not going to be unfamiliar, but there are state and local laws about sick leave and what must be paid, and what is job-protected and there is also the federal Family and Medical Leave Act which does not require *paid* leave but does require that employers grant *unpaid*, job-protected leave. That is, you can't fill their position permanently while they are gone, while someone is out sick or caring for a close family member who is sick.

There are also wage and hour laws that may be implicated. This would be particularly in the case of salaried employees and whether you can deduct from salaried employees pay for days when they are not working. The general rule is that if someone has a salary, they are supposed to get that salary every week, kind of regardless of the number of hours that they have worked. But there are exceptions to that, including for sick time under certain circumstances. And there are also

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state and local wage and hour laws about reporting pay. That is to say, when an employee takes the trouble of showing up to work and then is told that there is no work to be done, what are the requirements for pay under those circumstances.

Again, happy to field questions as best I can. But those are kind of subject to a patchwork of jurisdiction-specific laws and a little bit case-by-case, so tough to offer too much generic advice here, but those are laws to be aware of.

Mark Barnes: Doug, we have another question which is, “Is it required, is there any kind of legal requirement, that the employer offer an accommodation of work at home for a worker who has not been told by the public health department or even by their physician that there is risk, but nevertheless they are worried and they want to work at home.

Doug Brayley: Not on those facts. What may be required is a reasonable accommodation is if someone comes forward to you and says, “Hey, I have a disability namely my immune system is compromised because I have HIV Aids. And therefore I feel the particular need to stay home.” There maybe an obligation there to make the reasonable accommodation.

Now there is the background principle that you do not as an employer have to make an accommodation that would make an “undue burden.” That is kind of a mealy-mouthed phrase just like “reasonable accommodation” can be a bit of a mealy-mouthed phrase, so I think that you should talk to a lawyer before you make a firm decision on that. But that would be the context in which an employer may be *required* to accommodate an employee request when it is mostly out of nervousness or a prophylactic not because they actually have a medical condition that requires it.

Moving on to Slide 36, and this is also in writing on our FAQs, there are some steps that you can take now and we would recommend that you take now. I wouldn’t necessarily say that these are steps that you legally must take now or else you would suffer immediately liability, but I think they are best practices that we recommend and that we are seeing a lot of other employers out in the market taking.

Number one. Educate your employees about guidance from the WHO and CDC. This includes, you know, putting up posters in your bathrooms reminding people to wash their hands for 20 seconds. To use soap and water. This involves educating your employees about travel bans and travel restrictions and advisories.

We recommend that you instruct employees who are experiencing symptoms consistent with the coronavirus to stay at home and away from the workplace. We recommend that, if you aren’t already, that you make sure that everybody has a good place to wash up regularly and maybe think about providing hand sanitizer all over the place in the workplace.

As a pragmatic matter we recommend designating a person or a team as the contact point for coronavirus-related inquiries, that way you can ensure that that specific team is up to date on the latest company thinking, employer thinking, on how to respond to this so you can funnel all the inquiries to one place.

On a similar line, we suggest that you consider preparing an internal response *plan* which is really the point that I’ve already covered, just putting it down, just making sure everyone is on the same page about what steps the company is taking or what restrictions the company is putting into place. For example, on travel or working from home.

And finally, consider at least, cancelling or postponing non-essential meetings or company gatherings. Again, not a must-do, just something to consider if there is a meeting especially that is drawing colleagues from around the world, consider whether that might be better to occur at some other date.

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Mark Barnes: Doug I have another question for you that has come in. What about the issue of having in a large workplace where the scale would warrant it, especially in areas that's been hit like Seattle or San Francisco on the West Coast so far, having for a large employer to get a medical consultant to help them sort through the case-by-case determinations in the highly-suspected cases and even in the confirmed cases.

Doug Brayley: I think that is a fantastic idea, you know. That way you actually have people with medical training whether it is an M.D. or an R.N. or something like that making these what are really medical decisions and not relying on the judgment of lawyers or HR people or executives. We are all doing our best, but on those sorts of questions I think a medical consultant is a fantastic idea. That person can also liaise with the public health authorities on your behalf and may be able to cut through some of the verbiage that otherwise would trip us up.

Mark Barnes: In a healthcare workplace, Doug, can you rely on or try at least at the beginning if you want to do this, to access, for example, your employee health service and the nurses and the physician who presumably supervises that service?

Doug Brayley: That is right. A lot of larger employers do have some sort of existing on-site medical staff or employee health service and that may be your first and easiest and certainly quickest point of contact.

Mark Barnes: Okay. Thanks, Doug.

Doug Brayley: On Slide 37 I have listed a few practical points to think about. And I phrased it that way as points to think about for a reason. And that is that there are not clear answers here about what you must or must not do. And in fact, the facts on the ground of this outbreak are changing. It is not obvious that we could give you thou shalts and thou shalt nots. But, you know, as Mark already alluded to, there are questions about what to do about employees who are nervous about reporting to the workplace but are not themselves ill and are not caring for an ill family member. That sort of absence from work, absence because you are nervous about being contaminated, is not covered by the Family Medical Leave Act, it would not be covered by most or all state and local paid sick time laws or, and in fact, most employer sick time laws that I am aware of.

That said, we are in a time when people's anxieties are heightened and I think my pragmatic, not legal, my *pragmatic* recommendation would be that if you can make it work for someone to work from home, this might be a good time to accommodate them.

Similarly, you should probably be thinking ahead to how you will respond if there are other disruptions that may not be covered by your typical policies. For example, in other countries we have seen schools start to be closed for extended periods of time. How will you respond if you have parents who are all of a sudden in a pretty serious childcare crisis because the schools are closed? What can you do to make it possible for them to keep doing their job from home with their children or otherwise make it possible for things to move on as best they can?

You should think ahead about what if the mass transit system in your metro area is shut down. You know, a lot of workers rely on that to get to work. How can you accommodate them or what mitigating steps could you take?

And finally think ahead to how you would or will respond if you do have an employee who reports to you that they do have a confirmed case of COVID-19. Mark is actually quite well versed in that due to his background in public health, but you know the headline advice in that situation is call your public health authority and do what they say. In that

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situation, where you have a confirmed case of the disease, let's trust the real health professionals and the lawyers can come in second place after them.

Mark Barnes: Doug, thank you. We actually have a ton of questions that have come in about the employment issues. I think what we will do is we will hold those for a minute and we will go to Jeremiah and talk for a minute about some of the public company issues and then for everybody on the phone we are going to come back to a ton of questions in regard to how to handle some categories of situations in the workplace. So Jeremiah, why don't you take us briefly in terms of the legal issues for public companies, and then as I said, we'll come back to the questions in regard to employment and labor conditions.

Jeremiah Williams: Okay, thanks, Mark. I am just going to talk very briefly about SEC guidance in this area with respect to financial reporting and disclosures. Not a surprise that the SEC's been following this very closely. And they have made a number of statements in press releases over the last several weeks. And there are three points that have come out in these statements I just want to talk about. The most recent which was just yesterday.

The first thing is the SEC's actually tried to stress making it easier for issuers and for companies or entities that have filing requirements. So yesterday they came out with some regulatory relief, saying that for public companies can get a 45-day extension for certain filings such as annual and quarterly reports. That is particularly timely since we are right in the season for that. For a lot of year end companies – who have a year end financial calendar – they are filing their annual reports now. So that is timely. 45-day extension for that. They have also granted other types of relief to other types of issuers.

The Division of Investment Management has come out, for example, and said that for investment advisors to register funds there is a waiving of in-person meeting requirements through mid-June. And then, perhaps most *importantly*, what the SEC has said is that these are kind of specific exceptions they've made, but they've also said, "Listen, if you have a situation that doesn't fall into these categories, give us a call. Reach out to the staff. We are happy to talk to people" and they are giving an indication they are going to be accommodating. So, you know, people's issue that they are dealing with as far as people's time or people not being able to travel, things of that nature, should not create a regulatory problem, at least in terms of like the regular filings. That is the first point.

The second point is that in these statements and also in the one yesterday, the SEC has really cautioned companies about how they handle non-public information about the company's response or handling of the coronavirus. And you can picture a typical situation where you have a handful of people who really are closely monitoring things and are aware of what's going on and making decisions and this is just really more of a reminder for two things that can come out of this.

One, in terms of material non-public information, MNPI, just making sure you don't have a situation where you have directors or officers who are trading while in knowledge of some information that is material about a coronavirus response or issue and that material has not been disseminated to the public generally. And a related point in terms of information is avoiding selective disclosure. So Reg FD, making sure, that if something is said about, you know, how the coronavirus is affecting the company or its performance, if that is something that is said, in an appropriate manner and is not done selectively.

And that is also kind of tied to another point, which is I think this is the time when I think a company should be particularly mindful and diligent about their social media policies. Making sure they don't have some people making kind of offhand remarks about something going on and that again has not been vetted the way it should be. Or not been disseminated properly.

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The last point that the SEC has made is the most important point. The one I want to focus on, is about making adequate disclosure. I think there is a good example with how the SEC handled Brexit from back in the 2018 timeframe. The SEC saw what types of disclosures that companies were making about Brexit and about the risks there and ____ [?] Craydon actually came out and made a statement, and he actually gave a hypothetical. He said, “You know, I have seen kind of disclosures like Company A, where they give a thoughtful analysis of a potential risk posed by a hard Brexit, and where there is no deal in place and that they are talking about the effects from a company supply chain of business prospects and that is Company A.” “And then you see Company B just identifies Brexit as a business threat king of generically and doesn’t say anything else.”

And his point was that the Company A response is really the right one. And that companies need to be very diligent and thoughtful about the disclosures that they are making. So in light of that I just wanted to take a few minutes just to talk about what are the best practices in terms of thinking about how public companies are disclosing coronavirus risks. This is something we have been tracking, something that we’ve been counseling clients on. And you know just looking at disclosures that have been made, some have been more effective than others.

And so what is an example of aspects of an effective disclosure? I think there are two parts. The first part is talking about what is going on right now. What has happened and what the company is doing about it. And this gets into also into mitigation as well. Like what are you doing to mitigate the risks?

Just to give a couple of examples, there is a retailer in its published 10K that said “We closed more than half of our stores in China.” A very specific fact. Like telling investors, “We’ve actually had to close a lot of the stores” and giving like an idea of the magnitude of that. And a pharmaceutical company in their disclosure they went into a fair amount of detail about how initially operations were closed in China in February. Some operations have come back online and resumed. But even those are not up to normal level because employees are still transitioning from working at home, to coming to the office. The pharmaceutical company also talked about its collaboration partner, what was going on with it. And so, it was just like very specific as far as letting investors know what is going on. So, that is something that I think companies should be thinking about and should be doing.

The second part of this is the *tougher* part which is the future risk. And this is obviously a lot of uncertainty and the coronavirus is vastly developing and evolving. Each day brings different news, so this is a little bit tougher. And so looking at sort of the disclosures here, I think the best ones, tend to just say what they can. And I think importantly they are not limiting, they are not assuming that it stays where it is. They are not just talking about China, or places where it is affected now, but talking about what happens if this spreads.

So, for example, going back to the same pharmaceutical company I talked about before, they talked about how they have a limited stockpile of a specific drug. One of their drugs. They have a limited stockpile and about how because operations, if things continue, they are going to eventually run out of that, and they are not going to maybe make more because of supply chain limitation.

One thing that Michael talked about a little bit earlier was about clinical trials in China. This pharmaceutical company disclosed about its current and upcoming clinical trials and about, you know, potential problems with site initiation and patient enrollment being delayed. Talked about the effect of hospitals prioritizing the coronavirus which could have an impact on resources available for clinical trials and also the pharmaceutical company talked about how this is not just an issue for clinical trials in China, but also in other parts of the world if the virus continues to spread.

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And then for a hospital company, they talked about, in their disclosure, about the potential – this is the future risk – of patients cancelling or deferring elective procedures and also about treatment of coronavirus patients resulting in a temporary shutdown or a diversion of resources about disruption of their pharmaceutical supplies, the disruption of their medical supplies. So this is just a couple of examples. I think the most effective ones are the ones that are just telling people what is going on now and also just giving some specific thought into how this could affect their business.

And when you talk about disclosures, one other thing I just want to mention is the danger of “may.” And the SEC -- this has been a longstanding SEC position – that saying something *may* happen when, in effect, it already occurred, can be misleading. So if you say our supply chain may be affected, when in fact at this time you have already seen supply chain disruption, it is no longer sufficient to just say “may.”

And just two other quick thoughts in terms of disclosures, just being thoughtful. The examples I gave were written disclosures that were formal and then reports of that nature. Those are usually well scrubbed and vetted. I think companies need to be particularly mindful about informal discussions. I talk about social media. If you have people appearing at conferences or things like that, just making sure that what people are saying is accurate. Making sure that if there has been earnings guidance given, to what extent the company is sticking by its earnings guidance. So maybe it needs to revise that? And so those are things that you should be cognizant of, as well,

Mark Barnes: Hey, Jeremiah, we have a question about the ... this is not really about the business conditions that are created by COVID, but it is really about what happens if there actually is a serious outbreak in a particular company. One can imagine for example, even a white collar or a blue collar workforce in which there were say 20% of the workforce had been depleted because they actually were diagnosed with coronavirus. Or let's say another example that the questioner gives is “What if you had to cut two or three from the C suite who were affected by this, then what is the standard for disclosure? I mean, we know that there is a government example which is the government of Iran has been heavily affected, I mean at the highest levels by I think 23 different people who are at the upper echelons of government have been diagnosed as having coronavirus. That is only a government entity, as opposed to a private, but what do you think about that?”

Jeremiah Williams: Yeah, I think that is a good question. Those are both examples are definitely material events. Both in the context of your know you have a widespread issue in a company or you just have just a couple of people, but they are really, really critical people. And so this actually leads to the question of when these things have to be disclosed. So, you know, I think in both of those examples, the companies really want to think about saying something. And I think this obviously dovetails a little bit with the earlier discussion about being respectful of people, and sort of like people's ... if it is a CEO, a particular person, that can be a tough thing to respect people's privacy, but those both I think are material events that could, that should be disclosed in some form. I think you have to think about the manner in which you do it and how you do it. But those are both material events.

Mark Barnes: Okay, great. Thank you. So we are going to go back to many of the questions that have come in. Most of which frankly are about the workplace issues. So an example, would be, actually we have gotten different iterations of kind of the same question and let me pose it. I will try to say what I think and Doug why don't you weigh in and anybody else who is a presenter is welcome to weigh in, as well.

We got a lot of questions that have come over the transom in regard to what to do about an employee who in a social situation, for example, has been exposed to someone who has A) been suspected of possibly having coronavirus and been quarantined for that, B) someone who actually has been diagnosed with coronavirus. So what do you do with that person?

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And then there are other iterations of the question in regard to what about the spouse of that person? Or the social friend of the social friend of a work colleague of someone who has coronavirus? And I will tell you, you know, I have served in many public health capacities. I am not trained medically, but I will tell you what we have ... we have been consulting extensively with people who are experts, who are physicians and scientists and who are specialists in infectious disease. And what we have been told is that the immediate concentric circle around the diagnosed case, those are people about whom, for whom, we should be concerned about the risks. Not only the risks to them, but the risks if they have contracted it they might spread it to somebody else.

But we have also been told that when you go beyond that first concentric circle to the contacts of the contacts, the risk becomes so small that at least at the current time, those are not people about whom we should obsess unless those people who are in the second circle are actually people who are so close, for example spouses and children, that they share ... that they have been in very close proximity to each other. And that for a case in which a hypothetical in which the index case really is a diagnosed coronavirus case. The person who has tested positive. For the person who is only suspected of having it and been quarantined, until they can be tested, etc., then the question is, there are their contacts, but then when you go beyond that, you go beyond the immediate concentric circle, you are in a public health ... from a public health perspective we are told, you are in a situation in which the risk becomes really vanishingly small. And it really doesn't really require intervention.

But with all of these cases, as Doug and I have said, the ... and I think it is just really common sense, you have these questions and you have to rely on someone who has an M.D. after their name, you got to rely on someone who is in the public health department. These are questions that you should be posing to the local health department help officers because they can help you answer these questions that is credible and also comes from a regulatory perspective.

Doug Brayley: Yes, I think that is exactly right. The "What should you do?" question is best posed to the public health folks. What *may* you do, as an employer, you may at any time instruct one of your employees to stay home and work from home or just stay home and not come to work. That is no problem. Instructing them to do so and not paying them is a more complicated question that you should probably talk to counsel about. As before, what I am seeing in the market and I think our general advice would be that if you can see your way doing it, I think paying people to encourage compliance is probably the best public health outcome. But again, more complicated if you are thinking about unpaid. But the bottom line is if you would feel more comfortable instructing someone to work from home, go for it.

Mark Barnes: There is a question, Doug, about whether there is any discussion of the policy implications of groups of employees, who probably are blue collar and don't have sick leave benefits and are faced with an extended "don't come to work" policy and what to do about them. Groups like part time employees or temporary employees. Could employers be asked to pick up extra costs perhaps especially if these become prolonged issues and are there any government policies or programs that might help with those kinds of expenses? Is there any precedent for federal level response?

Well, there is a precedent which is 9/11 and the kinds of subsidies that were given to employers below 14th Street in New York. That comes to mind immediately. But you may have other thoughts about this.

Doug Brayley: Yeah. I mean for folks who are hourly employees, the principle is that you get paid for the hours you work. So if you are not working, you are not getting paid. And if those employees do not have paid sick time benefits or anything similar, then there would be no legal obligation to pay them. Big asterisk there for unionized workplaces ... may be a very different analysis. That would depend a lot on your collective bargaining agreement, so definitely do not take my advice with regard to the unionized workplaces which are a whole set of other issues.

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And I think Mark is right, that whether employers might feel obligated or pressured to pick up costs for those employees, is a different question. More of a political question than a legal one. I could see it happening. Just to repeat the same advice, what we are seeing at least in the short term a lot of employers are picking up that tab for the sake of public health.

Mark Barnes: Doug, can companies require a 14-day quarantine after all travel or just require it after one has travelled to one of the level 2 or 3 countries.

Doug Brayley: You *can* and you *may*, but I would again recommend talking to your public health authority about whether that is prudent in their view.

Mark Barnes: And to answer that with what I know, from talking to public health folks, in this maelstrom, I think that they would say it is probably not necessary for all travel. It is probably a good idea for those who have come from within the last 14 days from one of the tagged countries.

You know one of the problems here is that right now the public health authority is able to focus on individual cases, individual countries like Italy, Iran and China, but if there becomes widespread community transmission in many countries, then we may be in a situation in which it could be all travel, or all international travel, for example. But we are not there yet, but if this becomes a widespread transmission, there will be much less attention to individual cases and much more attention to, for example, this is a question for you, Doug, for example ... we have heard some employers in the last few days have decided, for example, to rotate their staff so they have fewer people in the office. They still have an office staff, but they send 20% home for a week. And then they juggle that, and another 20% goes out next week in an attempt, really, to reduce the density of the population in the workplace.

Doug Brayley: I think that is another example of something you *may* do, but whether you *must* do it, I don't think anyone *must* do that yet. I don't think you must do it until the public health authorities tell you that you must do it.

A related question to the point about requiring quarantine after all travel, we have heard some employers ask whether they can ban their employees from taking mass transit to get to work. The answer to that is I suppose you could, although I think that does raise some pretty significant equity questions if you have your lower paid employees relying on mass transit and management have their own cars, how are you going to deal with that? Are you going to make it possible for those folks to work from home if you are going to ban them from using mass transit. That would be another example of getting out ahead of what the public health authorities are saying is required or necessary or prudent.

Mark Barnes: Doug, is there any legal vulnerability for healthcare employers to be subject to whistleblower retaliation for claims for not providing a safe and healthy work environment. If so, is that true for any laws other than OSHA? And the questioner is asking about health care employers like hospitals, but I mean OSHA, the general duty call of OSHA extends to all employers. So what do you think about that?

Doug Brayley: Yes, the OSHA does have a whistleblower provision and you are _____ claims and the facile answer is to provide a safe workplace and to protect against *known* risks. I emphasize *known* because I think that that would not impose upon you a burden of making your workplace going above and beyond what the public health authorities are recommending or beyond best practices. But, yes, there is some risk of that.

Mark Barnes: Here is a question that I really think requires a public health answer but we can ... any of us might weigh in. "If an employer allows back into the office an employee who has visited a higher risk area in the U.S. like Seattle

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King's County, or California, without coming back and quarantining themselves, does that create a hazardous place in the office?

I think the answer to that is there are no public health recommendations for quarantining people who come from California and Seattle and until that happens ... there may be a marginally higher risk but it doesn't seem like one that would merit taking any kind of employment restrictive actions at that point, at least not now.

Doug Brayley: Yeah, I agree with that. And another point just to think about is that workplace related injuries and damages that you suffer as a result of workplace safety are generally covered by workers comp. You are not talking about unrestricted liability for negligence in tort claims, you are looking at the workers comp regime. This varies state to state so this is not legal advice, but generally in order to lose the protection of workers comp, you have to be doing something willfully dangerous. And I think that is hard to argue that doing anything other than ... that failing to go above and beyond public health recommendations is willfully dangerous.

Mark Barnes: If an employee ... we actually have kind of talked about a variant of this, but there is an employee who say has been recently in cancer chemotherapy, has underlying HIV infection, has chronic diabetes, therefore is immune-compromised for these reasons and is concerned about their liabilities because they have to take public transportation for work, then would it be a reasonable accommodation if you can and if it is an undue burden, to offer that they would work at home.

Doug Brayley: Yeah, it might be.

Mark Barnes: Okay. That is what I thought. Doug, what about the issue of what to do ... I mean this is one that you and I and Val on this call at Ropes have gotten many times. Perhaps it is so common it hasn't come in over the transom. But what do you do when you have someone in the workplace who is today sniffing, coughing -- a hacking cough -- is visibly ill. What do you do?

Doug Brayley: Okay, so again I am going to distinguish between what you *must* do and what you *should* do and what you *may* do. You *may* tell that employee to go home. I think you probably should tell that employee to go home. But I don't think you *must* tell that employee to go home. Do you disagree, Mark?

Mark Barnes: No, I don't disagree. I mean, let's face it, most of the people that have hacking coughs do not have coronavirus. And there is no particular recommendation from the public health authorities. It may differ from state to state and locality to locality that everybody must stay home. There is a recommendation, I think, that is pretty clear at this point that people who are ill with a respiratory type illness *should* stay home and *should* be encouraged to stay home. That is really what you should do and if they are particularly sick, you should tell them that they should go to their doctor and get looked at and have an X-ray. And if the doctor thinks they fit the clinical profile of COVID, he or she can advocate that they would get one of the tests of limited availability which may predictably as Michael said going to become more prevalent as the laboratories are able to open and make available their own laboratory-developed tests under the authority that the CDC has given them, at least in this limited period, which would undoubtedly be extended after the fifteen days is up. So I think that is the answer that we have been giving.

Doug Brayley: And that may, should and must answer about sending sick employees home is not particularly different than the advice you would give during seasonal flu season.

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Mark Barnes: Right. What about somebody who is diagnosed with COVID and what do you do about the obligation of confidentiality toward the employee and the question actually talks about HIPPA confidentiality but remember that HIPPA is only extending to health care providers not to regular employers. Most employers are not covered entities under HIPPA, but they never have confidentiality obligations.

Doug Brayley: Yes, I think it is a pretty widespread conception out there that employers have some sort of self-standing HIPPA obligation. That just isn't true. So setting that aside. Yeah, I think there are generally obligations toward employee confidentiality and even where there aren't legal obligations there are expectations which may be just as important.

In the case of someone who has been actually diagnosed with COVID-19, I think the advice is to call the public health authority and make whatever disclosures that the public health authority recommends and in the way that the public health authority recommends them. Mark can talk about how that usually goes. From my understanding, they usually would not be instructing you to disclose the name of the person who is the index case or who may have caused their exposure. But look, does that pose some arguable conflict between protecting employee confidentiality and privacy, and the public health authority instructions?

Mark Barnes: I think arguably.

Doug Brayley: But I will tell you what. If your choice is between arguably violating employee privacy and disobeying the order of a public health authority during a pandemic, I would much rather have you follow the public health authority and deal with the arguable privacy claim later.

Mark Barnes: I think that is right, Doug. I mean just so people know, if there is someone who is actually confirmed as having COVID, the way that this will work, is that that positive test result will get reported by their health care provider and/or by the laboratory that tested it to the public health department at the local, county or state level. And at that point, what will happen is that the public health authority will send out a public health worker who is trained in assessing the context of someone who has actually been diagnosed with this illness. They will do that at the person's home, they will do that at the person's church or synagogue, and they'll do that at the person's workplace.

You will if you have a COVID virus diagnosis within your work force, you will have a public health worker ... you can expect a public health worker to show up. The methodology is that they actually do not, that they are instructed to the extent possible not to disclose the identity of the index case. But that is very difficult in this situation because in order to be able to assess the contacts you have to actually ask people who's been in contact with this particular individual.

But that is on the health department to make that disclosure, assess the contacts, and they will tell you who the contacts are within your work force, who may be at risk and then they will advise you probably to send those people home for 14 or 21 days.

And by the way, one of the problems here that we have run into is the lack of data, lack of reliability of data from China. Also even more so, from Iran, because it looks as though there have been plenty more cases that probably have not been reported. So we don't have a firm idea yet of exactly the incubation period is. It could be 14 days, it could 21, it could be 28. The standard right now is 14, but there is some debate about that.

And remember also that not everybody who is exposed, and this is important to keep in mind, not everyone exposed is actually going to get ... to acquire infection. And those who acquire infection, not all of the, in fact a very small

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minority of them, are going from what we know now, to get any kind of very serious illness. And of *those* people, an even smaller percentage, would end up potentially in the hospital.

So the vast majority of people, even when they are exposed to a COVID case are not going to get it. They are not going to get infected. Their body will fight off the infection. The infection won't lodge. So it is important to keep all of this in some perspective. And that is one of our great hopes that this will, because it is more efficient in transmission than the regular flu, that ultimately because of the kinds of precautions that employers and others are taking, that it will burn itself out and the chain... and any kind of ... there will be a tipping point in the chain ... so there is actually ultimately a reduction in the number of infections.

The CLE credit, by the way for this, is 4655. The CLE code is 4655.

We are going to go on with a few more questions. Michael, Jeremiah or Val, did you guys want to add anything to the stuff that we have been talking about?

Michael Lampert: This is Michael. One point I will add, Mark you had mentioned, Doug, you had mentioned, that obviously guidance of people of an M.D. or R.N. after their name is most helpful in making some of the determinations around clinical necessity. With that acknowledged, and that correct and that said, the CDC does have on its website a lot of guidance, there is a wealth of guidance that is available. That provides, among other things, information regarding appropriate care, treatment, approach for individuals who have been in proximity to others who are infected. And so that is a resource at any rate, not to discount the value of other providers but if people do have questions and want some sense for themselves as to what the health authorities are looking at, and haven't been to the CDC website, go there.

Mark Barnes: Val or Jeremiah, do you want to add anything else before I go to some other questions that have come in.

Valerie Bonham: Nope. I am good.

Jeremiah Williams: Yeah, go ahead. Yep.

Mark Barnes: So, here's a question, Doug, just ... the person is just asking sort of for confirmation on this. It seems okay to ask employees to tell us if they have come into contact with someone who has travelled to a high risk area, or otherwise might have COVID-19.

Doug Brayley: Yes.

Mark Barnes: Okay. Here's another question, an interesting question from someone who clearly knows ... has some detailed knowledge about this. There seems to be some provision under state law, and this under ... and state laws differ on the question I am about to raise ... but there seems to be some provision under some state laws for an individual employee of a private entity to be *deputized* as a volunteer to assist the state in responding to a public health emergency. Do you have any thoughts on considerations for employers or best practices to paper these arrangements to assure indemnification or limitation of liability for a company employee acting in that capacity? Doug?

Doug Brayley: That is not something with which I am aware.

Mark Barnes: Okay. Well, it does exist but it differs from state to state. And you definitely don't want your employees to take on that kind of responsibility and essentially become the arm of the local or state public health department

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without having at least an email exchange with the cognizant public health authority in which they clearly are designating this and directing you and your employee as to what to do. That is probably most likely in a situation in which there have been a widespread community outbreak. There is a shortage of public health workers to do the contact assessment and they would deputize for example a nurse who is in the employee health clinic to do that kind of outreach and contact assessment. So that is what would happen.

There is another question about insurance that might ... and that is ... are there any implications here for DNO insurance? And Jeremiah, this is really for you, too. For DNO insurance, for liability insurance? Is there anything that people ... that companies should be looking at in their insurance policies?

Jeremiah Williams: That is a good question. I don't know to what extent this would be covered in a standard direct office ... I think as a general matter it would be good to review an insurance policy and see what it says. I don't know if I have a view if whether this is something that would be implicated by it or not. But I think it is good practice just to review it and see what is there.

Doug Brayley: Yeah, I agree with that. Just double check in your workers comp coverage, your general personal injury liability coverage to the extent that workers comp doesn't pick it up.

Mark Barnes: Doug, a complicated question but one which is important in regard to employment practices, under the Family Medical Leave Act and also state and local sick leaves and ____ laws we can ask as an employer for a fitness for duty certification for employees own serious health condition. And under the ADA we can ask an employee to undergo a medical examination if we have a reasonable belief based on objective evidence that the employee poses or may pose a direct threat in the workplace.

Doug Brayley: I am nodding. I agree.

Mark Barnes: But if an employee takes family medical leave to care for a sick family member, can the employer require the employee to go to a medical provider to be screened and cleared for coronavirus prior to allowing the employee to return to work under the ADA direct threat theory, even though we could not ask for a fitness for duty certification for an employee returning from caring for a serious health condition of a family member under FMLA.

Doug Brayley: it is a great question. I am assuming from the hypothetical that the family member whom the employee has been taking care of was a COVID-19 patient?

Mark Barnes: That is the cleaner case and the easier case.

Doug Brayley: I think in that case the answer is yes. You can ask for that fitness for duty report because then I think that you would pretty clearly fall under the direct threat exception under the ADA. If it is someone who had the sniffles that they were caring for, I think it is a closer call. That the other argument would be that regular influenza and illness is not a disability and therefore would not even fall under the disability discrimination laws. So, but I do think that is a tougher case than in the case of someone who is caring for a COVID-19 patient.

Mark Barnes: Okay. Great. We have a question here which is rather obscure but I will try to answer it, since it falls into what I do when I am not worried about COVID. And that is from a major university or medical center comes the question about what do you do about the expenditure of federal grant money, well, though this can also be a question for a business that has a contract with the department of defense or the department of energy, what do you do about the

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expenses of meetings that were going to be funded by federal money but have been canceled because of the COVID virus. What do you do about the inability of a lab to reopen because someone has actually been diagnosed in the laboratory with COVID and there is essentially an out of work time for the lab staff, especially the lab staff who really have to be in the lab to do their work? I think the answer to that question is no, there is no guidance about that, but I think there will be, especially to the extent that the larger that this becomes as a public health problem, the more prevalent the infection is, then I think all the federal agencies that fund research either in private industry through the SBIR program or a few other programs or that are funding research activities and service activities in the not-for-profit sectors -- universities, medical centers, etc. -- they are going to have to answer these questions since they definitely will be presented with these questions.

Valerie Bonham: And Mark, I would add on that, that they will. The basic question isn't novel as to what will we do when fulfilling the terms of a grant or a contract are somehow impeded in an extraordinary circumstance, and so even though they haven't gotten to it yet, I would expect guidance out of the funding agencies.

Doug Brayley: To add onto my last question about fitness for duty, I was just looking back at 2009 ... or the guidance that EEOC put out in connection with H1N1, and in that the EEOC takes the position that asking the doctor or the doctor's note would not be a disability related inquiry or if the pandemic was truly severe would be justified under the direct threat standard. At least as of 11 years ago the EEOC thought that asking for that note would be okay under the ADA.

Mark Barnes: Here's a note from a general counsel somewhere. On the insurance policy question, check the CGL or property policies for business interruption insurance, endorsements may not speak to disease and viruses and the spread of public health conditions.

Doug Brayley: That's a good point.

Mark Barnes: Yep, that is a very good point. Okay. I think that we have actually gone through just about all of the questions. Michael, was there anything else that you wanted to say in regard to any of the questions that have come in?

Michael Lampert: Nothing on the questions. Instead, I will make just a shameless plug for organizations in the health care sector in particular or investors in them. On the 19th of March at 2 o'clock Eastern, 11 o'clock Pacific, we will take a deep and a broader dive there.

Mark Barnes: Okay, that is great. Thank you.

Well, I think with that we are going to stop. We actually were able to cover ... I think ... a lot of the questions actually overlapped with one another. And I tried to phrase them in a way that would cover everything ... at least the theme and the questions that you've sent in.

So I do want to thank you. Remember that there is the CDC guidance that is available. Take refuge in that. And take refuge in the guidance that is undoubtedly on the websites of your state health departments and your local health department because they will give an imprimatur if you follow them. They will give an imprimatur of appropriateness. So what you do in regard with your customers, your patients, your employees, your colleagues, ... remember that as Michael said there is going to be a webinar in about a week and a half specifically for the health care work places and the health care facilities and how they are dealing with this both in regards to patients and visitors, as well as in regard to the health care workers.

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There is another question, Doug, that has come in. In regard to what one does with visitors to the workplace. And screening visitors to the workplace. When someone comes in. When you have a visitor, a visiting scholar in a university. A visiting person from another company in an office setting in New York or Boston or San Francisco. Do you get to ask them questions? And if so, what questions do you get to ask them?

Doug Brayley: Well, not really an employment law question because those visitors aren't your employees. So, I think from my narrow perspective, you can ask them whatever the heck you want. I think the public health answer is probably that if you put them through a thorough screening you may be getting well out ahead of where the public health authorities are.

Mark Barnes: Yeah. And you also have to be careful. Because these places are places of public accommodation. So the employment laws don't apply, but the state and local discrimination laws apply as well as the federal ADA and Title VI, for example, which is public accommodation rather than employment. If you are going to do it, you gotta do it for everybody.

Doug Brayley: Not just people you suspect are from high risk areas.

Mark Barnes: Here's another one. We still have a few minutes. I am going to keep going with the questions because they are still coming in. If an exempt employee, that is he is not a member of the bargaining unit, manager, an employee, is diagnosed with COVID and self-quarantined due to exposure, and we require that they use sick time plus Family Medical Leave Act, but they run out before the 14 day period, can we not dock their pay for the two days in the week that they don't have sick time coverage, or does that risk the argument that they are then to be considered non-exempt.

Doug Brayley: Let's take that off line. There are some moving pieces on that one, but it is the right question to be asking.

Mark Barnes: Okay, well thank you all for being on the call. We hope this was of some help. There are FAQs that Ropes & Gray has put out on our own website. They cover many of these issues in a way that you can easily access. Remember that this is not legal advice. If you want our legal advice, call us. But we tried to give as much information as we can under the circumstances.

So thank you very much and we wish you well. Goodbye.

Operator: This concludes the day's conference call. Thank you for your participation. You may now disconnect.