

PROGNOSIS

THE PRESIDENT'S REPORT

BY WILLIAM R. SHENTON

RECENT CORPORATE SCANDALS HAVE profoundly affected the American public's views of corporate leaders, with more than 60 percent of respondents in a March poll conducted by the Pew Research Center saying they believe that corporate leaders have "low ethical standards." The Oct. 7, 2002, edition of *BusinessWeek* featured a special report on corporate boards, including a "Hall of Shame" for boards that it found to be insufficiently active or independent of management. On the brighter side, *BusinessWeek* does foresee a "revolution in corporate governance" that will result from this increased attention.

With all the recent attention from media and regulatory agencies, we may indeed be at the dawn of a new era of heightened scrutiny of corporate boards and the way they oversee their organizations. Of course, meticulous scrutiny of corporate actions is old news to our health care clients. We are accustomed to longstanding and meticulous attention from agencies like the Office of Inspector General of DHHS, in the many guidances and model compliance plans it has issued for health care organizations. But this effect now may be magnified as corporate America emerges from the troubled waters of the past two years. Fortunately, an important resource for every health care

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Cost Share Provisions – An Alternative to Noncompetition Clauses

BY DAVID B. HAWLEY

Introduction

The scenario is familiar: A health care practice hires a physician under a contract of employment. The physician practices in a specialized field and is one of few such practitioners in the area in which the health care practice operates. In order to protect its business interests, the health care practice includes a noncompetition clause in the employee's employment contract.

After several years, the employee leaves the practice and sets up shop within the geographic area prohibited by the noncompetition clause. The practice brings suit, seeking injunctive relief to prevent the continued operation of the former employee's office. Because of the former employee's specialization, however, a court rules the noncompetition clause unenforceable, finding that such clause violates public policy. The health care practice is left with a competitor in its service area and begins to see a drain on its revenues as a result.

What are the options for the health care practice at the outset of the employment relationship? The practice may include a noncompetition clause

in the employment contract, knowing that it could be found unenforceable, but hoping that it will deter the employee from competing. On the other hand, the practice may insert a liquidated damages clause into the employment agreement, using some dollar figure chosen as a reasonable estimate of damages. As a result of the recent North Carolina Court of Appeals decision in **Eastern Carolina Internal Medicine PA v. Faidas**,¹ the court confirmed that the practice has another option—the insertion of a cost share provision into the employment contract.

Although a cost share provision may appear to be a new creation, it really is a variation on a liquidated damages clause. The cost share provision, however, must be carefully crafted and based on an effort by the health care practice to make a detailed evaluation of what its costs and expenses most likely would be if an employee left employment and established a competing practice in violation of the employment agreement.

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board has been developed by the OIG and the American Health Lawyers Association, and we should all pay careful attention. This resource, entitled *Corporate Responsibility and Corporate Compliance: A Resource For Healthcare Boards of Directors*, provides a checklist of important points for health care boards and their counsel in overseeing compliance plans. I recently had the privilege of listening in on a teleconference sponsored by the Health Care Compliance Association about this new resource, and thought that I could highlight a few key features for you.

The resource echoes the message that has been emphasized throughout the business press—that directors must take an active role in overseeing the management of their companies. It notes one positive factor that may distinguish the health care industry: the dramatic growth in health care compliance programs—from 55 percent in 1999 to almost 90 percent in 2002. But the resource also emphasizes that just having a compliance plan is not enough; there must also be active involvement by the board, directly or through the appropriate committee structure, in overseeing the structure and operation of the compliance plan.

The resource suggests that a board's involvement should start with the fundamental structural aspects of the compliance program. This includes establishing a culture of compliance through a code of conduct, identifying significant compliance risk areas, marshalling appropriate resources and identifying the right personnel to run the program, and finally, establishing reporting responsibilities and lines of authority to the board.

This last point, the reporting responsibility, ties the board directly to the ongoing oversight of the compliance program. The resource recognizes that while management must remain primarily responsible for the day-to-day operation of the company, including its compliance plan, the board should have an active role on a number of key issues, including:

- ♦ Identifying the compliance-related education and training that is in place throughout the organization and how its effectiveness has been assessed;
- ♦ Determining how the organization periodically evaluates the effectiveness of the compliance program, including reporting systems like a compliance hotline;
- ♦ Defining how the board is kept informed on significant regulatory and industry developments affecting the organization's risk areas and how the compliance program is restructured to accommodate any new risks;
- ♦ Maintaining appropriate personnel protections, both for the "whistleblowers" and for those who are accused of misconduct;
- ♦ Establishing guidelines for reporting compliance violations to the board; and
- ♦ Adopting policies that govern the reporting of probable violations of law to government authorities.

To emphasize its fundamental message of active board involvement on these issues, the resource quotes the opinion in the **Caremark** case, where the court found no breach of fiduciary duty by the company's board, but noted ominously:

"[A] director's obligation includes a duty to attempt in good faith to assure that a corporate information and reporting system, which the board concludes is adequate, exists, and that failure to do so under some circumstances may, in theory at least, render a director liable for losses caused by non-compliance with applicable legal standards."

As boards of health care organizations and their counsel respond to the new corporate environment, the new OIG/AHLA resource will be an important tool to help directors to recognize and exercise their responsibilities, and can also serve as an "industry-standard" roadmap that defines key aspects of the board's oversight of the compliance plan. I commend it for your careful attention as you advise your health care clients in these troubled times. ■

Editors' Comments

As the editors of *Prognosis*, we are very receptive to any ideas that you may have concerning the topics which should be covered in future editions of *Prognosis*.

If you wish to submit your ideas, or better yet, submit articles for consideration of

publication in *Prognosis*, please e-mail the *Prognosis* co-editors at: davidbohm@cconnect.net or lgordon@nmrs.com. Thank you for your support and we look forward to hearing from you. ■

**Traditional Noncompetition
Clauses in Physician Employment
Agreements**

Aside from the other normal tests for the validity of a noncompetition clause (i.e., in writing, reasonable as to time and territory, entered into as part of a contract of employment, and entered into for valuable consideration), North Carolina's appellate courts have carefully scrutinized physician noncompetition clauses to determine whether such clauses violate state public policy. In three cases, **Statesville Medical Group PA v. Dickey**,² **The Nalle Clinic Company v. Parker**,³ and **Iredell Digestive Disease Clinic PA v. Petrozza**,⁴ the North Carolina Court of Appeals held that the noncompetition clauses in physician employment agreements were unenforceable because they violated public policy.

In **Iredell**, the Court of Appeals reviewed a contractual covenant that prohibited the defendant physician from practicing in the specialties of gastroenterology and internal medicine for a period of three years within a 20 mile radius of Statesville. The **Iredell** Court engaged in a balancing of the public's interest in adequate health care versus the parties' freedom of contract rights. The test, according to the court, was whether enforcing the contractual obligation would have created "a substantial question of potential harm to the public health" as opposed to merely "inconvenience[ing] the public without causing substantial harm."⁵ The **Iredell** Court focused on the "monopoly" effect that enforcement of the provision would have had, including the effect on fees in the future and the availability of medical care during an emergency.⁶ The court also voiced concern about preserving the doctor-patient relationship and the patient's choice of physicians. On these bases, the court concluded that the public health and welfare would be harmed and declared the covenant void as against public policy.⁷

In **Nalle**, the noncompetition covenant at issue would have prohibited the defendant from practicing pediatric endocrinology within Mecklenburg County for two years following his termination of employment.

Citing **Iredell** as controlling authority, the Court of Appeals determined that enforcement of the covenant would create a "substantial question of potential harm to the public health," in that the defendant was the only full-time pediatric endocrinologist in Mecklenburg County.⁸ To prohibit him from practicing would have created an excessive workload for the only other part-time pediatric endocrinologist in the county and likely would have resulted in critical delays in patient care and treatment. Accordingly, the **Nalle** court held the covenant "unenforceable as a matter of law as against public policy."⁹

In **Statesville**, the Court of Appeals again applied the "substantial question of potential harm" to the public health standard to strike down a covenant that would have prevented an endocrinologist from practicing for a two-year period in Iredell County. To determine the risk of substantial harm, the court identified the following factors: "the shortage of specialists in the field in the restricted area, the impact of plaintiff establishing a monopoly of endocrinology practice in the area, including the impact on fees in the future and the availability of a doctor at all times for emergencies, and the public interest in having a choice in the selection of a physician."¹⁰ Because enforcing the covenant "would grant plaintiff a monopoly for two years, substantially impede patients' access to their physician of choice, and impair their ease of access to second opinions," the **Statesville** court declared the covenant unenforceable.¹¹

The trend in these cases showed an emphasis on patient choice and the avoidance of a monopoly in determining the enforceability of noncompetition clauses in physician employment agreements, particularly where the employee practiced in a relatively unique field of medicine. To overcome these factors, health care practices turned to liquidated damages clauses to provide a measure of relief when an employee decides to open his or her own health care practice within the operating area of his or her former employer. Unfortunately, an improperly drafted liquidated damages clause could result in a finding that the clause was actually a penalty.

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Liquidated Damages Clauses

Under North Carolina law, the parties to a contract may agree that liquidated damages will be paid as compensation for injuries in the event of a breach of the contract.¹² Such a provision will be enforced unless it is determined that the provision is actually a penalty imposed to deter a possible breach of the contract. The test for whether a designated amount is a liquidated damages clause or a penalty was established by the North Carolina Supreme Court:

"[A] stipulated sum is for liquidated damages only (1) where the damages which the parties might reasonably anticipate are difficult to ascertain because of their indefiniteness or uncertainty and (2) where the amount

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stipulated is either a reasonable estimate of the damages which would probably be caused by a breach or is reasonably proportionate to the damages which have actually been caused by the breach.”¹³

In evaluating a liquidated damages clause, the Supreme Court in **Knutton** also stated that courts should consider “the nature of the contract, and its words, and try to ascertain the intentions of the parties; and also will consider that the parties, being informed as to the facts and circumstances, are better able than any one else to determine what would be a fair and reasonable compensation for a breach.”¹⁴

In **Faidas**, the North Carolina Court of Appeals was confronted with the issues of the cost share provision being a covenant not to compete or a valid liquidated damages clause.

The Cost Sharing Provision in Faidas

In **Faidas**, Eastern Carolina Internal Medicine PA (ECIM) and Dr. Anna Faidas, a board-certified oncologist, entered into an employment agreement in July 1996. The employment agreement contained a cost sharing provision that included:

- ♦ A specific statement that the parties agreed that ECIM would incur significant expenses and indebtedness by employing Dr. Faidas;
- ♦ A specific statement that ECIM would sustain economic loss as the result of Dr. Faidas’ termination of employment and the absence of revenue to help cover ECIM’s overhead expenses;
- ♦ A specific statement that the parties agreed that ECIM would suffer economic damages from such termination and that the cost sharing provision was a reasonable estimate of damages and an equitable reimbursement of damages;
- ♦ A clause whereby Dr. Faidas agreed to pay the cost share amount if her employment was terminated and she began practicing in a particular three county area within one year of the termination; and
- ♦ A detailed description of how the cost share amount would be calculated.

The formula for the cost share amount used factors such as the total operating expenses of ECIM for the year prior to termination of employment and the number of full-time employees of ECIM during that year.

In May 1998, Dr. Faidas resigned from employment with ECIM and within two months opened her own practice of oncology in Craven County. ECIM filed suit, seeking to enforce the cost sharing provision. Both parties moved for summary judgment, and the trial court granted summary judgment for ECIM.¹⁵ Dr. Faidas appealed.

On appeal, Dr. Faidas argued that the cost sharing provision was a void and unenforceable covenant not to compete or, alternatively, was an unenforceable penalty and not a valid liquidated damages clause.¹⁶ The Court of Appeals rejected both of these arguments.

First, the court held that the cost sharing provision was similar to a forfeiture clause it had found valid in an earlier

case, **Newman v. Raleigh Internal Medicine Associates**.¹⁷ In doing so, the court held that the cost sharing provision did not prohibit Dr. Faidas from practicing her profession, but only required that she pay the cost sharing amount if she decided to do so in the three county area named in the cost sharing provision.¹⁸ Thus, the strict scrutiny normally applied to noncompetition clauses regarding reasonableness and public policy was not appropriate for the cost sharing provision.¹⁹ Second, the court held that the cost sharing provision was an enforceable liquidated damages clause. The court noted that “the nature of the contract, the intention of the parties, ... the stipulation of the parties [that the cost sharing amount was a reasonable estimate of ECIM’s damages], the fact that the parties are better able than anyone to determine a reasonable compensation for a breach, and the fact that the damages were difficult to ascertain” reinforced that the cost sharing provision was a valid liquidated damages clause.²⁰

Future Use of Cost Sharing Provisions

As noted previously, the concept of a cost sharing clause is not new, as the Court of Appeals held in **Faidas**, it may be crafted in an employment agreement as a valid liquidated damages clause. What is unique about such a provision is how it must be structured.

First, the wording of the clause should be clear and precise in demonstrating that the parties agree that the employer will incur economic damages if the employee competes in a given geographic area, and that the parties agree that the damages amount is a reasonable estimate of potential damages.

Second, a cost sharing provision should be tied to an objective measure, such as the total administrative costs of the employer in a given year, and the formula for calculating the cost share should be described in specific terms.

Third, the intent of the employer not to prevent its former employee from competing in a given area, but to pay for the decision to do so, should be clearly evident from the language of the cost sharing provision and from the employer’s actions if a breach does occur.

Many practitioners will argue, as the defendant in **Faidas** did, that the cost sharing provision actually is a non-competition clause dressed up in a different name, and that courts should scrutinize such clauses for reasonableness and in light of public policy. What this argument fails to recognize is that the agreement of the parties, particularly their agreement that competition is fine as long as the employer can recoup some measure of lost revenues and prior expenses, removes the cost sharing provision from the realm of public policy determination and places it squarely in the hands of the employee. The physician is not outright banned from practicing in the defined geographic area. It just will require payment of a cost share for the physician to do so. ■

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Liquidation Damages for Competition – Opportunities and Pitfalls

PHYSICIAN AGREEMENTS COMMONLY INCLUDE VARIOUS PROVISIONS to deter the physician from establishing a competing practice within a defined geographic area. Such provisions are generally subject to scrutiny for public policy concerns, namely, that enforcement may harm the public by depriving them of access to health care providers. The Court of Appeals in **Eastern Carolina Internal Medicine PA v. Faidas**,¹ makes clear once and for all that a reasonable liquidated damages provision that allows the physician to continue to practice in the designated geographic area upon payment of monies determined by an agreed, predetermined formula ameliorates any public policy concern which would normally void such a contractual provision.

After **Faidas**, it is undisputed that a reasonable cost-sharing provision may be enforceable without resort to any heightened scrutiny for public policy concerns. However, it would be wrong to conclude that only cost sharing provisions can serve this function. In fact, **Faidas** and its predecessors suggest that a variety of buyout provisions may be enforceable. Moreover, **Faidas** leaves open the question of the enforceability of an agreement that contains a liquidated damages provision that is unreasonable.

Faidas and its Predecessors

In **Faidas**, a physician agreed to an employment contracting provision that required her to pay a share of the practice's total operating expenses as damages (cost sharing provision) if she chose to practice medicine in a three county area for a year after her termination. The Court of Appeals concluded that the cost sharing provision was a "forfeiture" that "simply provides for the loss of rights or privileges" if the physician competed with her employer. While the dissent argued that the provision was more than a forfeiture, because the employee would be required to pay a sum of money to her former employer, rather than her former employer withholding sums due to her, the court rejected that distinction and concluded that:

"The contract does not prohibit defendant from engaging in the practice of her profession, but only provides that if she does so within the described three county area, she will pay a certain sum for making this choice. Accordingly, we hold that the 'cost-sharing' provision is not a covenant not to compete and we do not subject it to the strict scrutiny as to reasonableness and public policy required with a covenant not to compete."²

The case the **Faidas** court relied on in reaching its conclusion, **Newman v. Raleigh Internal Medicine Assocs.**,³ contained similar reasoning. There, Dr. Newman had agreed to forfeit any salary continuation that he otherwise would have received upon termination of his employment in the event he chose to engage in a similar practice in the

county within three years after he terminated his employment. The **Newman** court held that Dr. Newman's agreement was not a covenant not to compete, because it provided his employer no right to interfere with his post-termination practice, but at a cost to the doctor.

Following this logic, then, as refined by **Faidas**, any agreement that requires a physician to "pay a certain sum" for choosing to compete, rather than barring the competition outright, would not be analyzed by the court as a covenant not to compete.

Only after reaching the conclusion that a payment option rendered the physician's agreement something other than a covenant not to compete did the **Faidas** court turn to the issue of whether the cost sharing amount was enforceable as liquidated damages or rather was an unenforceable penalty. On this point, the court determined that the cost sharing amount was reasonable, even though it represented in part damages attributable to the physician's termination of practice independent of any subsequent competition. In reaching this conclusion, the court also considered that the parties were sophisticated, that they stipulated in the contract that the cost sharing amount was a reasonable estimate of damages, and that actual damages were difficult to ascertain—elements likely to be present in most similar agreements between physicians and their practices.

The conclusion that liquidated damages may save an otherwise unenforceable noncompete subject to public policy challenge was, in fact, suggested in the seminal case setting forth the public policy issue arising with physician non-compete agreements. In **Iredell Digestive Disease Clinic PA v. Petrozza**,⁴ Dr. Petrozza had entered into an agreement barring his practice for three years within 20 miles of the town where he practiced, and also containing a liquidated damages provision of \$50,000, plus 15 percent of his gross income per year for three years. The **Petrozza** court denied injunctive relief, citing public policy concerns, but also held that "the inclusion in the contract between the parties of a liquidated damages provision specifically measured as a lump sum plus a percentage of the defendant's gross revenues clearly indicates that the parties contemplated that any damages flowing from a breach of the covenant not to compete would be duly and satisfactorily remedied by an award of money, the amount of which could be easily proven at trial." Notably, the physician in that case specifically argued that the provision provided him with the "alternative to perform or pay."

Thus, although the **Petrozza** court refused to enforce the terms of the agreement which would have prohibited the physician from practicing, the court left unanswered

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whether Dr. Petrozza would be ultimately required to pay the liquidated damages. In that case, notably, the liquidated damages were only that—damages for breach—and not any reflection of the “cost sharing” provision found in **Faidas**. Therefore, while a cost sharing provision may in many instances serve as a reasonable measure of liquidated damages, it is by no means the only measure to attain such an objective.

Alternatives to Cost Sharing Provisions

It is also unwise to conclude that all cost sharing provisions, even like the one used in **Faidas**, will pass muster in courts. **Faidas** makes clear that they are still subject to a liquidated damages analysis. Therefore, if a cost sharing amount is out of proportion to actual or prospective damages from competition, it may still not be enforceable. For example, in **Faidas**, the court was swayed by the amount that the cost share amount was only three percent of the revenue generated by the physician for her employer; using the same formula in different circumstances could lead to dramatically different results.

Moreover, **Faidas** leaves unanswered the issue of what happens in the event liquidated damages set by the contract are, in fact, deemed unreasonable by the court. In **Faidas**, the court first determined that the physician’s option to pay “a certain sum” removed the agreement from any consideration as a covenant not to compete, and only then did it consider whether the amount was reasonable as liquidated damages. It is unclear what the court would have done had it concluded that the set amount was not reasonable, or, in other words, it determined that the set amount was a penalty. Would it have gone back to do a public policy analysis on the covenant? Or would it have simply determined that liquidated damages were not enforceable and considered instead what actual damages, if any, were appropriate?

It is hard to imagine a court determining that there is no public policy issue where the set amount of liquidated damages is patently out of line with any conceivable damages. For example, what if Dr. Faidas had agreed to a cost sharing

provision which was 100 times larger than the one in the original contract? One can assume that a court may decide that such a physician is not presented with a true choice of paying to practice and therefore the agreement is simply a conventional covenant not to compete, subject to scrutiny for public policy concerns.

A more difficult question arises where the set amount is clearly within the physician’s means and willingness to pay, but for some reason the set amount is determined by a court not to be reasonable as liquidated damages under North Carolina’s traditional test. For example, assume that the parties knew that the damages from competition would be small. In that situation, a court may hold that because the damages are not reasonable, the agreement is still a covenant not to compete. A court may, given the reasoning in **Faidas**, conclude that the physician has the choice to practice, so the agreement is not a covenant not to compete, but the court would substitute actual damages rather than liquidated damages.

The lesson from either result is the same: the parties must carefully determine what amount, if any, reasonably represents potential damages from competition. While cost sharing may provide one avenue, other possibilities exist, such as the physician’s salary or gross or net revenues, to provide the basis from which liquidated damages may be calculated. Cost sharing, while a valuable option, is neither the only option, nor, in all cases, the best option. A physician must anticipate that other kinds of liquidated damages may, in fact, be enforced against him, while a practice must be alert to a challenge that such damages may be deemed an unreasonable penalty. ■

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Endnotes

1. 149 N.C. App. 940, 564 S.E.2d 53, aff’d, 356 N.C. 607, 572 S.E.2d 780 (2002).
2. **Faidas**, 149 N.C. App. at 945, 564 S.E.2d at 56.
3. 88 N.C. App. 95, 362 S.E.2d 623 (1987).
4. 92 N.C. App. 21, 373 S.E.2d 449 (1988).

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Endnotes

1. 149 N.C. App. 940, aff’d, 356 N.C. 607 (2002).
2. 106 N.C. App. 669 (1992), review denied, 333 N.C. 257 (1993).
3. 101 N.C. App. 341, review denied, 329 N.C. 499 (1991).
4. 92 N.C. App. 21 (1988), aff’d, 324 N.C. 327 (1989).
5. Iredell, 92 N.C. App. at 27-28.
6. Id. at 30-31.
7. Id. at 31.
8. 101 N.C. App. at 345 (quoting Iredell, 92 N.C. App. at 345).

9. Id.
10. Statesville, 106 N.C. App. at 673.
11. Id. at 674.
12. *Knutton v. Cofield*, 273 N.C. 355, 360-62 (1968).
13. Id. at 361 (quoting 22 Am. Jur. 2d Damages § 214 (emphasis in original)).
14. Id. (quoting *Bradshaw v. Milliken*, 173 N.C. 432, 435 (1917)).
15. Id. at 942.
16. Id. at 942.
17. 88 N.C. App. 95 (1987).
18. Id. at 945.
19. Id.
20. Id. at 947

Now That Compensation for Smallpox Vaccine Volunteers is Available, Health Care Providers Will Again Struggle With Difficult Decisions

BY GINA M. PLAUE

WITH THE PASSAGE OF A FEDERAL COMPENSATION PACKAGE FOR individuals injured by the smallpox vaccine, vaccinations may go forward after being virtually stalled in North Carolina and around the country. Health care providers designating personnel to be vaccinated, and those actually administering the vaccination, must be well-informed with regard to their protection from liability for adverse events relating to vaccination. This article will give a background of the federal vaccination program and the recent developments with respect to compensation, as well as a summary of Section 304 of the Homeland Security Act of 2002,¹ which provides protection to health care providers and others participating in the program.²

The Federal Smallpox Vaccination Program

On Dec. 13, 2002, President Bush announced a national smallpox vaccination program, asking health care workers and “first responders” to volunteer for vaccination. The program outlined a schedule for vaccination:

- ♦ 450,000 health care workers vaccinated by the end of February 2003 (Phase I);
- ♦ 10 million fire service and emergency responders (Phase II); and
- ♦ eventually, the public (Phase III).

When the program was announced, the Centers for Disease Control and Prevention (CDC) reported the following statistics based on past experience with the smallpox vaccine:

- ♦ About 1,000 people for every one million vaccinated experience serious but not life-threatening reactions (such as spread of the virus elsewhere on the body);
- ♦ Between 14 and 52 people for every one million vaccinated experience potentially life-threatening reactions (such as skin reactions or inflammation of the brain); and
- ♦ One or two people for every one million vaccinated may die.

In addition, the CDC reported that most people who receive the virus will experience some type of basic reaction beginning eight to 12 days after vaccination, including sore arm, fever, headache and body fatigue. Although these are mild reactions, they may be enough to keep the individual home from work for a short period of time.

Finally, the CDC cautioned against vaccination of certain individuals with: (1) lowered immune systems, such as those who are HIV-positive, transplant recipients and cancer patients; and (2) persons with certain skin conditions, including eczema. Anyone living with an individual meet-

ing these criteria was also cautioned against vaccination.

Recognizing that entities participating in the program, for example manufacturers or distributors of the vaccines and health care providers administering the vaccine, were concerned with potential liability given the risk for adverse reactions, Congress passed Section 304 of the Homeland Security Act of 2002 (Act). As discussed in more detail below, the Act protects from liability certain individuals and entities participating in the smallpox vaccination program by substituting the United States as a defendant in actions for money damages against these individuals and entities. Importantly, however, recovery against the federal government under Section 304 depends on the success of these claims, which require proof of fault. Section 304 does not provide for “no-fault” compensation of volunteers who have been adversely affected by vaccination.

Implementation of the Program

To trigger Section 304’s protections, the Secretary of the United States Department of Health and Human Services (HHS) must make a declaration that administration of a smallpox “countermeasure” is advisable, concluding that an actual or potential bioterrorist incident or other actual or potential public health emergency warrants such countermeasure. The Secretary must specify the covered countermeasures, the categories of individuals to whom the countermeasures may be administered, and the beginning and end dates of the declaration.

On Jan. 24, 2003, HHS Secretary Tommy Thompson made such a declaration, to be effective for one year from that date. The “covered countermeasures” include: 1) Vaccinia (Smallpox) vaccines, including the Dryvax vaccine, Cidofivir and derivatives thereof; and 2) Vaccinia Immune Globulin. Individuals to whom these countermeasures are to be administered, in accordance with the president’s plan, are: 1) health care workers; 2) members of smallpox response teams; 3) public safety personnel; and 4) personnel associated with certain federal government facilities abroad. Following the declaration, 274,800 vaccinations were delivered to 49 states and four county and municipal health departments, including 7,500 to North Carolina. Vaccination began slowly across the country. Of the 60 North Carolina hospitals asked to participate in the program by state health officials, only 27 agreed. Those hospitals that declined to participate generally did not cite liability concerns, but instead cited concerns about compensation to individuals

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adversely affected by the vaccinations.

Almost two months into the program, in March 2003, several reports surfaced of heart-related problems among vaccinated health care workers, including at least one instance where a heart attack following vaccination resulted in the individual's death. In response, the CDC issued a warning to individuals with a history of heart disease, recommending that any individuals with known risk factors, such as cardiomyopathy, previous heart attack, history of angina, or other evidence of coronary artery disease, be temporarily deferred from receiving the smallpox vaccination while the CDC studied the connection.

Given these growing concerns over adverse reactions to the vaccination and the low level of volunteer participation, federal legislators debated the passage of a federal "no-fault" compensation package, defeating several versions of such a package. In North Carolina, legislators reacted by introducing their own solution for state employee volunteers. Passed by the House in April, North Carolina House Bill 273 would, among other things, add the treatment of adverse reactions to smallpox vaccines to coverage under the medical plan for state workers, require that a state employee's absence from work resulting from an adverse reaction not be counted toward the employee's sick time, and allow individuals living with a vaccinated state employee to apply to the North Carolina Industrial Commission for money damages in the event of an adverse reaction. House Bill 273 would require individuals to seek any available federal benefits as a condition precedent to recovery under the state program.

As this debate was waging, and more adverse reactions were being reported (including two additional fatalities), vaccinations around the country and in North Carolina virtually came to a halt. At this time, only about 31,000 civilian health care and public health staff have been vaccinated, including only 1,215 out of the expected 7,500 in North Carolina.

The Federal Compensation Package

Finally, on April 16, 2003, President Bush signed House Bill 1770, entitled "Smallpox Emergency Personnel Protection Act of 2003." This law provides for several types of compensation to affected individuals, including:

- ♦ Reimbursement by the federal government for the cost of medical treatment relating to adverse reactions;
- ♦ Compensation for lost wages beyond the first five days of work missed;
- ♦ Up to \$50,000 annually in lost wages for persons permanently injured or partially disabled, subject to certain lifetime limits; and
- ♦ Compensation for family members in the event of the injured party's death.

Many analysts predict that the passage of this compensation package will spur more volunteers to take part in the program. Others contend that the risks of vaccination still outweigh the benefits offered by the compensation pro-

gram. At any rate, health care providers will again be considering whether to recommend inoculation of their workforce, and whether to actually participate in the program by administering vaccinations. The potential extent of their liability for adverse events will be an important part of that decision.

Section 304 Protection

As noted above, Section 304 generally provides that any claim for liability for injury or death arising out of the administration of a smallpox "countermeasure," as defined in the applicable Secretary Declaration, must be brought exclusively against the United States and not against individuals or entities protected by Section 304. Specifically, the following individuals and entities are "covered persons" and thus protected pursuant to the act: 1) a manufacturer or distributor of a countermeasure; 2) a health care entity under whose auspices a countermeasure was administered; 3) a licensed health professional or other authorized individual who administered a countermeasure; and 4) an official, agent, or employee of any of these entities or individuals.

Section 304 provides that the United States will be liable to an individual only if the countermeasure was administered by a licensed health professional or other person authorized to administer the countermeasure, and the individual was within a category of individuals covered by the applicable Secretary Declaration (or the person administering the countermeasure had reasonable grounds to believe the individual was within such category). The United States may also be liable to an individual who was not inoculated, but who develops vaccinia, if the individual develops vaccinia during the effective period (or within 30 days of the end) of a declaration or if the individual resides or has resided with a vaccinated individual.

Section 304 actions must be brought against the United States under the Federal Tort Claims Act, 28 U.S.C. Sections 1346(b) and 2671, *et seq.* Therefore, claimants must prove negligence or some other degree of fault in order to prevail. Since some adverse reactions will occur even if the vaccine is properly administered, many claimants will be unable to succeed in a Section 304 claim.

Health care providers must be aware that the protection afforded "covered persons" is not absolute. If a covered person fails to cooperate with the United States in the defense of the claim, the government can move to substitute the covered person as the defendant in the case. In addition, if the adverse event is caused by the gross misconduct, recklessness, illegal conduct, or failure to carry out a contractual obligation of the covered person, the United States has a right of contribution against the covered person.

Finally, an important question for health care providers is whether they qualify as "a health care entity under whose auspices a countermeasure was administered." Presumably, health care entities actually administering vaccines are covered by this definition, but what about health care providers

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who designate personnel to receive the vaccine but do not actually administer the vaccine? The statute does not define the phrase "health care entity;" however, the Secretary's Declaration states:

[a] 'health care entity under whose auspices such countermeasure was administered' as used in [the Act], includes but is not limited to, hospitals, clinics, state and local health departments, health care entities, and contractors of any of those entities that (a) administer covered countermeasures; (b) designate officials, agents, or employees to receive or administer covered countermeasures; or (c) are identified by state or local government entities or the United States Department of Health and Human Services to participate in the vaccination program, whether that participation is in the United States or abroad.

Based on this portion of the declaration, the CDC takes the position that health providers designating personnel to receive the vaccination are covered by Section 304, even if they are not administering the vaccine.

Of course, health care providers in this situation may be liable under applicable workers' compensation laws, which the CDC has concluded are not supplanted by Section 304. The determination of whether a particular smallpox vaccination adverse event qualifies for workers compensation coverage will depend on state law.³ If the event does quali-

fy for workers' compensation, the CDC has interpreted Section 304 to prohibit additional Section 304 claims based on actions of other "covered person" third parties (i.e. the manufacturer of the vaccine or the administrator of the vaccine) if the state workers' compensation law is an "exclusive remedy." These issues will undoubtedly be further analyzed and eventually decided by the appropriate bodies as vaccinations move forward over the coming months. ■

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Endnotes

1. Pub. Law 107-296 (Nov. 25, 2002)(to be codified at 42 U.S.C § 233(p)).
2. Portions of this article are based on an outline originally prepared by Mary Beth Johnston, Esq. For more information on the smallpox vaccination program and Section 304, visit www.cdc.gov/smallpox.
3. For an analysis of this question in North Carolina, concluding that injuries from smallpox vaccinations are covered, see Juffras, Diane, "Does the North Carolina Workers' Compensation Act Cover Injuries Resulting from Smallpox Vaccination?," Public Personnel Law, No. 28 (February 2003).

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What Every Employer Should Know About Military Leaves and the Uniformed Services Employment and Re-Employment Rights Act

BY DAVID L. WOODARD

IN THE WAKE OF THE WORLD TRADE CENTER TERRORIST ATTACKS, military action in Afghanistan, and, most recently, the war with Iraq, many employers are experiencing an impact on their workforces as military reservists and members of the National Guard are called into active military service. Once the military engagements conclude, most of those employees will return to civilian life, and they will understandably seek to return to their former jobs. The Uniformed Services Employment and Re-Employment Rights Act (USERRA) governs the relationship between these employees and their employers, providing extensive employee protections, such as: mandatory military leave, benefit maintenance, job preservation, and reinstatement rights. Employers and the attorneys may necessarily need to be familiar with the application of USERRA. The following discussion is by no means exhaustive, but is intended to acquaint employers with the fundamental rights and obligations created by USERRA.

I. Coverage

Determining who is a covered employer under USERRA is simple—the act covers all public and private sector employers, regardless of size or number of employees.

Employee coverage is equally expansive. Any employee whose absence from a job is necessitated by reason of “service in the uniformed services” is covered, whether the service is during times of war or in times of peace. The service may be voluntary or involuntary, and expressly includes: (1) active duty; (2) active duty for training; (3) initial active duty for training; (4) inactive duty training; (5) full-time national guard duty; (6) absence from work for examinations to determine a person’s fitness for any of the foregoing; and (7) funeral honors duty.

Under USERRA, “uniformed services” includes the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the president in time of war or national emergency. For the purpose of this article, all forms of covered “service in the uniformed service” are referred to collectively as “military service.”

II. Employee Obligations

Prior to departing for military service, employees must provide employers advance oral or written notice of their absence. The notice may come from the employee or from an appropriate military officer. An employee is not required to present written orders. Advance notice is not required if

the giving of such notice is prevented by military necessity or is otherwise impossible or unreasonable.

If an employee wishes to return to work when released from military service, USERRA imposes varying obligations on the employee, depending on the length of the military service. If an employee’s military service is less than 31 days, the employee must report back to work by the beginning of the first regularly scheduled work period that would fall eight hours after the end of the first full calendar day after completion of military service (allowing a reasonable time for safe transportation from the place of service to the employee’s home). If an employee’s military leave is between 31 and 180 days, the employee must submit an application for reemployment no later than 14 days after completion of military service. If an employee’s military service lasts 181 days or more, the employee must submit an application for re-employment no later than 90 days after completion of military service.

The above deadlines are not hard and fast. If an employee is hospitalized or is recovering from an illness or injury incurred or aggravated during military service, the time periods outlined above do not begin to run until the employee has recovered (as long as the recovery period lasts no more than two years). In addition, if an employee is unable to report back to work within the above time periods, through no personal fault, he or she may report back to work as soon as possible in the case of military leave lasting less than 31 days, or, in the case of an employee on military leave lasting 31 to 180 days, the employee may submit an application for reemployment the first full calendar day that submission becomes possible. No extension is expressly provided for employees on military leave lasting more than 181 days.

Even though USERRA imposes the foregoing deadlines for reporting back to work and applying for re-employment, an employee who fails to comply with those obligations does not automatically forfeit the rights and benefits created by USERRA. Such employees do, however, become subject to the employer’s normal policies and practices for dealing with unexcused absences from work.

III. Employer Obligations

USERRA protects the benefits and seniority-based rights provided to employees in the ordinary course of employment, and mandates, with few exceptions, that covered employees be returned to their same or similar positions at the conclusion of military leave.

A. Preservation of Employee Benefits.

USERRA’s protection extends, in varying degrees, to

just about every employee benefit offered by an employer.

1. Vacation and Other Paid Leave.

Employers are not required to pay regular wages to employees who are on military leave, but they must permit employees to use any vacation or similar paid leave that had accrued prior to the beginning of the employee's military leave. This does not mean that an employer may require or pressure an employee to exhaust accrued vacation or other paid leave. The decision to use paid leave is left entirely at the discretion of the employee.

If an employer allows employees on any type of non-military leave to continue to accrue paid time off during leave, then the employer must allow employees on military leave to continue to accrue paid time off. In addition, if an employer's policy for paid time off provides for accrual at different rates based on length of service, an employee returning from military leave is entitled to begin accruing paid time off at the rate he or she would have been accruing if there had been no absence for military service leave.

2. Health Care Plans

If an employee's (or any dependents') health plan coverage would terminate because of an absence due to military service, USERRA creates a COBRA-like right for the employee to continue coverage. The employee must be allowed to continue his or her (or any dependents') coverage for up to 18 months or for the period of military service (including the time to report back to work or apply for reemployment), whichever is less. An employee may be required to pay his or her normal portion of any health care premium for military leave that lasts up to 30 days. If military service lasts more than 30 days, an employee may be required to pay up to 102 percent of the full premium for healthcare coverage.

3. Pension Plans

USERRA provides that an employee who is on military leave does not incur a break in service for retirement plan purposes. USERRA requires that returning service members must be treated as if they had been continuously employed for pension purposes, regardless of the type of pension plan the employer has adopted. This applies to vesting (determining when the employee qualifies for a pension) and also benefit computation (determining the amount of the employee's monthly pension check). Because of the complex issues that arise with respect to vesting and contributions under the terms of the various types of pension plans, under the Employee Retirement Income and Security Act and under the Internal Revenue Code, it is advisable for employers to consult with experienced employee benefits counsel regarding how to handle pension rights of employees returning from military leave.

4. Rights Under the Family and Medical Leave Act

To qualify for leave under the Family and Medical Leave Act (FMLA), employees must work for a covered employer for at least 12 months and for 1,250 hours in the 12 month period immediately preceding the request for leave.

Because military service necessarily takes employees out of active employment with their regular employers, some employees who might otherwise have satisfied the FMLA's eligibility requirements might not have worked the requisite number of months or hours required for coverage under the FMLA. However, employers should be careful not to deny such employees any rights under the FMLA when they return to active employment based solely on their failure to work the requisite number of months or hours. The United States Department of Labor has issued a memorandum stating its enforcement position that USERRA requires employers to count the time employees spend in military service toward the FMLA's eligibility requirements.

5. All Other Benefits

Employees on military leave are entitled to the most favorable treatment accorded to employees who are on non-military types of leave. Thus, if any benefit accrues or is continued by an employer for employees on some type of employer provided leave, e.g., life insurance even if it is not continued from employees on all types of leave, it must be continued for employees on military leave.

B. The Obligation To Re-Employ

An employer's obligation to reinstate an employee to a particular job varies, depending in large part on the length of the employee's military leave. In essence, USERRA requires employers to re-employ returning service-members in the job that they would have attained had they not been absent for military service, including the same seniority, status and pay, as well as other rights and benefits determined by seniority. This component of USERRA, known as the "escalator principle," means that if it is reasonably certain that the employee would have been promoted had he or she not left to perform military service, the employee must be employed in the promoted position.

If it is not possible to immediately re-employ a returning service member in a escalated position, USERRA requires that reasonable efforts (such as training or retraining) be made to enable returning service members to refresh or upgrade their skills to help them qualify for re-employment. USERRA also provides for alternative reemployment positions if the service member cannot qualify for the escalated position.

USERRA provides additional protection to employees who suffer a disability due to military service. Employers must make reasonable efforts to accommodate such a disability so that the employee may be re-employed in the position that the person would have held if he or she had been continuously employed with no interruption for military service. If efforts to accommodate fail, the disabled employee must be re-employed in a position of equivalent seniority, status, and pay. If the employee is not, or cannot become, qualified for the aforementioned jobs, the employee must be reemployed in a position that, consistent with the circumstances of that employee's case, most nearly approximates a position of equivalent seniority, status, and pay.

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One of the most noteworthy features of USERRA is that it temporarily removes returning service members from employment-at-will status. Employees returning from military leave may not be terminated without cause for one year after the date of re-employment if the employee's period of military service was more than six months. If the employee's military service lasted between 30 and 180 days, the employee may not be terminated without cause for six months after the date of re-employment. Employees who served less than 30 days receive no similar protection.

IV. When Re-Employment is Unnecessary

There are narrow exceptions to USERRA's reemployment requirements. An employer is not required to re-employ someone whose military service terminates pursuant to a dishonorable or other bad conduct discharge, by reason of a sentence of general court martial, or under a limited number of other conditions relating generally to bad conduct. In addition, an employer is relieved of the re-employment requirement if: (1) the employer's circum-

stances have changed so much that re-employment is impossible or unreasonable; (2) if undue hardship would be imposed on the employer in either trying to accommodate a disability or in trying to train an employee for re-employment; or (3) if the position from which the employee left was for a brief, non-recurrent period.

V. Conclusion

USERRA is very detailed and contains many more exceptions and requirements than may be fully addressed in this article. Employers should not hesitate to seek guidance from legal counsel regarding the handling of benefits and reemployment rights of employees returning from military leave. In addition, employers would be well advised to seek legal counsel prior to terminating, or taking any other adverse employment action against, an employee who has been on military leave. ■

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