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Occupational Safety and Health Administration (OSHA): COVID-19 Emergency Temporary Standards (ETS) on Health Care Employment and Vaccinations and Testing for Large Employers

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SUMMARY

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Occupational Safety and Health Administration (OSHA): COVID-19 Emergency Temporary Standards (ETS) on Health Care Employment and Vaccinations and Testing for Large Employers

On June 21, 2021, the Occupational Safety and Health Administration (OSHA) promulgated an Emergency Temporary Standard (ETS) for the prevention of the transmission of SARS-CoV-2, the virus that causes COVID-19 in health care employment settings.

On November 5, 2021, OSHA promulgated an additional ETS that requires employers with 100 or more employees to require that all employees either be fully vaccinated against COVID-19 by January 4, 2022, or test negative for COVID-19 weekly in order to work onsite.

On November 6, 2021, the U.S. Court of Appeals for the Fifth Circuit ordered a stay on the OSHA COVID-19 vaccination and testing ETS pending additional judicial review.

The Occupational Safety and Health Act of 1970 (OSH Act) gives OSHA the ability to promulgate an ETS that would remain in effect for up to six months without going through the normal review and comment process of rulemaking. OSHA, however, has rarely used this authority in the past—not since the courts struck down its ETS on asbestos in 1983.

The OSHA COVID-19 ETS for health care employers requires health care employers to develop COVID-19 plans and protect employees from COVID-19 exposure through health screenings, personal protective equipment (PPE), building ventilation, and physical distancing and barriers. The ETS requires health care employers to remove any employees with COVID-19 from the workplace while providing them with certain benefits. Health care employers are not required to mandate that their employees receive a COVID-19 vaccine but must provide reasonable time off for employees to receive a vaccine and recover from any vaccine-related side effects. The ETS includes new COVID-19 recordkeeping and reporting requirements for health care employers and permits health care employers to forgo the medical evaluation and fit-testing requirements of OSHA's respiratory protection standard when providing respirators to employees in certain circumstances.

The OSHA COVID-19 vaccination and testing ETS requires all employers with 100 or more employees to either require all employees to be vaccinated to work onsite or permit unvaccinated employees to provide weekly negative COVID-19 tests and wear face coverings to work onsite. Employers must provide employees with paid time off to receive COVID-19 vaccines and recover from any side effects. However, employers are not required to pay for COVID-19 tests or face coverings. The vaccine and testing requirements of the ETS are effective January 4, 2022.

While the COVID-19 ETS for health care employers applies only to health care employers, and the COVID-19 vaccination and testing ETS applies only to employers with 100 or more employees, all employers are required to comply with the general duty clause of the OSH Act as well as existing OSHA standards on respiratory protection and recordkeeping that may apply to the current COVID-19 pandemic. Pursuant to guidance issued by OSHA on May 22, 2021, employers are not required to record or report any injuries or illnesses caused by the COVID-19 vaccine. This guidance supersedes earlier OSHA guidance that had required employers to record and report adverse reactions to the vaccine if vaccination was a condition of employment.

The California Division of Occupational Safety and Health (Cal/OSHA), which operates California's state occupational safety and health plan, has had an aerosol transmissible disease (ATD) standard since 2009. This standard includes, among other provisions, the requirement that employers provide covered employees with respirators, rather than surgical masks, when these workers interact with ATDs, such as known or suspected COVID-19 cases. In addition, according to the Cal/OSHA ATD standard, certain procedures require the use of powered air purifying respirators (PAPR). Cal/OSHA has also promulgated an ETS to specifically address COVID-19 exposure in the workplace. The agency that operates the state occupational safety health plan in Michigan (MIOSHA) has promulgated an ETS, which was later rescinded and replaced

with the OSHA COVID-19 ETS for health care employers, to specifically address COVID-19 in workplaces. In January 2021, the Virginia state plan (VOSH) promulgated a permanent standard to supersede its ETS, and in May 2021, the Oregon state plan (Oregon OSHA) replaced its ETS with a permanent standard.

States with state occupational safety and health plans must adopt and enforce all OSHA standards, including the ETS for health care employers and the COVID-19 vaccination and testing ETS for large employers.

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Occupational Safety and Health Administration Standards

Section 6 of the Occupational Safety and Health Act of 1970 (OSH Act) grants the Occupational Safety and Health Administration (OSHA) of the Department of Labor the authority to promulgate, modify, or revoke occupational safety and health standards that apply to private sector employers, the United States Postal Service, and the federal government as an employer.[1] In addition, Section 5(a)(1) of the OSH Act, commonly referred to as the general duty clause, requires that all employers under OSHA's jurisdiction provide workplaces free of "recognized hazards that are causing or are likely to cause death or serious physical harm" to their employees.[2] OSHA has the authority to enforce employer compliance with its standards and with the general duty clause through the issuance of abatement orders, citations, and civil monetary penalties. The OSH Act does not cover state or local government agencies or units. Thus, certain entities that may be affected by Coronavirus Disease 2019 (COVID-19), such as state and local government hospitals, local fire departments and emergency medical services, state prisons and county jails, and public schools, are not covered by the OSH Act or subject to OSHA regulation or enforcement.

State Plans

Section 18 of the OSH Act authorizes states to establish their own occupational safety and health plans and preempt standards established and enforced by OSHA.[3] OSHA must approve state plans if they are "at least as effective" as OSHA's standards and enforcement.[4] If a state adopts a state plan, it must also cover state and local government entities, such as public schools, not covered by OSHA. Currently, 21 states and Puerto Rico have state plans that cover all employers, and 5 states and the U.S. Virgin Islands have state plans that cover only state and local government employers not covered by the OSH Act.[5] In the remaining states, state and local government employers are not covered by OSHA standards or enforcement. State plans may incorporate OSHA standards by reference, or states may adopt their own standards that are at least as effective as OSHA's standards. State plans do not have jurisdiction over federal agencies and generally do not cover maritime workers and private sector workers at military bases or other federal facilities.

Promulgation of OSHA Standards

OSHA may promulgate occupational safety and health standards on its own initiative or in response to petitions submitted to the agency by various government agencies, the public, or employer and employee groups.[6] OSHA is not required, however, to respond to a petition for a

[1] 29 U.S.C. §655. The provisions of the Occupational Safety and Health Act of 1970 (OSH Act) are extended to the legislative branch as an employer by the Congressional Accountability Act (P.L. 104-1).

[2] 29 U.S.C. §654(a)(1).

[3] 29 U.S.C. §667.

[4] For additional information on Occupational Safety and Health Administration (OSHA) state plans, see CRS Report R43969, *OSHA State Plans: In Brief, with Examples from California and Arizona*.

[5] Information on specific state plans is available from the OSHA website at https://www.osha.gov/stateplans.

[6] Per Section 6(b)(1) of the OSH Act [29 §655(b)(1)], a petition may be submitted by "an interested person, a representative of any organization of employers or employees, a nationally recognized standards-producing

standard or to promulgate a standard in response to a petition. OSHA may also consult with one of the two statutory standing advisory committees—the National Advisory Committee on Occupational Safety and Health (NACOSH) or the Advisory Committee on Construction Safety and Health (ACCSH)—or an ad-hoc advisory committee for assistance in developing a standard.[7]

Notice and Comment

OSHA's rulemaking process for the promulgation of standards is largely governed by the provisions of the Administrative Procedure Act (APA) and Section 6(b) of the OSH Act.[8] Under the APA informal rulemaking process, federal agencies, including OSHA, are required to provide notice of proposed rules through the publication of a Notice of Proposed Rulemaking in the *Federal Register* and to provide the public a period of time to comment on the proposed rules.

Section 7(b) of the OSH Act mirrors the APA in that it requires notice and comment in the rulemaking process.[9] After publishing a proposed standard, the public must be given a period of at least 30 days to provide comments. In addition, any person may submit written objections to the proposed standard and may request a public hearing on the standard.

Statement of Reasons

Section 6(e) of the OSH Act requires OSHA to publish in the *Federal Register* a statement of the reasons the agency is taking action whenever it promulgates a standard, conducts other rulemaking, or takes certain additional actions, including issuing an order, compromising on a penalty amount, or settling an issued penalty.[10]

Other Relevant Laws and Executive Order 12866

In addition to the APA and OSH Act, other federal laws that generally apply to OSHA rulemaking include the Paperwork Reduction Act,[11] Regulatory Flexibility Act,[12] Congressional Review Act,[13] Information Quality Act,[14] and Small Business Regulatory Enforcement Fairness Act (SBREFA).[15] Also, Executive Order 12866, issued by President Clinton in 1993, requires

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organization, the Secretary of Health and Human Services (HHS), the National Institute for Occupational Safety and Health, or a state or political subdivision."

[7] The National Advisory Committee on Occupational Safety and Health (NACOSH) was established by Section 7(a) of the OSH Act [29 U.S.C. §656(a)]. The Advisory Committee on Construction Safety and Health (ACCSH) was established by Section 107 of the Contract Work Hours and Safety Act (P.L. 87-581). Section 7(b) of the OSH Act provides OSHA the authority to establish additional advisory committees.

[8] The Administrative Procedure Act (APA) is codified at 5 U.S.C. §§500-596. For detailed information on federal agency rulemaking and the APA, see CRS Report RL32240, *The Federal Rulemaking Process: An Overview*.

[9] 29 U.S.C. §655(b).

[10] 29 U.S.C §655(e).

[11] 44 U.S.C. §§3501-3520.

[12] 5 U.S.C. §§601-612.

[13] 5 U.S.C. §§801-808.

[14] 44 U.S.C. §3516 note.

[15] 5 U.S.C. §601 note. For information on these additional laws that apply to OSHA rulemaking, see U.S. Government Accountability Office (GAO), *Workplace Safety and Health: Multiple Challenges Lengthen OSHA's Standard Setting*, GAO-12-330, April 2012, Appendix II, at https://www.gao.gov/products/GAO-12-330 (hereinafter cited as GAO-12-330, *Workplace Safety and Health*).

agencies to submit certain regulatory actions to the Office of Management and Budget (OMB) and Office of Information and Regulatory Affairs (OIRA) for review before promulgation.[16]

OSHA Rulemaking Time Line

OSHA rulemaking for new standards has historically been a relatively time-consuming process. In 2012, at the request of Congress, the Government Accountability Office (GAO) reviewed 59 significant OSHA standards promulgated between 1981 (after the enactments of the Paperwork Reduction Act and Regulatory Flexibility Act) and 2010.[17] For these standards, OSHA's average time between beginning formal consideration of the standard—either through publishing a Request for Information or Advance Notice of Proposed Rulemaking in the *Federal Register* or placing the rulemaking on its semiannual regulatory agenda—and promulgation of the standard was 93 months (7 years, 9 months). Once the Notice of Proposed Rulemaking was published for these 59 standards, the average time until promulgation of the standard was 39 months (3 years, 3 months).

In 2012, OSHA's Directorate of Standards and Guidance published a flowchart of the OSHA rulemaking process on the agency's website.[18] This flowchart includes estimated duration ranges for a variety of rulemaking actions, beginning with pre-rule activities—such as developing the idea for the standard and meeting with stakeholders—and ending with promulgation of the standard. The flowchart also includes an estimated duration range for post-promulgation activities, such as judicial review. The estimated time from the start of preliminary rulemaking to the promulgation of a standard ranges from 52 months (4 years, 4 months) to 138 months (11 years, 6 months). After a Notice of Proposed Rulemaking is published in the *Federal Register*, the estimated length of time until the standard is promulgated ranges from 26 months (2 years, 2 months) to 63 months (5 years, 3 months). **Table 1** provides OSHA's estimated time lines for six major pre-rulemaking and rulemaking activities leading to the promulgation of a standard.

Table 1. OSHA Rulemaking Process: Estimated Durations of Activities

Stage	Activities	Estimated Duration
1	Preliminary rulemaking activities	12-36 months
2	Developing the proposed rule	12-36 months
3	Publishing the Notice of Proposed Rulemaking (NPRM)	2-3 months
4	Developing and analyzing the rulemaking record, including public comments and hearings	6-24 months
5	Developing the final rule, including Office of Information and Regulatory Affairs (OIRA) submission	18-36 months
6	Publishing the final rule (promulgating the new standard)	2-3 months
Total estimated duration		52-138 months
Estimated duration from NPRM to final rule		26-63 months

Source: Congressional Research Service (CRS) with data from Occupational Safety and Health Administration (OSHA), Directorate of Standards and Guidance, *The OSHA Rulemaking Process*, October 15, 2012.

[16] Executive Order 12866, "Regulatory Planning and Review," 58 *Federal Register* 51735, October 4, 1993.

[17] GAO-12-330, *Workplace Safety and Health*.

[18] OSHA, Directorate of Standards and Guidance, *The OSHA Rulemaking Process*, October 15, 2012.

Judicial Review

Both the APA and the OSH Act provide for judicial review of OSHA standards. Section 7(f) of the OSH Act provides that any person who is "adversely affected" by a standard may file, within 60 days of its promulgation, a petition challenging the standard with the U.S. Court of Appeals for the circuit in which the person lives or maintains his or her principal place of business.[19] A petition for judicial review does not automatically stay the implementation or enforcement of the standard. However, the court may order such a stay. OSHA estimates that post-promulgation activities, including judicial review, can take between four and 12 months after the standard is promulgated.[20]

Emergency Temporary Standards

Section 6(c) of the OSH Act provides the authority for OSHA to issue an Emergency Temporary Standard (ETS) without having to go through the normal rulemaking process. OSHA may promulgate an ETS without supplying any notice or opportunity for public comment or public hearings. An ETS is immediately effective upon publication in the *Federal Register*. Upon promulgation of an ETS, OSHA is required to begin the full rulemaking process for a permanent standard with the ETS serving as the proposed standard for this rulemaking. An ETS is valid until superseded by a permanent standard, which OSHA must promulgate within six months of publishing the ETS in the *Federal Register*.[21] An ETS must include a statement of reasons for the action in the same manner as required for a permanent standard. State plans are required to adopt or adhere to an ETS, although the OSH Act is not clear on how quickly a state plan must come into compliance with an ETS.

ETS Requirements

Section 6(c)(1) of the OSH Act requires that both of the following determinations be made in order for OSHA to promulgate an ETS:

- that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and
- that such emergency standard is necessary to protect employees from such danger.

Grave Danger Determination

The term *grave danger*, used in the first mandatory determination for an ETS, is not defined in statute or regulation. The legislative history demonstrates the intent of Congress that the ETS process "not be utilized to circumvent the regular standard-setting process," but the history is unclear as to how Congress intended the term grave danger to be defined.[22]

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[19] 29 U.S.C. §655(f).

[20] OSHA, Directorate of Standards and Guidance, *The OSHA Rulemaking Process*, October 15, 2012.

[21] 29 U.S.C §655(c)(2). The statute is not clear on what happens if OSHA is unable to promulgate a permanent standard within six months. For additional information see the section "ETS Duration" later in this report.

[22] U.S. Congress, Senate Labor and Public Welfare, Subcommittee on Labor, *Legislative History of the Occupational Safety and Health Act of 1970 (*S. 2193*, P.L. 91-596)*, committee print, prepared by Subcommittee on Labor, 91st Cong., 1 sess., June 1971, 52-531 (Washington: GPO, 1971), p. 1218.

In addition, although the federal courts have ruled on challenges to previous ETS promulgations, the courts have provided no clear guidance as to what constitutes a grave danger. In 1984, the U.S. Court of Appeals for the Fifth Circuit in *Asbestos Info. Ass'n v. OSHA* issued a stay and invalidated OSHA's November 1983 ETS lowering the permissible exposure limit for asbestos in the workplace.[23] In its decision, the court stated that "gravity of danger is a policy decision committed to OSHA, not to the courts."[24] The court, however, ultimately rejected the ETS, in part on the grounds that OSHA did not provide sufficient support for its claim that 80 workers would ultimately die because of exposures to asbestos during the six-month life of the ETS.

Necessity Determination

In addition to addressing a grave danger to employees, an ETS must also be *necessary* to protect employees from that danger. In *Asbestos Info. Ass'n*, the court invalidated the asbestos ETS for the additional reason that OSHA had not demonstrated the necessity of the ETS. The court cited, among other factors, the duplication between the respirator requirements of the ETS and OSHA's existing standards requiring respirator use. The court dismissed OSHA's argument that the ETS was necessary because the agency felt that the existing respiratory standards were "unenforceable absent actual monitoring to show that ambient asbestos particles are so far above the permissible limit that respirators are necessary to bring employees' exposure within the PEL of 2.0 f/cc."[25] The court determined that "fear of a successful judicial challenge to enforcement of OSHA's permanent standard regarding respirator use hardly justifies resort to the most dramatic weapon in OSHA's enforcement arsenal."[26]

In 2006, the agency considered a petition from the United Food and Commercial Workers (UFCW) and International Brotherhood of Teamsters (IBT) for an ETS on diacetyl, a compound then commonly used as an artificial butter flavoring in microwave popcorn and a flavoring in other food and beverage products. The UFCW and IBT petitioned OSHA for the ETS after the National Institute for Occupational Safety and Health (NIOSH) and other researchers found that airborne exposure to diacetyl was linked to the lung disease *bronchiolitis obliterans*, now commonly referred to as "popcorn lung."[27] According to GAO's 2012 report on OSHA's standard-setting processes, OSHA informed GAO that although the agency may have been able to issue an ETS based on the grave danger posed by diacetyl, the actions taken by the food and beverage industries, including reducing or removing diacetyl from products, made it less likely that the necessity requirement could be met.[28]

ETS Duration

Section 6(c)(2) of the OSH Act provides that an ETS is effective until superseded by a permanent standard promulgated pursuant to the normal rulemaking provisions of the OSH Act. Section 6(c)(3) of the OSH Act requires OSHA to promulgate a permanent standard within six months of

[23] 727 F.2d at 415, 425-427 (5th Cir. 1984).

[24] 727 F.2d at 427 (5th Cir. 1984).

[25] 727 F.2d at 427 (5th Cir. 1984). The ETS mandated a permissible exposure limit (PEL) for asbestos of two asbestos fibers per cubic centimeter of air (2.0 f/cc).

[26] 727 F.2d at 427 (5th Cir. 1984).

[27] See, for example, Centers for Disease Control and Prevention (CDC): National Institute for Occupational Safety and Health (NIOSH), *NIOSH Alert: Preventing Lung Disease in Workers who Use or Make Flavorings*, DHHS (NIOSH) publication no. 2004-110, December 2003, at https://www.cdc.gov/niosh/docs/2004-110/.

[28] GAO-12-330, *Workplace Safety and Health*.

promulgating the ETS. As shown earlier in this report, six months is well outside of historical and currently expected time frames for developing and promulgating a standard under the notice and comment provisions of the APA and OSH Act, as well as under other relevant federal laws and executive orders. This dichotomy between the statutory mandate to promulgate a standard and the time lines that, based on historical precedent, other provisions in the OSH Act might realistically require for such promulgation raises the question of whether or not OSHA could extend an ETS's duration without going through the normal rulemaking process. The statute and legislative history do not clearly address this question.

OSHA has used its ETS authority sparingly in its history. As shown in **Table A-1**, in the 11 times OSHA has issued an ETS, the courts have fully vacated or stayed the ETS in four cases and partially vacated the ETS in one case.[29] In five of the seven ETSs that were not challenged, were fully or partially upheld by the courts, or are still active, OSHA issued a permanent standard either within the six months required by the statute or within several months of the six-month period and always within one year of the promulgation of the ETS.[30] Each of these five cases, however, occurred before 1980, after which a combination of additional federal laws and court decisions added additional procedural requirements to the OSHA rulemaking process. OSHA did not attempt to extend the ETS's expiration date in any of these cases.

Although the courts have not ruled directly on an attempt by OSHA to solely extend the life of an ETS, in 1974, the U.S. Court Appeals for the Fifth Circuit held in *Florida Peach Growers Ass'n v. United States Department of Labor* that OSHA was within its authority to amend an ETS without going through the normal rulemaking process.[31] The court stated that "it is inconceivable that Congress, having granted the Secretary the authority to react quickly in fast-breaking emergency situations, intended to limit his ability to react to developments subsequent to his initial response."[32] The court also recognized the difficulty OSHA may have in promulgating a standard within six months due to the notice and comment requirements of the OSH Act, stating that in the case of OSHA seeking to amend an ETS to expand its focus, "adherence to subsection (b) procedures would not be in the best interest of employees, whom the Act is designed to protect. Such lengthy procedures could all too easily consume all of the temporary standard's six months life."[33]

OSHA COVID-19 ETS for Health Care Employers

On June 21, 2021, OSHA promulgated an ETS for the prevention of COVID-19 in health care employment.[34] The ETS requires a covered employer to create a COVID-19 plan, includes provisions for the prevention of COVID-19 in the workplace, requires new recordkeeping in

[29] Mark A. Rothstein, "Substantive and Procedural Obstacles to OSHA Rulemaking: Reproductive Hazards as an Example," *Boston College Environmental Affairs Law Review*, vol. 12, no. 4 (August 1985), p. 673.

[30] For example, OSHA promulgated the Acrylonitrile (vinyl cyanide) ETS on January 17, 1978, and the permanent standard on October 3, 1978, with an effective date of November 2, 1978. The preamble to the permanent standard published in the *Federal Register* does not include information on the status of the ETS during the time between its expiration and the promulgation of the permanent standard. OSHA, "Occupational Exposure to Acrylonitrile (Vinyl Cyanide)," 43 *Federal Register* 45762, October 3, 1978.

[31] 489 F.2d. 120 (5th Cir. 1974).

[32] 489 F.2d. at 127 (5th Cir. 1974).

[33] 489 F.2d. at 127 (5th Cir. 1974).

[34] OSHA, "Occupational Exposure to COVID-19; Emergency Temporary Standard," 86 *Federal Register* 32376, June 21, 2021.

COVID-19 cases, and (in certain circumstances) permits employers to forgo the medical evaluation and fit-testing requirements of the OSHA respiratory protection standard. The ETS became effective with its publication in the *Federal Register*, with covered employers required to comply with all provisions of the ETS—with the exceptions of the physical distancing, building ventilation, training, and mini-respiratory-protection provisions—by July 6, 2021. Covered employers must comply with the physical distancing, building ventilation, training, and mini-respiratory-protection provisions by July 21, 2021. While the *Federal Register* announcement does not specify a specific duration for the COVID-19 ETS, per the OSH Act, an ETS is effective until replaced by a permanent standard within six months. The publication of the COVID-19 ETS in the *Federal Register* also included a request for comments on the ETS and on whether the ETS should become a permanent standard. In the preamble to the ETS, OSHA states that all state plans must adopt the ETS within 30 days of its publication and notify OSHA within 15 days of the actions they plan to take to adopt the ETS.[35] The ETS is not retroactive.

Petitions for Judicial Review

On June 24, 2021, National Nurses United filed a petition for judicial review of the COVID-19 ETS in the U.S. Court of Appeals for the Ninth Circuit.[36] Also on June 24, 2021, the United Food and Commercial Workers (UFCW) and AFL-CIO filed a petition for judicial review of the COVID-19 ETS in the U.S. Court of Appeals for the District of Columbia Circuit. In its petition the UFCW and AFL-CIO state as grounds for review that the ETS "fails to protect employees outside the healthcare industry who face a similar grave danger from occupational exposure to COVID-19."[37] On July 8, 2021, National Nurses United voluntarily withdrew its petition for judicial review of the COVID-19 ETS.

Justification for the COVID-19 ETS for Health Care Employers

In the preamble to the ETS published in the *Federal Register*, OSHA provides a justification for the ETS by addressing the requirements in the OSH Act that employees are exposed to grave danger from exposure to SARS-CoV-2 and that an ETS is necessary to protect employees from such danger.

Grave Danger Determination

In its justification for a COVID-19 ETS for health care employment, OSHA states that the agency "has determined that healthcare employees face a grave danger from the new hazard of workplace exposures to SARS-CoV-2 except under a limited number of situations (e.g., a fully vaccinated workforce in a breakroom)."[38] OSHA's determination that COVID-19 meets the grave danger standard required for an ETS rests on evidence and research on the following factors:

- the health consequences of COVID-19, including mortality and short-term and long-term health consequences from COVID-19, even in cases determined by the Centers for Disease Control and Prevention (CDC) to be "mild;"

[35] OSHA, "Occupational Exposure to COVID-19," p. 32560.

[36] National Nurses United v. OSHA, Docket No. 21-71142 (9th Cir. June 24, 2021).

[37] United Food and Commercial Workers and American Federation of Labor and Congress of Industrial Organizations v. OSHA, et al., Docket No. 21-1143 (D.C. Cir. June 24, 2021).

[38] OSHA, "Occupational Exposure to COVID-19," p. 32381.

- the elevated risk of COVID-19 transmission in the workplace due to common elements of workplaces such as shared work spaces; and
- the risk of COVID-19 transmission in health care settings where known or suspected infectious patients are receiving medical treatment.[39]

Necessity Determination

Inadequacy of Current Standards and Guidance

OSHA states that an ETS is necessary as it is the only means the agency has to control COVID-19 exposure in health care workplaces. The agency states that current OSHA standards—such as those covering respiratory protection, personal protective equipment (PPE), sanitation, and hazard communication—do not provide sufficient protection to health care employees exposed to known or suspected infectious persons. OSHA also states that its own guidance and that provided by other agencies such as the CDC do not provide sufficient protections to employers as such guidance is voluntary and not enforceable. OSHA claims that there is a need for a uniform set of requirements for health care employers in all states regardless of whether the state has adopted its own COVID-19 standards and cites a petition filed by the occupational safety consulting firm ORCHSE Strategies requesting an ETS as evidence that some employers favor the uniform set of national requirements provided by an ETS.[40]

Inadequacy of the General Duty Clause

OSHA asserts that the general duty clause provides inadequate protections to employees. Unlike the ETS, the general duty clause does not contain specific requirements for employers. In addition, OSHA claims that there is a "heavier" burden of proof that the agency must meet for enforcement of the general duty clause versus enforcement of a standard or ETS.[41] Enforcement of the general duty clause is also limited by the inability to require specific hazard abatements and the inability to assess higher civil monetary penalties for egregious or willful violations. OSHA also states that the general duty clause does not provide complete protection at multi-employer worksites, such as hospitals, where several employers may control workplace safety conditions and thus may be liable for violations.

Vaccines and the Need for an ETS

OSHA argues in the preamble to its ETS that the development, availability, and overall success of the COVID-19 vaccines in the United States do not obviate the need for an ETS but rather serve as evidence of the need for an ETS. OSHA states that it has a statutory responsibility to protect all workers, including those who are unvaccinated, regardless of the reason for those workers' vaccine refusals. OSHA claims that the ETS encourages vaccination among health care workers, as many as 25% of whom may not be fully vaccinated, by exempting fully vaccinated workers from certain requirements in the ETS and by requiring that employers provide paid time off for employees to receive the COVID-19 vaccine, thus eliminating what the agency cites as a major barrier to vaccination.[42] In addition, OSHA asserts that the ETS will provide additional protections to non-vaccinated employees, including those who are unable to be vaccinated due to

[39] OSHA, "Occupational Exposure to COVID-19," pp. 32382-32383.

[40] OSHA, "Occupational Exposure to COVID-19," p. 32422.

[41] OSHA, "Occupational Exposure to COVID-19," p. 32418.

[42] OSHA, "Occupational Exposure to COVID-19," p. 32423.

medical or other reasons and those with compromised immune systems that may limit the effectiveness of the vaccine. Finally, OSHA states that while more evidence is needed to determine the overall effectiveness and duration of the effectiveness of the vaccines and the impact of new variants of COVID-19 on vaccine effectiveness, the ETS will continue to provide protections to workers regardless of vaccine status or efficacy.

Employers Covered by the COVID-19 ETS for Health Care Employers

The COVID-19 ETS for health care workers applies to all settings where employees provide health care services or health care support services, unless exempted in the ETS or otherwise exempt from OSHA coverage.[43] *Health care services* is defined in the ETS as "services that are provided to individuals by professional healthcare practitioners (e.g., doctors, nurses, emergency medical personnel, oral health professionals) for the purpose of promoting, maintaining, monitoring, or restoring health."[44] Health care support services are those that facilitate the provision of health care services and include such activities as patient admissions, food service, facility maintenance, and housekeeping.

Employers in the following workplace settings and situations are exempt from the ETS:

- the provision of first aid other than by a licensed health care worker;
- the dispensing of prescriptions in retail pharmacies;
- non-hospital ambulatory care settings where all non-employees are screened prior to entry and known or suspected COVID-19 cases are not permitted entry;
- well-defined hospital ambulatory care settings where all employees are fully vaccinated against COVID-19 and all non-employees are screened prior to entry and known or suspected COVID-19 cases are not permitted entry;
- home health care settings where all employees are fully vaccinated against COVID-19 and all non-employees are screened prior to entry and known or suspected COVID-19 cases are not present;
- health care support services performed offsite, such as offsite laundry services; and
- telehealth services without direct patient contact.[45]

In cases in which health care services are provided in a traditional non-health-care setting, such as a medical clinic inside of a workplace, the ETS applies only to the health care setting and not the rest of the facility. Similarly, if emergency health care is provided in a non-health-care setting, such as emergency medical services responding to a non-health-care facility, the ETS applies only to the provision of the emergency health care.

[43] Per Section 3(5) of the OSH Act (29 C.F.R. §652(5)), OSHA does not have jurisdiction over the activities of state or local governments as employers. State and local government employers must, however, be covered by any state occupational safety and health plan approved pursuant to Section 18 of the OSH Act (29 U.S.C. §667). Because state occupational safety and health plans must be at least as effective as federal OSHA requirements, these state and local government employees would be covered by the stricter federal OSHA requirements.

[44] 29 C.F.R. §1910.502(b).

[45] 29 C.F.R. §1910.502(a)(2).

Key Elements of the COVID-19 ETS for Health Care Employers

COVID-19 Plan

Each employer covered by the ETS is required to develop and implement a COVID-19 plan.[46] For covered employers with 10 or more employees, the plans must be in writing. In developing and implementing the COVID-19 plan, an employer must

- assign at least one COVID-19 safety coordinator, knowledgeable in infection control, to monitor and ensure compliance with the COVID-19 plan;
- conduct a workplace-specific hazard assessment;
- involve non-managerial employees and their representatives in the development and implementation of the COVID-19 plan and the hazard assessment;
- monitor the effectiveness and update the COVID-19 plan;
- address the hazards identified in the hazard assessment;
- include policies to minimize the risk of COVID-19 transmission for each employee; and
- communicate and coordinate COVID-19 prevention policies with other employers at multi-employer worksites.

Patient Screening and Management

In settings in which direct patient care is provided, the covered employer must limit access to the facility and screen and triage patients, clients, vendors, visitors, and other non-employees for COVID-19.[47] Covered employers must also comply with the CDC's guidance document *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic*, updated on February 23, 2021.[48]

Standard and Transmission-Based Precautions

Covered employers must comply with the CDC's guidance document *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*, as updated in July 2019.[49]

[46] 29 C.F.R. §1910.502(c).

[47] 29 C.F.R. §1910.502(d).

[48] CDC, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated February 23, 2021, https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html.

[49] CDC, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Health Care Settings*, updated July 2019, https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf.

PPE[50]

Facemasks

Covered employers must provide employees with facemasks that are cleared by the Food and Drug Administration (FDA), authorized by an FDA Emergency Use Authorization (EUA), or described in an FDA enforcement policy and ensure their proper use, covering the nose and mouth, whenever employees are indoors or occupying a vehicle with other people for work purposes.[51] The covered employer must provide sufficient masks to ensure that each employee may change his or her mask at least once per day when soiled and when necessary for patient care purposes. Facemasks are not required to be worn when employees are alone or eating or drinking and separated from other persons. When it is important to see the employee's mouth, such as when communicating with a person who is deaf, an employee may wear an alternative face covering such as a face shield. An employee can also be exempted from wearing a facemask due to a disability, for religious reasons, or if the employer can demonstrate that wearing a facemask would put the employee at risk of serious injury or death.

Respirators and Other PPE When Exposed to Known or Suspected COVID-19 Cases

Covered employers must provide employees who have contact with known or suspected COVID-19 cases with respirators, gloves, isolation gowns or protective clothing, and eye protection. Respirators must be provided and used in accordance with OSHA's respiratory protection standard.[52] When an employee is performing an aerosol-generating procedure, such as intubation, on a known or suspected COVID-19 case, the employer is encouraged, but not required, to provide the employee with an elastomeric respirator or powered-air purifying respirator (PAPR).[53] Covered employers must also comply with PPE requirements in CDC's guidance document *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*, as updated in July 2019.[54]

Aerosol-Generating Procedures

Whenever an aerosol-generating procedure is performed on a known or suspected COVID-19 case, the covered employer must ensure that only the minimum number of essential persons are present during the procedure and that the procedure is performed in an existing airborne infection isolation room (AIIR), if available.[55] An AIIR is a permanent or temporary negative air pressure room with air handling capacity designed to isolate a patient. After the aerosol-generating procedure is completed, all surfaces and equipment in the room must be cleaned and disinfected.

[50] For additional information on OSHA's standards for respiratory PPE, see the section "OSHA Respiratory Protection Standard" later in this report.

[51] 29 C.F.R. §1910.502(f)(1).

[52] 29 C.F.R. §1910.134.

[53] 29 C.F.R. §1910.502(f)(3) note 1.

[54] CDC, *2007 Guideline for Isolation Precautions*.

[55] 29 C.F.R. §502(g).

Physical Distancing

Except in brief situations in which people are moving, such as in a hallway, covered employers must ensure that employees are separated from all other persons by at least six feet when indoors unless such separation is not feasible for a specific task, such as direct patient care.[56] When six feet of distancing is not feasible, covered employers must ensure as much separation between employees and other persons as possible.

Physical Barriers

In fixed workspaces where six feet of separation between employees and other persons is not possible, such as appointment check-in desks, covered employers must separate persons with fixed barriers that are cleanable or disposable and sufficiently sized to block the pathway between the persons' faces.[57]

Cleaning and Disinfection

In patient care areas and resident rooms and on medical devices and equipment, covered employers must conduct cleaning and disinfection in accordance with the CDC's guidance documents *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic*, updated February 23, 2021,[58] and *Guidelines for Environmental Infection Control in Health-Care Facilities*, updated July 2019.[59]

In all other areas, the covered employer must clean high-touch surfaces and equipment at least daily in accordance with manufacturers' instructions.[60] If a known COVID-19 case has been in the workplace in the previous 24 hours, the covered employer must clean and disinfect any areas likely to have been contaminated in accordance with the CDC's guidance document *COVID-19: Cleaning and Disinfecting Your Facility; Every Day and When Someone Is Sick*, updated April 5, 2021.[61]

Covered employers must also provide hand sanitizer that is at least 60% alcohol or accessible hand washing facilities.[62]

Building Ventilation

Covered employers who own or control buildings with existing heating, ventilation, and air conditioning (HVAC) systems must ensure that

- the HVAC system is used in accordance with the manufacturer's instructions and design specifications;

[56] 29 C.F.R. §502(h).

[57] 29 C.F.R. §502(i).

[58] CDC, *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic*.

[59] 29 C.F.R. §502(j)(1); CDC, *Guidelines for Environmental Infection Control in Health-Care Facilities*, updated July 2019, https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf.

[60] 29 C.F.R. §502(j)(2).

[61] CDC, *COVID-19: Cleaning and Disinfecting Your Facility; Every Day and When Someone Is Sick*, updated April 5, 2021, https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html.

[62] 29 C.F.R. §502(j)(3).

- the amount of outside air circulating through the system and the number of air changes per hour are maximized, to the extent possible;
- all air filters are rated Minimum Efficiency Reporting Value (MERV) 13 or higher or, if MERV-13-rated filters are not compatible with the HVAC system, the highest compatible MERV-rated filters are used;
- all air filters are maintained and replaced as necessary; and
- all intake ports for outside air are cleaned and maintained.[63]

Covered employers with existing AIIRs must maintain and operate these rooms in accordance with design and construction criteria.[64]

Health Screening and Medical Management

Screening

Covered employers must screen all employees for COVID-19 before each workday and work shift. Screening can be conducted by employee self-screening or by the employer.[65] If a COVID-19 test is used as part of the screening, it must be provided at no cost to the employee.

Employee Notification to Employer of COVID-19 or Symptoms

Covered employers must require employees to notify them when they:

- test positive for or is diagnosed with COVID-19;
- are told by health care providers that they are suspected to have COVID-19;
- are experiencing an unexplained loss of taste and/or smell; or
- are experiencing a fever of 100.4 degrees Fahrenheit or more and a new unexplained cough with shortness of breath.[66]

Employer Notification to Employees of COVID-19 in the Workplace

Covered employers must make the following notifications within 24 hours of receiving information that a COVID-19 case was in the workplace:

- notify each employee who was not wearing a respirator and other appropriate PPE and was in close contact with the COVID-19 case with the dates the contact occurred; and
- notify all other employees and other employers with employees in the facility who were not wearing respirators and other appropriate PPE and were in a well-defined area of the workplace (such as a patient care floor) with the COVID-19 case during the period beginning two days before the case became sick or, if asymptomatic, submitted a sample for testing and lasting until the case was isolated.[67]

[63] 29 C.F.R. §502(k)(1).

[64] 29 C.F.R. §502(k)(2).

[65] 29 C.F.R. §502(l)(1).

[66] 29 C.F.R. §502(l)(2).

[67] 29 C.F.R. §502(l)(3).

Notifications must be made without revealing the name, contact information, or occupation of any employee. Notification does not need to be made in cases in which a medical facility routinely provides services to known or suspected COVID-19 cases, such as COVID-19 testing centers, emergency departments, and inpatient COVID-19 wards.

Medical Removal

Covered employers must immediately remove from the workplace any employee who tests positive for or is diagnosed with COVID-19 and make a return to work decision on that employee in accordance with the CDC's guidance documents *COVID-19: Isolation If You Are Sick; Separate Yourself from Others If You Have COVID-19*, updated February 18, 2021,[68] and *COVID-19: Return to Work Criteria for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)*, updated February 16, 2021.[69]

Covered employers must immediately remove from the workplace any employee who:

- is told by a health care provider that he or she is suspected to have COVID-19,
- is experiencing an unexplained loss of taste and/or smell, or
- is experiencing a fever of 100.4 degrees Fahrenheit or more and a new unexplained cough with shortness of breath.[70]

Covered employers may make return-to-work decisions on such employees in accordance with the two CDC guidance documents referenced above or permit return to work when the employee tests negative on a COVID-19 polymerase chain reaction (PCR) test provided by the employer at no cost to the employee. If the employee refuses to be tested, he or she forfeits all medical removal protections (discussed in the next section of this report) and must remain out of work until the covered employer makes a return to work determination in accordance with the two CDC guidance documents referenced above.

Covered employers are required to immediately remove from the workplace any employee who was not wearing a respirator and other appropriate PPE and was in close contact with a COVID-19 case in the workplace, except in workplaces that routinely provide services to COVID-19 cases.[71] Such an employee must remain out of work for 14 days or until seven days after testing negative on a COVID-19 PCR test administered by the employer at no cost to the employee and administered at least five days after the close contact with the COVID-19 case. If the employee refuses to be tested, he or she forfeits all medical removal protections (discussed in the next section of this report). A covered employer is not required to remove from the workplace an employee who was not wearing a respirator and other appropriate PPE and was in close contact with a COVID-19 case in the workplace if that employee is asymptomatic for COVID-19 and is fully vaccinated against COVID-19 or had COVID-19 and recovered in the past three months.

Covered employers may require employees subject to medical removal to work remotely or in isolation if suitable work is available.[72]

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[68] CDC, *Isolation If You Are Sick; Separate Yourself from Others If You Have COVID-19*, updated February 18, 2021.

[69] 29 C.F.R. §§502(l)(4)(i) and (l)(6); CDC, *COVID-19: Return to Work Criteria for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)*, updated September 10, 2021, https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html.

[70] 29 C.F.R. §§502(l)(4)(ii) and (l)(6).

[71] 29 C.F.R. §502(l)(4)(iii).

[72] 29 C.F.R. §502(l)(4)(iv).

Medical Removal Protection Benefits

Covered employers who require employees who have been removed from the workplace to work remotely or in isolation must continue to provide those employees with their regular pay and benefits.[73]

The medical removal protection provisions do not apply to covered employers with 10 or fewer employees on June 21, 2021.[74] All other covered employers must provide all of the fringe benefits normally provided to the employee and the following pay to the removed employee:

- for covered employers with 500 or fewer employees, the employee's full amount of normal pay, up to $1,400 per week, for the first two weeks, followed by two-thirds of the employee's normal pay, up to $200 per day, for all remaining weeks; and
- for covered employers with more than 500 employees, the employee's full amount of normal pay, up to $1,400 per week, for the entire removal period.[75]

The amount that a covered employer must pay to a removed employee is reduced by any public or employer-provided payments (such as sick leave) received by the employee during the employee's removal.[76]

Upon return to the workplace, a removed employee is entitled to all employment rights and benefits, including the right to his or her previous job.[77]

Vaccination

Each covered employer is required to provide employees with a reasonable amount of paid leave to receive a COVID-19 vaccine and recover from any vaccine-related side effects.[78] Covered employers are not required to mandate that their employees receive a COVID-19 vaccine.

Training

Covered employers must provide training on COVID-19 prevention, in appropriate languages and at appropriate literacy levels, to all employees.[79] Training must be conducted by a person knowledgeable about the subject matter, and employees must have the opportunity to ask questions during the training. Covered employers must ensure that trained employees understand at least the following:

- how COVID-19 is transmitted and how to reduce transmission through hand hygiene and covering the nose and mouth, the signs and symptoms of COVID-19, the risk factors for severe illness from COVID-19, and when to seek medical attention;
- patient screening and management policies and procedures;
- workplace tasks that could result in transmission of COVID-19;

[73] 29 C.F.R. §502(l)(5)(ii).
[74] 29 C.F.R. §502(l)(5)(i).
[75] 29 C.F.R. §502(l)(5)(iii).
[76] 29 C.F.R. §502(l)(5)(iv).
[77] 29 C.F.R. §502(l)(5)(v).
[78] 29 C.F.R. §502(m).
[79] 29 C.F.R. §502(n).

- policies and procedures to prevent COVID-19 transmission that are applicable to an employee's duties;
- agreements between multiple employers in a workplace related to shared spaces and equipment;
- policies and procedures for the use of PPE;
- cleaning and disinfecting policies and procedures;
- paid leave available from the employer or under federal, state, or local law for COVID-19 and available workplace flexibility policies;
- the names of the safety coordinators identified in the required COVID-19 plan;
- the requirements of the COVID-19 ETS; and
- how employees can receive copies of the COVID-19 ETS, employer policies and procedures developed under the ETS, and the written COVID-19 plan, if applicable.

Covered employers are required to provide retraining to an employee when that employee takes on new job tasks, workplace policies or procedures change, or there is evidence that the employee has not retained the information from the previous training.

Anti-Retaliation[80]

Covered employers must notify all employees of their rights to the protections offered by the COVID-19 ETS and that employers are prohibited from discharging or discriminating against employees for exercising these rights.[81]

Recordkeeping and Reporting[82]

The recordkeeping and reporting provisions of the COVID-19 ETS do not apply to covered employers with 10 or fewer employees on June 21, 2021.[83] All other covered employers must retain all versions of their COVID-19 plans and maintain logs of all COVID-19 cases among employees, regardless of whether the COVID-19 transmission occurred in the workplace.[84] All versions of the COVID-19 plan and the COVID-19 log (with identifying information redacted) must be provided, within one business day of being requested, to any employee or the personal or authorized representative of any employee. An employee and his or her authorized representative may examine his or her unredacted personal entry in the COVID-19 log. Covered employers must report to OSHA any employment-related COVID-19 fatalities or inpatient hospitalizations in the same manner as any other employment-related fatalities or inpatient hospitalizations.[85]

[80] For additional information on OSHA's enforcement of anti-retaliation and whistleblower protection provisions, see the section "Whistleblower Protections" later in this report.

[81] 29 C.F.R. §502(o).

[82] For additional information on OSHA's COVID-19 recordkeeping and reporting requirements for employers not covered by the ETS, see the section "COVID-19 Recordkeeping" later in this report.

[83] 29 C.F.R. §502(q)(1).

[84] 29 C.F.R. §502(q).

[85] 29 C.F.R. §502(q). OSHA regulations at Title 29, Section 1904.39, of the *Code of Federal Regulations* require employers to report to OSHA any employment-related fatalities within eight hours and any employment-related inpatient hospitalizations within 24 hours.

Mini-Respiratory Protection

The PPE provision of the COVID-19 ETS permits covered employers to provide their employees with respirators when respirators are not specifically required by the ETS. Under OSHA's respiratory protection standard, employers must provide a medical evaluation to each employee who is provided a respirator to ensure that such employee may safely use the respirator and must ensure that the fit of each type of respirator used by an employee is properly tested to ensure a tight seal around the face (referred to as fit testing).[86]

Under the mini-respiratory-protection provision of the COVID-19 ETS, employers who provide respirators to their employees when respirators are not specifically required may forgo the medical evaluation and fit-testing requirements of the respiratory protection standard.[87] Such covered employers must ensure that employees are trained in respirator use; conduct their own user-seal tests of the respirators before each use; and comply with appropriate procedures for the storage, reuse, and discontinuation of respirators.[88] When respirators are required by the COVID-19 ETS, employers must comply with all elements of the OSHA respiratory protection standard, including medical evaluation and fit testing.

OSHA ETS on COVID-19 Vaccination and Testing

On November 5, 2021, OSHA promulgated an ETS on COVID-19 vaccination and testing for all large employers.[89] This ETS requires that all employers with 100 or more employees develop written policies requiring that employees be fully vaccinated against COVID-19. As an alternative, employers may develop written policies that allow employees to choose to either be fully vaccinated against COVID-19 or provide proof of weekly negative COVID-19 tests and wear face coverings while in the workplace. Employers are not required to pay for COVID-19 tests or pay for or provide face coverings. Employers must develop vaccination and testing plans within 30 days of the publication of the ETS (December 5, 2021) and must enforce the requirements for testing of unvaccinated employees within 60 days (January 4, 2022).

While the *Federal Register* announcement does not specify a specific duration for the COVID-19 ETS, per the OSH Act, an ETS is effective until replaced by a permanent standard within six months. The publication of the COVID-19 ETS in the *Federal Register* also included a request for comments on the ETS and on whether the ETS should become a permanent standard. In the preamble to the ETS, OSHA provides that all state plans must adopt the ETS within 30 days of its publication and notify OSHA within 15 days of the actions they plan to take to adopt the ETS. The ETS is not retroactive.

[86] For additional information on OSHA's respiratory protection standard, see the section "OSHA Respiratory Protection Standard" later in this report.

[87] 29 C.F.R. §504.

[88] In a user-seal check, the user of the respirator checks the fit and seal of the respirator to his or her face by exhaling or inhaling to determine if any air passes between the face and respirator.

[89] OSHA, "COVID-19 Vaccination and Testing; Emergency Temporary Standard," 86 *Federal Register* 61402, November 5, 2021.

Petitions for Judicial Review

Petitions for judicial review of the COVID-19 vaccination and testing ETS have been filed in the U.S. Courts of Appeals for the Fifth,[90] Sixth,[91] Eighth,[92] and Eleventh[93] Circuits. The plaintiffs in these cases include 26 states and numerous employers.[94]

On November 6, 2021, the U.S. Court of Appeals for the Fifth Circuit ordered that the COVID-19 vaccination and ETS be stayed pending judicial review.

Justification for the COVID-19 Vaccination and Testing ETS

In the preamble to the COVID-19 vaccination and testing published in the *Federal Register*, OSHA provides a justification for the ETS. Specifically, OSHA cites the requirements in the OSH Act that employees are exposed to grave danger from exposure to SARS-CoV-2 and that an ETS is necessary to protect employees from such danger.

Grave Danger Determination

In its justification for the COVID-19 vaccination and testing ETS, OSHA states that it has found that "employees can be exposed to the virus in almost any work setting; that exposure to SARS-CoV-2 can lead to infection … and that infection in turn can cause death or serious impairment of health, especially in those who are unvaccinated."[95]

OSHA's determination that COVID-19 meets the grave danger standard required for an ETS rests on evidence and research on the following factors:

- the grave danger that all unvaccinated workers, with some exceptions, face from SARS-Cov-2, including death and severe health effects;
- the increase in infectiousness and transmission, and possible increase in severity of health effects from the B.1.617.2 (Delta) variant, which now accounts for 99% of the COVID-19 circulating in the United States; and
- evidence of pre-symptomatic and asymptomatic transmission of COVID-19.[96]

Necessity Determination

OSHA states that vaccination is the most effective strategy to control the spread of COVID-19 and that vaccination has advantages over non-pharmaceutical control strategies such as social distancing.[97] However, OSHA estimates that approximately 39% of workers who are covered by

[90] Texas, et. al. v. OSHA, Docket No. 21-50353 (5th Cir. Nov. 5, 2021).

[91] Kentucky, et. al. v. OSHA (6th Cir. Nov. 5, 2021).

[92] Missouri, et. al. v. Biden, et. al. (8th Cir. Nov. 5, 2021).

[93] Florida, et. al. v. OSHA, Docket No. 21-13866 (11th Cir. Nov. 5, 2021).

[94] The states of Louisiana, Mississippi, South Carolina, Texas and Utah (Fifth Circuit); Idaho, Kansas, Kentucky, Ohio, Oklahoma, Tennessee, and West Virginia (Sixth Circuit); Alaska, Arizona, Arkansas, Iowa, Missouri, Montana, Nebraska, New Hampshire, North Dakota, South Dakota, and Wyoming (Eigth Circuit); and Alabama, Florida, and Georgia (Eleventh Circuit) are plaintiffs in these cases.

[95] OSHA, "COVID-19 Vaccination and Testing; Emergency Temporary Standard," p. 61411.

[96] Ibid., at pp. 61408-61424.

[97] Ibid., at p. 61434.

the COVID-19 vaccination and testing ETS are not fully vaccinated against COVID-19.[98] In some states, laws or executive orders prohibit employers from implementing vaccine mandates for their employees, necessitating a national standard to overcome these barriers to vaccination and create a uniform national policy on vaccination.

OSHA justifies allowing employers to allow employees to opt out of getting vaccinated against COVID-19 by submitting to weekly COVID-19 testing and wearing face coverings in the workplace by stating that the "exigent circumstances" of the COVID-19 pandemic require OSHA to promulgate an ETS without having the opportunity to fully study the "potential spectrum of impacts on employers and employees, including the economic and health impacts, that would occur if OSHA imposed a strict vaccination mandate with no alternative compliance option."[99] OSHA notes that as part of the process of promulgating a permanent standard on vaccination required by Section 6(c) of the OSH Act, the agency is soliciting public comments on whether a vaccine mandate without any options of alternative means of compliance is warranted.[100]

Employers Covered by the COVID-19 Vaccination and Testing ETS

The COVID-19 vaccination and testing ETS covers all employers with 100 or more employees at any time the ETS is in effect, with the following exceptions:[101]

- workplaces covered by the vaccination rules provided in the "Guidance for Federal Contractors and Subcontractors" issued by the Safer Federal Workforce Task Force, including executive branch agencies with the exception of the U.S. Postal Service;[102] and
- work settings covered by the COVID-19 ETS for health care employers.

When determining the number of employees for an employer, all employees are counted, including those at multiple worksites owned by the employer; part-time and seasonal employees; and persons working remotely, from home, or otherwise not working in a physical office.[103]

In the preamble to the COVID-19 vaccination and testing ETS, OSHA provides the following reasons why the ETS does not apply to employers with fewer than 100 employees:

- the agency lacks confidence in the feasibility of small employers to comply with the ETS;
- the 100-employee threshold allows the ETS to cover two-thirds of private sector workers in the United States;
- the 100-employee threshold will allow the ETS to cover the largest workplace facilities, where the deadliest COVID-19 outbreaks can occur; and

[98] Ibid., at p. 61431.

[99] Ibid., at p. 61436.

[100] The request for comments is included in the preamble to the ETS at pp. 61403-61404.

[101] 29 C.F.R. §§1910.501(b)(1) and (2). The ETS is part of the OSHA standards for general industry. The OSHA standards for employers in marine terminals, longshoring, construction, and agriculture incorporate the provisions of the ETS by reference.

[102] Safer Federal Workforce Task Force, *COVID-19 Workplace Safety: Guidance for Federal Contractors and Subcontractors*, September 24, 2021, https://www.saferfederalworkforce.gov/downloads/Draft%20contractor%20guidance%20doc_20210922.pdf.

[103] OSHA, "COVID-19 Vaccination and Testing, Emergency Temporary Standard," pp. 61513-61514.

- an employee threshold for compliance has been used by federal agencies, such as the Equal Employment Opportunity Commission, and by Congress in enacting legislation such as the Family First Coronavirus Response Act (P.L. 116-127), Affordable Care Act (P.L. 111-148), and Family and Medical Leave Act (P.L. 103-3).[104]

The COVID-19 vaccination and testing ETS does not apply to workers who:

- do not work in settings where other people, such as coworkers or customers, are present;
- work from home; or
- work exclusively outdoors.[105]

However, these workers are counted when determining if an employee meets the 100-employee threshold.

Key Elements of the COVID-19 Vaccination and Testing ETS

Mandatory Vaccination Policy

A covered employer is required to establish, implement, and enforce a written mandatory vaccination policy. This policy must require the vaccination of all covered employees, as soon as practicable, with the following exceptions:

- employees for whom a vaccine is medically contraindicated,
- employees for whom a delay in vaccination is medically necessary, and
- employees who are legally entitled to reasonable accommodations under federal law because they have disabilities or religious beliefs that conflict with the vaccine requirement.[106]

An employee is considered to be fully vaccinated when two weeks has elapsed from the final dose of a COVID-19 vaccine that is approved or authorized for emergency use by the FDA, listed for emergency use by the World Health Organization, or administered in the United States as part of a clinical trial.[107]

A covered employer may, but is not required to, establish, implement, and enforce a written policy that permits any employee to choose between being fully vaccinated or providing proof of a negative COVID-19 test at least once every seven days and wearing a face covering in the workplace.[108] The employer is not required to provide or pay for the COVID-19 testing or face covering.[109]

A COVID-19 test used to permit an employee to work without being fully vaccinated must be cleared, approved, or authorized by the FDA, including in an EUA, to detect current SARS-CoV-

[104] Ibid., at pp. 61512-61513.

[105] 29 C.F.R. §1910.501(b)(3).

[106] 29 C.F.R. §§1910.501(c) and (d)(1).

[107] 29 C.F.R. §1910.501(c).

[108] 29 C.F.R. §1910.501(d)(2).

[109] 29 C.F.R. §§1910.501(g)(1) Note 1 and (i) Note 2.

2 infection. The test must be administered in accordance with its instructions. The test cannot be self-administered and self-read unless observed by the employer or a telehealth provider.[110]

Determination of Vaccination Status

Covered employers must require their employees to provide proof of vaccination status. Any employee who does not submit acceptable proof of full vaccination is considered to be unvaccinated.[111] The following are acceptable forms of proof of vaccination status:

- record of immunization from a health care provider or pharmacy;
- copy of the COVID-19 Vaccine Record Card;
- medical records documenting the vaccination;
- copy of immunization records from a public health, state, or tribal immunization information service;
- any other official documentation that contains the type of vaccine administered, the dates of administration, and the name of the person or site that administered the vaccine.[112]

An employee who is unable to provide acceptable proof of vaccination may provide a signed statement attesting to his or her vaccination status and that he or she has lost or is otherwise unable to provide acceptable proof of vaccination. The attestation statement of the employee must include the following language:

> I declare (or certify, verify, or state) that this statement about my vaccination status is true and accurate. I understand that knowingly providing false information regarding my vaccination status on this form may subject me to criminal penalties.[113]

Employers are required to maintain records of employee vaccination and rosters of vaccinated employees for the duration of the time the ETS is in effect.[114] An employer who has determined the vaccination status of an employee before the effective date of the ETS is not required to receive additional documentation from the employee.[115]

Employer Support and Paid Leave for Vaccination

Covered employers must provide employees paid leave of up to four hours for the employee to travel to and from a vaccination site and receive each vaccination dose, for a total of eight hours of leave. The employee is not required to pay for travel expenses.[116]

Covered employers must provide paid sick leave, which can include the use of an employee's accrued sick leave, to allow employees reasonable time off of work to recover from the side effects of each vaccine dose.[117]

[110] 29 C.F.R. §1910.501(c).

[111] 29 C.F.R. §1910.501(e)(3).

[112] 29 C.F.R. §1910.501(e)(2).

[113] 29 C.F.R. §1910.501(e)(2)(vi).

[114] 29 C.F.R. §1910.501(e)(4).

[115] 29 C.F.R. §1910.501(e)(5).

[116] 29 C.F.R. §1910.501(f)(1).

[117] 29 C.F.R. §1910.501(f)(2).

COVID-19 Testing for Employees Not Fully Vaccinated

Covered employers must ensure that all employees who are not fully vaccinated, either because of a medical or religious exemption from the vaccine requirements or as part of an employer's policy that allows testing in lieu of vaccination, are tested for COVID-19 as follows:

- an employee who reports, at least once every seven days, to a workplace where other people are present must be tested at least once every seven days and present the result of the test to the employer within seven days of providing the last test result to the employer; and
- an employee who reports, less than once every seven days, to a workplace where other people are present must be tested within seven days of returning to such a workplace and must present the test result to the employer before returning to such a workplace.[118]

An employer may not require any employee to be tested for COVID-19 within 90 days following a positive COVID-19 test or diagnosis.[119] Employers must keep records of employee COVID-19 tests for the duration of time the ETS is in effect.[120]

An employer is not required to provide or pay for COVID-19 tests for employees or provide any paid time off for testing.[121] A COVID-19 test used to permit an employee to work without being fully vaccinated must be cleared, approved, or authorized by the FDA, including in an EUA, to detect current SARS-CoV-2 infection. The test must be administered in accordance with its instructions. The test cannot be self-administered and self-read unless observed by the employer or a telehealth provider.[122]

Employee Notification of Positive COVID-19 Test and Removal

Covered employers must require that all employees notify them of any positive COVID-19 test or diagnosis. Employers must remove any employees with positive COVID-19 tests or diagnoses from the workplace until one of the following takes place:

- the employee receives a negative result on a COVID-19 nucleic acid amplification test (NAAT) following an antigen test;
- the employee meets the criteria to return to work provided in the CDC document *COVID-19: Isolation If You Are Sick; Separate Yourself from Others If You Have COVID-19, updated February 18, 2021*; or
- the employee receives a recommendation to return to work from a licensed health care provider.[123]

The employer is not required to provide any paid leave to employees who are removed from work due to a positive COVID-19 test or diagnosis and covered by this ETS.[124] This differs from the

[118] 29 C.F.R. §1910.501(g)(1).

[119] 29 C.F.R. §501(g)(3).

[120] 29 C.F.R. §501(g)(4).

[121] 29 C.F.R. §1910.501(g)(1) Note 1.

[122] 29 C.F.R. §1910.501(c).

[123] 29 C.F.R. §1910.501(h)(2).

[124] 29 C.F.R. §1910.501(h)(2) Note 1.

medical removal provisions of the COVID-19 ETS for health care employers, which includes paid medical removal.[125]

Face Coverings

Covered employers must require that all employees who are not fully vaccinated wear face coverings when indoors in the workplace or when in a work vehicle with another person, except when wearing a face covering is not feasible or creates a hazard.[126] A face covering must

- completely cover the nose and mouth;
- be made of two or more layers of breathable fabric that is tightly woven such that light does not pass through when held up to a light source;
- be secured with ties, ear loops, or elastic bands that go behind the head or is a gaiter with either two layers of fabric or folded into two layers;
- fit snugly over the nose, mouth, and chin with no large gaps on the outside of the face;
- have no slits, holes, exhalation valves, or other openings; and
- be replaced when wet, soiled, or damaged.[127]

An employer may not prevent any employee from wearing a face covering unless the employer can demonstrate that wearing a face covering would create a hazard of injury or death, such as interfering with the safe operation of equipment.[128] An employer may not prohibit customers from wearing face coverings.[129]

An employer must permit employees to wear respirators and may provide respirators to employees. If respirators are worn, the employer must comply with the mini-respiratory protection provision of the COVID-19 ETS for health care employment.[130]

Information Provided to Employees

Covered employers must provide all employees with the following information, in appropriate language and literacy levels:

- the requirements of the COVID-19 vaccination and testing ETS and employer policies to comply with the ETS;
- the CDC document "Key Things to Know about COVID-19 Vaccines;"[131]
- the anti-retaliation and whistleblower protection provisions of the OSH Act and OSHA standards; and

[125] 29 C.F.R. §1910.502(l)(5)(iii).

[126] 29 C.F.R. §1910.501(i)(1).

[127] 29 C.F.R. §§1910.501(c), (i)(1), and (2).

[128] 29 C.F.R. §1910.501(i)(3).

[129] 29 C.F.R. §1910.501(i)(5).

[130] 29 C.F.R. §1910.501(i)(4), incorporating 29 C.F.R. §1910.504 by reference.

[131] CDC, *Key Things to Know about COVID-19 Vaccines*, October 7, 2021, https://www.cdc.gov/coronavirus/2019-ncov/vaccines/keythingstoknow.html.

- the prohibitions of Title 18, Section 1001, of the *U.S. Code* and Section 17(g) of the OSH Act[132] which provide criminal penalties for knowingly supplying false statements or documents.[133]

Reporting COVID-19 Fatalities and Hospitalizations to OSHA

Covered employers must report each work-related COVID-19 fatality to OSHA within eight hours of the employer learning about the fatality and each work-related COVID-19 inpatient hospitalization within 24 hours.[134] A work-related COVID-19 fatality or hospitalization is one that results from a COVID-19 exposure in the workplace.[135]

Availability of Records

Covered employers must make the following records available to specified individuals or organizations in the following manner:

- an employee's vaccine documentation and COVID-19 test results, by the end of the following business day, to the employee or a person with the written consent of the employee;
- the aggregate number of fully vaccinated employees and total number of employees at a workplace, by the end of the next business day, to an employee or employee representative;
- the employer's written vaccine policy and aggregate number of fully vaccinated employees and total number of employees, within four hours, to OSHA; and
- all documents and records required by the COVID-19 vaccination and testing ETS, by the end of the next business day, to OSHA.[136]

Other OSHA Standards Related to COVID-19

While the COVID-19 ETS applies only to health care employers, all employers are required to comply with other OSHA standards that, while not specific to COVID-19, may cover situations related to the prevention of COVID-19 transmission in the workplace. OSHA may enforce the general duty clause in the absence of a standard if it can be determined that an employer has failed to provide a worksite free of "recognized hazards" that are "causing or are likely to cause death or serious physical harm" to workers.[137] In addition, OSHA's standards for the use of PPE may apply in cases in which workers require eye, face, hand, or respiratory protection against COVID-19 exposure.[138]

[132] 29 U.S.C. §666(f).

[133] 29 C.F.R. §501(j).

[134] 29 C.F.R. §501(k).

[135] OSHA, "COVID-19 Vaccination and Testing, Emergency Temporary Standard," pp. xxx (p. 454)

[136] 29 C.F.R. §501(l).

[137] 29 U.S.C. §654(a)(1).

[138] 29 C.F.R. §§1910.133, 1910.134, and 1910.138.

OSHA Respiratory Protection Standard

National Institute for Occupational Safety and Health Certification

The OSHA respiratory protection standard requires the use of respirators certified by NIOSH in cases in which engineering controls, such as ventilation or enclosure of hazards, are insufficient to protect workers from breathing contaminated air.[139] Surgical masks, procedure masks, and dust masks are not considered respirators. NIOSH certifies respirators pursuant to federal regulations.[140] For nonpowered respirators, such as filtering face piece respirators commonly used in health care and construction, NIOSH classifies respirators based on their efficiency at filtering airborne particles and their ability to protect against oil particles. Under the NIOSH classification system, the letter (N, R, or P) indicates the level of oil protection as follows: N—no oil protection; R—oil resistant; and P—oil proof. The number following the letter indicates the efficiency rating of the respirator as follows: 95—filters 95% of airborne particles; 97—filters 97% of airborne particles; and 100—filters 99.7% of airborne particles. Thus an N95 respirator, the most common type, is one that does not protect against oil particles and filters out 95% of airborne particles. An R or P respirator can be used in place of an N respirator.

A respirator that is past its manufacturer-designated shelf life is no longer considered to be certified by NIOSH. However, in response to potential shortages in respirators, NIOSH has tested and approved certain models of respirators for certified use beyond their manufacturer-designated shelf lives.[141]

Respirators designed for certain medical and surgical uses are subject to both certification by NIOSH (for oil protection and efficiency) and regulation by the FDA as medical devices. In general, respirators with exhalation valves cannot be used in surgical and certain medical settings because, although the presence of an exhalation valve does not affect the respirator's protection afforded the user, it may allow unfiltered air from the user into a sterile field. On March 2, 2020, FDA issued an EUA to approve for use in medical settings certain NIOSH-certified respirators not previously regulated by FDA.[142]

Medical Evaluation and Fit Testing

The OSHA respiratory protection standard requires that the employer provide a medical evaluation to the employee to determine if the employee is physiologically able to use a respirator. This medical evaluation must be completed before any fit testing. For respirators designed to fit tightly against the face, the specific type and model of respirator that an employee is to use must be fit tested in accordance with the procedures provided in Appendix A of the OSHA respiratory protection standard to ensure there is a complete seal around the respirator when worn.[143] Once an employee has been fit tested for a respirator, he or she is required to be fit tested annually or whenever the model of respirator, but not the actual respirator itself, is

[139] 29 C.F.R. §1910.134.

[140] 42 C.F.R. Part 84.

[141] NIOSH, *Release of Stockpiled Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response*, February 28, 2020, at https://www.cdc.gov/coronavirus/2019-ncov/release-stockpiled-N95.html.

[142] Letter from RADM Denise M. Hinton, chief scientist, FDA, to Robert R. Redfield, Director, CDC, March 2, 2020, at https://www.fda.gov/media/135763/download.

[143] 29 C.F.R. §1910.134 Appendix A. PAPRs that do not require a seal to the user's face do not need to be fit tested.

changed. Each time an individual uses a respirator, he or she is required to perform a check of the seal of the respirator to his or her face in accordance with the procedures provided in Appendix B of the standard.[144] On March 14, 2020, OSHA issued guidance permitting employers to suspend annual fit testing of respirators for employees that have already been fit tested on the same model respirator.

Temporary OSHA Enforcement Guidance on the Respiratory Protection Standard

In response to shortages of respirators and other PPE during the national response to the COVID-19 pandemic, OSHA has issued five sets of temporary enforcement guidance to permit the following exceptions to the respiratory protection standard:

1. employers may suspend annual fit testing of respirators for employees that have already been fit tested on the same model respirator;[145]
2. employers may permit the use of expired respirators and the extended use or reuse of respirators, provided the respirator maintains its structural integrity and is not damaged, soiled, or contaminated (e.g., with blood, oil, or paint);[146]
3. employers may permit the use of respirators not certified by NIOSH, but approved under standards used by the following countries or jurisdictions, in accordance with the protection equivalency tables provided in Appendices A and B of the enforcement guidance document:
    - Australia,
    - Brazil,
    - European Union,
    - Japan,
    - Mexico,
    - People's Republic of China, and
    - Republic of Korea.[147]
4. employers may permit the re-use of respirators decontaminated in accordance with CDC decontamination guidance;[148] and

[144] 29 C.F.R. §1910.134 Appendix B.

[145] OSHA, *Temporary Enforcement Guidance—Health Care Respiratory Protection Annual Fit-Testing for N95 Filtering Facepieces During the COVID-19 Outbreak*, March 14, 2020, at https://www.osha.gov/memos/2020-03-14/temporary-enforcement-guidance-healthcare-respiratory-protection-annual-fit; and OSHA *Expanded Temporary Enforcement Guidance on Respiratory Protection Fit-Testing for N95 Filtering Facepieces in All Industries During the Coronavirus Disease 2019 (COVID-19) Pandemic*, April 8, 2020, at https://www.osha.gov/memos/2020-04-08/expanded-temporary-enforcement-guidance-respiratory-protection-fit-testing-n95.

[146] OSHA, *Enforcement Guidance for Respiratory Protection and the N95 Shortage Due to the Coronavirus Disease 2019 (COVID-19) Pandemic*, April 3, 2020, at https://www.osha.gov/memos/2020-04-03/enforcement-guidance-respiratory-protection-and-n95-shortage-due-coronavirus. Under this guidance, employers are required to address in their written respiratory protection plans when respirators are contaminated and not available for use or reuse.

[147] OSHA, *Enforcement Guidance for Use of Respiratory Protection Equipment Certified under Standards of Other Countries or Jurisdictions During the Coronavirus Disease 2019 (COVID-19) Pandemic*, April 3, 2020, at https://www.osha.gov/memos/2020-04-03/enforcement-guidance-use-respiratory-protection-equipment-certified-under.

[148] OSHA, *Enforcement Guidance on Decontamination of Filtering Facepiece Respirators in Healthcare During the Coronavirus Disease 2019 (COVID-19) Pandemic*, April 24, 2021, at https://www.osha.gov/memos/2020-04-24/

5. employers may permit the use of NIOSH-approved tight-fitting PAPRs in place of respirators when respirator fit testing is not feasible due to supply issues.[149]

COVID-19 Recordkeeping

Sections 8(c) and 24(a) of the OSH Act require employers to maintain records of occupational injuries and illnesses in accordance with OSHA regulations.[150] OSHA's reporting and recordkeeping regulations require that employers with 10 or more employees must keep records of work-related injuries and illnesses that result in lost work time for employees or that require medical care beyond first aid.[151] Employers must also report to OSHA, within eight hours, any workplace fatality and, within 24 hours, any injury or illness that results in in-patient hospitalization, amputation, or loss of an eye. Employers in certain industries determined by OSHA to have lower occupational safety and health hazards are listed in the regulations as being exempt from the recordkeeping requirements but not the requirement to report to OSHA serious injuries, illnesses, and deaths.[152] Offices of physicians, dentists, other health practitioners and outpatient medical clinics are included in the industries that are exempt from the recordkeeping requirements.

OSHA regulations require the employer to determine if an employee's injury or illness is related to his or her work and thus subject to the recordkeeping requirements.[153] The regulations provide a presumption that an injury or illness that occurs in the workplace is work-related and recordable unless one of the exemptions provided in the regulations applies.[154] One of the listed exemptions is "The illness is the common cold or flu (Note: contagious diseases such as tuberculosis, brucellosis, hepatitis A, or plague are considered work-related if the employee is infected at work)."[155]

Because of the nature of COVID-19 transmission, which can occur outside of work as well as in the workplace, it can be difficult to determine the exact source of any person's COVID-19 transmission. Absent any specific guidance, this may make it difficult for employers to determine if an employee's COVID-19 is subject to the recordkeeping requirements.

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enforcement-guidance-decontamination-filtering-facepiece-respirators-healthcare; and CDC, *Implementing Filtering Facepiece Respirator (FFR) Reuse, Including Reuse after Decontamination, When There Are Known Shortages of N95 Respirators*, October 19, 2021, at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html.

[149] OSHA, *Temporary Enforcement Guidance—Tight-Fitting Powered Air Purifying Respirators (PAPRs) Used During the Coronavirus Disease 2019 (COVID-19) Pandemic*, October 2, 2021, at https://www.osha.gov/memos/2020-10-02/temporary-enforcement-guidance-tight-fitting-powered-air-purifying-respirators.

[150] 29 U.S.C. §§657(c) and 673(a).

[151] OSHA's reporting and recordkeeping regulations are at Title 29, Part 1904, of the *Code of Federal Regulations*.

[152] The list of exempted industries is at Title 29, Subpart B, Appendix A, of the *Code of Federal Regulations*. States with state occupational safety and health plans may require employers in these exempted industries to comply with the recordkeeping requirements.

[153] 29 C.F.R. §1904.5.

[154] 29 C.F.R. §1905.5(a).

[155] 29 C.F.R. §1904.5(b)(2)(viii).

Initial OSHA Recordkeeping Guidance

On April 10, 2020, OSHA issued enforcement guidance on how cases of COVID-19 should be treated under the recordkeeping requirements.[156] This guidance stated that COVID-19 cases were recordable if they were work-related.

Under this guidance, employers in the following industry groups were to fully comply with the recordkeeping regulations, including the requirement to determine if COVID-19 cases were work-related:

- health care;
- emergency response, including firefighting, emergency medical services, and law enforcement; and
- correctional institutions.

For all other employers, OSHA required employers to determine if COVID-19 cases were work-related and subject to the recordkeeping requirements only if both of the following two conditions were met:

1. There was objective evidence that a COVID-19 case may have been work-related. This could have included, for example, a number of cases developing among workers who worked closely together without an alternative explanation.
2. The evidence of work-relatedness was reasonably available to the employer. For purposes of this guidance, examples of reasonably available evidence included information given to the employer by employees, as well as information that an employer learned regarding its employees' health and safety in the ordinary course of managing its business and employees.

Updated OSHA Recordkeeping Guidance

OSHA issued new guidance, effective May 26, 2020, on recordkeeping of COVID-19 cases.[157] This new guidance rescinds the previous guidance issued by OSHA on April 10, 2020. Under this new guidance, all employers, regardless of type of industry or employment, are subject to the recordkeeping and reporting regulations for work-related cases of COVID-19. To determine if an employer has made a reasonable determination that a case of COVID-19 was work-related, OSHA says it will consider the following factors:

- the reasonableness of the employer's investigation of the COVID-19 case and its transmission to the employee,
- the evidence that is available to the employer, and
- the evidence that COVID-19 was contracted at work.

The guidance provides examples of evidence that can be used to demonstrate that a COVID-19 case was or was not work-related, such as if an employee had frequent close contact with members of the public in an area with ongoing community transmission of COVID-19.

[156] OSHA, *Enforcement Guidance for Recording Cases of Coronavirus Disease 2019 (COVID-19)*, April 10, 2020, https://www.osha.gov/memos/2020-04-10/enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19.

[157] OSHA, *Revised Enforcement Guidance for Recording Cases of Coronavirus Disease 2019 (COVID-19)*, May 19, 2020, https://www.osha.gov/memos/2020-05-19/revised-enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19.

Injuries and Illnesses Caused by the COVID-19 Vaccine Are Not Subject to Recording and Reporting Requirements

OSHA guidance, issued in the form of questions and answers on the OSHA COVID-19 Frequently Asked Questions webpage on May 22, 2021, provides that the agency will not require any employers to record or report any injuries or illness resulting from the COVID-19 vaccine even if vaccination is a condition of employment. This guidance is to remain in effect through May 2022.[158]

Whistleblower Protections

Section 11(c) of the OSH Act prohibits any person from retaliating or discriminating against any employee who exercises certain rights provided by the OSH Act.[159] Commonly referred to as the whistleblower protection provision, this provision protects any employee who takes any of the following actions:

- files a complaint with OSHA related to a violation of the OSH Act;
- causes an OSHA proceeding, such as an investigation, to be instituted;
- testifies or is about to testify in any OSHA proceeding; and
- exercises on his or her own behalf, or on behalf of others, any other rights afforded by the OSH Act.[160]

Other rights afforded by the OSH Act that are covered by the whistleblower protection provision include the right to inform the employer about unsafe work conditions; the right to access material safety data sheets or other information required to be made available by the employer; and the right to report a work-related injury, illness, or death to OSHA.[161] In limited cases, the employee has the right to refuse to work if conditions reasonably present a risk of serious injury or death and there is not sufficient time to eliminate the danger through other means.[162]

In the 116th Congress, the COVID-19 Every Worker Protection Act of 2020 (H.R. 6559/S. 3677) would have required OSHA to promulgate an ETS and required the ETS and permanent standard promulgated pursuant to the legislation to expand the protections for whistleblowers. The following additional activities taken by employees would have granted them protection from retaliation and discrimination from employers and agents of employers:

- reporting to the employer; a local, state, or federal agency; or the media or on a social media platform the following:

[158] OSHA, *COVID-19: Frequently Asked Questions*, https://www.osha.gov/coronavirus/faqs#vaccine. This guidance supersedes previous guidance, issued on April 21, 2021, that required employers to record and report injuries and illnesses from the COVID-19 vaccine if the employers required the vaccine as a condition of employment.

[159] 29 U.S.C. §660(c). OSHA also enforces whistleblower provisions in 22 other federal statutes. Information on statutes with whistleblower provisions enforced by OSHA is at OSHA, *Whistleblower Statutes Summary Chart*, October 17, 2009, https://www.whistleblowers.gov/sites/wb/files/2019-12/WB-Statute-Summary-Chart-10.8-Final.pdf.

[160] 29 C.F.R. §1977.3. Public sector employees, except employees of the U.S. Postal Service, are not protected by the whistleblower provision but may be covered by whistleblower provisions in other federal and state statutes.

[161] For additional information on other rights covered by the whistleblower protection provision, see OSHA, January 9, 2019, *Investigator's Desk Aid to the Occupational Safety and Health Act (OSH Act) Whistleblower Protection Provision*, pp. 5-7, https://www.osha.gov/sites/default/files/11cDeskAid.pdf.

[162] 29 C.F.R. §1977.12(b)(2).

  - a violation of the ETS or permanent standard promulgated pursuant to the legislation,
  - a violation of the infectious disease control plan required by the ETS or permanent standard, or
  - a good-faith concern about an infectious disease hazard in the workplace;
- seeking assistance from the employer or a local, state, or federal agency with such a report; and
- using personally supplied PPE with a higher level of protection than offered by the employer.

State Occupational Safety and Health Standards

States have the authority to establish their own occupational safety and health plans and preempt standards established and enforced by OSHA.[163] OSHA must approve state plans if they are "at least as effective" as OSHA's standards and enforcement. If a state adopts a state plan, it must also cover state and local government entities, such as public schools, not covered by OSHA. State plans may incorporate OSHA standards by reference, or states may adopt their own standards that are at least as effective as OSHA's standards. If a state has a standard that is stricter than an OSHA standard, the state standard would apply.

Two states, California and Michigan, have issued temporary standards under their state plans that directly address COVID-19 exposure, with Michigan's temporary standards rescinded and replaced by the OSHA COVID-19 ETS for health care employers. In addition, Oregon and Virginia have issued permanent COVID-19 standards, and California has had a permanent state standard covering aerosol transmission of diseases since 2009. **Table A-2** in the Appendix to this report provides a summary of these state standards.

California: Cal/OSHA Aerosol Transmissible Disease Standard

The California Division of Occupational Safety and Health (Cal/OSHA), under its state plan, promulgated its aerosol transmissible disease (ATD) standard in 2009.[164] The ATD standard covers most health care workers (including emergency medical services and police transport or detention of infected persons) and laboratory workers, as well as workers in correctional facilities, homeless shelters, and drug treatment programs. Under the ATD standard, SARS-CoV-2, the virus that causes COVID-19, is classified as a disease or pathogen requiring airborne isolation. This classification subjects the virus to stricter control standards than diseases requiring only droplet precautions, such as seasonal influenza.[165] The key requirements of the ATD standard include

- written ATD exposure control plan and procedures;

[163] 29 U.S.C. §667.

[164] *Aerosol Transmissible Diseases*, Cal. Code Regs. tit. 8, §5199, available at https://www.dir.ca.gov/title8/5199.html. The California state plan covers all state and local government agencies and all private sector workers in the state, with the exception of maritime workers; workers on military bases and in national parks, monuments, memorials, and recreation areas; workers on federally recognized Native American reservations and trust lands; and U.S. Postal Service contractors.

[165] Cal. Code Regs. tit. 8, §5199 Appendix A.

- training of all employees on COVID-19 exposure, use of PPE, and procedures if exposed to COVID-19;
- engineering and work practice controls to control COVID-19 exposure, including the use of airborne isolation rooms;
- provision of medical services to exposed employees, including post-exposure evaluation of employees and treatment and vaccines, if available;
- the removal, without penalty to the employees, of exposed employees,
- specific requirements for laboratory workers, and
- PPE requirements.

Cal/OSHA Aerosol Transmissible Disease PPE Requirements

The Cal/OSHA ATD standard requires that employers provide employees PPE, including gloves, gowns or coveralls, eye protection, and respirators certified by NIOSH at least at the N95 level whenever workers

- enter or work in an airborne isolation room or area with a case or suspected case;
- are present during procedures or services on a case or suspected case;
- repair, replace, or maintain air systems or equipment that may contain pathogens;
- decontaminate an area that is or was occupied by a case or suspected case;
- are present during aerosol generating procedures on cadavers of cases or suspected cases;
- transport a case or suspected case within a facility or within a vehicle when the patient is not masked; or
- are working with a viable virus in the laboratory.

In addition, a PAPR with a high-efficiency particulate air (HEPA) filter must be used whenever a worker performs a *high-hazard procedure* on a known or suspected COVID-19 case.[166] High-hazard procedures are those in which "the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens"—they include intubation, airway suction, and caring for patients on positive pressure ventilation.[167] Emergency medical services (EMS) workers may use N100, R100, or P100 respirators in place of PAPRs.

Cal/OSHA COVID-19 ETS

On November 19, 2020, the California Occupational Safety and Health Standards Board approved an ETS to specifically address COVID-19 exposure in the workplace.[168] This ETS became effective on November 30, 2020. The Cal/OSHA ETS applies to all covered employers in the state, including state and local government entities, and provides for broader protections than the Cal/OSHA ATD standard. The Cal/OSHA ETS includes specific provisions that apply to employer-provided housing and transportation. On June 17, 2021, the California Occupational

[166] A PAPR uses a mechanical device to draw in room air and filter it before expelling that air over the user's face. In general, PAPRs do not require a tight seal to the user's face and do not need to be fit tested.

[167] Cal. Code Regs. tit. 8, §5199(b).

[168] *COVID-19 Prevention*, Cal. Code Regs. tit. 8, §§3205-3205.4, available at https://www.dir.ca.gov/dosh/coronavirus/ETS.html.

Safety and Health Standards Board voted to amend the Cal/OSHA ETS to permit fully vaccinated employees to work indoors without facemasks or face coverings and all employees, regardless of vaccination status, to work outdoors without facemasks or face coverings. The amended Cal/OSHA ETS expires on January 14, 2022.

Michigan: MIOSHA COVID-19 Emergency Rules

On October 14, 2020, the director of the Michigan Department of Labor and Economic Opportunity, which operates Michigan's state occupational safety and health plan (MIOSHA), promulgated emergency rules, with a duration of six months, to address workplace exposure to COVID-19. On April 10, 2021, the MIOSHA emergency rules were extended for an additional six months through October 14, 2021. These rules were amended, effective May 24, 2021, based on updated CDC guidance, and the amended rules were to remain in effect through October 14, 2021.[169] On June 22, 2021, the Michigan Department of Labor and Economic Opportunity rescinded the MIOSHA COVID-19 emergency rules and replaced them with the OSHA COVID-19 ETS health care employers. The OSHA ETS will remain in force in Michigan through December 22, 2021. The Michigan emergency rules apply to all employers covered by the state plan.

Oregon: Oregon OSHA COVID-19 Permanent Administrative Rules

On November 6, 2020, the Oregon Department of Consumer and Business Services, which operates Oregon's state plan (Oregon OSHA), adopted temporary administrative rules to specifically address COVID-19 exposures in the workplace. These rules were set to expire on May 4, 2021. On May 4, 2021, permanent administrative rules became effective.[170] These permanent rules will remain in effect until repealed or revised by Oregon OSHA. Since the promulgation of the permanent administrative rules, Oregon has adopted three temporary amendments to the rules, with the most recent amendment issued on September 14, 2021, to bring Oregon into compliance with the provisions of the OSHA COVID-19 ETS for health care employers. While the administrative rules are permanent, the amendments expire on December 26, 2021.

Virginia: VOSH COVID-19 Permanent Standard

On July 15, 2020, the Virginia Safety and Health Codes Board adopted an ETS to specifically protect employees from exposure to SARS-CoV-2, the virus that causes COVID-19.[171] On

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[169] *Emergency Rules: Coronavirus 2019 (COVID-19)*, available at https://www.michigan.gov//documents/leo/Final_MIOSHA_Rules_705164_7.pdf. The Michigan state plan covers all state and local government agencies and all private sector workers in the state, with the exception of maritime workers, U.S. Postal Service contractors, workers at businesses owned or operated by tribal members at Indian reservations, and aircraft cabin crew members.

[170] *Addressing COVID-19 Workplace Risks*, Or. Admin. R. 437-001-0744, available at https://osha.oregon.gov/OSHARules/div1/437-001-0744.pdf. The Oregon state plan covers all state and local government agencies and all private sector workers in the state, with the exception of maritime workers, private sector establishments within the boundaries of Indian reservations and federal military reservations, employment at Crater Lake National Park and the U.S. Department of Energy Albany Research Center, U.S. Postal Service contractors, and aircraft cabin crew members during flight operations.

[171] *Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19*, 16 Va. Admin. Code §25-220, available at https://www.doli.virginia.gov/wp-content/uploads/2020/07/RIS-filed-RTD-Final-ETS-7.24.2020.pdf. This ETS was

January 12, 2021, the Virginia Safety and Health Codes Board voted to promulgate a permanent COVID-19 standard that supersedes the ETS.[172]

This ETS, promulgated under Virginia's state occupational safety and health plan (VOSH), was the first state standard to specifically address COVID-19 in the workplace.[173] As an ETS, the VOSH standard was to expire within six months of its effective date, upon expiration of the governor's state of emergency, when superseded by a permanent standard, or when repealed by the Virginia Safety and Health Codes Board, whichever came first. The VOSH permanent standard applies to all state and local government agencies and all covered private sector employees in the state and does not contain additional requirements for any specific industries.

Among the concerns raised by groups opposed to the VOSH permanent standard was that, because the standard is permanent, employers would be required to comply with the COVID-19 prevention requirements even after the COVID-19 pandemic has ended.[174] While the standard is permanent, a provision in the standard requires that within 14 days of expiration of the governor's COVID-19 state of emergency and the commissioner of health's COVID-19 declaration of public emergency, the Virginia Safety and Health Codes Board must meet to determine if there is a continued need for the standard.

effective upon publication in a Richmond, VA, newspaper during the week of July 27, 2020.

[172] *Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19*, 16 Va. Admin. Code §25-220, available at http://www.doli.virginia.gov/wp-content/uploads/2021/01/Final-Standard-for-Infectious-Disease-Prevention-of-COVID-19-16VAC25-220-1.15.2021.pdf. This permanent standard is effective on January 27, 2021.

[173] The Virginia state plan covers all state and local government agencies and all private sector workers in the state, with the exception of maritime workers, U.S. Postal Service contractors, workers at military bases or other federal enclaves in which the federal government has civil jurisdiction, workers at the U.S. Department of Energy's Southeastern Power Administration Kerr-Philpott System, and aircraft cabin crew members.

[174] See, for example, letter from Hobey Bauhan, President, Virginia Poultry Federation, to Princy Doss, Director of Policy, Planning and Public Information, and Jay Withrow, Director, Division of Legal Support, Virginia Department of Labor and Industry, January 7, 2021,

Appendix.

Table A-1. OSHA Emergency Temporary Standards (ETS)

Year	Subject of ETS	*Federal Register* Citation of ETS	Result of Judicial Review	Judicial Review Case Citation
1971	Asbestos	36 *Federal Register* 23207 (December 7, 1971)	Not challenged	—
1973	Organophosphorous pesticides	38 *Federal Register* 10715 (May 1, 1973); amended by 38 *Federal Register* 17214 (June 29, 1973)	Vacated	*Florida Peach Growers Ass'n v. United States Department of Labor,* 489 F.2d 120 (5th Cir. 1974)
1973	Fourteen carcinogens	38 *Federal Register* 10929 (May 3, 1973)	Twelve upheld, two vacated	*Dry Color Mfrs. Ass'n v. Department of Labor,* 486 F.2d 98 (3d Cir. 1973)
1974	Vinyl chloride	39 *Federal Register* 12342 (April 5, 1974)	Not challenged	—
1976	Diving operations	41 *Federal Register* 24271 (June 15, 1976)	Stayed	*Taylor Diving & Salvage Co. v. Department of Labor*, 537 F.2d 819 (5th Cir. 1976)
1977	Benzene	42 *Federal Register* 22515 (May 3, 1977)	Stayed	*Industrial Union Dep't v. Bingham*, 570 F.2d 965 (D.C. Cir. 1977)
1977	1,2 Dibromo-3-chloropropane (DBCP)	42 *Federal Register* 45535 (September 9, 1977)	Not challenged	—
1978	Acrylonitrile (vinyl cyanide)	43 *Federal Register* 2585 (January 17, 1978)	Stay denied	*Vistron v. OSHA*, 6 OSHC 1483 (6th Cir. 1978)
1983	Asbestos	48 *Federal Register* 51086 (November 4, 1983)	Stayed	*Asbestos Info. Ass'n v. OSHA*, 727 F.2d 415 (5th Cir. 1984)
2021	COVID-19 for health care employers	86 *Federal Register* 32376 (June 21, 2021)	Petitions for review filed on June 24, 2021	*United Food and Commercial Workers and American Federation of Labor and Congress of Industrial Organizations v. OSHA, et al.*, Docket No. 21-1143 (D.C. Cir. June 24, 2021)

Year	Subject of ETS	*Federal Register* Citation of ETS	Result of Judicial Review	Judicial Review Case Citation
2021	COVID-19 vaccination and testing	86 *Federal Register* 61402 (November 5, 2021)	Stay ordered by U.S. Court of Appeals for the Fifth Circuit on November 6, 2021	*Texas, et. al. v. OSHA*, Docket No. 21-50353 (5th Cir. Nov. 5, 2021) *Kentucky, et. al. v. OSHA* (6th Cir. Nov. 5, 2021) *Missouri, et. al. v. Biden, et. al.* (8th Cir. Nov. 5, 2021) *Florida, et. al. v. OSHA*, Docket No. 21-13866 (11th Cir. Nov. 5, 2021)

Source: CRS with data from Mark A. Rothstein, "Substantive and Procedural Obstacles to OSHA Rulemaking: Reproductive Hazards as an Example," *Boston College Environmental Affairs Law Review*, vol. 12, no. 4 (August 1985), p. 673.

Table A-2. State Occupational Safety and Health Standards That Apply to COVID-19

State	Standard	Covered Employers	Issued	Expires
California (Cal/OSHA)	Aerosol Transmissible Disease (ATD)[a]	Health care, laboratories, corrections facilities, homeless shelters, and drug treatment centers	July 6, 2009	Permanent
	COVD-19 Prevention[b]	All employers	November 30, 2020 June 17, 2021 (amended)	January 14, 2022
Michigan (MIOSHA)	Emergency Rules: Coronavirus 2019 (COVID-19)[c]	All employers, with additional rules for specific industries	October 14, 2020, April 10, 2021 (extended) May 24, 2021 (amended)	Rescinded on June 22, 2021, and replaced with OSHA COVID-19 ETS for health care employers, which expires in Michigan on December 22, 2021
Oregon (Oregon OSHA)	Addressing COVID-19 Workplace Risks[d]	All employers, with additional rules for specific industries	November 6, 2020 (ETS), reissued December 11, 2020 May 4, 2021 (permanent standard)	Permanent[f]
Virginia (VOSH)	Infectious Disease Prevention: SARS-CoV-2 Virus that Causes COVID-19[e]	All employers	July 27, 2020 (ETS), January 12, 2021 (permanent standard)	Permanent[g]

Source: Congressional Research Service (CRS).

a. Available at https://www.dir.ca.gov/title8/5199.html.

b. Available at https://www.dir.ca.gov/dosh/coronavirus/ETS.html.

c. Available at https://www.michigan.gov//documents/leo/Final_MIOSHA_Rules_705164_7.pdf.

d. Available at https://osha.oregon.gov/OSHARules/div1/437-001-0744.pdf.

e. Available at http://www.doli.virginia.gov/wp-content/uploads/2021/01/Final-Standard-for-Infectious-Disease-Prevention-of-COVID-19-16VAC25-220-1.15.2021.pdf.

f. Oregon OSHA is required to consult with state agencies and other stakeholders to determine when the permanent rules can be amended or repealed, with the first of these consultations to occur no later than July 2021. After the first consultations, ongoing consultations are required every two months until the rules are repealed.

g. Within 14 days of expiration of the governor's COVID-19 state of emergency and the commissioner of health's COVID-19 declaration of public emergency, the Virginia Safety and Health Codes Board must meet to determine if there is a continued need for the standard.

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