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March 2, 2021

Via E-Mail and First-Class Mail

James S. Frederick
Principal Deputy Assistant Secretary of Labor
Occupational Safety and Health Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Re: Comments and Recommendations For OSHA's COVID-19 Emergency Rulemaking

Dear Mr. Frederick:

On behalf of *The Employers COVID-19 Prevention Coalition* (the coalition), we submit the following comments and recommendations for your consideration as you evaluate whether to promulgate a federal COVID-19 prevention emergency temporary standard (ETS) applicable to wide swaths of US workplaces, the scope and terms of any such ETS, and generally how best to protect workers from the spread of COVID-19 in the workplace.

While we understand the Occupational Safety and Health Administration (OSHA) has not commenced a traditional rulemaking or opened a formal docket for this matter due to the urgency associated with the ongoing COVID-19 pandemic, and that OSHA has not formally solicited written stakeholder comments, we respectfully urge the agency to consider this feedback from the regulated community about how to most effectively prevent workplace transmission of COVID-19.[1] Our coalition members have been on the frontlines of this pandemic fighting COVID-19 for the last year, and in so doing, have learned valuable lessons about the practices, policies, and controls that most effectively prevent workplace transmission, and contrarily, those that are less effective in preventing spread of the virus and/or inadvertently pose other risks, and those that impose burdens that substantially outweigh any benefit or are simply unworkable at most workplaces.

The Coalition is composed of a diverse group of national employers and trade associations representing many industries, including healthcare, manufacturing, construction, petrochemical, airline operations, retail, construction, aerospace defense, shipping/logistics, food distribution, agriculture and many more, with millions of employees across every state

[1] Assuming there will be no pre-rule public comment period, the coalition urges OSHA to consider following a process like adoption of a Direct Final Rule, whereby OSHA opens a brief comment period for stakeholders to submit comments *after the rule is promulgated*. OSHA could still promulgate the ETS swiftly to address the urgency of the pandemic, but still provide stakeholders a meaningful opportunity to comment on the ETS, and OSHA a meaningful opportunity to consider revisions to the rule based on post-promulgation public comment.

in the nation. Prior to even the first state's ETS, our coalition members had developed and implemented thoughtful COVID-19 prevention programs, and have achieved real success mitigating the spread of the coronavirus in their workplaces. In many instances, our employers banded together with their employees to consider how best to prevent virus transmission in their individual facilities, plants, stores, and warehouses. The recommendations we offer today, therefore, represent what we consider the collective wisdom of employers and the essential employees who have worked through this national health crisis. The common thread among our coalition members is that they are responsible employers who care deeply about their employees' health and safety.

The coalition does not oppose a COVID-specific federal regulation. Indeed, we support promulgation of an ETS, but only one that is effective in its purpose – to minimize workplace transmission of COVID-19 – and reasonable in its burdens. We very much want to help OSHA craft such a regulation in an effort to move the nation past this tragic and relentless crisis. We hope this letter helps OSHA develop a robust, protective, and workable ETS.

Here we provide General Comments to address overarching issues that coalition members have faced regarding COVID-19 compliance and how those issues should be managed, as well as a series of Specific Comments about particular provisions OSHA is likely considering, with recommendations for how they may most effectively be incorporated in the ETS.

GENERAL COMMENTS

A robust ETS standard will be helpful, but an unworkable one will not. We hope the following general observations will be useful to OSHA as you consider development of an ETS.

1. The ETS Should Incorporate an Implementation Period or a "Grace" Period.

Many US employers already have substantial infection control protocols in place, and certainly that is the case for all of our coalition members. Notwithstanding, there undoubtedly will be some nuances in the ETS that will require revisions to written programs already implemented, tweaks to hazard assessments already performed, and updates to training already conducted. OSHA should, therefore, provide employers with a reasonable opportunity to come into compliance with the nuances created by its ETS.

For those employers who already have robust COVID-19 mitigation programs, but which are not perfectly aligned with the ETS, allowing a reasonable amount of time for revisions to their programs will not leave workers exposed to COVID-19, as their existing programs already provide protection. To the extent there are employers who have not already established COVID-19 programs, even these employers should have some minimal amount of time to prepare and develop programs, conduct the necessary hazard assessments, and obtain the necessary equipment and materials (plastic barriers; PPE; thermometers used to screen workers; signage and floor markings; etc.) to meet the new standard.

Thus, the ETS should provide for at least thirty days for employers to come into compliance. This can be accomplished in one of two ways. OSHA could follow the VOSH ETS model, and establish staggered compliance deadlines – for instance, an early deadline could be set to

complete a hazard assessment; a few additional weeks could be provided to update written programs and conduct any gap training based on the assessment, etc. Alternatively, OSHA could use its enforcement discretion to provide an initial enforcement "grace period," wherein employers making good faith efforts to come into compliance would not be cited, in the same manner OSHA followed with its recent occupational health standards for beryllium and silica. The grace period should serve as a time when employers are determining precisely what is required under the new ETS, assess whether any of those requirements are missing from their existing COVID-19 programs, and make those revisions. During this grace period, OSHA would not bring enforcement actions against employers who are not fully compliant with the ETS, *as long as the employers can demonstrate that they have already implemented programs to control transmission of the virus in their workplaces or have made good faith efforts to come into compliance with the new ETS.*

Use of a "grace period" may be more effective than staggered compliance deadlines because it will allow OSHA to immediately enforce against recalcitrant employers who have done nothing to protect their workers during the pandemic, yet provide a reasonable amount of time for employers working in good faith to align their program with a new standard.

2. ***For the Sake of Consistency, OSHA Should Require State Plans to Implement <u>Identical</u> Standards to the Federal ETS.***

The single greatest compliance challenge faced by national employers with facilities across the country over the last year has been to navigate the complex patchwork of competing and at times contradictory mandates, restrictions, requirements and guidance issued by local and state health departments, governors' executive orders, state OSH Plan emergency rules, the Centers for Disease Control and Prevention (CDC), and OSHA. In many instances, the costs of simply deciphering "what applies where," analyzing whether COVID-19 cases are work-related under diverging standards, and identifying the legal nuances applicable in each state (or even at the county level) has far surpassed the cost of implementing actual engineering and administrative controls. This "patchwork" problem has been described by members of our coalition as "unimaginably difficult and exorbitantly expensive."

Other coalition members have described having to create separate regional teams solely focused on reviewing and reporting out nuances in COVID-19 related requirements or prohibitions in different states, with another team responsible to customize dozens of different written COVID-19 programs for virtually identical operations. It has not just been different requirements and prohibitions that have created compliance chaos. Variations in regulatory terminology to refer to the same concepts has also caused confusion; e.g., "Close Contact" (MIOSHA); "COVID-19 Exposure" (Cal/OSHA); "occupational exposure" (VOSH).

Anecdotal evidence from coalition members indicates that it has taken multiple work hours per day to determine the differences between requirements in different states for reporting COVID positive cases to health departments and the State Plans (1-2 hours per case for each new county), and that unclear reporting guidelines made it difficult to find to whom the cases should be reported. Indeed, widespread experience strongly indicates that even today, many states and counties still appear confused and uncertain about their own notification

obligations. Another coalition member reported that multiple hours were spent by managers trying to report COVID-19 cases to local county health authorities and/or state agencies, and that the managers reported being on hold for long periods of time, not being able to get a live person, being transferred to multiple departments, and being told that reports were not necessary, leading to multiple follow-up phone calls over multiple days. Another coalition member has spent approximately forty hours just putting together a compendium of each state's COVID-19 related regulations and mandates, and spends an additional two to four hours per week updating the summary.

Uniformity, consistency and simplicity are critical to compliance and effectiveness. Our coalition urges OSHA to use its authority to prevent further complication of the "patchwork" problem by preventing the 22 State Plans from each developing disparate COVID-19 regulations that differ from the one federal OSHA is about to issue. Regardless of intent, state nuances have already added a thick layer of confusion to an already immensely challenging compliance puzzle. For national employers, being required to learn and adjust their COVID-19 programs to comply with potentially 23 different ETSs (fed OSHA's and all of the State Plans' ETSs) would severely strain resources even for the largest companies, and most certainly would divert resources that are otherwise urgently needed for their efforts to control COVID-19 in their workplaces. Protecting employees from COVID-19 does not need to be complicated; complying with a patchwork of hundreds of differing requirements for reporting, notifications, testing, assessments, training, written programs, workplace controls, etc., is extraordinarily and unnecessarily complicated.

OSHA has authority under the OSH Act to require State Plans to promulgate standards identical to a federal OSHA standard. While Sec. 18 of the Act provides states authority generally to promulgate occupational safety and health standards *as effective as* federal standards (thereby allowing different but equally or more effective standards), the agency has used its authority to mandate *identical* standards where consistency is critical. For example, OSHA's injury and illness recordkeeping regulation, at Sec. 1904.37(b), mandates that State Plans "have the *same requirements* as Federal OSHA for determining which injuries and illnesses are recordable and how they are recorded." For good reason, OSHA determined that OSHA 300 logs need uniformity and consistency in recording to be useful for benchmarking, trends analysis and other purposes.

Here, good cause exists to exert this same authority relied on to mandate identical OSHA recordkeeping, to mandate that State Plans promulgate the same COVID-19 prevention standard adopted by OSHA. However, to the extent OSHA does not go so far as to mandate that State Plans promulgate identical COVID-19 prevention standards, the coalition urges OSHA to, at the very least, urge the State Plans consider the importance of consistency as they undertake their emergency rulemakings.

3. OSHA Should Ensure the ETS Provides Flexibility to Comply with Evolving CDC Guidance.

CDC has consistently and regularly updated its COVID-19 prevention guidelines based on emerging science and data as it continues to study and gain an understanding of SARS-CoV-2. Over the past year, the CDC has updated workplace-related guidelines multiple times each

month, often in ways that directly contradict prior guidance. That is understandable, of course, in the context of any novel virus like this. For example, in October 2020, CDC updated its guidance regarding the airborne nature of SARS-CoV-2; prior to that COVID-19 was understood to be principally transmitted by droplets and/or surface contamination. Additionally, CDC revised its "return-to-work" criteria at least twice over the summer of 2020 – once addressing the recommended number of days of home isolation, and later, within days of Virginia OSHA (VOSH) issuing its state ETS, eliminating the test-based criteria, which had just been memorialized in the VOSH ETS. And most visibly, over the course of the pandemic, the CDC rejected the need for face coverings, then recommended their use when distancing could not be maintained, then recommended them for most indoor work, and most recently, just last month, updated its guidance to consider "double masking."

The lesson from this constantly changing landscape, a lesson VOSH learned the hard way, is that any effective ETS must provide flexibility to allow employers to revise their programs consistent with updated CDC guidance without running afoul of the ETS. While OSHA has considerable expertise in controlling workplace hazards, the coronavirus hazard is not uniquely a workplace hazard – it does not originate in or emanate from the workplace or work practices; it is not a by-product of an operation or task performed at a workplace. Rather, it is a community hazard coincidentally, inadvertently and unknowingly carried into the workplace by employees and the public. The pandemic is, first and foremost, a public health concern, rather than a workplace hazard, and as such, the principal policymaker for defeating it should remain the CDC, the preeminent US authority on public health and infectious disease. This is not to say that OSHA does not have jurisdiction to establish a standard requiring mitigation protocols; however, that standard should not require employers to ignore the guidelines set by the CDC in order to comply with OSHA's ETS.

To that end, the coalition endorses the adoption of an approach similar to that included in VOSH's COVID-19 standard. As referenced above, it was only days after VOSH issued its ETS that the CDC upended its "return-to-work" guidance, leaving a major element of VOSH's ETS out of step with the current scientific consensus only days after the ETS was issued. Other elements of the VOSH rule similarly fell behind current CDC guidance over the next few months. Thankfully, the drafters of VOSH's ETS had the foresight to build in flexibility for employers, employees, and VOSH to keep up with the evolving science and data related to the virus. Specifically, they incorporated a provision that essentially allows employers to be deemed in compliance with the ETS if they comply with updated CDC guidelines, even where they conflict with a specific term in the ETS. *See* 16VAC25-220-10(E).

The California Division of Occupational Safety and Health (Cal/OSHA) and the California Occupational Safety and Health Standards Board did not follow the same approach as VOSH, and experienced the same types of issues, but without an efficient mechanism to address them. For example, only a few days after Cal/OSHA's ETS went into effect, the CDC relaxed its quarantine guidelines, prompting the California Department of Public Health (CDPH) to update its COVID-19 Quarantine Guidance, and Governor Newsom to issue an Executive Order (EO) regarding the same. *See* CDC Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing (last updated December 2, 2020); *see also* CDPH COVID-19 Quarantine Guidance (December 14,

2020); and California EO N-84-20 (December 14, 2020). Despite the EO suspending some of the then-outdated and conflicting Cal/OSHA ETS requirements, this caused significant confusion and uncertainty among the regulated community.

To keep up with evolving science and avoid confusion, the coalition strongly recommends that OSHA adopt an approach like VOSH did, with regulatory text that allows employers to follow current CDC guidance. Here is specific language we recommend: *"To the extent an employer complies with an applicable recommendation contained in CDC guidelines, whether written in mandatory or non-mandatory terms, to mitigate COVID-19 related hazards addressed by this standard, even if the CDC guidelines conflict with the terms of this standard, the employer's actions shall be considered in compliance with the related terms of this standard."*

4. *The ETS Should Recognize and Account for the Special Circumstances of Critical Infrastructure Workers.*

From the outset of the pandemic, CDC has recognized the need for critical infrastructure to maintain fundamental operations necessary for Americans to live and continue to access vital services, and the ways in which those who support such infrastructure can safely remain in the workplace. The weight of the American economy is on critical infrastructure employers and employees. They have carried the economy for the last year, and will continue to do so into the foreseeable future. They have been responsible for everything from developing testing kits to keeping toilet paper on the grocery store shelves to now delivering and distributing the life-saving vaccines. The challenges employers have faced – and the efforts they have made – to fulfill their responsibilities to provide essential services while also keeping their employees safe have been herculean.

Our coalition does not support sacrificing worker safety to keep the economy going; however, we also believe it would be unwise policy, bordering on irresponsible, for OSHA to impose burdens on employers that are not based in the science relied upon by the CDC. As emphasized above, CDC is *the* preeminent public health authority on SARS-CoV-2, and we trust Dr. Walensky's CDC will base all guidance and recommendations on the agency's best understanding of the science, and with the protection of employees and the public as the utmost objective. CDC guidance that is grounded in the best available science, therefore, should serve as the appropriate benchmark for employers to establish protection of their workforce.

Under CDC's current guidance, "[t]o ensure the continuity of essential functions, CDC advises that critical infrastructure workers may be permitted to continue working following potential exposure to a person with confirmed COVID-19," so long as they are asymptomatic, and follow certain risk mitigation precautions, such as universal masking and monitoring for symptoms. *See* CDC COVID-19 Critical Infrastructure Sector Response Planning (last updated December 3, 2020). Additionally, CDC also has now determined that a 7-day quarantine period is sufficient if employees obtain a negative PCR test after day 5. This CDC return-to-work standard should be an option available to all critical infrastructure under the ETS.

Thus, at least where essential functions in critical infrastructure are involved, the ETS should allow employees to return to work under the reduced quarantine requirements following conditions and parameters set forth by CDC.

5. The ETS Should Include a Sunset Provision

Assuming OSHA promulgates an ETS, it will be designed to address the unique characteristics of transmission of the SARS-CoV-2 virus and will require mitigation strategies and prevention techniques tailored to prevent transmission of this particular coronavirus. Accordingly, the ETS should include a sunset provision triggering automatic expiration based on some designated official status, such as the President declaring an end to the National Emergency Status or the World Health Organization (WHO) removing the global pandemic designation from the public health crisis description. The emergency standard should serve its purpose, and then expire.

OSHA commenced a rulemaking to develop a more generic infectious disease standard applicable to the healthcare industry over a decade ago, but never completed that rulemaking. It would be inappropriate to short-circuit further rulemaking efforts on an infectious disease standard by keeping the ETS (or a subsequent permanent standard based on a COVID-19 ETS) "on the books" in its place. If OSHA wishes to promulgate a broader infectious disease standard to address a broad range of infectious diseases, it should pick up the rulemaking process set aside in 2017, and actively continue that process rather than converting this ETS and attendant permanent rule into such a standard. Public participation in the emergency rulemaking process has been essentially non-existent and will be severely limited in an abbreviated permanent standard rulemaking. It would be patently unfair to the regulated community – both employees and employers – and likely legally impermissible to essentially do an end run around the notice-and-comment process required by Section 6(b) of the OSH Act and the Administrative Procedures Act by parlaying a COVID-19 ETS into a generic, permanent infectious disease standard. Doing so also would be ill-advised from a substantive standpoint. Additional or different requirements may be appropriate in a more general infectious disease standard that are not included in the ETS, and there may be requirements in the ETS, such as testing, that are not appropriate in a general standard.

This is not to say that the lessons learned from the mitigation strategies employed during this pandemic should not inform the agency in another, broader rulemaking to develop an infectious disease standard. However, the ETS should not automatically transform into that. It should expire upon victory over the SARS-CoV-2 pandemic.

SPECIFIC COMMENTS

1. OSHA Should Exempt COVID-19 from 1904 Injury and Illness Recordkeeping and Set a New Requirement to Maintain a Separate COVID-19 Case Log.

Second only in frustration to dealing with the "patchwork" problem, has been ascertaining whether COVID-19 positive cases should be logged on employers' OSHA 300 Logs. In fact, coalition members find work-relatedness investigations to be the most inefficient and ineffective activity associated with COVID-19 response.

While anecdotal, estimates of the extraordinary amounts of time spent on this activity are telling. One coalition member, a national employer, reports that it has spent approximately 600 hours since July 2020 on work-relatedness determinations and 300 Log recordkeeping. Another coalition member reports that it has taken roughly 300 hours thus far to determine recordkeeping work-relatedness, which does not include the time spent by workers' compensation personnel undertaking their related exercise. Multiple other members estimate spending more than 1,000 hours thus far on COVID-19 recordkeeping. Another member reports having established, early on in the pandemic, a core team of medical, safety, and legal experts to evaluate suspected and confirmed COVID-19 cases, conduct contact tracing, and make recordkeeping determinations, and that 10-member team meets 2-3 times per week.

A common thread among all our members is that a very small percentage of cases are determined to be work-related, and all the time spent on this exercise contributes nothing to reducing spread of the virus in the workplace. A 300 Log is an utterly useless tool for contact tracing – logging cases after a calendar week, logging only cases involving your own employees, and logging only work-related cases does not help you identify and remove infected individuals from the workplace. And the limited information included on a 300 Log does not help improve workplace controls. Coalition members devote tremendous energy and resources to identifying every close contact of a positive COVID-19 case involving their employees, regardless of the source of the infection. But this process is an immediate one, unrelated to recording cases on the 300 Log.

The reason that recordkeeping has been so resource-consuming is that identifying the specific exposure that caused a COVID-19 infection is every bit as challenging as identifying the source of the common cold or the flu. The viruses are invisible and ubiquitous. It was for that reason that, by regulation, OSHA exempted the cold and flu from injury and illness recordkeeping. To avoid wasting these resources, the coalition strongly recommends that OSHA adopt a two-pronged approach to COVID-19 case tracking in the ETS:

(1) Follow the Cal/OSHA model, and set a requirement for employers to maintain a separate COVID-19 Case Log, where every single case involving an employee is logged, regardless where the employee contracted the virus. That log can include a host of actually useful information, like test dates or symptom onset dates, work locations, potential close contacts, and the like.

(2) As a tradeoff for this new, more comprehensive and useful COVID-19 Case Log, the ETS should expressly exempt COVID-19 cases from 300 Log recordkeeping, in the same manner as the cold and flu recordkeeping exemption.

The ETS could include a requirement that the COVID-19 Case Log be made available to OSHA upon request, like 1904 recordkeeping forms, which would obviate the need for OSHA to obtain medical access orders to obtain basic case data during inspections. To the extent this

approach is given consideration, however, coalition members urge OSHA to ensure that the COVID-19 Case Log would be protected from FOIA disclosure.[2]

Disclosure of the Case Log with personal identifying information, including medical information (COVID-19 status), should not be required to be provided to anyone other than OSHA. To the extent an employee or employee representative wanted the Case Log, employers should be able to scrub it of PII before disclosure.

A COVID-19 tracking effort done outside the context of the 300 Log, which eliminates the need to engage in the time-intensive work-relatedness exercise, is a palatable approach that saves manpower resources, yet allows for the collection of useful information. This approach would not interfere with contact tracing to identify close contacts of employees who are positive cases. Tracking COVID-19 cases in the workplace, regardless of work-relatedness, is critical to controlling the pandemic, and our recommended approach would provide for a more productive form of case tracking.

2. Quarantine Requirements for Close Contacts Should Not Apply to Employees Wearing N95s, Even Voluntary-Use.

Per CDC guidance,[3] "the determination of close contact should be made irrespective of whether the person with COVID-19 or the contact was wearing a [cloth face covering]." However, an individual wearing an N95 respirator, or more substantial respiratory PPE, may not need to be treated as a close contact, and required to quarantine after extended close interactions with an infected individual. Some jurisdictions only apply that carveout for N95s used in the context of a full respiratory protection program, with fit testing, medical evaluations, written respiratory protection programs, and respirator training. The coalition strongly encourages OSHA to allow employers to credit any N95 use to avoid a determination of close contact, even voluntary-use respirators; i.e., exempt from the definition of a close contact or from quarantine requirements, any employee wearing an N95 or higher form of respiratory protection, whether mandatory or voluntary-use.

As the scientific consensus on COVID-19 spread is evolving to focus more on airborne transmission (as opposed to droplet transmission), OSHA should take steps to incentivize greater use of N95s. Although an N95 mandate for all workplaces is not remotely feasible, requiring a written respiratory protection program, fit testing, and medical evaluations before allowing an employer to take credit for an N95 to avoid a close contact finding would create an enormous disincentive for employers to supply and encourage their use.

We acknowledge the data that suggests there is somewhat of a difference in the level of protection between a fit-tested N95 respirator and one that has not been fit-tested. But that is the wrong comparison. What OSHA should be comparing to decide how to treat N95 use under the ETS, is the level of protection of an N95 that has not been fit tested vs. the level of

[2] FOIA Exemption 6 permits the government to withhold all information about individuals in "personnel and medical files and similar files" when the disclosure of such information "would constitute a clearly unwarranted invasion of personal privacy."

[3] *See* CDC's Public Health Guidance for Community-Related Exposure.

protection of the simple face coverings that most non-healthcare workers are wearing now. There can be no reasonable dispute that an N95, even without a fit test, is far more protective than a simple face covering. But employers nationwide are foregoing N95s because if they require their use, OSHA could enforce any technical deficiency under the respiratory protection standard, and if they do not require, but merely supply and permit their use, employees will still be lost to a quarantine if they have a prolonged close contact with an infected co-worker, despite the protection of the N95. The result is many fewer N95s being used in general (non-healthcare) industry.

We strongly encourage OSHA to eliminate disincentives to N95 use. There is precedent for employing an OSH regulation to encourage greater voluntary N95 use in lower risk environments. For example, Cal/OSHA's "Protection from Wildfire Smoke" Rule does not require adherence to all elements of Cal/OSHA's respiratory protection standard (Sec. 5144) for use of N95s in every context. Rather, the Wildfire Smoke rule requires employers to provide N95 respirators to employees for voluntary use when the AQI is between 150 and 500. The rule only requires adherence to all elements of Sec. 5144 if the AQI is extraordinarily high, akin in the COVID-19 context to work around known or suspected COVID-19 patients, where respiratory PPE is mandatory.

3. The ETS Should Use a Tiered Hazard Assessment Approach and Set Different Levels of Requirements Based on Exposure Risk Categories

Based on the experience coalition members have had in identifying hazards in their workplaces over the last year, it is clear that categorizing COVID-19 hazards into tiers of risk based on job activity provides a manageable and efficient way to determine and implement controls. Based on qualitative assessments of coalition members' workplaces, tiering of hazards and identification and implementation of controls on this basis has shown to be effective in managing COVID-19 risks.

VOSH adopted a tiered hazard assessment approach in its ETS, which by and large has been workable to implement. VOSH's ETS requires employers to assess their workplace for virus exposure by classifying each job task according to the hazards employees are potentially exposed to into one of four categories of exposure – very high, high, medium and low. *See* 16VAC25-220-40(B)(1). The standard provides specific definitions for each hazard category. *See* 16VAC25-220-30. Coalition members support such an approach generally.

In defining the "lower" category, our coalition recommends use of VOSH's definition at 16VAC25-220-30:

> *"Lower" exposure risk hazards or job tasks are those . . . that do not require contact inside six feet with persons known to be, or suspected of being, or who may be infected with SARS-CoV-2. Employees in this category have minimal occupational contact with other employees, other persons, or the general public, such as in an office building setting, or are able to achieve minimal occupational contact with others through the implementation of engineering, administrative and work practice controls.*

If a hazard assessment reveals that employees have "minimal occupational contact" as set forth in VOSH's definition, these employees should properly be categorized as having "lower" risk exposure. Most importantly, certain requirements of the standard do not apply at workplaces with only lower risk exposures (e.g., air handling requirements; physical barrier requirements; requirements to have a written plan and conduct certain training; etc.) *See generally* 16VAC25-220-50-80. This is especially important for small businesses, many of which have struggled financially during this pandemic and should not be required to expend limited resources on requirements that do not provide a significant impact on virus transmission, because that transmission risk is already recognized to be low.

Additionally, like the VOSH rule, a federal ETS should allow grouping of tasks for classification purposes. VOSH's standard states that "[t]asks that are similar in nature and expose employees to the same hazard may be grouped for classification purposes[,]" *see* 16VAC25-220-40(B)(1). And VOSH's guidance explains that grouping can extend across workplaces. *See* VOSH COVID-19 Standard FAQs § 40 #10 (if an employer has consistent types of job tasks across multiple worksite locations, the employer may prepare a risk assessment that provides corporate-wide classification of job tasks by risk category for its Virginia locations that could meet the requirements of the standard). This concept is also reflected in Oregon OSHA's ETS: "If an employer has multiple facilities that are substantially similar, its assessment may be developed by facility type rather than site-by-site so long as any site-specific information that affects employee exposure risk to COVID-19 is included in the assessment." *See* OAR 437-001-0744(3)(g). The coalition urges OSHA to incorporate this grouping approach into the federal ETS. Large, multi-state employers have similar workplaces located across the nation; it would be a significant waste of time and resources for employers to have to separately assess the same hazards across these worksites. Accordingly, the federal ETS should make clear that hazards and worksites that are substantially similar in nature may be grouped for categorization purposes, even across different workplaces.

4. If the ETS Includes Health Screening Requirements, They Should Be Flexible and Should Not Require Data Collection.

Coalition members have been conducting health screenings or requiring their employees to self-screen to prevent employees with COVID-19 from coming to work for nearly a year, and have developed various screening mechanisms. Some screenings are done essentially "at the plant gate," while others are self-administered by the employees prior to clocking in to start a shift or at home before coming to work. Providing these types of options is consistent with CDC recommendations and other state ETS requirements.

For example, the CDC states that employers should consider encouraging individuals planning to enter the workplace to self-screen prior to coming onsite, but may decide to actively screen employees for symptoms rather than relying on self-screening. *See* CDC "General Business Frequently Asked Questions" (last updated February 11, 2021). Cal/OSHA's ETS states that, while employers must develop and implement a process for screening employees for and responding to employees with COVID-19 symptoms, they may ask employees to evaluate their own symptoms before reporting to work . . . . *See* 8 CCR

3205(c)(2)(B). Indeed, many of our coalition members do both. Additionally, systems have been developed and employees trained to ensure proper communication of screening information to management, so decisions can be made immediately about quarantining employees and follow-ups can be done. A health screening requirement in the ETS should allow employers flexibility to adopt a system that works for them and their workforce, as long as it is consistent with CDC guidance.

Additionally, a health screening requirement should not mandate collection of information that would result in the creation of an "employee medical record" subject to the lengthy preservation requirements of 29 C.F.R. Section 1910.1020, or even better, should expressly exempt any records that are created in these screening processes from those preservation requirements. Application of the 1910.1020 thirty plus year retention requirement to this health screening data serves no useful purpose and creates long-term administrative burdens for employers. Michigan employers are dealing with such a requirement. MIOSHA's Emergency Rule requires all employers to "maintain a record of screening for each employee or visitor entering the workplace." *See* MIOSHA COVID-19 Emergency Rules Rule 11(1)(b). Coalition members dealing with this requirement indicate that this is a significant administrative headache that provides no value to their COVID-19 prevention efforts. The point of screening is to immediately screen an employee out of the workplace, not to create some record that can be accessed in twenty months or twenty years by an employee. Indeed, to the extent any tracking record is necessary to determine when an employee was "screened out," employers may reasonably rely on the other documentation such as leave records that they keep and maintain as a matter of course.

Additionally, creation of such a record would be in tension with guidance provided by OSHA last summer, which stated:

> *If an employer implements health screening or temperature checks and chooses to create records of this information, those records might qualify as medical records under the Access to Employee Exposure and Medical Records standard (29 CFR 1910.1020). The employer would then be required to retain these records for the duration of each worker's employment plus 30 years and follow confidentiality requirements. As explained above,* ***employers need not make a record of temperatures when they screen workers, but instead may acknowledge a temperature reading in real-time. In addition, temperature records do not qualify as medical records under the Access to Employee Exposure and Medical Records standard unless they are made or maintained by a physician, nurse, or other health care personnel, or technician.***

See OSHA "Guidance on Returning to Work" (p. 13) (June 2020) (emphasis added). Here, OSHA makes clear that employers "need not make a record" if they acknowledge a temperature reading in real-time, and that, unless temperature checks are made or maintained by a physician, nurse, or other health care personnel, or technician, temperature records are not medical records, and thus, need not be maintained for 30+ years.

To be clear, the coalition does not oppose conducting health/temperature screenings to keep suspected COVID-19 cases out of the workforce. However, we believe doing so should not impose additional, unnecessary record-making or record preservation obligations.

5. The ETS Should Adopt a Contact Tracing Provision That is Limited to the Confines of the Workplace and Follows Virginia OSHA's Approach in Terms of Breadth

The Coalition understands that contact tracing is a fundamental component to mitigating potential COVID-19 transmission in the community, and similar strategies are useful to identify and isolate close contacts in the workplace. We support inclusion in the ETS of some form of contact tracing type requirement. However, the coalition believes the scope of any such provision must not extend beyond the workplace. Indeed, employers should ask COVID-19 cases about their close contacts at the workplace so that any employees with whom the case might have had prolonged close interactions can be immediately notified, isolated, and removed from the workplace to quarantine.

However, to the extent OSHA is considering a contact tracing requirement whereby employers must ask COVID-19 cases about their close contacts *outside of work*, the coalition believes that would be inappropriate and is best left to local health departments. Any contact tracing provision that imposes additional burdens on employers by requiring them to act as quasi-public health departments would not only be a significant waste of time and resources, but would also be counterproductive, as health departments themselves are better qualified and situated to provide this function.

Additionally, with respect to the breadth of any contact tracing provision included in the ETS, the coalition generally supports VOSHA's approach in this regard. Although the Virginia rule explicitly states that "[n]othing in [its] standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease[,]" *see* 16VAC25-220-10(H), employers must still provide prompt notice to their own employees and other employers whose employees may have been exposed about their possible exposure. *See* 16VAC25-220-40(B)(7)(a). As set forth in VOSH COVID-19 Standard FAQs § 40 #23, "The intent of the notification requirement is to provide employees information of a [']possible[']exposure so that employees can make decisions for themselves on the appropriate course of action to take." Coalition members support this approach in favor of the approach taken by Cal/OSHA, which requires employers to conduct extensive investigations for purposes of contact tracing. *See* 8 CCR 3205(c)(3)(B). Rather than requiring employers to complete a full-blown investigation, employers should be deemed in compliance if they complete a questionnaire asking the COVID-19 case about his/her close contacts while at work, provide notice to any employee close contacts of their potential exposure, and require close contacts to quarantine, as appropriate.

6. OSHA Should Not Include An Exclusion Pay and Benefits Provision in an ETS.

OSHA should not include a provision mandating exclusion pay and/or benefits to any employees excluded from the workplace pursuant to the terms of an ETS due to COVID-19 concerns or quarantine or isolation orders.

First, if such a significant economic decision is to be made, it should be Congress that makes it. In the circumstances of a national pandemic, a legislative body should weigh the pros and cons and determine whether such a provision would be proper, as well as its contours and requirements. At the outset of the COVID-19 pandemic, Congress enacted and the President

signed the Families First Coronavirus Response Act (FFCRA) which, among other things, provided emergency paid sick leave and expanded family and medical leave requirements under federal law. Pub. L. 116-127. Importantly, the costs to private employers of providing such benefits under the FFCRA were ultimately covered by the Federal Government, as Congress provided tax credits for those employers in the full amount of any FFCRA leave taken by their employees. If extended pay benefits are to be provided to employers under an OSHA ETS, it should be done in the same fashion as these benefits conferred under the FFCRA.

Second, employers' experience with Cal/OSHA's ETS, which includes a controversial exclusion pay provision, is instructive. Rushed through on an "emergency basis," the California ETS essentially requires employers to pivot on a dime and start providing a special kind of sick pay to employees, which is causing significant confusion and great challenges to California employers, especially small employers. The Cal/OSHA ETS was immediately superseded in relevant parts by executive orders from California's Governor, and the state agency has issued numerous sets of "frequently asked questions" in an attempt to clarify the imprecise language it enacted. And while the cost to employers has been tremendous, a fair review of California's experience compared to other states does not lead to the conclusion that the exclusion pay provision has led to any significant benefit or protection. The purpose of such a provision is to encourage employees to report their close contact exposures and potential infections so they can be excluded from the workplace.

Finally, it is highly questionable whether OSHA has the statutory authority to enact such a provision. *See* 29 U.S.C. § 653(a) (chapter applies only to "employment performed in a workplace"). Because pay for employees *excluded from the workplace* would obviously not apply to "employment performed in a workplace," OSHA likely has no authority to require it. Moreover, any such pay requirement would likely run afoul of the statutory mandate that nothing in the OSH Act affect any workmen's compensation law or "enlarge or … affect in any other manner the common law or statutory rights, duties, or liabilities of employers and employees under any law with respect to injuries, diseases, or death of employees arising out of, or in the course of, employment." 29 U.S.C. § 653(b)(4). Likewise, the enactment of the FFCRA, and the Wage and Hour Division's exercise of regulatory authority pursuant to the FFCRA, likely preempts any overlapping regulations promulgated by OSHA at this late date. *See* 29 U.S.C. § 653(b)(4)(1) "Once another federal agency exercises its authority over specific working conditions, OSHA cannot enforce its own regulations covering the same conditions." *Mushroom Transportation Co., Inc.*, Docket No. 1588 (OSHRC 1973). Accordingly, because the Wage and Hour Division already oversees and has exercised its authority with regard to the payment and leave provisions of the FLSA, the FMLA and the FFCRA, any further action by OSHA in this realm is preempted.

For these reasons, OSHA should not include any exclusion pay and benefits provision in any ETS it promulgates. If OSHA does choose to include some sort of exclusion pay requirement in its COVID-19 ETS, then at the very least, it should: (1) limit any costs on private employers to cases contracted or close contracts provably experienced in the employer's workplace; (2) disallow any COVID-19 specific-pay where the affected employee fails to follow the employer's COVID-19 protocols; (3) limit the provision only to employers already providing

paid leave to employees in other circumstances; and (4) cap the amount/duration of pay continuation to a reasonable standard.

7. Any Outbreak Provision Should Be Based on Transmission in the Workplace and Be Triggered Based on a Percentage Threshold.

The coalition agrees that workplace outbreaks should be quickly identified and addressed. However, we believe those circumstances will already be fully and effectively addressed by the likely backbone provisions of the ETS, including identification and removal of infected workers and close contacts, notification requirements to close contacts, pre-work health screening, and the panoply of engineering and administrative controls. No separate "outbreak" provision(s), like those included in the Cal/OSHA ETS are needed. But to the extent that there is an outbreak provision included in OSHA's ETS, unlike the Cal/OSHA rule, it must be crafted in a manner that captures only true workplace outbreaks.

The entire concept of a workplace "outbreak" is that the virus is being spread among co-workers in and because of the workplace. Random, coincidental cases that arise among a workforce, which have nothing to do with one another and which are not indicative of spread from worker to worker, should not trigger any outbreak provision of an ETS. Otherwise, the employer is essentially substituted for the local public health authority in managing community spread. Accordingly, to the extent the ETS includes an outbreak provision that may require certain notifications to OSHA or to health departments, or any other obligations, it should be based exclusively on multiple cases for which there is an epidemiological link to each other and to the workplace.

Coalition members have had significant experience dealing with the VOSH and Cal/OSHA ETSs (among others) regarding reportable COVID-19 workplace "outbreaks," and believe their experiences in these states provide valuable insight into exactly the types of outbreaks that should ***not*** be captured by the ETS. These state standards establishing outbreaks are fundamentally flawed because they either capture all COVID-19 cases, rather than just work-related transmissions and/or do not require any sort of connection between the cases. Thus, "outbreaks" – which trigger multiple onerous requirements (like notifications, weekly testing of broad swaths of the workforce, HVAC upgrades, etc.) – are defined to occur when there actually has not been an outbreak at the workplace by any scientific understanding of that term. This is a fundamental flaw in the state programs that should not be included in the federal OSHA ETS.

With respect to the VOSH rule, for example, one of the greatest flaws of its outbreak scheme is that it contains no geographic or temporal parameters to determine whether the cases were actually transmitted in the workplace. VOSH requires employers to notify the Virginia Department of Labor of "three or more of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period." *See* 16VAC25-220-40(B)(7)(e). In guidance, VOSH clarifies that "place of employment" means that the 3 or more infected employees worked at the same work site within two days prior to symptom onset (or positive test if the employee is asymptomatic) until 10 days after onset (or positive test). *See* VOSH COVID-19 FAQs § 40 #8. Thus, if Employees A, B, and C were all at the same work site during their respective infectious periods within a 14-day window, the employer would be required to notify VOSH of an

"outbreak," even if employees A, B, and C know with certainty they each separately contracted the virus from a sick relative at home, all work in three completely separate areas of the worksite, were not close contacts of one another, and perhaps never even saw each other. An employer would be required to report an "outbreak" to VOSH even if the three employees worked three completely separate shifts. To call this a workplace outbreak is misleading and provides no actual benefit in controlling spread of the virus.

In terms of Cal/OSHA's ETS, it does include some geographic and temporal parameters around outbreaks that are a little more sensible. The California ETS defines an outbreak as "three or more COVID-19 cases in an exposed workplace within a 14-day period[,]" where "exposed workplace" means "any work location, working area, or common area at work used or accessed by a COVID-19 case during the high-risk period . . . ." *See* 8 CCR 3205.1(a); 8 CCR 3205(b)(7). The California rule's incorporation of a common place and common time element into its outbreak analysis is also sensible, allowing employers to consider each shift as a separate ['] exposed workplace.[']" *See* Cal/OSHA COVID-19 ETS FAQs "Outbreaks and the 'Exposed Workplace'" #9. However, Cal/OSHA's outbreak definition is still too broad to serve as a model because it does not permit employers to consider outside sources of transmission in their outbreak analyses. For example, assume employees A, B, and C all work 2nd Shift in XYZ Department, and were working in XYZ Department during their respective high-risk exposure periods within a 14-day window. This would be considered an outbreak under the California ETS, even if employees B and C report to their employer that they had household family members test positive a few days before, and that employees B and C actively cared for their family members while they were sick.

Based on these and other experiences, therefore, the coalition encourages OSHA to base any outbreak provision on transmission in the workplace. Coalition members believe the California Department of Public Health's (CDPH) guidance here is useful. In its definition of "outbreak" for workplaces, the CDPH informs local health departments that an outbreak consists of "[a]t least three probable or confirmed COVID-19 cases[] within a 14-day period in people who are *epidemiologically-linked*[] in the setting, are from different households, and are not identified as close contacts[] of each other in any other case investigation." *See* CDPH "Non-Healthcare Congregate Facilities COVID-19 Outbreak Definitions and Reporting Guidance for Local Health Departments" (Oct. 13, 2020) (emphasis added). CDPH includes in a footnote that "[e]pidemiologically-linked cases include persons with close contact[] with a confirmed or probable case of COVID-19 disease; OR a member of a risk cohort as defined by public health authorities during an outbreak. This includes persons with *identifiable connections to each other*, such as sharing a defined physical space; e.g. in an office, facility section or gathering, indicating a higher likelihood of linked spread of disease than sporadic community incidence." *See id.* (emphasis added). If any special outbreak provision is considered for the federal ETS, the coalition supports an analysis like CDPH has identified, which unfortunately, Cal/OSHA has ignored in its ETS.

In addition, any outbreak provision in a federal ETS should be defined to occur only when a *percentage* of positive epidemiologically-linked cases occurs, rather than simply a set number of such cases. Both VOSH and Cal/OSHA establish a threshold of three employees to trigger an outbreak, without any consideration for the size of the workplace. This reflects a significant

departure from reality. For example, a very large workplace could have three cases, which could reflect a much better infection rate than the general population, but still be considered in outbreak status. Accordingly, the coalition encourages OSHA to consider a threshold percentage trigger. Many health departments have used 4% to define outbreaks; we support that approach.

In sum, to the extent the ETS includes special outbreak provisions at all, which we discourage, requiring employers to notify OSHA or health departments of COVID-19 cases, or undertake special testing or other responsive actions, that should be triggered by true work-related outbreaks of a percentage (rather than numeric) threshold of cases.

8. If a COVID-19 Coordinator Or Similar Role is Established by the ETS, Using a Corporate Officer in the Role Should Be Sufficient.

To the extent the ETS requires assignment of a COVID-19 program coordinator or administrator, OSHA should allow companies to assign a corporate or company-wide representative to that position, as long as s/he can coordinate with worksite-specific representatives to maintain implementation oversight and enforcement duties. For purposes of ensuring the role is filled with someone knowledgeable about infection control strategies, and for the consistent, efficient and effective implementation of the company's COVID-19 program, national employers should be permitted to designate a corporate workplace coordinator who is responsible for the overarching policies and procedures contained within the COVID-19 prevention program.

Additionally, to the extent OSHA follows VOSH's requirement that its plan administrator must have special expertise in infection control, OSHA should clarify that a third-party expert is not required, nor are public health/infectious disease credentials. *See* 16VAC25-220-70(C)(1) ("Identify the name or title of the person responsible for administering the plan. This person shall be knowledgeable in infection control principles and practices as the principles and practices apply to the facility, service, or operation."). The cost of hiring third party consultants to assume this role could be crippling to businesses, especially small businesses. Rather, OSHA should clarify that an understanding of the basic principles and concepts of SARS-CoV-2 (its general nature, transmission mechanisms and methods of control) is sufficient.

As to the local worksite coordinator, OSHA should not require, as MIOSHA does, that a local coordinator be present at the worksite 24/7. As companies comply with labor and employment standards mandating break times, CDC guidance mandating quarantine, and the staffing realities of operations during a global pandemic, it is not feasible that a workplace coordinator will be physically present on-site at all times when employees are present, nor is that necessary for a coordinator to be effective.

9. Any Ventilation-Related Requirements in the ETS Should be Performance-Oriented.

To the extent OSHA addresses ventilation requirements in the ETS, they should be flexible (i.e., performance-oriented), and be limited in coverage to existing HVAC systems. The coalition acknowledges the importance of ventilation and air filtration in light of the risk of airborne transmission of the virus. However, ventilation upgrades have proven to present exorbitant,

often infeasible costs. Indeed, one Coalition member reported having upgraded its air filters in its California locations to MERV-13 ratings, adding an approximate cost of $20,000 annually.

Accordingly, to ensure an effective *and manageable* federal ETS, we recommend OSHA adopt an approach similar to that adopted by VOSH in its ETS, requiring certain employers with higher risk exposure workplaces to ensure existing air handling systems under their control are maintained in accordance with manufacturer instructions, and are utilized, to the extent feasible and within design parameters, to achieve effective airflow supply to occupied spaces. *See e.g.*, 16VAC25-220-60(B)(1). Other ventilation-related requirements that the coalition would consider reasonable, feasible, and effective, include:

- Inspecting filters to ensure they are within service life and appropriately installed, and inspecting filter housing and racks to ensure appropriate filter fit;
- Evaluating air filtration to identify opportunities to increase filtration levels within the system's design requirements, and manufacturer's installation instructions and listings;
- Evaluating the positioning of supply and exhaust air diffusers and/or dampers, and adjusting zone supply and exhaust flow rates to establish measurable pressure differentials;
- Ensuring exhaust fans in restroom facilities are functional and operating when the building is occupied; and
- Employees sharing ground transportation should use natural ventilation to increase outdoor air dilution of inside air in a manner that will aid in mitigating the spread of SARS-CoV2 virus and COVID-19 disease transmission to employees and when environmental conditions and transportation safety and health requirements allow.

Many of these requirements are similar to the recommendations set forth in OSHA's January 2021 guidance entitled, "Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace," under its "Additional Detail on Key Measures for Limiting the Spread" section. *See* OSHA "Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace" (January 29, 2021).

However, regulatory text that sets more specific requirements, or a truly specification-oriented approach, such as mandating: (1) specific levels of air filtration (e.g., MERV-13 filters); a specific volume of air turnover per hour; or (3) compliance with a specific guidance documents, such as from the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), will require many workplaces to undertake significant infrastructure upgrades that would push even many large employers to shutdown workplaces rather than take on these capital projects.

10. The ETS Should Provide Employees Flexibility to Wear Face Coverings of Their Choosing and Recognize Good Faith Efforts to Procure Them When Supplies Are Low.

CDC guidance on face coverings has evolved dramatically from the outset of the pandemic. Indeed, in the early months, CDC did not recommend masks at all. By April 2020, CDC began to recommend that people wear cloth or fabric face coverings when they enter public spaces, such

as grocery stores and public transit, for source control, but not for personal protection. Now, CDC indicates that masks are useful in preventing people from spreading *and contracting* COVID-19, and beginning last month, masks are now required on planes, buses, and other forms of public transportation and in transportation hubs such as airports and train stations.

Our coalition recognizes the importance of masking and does not oppose a mask requirement for employees and others working indoors (unless isolated in a closed, private workspace) and outside where distancing cannot be maintained. Masking requirements have been a fundamental element of the coalition members' COVID-19 programs. However, the coalition encourages OSHA to decline to set prescriptive requirements around the type of face coverings worn by employees.

Employers have faced significant challenges in certain areas in obtaining employee buy-in for masking. Mandating certain types of mask will only exacerbate the challenge of ensuring employee compliance. Additionally, employers have little to no control over the types of face coverings that others who come onsite (e.g., customers, patients, visitors, etc.) may wear.

Accordingly, the coalition urges OSHA to adopt an ETS that provides employees with flexibility to wear the face coverings/masks of their choosing. Relatedly, to the extent OSHA is considering a requirement for employers to *provide* face coverings, coalition members urge OSHA to allow employers flexibility with respect to the types of face coverings they must provide. If OSHA imposes a strict requirement on the style of face covering that must be provided, supplies are bound to diminish, as was seen (and can still be seen) with the supply of N95s, and huge investments already made to supply face coverings will be squandered.

The coalition also urges OSHA to expressly state – through the rule or in enforcement guidance – that any requirement to procure face coverings will be weighed against supply considerations. Indeed, ASTM F3502-21 compliant face coverings may not be available in mass supply for quite some time. Accordingly, if there is any requirement for employers to provide face coverings (and/or other protective equipment), OSHA should build in a recognition that, where supplies are short, an employer's good faith efforts to procure such equipment will be deemed compliant for enforcement purposes. If OSHA should set a specific face covering style requirement, the ETS should allow employees who have already provided face coverings to deplete their supply before moving to a new style of face covering.

11. A Training Carve-Out Should be Allowed for Employers Who Already Provided Materially Compliant COVID-19 Training.

Employers have had COVID-19 prevention programs in place for months, and have provided multiple training events since the outset of the pandemic. Nevertheless, as state and local COVID-19 regulations and mandates have rolled out, many of those new mandates have required minor, immaterial changes to written programs, and have set specific training topics, such as covering the requirements of the new regulation or mandate, or covering the employer's updated COVID-19 prevention program. *See e.g.*, 8 CCR 3205(c)(5)(A) (requiring employers to provide training on "[t]he employer's COVID-19 policies and procedures to protect employees from COVID-19 hazards."); 16VAC25-220-80(B)(10) (requiring certain employers to provide training on "[t]he employer's Infectious Disease Preparedness and

Response Plan, where applicable."). In those circumstances, despite having already conducted effective and thoughtful COVID-19 training, employers have had to reconvene employees for another, or a series of several, training events, even where programmatic changes were immaterial, and therefore, the retraining provided only minimal value.

Training is costly and time consuming. For example, one coalition member reported that it has spent approximately $500,000 on COVID-19 related training in California alone. OSHA should thus allow a limited carve-out for employers who have already provided employees training on their programs, where their programs are not materially different from the federal ETS. That could be accomplished by permitting employers to communicate updated information to employees, rather than to convey it in a training event.

12. The ETS Should Permit, But Not Require, Employer Vaccine Mandates, and Should Relax Quarantine Requirements for Fully Vaccinated Employees.

To the extent a federal ETS addresses employer vaccine policies, it should permit, but not require, employers to mandate vaccines as a condition of employment. If employers choose to mandate vaccination, the coalition understands that the ETS may require those employers to compensate their employees for their time associated with obtaining the vaccine. The coalition does not oppose such a requirement, but encourages OSHA to provide employers the flexibility to compensate employers by either: (1) covering the employees' actual costs plus his/her hourly rate for time spent traveling and waiting for the vaccination; or (2) paying the employee a flat rate (½ day of pay at regular wages). Allowance for the ½ day flat rate option provides predictability for employers, and also allows them and their employees to avoid the administrative burden of tracking time spent traveling and waiting.

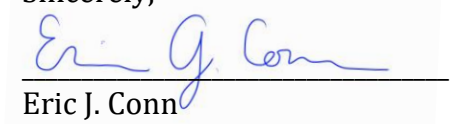
More importantly, now that the vaccination process is underway, a federal ETS should adopt quarantine guidance that exempts fully vaccinated employees from close contact quarantine requirements (and any testing requirements that might be included in the ETS). The ETS could include express language like that issued by the Oregon Local Public Health Authority in this area: "Close contacts who have been fully immunized with COVID-19 vaccine … and who are at least 14 days beyond completion of the vaccine series at the time of their exposure are not required to quarantine. Fully-immunized close contacts should still monitor themselves for symptoms of COVID-19 during the 14 days after exposure, and if symptoms develop they should isolate and seek testing[. . . .]" Alternatively, the ETS could simply indicate that compliance with CDC guidelines constitutes ETS compliance, as discussed above. The CDC's recent guidance on vaccinated individuals states: "[V]accinated persons with an exposure to someone with suspected or confirmed COVID-19 are not required to quarantine if they meet all of the following criteria:

- Are fully vaccinated (i.e., ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine)
- Are within 3 months following receipt of the last dose in the series
- Have remained asymptomatic since the current COVID-19 exposure…."

CONCLUSION

The Coalition respectfully requests that OSHA give meaningful consideration to the comments and recommendations provided as the agency moves ahead with issuing a COVID-19 ETS.

Sincerely,



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