Occupational Safety and Health Administration (OSHA): Emergency Temporary Standards (ETS) and COVID-19

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SUMMARY

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Occupational Safety and Health Administration (OSHA): Emergency Temporary Standards (ETS) and COVID-19

The Occupational Safety and Health Administration (OSHA) does not currently have a specific standard that protects healthcare or other workers from airborne or aerosol transmission of disease or diseases transmitted by airborne droplets. Some in Congress, and some groups representing healthcare, meat and poultry processing, and other workers, are calling on OSHA to promulgate an emergency temporary standard (ETS) to protect workers from exposure to SARS-CoV-2, the virus that causes Coronavirus Disease 2019 (COVID-19). 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 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. Also, according to the Cal/OSHA ATD standard, certain procedures require the use of powered air purifying respirators (PAPR). Both OSHA and Cal/OSHA have issued enforcement guidance to address situations when the shortage of respirators may impede an employer's ability to comply with existing standards.

The Virginia state occupational safety and health plan (VOSH) has promulgated an ETS that directly addresses employee exposure to SARS-CoV-2. This standard requires employers to determine the level of COVID-19 risks associated with their job tasks and provides requirements for engineering, administrative and work practice controls, and the provision of personal protection equipment (PPE) based on risk levels. The VOSH ETS also expands on the existing OSHA whistleblower protection standard to protect employees who raise concerns about COVID-19 exposure in the media or through social media.

H.R. 6139, the COVID-19 Health Care Worker Protection Act of 2020, would require OSHA to promulgate an ETS on COVID-19 that incorporates both the Cal/OSHA ATD standard and the Centers for Disease Control and Prevention's (CDC's) 2007 guidelines on occupational exposure to infectious agents in healthcare settings, with similar provisions in S. 3475. The CDC's 2007 guidelines generally require stricter controls than its interim guidance on COVID-19 exposure. The provisions of H.R. 6139 were incorporated into the version of H.R. 6201, the Families First Coronavirus Response Act, as introduced in the House. The OSHA ETS provisions were not included in the version of legislation that passed the House and the Senate and was signed into law as P.L. 116-127.

H.R. 6379, as introduced in the House, also would include a requirement for an OSHA ETS and permanent standard to address COVID-19 exposure, with similar provisions in S. 3584. H.R. 6559 would include the requirements for an ETS and permanent standard, clarify the requirement that employers must report work-related COVID-19 cases, and expand protections for whistleblowers, with similar provisions in S. 3677. The provisions of H.R. 6559 were included in H.R. 6800, The Heroes Act, passed by the House on May 15, 2020.

The American Hospital Association (AHA) claims that because SARS-CoV-2 is primarily transmitted by airborne droplets and surface contacts, surgical masks (rather than N95 respirators) are sufficient protection for workers coming into routine contact with COVID-19 cases. However, the global shortage of respirators and other equipment and the lack of sufficient testing capacity may adversely impact some hospitals' capacities to treat patients if stricter requirements to provide personal protective equipment (PPE) to employees were to be enacted. The AHA also opposes provisions that would require an ETS to be based on existing state occupational safety and health standards.

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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 (DOL) 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 also must 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.

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

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 provide the public a period of time to provide comments 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

[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 historically has 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 Advanced 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.

[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, at https://www.osha.gov/OSHA_FlowChart.pdf.

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, at https://www.osha.gov/OSHA_FlowChart.pdf.

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 4 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.

[19] 29 U.S.C. §655(f).

[20] OSHA, Directorate of Standards and Guidance, *The OSHA Rulemaking Process*, October 15, 2012, at https://www.osha.gov/OSHA_FlowChart.pdf.

[21] 29 U.S.C §655(c)(2).

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]

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]

Although OSHA has not promulgated an ETS since the 1983 asbestos standard, it has since determined the necessity of an ETS. In 2006, the agency considered a petition from the United

[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.

[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).

Food and Commercial Workers (UFCW) and International Brotherhood of Teamsters (IBT) for an ETS on diacetyl. 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, then commonly used as an artificial butter flavoring in microwave popcorn and a flavoring in other food and beverage products, 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 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 and not since the asbestos ETS promulgated in 1983. As shown in **Table A-1** in the Appendix, of the nine 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] Of the five cases that were not challenged or that were fully or partially upheld by the courts, 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 cases, however, occurred before 1980, when 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

[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*.

[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.

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 Standards Related to COVID-19

Current OSHA Standards

Currently, no OSHA standard directly covers exposure to airborne or aerosol diseases in the workplace. As a result, OSHA is limited in its ability to enforce protections for healthcare and other workers who may be exposed to SARS-CoV-2, the virus that causes COVID-19.[34]

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.[35] In addition, OSHA's standards for the use of personal protective equipment (PPE) may apply in cases in which workers require eye, face, hand, or respiratory protection against COVID-19 exposure.[36]

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.[37] Surgical masks, procedure masks, and dust masks are not considered respirators. NIOSH certifies respirators pursuant to federal regulations.[38] For nonpowered respirators, such as filtering face piece respirators commonly used in healthcare 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

[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 has a standard on blood-borne pathogens (29 C.F.R. §1910.1030) but does not have a standard on pathogens transmitted by airborne droplets.

[35] 29 U.S.C. §654(a)(1).

[36] 29 C.F.R. §§1910.133, 1910.134, and 1910.138.

[37] 29 C.F.R. §1910.134.

[38] 42 C.F.R. Part 84.

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.[39]

Respirators designed for certain medical and surgical uses are subject to both certification by NIOSH (for oil protection and efficiency) and regulation by the Food and Drug Administration (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 Emergency Use Authorization (EUA) to approve for use in medical settings certain NIOSH-certified respirators not previously regulated by FDA.[40]

CDC Interim Guidance on Respiratory Protection

On March 10, 2020, the Centers for Disease Control and Prevention (CDC) updated its interim guidance for the protection of healthcare workers against exposure to COVID-19 to permit healthcare workers caring for known or suspected COVID-19 cases to use "facemasks" when respirators are not available or are in limited supply.[41] This differs from the CDC's 2007 guidelines for control of infectious agents in healthcare settings, which required the use of respirators for treatment of known or suspected cases.[42] CDC states that respirators should be prioritized for use in medical procedures likely to generate respiratory aerosols. Before this interim guidance was released, Representative Bobby Scott, Chairman of the House Committee on Education and Labor, and Representative Alma Adams, Chair of the Subcommittee on Workforce Protections, sent a letter to Secretary of Health and Human Services (HHS) Alex M. Azar II expressing their opposition to this change in the interim standard.[43]

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[39] 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.

[40] Letter from RADM Denise M. Hinton, chief scientist, Food and Drug Administration (FDA), to Robert R. Redfield, Director, CDC, March 2, 2020, at https://www.fda.gov/media/135763/download. The list of respirators approved under this Emergency Use Authorization (EUA) is in Appendix B to this letter, updated at https://www.fda.gov/media/135921/download.

[41] Although the interim guidance does not specifically define the term *facemask*, it does differentiate between a facemask and a respirator such that any recommendation to use a facemask does not require the use of a respirator. CDC, *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings*, updated March 10, 2020, at https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html.

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

[43] Letter from Representative Robert C. "Bobby" Scott, chairman, House Committee on Education and Labor, and Representative Alma S. Adams, chair, Subcommittee on Workforce Protections, to The Honorable Alex M. Azar II, Secretary of HHS, March 9, 2020, at https://edlabor.house.gov/imo/media/doc/Azar%20Redfield%20Letter_SIGNED%202020-03-09.pdf.

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.[44] 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 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.[45] 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 three 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;[46]
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);[47] and
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,

[44] 29 C.F.R. §1910.134 Appendix A. Powered air purifying respirators (PAPR) that do not require a seal to the user's face do not need to be fit tested.

[45] 29 C.F.R. §1910.134 Appendix B.

[46] OSHA, *Temporary Enforcement Guidance - Healthcare 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.

[47] 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.

- People's Republic of China, and
- Republic of Korea.[48]

California: Cal/OSHA Aerosol Transmissible Disease Standard

Although no OSHA standard specifically covers aerosol or airborne disease transmission, the California Division of Occupational Safety and Health (Cal/OSHA), under its state plan, promulgated its aerosol transmissible disease (ATD) standard in 2009.[49] The ATD standard covers most healthcare workers, 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.[50] The key requirements of the ATD standard include

- written ATD exposure control plan and procedures,
- 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 employees, including removal 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; and
- are working with a viable virus in the laboratory.[51]

[48] 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.

[49] Cal. Code Regs. tit. 8, §5199.

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

[51] California Division of Occupational Safety and Health (Cal/OSHA), *Interim Guidance for Protecting Health Care*

In addition, a powered air purifying respirator (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.[52] 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.[53] Emergency medical services (EMS) workers may use N100, R100, or P100 respirators in place of PAPRs.

Cal/OSHA Interim Guidance on COVID-19

Cal/OSHA has issued interim guidance in response to shortages of respirators in the state due to the COVID-19 pandemic response.[54] Under this interim guidance, if the supply of N95 respirators or PAPRs are insufficient to meet current or anticipated needs, surgical masks may be used for low-hazard patient contacts that would otherwise require the use of respirators, and respirators may be used for high-hazard procedures that would otherwise require the use of PAPRs.

Virginia: VOSH COVID-19 ETS

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.[55] This ETS, promulgated under Virginia's state occupational safety and health plan (VOSH) is the first state standard to specifically address COVID-19 in the workplace. As an ETS, the VOSH standard expires 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 comes first. The ETS can be extended only through the normal state rulemaking process.

Unlike the Cal/OSHA ATD standard, the VOSH ETS applies to all employers in the state. As part of a state plan, the VOSH ETS applies to state and local government entities, such as public schools, as employers. All employers in Virginia must comply with the following ETS requirements:

- exposure assessment and determination, notification of suspected cases and contacts with those cases, and employee access to their own exposure and medical records;
- return to work of employees known or suspected to have COVID-19 based on a duration of time since last symptoms or negative COVID-19 tests;[56]

Workers from Exposure to Coronavirus Disease (COVID-19), March 2020, at https://www.dir.ca.gov/dosh/Coronavirus-info.html.

[52] 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.

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

[54] California Division of Occupational Safety and Health (Cal/OSHA), *Cal/OSHA Interim Guidance on COVID-19 for Health Care Facilities: Severe Respirator Supply Shortages*, March 28, 2020, at https://www.dir.ca.gov/dosh/coronavirus/Cal-OSHA-Guidance-for-respirator-shortages.pdf.

[55] *Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19*, 16 Va. Admin. Code §25-220. This ETS is effective upon publication in a Richmond, VA, newspaper during the week of July 27, 2020.

[56] A COVID-19 test for the purposes of determining if an employee can return to work must be paid for by the employer or offered such that the employee bears no cost for the test.

- maintenance of physical distancing between employees while working and on paid breaks at the worksite, including restricted access to the worksite and common areas and break rooms;
- compliance with applicable existing PPE and respiratory protection standards when physical distancing between employees is not possible; and
- sanitation and disinfection requirements.

For all employers, if engineering, administrative, or work practice controls are not feasible or do not provide sufficient protection from SARS-CoV-2 transmission, then PPE, including respiratory PPE—such as respirators, if necessary—must be provided to employees.

VOSH ETS Hazard and Job Task Classification

The VOSH ETS requires that each employer assess its workplace for hazards and job tasks that potentially expose employees to the SARS-CoV-2 virus. Employers must classify each job task as having a "very high," "high," "medium," or "lower" risk level of exposure, according to the hazards to which employees are potentially exposed. The VOSH ETS provides the following examples of activities for the "very high" and "high" risk levels:

- "very high" risk activities include
  - using aerosol-generating procedures, such as intubation, on patients known or suspected to be infected with SARS-CoV-2;
  - collecting or handling specimens from patients known or suspected to be infected with SARS-CoV-2; and
  - performing an autopsy involving aerosol-generating procedures on the body of a person known or suspected to be infected with the SARS-CoV-2 virus at the time of death; and
- "high risk" activities include
  - health care services, including inpatient care, outpatient care, skilled nursing care, and nonmedical support services such as room cleaning, provided to patients known or suspected to be infected with SARS-CoV-2;
  - first responder and medical transport services to patients known or suspected to be infected with SARS-CoV-2; and
  - mortuary services to persons known or suspected to be infected with the SARS-CoV-2 virus at the time of death.

"Medium" risk activities are those that require employees to have more than minimal contact, within six feet of other employees, customers, or members of the public who are not known or suspected to be infected with SARS-CoV-2.[57] "Lower" risk activities are those that do not require contact with other persons within six feet or that are able to utilize the following types of engineering, administrative, or work practice controls to minimize contact between persons:

- installation of floor to ceiling barriers, such as barriers between cashiers and customers;
- telecommuting;
- staggered work shifts to reduce the number of workers at a site;

[57] Examples of "medium" risk work activities are provided in the VOSH ETS at 16 Va. Admin. Code §25-220-30.

- delivering services remotely, including curbside pickup of retail purchases; and
- mandatory physical distancing of persons.

The use of face coverings other than respirators or medical or surgical masks, including cloth face coverings now required by several states, is not an acceptable method of minimizing physical contact between persons. However, the VOSH ETS requires the use of face coverings for brief contacts between persons within six feet of each other.

Engineering, Administrative, Work Practice, and PPE Requirements for "Very High," "High," and "Medium" Risk Activities

Employers with job tasks or activities in the "very high," "high," or "medium" risk classifications must adhere to specific engineering, administrative, work practice, and PPE requirements. For "very high" and "high" risk activities, engineering controls include the use of airborne infection isolation rooms (AIIR) for known or suspected COVID-19 patients and aerosol-generating procedures and Biosafety Level 3 (BSL-3) precautions for the handling of specimens from known or suspected COVID-19 patients.[58]

Employers with "very high" and "high" risk activities must implement administrative and work practice controls, including the prescreening of all employees to ensure that employees do not have signs or symptoms of COVID-19; enhanced medical screening of employees during COVID-19 outbreaks; and the use of flexible work arrangements, such as telecommuting, when feasible. In addition, all employers with "very high" or "high" risk activities must provide, to the extent feasible, psychological and behavioral support to address employee stress at no cost to the employee.

The standard also provides for engineering, administrative, and work practice controls for "medium" risk activities.[59]

PPE Requirements for "Very High" and "High" Risk Activities

Employers with "very high" and "high" risk activities, who are not already covered by the general OSHA PPE standards, are required to comply with the VOSH ETS requirements for PPE. An employer subject to these requirements must assess the workplace to determine if there are any COVID-19 hazards present or likely to be present that would require the use of PPE by employees. The employer must provide for the participation of employees and employee representatives in this assessment process and verify that this assessment has been conducted through a written certification.

If hazards that require PPE are identified, the employer must select and provide the appropriate PPE to each employee and ensure that PPE fits properly. If respiratory PPE, such as respirators or PAPR are used as PPE, the existing OSHA standards for respiratory PPE, which include medical evaluation of employees and fit testing, must be followed.

[58] The VOSH ETS requires compliance with Biosafety Level 3 precautions provided in HHS, *Biosafety in Microbiological and Biomedical Laboratories. Fifth Edition*, HHS Publication no. (CDC) 21-1112, December 2009, at https://www.cdc.gov/labs/BMBL.html.

[59] Engineering, administrative, and work practice controls for "medium" risk activities are provided in the VOSH ETS at 16 Va. Admin. Code §25-220-60.

Unless contraindicated by the hazard and PPE assessment, when any employee is in contact within six feet of any person known or suspected to be infected with SARS-CoV-2, that employee must be provided with the following types of PPE:

- gloves,
- gown large enough to cover areas needing protection,
- face shield or goggles, and
- respirator.

While there are no specific PPE requirements for "medium" risk activities, PPE may be required based on an assessment of the hazards of these activities.

Infectious Disease Preparedness and Response Plan and Training

Infectious Disease Preparedness and Response Plan

All employers with "very high" and "high" risk activities, and employers with 11 or more employees and "medium" risk activities, must develop written infectious disease preparedness and response plans. These plans must be developed with input from employees. The deadline for the development of these plans is 60 days from the effective date of the ETS.

The infectious disease preparedness plan must include a consideration of the COVID-19 risks in the workplace, and to the extent possible and in compliance with medical privacy laws, the specific risks faced by employees with certain preexisting medical conditions. The plan must include contingency plans for continued operations during a COVID-19 outbreak and provide for the prompt identification and isolation of employees with known or suspected COVID-19 and a procedure for employees to notify the employer of COVID-19 signs or symptoms. The plan must also address interactions between the employer's worksite and other businesses, such as vendors and contractors to ensure employees of these businesses comply with the VOSH ETS and the employer's infectious disease preparedness and response plan.

Training

All employers with "very high," "high," or "medium" risk activities must provide training to all employees, including those employees whose work does not involve any COVID-19 risks. This training must teach employees to recognize the hazards of the SARS-CoV-2 virus, signs and symptoms of COVID-19, and the procedures to minimize SARS-CoV-2 hazards. If the employer has an infectious disease preparedness and response plan, training must be provided on this plan. Written certification of training must be prepared, and retraining must be provided when necessary.

Employers with only "lower" risk activities are not required to prepare a formal training plan but must provide oral or written communication on the hazards of SARS-CoV-2, the signs and symptoms of COVID-19, and measures to minimize SARS-CoV-2 exposure. VOSH is required to develop an information sheet that employers can use to satisfy this training requirement.

Training must be provided within 30 days of the effective date of the standard, except for training on the infectious disease preparedness and response plan, which must be completed within 60 days.

Whistleblower Protections

The VOSH ETS prohibits any employer from discharging or otherwise discriminating against any employee who does the following:

- exercises his or her rights under the ETS or existing whistleblower protection provisions, including the limited right of an employee to refuse work because of a reasonable fear of injury or death or serious injury;[60]
- provides and wears his or her own PPE, provided the PPE does not create a greater hazard to the employee or create a serious hazard to other employees; or
- raises a reasonable concern about SARS-CoV-2 and COVID-19 infection control to the employer, the employer's agent, other employees, the government, or the public through any type of media including social media.

OSHA Infectious Disease Standard Rulemaking

In 2010, OSHA published a Request for Information in the *Federal Register* seeking public comments on strategies to control exposure to infectious diseases in healthcare workplaces.[61] After collecting public comments and holding public meetings, OSHA completed the SBREFA process in 2014. Since then, however, no public actions have occurred on this rulemaking; since spring 2017, this rulemaking has been listed as a "long-term action" in DOL's semiannual regulatory agenda.

Congressional Activity to Require an OSHA Emergency Temporary Standard on COVID-19

On March 5, 2020, Representative Bobby Scott, chairman of the House Committee on Education and Labor, and Representative Alma Adams, chair of the Subcommittee on Workforce Protections, sent a letter to Secretary of Labor Eugene Scalia calling on OSHA to promulgate an ETS to address COVID-19 exposure among healthcare workers.[62] This letter followed a January 2020 letter requesting that OSHA reopen its rulemaking on the infectious disease standard and begin to formulate for possible future promulgation an ETS to address COVID-19 exposure.[63] Senator Patty Murray, ranking member of the Senate Committee on Health, Education, Labor, and Pensions and a group of Democratic Senators sent a similar letter to the Secretary of Labor calling for an OSHA ETS.[64]

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[60] In order to exercise this right, the employee must, if possible, have sought unsuccessfully to have the employer remedy the hazard, and there must be insufficient time to attempt to remedy the hazard through normal regulatory enforcement channels. This right is provided in the OSHA standards at 29 C.F.R. §1977.12(b)(2) and in the VOSH standards at 16 Va. Admin. Code §25-60-110.

[61] OSHA, "Infectious Diseases," 75 *Federal Register* 24835, May 6, 2010.

[62] Letter from Representative Scott, chairman, House Committee on Education and Labor, and Representative Adams, chair, Subcommittee on Worker Protections, to The Honorable Eugene Scalia, Secretary of Labor, March 5, 2020, at https://edlabor.house.gov/imo/media/doc/2020-03-05%20OSHA%20ETS%20Letter.pdf.

[63] Letter from Representative Scott, chairman, House Committee on Education and Labor, and Representative Adams, chair, Subcommittee on Worker Protections, to The Honorable Eugene Scalia, Secretary of Labor, January 30, 2020, at https://edlabor.house.gov/imo/media/doc/2020-01-30%20RCS%20to%20DOL%20Corona%20Letter_SIGNED1.pdf.

[64] Letter from Senator Patty Murray, ranking member, Senate Committee on Health, Education, Labor, and Pensions, Senator Robert Menendez, and Senator Tammy Baldwin, et al. to The Honorable Eugene Scalia, Secretary of Labor,

In addition, in March 2020, David Michaels, who served as the Assistant Secretary of Labor for Occupational Safety and Health during the Obama Administration, wrote an op-ed in *The Atlantic* calling on OSHA to promulgate a COVID-19 ETS.[65] On March 6, 2020, the AFL-CIO and 22 other unions petitioned OSHA for an ETS on infectious diseases that would cover all workers with potential exposures.[66] OSHA formally denied the AFL-CIO petition on May 29, 2020, claiming that an ETS is not necessary to protect employees from infectious diseases generally, or from COVID-19.[67] National Nurses United submitted a similar petition requesting that OSHA promulgate an ETS based largely on the Cal/OSHA ATD standard.[68] On May 4, 2020, the Center for Food Safety and Food Chain Workers Alliance submitted a petition requesting that OSHA promulgate an ETS to protect meat and poultry processing workers from COVID-19 exposure in the workplace.[69] On May 18, 2020, the AFL-CIO petitioned the U.S. Court of Appeals for the D.C. Circuit for a writ of mandamus to compel OSHA to promulgate a COVID-19 ETS.[70] The circuit court denied this petition on June 11, 2020.

H.R. 6139, the COVID-19 Health Care Worker Protection Act of 2020

On March 9, 2020, Representative Bobby Scott introduced H.R. 6139, the COVID-19 Health Care Worker Protection Act of 2020. This bill would require OSHA to promulgate a COVID-19 ETS within one month of enactment. The ETS would be required to cover healthcare workers and any workers in sectors determined by the CDC or OSHA to be at an elevated risk of COVID-19 exposure. The ETS would be required to include an exposure control plan provision and be, at a minimum, based on CDC's 2007 guidance and any updates to this guidance. The ETS would also be required to provide no less protection than any state standard on novel pathogens, thus requiring OSHA to include the elements of the Cal/OSHA ATD standard and VOSH COVID-19 ETS in this ETS. Title II of the bill would provide that hospitals and skilled nursing facilities that receive Medicare funding and that are owned by state or local government units and not subject to state plans would be required to comply with the ETS. Similar provisions are included in S. 3475.

P.L. 116-127, the Families First Coronavirus Response Act

The provisions of H.R. 6139 were included as Division C of H.R. 6201, the Families First Coronavirus Response Act, as introduced in the House. The American Hospital Association

March 9, 2020, at https://www.baldwin.senate.gov/imo/media/doc/20200309%20OSHA%20ETS%20Letter.pdf.

[65] David Michaels, "What Trump Could Do Right Now to Keep Workers Safe From the Coronavirus," *The Atlantic*, March 2, 2020, at https://www.theatlantic.com/ideas/archive/2020/03/use-osha-help-stem-covid-19-pandemic/607312/.

[66] Letter from Richard L. Trumka, president, AFL-CIO, to The Honorable Eugene Scalia, Secretary of Labor, March 6, 2020, at https://aflcio.org/statements/petition-secretary-scalia-osha-emergency-temporary-standard-infectious-disease.

[67] Letter from Loren Sweatt, Principal Deputy Assistant Secretary of Labor, to Richard L. Trumka, President, AFL-CIO, May 29, 2020.

[68] Letter from Bonnie Castillo, executive director, National Nurses United, to The Honorable Eugene Scalia, Secretary of Labor, and The Honorable Loren Sweatt, Principal Deputy Assistant Secretary of Labor for Occupational Safety and Health, March 4, 2020, at https://act.nationalnursesunited.org/page/-/files/graphics/NNUPetitionOSHA03042020.pdf.

[69] Center for Food Safety and Food Chain Workers Alliance, *Rulemaking Petition to the United States Department of Labor, Occupational Safety and Health Administration*, May 4, 2020, at https://www.centerforfoodsafety.org/files/2020-05-04-osha-ets-petition_58890.pdf.

[70] In re: American Federation of Labor and Congress of Industrial Organizations, D.C. Cir., No. 19-1158, May 18, 2020. This petition was filed in the U.S. Court of Appeals as Section 6(f) of the OSH Act [29 U.S.C. §655(f)] grants this court exclusive jurisdiction to provide judicial review of OSHA standards.

(AHA) issued an alert to its members expressing its opposition to the OSHA ETS provisions in the bill.[71] Specifically, the AHA opposed the requirement that the ETS be based on the CDC's 2007 guidance. The AHA stated that unlike severe acute respiratory syndrome (SARS), which was transmitted through the air, COVID-19 transmission is through droplets and surface contacts. Thus, the requirement of the 2007 CDC guidance that N95 respirators, rather than surgical masks, be used for patient contact is not necessary to protect healthcare workers from COVID-19, and the use of surgical masks is consistent with World Health Organization guidance. The AHA also claimed that shortages of available respirators could reduce the capacity of hospitals to treat COVID-19 patients, due to a lack of respirators for staff. The OSHA ETS provisions were not included in the version of the legislation that was passed by the House and the Senate and signed into law as P.L. 116-127.

H.R. 6379, the Take Responsibility for Workers and Families Act

Division D of H.R. 6379, the Take Responsibility for Workers and Families Act, as introduced in the House on March 23, 2020, includes the requirement that OSHA promulgate an ETS on COVID-19 within seven days of enactment and a permanent COVID-19 standard within 24 months of enactment to cover healthcare workers, firefighters and emergency response workers, and workers in other occupations that CDC or OSHA determines to have an elevated risk of COVID-19 exposure. Division D of H.R. 6379 would amend the OSH Act, for the purposes of the ETS only, such that state and local government employers in states without state plans would be covered by the ETS. The provisions of Division D of H.R. 6379 were also included in S. 3584, the COVID-19 Workers First Protection Act of 2020, as introduced in the Senate.

This legislation would specifically provide that the ETS would remain in force until the permanent standard is promulgated and would explicitly exempt the ETS from the Regulatory Flexibility Act, Paperwork Reduction Act, and Executive Order 12866. OSHA would be granted enforcement discretion in cases in which it is not feasible for an employer to fully comply with the ETS (such as a case in which PPE is unavailable) if the employer is exercising due diligence to comply and implementing alternative means to protect employees.

Like the provisions in H.R. 6139 and the version of H.R. 6201 introduced in the House, the ETS and permanent standard under H.R. 6379 would be required to include an exposure control plan and provide no less protection than any state standard on novel pathogens, thus requiring OSHA to include the elements of the Cal/OSHA ATD standard and VOSH COVID-19 ETS in this ETS and permanent standard. Although the ETS provisions in H.R. 6139 and H.R. 6201 would require that the ETS be based on the 2007 CDC guidance, specific reference to the 2007 guidance is not included in this legislation. Rather, under H.R. 6379, the ETS and permanent standard would have to incorporate, as appropriate, "guidelines issued by the Centers for Disease Control and Prevention, and the National Institute for Occupational Safety and Health, which are designed to prevent the transmission of infectious agents in healthcare settings" and scientific research on novel pathogens.

States with occupational safety and health plans would be required to adopt the ETS, or their own ETS at least as effective as the ETS, within 14 days of the legislation's enactment.

[71] Emily Kopp, "Hospitals want to kill a policy shielding nurses from COVID-19 because there aren't enough masks," *Roll Call*, March 3, 2020, at https://www.rollcall.com/2020/03/13/hospitals-want-to-kill-a-policy-shielding-nurses-from-covid-19-because-there-arent-enough-masks/. This alert is available to American Hospital Association (AHA) members on the AHA website at https://www.aha.org.

H.R. 6559, the COVID-19 Every Worker Protection Act of 2020

H.R. 6559, the COVID-19 Every Worker Protection Act of 2020, was introduced in the House by Representative Bobby Scott on April 21, 2020. This legislation includes the ETS and permanent standard provisions of Division D of H.R. 6379 and S. 3584 and would require that these standards cover healthcare workers, emergency medical responders, and "other employees at occupational risk" of COVID-19 exposure. This legislation also adds two provisions that would clarify the requirements for employers to record work-related COVID-19 infections and strengthen the protections against retaliation and discrimination offered to whistleblowers. Similar provisions are included in S. 3677 and were incorporated into H.R. 6800, the Heroes Act, as passed by the House.

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.[72] 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.[73] Employers must also report to OSHA, within 8 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.[74] 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.[75] 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.[76] One of the listed exemptions is as follows:

> 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).[77]

Because of the nature of COVID-19 transmission, which can occur in the community as well as 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.

[72] 29 U.S.C. §§657(c) and 673(a).

[73] OSHA's reporting and recordkeeping regulations are at 29 C.F.R. Part 1904.

[74] The list of exempted industries is at 29 C.F.R. Subpart B, Appendix A. States with state occupational safety and health plans may require employers in these exempted industries to comply with the recordkeeping requirements.

[75] 29 C.F.R. §1904.5.

[76] 29 C.F.R. §1905.5(a).

[77] 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.[78] 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:

- healthcare;
- 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.[79] 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 recording 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.

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

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

H.R. 6559

H.R. 6559 would require that the ETS and permanent standard established pursuant to the legislation include the requirement for the recording and reporting of all COVID-19 cases in accordance with OSHA regulations in place at the time of enactment. By referencing the regulations in place, this provision would serve to supersede OSHA's guidance from April 10, 2020, and apply the requirement, currently provided in the guidance effective May 26, 2020, to determine the work-relatedness of COVID-19 cases to all employers covered by the recordkeeping regulations.

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.[80] 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.[81]

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.[82] 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.[83]

H.R. 6559 would require that the ETS and permanent standard promulgated pursuant to the legislation expand the protections for whistleblowers. The following additional activities taken by employees would grant 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:
  - 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

[80] 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, at https://www.whistleblowers.gov/sites/wb/files/2019-12/WB-Statute-Summary-Chart-10.8-Final.pdf.

[81] 29 C.F.R. §1977.3. Public-sector employees, except employees of the United States Postal Service, are not protected by the whistleblower provision, but may be covered by whistleblower provisions in other federal and state statutes.

[82] 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, at https://www.osha.gov/sites/default/files/11cDeskAid.pdf.

[83] 29 C.F.R. §1977.12(b)(2).

- 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.

H.R. 6800, The Heroes Act

The provisions of H.R. 6559, including the provisions relating to recordkeeping and whistleblower protections, were included as Title III of Division L of H.R. 6800, The Heroes Act. H.R. 6800 was passed by the House on May 15, 2020. In a letter to Speaker of the House Nancy Pelosi, the AHA expressed its opposition to the ETS provisions in The Heroes Act citing the potential for confusion that new regulations could bring and the "ongoing global lack of supplies, equipment and testing capability" faced by hospitals.[84] The AHA also stated that the provision that would require the ETS to be based on state standards "suggests that the federal government is surrendering its responsibility to appropriately regulate the nation to a state government agency without consideration of whether that state's decisions are appropriate for implementation anywhere and everywhere."

[84] Letter from Thomas P. Nickels, Executive Vice President, American Hospital Association, to Hon. Nancy Pelosi, Speaker, U.S. House of Representatives, May 14, 2020, at https://www.aha.org/system/files/media/file/2020/05/web-AHALettertoHouseonHEROESAct051420final.pdf.

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)

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.

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