August 20, 2021

Mr. James "Jim" Frederick
Principal Deputy Assistant Secretary
U.S. Department of Labor
Occupational Safety and Health Administration
Room: S2315
200 Constitution Ave., NW
Washington, DC 20210

Via Electronic submission: www.regulations.gov

Re: Docket No. OSHA-2020-0004; RIN 1218-AD36; Comments on Occupational Exposure to COVID-19; Emergency Temporary Standard; 86 Fed. Reg. 32376 (June 21, 2021)

Dear Mr. Frederick:

The Coalition for Workplace Safety ("CWS") respectfully submits these comments in response to the Occupational Safety and Health Administration's ("OSHA") "Occupational Exposure to COVID-19; Emergency Temporary Standard," 86 Fed. Reg. 32376 (June 21, 2021). We appreciate OSHA's consideration of these comments as it determines how to proceed with the Emergency Temporary Standard ("ETS").

The CWS is comprised of associations and employers who believe in improving workplace safety through cooperation, assistance, transparency, clarity, and accountability. The CWS believes that workplace safety is everyone's concern. Improving safety can only happen when all parties – employers, employees, and OSHA – have a strong working relationship.

CWS members, and employers across the country, understand the significance of the COVID-19 pandemic and have made protecting workers against COVID-19 exposure a top priority. We appreciate efforts by OSHA, the Centers for Disease Control and Prevention and other agencies to provide timely information and guidance over the course of the last 16 months about the evolving understanding of COVID-19 and related hazard mitigation strategies.

Notwithstanding this, the CWS has significant concerns with the ETS:

- The CWS is disappointed by the process undertaken by OSHA to issue the standard. Since the pandemic started employers have been navigating through new requirements and taking actions to keep their workforces safe. As a result, employers have experience and best practices which could have helped to inform the standard. Despite numerous requests from stakeholders, there was no public docket for comment. Given five months elapsed between the start of the Biden Administration

and issuance of the ETS, the Agency had ample opportunity to solicit stakeholder input related to the ETS, but unfortunately chose not to do so.

- The CWS strongly disagrees that OSHA has met the statutory requirements for issuing an ETS, even one with a limited scope. As OSHA itself has stated, an ETS is the most "dramatic" weapon the Agency possesses and, thus, the statutory requirements to promulgate such a rule are very stringent. In this instance, OSHA has not met those stringent requirements. OSHA must show that there is a "grave danger" facing employees and that the ETS is "necessary" to address it. The arrival and dissemination of three vaccines and increased protective measures have undermined OSHA's conclusions about a grave danger, and OSHA provides no specific explanation about why the ETS is necessary, relying instead on the broad deference courts have typically given OSHA's conclusions.

- Several proposed provisions in the ETS go beyond OSHA's statutory authority, including the medical removal protection benefits provision, the requirement for a COVID-19 Log, and the anti-retaliation provisions in the rule.

- OSHA's economic feasibility analysis lacks virtually any evidence supporting its conclusions. OSHA is not permitted to conduct an economic analysis that is based largely on the Agency's "best judgment," even in the context of an ETS. Furthermore, OSHA's economic analysis undermines the Agency's need for the ETS. OSHA estimates that virtually all of the employers covered by the rule are *already implementing the ETS*. If so, this is entirely inconsistent with the Agency's position that the ETS is necessary to protect employees from COVID-19.

The CWS's concerns are set forth more fully below. The CWS requests that the Agency *not* make the ETS permanent after the six-month period provided in the statute. However, should the Agency choose to do so, it must remove the provisions that clearly exceed OSHA's legal authority and address the economic feasibility issues described below.

1. OSHA's Rulemaking Was Not Transparent and Lacked Meaningful Input From Employers.

In the CWS's view, the Agency did not meaningfully engage with the public and provide an opportunity for public input regarding the best approaches to protect workers from occupational exposure to COVID-19.

While OSHA conducted listening sessions, via conference calls, allowing stakeholders to speak for three minutes, these listening sessions were not widely advertised and were available only to stakeholders that received a direct invitation from OSHA. This limited OSHA's insights to only those groups with which it had already established lines of communication and barred other stakeholders from having an opportunity to provide input and feedback on OSHA's regulatory options. Moreover, the Agency failed to provide stakeholders with specific details on a possible ETS. Because the stakeholders invited to engage with OSHA through its listening sessions were limited to three-minute oral presentations and were not provided details on

possible regulatory approaches, these stakeholders also lacked the opportunity to provide substantive or meaningful comment.

OSHA also declined individual meetings and, during the listening sessions explicitly rejected accepting written public comments prior to publication of the ETS. By taking this position, OSHA deprived itself of useful information from stakeholders with experience in dealing with the pandemic. Employers, workers, state agencies, and subject matter experts each have developed unique perspectives over the course of the past year of responding to the pandemic. This input would have been helpful to the Agency as it determined the best approach for addressing the pandemic.

Furthermore, OSHA *had* the opportunity to better engage the public during development of the ETS. *Five months elapsed between the start of the Biden Administration and the issuance of the ETS.* That was more than enough time for the Agency, at a minimum, to open a public docket, provide detail on possible direction, receive written comments, hold stakeholder meetings open to the public that were widely publicized, and otherwise learn from the best practices of employers who have been at the forefront of battling the pandemic.

The OSH Act does not require OSHA to engage in any particular stakeholder outreach prior to promulgation of an ETS. However, in this instance, OSHA had the opportunity to do so and chose not to. In the CWS's view, this was a serious mistake.[1]

2. OSHA Has Not Established A "Grave Danger" Necessitating An ETS.

Under the Act, the Secretary has authority to issue an emergency temporary standard to take immediate effect upon publication in the *Federal Register* **only** when the Secretary makes two specific determinations. First, that "employees are exposed to grave danger;" and, second, that an "emergency standard is necessary to protect employees from such danger." 29 U.S.C. 655(c). In this instance, the record does not support either finding.[2]

a. *OSHA did not meet the requirements of 29 U.S.C. 655(c) because it failed to consider the impact of vaccinations in its grave danger analysis.*

The ETS applies to workers performing healthcare services and workers performing healthcare support services. 29 C.F.R. 1910.502(a). Healthcare services mean "services that are provided to individuals by professional healthcare practitioners (e.g., doctors, nurses, emergency

[1] The CWS is also concerned with statements made in the preamble to the rule suggesting that OSHA has the authority to continue to make ongoing changes to the rule without notice and comment. Throughout the preamble, OSHA states that it will continue to monitor developments and make adjustments to the rule, as necessary. *See, e.g.*, 86 Fed. Reg. at 32398 ("OSHA, too, will continue to monitor this issue and revise the ETS as appropriate.") While the CWS appreciates the Agency's desire to be flexible as the pandemic evolves, we believe OSHA does not have the authority to make ongoing changes to the rule that impose costs on employers without meaningful notice and comment.

[2] The CWS is not arguing that a rule related to COVID-19 in certain industries may or may not be justified under Section 6(b)(5) of the OSH Act. Whether employees are exposed to a significant risk of harm in the healthcare industry from COVID-19 and whether a rule will substantially reduce that risk are separate issues not addressed in these comments. What is at issue, however, is whether the requisite *Section 6(c) requirements have been met*, given the extraordinary step of imposing substantial requirements on employers without notice and an opportunity for comment.

medical personnel, oral health professionals) for the purpose of promoting, maintaining, monitoring, or restoring health." "Healthcare support services mean services that facilitate the provision of healthcare services." 29 C.F.R. 1910.502(b). The crux of OSHA's argument is that despite increasing availability of vaccines and the protective measures undertaken by the healthcare industry throughout the pandemic (including extensive use of personal protective equipment), certain employees, even those who are fully vaccinated, in the healthcare industry still face a grave danger in the performance of their jobs. And this grave danger necessitates issuance of the ETS.

While the CWS does not dispute that there is a risk of exposure to COVID-19 in the healthcare industry, the prevalence of vaccines and the protective measures in place were not fully considered by the Agency. In particular, OSHA acknowledges the broad uptake of vaccines, but does not actually consider the impact vaccines have on the grave danger assessment.

Most of the data that OSHA uses to support the grave danger assessment relates to the impact of COVID-19 on *unvaccinated* employees. This ignores the realities of the largely vaccinated workforce to which the ETS applies. Healthcare workers were the first group of people eligible to receive COVID-19 vaccines, following FDA Emergency Use Authorization for the Pfizer and Moderna vaccines in December 2020.[3] By April 19, 2021, every adult in the United States was eligible to receive a vaccine.[4] As of August 10, 2021, 71.2 percent of the United States adult population had received at least one dose of vaccine; and 61.2 percent of the adult population is fully vaccinated.[5] Moreover, since the ETS was issued many employers covered by the ETS have implemented mandates that their employees be vaccinated or at least made clear that unvaccinated employees will be subject to regular testing.

In addition, the effectiveness of the vaccines against mild and severe COVID-19 is substantial, as OSHA recognizes in the preamble. Even with recent outbreaks driven by the Delta variant, unvaccinated people remain the greatest concern.[6] According to the CDC, "the COVID-19 vaccines authorized in the United States are highly effective at preventing severe disease and death, including against the Delta variant."[7] Even though some fully vaccinated individuals will become infected and experience illness, "the vaccine still provides them strong protection against serious illness and death."[8]

Notwithstanding the distinction between vaccinated and unvaccinated employees, throughout the preamble, OSHA emphasizes the risk to unvaccinated workers. However, given the prevalence and widespread availability of vaccines, basing the grave danger analysis on this

[3] The Advisory Committee on Immunization Practices' Interim Recommendation for Allocation of Initial Supplies of COVID-19 Vaccine – United States, 2020, ACIP, CDC (Dec. 11, 2020) (available at https://www.cdc.gov/mmwr/volumes/69/wr/mm6949e1.htm).
[4] *See* All U.S. Adults Now Eligible for COVID-19 Vaccine, Axios (Apr. 19, 2021) (available at https://www.axios.com/covid-vaccine-eligibility-all-states-2d842548-892a-40c1-91a6-07ae9a3b0ca1.html).
[5] COVID-19 Vaccinations in the United States, COVID Data Tracker, CDC, https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total (last visited Aug. 11, 2021).
[6] Delta Variant: What We Know About the Science, CDC, Aug. 6, 2021, https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html.
[7] *Id*.
[8] *Id*.

population (which continues to shrink and is particularly small with respect to healthcare workers) is inappropriate. Under these circumstances, measures to abate the danger posed by COVID-19 are generally available and well-advertised to the population at large. Individuals in healthcare settings can appropriately assess their own risk level with respect to COVID-19. In addition, with recent levels of severe community spread of COVID-19 across the country, *an individual's exposure to COVID-19 is more likely the cause of community spread than any particular workplace environment*.

b. *OSHA failed to establish a "grave danger" for workers performing healthcare support services*.

Virtually all of the evidence supporting the grave danger finding is focused on healthcare workers, and, as a result, fails to address the issue of how COVID-19 poses a grave danger to *healthcare support workers* covered by the ETS. OSHA's references to "healthcare employees" throughout the preamble section that addresses its grave danger finding assume that all healthcare employees covered by the ETS, by nature of their work, are more prone to COVID-19 exposure than in any other workplace in an area of community spread. *See* 86 Fed. Reg. at 32382 ("This monumental tragedy is largely handled by healthcare employees who provide care for those who are ill and dying, leading to introduction of the virus not only in their daily lives in the community but also in their workplace…") Indeed, OSHA states that its "determination that there is a grave danger to healthcare employees rests on the severe health consequences of COVID-19…*and that these workplace settings provide direct care to known or suspected COVID-19 cases*." 86 Fed. Reg. at 23382 (emphasis added). However, this is not consistent with the scope of the ETS.

The rule also applies to a wide-range of workers that do *not* engage in direct patient care, including admissions personnel, receptionists, patient food services, equipment and facility maintenance, laundry services, medical waste handling services, and medical equipment cleaning and reprocessing services. 29 U.S.C. § 1910.502(b). OSHA has not provided the needed information to support applying the requirements to employers supporting healthcare workers, as set forth in the rule.

c. *OSHA has not adequately demonstrated grave danger to many work environments covered by the rule*.

OSHA focuses its grave danger analysis on acute care and certain long term care industries. However, the rule is applied to a vast array of "healthcare" industries where there is no evidence supporting the finding of a grave danger. These covered industries include: pharmacies and drug stores, facility support services, staffing agencies, elementary and secondary schools, colleges and universities, professional schools, offices of physicians, mental health specialists, dentists, chiropractors, optometrists, physical, occupational, and speech therapists, podiatrists, family planning centers, outpatient mental health and substance abuse centers, HMO medical centers, kidney dialysis centers, freestanding ambulatory surgical and emergency centers, outpatient care centers, home health care services, ambulance services, blood and organ banks, general medical and surgical hospitals, psychiatric and substance abuse hospitals, specialty hospitals, skilled nursing facilities, residential intellectual and developmental disability facilities, continuing care retirement communities, assisted living facilities for the

elderly, other residential care facilities, sports teams and clubs, and firefighters and EMTs. 86 Fed. Reg. at 32488.

OSHA offers no evidence to demonstrate why employees in industries such as those employed by staffing agencies, elementary schools, colleges and universities, or sports teams and clubs face a grave danger from COVID-19 that merits coverage by the ETS for healthcare workers. In addition, OSHA offers no evidence as to why it treats certain healthcare workers that do not treat patients for COVID-19 as if they face the same danger as those healthcare workers directly treating patients for COVID-19. For example, it does not explain why employees at mental health specialists, chiropractors, optometrists, physical therapists, podiatrists, or family planning centers face a grave danger from COVID-19 due to their work environment, as opposed to from general community spread.

d. *OSHA provides no evidence that the ETS, rather than other steps the Agency can take, including guidance and regular rulemaking, is "necessary" to protect healthcare workers from any danger posed by COVID-19.*

To issue the ETS, OSHA must also demonstrate that the ETS, rather than other steps the Agency can take, is "necessary" to address the purported grave danger. Despite the comprehensive approach taken by employer and employee groups, the public health community, state and local leaders, and numerous agencies of the federal government over the course of the pandemic, OSHA now states that this ETS is necessary to protect workers, 16 months after COVID-19 first emerged as a threat in this country. Like the Agency's grave danger analysis, OSHA's position is unavailing.

In 2020, in responding to legal challenges seeking to force OSHA to issue an ETS, OSHA stated that its standards, guidance, and enforcement tools were adequate to protect employees from the dangers of COVID-19. 86 Fed. Reg. at 32414. As the case counts related to COVID-19 waxed and waned over the course of the pandemic, OSHA continued to assert this position.

To justify the ETS, OSHA has now changed this position, to assert that the tools in its toolbox are actually incapable of protecting healthcare workers and workers in healthcare support services. The Agency suggests that upon reflection, it has learned that its use of the General Duty Clause (Section 5(a)(1) of the OSH Act) and relevant standards are unable to effectively address COVID-19. But the reasoning used to support this is not dependent upon the changing course of the pandemic, but rather simply a *change in position* to justify a new policy determination.

For example, the Agency laments that using the General Duty Clause to enforce against COVID-19 is not sufficient because doing so imposes a "heavy litigation burden" on the Agency and that the General Duty Clause does not provide employers with specific requirements to follow. 86 Fed. Reg. at 32418. While that may be true, these characteristics of the General Duty Clause existed in 2020 (and for decades before that) when the Agency made its determination that an ETS was *not* necessary to protect against COVID-19. Nothing has changed, except for the Agency now wanting to adopt a different policy outcome.

The Agency also states that its own enforcement of COVID-19 was hampered by the failure to have an ETS, citing complaints issued that were not inspected. 86 Fed. Reg. at 32415. Failure to have an ETS in place served as no obstacle to OSHA initiating an inspection of a workplace following a COVID-19 complaint. There is *no* requirement under the OSH Act or elsewhere that in order for OSHA to investigate a complaint – and potentially issue citations – there must be a comprehensive standard applicable to the conditions involved the complaint. The extent to which OSHA investigated or did not investigate complaints is completely unrelated to whether an ETS was in effect.

OSHA also does not discuss the comprehensive state-plan standards that have been previously promulgated to address COVID-19 and whether those state standards were shown to be more effective than OSHA guidance and general duty clause enforcement approach. As discussed below, these state standards have not been proven to be effective at addressing the spread of COVID-19, as the evidence demonstrates the pandemic is largely driven by community spread and not workplace exposures.

3. Several Provisions Of The Rule Exceed OSHA's Statutory Authority.

The ETS contains three requirements that the CWS believes exceed OSHA's statutory authority: the medical removal protection benefits provision (29 C.F.R. 1910.502(l)(5)); the requirement that employers maintain a COVID-19 Log that includes cases without a workplace nexus. (29 C.F.R. 1910.502(q)(2)); and the inclusion of a provision that permits OSHA to pursue cases of alleged retaliation against employers through Citations and Notifications of Penalty, rather than through the congressionally mandated Section 11(c) process (29 C.F.R. 1910.502(0)). Should the Agency go forward in finalizing the ETS, these requirements must be removed from any final standard.

a. Medical Removal Protection Benefits.

As OSHA has in other health standards, the Agency included a requirement in the ETS that employers maintain the pay and benefits of employees who (1) must be removed from the workplace because of a positive COVID-19 test result, symptoms of COVID-19, or a diagnosis of COVID-19 from a healthcare provider; and (2) an employee who must be removed as a close contact from a workplace exposure. *See* 86 Fed. Reg. at 32624. The Agency has placed some limits on these benefits and also has allowed employers to offset the benefits with other leave and benefit programs. *Id*. at 32625. OSHA has stated the purpose of the benefits is to ensure that employees are willing to report signs and symptoms of COVID-19 without fear of losing pay and benefits. *Id*. at 32595.

The CWS submits that medical removal protection benefits in this ETS, as with other OSHA standards that have included it, violates Section 4(b)(4) of the OSH Act. Section 4(b)(4) prohibits any OSHA standard from affecting in any manner "any workmen's compensation law or to enlarge or diminish 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).

While courts have upheld prior medical removal protection benefit provisions, these provisions have been more limited in practice, as the hazards involved have been limited to the workplace and involved fewer potentially affected employees. Many states have taken unprecedented action to ensure coverage of COVID-19 cases by the workers compensation system. This requirement is sure to push more employees into that system in violation of Section 4(b)(4).

Irrespective of Section 4(b)(4), however, OSHA's extension of medical removal protection benefits to employees who have contracted COVID-19 from non-work-related exposures expands OSHA's rulemaking authority beyond any previous health standard. In every standard where OSHA has included medical removal protection benefits, the hazard at issue was one solely driven by a work-related exposure, as alluded to above. Here, OSHA is requiring employers to pay benefits to employees who may have been exposed and *contracted COVID-19 outside of the workplace*.

b. COVID-19 Log.

The ETS also includes a requirement that employers maintain a COVID-19 Log. 29 C.F.R. 1910.502(q)(2)(ii). The Log "must contain, for each instance, the employee's name, one form of contact information, occupation, location where the employee worked, the date of the employee's last day at the workplace, the date of the positive test for, or diagnosis of, COVID-19, and the date the employee first had one or more COVID-19 symptoms, if any were experienced." 29 C.F.R. 1910.502(q)(2)(ii)(A). Furthermore, an employer must "record each instance identified by the employer in which an employee is COVID-19 positive, *regardless of whether the instance is connected to exposure to COVID-19 at work*." 29 C.F.R. 1910.502(q)(2)(ii). (emphasis added)

As with the medical removal protection benefits provision, requiring employers to record cases of non-work-related COVID-19 improperly expands an employer's obligations to monitor and document exposures that occur outside of the workplace. This places a burden on employers beyond what was anticipated by Congress when it promulgated the OSH Act. "The Secretary…shall prescribe regulations requiring employers to maintain accurate records of …*work-related* deaths, injuries and illnesses…." 29 U.S.C. 657(c)(2). (emphasis added)

The CWS also questions the stated purpose of the requirement, which is "intended to assist employers with tracking and evaluating instances of employees who are COVID-19 positive without regard to whether those employees were infected at work. The tracking will help evaluate potential workplace exposure to other employees." 86 Fed. Reg. at 32626. As a practical matter, local public health departments still require contact tracing and this is performed frequently under their direction. There is no need for employers to establish a separate COVID-19 Log, which will only add recordkeeping burdens, and increase citation opportunities, without improving workplace safety and health.

c. Anti-retaliation Provision.

OSHA lacks statutory authority to promulgate the anti-retaliation and discrimination provisions of the rule, included at 29 C.F.R. 1910.502(o). Congress provided clearly and

unambiguously that discrimination complaints must proceed under Section 11(c) of the OSH Act, explicitly rejecting civil penalties and administrative review for discrimination claims.

Section 11(c) of the OSH Act protects an employee from retaliation on the basis of filing a complaint, testifying with respect to a Section 11(c) proceeding, or exercising any right afforded by the Act on behalf of himself or others. 29 U.S.C. 660(c)(1). The scope of rights protected implicitly and explicitly under the Act is broad. Sections 11(c)(2) and 11(c)(3) outline the procedural process Congress explicitly created for employees who believe they have been discriminated against. *See* 29 U.S.C. 660(c)(2) and 660(c)(3). Congress provided that an employee must file a complaint with the Secretary within 30 days of the violation occurring. 29 U.S.C. 660(c)(2). The Secretary then must investigate the complaint and, if the Secretary determines that a violation has occurred, pursue an action in a United States district court to seek appropriate relief, including rehiring or reinstatement of the employee to his or her former position with back pay. *Id.* Congress specifically gave the Secretary 90 days to complete the investigation and notify the complainant of his or her determination regarding the allegations in the complaint. 29 U.S.C. 660(c)(3).

Through these Section 11(c) provisions, Congress provided procedures to address all alleged discrimination by employers against an employee for exercising rights under the Act. As such, Congress was not silent regarding how to handle retaliation in the workplace, the very issue addressed by the ETS at paragraph 1910.502(o). "Where a statute's language carries a plain meaning, the duty of an administrative agency is to follow its commands as written, not to supplant those commands with others it may prefer." *SAS Inst., Inc. v. Iancu*, 138 S. Ct. 1348, 1355 (2018). There is no need to go beyond the plain language of Section 11(c) here, because Congress spoke directly to the Agency's authority to handle claims of retaliation. Furthermore, if Congress wished to provide separate discrimination penalties for employers solely with respect to COVID-19 safety requirements, it knew how to do so and could have included plain language to that effect in any of its COVID-19 response legislation enacted over the past 17 months.

As a practical matter, OSHA's approach would render Section 11(c) irrelevant with respect to rights exercised under the ETS, as the Agency would always choose its own administrative approach over going to court. Under the ETS, an employee would not have to file a complaint pursuant to Section 11(c) to obtain reinstatement or back pay. This would circumvent the due process for judicial review that Section 11(c) affords employers. And, in essence, it would extend the 30-day period required for filing a complaint under Section 11(c) to six months, the statute of limitations for issuance of citations.

This is not the first time OSHA has exceeded its statutory authority to include an anti-retaliation provision in a rulemaking. *See* Improve Tracking of Workplace Injuries and Illnesses, 81 Fed. Reg. 29624, 29627 (May 12, 2016). As OSHA notes in its preamble to the ETS, OSHA is undergoing a facial challenge to the validity of the 2016 Recordkeeping rule's anti-retaliation provision, which is pending in the U.S. District Court for the Western District of Oklahoma. The OSH Act legislative history clearly establishes that Congress never intended for OSHA to have the authority the Agency has now given itself, i.e. to convert whistleblower claims into citable offenses—first in its 2016 Recordkeeping rule and now in Section 1910.502(o)—nor did it expressly or implicitly grant such authority to promulgate such a regulation. Indeed, Congress contemplated and rejected making discriminatory actions subject to a civil penalty through the

issuance of a citation. The final bill rejected allowing the Secretary to issue citations and civil penalties for discriminatory actions in lieu of a full process whereby employees could file complaints and employers could have an opportunity for judicial review in the district courts. 29 U.S.C. 661(c). Congress's decision to reject putting the provision addressing discriminatory acts in the "Penalties" section of the Statute and instead placing it in the "Judicial Review" section of the Act is consequential.

Although OSHA states Section 6(c) of the Act gives the Agency "almost 'unlimited discretion,'" in determining which provisions are "reasonably necessary" to protect employees under an emergency standard, the extensive consideration of this matter by Congress in the past should be a material consideration in OSHA's decision to promulgate an anti-retaliation provision under the ETS. 86 Fed. Reg. at 32603. OSHA claims that the anti-retaliation provision is "reasonably necessary" because employee participation is critical to the success of the ETS. *Id*. at 32604. However, it offers no evidence to show that employee participation is more important with respect to a COVID-19 safety standard than with respect to any other safety standard. In 1910.502(o), OSHA gives itself the very authority Congress rejected. OSHA seeks to side-step what it believes to be a weak and cumbersome requirement for employees under Section 11(c). The Agency prefers a citation-based enforcement mechanism so that it can bypass the necessary element of an employee complaint and the statutory timeframes specifically established by Congress. OSHA would prefer to decide when employers are engaging in adverse action rather than waiting for an employee to allege such action in a complaint. Even under its emergency standard authority, OSHA cannot simply rewrite the Act more to its liking.

4. OSHA's Economic Feasibility Analysis Lacks Evidence Supporting Its Conclusions.

OSHA is required to demonstrate that its rules—including this ETS—are technologically and economically feasible. *See* 86 Fed. Reg. at 32484 ("A standard must be economically feasible in order to be 'necessary' under section 6(c)(1) of the OSH Act."). A standard is economically feasible if it does not "threaten" the existence of, or cause massive economic dislocations within, a particular industry or alter the competitive structure of that industry. *United Steelworkers of Am. v. Marshall*, 647 F.2d 1189, 1265 (D.C. Cir. 1980). Feasibility sets a critical boundary to OSHA's rulemaking authority. It reflects Congress's judgment that OSHA's authority in the realm of workplace safety and health is not limitless, and the Agency must consider the ability of industry to comply with the requirements of new health standards and the related costs. OSHA has historically found a standard to be economically feasible if its costs do not exceed ten percent of profits or one percent of revenues for affected industries. Furthermore, OSHA must make its economic feasibility determinations based upon substantial evidence in the rulemaking record as a whole. In this instance, OSHA's economic feasibility analysis is devoid of virtually any evidence supporting its conclusions and its simplifying assumptions understate the costs of compliance significantly, as well as undercut the need for the rule in the first instance.

a. OSHA's economic feasibility analysis lacks virtually any supporting evidence and is, instead based largely on OSHA's "best judgment."

In its economic analysis, OSHA engages in several steps to estimate the costs of compliance and the impact of those costs on affected industries. This includes identifying

affected industries, estimating the cost of various provisions, estimating baseline compliance with the new ETS, calculating the costs per establishment, and then assessing the economic impacts of those costs on the industries affected. OSHA's approach to its economic feasibility analysis for the ETS is essentially the same as the approach taken by the Agency in other Section 6 rulemakings.

Here, however, without the benefit of notice and comment, the Agency has not justified its estimates. There are multiple instances throughout the preamble where OSHA has no evidence to support an estimate and, instead, simply uses its "best judgment." *See, e.g.*, 85 Fed. Reg. at 32499 (estimating costs for respiratory protection "based on OSHA's best professional judgment"); 85 Fed. Reg. at 32500 (estimating use of certain PPE "based on best professional judgment"); 85 Fed. Reg. at 32505 (estimating number of barriers "based on agency judgment").

In those instances where OSHA relies on actual data and evidence, that evidence is significantly outdated. For example, OSHA examined information from the 2013 Small Business Regulatory Enforcement and Fairness Act ("SBREFA") panel related to its pre-proposal rule on "Occupational Exposure to Infectious Diseases in Healthcare and Other Related Work Settings." The information included in that analysis, however, is eight years old (at best) and does not reflect at all the impact of the pandemic on the industries affected. In another instance, OSHA cited to its tuberculosis rulemaking conducted in 1997 to establish one-time maintenance costs for ventilation in the rule. Put simply, OSHA is relying on information from almost 25 years ago in analyzing the feasibility of a significant provision in the rule.

The OSH Act requires much more from the Agency in providing credible economic feasibility determinations.

b. In estimating the costs of compliance, OSHA assumes a degree of current compliance that (1) significantly understates the cost of the rule, and (2) undercuts the need for the rule in the first instance.

One of the key analyses in determining economic feasibility involves calculating the overall costs of the rule to affected employers. In determining this, OSHA must estimate the extent to which employers are already following the requirements of the rule analyzed. OSHA only assigns a cost of compliance to those employers that are not otherwise complying with the standard.

In the economic analysis in the ETS, OSHA does not cite to *any specific evidence* of current compliance, except to reference the baseline compliance calculated in the 2013 SBREFA report discussed above. OSHA then summarily assumes that "some compliance rates were likely too low [in the 2013 SBREFA report] given the heightened awareness of infection control practices, the amount of time since the pandemic started, and, especially, the outbreaks in healthcare settings and recognition of the importance of infection control measures for protecting workers and patients." 86 Fed. Reg. at 32495.

Without any further evidence, OSHA then assumes that 75 percent of all covered employers with more than 20 employees are already in compliance with the *vast majority of* the provisions of the ETS. For "very small entities" (fewer than 20 employees), OSHA assumes that

50 percent are already in compliance. This rate of compliance is far above the rate that OSHA has assumed in other standards. For example, in OSHA's silica rule, the Agency actually assumed no baseline compliance for virtually any of the ancillary provisions in the rule. 81 Fed. Reg. at 16286, 16463 (Mar. 25, 2016). ("Other than respiratory protection, OSHA did not assume baseline compliance with any other ancillary provision, even though some employers have reported that they currently monitor silica exposure, provide silica training, and conduct medical surveillance.")

By assuming such a high-level of current compliance, OSHA underestimates the costs of the standard and, thus, the feasibility of the rule. This is significant, given that several NAICS codes exceed one of the thresholds for infeasibility established by the Agency. *See* OSHA "Screening Analysis for All Establishments," "Screening Analysis for SBA Small Entities," and "Screening Anlysis for Very Small Entities," 86 Fed. Reg. at 32526-32534.

Despite this estimate of very high levels of compliance, the Agency makes a point to assert that this does not undercut the immediate need for the standard: "Despite this estimated baseline compliance, employer compliance is not so widespread, nor does it incorporate enough of the practices required by this ETS, as to render this ETS unnecessary." *Id*. at 32495. To further buttress this argument, OSHA then cites to a 1990 study, termed the "Swiss Cheese Model of Accident Causation," arguing that each control measure actually has holes, and thus the ETS's "stacking" of controls remains necessary. *Id*.

OSHA cannot have it both ways. If no fewer than 75 percent of covered employers with over 20 employees are complying with the requirements of the ETS, OSHA cannot convincingly assert that the ETS is immediately necessary to address the grave danger.

c. OSHA's assumptions in its benefits analysis are similarly flawed.

In the economic analysis, OSHA also calculates the benefits of the rule. Again, the estimates the Agency uses are based on assumptions that are almost completely lacking in evidentiary support.

First, OSHA assumes that the monthly average number of infections and fatalities that will occur over the next six months (the duration of the ETS) will mirror the monthly average infections and fatalities over the first twelve months of the pandemic, starting on April 1, 2020. *Id*. at 32539. There is no evidence for this; it is just the Agency's simplifying assumption. Indeed, even with emergence of the delta variant, overall infection and fatality rates have decreased due to uptake, with some pockets of resistance, of the vaccines.

Second, OSHA applies another simplifying assumption that only 20 percent of COVID-19 infections are the result of community spread. Thus, 80 percent of COVID-19 infections are spread through the workplace. *Id*. at 32542. This assumption appears based on just a few studies, none of which appear to be focused on the healthcare environments at issue in the ETS. The reality is that identifying the exact exposure that causes a person to get COVID-19 can be exceedingly difficult and involves questions of lifestyle habits outside the control of any employer.

Third, OSHA assumes that the ETS will be 75 percent effective overall. According to the Agency, this takes into account the 20 percent community spread, but the number itself is not based on any data:

> For its main estimate of benefits, OSHA has *selected* a 75 percent overall effectiveness rate of the ETS for all [health care workers], taking into account both the workplace preventiveness of the ETS and community transmission. This higher rate reflects the expectations that workers covered by the ETS will have enhanced ventilation and that roughly a quarter of those workers are required to wear respirators and other PPE because of exposure to people with suspected or confirmed COVID-19. *Id. at 32544* (emphasis added).

OSHA seems to be generating these numbers without any data to support them. In particular, OSHA ignores what is potentially the best available evidence regarding the effectiveness of the ETS: the states that have implemented a mandatory ETS during the pandemic. This includes at least four states: California; Virginia; Michigan; and Oregon. This evidence would be a useful tool to OSHA to determine to what extent benefits will result from the ETS.

A review of case rates in those states, however, show that the various emergency temporary standards put into effect had mixed results, at best, with respect to declining rates of cases and fatalities.

State Plan ETS	**State Plan ETS Effective Date**	**Daily New Cases as of Effective Date**	**Daily New Cases as of Effective Date + 1 month**	**Daily New Cases as of Effective Date + 3 months**	**Daily New Cases as of Effective Date + 6 months**
CA	11/30/2020	14,391.4 cases 36.4 per 100k residents	37,466.7 cases 94.8 per 100k (12/30/2020)	5,360.1 cases 13.6 per 100k (2/28/2021)	1,134.0 cases 2.9 per 100k (5/30/2021)
MI	10/14/2020	1,325.4 cases 13.3 per 100k residents	6,669.6 cases 66.8 per 100k (11/14/2020)	3,064.7 cases 30.7 per 100k (1/14/2021)	7,846.6 cases 78.6 per 100k (4/14/2021)
OR	11/16/2020	927.3 cases 22.0 per 100k residents	1,331.0 cases 31.6 per 100 k (12/16/2020)	420.4 cases 10.0 per 100k (2/16/2021)	611.3 cases 14.5 per 100k (5/16/2021)
VA	7/27/2020	1,099.6 cases 12.9 per 100k residents	956.7 cases 11.2 per 100k (8/27/2020)	1,093.6 cases 12.8 per 100k (10/27/2020)	4,708.9 cases 55.2 per 100k (1/27/2021)

U.S. COVID Risk & Vaccine Tracker, COVID Act Now, https://covidactnow.org/?s=21611087 (last visited Aug. 10, 2021).

The experience of these states, in fact, demonstrates that emergency temporary standards have *not* been particularly effective at reducing cases of COVID-19 and case rates are more aligned with the extent of community spread, which is far more likely to be influenced by vaccination rates than a workplace standard.

5. Conclusion.

The CWS appreciates OSHA's consideration of these comments. The COVID-19 pandemic has led to unprecedented challenges for employers, employees, and other stakeholders. The CWS disagrees that circumstances warrant the issuance of the ETS. Furthermore, should OSHA make the standard permanent, it must remove provisions that exceed the Agency's authority and perform a more realistic economic analysis.

Sincerely,

American Mold Builders Association
Associated Builders and Contractors
HR Policy Association
Independent Electrical Contractors
International Foodservice Distributors Association
International Warehouse Logistics Association
Motor & Equipment Manufacturers Association
National Association of Electrical Distributors
Heating, Air-conditioning, & Refrigeration Distributors International
National Association of Wholesaler-Distributors
National Automobile Dealers Association
National Council of Chain Restaurants
National Grain and Feed Association
National Association of Home Builders
National Retail Federation
National Stone, Sand & Gravel Association
National Tooling and Machining Association
North American Die Casting Association
Precision Machined Products Association
Precision Metalforming Association
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