



April 22, 2022

The Honorable Doug Parker  
Assistant Secretary  
Occupational Safety and Health Administration  
U.S. Department of Labor  
200 Constitution Ave., NW  
Washington, DC 20210

Re: Coalition for Workplace Safety  
Docket No. OSHA-2020-0004; RIN 1218-AD36  
Comments on Occupational Exposure to COVID-19 in Healthcare Settings;  
87 Fed. Reg. 16426 (March 23, 2022)

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Dear Mr. Parker:

The Coalition for Workplace Safety (“CWS”) respectfully submits these comments in response to the Occupational Safety and Health Administration’s (“OSHA” or the “Agency”) notice of limited reopening of the comment period related to its “Occupational Exposure to COVID-19 in Healthcare Settings” rule, 87 Fed. Reg. 16426 (March 23, 2022). The CWS appreciates OSHA’s consideration of these comments regarding the “potential provisions or approaches” OSHA is considering for a final standard.

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. For the past 25 months, they have closely followed state and local Department of Public Health requirements, recommendations from OSHA, the Centers for Disease Control and Prevention (“CDC”) and other agencies who have provided timely information and guidance regarding the evolving understanding of COVID-19 and related hazard mitigation strategies.

Notwithstanding this, the CWS notes that OSHA issued the “Occupational Exposure to COVID-19; Emergency Temporary Standard,” 86 Fed. Reg. 32376 (June 21, 2021) (“Healthcare ETS”) under the expedited processes authorized by Section 6(c) of the Occupational Safety and Health Act (“OSH Act”) when the country was in a significantly different stage of the pandemic. OSHA announced its withdrawal of the Healthcare ETS on December 27, 2021, just days after allowing the statutory deadline for OSHA to issue a permanent standard under the OSH Act to lapse. For both procedural and practical reasons, it is inappropriate for OSHA to revive it.

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These comments will address: (1) OSHA’s lack of transparency and notice in developing the Healthcare ETS and, now, a final standard; (2) OSHA’s need to follow all OSH Act 6(b) procedures before issuing a permanent standard; (3) other procedural requirements that OSHA side-stepped in developing this standard; (4) OSHA’s apparent attempt to regulate the hazards of daily life in this proposed expansion of the ETS; and (5) practical difficulties in applying a standard tailored for the healthcare industry to other settings. The CWS previously raised concerns with the Healthcare ETS in its comments on that rulemaking submitted to OSHA on August 20, 2021. The CWS incorporates those comments and all concerns expressed therein into this submission.

**1. OSHA’s new proposals do not provide sufficient notice of proposed requirements to support issuance of a final standard.**

*A. Vague “Proposed Provisions and Approaches” Instead of Regulatory Text*

The Administrative Procedure Act (“APA”) establishes requirements for public notice and comment in the agency rulemaking process. 5 U.S.C. § 553(b), (c). To meet the notice requirements of the APA, an agency must “affor[d] interested persons a reasonable and meaningful opportunity to participate in the rulemaking process.” *See Forester v. CPSC*, 559 F.2d 774, 787 (D.C. Cir. 1977). OSHA has not done so here.

In this notice, OSHA provides several “proposed provisions and approaches” that it is considering for a final standard but provides no regulatory text to accompany these proposals. Instead, the nine “potential provisions or approaches,” which OSHA states are not intended “to list all of the potential changes from the ETS,” are each set forth in a brief paragraph that, in some cases, is no more than two sentences long. OSHA provides no reason for its lack of regulatory text to accompany these proposals, which follow the issuance of the Healthcare ETS they would modify by a full nine months. Without such text, commenters must resort to guesswork to piece together how these vastly different proposals would impact the requirements of a final standard.

These proposed changes run the gamut from propositions that would expand the scope of a final rule to others that would roll back requirements that have proved to be unduly burdensome. There is even a proposed change to extend the rule’s application to future airborne pathogens. In some cases, the proposed changes cannot be read harmoniously. For example, in one instance OSHA suggests that it might remove existing exemptions to the scope of the rule’s coverage; in others, OSHA suggests that the compliance burden would be limited due to existing scope exemptions. The significant ambiguity and lack of clarity in the Agency’s proposal leaves commenters without sufficient information or detail to ascertain what might be required of them in a final permanent standard.

The public’s job in deciphering these proposals is made even more difficult given the variety and breadth of approaches OSHA and other regulatory agencies have taken in responding to the workplace impacts of COVID-19. Since March 2020, federal OSHA, state OSHA plans, the Centers for Disease Control and Prevention (“CDC”), and other federal, state and local regulatory agencies have issued a plethora of guidance and best practices that has been ever-changing as more is learned about COVID-19. While these varying approaches have allowed flexibility in the pandemic response as we become better informed about the approaches best-suited to mitigate the hazards presented by COVID-19, they also provide a trove of possible

regulatory provisions that make it difficult for commenters to assess what is meant by any particular, vague, “potential provisions or approaches” referenced by OSHA in its notice.

This concern is further exacerbated by the fact that the Healthcare ETS, which was not informed by full notice and comment, raised questions within the regulated community regarding compliance obligations when it was implemented. In light of these circumstances, it is critical that OSHA provide the public with an opportunity to comment on proposed regulatory text, and not merely these vague proposals that leave OSHA’s intentions unclear. OSHA has not provided a reasonable and meaningful opportunity to participate in the public comment process as it relates to this proposal. Without additional clarity from OSHA, a final rule with a broadened scope of coverage or any significant new provisions would fail to meet the procedural requirements of the OSH Act and the APA.

### *B. Ambiguity Regarding Scope of Coverage*

OSHA’s proposals to expand the scope of coverage and applicability of the Healthcare ETS in a permanent standard raise particular concern. OSHA states that it did not include the NAICS code of “a number of industries that may have settings with embedded clinics” in its Healthcare ETS Industry Profile. OSHA further states that the Healthcare ETS nonetheless applied to those clinics, and that “OSHA is considering including these industries in the final rule’s industry profile.” Still, OSHA does not provide the NAICS codes of the industries it intends to include in the final rule. As a result, entities in such industries are not on notice that they may fall into coverage under a permanent standard. Without specific language clarifying OSHA’s intentions in expanding the scope of coverage under a permanent standard, interested parties do not have sufficient information to know whether they would be covered under a final rule, and if so, to what extent.

## **2. The ETS should no longer serve as a basis for issuing a permanent standard; instead, OSHA must begin with the rulemaking procedures provided by Section 6(b) of the OSH Act.**

### *A. OSHA Withdrew the ETS on December 27, 2021.*

Section 6(c) of the OSH Act provides expedited mechanisms, when certain conditions are met, for the Agency to issue an emergency temporary standard (“ETS”) that bypasses some of the procedural requirements for issuing a permanent standard under Section 6(b) of the Act. Recognizing that an ETS imposes a regulatory burden without the benefit of improvement by these additional requirements, Section 6(c) requires that OSHA follow the issuance of an ETS with the development and promulgation of a permanent standard which *shall* issue “no later than six months after publication” of the ETS. 29 U.S.C. § 655(c)(3). The ETS, then, “shall be effective until superseded by” such subsequent permanent standard. 29 U.S.C. § 655(c)(2). Courts have read these provisions together to mean that an ETS is “to be effective for no more than six (6) months.” *Taylor Diving and Salvage Co., Inc. v. Dep’t of Labor*, 537 F.2d 819, 820 (5th Cir. 1976). *See also Dry Color Mfrs’ Ass’n v. Dep’t of Labor*, 486 F.2d 98, 108 (3rd Cir. 1973) (“...that sacrifice is mitigated somewhat by the fact that an emergency temporary standard must be replaced within six months...”); *Fla. Peach Growers Ass’n v. Dep’t of Labor*, 489 F.2d 120, 127 (5th Cir. 1974) (“...the emergency temporary standards which have a maximum duration of six months.”); *Asbestos Info. Ass’n of North Am. v. OSHA*, 727 F.2d 415, fn13 (5th Cir. 1984) (“The statute does not contemplate the agency’s allowing the new rule to lapse.”).

Here, OSHA published the Healthcare ETS in the Federal Register on June 21, 2021, with immediate effect. OSHA subsequently missed its deadline to promulgate a permanent standard, as required by Section 6(c)(3), on December 21, 2021. Days later, on December 27, 2021, OSHA announced via a posted statement on its website that it was withdrawing the Healthcare ETS. Statement on the Status of the OSHA COVID-19 Healthcare ETS, OSHA (Dec. 27, 2021). In this statement, OSHA further provided that employers previously covered by the ETS would now be covered by the General Duty Clause. *Id.* By doing so, OSHA put the public on notice of the Healthcare ETS’s withdrawal. A withdrawn proposal is not a viable basis for issuing a permanent standard. Utilizing a withdrawn ETS as the proposal for pursuing a permanent standard defies the basic principles of notice required by both the APA and the OSH Act. If it chooses to pursue a permanent standard addressing Occupational Exposure to COVID-19 in Healthcare Settings, the Agency must first issue a proposal with accompanying regulatory text, seek public comment, and comply with other appropriate rulemaking procedures.

*B. The ETS is Not A Mechanism to Fast-Track Long-Term Policy Goals.*

The OSH Act also fails to contemplate the issuance of an interim proposal between the promulgation of an ETS and the subsequent permanent standard that replaces it. The OSH Act’s Section 6(c) mechanisms are intended to provide expedited procedures when needed to quickly address a new and severe hazard in the workplace. Its provisions are premised on the idea that swift action is necessary to appropriately protect workers from such new hazard. Here, OSHA has not only let the ETS expire, but announced its withdrawal. It now proposes to expand coverage and applicability of the ETS provisions in a permanent standard. This is an inappropriate use of the expedited procedures available for an ETS.

Courts have previously cast doubt on OSHA’s use of ETS mechanisms as a “stop-gap measure” where efforts to address an existing hazard are slow-moving. *Asbestos Info. Ass’n*, 727 F.2d at 422. Here, OSHA’s attempt to revive a withdrawn ETS in pursuit of issuing a permanent standard with broader scope and applicability raises concerns regarding whether this is an appropriate use of the ETS mechanisms. Any permanent standard issued using the expedited procedures under Section 6(c) of the OSH Act must not include an expanded scope and the Healthcare ETS should not be used as a springboard for a broader permanent standard.

**3. Other significant procedural deficiencies exist with respect to OSHA’s development of this standard, and such process cannot support a final permanent standard.**

*A. Failure to Follow Long-Standing Rulemaking Practices*

Executive Order (“EO”) 12866, “Regulatory Planning and Review,” established the processes for review of “significant” rulemakings that have guided agency rulemaking since 1993. 58 Fed. Reg. 51735 (Oct. 4, 1993). This EO requires “coordinated review” of agency rulemakings by the Office of Management and Budget’s Office of Information and Regulatory Affairs (OIRA) in order “to ensure that regulations are consistent with applicable law, the President’s priorities, and the principles set forth in this Executive order, and that decisions made by one agency do not conflict with the policies or actions taken or planned by another agency.” This requirement is even more important when a rulemaking addresses a subject that has become the focus of a coordinated across-government response, like the COVID-19 pandemic.

For each “significant” rulemaking, the EO requires the promulgating agency to provide OIRA with “the text of the draft regulatory action, together with a reasonably detailed description of the need for the regulatory action and an explanation of how the regulatory action will meet that need,” among other disclosures, and make the same information available to the public. Here, OSHA completely side-steps this requirement by failing to provide regulatory text to accompany its potential provisions or approaches to amend the Healthcare ETS. This is not a heavy lift, given OSHA has already published the lengthy regulatory provisions of the ETS, and would only have had to demonstrate how its proposals would modify this language. Instead, OSHA’s proposals have resulted in significant confusion as to what the Agency might be considering in a final rule.

The EO even contemplates that a rulemaking may occur in “emergency situations or when an agency is obligated by law to act more quickly than normal review procedures allow,” and still requires agency compliance with these procedures “to the extent practicable.” Here, OSHA issued proposed revisions to the ETS over nine months after it was published in the Federal Register. Under such circumstances, OIRA review of proposed regulatory text is entirely feasible.

EO 12866 also provides that in the interest of “afford[ing] the public a meaningful opportunity to comment on any proposed regulation,” in most cases the rulemaking should include a period for public comment “of not less than 60 days.” Here, without any prior notice, OSHA published nine proposed alternative approaches for a final standard, without accompanying regulatory text, yet provides only a mere 30 days for comment. These processes, taken together, are a complete rejection of the processes and principles established by EO 12866 and reaffirmed by EO 13563 in 2011. 76 Fed. Reg. 3821 (Jan. 21, 2011).

#### *B. Failure to Appropriately Consider Impact on Small Entities*

The Small Business Regulatory Enforcement Fairness Act of 1996 (“SBREFA”) fulfills the important policy goal of ensuring that the impact of regulatory actions on small entities is considered in the administrative agency rulemaking process. Under SBREFA, OSHA must consider the impacts of a proposal on small entities before engaging in rulemaking. OSHA is required to notify the Small Business Administration (SBA) Office of Advocacy whenever it is considering a proposal that is expected to have a significant economic impact on a substantial number of small entities, and to convene a Small Business Advocacy Review Panel to review the draft proposal and hear comments from small entity representatives. OSHA is then required to publish the Review Panel’s report in the Federal Register along with the proposed rule. OSHA can avoid the SBREFA procedures if it can certify that the proposal will not trigger the critical level of impact, and provide a factual basis for the certification.

OSHA has taken none of these steps in its pursuit of a permanent standard addressing “Occupational Exposure to COVID-19 in Healthcare Settings.” The Agency did not follow SBREFA requirements initially when developing the ETS, and, thus far, has not initiated any actions under SBREFA as it works to develop a permanent standard. OSHA draws some information in its Cost Analysis from a 2013 Small Business Advisory Review Panel that was convened to review its pre-proposal rule on “Occupational Exposure to Infectious Diseases in Healthcare and Other Related Work Settings” that the Agency seems to find sufficiently related to its current proposal. However, this does not satisfy SBREFA requirements for the current rulemaking. First, the ETS was developed to address a new workplace hazard meaning OSHA

cannot rely on studies and reports that were developed before the hazard existed. Second, this fails to account for the economic condition of small entities more than two years into a pandemic that has had significant effects across all sectors of the economy. And while OSHA requests feedback on the impact of its proposal on small entities, the lack of regulatory text to accompany its current proposal makes the provision of any substantive feedback impossible.

C. *Inability to Support Economic Feasibility Analysis with Evidence.*

OSHA is required to demonstrate that its rules 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.

As communicated in CWS’s previous comments, the economic feasibility analysis included in the Healthcare ETS is devoid of virtually any evidence. The Agency attempted to identify affected industries, estimate the cost of various provisions, estimate baseline compliance costs, calculate the costs per establishment, and assess the economic impacts of those costs on the affected industries without the benefit of notice and comment. And so, without evidence to support its estimates, OSHA instead relied on 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 relied on actual data and evidence, that evidence is significantly outdated. For example, OSHA examined information from the 2013 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 now nine years old (at best) and does not reflect the impact of the pandemic on the industries affected or take into account the current economic environment. 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 relied on information from 25 years ago in analyzing the feasibility of a significant provision in the Healthcare ETS.

Now, as OSHA proposes nine “potential provisions and approaches” that would modify the Healthcare ETS in a final standard, it also asks for comment on issues it should consider “with respect to the technical or economic feasibility of complying with a possible revised rule.” 87 Fed. Reg. 16430. Because OSHA’s proposals are unclear, confusing, and lack proposed regulatory text, it is impossible to determine what entities a final standard would regulate or what it would require, and thus impossible to develop any meaningful estimates regarding the economic feasibility of compliance. The burden for demonstrating feasibility is on OSHA, not

those subject to the regulation. OSHA cannot expect regulated employers to do OSHA's job for it.

**4. The proposals in OSHA's notice exceed its authority under the OSH Act as outlined in *Nat'l Fed'n Indep. Bus. V. Dep't of Labor*, 595 U.S. (Jan. 13, 2022).**

In its recent decision, the Supreme Court of the United States set limits on OSHA's ability to regulate the hazard posed by COVID-19. The Supreme Court made clear that "[t]he [OSH] Act empowers the Secretary to set *workplace* safety standards, not broad public health measures." *Nat'l Fed'n Indep. Bus. v. Dep't of Labor*, 595 U.S. \_\_\_ (Jan. 13, 2022) (Slip Op. at 6) (emphasis in original). While the Supreme Court recognized that "COVID-19 is a risk that occurs in many workplaces, it is not an *occupational* hazard in most" (emphasis in original). The Supreme Court described COVID-19 as a "universal risk" which poses the same day-to-day dangers as "crime, air pollution, or any number of communicable diseases." *Id.* at 6-7. Thus, the majority held, allowing OSHA to regulate broadly "the hazards of daily life—simply because most Americans have jobs and face those same risks while on the clock" would expand OSHA's authority beyond the bounds Congress set for it. *Id.* at 7.

OSHA's proposal to broaden the scope of the ETS beyond the healthcare industry seems to be yet another attempt to impermissibly regulate "the hazards of daily life." The Supreme Court recognized that OSHA may regulate occupation-specific risks related to COVID-19 through targeted regulations. *Id.* The Healthcare ETS was specifically tailored to the healthcare industry, subject to certain carveouts that OSHA rightfully recognized do not present the increased risk of exposure to COVID-19 that exists in direct patient care settings despite the fact that the work may occur in a healthcare environment. OSHA has not provided any justification for its proposal that would roll back these exemptions and broaden the scope of the ETS to a number of additional industries. It is questionable any such justification exists as COVID-19 vaccines are widely available in United States: 88.8% of the U.S. adult population over 18 years of age has received at least one dose of the COVID-19 vaccine, with 75.9% of the adult population having been fully vaccinated. This means that 218.9 million Americans are fully vaccinated against COVID-19. COVID-19 Vaccination in the United States, CDC (April 18, 2022). These numbers continue to grow as deaths and hospital admissions due to COVID-19 have declined significantly since the beginning of 2022. COVID-19 Vaccination in the United States, CDC (April 18, 2022). Given OSHA's original intention to limit the scope of the ETS to the healthcare industry and the lack of any evidence supporting expansion of the ETS beyond the healthcare industry, it seems that OSHA is attempting to broaden the scope of the ETS simply because "most Americans have jobs and face those same risks while on the clock." The Supreme Court has made clear that such an approach is beyond OSHA's regulatory authority.

**5. OSHA's proposal to expand the scope of coverage under the standard presents compliance challenges due to the lack of any proposed regulatory text.**

Without including the specific text that OSHA is proposing to put in place, employers and others affected by the proposal cannot evaluate the true impact of the revisions that OSHA is contemplating. The lack of regulatory text also presents compliance issues as there is no explanation as to how OSHA intends to reconcile seemingly contradictory provisions within the proposal.

For instance, one of the changes set forth is to remove the exemption from coverage for ambulatory care facilities where patients are screened out if they are COVID positive. The apparent result of this proposal is that the ETS would extend to cover far more employers, regardless of their screening procedures for non-employees and/or vaccination status of employees. *See* 87 Fed. Reg. 16427, A.3. OSHA does not specify whether it is proposing to remove this exemption from non-hospital ambulatory care settings, well-defined hospital ambulatory care settings, or both. Regardless, OSHA then appears to contradict this provision when it proposes to expand the number of industries covered by the ETS. *See* 87 Fed. Reg. 16427, C.1.1A. In justifying this expansion, OSHA states that it “anticipate[s] that many embedded clinics will be fully exempt under the non-hospital ambulatory care exception; and, if the rule applies, it will apply only with respect to embedded clinics and not the entire facility.” *Id.* In other words, OSHA cites to an exemption that it appears to be removing from the ETS as justification for expanding the industry profile of the ETS. Without being provided with the proposed regulatory text, it is impossible to reconcile these contradictory provisions. Further, if OSHA truly intends to remove the exemption for non-hospital ambulatory care facilities, the breadth of this proposal would result in a significant expansion of the ETS and a number of workplaces who were previously exempt from coverage would have to prepare to implement the various requirements of the ETS. This would greatly exceed the “minimal costs or no costs” currently anticipated by OSHA for these employers.

## **6. Conclusion**

The CWS appreciates OSHA’s consideration of these comments. The COVID-19 pandemic has resulted in unprecedented challenges for employers, employees, and other stakeholders. The CWS believes unequivocally that OSHA is not permitted to, and must not, issue a permanent standard after having withdrawn the Healthcare ETS in December 2021. If OSHA believes such a standard is warranted, the only path available is to propose such a standard *de novo* consistent with the rulemaking requirements in the OSH Act and the APA.

Sincerely,

Coalition for Workplace Safety

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