WorkCare Briefing: Trending Beyond COVID-19
Questions & Answers
November 3, 2021

The following questions were asked during WorkCare's monthly webinar series on Trending Beyond COVID-19. Anthony Harris, M.D., M.B.A., M.P.H., WorkCare's Chief Innovation Officer and Associate Medical Director, presented the webinar and provided these answers. In a departure from our usual format, Dr. Harris devoted most of the hour to answering questions about the new COVID-19 Emergency Temporary Standard announced on Nov. 4, 2021, by OSHA. Please refer to previous Q&As if your question is not answered here.

Here are links for your reference:

- *November 3 Webinar Recording*
- *Questions & Answers from the October 6 Webinar*

OSHA's newly released COVID-19 emergency temporary standard (ETS) applies to private companies with 100 or more employees.

EMERGENCY TEMPORARY STANDARD

Q: What are some of the aspects of OSHA's COVID-19 emergency temporary standard (ETS) that may cause confusion for covered employers?

A: Some of the most common questions are around cost. We know that the cost of weekly testing for employees who are not vaccinated can be passed through to those employees. There is not yet a clear approach from a strategy standpoint outside the level of competitiveness of the job market in which businesses are located. Looking at the turnover rate and the job market, in general, will help inform you as to whether your company should pass that cost on to your employees. If you have a competitive environment, now asking the employees who are not vaccinated to pay for their testing, which is permissible according to the OSHA mandate and Equal Employment Opportunity Commission (EEOC) guidance, could potentially set up a scenario in which it is more difficult to retain employees in that environment. What we've seen so far is that some employers are bearing the cost of the weekly testing.

The next cost-related issue in the ETS that we've seen is the mandate to provide paid time off for employees to get the vaccine. If you have 100,000 employees, that's a significant cost. This includes the time away to get vaccinated (up to four hours per vaccination). We also know that paid time off will be on the employer for any reaction to the vaccine. You are on the hook to make sure that the employee goes and gets the vaccine. If they have side effects from that vaccine that warrant sick time, then they qualify for paid time off. That potentially is a huge cost. The difficulty in that is discerning who has side effects from the vaccine. We've been providing a lot of employers with COVID employee screening services. In doing so, we've seen the side effects from vaccinations and have also recommended that individuals be off work while they are having a response to the vaccination. As an employer, it's very difficult to scale for a population of workers to go get the vaccine with paid time and then who claim to have a response. How do you ensure that it's valid and not individuals leveraging the opportunity to have some paid vacation after their vaccination? Something that we've been doing for months now is using our clinical knowledge to decipher what an employee is complaining about and whether it makes clinical sense. We may recommend that they go to their primary care provider and get some objective clinical data around the response they're having to the vaccine if there is truly a concern. If not, we want to document that and hold that as protected health information (PHI) so that we have a clear paper trail of the individual's response to the

vaccination. These are things that the ETS is saying that employers should bear the cost for.

However, there are now systems in place to help you identify where those costs should be allocated appropriately so that we limit gamification of the mandates from a vaccination standpoint. We've been dealing with this since vaccines became available, but it's going to be difficult to scale because of these mandates. These are some of the high points.

Q: What is the projected date for implementation of the ETS?

A: Covered employers must require their workers to be fully vaccinated by Jan. 4 or submit to weekly coronavirus testing and mask-wearing while in the workplace. The deadline for employers to enforce the mask mandate is Dec. 5. We know that several corporations would like to delay implementation until after the holidays, which is a peak time for temporary workers. The ETS may offer a disincentive for those workers to enter the workforce.

Q: Once the ETS is in place, what will be the protocol to eventually remove the standard, or will this be indefinite?

A: OSHA has said it expects the ETS to be in effect for at least six months. We know that the ETS will not be in perpetuity and that it may be used as the basis for rulemaking on a permanent standard with public input. We know that COVID is not going to leave us or become an endemic before then. This standard is intended to help us deal with COVID from a loss of life or severity standpoint as well as limiting transmission. We know that there will be a significant portion of the population in the U.S. that will not get vaccinated, will have waning immunity or be naïve to COVID-19 infection. That is something that everyone is anticipating for all of 2022 at this point.

Q: How does the ETS address accommodations? For example, under the federal contractor requirements, there's an exemption process. When the ETS goes into place, will exemptions have a testing component?

A: In terms of accommodations, whether they are reasonable or place an undue burden on the employer is the litmus test. It is similar to what we're seeing with accommodation classically under the EEOC and Americans with Disabilities Act (ADA). One issue related to accommodation is the request of workers who have been working remotely to not come back into the office or plant because they claim it will increase their risk for COVID transmission. We're seeing this starting to play out where lawsuits are being filed against companies to prevent the company from mandating that an employee returns to the office, and discrimination claims as a result of that company mandate. From that perspective, if the employer determines that it's an unreasonable burden from a business perspective to accommodate that employee, then they are not obligated to accept that accommodation. We will likely see this play out for the testing requirement, as well, in terms of workers filing lawsuits to avoid this mandate. From the looks of it, the EEOC is going to side with the employer from an unreasonable burden perspective.

Q: Can the paid time off be part of the employee's normal sick time or does it have to be separate? For paid time off requirements, do we need to offer additional PTO, or can they use existing banks?

A: I believe the EHS will not prohibit you from including paid time off in an employee's existing bank or allocated PTO, as long as you are providing the time off for COVID vaccination and any side effects. I believe employers will not be burdened with having to provide additional time off to what currently exists.

Q: How does the ETS differ from the executive order for mandatory vaccination of employees of a government contractor?

A: Federal contractors and subcontractors with a covered contract are required to conform to the following workplace safety protocols: 1. COVID-19 vaccination of covered contractor employees, except in limited circumstances where an employee is legally entitled to an accommodation; 2. Compliance by individuals, including covered contractor employees and visitors, with guidance related to masking and physical distancing while in covered contractor workplaces; and 3. designation by covered contractors of a person or persons to coordinate COVID-19 workplace safety efforts at covered contractor workplaces. As noted in related guidance, in most circumstances individuals who are not fully vaccinated need to follow applicable masking, physical distancing and testing protocols.

Q: What do you think is likely to occur in at the local or regional level when the ETS goes into effect?

A: We're going to see what we've seen already, the workforce leaving, retiring early and a potential bottleneck in terms of services that are provided. We've seen it happen in New York – although 91 percent of public workers are vaccinated, there are still 9,000 workers who are not. Police forces and firefighters have had to close several locations and not provide those public services. We know that's going to roll into the private sector. We've all seen what has happened with the airlines having delays potentially because of the mandates and not having enough employees. We're going to see that with employees potentially walking off the job or retiring early and then a bottleneck in services provided. It's going to be unavoidable in terms of the vaccine itself. We amplify that if we pass the costs on to the employee. We're providing the motivation for them to leave from a financial standpoint.

Q: What are the requirements for remote workers?

A: Remote workers are covered. For example, if you have 100 employees and every person lives in a different city, it doesn't matter. You would still have to follow the ETS. In that scenario, you have to determine what the best strategy is in requiring the vaccine. The EEOC has supported requiring the vaccine and not giving the option for weekly testing. Meaning, you can fire people if they refuse to get vaccinated. That's going to be a tough road for employers to go down, but we've seen it play out at the city and community level with public workers. We know that there are companies nationally making it a requirement for employment. That is a good strategy to avoid additional costs for testing or trying to figure out whether to pass the additional cost on to the employee. Making the requirement to be vaccinated or fired, is legally supported, but it doesn't mean a lawsuit will not come up. However, you'll likely win the lawsuit if there is pushback from employees. It is going to be the most cost-effective approach to being compliant with the ETS. We've seen home tests for remote workers work well.

TESTING

Q: Do you anticipate significant shortages in rapid tests and PCR tests after the ETS comes out?

A: There is an anticipation of demand outpacing supply. We're already seeing this in over-the-counter tests. In a lot of places, you can't go to CVS or Walgreens and get an over-the-counter test because the supply is not there. We also anticipate that being the case for corporations that are trying to comply with the ETS. There will not be any specifications in the ETS on whether you should use a rapid test or a PCR test. Any FDA-authorized test will be allowed. We know that manufacturers have tried to ramp up these tests. We have seen a bottleneck in our operations regarding getting tests out. That has been resolved in recent weeks, but that's pre-ETS. We have companies that have ordered $2.5 million worth of tests already because they have implemented corporate-wide mandates. Many of them have federal workers. That's one of the aspects that we know is unavoidable. If you are a federal employee, you are under the mandate at this time. If you have a federal contract you are also under the mandate at this time. We see them already getting behind in their weekly testing for their workforce. We will likely see a similar demand strain once the ETS is published.

With supply shortages, we expect pool testing to ramp up once the ETS is published. We know that pool testing is a way to mitigate costs in terms of providing weekly molecular tests for the largest number of people possible. Combining samples in a pool testing scenario may become the dominant option that employers use for onsite testing. If you have a remote workforce, pool testing will not be advantageous. A home test will be the predominant way to be compliant. However, it is still an option to tell your workforce to go get tested every week and leave it to them to figure it out. If you're in a hot job market this may decrease your ability to retain talent if you don't provide solutions.

Q: If you have employees who work remotely and don't get tested weekly, is the employer on the hook, or is it merely the notion that you have a system in place, and you have a way to deal with non-compliance internally before OSHA comes knocking?

A: We don't know that yet. You should have a system in place to deal with non-compliance. Do you dismiss workers like we've seen in some cases? Leveraging a digital platform to keep track of compliance is advantageous.

VACCINATION AND VACCINES

Q: Do you anticipate that the Centers for Disease Control and Prevention (CDC) will redefine what it means to be fully vaccinated?

A: It's possible. If we look at the data from Israel, we see that a third shot (booster) is necessary to get reduced transmission risk back above 90 percent. At this point, it's dismal in terms of protection from transmission risk: 61 percent of the vaccinated population may still be able to contract and transmit COVID. A booster may be required, and the CDC may redefine that being fully vaccinated is three doses. An employer would then need to document the third shot to be compliant with the new definition of being fully vaccinated. They would also need to understand who is still at risk for contracting and spreading COVID in the workplace. There are a lot of layers that we're potentially up against, not just because of the ETS, but also what we're still learning about the virus and the evolution of vaccines. With the approval of the Pfizer vaccine for ages 5-11, we should see household exposures go down, which in turn will translate into a decrease of exposures in the workplace. The data states that one-third of parents will be in line to get their kids vaccinated right away, one-third of parents will wait for weeks or a month or two to see what the side effects are, and one third will not get their kids vaccinated at all. The data is clear that side effects are the same as they are for adults: sore arm and mild symptoms.

Q: How is it legal to mandate an experimental and unproven vaccine?

A: This vaccine is not so much experimental as it is novel. The mRNA vaccines are not all novel/experimental, but they are novel to address a virus. We also have traditional vaccines such as Johnson & Johnson using adenovirus-produced antibodies. This is not anything new for us as a society (i.e., smallpox and the flu). All vaccines that came about were tested in the same manner that these vaccines have been tested and administered. From a population health standpoint, the vaccines prevent harm and loss of life. It's no different from what we saw decades ago. It's only different in that we have not seen this level of a pandemic for several decades. MERS and SARS of 2003 did not hit at the level that the coronavirus has hit. It's natural to have a back and forth on whether this is something we should be mandating. However, mandates are also not new. We have mandated other vaccines, such as for schools and universities. The only difference now is that a lot of individuals getting vaccinated are not applying for public schools. When you send your child to a public school they are required to be vaccinated against other diseases. Those are things that have been in place and are legal. The EEOC says that it's legal to mandate COVID vaccination in

the same way other vaccines are mandated for students. We're likely not going to see an override of the mandate from a legal standpoint.

Q: What are legitimate medical reasons for employees to be exempt from vaccinations? Should employers require a doctor's note?

A: For exemptions, we believe, and our practice has been, that if there is a medical indication, we would like the employee's primary care physician to weigh in on that. We will review that recommendation to make sure it is consistent with best practices. If the individual does not involve their physician, then it calls into question whether there is an underlying condition and how that condition may be impacted by vaccination. At this point, there are very few risks, because the risk profile has been low from any side effects that would have poor outcomes for individuals. That being said, there will be scenarios in which a primary care physician recommends against getting vaccinated because of ongoing treatment. We've seen and have reviewed scenarios in which an individual may be undergoing chemotherapy for cancer or immunotherapy for underlying conditions. Introducing the vaccine would cause potential harm in the immune response for that individual. That's the level of granularity that we require to support and sign off on a medical exemption. We've also seen data the vaccine does not affect women who are pregnant. It's on us as EHS professionals to communicate that data so we put people at ease around getting vaccinated, and so that we don't see a flood of exemption applications for things that are not indications for the exemption. Yale Health at Yale University has published a list of what's permissible and not permissible for exemption. It helps employees at the university understand whether they should even apply for an exemption. They did see a decrease in exemption applications once they published reasons for medical exemptions that include the following:

- Documented history of severe allergic reaction to a component of each currently available COVID-19 vaccine
- Documented history of severe or immediate-type hypersensitivity allergic reaction to a COVID-19 vaccine, and separate contraindication to other available formulations
- Receiving immunosuppressive (weakens the immune system) treatment and advised by a medical provider to defer vaccination until a future date
- Another medical condition where it is advised by a medical provider to forgo vaccination.

Reasons for a temporary medical exemption include:

- Having been treated for COVID-19 with monoclonal antibodies or convalescent plasma (90-day exemption)
- Having been diagnosed with multisystem inflammatory syndrome (90-day exemption)
- Recent COVID-19 infection and within the isolation period or continued symptoms and advised by medical provider to defer vaccination. (90-day exemption)
- Another medical condition where it is advised by a medical provider to defer vaccination until a future date.
- Examples of conditions that are NOT considered for a medical exemption include:
- History of severe allergic reactions to foods, oral medications, latex, pets, insects, and environmental triggers
- History of immunocompromising conditions where the vaccine may be less effective
- Fear of needles
- A history of vaccine side effects or general avoidance of vaccines

Examples of conditions that are NOT considered for a medical exemption include:

- History of severe allergic reactions to foods, oral medications, latex, pets, insects, and environmental triggers
- History of immunocompromising conditions where the vaccine may be less effective
- Fear of needles
- A history of vaccine side effects or general avoidance of vaccines.

Q: Can WorkCare support employers who want to outsource the activities of verifying religious or medical exemptions?
A: WorkCare is available to assist clients with medical verifications.

Q: We're looking for advice on booster shot management recommendations for employers and updates for natural immunity considerations. Is there any more research related to that?
A: Additional data is showing that those who have recovered from COVID-19 and then get vaccinated are in a better scenario than those who have been vaccinated without a previous infection. You're better off being vaccinated after you've had COVID-19. We know that immunity wanes over time for those who have natural immunity. There has been some suggestion that those who have recovered from COVID-19 are good for up to 12 months. That is not the perspective for preventing another transmission or contracting COVID-19. The data shows that some will have memory B cells against COVID-19 in their bone marrow for up to 12 months, but that doesn't correlate with being protected against another infection. We're seeing the same phenomenon with natural immunity that we're seeing with acquired immunity. Immunity wanes and there is increased susceptibility in contracting and transmitting COVID after vaccination or previous infection. That is why I believe that we should be getting quantitative titers. Having a quantitative titer that can detail whether an individual has immunity or not, the same way we do with hepatitis B and other vaccination scenarios, is what we should be focusing our energy on. Unfortunately, we only have a small amount of quantitative data that says, "yes you have the antibodies for COVID-19," but it cannot tell you that those antibodies are sufficient to protect you from subsequent infection. Quest and LabCorp offer those tests, but they are limited in telling us whether we should get a booster or if we should administer a vaccine to someone who has had COVID. We still don't know how long the booster will last. It does get you up to 93 percent, but we don't know for how long. In the months to come, we will learn that, but we may be in a scenario where we need a booster every six months to maintain our immunity. I hope that's not the case, but it may be.

Q: What is your medical opinion on a "mix and match" with the boosters, specifically, a person who previously received Johnson & Johnson and receives a Pfizer or Moderna booster?
A: We follow CDC guidance for booster shots: People may receive the vaccine type that they originally received or another type depending on their preference and vaccine availability. People in the U.S. who received the single dose Johnson & Johnson/Janssen shot are eligible for a booster of one of the three FDA-authorized vaccines if they are at least 18 years old and it has been at least two months since they received their initial shot.

Q: Should employers be tracking employees' vaccination type and the date and sending them reminders based on the CDC guidance?
A: To help your employee population get vaccinated, get boosters when appropriate and help your organization remain compliant, that is a clear best practice. You should leverage an internal system or a third-party platform to do so. You should automate this, so you're not adding additional staff just to

monitor everything. Yes, sending reminders to your workforce will help and encourage them. We want protection to be the norm and to create a culture that will protect the workforce and get things back to normal.

Q: My understanding is Comirnaty was approved but is it available?
A: Yes, it is available. Please refer to the Food and Drug Administration website for information on the Comirnaty vaccine. Comirnaty is an FDA-approved Pfizer and BioNTech vaccine brand name. Comirnaty was previously referred to as the Pfizer COVID-19 vaccine. The formulation used in the FDA-approved Comirnaty vaccine is identical to the shot that previously received FDA emergency use authorization.

Q: Is getting vaccinated an OSHA recordable? Will a reaction from the vaccine affect the count of recordable cases?
A: The Department of Labor and OSHA, as well as other federal agencies, encourage COVID-19 vaccinations. OSHA has stated it will not enforce 29 CFR 1904 recording requirements to require any employers to record worker side effects from COVID-19 vaccination through May 2022. The agency said it will reevaluate that policy after that time.

MASK GUIDELINES

Q: Do we anticipate the CDC updating its face covering guidelines based on the federal requirements for vaccinations?
A: We do, but it will only be after boosters. This is because of the data. We know that transmission risk is not fully mitigated by being fully vaccinated. Breakthrough transmissions are happening across the board. We have one employer reporting 70 percent of its COVID cases are in the fully vaccinated population. We're seeing the data from Israel play out where only 39 percent of the fully vaccinated population is protected from transmission. That is why individuals still need to mask up and practice social distancing when possible, and why the CDC will not change its mask policy until we have more Americans vaccinated with the booster. At this point, we're just at 10 percent of the population having received a booster. As we've seen with the Israel data, we will need a higher percentage of Americans who have had their booster before mask guidelines will change.

EXPOSURE RISK

Q: Doesn't the extremely low vaccination rate (~3 percent) in other continents (Africa) still pose a significant potential risk of new variants reaching the U.S., especially with business and pleasure travel expected to resume?
A: The spread of variants remains a concern worldwide. That is why it is important to get vaccinated and wear a mask and practice social distancing when traveling. Refer to the World Health Organization (WHO) coronavirus dashboard and the Johns Hopkins Coronavirus Resource Center for world maps and current case rates. Refer to the CDC for domestic and international travel guidance.