DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Parts 1910, 1915, 1917, 1918, 1926, and 1928

[Docket No. OSHA–2020–0004]

RIN 1218–AD36

Occupational Exposure to COVID–19 in Healthcare Settings

AGENCY: Occupational Safety and Health Administration (OSHA), Labor.

ACTION: Proposed rule; request for comments.

SUMMARY: OSHA is proposing to remove OSHA's COVID–19 Emergency Temporary Standard and its associated recordkeeping and reporting provisions from the Code of Federal Regulations.

DATES: *Comments:* Comments in response to OSHA's proposal must be submitted in Docket No. OSHA–2020–0004 on or before September 2, 2025.

ADDRESSES:

Written comments: You may submit comments and attachments, identified by Docket No. OSHA–2020–0004, electronically at *http://www.regulations.gov,* which is the Federal e-Rulemaking Portal. Follow the instructions online for making electronic submissions.

Instructions: All submissions must include the agency's name and the docket number for this rulemaking (Docket No. OSHA–2020–0004). All comments, including any personal information that is provided, are placed in the public docket without change and may be made available online at *http://www.regulations.gov.* Therefore, OSHA cautions commenters about submitting information they do not want made available to the public, or submitting materials that contain personal information (either about themselves or others), such as Social Security Numbers and birthdates.

When uploading multiple attachments to *http://www.regulations.gov,* please number all of your attachments because *http://www.regulations.gov* will not automatically number the attachments. This numbering will be very useful in identifying all attachments. For example, Attachment 1—title of your document, Attachment 2—title of your document, Attachment 3—title of your document. For assistance with commenting and uploading documents, please see the Frequently Asked Questions on *http://www.regulations.gov.*

Docket: To read or download comments or other materials in the docket, go to Docket No. OSHA–2020–0004 at *http://www.regulations.gov.* All comments and submissions are listed in the *http://www.regulations.gov* index; however, some information (*e.g.,* copyrighted material) is not publicly available to read or download through that website. All comments and submissions, including copyrighted material, are available for inspection through the OSHA Docket Office. Documents submitted to the docket by OSHA or stakeholders are assigned document identification numbers (Document ID) for easy identification and retrieval. The full Document ID is the docket number plus a unique four-digit code. For example, the Document ID number for OSHA's COVID–19 Healthcare ETS is OSHA–2020–0004–1033. Some Document ID numbers also include one or more attachments.

When citing exhibits in the docket, OSHA includes the term ''Document ID'' followed by the last four digits of the Document ID number. For example, document OSHA–2020–0004–1033 would appear as ''Document ID 1033.'' Citations also include the attachment number or tab number, if applicable. In a citation that contains two or more Document ID numbers, the Document ID numbers are separated by semi-colons (*e.g.,* ''Document ID 1231, Attachment 1; 1383, Attachment 1''). OSHA may also cite items that appear in another docket. When that is the case, OSHA includes the full document ID for the corresponding docket entry. For example, a citation to OSHA's notice seeking public comments on its proposal to extend the approval of the information collection requirements in the COVID–19 Emergency Temporary standard, which is document number 0004 in Docket No. OSHA–2021–0003, would read ''Document ID OSHA–2021–0003–0004.'' This information can be used to search for a supporting document in the docket at *www.regulations.gov.* Contact the OSHA Docket Office at (202) 693–2350 (TTY number: 877–889–5627) for assistance in locating docket submissions.

FOR FURTHER INFORMATION CONTACT:

For press inquiries: Contact Frank Meilinger, Office of Communications, Occupational Safety and Health Administration, U.S. Department of Labor; telephone (202) 693–1999; email *oshacomms@dol.gov.*

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For copies of this ***Federal Register*** *document:* Electronic copies of this **Federal Register** notice are available at *http://www.regulations.gov.* This notice, as well as news releases and other relevant information, are also available at OSHA's web page at *www.osha.gov.* A 100-word summary of this proposed rule is available on *https://www.regulations.gov.*

SUPPLEMENTARY INFORMATION:

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I. Executive Summary

OSHA is proposing to remove from the Code of Federal Regulations (CFR), the recordkeeping and reporting provisions in 29 CFR 1910 subpart U that are still in effect (specifically 29 CFR 1910.502(q)(2)(ii), (q)(3)(ii)–(iv), and (r)). OSHA requests comment on the proposed removal. OSHA estimates annual cost savings of $1,587,494 from the removal of these provisions. OSHA also intends to remove the rest of 29 CFR 1910 subpart U from the CFR upon finalization of this rulemaking. This is a deregulatory action per Executive Order 14192, ''Unleashing Prosperity Through Deregulation'' (90 FR 9065, Feb. 6, 2025).

II. Pertinent Legal Authority

The purpose of the Occupational Safety and Health Act (29 U.S.C. 651 *et seq.*) (''the Act'' or ''the OSH Act'') is ''to assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources'' (29 U.S.C. 651(b)). To achieve this goal

Congress authorized the Secretary of Labor (''the Secretary'') to promulgate standards to protect workers, including the authority ''to set mandatory occupational safety and health standards applicable to businesses affecting interstate commerce'' (29 U.S.C. 651(b)(3); *see also* 29 U.S.C. 654(a)(2) (requiring employers to comply with OSHA standards), 29 U.S.C. 655(a) (authorizing summary adoption of existing consensus and established federal standards within two years of the Act's enactment), 29 U.S.C. 655(b) (authorizing promulgation, modification or revocation of standards pursuant to notice and comment), and 29 U.S.C. 655(b)(7) (authorizing OSHA to include among a standard's requirements labeling, monitoring, medical testing, and other information-transmittal provisions)). An occupational safety and health standard is ''. . . a standard which requires conditions, or the adoption or use of one or more practices, means, methods, operations, or processes, *reasonably necessary or appropriate* to provide safe or healthful employment and places of employment'' (29 U.S.C. 652(8) (emphasis added)). The Secretary may also issue regulations requiring employers to keep records regarding their activities related to the Act, as well as records of work-related deaths, injuries, and illnesses (29 U.S.C. 657(c)(1)–(2)).

In addition, section 6(c) of the Act gives OSHA the authority to issue Emergency Temporary Standards where it finds a standard is necessary to protect workers from a grave danger (29 U.S.C. 665(c)). As described in more detail in the Background section, below, OSHA issued the bulk of the Emergency Temporary Standard (''ETS'') for COVID–19 pursuant to this rarely used provision. However, the recordkeeping and reporting provisions associated with the ETS were issued under OSHA's authority to prescribe recordkeeping and reporting requirements in section 8(c)(1)–(3) of the Act (29 U.S.C. 657(c)(1)–(3)). OSHA is engaging in notice and comment rulemaking to remove the recordkeeping and reporting provisions pursuant to the Administrative Procedure Act (APA) (5 U.S.C. 553(b)–(c)). Rulemaking actions that require notice and comment under the APA include repealing a rule (5 U.S.C. 551(5)).

III. Background

On June 21, 2021, OSHA issued an ETS to protect workers in healthcare settings from exposure to SARS–CoV–2, the virus that causes COVID–19 (86 FR 32376, June 21, 2021).[1] At that time, OSHA found that COVID–19 presented a grave danger to healthcare and healthcare support workers and that the ETS was necessary to protect those workers from that grave danger. The ETS was codified at 29 CFR 1910 subpart U. It also served as a proposed rule for a rulemaking on occupational exposure to COVID–19 in healthcare settings, per section 6(c)(3) of the OSH Act (29 U.S.C. 655(c)(3)), so OSHA accepted comments and held an informal rulemaking hearing on the proposed rule (*see* 86 FR 32376; 87 FR 16426, Mar. 23, 2022).

In the same June 2021 **Federal Register** document in which OSHA issued the ETS, OSHA also promulgated COVID–19 recordkeeping and reporting provisions pursuant to a different provision of the OSH Act, section 8(c) (29 U.S.C. 657(c)). For these recordkeeping and reporting provisions, OSHA invoked an independent exemption from the notice and comment requirements of the APA (5 U.S.C. 553(b)(B)),[2] finding good cause to forgo notice and comment given the grave danger presented by the pandemic (*see* 86 FR 32559). These provisions, which require employers to establish, maintain, and provide copies of a COVID–19 log and to report COVID–19 fatalities and hospitalizations among their staff, were codified at 29 CFR 1910.502(q)(2)(ii), (q)(3)(ii)–(iv), and (r).

On December 27, 2021, OSHA announced on its website that the agency would be unable to finalize a COVID–19 standard for healthcare ''in a timeframe approaching the one contemplated by the OSH Act'' (*see* Document ID 2491) and stopped enforcing all of 29 CFR 1910 subpart U except for the recordkeeping and reporting provisions. At that time, OSHA also announced that the recordkeeping and reporting requirements in 29 CFR 1910.502 would remain in effect (*see* Document ID 2491). Several years later, on January 15, 2025, OSHA terminated the rulemaking that was initiated by OSHA's issuance of the ETS and the related recordkeeping and reporting obligations, on the basis that the COVID–19 public health emergency was over and any ongoing COVID–19 hazards would be better addressed in a rulemaking focusing on the broader hazard of infectious diseases (*see* 90 FR 3665, 3666). Terminating the rulemaking process, however, did not affect the status of either the recordkeeping and reporting requirements or the other provisions, all of which remain in the CFR. Subsequently, on February 5, 2025, OSHA issued a memo temporarily staying enforcement of the recordkeeping and reporting requirements (*see* Document ID 2888). Therefore, at this time, OSHA is not enforcing any of the COVID–19-related requirements that were promulgated in the initial June 2021 notice, although they remain in the text of the CFR at 29 CFR 1910 subpart U.

IV. Explanation of Agency Action

A. Explanation of the Proposed Removal of the Recordkeeping and Reporting Provisions From the Code of Federal Regulations

OSHA is proposing to remove the COVID–19 recordkeeping and reporting provisions that are in 29 CFR 1910 subpart U, specifically 29 CFR 1910.502(q)(2)(ii), (q)(3)(ii)–(iv), and (r). OSHA requests comment on this proposed action.

When these recordkeeping and reporting provisions were promulgated in June 2021, they were promulgated pursuant to section 8(c) of the OSH Act (29 U.S.C. 657(c)), which governs records and other information regarding occupational illnesses and injuries. While OSHA normally engages in notice and comment rulemaking before promulgating regulations pursuant to section 8(c), the agency invoked the ''good cause'' exemption in the APA (*see* 5 U.S.C. 553(b)(B)), which permitted OSHA to forgo notice and comment for these provisions given the grave danger posed by COVID–19 in the settings covered by the regulations (*see* 86 FR 32376, 32559).

The COVID–19 recordkeeping and reporting provisions require covered healthcare employers to: (1) establish and maintain a COVID–19 log to record all cases of COVID–19 among their employees, regardless of whether the cases are work-related (29 CFR 1910.502(q)(2)(ii)); (2) make the COVID–19 log or some version of it available to their employees, employee representatives, and OSHA (29 CFR 1910.502(q)(3)(ii)–(iv)); and (3) report work-related COVID–19 fatalities and hospitalizations among employees to OSHA, regardless of how much time passed between the work-related

[1] OSHA uses the terms SARS–CoV–2 and COVID–19 interchangeably in this notice.

[2] The APA notice requirement does not apply ''when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest'' (5 U.S.C. 553(b)(B)). Because of ambiguity in the structure of this APA provision, this ''good cause'' exemption has sometimes been cited as 5 U.S.C. 553(b)(3)(B), as it was in OSHA's June 2021 **Federal Register** document.

exposure to COVID–19 and the employer learning about the fatality or hospitalization (29 CFR 1910.502(r)). These provisions were important adjuncts to the COVID–19 ETS and were designed to work hand-in-hand with the ETS's requirements in order to prevent cases of COVID–19 among workers in the covered establishments. For example, under the health screening and management provisions of the ETS, 29 CFR 1910.502(l), employers had to screen their employees for COVID–19 symptoms as well as require employees to report COVID–19 symptoms and infections to their employers; infections would then be recorded on the COVID–19 log, per 29 CFR 1910.502(q)(2)(ii), to assist employers in quickly identifying potential exposures and outbreaks among staff. As OSHA stated in the ETS, ''the requirement to establish and maintain a COVID–19 log will ultimately assist employers in preventing workplace transmission [of COVID–19]'' (86 FR 32607).

After OSHA stopped enforcing the bulk of 29 CFR 1910 subpart U at the end of 2021, however, the recordkeeping and reporting provisions were no longer part of an integrated regulatory scheme. For instance, without the requirement for employee screening and notification of symptoms and infections in 29 CFR 1910.502(l), the recordkeeping and reporting provisions are of lesser utility, especially now that COVID–19 vaccines are widely available and the public health emergency has ended. COVID–19 cases and reporting are now treated by the Centers for Disease Control and Prevention (CDC) and medical professionals more like flu and other respiratory illnesses than when the ETS was promulgated. For example, in September of 2022 the CDC revised its prior guidance by removing previously recommended work restrictions for asymptomatic healthcare providers who experience ''higher risk exposures,'' negating some of the purpose of tracking COVID–19 cases in healthcare workplaces (*see* Document ID 2411).

Further, detection of COVID–19 cases and the public health surveillance mechanisms for COVID–19 have changed dramatically since the recordkeeping and reporting provisions were promulgated in 2021. While cases of COVID–19 were initially detected solely through testing conducted by certified laboratories, which were required to report positive cases, most COVID–19 testing is now through self-administered tests at home and there is no requirement to report positive test results (*see* Document ID OSHA–2021–0003–0008). Commenting on OSHA's October 9, 2024, **Federal Register** notice soliciting comments on the extension of the information collection requirements in the recordkeeping and reporting provisions (''ICR extension notice''; 89 FR 81949), the Association for Professionals in Infection Control and Epidemiology (APIC) stated that, for these reasons, the accuracy of the data collected by employers under the COVID–19 log provision has declined. ''[W]ith the ending of the COVID–19 pandemic and the public health emergency, collection of COVID–19 infection data is not providing the value it once did. Routine workplace testing is not required, and employees are not reliably self-reporting COVID–19 infections, which results in incomplete and unreliable data'' (Document ID OSHA–2021–0003–0008).

Even if the data obtained from employee self-reporting was sufficient for an employer to determine which of its employees might be exposed to COVID–19 at work, it is no longer as clear that it is important to provide this additional recordkeeping tool solely for this disease. OSHA notes that if 29 CFR 1910.502(q)(2)(ii) and (q)(3)(ii)–(iv) are removed, some employers that were covered by those requirements would still have an obligation to record work-related cases of COVID–19 on their OSHA Forms 300, 300A, and 301, per OSHA's standard recordkeeping regulations in 29 CFR part 1904 (*see* 29 CFR 1904 subparts B, C, and E). However, withdrawal of 29 CFR 1910.502(q)(2)(ii) and (q)(3)(ii)–(iv) would relieve employers of the burden of recording some cases of COVID–19 (the work-related ones) on two separate sets of forms (the standard OSHA injury and illness forms as well as the COVID–19 log). APIC urged OSHA to do just that in treating COVID–19 the same as other occupationally acquired illnesses, noting that ''other respiratory illnesses which may yield similar outcomes and issues for healthcare workers are not singled out for reporting purposes, so OSHA does not have an accurate assessment of the actual impact of viral respiratory illnesses on the healthcare workforce'' (Document ID OSHA–2021–0003–0008).

Similarly, removing the reporting requirements in 29 CFR 1910.502(r) does not eliminate the requirement to report work-related cases of COVID–19 to OSHA. Under OSHA's standard recordkeeping and reporting provisions in 29 CFR part 1904, employers are required to report hospitalizations and deaths that occur as a result of work-related incidents within 24 hours or 30 days, respectively, of an employee's exposure in the work environment (*see* 29 CFR 1904.39(b)(6)). The reporting requirements associated with the ETS eliminated those time limits, making deaths and hospitalizations caused by workplace exposures to COVID–19 reportable regardless of the time that elapsed between the exposure and the reportable event (*see* 29 CFR 1910.502(r)(1)–(2)). Returning to the requirements in part 1904, therefore, would mean that employers would have to report fatalities and hospitalizations related to workplace exposures to COVID–19 only if the fatality occurs within 30 days of the exposure or the hospitalization occurs within 24 hours of the exposure; fatalities or hospitalizations occurring outside of these time periods would not have mandatory reporting.

While this reversion is likely to reduce the number of COVID–19 cases reported to OSHA because the incubation time for COVID–19 would make it uncommon to cause hospitalization within 24 hours of exposure, the same is true for the vast majority of other respiratory illnesses. Moreover, this result does not seem inappropriate for COVID–19. OSHA's reporting provisions are primarily designed to assist the agency in its enforcement work; they provide OSHA with information to determine whether it is necessary for the agency to conduct an immediate investigation at the establishment that makes the report (86 FR 32611). Given the changed circumstances since the ETS COVID–19 reporting provisions were promulgated, the requirement to report COVID–19-related fatalities and hospitalizations has lost importance and no longer warrants a separate reporting system beyond that required for other diseases. And, as discussed above with respect to the recordkeeping provisions, employers' knowledge about COVID–19 cases among their employees is now much more limited, so reporting of hospitalizations and fatalities to OSHA would, similarly, be constrained. In addition, several other factors noted previously—the end of the COVID–19 public health emergency, the availability of COVID–19 vaccines, the treatment of COVID–19 more like other respiratory illnesses by medical professionals, and the elimination by the CDC of many COVID–19-related recommendations for healthcare facilities—indicate that the need for a COVID–19-specific reporting provision to trigger immediate OSHA inspections has declined.

Based on the reasons above, the agency believes it is no longer appropriate to apply recording and reporting regulations to COVID–19 that

are more burdensome than those already required for other infectious illnesses under OSHA's generally applicable reporting and recordkeeping requirements in 29 CFR part 1904. To the extent additional reporting or recordkeeping tools are necessary and appropriate, they could be considered as part of a broader rulemaking that would facilitate employer adoption of more cohesive and consistent recordkeeping and reporting policies to address workplace-transmissible diseases. But in the absence of additional evidence that recording and reporting continue to provide meaningful assistance to employers to an extent warranted by the burdens they place on those employers, OSHA proposes to remove these COVID–19-specific requirements. Therefore, OSHA has made a preliminary determination that 29 CFR 1910.502(q)(2)(ii), (q)(3)(ii)–(iv), and (r) should be removed from the CFR. OSHA requests comment on the proposed action.

B. Explanation of the Removal of the Non-Recordkeeping and Reporting Provisions From the Code of Federal Regulations

If OSHA finalizes this rulemaking by removing the recordkeeping and reporting provisions as proposed, OSHA also intends to remove the remaining provisions of 29 CFR 1910 subpart U (*i.e.,* the ones not discussed in section IV.A, above) from the CFR. OSHA is not requesting comment on this aspect of this notice because, as explained below, removing these provisions is simply an administrative formality, the purpose of which is to avoid confusion among the regulated community.

As noted above, OSHA issued the COVID–19 ETS in June 2021 pursuant to section 6(c) of the OSH Act (29 U.S.C. 655(c)), which allows OSHA to bypass the usual notice and comment rulemaking process. Section 6(c)(3) of the Act (29 U.S.C. 655(c)(2), (3)), however, provides that an ETS serves as a proposal for a permanent standard under the OSH Act, and indicates that a permanent standard should be promulgated within six months of publication of the ETS. Approximately six months after issuing the ETS, on December 27, 2021, OSHA announced that it could not complete a final rule ''in a timeframe approaching the one contemplated by the OSH Act'' and stopped enforcing the non-recordkeeping portions of the healthcare ETS (*see* Document ID 2491). OSHA specified, however, that ''the COVID–19 log and reporting provisions, 29 CFR 1910.502(q)(2)(ii), (q)(3)(ii)–(iv), and (r), remain in effect'' (Id.). Subsequently, in January 2025, OSHA terminated the rulemaking process that was initiated by issuance of the ETS (*see* 90 FR 3665).

OSHA intends to remove the non-recordkeeping and reporting provisions of the ETS from the CFR upon finalization of this action, but removal of those provisions does not require public notice or comment. OSHA terminated the rulemaking that would have finalized these provisions and, because requirements issued under the OSH Act's ETS authority are time-limited (*see* 29 U.S.C. 655(c)(3)), OSHA can no longer enforce them. Thus, the removal of that language is a purely administrative action for which notice and comment is unnecessary (*see* 5 U.S.C. 553(b)(B)). Accordingly, any comments on removal of the non-recordkeeping and reporting provisions will be considered outside the scope of the rulemaking. If, as discussed in section IV.A, above, OSHA finalizes this action by removing the recordkeeping and reporting provisions as well, this would result in the removal from the CFR of all of 29 CFR 1910 subpart U, namely 29 CFR 1910.501[reserved], .502, .504, .505, and .509.

OSHA also intends to remove outdated references to 29 CFR 1910.501 as part of finalizing this rulemaking. Those references, in 29 CFR 1915.1501, 1917.31, 1918 subpart K, 1926.58, and 1928.21(a)(8) are outdated because they refer to provisions in the CFR which were removed when OSHA withdrew its ETS on COVID–19 Vaccination and Testing (*see* 87 FR 3928, Jan. 26, 2022). Because these references do not point to an existing regulation, they need to be removed from the CFR. As this is a purely administrative action for which notice and comment is unnecessary (*see* 5 U.S.C. 553(b)(B)), any comments on this issue will be considered outside the scope of this rulemaking.

V. Preliminary Economic Analysis

A. Introduction

This section presents OSHA's preliminary economic analysis of the cost savings and foregone benefits anticipated to result from OSHA's proposal to remove from the CFR the recordkeeping and reporting provisions in 29 CFR 1910 subpart U (specifically 29 CFR 1910.502(q)(2)(ii), (q)(3)(ii)–(iv), and (r)), as described in section IV above. OSHA estimates that the proposal to remove these provisions would result in annual cost savings of $1,587,494 (2024 dollars) and present value cost savings of $22,678,488 (2024 dollars, at 7 percent discount rate) to employers. This analysis demonstrates that this proposed rule is economically feasible, as required by section 6(b)(5) of the OSH Act (29 U.S.C. 655(b)(5); *see Am. Textile Mfrs. Inst., Inc.* v. *Donovan,* 452 U.S. 490, 513 n. 31 (1981), *United Steelworkers of Am.* v. *Marshall,* 647 F.2d 1189, 1272 (D.C. Cir. 1981)).

B. Cost Savings

I. Introduction

This section presents OSHA's preliminary estimated cost savings from the proposal to remove the COVID–19 recordkeeping and reporting provisions in 29 CFR 1910 subpart U. OSHA estimates that the proposal will result in annual cost savings of $1,587,494 (2024 dollars) and present value cost savings of $22,678,488 (2024 dollars, at 7 percent discount rate) to employers (*see* Document ID 2884 for calculations).[3]

II. Inputs for Cost Savings Analysis

This section presents the inputs used in the cost savings analysis.

a. Affected Entities, Establishments, and Employees

Table V.B.1. reproduces the industry profile of affected entities, establishments, and employees, by industry and entity size (all sizes, Small Business Administration (SBA)/Regulatory Flexibility Act (RFA)-defined small,[4] and very small (fewer than 20 employees), respectively) from the preliminary economic analysis for the COVID–19 Healthcare ETS (86 FR 32376, 32483–32558). In that analysis, OSHA estimated that 562,510 entities, 748,816, establishments, and 10,338,353 employees were affected by the COVID–19 ETS and would be impacted by this proposed rule.[5] OSHA notes that it has not attempted to account for growth in the number of entities and establishments that would be affected

[3] Present value of cost savings is calculated using a 7 percent end-of-period discount rate per guidance from the Office of Management and Budget (Document ID 2886).

[4] There are three types of small entities under the RFA definitions: (1) small businesses; (2) small non-profit organizations; and (3) small governmental jurisdictions. The SBA uses characteristics of businesses classified by NAICS industry as a basis for determining whether businesses are small. SBA-defined small entity size criteria vary by industry but are usually based on either number of employees or revenue. A non-profit organization is considered small if it is independently owned and operated and not dominant in its field (which suggests that some nonprofits might not be small entities, but in this preliminary economic analysis, as OSHA customarily does, all nonprofits are assumed to be small). A small governmental jurisdiction is a government of a city, county, town, township, village, school district, or special district with a population of less than 50,000.

[5] Cost savings for the recordkeeping provision exclude employers with 10 or fewer employees because they were exempt from this requirement (*see* 29 CFR 1910.502(q)(2)).

by the removal of the COVID–19 recordkeeping and reporting requirements, so these estimates do not reflect cost savings realized by new entrants into the market since 2021.

TABLE V.B.1—NUMBER OF AFFECTED ENTITIES, ESTABLISHMENTS, AND EMPLOYEES, BY ENTITY SIZE

[2021]

NAICS code	NAICS title	Setting	All sizes			SBA/RFA-defined small			Very small (<20 employees)		
			Affected entities	Affected establishments	Covered employees	Affected entities	Affected establishments	Covered employees	Affected entities	Affected establishments	Covered employees
446110	Pharmacies and Drug Stores	First Aid and Emergency Care	4,810	12,007	42,090	4,726	5,113	11,265	4,255	4,324	7,084
561210	Facility Support Services	Correctional Facility Clinics	536	1,680	15,007	466	642	3,637	283	285	299
561311	Employment Placement Agencies.	Home Health Care and Temp Labor.	1,415	1,588	4,032	1,328	1,374	1,870	1,135	1,141	311
611110	Elementary and Secondary Schools.	School/Industry Clinics	14,909	15,596	66,703	6,787	7,351	16,218	5,546	5,551	2,323
611210	Junior Colleges	School/Industry Clinics	403	494	2,709	154	204	343	109	109	15
611310	Colleges, Universities, and Professional Schools.	School/Industry Clinics	1,734	2,238	58,662	546	887	36,181	398	398	174
611710	Educational Support Services	School/Industry Clinics	494	541	176	479	498	111	451	453	39
621111	Offices of Physicians (except Mental Health Specialists).	Other Patient Care	161,977	212,620	1,425,789	158,777	170,727	838,683	145,362	146,650	374,414
621112	Offices of Physicians, Mental Health Specialists.	Other Patient Care	10,568	10,817	23,789	10,562	10,811	23,705	10,170	10,218	14,956
621210	Offices of Dentists	Other Patient Care	125,335	136,468	635,139	124,962	129,598	585,112	119,903	121,553	480,976
621310	Offices of Chiropractors	Other Patient Care	38,696	39,340	72,557	38,679	39,292	71,933	38,364	38,610	67,048
621320	Offices of Optometrists	Other Patient Care	19,627	22,386	35,556	19,524	21,361	32,954	18,608	19,242	25,753
621330	Offices of Mental Health Practitioners (except Physicians).	Other Patient Care	24,251	25,370	9,288	24,240	25,359	9,239	23,029	23,146	4,086
621340	Offices of Physical, Occupational and Speech Therapists and Audiologists.	Other Patient Care	26,746	40,431	237,533	26,045	28,976	118,847	23,945	24,491	63,632
621391	Offices of Podiatrists	Other Patient Care	7,304	8,092	17,344	7,283	7,915	16,716	7,032	7,278	13,186
621399	Offices of All Other Miscellaneous Health Practitioners.	Other Patient Care	19,487	22,696	45,487	19,332	20,285	40,349	18,345	18,445	21,867
621410	Family Planning Centers	Other Patient Care	1,479	2,349	11,461	1,452	2,184	9,579	1,225	1,257	3,095
621420	Outpatient Mental Health and Substance Abuse Centers.	Other Patient Care	6,664	11,967	45,022	6,381	10,511	39,061	4,147	4,207	3,164
621491	HMO Medical Centers	Other Patient Care	27	1,723	70,472	19	1,054	22,391	6	6	1
621492	Kidney Dialysis Centers	Other Patient Care	432	7,904	63,592	384	929	9,049	254	263	814
621493	Freestanding Ambulatory Surgical and Emergency Centers.	First Aid and Emergency Care	4,401	7,660	86,472	3,934	4,489	41,134	2,652	2,665	10,113
621498	All Other Outpatient Care Centers.	Other Patient Care	6,775	14,825	203,061	6,416	12,359	173,068	3,977	4,066	11,216
621610	Home Health Care Services	Home Health Care and Temp Labor.	23,855	33,581	834,687	23,122	25,758	475,455	14,871	14,904	44,155
621910	Ambulance Services	First Aid and Emergency Care	3,230	5,672	145,161	3,102	4,318	94,763	1,661	1,678	10,106
621991	Blood and Organ Banks	Other Patient Care	339	1,587	48,473	289	959	31,527	173	178	650
621999	All Other Miscellaneous Ambulatory Health Care Services.	First Aid and Emergency Care	3,587	4,387	41,463	3,287	3,486	17,993	2,918	2,945	6,419
622110	General Medical and Surgical Hospitals.	General Hospitals	2,867	5,281	3,519,001	2,164	3,933	2,739,276	64	68	113
622210	Psychiatric and Substance Abuse Hospitals.	Other Hospitals	1,275	1,443	89,079	192	242	25,481	41	41	76
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals.	Other Hospitals	424	920	157,898	182	324	75,728	23	23	36
623110	Nursing Care Facilities (Skilled Nursing Facilities).	Nursing Homes	9,333	17,137	1,115,312	8,623	10,370	619,981	2,200	2,231	6,478
623210	Residential Intellectual and Developmental Disability Facilities.	Long Term Care (excluding nursing homes).	7,597	35,213	411,523	6,729	27,482	313,858	3,664	3,729	14,333
623220	Residential Mental Health and Substance Abuse Facilities.	Long Term Care (excluding nursing homes).	4,305	8,081	59,442	4,064	7,165	48,412	2,044	2,076	3,341
623311	Continuing Care Retirement Communities.	Nursing Homes	3,899	5,570	273,792	3,661	4,383	221,064	1,369	1,374	5,117

TABLE V.B.1—NUMBER OF AFFECTED ENTITIES, ESTABLISHMENTS, AND EMPLOYEES, BY ENTITY SIZE—Continued
[2021]

NAICS code	NAICS title	Setting	All sizes			SBA/RFA-defined small			Very small (<20 employees)		
			Affected entities	Affected establishments	Covered employees	Affected entities	Affected establishments	Covered employees	Affected entities	Affected establishments	Covered employees
623312	Assisted Living Facilities for the Elderly.	Nursing Homes	14,597	20,052	275,201	14,000	15,760	154,667	10,598	10,667	32,995
623990	Other Residential Care Facilities	Long Term Care (excluding nursing homes).	3,401	5,362	29,369	3,145	4,849	25,952	1,945	1,963	2,687
711211	Sports Teams and Clubs	School/Industry Clinics	79	85	95	66	68	13	50	50	3
922160	Public Firefighter-EMTs	First Aid and Emergency Care	5,648	5,648	165,915	5,005	5,005	91,820	917	917	7,046
Total			562,510	748,816	10,338,353	540,108	616,019	7,037,434	471,735	477,203	1,238,122

Source: Preliminary economic analysis for the COVID–19 Healthcare ETS (86 FR 32376, 32483–32558).

Notes: NAICS 922160 includes government and volunteer firefighters, including those cross-trained as EMTs. OSHA obtains estimates of the number of public firefighter-EMT entities and employees from the U.S. Fire Administration (USFA) National Fire Department Registry, rather than a NAICS-based data source.

Due to rounding, figures in the columns may not sum to the totals shown.

b. Compliance Rates

Table V.B.2. presents the rates of baseline compliance with the COVID–19 recordkeeping and reporting provisions estimated in the preliminary economic analysis of the COVID–19 Healthcare ETS (hereafter ''pre-ETS rates of compliance''). Depending on the provision, estimated pre-ETS rates of compliance (*i.e.,* share of establishments in compliance) vary by entity size. For reporting of hospitalizations and recordkeeping, estimated pre-ETS rates of compliance were zero for all affected establishments regardless of entity size.[6] For reporting of fatalities, estimated pre-ETS rates of compliance were 50 percent for establishments of very small entities and 75 percent for all others. OSHA's estimated cost savings from this proposal would result from the reduction in the share of establishments that are performing the relevant recordkeeping and reporting activities, from 100 percent of employers to pre-ETS rates of these activities.

TABLE V.B.2—PRE-ETS RATES OF COMPLIANCE BY PROVISION

Provision	Very small (<20 employees) (%)	SBA/RFA-defined small and not very small (%)	Large (%)
Recordkeeping	0	0	0
Reporting COVID–19 fatalities to OSHA	50	75	75
Reporting COVID–19 hospitalizations to OSHA	0	0	0

Source: Preliminary economic analysis for the COVID–19 Healthcare ETS (86 FR 32376, 32483–32558).

c. COVID–19 Cases

Per the preliminary economic analysis of the COVID–19 Healthcare ETS (86 FR 32376, 32483–32558), OSHA assumes that the following COVID–19 positive cases would no longer need to be recorded in the COVID–19 log and that the related hospitalizations and fatalities would no longer need to be reported to OSHA (*see* Document ID 1031, Attachment 4, ''Recordkeeping(Cur)'' and ''Reporting(Cur)'' tabs):

- COVID–19 positive cases: 0.95 percent of employees per establishment [7] [8]
- COVID–19 fatalities: 0.001 percent of employees per establishment
- COVID–19 hospitalizations: 8.4 hospitalizations per fatality

d. Unit Labor Burden

Table V.B.3. presents the unit labor burden estimates for General and Operations Managers (SOC 11–1020) and Information and Records Clerks (SOC 43–4000) (*e.g.,* per COVID–19 case per establishment) for complying with the COVID–19 recordkeeping and reporting provisions. OSHA assumes that the unit labor burden and job categories have not changed from the preliminary economic analysis of the COVID–19 Healthcare ETS (86 FR 32376, 32483–32558).

TABLE V.B.3—UNIT LABOR BURDEN

Provision	Occupation	Unit	Labor burden
Recordkeeping	Information and Records Clerk	Hours per COVID–19 positive case per establishment.	0.17
Reporting COVID–19 fatalities and hospitalizations to OSHA.	General and Operations Manager	Hours per COVID–19 fatality or hospitalization per establishment.	0.75

Source: Preliminary economic analysis for the COVID–19 Healthcare ETS (86 FR 32376, 32483–32558).

e. Wage Rates

To estimate monetized cost savings from the proposal, OSHA took the loaded hourly wage rates (*i.e.,* base wages plus fringe benefits plus overhead) for General and Operations Manager (SOC 11–1020) and Information and Records Clerk (SOC 43–4000) from the preliminary economic analysis for the COVID–19 Healthcare ETS (86 FR 32376, 32483–32558) and the accompanying spreadsheet (Document ID 1031, Attachment 4, ''Labor Rates'' tab) and adjusted these figures from 2018 dollars to 2024 dollars using the Bureau of Economic Analysis's GDP deflator (Document ID 2885). Table V.B.4. presents the loaded hourly wage rates (2024 dollars) for General and Operations Managers (SOC 11–1020) and Information and Records Clerks (SOC 43–4000) by industry.

[6] The recordkeeping provision at 1910.502(q)(2)(ii) requires employers to ''establish'' (*i.e.,* create) as well as ''maintain'' a COVID–19 log. OSHA's estimated annual total cost savings do not include savings for establishing a COVID–19 log because those costs have already been incurred (*see* Document ID 2886) for more detail on sunk costs). To the extent that employers newly entering the market would also incur the cost of establishing the COVID–19 log in absence of the proposed removal, OSHA's estimated annual total cost savings would be an underestimate. Assuming that establishing the COVID–19 log incurs 0.5 hours of one-time labor from a General and Operations Manager (SOC 11–1020) per establishment whose entity has more than 10 employees (as assumed in the preliminary economic analysis for the COVID–19 Healthcare ETS (86 FR 32376, 32483–32558)), an average newly entering employer (with more than 10 employees) would save $54.75 per establishment (2024 dollars) due to no longer being required to establish a COVID–19 log.

[7] For both the COVID–19 positive case rate and the fatality rate, the estimates from the COVID–19 Healthcare ETS were for a 6-month period, because that rule was only expected to be in effect for approximately 6 months. In its calculations for this proposal, OSHA doubled the COVID–19 rates presented in the ETS in order to represent a full year of cost savings from removal of these provisions and provide consistency with how OSHA normally presents its regulatory cost figures.

[8] OSHA used the COVID–19 positive case and fatality numbers from the COVID–19 Healthcare ETS because the CDC database upon which it relied for those numbers in 2021 is not currently providing equivalent data due to a number of factors, one of which is that most COVID–19 tests are performed at home and do not get reported.

TABLE V.B.4—LOADED WAGE RATES
[2024$]

NAICS code	NAICS title	Setting	Loaded hourly wage (2024$)	
			General and operations manager (SOC Code 11–1020)	Information and records clerk (SOC Code 43–4000)
446110	Pharmacies and Drug Stores	First Aid and Emergency Care	$78.75	$38.73
561210	Facility Support Services	Correctional Facility Clinics	111.49	43.47
561311	Employment Placement Agencies	Home Health Care and Temp Labor	111.49	43.47
611110	Elementary and Secondary Schools	School/Industry Clinics	114.78	45.98
611210	Junior Colleges	School/Industry Clinics	114.78	45.98
611310	Colleges, Universities, and Professional Schools	School/Industry Clinics	114.78	45.98
611710	Educational Support Services	School/Industry Clinics	114.78	45.98
621111	Offices of Physicians (except Mental Health Specialists)	Other Patient Care	114.03	43.50
621112	Offices of Physicians, Mental Health Specialists	Other Patient Care	114.03	43.50
621210	Offices of Dentists	Other Patient Care	114.03	43.50
621310	Offices of Chiropractors	Other Patient Care	114.03	43.50
621320	Offices of Optometrists	Other Patient Care	114.03	43.50
621330	Offices of Mental Health Practitioners (except Physicians)	Other Patient Care	114.03	43.50
621340	Offices of Physical, Occupational and Speech Therapists and Audiologists.	Other Patient Care	114.03	43.50
621391	Offices of Podiatrists	Other Patient Care	114.03	43.50
621399	Offices of All Other Miscellaneous Health Practitioners	Other Patient Care	114.03	43.50
621410	Family Planning Centers	Other Patient Care	114.03	43.50
621420	Outpatient Mental Health and Substance Abuse Centers	Other Patient Care	114.03	43.50
621491	HMO Medical Centers	Other Patient Care	114.03	43.50
621492	Kidney Dialysis Centers	Other Patient Care	114.03	43.50
621493	Freestanding Ambulatory Surgical and Emergency Centers	First Aid and Emergency Care	114.03	43.50
621498	All Other Outpatient Care Centers	Other Patient Care	114.03	43.50
621610	Home Health Care Services	Home Health Care and Temp Labor	114.03	43.50
621910	Ambulance Services	First Aid and Emergency Care	114.03	43.50
621991	Blood and Organ Banks	Other Patient Care	114.03	43.50
621999	All Other Miscellaneous Ambulatory Health Care Services	First Aid and Emergency Care	114.03	43.50
622110	General Medical and Surgical Hospitals	General Hospitals	153.26	51.42
622210	Psychiatric and Substance Abuse Hospitals	Other Hospitals	153.26	51.42
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	Other Hospitals	153.26	51.42
623110	Nursing Care Facilities (Skilled Nursing Facilities)	Nursing Homes	93.23	37.23
623210	Residential Intellectual and Developmental Disability Facilities	Long Term Care (excluding nursing homes).	93.23	37.23
623220	Residential Mental Health and Substance Abuse Facilities	Long Term Care (excluding nursing homes).	93.23	37.23
623311	Continuing Care Retirement Communities	Nursing Homes	93.23	37.23
623312	Assisted Living Facilities for the Elderly	Nursing Homes	93.23	37.23
623990	Other Residential Care Facilities	Long Term Care (excluding nursing homes).	93.23	37.23
711211	Sports Teams and Clubs	School/Industry Clinics	106.73	46.23
922160	Public Firefighter-EMTs	First Aid and Emergency Care	114.03	43.50

Sources: Preliminary economic analysis for the COVID–19 Healthcare ETS (86 FR 32376, 32483–32558); Document ID 1031, Attachment 4, ''Labor Rates'' tab; Document ID 2885.

Note: For NAICS 922160—Public Firefighter-EMT wages, OSHA assigns the same values estimated for Ambulance Services, as these values are judged to be more representative of wages for this specific service versus wages based on NAICS 922160 data.

III. Total Cost Savings

This section presents a preliminary estimate of annual total cost savings that would result from the proposal. Total cost savings are a product of the number of covered employees in the affected establishments (presented above in *Affected Entities, Establishments, and Employees,* Section V.B.II.a); the associated unit labor burden (presented above in *Unit Labor Burden,* Section V.B.II.d); the rates of COVID–19 cases (presented above in *COVID–19 Cases,* Section V.B.II.c); and the reduction in employers' compliance, from 100% current compliance to pre-ETS rates of compliance (presented above in *Compliance Rates,* Section V.B.II.b). Total cost savings in hours are monetized by the associated wage rates (presented above in *Wage Rates,* Section V.B.II.e).

Tables V.B.5., V.B.6., and V.B.7. present OSHA's preliminary estimates of the annual total cost savings of the proposal (by industry, provision, and overall). OSHA estimates that the proposal will result in annual total cost savings of $1,587,494 (2024 dollars). OSHA requests comments on all aspects of this preliminary economic analysis, including whether OSHA should update the aspects of its analysis that were taken from the economic analysis for the COVID–19 Healthcare ETS to reflect more recent data (*e.g.,* establishment numbers, COVID–19 case rate, COVID–19 fatality rate). OSHA also welcomes comment on data sources and methodologies that would be useful for allowing the most clear and direct comparison between the cost estimates in the COVID–19 Healthcare ETS and an analysis of cost savings for removing the recordkeeping and reporting requirements.

TABLE V.B.5—ANNUAL TOTAL COST SAVINGS—RECORDKEEPING
[2024$]

NAICS code	NAICS title	Setting	Entity size		
			All entities	SBA/RFA-defined small	Very small (<20 employees)
446110	Pharmacies and Drug Stores	First Aid and Emergency Care	$5,831.35	$2,042.83	$1,529.01
561210	Facility Support Services	Correctional Facility Clinics	2,116.02	547.49	87.08
561311	Employment Placement Agencies	Home Health Care and Temp Labor	703.16	404.86	189.83
611110	Elementary and Secondary Schools	School/Industry Clinics	12,784.06	5,417.80	3,390.49
611210	Junior Colleges	School/Industry Clinics	438.36	93.18	45.26
611310	Colleges, Universities, and Professional Schools.	School/Industry Clinics	8,666.30	5,386.14	132.38
611710	Educational Support Services	School/Industry Clinics	83.92	74.36	63.94
621111	Offices of Physicians (except Mental Health Specialists).	Other Patient Care	176,134.14	95,094.57	31,010.67
621112	Offices of Physicians, Mental Health Specialists.	Other Patient Care	1,849.41	1,837.70	630.06
621210	Offices of Dentists	Other Patient Care	57,589.43	50,684.07	36,309.97
621310	Offices of Chiropractors	Other Patient Care	3,598.80	3,512.68	2,838.45
621320	Offices of Optometrists	Other Patient Care	6,026.62	5,667.42	4,673.49
621330	Offices of Mental Health Practitioners (except Physicians).	Other Patient Care	2,348.12	2,341.30	1,630.03
621340	Offices of Physical, Occupational and Speech Therapists and Audiologists.	Other Patient Care	29,491.33	13,108.91	5,487.40
621391	Offices of Podiatrists	Other Patient Care	1,618.52	1,531.88	1,044.63
621399	Offices of All Other Miscellaneous Health Practitioners.	Other Patient Care	4,688.86	3,979.67	1,428.49
621410	Family Planning Centers	Other Patient Care	1,494.09	1,234.21	339.31
621420	Outpatient Mental Health and Substance Abuse Centers.	Other Patient Care	6,977.24	6,154.51	1,199.46
621491	HMO Medical Centers	Other Patient Care	9,727.35	3,090.71	0.20
621492	Kidney Dialysis Centers	Other Patient Care	8,774.66	1,245.96	109.24
621493	Freestanding Ambulatory Surgical and Emergency Centers.	First Aid and Emergency Care	11,950.28	5,692.18	1,410.40
621498	All Other Outpatient Care Centers	Other Patient Care	27,887.79	23,747.76	1,407.07
621610	Home Health Care Services	Home Health Care and Temp Labor	113,833.19	64,247.66	4,714.47
621910	Ambulance Services	First Aid and Emergency Care	19,708.10	12,751.46	1,066.14
621991	Blood and Organ Banks	Other Patient Care	6,673.96	4,334.94	72.93
621999	All Other Miscellaneous Ambulatory Health Care Services.	First Aid and Emergency Care	5,392.99	2,153.40	555.83
622110	General Medical and Surgical Hospitals	General Hospitals	574,111.87	446,899.59	4.46
622210	Psychiatric and Substance Abuse Hospitals.	Other Hospitals	14,539.50	4,163.41	18.51
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals.	Other Hospitals	25,761.35	12,355.33	6.07
623110	Nursing Care Facilities (Skilled Nursing Facilities).	Nursing Homes	131,570.14	73,050.30	569.24
623210	Residential Intellectual and Developmental Disability Facilities.	Long Term Care (excluding nursing homes).	48,153.63	36,615.16	1,228.37
623220	Residential Mental Health and Substance Abuse Facilities.	Long Term Care (excluding nursing homes).	7,378.33	6,075.25	750.33
623311	Continuing Care Retirement Communities	Nursing Homes	32,270.21	26,040.76	528.08
623312	Assisted Living Facilities for the Elderly	Nursing Homes	31,427.05	17,186.77	2,812.05
623990	Other Residential Care Facilities	Long Term Care (excluding nursing homes).	3,841.66	3,437.99	689.45
711211	Sports Teams and Clubs	School/Industry Clinics	26.22	14.07	12.65
922160	Public Firefighter-EMTs	First Aid and Emergency Care	22,657.93	12,430.51	728.94
Total			1,418,125.91	954,646.80	108,714.36

Sources: Preliminary economic analysis for the COVID–19 Healthcare ETS (86 FR 32376, 32483–32558); Document ID 1031, Attachment 4, ''Labor Rates'', ''All Costs(Current)'', ''Recordkeeping(Cur)'', and ''SAS Output_10FEB'' tabs; Document ID 2885.
Note: Due to rounding, figures in the columns may not sum to the totals shown.

TABLE V.B.6—ANNUAL TOTAL COST SAVINGS—REPORTING
[2024$]

NAICS code	NAICS title	Setting	Entity size		
			All entities	SBA/RFA-defined small	Very small (<20 employees)
446110	Pharmacies and Drug Stores	First Aid and Emergency Care	$439.27	$119.13	$75.71
561210	Facility Support Services	Correctional Facility Clinics	220.79	53.60	4.53
561311	Employment Placement Agencies	Home Health Care and Temp Labor	59.43	27.63	4.71
611110	Elementary and Secondary Schools	School/Industry Clinics	1,010.78	246.52	36.19
611210	Junior Colleges	School/Industry Clinics	41.01	5.20	0.23
611310	Colleges, Universities, and Professional Schools.	School/Industry Clinics	888.12	547.79	2.71
611710	Educational Support Services	School/Industry Clinics	2.69	1.70	0.61
621111	Offices of Physicians (except Mental Health Specialists).	Other Patient Care	21,605.22	12,775.71	5,793.57

TABLE V.B.6—ANNUAL TOTAL COST SAVINGS—REPORTING—Continued
[2024$]

NAICS code	NAICS title	Setting	Entity size		
			All entities	SBA/RFA-defined small	Very small (<20 employees)
621112	Offices of Physicians, Mental Health Specialists.	Other Patient Care	364.27	362.99	231.42
621210	Offices of Dentists	Other Patient Care	9,760.93	9,008.57	7,442.46
621310	Offices of Chiropractors	Other Patient Care	1,120.32	1,110.94	1,037.48
621320	Offices of Optometrists	Other Patient Care	545.93	506.79	398.50
621330	Offices of Mental Health Practitioners (except Physicians).	Other Patient Care	141.46	140.72	63.22
621340	Offices of Physical, Occupational and Speech Therapists and Audiologists.	Other Patient Care	3,599.92	1,815.01	984.62
621391	Offices of Podiatrists	Other Patient Care	266.57	257.13	204.04
621399	Offices of All Other Miscellaneous Health Practitioners.	Other Patient Care	693.59	616.32	338.36
621410	Family Planning Centers	Other Patient Care	173.71	145.40	47.90
621420	Outpatient Mental Health and Substance Abuse Centers.	Other Patient Care	678.46	588.82	48.95
621491	HMO Medical Centers	Other Patient Care	1,059.83	336.74	0.02
621492	Kidney Dialysis Centers	Other Patient Care	956.71	136.44	12.59
621493	Freestanding Ambulatory Surgical and Emergency Centers.	First Aid and Emergency Care	1,304.84	623.01	156.49
621498	All Other Outpatient Care Centers	Other Patient Care	3,058.71	2,607.64	173.56
621610	Home Health Care Services	Home Health Care and Temp Labor	12,572.07	7,169.57	683.25
621910	Ambulance Services	First Aid and Emergency Care	2,187.48	1,429.53	156.38
621991	Blood and Organ Banks	Other Patient Care	729.27	474.42	10.06
621999	All Other Miscellaneous Ambulatory Health Care Services.	First Aid and Emergency Care	626.35	273.39	99.33
622110	General Medical and Surgical Hospitals	General Hospitals	71,129.97	55,369.32	2.34
622210	Psychiatric and Substance Abuse Hospitals.	Other Hospitals	1,800.61	515.09	1.57
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals.	Other Hospitals	3,191.63	1,530.72	0.74
623110	Nursing Care Facilities (Skilled Nursing Facilities).	Nursing Homes	13,715.79	7,625.37	81.95
623210	Residential Intellectual and Developmental Disability Facilities.	Long Term Care (excluding nursing homes).	5,065.04	3,864.18	181.32
623220	Residential Mental Health and Substance Abuse Facilities.	Long Term Care (excluding nursing homes).	732.07	596.45	42.26
623311	Continuing Care Retirement Communities	Nursing Homes	3,368.27	2,719.95	64.73
623312	Assisted Living Facilities for the Elderly	Nursing Homes	3,395.51	1,913.46	417.42
623990	Other Residential Care Facilities	Long Term Care (excluding nursing homes).	362.06	320.05	34.00
711211	Sports Teams and Clubs	School/Industry Clinics	1.34	0.18	0.04
922160	Public Firefighter-EMTs	First Aid and Emergency Care	2,498.26	1,383.95	109.03
Total ..	.....	.....	169,368.26	117,219.42	18,942.28

Sources: Preliminary economic analysis for the COVID–19 Healthcare ETS (86 FR 32376, 32483–32558); Document ID 1031, Attachment 4, ''Labor Rates'', ''All Costs(Current)'', and ''Reporting(Cur)'' tabs; Document ID 2885.
Note: Due to rounding, figures in the columns may not sum to the totals shown.

TABLE V.B.7—ANNUAL TOTAL COST SAVINGS—ALL PROVISIONS
[2024$]

NAICS code	NAICS title	Setting	Entity size		
			All entities	SBA/RFA-defined small	Very small (<20 employees)
446110	Pharmacies and Drug Stores	First Aid and Emergency Care	$6,270.63	$2,161.96	$1,604.71
561210	Facility Support Services	Correctional Facility Clinics	2,336.81	601.09	91.60
561311	Employment Placement Agencies	Home Health Care and Temp Labor	762.58	432.49	194.55
611110	Elementary and Secondary Schools	School/Industry Clinics	13,794.84	5,664.32	3,426.68
611210	Junior Colleges	School/Industry Clinics	479.37	98.38	45.49
611310	Colleges, Universities, and Professional Schools.	School/Industry Clinics	9,554.41	5,933.93	135.09
611710	Educational Support Services	School/Industry Clinics	86.61	76.06	64.55
621111	Offices of Physicians (except Mental Health Specialists).	Other Patient Care	197,739.35	107,870.28	36,804.23
621112	Offices of Physicians, Mental Health Specialists.	Other Patient Care	2,213.68	2,200.70	861.48
621210	Offices of Dentists	Other Patient Care	67,350.35	59,692.64	43,752.43
621310	Offices of Chiropractors	Other Patient Care	4,719.12	4,623.62	3,875.93
621320	Offices of Optometrists	Other Patient Care	6,572.55	6,174.21	5,071.99
621330	Offices of Mental Health Practitioners (except Physicians).	Other Patient Care	2,489.58	2,482.02	1,693.26
621340	Offices of Physical, Occupational and Speech Therapists and Audiologists.	Other Patient Care	33,091.25	14,923.92	6,472.01
621391	Offices of Podiatrists	Other Patient Care	1,885.09	1,789.01	1,248.67

TABLE V.B.7—ANNUAL TOTAL COST SAVINGS—ALL PROVISIONS—Continued
[2024$]

NAICS code	NAICS title	Setting	Entity size		
			All entities	SBA/RFA-defined small	Very small (<20 employees)
621399	Offices of All Other Miscellaneous Health Practitioners.	Other Patient Care	5,382.44	4,595.99	1,766.85
621410	Family Planning Centers	Other Patient Care	1,667.80	1,379.61	387.21
621420	Outpatient Mental Health and Substance Abuse Centers.	Other Patient Care	7,655.70	6,743.34	1,248.41
621491	HMO Medical Centers	Other Patient Care	10,787.18	3,427.45	0.23
621492	Kidney Dialysis Centers	Other Patient Care	9,731.38	1,382.40	121.83
621493	Freestanding Ambulatory Surgical and Emergency Centers.	First Aid and Emergency Care	13,255.12	6,315.18	1,566.89
621498	All Other Outpatient Care Centers	Other Patient Care	30,946.50	26,355.40	1,580.62
621610	Home Health Care Services	Home Health Care and Temp Labor	126,405.25	71,417.23	5,397.72
621910	Ambulance Services	First Aid and Emergency Care	21,895.57	14,180.99	1,222.52
621991	Blood and Organ Banks	Other Patient Care	7,403.22	4,809.37	82.99
621999	All Other Miscellaneous Ambulatory Health Care Services.	First Aid and Emergency Care	6,019.34	2,426.78	655.15
622110	General Medical and Surgical Hospitals	General Hospitals	645,241.85	502,268.91	6.80
622210	Psychiatric and Substance Abuse Hospitals.	Other Hospitals	16,340.12	4,678.50	20.08
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals.	Other Hospitals	28,952.97	13,886.05	6.81
623110	Nursing Care Facilities (Skilled Nursing Facilities).	Nursing Homes	145,285.93	80,675.67	651.19
623210	Residential Intellectual and Developmental Disability Facilities.	Long Term Care (excluding nursing homes).	53,218.67	40,479.34	1,409.69
623220	Residential Mental Health and Substance Abuse Facilities.	Long Term Care (excluding nursing homes).	8,110.39	6,671.70	792.59
623311	Continuing Care Retirement Communities	Nursing Homes	35,638.48	28,760.70	592.82
623312	Assisted Living Facilities for the Elderly	Nursing Homes	34,822.55	19,100.23	3,229.47
623990	Other Residential Care Facilities	Long Term Care (excluding nursing homes).	4,203.72	3,758.04	723.45
711211	Sports Teams and Clubs	School/Industry Clinics	27.57	14.25	12.69
922160	Public Firefighter-EMTs	First Aid and Emergency Care	25,156.19	13,814.46	837.97
Total			1,587,494.18	1,071,866.22	127,656.65

Sources: Preliminary economic analysis for the COVID–19 Healthcare ETS (86 FR 32376, 32483–32558); Document ID 1031, Attachment 4, ''Labor Rates'', ''All Costs(Current)'', ''Recordkeeping(Cur), ''Reporting(Cur)'', and ''SAS Output_10FEB'' tabs; Document ID 2885.
Note: Due to rounding, figures in the columns may not sum to the totals shown.

C. Economic Feasibility

This section presents OSHA's preliminary findings on the economic feasibility of the proposal for affected industries. Because the proposal would remove existing recordkeeping and reporting requirements in 29 CFR 1910 subpart U, this proposed rule would not impose new costs on employers. Instead, as discussed above in *Cost Savings* (Section V.B. of this preamble) OSHA estimates the proposal would result in annual total cost savings of $1,587,494 (2024 dollars), spread out among affected employers, and would impose no additional costs on employers. Because this proposal would result in cost savings, OSHA preliminarily finds that the proposal would be economically feasible for all affected industries.

D. Benefits

This section discusses potential foregone benefits that would stem from OSHA's proposal to remove the recordkeeping and reporting provisions in 29 CFR 1910 subpart U.[9]

As discussed in *Explanation of Agency Action* (Section IV. of this preamble), the recordkeeping and reporting provisions in 29 CFR 1910 subpart U were intended to supplement the non-recordkeeping and reporting provisions in the COVID–19 Healthcare ETS and assist employers in effectively preventing workplace transmission of COVID–19 among employees in covered settings. In the COVID–19 Healthcare ETS, OSHA's benefits calculations were therefore performed on a per-case-prevented basis for the standard as a whole, with no attempt to quantify the specific benefits attributable to any particular provision of the standard. As a result, OSHA is unable to quantify any benefit reduction, consistent with the 2021 analysis, from the removal of just the recordkeeping and reporting provisions of subpart U. OSHA welcomes comment on this determination.

E. Review Under Executive Order 12866

Executive Order (E.O.) 12866, ''Regulatory Planning and Review'' (58 FR 51735 (Oct. 4, 1993)), requires agencies, to the extent permitted by law, to (1) propose or adopt a regulation only upon a reasoned determination that its benefits justify its costs (recognizing that some benefits and costs are difficult to quantify); (2) tailor regulations to impose the least burden on society, consistent with obtaining regulatory objectives, taking into account, among other things, and to the extent practicable, the costs of cumulative regulations; (3) select, in choosing among alternative regulatory approaches, those approaches that maximize net benefits; (4) to the extent feasible, specify performance objectives, rather than specifying the behavior or manner of compliance that regulated

[9] In a typical regulatory impact analysis, strictly speaking, reduced costs to employers would be presented as a benefit of a rule while any potential negative impacts from removing requirements that resulted in those lower costs would be a cost of a rule. For the sake of maintaining comparability with the preliminary economic analysis that accompanied the ETS, OSHA is presenting cost savings in the cost section and potential foregone benefits in this benefits section.

entities must adopt; and (5) identify and assess available alternatives to direct regulation, including providing economic incentives to encourage the desired behavior, such as user fees or marketable permits, or providing information upon which choices can be made by the public.

Section 6(a) of E.O. 12866 also requires agencies to submit ''significant regulatory actions'' to OIRA for review. OIRA has determined that this proposed rule does not constitute a ''significant regulatory action'' under section 3(f) of E.O. 12866. Accordingly, this proposed rule was not submitted to OIRA for review under E.O. 12866.

F. Review Under the Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) requires preparation of an initial regulatory flexibility analysis (IRFA) and a final regulatory flexibility analysis (FRFA) for any rule that by law must be proposed for public comment, unless the agency certifies that the rule, if promulgated, will not have a significant economic impact on a substantial number of small entities.

OSHA reviewed this proposed rule under the provisions of the Regulatory Flexibility Act. This rule proposes to eliminate burdensome regulations. Therefore, OSHA initially concludes that the impacts of the rescission would not have a ''significant economic impact on a substantial number of small entities,'' and that the preparation of an IRFA is not warranted. OSHA will transmit this certification and supporting statement of factual basis to the Chief Counsel for Advocacy of the Small Business Administration for review under 5 U.S.C. 605(b).

VI. Technological Feasibility

This proposed rule would remove recordkeeping and reporting requirements related to COVID–19 in the workplace. Workplaces that were covered by the COVID–19 Healthcare ETS and the related recordkeeping and reporting requirements in 29 CFR 1910 subpart U will no longer have to maintain a COVID–19 log, record cases of COVID–19 on the log, or report to OSHA some fatalities and hospitalizations caused by COVID–19. Because this rule would remove regulatory requirements, OSHA anticipates employers would have no technological issues complying with the rule. Accordingly, the agency preliminarily concludes that the proposed rule would be technologically feasible for affected employers.

VII. Additional Requirements

A. State Plans

Under section 18 of the OSH Act, 29 U.S.C. 651 *et seq.,* Congress expressly provides that States may adopt, with Federal approval, a plan for the development and enforcement of occupational safety and health standards that are ''at least as effective'' as the Federal standards in providing safe and healthful employment and places of employment (29 U.S.C. 667). OSHA refers to these OSHA-approved, State-administered occupational safety and health programs as ''State Plans.'' [10] Once approved, State Plans have an ongoing obligation to maintain an occupational safety and health program that is at least as effective as Federal OSHA's program (*see* 29 CFR 1953.1(b)).

When Federal OSHA makes a significant change to the Federal program that would have an adverse impact on the ''at least as effective'' status of the State program if a parallel State program modification were not made, State adoption of a change in response to the Federal program change is required (29 CFR 1953.4(b)(1)). However, a change to the Federal program that would not result in any diminution of the effectiveness of a State Plan compared to Federal OSHA generally would not require adoption by the State (29 CFR 1953.4(b)(1)).

As explained previously in this preamble, OSHA is proposing a deregulatory action to remove the recordkeeping and reporting provisions in 29 CFR 1910 subpart U that are still in effect (specifically 29 CFR 1910.502(q)(2)(ii), (q)(3)(ii)–(iv), and (r)). OSHA has preliminarily determined the proposed change to the Federal program would not result in any diminution of the effectiveness of a State Plan compared to Federal OSHA, and therefore State Plans are not required to amend their regulations. OSHA seeks comment on this assessment of its proposal.

B. OMB Review Under Paperwork Reduction Act of 1995

The proposed standard would remove regulatory provisions that contain collection-of-information requirements that have been reviewed and approved by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*) and OMB's regulations at 5 CFR part 1320. The existing collection-of-information requirements were approved under OMB Control Number 1218–0277. OMB last renewed its approval of the requirements on April 22, 2025.

If OSHA removes 29 CFR 1910.502(q)(2)(ii), (q)(3)(ii)–(iv), and (r), as proposed, the underlying requirements for the information collections would no longer exist. In OSHA's most recent supporting statement for the information collection requirements contained in these recordkeeping and reporting provisions, the burden on employers of complying with those provisions is 23,714 hours, with an associated cost of $707,355. This rulemaking, if finalized, would therefore result in the removal of the burden and associated costs in those amounts. OSHA requests comment on this analysis.

C. Other Statutory and Executive Order Considerations

OSHA has considered its obligations under the Unfunded Mandates Reform Act (UMRA) (2 U.S.C. 1501 *et seq.*), the National Environmental Policy Act (NEPA) (42 U.S.C. 4321 *et seq.*), and the Executive Orders on Consultation and Coordination With Indian Tribal Governments (E.O. 13175, 65 FR 67249 (Nov. 6, 2000)), Federalism (E.O. 13132, 64 FR 43255 (Aug. 10, 1999)), and Protection of Children From Environmental Health Risks and Safety Risks (E.O. 13045, 62 FR 19885 (Apr. 23, 1997)). Given that this is a deregulatory action that involves the removal of recordkeeping and reporting requirements, that OSHA does not foresee economic impacts of $100 million or more, and that the action does not constitute a policy that has federalism or tribal implications, OSHA has determined that no further agency action or analysis is required to comply with these statutes and executive orders.

List of Subjects in 29 CFR Parts 1910, 1915, 1917, 1918, 1926, and 1928

COVID–19, Disease, Health facilities, Health, Health care, Occupational health and safety, Public health, Quarantine, Reporting and recordkeeping requirements, Respirators, SARS–CoV–2, Telework, Vaccines, Viruses.

VIII. Authority and Signature

Amanda Laihow, Acting Assistant Secretary of Labor for Occupational

[10] Of the 29 States and U.S. territories with OSHA-approved State Plans, 22 cover public and private-sector employees: Alaska, Arizona, California, Hawaii, Indiana, Iowa, Kentucky, Maryland, Michigan, Minnesota, Nevada, New Mexico, North Carolina, Oregon, Puerto Rico, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, and Wyoming. The remaining six States and one U.S. territory cover only State and local government employees: Connecticut, Illinois, Maine, Massachusetts, New Jersey, New York, and the Virgin Islands.

Safety and Health, authorized the preparation of this document under the authority granted by sections 4, 6, and 8 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 653, 655, 657); section 107 of the Contract Work Hours and Safety Standards Act (the Construction Safety Act) (40 U.S.C. 333); section 41 of the Longshore and Harbor Worker's Compensation Act (33 U.S.C. 941); 5 U.S.C. 553, Secretary of Labor's Order No. 8–2020 (85 FR 58393), and 29 CFR part 1911.

Dated: June 20, 2025.

Amanda Laihow,

Acting Assistant Secretary of Labor for Occupational Safety and Health.

Proposed Amendments

For the reasons stated in the preamble, OSHA proposes to amend 29 CFR parts 1910, 1915, 1917, 1918, 1926, and 1928 as follows:

PART 1910—OCCUPATIONAL SAFETY AND HEALTH STANDARDS

Subpart U—COVID–19

■ 1. The authority for 29 CFR part 1910, subpart U, continues to read as follows:

Authority: 29 U.S.C. 653, 655, and 657; Secretary of Labor's Order No. 8–2020 (85 FR 58393); 29 CFR part 1911; and 5 U.S.C. 553.

■ 2. Remove Subpart U—COVID–19

PART 1915—OCCUPATIONAL SAFETY AND HEALTH STANDARDS FOR SHIPYARD EMPLOYMENT

■ 3. The authority citation for 29 CFR part 1915 continues to read as follows:

Authority: 33 U.S.C. 941; 29 U.S.C. 653, 655, 657; Secretary of Labor's Order No. 12–71 (36 FR 8754); 8–76 (41 FR 25059), 9–83 (48 FR 35736), 1–90 (55 FR 9033), 6–96 (62 FR 111), 3–2000 (65 FR 50017), 5–2002 (67 FR 65008), 5–2007 (72 FR 31160), 4–2010 (75 FR 55355), 1–2012 (77 FR 3912), or 8–2020 (85 FR 58393); 29 CFR part 1911; and 5 U.S.C. 553, as applicable.

Subpart Z—Toxic and Hazardous Substances

■ 4. Remove § 1915.1501

PART 1917—MARINE TERMINALS

■ 5. The authority citation for 29 CFR part 1917 continues to read as follows:

Authority: 33 U.S.C. 941; 29 U.S.C. 653, 655, 657; Secretary of Labor's Order No. 12–71 (36 FR 8754), 8–76 (41 FR 25059), 9–83 (48 FR 35736), 1–90 (55 FR 9033), 6–96 (62 FR 111), 3–2000 (65 FR 50017), 5–2002 (67 FR 65008), 5–2007 (72 FR 31160), 4–2010 (75 FR 55355), 1–2012 (77 FR 3912), or 8–2020 (85 FR 58393), as applicable; and 29 CFR part 1911.

Sections 1917.28 and 1917.31 also issued under 5 U.S.C. 553.

Section 1917.29 also issued under 49 U.S.C. 1801–1819 and 5 U.S.C. 553.

Subpart B—Marine Terminal Operations

■ 6. Remove § 1917.31

PART 1918—SAFETY AND HEALTH REGULATIONS FOR LONGSHORING

■ 7. The authority citation for 29 CFR part 1918 continues to read as follows:

Authority: 33 U.S.C. 941; 29 U.S.C. 653, 655, 657; Secretary of Labor's Order No. 12–71 (36 FR 8754), 8–76 (41 FR 25059), 9–83 (48 FR 35736), 1–90 (55 FR 9033), 6–96 (62 FR 111), 3–2000 (65 FR 50017), 5–2002 (67 FR 65008), 5–2007 (72 FR 31160), 4–2010 (75 FR 55355), 1–2012 (77 FR 3912), or 8–2020 (85 FR 58393), as applicable; and 29 CFR 1911.

Sections 1918.90 and 1918.110 also issued under 5 U.S.C. 553.

Section 1918.100 also issued under 49 U.S.C. 5101 *et seq.* and 5 U.S.C. 553.

Subpart K—COVID–19

■ 8. Remove Subpart K—COVID–19

PART 1926—SAFETY AND HEALTH REGULATIONS FOR CONSTRUCTION

Subpart D—Occupational Health and Environmental Controls

■ 9. The authority citation for 29 CFR part 1926, subpart D, continues to read as follows:

Authority: 40 U.S.C. 3704; 29 U.S.C. 653, 655, and 657; and Secretary of Labor's Order No. 12–71 (36 FR 8754), 8–76 (41 FR 25059), 9–83 (48 FR 35736), 1–90 (55 FR 9033), 6–96 (62 FR 111), 3–2000 (65 FR 50017), 5–2002 (67 FR 65008), 5–2007 (72 FR 31159), 4–2010 (75 FR 55355), 1–2012 (77 FR 3912), or 8–2020 (85 FR 58393), as applicable; and 29 CFR part 1911.

Sections 1926.59, 1926.60, and 1926.65 also issued under 5 U.S.C. 553 and 29 CFR part 1911.

Section 1926.61 also issued under 49 U.S.C. 1801–1819 and 5 U.S.C. 553.

Section 1926.62 also issued under sec. 1031, Public Law 102–550, 106 Stat. 3672 (42 U.S.C. 4853).

Section 1926.65 also issued under sec. 126, Public Law 99–499, 100 Stat. 1614 (reprinted at 29 U.S.C.A. 655 Note) and 5 U.S.C. 553.

■ 10. Remove § 1926.58

PART 1928—OCCUPATIONAL SAFETY AND HEALTH STANDARDS FOR AGRICULTURE

■ 11. The authority citation for 29 CFR part 1928 continues to read as follows:

Authority: Sections 4, 6, and 8 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 653, 655, 657); Secretary of Labor's Order No. 12–71 (36 FR 8754), 8–76 (41 FR 25059), 9–83 (48 FR 35736), 1–90 (55 FR 9033), 6–96 (62 FR 111), 3–2000 (65 FR 50017), 5–2002 (67 FR 65008), 4–2010 (75 FR 55355), or 8–2020 (85 FR 58393), as applicable; and 29 CFR 1911.

Section 1928.21 also issued under 49 U.S.C. 1801–1819 and 5 U.S.C. 553.

Subpart B—Applicability of Standards

■ 12. Remove § 1928.21(a)(8)

[FR Doc. 2025–11625 Filed 6–30–25; 8:45 am]

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DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Parts 1910, 1917, and 1918

[Docket No. OSHA–2025–0011]

RIN 1218–AD62

Cotton Dust

AGENCY: Occupational Safety and Health Administration (OSHA), Labor.

ACTION: Proposed rule; request for comments.

SUMMARY: This proposed rule revises some substance-specific respirator requirements to allow different types of respirators to be used under OSHA's Cotton Dust standard and better aligns this standard with OSHA's Respiratory Protection standard.

DATES: Comments and other information, including requests for a hearing, must be received on or before September 2, 2025.

Informal public hearing: OSHA will schedule an informal public hearing on the rule if requested during the comment period. If a hearing is requested, the location and date of the hearing, procedures for interested parties to notify the agency of their intention to participate, and procedures for participants to submit their testimony and documentary evidence will be announced in the **Federal Register**.

ADDRESSES:

Written comments: You may submit comments and attachments, identified by Docket No. OSHA–2025–0011, electronically at *https://www.regulations.gov,* which is the Federal e-Rulemaking Portal. Follow the instructions online for making electronic submissions.

Instructions: All submissions must include the agency's name and the docket number for this rulemaking (Docket No. OSHA–2025–0011). When uploading multiple attachments to