

PROTECTING EMPLOYEES, EMPLOYERS AND THE PUBLIC: H1N1 AND SICK LEAVE POLICIES

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BEFORE THE

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EDUCATION AND LABOR

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PROTECTING EMPLOYEES, EMPLOYERS AND THE PUBLIC: H1N1 AND SICK LEAVE POLICIES

**Tuesday, November 17, 2009
U.S. House of Representatives
Committee on Education and Labor
Washington, DC**

The committee met, pursuant to call, at 10:00 a.m., in room 2175, Rayburn House Office Building, Hon. George Miller [chairman of the committee] presiding.

Present: Representatives Miller, Kildee, Payne, Andrews, Scott, Woolsey, Hinojosa, McCarthy, Tierney, Wu, Holt, Davis, Bishop of New York, Loeb sack, Hirono, Altmire, Hare, Clarke, Courtney, Shea-Porter, Fudge, Polis, Tonko, Titus, Chu, Kline, Petri, McKeon, Biggert, Wilson, McMorris Rodgers, Guthrie, Roe, and Thompson.

Staff present: Aaron Albright, Press Secretary; Tylease Alli, Hearing Clerk; Tico Almeida, Labor Counsel (Immigration and International Trade); Jody Calemine, General Counsel; Lynn Dondis, Labor Counsel, Subcommittee on Workforce Protections; David Hartzler, Systems Administrator; Broderick Johnson, Staff Assistant; Gordon Lafer, Senior Labor Policy Advisor; Richard Miller, Senior Labor Policy Advisor; Alex Nock, Deputy Staff Director; Joe Novotny, Chief Clerk; Rachel Racusen, Communications Director; Meredith Regine, Junior Legislative Associate, Labor; James Schroll, Junior Legislative Associate, Labor; Dray Thorne, Senior Systems Administrator; Michele Varnhagen, Labor Policy Director; Mark Zuckerman, Staff Director; Andrew Blasko, Minority Speech Writer and Communications Advisor; Kirk Boyle, Minority General Counsel; Casey Buboltz, Minority Coalitions and Member Services Coordinator; Ed Gilroy, Minority Director of Workforce Policy; Rob Gregg, Minority Senior Legislative Assistant; Ryan Murphy, Minority Press Secretary; Jim Paretto, Minority Workforce Policy Counsel; Molly McLaughlin Salmi, Minority Deputy Director of Workforce Policy; and Linda Stevens, Minority Chief Clerk/Assistant to the General Counsel.

Chairman MILLER [presiding]. The committee will come to order to conduct a hearing on “Protecting employees and employers and the public: H1N1 and sick leave policies.” I would like to welcome everyone this morning on a very important topic.

We are meeting today in the midst of a global pandemic. The H1N1 virus is sweeping our country, closing hundreds of schools, idling thousands of workers, and affecting millions of Americans. The H1N1 flu virus is now officially widespread in at least 48

states, and the president has designated the virus a public health emergency.

The Centers on Disease Control reports that the flu spread is very unusual this early in the season, and deaths among children and young adults are higher than expected. The CDC estimates that 22 million Americans have already become ill in the last 6 months with H1N1, and 3,900 have died. A recent study predicted that 63 percent of Americans will be infected by the virus by the end of December.

Fortunately, public health officials did have an early warning this spring on the potential of a widespread outbreak. The Obama administration and public health officials took immediate steps to develop policies to slow the spread of H1N1 flu and minimize the disruptions, but all of the planning and preparations cannot fully address the uncertainties surrounding the new highly contagious virus.

While I applaud the quick identification and development of the vaccine, the delays of producing and delivering the vaccine to targeted populations have concerned millions of Americans. I am encouraged with the report that private vaccine manufacturers have worked out the production issues, and we seem to be back on track to getting the needed vaccine to the American people. The H1N1 vaccine is the new viral tactic to slow the infection rate.

While we fix the supply issues, the public health officials emphasize that there are additional ways to slow the spread of this dangerous virus. The CDC has issued guidance and recognizes the role employers and workers play in slowing the spread of the disease. According to the CDC, an individual who comes to work with H1N1 will infect about 10 percent of his or her co-workers.

They recommend that any worker with influenza-type illnesses stay home and that employers should allow workers to stay home without fear of any reprisals and without fear of losing their jobs. But the recommendation is easier made than followed, because for more than 50 million workers without paid sick leave, taking a day off from work means a pay cut or worse. Workers fear that they will be punished for taking time off either by losing pay because they do not have paid sick days or even by being fired.

Employees of the food service, hospitality industry, school and health care fields are among those who cannot afford to stay home when they are sick. Because these employees have direct contact with the public, the consequences of coming to work sick are not only damaging to their health, but could damage the public health as well.

Let us face one simple fact. When you are struggling to make ends meet, you are going to do everything possible not to miss a day's pay. The lack of paid sick leave encourages workers who may have H1N1 to hide their symptoms and come to work sick, spreading the infection to co-workers, customers and the public. It is not good for our nation's public health or for businesses.

The National Partnership of Women and Families found that sick employees who go to work cost the economy about \$180 billion in lost productivity. This is a significant loss of productivity for the American economy compared to the minimal cost of providing a few paid sick days a year. The Bureau Of Labor Statistics says the cost

of paid leave borne by employers for lower wage workers only accounts for 4.2 percent of their total compensation.

Despite these minimal costs, current federal law does not mandate that employers provide paid sick leave to their workers. This is why members of Congress have been pushing for universal paid leave policies that will ensure workers at all income levels are able to take advantage of paid leave policies. I strongly support these efforts.

However, the current H1N1 pandemic demanded an emergency response. Two weeks ago Congresswoman Woolsey and I introduced temporary and emergency legislation to help workers and employers deal with the spread of the H1N1 flu virus. The Emergency Influenza Containment Act will guarantee sick workers 5 days of paid leave if their employer directs or advises them to stay home.

This temporary legislation will slow the advance of H1N1 being spread through the workplace and encourage open communication between employees and their employers on sick leave policies. This emergency measure will not and should not supplant the need for comprehensive paid family leave policies, but I believe that it will be a circuit breaker needed to get this virus under control while protecting workers, employers and the public.

I will continue to work with other members, such as Congresswoman Rosa DeLauro, in their efforts to win permanent reform in this area.

But I would like to thank the witnesses for joining us today on this important hearing and look forward to all of your testimony. And with that, I would like to recognize the senior Republican member of our committee, Mr. Kline, for an opening statement.

[The statement of Mr. Miller follows:]

Prepared Statement of Hon. George Miller, Chairman, Committee on Education and Labor

I would like to welcome everyone this morning on a very important topic.

We are meeting today in the midst of a global pandemic. The H1N1 virus is sweeping our country—closing hundreds of schools, idling thousands of workers, and infecting many millions of Americans.

The H1N1 flu virus is now officially “widespread” in at least 48 states and the President has designated the virus a public health emergency.

The Centers for Disease Control reports that the flu’s spread is very unusual this early in the season and deaths among children and young adults are higher than expected. The CDC estimates that 22 million Americans have already become ill in the last six months with H1N1 and 3,900 have died.

A recent study predicted that 63 percent of Americans will be infected with the virus by the end of December.

Fortunately, public health officials did have an early warning this spring of the potential of a widespread outbreak. The Obama administration and public health officials took immediate steps to develop policies to slow the spread of the H1N1 flu and minimize disruptions.

But all the planning and preparations cannot fully address the uncertainties surrounding a new, highly contagious virus. While I applaud the quick identification and development of a vaccine, the delays of producing and delivering the vaccine to target populations have concerned millions of Americans. I am encouraged reports that private vaccine manufacturers have worked out production issues and we seem to be back on track to getting the needed vaccine to the American people.

The H1N1 vaccine is one vital tactic to slow the infection rate. While we fix the supply issues, public health officials emphasize that there are additional ways to slow the spread of this dangerous virus.

The CDC has issued guidance that recognizes the role employers and workers play in slowing the spread of disease. According to the CDC, an individual who

comes to work with H1N1 will infect about 10 percent of his or her co-workers. They recommend that any worker with an influenza-type illness stay home, and that employers should allow workers to stay home “without fear of any reprisals” and “without fear of losing their jobs.”

But, that recommendation is easier made than followed.

Because for the more than 50 million workers without paid sick leave, taking a day off from work means a pay cut or worse. Workers fear they will be punished for taking time off, either by losing pay because they do not have paid sick days or even fired. Employees in the food-service and hospitality industry, schools and health care fields are among those who cannot afford to stay home when they're sick.

Because these employees have direct contact with the public, the consequences of coming into work sick are not only damaging to their health, but could be damaging for the public's health as well.

Let's face some simple facts: when you're struggling to make ends meet you're going to do everything possible to not miss a day's pay. The lack of paid sick leave encourages workers who may have H1N1 to hide their symptoms and come to work sick—spreading infection to coworkers, customers and the public.

This isn't good for our nation's public health or for businesses.

The National Partnership for Women and Families found that sick employees who still go to work cost the economy \$180 billion in lost productivity. This is a significant loss in productivity for the American economy compared to the minimal cost of providing a few paid-sick days a year.

The Bureau of Labor Statistics says that the costs of paid leave borne by employers for lower-wage workers only accounts for 4.2 percent of their total compensation. Despite these minimal costs, current federal law does not mandate that employers provide paid leave to their workers.

This is why members of Congress have been pushing for universal paid leave policies that will ensure workers of at all income levels are able to take advantage of paid leave policies.

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This emergency measure will not, and should not, supplant the need for comprehensive paid family leave policies. But I believe it will be a circuit breaker needed to get this virus under control, while protecting workers, employers and the public.

I will continue to work with other members such as Congresswoman DeLauro in their efforts to win permanent reform in this area.

I would like to thank the witnesses for joining us today for this important hearing and forward to your testimony.

Mr. KLINE. Thank you, Mr. Chairman.

Good morning to all. I absolutely concur with the chairman that our topic today is indeed a timely one, with employers, workers and their families facing the uncertainty of a widespread influenza outbreak was wide-ranging effects.

Unfortunately, the uncertainty I mentioned is pervasive. Even the scope of the outbreak is apparently unknown. The Washington Post reported on Friday that, “Total H1N1 cases in the United States range from 14 million to 44 million and total deaths range from 2,500 to 6,100.”

Adding to the confusion, the administration's early estimates of vaccine availability were significantly overstated, resulting in long lines and shortages while vaccine production ramped up. Nonetheless, Americans are coping with the situation as well as they can. From schools and workplaces to shopping centers and transit sys-

tems, we are seeing the implementation of simple safeguards, such as using hand sanitizer and limiting person-to-person contact in an effort to reduce exposure.

We are here this morning to talk specifically about workplace policies designed to limit the spread of H1N1, including the availability of sick leave for workers who fall ill. To understand these issues, we need a bit of context.

We should know that in 2008 nearly all full-time employees in the United States, fully 93 percent, had access to paid sick leave. The majority of part-time workers had paid sick leave as well, although 82 percent of these workers are employed part-time voluntarily in order to have the flexibility to manage work and family obligations.

We all know federal mandates are particularly onerous for small businesses, so it is important to look specifically at this category of employers as we consider new federal policies. The data tell us that 76 percent of all workers in small businesses with fewer than 50 employees have paid illness leave, while other employers have informal plans—for example, granting paid time off for health-related concerns on a case-by-case basis.

We must also be mindful of the existing Family Medical Leave Act, which provides unpaid leave for medical reasons and carries a host of notification and certification procedures of its own. With so many workers already having access to a variety of sick leave options, we need to look very carefully at proposals to add a new layer of federal leave mandates.

A number of questions remain unanswered. How would these paid leave requirements interact with existing leave policies? What kind of notification or certification would be required? And is it a wise idea to put employers in the business of diagnosing medical conditions and deciding when workers should be sent home and when they are well enough to return to work?

The H1N1 outbreak is a serious concern, and employers across the country are taking steps already to minimize infection and prevent the spread of the flu in their workplaces. This is clearly new and unknown territory, and we must tread very carefully as we attempt to minimize the spread of H1N1 while avoiding the creation of confusing, duplicative and costly new mandates that could harm the very workers we are trying to protect.

I look forward to hearing from our witnesses and gaining a better understanding of the existing policies and practices and how they are being applied to the current influenza outbreak.

And with that, Mr. Chairman, I thank you and yield back.

[The statement of Mr. Kline follows:]

**Prepared Statement of Hon. John Kline, Senior Republican Member,
Committee on Education and Labor**

Good morning Chairman Miller. Our topic today is a timely one, with employers, workers, and their families facing the uncertainty of a widespread influenza outbreak with wide ranging effects.

Unfortunately, the uncertainty I mentioned is pervasive. Even the scope of the outbreak is unknown. The Washington Post reported on Friday that “total H1N1 cases in the United States range from 14 million to 34 million, and total deaths range from 2,500 to 6,100.”

Adding to the confusion, the Administration's early estimates of vaccine availability were significantly overstated, resulting in long lines and shortages while vaccine production ramped up.

Nonetheless, Americans are coping with the situation as well as they can. From schools and workplaces to shopping centers and transit systems, we are seeing the implementation of simple safeguards such as using hand sanitizer and limiting person-to-person contact in an effort to reduce exposure.

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I look forward to hearing from our witnesses and gaining a better understanding of the existing policies and practices, and how they're being applied to the current influenza outbreak. Thank you, and I yield back.

Chairman MILLER. Thank you very much.

And with that, I would like to introduce our panel and say that pursuant to committee rule 7C, all members may submit an opening statement in writing, which will be made part of the permanent record.

Our first witness will be Dr. Anne Schuchat, who currently serves as the assistant surgeon general of the United States Public Health Service and director of the National Center for Immunization and Respiratory Diseases at the Center for Disease Control and Prevention. In addition, Dr. Schuchat is also the chief health officer for the CDC's H1N1 response. Dr. Schuchat has spent more than 20 years at CDC, working on immunization, respiratory and infectious diseases.

Dr. Georges Benjamin has served as executive director of the American Public Health Association, the nation's oldest and largest organization of public health professionals since December of 2002. Prior to this position, Dr. Benjamin served as secretary of many divisions of the Maryland Department of Health, as well as also serving as acting commissioner of public health for the District of Co-

lumbia. Dr. Benjamin is also a member of the Institute of Medicine at the National Academies of Science.

Bruce Clarke is the president and CEO of Capital Associated Industries and also serves as chairman of the Employment and Labor Policy Subcommittee of the National Association of Manufacturers. Capital Associated Industries is a nonprofit employers association, which provides 1,200 member companies with executive, management and human resource information and services.

Debra Ness is the president of the National Partnership for Women and Families, one of the country's leading organizations promoting policies to help women and men meet the dual demands of work and family. Prior to assuming her current role, Ms. Ness served as the executive vice president of the National Partnership for 13 years. Ms. Ness is also a national leader in efforts to improve health care, including serving on the National Quality Forum established by the president's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, with the mission of developing national strategies for health care quality measurement and reporting.

Welcome to all of you. Thank you for taking your time to share your knowledge and expertise with the committee.

And, Dr. Schuchat, we will begin with you. You have been here before, but a green light will go on. That will tell you that you have 5 minutes for your testimony. An orange light will come on to suggest you might want to start wrapping up with about a minute left. And then you wrap up when the red light is on in the manner most coherent and convenient to you. So, welcome.

STATEMENT OF DR. ANNE SCHUCHAT, DIRECTOR, NATIONAL CENTER FOR IMMUNIZATION AND RESPIRATORY DISEASES, CHIEF HEALTH OFFICER, H1N1 RESPONSE, CENTERS FOR DISEASE CONTROL AND PREVENTION

Dr. SCHUCHAT. Thank you, Chairman Miller, Ranking Member Kline, and other members of the committee. It is really a pleasure to come back to update the committee on the administration's comprehensive response to the H1N1 virus and discuss the impact that the pandemic is having on work, school and society.

We have estimated that the first 6 months of this pandemic, the virus has led 22 million people to become ill, 98,000 people to be hospitalized, and about 4,000 people to die. The virus is spreading widely in 46 states. It is beginning to decrease in many places, but it is still way higher than baseline for this time of year.

So far, there has been no change in the illness pattern, the age pattern or underlying conditions. Ninety percent of people who have died from this virus are under 65 years of age, a complete opposite with what we see for seasonal flu. Two-thirds of the children who have died have underlying conditions—asthma, neurologic problems and so forth, and so we know that pregnant women and adults with chronic medical conditions are at higher risk than others.

So far, there has been no change in the virus. This is good news, because it means it hasn't become more virulent. It is also good news, because the vaccines that we are making perfectly match the strain and should have good effectiveness.

But influenza, including the H1N1 virus, is unpredictable, and we do not know the trajectory that the virus will have in the weeks and months ahead. We know that previous pandemics have had multiple waves, and we are mindful the disease may continue to spread and that we may have waves of this disease through the next several months. The typical flu season goes from December to May, and we are mindful that we have a long road ahead.

CDC's role I am going to go through in a little bit of detail, but first I want to thank Congress for the incredible support that we have received to strengthen the preparedness of the country. It really is a little terrifying to think of where we would be if we had not been investing in the past several years in improved preparedness at the state and local level, the federal level, and the global level.

CDC responded promptly last fall, identifying and characterizing this new virus, developing a strain to form a candidate for vaccine development, carrying out epidemiologic and laboratory surveillance in the U.S. and around the world. Our response has been comprehensive and aggressive, using science as the base for our approaches.

We rapidly deployed assets, including life-saving antivirals and a significant portion of respiratory protection from our strategic national stockpile. We prepared and shaped laboratory kits to states around the country and to over 150 countries. We sent field teams to assist at home and abroad.

We have issued guidance for schools, businesses and so forth, reminding them about how important sick leave is. We have issued guidance and updated that guidance for health care workers, mentioning respiratory protection and the steps that could be taken to extend the supply of respiratory protection.

We have incorporated new antiviral medicines that can be delivered intravenously with the help of the FDA. We have focused on communication, and we have focused on vaccination. We are in the midst of a large national voluntary vaccination effort that is unprecedented in its scope.

We, like others, are disappointed in the vaccine production and has been to some extent the victim of a slow-growing virus, but production is accelerating, and substantial amounts are now becoming available. Today 48.5 million doses of H1N1 vaccine has become available for the states to order. They have prioritized groups at highest risk to receive the vaccine during this phase where it is in limited supply, and we are supporting states and local authorities to make the best decisions about how to reach the priority groups with the scarce vaccine.

We think it is very important to use vaccine as soon as it is available as effectively and efficiently as possible. We are focusing on safety and not taking any shortcuts either in vaccine release or in monitoring safety as the vaccine is in larger scale use, working hard with our partners in HHS and beyond to focus on the state and local infrastructure that is so vital in our response.

Today's hearing highlights the human and economic impact that influenza has, and in general illness really can cause work loss and threaten business continuity. Our guidance is for individuals to

stay home when they are sick. Twenty-four hours after a fever is gone is what we have recommended, based on updated evidence.

We know that we have issued guidance to businesses to be flexible in sick leave and make it easy for workers to do the right thing. It is important to have the right policies in place and have careful planning for contingencies at businesses. Our goal in public health is to make it easy for employees to make the right choices to stay home, avoid infecting co-workers, and recover.

I look forward to regular communications with the public and Congress and to answering the questions that you have.

[The statement of Dr. Schuchat follows:]

Prepared Statement of RADM Anne Schuchat, M.D., Assistant Surgeon General; Director, National Center for Immunization and Respiratory Diseases (NCIRD), Centers for Disease Control and Prevention, U.S. Department of Health and Human Services

Chairman Miller, Ranking Member Kline, members of the Committee, thank you for this opportunity to update you on the public health challenges of 2009 H1N1 influenza.

The Centers for Disease Control and Prevention (CDC) and our colleagues throughout the Department of Health and Human Services (HHS) are working in close partnership with many parts of the federal government, as well as with states and localities, under a national preparedness and response framework for action that builds on the efforts and lessons learned from the past few months, this previous spring and influenza preparedness trainings conducted during the last several years. Working together with governors, mayors, tribal leaders, state and local health departments, the medical community and our private sector partners, we have been monitoring the spread of H1N1 and facilitating prevention and treatment, including implementing a vaccination program. CDC also has deployed staff, both domestically and globally, to assist in epidemiologic investigation of the virus and support state, local and territorial health departments with the H1N1 mass vaccination campaign.

Influenza is probably the least predictable of all infectious diseases, and the 2009 H1N1 pandemic has presented considerable challenges—in particular the delay in production of a vaccine due to slow growth of the virus during the manufacturing process. Today I will update you on the overall situation, provide an update on vaccination status, and discuss other steps we are taking to address these challenges.

This hearing is also an important opportunity to consider the impact this pandemic has had on work, school, and society. And although we are focused this year on the impact of the H1N1 pandemic, it is important to remember that even in a normal year, individuals and institutions are impacted by illnesses, as reflected in lost work and school days and lower productivity. Data from our National Center for Health Statistics in 2008 show, for example, that employed adults 18 years of age and over experienced an average of 4.4 work-loss days per person due to illness or injury in the past 12 months, for a total of approximately 698 million work-loss days.

Tracking and Monitoring Influenza Activity

One major area of effort is the tracking and monitoring of influenza activity, which helps individuals and institutions monitor and understand the impact of the 2009 H1N1 virus. Since the initial spring emergence of 2009 H1N1 influenza, the virus has spread throughout the world. H1N1 was the dominant strain of influenza in the southern hemisphere during its winter flu season. Data about the virus from around the world—much of it collected with CDC assistance—have shown that the circulating pandemic H1N1 virus has not mutated significantly since the spring, and the virus remains very closely matched to the 2009 H1N1 vaccine. This virus also remains susceptible to the antiviral drugs oseltamivir and zanamivir, with very rare exception.

Unlike a usual influenza season, flu activity in the United States continued throughout the summer, at summer camps and elsewhere. More recently, we have seen widespread influenza activity in 48 states; any reports of widespread influenza this early in the season are very unusual. Visits to doctors for influenza-like illness as well as flu-related hospitalizations and deaths among children and young adults also are higher than expected for this time of year. We are also already observing

that more communities are affected than those that experienced H1N1 outbreaks this past spring and summer.

Almost all of the influenza viruses identified so far this season have been 2009 H1N1 influenza A viruses. However, seasonal influenza viruses also may cause illness in the upcoming months—getting one type of influenza does not prevent you from getting another type later in the season. Because of the current H1N1 pandemic, several additional systems have been put in place and existing systems modified to more closely monitor aspects of 2009 H1N1 influenza. These include the following:

Enhancing Hospitalization Surveillance: CDC has greatly increased the capacity to collect detailed information on patients hospitalized with influenza. Using the 198 hospitals in the Emerging Infections Program (EIP) network and 6 additional sites with 76 hospitals, CDC monitors a population of 25.6 million to estimate hospitalization rates by age group and monitor the clinical course among persons with severe disease requiring hospitalization.

Expanding Testing Capability: Within 2.5 weeks of first detecting the 2009 H1N1 virus, CDC had fully characterized the new virus, disseminated information to researchers and public health officials, and developed and begun shipping to states a new test to detect cases of 2009 H1N1 infection. CDC continues to support all states and territories with test reagents, equipment, and funding to maintain laboratory staff and ship specimens for testing. In addition, CDC serves as the primary support for public health laboratories conducting H1N1 tests around the globe and has provided test reagents to 406 laboratories in 154 countries. It is vital that accurate testing continue in the United States and abroad to monitor any mutations in the virus that may indicate increases in infection severity, resistance to antiviral drugs, or a decrease in the match between the vaccine strain and the circulating strain.

Health Care System Readiness: HHS is also using multiple systems to track the impact the 2009 H1N1 influenza outbreak has on our health care system. HHS is in constant communication with state health officials and hospital administrators to monitor stress on the health care system and to prepare for the possibility that federal medical assets will be necessary to supplement state and local surge capabilities. To date, state and local officials and health care facilities have been able to accommodate the increased patient loads due to 2009 H1N1, but HHS is monitoring this closely and is prepared to respond quickly if the situation warrants.

Implementing a Flu-related School Dismissal Monitoring System: CDC and the U.S. Department of Education (ED), in collaboration with state and local health and education agencies and national non-governmental organizations, have implemented a flu-related school dismissal monitoring system for the 2009-2010 school year. This monitoring system generates a verified, near-real-time, national summary report daily on the number of school dismissals by state across the 130,000 public and private schools in the United States, and the number of students and teachers impacted. The system was activated August 3, 2009. This has helped us to calibrate our messages and guidance and may have contributed to the smaller number of school closings seen in the fall relative to those seen in the spring.

Providing Science-Based Guidance

A second major area of effort in support of individuals and institutions is to provide science-based guidance that allows them to take appropriate and effective action. Slowing the spread and reducing the impact of 2009 H1N1 and seasonal flu is a shared responsibility. We can all take action to reduce the impact flu will have on our communities, schools, businesses, other community organizations, and homes this fall, winter, and spring.

There are many ways to prevent respiratory infections and CDC provides specific recommendations targeted to a wide variety of groups, including the general public, people with certain underlying health conditions, infants, children, parents, pregnant women, and seniors. CDC also has provided guidance to workers and in relation to work settings, such as health care workers, first responders, and those in the swine industry, as well as to laboratories, homeless shelters, correctional and detention centers, hemodialysis centers, schools, child care settings, colleges and universities, small businesses, and federal agencies.

With the holidays coming up, reducing the spread of 2009 H1N1 influenza among travelers will be an important consideration.

CDC quarantine station staff respond to reports of illness, including influenza-like illness when reported, in international travelers arriving at U.S. ports of entry. Interim guidance documents for response to travelers with influenza-like illness, for airline crew, cruise ship personnel and Department of Homeland Security port and field staff have been developed and posted online. As new information about this

2009 H1N1 influenza virus becomes available, CDC will evaluate its guidance and, as appropriate, update it using the best available science and ensure that these changes are communicated to the public, partners, and other stakeholders.

In preparation for the upcoming months when we expect many families and individuals to gather for the holidays, we are preparing to launch a national communications campaign to encourage domestic and international travelers to take steps to prevent the spread of flu. Plans are to display public advertisements with flu prevention messages in ports of entry and various other advertising locations, such as newspapers and online advertisements, both before and during the upcoming holiday travel season.

Supporting Shared Responsibility and Action through Enhanced Communication

A third major area of effort is to support shared responsibility and action through enhanced communication to individuals. Our recommendations and action plans are based on the best available scientific information. CDC is working to ensure that Americans are informed about this pandemic and consistently updated with information in clear language. The 2009 H1N1 pandemic is a dynamic situation, and it is essential that the American people are fully engaged and able to be part of the mitigation strategy and overall response. CDC will continue to conduct regular media briefings, available at flu.gov, to get critical information about influenza to the American people.

Some ways to combat the spread of respiratory infections include staying home when you are sick and keeping sick children at home. Covering your cough and sneeze and washing your hands frequently will also help reduce the spread of infection. Taking personal responsibility for one's health will help reduce the spread of 2009 H1N1 influenza and other respiratory illnesses.

CDC is communicating with the public about ways to reduce the spread of flu in more interactive formats such as blog posts on the Focus on Flu WebMD blog, radio public service announcements, and podcasts.

Through the CDC INFO Line, we serve the public, clinicians, state and local health departments and other federal partners 24 hours/day, 7 days/week, in English and Spanish both for phone and email inquiries. Our information is updated around the clock so we are well positioned to respond to the needs and concerns of our inquirers. Our customer service representatives get first-hand feedback from the public on a daily basis. In addition to the H1N1 response, we continue to provide this service for all other CDC programs.

Prevention through Vaccination

A fourth major area of effort is prevention through vaccination. Vaccination is our most effective tool to reduce the impact of influenza. Despite rapid progress during the initial stages of the vaccine production process, the speed of manufacturing has not been as rapid as initially estimated. CDC, in collaboration with Food and Drug Administration (FDA), characterized the virus, identified a candidate vaccine strain, and our HHS partners expedited manufacturing, initiated clinical trials, and licensed four 2009 H1N1 influenza vaccines all within five months. The speed of this vaccine development was made possible due to investments made in vaccine advanced research and development and vaccine manufacturing infrastructure building through the office of the Assistant Secretary for Preparedness and Response (ASPR), Biomedical Advanced Research and Development Authority (BARDA) over the past four years, and in collaboration with CDC, the National Institutes of Health (NIH), and FDA. The rapid responses of HHS agencies, in terms of surveillance, viral characterization, pre-clinical and clinical testing, and assay development, were greatly aided by pandemic preparedness efforts for influenza pandemics set in motion by the H5N1 virus re-emergence in 2003, and the resources Congress provided for those efforts.

Pandemic planning had anticipated vaccine becoming available 6-9 months after emergence of a new influenza. 2009 H1N1 vaccination began in early October—5 months after the emergence of 2009 H1N1 influenza. Critical support from Congress resulted in \$1.44 billion for states and hospitals to support planning, preparation, and implementation efforts. States and cities began placing orders for the 2009 H1N1 vaccine on September 30th. The first vaccination with 2009 H1N1 influenza vaccine outside of clinical trials was given October 5th. Tens of millions of doses have become available for ordering, and millions more become available each week. Although significant delays in vaccine production by manufacturers have complicated the early immunization efforts, vaccine will become increasingly available over the weeks ahead, and will become more visible through delivery in a variety of settings, such as vaccination clinics organized by local health departments, healthcare provider offices, schools, pharmacies, and workplaces.

CDC continues to offer technical assistance to states and other public health partners as we work together to ensure the H1N1 vaccination program is as effective as possible. Since September 30th, although the number of H1N1 vaccine doses produced, distributed, and administered has grown less quickly than projected, states have begun executing their plans to provide vaccine to targeted priority populations. Although we had hoped to have more vaccine distributed by this point, we are working hard to get vaccine out to the public just as soon as we receive it.

H1N1 vaccines are manufactured by the same companies employing the same methods used for the yearly production of seasonal flu vaccines. H1N1 vaccine is distributed to providers and state health departments similarly to the way federally purchased vaccines are distributed in the Vaccines for Children program. Two types of 2009 H1N1 vaccine are now available: injectable vaccine made from inactivated virus, including thimerosal-free formulations, and nasal vaccine made from live, attenuated (weakened) virus.

CDC's Advisory Committee on Immunization Practices (ACIP) has recommended that 2009 H1N1 vaccines be directed to target populations at greatest risk of illness and severe disease caused by this virus. On July 29, 2009, ACIP recommended targeting the first available doses of H1N1 vaccine to five high-risk groups comprised of approximately 159 million people; CDC accepted these recommendations. These groups are: pregnant women; people who live with or care for children younger than 6 months of age; health care and emergency services personnel; persons between the ages of 6 months through 24 years of age; and people from ages 25 through 64 years who are at higher risk for severe disease because of chronic health disorders like asthma, diabetes, or compromised immune systems. These recommendations provide a framework from which states can tailor vaccination to local needs.

Ensuring a vaccine that is safe as well as effective is a top priority. CDC expects that the 2009 H1N1 influenza vaccine will have a similar safety profile to seasonal influenza vaccine, which historically has an excellent safety track record. So far the reports of adverse events among H1N1 vaccination are generally mild and are similar to those we see with seasonal flu vaccine. We will remain alert, however, for the possibility of rare, severe adverse events that could be linked to vaccination. CDC and FDA have been working to enhance surveillance systems to rapidly detect any unexpected adverse events among vaccinated persons and to adjust the vaccination program to minimize these risks. Two primary systems used to monitor vaccine safety are the Vaccine Adverse Events Reporting System (VAERS), jointly operated between CDC and FDA, and the Vaccine Safety Datalink (VSD) Project, a collaborative project with eight managed care organizations covering more than nine million members. These systems are designed to determine whether adverse events are occurring among vaccinated persons at a greater rate than among unvaccinated persons. CDC has worked with FDA and other partners to strengthen these vaccine safety tracking systems and we continue to develop new ways to monitor vaccine safety, as announced earlier this week by the Federal Immunization Safety Task Force in HHS. In addition, based on the recommendation of the National Vaccine Advisory Committee (NVAC), HHS established the H1N1 Vaccine Safety Risk Assessment Working Group to review 2009 H1N1 vaccine safety data as it accumulates. This working group of outside experts will conduct regular, rapid reviews of available data from the federal safety monitoring systems and present them to NVAC and federal leadership for appropriate policy action and follow-up.

More than 36,000 people die each year from complications associated with seasonal flu. CDC continues to recommend vaccination against seasonal influenza viruses, especially for all people 50 years of age and over and all adults with certain chronic medical conditions, as well as infants and children. As of the fourth week in October, 89 million doses of seasonal vaccine had been distributed. It appears that interest in seasonal flu vaccine has been unprecedented this year. Manufacturers estimate that a total of 114 million doses will be brought to the U.S. market.

Reducing the Burden of Illness and Death through Antiviral Distribution and Use

In the spring, anticipating commercial market constraints, HHS deployed 11 million courses of antiviral drugs from the Strategic National Stockpile (SNS) to ensure the nation was positioned to quickly employ these drugs to combat 2009 H1N1 and its spread. In early October, HHS shipped an additional 300,000 bottles of the oral suspension formulation of the antiviral oseltamivir to states in order to mitigate a predicted near-term national shortage indicated by commercial supply data. In addition, the Secretary authorized the release of the remaining 234,000 bottles of pediatric Tamiflu(r) on October 29th. We will continue to conduct outreach to pharmacists and providers related to pediatric dosing and compounding practices to help assure supplies are able to meet pediatric demand for antiviral treatment. Finally, CDC and FDA have also worked together to address potential options for treatment

of seriously ill hospitalized patients with influenza, including situations in which physicians may wish to use investigational formulations of antiviral drugs for intravenous therapy. The FDA issued an emergency use authorization (EUA) on October 23rd, 2009, for the investigational antiviral drug peramivir intravenous (IV) authorizing the emergency use of peramivir for the treatment of certain hospitalized adult and pediatric patients with confirmed or suspected 2009 H1N1 influenza infection. Physician requests for peramivir to be used under the EUA are managed through a CDC web portal.

Closing Remarks

CDC is working hard to limit the impact of this pandemic, and we are committed to keeping the public and the Congress fully informed about both the situation and our response. We are collaborating with our federal partners as well as with other organizations that have unique expertise to help CDC provide guidance to multiple sectors of our economy and society. There have been enormous efforts in the United States and abroad to prepare for this kind of challenge.

Our nation's current preparedness is a direct result of the investments and support of Congress over recent years, effective planning and action by Federal agencies, and the hard work of state and local officials across the country. We look forward to working closely with Congress as we address the situation as it continues to evolve in the weeks and months ahead.

Again, Mr. Chairman, thank you for the opportunity to participate in this conversation with you and your colleagues. I look forward to answering your questions.

Chairman MILLER. Thank you very much.
Dr. Benjamin?

**STATEMENT OF DR. GEORGES C. BENJAMIN, EXECUTIVE
DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION**

Dr. BENJAMIN. Well, good morning, Chairman Miller and Ranking Member Kline and members of the committee. Thank you very much for allowing me to be here.

As you know, APHA has been around for quite a while. We have been around since 1872, and I spent last evening looking at our recommendations back in 1918, the last time we had a great pandemic in our country. And interestingly enough, short of vaccine, many of our recommendations were the same. They were: try to be in good health, wash your hands, cover your nose and mouth when you cough and sneeze, and avoid being around other people, or try to, where you might, unfortunately, infect them.

Dr. Schuchat and you, Mr. Chairman, talked a great deal about the data, and you have my written remarks, and I won't repeat those, but just to point out that one of the things that APHA has been talking about a lot is the importance for us to have a resilient community. And part of resiliency means that you have to have a much more comprehensive engagement in just the health and public health people in this response.

Obviously, this type of an outbreak dramatically affects business. And we think that there is a huge role that paid sick leave for workers plays in really building an essential and resilient community. So let me talk first about the paid sick leave benefits for business.

We think legislation like the one you have, Chairman, and others, as you mentioned, that are being talked about on the Hill today can be a win-win for both the public health and business. And, you know, employers don't want sick people in the workplace, and sick workers don't want to be at work. But the incentives that we have today often incentivize workers to come to work, particu-

larly when they are not well and they don't get paid for staying home. And I asked myself as I came into work today—I came in my building, so let me just walk you through what I saw.

So when you walk into our building, we have a really nice building on I Street in downtown D.C., and we have a receptionist that you walk past. And then you get in an elevator with other people as you drive up to the various floors. I noticed my staff congregating around the coffee pot in a nice, relatively enclosed room and, of course, some meeting in a conference room. Many of our employees are in open cubicles.

I would argue that, despite this being a public health association, having lots of hand sanitizer around and lots of signs, and I remember the last time I actually, like many other people, tried to tough it out and came to work when I wasn't feeling well, the workplace can very well be an incubator for the spread of infectious diseases, if we don't encourage people not to come to work.

So we think very strongly that sick pay, sick leave for employees, can enhance productivity, catch people before they want to come to work. See, the problem when you come to work and you send people home when they are sick, because they are incentivized to come to work and tough it out, is that they are infecting people all the way along the way as they come into the workplace. And so we think that any proposal ought to incentivize people not to come to work when they are sick, to do the right thing and stay home.

Secondly, I think the paid sick leave benefits for employees and their families goes without saying. Certainly, if you have a sick loved one at home, you want to be able to stay home and take care of them. Many parents—good, caring parents—when they have to make a decision around paying the bills and paying the mortgage and a child is not too sick, we all know stories of parents sending their kids to school or to day care, only to get called in the middle of the day, because the child really isn't feeling well, and you have got to go pick them up.

Well, in an infectious disease, that is a real problem. Paid sick leave certainly encourages people not to put themselves at risk, not put their kids at risk, not put their communities at risk, and so we strongly support that as a core principle.

And then, obviously, paid sick leave benefits the community and consumers just simply because if you are in a business and someone is sick and that business, particularly with this kind of infectious disease, they may often infect your customers. And the last thing you want to do, of course, is make a customer ill. So we think that legislation like this and other legislation that we have, discussing like this on the Hill today, aptly promote the public health and promote productivity in the workplace, and we are here to support that.

APHA has had a policy which supports employers to make comprehensive plans around these kinds of events, particularly contingency in emergency preparedness plans, continuity of operations plans. And the worst thing one can do, and the worst problem one has, even as a small employer, is to not be prepared for this kind of thing. I know that there is a lot of debate about what this costs small employers, but I would submit that the cost to not do this can certainly put a small employer out of business as well.

With that, I will stop. Thank you very much.
 [The statement of Dr. Benjamin follows:]

**Prepared Statement of Georges C. Benjamin, M.D., FACP, FACEP (E),
 Executive Director, American Public Health Association**

Chairman Miller, Ranking Member Kline, members of the Committee, thank you for the opportunity to join you this morning to represent the views of the American Public Health Association (APHA) on the important role that sick leave policies play in the containment of H1N1 infection and in the public health well-being of America. APHA is the oldest and most diverse organization of public health professionals in the world representing a broad array of health officials, educators, environmentalists, policy-makers, and health providers at all levels working both within and outside government organizations and education institutions to improve the health of our nation and the world.

Influenza is a public health threat that arrives in our communities every fall. However, the emergence this year of the novel H1N1 virus has demonstrated the capacity for a widespread outbreak and the potential complications should the virus become a more virulent strain than exists today. We are very pleased that the Committee is looking at the critical issues facing both employees and employers as we deal with the impacts of H1N1 on the workplace.

Since identified in April of this year, health officials estimate that 22 million people have been sickened by H1N1. Latest infection estimates indicate that about 98,000 people have been hospitalized and about 4,000 have died due to H1N1; 36,000 and 540 of which are children, respectively.ⁱ

Information analyzed by CDC indicates that the 2009 H1N1 flu has caused greater disease burden in people younger than 25 years of age than older people. Compared with seasonal flu, there are relatively fewer cases and deaths reported in those over 65 years of age. More so than seasonal flu, therefore, H1N1 flu is affecting the younger workforce.ⁱⁱ

The response toward building a resilient and healthy community requires thorough planning and a comprehensive approach at all levels of society from individuals to families; and in all places where we play, learn and work. Resiliency enables a community to withstand the ravages of a pandemic and hasten the community's return to normal. Paid sick leave for workers is essential to building resilient communities in an infectious emergency.

Operationalizing our response to the H1N1 outbreak requires a coordinated effort across all levels of society. The federal government sets the national tone for successful emergency response and provides the latest information, guidance, research and advice. In the face of H1N1, the federal government has successfully led preparedness efforts by creating a national plan, working quickly to identify the viral strain, create the substrate to grow the vaccine, and collaborating with state and local health departments to respond to the outbreak.

However, all sectors in our communities must be prepared as well. Businesses need to have a plan in place to reduce the spread of infectious disease in the workplace, and personnel policies that supports the goal of ensuring the health and wellbeing of their employees, their customers and their business. Paid sick leave for employees supports this goal.

We know that people with H1N1 are going into work everyday. Companies subject to the Family and Medical Leave Act are required to offer unpaid sick leave, but most employees without a paid sick leave benefit do not have the financial security necessary to stay home from work when they or a family member are sick. This problem is especially problematic during the current H1N1 pandemic.

I. Paid Sick Leave Benefits for Business

An unhealthy worker or somebody in the workplace spreading disease affects business. CDC estimates that a sick worker can infect one in ten co-workers. While voluntary action is an option, an infectious worker who may spread disease to co-workers and customers is a threat not only for the business, but to the public at large as well. Sick workers are not productive ones and by spreading disease in the workplace risk the overall productivity of the business. By providing paid leave for sick workers, worker safety and business productivity can both be enhanced—a win for employers. This is particularly a plus for small employers where preventable

ⁱU.S. Centers for Disease Control and Prevention. Weekly 2009 H1N1 Flu Media Briefing, November 12, 2009. Available at www.cdc.gov/media/.

ⁱⁱU.S. Centers for Disease Control and Prevention. 2009 H1N1 Flu ("Swine Flu") and You. Available at <http://www.cdc.gov/h1n1flu/qa.htm>.

losses of even a small number of workers can have a devastating effect on the business. Mandatory sick leave encourages employees to stay out of the workplace when appropriate, protecting the business and I believe hastens the employees return to productive work.

II. Paid Sick leave Benefits for Employees and Their Families

While we want to encourage workers to make healthy and rational decisions, when they are faced with the choice of staying home sick without pay or going into work sick so they can put food on the table and pay their mortgage, many workers choose to go to work and “tough it out,” putting their co-workers and their customers at risk.

Additionally, if an employee has a sick family member, often a child, the employee has to decide if they should stay home to care for the sick family member and lose pay or, send the child to school or daycare so they can go to work. Obviously, sick children should stay at home, however even caring parents challenged with the decision to pay the bills or not; may err on the side of sending the child to school, if the child does not appear to be too ill. Sick children are not productive learners, and being in school or daycare puts the rest of the community at risk, particularly with infectious diseases like influenza. Employees who are parents should not have to make this choice.

III. Paid Sick Leave Benefits for Customers and the General Public

Prevention is the best tool individuals, businesses, and communities have to staying off the spread of influenza infection. Vaccination is always the first line of defense with vaccine preventable diseases. Seasonal flu vaccine is available now and should be given as recommended by public health authorities. Initial doses 2009 H1N1 flu vaccine should also be given as recommended as available.

Nonpharmaceutical measures such as:

1. Covering your nose and mouth with a tissue, or your elbow, when you cough or sneeze;
2. Washing your hands frequently with soap and water, or alcohol-based hand-rubs if soap and water are not available; and
3. Social distancing strategies such as staying home from work or school if you get sick, and limit contact with others until you are symptom free for at least 24 hours to keep from infecting others.ⁱⁱⁱ Paid sick leave is an important tool to make social distancing an effective strategy in the workplace.

While there have been some improvements, too few businesses today have pandemic influenza preparedness plans in place.^{iv} APHA policy strongly supports the development and implementation of pandemic preparedness plans within the business communities.^v Such plans should include:

1. Employee training and education programs related to pandemic influenza to ensure that employees are aware of how to prevent transmission of the flu, signs and symptoms of the virus, and the need to stay home from work when they are sick; and
2. Policies for employee compensation and sick leave that would be used during a pandemic that are not punitive and provide employees with adequate financial security to enable them to stay home from work when they or a family member are sick.

Our last line of defense against spreading infection lies with each and every one of us. We have both an individual and collective responsibility to keep ourselves healthy and help prevent the spread of flu. We should follow the guidance from health authorities: get vaccinated against both seasonal and H1N1 flu, wash our hands often with soap and water, and avoid close contact with those who are sick.

If we become ill, it also means helping our family, friends, co-workers and community stay healthy by staying home from work, avoiding public places, covering our mouth and nose when we cough or sneeze, and practicing good hand hygiene.

We’ve come a long way in being prepared for public health emergencies such as an H1N1 flu outbreak, but we have more work to do to protect America’s health. Paid sick leave for employees is one important next step.

ⁱⁱⁱ American Public Health Association. H1N1 Facts. Available at www.getreadyforflu.org/preparedness/H1N1-new.htm.

^{iv} Center for Infectious Disease and Policy. Conference poll: 18% of businesses have pandemic plan [press release], February 15, 2006. Available at www.cidrap.umn.edu/cidrap/content/influenza/biz-plan/news/feb1506survey.html.

^v American Public Health Association. Preparing for Pandemic Influenza, Policy Number: 20063, November 8, 2006.

Chairman MILLER. Thank you.
Mr. Clarke?

**STATEMENT OF BRUCE CLARKE, PRESIDENT AND CEO,
CAPITAL ASSOCIATED INDUSTRIES, INC.**

Mr. CLARKE. Good morning, Chairman Miller, Ranking Member Kline, committee members, panelists. I am Bruce Clarke. I am CEO of Capital Associated Industries, a nonprofit employers' association that serves over 1,000 North Carolina employers and helps them manage well, pay well, benefit well, and stay in compliance with thousands of federal, state and local workplace rules.

Our members are concerned about employee health, their families' health, and, yes, even business continuity in a pandemic. We understand the emergency, and we are adapting to it. But we also understand the longer-term issues caused by paid leave mandates. We survey our members and their benefits practices and link our survey data with similar groups around the nation.

When it comes to availability of paid time for absence due to illness, the glass is not just half full—the glass is over 80 percent full. I believe the marginal visible benefit of the proposed national mandates will create far more invisible and unintended consequences and that the glass will actually be less full than it is today. Here is why.

Employers provide dozens of benefits to give employees paid time away from work. There are literally hundreds of mixtures and combinations of these benefits crafted to suit a specific workplace best. An example: we have a large food processor that provides no paid sick days as such. Instead, they chose to purchase a fully insured short-term disability policy for every single hourly employee in the facility, providing a wage substitute during their illness of up to 6 months. This is designed to prevent true financial ruin during a medium-term illness.

Who is to say this company should spend their benefits dollars on 5 or 7 sick days instead? Who wins from that trade-off? Employers are usually rational economic units. If told to carve out 3 percent of payroll for a specific benefit, they will do so, and then reduce spending on other pay and benefits.

This problem of benefits substitution may be most acute in PTO, or paid time-off policies, which typically lump vacation, sick and personal days into one bank and allow use for any of these purposes. Employers that provide PTO time without labeling days specifically as sick days must decide whether to add the new mandated benefit to the current benefit or to reduce one while creating the other. One-quarter of employers use PTO accounts and would face this dilemma.

Anything that forces a PTO plan to carve out days specifically for illness also punishes people who want those days available for other personal use or simply desire privacy about the reason for their use.

Our own surveys of employers nationwide tell us that 80 percent-plus of employers provide a paid sick day benefit, with the average being 7 to 9 days per year when there is a defined number. Seventy to 90 percent allow use of sick time for non-emergency needs like

dental visits, routine doctors visits, plus used for family members' needs.

Vacation pay is provided by 95 percent-plus of employers, and virtually all employers allow its use for any reason. More than half of the employers provide qualified part-time employees vacation and/or sick days on a reduced schedule. Mandating paid sick time policies will force a new baseline from which all employers with 15 employees will be required to rewrite their many types of pay when not working policies.

Flexibility will be reduced to balance costs. Examples of my members' recent flexible responses to H1N1 include extra pandemic flu time off banks that go beyond current sick or PTO days, borrowing from future sick time accruals when current accounts are exhausted, making up lost paid time on other days and on other projects, unlimited paid days—sick days—for flu-like symptoms whenever there is a national or local pandemic declared, granting extra paid sick days if the employee or family member took the flu shot, if it was available, paying for the flu shots.

Employers are working hard to treat employees as they would wish to be treated within the bounds of hard economic realities. These are the reasons why I believe we should leave that paid time off glass over 80 percent full, and we should not risk damaging the overall level and types of paid time off by favoring one type over another through a national mandate.

In closing, my comments today have focused primarily on the impact of the Healthy Families Act upon employer policies and flexibility. I would like to make a brief comment on the recently proposed Emergency Influenza Containment Act.

I am concerned that the bill leaves too many key provisions unclear and ill-defined for a law designed to take effect 15 days after enactment. Employers are not expert at diagnosing illness, and idle comments about that from a supervisor or manager may be perceived as directing or suggesting that they go home.

The safe harbor provision may or may not apply when an employer uses its normal processes for leave. With the safe harbor applied to PTO plans, which do not mention sick pay specifically? It suffers as well from the problems caused by any national mandate in the context of a complex but effective employer-provided way of paid leave.

Thank you for the time to speak with you today. I look forward to your questions.

[The statement of Mr. Clarke follows:]

Prepared Statement of A. Bruce Clarke, J.D., President and CEO, Capital Associated Industries, Inc.

Good morning Chairman Miller, Ranking Member Kline and distinguished members of the Committee. I appreciate the opportunity to speak with you today about employer-paid sick leave policies and ways that employers are responding to the current H1N1 influenza outbreak.

I am Bruce Clarke, President and CEO of Capital Associated Industries (CAI), a non-profit employers' association that helps 1,000 North Carolina employers manage well, pay well, provide high-quality benefits and stay in compliance with thousands of federal, state and local workplace rules.

While the Committee continues to explore paid leave issues, it is important to recognize the broad scope of their impact and the efforts that are already underway by employers to respond to the current H1N1 pandemic.

CAI shares your goal of protecting the health of the American workforce while minimizing the spread of any contagious disease. As the Committee considers legislation, however, it is important that any proposal support and protect the existing paid leave programs and workplace flexibility initiatives employers have in place—especially among our nation’s smallest employers.

Overview of Existing Employer Leave Practices

Our national network of Employer Associations cooperates each year on surveys asking hundreds of questions about pay and benefits at thousands of workplaces nationwide.

I can say confidently that when it comes to the availability of paid leave from employers for sick leave, the glass is not just half full; it is more than 80 percent full. I believe the marginal perceived visible benefit of a proposed national mandate will create far more invisible and unintended detriments that will, most importantly, result in that glass being considerably less full than it is today.

Today, employers provide dozens of types of benefits that give employees paid leave. Manufacturers in particular have provided generous family-friendly benefits that include leave programs. According to the Department of Labor’s Bureau of Labor Statistics (BLS), nearly all full-time workers have access to paid illness leave. Specifically, the Monthly Labor Report in February 2009 shows that 93 percent of full-time workers and over half of part-time employees have access to paid sick leave.

According to the BLS, manufacturing employees on average earn over 20 percent more in compensation than the rest of the workforce and 96 percent of manufacturers provide a paid leave benefit that their employees can use specifically for illness, doctor’s appointments or to care for an ill family member.

While some may point to the lack of formal requirements for employers in the U.S. to provide paid leave, the reality is that such types of leave are already widespread in our workforce. Paid leave is an important component of a wide variety of different types of leave provided to employees.

Annually, my organization surveys our members on hundreds of business practices, wages, health care benefits and other data to keep them competitive and aware of market conditions. Our most recently published Policy and Benefits survey for 2009-2010 shows:

- Over 80 percent of employers in North Carolina provide a specific paid leave benefit, with the average being 7 to 9 days per year;

- 70 to 90 percent of respondents allow use of sick time for non-emergency needs like dental and routine doctor visits and for ill family members;

- Vacation pay is such a common benefit in the group of employers with more than 15 employees that we only ask them how many days they provide, not whether they provide it. Virtually all allow its use for personal and family illness;

- 60 percent of employers in this survey even provide long-term disability policies for employees; and

- More than half of the employers provide qualified part-time employees accrual of vacation and/or sick days on a reduced schedule.

While most private sector employees are provided some form of paid leave, many employers don’t differentiate between various types of leave. There is evidence of a growing trend by employers to provide general paid time off (PTO) plans that allow employees to use their leave in the way that best fit their needs. A flexible PTO policy supports and encourages employees to stay home when they are sick or to take care of ill family members. These systems also protect employees’ privacy as employees often do not have to disclose to their employers the reasons why they are requesting time off.

In particular, over one-quarter of manufacturers use such a policy, and that number is growing. Employers require the flexibility to continue to provide their employees with the benefits and paid leave models that best fit the needs of their individual businesses and workforces.

Employer Response to the H1N1 Outbreak

Just as many families across the country are taking steps to protect against the further spread of the H1N1 flu, many employers also have developed or are in the process of developing continuity plans to proactively mitigate the spread of H1N1 in the workplace. These plans seek to ensure that businesses can function during this national emergency while addressing the needs of their employees.

Examples of these responses include: telecommuting, job sharing, waiving notice requirements, absence forgiveness and paid time off for the employee’s own illness or to care for ill family members.

Mandating paid sick leave policies will create a new baseline structure from which all employers with over 15 employees will be required to re-write their many types of “pay when not working” policies. I believe that starting over from that mandated foundation and its rigid terms will discourage the kinds of innovative and additive benefits we see employers spontaneously creating during this pandemic.

I have recently asked our members in North Carolina what specific steps that they are taking. I have heard a wide variety of responses from many members, including:

- Paying for vaccines to be administered at job sites;
- Advising employees to stay home if they are displaying flu-like symptoms without any disciplinary actions or having the leave count against them;
- Allowing employees to make up for the missed hours with additional shifts;
- Allowing them to work from home with greatly reduced responsibilities;
- Enabling employees to advance sick days forward; and
- Allowing employees additional paid time off to take care of ill family members.

While some employers may not have taken specific action in response to the H1N1 outbreak, these employers are clearly the exception to the widespread practices taking place today. These types of creative approaches are the result of flexibility that employers have to develop policies that best fit their workforce needs. Any proposal that mandates the type of leave that employers must provide will ultimately threaten overall levels and types of responses employers are engaged in.

Congressional Proposals

There has been much discussion of paid leave proposals in light of this outbreak. However, it’s important that Congressional activity not threaten employers’ ability to creatively design programs that meet the unique needs and constraints of their workforce.

Federal paid leave policy should encourage employers to provide paid sick leave rather than impose restrictive, one-size-fits-all mandates. Such requirements applied to the broad, diverse industries that make up our nation’s economy negatively impact all employers, especially small businesses, and limit our ability to retain and create new jobs.

Many of the proposals introduced, such as the Healthy Families Act, are overly burdensome because they apply to the smallest of employers. Under the Healthy Families Act proposal—employers of all sizes would be subject to the same restrictive leave mandate that includes both part-time and full-time employees. This would be on top of or in addition to requirements in place in several states and municipalities. Congress has previously recognized the disproportionate impact leave mandates have on small employers in related employment statutes like the Family Medical Leave Act. Federal legislation should continue to reflect these principles.

In many ways, such mandate proposals would actually hinder current efforts by employers. Specifically, the Emergency Influenza Containment Act would place requirements on employers without comprehensive guidance from the Department of Labor on how to implement them.

Additionally, the language of this proposal creates a leave entitlement to employees directed, instructed or advised by their employer to not come into work or to leave work if they are displaying contagious symptoms. This overly broad definition will make effective implementation by employers difficult. In many workplaces, it may also discourage employers from sending employees home. We have several questions about how this bill would be implemented:

- The bill states that paid leave should be provided to employees who are directed by their employer to come into work. However—how should “directed” be interpreted? Employers could have a range of conversations or contacts with their employees, which might or might not rise to the level of a “direction”.
- Who is the employer? What if a lower level supervisor says something that is later revoked by someone with more authority?
- What does it mean to have the employer “believe the employee has symptoms of a contagious illness?” Is one sneeze enough for them to form this conclusion? Employers are typically not medical professionals able to make this determination.
- How is an employer to protect the rights of employees’ privacy with regard to their determination if an employee has been in close contact with an individual who has such symptoms?
- Under this bill—an employer can terminate the paid leave if he or she “believes the employee * * * has symptoms of a contagious illness or poses a threat of contagion to other employees or to the public.” How would an employer formulate this belief if the employee isn’t present in the workplace?
- This bill would take effect 15 days after enactment without any implementation regulations or timeliness for when guidance from the federal government will be

provided. How are employers expected to meet this bill's requirements without appropriate regulations in place?

- This bill attempts to provide a safe harbor for employers who either do not employ 15 or more employees or already meet its conditions. (See Sec. 10 (3) (A), (B).)

How would employers provide PTO plans, where an employee has paid leave provided without specifying the reason for being treated? Such plans are becoming very popular as they relieve employers of the need to track multiple kinds of leave and the reasons for the leave and typically allow employees to receive the paid leave in compensation when they terminate employment.

Would employers get credit only for offering a traditional paid sick leave style plan?

What happens if an employee is provided leave but has exhausted it by the time he or she needs to be out under this bill?

How should part-time employees be treated with respect to whether an employer employs 15 or more employees?

What if the company uses an employee agency? How should those employees be counted?

The language of Section (B) says that for an employer policy to qualify, it must not only provide five days of paid sick leave per 12 month period, but that this leave "may be used at the employee's discretion." Such a requirement would disqualify many employer leave policies that would otherwise satisfy this safe harbor as employers frequently include a provision that leave be subject to notification, scheduling, or other requirements. Would such requirements disqualify a leave policy from satisfying this safe harbor?

These proposals lack the necessary clarity for employers to effectively implement and would limit the flexibility employers have to address their workforce needs.

Further, these current proposals do not recognize employers that are already providing generous levels of paid leave from any mandated leave requirements. Specifically, they will require employers that provide generous leave benefits through a PTO system to add additional leave on top of their existing benefit mix—thus adding costs.

If employers are required to carve out 3 percent of overall payroll dollars for a specific benefit to be used under specific conditions with specific rollover provisions and penalties for violations, they will do so as a group but by reducing expenditures on other pay and benefits. The problems with benefit substitution are most acute in employers that utilize general PTO policies which typically combine vacation/sick/personal days into one bank of time and allow use for any of those purposes. If employers are mandated to provide a certain level of a specific leave benefit—they must decide whether to add that on top of existing employer leave policies or to reduce the existing in order to meet the new mandate.

A mandate would be a strong disincentive for employers to utilize PTO programs. Under such a system, they could no longer control the terms of use and accrual on the newly mandated days of paid sick time. Employers would either have to carve out separate leave to meet the definitions of the new mandate or have to convert their entire PTO system to be subject to the same procedural rules as the new mandate.

As our economy begins to recover from the most severe recession since the Great Depression, businesses need to maintain flexibility in order to survive, grow and provide jobs in the face of ongoing challenges, including the potential impact of contagious illnesses such as H1N1.

Conclusion

During this public health crisis and challenging economic times, I strongly caution against Congress rushing legislation that doesn't recognize and protect efforts currently underway by employers and hinders existing response and job creation efforts. Employers are in the best position to understand the needs of their workforce.

Employers have serious concerns with many aspects of the paid leave proposals as currently drafted. However, I look forward to working with the Committee to meet our shared goal of maintaining a healthy and productive workforce while ensuring the job retention and job creation that will assist economic recovery efforts.

Thank you for the opportunity to testify before the Committee, and I welcome your questions.

Chairman MILLER. Ms. Ness?

**STATEMENT OF DEBRA L. NESS, PRESIDENT, NATIONAL
PARTNERSHIP FOR WOMEN AND FAMILIES**

Ms. NESS. Good morning, Chairman Miller, Ranking Member Kline, members of the committee and fellow panelists.

The National Partnership for Women and Families is a nonprofit, nonpartisan advocacy group that has been working on issues important to women and families for almost four decades. I thank you for inviting me to testify in support of this legislation that workers urgently need during this national H1N1 emergency.

And, Mr. Chairman, a special thank you to you for all you have done to shine a spotlight on this issue.

The National Partnership leads a very broad-based coalition in support of paid sick days. I am testifying today on behalf of the millions of people represented by civil rights, women's, children's, anti-poverty, disability, labor, health and faith-based communities. We all urge you to move quickly to pass legislation that guarantees working people paid, job protected time off from work to recover from their own illness or to care for a sick child or family member, especially during this H1N1 epidemic.

It is a travesty that millions of hard-working people in this country have no paid sick days. Almost half of private-sector workers and four in five low-wage workers, most of them women, don't have a single paid sick day. And especially now, when H1N1 has infected millions, our failure to provide a minimum standard of paid sick days is taking a terrible toll.

Over the past few months, experts and public officials from the CDC to the president have been telling us to stay home and keep sick children home to prevent the spread of the virus. That is great advice, but unfortunately, millions of workers simply cannot take that advice. For them, staying home means risking their paychecks and even their jobs.

So what is responsible? What is doing the right thing when staying home means risking that paycheck that your family depends on?

People who provide care for family members face even greater challenges. We know that the H1N1 virus attack rate among children and youth is especially high. Many of them need a parent to care for them when they get sick. And that is why the lack of paid sick days is particularly challenging for working women who have primary responsibility for child care as well as elder care.

Our failure to guarantee paid sick days also is particularly hard on low-income people and those in communities of color, who tend to hold the low-wage, no benefit jobs. The Boston Public Health Commission recently reported that the incidence of H1N1 is much higher for African-Americans and Latinos in that city. Without paid sick days and the ability to stay home or get care, the disease spreads more rapidly and people get sicker.

The lack of paid sick days is also putting our public health at risk. Only 22 percent of food service and public accommodation workers have paid sick days. Workers in child care centers and nursing homes disproportionately lack paid sick days. They are forced to work when they are sick, and in so doing they put their co-workers, those they care for, and the public at risk.

And while the need for paid sick days is particularly compelling during this H1N1 emergency, the reality is that working families struggled without paid sick days prior to this emergency, and they will continue to struggle unless and until Congress acts. Every year seasonal flu and other illnesses strike millions of us, and every year our failure to let workers earn paid sick days puts the economic security of families at risk. And the recession we are in exacerbates the problem.

I certainly don't need to tell you how many families that once relied on two incomes are now managing on one or none. In a survey last month, five out of six workers said the recession was creating more pressure to show up for work, even when they are sick.

Mr. Chairman and members of the committee, we need a minimum standard of paid sick days so that taking time off for the flu or any other illness does not lead to financial disaster.

Finally, I would like to end with the point that paid sick days are also good for business and our economy. Today Stanford University Press is releasing a book called "Raising the Global Floor," a book by Jody Heymann that reports on an 8-year study examining the impact of paid sick days, paid family leave, breast-feeding and other family-friendly policies around the world.

It concludes that nations that guarantee leave to care for personal or family health needs are actually ranked highest in terms of economic competitiveness. And I would be happy to provide copies of that book for every member of this committee.

The research confirms that when businesses take care of their workers, they are better able to retain them. And when workers have paid time off, their commitment, their productivity and their morale increases. Employers reap the benefit of lower turnover in training cost.

The cost of losing an employee is often much greater than the cost of providing short-term leave to retain an employee. And in this economy and during this health emergency, smart businesses know that they can't afford presenteeism, workers who go to work sick and get other people sick and cause more absenteeism. Presenteeism costs our national economy \$180 billion annually more than absenteeism.

So like the minimum wage, our nation needs a basic federal labor standard of paid sick days that protect all employees, is paid, is job protected, is accessible to workers at their discretion, and is available to care for a sick child or parent. I urge you to pass the Healthy Families Act quickly. And I thank you for this opportunity to testify.

[The statement of Ms. Ness follows:]

Prepared Statement of Debra L. Ness, President, National Partnership for Women and Families

Good morning Chairman Miller, Ranking Member Kline, members of the Committee and my distinguished fellow panelists. Thank you for inviting us to talk about the policies our nation's workers urgently need during this H1N1 flu emergency. Chairman Miller, you've been a consistent champion on a broad range of issues that support working families, including paid sick days. Your leadership during this national H1N1 emergency has caused media and the public to acknowledge the connection between giving workers the chance to earn paid sick days and stopping the spread of H1N1.

I am Debra Ness, President of the National Partnership for Women & Families, a non-profit, non-partisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care, and policies that help workers meet the dual demands of work and family. I am here to testify on behalf of a broad coalition of children's, civil rights, women's, disability, faith-based, community and anti-poverty groups as well as labor unions, health agencies and leading researchers at top academic institutions. They include 9to5, MomsRising.org, the Leadership Conference on Civil Rights, the AFL-CIO and SEIU, the Family Values @ Work Consortium, the National Organization for Women and dozens of other organizations. Together, we urge Congress to quickly pass legislation that guarantees working people paid, job-protected time off from work to recover from illness and to care for a sick child or family member—especially during this national H1N1 flu emergency.

Workers Need Paid Sick Days During this H1N1 Flu Emergency

In recent months, much attention has focused on the H1N1 virus and the best ways to contain it—and with good reason. H1N1 is a novel flu virus that experts predict may result in many more illnesses, hospitalizations and deaths this year than would be expected in a typical flu season.¹ Forty-eight states had “widespread flu activity” as of Oct. 31, according to the Centers for Disease Control and Prevention (CDC).² The CDC recorded nearly 18,000 hospitalizations and nearly 700 deaths related to H1N1 flu between Aug. 30 and Oct. 31.³ The virus is now so widespread that the CDC and World Health Organization are no longer keeping track of the number of individual cases. Officials estimate that if 30 percent of the population contract the virus, it could mean approximately 90 million people in the U.S. could become ill, 1.8 million may need to be hospitalized, and approximately 30,000 could die.⁴ As a result, President Barack Obama declared the H1N1 flu outbreak a national emergency, allowing hospitals and local governments to quickly set up alternate sites for treatment and triage procedures, if needed, to handle any surge of patients.⁵

Week after week, government officials urge sick workers to stay home and keep sick children at home to prevent the spread of the H1N1 virus. Commerce Secretary Gary Locke said that “if an employee stays home sick, it’s not only the best thing for that employee’s health, but also his coworkers and the productivity of the company.”⁶ Health and Human Services Secretary Kathleen Sebelius said that “one of the most important things that employers can do is to make sure their human resources and leave policies are flexible and follow public health guidance.”⁷

The CDC has also issued recommendations: “People with influenza-like illness [must] remain at home until at least 24 hours after they are free of fever * * * without the use of fever-reducing medications.”⁸ In addition to the guidance for workers, officials have stated that schools and child care providers will need to rely on parents to keep children at home if they are feverish.⁹ This is excellent advice, as far as it goes, but unfortunately, taking this advice isn’t an option for millions of workers. They may want to do the right thing and do all they can to prevent the spread of the H1N1 virus. But for many, doing their part means risking their paychecks and even their jobs, because they lack job-protected paid sick days.

Working people need paid time off from their jobs to recover from the H1N1 flu and care for sick family members—and prevent further spread of the virus. Yet, the reality is that nearly half (48 percent) of private-sector workers lack paid sick days.¹⁰ The same is true for nearly four in five low wage workers—the majority of whom are women.¹¹ Women also are disproportionately likely to lack paid sick days because they are more likely than men to work part-time, or to cobble together an income by holding more than one part-time position. Only 16 percent of part-time workers have paid sick days, compared to 60 percent of full-time workers.¹²

Especially during this epidemic, workers with caregiving responsibilities in particular have an urgent need for paid sick days. The highest H1N1 virus attack rate is among 5-to 24-year olds, many of whom need to stay home from school when sick—often with a parent to care for them.¹³ That’s why the lack of paid sick days is particularly challenging for working women—the very people who have primary responsibility for most family caregiving. In fact, almost half of working mothers report that they must miss work when a child is sick. Of these mothers, 49 percent do not get paid when they miss work to care for a sick child.¹⁴

Our Failure to Establish a Paid-Sick-Days Standard is Putting the Public Health at Risk During the H1N1 Emergency

Our nation’s failure to provide a minimum standard of paid sick days is putting our public health at risk. Many of the workers who interact with the public every day are without paid sick days. Only 22 percent of food and public accommodation workers have any paid sick days, for example. Workers in child care centers and

nursing homes, and retail clerks disproportionately lack paid sick days.¹⁵ Because the lack of paid sick days forces employees to work when they are ill, their coworkers and the general public are at risk of contagion.

Research released this year by Human Impact Partners, a non-profit project of the Tides Center, and the San Francisco Department of Public Health, found that providing paid sick days to workers will significantly improve the nation's health. This groundbreaking study found that guaranteeing paid sick days would reduce the spread of pandemic and seasonal flu. More than two-thirds of flu cases are transmitted in schools and workplaces. Staying home when infected could reduce by 15 to 34 percent the proportion of people impacted by pandemic influenza.

The Human Impact Partners analysis also found that if all workers had paid sick days, they would be less likely to spread food-borne disease in restaurants and the number of outbreaks of gastrointestinal disease in nursing homes would reduce. The researchers provided evidence that paid sick days may be linked to less severe illness and shorter disability due to sickness, because workers with paid sick days are 14 percent more likely to visit a medical practitioner each year, which can translate into fewer severe illnesses and hospitalizations. They also found that parents with paid time off are more than five times more likely to provide care for their sick children.

Recent data on the impact of the H1N1 virus in Boston, Mass. shows that the outbreak has hit certain mostly low-income communities harder than other communities. The Boston Public Health Commission reported that more than three in four Bostonians who were hospitalized because of H1N1 were black or Hispanic.¹⁶ Boston's experience is not unique. Communities of color all across the country face similar health disparities and they may be due, in part, to the fact that low-wage workers are less likely to have paid sick days.

Beyond the H1N1 Emergency

While the need for paid sick days may seem particularly compelling during the H1N1 emergency, the reality is that working families struggled without paid sick days prior to this emergency, and they will continue to struggle after this emergency unless Congress takes action. Paid sick days aren't just about protecting the public's health—they are also about protecting the economic security of millions of workers and their families. One in six workers report that they or a family member have been fired, suspended, punished or threatened with being fired for taking time off due to personal illness or to care for a sick relative, according to a 2008 University of Chicago survey commissioned by the Public Welfare Foundation. To put a face on some of those statistics, I'd like to share with you a few stories from working people:

- Heather from Cedar Crest, New Mexico told us: "In October, I got very sick with diverticulitis. My doctor put me on bed rest for two weeks. While I was out, my boss hounded me to come back, but I was way too sick. I told him I would be back as soon as I could. I was not receiving sick pay at all. When I did go back to work early, he fired me and told me he needed someone he could count on. I worked for this man for two years. I was shocked. Sometimes things happen and you get sick. How are you to foresee these things?"

- Noel from Bellingham, Washington wrote to us: "I had to work while having bouts of awful bronchitis and walking pneumonia. I got no time off at all even when I was in severe pain, coughing up phlegm or vomiting. Instead I had to act like I wasn't sick, and keep up the same standards and smiling face. * * * I couldn't take unpaid days off from work because I couldn't afford to do that. I needed the money to pay for things like rent and food. When my quality of work suffered substantially from having to go to work while so sick, I was fired from my job because according to my then-supervisor, I did not create a happy environment for the customers."

The H1N1 outbreak has come during a painful recession, and both have exacerbated the need for paid sick days. I don't need to tell you that the economic crisis has been devastating for working families. More than 11.6 million workers have lost their jobs, and millions more are underemployed. In October, the unemployment rate was 10.2 percent—the highest level since December 1983. The unemployment rate for African Americans was 15.7 percent, the rate for Hispanics was 13.1 percent, and the rate for whites was 9.5 percent in October 2009.¹⁷ For many families that once relied on two incomes, this crisis has meant managing on one income or no income at all. As a result, families are not only losing their economic stability, but their homes: one in nine mortgages is delinquent or in foreclosure.¹⁸

Five out of six workers (84 percent) say the recession and the scarcity of jobs are creating more pressure to show up for work, even when they are sick.¹⁹ Workers are understandably anxious about their job security, and many are unable to take any risk that might jeopardize their employment—even if they are stricken with

H1N1. Especially now, when so many workers are suffering terribly, we must put in place a minimum labor standard so taking time off for illness doesn't lead to financial disaster. Workers have always gotten sick and always needed to care for children, family members and older relatives—and they have always managed to be productive, responsible employees. But without a basic labor standard of paid sick days, families' economic security can be at grave risk when illness strikes.

In addition, as our population ages, more workers are providing care for elderly parents. When working people have to take unpaid time off to care for a parent, spouse or sibling, they face often-terrible financial hardship. More than 34 million caregivers provide assistance at the weekly equivalent of a part-time job (more than 21 hours per week), and the estimated economic value of this support is roughly equal to \$375 billion²⁰—a huge contribution to the health and well-being of their families. Caregivers contribute more than time; 98 percent reported spending on average \$5,531 a year, or one-tenth of their salary, for out-of-pocket expenses.²¹ Yet, many lose wages each time they must do something as simple as taking a family member to the doctor.

Businesses Benefit from Paid Sick Days Policies

Research confirms what working families and responsible employers already know: when businesses take care of their workers, they are better able to retain them, and when workers have the security of paid time off, their commitment, productivity and morale increases, and employers reap the benefits of lower turnover and training costs. Furthermore, studies show that the costs of losing an employee (advertising for, interviewing and training a replacement) is often much greater than the cost of providing short-term leave to retain existing employees. The average cost of turnover is 25 percent of an employee's total annual compensation.²²

As mentioned previously, paid sick days policies also help reduce the spread of illness in workplaces, schools and child care facilities. In this economy, and during this time of a national health emergency, businesses cannot afford "presenteeism," which occurs when, rather than staying at home, sick employees come to work and infect their co-workers, lowering the overall productivity of the workplace. "Presenteeism" costs our national economy \$180 billion annually in lost productivity. For employers, this costs an average of \$255 per employee per year and exceeds the cost of absenteeism.²³ In addition, paid sick days policies help level the playing field and make it easier for businesses to compete for the best workers.

Already, many savvy employers have responded to the H1N1 outbreak by expanding or improving their paid sick days policies. For example, Medtronic Inc. has reacted by granting all its employees, including hourly workers, three additional paid sick days. Best Buy has instructed its managers to send employees home if they arrive at work sick, and to pay them for the remainder of the day, even if they do not have any sick time.²⁴ Texas Instruments, Inc. has relaxed its sick days policy, allowing workers to take as many days as they need to recover, by granting them the option of borrowing against future leave.²⁵ These businesses and many others know that it is in their best interest to make sure that they do not have masses of sick workers on the job. They know that paid sick days must be part of their operating plans if they are going to keep their doors open and their businesses thriving during these difficult economic times when H1N1 flu is spreading.

The Nation Needs Policies that Allow Workers to Meet their Job and Family Responsibilities

Our nation has a proud history of passing laws that help workers in times of economic crisis. Social Security and Unemployment Insurance became law in 1935; the Fair Labor Standards Act and the National Labor Relations Act became law in 1938, all in response to the crisis the nation faced during the Great Depression. Working people should not have to risk their financial health when they do what all of us agree is the right thing—take a few days to recover from contagious illness, or care for a family member who needs them. Now is the time to protect our communities and put family values to work by adopting policies that guarantee a basic workplace standard of paid sick days.

At present, no state requires private employers to provide paid sick days. The cities of San Francisco, the District of Columbia and Milwaukee have passed ordinances requiring that private employers provide paid sick days. This year, more than 15 cities and states have considered paid sick days laws to ensure that this basic labor standard becomes a right for all workers. This is a national movement now, and we expect it to expand to more than 25 campaigns next year. But illness knows no geographic boundaries, and access to paid sick days should not depend on where you happen to work. That's why a federal paid sick days standard is so badly needed.

Like the minimum wage, there should be a federal minimum standard of paid sick days that protects all employees, with states and individual employers given the freedom to go above the federal standard as needed to address particular needs of their residents or workers.

Working people need a basic labor standard of sick time that is:

- Paid;
- Job protected;
- Accessible to workers at their discretion (by notifying the employer verbally or in writing);
- Available for workers to use to care for themselves or a child or parent; and
- Up to seven days (or 56 working hours).

These key principles are included in the Healthy Families Act. The legislation guarantees workers the right to determine whether they need to take a paid sick day, provides strong job protections, and lets workers take paid time off to care for a sick child or parent.

These core principles are supported not only by advocates, but also by members of the House of Representatives and the Senate. They are reflected not only in the Healthy Families Act, but in proposed legislation in more than a dozen states, including California.

These core principles may never be more important than they are during this national H1N1 emergency. To that end, we support emergency legislation for the duration of the H1N1 epidemic that contains these core principles and addresses the unique circumstance of this H1N1 emergency.

Because of the dangers posed by H1N1 and its ability to spread quickly in a community, in addition to the principles outlined above, we would support legislation to fully protect workers and the public health by:

- Enabling workers to take paid sick time during closure of a workplace or a child's school or care facility due to a contagious illness;
- Covering all sizes of employers and all types of employees, so that no workplace or worker is left vulnerable to the H1N1 virus; and
- Establishing a Dept. of Labor and Dept. of Health and Human Services toll-free telephone call center and website to enable workers to report violations, which the government would investigate and resolve, working with the employer.

Such emergency legislation would be effective immediately upon passage, and it would sunset in two years.

Congress should waste no time in passing paid sick days legislation so that working people can earn paid time off and help prevent the spread of illnesses, without jeopardizing their economic security. This year's public health crisis is the H1N1 virus but, in reality, millions of working people face the heart-wrenching decision of whether to send a feverish child to school and collect a paycheck, or stay home with her and lose pay. Or they must choose whether to go to work sick and get paid, or stay home to recover and fall behind on the rent.

Chairman Miller and members of the Committee, I thank you for the opportunity to participate in this important discussion, and we look forward to working with you to ensure that America's workers have a basic right of paid sick days. We sincerely appreciate your efforts in recent weeks to highlight this critical issue. Like you, we share the desire to promptly pass both emergency and long-term, permanent legislation that will protect the public health and is feasible for both employers and workers. And we look forward to working with you.

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¹⁹Angus Reid Strategies for Mansfield Communications online survey of 1,028 workers, conducted 9/10–9/12/09. Margin of error: +/- 3.1% points.

²⁰Ari Houser and Mary Jo Gibson, AARP Public Policy Institute, "Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update."

²¹Jane Gross, "Study Finds Higher Costs for Caregivers of Elderly," New York Times, 11/19/07.

²²Employment Policy Foundation 2002. "Employee Turnover—A Critical Human Resource Benchmark." HR Benchmarks (December 3): 1-5.

²³Ron Goetzal, et al. Health Absence, Disability, and Presenteeism Cost Estimates of Certain Physical and Mental Health Conditions Affecting U.S. Employers, Journal of Occupational and Environmental Medicine, April 2004.

²⁴Next test: Flu 101, Suzanne Ziegler, Minneapolis Star Tribune, September 23, 2009 www.startribune.com/lifestyle/health/60463767.html?elr=KArksi8cyaiUo8cyaiUiD3aPc:—Yyc:UU

²⁵Sick Time: Employers Gear Up for Swine Flu, Betsy McKay and Dana Mattioli, Wall Street Journal, November 2, 2009

<http://online.wsj.com/article/SB20001424052748704746304574508110025260366.html>

Chairman MILLER. Thank you.

Thank you very much, all of you, for your testimony. As you can see, there is a fair amount of interest on the committee, so we are going to have to be brief here, but we will try to give everybody an opportunity to ask questions.

Dr. Schuchat and Dr. Benjamin, I have been looking at this legislation. As we drafted this legislation, the idea is that when we look at school policies, it seems to be—and workplace policies—you are trying to provide some circuit breaker within that space to stop the H1N1 from spreading. I mean is that what we are trying to do when we close the school or we try to get parents to keep their kids at home or have workers go home—that is the purpose, the public health purpose here?

Dr. Schuchat. You know, there is a direct benefit for people in an office slowing the spread. I think we learned from the spring that closing schools for a week was extremely disruptive to communities and society and the children.

And with a focus on keeping ill people out of the schools or out of the workplace, it was a much less disruptive approach, but important to reduce the spread to others and give people time to heal. But we knew that keeping kids home, even for that 3 to 5 days that might be necessary meant a parent often needed to stay home with them and had a ripple effect.

Chairman MILLER. So a school policy is a little bit dependent upon the parental policy at the workplace.

Dr. Schuchat. Yes, absolutely.

Chairman MILLER. Yes. Yes.

Dr. Benjamin?

Dr. Benjamin. Yes, I would agree with that. They are really interdependent. And, you know, we know clearly that you can slow

the spread of the disease, lots of models that have shown that. But if you think about it, it is kind of common sense as well.

Chairman MILLER. Mr. Clarke, let me ask you something. For the somewhere around 40 to 60 million people who don't have paid leave policy, your concern is that for your employers, who may have a comparable policy, that they be allowed to use that comparable policy in place of this, whether it is called paid sick leave or paid time off or whatever combination that is, that you don't want to see this as additive to that? You want to see this if an employer gives you 7 days of paid time off or 10 days of paid time off, you could use that. If they allow you to borrow from the future, you could do that. You want to stay within those policies that your employers have. Is that correct?

Mr. CLARKE. Well, primarily, yes, on the paid time off argument—

Chairman MILLER. Whether we—yes.

Mr. CLARKE. Yes. And the issue with paid time off is there is no day in that bucket called "sick days."

Chairman MILLER. No, I understand that.

Mr. CLARKE. Right.

Chairman MILLER. So you want that—I am not asking you to endorse the policy. I am not stretching here too far.

Mr. CLARKE. Okay.

Chairman MILLER. You would ask that that be made compatible, that that currently, I assume, under the theory of paid time off is that the employee can choose the purposes for which they want to use that that time—in theory, right?

Mr. CLARKE. Yes.

Chairman MILLER. So you don't want to label those times or lay on top of that additional days.

Mr. CLARKE. That is true.

Chairman MILLER. What do we do for the people that there is no policy?

Mr. CLARKE. Well, I agree with that first point that, you are right, we want these to coordinate well and not overlap, and, sir, on the issues with the two bills that are at issue here today is that the safe harbor provisions do not accomplish that.

Chairman MILLER. Okay.

Mr. CLARKE. So there is a serious issue with that there.

On your other point, the numbers that are bandied around we certainly don't accept. We don't believe they are supported by numbers that we collect ourselves.

Chairman MILLER. I know, but the Bureau of Labor Statistics collects these, and they are used by all the other organizations.

Mr. CLARKE. Exactly. The—

Chairman MILLER. I mean you are taking information in North Carolina.

Mr. CLARKE. Well, the reason we don't accept the numbers are that those—and I have looked at these studies—often they very narrowly define paid leave. They won't get credit for time off unless it is called paid sick leave. That is going to take a PTO account that has no day called paid sick leave and put them in the category of no sick days provided. Those sorts of issues exaggerate the problem. I am not saying there is no problem.

Chairman MILLER. Let me just—I got to move, because my colleagues are going to beat me up here.

Ms. NESS, on this question of if you have a paid time off policy of X number of days, do you have a problem with this being compatible with that or that being safe harbored?

Ms. NESS. No, the Healthy Families Act is crafted so that if a work—

Chairman MILLER. Right.

Ms. NESS [continuing]. If the workplace or employer already has in place a policy that would allow people to use 7 days as paid sick days, that would be acceptable. They would not have to change their policy.

Chairman MILLER. Okay. And then what do we do with those who don't have that policy?

Ms. NESS. Well, that is why we need the Healthy Families Act. And, if anything, I think those Bureau of Labor Statistics numbers actually underestimate the number of folks who lack paid sick days, because they often count in those numbers folks who are on the job and the employer generally provides paid sick days, but there are job tenure requirements that prevent people from being able to use paid sick days for periods of months, or up to a year in some cases.

Chairman MILLER. They may exclude part-time workers in that policy or it may exclude—

Ms. NESS. Part-time workers—

Chairman MILLER [continuing]. One level of workers and not others?

Ms. NESS. Part-time workers are the least likely to have paid sick days. I think the number is something like 15 percent of part-time workers have paid sick days.

Chairman MILLER. Thank you.

Mrs. McMorris Rodgers?

Mrs. MCMORRIS RODGERS. Good morning, everyone.

And I want to thank the chairman and the ranking member for holding this hearing.

I also want to thank all of our witnesses for being here.

I just wanted to make a few observations before I get to my question. Over the last several months we have heard a great deal about the H1N1 pandemic, from the shortage of vaccines to more than 22 million individuals affected by the disease, 90 percent of whom are under the age of 65.

As a mom, there is not an issue that is more important to me than ensuring that my son is healthy, but the statistics also revealed the potential for serious strains on our nation's businesses. It strains employers and employees alike. And for the most part, businesses have been one step ahead, implementing policies that promote healthy work environments, such as telecommuting, job sharing, paid time off. In fact, according to the Department of Labor, 83 percent of businesses in the private sector offer their employees access to paid leave, which can be used for illness or injury or situations such as H1N1 flu.

Despite these innovations, several bills have been introduced to respond to the emergency, including more mandates on small businesses. In a stagnant economy with unemployment at its highest

level since 1983 and productivity inching along, we need to ensure that the response provides the flexibility that employers and employees need, flexibility that ensures employees can take care of themselves and their families and flexibility that allows businesses to remain productive.

With this in mind, I would like each of the witnesses to comment. What does mandated paid sick leave offer share what I that a flexible workplace program doesn't? Shouldn't both employers and employees decide what is best for them, not Congress?

Dr. Schuchat. As a public health expert, what our goal is is to make it easy for employees to do the right thing, the healthy thing for them and the best thing for the workplace. And so our focus has been to look at the evidence and determine what is the best thing.

And we have found that staying home for 24 hours after you are sick with the flu, after the fever has gone, makes the most sense. It is a balance of making sure you are better and reducing the chance you are going to infect other people. And so whatever will make it easy for people to do the right thing is really what we are promoting. Thank you.

Dr. Benjamin. I think the idea of having flexible policies is great, as long as there are not barriers. In other words the employee gets to say, "I am the one that is sick," you don't have to get permission to stay home, and that the processes to verify your illness are reasonable. In my job we allow people to be out for 3 days before even beginning to discuss whether or not they need to bring a doctor's note in, for example.

Mrs. MCMORRIS RODGERS. Okay, okay. Good. Thanks.

Mr. CLARKE. Well, to respond to your question, I certainly come at this from a glass is close to full perspective, and so when I hear mandates and read the mandates of these two bills, I see four things. I see that mandates would hurt employers that have good and flexible benefits and hurt those employees that enjoy that flexibility, particularly in the PTO circumstance.

I believe they hurt employees who would like to use those days for other purposes. I believe that it hurts small employers with costs that they may not be able to bear. We are talking about 3 percent of payroll here on this seven-day mandate.

And I believe it hurts job creation with small employers. I don't think we can overlook the fact that as it gets more expensive to hire and to retain, you get less hiring and retention.

Mrs. MCMORRIS RODGERS. Okay. Thank you.

Ms. NESS. I think that policies that afford workers the flexibility to use the time as paid sick days are terrific, and the Healthy Families Act is drafted in a way to allow those policies to stand.

I think the numbers, though, speak for themselves. Too many workers—we are talking millions of workers—don't have that kind of flexibility. And I would argue that it is more costly to employers not to provide this leave than it is to provide it.

And again, I am coming fresh from this event releasing this so-called "Raising the Global Floor," which looked at the 190 countries in the world that are part of the U.N. And of those, 163 provide paid sick days. The U.S. is among those that don't. Of the 15 most economically competitive nations in the world, the U.S. is the only one that does not provide paid sick days. That book, after 8 years

of research, does a very, very good job of showing that these kinds of policies do not negatively impact economic competitiveness or job creation.

Mrs. MCMORRIS RODGERS. Well, I thank everyone for their comments. I just believe as much as we can focus on flexibility for both employers and employees, that it is a win-win. And we need to be encouraging those policies that make it possible, that will keep our businesses competitive and make sure that employees have a job, too.

Chairman MILLER. Thank you.

Mr. KILDEE?

Mr. KILDEE. Thank you, Mr. Chairman.

Let me address this to the panel, and any of you may answer, if you can. Has there been any study on the difference in the cost of having the sick continue to come to work with their accompanying inefficiency and the possibility of infecting others or staying away from work while recuperating? Has there been any study at all indicating the financial or fiscal aspects of doing one or the other?

Dr. Benjamin, do you have any comment on that?

Dr. Benjamin. I am not aware of such a study, but I am not sure you can get such a study through an institution or review board.

Mr. KILDEE. Okay.

Dr. Benjamin. I just remind you that in a small percentage of cases, influenza is a fatal disease, so the cost certainly in terms of dollars is interesting, but the cost in terms of human terms is tragic.

Mr. KILDEE. Right. We recognize that as more than a fiscal thing, but even on that alone, there might be some measurable way of finding whether staying at home and not infecting others or coming to work with your inefficiency and infecting others, that might be even a fiscal—

Doctor?

Dr. Schuchat. Yes, there have been studies of the economic toll of influenza that have looked at, you know, the loss of work, the loss of productivity, the seeking medical care, and so forth. And it is many, many billions of dollars that is lost through the annual seasonal flu. A pandemic would then cause a lot more economic loss. So I am not thinking of a particular study that added on that the cost of a few days off, but certainly, the business loss of influenza substantial.

Mr. KILDEE. This is a corollary of that. Last Saturday I went through the schedule of the week and saw we were having this hearing, and then went to Mass on Sunday. And the priest is a pretty good businessman, too, plus a very good priest, and he said, "Listen, I hear sneezing and hacking and coughing out there. Let me say this. First of all, if you are doing that, don't take the common cup. Don't shake "peace be with you" with your neighbor after you, you know, sneeze into your hand. And why don't you stay at home? Don't come to Mass. Miss Mass. That is the loving thing to do, not to come to Mass. Stay home. No matter what they told you in the third grade, stay home."

So I mean we have to be realistic. There is a problem you cause socially when you bring your infection with you into work, and

while there are moral aspects to this also, so morally it is better to stay at home and miss Mass than go to Mass and spread the influenza, but there is, I am sure, a fiscal measure there that it would be interesting to study. But I will leave it at that and thank you very much.

And thank you, Mr. Chairman.

Chairman MILLER. Mr. Roe?

Mr. ROE. Thank you.

Just for my good friend about Mass, I usually do a cough count during silent prayer at church, and when it is too high, I try to get out of there, if I can.

I guess I have unique perspective of all this, being a physician and also running a small medical practice. In our practice we do have personal days, which you were talking about, so our folks can choose whatever they want to use them for. It is not specifically labeled. And I hate to lose that flexibility. They are able to use them if they are ill or if they have something with their child at school that they want to go to or anything they want to use it for. I think that would be a step back.

As Congresswoman McMorris Rodgers just said, small businesses are struggling right now, and what I would do to encourage—and just a comment from you all—to encourage small businesses is to look for a tax break for those that would provide that, because right now, if I can get up and go to my medical practice, nothing happened. There was no revenue produced.

And in all due respect, Dr. Benjamin, you have a certain amount that is appropriated that you manage each year. In a small business they have no revenue until they produce a service or goods. And when those goods and services are produced, then they have revenue to pay out. And when they lose that, through whether it is illness or injury, so a business is motivated to keep healthy workers and to keep them on. We all know that. I mean I know from my own practice that I want educated, healthy people.

And certainly as you pointed out, the turnover is very costly, whether it is a police department or fire department or medical office where you have to retrain people. So I think if we look at this, just to comment, and certainly, Mr. Clarke, you on a tax break for someone to encourage them to do that as opposed to a penalty.

Mr. CLARKE. Certainly. If I was asked about alternatives to either the HFA or EICA, it would be to look at things like that. It would be to look at incentives for smaller employers, particularly those employers where the lack of paid sick time may be more percentage-wise evident that an incentive based system would be preferable. I would certainly agree with that.

Dr. Benjamin. Let me just step and push back a little bit. Actually, you know, even though APHA is a nonprofit, we are really a business. We have about a \$16 million revenue stream, and we publish the “American Journal of Public Health,” and we have a small book publishing company.

But let me revert back to my ER doc days. When I was an emergency physician, which is how I spent most of my clinical days, if I didn’t work, I didn’t get paid. And we have millions of practitioners just like you. And when you are practicing, if you didn’t

have a partner, your business really came to a stop. So I personally have some sensitivity to the concept of not having paid sick leaves.

Now, you know, as you know, that meant I worked more shifts when I came back. But many people in our country don't have that option to be able to do that, and that is why I am a strong supporter of paid sick leave.

Mr. ROE. Would you think about a tax break for small businesses that are struggling right now instead of another mandate to them to provide a benefit they don't have the revenue for? Would you look at that?

Dr. Benjamin. Well, I think that there are many innovative ways for Congress to figure out how to fund this and support and incentivize businesses, you know, to do that. You know, I am certainly not a tax expert. But if it would serve that principle—in other words, allow businesses to be flexible, offer the benefit, the real issue, as you know, is how do you pay for it?

Mr. ROE. I think one of the—exactly—I think one of the things, too, is to not take that flexibility away from our employees, is that they are able to pick. I mean they are sick, they can stay out. You don't want somebody with the flu at work and infecting everybody else at work. That is just common sense, as everybody knows that.

But that person should—if they want to use their personal day for that or need to use their personal day for that, they can. Or if they need to use their personal day to be with a sick parent in a hospital or a child's play at school, that is what I would like to see happen.

Dr. Benjamin. I don't think anyone is disagreeing with the flexibility issue, you know, as long as the barriers—or that the system is constructed in such a way that it functionally looks like sick leave, acts like sick leave, so that it is accessible, truly accessible to the employee. I don't think anyone would disagree with you, sir.

Mr. ROE. I want to thank the panel.

It is an excellent panel, Mr. Chairman, you have assembled today. Thank you.

Chairman MILLER. Thank you.

Mr. Andrews?

Mr. ANDREWS. Thank you, Mr. Chairman.

Mr. CLARKE, in looking at H.R. 3991, the Emergency Influenza Containment Act, I appreciate the fact I think you have made some very constructive suggestions as to how some of the definitions might be tightened up, but I want to come back to the core of that legislative proposal.

If a person went to work today and was coughing and sneezing, and their immediate supervisor with authority over them said, "I am very concerned that you have H1N1. Go home. Come back in 5 days, and we are going to dock your pay for the next 5 days," do you think that the employer should be allowed to do that?

Mr. CLARKE. Well, I will answer your question, because I think people should answer questions that are put to them. Do I think they should be allowed? Yes. Do I think it is good policy? No. Do I think it happens very often? No. What I see happening particularly in this H1N1 pandemic is that employers are even addressing issues that neither of these bills address. That is, when someone is out of paid sick leave, they are allowing them to take more.

Mr. ANDREWS. Well, I understand that. If I may, so someone is going to bear the cost of that 5 days missed work. You think it should be the employee, not the employer, right?

Mr. CLARKE. I do not think it should be the employee, but do I think it is a matter of federal law to prevent that result? No.

Mr. ANDREWS. Well, what other way could we prevent that result?

Mr. CLARKE. Well, it is already prevented by the marketplace. There is such a high percentage of paid sick leave, vacation, personal days, other types of time off.

Mr. ANDREWS. But what about for the 39 percent of private-sector employees who don't have that protection by the marketplace? What about them? Do you think they should bear this cost, rather than the employer?

Mr. CLARKE. Well, you know, this whole issue—and I am always interested in how this issue is framed—it is really not an all or nothing issue. You know, all people who are sick don't stay home. All people who—

Mr. ANDREWS. No, no, I understand that, but in my hypothetical, this is the case, because the bill doesn't say that everybody gets this paid leave.

Mr. CLARKE. Right.

Mr. ANDREWS. It says if your employer instructs you to, directs you to go home, you get the paid leave. So under these facts, this is a situation where a person has been told that they have no choice but to go home and be docked the 5 days' worth of pay. You think that the employee should bear that cost.

Mr. CLARKE. I do not think that employee should bear that cost—

Mr. ANDREWS. So what is the alternative?

Mr. CLARKE. My answer is I don't think it should be a matter of federal law to prevent that result in isolated situations.

Mr. ANDREWS. But how should we prevent it? How should we prevent it?

Mr. CLARKE. Well, you prevent it in ways that are creatively prevented at the workplace now. I mentioned a very large food processor—you would recognize their name—that provides no paid sick leave. Instead, they are providing 6 months of short-term disability paid leave in the instance of the medium term illness.

Mr. ANDREWS. But do you think that is typical of the 39 percent of private-sector employees who don't have this protection, or atypical?

Mr. CLARKE. No, I think that is an atypical example, but I think it is typical to have creative results.

Mr. ANDREWS. But what about the more typical example, then, where an employer doesn't offer that sort of cafeteria plan of leave? How should we avoid this cost being imposed on the employee?

Mr. CLARKE. All right, well, on some level, again, to answer your question and to be upfront with you, on some level, the only way to have no example like that occur is to get very, very specific and mandatory on all levels of leave. And I doubt that as a country that we want to do that.

Mr. ANDREWS. Well, but of course, this isn't about all levels of leave. This is about this condition where a person has been di-

rected to miss work and to be docked their pay, right? This is not about universal paid leave. This is about a very specific fact pattern, where the employer holds the authority to tell someone they have to miss this time off.

And, you know, the cost is borne by someone, right? There are three choices. It can be borne by the taxpayers. It can be borne by the employer or borne by the employee.

Mr. CLARKE. Right.

Mr. ANDREWS. Do you think it should be borne by the employee?

Mr. CLARKE. I don't think it should be. My answer when I said yes was as to the federal mandate to cure it.

Mr. ANDREWS. But can you give us—I understand that, but can you tell me how we can avoid the employee bearing that cost, if we don't have a law that says this?

Mr. CLARKE. Well, the creative ways that we discussed, I think, a little bit earlier around incentives, around even perhaps, I think, in HFA the bill has a study provision. Maybe let us do that study before the bill was passed and find out the true scope of the problem, find out really how many examples there are like this.

Mr. ANDREWS. I understand it. I think you and I would both agree that while people are waiting for this study to get done, and they miss 5 days' work and don't make their rent payment or can't buy their groceries, that is not very satisfactory.

I don't want to see this cost imposed on small businesses arbitrarily, but this is a situation where the employer has made an election to say, "I want you—I am telling you to go home. I am telling you to go home. You can't come to work today." And I don't think that is fair.

Chairman MILLER. Mr. Thompson?

Mr. THOMPSON. Thank you, Mr. Chairman. Mr. Chairman, I would like to ask unanimous consent to submit a letter for the record.

[The information follows:]

NYDIA M. VELAZQUEZ, NEW YORK
CHAIRWOMAN

SAM GRAVES, MISSOURI
RANKING MEMBER

Congress of the United States
U.S. House of Representatives
Committee on Small Business
2301 Rayburn House Office Building
Washington, DC 20515-6515

November 16, 2009

The Honorable George Miller
Chairman
Committee on Education and Labor
U.S. House of Representatives
2181 Rayburn Building
Washington, DC 20515

The Honorable John Kline
Ranking Member
Committee on Education and Labor
U.S. House of Representatives
2101 Rayburn Building
Washington, DC 20515

Dear Chairman Miller and Ranking Member Kline:

We are writing to express concerns about legislation that would impose yet another new mandate on small businesses, our nation's strongest job creators, in a very difficult economy.

We understand that the Committee on Education and Labor is expected to hold a hearing on H1N1, which we understand will likely examine proposals such as H.R. 3991, the Emergency Influenza Containment Act, on November 17, 2009. As you know, this legislation would require that employers with as few as 15 employees provide five days of paid sick leave per 12 month period to all full or part time employees who are sent home by their employer or directed to stay home by their employer because of a contagious illness, such as the H1N1 virus. There are civil and criminal penalties for a violation of this Act.

On September 9, 2009, the Committee on Small Business held a hearing on the impact of the H1N1 influenza virus on small firms. Small business owners want to keep their workplaces healthy during the flu season. Witnesses testified that through diligent preparedness and communication, they will work to keep their companies functioning and craft flexible work and employee schedules.

Our entrepreneurs are already saddled with innumerable taxes, mandates, regulations and paperwork burdens. They are being threatened with even higher taxes, additional mandates and the prospect of having to lay off workers if H.R. 2454, the American Clean Energy and Security Act, and H.R. 3962, the Affordable Health Care for America Act, become law. All this while they struggle to generate 70% of the new jobs in the economic recovery.

As Members of the House Committee on Small Business, we are concerned that imposing this additional mandate on small businesses will destroy the very financial viability and flexibility that allows them to respond to the market. While small business owners certainly want to protect their employees and customers from exposure to illness, they should not have to put their businesses at financial risk by compensating employees for sick leave. In addition, an employer and employee should have the freedom to negotiate the benefit structure that works best for them. Some employers who currently offer paid vacation may not be able to afford to do so if they are required to offer paid H1N1 leave. This bill does not address employment situations such as teleworking, flextime, or companies that offer a single bank of leave combining vacation, sick and personal leave. It does not take into account specialized industries such as construction, which build leave policies around the timing and cycles of their businesses. A new mandate will almost certainly require compliance with additional regulations, certifications and paperwork, all of which disproportionately affect small firms, are costly and take time away from running the business and creating jobs.

At a time when our nation's unemployment rate is 10.2 percent, we should be helping small businesses to increase employment. Imposing a mandate requiring paid sick leave is the wrong thing to do. Such a requirement could instead result in employers eliminating jobs or other employee benefits.

We urge you to consider the negative consequences of this legislation on small businesses in an unprecedented economic environment.

Sincerely,



Rep. Sam Graves
Ranking Republican
Committee on Small Business



Rep. Glenn Thompson
Member
Committee on Education and Labor
Committee on Small Business

Mr. THOMPSON. As a member of the House Small Business Committee in addition to my responsibilities here in Education and Labor, I have an additional responsibility to do my best to ensure the proposals we are looking at today take into consideration the needs of our nation's small businesses who employ so many Americans and the American workforce.

On September 9, 2009, the Committee on Small Business had a hearing on the impact of H1N1 influenza virus on small firms, and we learned, as suspected, that small business owners are making strides to keep workplaces healthy during the flu season. The witnesses testified that they are crafting flexible work and employee schedules, as Mr. Clarke made reference to some of those that he

has observed, that—and are doing their best to address the H1N1 outbreak.

An employee should have the freedom to negotiate benefit structure that works best for them. And some employers who currently offer paid vacation may not be able to afford to do so if they are required to offer paid H1N1 leave. At a time when our nation's unemployment rate is 10.2 percent, we should help small businesses increase employment.

This letter was also signed by the ranking member of the Small Business Committee and addresses some of these issues. As the committee moves forward, we need to take into account small businesses' unique needs and ensure that we don't create policies where, however well intentioned, they may have an adverse effect on our nation's economic engine.

I appreciate the panel coming today. I had some specific questions.

Mr. CLARKE, in your testimony you mentioned a number of unanswered questions regarding the Emergency Influenza Containment Act. What in your view are the most important of those unanswered questions?

Mr. CLARKE. Well, they are largely definitional. What does it mean to suggest or direct? I mean this is what happens in reality in workplaces. People have conversations. People typically are friends. People are concerned about each other. And his supervisor has a conversation with someone who appears to be ill or getting ill. Is that suggesting or directing?

The significant problem, though, is just like it is with HFA, is what is the impact on the paid time off plans? And what is going to be the impact of the mandate on employer flexibility, because just like HFA, there is a specific safe harbor there saying if you provide this mandated benefit in another way, it is not additive?

But that mandated benefit has so many strings and issues in it that most employers would not be in compliance with that today, so it would either be additive or it would have to replace an existing benefit.

Small employers, if I may say, small employers provide paid sick leave. The surveys, they show up as providing paid sick leave as much, really, as larger employers do. The difference is that small employers tend as a group not to have defined policies on every issue, or really even on any issue in some cases.

So some of them have concerns about handbooks and policy manuals and things like that, and they are very much more in the moment. And that really is to employees' benefit during a pandemic like this that is recognized nationally, that has got very good science behind it, that is in the news, and really in our experience encourages small employers to do more than you might find in a written and sort of hard coded policy at a medium or larger size site.

Mr. THOMPSON. The supporters of another bill that we have heard discussed this morning, the Healthy Families Act, suggest that the bill is targeted at those employers who do not offer paid sick leave and claim that employers who do not offer paid sick leave currently would not be affected by the legislation. Is that how you read the bill? And if not, how would you read it?

Mr. CLARKE. I read the bill's mandate to say that if you provide these sick days in this way with these conditions with these carryovers with these prerogatives with these notice provisions with all these particular details, and you also provide 7 days otherwise, you don't have to add it.

However, I really cannot think in my mind of an employer that has a sick pay plan that meets the current safe harbor. So an employer that is going to have to open up their plan to try to comply with that safe harbor is going to have to—he will, I believe, open up a broad look at their paid time off policies and try to balance the cost with what is being added in their minds.

Mr. THOMPSON. Okay. Thank you.

I yield back, Mr. Chairman.

Chairman MILLER. Mr. Hare?

Mr. HARE. Thank you, Mr. Chairman.

I would like to direct the committee's attention to written testimony that was submitted to the committee by Melanie Disher from my home state of Illinois. And Melanie is a food service worker at Plainfield North High School and is an employee of Sodexo, a private company contracted by the school to provide cafeteria services.

She is a shining example of someone who can't afford to take sick days and has to work while ill, potentially exposing children and other staff members to germs. Melanie's situation is indicative of the problem all across the country, especially among those who are considered low-wage or part-time workers. Workers deserve the resources necessary to not only protect their health, but the health of their co-workers and as in Melanie's case, schoolchildren.

The Centers for Disease Control recommends that individuals experiencing flu-like symptoms stay home, but for too many workers staying at home means the loss of vital income, marks against their work record, or other negative implications. Having paid sick leave not only ensures that sick individuals can recover, but also stems the incidence of infection, protecting the safety of at-risk populations.

With that, Mr. Clarke, the CDC estimates that sick workers can infect one in 10 of their colleagues. Doesn't this fact clearly point to the need to ensure that workers are guaranteed paid sick leave, especially if the people they interact with are part of an at-risk group, such as children? I would think that if you had young kids in school and you knew that the food service workers were going there ill and that your child would be exposed to this, I think that would be a pretty scary situation as a parent.

Mr. CLARKE. Yes, I have to certainly sympathize with that last comment as a parent and as a fellow human being on this planet, but my response is that the glass is over 80 percent full, and that is going to be a fairly rare circumstance or one that is occurring primarily in part-time employment.

Part-time employment typically does in this country not carry very many pay benefits. About half the employers provide a paid benefit in the part-time environment. Part-time is very common in food service and hospitality. I mean it is likely—I don't know—that that individual is part-time. And I would hope that her employer would give her and provide her a paid benefit proportionate to the hours that she works.

Mr. HARE. Just two things, Mr. Clarke. You know, I have heard you mention 80 percent full several times in your testimony today, and I appreciate your being here, but as Chairman Andrews pointed out, what about these 39 percent of people who don't have it? And we are in a recession. We have got 10.2 percent of people who aren't working. Many of these are single parents.

Mr. CLARKE. Right.

Mr. HARE. They are going to work. They are sick. They are in food service. They may be serving us. I remember we had a hearing on this before, and I asked the panel across the board and said, "How many of you would order a tenderloin if you knew that the person serving it to you was coughing and sneezing all over the place?" And nobody raised their hand.

My concern is for these people who don't have it. And what do we do to give it? It would just seem to me that especially if the employer is telling them, "Look, you are coughing and I don't like the way—you have got to go home." And they should. I don't want them, you know, want them infecting people.

But they are not going to get anything out of this. And for many of them, that is the difference between being able to pay for health care, being able to put groceries, being able to buy prescriptions to get better. I just don't know what we would do with those 39 percent of people. And that is an awful lot of people out there.

Mr. CLARKE. Right, and I certainly appreciate that concern. I think the answer really goes to what pool there you are looking at when you come up with that percentage number. I am not going to say there is no one in this country that works for a living that has no paid time off and might suffer one of the consequences that you or the other congressmen mentioned. My point is that the pool is much, much smaller than those statistics present. And let me give an example of why that is.

Someone mentioned that 93 percent figure that the Bureau of Labor Statistics from the USDOL published in February of 2009, that 93 percent of full-time employees receive paid sick leave. Now, they got to that number by accumulating vacation, sick, personal and similar kinds of paid leave. And they accumulated that and called it all sick leave.

If you want to do a study that says I am only going to count you as receiving sick leave if you have a piece of paper in front of you that says you get X days of sick leave, you are going to increase the pool of people who do not have paid sick leave, in your mind. I mean there is a fundamental issue there. I don't know where the exact number is. You know, these things vary within ranges. But there are two fundamental different foundations there in those surveys.

Mr. HARE. Well, I will just conclude by saying this. In the factory that I used to work at, which was an organized factory, there was no paid sick leave. If you are sick, and most of the time when I was—I worked there 13 years—I just came to work, because I had a couple of young kids that I had to provide for. And when you are working piecemeal, you are pushing all day long just trying to make ends meet.

And we couldn't borrow from any account. We couldn't borrow from our vacation. We couldn't borrow. And we had no personal

leave, so, you know, I have been there and done that, and I just hope that this bill passes, because for those people who don't have it, we clearly have to provide it. And I thank you.

Thank you, Mr. Chairman.

Chairman MILLER. Thank you.

Mr. Courtney? Mr. Courtney, might I ask you to yield for 30 seconds?

Mr. COURTNEY. I would be happy to.

Chairman MILLER. That 93 percent figure, Mr. Clarke, was manufacturing employers, right?

Mr. CLARKE. No, Mr. Chairman, that was overall. Actually, manufacturing was 96 percent.

Chairman MILLER. It was overall. Okay.

Mr. CLARKE. Manufacturing had the highest percentage of paid sick leave of any other sector in the country.

Chairman MILLER. Check the record on that.

Okay. Mr. Courtney?

Mr. COURTNEY. Thank you, Mr. Chairman.

Ms. NESS, I would like to sort of review with you a little bit the differences between H.R. 3991 and the Healthy Families Act, because I mean one of the concerns I frankly have about 3991 is that the trigger for sick pay under that proposal is really an employer decision. In other words, the employee, the way I read it, almost has to present himself or herself at the workplace, and then the employer makes the decision that, "Okay. It is time for you to go home."

I mean there is really no scenario in this language that really started that somebody wakes up that morning and just says, you know, "I don't think I should go to work." To comply with Dr. Schuchat's, you know, goal, which is to make it easy for the employee, I am a little concerned at just about the way this is structured, and I don't know if you want to comment on that.

Dr. Schuchat. Yes, we share that concern. And I see that as a starting point that we need to improve on. I think there are some very core principles to make emergency legislation meaningful. I think it has to be job protected. It has to be paid. And I think it has to be at the employee's discretion.

The employee has to be able to call in and say, "I am too sick to come to work." Otherwise, we are defeating the purpose of trying to reduce the amount of contagion spread by sick workers going into the workplace. We also believe that the leave needs to be usable not just for the person who is ill, but also if that person is taking care of an ill family member, like a sick child that needs to be kept home from school.

Mr. COURTNEY. I mean again, as—and I am also just sort of trying to visualize other scenarios where if somebody is at work coughing—they are in a factory floor or office where there are other people around—that person gets sent home, and then the rest of the staff is sitting there thinking, "Well, I was there when that person was coughing." The structure of this, really, I just find it somewhat questionable.

Dr. Schuchat. It becomes even more problematic when you think about the kinds of workers that we are talking about, who tend not to have paid leave. They are the folks who are interacting with the

public on a regular basis, so a lot of these are childcare workers. They are nursing home workers. They are food service workers. They are workers in public accommodations, in hotels and retail. So they are the very folks who are interacting the most with the public, who you really don't want to have coming to work sick.

Mr. COURTNEY. Whereas the Healthy Families Act, I mean, really again doesn't tie the who decides to the employer, it creates just basically several more broad-based sick leave benefits, which allows the worker with a doctor's note or whatever to qualify for the sick leave. And, you know, again, I am not trying to be proud, you know, difficult here, but it just seems like that provides a path that achieves what the public health officials are saying is really the goal here, which is to make it easier for workers to not spread H1N1.

Ms. NESS. Correct. And we look forward to working with the committee to build those core principles into any emergency legislation that would go forward.

Mr. COURTNEY. I don't know if, Dr. Schuchat or Dr. Benjamin, you want to comment on this sort of employer trigger that is in 3991.

Dr. Schuchat. I mean from a public health perspective the best thing is not to go to work or school when you are sick, to be able to not do that. We have actually also recommended that if you are not really ill, we don't want you to actually go to a doctor's just to get a doctor's note, because that can clog up the health care system.

And so some of the outreach that has been done to the business community has been about, you know, flexibility about that, so that we don't overburden the health care system in order to—you know, for people who wouldn't otherwise have to go there.

Mr. COURTNEY. Dr. Benjamin?

Dr. Benjamin. I will just agree with Ms. Ness' perspective on that. I think that is accurate. Do you want to encourage people not to come and work? Incentives should be to stay home when you are sick.

Mr. COURTNEY. All right. Thank you.

And as far as, I guess, Ms. Ness, if someone is home and is able to work from home with, you know, telecommuting, I mean there really should be some accommodation, hopefully. I mean we are living in a world where that is becoming more common. I mean I don't know if you have any comments about whether that should be incorporated.

Ms. NESS. Well, I think we are all for flexibility. I think it has its limitations when you are talking about workers, for example, who are hotel workers, for example, or somebody who is a short order cook or—I mean there are some jobs that you can't do flexibly from home. So certainly, we are very enthusiastic supporters of flexibility, but there are millions of workers for whom flexibility is not an option.

Mr. COURTNEY. Thank you.

I yield back.

Chairman MILLER. Mrs. Biggert?

Mrs. BIGGERT. Thank you, Mr. Chairman.

Rear Admiral Schuchat, I have a couple of questions about the vaccines and particularly the H1N1. I know that you—in your testimony you said that the vaccine is targeted, you know, the available doses, in priorities such as, you know, pregnant women, children and people that care for children.

But it seems like what has happened, and we had a change in how the vaccines are delivered, and just going around and seeing so many places where they say they have the vaccine, and then you will see these huge, huge, long lines of people waiting for several hours and, you know, holding their children. And it didn't seem to be the best way that should be given out, particularly even getting the people together that have the potential of being sick.

How was the policy determined how they would be distributed? And did it work?

Dr. Schuchat. The recommendations for who ought to be vaccinated when supplies are relatively scarce came from CDC's advisory committee on immunization practices. It is a science-based committee, and they came up with these five that ought to be vaccinated before others.

The vaccine is coming from five different manufacturers, and it is going to the central distributor that CDC manages. States and large cities order vaccine proportionate to their population and have it shipped from that central distributor to the sites that they designate. There is state and local authority in directing those sources.

We know that 34 states have already carried out school located clinics to reach large numbers of children, that virtually all states have directed doses to hospitals for health care workers and high-risk populations. Most states have sent some alloquets to providers' offices to reach the high-risk people there. Some have also started, I believe—I think 14 states have started to provide some doses to the retail pharmacy venues that can reach additional people. Some have gone to employer clinics.

The states and the cities are directing the vaccine doses in the ways that they believe are the most effective to reach the priority groups. We know that the vast majority of vaccine has gone for the high-risk population, but that they have been doing mass clinics.

I think everyone wishes there weren't long lines, that it were easier for people, particularly pregnant women, parents of young children, to easily get their loved ones vaccinated. And with a limited supply, it has been challenging, but it is getting better each day.

Mrs. BIGGERT. Well, did your advisory committee give any information on how they would have given this out? It seems to me that if you have got different groups and priorities, that the way to do it would have been through the pediatrician or a doctor's office. And as I recall, that usually seems to be the starting point for distribution. And was this a change from all the states? Or how does that happen?

Dr. Schuchat. The doctors' offices are the key component. One of the challenging things about vaccinating during a pandemic is how busy the doctors' offices have been, particularly the pediatricians' offices. We know that in the spring in New York City, doctors, pediatricians, were actually having to cancel their well child visits,

which is where they give out vaccines. So this was much more of a flexible approach, often trying to find, you know, lots of doctors' offices, but also as a venue.

One critical piece is that doctors who care for pregnant women rarely get vaccines, and we have really had to push hard to get obstetricians to sign up for vaccine. In some states it has been a great response. In others it has been a little trickier. So local health departments, hospitals and others are really pitching in where the provider community might not have been able to fill the need.

But certainly, providers are among the large numbers that are getting vaccine and using it. Of course, some people don't have providers, and so there are these other venues so that they would be able to be vaccinated.

Mrs. BIGGERT. Well, it seems that there has been short supply. Would you be able to meet the need for this before everyone gets sick?

Dr. Schuchat. The demand has been tremendous for vaccine. This differs from some other countries, where the public is a little more skeptical of the need for vaccine and the value of it. But demand has been very high. Supply is getting better, but it is not there yet, and our goal every day is to use the supply that is there as effectively as possible.

We hope that in the weeks ahead it is going to get better, but demand is very high right now, and it is difficult to say when the lines will be shorter, when it would just be easier for people who have been recommended to be vaccinated, to be able to be.

Mrs. BIGGERT. Well, if you have it to do over again, would there be any difference in the way that you would approach the distribution?

Dr. Schuchat. I think that the central distribution and the state and local authority have been very important in us reaching as many people as we have reached. I think doing it over again, the messaging and expectation setting could have been much better, that I think people thought we would be in much better shape by now and are very frustrated. And I wish that we had communicated in a way that made it easier for people to know that it was going to be tough.

Mrs. BIGGERT. Thank you.

Yield back.

Chairman MILLER. Mr. Tonko?

Mr. TONKO. Thank you, Mr. Chair.

Ms. NESS, you in your testimony cited the fact that several companies have expanded their policies, their sick leave policies in response to the H1N1 virus. And then I think it was three companies—

Chairman MILLER. Mr. Tonko, could you pull your microphone up to you a little bit?

Mr. TONKO. Three companies that you mentioned in the testimony had done so. Do you know how these companies have fared in comparison to other companies in terms of controlling or keeping their workforce healthy?

Ms. NESS. I don't have data on how they have fared, and I think those actions are relatively recent. So we would be happy to try to

get back to you on that, but I think it points out the need for us to take action.

In such a tight and competitive economic environment, I think leveling the playing field here and encouraging all employers to do the right thing would probably make it easier in this environment for employers to all take the steps that we need them to take right now.

Mr. TONKO. And, Dr. Schuchat, you talked about bringing together CDC and the Department of Education so as to allow for state and local agencies to calibrate their message and provide guidance. Would you recommend similar systems be available to tailor, perhaps, the needs in our business community for their workforces?

Dr. Schuchat. You know, we have been working with business as well. The public health connections with the Department of Commerce, Department of Labor, and so forth have been extensive, and also Homeland Security, about continuity of business. We have also done a lot of outreach with the U.S. Chamber of Commerce, the Business Group on Health and others.

I think critical for a pandemic response is good communication and partnership. And the partnership with education has been incredible. It has really been extremely strong. I think the education sector felt that pandemic the strongest in the spring and all through the summer worked very hard to ready the schools. It has been a great success, because the disruption to the school system has been much lower. USDA stepped up and made sure that there were school lunches for some of the kids where schools did have to be closed.

We have done much better this fall than we did in the spring responding, and with the business community I think we have been trying, but we could always do better.

Mr. TONKO. Where do you think the improvements can come with the business community? I hear this, you know, summer outcome with the school systems. Where could we improve with the business community?

Dr. Schuchat. You know, I think one feature that has been nice with education has been our tracking system. We have been monitoring school dismissals and really had a metric of the success of the interventions, that we had the new guidance, and so forth.

It may be that we don't yet have the right metrics to understand how we are doing with business, but it is also a less centralized universe, you know, in terms of the partnership. So I am sure that this committee would have good ideas of about how we could strengthen the work, but we have been paying a lot of attention to it.

Mr. TONKO. Then, Mr. Clarke, with the paid time off situation and the flexibility factor that you keep mentioning, while that may seem to be a workable solution for employees and employers, what about situations where the available time is used too—and then, for instance, someone could have used that time for a vacation earlier this year?

What happens when, from a public health policy perspective, when an individual is sick at the workplace, is required to go home,

or is ordered to go home with no available time, given that flexibility?

Mr. CLARKE. Right. No, I really appreciate that point, and I think that is the point that we miss in most of this discussion. We missed it in the HFA. We miss it in the EICA. We don't address what happens when you didn't have basic plan that did meet the safe harbor. You are now out of sick time. What happens next?

And what I got to complement the surgeon general's office, the CDC, what has happened in the employer community is there is such a deep awareness of what is going on with this pandemic, with this flu, that so many employers are thinking about just exactly what you asked and doing things like I mentioned—that is, adding extra days to the bank or coming up with other ways—“Look, come in on another day, a day you weren't normally scheduled. Come in then and make up that time. Let us get you paid that way”—all sorts of creative ways either just to give the time, the paid time to them, or to have a way to make it up.

But those issues are being addressed in the marketplace, are really not addressed in these two bills.

Mr. TONKO. And if the worker is absent from work or ordered to be absent from work, with that lack of flexibility remaining because time has been used, the economics of it, who—you know, are you suggesting that the business would pay them if they came in to make up that time?

Mr. CLARKE. I am suggesting that many are telling me that is their current plan. I don't know, certainly, the percentage exactly that will do that. What I can tell you is there is a growing awareness of that need, a growing awareness of the medical facts, a growing awareness of the fact that this is a very contagious flu, a growing awareness of all these factors, and employers are reacting to that.

I am not suggesting every employer is in every situation. What I am suggesting to you is that they are listening, they care about it. These human resource professionals that we work with every day are on top of this. If we run a tele-seminar for our members, it is way oversubscribed in 2 days. If we have a webinar, it is well subscribed. These companies are on top of it and care about their employees.

Chairman MILLER. Mr. Guthrie?

The gentleman's time has expired.

Mr. Guthrie?

You don't have—oh, maybe 1 minute?

Mr. GUTHRIE. One quick question.

Chairman MILLER. Okay, one quick one.

Mr. GUTHRIE. On the safe harbor in the bill, and this is for Mr. Clarke, if the employer requires notice of medical certification or call-in procedures, the use of paid sick leave, does it appear to you that the bill's safe harbor not apply?

Mr. CLARKE. It appears to me the safe harbor would not apply. These safe harbors have very specific provisions, and if they are not all checked in the right way, then there is no safe harbor.

Chairman MILLER. Thank you.

Ms. Chu?

Ms. CHU. Ms. Ness, you talk about the fact that there are 15 cities and states that have considered paid sick day laws and that you are involved in about 25 campaigns across the nation on paid sick leave. I know that there could be local initiatives with regard to paid sick leave, but why in this case is it a point to have a federal standard?

Ms. NESS. Well, mainly because right now there are only three localities in this country where there is a standard: San Francisco, Washington, D.C., and Milwaukee, which is actually being contested at the moment. And we are talking about millions of workers who need this basic workplace protection, and a patchwork approach isn't going to help to many millions of those workers.

We need a basic labor standard, and the arguments that we hear today about why we can't do this now are the same arguments we have heard every time we move to put in place a workplace protection like this. And the evidence always shows that most of the claims about negative impact on business and negative impact on jobs never really materialized. We have good evidence that shows that this makes sense both for workers and for businesses, and we have reached the point where we need to act.

I would like to just highlight this with the one reference to my earlier testimony, which is that communities of color and low-income communities are particularly hard hit by the lack of this protection. And there is some evidence now that the rate of H1N1 in those communities is higher. The rate of hospitalization in those communities is higher.

If you think about it, it makes sense. People who don't have paid sick days can't stay home, can't take care of themselves, can't get care. They get sicker. They are sick longer, et cetera.

Ms. CHU. Dr. Schuchat, could you address why there should be a federal standard, if we are to do such a thing?

Dr. Schuchat. No, as a public health expert, our—and my colleagues and I at CDC are just keen that it is easy for people to do the right thing. And we have issued guidance from the federal level to help employers, schools, health care workers and others know what the best science suggests. And that suggests that staying home when you are sick for 24 hours after the fever has broken is the best medical advice. It helps you get better, but it helps you from infecting other people, so this is really our approach, you know.

As a center director at CDC, I have about 800 people who work for me, and I have a very committed workforce that wants to come into work. It is very fortunate that my workforce has benefits that let them stay home when they are sick and that they do that kind of work that lets them telecommute, so it is just—I think our goal is just to make it easy for people to do the right thing and not infect their co-workers.

Ms. CHU. Ms. Ness, I was chair of an underground economy task force when I was in the legislature in California, and I know that it is very difficult to enforce the standards, even very basic things such as minimum wage. How could we ensure that once we pass this law that it could be enforced? How could we ensure that there would not be employers that would just send employees home and then just stop their pay?

Ms. NESS. Well, given that this is emergency legislation, there would need to be very rapid response. And with an emergency response to gearing up for the right kind of enforcement, we believe there needs to be call centers where people can call for help to understand and also to report when the law is not being followed.

We think the Department of Labor would need to set up some rapid response teams to make sure, given the emergency nature of this legislation, that we have got the right enforcement in place. And there needs to be real education both for employers and employees.

Ms. CHU. Dr. Schuchat, I wanted to—you talked about enforcement—I want to raise an issue that happened in my district. There was a tragedy that occurred with a woman named Monica Rodriguez, who was pregnant and went to a hospital, and she was coughing. They just sent her home with cough syrup. She went to another hospital 2 days later and was admitted into the intensive care, and it turned out she did have H1N1, and she died, as well as her unborn child.

It seems crystal clear what the guidelines are with regard to pregnant women with severe flu-like systems. Can you tell me what kind of enforcement mechanisms there are for hospitals to actually follow these guidelines?

Dr. Schuchat. Yes, we have really been intensifying our outreach to the obstetric community, to the health care community. There is just a long-term tradition of reluctance among pregnant women and their caregivers to give the medicines. There is a fear that, you know, we don't know if this is a safe approach. There have been some misunderstandings about the lab tests and their accuracy.

We have really been working hard to get the message out that a woman who is pregnant who has got a fever and cough really needs to be given antiviral medicines. They can be lifesaving. This is not just something to pooh-pooh and something we want women to know, to take very seriously, and their doctors. We have done a lot of outreach much more intensively over the past couple of months as disease has increased and just trying to hope that we can decrease that kind of terrible story.

Ms. CHU. Thank you.

I yield back.

Chairman MILLER. Ms. Fudge?

Ms. FUDGE. Thank you, Mr. Chairman.

I thank all of you for being here today.

Mr. CLARKE, in your testimony, and correct me if I maybe didn't read this properly, but in your testimony, your written testimony, you appear to have looked rather closely at employees that in general have relatively high wages and more flexible workplaces. Did you have the opportunity at all to analyze the legislation from the perspective of individuals in industries or occupations earning less income or in less flexible workplaces?

Mr. CLARKE. Well, yes. Our membership literally goes from workplaces with two employees to, in one case, probably 20,000 employees, and half of our membership is under 100 employees, so that is a partial answer. But what I am really—

Ms. FUDGE. No, I am looking at the incomes of the employees.

Mr. CLARKE. Oh, yes. Oh, yes. And, oh, gee, widely, widely variable. This is a, you know—

Ms. FUDGE. No, no, no. That is not my question. I understand that it is very variable, but in your testimony you basically look at people who make a lot of money, who make more than the norm.

Mr. CLARKE. Oh, no, no. I wouldn't say that at all. We have a lot of processing facilities, a lot of, you know, low-end manufacturing, a lot of roles—hospitality, food service, hospital, bank, office work that is not highly paid at all. Where I am going with that is that I think our mix represents the market fairly well.

But where I am going with this is that, again, neither of these bills reached down below the 15-employee threshold. I am not, certainly, advocating that you change the threshold. I just think we need to recognize that a disproportionate percentage of the issues we have discussed today likely come from the under 15-employee group. And it is also the toughest group to put a mandate on economically. So I think that is an important point to make.

Ms. FUDGE. Well, I am not making that point. My point is in your testimony you really do look at people who are in manufacturing who make more than the norm, and you did not really, in my opinion, look at those who are in lower income brackets and those who are in less flexible workplaces.

Ms. NESS, you talked a bit about using some kind of a Web site or hotline or telephone line to report retaliation or the discrimination that is based upon employees taking time off. Do you really think that the telephone hotline or Web site are enough to encourage workers to take time off in the face of possible retaliation or discrimination by their employers? And do you have any other recommendations that we may be able to use to minimize that?

Ms. NESS. No, I don't think that by itself is enough. I think it is a tool, particularly if we are talking about emergency legislation that we are trying to get up and running quickly. It is a tool to both answer questions and also to report problems.

But there needs to be serious resources allocated within the Department of Labor to do the proper enforcement. They need all the tools they need to be able to do the data collection to make sure that employers are doing the right thing, and they need to do serious education of both the employers and the employees.

I think enforcement should be combined with strong education, but if we are talking about emergency legislation, there probably needs to be some very quick rapid response in a telephone hotline to facilitate, not as a substitute for, rapid enforcement.

Ms. FUDGE. Thank you.

And I just want to say for the record, Mr. Chairman, that understand I didn't run a small business, but as the mayor of a city, I had more than 250 employees in a small city. We had the kinds of programs you are talking. We had sick leave. We had vacation time. We had personal days, et cetera.

If I had allowed to people to just take a vacation day when they felt sick, with no prior warning or to just use the time any way they wanted to use it, I couldn't get the trash picked up, I couldn't get the firefighters out, I couldn't get the police department out. So it really is very different.

It is very different to say that there is a pool and they can just use it any way they want to. In theory that sounds good, but in practice it does not work. So I just want to say that for the record, Mr. Chairman. Thank you. I yield back.

Chairman MILLER. Mr. Loeb sack?

Mr. LOEBSACK. Thank you, Mr. Chairman.

Thanks to all of you on the panel. And as a representative from Iowa, I am very appreciative of the fact—I wasn't in here the whole time, but I think everyone has said H1N1 and has not used the less formal term for this, so thank you very much for using H1N1.

Dr. Schuchat, I tried to write down some of the numbers that you gave us. Did you say that so far 48.5 million doses have been distributed? Is that correct?

Dr. Schuchat. As of today, 48.5 million doses have become available for the states to order.

Mr. LOEBSACK. Okay. Do we know how many of them have actually been distributed and actually been taken?

Dr. Schuchat. We know that the states are doing a very good job ordering their doses, and, you know, within a day or so that the doses are shipped out to them.

We are carrying out coverage surveys, so we will have a better sense of the proportion of the population that has received the vaccine. Our preliminary data suggest that it is going to the high risk people right now, but I think later this week we are hoping to get those numbers cleared up and be able to release them, at least the early coverage data.

Mr. LOEBSACK. The reason I asked—it sounds like this is a very complicated outreach program. It is very complicated. I would like to see a little chart, if you will, sir, you know, laying out the high-risk populations, laying out what the CDC does, and then at the state and local level, who is responsible for what essentially. But do you have any estimate as to the number of doses that will eventually have to be distributed and taken by individuals?

Dr. Schuchat. It is extremely difficult to come up with that number. One of the things that we know is the number in the population group, the 159 million in these five groups that we have targeted, does not equate to the number of doses that we need.

We know that we never have 100 percent uptake of any intervention. With seasonal flu about 100 million people get it each year—the vaccine. And we recommend it for about 253 million people. We think the demand is greater for the H1N1 vaccine than for seasonal flu in usual years, but we don't know exactly where that sweet spot will be when we are finally able to reach—achieve—really to meet the demand.

One thing that has happened is that area-to-area and week-by-week, demand can change. So we are working really hard now to use every dose we get. And what will happen over the weeks ahead with demand, whether it will increase further or decrease, we don't know. We are certainly planning to try to have more vaccine than the demand, but when we will get to that point I don't know.

Mr. LOEBSACK. All right. And you do have a system in place where you can be tracking all this, obviously, in the feedback, and—

Dr. Schuchat. That is right. We have a national H1N1 influenza survey that is being carried out. And then we are also supplementing the behavior risk factor surveillance system, which would give us state specific coverage data and also will let us see how are we doing in pregnant women, how are we doing in health care workers, in children, and so forth, so that we can get a little bit more granular data.

And perhaps in the future we will be able to learn a little bit about where did we do very well and where did we not do as well. The system works based on state and local direction of the programs, and we are really trying to find best practices and share them quickly.

Mr. LOEBSACK. So you are getting feedback all the time. You are refining the system all the time. So I mean the goal, obviously, is to get these—the vaccine doses—to as many people who need them as possible, so all along the way you are trying to refine the—

Dr. Schuchat. That is right. I think the spirit is continuous quality improvement, not waiting for 2 years from now to figure out what is the best way to go.

Mr. LOEBSACK. Right.

Dr. Schuchat. And I can say that at the state and local level, day-by-day they are improving. You know, some of those long lines we saw, the next day the health departments were handing out numbers and figuring out, okay, we got 2,000 doses, 2,500 people in line, giving the last 500 people early notice that you are not going to make it today, but if you come back tomorrow, we will put you up at the head.

Mr. LOEBSACK. Okay. Thank you.

Ms. NESS, a quick question about—did I hear you say that there is a correlation essentially between income level and number of paid sick leave—sick days? Is that correct?

Ms. NESS. Yes, what I said is that low-income workers, workers in low-wage positions, are less likely to have these kinds of job protections.

Mr. LOEBSACK. Can you elaborate on that? I mean how strong is that correlation? I don't know if you have an R for me or any kind of a statistic for us.

Ms. NESS. We know that if you look at all workers, for all private sector workers it is approximately half that don't have paid sick days. But if you look at low-wage workers, we are talking four out of five.

Mr. LOEBSACK. Okay.

Ms. NESS. Another way to think about it is 22 percent of food service or public accommodations workers—folks, for example, who work in hotels—have paid sick days—only 22 percent. That is sort of less than a quarter of the workforce would apply to nursing home workers and child care workers as well.

Mr. LOEBSACK. Okay. Thank you.

Thank you, Mr. Chairman.

Chairman MILLER. Thank you.

Dr. Benjamin, I think we have to excuse you, I am told, so—that you have another commitment. So thank you very much for your time. If we have questions, we will follow up with you in writing, if that is all right.

Dr. Benjamin. Yes, sir. Thank you very much.

Chairman MILLER. Thank you very much for your time.

Mr. Payne?

Mr. PAYNE. Thank you.

Actually, as we in New Jersey are very concerned as other parts in our—now, the first death of H1N1 in New Jersey occurred in my district, West Orange. And currently, we have had 22 deaths so far. We have had nearly 800,000 doses provided, about 40 percent of what our needs are in the state. So we are still lagging behind. And, of course, we have certainly a preference to pregnant women and young children.

And let me just ask you, Doctor, has the question of pregnant women been answered yet? Initially, there was a question of whether they should take it, whether they shouldn't take it. And, of course, the early doses we know were in pregnant women, therefore, the need being there. However, the question of whether it was safe enough—how has that been worked out?

Dr. Schuchat. Based on everything that we know right now, the risk of H1N1 disease in pregnancy greatly exceeds any hypothetical risk from the vaccine. NIH has carried out a clinical trial in pregnant women, and the initial results suggest very good immune response from the vaccine, suggesting it will work really well, and no red flags in terms of safety.

There is an effort to commitment to follow up the women in that trial long-term and their babies, and then also nationally to do some monitoring in pregnancy. There haven't been any red flags at this point in the use of vaccine in pregnant women, but we do continue to get these very sad stories of women who are really in critical care, on life support, and sadly, many of them having died.

So we know that this is a bad disease in pregnancy, and the vaccine is made exactly the same way as seasonal flu vaccine, which is used in lots of pregnant women and has a very good safety track record.

Mr. PAYNE. Ms. Ness, you mentioned in your testimony that several cities—the District of Columbia, San Francisco, Milwaukee—provide paid sick leave and by ordinance. I wonder if—have these cities found that the employer mandates is a great burden on employers? And are employers in those cities complaining about workers abusing this privilege?

Ms. NESS. Well, San Francisco is the one city that has been in place long enough for us to actually take a look. And the results have been very encouraging. In fact, there was some research done to look at job creation, and it turned out that job creation in the city of San Francisco was actually higher since this mandate than in the surrounding areas that did not have the guaranteed paid sick days.

Mr. PAYNE. Thank you.

Mr. CLARKE, in your Capital Associations Industries, what type of industries basically are there? I was out, and you might have mentioned it. Are they manufacturing—primarily manufacturing, right?

Mr. CLARKE. Well, at our founding back in the 1960s, it was primarily manufacturing. Today it is about 32 percent manufacturing. We really represent the broad spectrum of the business community.

Mr. PAYNE. Okay. And, of course, as you have heard previously, I guess, there is always a lot of concern about particularly those—and, you know, our society is sort of—things, you know, sort of upside down—those who have the, in my opinion, some of the more important positions—food service, caring for the elderly, caring for children, and it is quite a few people in that category, of course, tend to be the lowest paid.

And when you are low paid, you certainly are not expecting to have robust employee benefits. And so, you know, I am looking at that at 80—mine was 80 percent full, too, but it is empty now—your 80 percent glass that you keep saying about how good things are for four-fifths of the people. You therefore assume that that last 20 percent, that unfilled glass, is primarily filled with those folks who are working with the elderly, working at, you know, homes for geriatrics, food service workers.

How do you kind of, you know, figure out, even if it is just a 20 percent, isn't this kind of an important 20 percent that is not covered, and that you still contend that a person should be responsible for their own sick leave, since in many instances these places do not provide them? How do you reconcile all that?

Mr. CLARKE. Well, sure. The food service industry is not, you know, all monolith. There are some large, very large companies that play in that space. They are going to have a different set of benefits, perhaps a different view toward all types of paid leave. A very small player, a very local individual, a caterer, for example—not to pick on caterers—might not have that level of sophistication or economic wherewithal, so it is, you know, I think it is difficult to take an industry and say that industry would not have this benefit.

I think the comment I would make is that the industries you mentioned tend to have a higher proportion of people that work part-time, and that about half of the time part-time employees, even in those industries that you named, are accumulating sick days, but simply at a lower rate proportionate to the hours that they work.

Chairman MILLER. Ms. Woolsey?

Ms. WOOLSEY. Thank you, Mr. Chairman, for holding this hearing, because it is not only important, it is timely right now.

Our witnesses have pointed out that H1N1 has now spread to 46 states and that it is certainly a serious threat to public health, particularly when workers come to work sick, because they can't afford to do otherwise. Ultimately, I believe we need to pass Representative DeLauro's Healthy Families Act so that all workers have paid sick days and job protections when they need to care for themselves and their families.

But to face our current crisis this emergency legislation is needed. I think we need to tweak it here and there, but that is why I co-sponsored the Emergency Influenza Containment Act that was introduced by Chairman Miller, which, by the way, I hope everybody is aware—we keep talking about small business—this legislation exempts small employers, and actually over 80 percent of our workers in 2005, annually, were employed by small businesses that employed under 20 employees. So small employers are pretty well

exempted from this, and that's 80 percent of our workforce right then and there.

But the goal is a good start, Mr. Chairman, and it certainly addresses an emergency situation.

Ms. NESS, I really agree with a lot of what you said in your testimony about strong job protection and employees needing to have discretion on whether—really, both of you said that, and so did Dr. Benjamin—that it really should not just be left up to the employer.

And so here is my question, because I don't want to repeat everything everybody has said. If there is a question, if we need to have verification, or if the employer doesn't believe the employee, who is the tiebreaker on this? What would you suggest that we have just to make sure that employers don't feel like they are being taking advantage of and that employers don't take advantage of their employees.

Ms. NESS. Right, right. Well, as we know, many employers successfully manage paid days policies today, so it is not like this is something groundbreaking a new. And I think there is a large body of experience we can draw on. But that Healthy Families Act does allow employers to request a medical certification after a three-day period. That is a protection that was built into the legislation.

I also would say, you know, we hear all the time about concerns that employees might misuse this. The data show that when employees do have paid sick days, about half of all employees don't use them. And when you look specifically at employees that have a minimum of seven paid sick days, the average amount that employees take is around 2.5 days.

Ms. WOOLSEY. And would you like to take it one step further? Female employees take their sick time off for their families.

Ms. NESS. Yes, I mean we feel very strongly that any kind of paid sick leave legislation needs to make sure that it is family flexible. And we tend to think particularly now with the H1N1 epidemic about children needing care.

But we are also facing a tsunami of caregiving challenges in this country as our population ages. And it is expected that over the next couple of years half of the workforce will be caregivers. And so these issues, while we have an emergency situation right now with H1N1, these caregiving challenges are not going away. They are only going to get worse.

Ms. WOOLSEY. Taking care of not only their own children, but their parents.

Ms. NESS. That is right. And for women in particular, women who are in particular in the baby boomer generation right now are being hit from every direction. They are not only still taking care of the younger generation, they are increasingly taking care of elders, who are living longer and also living sicker, so their health care needs are more complex.

And because of the rapid increase in chronic conditions, they are also grappling with their own health care conditions. So for women, the need for there to be some basic minimum number of paid sick days is tremendous.

Ms. WOOLSEY. Dr. Schuchat, do you have any comments on verification?

Dr. Schuchat. You know, I can say that in the midst of this particular pandemic, we have focused on ways to decrease the pressure on the health care system, both to have people not clog up the emergency departments with relatively mild illness and to have to discourage people or employers from visiting the doctors just to get a note, because that can actually tie up very scarce resources.

So I think we have urged flexible release policies and also the temporary release from that need to get the note because of the negative impact it would have on the health care system.

Ms. WOOLSEY. Thank you.

Ms. HIRONO. Thank you, Mr. Chairman.

Several of my colleagues have already taken note of the fact that H.R. 3991 is it is up to the employers to kick off this coverage requirement. My question to Mr. Clarke and Ms. Ness is do you think in the real world that this would therefore result in many employers not asking their employees to stay home because they are sick?

Mr. CLARKE. You know, I would hope not. I would hope not. Though, if you do assume, if you do come from the point of view that there are employers that want to minimize every expense, don't want to provide an employee anything, either because they can't or they just won't, if you categorize a group of employers that way, then it is easy to say, well, that group with that mindset is not going to suggest or direct. I think that is a conclusion that you can make about this hypothetical group of employers.

Ms. HIRONO. Ms. Ness?

Ms. NESS. Well, I would like to think that all employers would do the right thing, but the numbers right now show that they don't. And so I believe it is important that we not leave it to employers' discretion as to whether or not somebody should stay home if they are sick or to be able to say you must come in even though you are sick. I do think it is important for that to be at the employees' discretion, even though I would like to think that most employers behave in a very humane way.

Ms. HIRONO. Ms. Ness, you mentioned San Francisco's mandate. Is that at the employees' decision to—

Ms. NESS. Yes, it is.

Ms. HIRONO [continuing]. Require coverage?

Ms. NESS. In all three cities it was an employee decision.

Ms. HIRONO. Mr. Clarke, would your objection to this bill be even greater if it was changed to—on H.R. 3991 that if we were to change that to employee's action as opposed to the employer's control?

Mr. CLARKE. Yes, I think unilateral, non-communicative, don't have to speak to you for 3 days, don't have to report what I am doing for 2 days is a very, very unworkable right to give an employee base. Yes, I think that would be very difficult.

Ms. HIRONO. Although apparently San Francisco has done this and the world has not come to an end there.

Mr. CLARKE. Some may debate you on that one.

Ms. HIRONO. Thank you very much.

I yield back.

Chairman MILLER. Would the gentlewoman yield for a second? Let me just—

Ms. HIRONO. Yes.

Chairman MILLER. Mr. Clarke, you suggest that—I think you are probably correct in most instances that there probably is relatively a few number of employers that just view any of these things as antithetical to whether it is their profitability, their survivability, however they judge the outcomes of their businesses.

But then if that is a very low number, and in the greater emphasis that you are talking about, employers are willing to trust employees for 7 days to say, “I have got to take care of my kid or I am going to stay home, I am sick” or whatever the situation is, that we don’t assume that those people are gaming the system.

Is this essential to have what is viewed as sort of a employer protection at the employer discretion in the bill at all? I mean are we still talking—are we really focusing on such a small number of employers that the safeguard really is sort of not real?

Mr. CLARKE. Well, hypothetically, that could be the case, except that the way the bill is written about the other things around the safe harbor, the other things that have to be in place, if it was purely an issue of does employer-based discretion make a mandated leave more palatable to the employer? Well, yes. But when you layer that around with the barest details that have to be in place, that really blunts that advantage.

Chairman MILLER. All right. It is a beginning. Thank you.

Mrs. Davis is next.

Mrs. DAVIS. Thank you, Mr. Chairman.

And, Dr. Schuchat, first you mentioned that you were able to track schools to have information about how they are doing, the number of students that are absent, et cetera, and the reason for that. Is there a database set up so that businesses can respond?

I am thinking of really the restaurants in my district, for example, and I think the people who are working part-time and are facing the public—there are many, many professions, occupations that are doing that—but particularly in the restaurant business, I think this is a real concern, and a lot of them have more than 25 or 100 employers. I mean is there a way to actually track what is happening in that area?

Dr. Schuchat. No, I am not aware of a systematic tracking. It may be that Department of Commerce or Department of Labor has something that we are not collaborating on. We have been doing some general surveys or polls with some universities to understand the impact that the pandemic is having on different sectors.

We did one—or Harvard did one, I think, this summer that looked at employers and their policies. It was before the increase in disease in the fall, and so whether—we will need to check and see if there is anything ongoing or that might be done that would look at those matters.

Mrs. DAVIS. Yes, it seems like there might be a fairly simple way of doing that and allowing them to kind of report those numbers, because if in fact it is spreading faster in that industry as opposed to other industries, I don’t know.

Do you know, Mr. Clarke? Any thoughts about that at all from your constituency?

Mr. CLARKE. I do not. I think the doctor would be a lot more qualified on that point.

Mrs. DAVIS. Okay. Thank you.

And then in terms of the information that they receive, small businesses don't—you know, they are so busy just making payroll that they don't have a lot of time to be checking and seeing what kind of information is out there. How are we getting that information out to them? What resources are they able to use? And, you know, are they using it?

Dr. Schuchat. There has been an active outreach effort. The Commerce Department, HH, U.S. Chamber of Commerce have been trying to get information out, not just to the larger businesses, but to the small businesses.

We partner with the Small Business Administration on some of that, looking at those Web and other venues to reach people. Particularly as we issued new guidance, we wanted to make sure it was broadly received. And the state partners and some of those organizations have really helped with that locally.

Mrs. DAVIS. Great.

Mr. CLARKE. Representative Davis, if I might say, the communication has been terrific.

Mrs. DAVIS. Oh, okay.

Mr. CLARKE. The Internet has just made it so accessible. I think any employer that touches any business-oriented organization has received multiple messages and links and assets regarding H1N1. And I doubt that I have been in a place in the past month that didn't have good practice guidelines hanging on every wall in that employer's place.

Mrs. DAVIS. Well, thank you.

Mr. Chairman, I think this is an important issue. There certainly are challenges. I don't think everybody acknowledges that there can be some misuse of some of this, but on the other hand, you know, the alternative is not a good one either. I mean that is life and death issues for people, and so I think we need to try and figure out how best to deal with it.

Thank you, Mr. Chairman.

Chairman MILLER. Mrs. McCarthy?

Mrs. MCCARTHY. Thank you, Mr. Chairman.

Mr. CLARKE, could you define what a small business is?

Mr. CLARKE. Well, I think the SBA definition is under 100 employees, I believe, but it is really in the eye of the beholder. I have met people with 30 employees that think they are medium-size, and I have met people with 200 that call themselves small.

Mrs. MCCARTHY. Actually, the number goes much higher. Some areas would say small businesses are 400 and under, but basically, what we are talking about an awful lot of our part-time workers. If you work for a large corporation, yet they have a lot of retail stores, and most of the women that work in those retail stores are part-timers, none of them get health care. They get minimum wage, just about.

But the other thing that I was interested in—you kept talking about short-term sick leave. That is a policy that the employee can buy? Or does the employer offer that?

Mr. CLARKE. The example I gave was a large food processor that provides that free of charge to the employee base, to the hourly em-

ployees, and that provides up to 6 months of short-term disability wage replacement during an illness lasting up to 6 months.

Mrs. MCCARTHY. Do you know that with taking short-term insurance that if you came down with a virus or anything else, you would be turned down for any kind of large health care policy that you might want to go into later down the road that—because they have preemption, as far as pre-existing conditions?

I mean that is one of the problems with the short-term. If you use that short-term, whether it is a college student getting a bridge between short-term and full-term, they have quite a bit in there as far as saying that if you have a pre-existing condition, which we know could be almost anything, they could be turned down for full-time insurance.

So would it not be true that for some of the stores or people that you represent, it could be a shortcut, because they would not be able to get full-time health care insurance for their employees?

Mr. CLARKE. Well, I am really not aware of the facts you state, and I can't dispute them. What I can say is that I have never seen an employee enter an STD, or short-term disability policy, whether that was insured or whether that was paid by the employer's checkbook, which most of them are—

Mrs. MCCARTHY. I will be honest with you. I would think that most employers don't even know that some of the health care provisions that they give their employees—and I am not saying they are doing this on purpose—I am just saying that if an employee has any kind of an illness, any kind of a disease, they can be—high blood pressure—so we are talking about—Ms. Ness was actually talking about it—if you have underserved communities, the majority, unfortunately, have high blood pressure. They have diabetes. They have other illnesses that could actually be controlled as a chronic care, but they would be denied health care. And I think that is one of the reasons that we are fighting for stopping pre-conditions.

Ms. NESS, could you follow up on that as far as large corporations, but individual stores, which are mostly run by women, or work there?

Ms. NESS. Well, I think you are underscoring the fact that women are the majority of part-time workers, and those part-time workers tend not to have any benefits. And so sometimes you have an employer that is offering decent full-time benefits, but they are not available to the part-time benefits.

Many of the women in those very low-wage jobs are stringing together more than one job in order to make ends meet to support their family. For those women, not having any benefits is—it ripples through every aspect of their lives. They not only don't have time off when they are sick, they don't have health insurance, and they don't have any ability to take care of their children when their children get sick.

And, you know, we often say that a lot of these women are just one sick kid away from losing their job, one sick kid away from unemployment. There really is no safety net or any protections for them.

Mrs. MCCARTHY. I know one of my colleagues brought it up a little bit earlier, but when we see how this virus spread so rapidly—

we saw it in our schools; we have seen it in some of our nursing homes where there are a lot of part-time workers, especially workers that are only from the underserved area—and yet, you know, we keep talking about the costs of not having someone go home.

I know in my office—and we are lucky; we are the federal government; we don't have pre-existing conditions, as far as that goes—maybe I am a little paranoid about it, but on every desk we have some, you know, to clean your hands when you come in. Our business, we shake hands constantly with everybody.

But the cost of when the flu hits the office, the cost of it spreading, because not only is it in the office, depending on how they transfer to go to work—New York City, the largest cities, you are talking about trains and subways, you are talking about buses—could you expand on that, Doctor?

Dr. Schuchat. Yes, our recommendations are that people not only stay home from work or school when they are sick, but they stay home, that they are not just—that kids who are sick not, you know, not go to school, but then go off and hang out with their friends. The idea there is to limit spread.

There have been economic analyses of the cost of seasonal influenza on society in terms of both lost work and the impact on spread and so forth, and it is many, many billions of dollars each year that we spend on that disease, even when it is not causing excessive rates like we are having now with this pandemic, which is striking more a younger working age population than would seasonal flu in terms of the severe complications.

Mrs. MCCARTHY. Thank you.

Chairman MILLER. Mr. Scott?

Mr. SCOTT. Thank you, Mr. Chairman.

I want to thank our witnesses.

Ms. NESS, we exempt businesses with with less than 15 employees. Most employers with more than that would have some kind of sick leave. Do you have any idea of how many people this bill would actually cover?

Ms. NESS. NO, I need to get back to you on those numbers.

Mr. SCOTT. Dr. Schuchat, from a public health policy perspective, what effect—you kind of talked a little bit of this in response to the last question—what effect would this have on preventing an epidemic? It is not limited to epidemics, and presumably we are trying to prevent them from happening. And on all the kinds of things that we can do to prevent epidemics, where would this bill fall in a priority list?

Dr. Schuchat. Well, we think that the ability to slow the spread of infectious diseases like flu is important in terms of that they picture a disease. With a pandemic in particular, we are trying to slow the spread, but in order to, you know, benefit people who won't get infected, but also to decrease the pressure on the health care system, which may, you know, have errors if there are too many people sick at the same time, and also to buy more time for vaccine production so that we can protect more people from ever getting sick.

So the idea, you know, since the spring that we have been pushing—stay home when you are sick; keep your children home when they are sick—is in order to reduce illness and really delay the im-

fact that we have on these other sectors. So it is a very important feature, particularly in an area where there is scarce vaccine.

Mr. SCOTT. With all the exemptions and what kind of effect would you expect the passage of this bill to produce? What effect?

Dr. Schuchat. I can just speak to the public health side that, you know, our sense is that when it is easier for people to make healthy choices, they are more likely to, and that that is in the public interest.

Mr. SCOTT. Mr. Clarke, in terms of enforcement, is there any reason to believe that it would be harder to enforce this act than the minimum wage bill under the fair labor standards? Is the enforcement mechanism—yes, can you comment on the enforcement mechanism?

Mr. CLARKE. Yes. Yes, I could make two comments. I think it was mentioned earlier that the minimum wage law has such broad application for the workplace—you know, employers well under 15 employees would be covered by minimum wage. And it is, in my opinion, a under enforced law. You know, I have been around workplaces for 26 years, and I think it is a very difficult task for any government agency to get to every workplace and address every conceivable issue, be it minor be it major, so I think that is a very difficult task.

I think what makes it even more difficult to enforce a new emergency act like this is that it is new, that it will not be, for some extended period of time, well understood in its detail, will not for some period of time be, because it has got such a short enactment date on it, well complied with, I think, universally. Those things take time.

Mr. SCOTT. Well, in terms of enforcement, wouldn't you expect the enforcement to take place when there are complaints? And you wouldn't expect federal workers to be running around trying to visit all the employers. They would wait for somebody to complain.

Mr. CLARKE. That is true. Most complaints of minimum wage, and I would expect it of this statute, would be based on employee complaint.

Mr. SCOTT. And finally, Dr. Schuchat, could you give us an idea of what the rate of production of the vaccine is now?

Dr. Schuchat. Yes, as of today there are 48.5 million doses available for the states to order. We are working hard with them—

Mr. SCOTT. All right, wait a minute—for the states to order?

Dr. Schuchat. That is right. That means that—

Mr. SCOTT. Does that include the ones they have already ordered?

Dr. Schuchat. It includes what they have already ordered. It is a cumulative total. And each morning the states receive an allocation number, you know, that subtracts what they have already ordered and tells them you have got so many new doses or old doses. This is how many you can order from today. They put in their orders every day, and the orders are submitted to the central distributor and shipped the next day.

So we have been working hard with the manufacturers to try to be able to look at the next several weeks' estimates and are hoping to be able to share that more publicly very soon. As you know, it has been very difficult to predict what the yields would be. And the

past, you know, 2 months really we were not where we wanted to be since we started immunizing.

This past week we missed the projection by about three million doses. Next week we—the current week we believe will be better, but it has really been very challenging.

Mr. SCOTT. How many doses a week are you producing?

Dr. Schuchat. It has ranged. You know, the first week or 2 was about 2.5 million, and then we hit, I think, 11 million doses a week a couple of weeks ago. Last week we only got about 5 million doses.

Mr. SCOTT. Why is it not continuing to increase?

Dr. Schuchat. What happens—right—what happens is there is a certain part of this that was due to the slow-growing virus and just that low yields that many of the manufacturers were getting. Most of them have been able to find better growing viruses and are getting higher yields.

And the very last stages of production involve testing individual lots. And what happened last week and, I believe, has happened certain weeks is that that very last test stage you can't predict whether everything was going to pass the testing or need to be further looked at. And so some of the lower results were because lots could not be released.

Some of the other decrease was due to delayed shipment because of the bad weather in parts of the country, that the doses didn't actually reach our central distributor on Friday. They reached it on Saturday because of the storm. And so, you know, this is a day-by-day thing, and even when the manufacturers really are on top of everything, their predictions need to incorporate some of these last-minute things that they wouldn't know the week before.

Mr. SCOTT. Thank you, Mr. Chairman.

Chairman MILLER. Just quickly, in the absence of this legislation, people are obviously going to make decisions about staying home or not. And I guess the question is can they be fired for that in the workplace? And I assume the answer is today, yes, you could be. I assume, Ms. Ness and Mr. Clarke, you would not agree with that policy.

Mr. CLARKE. No. No, no one should be fired because they had to stay home because they were sick. Of course not. And there are laws in states that would prevent that.

To take a federal law that prevents that, the salaried exempt statues, the wage and hour statutes for salaried exempt provide that you must provide a certain number of paid sick days. I mean that is already in place for salaried exempt and that you can't be retaliated against for using your salaried exempt rights.

And so, no, no one should be fired for that. I wouldn't support that.

Chairman MILLER. But there is a universe of people out there that in fact can be fired. I am not—I wouldn't—I assume we would endorse a policy that says you can't be fired for that reason, but there is a universe of people out there that clearly can be and are fired for missing a day of work for whatever reason.

Mr. SCOTT. Mr. Chairman?

Chairman MILLER. Mr. Scott?

Mr. SCOTT. There are some states that are employer employee at will, where there are really no rights at all—Virginia, for example. Is there any restraint in Virginia? You stay home, you get fired?

Mr. CLARKE. In North Carolina?

Mr. SCOTT. In Virginia.

Mr. CLARKE. I can't speak to Virginia. In North Carolina, yes, there are. And the reason I say there are is that illness—you know, employers are very careful. I run into this all the time. Employers are very careful to not get into discussions with employees about the details of an illness, because they can easily take you to discussion around disability, which can easily take you to a violation on our state disability act or the federal disability act.

So, you know, this whole area is—while maybe perhaps not technically regulated in a sense, the chairman cites—

Chairman MILLER. The safest policy would be not to discuss anything, but to fire you.

Mr. CLARKE. That doesn't look like—

Chairman MILLER. That is not the outcome we are looking for.

Ms. NESS, do you want to comment?

Ms. NESS. Yes, I just want to say you are absolutely right. There are people—

Chairman MILLER. Your mic is not on.

Ms. NESS. Sorry. You are absolutely right. There are folks who can be fired, and that is why we need the Healthy Families Act as a basic standard to prevent that from happening.

Chairman MILLER. Mr. Thompson, anything before we—

Mr. THOMPSON. I just want to thank the panel for the information provided and just to say, you know, certainly, having worked in the Emergency Medical Service as a volunteer, prevention—what we invest in prevention—goes far beyond, you know, finding a cure and addressing all the issues we have here.

So, certainly, Admiral, I share your frustration in terms of the amount of—I mean we knew this was coming. We saw the first signs of it back in the spring, and so I share your frustration on the amount of vaccines that are available. I certainly would think that one of the things—and I am not looking for a response, but to encourage that after we go through the health risk, that maybe financial risk is on that list of vaccinations, working partnerships.

I will be interested in working more with this on the Small Business Committee as well, at looking how we can work with our small businesses with partnerships to help protect the people and keep them, because this hearing is not about—I mean this is about H1N1, so—and that is certainly a specific thing that we should look into doing our best to prevent as well.

Chairman MILLER. Thank you all very much for your testimony. I hope that we can continue to work with you as we develop this legislation.

And I would ask unanimous consent to enter into the record not the letter that you requested, right, but signed? I didn't respond to your request at that time. And also a letter—written testimony—from Melanie Disher, Sodexo food service worker, Plainfield North High School, Illinois, and which I think was read into.

And without objection, members will have 14 days to submit their additional testimony.

Thank you so much for your time. It has been lengthy, but I think very helpful to the committee.

Thank you to the CDC for everything that you are doing in our general population. Thank you.

[Additional submissions of Mr. Kline follow:]

November 17, 2009.

Hon. GEORGE MILLER, *Chairman*; Hon. JOHN KLINE, *Ranking Member*,
Committee on Education and Labor, U.S. House of Representatives, 2181 Rayburn House Office Building, Washington, DC.

DEAR CHAIRMAN MILLER AND RANKING MEMBER KLINE: We write today in reference to the recently introduced Emergency Influenza Containment Act (H.R. 3991). While we share your goal of protecting the health of the American workforce and minimizing the spread of the H1N1 virus and other contagious illnesses, we must oppose H.R. 3991 as it is currently drafted. The bill's vague provisions would significantly impair employers' existing paid leave programs and initiatives, thus creating a convoluted and unworkable mandate impacting businesses of all sizes.

As you know, many employers have developed, or are in the process of developing, continuity plans in response to the current H1N1 outbreak. These plans include the full range of workplace flexibility options, including telecommuting, job sharing, schedule changes, shift swapping and paid time off for the employee's own illness or to care for ill family members. In addition, the vast majority of employers, more than 80 percent, already provide employees with paid time off that may be used as sick leave. The rigid requirements of H.R. 3991 threaten employers' ability to flexibly and creatively design programs that meet the unique needs and constraints of that employer and its employees. Moreover, the legislation fails to adequately recognize and clearly exempt from any mandated paid leave requirement employers that are already providing paid leave that may be used for sick leave to its employees.

As our economy begins to recover from the most severe recession since the Great Depression, businesses need to maintain flexibility in order to survive, grow and provide jobs in the face of ongoing challenges, including the potential impact of contagious illnesses such as H1N1. A one-size-fits-all paid leave mandate that is applied to the broad, diverse industries that make up our nation's marketplace would negatively impact all employers, including small businesses, and limit our ability to retain and create new jobs.

The attached document outlines in more detail the important concerns we have about the Emergency Influenza Containment Act. We look forward to working with the Committee to address our shared goal of maintaining a healthy and productive workforce while ensuring the job retention and job creation that will ultimately bring us out of this recession.

Sincerely,

AMERICAN BAKERS ASSOCIATION,
AMERICAN HOTEL & LODGING ASSOCIATION,
ASSOCIATED BUILDERS AND CONTRACTORS,
ASSOCIATION OF EQUIPMENT MANUFACTURERS,
AMERICAN FOUNDRY SOCIETY,
ASSOCIATED GENERAL CONTRACTORS,
COLLEGE AND UNIVERSITY PROFESSIONAL FOR HUMAN RESOURCES,
FOOD MARKETING INSTITUTE,
HR POLICY ASSOCIATION,
INDEPENDENT ELECTRICAL CONTRACTORS,
INTERNATIONAL FOODSERVICE DISTRIBUTORS ASSOCIATION,
INTERNATIONAL FRANCHISE ASSOCIATION,
NORTH AMERICAN DIE CASTING ASSOCIATION,
NATIONAL ASSOCIATION OF HOME BUILDERS,
NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS,
NATIONAL CLUB ASSOCIATION,
NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
NATIONAL RETAIL FEDERATION,
NATIONAL ROOFING CONTRACTORS ASSOCIATION,
NATIONAL SMALL BUSINESS ASSOCIATION,
PLUMBING-HEATING-COOLING CONTRACTORS—NATIONAL ASSOCIATION,
PRINTING INDUSTRIES OF AMERICA,
RETAIL INDUSTRY LEADERS ASSOCIATION,
SMALL BUSINESS & ENTREPRENEURSHIP COUNCIL,
TREE CARE INDUSTRY ASSOCIATION.

Emergency Influenza Containment Act H.R. 3991

Employer Action Triggers

- The bill provides paid leave for workers who are “directed” or advised by their employer to leave work or not come into work because the employer “believes the employee has symptoms of a contagious illness, or has been in close contact with an individual who has” these symptoms. (See Sec. 3 (a), (b).)
 - This legislation does not define how the term “directed” should be defined. As a result, employers could have a range of conversations or contacts with their employees which might or might not rise to the level of a “direction”. Pre-existing guidance contained in employer policies could be construed to meet this definition therefore triggering employer payment obligations.
 - This legislation doesn’t define who can act as the employers. As written the determination could be made by a lower level supervisor that could be later revoked by someone with more authority.
 - The legislation leaves the determination of symptoms to the employers if they “believe the employee has symptoms of a contagious illness.” The legislation lacks a clear threshold that would be sufficient to form this conclusion. Typically, most employers are not medical professionals, nor do they usually have such medical professionals on site to make this determination.
 - This bill lacks protections for employee privacy rights with regard to an employer determining whether an employee has been in close contact with an individual who has such symptoms.

Employee Compensation

- The bill calculates the rate of pay “based on the employee’s regular rate of pay and the number of hours the employee would otherwise be normally scheduled to work (sic)” (See Sec. 3 (c) (2) (a).)
 - This legislation does not address how overtime pay would be taken into account.
 - The hours an employee might normally be scheduled to work might not be fixed, or set for the time that the employee would be out. This legislation lacks the necessary guidance to make this determination.

Employer Guidance

- The Secretary is directed to issue guidelines to assist employers on these calculations, but no deadline for these guidelines is set, while the bill is supposed to take effect 15 days after enactment. (See Sec. 3 (c) (2) (b), Sec. 8.)
 - This legislation does not provide for the Secretary to issue implementing regulations to assist employers in fully understanding their obligations. The absence of regulations, and the notice and comment process to develop them, will mean that employers will be left to figure out how to implement this law on their own and heighten the risk that they will not be in compliance.

Employer Termination of Leave

- The bill allows an employer to indicate to the employee that it no longer “believes the employee * * * has symptoms of a contagious illness or poses a threat of contagion to other employees or to the public (sic)” (See Sec. 3 (c) (4).)
 - As noted above, employers are not typically in the position of making such medical determinations. Nor would they be able to examine the employee once they are at home, or not at work.

Impact on Current Policies and Requirements

- The bill specifies that “nothing in this Act shall be construed to in any way to diminish the rights or benefits that an employee is entitled to” based on another federal, state or local law, collective bargaining agreement, or existing employer policy. (See Sec. 7.)
 - This provision lacks the necessary clarity to be effectively implemented.
 - One interpretation would be that it means an employer would have to restore any paid leave used as a result of them directing an employee to stay home so that in effect, an employer would have to add five days to what they are currently providing.
 - Another interpretation would be that an employer would not be able to adjust their current policy to reflect that paid leave they would have to provide under this bill, i.e. they could not reduce the amount of leave they provide from 10 days to five days.

Sunset of Bill

- This bill is supposed to sunset two years after enactment. (See Sec. 9.)

- There is no history of such a benefit being enacted and then being removed. There is no such thing as a temporary benefit, just as there is no such thing as a temporary tax.

Definition of Illness

- This bill defines a “contagious illness” as including “influenza-like-illnesses such as the novel H1N1 virus.” (See Sec. 10 (1).)
 - “Influenza-like-illnesses” is a very open ended phrase that could end up meaning many conditions.
 - This bill is described as responding only to the current epidemic of H1N1, however that illness is not the only condition for which leave would have to be paid. The current definition would result in an overly broad application.

Definition of Covered Employers—Safe Harbor

- This bill attempts to provide a safe harbor for employers that either do not employ 15 or more employees, or already meet its requirements. (See Sec. 10 (3) (A), (B).)
 - However, the bill does not take into account the growing trend by employers to provide Paid Time Off (PTO) plans. Under these plans employees are provided with paid leave without specifying the reason for its use. Such plans are becoming very popular as they relieve employers of the need to track multiple kinds of leave, and the reasons for the leave, and typically allow employees to receive the paid leave in compensation when they terminate employment. Under the current language, whether employers would be exempted if they offer a PTO style plan is not clear.
 - The bill does not make clear whether additional paid leave must be provided if an employee has already been provided leave, but has exhausted it by the time they need to be out under this bill.
 - The bill does not define the application of leave for employees that are contracted through an employment agency.
 - The bill does not specify how part time or temporary employees should be treated for purposes of the 15 employee threshold.
 - The language of (B) says that for an employer policy to qualify, it must not only provide five days of paid sick leave per 12 month period, but that this leave “may be used at the employee’s discretion.” Such a requirement would disqualify many employer leave policies that would otherwise satisfy this safe harbor as employers frequently include a provision that leave be subject to notification, scheduling, or other requirements. The bill does not make clear if such requirements disqualify a leave policy from satisfying this safe harbor.

November 17, 2009.

Hon. GEORGE MILLER, *Chairman*; Hon. JOHN KLINE, *Ranking Member*,
Committee on Education and Labor, U.S. House of Representatives, 2181 Rayburn
House Office Building, Washington, DC.

DEAR CHAIRMAN MILLER AND RANKING MEMBER KLINE: On behalf of the signed organizations and our contractors, subcontractors, material suppliers and employees across the nation, we would like to express our opposition to H.R. 3991, the Emergency Influenza Containment Act (EICA). Due to the adverse impact the bill will have on small business owners, as well as the counterproductive effect it will have on existing leave and benefit packages, we urge your opposition to this legislation.

Employers offer compensation packages, including leave and other benefits, in order to recruit and retain the best employees. Our members are rightfully proud of the compensation packages they currently offer, as the benefits included in those packages are reflective of the realities of their industries, the preferences of employees and the premium business owners place on quality craftsmanship and a productive work environment. At the same time, the construction industry is facing unprecedented challenges, with an industry-wide unemployment rate of 18.7%, and construction employers attempting to create jobs are in no position to absorb another costly government mandate.

The EICA would require businesses with 15 or more employees to provide their employees five days of paid sick leave every 12 months if the employer advises or directs an employee to leave or not come into work because it is believed that employee has a contagious illness, or has been in close proximity to an individual with a contagious illness.

This legislation would become law 15 days after enactment, unfortunately without federal regulations, and would also sunset after two years. Federal regulations have a valuable place in interpreting federal statute, and without the input of a broad

segment of both regulators and the regulated community, it is hard to know exactly how to interpret the day-to-day situations that all employers may face. In H.R. 3991, we are very concerned about several vague provisions that provide few answers, while raising many questions.

First, it is unclear under the legislation what it means to advise or direct an employee to leave work or stay at home, and at what point the employer may recall that worker. Is an employer policy stating employees should stay at home when ill enough to constitute “advise or direct,” or must the employer specifically tell that employee not to come in? It is equally unclear when an employer may call an employee back to work, as employers can face liability based on what a fact finder may deem it believed with respect to an employee’s health or contagiousness. Next, the lack of regulatory guidelines will undoubtedly create situations where employers unwittingly fail to adhere to the vague nature of the new statute despite their best efforts to do so. Additionally, it is unclear how EICA will impact existing leave policies. This is especially troublesome considering that more than 80 percent of business owners currently offer paid leave of some kind. It is also especially difficult in construction to develop a comprehensive leave policy where a large segment of the industry is part-time, project-based or seasonal work.

Finally, we would be remiss if we failed to address the larger problem with paid leave mandates, whether related to H1N1 or not. The economic hardships facing our nation have acutely impacted the construction industry. Our industry has seen historic highs in job losses, with more than 1.7 million construction workers without employment. At a time when employers are struggling to avoid layoffs and business closures, imposing paid leave mandates on employers is unwise policy that threatens jobs and the viability of many of the nation’s small businesses.

As we have stated in the past, we remain ready to work with Congress in a constructive way to address the impact of current tax and regulatory policies on the ability of employers to offer the best benefits possible in the modern workplace. We look forward to having constructive discussions on these topics, but those conversations must begin with the recognition that onsize-fits-all mandates from Congress are a political rather than practical answer to a very complex issue.

In the meantime, as the Committee considers H.R. 3991, we strongly encourage your opposition to this unnecessary and harmful legislation.

Sincerely,

AIR CONDITIONING CONTRACTORS OF AMERICA,
 ASSOCIATED BUILDERS AND CONTRACTORS,
 INDEPENDENT ELECTRICAL CONTRACTORS,
 NATIONAL ASSOCIATION OF HOME BUILDERS,
 NATIONAL ROOFING CONTRACTORS ASSOCIATION,
 PLUMBING-HEATING-COOLING CONTRACTORS—NATIONAL ASSOCIATION.



December 1, 2009

Chairman George Miller
 Committee on Education and Labor
 U.S. House of Representatives
 2181 Rayburn House Office Building
 Washington, DC 20515

Re: Response to Your Request of November 18

Dear Chairman Miller:

Thank you for the opportunity to speak before the Committee on Education and Labor November 17th.

This letter is in response to your November 18th request for additional information for the record.

Request #1: A copy of the policy describing the mentioned member company benefit of a six-month short-term disability (STD) policy provided as an alternative to paid sick days.

In my search for examples of creative responses to the H1N1 pandemic, I committed to our members we would not reveal their identities nor seek to involve them in a public way. For reasons evident during the November 17th hearing, employers doing many generous and creative things do not want to be identified in isolation for those things they choose not to provide. If a specific policy from a single employer is more helpful to you, I am willing to canvass a small group of member companies with similar policies with the clear understanding their policy will be shared with the Committee. I estimate that would take seven to fourteen days.

In the meantime, I believe we have something even more responsive to your central question: do employers provide a short-term disability benefit with a wage substitute during a medium-length illness, and if so, who pays for the benefit?

Enclosed is a copy of questions 21 through 33 of both our local and national survey regarding STD policies.

You will see from Question 21 that STD is a common benefit. Short-term disability fills the medium term gap between paid time off/sick sick days/vacation and long-term disability. It is common to find STD plans that kick in after two weeks of absence, or, upon hospitalization. Sometimes, these are "checkbox" plans where the employer pays all of the benefit directly to the employee as wages.

Raleigh: 2900 Highwoods Blvd. Raleigh, NC 27604-1060 | voice 919.878.9222 fax 919.872.6599

Greensboro: 7817 National Service Road, Suite 509 Greensboro, NC 27409-9402 | voice 336.668.7746 fax 336.668.3282

Capital Associated Industries, Inc. | www.capital.org

More than 50% of survey participants offer insured plans (Q22) with at least 80% paying 100% of the premium (Q23). STD provides 68 to 74% of pay when needed (Q25) and over half the time the STD benefit lasts for 26 weeks or more (Q26). Sick pay coordinates with the STD benefit to cover the waiting period 36 to 50% of the time. About half the time there is no specifically designated sick pay benefit provided by employers offering STD (Q31). Remember that having no "specific sick pay benefit" does not mean there are no paid days for sickness: PTO, personal days, or other "as needed" programs are common.

In sum, there are many employers providing company-paid STD to their employees and it appears more often than I realized, they see STD as a substitute for a specifically designated sick pay benefit. In my view, this is a rational decision protecting an employee from true financial ruin due to illness.

Request #2: Information collected by CAI describing the extent to which PTO leave can be used the same way as designated sick leave; that is, without advance notice and without approval based on staffing or scheduling.

Our survey asks 400 questions about policies and benefits of all types. We do not ask for details that vary widely among employers or are too complex to summarize and record in a survey format. I am providing summary data from our 2009-10 survey specifically from our member companies as well as the data for the same questions in the cooperatively prepared national survey conducted at the same time using the same questions. Our questions allow for responses in a number of categories (such as exempt/non-exempt/clerical/production-maintenance/union/non-union) so I selected the approximate mid-point of NU/CT/SMP groups where most of the data is sourced.

Number of Employer Participants by Employee Size

Size Category	# Co's CAI	# Co's National	% Co's CAI	% Co's National
1-100	89	1138	38.5	46.9
101-599	108	1023	46.8	42.2
Over 500 Ee's	34	266	14.7	11
Total	231	2427	100%	100%

Does Your Organization use a Paid Time Off Bank?

	CAI 1-100	National 1-100	CAI 101-500	National 101-500	CAI >500	National >500	CAI Total	National Total
Yes	25%	27%	18%	28%	26%	31%	22%	28%

Do You Include Sick Days in Your PTO Bank?

Type	CAI 1-100	National 1-100	CAI 101-500	National 101-500	CAI >500	National >500	CAI Total	National Total
Sick	94%	92%	94%	90%	84%	83%	92%	90%

Do You Require Employees to Specify the Reason for Using PTO Days?

	CAI 1-100	National 1-100	CAI 101-500	National 101-500	CAI >500	National >500	CAI Total	National Total
No	83%	85%	91%	84%	57-70%	88%	83%	85%

This data reflects the dominant feature of PTO banks: the employer does not need or want to know why the employee is away from work. The exception to this general rule, and the primary reason for <100% "No" responses, is that some rationale is required when an employee simply fails to report to work due to an immediate need.

We do not have survey data on the issue of advance notice or staffing/scheduling concerns. It varies by organization and is one of the reasons why paid time is such a comprehensive web of benefits and difficult to rigidly categorize, or to impose a national mandate and safe harbor.

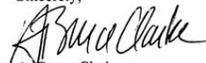
Our experience in general is that employers with PTO banks treat the need for sick time off the same as employers without a bank (i.e., those that have a defined number of designated sick days). They typically want notice before the workday or shift begins, unless the need is immediate, then they want a phone call as soon as practical. They typically do not ask for medical documentation unless the absence is for three days or more or there is some reason to suspect the truthfulness of the need (Monday or Friday patterns of absence and such). If the medical need can be scheduled, they want notice before the event so scheduling is easier (and that varies, but one or two weeks notice would be typical).

Employers do put notice and timing restrictions on use of PTO if the need is NOT immediate. This varies widely based on business type and staffing needs. For some, notice before the shift, or notice of three days is sufficient. Others want more notice if the absence will be longer than a day, such as a month or more notice to schedule a week's time off. Still others are less concerned about the amount of notice and more concerned about whether there are others scheduled off work at the same time in the same job category, or if it is a unique job.

I am not aware of any PTO bank plan that prevents an employee from using the account immediately if the medical need is also immediate. That would make no sense because immediate needs cannot be planned by definition. Immediate unplanned need for a PTO day off will typically require the employee to identify the reason for the need.

I trust this is responsive to your questions. Please let me know if I can help in any other way. Thank you for the opportunity to speak with the Committee.

Sincerely,



A. Bruce Clarke
CEO

SHORT-TERM DISABILITY INSURANCE [SUPPLEMENTAL COVERAGE, NOT STATE-REQUIRED]

21. Employees become eligible for short-term disability income insurance coverage:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Following waiting period (best average below)	100.0%	61.6%	47.0%	60.0%	100.0%	55.4%	31.9%	61.7%	40.0%	61.3%	58.4%	84.4%	82.5%	55.1%	51.1%	59.9%
Immediately	.0%	7.8%	10.9%	.0%	.0%	19.5%	19.8%	.0%	20.0%	22.6%	28.1%	.0%	12.5%	15.5%	17.0%	.0%
First of the month after hire	.0%	17.2%	18.1%	21.6%	.0%	17.4%	19.8%	24.7%	.0%	12.0%	9.4%	9.1%	.0%	18.0%	17.8%	21.8%
Coverage not provided	.0%	23.4%	24.1%	28.4%	.0%	8.7%	8.5%	13.6%	40.0%	3.2%	3.1%	4.5%	25.0%	12.8%	13.6%	18.6%
Organizations Responding	1	64	83	74	2	92	106	81	5	31	32	22	8	187	221	177

Average waiting period to become eligible for short-term disability income insurance coverage:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg # of months	2.0	3.3	3.5	3.5	3.0	3.6	3.4	3.4	6.0	6.3	7.3	5.9	4.3	4.0	4.1	3.9
Organizations Responding	1	34	40	39	2	54	59	53	3	20	20	19	6	108	119	111

(U) = Union Production, Maintenance and Service (CT) = Non-Exempt Clerical and Technical
(NU) = Non-Union Production, Maintenance and Service (SMP) = Exempt Supervisory, Managerial and Professional

22. Is your short-term disability insurance program:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Insured	100.0%	75.0%	75.8%	76.6%	50.0%	54.1%	54.1%	50.5%	33.3%	46.7%	38.7%	33.3%	50.0%	58.9%	58.6%	56.6%
Self-Funded	.0%	25.0%	24.2%	23.4%	50.0%	45.9%	45.9%	49.5%	66.7%	63.3%	61.3%	66.7%	50.0%	41.1%	41.4%	43.4%
Organizations Responding	1	48	62	64	2	85	98	95	3	30	31	30	6	163	191	188

23. Organizations indicating employee-pays-all or organization-pays-all for short-term disability insurance premiums:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Employee pays all	.0%	29.8%	25.4%	21.3%	.0%	17.6%	16.7%	13.6%	.0%	12.5%	12.0%	7.7%	.0%	20.7%	19.2%	15.9%
Organization pays all	100.0%	70.2%	74.6%	78.7%	100.0%	82.4%	83.3%	86.4%	100.0%	87.5%	87.5%	92.3%	100.0%	79.3%	80.8%	84.5%
Organizations Responding	1	47	59	61	2	74	84	81	2	24	24	26	5	145	167	166

Average percent of short-term disability insurance premium paid by organization - EXCLUDING organizations paying 0% or 100%:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg % of premium	n/a	55.0%	55.0%	55.0%	n/a	62.1%	61.9%	61.7%	50.0%	53.3%	56.7%	40.0%	50.0%	59.2%	59.7%	59.2%
Organizations Responding	0	2	2	2	0	9	10	11	1	3	4	1	1	14	16	14

24. Maximum weekly short-term disability benefit, if flat amount:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg \$ amount	\$375	\$560	\$1,348	\$1,473	\$325	\$516	\$675	\$738	n/a	\$385	\$700	\$1,300	\$350	\$511	\$684	\$1,062
Organizations Responding	1	11	11	12	1	22	20	17	0	5	5	2	2	38	36	31

25. Maximum weekly short-term disability benefit, if percent of pay:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg % of pay	n/a	68%	69%	69%	n/a	65%	69%	74%	55%	67%	78%	63%	55%	66%	71%	74%
Organizations Responding	0	28	40	40	0	47	56	56	2	20	22	22	2	95	118	118

26. Average maximum number of weeks paid for short-term disability:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg # of weeks	28.0	19.2	18.6	18.6	22.0	20.3	19.2	19.9	19.5	25.8	26.9	27.4	21.8	21.0	20.3	20.3
Organizations Responding	1	44	53	55	2	80	90	85	2	29	29	28	5	153	172	168

Organizations indicating 12, 13, 26 or 52 paid weeks maximum for short-term disability:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
12 weeks	.0%	16.7%	17.1%	14.0%	.0%	16.1%	17.9%	16.1%	.0%	20.8%	20.0%	16.7%	.0%	17.2%	18.0%	15.5%
13 weeks	.0%	33.3%	34.1%	37.2%	.0%	22.6%	26.9%	29.0%	50.0%	4.2%	4.0%	4.2%	25.0%	32.1%	24.8%	27.1%
26 weeks	100.0%	47.2%	46.3%	45.5%	100.0%	59.7%	53.7%	53.2%	50.0%	70.8%	68.0%	70.8%	75.0%	59.2%	54.1%	54.2%
52 weeks	.0%	2.8%	2.4%	2.3%	.0%	1.6%	1.5%	1.6%	.0%	4.2%	6.0%	8.3%	.0%	2.9%	3.0%	3.1%
Organizations Responding	1	36	41	43	1	62	67	62	2	24	25	24	4	122	133	129

Number of organizations indicating the maximum amount of paid weeks for short-term disability varies depending on length of service:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Organizations Responding	0	4	5	5	0	4	7	8	0	1	1	1	0	9	13	14

27. The average short-term disability waiting period (eligibility for payment) for an absence where the employee is not in hospital is:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg # of days	7.0	9.1	8.9	9.2	6.0	10.0	9.7	9.1	7.0	10.5	9.5	11.4	6.6	9.9	9.4	9.5
Organizations Responding	1	47	54	56	2	83	96	92	2	30	30	29	5	160	180	177

Number of organizations where eligibility for payment is dependent on the organization's medical staff guidance:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Organizations Responding	0	1	2	2	0	1	1	1	0	0	0	0	0	2	3	3

Number of organizations that either have no short-term disability waiting period or a 7-day waiting period where employee is not in hospital:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
No waiting period	0	3	6	7	0	6	12	19	0	0	3	6	0	9	21	32
7-day waiting period	1	20	21	21	1	35	35	32	2	14	13	11	4	65	70	64

28. Short-term disability waiting period (eligibility for payment) for an absence where employee is in hospital:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg # of days	0	7.6	7.7	9.2	6.0	9.1	8.9	8.3	7.0	9.8	8.2	10.3	5.2	8.8	8.4	8.9
Organizations Responding	1	47	56	58	2	84	97	93	2	30	30	29	5	161	183	180

Number of organizations that either have no short-term disability waiting period or a 7-day waiting period where employee is in hospital:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
No waiting period	1	11	14	16	0	14	21	27	0	6	10	11	1	31	45	54
7-day waiting period	0	15	17	16	1	30	30	27	2	12	11	10	3	57	58	53

29. Short-term disability waiting period (eligibility for payment) if due to accident:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg # of days	0	5.3	5.9	6.1	2.5	6.9	8.7	9.2	3.1	8.9	7.4	10.1	2.4	7.8	7.6	7.8
Organizations Responding	1	47	56	58	2	83	96	92	2	29	29	28	5	159	181	178

Number of organizations that either have no short-term disability waiting period or a 7-day waiting period if due to accident:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
No waiting period	1	20	22	23	1	21	27	32	1	8	11	11	3	49	60	66
7-day waiting period	0	7	10	9	0	23	24	21	1	10	10	9	1	40	44	39

30. Does your short-term disability plan cover eligible employees until long-term disability coverage begins?

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Yes, no gap in coverage	.0%	87.5%	87.0%	88.0%	100.0%	93.1%	94.2%	94.2%	100.0%	92.9%	92.9%	92.9%	100.0%	91.4%	91.7%	92.4%
No, there is a gap between STD and LTD	.0%	12.5%	13.0%	12.0%	0%	6.9%	5.8%	5.7%	.0%	7.1%	7.1%	7.4%	.0%	8.6%	8.3%	7.6%
Organizations Responding	0	40	54	57	2	72	80	88	2	28	28	27	4	140	168	172

31. Do you supplement short-term disability insurance benefits?

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Yes, sick leave is paid during insurance waiting period	.0%	41.3%	45.9%	44.4%	.0%	34.9%	35.8%	36.6%	.0%	29.6%	36.7%	33.3%	.0%	35.9%	39.8%	38.8%
Yes, difference between insurance benefits and full pay	.0%	.0%	.0%	1.6%	.0%	1.2%	1.1%	1.1%	.0%	3.7%	3.3%	7.4%	.0%	1.3%	1.1%	2.2%
Yes, sick pay is used when insurance benefits are exhausted	.0%	.0%	3.3%	3.2%	.0%	.0%	.0%	.0%	.0%	.0%	3.3%	.0%	.0%	.0%	1.6%	1.1%
Yes, sick pay must be exhausted before insurance benefits begin	.0%	6.5%	4.9%	4.8%	.0%	13.3%	13.7%	14.0%	.0%	7.4%	10.0%	7.4%	.0%	10.3%	10.3%	9.8%
Does not apply	.0%	52.2%	45.9%	46.0%	100.0%	59.6%	48.4%	48.4%	100.0%	59.3%	46.7%	51.9%	100.0%	52.8%	47.3%	48.1%
Organizations Responding	0	48	61	63	2	83	95	93	2	27	30	27	4	156	186	183

32. Do you have a time limit within which you will guarantee an employee's current job while on a short-term disability leave?

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Yes, as required by FMLA	100.0%	63.2%	62.3%	61.9%	100.0%	90.7%	90.3%	90.4%	66.7%	64.5%	64.5%	61.3%	83.3%	77.4%	76.1%	76.1%
Yes, specified time (see average below)	.0%	2.0%	4.8%	4.8%	.0%	8.1%	7.1%	7.4%	33.3%	35.5%	32.3%	32.3%	16.7%	11.4%	10.9%	10.6%
No	.0%	34.7%	32.8%	33.3%	.0%	1.2%	2.0%	2.1%	.0%	.0%	3.2%	6.5%	.0%	10.8%	12.1%	13.3%
Organizations Responding	1	49	61	63	2	86	98	94	3	31	31	31	6	166	190	188

Average number of months current job is guaranteed while on short-term disability leave:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg # of months	6.9	12.0	7.0	7.0	7.3	7.3	7.3	7.3	6.0	6.5	6.9	6.9	6.0	7.1	7.1	7.1
Organizations Responding	0	1	3	3	0	7	7	7	1	11	10	10	1	19	20	20

33. Under what conditions is a doctor's certificate required for short-term disability?

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Granting of original leave	100.0%	89.1%	88.1%	88.5%	100.0%	95.3%	95.9%	95.7%	100.0%	93.5%	93.5%	93.3%	100.0%	93.2%	93.0%	93.0%
Every 30 days during leave	100.0%	41.3%	35.6%	36.1%	.0%	30.6%	28.0%	28.7%	.0%	35.5%	35.0%	30.0%	20.0%	34.6%	32.1%	31.4%
Extension of leave	.0%	67.4%	62.7%	59.0%	100.0%	75.3%	75.3%	75.5%	100.0%	74.2%	74.2%	73.3%	80.0%	72.8%	71.1%	69.7%
Return from leave	100.0%	84.8%	83.1%	83.6%	100.0%	82.4%	82.5%	81.9%	100.0%	83.9%	83.9%	83.3%	100.0%	83.3%	82.9%	82.7%
Organizations Responding	1	46	59	61	2	85	97	94	2	31	31	30	5	162	187	185

SHORT-TERM DISABILITY INSURANCE [SUPPLEMENTAL COVERAGE, NOT STATE-REQUIRED]

21. Employees become eligible for short-term disability income insurance coverage:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Following waiting period (see average below)	45.8%	38.5%	35.4%	39.3%	45.3%	49.4%	47.5%	51.9%	48.5%	52.6%	48.4%	55.2%	46.2%	44.9%	42.5%	46.1%
Immediately	4.2%	7.7%	8.9%	.0%	5.1%	11.0%	12.2%	.0%	16.7%	14.8%	17.3%	.0%	7.6%	10.0%	11.1%	.0%
First of the month after hire	18.4%	23.3%	23.8%	26.3%	26.3%	23.7%	24.9%	29.3%	13.6%	20.6%	23.3%	28.1%	21.5%	23.2%	24.1%	27.7%
Coverage not provided	30.6%	30.8%	31.3%	34.4%	23.4%	16.9%	15.6%	18.8%	21.2%	11.8%	11.0%	16.7%	24.7%	21.9%	22.3%	26.2%
Organizations Responding	72	88	104	95	137	85	91	817	68	228	294	203	275	1841	2294	1885

Average waiting period to become eligible for short-term disability income insurance coverage:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg # of months	3.9	3.5	3.7	3.7	4.6	4.1	4.0	4.0	3.7	4.3	4.3	3.9	4.2	3.9	3.9	3.8
Organizations Responding	34	354	405	400	68	448	486	407	39	129	136	115	141	931	1027	966

22. Is your short-term disability insurance program:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Insured	72.9%	74.4%	73.3%	72.3%	49.8%	52.9%	52.0%	50.3%	35.3%	41.1%	38.2%	34.9%	51.0%	59.7%	58.8%	57.4%
Self-Funded	27.1%	25.6%	26.7%	27.7%	51.4%	47.1%	48.0%	49.7%	64.7%	58.9%	61.8%	65.1%	49.0%	40.3%	41.2%	42.6%
Organizations Responding	48	597	711	722	109	737	829	815	51	202	225	218	208	1536	1765	1755

23. Organizations indicating employee-pays-all or organization-pays-all for short-term disability insurance premiums:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Employee pays all	7.5%	18.6%	18.8%	18.4%	7.8%	20.0%	19.7%	18.2%	9.1%	18.5%	17.1%	14.8%	8.1%	19.7%	19.0%	17.8%
Organization pays all	92.5%	80.4%	81.2%	81.6%	92.2%	80.0%	80.3%	81.8%	90.9%	81.5%	82.9%	85.2%	91.9%	80.3%	81.0%	82.2%
Organizations Responding	40	521	637	643	77	634	702	687	44	178	199	196	161	1333	1538	1526

Average percent of short-term disability insurance premium paid by organization - EXCLUDING organizations paying 0% or 100%:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg % of premium	69.0%	65.3%	65.7%	64.9%	69.3%	65.4%	62.9%	62.1%	73.8%	64.3%	66.1%	68.8%	70.1%	64.2%	64.2%	63.6%
Organizations Responding	5	39	39	39	13	57	65	64	4	13	15	9	22	109	119	112

24. Maximum weekly short-term disability benefit, if flat amount:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg \$ amount	\$309	\$463	\$641	\$695	\$354	\$502	\$689	\$785	\$423	\$544	\$712	\$977	\$354	\$491	\$670	\$757
Organizations Responding	29	153	173	168	59	184	185	161	28	108	149	153	27	116	377	354

25. Maximum weekly short-term disability benefit, if percent of pay:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg % of pay	65%	66%	68%	70%	72%	69%	72%	75%	68%	71%	74%	79%	69%	68%	71%	74%
Organizations Responding	17	287	369	380	34	408	483	495	20	128	149	153	71	823	1001	1028

26. Average maximum number of weeks paid for short-term disability:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg # of weeks	24.5	20.4	20.1	20.2	24.8	25.6	20.3	20.3	26.3	21.3	21.3	21.5	25.1	20.7	20.4	20.4
Organizations Responding	47	524	634	637	97	670	750	721	48	185	207	196	192	1379	1591	1564

Organizations Indicating 12, 13, 26 or 52 paid weeks maximum for short-term disability:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
12 weeks	2.5%	14.0%	17.2%	17.4%	9.6%	18.5%	19.3%	20.1%	.0%	15.7%	16.3%	16.7%	5.4%	16.6%	18.1%	18.6%
13 weeks	22.5%	32.0%	32.1%	32.6%	14.5%	25.3%	27.5%	28.8%	16.3%	20.1%	21.3%	20.8%	16.9%	27.1%	28.9%	29.3%
26 weeks	72.5%	52.4%	49.7%	49.2%	72.3%	55.4%	52.0%	50.0%	72.1%	62.3%	59.0%	58.3%	72.3%	55.2%	52.1%	50.8%
52 weeks	2.5%	1.1%	1.0%	.8%	3.6%	.9%	1.1%	1.0%	11.6%	1.9%	3.4%	4.2%	5.4%	1.1%	1.4%	1.3%
Organizations Responding	40	435	517	518	63	558	615	586	43	159	176	168	166	1152	1310	1282

Number of organizations indicating the maximum amount of paid weeks for short-term disability varies depending on length of service:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Organizations Responding	1	47	57	59	12	58	70	75	3	15	18	18	16	120	145	152

27. The average short-term disability waiting period (eligibility for payment) for an absence where the employee is not in hospital is:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg # of days	8.6	9.3	9.1	9.1	7.6	8.5	8.1	7.8	8.4	8.7	8.3	7.6	8.1	8.8	8.5	8.3
Organizations Responding	48	538	653	659	105	702	787	772	49	192	214	206	202	1432	1654	1636

Number of organizations where eligibility for payment is dependent on the organization's medical staff guidance:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Organizations Responding	NA	13	15	15	1	6	10	10	NA	2	2	3	1	21	27	28

Number of organizations that either have no short-term disability waiting period or a 7-day waiting period where employee is not in hospital:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
No waiting period	4	34	55	68	11	50	82	123	1	9	21	45	16	93	150	236
7-day waiting period	23	251	294	286	51	337	357	323	21	94	99	78	95	682	750	687

28. Short-term disability waiting period (eligibility for payment) for an absence where employee is in hospital:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg # of days	6.8	7.5	7.5	7.8	4.5	7.0	6.7	6.5	5.9	6.9	6.0	5.4	6.0	7.2	7.0	6.9
Organizations Responding	46	535	648	653	106	694	780	766	51	197	217	209	203	1426	1645	1628

Number of organizations that either have no short-term disability waiting period or a 7-day waiting period where employee is in hospital:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
No waiting period	17	131	160	167	46	170	218	243	21	56	71	85	84	363	449	496
7-day waiting period	14	191	228	221	26	264	279	253	10	22	75	62	50	527	562	536

29. Short-term disability waiting period (eligibility for payment) if due to accident:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg # of days	5.1	6.0	6.1	6.2	4.5	6.0	5.9	5.7	5.3	6.0	5.8	5.4	6.0	6.0	5.9	5.9
Organizations Responding	46	541	660	665	107	701	780	774	50	197	219	210	203	1430	1669	1648

Number of organizations that either have no short-term disability waiting period or a 7-day waiting period if due to accident:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
No waiting period	24	229	270	278	55	259	301	314	25	74	89	98	104	561	660	690
7-day waiting period	7	117	149	142	19	193	206	191	5	52	55	47	31	362	412	380

30. Does your short-term disability plan cover eligible employees until long-term disability coverage begins?

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Yes, no gap in coverage	74.2%	86.4%	88.3%	89.0%	66.7%	86.5%	90.2%	91.1%	89.5%	93.5%	93.6%	94.1%	74.2%	88.4%	89.9%	90.7%
No, there is a gap between STD and LTD	25.7%	13.6%	11.7%	11.0%	33.3%	13.5%	9.8%	8.9%	10.5%	6.5%	6.2%	5.3%	25.8%	11.6%	10.1%	9.3%
Organizations Responding	35	507	630	654	79	661	753	771	38	185	211	209	154	1343	1604	1634

31. Do you supplement short-term disability insurance benefits?

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Yes, sick leave is paid during insurance waiting period	22.9%	29.9%	35.1%	34.2%	26.7%	32.3%	35.9%	34.5%	25.5%	32.3%	35.6%	31.3%	25.5%	31.4%	35.5%	34.0%
Yes, difference between insurance benefits and full pay	0%	2.1%	2.3%	4.2%	2.0%	2.2%	2.6%	3.8%	2.0%	3.1%	3.7%	6.3%	1.6%	2.3%	2.6%	4.3%
Yes, sick pay is used when insurance benefits are exhausted	6.3%	2.4%	2.7%	2.7%	1.0%	1.6%	1.7%	1.5%	2.0%	1.5%	2.7%	2.4%	2.5%	2.0%	2.3%	2.1%
Yes, sick pay must be exhausted before insurance benefits begin	4.2%	8.2%	8.4%	8.0%	6.9%	8.1%	8.8%	8.4%	7.8%	7.7%	9.6%	6.7%	6.5%	6.1%	6.7%	8.3%
Does not apply	66.7%	57.4%	51.6%	50.8%	63.4%	55.5%	50.9%	51.8%	62.7%	55.4%	48.4%	51.4%	64.0%	56.3%	50.9%	51.4%
Organizations Responding	48	585	704	710	101	715	803	799	51	195	219	208	200	1495	1726	1719

32. Do you have a time limit within which you will guarantee an employee's current job while on a short-term disability leave?

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Yes, as required by FMLA	64.0%	64.7%	64.5%	63.8%	74.5%	84.2%	85.2%	85.0%	71.2%	81.0%	81.5%	81.4%	71.2%	78.2%	76.4%	75.9%
Yes, specified time (see average below)	8.0%	5.0%	5.0%	6.1%	12.7%	7.9%	7.0%	7.1%	23.1%	14.6%	14.1%	13.6%	14.2%	7.7%	7.1%	7.1%
No	28.0%	30.3%	30.4%	31.1%	12.7%	7.3%	7.8%	7.9%	5.8%	4.4%	4.4%	5.0%	14.6%	16.1%	16.5%	17.0%
Organizations Responding	50	600	716	726	110	747	837	827	52	205	227	220	212	1552	1780	1773

Average number of months current job is guaranteed while on short-term disability leave:

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total Responses			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Avg # of months	18.0	5.6	5.2	5.1	11.2	7.5	7.6	7.6	9.1	6.7	7.0	6.8	10.9	6.8	6.8	6.7
Organizations Responding	4	30	36	37	14	59	59	59	12	30	32	30	30	119	127	126

33. Under what conditions is a doctor's certificate required for short-term disability?

	1 - 100 employees				101 - 500 employees				Over 500 employees				Total			
	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP	U	NU	CT	SMP
Granting of original leave	92.2%	86.4%	86.9%	86.6%	91.9%	83.6%	83.6%	83.4%	98.0%	98.0%	97.8%	97.7%	92.4%	91.5%	91.5%	91.3%
Every 30 days during leave	31.4%	32.5%	30.3%	30.0%	38.7%	34.9%	33.7%	34.1%	33.3%	36.0%	36.4%	35.9%	35.7%	34.2%	32.7%	32.6%
Extension of leave	60.8%	62.9%	63.1%	62.7%	76.6%	74.4%	73.5%	73.7%	84.3%	77.6%	77.3%	76.9%	74.6%	70.4%	69.9%	69.6%
Return from leave	90.2%	77.7%	78.0%	78.5%	88.3%	85.7%	84.7%	84.5%	90.2%	84.2%	82.2%	81.6%	89.2%	82.4%	81.7%	81.7%
Organizations Responding	51	587	700	710	111	738	831	822	51	203	225	217	213	1529	1756	1748

[Whereupon, at 12:18 p.m., the committee was adjourned.]

