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Amy L. Major

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AN EXERCISE IN BACKWARDS LOGIC: HOW EXPANDING THE FAMILY AND MEDICAL LEAVE ACT CAN ENHANCE BUSINESS CONTINUITY & PRODUCTIVITY DURING A PUBLIC HEALTH EMERGENCY

Amy L. Major, J.D.

I. INTRODUCTION

When it began in the early spring of 2009, the H1N1 pandemic caused anxiety and fear for public health officials, health care providers, and the public. Those fears intensified in July of 2009 when the Centers for Disease Control and Prevention (CDC) announced that it encountered problems in the production of the H1N1 vaccine and only limited vaccine distribution would be possible by September and October of that year. As a result, the CDC and public health officials emphasized a number of non-pharmaceutical interventions, such as social distancing and self-isolation, to help contain the spread of H1N1 until the implementation of the CDC’s vaccination program. However, many American workers failed to heed the CDC’s guidance to stay home when they demonstrated symptoms of H1N1, largely due to lack of paid sick leave and fear of termination due to absenteeism, thereby diminishing the overall utility of these non-pharmaceutical interventions. In the end, the H1N1 pandemic did not cause public health problems nearly as severe as initially anticipated.

1. Seasonal Influenza and Flu Vaccine Information, NAT’L VACCINE INFO. CTR., http://www.nvic.org/vaccines-and-diseases/HINI-SWINE-FLU.aspx (last visited Mar. 24, 2011). Novartis, Sanofi Pasteur, and GlaxoSmithKline developed an inactivated, injectable vaccine, while MedImmune created a nasal spray vaccine containing live, attenuated virus. Id. Production of both types of vaccine was delayed throughout the summer of 2009. Id.


3. NAT’L VACCINE INFO. CTR., supra note 1.

* Senior Law & Policy Analyst, University of Maryland, Center for Health & Homeland Security.
individuals who contracted H1N1 suffered only a mild to moderate illness, and only a small percentage of those who contracted the virus required hospitalization or died from it.4

But what if the stakes were higher? What if the H1N1 pandemic had caused more severe illness in a majority of people who contracted the virus? What if the pandemic presented a more readily communicable strain of the flu, resulting in higher infection rates and therefore, higher rates of worker absenteeism, and creating millions or even billions of dollars5 worth of lost productivity for American businesses? To provide an incentive for compliance with recommended non-pharmaceutical interventions and enhance preparedness during future public health emergencies, Congress should consider adding emergency provisions to the Family and Medical Leave Act of 1993 (FMLA or Act) that could only be implemented during a declared national public health emergency. Congressional action in this regard should provide American workers with additional options for job-protected leave that can be triggered during a public health emergency.

This Article will first discuss the H1N1 pandemic of 2009 and examine the national response efforts to the pandemic. Second, it will address the impact of H1N1 on employee absences and business operations during 2009. Next, this Article will provide an overview of the FMLA, compare the Act to state family and medical leave laws, and analyze the application of the FMLA’s current provisions to the H1N1 pandemic. Finally, this Article will describe recommendations for the integration of emergency provisions into the federal FMLA that could be used to advance public health objectives during future pandemics.

II. THE H1N1 PANDEMIC

During March and April of 2009, outbreaks of respiratory illness and an increased number of reports of individuals suffering from influenza-like illnesses began occurring throughout Mexico.5 On April 12, 2009, the General Directorate of Epidemiology reported to the Pan American Health Organization (PAHO) that an outbreak of influenza-like illness occurred in

4. 2009 H1N1 Early Outbreak and Disease Characteristics, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 27, 2009), http://www.cdc.gov/h1n1flu/surveillanceqa.htm [hereinafter 2009 H1N1 Early Outbreak]. See also Questions and Answers, supra note 2.

5. CTRS. FOR DISEASE CONTROL & PREVENTION, Outbreak of Swine-Origin Influenza A (H1N1) Virus Infection – Mexico, 58 MORBIDITY & MORTALITY WKLY. REP. 453, 467-70 (Apr. 30, 2009), available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm58d0430a2.htm [hereinafter Outbreak of Swine-Origin Influenza].
Veracruz. Less than a week later, a case of atypical pneumonia in the Oaxaca State prompted Mexican public health authorities to increase their disease surveillance protocols throughout the country. On April 21, 2009, the CDC began reporting and investigating cases of febrile respiratory illness in two children in southern California. Upon discovering that H1N1 virus caused both infections and that neither child had recently had contact with pigs (who are common carriers of this type of virus), concerns arose that these infections represented a strain of H1N1 capable of human-to-human transmission. Comparative analysis of the viruses causing illness in Mexico and California revealed that the same strain of the H1N1 virus caused illnesses in both areas. Using this information, the CDC developed case definitions, which characterized a suspected H1N1 infection as a "severe respiratory illness with fever, cough, and difficulty breathing."

On April 24, 2009, public health officials discovered six additional cases of H1N1 in California and Texas. Testing revealed that these cases involved the same strain of H1N1 as the previously reported cases and, like the earlier cases, none of the infected individuals had recent exposure to pigs. Following the identification of a new novel H1N1 virus and the announcement of reported cases of widespread flu transmission in forty-six states, Acting-Secretary Charles E. Johnson of the U.S. Department of Health and Human Services (HHS) declared a national public health emergency on April 26, 2009 in order to "be proactive in responding to [the] new influenza virus" and "allow [the federal government] the flexibility . . .

6. Id.
7. Id.
8. CTRS. FOR DISEASE CONTROL & PREVENTION, Update: Swine Influenza A (H1N1) Infections – California and Texas, 58 MORBIDITY & MORTALITY WKLY. REP. 421, 435-437 (Apr. 24, 2009), available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm58d0424a1.htm [hereinafter Update: Swine Influenza A].
9. Id.
10. Outbreak of Swine-Origin Influenza, supra note 5.
11. Id.
to take additional steps to fully mobilize [its] prevention, treatment, and mitigation capabilities should those actions become necessary.\textsuperscript{13}

The CDC immediately began taking steps to contain the H1N1 outbreak in the United States. CDC officials worked closely with public health officials in states where officials identified cases of H1N1,\textsuperscript{14} provided information to the public regarding typical disease symptoms,\textsuperscript{15} and encouraged individuals experiencing characteristic symptoms to stay home from work and school while ill.\textsuperscript{16} For most people, H1N1 infection caused moderate, flu-like symptoms.\textsuperscript{17} However, for a select group of individuals that included pregnant women, young children, and people with underlying medical conditions (including asthma, chronic lung disease, and heart disease, among others), the H1N1 virus frequently caused more severe symptoms and complications that may have required hospitalization, in some cases.\textsuperscript{18}

\begin{enumerate}
  \item 2009 H1N1 Early Outbreak, supra note 4.
  \item H1N1 Flu Daily Update, supra note 14.
  \item 2009 H1N1 Early Outbreak, supra note 4.
  \item 2009 H1N1 Flu May be More Serious for Some, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 5, 2009), http://www.cdc.gov/h1n1flu/homecare/risks.htm. Individuals identified by the CDC as being at high-risk for developing flu-related complications included: children younger than age five, especially those younger than age two; adults age sixty-five and older; pregnant women; and people with underlying medical conditions, including asthma, neurological and neuro-developmental conditions, chronic lung disease, heart disease, blood disorders, endocrine disorders, kidney disorders, liver disorders, metabolic disorders, weakened immune systems due to disease or medication, and people younger than nineteen who are receiving long-term aspirin therapy. Symptoms of individuals who required hospitalization generally included fever, chills, head and body aches, fatigue, nasal congestion, cough, and, in some cases, vomiting and diarrhea. 2009 H1N1 Early Outbreak, supra note 4. See also CTRS. FOR DISEASE CONTROL & PREVENTION, 2009-2010 INFLUENZA SEASON TRIAGE ALGORITHM FOR ADULTS (OLDER THAN 18 YEARS OF AGE) WITH INFLUENZA-LIKE ILLNESS (Oct. 27, 2009), http://www.cdc.gov/h1n1flu/clinicians/pdf/adultalgorithm.pdf.
\end{enumerate}
The CDC issued recommendations to the public regarding measures that could be taken to minimize the spread of the virus. These included basic hygiene practices, such as engaging in frequent hand washing and covering one’s nose and mouth with a tissue while sneezing or coughing, as well as social distancing protocols designed to limit human interaction, such as staying home from work or school when one is sick and avoiding close contact with people infected with H1N1 or with symptoms of H1N1 infection. Because humans continue to shed the influenza virus for up to twenty-four hours after their fever goes away, the CDC advised sick individuals to remain at home until they had been fever-free, and without the use of fever-reducing medications, for twenty-four hours. This resulted in an average exclusion period of three to five days, as H1N1 typically caused a fever that lasted two to four days. Finally, the CDC issued guidance to health care providers regarding the use of oseltamivir (“Tamiflu©”) and zanamivir (“Relenza©”) to treat and prevent infection with the virus because an H1N1 vaccine was still only in the early phases of development and production.

With community outbreaks of H1N1 present in Canada, Mexico, and the United States by early June 2009, the World Health Organization (WHO) raised the global influenza pandemic alert to Phase Six, its highest level. Although development of a vaccine for H1N1 had begun as soon as officials formally identified the 2009 strain, the Food and Drug Administration (FDA) and CDC announced in July that selecting the appropriate strain of the virus for vaccine development presented difficulties, thereby delaying production. While the U.S. government contracted for a total of 193 million doses of H1N1 vaccine, officials estimated that production yielded


20. *Id.*


22. *Id.*


25. *Id.*
only limited supplies of the vaccine by September or October. Thus, the CDC issued guidance announcing priority groups for vaccine distribution. Priority groups established by the CDC's Advisory Committee on Immunization Practices (ACIP) included "pregnant women, people who live with or care for children younger than six months of age, health care and emergency medical services personnel, anyone six months through twenty-four years of age," and people between the ages of twenty-five and sixty-four who presented higher risks of complications from H1N1 because of the presence of chronic health conditions or compromised immune systems.

In the interim, the CDC recommended the continued use of antiviral medications and the implementation of a number of non-pharmaceutical interventions (NPIs) to contain the spread of H1N1. These non-pharmaceutical interventions included promoting frequent and effective hand washing in the workplace, educating employees on proper cough and sneeze etiquette, keeping common workplace areas and surfaces clean, and encouraging sick workers to stay home.

Both the CDC and the Occupational Safety and Health Administration (OSHA) also recommended

26. Id.

27. Questions and Answers, supra note 2.

28. Id.


30. U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES & U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT, Non-Pharmaceutical Interventions for Use During A Human Influenza Pandemic, http://www.pandemicpreparedness.org/uploads/ Non-PharmaceuticalInterventionsforUseI may09_6018.pdf. The primary goal of using non-pharmaceutical interventions is to reduce the number of opportunities for transmission of the pandemic influenza virus. NPIs are generally intended to delay rapid increases in the number of cases to increase the amount of time available for implementation of possible medical interventions, decrease the number of cases occurring at a given time to diminish the potential strain on healthcare resources, and reduce morbidity and mortality due to the pandemic. Id. See also Guidance for Businesses, supra note 29.

that employers consider how they could use social distancing measures, flexible scheduling, and telecommuting or remote access technologies to mitigate any disruptions to productivity that the H1N1 outbreak might cause.\(^{32}\)

The CDC discontinued official reporting of individual cases of confirmed and probable novel H1N1 infection by the end of July 2009, for a variety of reasons, including: “many people likely became mildly ill with novel H1N1 flu and never sought medical treatment; many people may have sought and received treatment but were never officially diagnosed; and, as the outbreak intensified, in some cases, testing was limited to only hospitalized patients[,]” making official diagnosis of H1N1 unlikely for the majority of mild-to-moderate cases.\(^{33}\) By August 21, the WHO “reported 182,166 confirmed cases of new swine (H1N1) influenza worldwide with 1,799 associated deaths[,]” while the CDC reported “522 deaths and 7,983 hospitalizations associated with swine flu cases reported in the U.S.”\(^{34}\)

The H1N1 influenza virus caused the first flu pandemic in nearly forty years.\(^{35}\) Estimates indicate that approximately fifty-seven million cases of H1N1 occurred in the U.S. between April 2009 and January 2010,\(^{36}\) with more than one million of those cases occurring between April and June 2009.\(^{37}\) Approximately 257,000 individuals required hospitalization as a result of complications from the virus, and 11,690 people ultimately died from it.\(^{38}\) The demographic most affected by the H1N1 virus presented perhaps the most unusual characteristic of the pandemic because it seemed to affect individuals under the age of sixty-five far more significantly than those aged sixty-five and over.\(^{39}\) “[A]pproximately 90% of estimated [H1N1-related] hospitalizations and 87% of estimated deaths from April 2009 through January 16, 2010 occurred in people younger than 65 years

\(^{32}\) OCCUPATIONAL SAFETY & HEALTH ADMIN., supra note 31.

\(^{33}\) 2009 H1N1 Early Outbreak, supra note 4.

\(^{34}\) NAT’L VACCINE INFO. CENTER, supra note 1.

\(^{35}\) Questions and Answers, supra note 2.

\(^{36}\) Id.

\(^{37}\) 2009 H1N1 Early Outbreak, supra note 4.

\(^{38}\) Questions and Answers, supra note 2.

\(^{39}\) Id.
III. EFFECTS OF THE H1N1 PANDEMIC: IMPACT ON BUSINESS OPERATIONS AND CONTINUITY PLANNING EFFORTS

Because of H1N1's disproportionate impact on Americans under the age of sixty-five, it likely caused greater disruptions to business operations than seasonal influenza. Estimates indicate that nearly twenty-six million employed Americans over the age of eighteen years may have contracted H1N1 between September and November 2009, the peak months of the pandemic. Additionally, nearly eighteen million employees took at least part of a week off work to recover from H1N1 infection; conversely, nearly eight million employees did not take any time off work while infected with H1N1. Although U.S. employers may have been happy that productivity did not decline as much as it might have thanks to this trend of "presenteeism" (attending work while ill), statistics suggest that employees who continued to attend work while infected with H1N1 may have caused the infection of as many as seven million of their co-workers, thereby lengthening the period during which business operations were most significantly impacted by the H1N1 virus.

40. *Id.* "The number of deaths was highest among people 25 to 49 years of age (39%), followed by people 50 to 64 year[s] of age (25%) and people 5 to 24 year[s] of age (16%)." 2009 H1N1 Early Outbreak, supra note 4.

41. *Questions and Answers, supra note 2.


43. *Id.* at 1, 7.

44. *Id.* at 1-2.

45. *Id.* at 1; cf. VICKY LOVELL, INST. FOR WOMEN'S POLICY RESEARCH, VALUING GOOD HEALTH: AN ESTIMATE OF COSTS AND SAVINGS FOR THE HEALTHY FAMILIES ACT (2005), http://www.nationalpartnership.org/site/DocServer/HFACBALovell.pdf?docID=367 (although the author wrote this article before the 2009 H1N1 outbreak, it explores the effects of presenteeism).
Absence caused by H1N1 reached its peak in October 2009. During this time, the rate of absence attributed to illness for public sector employees (ninety percent of whom have paid sick leave) rose by nearly eighty-four percent, while the rate for private sector employees (fifty-seven percent of whom have paid sick leave) increased by only sixty-six percent. However, while the total number of absences decreased in November 2009, suggesting a diminishing pandemic, the rates associated with the drop in absence due to illness between October and November reflected a nearly thirteen percent greater reduction in the public sector than in the private sector. This data shows that more private sector employees became ill with H1N1 during November than their public sector cohorts, suggesting that increased exposure to H1N1 due to ill employees continuing to work while sick likely contributed to the higher rate of H1N1 infection in the private sector.

So why did many private sector employees continue to work while ill with H1N1 when the majority of their public sector counterparts heeded the CDC's recommendation to stay home and reduce the possibility of infecting others with the virus? Although a variety of factors could be responsible for this discrepancy between public sector and private sector rates of absenteeism during the H1N1 pandemic, the most probable causes are lack of paid sick leave and fear of job loss due to absenteeism. Given the fact that the private sector employs nearly seventy-five percent of the American workforce, and that this sector experienced a longer disruption to business operations than the public sector did during the H1N1 pandemic, U.S.

46. DRAGO & MILLER, supra note 42, at 1-2.


48. Id.

49. DRAGO & MILLER, supra note 42, at 5.

50. Id.

51. Id. at 1-2.

52. Id. at 5.

53. Id.

54. DRAGO & MILLER, supra note 42, at 5.
employers are rightfully concerned about the potential impact of future pandemics on the ability to successfully maintain business operations.\textsuperscript{55} Upon being asked about preparedness for a pandemic flu, such as H1N1, only one-third of businesses stated that the business could sustain business operations without severe operational issues if fifty percent of employees could not report to work for two weeks.\textsuperscript{56} When the length of business disruption due to high absenteeism increased to one month, only one-fifth of businesses stated that the business could avoid significant operational problems.\textsuperscript{57} However, at the same time, only twelve percent of businesses indicated that the company had made any changes to employee policies or business operations, such as increasing the amount of sick leave provided to employees or modifying sick leave policies so that employees could take paid sick leave to care for ill family members, that might better prepare them for future public health emergencies following the H1N1 pandemic.\textsuperscript{58} This data indicates that a disconnect may exist between employers’ concerns regarding business continuity during a pandemic and the willingness or ability of businesses to take the necessary steps to create work environments that are better prepared to better sustain the impact of a public health emergency.

Modifying leave policies to provide greater sick leave coverage for employees might appear counterproductive to obtaining the goal of improved business continuity during a pandemic. However, statistics regarding the respective rates of absenteeism for the public and private sectors during the H1N1 pandemic suggest that the greater availability of paid sick leave for public sector employees may have shortened the time that illnesses disrupted business operations by nearly a month.\textsuperscript{59} The availability of paid sick leave allowed more public sector employees to stay home when they were ill with H1N1, so the likelihood of exposure to the virus in their workplace diminished. Such trends suggest that the availability of sick leave contributed to slowing the spread of H1N1, as evidenced by the significant


\textsuperscript{56} Id.

\textsuperscript{57} Id.

\textsuperscript{58} Id.

\textsuperscript{59} DRAGO & MILLER, supra note 42, at 5.
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decrease in public sector rates of absenteeism in November 2009 compared to private sector absentee rates that month.\(^6\) Similarly, data for non-pandemic rates of absenteeism demonstrates that a lack of paid sick leave is connected to more employees continuing to work while they have communicable illnesses.\(^6\) Compounding this problem is the fact that seventeen percent of employees report that they have either been fired or told they would be fired if they requested leave from work to deal with a personal illness or to care for an ill family member.\(^6\) This tandem of unfriendly employee policies—lack of paid sick leave and lack of job-protected leave—has likely contributed to enhanced transmission of communicable illnesses and, therefore, diminished productivity, for a large percentage of U.S. businesses.

The discrepancy between employers’ expressed concerns regarding business continuity during a pandemic and the lack of employee-friendly actions to increase preparedness following the H1N1 pandemic might be explained, to some extent, by the fact that the H1N1 outbreak did not cause as severe public health problems as had originally been anticipated. Given the relatively mild to moderate illness that H1N1 caused for the average American, many employers may not have experienced a sufficiently significant disruption to business operations to alarm them. In fact, only fifty-two percent of businesses reported concerns that there may be a more widespread and more severe outbreak of H1N1 in the fall of 2009, suggesting that just over half of American employers expressed concerns that a pandemic might cause significant business disruptions later that year.\(^6\)

But what if H1N1 had caused more severe illness in the majority of individuals or had been more highly communicable, and resulted in widespread, sustained absenteeism rates of greater than fifty percent across the United States? Analysis of employer and employee behavior in response to the H1N1 pandemic, particularly in the private sector, suggests that preparedness strategies for future public health emergencies should incorporate additional mechanisms to create incentives for encouraging

\(^6\) Id. Public sector absence due to illness rates dropped by 21.8 percent from October to November 2009, while private sector rates dropped by only 8.9 percent. Id.

\(^6\) For example, while fifty-three percent of all employees with paid sick leave report that they have gone to work while ill with a communicable disease, nearly sixty-eight percent of all employees without paid sick leave have done so, a fifteen percent difference between the two groups. SMITH, supra note 47, at 7.

\(^6\) Id. at 8.

\(^6\) Press Release, supra note 55.
employees to follow CDC guidance and stay home from work while ill or symptomatic in order to contain the spread of a pandemic. While the mandatory provision of paid sick leave for all American employees would be an ideal method of furthering these public health goals, the current political and economic climate makes that an unrealistic solution for the time being. However, to enhance employees' feelings of job security, and thereby encourage them to take leave while ill without fear of losing their job as a result, Congress should consider an expansion of the FMLA's current coverage to provide job-protected leave for the majority of American workers to care for themselves and for ill family members during a public health emergency.

IV. THE FAMILY AND MEDICAL LEAVE ACT OF 1993

A. Overview and Basic Provisions

Following a nearly ten-year legislative struggle to enact a law that would allow American workers to take time off to care for themselves and their families, Congress passed the FMLA. Signed into law by President Clinton, Congress created the FMLA to "balance the demands of the workplace with the needs of families, to promote the stability and economic security of families, and to promote national interests in preserving family integrity" by "entitl[ing] employees to take reasonable leave" for a specified set of medically-related circumstances. The Act, intended to benefit both employers and employees, is administered and enforced by the Wage and Hour Division of the U.S. Department of Labor's Employment Standards Administration for "all private, state and local government employees, and some federal employees."

The FMLA entitles covered employees to "up to 12 workweeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons," including any one or more of the following:


67. Id.
(a) For the birth and care of a newborn child,\(^68\)
(b) For the placement of a [child] with the employee for adoption or foster care;\(^69\)
(c) To care for the spouse, or a son, daughter, or parent, of the employee, if such spouse, son, daughter, or parent has a serious health condition;\(^70\)
(d) Because of a serious health condition that makes the employee unable to perform the functions of his or her position;\(^71\) and
(e) Because of any qualifying exigency . . . arising out of the fact that the spouse, [child], or parent of the employee is actively deployed (or deployment is impending) in the Armed Forces, or to care for a covered service-member with a serious injury or illness who is the spouse, child, parent, or next of kin of the employee.\(^72\)

The Act requires that employees taking leave under its provisions be restored to their original position, or to an equivalent position with equivalent pay, benefits, and other terms and conditions of employment, upon their return.\(^73\) Additionally, the FMLA mandates that employers maintain employees' health insurance benefits under any "group health plan" for the duration of leave at the same level of coverage as if the employee had not taken leave.\(^74\) Finally, employees taking leave under the


\(^{70}\) 29 U.S.C. § 2612(a)(1)(C). See also 29 C.F.R. §§ 825.112(a)(3), 825.122. A "serious health condition" may include a short-term illness or injury that requires continuing treatment; a condition that is permanent or long-term for which treatment may not be effective, such as Alzheimer's Disease, severe stroke, or cancer; and chronic, long-term conditions, such as asthma, diabetes, or epilepsy, that involve occasional periods of incapacity or require continuing treatment. 29 C.F.R. §§ 825.115(c)-(e).


\(^{74}\) 29 U.S.C. § 2614(c). See also 29 C.F.R. §§ 825.100(b), 825.209(a).
Act may not incur any loss of other employee benefits in relation to such leave, subject to certain limitations and exemptions.

Enforcement of the FMLA’s provisions may occur through civil action filed by the employee or through an administrative or civil action filed on the employee’s behalf by the Secretary of the U.S. Department of Labor. Employers are “prohibited from interfering with, restraining, or denying the exercise of (or attempts to exercise) any rights provided by the [FMLA,] or from “discharging or in any other way discriminating against any person” for “opposing or complaining about any unlawful practice,” or because of an employee’s involvement in any proceeding related to the FMLA. Employers who are found to have violated the FMLA’s provisions can be subject to a variety of sanctions, including mandatory rehiring of the employee whose FMLA rights were violated, payment of up to double the employee’s lost wages and benefits, and payment of the employee’s legal fees and costs.

The FMLA’s mandates apply to those employers who employ “50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.” As such, it covers all public agencies, including state, local, and federal employers, local education agencies (schools, with some limitations), and many private sector

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75. 29 U.S.C. § 2614(a)(2). “The taking of leave under section 2612 of this title shall not result in the loss of any employment benefit accrued prior to the date on which the leave commenced.” Id.

76. 29 U.S.C. §§ 2614(a)(3), (b). The Act allows for some limitations on seniority benefits, as well as providing exemptions for “key employees,” who are “among the highest paid 10 percent of all the employees employed by the employer within 75 miles of the employee’s worksite.” 29 C.F.R. §§ 825.216(b), 825.217.

77. 29 U.S.C. § 2617(a).


79. 29 C.F.R. § 825.220(a)(1).

80. 29 C.F.R. § 825.220(a)(2).

81. 29 C.F.R. § 825.400(c).

82. 29 U.S.C. § 2611(4)(B). See also 29 C.F.R. § 825.104(a). To be eligible, employees must work at a location in the United States or any U.S. territory or possession where at least fifty employees are employed by the employer within a seventy-five mile radius. See 29 C.F.R. § 825.110(a)(3).
employers. Any employee who "has been employed by [a covered employer] for at least 12 months" and who has worked at least 1,250 hours for that employer during the previous 12-month period is eligible to take leave under the Act. In some situations, FMLA leave may be taken intermittently—in hourly, daily, or weekly increments—and may also be taken on a part-time basis to reduce an employee’s daily or weekly work schedule. However, leave taken on either of these bases may be subject to employer approval. Although the FMLA provides employees with the right to take job-protected, unpaid leave, the employee may request—or the employer may require—that paid leave (including accrued sick, personal, or vacation leave) be substituted, when available, to cover a portion or all of the leave requested.

The Act imposes certain requirements on both employers and employees. Covered employers must post a notice, approved by the Secretary of Labor, which explains employees’ rights and responsibilities under the FMLA. Employee handbooks or other written guidance provided to employees must also include such notices. Additionally, when an employee requests leave or an employer "acquires knowledge that an employee’s leave may be for an FMLA-qualifying reason," the employer has a duty to notify the employee

83. See 29 C.F.R. § 825.105(e) (2001); FACT SHEET #28, supra note 66.


86. 29 C.F.R. § 825.202(a).

87. Id.


89. See supra note 88; FACT SHEET #28, supra note 66, at 2.

90. 29 C.F.R. § 825.300(a).
of his or her eligibility to take leave under the Act.91 Unless extenuating circumstances exist, such notice, along with a description of the employees’ rights and obligations associated with the leave, must be provided to the employee within five business days.92

Similarly, employees have obligations under the Act. The FMLA requires that employees provide employers with thirty-day advance notice of the need to take FMLA leave when the “need for leave is foreseeable” and such notice is practicable.93 However, when the need for leave is not foreseeable or advanced notice is not practicable, “notice must be given as soon as practicable” under the particular facts and circumstances of the case (usually the same or next business day).94 When requesting FMLA leave, employees must provide sufficient information for the employer to reasonably determine whether the Act’s provisions apply to the leave request,95 and the employer may require employees to submit a medical certification before approving FMLA leave.96 Medical certifications must include a description of the “serious health condition” for which the employee is requesting FMLA leave, as well as the date that the condition began or that treatment became necessary, and the expected duration of the condition or treatment.97 Employers may not, however, require the submission of medical information beyond that required by the certification form.98 Rather, if an employer deems a medical certification to be incomplete or insufficient, it must specify “in writing what additional information is necessary to make the certification complete and sufficient[;]” and allow the employee seven calendar days to provide the requested information.99

91. Id.

92. 29 C.F.R. §§ 825.300(a)-(c).


95. 29 C.F.R. § 825.301(b).


97. 29 C.F.R. § 825.306(a).

98. 29 C.F.R. § 825.307(a). See also FREQUENTLY ASKED QUESTIONS, supra note 88, at 7.

99. 29 C.F.R. § 825.305(c).
may be required to submit a recertification every thirty days, every six months, or each year, depending on the circumstances of the leave, and a "fitness-for-duty" certification may be required in order to verify that employees who have taken leave for their own personal illness are able to resume work.

B. Intersection with State FMLA Laws

Because Congress designed the FMLA to give American workers a basic right to a minimum level of unpaid, job-protected leave, the FMLA explicitly states that it does not preempt state or local family and medical leave laws that provide greater protections for employees. The FMLA provides that "[n]othing in this Act or any amendment made by this Act shall be construed to supersede any provision of any State or local law that provides greater family or medical leave rights than the rights established under this Act or any amendment made by [it]." As such, the federal FMLA provisions that provide greater protection for employees preempt state or local family and medical leave laws that provide less protection than the federal FMLA. Conversely, provisions of state or local laws that provide greater employee protections than the federal FMLA will not be preempted with respect to the specific sections of those laws that provide greater protection.

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100. 29 C.F.R. §§ 825.305(e), 825.308. Employers may request a new medical certification each leave year for medical conditions that last longer than one year. They may also request recertification no more than once every thirty days unless a minimum duration of treatment has been specified in the certification. Employers may uniformly request recertification of ongoing conditions every six months in conjunction with any absence under the FMLA. See also FREQUENTLY ASKED QUESTIONS, supra note 88, at 8.

101. 29 C.F.R. § 825.312 (2001). Employers may enforce uniformly-applied policies or practices requiring all similarly-situated employees who take medical leave to produce certification verifying their ability to resume essential functions of their job. See also U.S. DEP’T OF LABOR, WAGE & HOUR DIV., DOL’S FINAL RULE ON FAMILY AND MEDICAL LEAVE: PROVIDING MILITARY AND FAMILY LEAVE AND UPDATES TO THE REGULATIONS 4 (2008), http://www.dol.gov/whd/fmla/finalrule/factsheet.pdf.


103. 29 C.F.R. § 825.701 (2001).

Nothing in the FMLA supersedes any provision of State or local law that provides greater family or medical leave rights than those provided by the FMLA . . . . Employees are not required to designate whether the leave they are taking is FMLA leave or leave under State law, and an employer must comply with the appropriate (applicable) provisions of both . . . . If leave qualifies for
While great variation exists in state family and medical leave laws, they most frequently differ from the federal FMLA in five principal ways:

1. By providing a different number of weeks of unpaid, job-protected leave;\(^{104}\)

2. By providing paid leave for a portion of the employee’s requested leave;\(^{105}\)

3. By changing the minimum number of employees required for an employer to be covered by the FMLA’s provisions;\(^{106}\)

4. By expanding the definition of “family” beyond those included in the federal FMLA;\(^{107}\) and

FMLA leave and leave under State law, the leave used counts against the employee’s entitlement under both laws.

\(\textit{Id.}\)

\(104.\) States providing a different number of unpaid, job-protected leave include: District of Columbia (sixteen workweeks during a twenty-four-month period); Hawaii (four weeks per year); Maine (ten weeks during a two-year period); Minnesota (six weeks per year); New Jersey (twelve weeks during a twenty-four-month period); Rhode Island (thirteen consecutive workweeks in any two calendar years); and Wisconsin (six weeks per year). D.C. CODE §§ 32-502 – 32-503 (2010); HAW. CODE R. § 398-4 (2010); ME. REV. STAT. ANN. tit. 26, § 844 (2010); MINN. STAT. § 181.941 (2010); N.J. STAT. ANN. § 34:11B-4 (2011); R.I. GEN. LAWS § 28-48-2 (2011); WIS. STAT. § 103.10 (2010).

\(105.\) States providing paid leave include: California (six weeks); Hawaii (ten days, if employer allows it); New Jersey (six weeks, with a maximum of $524.00/week); Vermont (five weeks paid leave for birth of a child); and Wisconsin (five days of paid leave for bone marrow donation, and up to thirty days of paid leave for organ donation). CAL. GOV. CODE § 12945.2 (2011); HAW. CODE R. § 398-4 (2010); N. J. STAT. ANN. § 34:11B-4 (2011); R.I. GEN. LAWS § 28-48-2 (2011); VT. STAT. ANN. tit. 21, § 472 (2010); WASH. REV. CODE § 49.12.270 (2010); WIS. STAT. § 103.10 (2010).

\(106.\) States that require a lower number of employees for employers to be covered by the FMLA include the District of Columbia (minimum of twenty employees); Maine (minimum of fifteen employees); Minnesota (minimum of twenty-one employees); Rhode Island (minimum of thirty employees if state/public employer; minimum of fifty employees if private employer); and Vermont (minimum of ten employees for parental leave; minimum of fifteen employees for family leave). D.C. CODE § 32-516 (2010); ME. REV. STAT. ANN. tit. 26, § 843 (2010); MINN. STAT. § 181.940 (2010); R.I. GEN. LAWS § 28-48-1 (2011); VT. STAT. ANN. tit. 21, § 471 (2010).

\(107.\) Several states allow family leave to care for: domestic or civil union partners (California, Connecticut, District of Columbia, Maine, New Jersey, Rhode Island, and Vermont); grandparents (Hawaii); parents-in-law (Connecticut, Hawaii, New Jersey, Vermont, and Wisconsin); stepparents (New Jersey); siblings (Maine); and the children
(5) By expanding the list of reasons for which employees may use leave.\(^{108}\)

Despite the significant differences between various states' family and medical leave laws and the federal FMLA, it is somewhat alarming that almost none of these laws contain provisions that might be interpreted to allow employees to take leave for illness due to a public health emergency, such as pandemic influenza, or to care for an ill family member under these circumstances. Under current state and federal law, HHS, the CDC, and state and local public health agencies appear to have few options, other than the use of more extreme public health powers like isolation, quarantine, and restrictions of movement and public gathering, to encourage American workers to heed their guidance regarding use of non-pharmaceutical interventions in order to help contain a public health emergency.

C. Application of the FMLA's Current Provisions to Pandemic Influenza

The FMLA presently provides eligible employees with the right to take unpaid, job-protected leave when they are unable to work due to a serious health condition,\(^ {109}\) or in order to care for a covered family member (i.e., spouse, son, daughter, or parent) who has a serious health condition.\(^ {110}\)

Under the Act, a “serious health condition” includes “an illness, injury, impairment, or physical or mental condition that involves (A) inpatient care in a hospital, hospice, or residential medical care facility; or (B) continuing treatment by a healthcare provider.”\(^ {111}\) The FMLA’s regulations define “inpatient care” as “an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity as defined in [the Act’s regulations], or any subsequent treatment in connection with such inpatient care.”\(^ {112}\) Further, “incapacity,” as defined in the Act’s regulations,
equals the "inability to do work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom." 113

Guidance from the U.S. Department of Labor, which enforces the Act, confirms that influenza (seasonal or pandemic) could be considered a "serious health condition" — eligible for application of the FMLA's protections — in cases where significant complications arise that incapacitate an individual within the meaning of the Act. 114 So, for cases of H1N1 where an individual experiences such significant complications that he is incapacitated and requires hospitalization, FMLA leave would likely be available to provide him with job-protected time off from work while he is treated and attempts to recover. However, during the H1N1 pandemic, only 257,000 hospitalizations for H1N1-related complications arose out of nearly fifty-seven million cases of H1N1 infection. 115 While 257,000 hospitalizations may seem like a large number, it amounted to less than one percent of all estimated H1N1 cases. The fact that job-protected leave would have been available under the FMLA only for this small percentage of Americans is not very reassuring because it seems likely that someone who is sick enough to require hospitalization will take time off from work to recover, regardless of the consequences.

For the vast majority of American workers who became ill with H1N1 in 2009, the FMLA's provisions would have not provided them with any legitimate right to unpaid, job-protected leave to recover from H1N1 or to care for family members infected with the virus. Thus, leave provisions left most employees to decide for themselves whether to heed the CDC's guidance by staying home from work, or to disregard that guidance in light of the negative impact their absence at work might have on their employment. The CDC's guidance for H1N1 containment left employers with significant discretion; i.e., employers exercised their own judgment when considering whether or not to relax attendance policies or provide flexibility for employees. Yet this autonomy for employers stands in significant contrast with current public health research showing that containment of a pandemic is most possible during its initial stages when


113. 29 C.F.R. § 825.113(b).


115. Questions and Answers, supra note 2.
mitigation strategies, such as the use of antiviral prophylaxis, movement restrictions, and non-pharmaceutical interventions, like social distancing and self-isolation, are implemented within the first three weeks. In the early stages of a pandemic, when non-pharmaceutical interventions and other mitigation strategies are most necessary and successful in pandemic containment, employers currently control primary discretion for implementing such measures in the workplace.

Given knowledge that early implementation of non-pharmaceutical interventions is crucial to containment of a pandemic, and that research suggests that many workers expressed reluctance to follow guidance regarding social distancing during H1N1 because of a lack of sick leave and fears concerning job security, Congress would be prudent to provide HHS and the CDC with a tool that helps to tip the scales in favor of federal, state, and local public health agencies. Such a tool could be the creation of “emergency provisions” that expand the FMLA’s current coverage in specific ways during a public health emergency, such as a pandemic influenza.

V. INTEGRATING EMERGENCY PROVISIONS INTO THE FAMILY AND MEDICAL LEAVE ACT TO ADVANCE PUBLIC HEALTH OBJECTIVES DURING A PUBLIC HEALTH EMERGENCY

A. Federal Public Health Powers

Federal public health powers reside primarily in HHS. Accordingly, the Secretary of HHS has the authority, in conjunction with other public health officials, to use a number of powers to protect the public health. These powers include isolation and quarantine, restricting of movement of


Regulations prescribed under this section [may only] provide for the apprehension, detention, or conditional release of individuals ... for the purpose of preventing the introduction, transmission, or spread of such communicable diseases as may be specified from time to time in Executive orders of the President upon the recommendation of the Secretary, in consultation with the Surgeon General.

Id.
individuals, and maintaining the Strategic National Stockpile of drugs, vaccines, and other supplies. Under the Public Health Service Act (PHSA), the Secretary of HHS also has the authority to declare a public health emergency after determining that either "(1) a disease or disorder presents a public health emergency; or (2) a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists."[121]

One particular power at the Secretary's disposal is the authority to temporarily waive or modify the application of specific regulatory requirements for health care facilities during declared public health emergencies.[122] To use this power, the Secretary must declare a public health emergency pursuant to Section 319 of the PHSA.[123] Further, the President must declare an emergency or disaster pursuant to either the National Emergencies Act (NEA)[124] or the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act).[125] Once the necessary declarations are made, the Secretary may issue a waiver under Section 1135 of the Social Security Act to temporarily modify or eliminate certain requirements under Medicare, Medicaid, the Children's Health Insurance

119. 42 C.F.R. § 70.3 (2009).

The Secretary [of Health and Human Services], in collaboration with the Director of the Centers for Disease Control and Prevention, and in coordination with the Secretary of Homeland Security ... shall maintain a stockpile or stockpiles of drugs, vaccines, and other biological products, medical devices, and other supplies in such numbers, types, and amounts as are determined by the Secretary to be appropriate and practicable, taking into account other available sources, to provide for the emergency health security of the United States . . . .

Id.


Program, the Health Insurance Portability and Accountability Act (HIPAA), and the Emergency Medical Treatment and Active Labor Act (EMTALA) in order to enhance the ability of health care providers to effectively respond to a public health emergency.126

Taking a similar, two-pronged approach, it is possible for Congress to improve the ability of workers to comply with non-pharmaceutical interventions recommended by HHS and the CDC to help contain a public health emergency. First, Congress could expand the FMLA’s coverage in a number of ways to modify current limitations of the Act by including “emergency provisions” that could only be triggered during a declared public health emergency. Second, Congress could add provisions to the PHSA and to the FMLA that would give the Secretary of HHS and Secretary of the Department of Labor the authority to issue a joint waiver that would trigger specific emergency provisions in the FMLA. In theory, such emergency provisions would allow the majority of American workers to benefit from the Act’s mandate of job-protected leave during a public health emergency.

B. Expansion of the FMLA through Emergency Provisions

Currently, the FMLA has a number of limitations in coverage that negatively impact its ability to be a useful tool for public health authorities in encouraging compliance with CDC recommendations of non-pharmaceutical interventions (e.g., social distancing) during a public health emergency like H1N1. While revising the Act would certainly be highly controversial, including emergency provisions in the Act would create a balance between the goal of protecting the public health and providing American employers the autonomy to make important decisions regarding business operations.

To achieve this balance, Congress should consider adding a series of emergency provisions to the FMLA that would only take effect when the following three requirements have been satisfied: 1) the Secretary of HHS has declared a public health emergency pursuant to their authority under the PHSA; 2) the President has declared a national emergency pursuant to the NEA or the Stafford Act; and 3) the Secretary of Labor and the Secretary of HHS have issued a joint waiver approving the temporary implementation of

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126. 42 U.S.C. §§ 1320b-5(b)(1)-(7) (2010). Among others, Section 1135 waivers allow for modification or waiver of requirements pertaining to the following: conditions of participation, certification requirements, program participation requirements, and pre-approval requirements for health care providers participating in Medicare and Medicaid; state licensure requirements for health care providers; sanctions for certain actions and patient transfers that would normally violate EMTALA; and sanctions or penalties for actions that would normally violate the HIPAA Privacy Rule.
select emergency provisions in the FMLA pursuant to their authority under
the revised FMLA and PHSA, respectively. These emergency provisions
would temporarily modify the FMLA in a number of ways.

a. By expanding the definition of “serious health condition” to
include pandemic influenza and other communicable diseases when
a public health emergency has been declared by the Secretary of
HHS

Definitions of “serious health condition” under present FMLA regulations
could likely only apply to pandemic influenza if an individual has serious
complications that incapacitate him to the point that he can no longer work,
attend school, etc. During a declared public health emergency, this
definition should expand to include pandemic influenza and other
communicable diseases to ensure that individuals who don’t have access to
sick leave, or who have already used up their accrued sick leave, have a
legal right to unpaid, job-protected leave in the event that they need to take
time off to care for themselves or others. Such a provision would be the
single most important emergency FMLA provision for advancing the public
health goal of containing the spread of a pandemic or communicable disease
outbreak. This provision would open the door for eligible employees to take
FMLA leave to care for themselves and others while ill, thereby potentially
enhancing compliance with CDC recommendations of social distancing and
other non-pharmaceutical interventions.

b. By modifying or eliminating medical certification requirements
for an employee to take FMLA leave and fitness for duty
certification requirements to permit an employee to return to work

Pursuant to current FMLA regulations, employers are permitted to require
medical certification of a “serious health condition” before approving an
employee’s request for FMLA leave. Additionally, employers can also
require that employees submit a “fitness for duty” certification before they
are allowed to return to work following FMLA leave. However, during a
public health emergency, health care resources may be completely
overwhelmed, to the point that individuals may not even be able to make
appointments with their primary care physicians or other health care

114, at 1.


129. 29 C.F.R. § 825.312 (2001).
providers to receive treatment, thus making it nearly impossible to obtain the requisite medical and “fitness for duty” certifications. As such, the emergency provisions of the FMLA should permit these requirements to be waived during a public health emergency in order to decrease the administrative burden on health care providers and to streamline the process for employees to request and take FMLA leave. Dates for which the medical and “fitness for duty” certification requirements would be waived could be set in the joint waiver issued by the Secretary of Labor and the Secretary of HHS, ensuring that employees requesting FMLA leave for reasons not related to a public health emergency would still be required to comply with these certification mandates.

c. By setting a lower threshold for the minimum number of employees required for an employer to be covered by the Act

Currently, an employer must have fifty or more employees in order to be subject to the provisions of the FMLA. This creates a significant limitation in coverage, as nearly forty-one million Americans, or forty percent of the private sector workforce, are not covered by the provisions because their employers do not meet the threshold requirement for number of employees. To be most effective, the emergency provision should make the FMLA applicable to all employers, regardless of size. However, in the interest of protecting small businesses, which may be disproportionately affected by a pandemic, the minimum number of employees for the emergency provision could be set at ten, so that only employers with ten or more employees would be subject to the emergency provisions of the Act. This measure would still provide greater protections to American workers than current law, but would not adversely impact small businesses.

d. By lowering the number of hours of service required for an employee to be eligible for leave under the Act

The FMLA currently requires employees to have been employed for at least twelve months and to have provided at least 1,250 hours of service to their employer in order to be eligible for FMLA leave. During an emergency, these thresholds should be lowered to six months of employment for


and 625 hours of service time\(^{133}\) to ensure that more employees are eligible for FMLA leave, should they need to take it due to illness during a public health emergency. Also, requiring this lowered service time would most likely increase the possibility that an employee may have accrued paid leave that could be substituted for the unpaid leave provided by the FMLA, while still expanding the number of employees who would be eligible for FMLA leave.

\(e\). **By providing four additional weeks of unpaid, job-protected leave (for a maximum total of sixteen workweeks of FMLA leave per year):**

Employees are presently permitted to take up to twelve workweeks of FMLA leave during any twelve month period for one of the reasons specified under the Act.\(^{134}\) For most employees, this permitted amount of leave would probably be sufficient for them to take time off to care for themselves and their families during a public health emergency. Nevertheless, for two interconnected reasons, four additional weeks of FMLA leave should be permitted through the emergency provisions. First, certain public health emergencies caused by communicable diseases, like pandemic influenza, tend to occur in waves. Because of this, an employee may need a week off early in the pandemic to care for a sick child, but then may later find that additional time off is needed to care for himself or to care for other family members who are ill. Additional weeks of FMLA leave would appropriately respond to known pandemic patterns of infection.

Second, some illnesses, like H1N1, may disproportionately impact individuals who have underlying chronic health conditions or those with family members who have underlying chronic health conditions. Such individuals are more likely to have already used some of their permitted allowance of FMLA leave to treat the chronic condition, and therefore may not have a sufficient allowance of FMLA leave remaining to take leave during a pandemic. The additional four weeks of FMLA leave should be permitted under the emergency provisions to ensure that these individuals have sufficient leave to properly recover and are not reluctant to stay home while ill due to fear of losing their jobs.

Several of the above proposed emergency provisions are purposefully broad and could be viewed as overreaching, particularly by employers with significant interests in maintaining their financial bottom lines. However,

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\(^{133}\) Six hundred twenty-five hours of service time could be performed by working at least 12.5 hours a week/year, or alternatively, by working at least 24 hours a week/26 weeks.

given statistical data showing that the trend of presenteeism during H1N1 likely caused a longer period of business disruption for the private sector (due to contamination of the work environment from ill employees), business productivity and continuity could actually benefit from the addition of such emergency provisions. While the job protections afforded by these emergency provisions might increase employee absences in the short term during a public health emergency, providing employees with job-protected leave so that they could more easily stay home while ill and refrain from spreading the illness in question to their co-workers could actually diminish the rate of infection and shorten the length of time that business productivity was significantly disrupted. In turn, this could enhance business continuity and benefit employers across the U.S.

Similarly, if proposed for implementation during non-emergency situations, these emergency provisions would likely be deemed as too intrusive into the realm of commerce and summarily rejected by Congress. However, during declared emergencies, including public health emergencies, state and federal law uniformly recognizes that, in order to effectively respond to the emergency, governments have the authority to implement emergency measures that would normally not be permitted in a non-emergency situation. When choosing how to respond to an emergency, governments must frequently decide how to properly balance the competing interests of protection of the common good of society with protection of individual liberty and property rights.

Including these proposed emergency provisions in the FMLA is consistent with the current framework of emergency laws and should be viewed as merely one tool that could potentially be used by the federal government to help contain the spread of and mitigate the damage caused by a public health emergency. By requiring a number of administrative triggers for these emergency provisions (including the requirement of a declaration of a public health emergency by the Secretary of HHS and a declaration of emergency by the President), as well as mandating that the waiver to trigger emergency FMLA provisions be jointly issued by the Secretary of Labor and the Secretary of HHS, Congress could ensure that use of this power is not abused. Additionally, the requirement of a jointly-issued waiver would help federal officials within HHS and the Department of Labor to properly tailor the response strategies to the magnitude of the public health emergency by only electing to implement those emergency provisions that best met the goal of advancing public health response activities while simultaneously minimizing the amount of business disruption to American employers. Finally, like other emergency laws, the joint waiver could set a termination date for application of these emergency provisions, or alternatively, allow the Secretary of HHS and the Secretary of Labor to terminate the waiver once it is no longer necessary.
VI. CONCLUSION

The H1N1 pandemic provided an opportunity for public health officials to analyze human behavior during a public health emergency. One conclusion that can be drawn from statistics regarding rates of absenteeism during H1N1 is that many American workers expressed reluctance regarding recommended non-pharmaceutical interventions, such as self-isolation and social distancing, because of a lack of paid sick leave and fear of job loss resulting from absenteeism during the pandemic. To encourage higher rates of compliance in future public health emergencies, Congress should consider adding a tool, in the form of emergency FMLA provisions, which would provide the majority of Americans with the right to job-protected leave during a public health emergency. The addition of this tool to the arsenal of preparedness strategies currently maintained by HHS and the CDC would allow them to better contain future public health emergencies, like H1N1, and ultimately advance their goal of protecting the public health.