

**Statement
of the
American Hospital Association
before the
Subcommittee on Workforce Protections
of the
Education and the Workforce Committee
of the
U.S. House of Representatives**

Hearing on
“Examining Recent Actions by the Office of Federal Contract Compliance Programs”

*The OFCCP’s Jurisdictional Land Grab: The OFCCP’s Unwarranted Expansion of Jurisdiction
over Hospitals Providing Care for Service Members and other Federal Employees*

December 4, 2013

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement to the Education and the Workforce Committee’s Subcommittee on Workforce Protections as it examines “Recent Actions by the Office of Federal Contract Compliance Programs” (OFCCP).

The OFCCP has sought to expand aggressively its jurisdiction over health care providers, including providers participating in federal health care programs that, for many years, have been acknowledged by the OFCCP *not* to provide a jurisdictional basis for federal contractor status. The OFCCP now asserts that hospitals participating in certain unspecified components of TRICARE, the health care program for military service members and their families, and the Federal Employees Health Benefit Program (FEHBP), the health care program for civilian employees and their families, are federal contractors subject to its regulatory scheme. This assertion would, if accepted, convert virtually overnight a majority of our nation’s hospitals into federal contractors, without advance notice to or agreement by those hospitals. The OFCCP’s current position is not only inconsistent with the views of the federal agencies that administer TRICARE and FEHBP, but is also legally incorrect, will engender unnecessary and distracting litigation, and will divert precious resources that otherwise should be directed towards patient care.



To be clear, our nation's hospitals are not seeking to be excluded from coverage by nondiscrimination laws. These federal, state and local laws are and will remain applicable to hospital employers. Rather, the concerns expressed here are with the significant and sometimes crushing regulatory burden that the OFCCP imposes on employers that meet its definition for being a federal contractor.

Rather than pursue its expansionary tactics, the OFCCP should revert to the clear guidelines that the agency had in place for many years, under which hospitals providing care to participants in federally funded health benefit programs, including FEHBP, TRICARE and Medicare, were not considered federal contractors.

Given that the OFCCP has given no indication that it intends to revert to its prior clear and correct jurisdictional position, Congress should adopt legislation directing this outcome. Legislation would clarify for all concerned that recipients of payments from the Federal Government related to the delivery of health care services to individuals shall not be treated as Federal contractors by the OFCCP based on the work performed or actions taken by such individuals that resulted in the receipt of such payment. This type of legislation would help maintain a robust network of health care providers for service members, federal employees, and their families, by giving clear legal guidance that the care rendered to them under these federally funded programs would not unknowingly and incorrectly classify the providers as federal contractors.

THE OFCCP'S ATTEMPTS TO EXPAND ITS JURISDICTION OVER HEALTH CARE INSTITUTIONS

The OFCCP's expansionist agenda is based primarily on hospital participation in federally funded health benefit plans offered under TRICARE, FEHBP and Medicare Parts C and D. TRICARE, which is administered by the Department of Defense (DOD), provides health benefits for approximately 9.63 million military service members and their families. The DOD has reported to Congress that approximately 3,300 hospitals participate in TRICARE, a solid majority of the more than 5,700 hospitals registered in the U.S. According to the Office of Personnel Management (OPM), FEHBP covers more than 8 million current and former federal employees and retirees and their family members. Medicare is sponsored by the Centers for Medicare & Medicaid Services (CMS) and provides health insurance for about 50.7 million people. About 27 percent of Medicare participants (or more than 13 million people) are enrolled in Medicare Part C. The OPM and the CMS have not published the number of hospitals participating in FEHBP or Medicare Parts C and D, but the AHA understands that many U.S. hospitals provide patient care services under these federally funded programs.

The OFCCP's recent attempts to expand its jurisdiction has focused on the managed care components of these health plans. Generally speaking, "managed care," a term that has been in use since the early 1980s, refers to a system of health care that controls costs by placing limits on physicians and hospital fees and by restricting in some way the patient's choice of physicians and hospitals. A Health Maintenance Organization (HMO) and a Preferred Provider Organization (PPO) are examples of health plans that include managed care components.

Like many health plans offered in the private sector, the three federally funded health programs at issue offer a variety of plan options, many of which include managed care components. TRICARE, for example, offers an overlapping mix of more than 10 plan options, which include both a traditional indemnity or fee-for-service option (containing little, if any, managed care components), and PPOs and HMOs. FEHBP includes almost 300 plan options, running the gamut from pure indemnity plans to restrictive HMOs, with numerous options in between. Medicare includes both traditional indemnity plans under Parts A and B, as well as managed care components under Parts C and D. Given the wide variety of options provided under TRICARE and, especially, FEHBP, there is no clear dichotomy between “managed care” and “fee-for-service” options under TRICARE and FEHBP. (Appendix A includes additional background information on each of these federally funded programs.)

Through pending litigation, the OFCCP has asserted jurisdiction over hospitals that participate in certain unspecified managed care plans offered under federally funded health benefit programs. In addition, the OFCCP has issued internal directives that confirm the agency’s strategy to gain jurisdiction over an untold number (but certainly a majority) of hospitals operating in the U.S.

OFCCP’s Litigation to Expand its Jurisdiction. Until fairly recently, the OFCCP’s jurisdiction was fairly well-settled not to cover hospitals participating in federally funded health benefit programs. For example, since the 1990s, the OFCCP has acknowledged that it does not have jurisdiction over hospitals participating in Medicare because Medicare provider payments are considered federal financial assistance and not a government contract. (*See Partridge v. Reich*, 141 F.3d 920, 925-26 (9th Cir. 1998); *see also* OFCCP Directive No. 189 (1993) (“OFCCP considers health care institutions that provide services to Medicare and Medicaid beneficiaries as recipients of federal financial assistance and not as contractors”).)

More than 10 years ago, the OFCCP sought to extend its jurisdiction to cover hospitals participating in the FEHBP program. After the Administrative Review Board (ARB) rejected OFCCP’s claims in *In Re Bridgeport Hosp.*, ARB Case No. 00-034 (DOL Admin. Rev. Bd. Jan. 31, 2003), the agency backed down and acknowledged that it did not have jurisdiction over hospitals participating in the FEHBP. (*See* OFCCP Directive 262 (2003) (“OFCCP cannot use FEHBP coverage as a basis to assert jurisdiction over a health care provider”).)

Despite the OFCCP’s prior acknowledgement of its jurisdictional limits based on hospital participation in federally funded health benefit programs, the agency brought litigation against two hospitals based on their participation in TRICARE and FEHBP. In *OFCCP v. Florida Hospital of Orlando*, the agency brought an action against Florida Hospital asserting that, as a result of the hospital’s agreement to provide health care services to TRICARE beneficiaries pursuant to an agreement it had with a private company responsible for administering the TRICARE program, the hospital was a covered federal subcontractor. Following a decision by an Administrative Law Judge (ALJ) accepting the OFCCP’s argument, Congress passed Section 715 of the *National Defense Authorization Act for Fiscal Year 2012* (NDAA), which was signed

into law by President Obama.¹ NDAA included various amendments to the TRICARE program, including a provision exempting TRICARE network providers from federal contractor status.

Instead of honoring and enforcing the new law, the OFCCP continued to pursue a finding of federal contractor status against Florida Hospital, arguing to the ARB that NDAA did not act as a complete bar to a finding of federal contractor status based on participation in TRICARE. The OFCCP even suggested that the Secretary of Labor's authority should exceed that of Congress in this area, by arguing that "Congress usurped [the Secretary of Labor's] authority by limiting whether TRICARE network providers could be considered subcontractors under . . . the laws enforced by OFCCP." (*See* Plaintiff OFCCP's Resp. to ARB's Request for Briefing on the Impact of Section 715 of the National Defense Authorization Act, ARB Case No. 11-011 (filed Mar. 13, 2012).) After the ARB rejected the OFCCP's arguments, the OFCCP filed a petition for rehearing, again asserting that Congress's legislative act did not foreclose OFCCP's arguments of federal contractor status based on Florida Hospital's participation in TRICARE. This time, the ARB found in favor of the OFCCP on this issue, but remanded the case back to the ALJ for further findings regarding whether participation in TRICARE amounts to federal financial assistance that is not a federal contract. The case remains pending before the ALJ, five years after the OFCCP first brought the action.

Similarly, in *OFCCP v. UPMC Braddock*, the agency brought an action alleging that hospitals that had an HMO contract to provide health care services to FEHBP participants were federal subcontractors subject to OFCCP jurisdiction. Following an appeal by UPMC Braddock after a ruling by the ARB in favor of OFCCP, the District Court agreed with OFCCP's decision. That 2013 decision currently is on appeal to the D.C. Circuit Court of Appeals.

OFCCP Internal Directives. On Dec. 16, 2010, the OFCCP issued internally, but did not publicly publish, Directive 293, a document summarizing the agency's initiatives for how it intended to carry out its coverage assessments of health care providers. Directive 293 stated that health care providers that participate in a managed care program within TRICARE are covered federal subcontractors, regardless of other factors, including the DOD's position to the contrary, and also that health care providers who, pursuant to HMO contracts, provide services to FEHBP beneficiaries are covered federal subcontractors, regardless of OPM's position to the contrary. Directive 293 also included the OFCCP's first formal statement that participating in Medicare Part C (Advantage) or Medicare Part D (covering prescription drugs plans) may subject a health care provider to the agency's jurisdiction. Directive 293 expressly superseded the two prior directives of the agency that excluded completely jurisdiction based on participation in Medicare (Directive 189) and FEHBP (Directive 262).

On April 25, 2012, the OFCCP rescinded (at least nominally) Directive 293. In Directive 301, the agency stated that, while rescission of Directive 293 was warranted in light of "recent legislation and related development in pending litigation," the OFCCP reaffirmed that it would "continue to use a case-by-case approach to make coverage determinations in keeping with its regulatory principles applicable to contract and subcontract relationships and OFCCP case law."

¹ Pub. Law No. 112-81, 125 Stat. 1298 (Dec. 31, 2011).

In addition, Directive 301 reiterated that its rescission of Directive 293 “at this time” “should not be interpreted as reinstating prior Directive Numbers 189 and 262.” Thus, even though the OFCCP formally rescinded Directive 293, the agency has not retreated from the positions laid out in Directive 293. In fact, the OFCCP’s arguments in the pending litigation confirm that it continues to adhere to the jurisdictional positions set forth in Directive 293.²

THE OFCCP’S PROPOSED JURISDICTIONAL EXPANSION OVER HOSPITALS WOULD BE MASSIVE AND UNPRECEDENTED, LEADING TO SIGNIFICANT JURISDICTIONAL DISPUTES

If the OFCCP’s current agenda is upheld, the expansion of its jurisdiction would be unprecedented. With regard to the TRICARE program alone, more than 3,330 hospitals and clinics provide coverage to more than 9.6 million TRICARE beneficiaries.³ If all of these providers are included within the agency’s current definition of “federal subcontractor,” the OFCCP’s jurisdiction will expand to cover almost 60 percent of the registered hospitals in the U.S. And this does not even account for the numerous hospitals and health care providers that serve the more than 8 million FEHBP beneficiaries that would be considered federal contractors under the agency’s new policy.

The OFCCP’s assertion of jurisdiction over any given hospital does not rest on notice to that hospital or even the consent of that hospital. Rather, any health care provider with a contract that the agency deems to constitute a federal contract is, by operation of law, subject to the OFCCP’s jurisdiction. The OFCCP has made clear that “we didn’t know” and “we didn’t consent,” and even “we were told explicitly we weren’t a federal subcontractor by the agency that is directly responsible for the program,” are not valid defenses to a failure to comply with the agency’s regulations and compliance obligations.⁴

The OFCCP’s proposed “case by case” approach to determining federal contractor status based on the specific type of TRICARE or FEHBP plan that covers the care provided by a particular hospital inevitably will lead to confusion and jurisdictional disputes. The OFCCP has never explained which of the more than 10 health plan options provided under TRICARE or the almost 300 options under FEHBP would give rise to federal contractor status. The agency also has

² See, e.g., *OFCCP v. Florida Hosp. of Orlando*, Case No. 11-011 (ARB July 22, 2013) (discussing OFCCP’s arguments in favor of a majority ruling from the ARB that its jurisdiction extends to TRICARE providers); *UPMC Braddock v. Harris*, 2013 WL 1290939 (D.D.C. Mar. 30, 2013) (discussing the Secretary of Labor’s arguments in favor of the OFCCP’s right to assert jurisdiction over hospitals providing care to FEHBP participants through HMO plans).

³ DEPARTMENT OF DEFENSE, EVALUATION OF THE TRICARE PROGRAM: ACCESS, COST, AND QUALITY, FISCAL YEAR 2013 REPORT TO CONGRESS 9, available at [http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20\(FY%202013\).pdf](http://www.tricare.mil/tma/congressionalinformation/downloads/TRICARE%20Program%20Effectiveness%20(FY%202013).pdf) [hereinafter DOD REPORT TO CONGRESS].

⁴ See OFCCP Jurisdiction Webinar (Dec. 3, 2009), available at http://www.dol.gov/ofccp/Presentation/Jurisdiction_SOL_Webinar.pdf.

never clearly explained why it would have no jurisdiction over a hospital providing care under Medicare Parts A and B and certain plan options under TRICARE and FEHBP, yet expansive jurisdiction over other hospitals that provide care under Medicare Parts C and D and certain other unspecified plans under TRICARE and FEHBP.

The OFCCP's current guidelines for establishing federal contractor status will lead to illogical hair splitting. For example, under the OFCCP's standards, a tonsillectomy performed at Hospital A for a child of a service member who participates in a TRICARE plan option with a managed care component would cause Hospital A to be considered a federal contractor, while the same procedure at Hospital B for a child of a service member who participates in a fee-for-service TRICARE plan would not cause Hospital B to be considered a federal contractor. Such differing treatment of hospitals providing essentially the same care is illogical and troubling, particularly given the OFCCP's utter lack of guidance regarding which TRICARE and FEHBP plans contain sufficient elements of "managed care" such that the participating hospital would now be considered a federal contractor.

Through its prior internal directives, the OFCCP avoided this ambiguity and hair splitting by refusing to differentiate federal contractor status based on the particularities of the specific FEHBP health plan option through which a beneficiary obtains care. For the past decade and more, the OFCCP took the common sense approach, which it has now abandoned, that a hospital providing care through *any* of the plans offered by FEHBP or under Medicare was not considered a federal contractor based on this fact alone.

WHAT PROMPTED THIS CHANGE BY THE OFCCP?

The OFCCP's policy change regarding the scope of its jurisdiction is hugely significant for our nation's hospitals. Despite the potential impact of the agency's current agenda, no changes in the structure of the federal health benefit programs or the law occurred that could have prompted this change.

While ongoing modifications to the TRICARE and FEHBP programs occur frequently, the basic structure of these programs, including the presence of managed care components in the offered plans, have existed for decades. The Military Health System has included managed care components since at least the 1980s.⁵ Indeed, the TRICARE program itself was implemented in 1995 to improve health care delivery to beneficiaries "primarily through managed care support contracts..."⁶ The basic "triple option benefit" of TRICARE, providing the choice between three types of plans, two of which are managed care-type plans, remains substantively the same today as when first implemented. Managed-care options also have been included within the FEHBP since its inception, with a proliferation of different types of managed care plans in the 1990s. The model of the FEHBP, in which government subsidized premiums are used to

⁵ DEP'T OF DEFENSE, MHS HISTORY, http://www.health.mil/About_MHS/History.aspx (last visited Sept. 20, 2013).

⁶ 60 Fed. Reg. 52,095, 52,095 (Oct. 5, 1995)

purchase competing private plans, has not changed for decades. Managed care plans such as PPOs and HMOs were offered in the FEHB at least as early as 1998, and continue to be offered today.⁷

Similarly, with respect to legislative changes, nothing explains the OFCCP's new agenda. Other than NDAA, which restricted the scope of federal contractors for TRICARE providers, the statutory law defining contractor status has not substantively changed for decades. The last significant change in the law in this area occurred in 1977, when the *Federal Grant and Cooperative Agreement Act of 1977*, 31 U.S.C. §§6301 *et seq.* (the Grant Act) was passed to provide agencies guidelines for how to classify the relationships between the government and federal fund recipients.

Even though no substantive changes in the federal programs or applicable law have occurred that could explain the shift in the OFCCP's position of its own jurisdiction, the agency's recent assertion of jurisdiction over hospitals participating in TRICARE, FEHBP and Medicare represents a sea change for which no precedent exists. In fact, under both the Bush Administration (2000 – 2008) and the Clinton Administration (1992 – 2000), the OFCCP consistently excluded contractor status from being based on FEHBP and Medicare participation by hospitals.

In the AHA's view, the OFCCP's new agenda is not a good faith interpretation of congressional intent nor faithful abidance by the law. Rather, it represents an aggressive land grab by OFCCP aimed at a wholesale expansion of its jurisdiction over our nation's hospitals, which is both inconsistent with the positions taken by the federal agencies administering the health benefit programs at issue and without advance notice to, or agreement by, the participating hospitals.

THERE IS NO BASIS IN THE LAW FOR THE OFCCP'S CHANGED POSITION

The OFCCP's assertion of jurisdiction over health care providers that participate in these programs has no basis in law and is inconsistent with the position taken by the very agencies responsible for administering these programs. For more than 25 years, the OPM, the agency responsible for administering FEHBP, has expressly provided through its regulations that direct health care providers are not federal subcontractors.⁸ For more than 10 years, the OFCCP has

⁷ See Omnibus Consolidated and Emergency Supplemental Appropriations Act 1999, Pub. L. No. 105-77, 111 Stat. 1465 (Oct. 21, 1998) (excluding from certain coverage requirements Personal Care's HMO); National Defense Authorization Act for Fiscal Year 2000, § 703, Pub. L. No. 106.65, 113 Stat. 512, 682 (Oct. 5, 1999) (directing the Department of Defense Secretary to review coverage offered by at least 10 of the most subscribed private health plans under the FEHBP, "at least 5 of which shall be managed care organizations"). OPM, HEALTHCARE, <http://www.opm.gov/healthcare-insurance/healthcare/> (last visited Sept. 20, 2013).

⁸ See 48 C.F.R. § 1602.170-15 ("Subcontractor means any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor or another subcontractor, *except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.*" (emphasis added).

acquiesced to that interpretation, even issuing a policy directive reiterating its validity.⁹ As a result, for decades, numerous health care providers have entered into contracts to provide care for federal employees under the well-founded assumption that they were *not* federal contractors.

Similarly, interagency conflict exists with the DOD due to the OFCCP's assertion of jurisdiction over TRICARE participants. Like the OPM, the DOD has explicitly exempted TRICARE providers from federal subcontractor status. Through its own regulations, the DOD has designated TRICARE reimbursements as a form of federal financial assistance, which does not constitute a federal contract subject to OFCCP regulations.¹⁰

The OFCCP's new agenda conflicts directly with the longstanding regulations of the OPM and the DOD. Each executive agency should not be free to construct its own definitions of who is and is not a "federal contractor." Instead, uniform statutory criteria should be applied to avoid, as here, conflicting administrative interpretations of federal contractor status. In fact, Congress in the Grant Act expressly laid out those statutory criteria.¹¹

Under the Grant Act, TRICARE, FEHBP and Medicare reimbursements do not qualify as federal "procurement contracts" but instead are forms of federal financial assistance. Under the Grant Act, a procurement contract exists where the principal purpose of the relationship is to acquire "property or services for the direct benefit or use of the United States Government." Clearly, health benefit plan reimbursements are not for the direct benefit or use of the government. Instead, common sense and the language of the relevant legislation establishes that, literally, the "beneficiaries" of TRICARE are the service members, veterans and eligible dependents who receive medical services – that is, the benefits of the program. Likewise, the "beneficiaries" of FEHBP are federal employees, retirees and their families. These arrangements are analogous to Medicare, where the government makes payments to hospitals for the benefit of "that portion of the public entitled to Medicaid or Medicare coverage." The OFCCP's attempt to differentiate the FEHBP and TRICARE programs from those understood to constitute federal financial assistance, on the basis of "managed care" versus "fee-for-service" arrangements, is not supported by the Grant Act or any other legislative act.

In fact, the OFCCP appears to be largely ignoring congressional directives for establishing federal contractor status. While the agency certainly has the authority to apply its own

⁹ See OFCCP Policy Directive, 262 (Mar. 17, 2003) (clarifying that "health care providers having a relationship with FEHBP participants are not covered under the OFCCP's programs based solely on that relationship").

¹⁰ See 32 C.F.R. § 56.7(b)(21) (pursuant to Section 504, designating payments under Title 10, Chapter 55 of the United States Code as federal financial assistance); TRICARE OPERATIONS MANUAL AT CHANGE 108, ch. 1, sec. 5, para. 5.1 (all hospitals "determined to be authorized providers under TRICARE are subject to the provisions of Title VI") (updated Sept. 19, 2013).

¹¹ See 31 U.S.C. §§ 6301–6305. The OFCCP itself has previously relied on the Grant Act to differentiate between recipients of federal financial assistance and the two categories of payees, when it applied Grant Act criteria to determine that a Fire Department was a recipient of federal financial assistance, not a contractor subject to its jurisdiction. See *Partridge v. Reich*, 141 F.3d 920 (9th Cir. 1998).

regulations, it must do so within a statutory grant of authority. Congress has repeatedly exercised its right to determine who is and is not a federal contractor,¹² and Section 715 of the NDAA is only one of the more recent examples of Congress doing so. Unfortunately, rather than accept this legislative direction that hospitals participating in TRICARE should not be considered federal contractors, the OFCCP expended considerable litigation energies seeking to explain to the ARB why a statutory directive did not override the agency's own regulation. The result has been years more of litigation against Florida Hospital, with a case that is now back before an ALJ nearly five years after it was originally filed. The length, scope and expense of the lawsuits against hospitals providing care to federal employees, service members and their families is an incredible waste of resources, both for the government and for the hospitals.

THIS IS NOT AN ISSUE OF COMPLIANCE WITH NONDISCRIMINATION LAWS BUT RATHER, WITH THE SIGNIFICANT BURDEN IMPOSED BY THE REGULATORY SCHEME

Numerous legal obligations and regulatory burdens flow from a finding that an entity is a federal contractor. The Department of Labor, for instance, enforces seven laws that apply to federal contractors, including Executive Order 11246, Section 503 of the *Rehabilitation Act* (Section 503), the *Vietnam Era Veterans' Readjustment Assistance Act of 1974* (VEVRAA), the *Davis-Bacon and Related Act*, the *McNamara O'Hara Service Contract Act*, the *Walsh-Healey Public Contracts Act*, and the *Contract Work Hours and Safety Standards Act* (Title I), many of which have extensive data collection and affirmative action requirements. These substantial, and in many instances duplicative regulations, are costly and burdensome for hospitals to implement, diverting desperately needed resources from patient care.

Current Regulations Affecting Hospitals. Already, hospitals are subject to myriad laws and regulations. Dozens of federal entities have authority to regulate hospitals, subject to little or no coordination, and at least 10 of these agencies have jurisdiction over hospitals with respect to workforce issues alone, including but not limited to the Equal Employment Opportunity Commission, the National Labor Relations Board, the Occupational Safety and Health Administration, and the Office of Civil Rights at the U.S. Department of Health and Human Services. Hospitals are additionally subject to extensive regulation at the state and local level, including by licensure agencies, state Medicaid programs, boards of medicine, attorneys general, and state labor and employment agencies.

In part as a result of such extensive regulation, hospitals spend more than 20 percent of their revenues on administrative costs. The costs facing hospitals are only expected to increase with the implementation of significant, multi-stage compliance obligations under the *Patient Protection and Affordable Care Act* and other recent legislative reforms. The obligation to meet evolving federal requirements for implementation of electronic health records (EHR) is further straining the budgets of cash-strapped hospitals. For example, beginning next year, Medicare-

¹² See Grant Act, 31 U.S.C. §§6301; Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. § 4212,

participating hospitals that have not implemented an EHR system meeting certain objectives will be penalized with reduced reimbursements on all Medicare claims. Eventually, the widespread adoption of EHRs has the potential to save time and improve treatment outcomes. Implementing an EHR system, however, can cost a hospital between \$20 million and \$200 million, depending on the organization's size. Even hospitals that already have EHRs in place may face costs as high as \$10 million to upgrade their systems in accordance with federal requirements.

Importantly, each dollar spent on administrative costs is money that cannot be used to fulfill a hospital's primary mission: that is, providing quality patient care. In an environment where costs are high and capital is scarce, hospitals should not be required to divert additional funds toward complying with the OFCCP's extensive and costly regulatory scheme. This is particularly true where, as here, the agency has not demonstrated a particular need to impose upon hospitals affirmative action obligations that go significantly further than the antidiscrimination laws that already apply to all employers, including Title VII of the *Civil Rights Act of 1964*, 42 U.S.C. § 2000e *et seq.*, the *Americans with Disabilities Act*, 42 U.S.C. § 12111 *et seq.*, the *Uniformed Services Employment and Reemployment Rights Act*, 38 U.S.C. § 4301 *et seq.*, and numerous state and local laws and regulations.

OFCCP Regulatory Burdens. The OFCCP estimates that each designated federal contractor will spend an average of 103.18 hours per year complying with the agency's affirmative action requirements. The agency significantly underestimates its burden obligations imposed on government contractors.

Hospitals already subject to the OFCCP's jurisdiction as federal contractors report that they spend significantly more time complying with the agency's demands than estimated. For example, the OFCCP estimates that a contractor will spend an average of 33.7 hours each year conducting an update of its required Affirmative Action Plan (AAP). By contrast, St. Jude Children's Research Hospital offered congressional testimony that, as a federal contractor, the hospital spends more than 500 hours (or \$58,000) per year updating and maintaining the goals of its AAP.¹³ This time includes compiling the raw data for the AAP and submitting it to an outside consultant to create a plan. The hospital then spends additional hours reviewing the plan and taking steps to implement it.

These meticulous steps are not only required by the OFCCP but are also increasingly important as the agency becomes more aggressive in conducting compliance reviews. Indeed, St. Jude estimates that the number of hours that it spends updating its AAP rises to as many as 1,000 hours during an audit year—time that may be spread over a period as long as eight months. Contractors can be audited every two years. This process can be so burdensome that employers feel that they are “not focused on providing a fair and diverse workplace, but instead [on] surviving [their] next audit.”

¹³ *Reviewing the Impact of the OFCCP Program's Regulatory & Enforcement Actions: Hearing Before the Subcomm. on Health, Emp't, Labor & Pensions. Comm. on Educ. & the Workforce, 112th Cong. 2–3 (2012)* (prepared Testimony of Dana C. Bottenfield, St. Jude Children's Research Hospital), available at http://edworkforce.house.gov/uploadedfiles/04.18.12_bottenfield.pdf.

Costs of compliance with OFCCP regulations will be further increased by the implementation of recently issued regulations that impose new documentation requirements on federal contractors and require them to set hiring benchmarks and utilization goals for, among others, individuals with disabilities. Specifically, federal contractors must now, on an annual basis, document: (1) the number of applicants who self-identify as individuals with disabilities, or who are otherwise known to be individuals with disabilities; (2) the total number of job openings and total number of jobs filled; (3) the total number of applicants for all jobs; (4) the number of applicants with disabilities hired; and (5) the total number of applicants hired. These computations and comparisons must be maintained for a period of three years, and made available to the OFCCP at its request. Contractors are subject to enforcement action if they fail to set these goals, and if contractors fail to meet them, they will be required to take specific and detailed steps to develop action-oriented programs designed to correct any identified “problem areas.” The OFCCP has estimated that implementing these new regulations alone could cost the economy more than \$1 billion.¹⁴

In addition to monitoring the implementation of affirmative action plans, OFCCP jurisdiction entails other significant tasks and associated costs. For example, federal contractors must regularly monitor the availability of women and minorities in their respective recruiting areas, implement “job outreach initiatives,” establish applicant flow procedures, install costly computer programs to respond to OFCCP information requests, and, most recently, be prepared to respond to extensive agency audits and associated litigation threats regarding the appropriateness of their compensation system and procedures. Indeed, recent OFCCP initiatives in the latter area have resulted in the imposition of new compensation comparator requirements in undefined and ever-changing job groupings.¹⁵

HOSPITALS ARE BEING FACED WITH INCREASINGLY DIFFICULT CHOICES REGARDING WHETHER TO PROVIDE SERVICES TO MILITARY AND FEDERAL EMPLOYEES

With the imperative for health care providers to do more with less, hospitals will be forced to make difficult choices related to patient care if the OFCCP’s agenda is allowed to continue. On the one hand, hospitals may choose to continue to provide care for service members and other federal employees, expending the significant additional resources necessary to comply with the OFCCP’s complex regulatory scheme. Hospitals choosing this option will find their ability to offer services to patients, including service members and their families reduced, as they are

¹⁴ See OFCCP Final Rule to Improve Job Opportunities for Protected Veterans, *Regulatory Procedures and Burden Analysis* (estimating first-year costs in a range of \$177,296,772 to \$483,560,138, and recurring costs in subsequent years of \$120,386,058 to \$347,617,359) http://www.dol.gov/ofccp/regs/compliance/vevraa/vevraa_regulatory_procedures_qa_508c.pdf; OFCCP Final Rule to Improve Job Opportunities for Individuals with Disabilities, *Regulatory Procedures and Burden Analysis* (estimating first-year costs in a range of \$349,510,926 to \$659,877,833, and recurring costs in subsequent years of \$162,371,816 to \$395,258,387), *available at* http://www.dol.gov/ofccp/regs/compliance/section503/503_regulation_procedures_qa_508c.pdf.

¹⁵ See OFCCP Policy Directive, 307 (Feb. 28, 2013), *available at* <http://www.dol.gov/ofccp/regs/compliance/directives/dir307.htm>.

forced to divert their money and labor away from patient care to comply with paperwork burdens and regulatory costs.

On the other hand, certain hospitals may decide to opt out of federal assistance programs, such as TRICARE or FEHBP, limiting the health care options available to service members, federal employees and their families. The DOD already has recognized and reported a trend that fewer health care providers are accepting new TRICARE participants.¹⁶

As a third option, hospitals may choose to continue to offer services to service members and federal employees, but object to the OFCCP's assertion of jurisdiction. Hospitals deciding to challenge the agency's assertion of jurisdiction, however, run the substantial risk of being caught up in seemingly endless and costly litigation battles with the OFCCP, as the *Florida Hospital* and *UPMC Braddock* cases illustrate.

CONCLUSION

In the end, the delivery of patient care, whether provided as part of a fee for service or managed care contract, should not be deemed to be a federal contract. Rather, hospital participation in federally funded health care programs, including TRICARE, FEHBP and Medicare, should remain designated as federal financial assistance excluded by Congress from OFCCP jurisdiction.

Given that the OFCCP does not appear to be prepared to revert to the simple and understandable jurisdictional standards that the agency had in place for many years, legislation should be adopted that would clarify these jurisdictional standards. Legislation should be enacted providing that the OFCCP may not treat health care providers as federal contractors based on their delivery of health care services provided to individuals covered under TRICARE, FEHBP, or other federally funded health care benefit plans. The OFCCP's recent actions have indicated that such direct and unequivocal direction from Congress is necessary to stop its jurisdictional overreach. Anything less direct may risk falling victim to the OFCCP's interpretive gymnastics, similar to the OFCCP's response to Section 715 of the NDAA.

We look forward to working with this subcommittee to address the real concerns our nation's hospitals face due to the expansionist jurisdictional agenda of the OFCCP.

¹⁶ Dep't of Defense, GAO Report, 13-364, *TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries* (Apr. 2013), available at <http://www.gao.gov/assets/660/653487.pdf>.

APPENDIX A DESCRIPTIONS OF TRICARE, FEHBP, AND MEDICARE

TRICARE. TRICARE is a health care program that is part of the Military Health System, which provides health services support to the nation's military.¹⁷ TRICARE covers care provided directly in more than 400 military treatment facilities, and care "purchased" through civilian providers and institutions.¹⁸ The first version of TRICARE was enacted in 1956 and authorized the DOD to contract with civilian healthcare plans to provide healthcare services to active-duty and retiree members of the military and their dependents.¹⁹ In 1966, these benefits were extended to retired military personnel, their families, and certain surviving family members.²⁰ This early version was called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).²¹ In response to escalating costs and general beneficiary dissatisfaction with CHAMPUS, the DOD initiated a program in the 1980s called the CHAMPUS Reform Initiative (CRI) to provide more options to beneficiaries in their military healthcare choices.²² The CRI was one of the first programs to offer managed care options as part of the CHAMPUS program.²³ After the CRI proved successful, it was extended nationwide and renamed as TRICARE in the 1990s.²⁴

Today, TRICARE is managed by the *TRICARE Management Activity* (TMA).²⁵ The TMA is organized into four geographic regions, and has partnered with a regional contractor in each region to maintain a network of health service providers to support beneficiaries.²⁶ A network provider is a health care provider that contracts with a TRICARE regional contractor, and agrees to submit claims on behalf of beneficiaries and to accept the TRICARE allowable charge for health services provided to beneficiaries.²⁷ Providers submit claims to the regional contractor,

¹⁷ DOD REPORT TO CONGRESS, *supra* note 3, at 4.

¹⁸ DOD REPORT TO CONGRESS, *supra* note 3, at 1.

¹⁹ Dependents' Medical Care Act, Pub. L. No. 84-569, 70 Stat. 250 (1956) (current version at 10 U.S.C. § 1071 (2012)).

²⁰ Military Medical Benefits Amendments of 1966, Pub. L. No. 89-614, 80 Stat. 862 (1966) (current version at 10 U.S.C. § 1071 (2012)).

²¹ 32 C.F.R. part 199 (1986).

²² DEP'T OF DEFENSE, MHS HISTORY, http://www.health.mil/About_MHS/History.aspx (last visited Sept. 20, 2013).

²³ *Id.*

²⁴ 32 C.F.R. § 199.17 (2012).

²⁵ DEP'T OF DEFENSE, TRICARE: ABOUT US, <http://www.tricare.mil/Welcome/AboutUs.aspx> (last updated Aug. 2, 2013).

²⁶ *Id.* The regional contractors are as follows: North Region, Health Net Federal Services, LLC; South Region, Humana Military, a division of Humana Government Business; West Region, United Healthcare Military & Veterans; and Overseas Region, International SOS.

²⁷ TRICARE OPERATIONS MANUAL AT CHANGE 108, ch. 5, sec. 1, para. 2.3 (updated Sept. 19, 2013).

and the regional contractor makes government-funded reimbursement payments directly to the provider.²⁸

Health care providers that receive “federal financial assistance” must operate without discrimination based on race, color, national origin, or disability under statutes including Title VI of the *Civil Rights Act of 1964* (Title VI) and Section 504 of the *Rehabilitation Act of 1973* (Section 504).²⁹ The DOD has designated TRICARE reimbursements as a form of federal financial assistance.³⁰ More generally, the DOD has stated that any program or activity that provides “services, financial aid, or other benefits to individuals” is a form of federal financial assistance.³¹

TRICARE covers active duty service members and retirees of the seven uniformed services, their family members and survivors, and National Guard and Reserve members and their families.³² For the 2013 fiscal year, TRICARE is projected to cover 9.63 million total beneficiaries, and to have 477,891 network individual providers in the purchased care system.³³ The total cost of the TRICARE program is estimated to be approximately \$50 billion for 2013, including \$16 billion for private sector purchased care alone, or approximately 7.1 percent of total DOD expenditures.³⁴

TRICARE offers more than 10 health plans to its beneficiaries, but each of these plans is based on some combination of benefits found in three primary options: TRICARE Standard, TRICARE Extra, and TRICARE Prime.³⁵ TRICARE Standard is the successor to CHAMPUS and allows beneficiaries to see whichever provider they choose, but requires them to pay an annual deductible and cost share (co-insurance) for service provided.³⁶

TRICARE Extra is an option that operates similar to a Preferred Provider Organization (PPO).³⁷ Beneficiaries who obtain care from network providers pay the same deductible as under

²⁸ TRICARE REIMBURSEMENT MANUAL AT CHANGE 89, ch. 1, sec. 1, paras. 2.1 & 2.2 (updated Sept. 19, 2013).

²⁹ Civil Rights Act of 1964, Title VI, 42 U.S.C. § 2000d (prohibiting program or activity discrimination based on race, color, or national origin); Rehabilitation Act of 1973 § 504, 29 U.S.C. § 794 (same for disability).

³⁰ See *supra* note 10 and accompanying text.

³¹ 32 C.F.R. § 195.2(e) (pursuant to Title VI of the Civil Rights Act of 1964, defining programs or activities deemed to constitute federal financial assistance).

³² DEP’T OF DEFENSE, TRICARE: ELIGIBILITY, <http://www.tricare.mil/Welcome/Eligibility.aspx> (last updated Aug. 2, 2013).

³³ DOD REPORT TO CONGRESS, *supra* note 3, at 9.

³⁴ *Id.* at 17–18.

³⁵ *Id.* at 4.

³⁶ *Id.*

³⁷ *Id.*

TRICARE standard, but their cost share is reduced by 5 percent and the network provider files the claim on the beneficiary's behalf.³⁸

TRICARE Prime is another managed care option, but operates like a Health Maintenance Organization (HMO).³⁹ Enrollees choose or are assigned a primary care manager who helps manage the patient's care and arranges for necessary specialty provider services.⁴⁰ Enrollees can obtain care from providers other than through their primary care manager, but must pay a significantly higher deductible and cost share than under TRICARE Standard to do so.⁴¹

The Federal Employees Health Benefits Program (FEHBP). The FEHBP was created in 1960 to provide healthcare access to federal civilian employees and is administered by the OPM.⁴² The OPM seeks to provide a wide range of health plan options to federal employees.⁴³ In so doing, the OPM contracts with private plan carriers to provide access to healthcare.⁴⁴ Carrier, as defined by the OPM, refers to all entities with which the OPM contracts, including HMOs and more traditional health insurers.⁴⁵ Each year the OPM and the plan carrier negotiate the rates paid to the carrier.⁴⁶ This rate is paid through amounts withheld from beneficiaries' paychecks, plus a government contribution of up to 75 percent of the total premium.⁴⁷ Each plan carrier is responsible for reviewing and paying claims from beneficiaries and providers filed under the plan.⁴⁸ Managed care plan carriers such as PPOs and HMOs then contract with health providers in an effort to reduce costs and improve quality of care.⁴⁹

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² Federal Employees Health Benefits Act of 1959, Pub. L. No. 86-382, 73 Stat. 708 (1959); 5 C.F.R. part 890. See OPM, HEALTHCARE, <http://www.opm.gov/healthcare-insurance/healthcare/> (last visited Sept. 20, 2013) (describing FEHBP); 52 Fed. Reg. 16,032, 16,033 (May 1, 1987) ("OPM . . . contracts as an employer for health benefits on behalf of Federal employees.").

⁴³ 76 Fed. Reg. 38,282, 38,284 (June 29, 2011).

⁴⁴ OPM CARRIER HANDBOOK 3, available at <http://www.opm.gov/healthcare-insurance/healthcare/carriers/reference/carrier-handbook.pdf> (last revised Mar. 2003).

⁴⁵ 48 C.F.R. § 1602.170-1.

⁴⁶ OPM Carrier Handbook, *supra* note 44, at 35.

⁴⁷ *Id.* at 35–46.

⁴⁸ 5 C.F.R. § 890.105.

⁴⁹ See OPM, BENEFITS ADMINISTRATION LETTER NO. 96-402 (Sept. 10, 1996), available at <http://www.opm.gov/retirement-services/publications-forms/benefits-administration-letters/1996/96-402.pdf>.

The OPM's benefit contracts are considered federal acquisitions and are thus subject to the Federal Acquisition Regulation (FAR).⁵⁰ The OPM has the authority to implement FAR as it relates to the FEHBP to accommodate "the practical realities associated with the unique nature of health care procurements."⁵¹ Pursuant to this authority, in 1987 the OPM promulgated the Federal Employee Health Benefits Acquisition Regulation (FEHBAR).⁵² As part of this regulation, and to address concerns from a number of carriers, the OPM defined "subcontractor" to exclude "providers of direct medical services or supplies pursuant to the Carrier's health benefits plan."⁵³ According to the OPM, the subcontractor definition was added to clarify application of the regulation and because the OPM did not intend to review the records and approve each entity with which its plans contract.⁵⁴

The FEHBP is "the largest employer-sponsored group health insurance program in the world, covering more than 8 million federal employees, retirees, former employees, family members and former spouses."⁵⁵ Almost 300 health plans are offered through the FEHBP, each with a separate provider network.⁵⁶ The total annual cost of the FEHBP is \$43 billion.⁵⁷

The plans provided under the FEHBP vary, including fee-for-service plans, PPOs and HMOs.⁵⁸ Under the fee-for-service plans, the plan reimburses the beneficiary or the health care provider for the cost of care, but the beneficiary is not limited in the providers he or she may choose to see.⁵⁹ All of these plans require pre-certification to admit patients to a hospital and preauthorization of certain procedures.⁶⁰ Some plans include a PPO, which allows the beneficiary to lower his or her out-of-pocket expenses by going to an in-network provider.⁶¹

⁵⁰ See generally 48 C.F.R. ch. 16.

⁵¹ 48 C.F.R. § 1601.301; see also *id.* §§ 1601.101(b), 1601.103; 52 Fed. Reg. 16,032, 16,037 (May 1, 1987).

⁵² See 48 C.F.R. ch. 16.

⁵³ 48 C.F.R. § 1602.170-15. See 52 Fed Reg. at 16,032.

⁵⁴ 52 Fed. Reg. at 16,033, 16,035.

⁵⁵ OPM, FEHB PROGRAM HANDBOOK, "Introduction", available at <http://www.opm.gov/healthcare-insurance/healthcare/reference-materials/#url=FEHB-Handbook> (last visited Sept. 20, 2013) [hereinafter FEHB HANDBOOK].

⁵⁶ OPM, PATIENTS' BILL OF RIGHTS, <http://www.opm.gov/healthcare-insurance/healthcare/reference-materials/#url=Bill-of-Rights> (last visited Sept. 20, 2013); OPM, GUIDE TO FEDERAL BENEFITS 10 (2013), available at <http://www.opm.gov/healthcare-insurance/healthcare/plan-information/guide/2013-guides/70-1.pdf>.

⁵⁷ OPM, FEHB FACT SHEET (2012), available at <http://www.opm.gov/healthcare-insurance/open-season/resources/factsheet.pdf>.

⁵⁸ FEHBP HANDBOOK, *supra* note 55, "Health Plans."

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.*

Under the HMO plans, beneficiaries must choose a primary care physician who coordinates care and pre-certification of admission to hospitals and preauthorization of procedures.⁶² Health care is provided on a prepaid basis through designated providers within the HMO's geographic service area.⁶³ Some fee-for-service and HMO plans also provide a point-of-service option, which allows beneficiaries the option of going to a provider outside the plan's network to obtain care, in exchange for an increased deductible and cost share payment.⁶⁴

Medicare. The Medicare program was first enacted in 1935 and provides health insurance benefits for individuals age 65 or older and certain disabled individuals.⁶⁵ The administration of the Medicare Program is delegated to the Administrator of the CMS.⁶⁶ The CMS establishes, maintains, and administers agreements with state agencies, service providers, and other intermediaries in administering the program.⁶⁷ These intermediaries enroll providers into the Medicare program, process Medicare claims, and contract with and make payments to health service providers.⁶⁸ Participating health service providers generally agree to submit claims on behalf of beneficiaries, to accept the Medicare-approved amount as full payment for covered services, and to bill beneficiaries only for their deductible and coinsurance amount.⁶⁹

In 2012, Medicare covered about 50.7 million people, about 27 percent of whom were enrolled in Part C private health plans that “contract with Medicare to provide Part A and Part B health services.”⁷⁰ As of February, 2013 there were 447 Medicare Advantage plans, including 298 HMOs, 135 total PPOs, and 14 private fee-for-service plans.⁷¹ Total Medicare expenditures in 2012 were \$574.2 billion.⁷²

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ Social Security Act of 1935, Pub. L. No. 74-271, 49 Stat. 620 (Aug. 14, 1935); 42 U.S.C. § 1395c.

⁶⁶ CMS, MEDICARE GENERAL INFORMATION, ELIGIBILITY AND ENTITLEMENT MANUAL (PUB. 100-01), ch. 1, para. 20 (rev. Oct. 26, 2012), available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c01.pdf> [hereinafter CMS PUB. 100-01].

⁶⁷ *Id.* ch. 1, para. 30.1; CMS, MEDICARE MANAGED CARE MANUAL (PUB. 100-16), ch. 11 (rev. Jan. 7, 2011), available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c01.pdf>.

⁶⁸ CMS PUB. 100-01, *supra* note 66, ch. 1, paras. 40, 50.

⁶⁹ MEDICARE.GOV, KEEPING COSTS DOWN WITH ASSIGNMENT, <http://www.medicare.gov/your-medicare-costs/part-a-costs/assignment/costs-and-assignment.html> (last visited Sept. 20, 2013).

⁷⁰ 2013 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICARE INSURANCE TRUST FUNDS 6, available at <http://downloads.cms.gov/files/TR2013.pdf> [hereinafter 2013 MEDICARE REPORT].

⁷¹ MEDICARE PAYMENT ADVISORY COMMISSION, A DATA BOOK: HEALTH CARE SPENDING AND THE MEDICARE PROGRAM (June 2013), pg. 156, available at <http://www.medpac.gov/documents/Jun13DataBookEntireReport.pdf>.

⁷² 2013 MEDICARE REPORT, *supra* note 70, at 6.

Medicare Part A provides protection against the costs of hospital, related post-hospital, home health service, and hospice care.⁷³ Part B is a voluntary supplemental insurance program, with government-subsidized premiums paid by enrollees, and helps pay for medically necessary and preventive services.⁷⁴ Part C, also known as Medicare Advantage, was created in 1997 to provide enrollees with more health plan choices.⁷⁵ A Medicare Advantage plan may be a traditional fee-for-service plan or a managed care plan, including but not limited to HMO and PPO plans.⁷⁶ Part D was added in 2006 and is a voluntary prescription drug benefit program, also with government-subsidized premiums paid by enrollees, for individuals entitled to benefits under Part A, or enrolled under Part B or Part C, or as a standalone benefit plan.⁷⁷

⁷³ 42 U.S.C. §§ 1395c – 1395i-5.

⁷⁴ 42 U.S.C. §§ 1395j – 1395w-5.

⁷⁵ Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (Aug. 5, 1997). The Program under Part C was originally called Medicare+Choice, but was later renamed Medicare Advantage with the amendments from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

⁷⁶ 42 U.S.C. § 1395w-21(a)(2).

⁷⁷ 42 U.S.C. §§ 1395w-101 – 1395w-104. Part D was added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003).