Billing Code 4510-45

DEPARTMENT OF LABOR

Office of Federal Contract Compliance Programs

41 CFR Parts 60-1, 60-300, and 60-741

RIN 1250-AA08

Affirmative Action and Nondiscrimination Obligations of Federal Contractors and Subcontractors: TRICARE and Certain Other Health Care Providers

AGENCY: Office of Federal Contract Compliance Programs, Labor.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Office of Federal Contract Compliance Programs (OFCCP) is proposing to amend its regulations pertaining to its authority over TRICARE health care providers. The proposed rule is intended to increase access to care for uniformed service members and veterans and to provide certainty for health care providers who serve beneficiaries of TRICARE. It is also believed that this proposed rule may result in cost savings to the health care system. In a reconsideration of its legal position, the proposed rule would provide that OFCCP lacks authority over Federal health care providers who participate in TRICARE. In the alternative, the proposed rule would establish a national interest exemption from Executive Order 11246, Section 503 of the Rehabilitation Act of 1973, and the Vietnam Era Veterans' Readjustment Assistance Act of 1974 for health care providers with agreements to furnish medical services and supplies to individuals participating in TRICARE (in the alternative to a reconsideration of OFCCP's authority over such providers). OFCCP would nevertheless have authority over health care

providers participating in TRICARE if they hold a separate covered Federal contract or subcontract. Likewise, health care providers would remain subject to all other Federal, state, and local laws prohibiting discrimination and providing for equal employment opportunity. OFCCP has determined that special circumstances in the national interest justify proposing the exemption as it would improve uniformed service members' and veterans' access to medical care, more efficiently allocate OFCCP's limited resources for enforcement activities, and provide greater uniformity, certainty, and notice for health care providers participating in TRICARE.

DATES: To be assured of consideration, comments must be received on or before [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

ADDRESSES: Comments may be submitted, identified by Regulatory Information Number (RIN) 1250-AA08, by one of the following methods:

- Electronically: The Federal eRulemaking portal at http://www.regulations.gov. Follow the instructions found on that website for submitting comments.
- Mail, Hand Delivery, or Courier: Addressed to Harvey D. Fort, Deputy Director, Division of Policy and Program Development, Office of Federal Contract Compliance Programs, 200 Constitution Avenue NW, Room C-3325, Washington, DC 20210.

Instructions: Please submit one copy of your comments by only one method. Due to security concerns, postal delivery in Washington, DC, may be delayed. For faster submission, we encourage commenters to transmit their comment electronically via the http://www.regulations.gov website. All submissions must include OFCCP's name for identification.

Comments, including any personal information provided, become a matter of public record and will be posted on http://www.regulations.gov. Do not include any personally identifiable or confidential business information that you do not want publicly disclosed.

The Department will also make all the comments it receives available for public inspection during normal business hours at OFCCP at the above address. If you need assistance to review the comments, the Department will provide you with appropriate aids such as readers or print magnifiers. To schedule an appointment to review the comments and/or to obtain this notice of proposed rulemaking in an alternate format, please contact OFCCP at the telephone numbers or address listed below.

FOR FURTHER INFORMATION CONTACT: Harvey D. Fort, Deputy Director, Division of Policy and Program Development, Office of Federal Contract Compliance Programs, 200 Constitution Avenue NW, Room C-3325, Washington, DC 20210. Telephone: (202) 693-0104 (voice) or (202) 693-1337 (TTY). Copies of this document may be obtained in alternative formats (large print, braille, audio recording) by calling the numbers listed above.

SUPPLEMENTARY INFORMATION:

I. Legal Authority

Federal law requires Government contractors[1] to refrain from discriminating on the basis of race, sex, and other grounds. Additionally, Government contractors must take affirmative action to ensure equal employment opportunity.[2] OFCCP, situated in the Department of Labor

[1] As used in this preamble, the term *contractor* includes, unless otherwise indicated, Federal Government contractors and subcontractors. When used in reference to Executive Order 11246, it also includes federally assisted construction contractors and subcontractors.

[2] *See* E.O. 11246, section 202(1); 29 U.S.C. 793(a); 38 U.S.C. 4212(a)(1); 41 CFR 60-1.40, 60-2.1 through 60-2.17; *id.* §§ 60-300.40 through 60-300.45; id. §§ 60-741.40 through 60-741.47.

(Department), enforces these contracting requirements. OFCCP requires Government contractors to furnish information about their affirmative action programs (AAPs) and related employment records and data so OFCCP can ascertain compliance with the laws it enforces.[3]

OFCCP enforces three nondiscrimination and equal employment opportunity laws that apply to covered Federal contractors: Executive Order (E.O.) 11246, as amended,[4] Section 503 of the Rehabilitation Act of 1973, as amended (Section 503),[5] and the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended (VEVRAA).[6] In 1965, President Lyndon B. Johnson signed E.O. 11246, which (as amended) prohibits discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity, and national origin, as well as discrimination against applicants or employees because they inquire about, discuss, or disclose their compensation or that of others, subject to certain limitations. Six years after President Johnson signed E.O. 11246, Congress added disability as a protected class through Section 503 of the Rehabilitation Act.[7] And in 1974, Congress also covered veterans through the Vietnam Era Veterans' Readjustment Assistance Act, which prohibits discrimination on the basis of veteran status. All three laws also require Federal contractors to take affirmative steps to ensure equal employment opportunity in their employment practices.

OFCCP has rulemaking authority under all three laws.[8] Additionally, OFCCP has authority to exempt a contract from E.O. 11246, VEVRAA, and Section 503 if the Director of

[3] E.O. 11246, section 202(6); 41 CFR 60-1.4(a)(6), 60-1.43; *id.* §§ 60-300.40(d), 60-300.81; *id.* §§ 60-741.40(d), 60-741.81; *see also Chrysler Corp. v. Brown*, 441 U.S. 281, 286 (1979).
[4] E.O. 11246, 30 FR 12319 (Sept. 24, 1965).
[5] 29 U.S.C. 793.
[6] 38 U.S.C. 4212.
[7] 29 U.S.C. 793(a).
[8] E.O. 11246, section 201; 38 U.S.C. 4212(a)(2); 29 U.S.C. 793(a); E.O. 11758, section 2; Sec'y Order 7-2009, 74 FR 58834 (Nov. 13, 2009).

OFCCP determines that special circumstances in the national interest require doing so.[9] OFCCP's regulations allow the Director to grant national interest exemptions to groups or categories of contracts where he finds it impracticable to act upon each request for an exemption individually or where the exemption will substantially contribute to convenience in the administration of the laws.[10] These categorical exemptions follow the principle that an agency, whenever permitted, need not "continually . . . relitigate issues that may be established fairly and efficiently in a single rulemaking proceeding" that "could invite favoritism, disunity, and inconsistency."[11] These long-standing regulatory provisions allowing for categorical national interest exemptions are owed deference.[12] The provision permitting categorical exemption from E.O. 11246 was part of the original notice-and-comment regulation that implemented the Order, and has been in place for over fifty years.[13] The provisions permitting categorical exemptions from VEVRAA and Section 503 are patterned similarly and have been in place for decades as well.[14] Additionally, E.O. 11246's predecessor, E.O. 10925, contained a similarly worded exemption provision which was implemented through a regulation providing a substantially similar categorical exemption.[15]. OFCCP has granted categorical exemptions in the national

[9] E.O. 11246, section 204; E.O. 11758 sections 2–3, as amended; 29 U.S.C. 793(c)(1); 41 CFR 60-300.4(b)(1). E.O. 11246 refers to an "exemption" while VEVRAA and Section 503 use the term "waiver." This proposed rule uses the term "exemption" to refer to both.
[10] 41 CFR 60-1.5(b)(1), 60-300.4(b)(1), 60-741.4(b)(1).
[11] *Heckler v. Campbell*, 461 U.S. 458, 467 (1983); *see also Lopez v. Davis*, 531 U.S. 230, 243–44 (2001); *Am. Hosp. Ass'n v. NLRB*, 499 U.S. 606, 612 (1991) ("[E]ven if a statutory scheme requires individualized determinations, the decision maker has the authority to rely on rulemaking to resolve certain issues of general applicability unless Congress clearly expresses an intent to withhold that authority." (discussing *Campbell*, 461 U.S. at 467; *FPC v. Texaco, Inc.*, 377 U.S. 33, 41–44 (1964); *United States v. Storer Broad. Co.*, 351 U.S. 192, 205 (1956)).
[12] *Cf., e.g., United States v. Cleveland Indians Baseball Co.*, 532 U.S. 200, 220 (2001) ("We do not resist according such deference in reviewing an agency's steady interpretation of its own 61-year-old regulation implementing a 62-year-old statute. Treasury regulations and interpretations long continued without substantial change, applying to unamended or substantially reenacted statutes, are deemed to have received congressional approval and have the effect of law.") (quoting *Cottage Sav. Ass'n v. Commissioner*, 499 U.S. 554, 561 (1991))
[13] *See* 33 FR 7804, 7807 (May 28, 1968); *see also* 33 FR 3000, 3003 (Feb. 15, 1968) (notice of proposed rulemaking).
[14] *See* 39 FR 20566, 20568 (June 11, 1974); 41 FR 26386, 26387 (June 25, 1976).
[15] *See* E.O. 10925, section 303; 41 CFR 60-1.3(b)(1) (1962).

interest in the past.[16] OFCCP also may exercise prosecutorial discretion in determining its enforcement priorities.[17] OFCCP proposes this rule pursuant to all these authorities.

II. Introduction

OFCCP is proposing a rule that would clarify the scope of OFCCP's authority[18] and, to dispel any legal uncertainty, also further the national interest by explicitly exempting certain health care providers from OFCCP's enforcement activities. Specifically, in the E.O. 11246, VEVRAA, and Section 503 regulations, OFCCP would revise its definition of "subcontractor"—meaning subcontractors regulated by OFCCP—to exclude health care providers with agreements to furnish medical services and supplies to individuals participating in TRICARE.

OFCCP is concerned about differences in understanding among TRICARE health care providers regarding the scope of OFCCP's authority, and also about the potential that OFCCP's recent assertions of authority may be affecting uniformed service members' and veterans' access to health care.[19] OFCCP has also recently established a moratorium on enforcing the affirmative action obligations for health care providers deemed to be putative TRICARE subcontractors. OFCCP is accordingly proposing these changes to provide greater clarity to, and solicit feedback from, health care providers and other stakeholders before the expiration of the moratorium on May 7, 2021. OFCCP has reexamined its position that health care providers participating in TRICARE are among those Congress intended to be regulated and, for the reasons discussed

[16] *See* OFCCP, Hurricane Recovery National Interest Exemptions, https://www.dol.gov/ofccp/hurricanerecovery.htm.
[17] *See* 5 U.S.C. 701(a)(2); *Heckler v. Chaney*, 470 U.S. 821, 831 (1985); *Andrews v. Consol. Rail Corp.*, 831 F.2d 678, 687 (7th Cir. 1987); *Clementson v. Brock*, 806 F.2d 1402, 1404–05 (9th Cir. 1986); *Carroll v. Office of Fed. Contract Compliance Programs, U.S. Dep't of Labor*, 235 F. Supp. 3d 79, 84 (D.D.C. 2017).
[18] OFCCP often refers to the scope of its authority to enforce equal employment opportunity requirements as its *jurisdiction*. For this proposed rulemaking, OFCCP believes the word *authority* is more precise, since OFCCP does not have adjudicative power.
[19] *See* OFCCP, Directive 2014-01, TRICARE Subcontractor Enforcement Activities (May 7, 2014); OFCCP, Directive 2018-02, TRICARE Subcontractor Enforcement Activities (May 18, 2018).

below, now believes they are not. Given the decade of confusion that has accompanied this question, OFCCP also believes that lasting certainty for the health care field and Government health care program serving current and retired members of the armed services and their families is highly desirable. Therefore, OFCCP is also proposing, in the alternative, an exemption for health care providers under TRICARE. OFCCP believes the exemption is justified by special circumstances in the national interest. The exemption is expected to improve uniformed service members' and veterans' access to medical care and more efficiently allocate OFCCP's limited resources for enforcement activities, and provide greater uniformity, certainty, and notice for health care providers participating in TRICARE. Whether under the rationale of a lack of authority or via an exemption from that authority, the change proposed to OFCCP's regulatory text is the same: a revision of OFCCP's definition of "subcontractor" (i.e., subcontractors regulated by OFCCP) to exclude health care providers who only participate as providers in TRICARE.

The proposed rule is an E.O. 13771 deregulatory action because it is expected to reduce compliance costs and potentially the cost of litigation for regulated entities.

III. Administrative and Regulatory Background

A. Overview of OFCCP's Areas of Authority

E.O. 11246, VEVRAA, and Section 503 apply to entities holding covered Government contracts and subcontracts.[20] OFCCP has authority to enforce the requirements of these three laws and their implementing regulations. Contractors agree to those requirements in the equal opportunity clauses included in their contracts with the Federal Government, clauses which also

[20] *See* E.O. 11246, section 202; 29 U.S.C. 793(a); 38 U.S.C. 4212(a)(1).

require contractors to "flow down" these requirements to any subcontractors. The text of these clauses is set forth in E.O. 11246 section 202 and the implementing regulations for all three programs, and is also found in part 52 of title 48 of the Code of Federal Regulations, which contains the Federal Acquisition Regulation's standard contract clauses.[21] Federal law provides that these clauses "shall be considered to be part of every contract and subcontract required by [law] to include such a clause."[22] This is true "whether or not the [equal opportunity clause] is physically incorporated in such contracts."[23] Persons who have no contractual (or subcontractual) relationships with the Federal Government, however, have no obligation to adhere to OFCCP's substantive requirements.[24]

OFCCP's regulations define "Government contract" as any agreement or modification thereof between a department or agency of the Federal Government and any person for the purchase, sale or use of personal property or nonpersonal services.[25] Agreements pertaining to programs or activities receiving Federal financial assistance, however, are not considered covered contracts,[26] nor are other noncontract Government programs or activities. Federally assisted construction contracts, however, do come within OFCCP's authority under E.O. 11246.[27]

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[21] *See* 48 CFR 52.222-26, 52.222-35, 52.222-36.
[22] 41 CFR 60-14(e), 60-741.5(e), 60-250.5(e).
[23] *Id.*
[24] *See* 41 CFR 60-1.1 ("The regulations in this part apply to all contracting agencies of the Government and to contractors and subcontractors who perform under Government contracts, to the extent set forth in this part."); *see also id*. §§ 60-300.1(b), 60-741.1(b).
[25] *Id.* §§ 60-1.3, 60-300.2(n), 60-741.2(k).
[26] *See id.* §§ 60-1.1, 60-300.1(b), 60-741.4(a). Programs and activities receiving Federal financial assistance must comply with various other nondiscrimination laws, including Title VI of the Civil Rights Act of 1964 (prohibiting discrimination on the basis of race, color, or national origin) and Section 504 of the Rehabilitation Act of 1973 (prohibiting discrimination on the basis of disability).
[27] 41 CFR 60-1.1.

As defined in regulation, a covered "contract" includes a "contract or a subcontract."[28] A prime contract is an agreement with the Federal Government agency itself. A "subcontract" is any agreement or arrangement between a contractor and any person (in which the parties do not stand in the relationship of an employer and an employee): (1) For the purchase, sale or use of personal property or nonpersonal services which, in whole or in part, is necessary to the performance of any one or more contracts; or (2) Under which any portion of the contractor's obligation under any one or more contracts is performed, undertaken or assumed.[29]

Although, in general, organizations holding a contract or subcontract as defined are covered under E.O. 11246, Section 503, and VEVRAA, some exemptions apply. Contractors that only hold contracts below OFCCP's basic monetary thresholds are exempt.[30] Certain affirmative action requirements only apply depending on the type and dollar value of the contract held as well as the contractor's number of employees.[31] The regulations also exempt some categories of contracts under certain circumstances or for limited purposes, including those involving work performed outside the United States; certain contracts with state or local governments; contracts with religious corporations, associations, educational institutions or societies; educational

[28] *Id.* §§ 60-1.3, 60-300.2, 60-741.2.
[29] *Id.* §§ 60-1.3, 60-300.2(x), 60-741.2(x).
[30] *Id.* §§ 60- 1.5(a)(1), 60- 300.4(a)(1), 60- 741.4(a)(1). E.O. 11246's basic obligations apply to businesses holding a Government contract in excess of $10,000, or Government contracts which have, or can reasonably be expected to have, an aggregate total value exceeding $10,000 in a 12-month period. E.O. 11246 also applies to government bills of lading, depositories of Federal funds in any amount, and to financial institutions that are issuing and paying agents for U.S. Savings Bonds. Section 503 applies to Federal contractors and subcontractors with contracts in excess of $15,000. VEVRAA applies to Federal contractors and subcontractors with contracts of $150,000 or more. The coverage thresholds under Section 503 and VEVRAA increased from those listed in the statutes and OFCCP's regulations in accordance with the inflationary adjustment requirements in 41 U.S.C. 1908. *See* 80 FR 38293 (July 2, 2015); 75 FR 53129 (Aug. 30, 2010).
[31] 41 CFR 60-1.40, 60-300.40, 60-741.40.

institutions owned in whole or in part by a particular religion or religious organization; and contracts involving work on or near an Indian reservation.[32]

Additionally, as discussed earlier in this NPRM, OFCCP has authority to exempt entities and categories of entities from E.O. 11246, VEVRAA and Section 503 if the Director of OFCCP determines that special circumstances in the national interest require doing so.[33]

B. Overview of Prior Treatment of Health Care Providers Participating in TRICARE

OFCCP has routinely audited health care providers who are Government contractors, and it would continue to do so under this proposal.[34] Provided below is a brief overview of TRICARE and developments regarding OFCCP's interpretations and practice regarding its authority over health care providers participating in TRICARE.

1. TRICARE

TRICARE is the Federal health care program serving uniformed service members, retirees, and their families.[35] TRICARE is managed by the Defense Health Agency, which contracts with managed care support contractors to administer each TRICARE region. The managed care support contractors enter into agreements with individual and institutional health care providers in order to create provider networks for fee-for-service, preferred-provider, and health maintenance organization (HMO)-like programs. Fee-for-service plans reimburse beneficiaries or the health care provider for the cost of covered services. The TRICARE HMO-like program involves beneficiaries generally agreeing to use military treatment facilities and

[32] *See id.* §§ 60-1.5, 60-300.4, 60-741.4.
[33] E.O. 11246, section 204; 29 U.S.C. 793(c)(1); 41 CFR 60-300.4(b)(1).
[34] As noted throughout this proposal, health care providers who are prime government contractors, or who hold subcontracts apart from their provider relationship to a government health care program, included in this rule, would remain under OFCCP's authority.
[35] *See* 32 CFR 199.17(a).

designated civilian providers and to follow certain managed care rules and procedures to obtain covered services.

2. OFCCP and Health Care Providers Participating in TRICARE

In 2007, OFCCP for the first time in litigation asserted enforcement authority over a health care provider based solely on the hospital's delivery of medical care to TRICARE beneficiaries. The provider in this case, a hospital in Florida, disagreed with OFCCP's view, and OFCCP initiated enforcement proceedings in 2008 under the caption *OFCCP v. Florida Hospital of Orlando*. In 2010, an administrative law judge (ALJ) found for the agency.[36]

In December 2010—soon after the ALJ's decision in *Florida Hospital*—OFCCP issued a new directive on health care providers that superseded previous directives.[37] Directive 293 asserted that OFCCP had authority over certain health care providers participating in TRICARE and other Government health care programs.

Congress responded the next year. The National Defense Authorization Act for Fiscal Year 2012 (NDAA) included a provision addressing the maintenance of the adequacy of provider networks under the TRICARE program and TRICARE health care providers as purported Government subcontractors. Sec. 715of the NDAA provided that, for the purpose of determining whether network providers under TRICARE provider network agreements are Government subcontractors, a TRICARE managed care support contract that includes the requirement to establish, manage, or maintain a network of providers may not be considered to be a contract for the performance of health care services or supplies on the basis of such

[36] *OFCCP v. Fla. Hosp. of Orlando*, No. 2009-OFC-00002, 2010 WL 8453896 (ALJ Oct. 18, 2010).
[37] *See* OFCCP, Directive 293, Coverage of Health Care Providers and Insurers (Dec. 16, 2010) (rescinded Apr. 25, 2012).

requirement.[38] In April 2012, 16 months after it had been issued, OFCCP formally rescinded Directive 293.[39]

Meanwhile, the *Florida Hospital* litigation continued. Six months after OFCCP formally rescinded Directive 293, in October 2012, the Department's Administrative Review Board (ARB or Board) held that the NDAA's amendment to the TRICARE statute precluded OFCCP from asserting authority over the Florida hospital.[40] The Board dismissed OFCCP's administrative complaint against the hospital. Four of the five judges agreed that the hospital did not satisfy the second prong of OFCCP's regulatory definition of "subcontract." Two judges, Judge Corchado and Judge Royce, would have found for the agency on the basis of the first prong of the regulatory definition of "subcontract."[41]

The Board subsequently granted OFCCP's request for reconsideration. This time, a three-judge majority ruled for the agency. In July 2013, the Board concluded that the Florida hospital at issue satisfied the first prong of the agency's regulatory definition of "subcontract."[42] The Department's ARB remanded to the ALJ, however, to determine whether TRICARE constituted Federal financial assistance outside OFCCP's jurisdiction. Judge Igasaki and Judge Edwards dissented on the basis of their original opinion in the Board's first decision. They concluded that "the enactment of Section 715 of the NDAA removes OFCCP's jurisdiction under either Prong One or Prong Two based on the specific contract at issue in this case."[43]

[38] Pub. L. 112-81, section 715, 125 Stat. 1298, 1477 (2011), codified at 10 U.S.C. 1097b(a)(3).
[39] *See* Notice of Rescission No. 301 (Apr. 25, 2012).
[40] *OFCCP v. FLA. Hosp. of Orlando*, No. 11-011, 2012 WL 5391420 (ARB Oct. 19, 2012*).*
[41] Judge Brown concluded that the question about the first prong was not properly before the Board.
[42] *OFCCP v. Fla. Hosp. of Orlando*, No. 11-011, 2013 WL 3981196 (ARB July 22, 2013).
[43] *Id.* at *25 (Igasaki & Edwards, JJ., dissenting).

While the remand of *Florida Hospital* was pending, Congress introduced legislation to exempt all health care providers from OFCCP's enforcement activities and held a hearing regarding OFCCP's enforcement activities.[44] The Secretary of Labor at the time, in a letter to the leaders of the House Committee on Education and the Workforce and the Subcommittee on Workforce Protection, stated that the leaders "ha[d] made clear that, in [their] judgment, Congress intended to eliminate entirely OFCCP's jurisdiction over TRICARE subcontractors."[45] The Secretary's letter proposed that "in lieu of legislative action," OFCCP would "exercise prosecutorial discretion over the next five years to limit its enforcement activities with regard to TRICARE subcontractors."[46]

In May 2014, OFCCP issued Directive 2014-01, establishing a five-year moratorium on enforcement of affirmative action obligations for health care providers deemed to be TRICARE subcontractors.[47] OFCCP also administratively closed its open compliance reviews of contractors covered by the moratorium, which resulted in the dismissal of the *Florida Hospital* case.[48]

On May 18, 2018, OFCCP issued Directive 2018-02, a two-year extension of the previous moratorium.[49] Pursuant to this Directive, the moratorium will expire on May 7, 2021. OFCCP explained that it extended the moratorium out of concern that the approaching expiration of the moratorium and accompanying uncertainty over the applicability of the laws OFCCP enforces might contribute to the difficulties veterans and uniformed service members face when accessing health care. The Directive also explained that the extension would provide additional

[44] H.R. 3633, Protecting Health Care Providers from Increased Administrative Burdens Act, Hearing Before the Subcomm. On Workforce Protections of the H. Comm. on Educ. & the Workforce, 113th Cong. (Mar. 13, 2014) [hereinafter "2014 Hearing"].
[45] *Id.* at 3–5 (Sec'y of Labor Thomas E. Perez, Letter to Congressional Leaders, Mar. 11, 2014).
[46] *Id.* at 4.
[47] OFCCP, Directive 2014-01, TRICARE Subcontractor Enforcement Activities (May 7, 2014).
[48] *OFCCP v. Fla. Hosp. of Orlando*, No. 2009-OFC-00002 (ALJ Apr. 1, 2014).
[49] OFCCP, Directive 2018-02, TRICARE Subcontractor Enforcement Activities (May 18, 2018).

time to receive feedback from stakeholders. The Directive extended the scope of the moratorium to cover providers participating in the Department of Veterans Affairs' health benefits programs.[50]

IV. Proposal to Reconsider OFCCP's Authority over TRICARE

Since bringing the *Florida Hospital* case over a decade ago, and as reiterated in its 2014 and 2018 moratoria, OFCCP has consistently held the position that it holds authority over TRICARE providers.[51] In preparing this proposed rulemaking, OFCCP has carefully examined the authorities it administers, its legal position as stated in litigation and repeated public statements and guidance, the decisions in *Florida Hospital*, and Congress's recent actions. OFCCP has concluded that its recent assertions of authority over TRICARE providers warrant reconsideration. For the reasons below, OFCCP now believes it does not have authority over these providers simply because these providers choose to participate in TRICARE.

When OFCCP issued Directive 293, asserting authority over these health care providers, Congress reacted quickly by enacting Section 715 of the 2012 NDAA. "Where an agency's statutory construction has been fully brought to the attention of the public and the Congress, and the latter has not sought to alter that interpretation although it has amended the statute in other respects, then presumably the legislative intent has been correctly discerned." *N. Haven Bd. of Ed. v. Bell*, 456 U.S. 512, 535 (1982) (internal quotation marks omitted). OFCCP's history in this area shows the opposite with regard to TRICARE providers.

Regarding section 715 itself, it was clearly intended, both by its text and by the surrounding context, to reverse OFCCP's assertion of authority over TRICARE providers. The

[50] *Id.* at 1 n.1.

[51] *See, e.g.*, OFCCP, Frequently Asked Questions: TRICARE Subcontractor Enforcement Activities (Q. "Our hospital participates in the Federal Employees Health Benefits Program, but not TRICARE. Are we covered by the Moratorium?" A. "No. If your hospital does not participate in TRICARE, it is not covered by the Moratorium."), https://www.dol.gov/ofccp/regs/compliance/faqs/tricare_faq.htm.

section states, "For the purpose of determining whether network providers"—e.g., hospitals and physicians—"are subcontractors …, a TRICARE managed care support contract that includes the requirement to establish, manage, or maintain a network of providers may not be considered to be a contract for the performance of health care services on the basis of such requirement." The ARB held in *Florida Hospital* that it could nonetheless deem a health care provider a subcontractor where the TRICARE regional administrator could not "fulfill its contract to create an integrated health delivery system without the services from network providers like Florida Hospital."[52] But, upon reconsideration, OFCCP now believes the dissenting opinion in *Florida Hospital* gave the better reading of the statute. The dissent explained that because the "managed care prime contract. . . includes the requirement to maintain a network of providers, OFCCP's jurisdiction is removed. Under Section 715, the subcontract is no longer a 'subcontract' under [OFCCP's regulatory definition] because the element of the contract that is 'necessary to the performance of any one or more contracts' involves the provisions of health care network provider services to TRICARE beneficiaries."[53] The dissent's reading would prevent the statute from becoming a nullity—since the purpose of creating a provider network is to provide health care.

For this reason, after careful consideration, OFCCP has reconsidered its position and now believes it does not have jurisdiction over TRICARE providers.

V. Proposal to Establish a National Interest Exemption for Health Care Providers Participating in TRICARE

OFCCP believes that lasting certainty for TRICARE health care providers and patients is highly desirable. Therefore, OFCCP is also proposing, as an alternative, an exemption from E.O.

[52] *Fla. Hosp.*, 2013 WL 3981196, at *19.
[53] *Id.* at *29.

11246, Section 503, and VEVRAA for health care providers with agreements to furnish medical services and supplies to individuals participating in TRICARE. Nothing in the proposed action is intended to interfere with OFCCP's vital mission of enforcing equal employment opportunity in organizations that contract with the Government. OFCCP would retain authority over a health care provider participating in such a network or arrangement if the health care provider holds a separate covered Federal contract or subcontract. But as explained below, OFCCP believes that there are several reasons why special circumstances in the national interest warrant an exemption for TRICARE health care providers who do not hold such separate contracts.

First, OFCCP is concerned that the prospect of exercising authority over TRICARE providers is affecting or will affect the Government's ability to provide health care to uniformed service members, veterans, and their families. Congressional inquiries and testimony, as well as amicus filings in the *Florida Hospital* litigation, have brought to OFCCP's attention the risk that health care providers may be declining to participate in Federal health care programs that serve members of the military and veterans because of the presumed costs of compliance with OFCCP's regulations.[54] The former president of a TRICARE managed care support contractor testified that he feared they would lose smaller providers in their network because of the administrative costs and burdens associated with OFCCP's requirements, and he predicted that it would make it "much more difficult to build and retain provider networks."[55] TRICARE managed care support contractors similarly stated in an amicus brief that subjecting TRICARE providers to OFCCP's requirements would "make the already difficult task of finding health care

[54] 2014 Hearing, *supra* note 44; Examining Recent Actions by the Office of Federal Contract Compliance Programs, Hearing Before the Subcomm. on Workforce Protections of the H. Comm. on Education and the Workforce, 113th Cong. (2013) [hereinafter 2013 Hearing]; Reviewing the Impact of the Office of Federal Contract Compliance Programs' Regulatory and Enforcement Actions, Hearing Before the Subcomm. on Health, Emp't, Labor & Pensions of the H. Comm. on Educ. & the Workforce, 112th Cong. (2012).

[55] 2014 Hearing, *supra* note 44, at 24-26, 46-47, 149 (Prepared Statement and Testimony of Thomas Carrato, President, Health Net Federal Services).

professionals willing to act as network providers even more difficult."[56] A partner of a law firm testified that he has seen health care provider clients choose not to participate in TRICARE and in other programs because of the costs of compliance.[57] The American Hospital Association also testified that some hospitals may decline to participate out of concern that they could be found to be Federal contractors.[58]

Providers' decisions not to participate may exacerbate the well-documented difficulties that uniformed service members, veterans, and their families have accessing health care.[59] The unique nature of the health care system heightens OFCCP's concern about the refusal of providers to participate in health care programs for uniformed service members and veterans. Creating adequate networks of providers is a critical component of ensuring access to health care. These networks need to offer comprehensive services and cover all geographical areas where beneficiaries reside. An inadequate network may mean that beneficiaries are unable to obtain urgent and life-saving treatment. The willingness of health care providers to participate in TRICARE is thus especially important.

OFCCP requests comments from stakeholders that will help it to more thoroughly evaluate the potential impact of OFCCP compliance on uniformed service members' and

[56] Amicus Brief of Humana Military Health Services, Inc., Health Net Federal Services, LLC, and TriWest Healthcare Alliance dated May 2, 2012, at 9, *Fla. Hosp.*, 2013 WL 3981196; *see also* Amicus Brief of Human Military Health Services, Inc., Health Net Federal Services, LLC, and TriWest Healthcare Alliance dated December 29, 2010, at 2, *Fla. Hosp.*, 2013 WL 3981196 ("Subjecting the network providers to Federal affirmative action requirements will make it more difficult for the [TRICARE managed care support] contractors to find and retain providers willing to sign network agreements due to the added compliance requirements.").
[57] 2014 Hearing, *supra* note 44, at 34-35, 47 (Statement and Testimony of David Goldstein, Shareholder, Littler Mendelson P.C.).
[58] *Id.* at 17-18 (Prepared Statement of the American Hospital Association); 2013 Hearing, *supra* note 54, at 139 (Testimony of Curt Kirschner, Partner, Jones Day, on behalf of the American Hospital Association).
[59] *See, e.g.*, Government Accountability Office Report, GAO–18–361, TRICARE Surveys Indicate Nonenrolled Beneficiaries' Access to Care Has Generally Improved (Mar. 2018), *available at* https://www.gao.gov/assets/700/690964.pdf. The GAO found that, although there has been a slight improvement in TRICARE beneficiaries' access to care, 29 percent of nonenrolled beneficiaries still reported that they experienced problems finding a civilian provider. Nonenrolled beneficiaries are those that have not enrolled in TRICARE Prime, which is a managed care option that that mostly relies on military hospitals and clinics to provide care.

veterans' health care provider networks. Particularly, OFCCP seeks comments from health care providers regarding the impact of potential Federal subcontractor status on their decision to participate in health care programs for uniformed service members and veterans.

Second, OFCCP believes that an exemption is in the national interest because pursuing enforcement efforts against TRICARE providers is not the best use of its and providers' resources were it to, consistent with its public position until the issuance of this NPRM, attempt to exercise authority over those providers. Given the history in this area, such attempts—which would occur in the absence of this NPRM—could again meet with protracted litigation and unclear ultimate results: the *Florida Hospital* case proceeded for seven years and would have continued for some time into the future had it not been voluntarily dismissed. OFCCP believes its limited resources are better spent elsewhere, and it would be unreasonable to impose substantial compliance costs on health care providers when the legal justification for doing so would be open to challenge in light of the language in the NDAA and the question left unresolved in *Florida Hospital* as to whether TRICARE constitutes Federal financial assistance.

Third, OFCCP believes an exemption would be in the national interest because it would provide uniformity and certainty in the health care community with regard to legal obligations concerning participation in TRICARE. OFCCP conducts a case-by-case inquiry as to whether a particular entity is a covered subcontractor. The proposed exemption would dispense with an agreement-by-agreement analysis and the attendant uncertainty, legal costs, and litigation risk. Providers could choose to furnish medical services to beneficiaries of different types of TRICARE programs without hiring costly lawyers and performing time-intensive contract analysis to determine, as best they can, whether they are a subcontractor or simply a provider.

This exception would also harmonize OFCCP's approach with that of the Department of Defense. OFCCP is the office charged with administering and enforcing its authorities, but comity between agencies is desirable whenever possible, reduces confusion for the public, and helps ensure evenhanded and efficient administration of the law. The Department of Defense stated in the *Florida Hospital* litigation that "it would be impossible to achieve the TRICARE mission of providing affordable health care for our nation's active duty and retired military members and their families" if all TRICARE providers were subject to OFCCP's requirements.[60] The Department of Defense also classifies TRICARE as Federal financial assistance in DoD Directive 1020.1.[61] A unified approach should reduce confusion for the public and assist coordination in regulating Government contracts in the health care field.[62]

As noted earlier, of course, the uniformed service members and veterans' health care providers discussed here would still be subject to OFCCP's authority if they are prime contractors or have a covered subcontract with a Government contractor. For example, a teaching hospital that participates as a TRICARE provider but that also has a research contract with the Federal Government would still be considered a covered contractor subject to OFCCP authority.

For all of these reasons, the Director of OFCCP has determined that the proposed exemption would be justified by special circumstances in the national interest because it would increase access to care for uniformed service members and veterans and allow OFCCP to better allocate its resources, and provide uniformity and certainty for the Government and for health

[60] *OFCCP v. Fla. Hosp. of Orlando*, No. 2009-OFC-002, 2010 WL 8453896, at *2 (ALJ Oct. 18, 2010).
[61] *See* Dep't of Defense, Directive 1020.1, Nondiscrimination on the Basis of Handicap in Programs and Activities Assisted or Conducted by the Department of Defense, ¶ E1.1.2.21 (Mar. 31, 1982).
[62] Note that this regulation would not affect health care entities' obligations under Title VII of the Civil Rights Act or other civil rights laws enforced by other agencies.

care providers. The Director of OFCCP is also proposing that the requirements would be met for granting an exemption to a group or category of contracts. Since there are tens of thousands of providers that may be eligible for the exemption, it would be impracticable for OFCCP to act upon each provider's request individually and issuing a group exemption would substantially contribute to convenience in the administration of the laws.[63] OFCCP requests comments from stakeholders on the proposed exemption.

OFCCP is also considering and requests comments on whether health care providers participating in the Federal Employees Health Benefits Program (FEHBP)[64] should not be covered by OFCCP's authority. OFCCP is interested in comments from stakeholders and health care providers that participate in other Government health care programs, such as FEHBP, about the impact of OFCCP's requirements, if there is difficulty attracting and retaining participating providers, and whether a uniform rule is needed to avoid legal uncertainty. Some stakeholders have indicated that other Government health care programs may face difficulties similar to TRICARE.[65]

VI. Section-by-Section Analysis

Section 60-1.3 Definitions.

[63] 41 CFR 60-1.5(b)(1), 60-300.4(b)(1), 60-741.4(b)(1).

[64] FEHBP is the Federal health care program serving civilian Federal employees, annuitants, and their dependents. 5 U.S.C. 8901 *et seq.* The program is administered by the U.S. Office of Personnel Management. FEHBP offers two general types of plans: fee-for-service plans and HMO plans. The Department's Administrative Review Board held OFCCP did not have authority over a health care provider based on a reimbursement agreement with a health insurance carrier offering a fee-for-service FEHBP plan, but did have authority over a health care provider's agreement to provide services pursuant to a FEHBP HMO plan. *See OFCCP v. UPMC Braddock*, No. 08-048, 2009 WL 1542298 (ARB May 29, 2009), *aff'd*, *UPMC Braddock v. Harris*, 934 F. Supp. 2d 238 (D.D.C. 2013), *vacated as moot*, *UPMC Braddock v. Perez*, 584 F. App'x 1 (D.C. Cir. 2014); *In re Bridgeport Hosp.*, No. 00-023, 2003 WL 244810 (ARB Jan. 31, 2003).

[65] 2014 Hearing, *supra* note 44, at 17-18 (Prepared Statement of the American Hospital Association), 25-26, 46-47 (Prepared Statement and Testimony of Thomas Carrato, President, Health Net Federal Services), 34-35, 39-40 (Statement and Testimony of David Goldstein, Shareholder, Littler Mendelson P.C.); 2013 Hearing, *supra* note 54, at 67-68, 139 (Statement and Testimony of Curt Kirschner, Partner, Jones Day, on behalf of the American Hospital Association).

OFCCP proposes adding a paragraph to the definition of subcontract in the E.O. 11246 regulations noting that a subcontract does not include an agreement between a health care provider and health organization pursuant to which the health care provider agrees to furnish health care services or supplies to beneficiaries of TRICARE. OFCCP also proposes adding definitions of "agreement," "health care provider," and "health organization."

Section 60-300.2 Definitions.

OFCCP proposes adding a paragraph to the definition of subcontract in the VEVRAA regulations noting that a subcontract does not include an agreement between a health care provider and health organization pursuant to which the health care provider agrees to furnish health care services or supplies to beneficiaries of TRICARE. OFCCP also proposes adding definitions of "agreement," "health care provider," and "health organization."

Section 60-741.2 Definitions.

OFCCP proposes adding a paragraph to the definition of subcontract in the Section 503 regulations noting that a subcontract does not include an agreement between a health care provider and health organization pursuant to which the health care provider agrees to furnish health care services or supplies to beneficiaries of TRICARE. OFCCP also proposes adding definitions of "agreement," "health care provider," and "health organization."

VII. Regulatory Analysis

E.O. 12866 (Regulatory Planning and Review), E.O. 13563 (Improving Regulation and Regulatory Review), and E.O. 13771 (Reducing Regulation and Controlling Regulatory Costs)

Under E.O. 12866, the U.S. Office of Management and Budget's (OMB's) Office of Information and Regulatory Affairs (OIRA) determines whether a regulatory action is significant and, therefore, subject to the requirements of E.O. 12866 and OMB review. Section 3(f) of E.O. 12866 defines a "significant regulatory action" as an action that is likely to result in a rule that: (1) has an annual effect on the economy of $100 million or more, or adversely affects in a material way a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as economically significant); (2) creates serious inconsistency or otherwise interferes with an action taken or planned by another agency; (3) materially alters the budgetary impacts of entitlement grants, user fees, or loan programs, or the rights and obligations of recipients thereof; or (4) raises novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in E.O. 12866. The Office of Management and Budget has determined that this proposed rule is a significant action under E.O. 12866 and has reviewed the proposed rule.

E.O. 13563 directs agencies to propose or adopt a regulation only upon a reasoned determination that its benefits justify its costs; tailor the regulation to impose the least burden on society, consistent with obtaining the regulatory objectives; and in choosing among alternative regulatory approaches, select those approaches that maximize net benefits. E.O. 13563 recognizes that some benefits are difficult to quantify and provides that, where appropriate and permitted by law, agencies may consider and discuss qualitatively values that are difficult or impossible to quantify, including equity, human dignity, fairness, and distributive impacts.

This proposed rule is expected to be an E.O. 13771 deregulatory action.

The Need for the Regulation

The proposed regulatory changes are needed to provide clarity regarding OFCCP's authority over health care providers that provide services and supplies under TRICARE, improve uniformed service members' and veterans' access to medical care, more efficiently allocate OFCCP's limited resources for enforcement activities, and provide greater uniformity, certainty, and notice for health care providers participating in TRICARE. The proposed rule is intended to address concerns regarding the risk that health care providers may be declining to participate in TRICARE, which reduces the availability of medical services for uniformed service members, veterans, and their families. OFCCP is proposing to exempt health care providers with agreements to furnish medical services and supplies to individuals participating in TRICARE from E.O. 11246, Section 503, and VEVRAA.

Discussion of Impacts

In this section, the Department presents a summary of the costs and savings associated with the changes proposed in this notice of proposed rulemaking. The estimated labor cost to contractors is reflected in Table 1, below. The mean hourly wage of Management Analysts (SOC 13-1111) is $45.38 and Human Resources Managers (SOC 11-3121) is $60.91.[66] The Department adjusted these wage rates to reflect fringe benefits such as health insurance and retirement benefits, as well as overhead costs such as rent, utilities, and office equipment. The Department used a fringe benefits rate of 46 percent[67] and an overhead rate of 17 percent,[68] resulting in fully loaded hourly compensation rates for Management Analysts of $73.97 ($45.38

[66] BLS, Occupational Employment Statistics, Occupational Employment and Wages, May 2018, https://www.bls.gov/oes/current/oes_nat.htm.
[67] BLS, Employer Costs for Employee Compensation, https://www.bls.gov/ncs/data.htm. Wages and salaries averaged $24.86 per hour worked in 2018, while benefit costs averaged $11.52, which is a benefits rate of 46%.
[68] Cody Rice, U.S. Environmental Protection Agency, "Wage Rates for Economic Analyses of the Toxics Release Inventory Program," (June 10, 2002), https://www.regulations.gov/document?D=EPA-HQ-OPPT-2014-0650-0005.

+ ($45.38 × 46%) + ($45.38 × 17%)) and Human Resources Managers of $99.28 ($60.91 + ($60.91 × 46%) + ($60.91 × 17%)).

Table 1. Labor Cost

Major Occupational Groups	Mean Hourly wage	Fringe Benefit Rate	Overhead Rate	Fully Loaded Hourly Compensation
Management Analysts	$45.38	46%	17%	$73.97
Human Resources Managers	$60.91	46%	17%	$99.28

The Department estimates that 48 percent of the burden hours will be associated with Management Analysts and 52 percent for Human Resources Managers. Thus, the average hourly rate is estimated at $87.13 per hour (($73.97 × .48) + (99.28 × .52)).

Cost of Regulatory Familiarization

The Department acknowledges that 5 CFR 1320.3(b)(1)(i) requires agencies to include in the burden analysis for new information collection requirements the estimated time it takes for contractors to review and understand the instructions for compliance. To minimize the burden, OFCCP will publish compliance assistance materials including, fact sheets and responses to "Frequently Asked Questions." OFCCP may also host webinars for the contractor community that will describe the new requirements and conduct listening sessions to identify any specific challenges contractors believe they face, or may face, when complying with the requirements.

The Department believes that human resource personnel (human resource managers and management analysts) at each health care contractor establishment or firm within its authority will be responsible for understanding or becoming familiar with the new requirements. Therefore, the Department estimates that it will take a minimum of 30 minutes for a human resource professional at each TRICARE contractor establishment to either read the proposed

rule, read the compliance assistance materials provided by OFCCP, or participate in an OFCCP webinar to learn more about the new requirements. Consequently, the estimated burden for rule familiarization is 42,309 hours (84,617 establishments × 1/2 hour).[69] The Department calculates the total estimated cost of rule familiarization as $3,686,383 (42,309 hours × $87.13/hour) in the first year. The Department seeks public comments regarding the estimated number of establishments that would review this rule, the estimated time to review the rule, and whether management analysts and human resource managers would be the most likely staff members to review the rule. Table 2, below, reflects the estimated regulatory familiarization costs for the proposed rule.

Table 2. Regulatory Familiarization Cost	
Total number of health care contractor establishments	84,617
Time to review rule	30 minutes
Management Analysts and Human Resources Managers fully loaded hourly compensation (weighted 52 percent and 48 percent, respectively)	$87.13
Regulatory familiarization cost in the first year	$3,686,383

Cost Savings

While the proposed rule does not include any additional costs, it may result in cost savings as it reconsiders OFCCP's authority over health care providers with agreements to furnish medical services and supplies to individuals participating in TRICARE, and in the alternative, proposes a national interest exemption from E.O. 11246, VEVRAA, and Section 503 for these health care providers, thus eliminating any requirements associated with developing, updating, and maintaining AAPs.

[69] The determination of the estimated number of health care contractor establishments is discussed under Cost Savings, below.

To fully estimate the associated cost savings, the Department could use various data and information, only some of which are currently available. The partial analysis that follows sets forth relevant evidence and other helpful data that could be used to produce a more robust cost savings estimate to be used in the final rule.

To estimate the number of Federal contractors potentially impacted by the proposed rule, the Department identified the number of health care providers participating in TRICARE.[70] The Department further refined this universe to those entities with 50 or more employees, since the greatest burdens associated with the E.O. 11246, VEVRAA, and Section 503 requirements are associated with developing, updating, and maintaining AAPs.[71] The Department then determined the rate of compliance using OFCCP's compliance evaluation data from Fiscal Years 2012 through June 2019. The data showed that approximately 95 percent of health care providers scheduled for an OFCCP compliance evaluation during that period submitted their AAPs when requested and the remaining 5 percent submitted their AAPs after receiving a show cause notice. The scheduled health care providers included contractors ranging from 50 to more than 501 employees.

The Department identified the number of health care providers in the U.S. Census Bureau's Statistics of U.S. Businesses, using North American Industry Classification System

[70] OFCCP considered using its most recent EEO-1 numbers to conduct this analysis, but the reporting requirements are limited to prime contractors and first tier subcontractors. However, OFCCP's universe includes all tiers of subcontractors that meet the jurisdictional thresholds. Using EEO-1 data would underestimate the impact of the proposed rule. Thus, OFCCP relied upon the analysis described herein.

[71] The requirement to develop AAPs is based on employing 50 or more employees and having a contract that meets specific thresholds. OFCCP does not have information regarding the value of the contracts or financial agreements. Thus, the estimated number of establishments may be overstated as it may include establishments that have contracts of less than $50,000 (E.O. 11246 and Section 503) or have contracts of less than $150,000 (VEVRAA).

(NAICS) 621, 622, and 623. There are 707,634 health care providers of which 28.3 percent or 200,260 have 50 or more employees.[72]

The Department of Defense annual report to Congress reported that there were 155,500 TRICARE Primary Care Network Providers and 143,500 TRICARE Specialist Network Providers in FY2018.[73] The Department estimates that 28.3 percent of these providers have 50 or more employees. The Department believes that 84,617 providers ((155,500 + 143,500) × 28.3%)) are potentially impacted by the proposed rule.

Calculating cost savings is made more difficult because the savings may depend on whether the health care provider is still obligated to maintain an AAP under other contracts. Such obligations may come from many additional sources. For example, if the providers would qualify as Federal contractors due to activities outside what is covered by this proposed rule; or if they contract with states that mandate AAPs for certain employers.[74] Therefore, the estimate of affected TRICARE providers may overstate the number of entities that would actually realize cost savings as a result of this proposed rule. The Department requests comments that may assist refinement of the analysis, including: How often are health care providers subject to AAP rules imposed by states, and how similar are the state-level requirements to the provisions being rescinded by this proposed rule?

The rule proposes to amend § 60-1.3 to note that a subcontract does not include an agreement between a health care provider and a health organization pursuant to which the health care provider agrees to furnish services to beneficiaries of TRICARE. The clarification and

[72] Number of Firms, Number of Establishments, Employment, and Annual Payroll by Enterprise Employment Size for the United States, All Industries: 2016, https://www2.census.gov/programs-surveys/susb/tables/2016/us_6digitnaics_2016.xlsx?# (last accessed February 24, 2019).
[73] Evaluation of TRICARE Programs, Fiscal Year 2019, Report to Congress, https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program (last accessed September 17, 2019).
[74] https://ballotpedia.org/Federal_and_state_affirmative_action_and_anti-discrimination_laws.

amendment would result in a cost savings, as some affected contractors would no longer be required to comply with E.O. 11246 requirements and to engage in such activities as creating, updating, or maintaining AAPs or providing notifications to employees, subcontractors, or unions. The Department's current OMB approved Information Collection Request (ICR) for its supply and service program (1250-0003), ICR Reference No: 201811-1250-001, estimates an average of 91.44 hours per contractor to comply with the E.O. 11246 requirements.

The rule proposes to amend § 60-300.2 to note that a subcontract does not include an agreement between a health care provider and a health organization pursuant to which the health care provider agrees to furnish services to beneficiaries of TRICARE. The clarification and amendment would result in a cost savings, as some affected contractors would no longer be required to comply with VEVRAA requirements and to engage in such activities as creating, updating, or maintaining AAPs, listing job opportunity notices with the local or state employment service delivery systems, or providing notifications to employees, subcontractors, or unions. The Department's current OMB approved ICR for its VEVRAA requirements (1250-0004), ICR Reference No: 201610-1250-001, estimates an average of 16.86 hours per contractor to comply with the VEVRAA requirements.

The rule also proposes to amend § 60-741.2 to note that a subcontract does not include an agreement between a health care provider and a health organization pursuant to which the health care provider agrees to furnish services to beneficiaries of TRICARE. The clarification and amendment would result in a cost savings, as some affected contractors would no longer be required to comply with Section 503 requirements and to engage in such activities as creating, updating, or maintaining AAPs, or providing notifications to employees, subcontractors, or unions. OFCCP's current OMB approved ICR for its Section 503 requirements (1250-0005),

ICR Reference No: 201610-1250-002, estimates an average of 7.92 hours per contractor to comply with the Section 503 requirements.

Summary of Costs and Cost Savings

The Department estimates the annualized costs of the proposed rule for rule familiarization at $419,569 at a discount rate of 3 percent or $490,522 at a discount rate of 7 percent.

The Department invites comments regarding the assumptions, data sources, and methodologies used to estimate the impacts of this proposed rule. Additionally, the Department solicits comments from health care providers on their current costs of compliance that would be mitigated by this rulemaking. Finally, the Department requests comments on any available data that would indicate the extent to which health care providers, who are not otherwise required due to separate Federal contracts or subcontracts, have an expectation of compliance or have complied with current requirements.

Summary of Transfer and Benefits

E.O. 13563 recognizes that some rules have benefits that are difficult to quantify or monetize but are nevertheless important, and states that agencies may consider such benefits. This rule has equity and fairness benefits, which are explicitly recognized in E.O. 13563.

The proposed rule is designed to achieve these benefits by providing clear guidance to contractors, and increasing contractor understanding of OFCCP's authority as it relates to heath care providers. If the proposed rule decreases the confusion of Federal contractors, this impact most likely represents a transfer of value to taxpayers (if contractor fees decrease because they do not need to engage third party representatives to interpret OFCCP's requirements).

Alternative Discussion

In proposing this rule, the Department considered a non-regulatory alternative. This alternative was to continue issuing moratoria or other sub regulatory guidance in which OFCCP would exercise enforcement discretion and not schedule compliance evaluations of certain health care providers. The Department rejected this alternative, as it would result in much greater uncertainty among the regulated entities. The Department requests comments on any regulatory alternatives it might consider.

Regulatory Flexibility Act and E.O. 13272 (Consideration of Small Entities)

The Regulatory Flexibility Act of 1980 (RFA), 5 U.S.C. 601 *et seq*., establishes "as a principle of regulatory issuance that agencies shall endeavor, consistent with the objectives of the rule and applicable statutes, to fit regulatory and informational requirements to the scale of the business organizations and governmental jurisdictions subject to regulation." Public Law 96-354. The Act requires the consideration for the impact of a proposed regulation on a wide-range of small entities including small businesses, not-for-profit organizations, and small governmental jurisdictions.

Agencies must perform a review to determine whether a proposed or final rule would have a significant economic impact on a substantial number of small entities.[75] If the determination is that it would, then the agency must prepare a regulatory flexibility analysis as described in the RFA.[76]

However, if an agency determines that a proposed or final rule is not expected to have a significant economic impact on a substantial number of small entities, section 605(b) of the RFA provides that the head of the agency may so certify and a regulatory flexibility analysis is not required. *See* 5 U.S.C. 605. The certification must include a statement providing the factual basis

[75] *See* 5 U.S.C. 603.
[76] *Id.*

for this determination and the reasoning should be clear. The Department does not expect this rule to have a significant economic impact on a substantial number of small entities. The annualized cost at a discount rate of 7 percent for rule familiarization is $5.80 per entity ($43.57 in the first year) which is far less than 1 percent of the annual revenue of the smallest of the small entities affected by this proposed rule. Therefore, the Department certifies that this proposed rule will not have a significant impact on a substantial number of small affected entities.

Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) requires that the Department consider the impact of paperwork and other information collection burdens imposed on the public. According to the 1995 amendments to the Paperwork Reduction Act (5 CFR 1320.5(b)(2)(vi)), an agency may not collect or sponsor the collection of information or impose an information collection requirement unless the information collection instrument displays a currently valid OMB control number. The Department has determined that there is no new requirement for information collection associated with this proposed rule. The information collection requirements contained in the existing E.O. 11246, VEVRAA and Section 503 regulations are currently approved under OMB Control No. 1250-0003 (OFCCP Recordkeeping and Reporting Requirements – Supply and Service), OMB Control No. 1250-0004 (OFCCP Recordkeeping and Reporting Requirements – 38 U.S.C. 4212, Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended), and OMB Control No. 1250-0005 (OFCCP Recordkeeping and Reporting Requirements - Section 503 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 703). Consequently, this proposed rule does not require review by the Office of Management and Budget under the Paperwork Reduction Act of 1995, 44 U.S.C. 3501 *et seq*.

E.O. 13132 (Federalism)

The Department has reviewed this proposed rule in accordance with E.O. 13132 regarding federalism, and has determined that it does not have "federalism implications". This rule will not "have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government."

E.O. 13175 (Consultation and Coordination with Indian Tribal Governments)

This proposed rule does not have tribal implications under E.O. 13175 that requires a tribal summary impact statement. The proposed rule does not have substantial direct effects on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

List of Subjects

41 CFR Part 60-1

Administrative practice and procedure, Equal employment opportunity, Government contracts, Reporting and recordkeeping requirements.

41 CFR Part 60-300

Administrative practice and procedure, Civil rights, Employment, Equal employment opportunity, Government contracts, Government procurement, Individuals with disabilities, Investigations, Reporting and recordkeeping requirements, Veterans.

41 CFR Part 60-741

Administrative practice and procedure, Civil rights, Employment, Equal employment opportunity, Government contracts, Government procurement, Individuals with disabilities, Investigations, Reporting and recordkeeping requirements.

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Craig E. Leen,
Director, Office of Federal Contract Compliance Programs.

For the reasons set forth in the preamble, OFCCP proposes to amend 41 CFR parts 60-1, 60-300, and 60-741 as follows:

PART 60-1—OBLIGATIONS OF CONTRACTORS AND SUBCONTRACTORS

1. The authority citation for part 60-1 continues to read as follows:

Authority: Sec. 201, E.O. 11246, 30 FR 12319, 3 CFR, 1964-1965 Comp., p. 339, as amended by E.O. 11375, 32 FR 14303, 3 CFR, 1966-1970 Comp., p. 684, E.O. 12086, 43 FR 46501, 3 CFR, 1978 Comp., p. 230, E.O. 13279, 67 FR 77141, 3 CFR, 2002 Comp., p. 258 and E.O. 13672, 79 FR 42971.

Subpart A—Preliminary Matters; Equal Opportunity Clause; Compliance Reports

2. In § 60-1.3, revise the definition of "Subcontract" to read as follows:

§ 60-1.3 Definitions.

* * * * *

Subcontract. (1) Means any agreement or arrangement between a contractor and any person (in which the parties do not stand in the relationship of an employer and an employee):

(i) For the purchase, sale or use of personal property or nonpersonal services which, in whole or in part, is necessary to the performance of any one or more contracts; or

(ii) Under which any portion of the contractor's obligation under any one or more contracts is performed, undertaken or assumed; and

(2) Does not include an agreement between a health care provider and a health organization under which the health care provider agrees to provide health care services or supplies to natural persons who are beneficiaries under TRICARE.

(i) An agreement means a relationship between a health care provider and a health organization under which the health care provider agrees to provide health care services or supplies to natural persons who are beneficiaries under TRICARE.

(ii) A health care provider is a physician, hospital, or other individual or entity that furnishes health care services or supplies.

(iii) A health organization is a voluntary association, corporation, partnership, managed care support contractor, or other nongovernmental organization that is lawfully engaged in providing, paying for, insuring, or reimbursing the cost of health care services or supplies under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, network agreements, health benefits plans duly sponsored or underwritten by an employee organization or association of organizations and health maintenance organizations, or other similar arrangements, in consideration of premiums or other periodic charges or payments payable to the health organization.

* * * * *

PART 60-300—AFFIRMATIVE ACTION AND NONDISCRIMINATION OBLIGATIONS OF FEDERAL CONTRACTORS AND SUBCONTRACTORS REGARDING DISABLED VETERANS, RECENTLY SEPARATED VETERANS,

ACTIVE DUTY WARTIME OR CAMPAIGN BADGE VETERANS, AND ARMED FORCES SERVICE MEDAL VETERANS

3. The authority citation for part 60-300 continues to read as follows:

Authority: 29 U.S.C. 793; 38 U.S.C. 4211 and 4212; E.O. 11758 (3 CFR, 1971-1975 Comp., p. 841).

Subpart A—Preliminary Matters, Equal Opportunity Clause

4. In § 60-300.2, revise paragraph (x) to read as follows:

§ 60-300.2 Definitions.

* * * * *

(x) *Subcontract*. (1) Means any agreement or arrangement between a contractor and any person (in which the parties do not stand in the relationship of an employer and an employee):

(i) For the purchase, sale or use of personal property or nonpersonal services which, in whole or in part, is necessary to the performance of any one or more contracts; or

(ii) Under which any portion of the contractor's obligation under any one or more contracts is performed, undertaken or assumed; and

(2) Does not include an agreement between a health care provider and a health organization under which the health care provider agrees to provide health care services or supplies to natural persons who are beneficiaries under TRICARE.

(i) An agreement means a relationship between a health care provider and a health organization under which the health care provider agrees to provide health care services or supplies to natural persons who are beneficiaries under TRICARE.

(ii) A health care provider is a physician, hospital, or other individual or entity that furnishes health care services or supplies.

(iii) A health organization is a voluntary association, corporation, partnership, managed care support contractor, or other nongovernmental organization that is lawfully engaged in providing, paying for, insuring, or reimbursing the cost of health care services or supplies under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, network agreements, health benefits plans duly sponsored or underwritten by an employee organization or association of organizations and health maintenance organizations, or other similar arrangements, in consideration of premiums or other periodic charges or payments payable to the health organization.

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PART 60-741—AFFIRMATIVE ACTION AND NONDISCRIMINATION OBLIGATIONS OF FEDERAL CONTRACTORS AND SUBCONTRACTORS REGARDING INDIVIDUALS WITH DISABILITIES

5. The authority citation for part 60-741 continues to read as follows:

Authority: 29 U.S.C. 705 and 793; E.O. 11758 (3 CFR, 1971-1975 Comp., p. 841).

Subpart A—Preliminary Matters, Equal Opportunity Clause

6. In § 60-741.2, revise paragraph (x) to read as follows:

§ 60-741.2 Definitions.

* * * * *

(x) *Subcontract*. (1) Means any agreement or arrangement between a contractor and any person (in which the parties do not stand in the relationship of an employer and an employee):

(i) For the purchase, sale or use of personal property or nonpersonal services which, in whole or in part, is necessary to the performance of any one or more contracts; or

(ii) Under which any portion of the contractor's obligation under any one or more contracts is performed, undertaken or assumed; and

(2) Does not include an agreement between a health care provider and a health organization under which the health care provider agrees to provide health care services or supplies to natural persons who are beneficiaries under TRICARE.

(i) An agreement means a relationship between a health care provider and a health organization under which the health care provider agrees to provide health care services or supplies to natural persons who are beneficiaries under TRICARE.

(ii) A health care provider is a physician, hospital, or other individual or entity that furnishes health care services or supplies.

(iii) A health organization is a voluntary association, corporation, partnership, managed care support contractor, or other nongovernmental organization that is lawfully engaged in providing, paying for, insuring, or reimbursing the cost of

health care services or supplies under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, network agreements, health benefits plans duly sponsored or underwritten by an employee organization or association of organizations and health maintenance organizations, or other similar arrangements, in consideration of premiums or other periodic charges or payments payable to the health organization.

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