

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

Hearing on the
“Protecting Health Care Providers from Increased Administrative Burdens Act.”

March 13, 2014

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 Workforce Committee’s Subcommittee on Workforce Protections in support of H.R. 3633, the Protecting Health Care Providers from Increased Administrative Burdens Act.

H.R. 3633 is a bipartisan bill that has been narrowly crafted to accomplish one important outcome: to ensure that hospitals and other health care providers cannot be classified as federal contractors or subcontractors, and subjected to an extensive federal regulatory scheme, simply because they provide care to patients covered by a federally funded health benefit plan. In particular, H.R. 3633 will clarify that hospitals are not subject to the jurisdiction of the Office of Federal Contract Compliance Programs (OFCCP) solely as a result of their participation in Medicare; TRICARE, the health care program for military service members and their families; or the Federal Employees Health Benefit Program (FEHBP), which provides health insurance options to civilian government employees and their families.

The OFCCP has acknowledged that it does not have jurisdiction over hospitals participating in Medicare or the FEHBP. Within the past few years, however, the agency has laid the groundwork for a jurisdictional land grab based on essentially meaningless distinctions between the ways health care providers participate in federally funded health benefit programs. If Congress does not act, the OFCCP’s self-serving definition of its own authority will convert, virtually overnight, a majority of our nation’s hospitals into federal contractors, without advance notice to or agreement by those hospitals.



As explained in the AHA's testimony before this Subcommittee on December 4, 2013, the OFCCP's position is inconsistent with the law and with the views of the federal agencies that administer TRICARE and the FEHBP.¹ In addition, it will impose significant administrative burdens on America's hospitals, which already are and will remain subject to the requirements of federal, state and local antidiscrimination laws.

This executive overreach demands a clear and targeted congressional response. The AHA urges Congress to pass H.R. 3633 for three reasons:

1. The bill clearly defines the limits of OFCCP's jurisdiction without disturbing the agency's authority over institutions that have voluntarily entered into federal contracts;
2. The bill will prevent needless and costly litigation over the classification of health care providers as federal contractors and subcontractors; and
3. The bill removes obstacles to hospitals and other health care providers from providing health care services to members of the military, federal employees and their families.

H.R. 3633 CLEARLY DEFINES THE LIMITS OF OFCCP JURISDICTION

The OFCCP plainly has jurisdiction over hospitals that voluntarily enter into contracts or subcontracts with the federal government. Thus, for example, a hospital that entered into a contract to conduct research on behalf of the National Institutes of Health is required to comply with OFCCP regulations and, therefore, must develop annual affirmative action plans, implement sophisticated job applicant tracking systems, and engage in targeted outreach to women, minorities, individuals with disabilities, and veterans, in accordance with the OFCCP's numerous regulations.

In the AHA's view, however, the OFCCP's assertion of jurisdiction over hospitals that participate in federally funded health benefits programs has no basis in law. In fact, the OFCCP itself once agreed with this position. In 2003, the Department of Labor's Administrative Review Board (ARB) found that the OFCCP did not have jurisdiction over hospitals that provided services to federal employees covered by a fee-for-service plan through the FEHBP (*In re Bridgeport Hosp.*, ARB Case No. 00-034, 2003 WL 244810, at *1 (DOL Adm. Rev. Bd. Jan. 31, 2003)). In response to the ARB's ruling, the OFCCP issued a formal policy statement conceding that it "cannot use FEHBP coverage as a basis to assert jurisdiction over a health care provider" (*see* OFCCP Directive No. 262 (2003)). Likewise, the OFCCP has clarified that it "considers health care institutions that provide services to Medicare and Medicaid beneficiaries as recipients of federal financial assistance and not as contractors" (*see* OFCCP Directive No. 189 (1993)).

These previous statements regarding the OFCCP's jurisdiction are consistent with Congress's own definition of a federal procurement contract in the Federal Grant and Cooperative Agreement Act of 1977 (Grant Act). The Grant Act explains that a federal procurement contract has "the principal purpose of [acquiring] property or services *for the direct benefit or use of the*

¹ *See generally Examining Recent Actions by the Office of Federal Contract Compliance Programs: Hearing Before the Subcomm. on Workforce Protections, House Comm. on Education and the Workforce, 113th Cong. 9-11 (2013) (prepared Testimony of F. Curt Kirschner, American Hospital Association), available at http://edworkforce.house.gov/uploadedfiles/kirschner_statement_and_testimony.pdf ["2013 Testimony"].*

United States Government.” Clearly, hospitals participating in TRICARE, FEHBP and Medicare do not receive reimbursements because they are providing services for the benefit of the government. Instead, the “beneficiaries” of these payments are the service members, federal employees and retirees who receive medical care. The most logical reading of the Grant Act, thus, cannot be stretched to define health care providers participating in federally funded health benefit programs as federal contractors.

Regulations promulgated by the agencies responsible for TRICARE and the FEHBP agree with this conclusion. For more than 25 years, the Office of Personnel Management, which administers the FEHBP, has explicitly excluded from its definition of subcontractor “providers of direct medical services . . . pursuant to [a] health benefits plan.” Similarly, Department of Defense regulations designate TRICARE reimbursements as a form of federal financial assistance, which does not constitute a federal contract subject to OFCCP regulations.

Now, the OFCCP is taking a different position – one that not only creates unnecessary interagency conflict but also clashes with congressional directives. In 2006, the agency filed administrative complaints in *OFCCP v. UPMC Braddock*, seeking to enforce its affirmative action regulations against three hospitals affiliated with the University of Pittsburgh Medical Center. The OFCCP based its assertion of jurisdiction on the fact that the hospitals had an HMO contract to provide health care services to FEHBP participants. The hospitals objected to the agency’s line of reasoning, arguing that providing health care services to patients should not convert the hospitals into federal contractors. Eight years later, the case remains pending before the D.C. Circuit.

In another, well-publicized case, *OFCCP v. Florida Hospital of Orlando*, the agency has claimed that Florida Hospital is a covered federal subcontractor solely as a result of its agreement to provide health care services to TRICARE beneficiaries. Congress acted to head off this assertion of jurisdiction by passing Section 715 of the National Defense Authorization Act for Fiscal Year 2012 (NDAA), which President Obama signed into law in 2011. The NDAA included a provision expressly exempting TRICARE network providers from federal contractor status.

Instead of honoring and enforcing this new law, however, the OFCCP continued to pursue a finding of federal contractor status against Florida Hospital. The agency argued – contrary to congressional intent – that the NDAA did not act as a complete bar to its jurisdiction over TRICARE providers. In briefing to the ARB, the OFCCP even suggested that the Secretary of Labor’s authority *exceeds* that of Congress, complaining that the NDAA “usurped” the secretary’s authority to determine which providers are subcontractors under the laws that OFCCP enforces (*see* OFCCP’s Resp. to ARB’s Request for Briefing on the Impact of Sec. 715 of the NDAA, ARB Case No. 11-011 (filed Mar. 13, 2012)).

The ARB initially rejected the OFCCP’s arguments. In response to the agency’s petition for a rehearing, however, the ARB reversed its previous stance and ultimately agreed that the NDAA did not entirely foreclose the OFCCP’s assertion of jurisdiction over Florida Hospital. Five years after the agency first brought its action, the case remains pending before an administrative law judge (ALJ) to determine whether TRICARE reimbursements constitute a federal contract or federal financial assistance, over which the OFCCP does not have jurisdiction.

The OFCCP's persistent attempts to circumvent the NDAA confirm the need for legislation that places clear limits on the agency's jurisdiction. The Protecting Health Care Providers from Increased Administrative Burdens Act unambiguously states that the OFCCP cannot treat hospitals and other health care providers as federal contractors or subcontractors simply because the government reimburses them for providing health care services to participants in TRICARE, the FEHBP or any other federally funded health benefit program. At the same time, H.R. 3633 would not interfere with the OFCCP's rightful jurisdiction over hospitals and other health care providers that have voluntarily entered into government contracts and subcontracts. These organizations would still be subject to the affirmative action regulations enforced by the agency.

H.R. 3633 WILL PREVENT NEEDLESS AND COSTLY LITIGATION OVER THE CLASSIFICATION OF HEALTH CARE PROVIDERS AS FEDERAL SUBCONTRACTORS

The OFCCP's proposed alternative to the clear boundaries set by H.R. 3633 is a "case by case" approach to determining the federal subcontractor status of health care providers. Disturbingly, the agency has not articulated any clear standards that would govern this *ad hoc* approach, stating only that it will act "in keeping with its regulatory principles . . . and OFCCP case law." This vague explanation inevitably will lead to confusion and jurisdictional disputes. Indeed, under the OFCCP's approach, the vast majority of hospitals and health care providers are unlikely to realize that they may be considered federal subcontractors until the OFCCP notifies them of an impending compliance audit. This outcome is particularly unfair given that many hospitals agreed to participate in federally funded health benefit programs with the understanding that they would not thereby become subject to OFCCP jurisdiction. For example, in *UPMC Braddock*, the hospitals' HMO contracts explicitly provided that they were not federal subcontractors.

While the OFCCP has refused to offer any identifiable standard for judging who is a federal subcontractor, the agency's prior statements indicate that it will attempt to distinguish between hospitals that have entered into traditional fee-for-service agreements and those that participate in so-called "managed care" components of TRICARE, the FEHBP and Medicare Parts C and D. "Managed care" includes agreements between hospitals and health maintenance organizations (HMOs), preferred provider organizations (PPOs) and similar health plans, which make the provision of health care services a contract requirement. The OFCCP contemplates that hospitals providing services under these types of agreements are federal subcontractors subject to its jurisdiction. By contrast, the OFCCP has not asserted – and, given the *Bridgeport* decision, cannot assert – jurisdiction over participants in fee-for-service plans.

Unfortunately for America's hospitals, the OFCCP's position sets up a distinction without a difference. From the perspective of hospitals, fee-for-service plans, HMOs and PPOs are simply different mechanisms for accomplishing the same goal of reimbursing the health care providers for delivering care to patients. A hospital's responsibilities to care for a patient do not vary in any material way depending on the type of plan in which that patient is enrolled. Indeed, the only real difference for a hospital between providing care for a patient covered by an HMO and a patient covered by a fee-for-service plan is likely to be the contracted reimbursement rate. While

the plan administrators of managed care plans may have different responsibilities with respect to their covered participants than administrators of a fee-for-service plan, those administrator responsibilities generally are not passed through to the hospitals. Regardless of the type of plan involved, the role of the hospital remains the same, i.e., to provide care for the patient.

Even assuming, *arguendo*, that the OFCCP has articulated a meaningful distinction, it cannot explain how this distinction will practically be applied. Private pure fee-for-service plans, with no “managed” components to control costs, are on the verge of extinction. The plans that remain vary widely in organization and administration.

The three federally funded health benefit plans at issue are no exception to this trend. Together, they offer federal employees, retirees and their families hundreds of plan options, many of which include both fee-for-service and managed care components. TRICARE, for example, offers an overlapping mix of more than 10 plan options, including a traditional fee-for-service option (containing little, if any, managed care components), PPOs and HMOs. The 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.

The OFCCP has provided no guidance regarding which of these health plan options contain sufficient elements of “managed care” such that the participating hospital would be considered a federal subcontractor. As the examples of *Florida Hospital* and *UPMC Braddock* demonstrate, it could take years to resolve this lack of clarity through litigation – if a resolution is possible at all. In the meantime, hospitals that receive audit demands based on their participation in federally funded health benefit programs are presented with a Hobson’s choice between submitting to the OFCCP’s burdensome regulations or spending years bogged down in costly legal proceedings.

Congress must act to define clearly the OFCCP’s jurisdiction before additional hospitals are forced to bear these unnecessary expenses. H.R. 3633 will resolve the ambiguities that the OFCCP has created and curtail further litigation by clarifying that a hospital providing care under Medicare or through any of the plans offered by FEHBP or TRICARE is not considered a federal subcontractor based on this fact alone.

H.R. 3633 REMOVES OBSTACLES TO PROVIDING HEALTH CARE SERVICES TO MEMBERS OF THE MILITARY, FEDERAL EMPLOYEES AND THEIR FAMILIES

The OFCCP’s expansionist agenda is forcing hospitals to make another difficult choice: whether to risk providing care to military service members and federal employees at all. As set forth above, hospitals that choose to continue providing care to FEHBP and TRICARE participants may be required to expend significant additional resources to comply with the OFCCP’s complex regulatory scheme – even though these hospitals themselves hold no contracts with the federal government. The AHA previously explained in testimony to this committee that hospitals can spend hundreds of hours and tens of thousands of dollars simply updating and maintaining the Affirmative Action Plan required by the OFCCP. This time and capital

expenditure increases dramatically during audit years, and the OFCCP is conducting compliance reviews with increasing regularity.²

These additional administrative costs divert vital resources from hospitals' central mission of providing quality patient care. Faced with the risk of these increased burdens, some hospitals may decide to stop providing services to participants in TRICARE or the FEHBP, thus limiting the health care options available to federal employees, service members, and their families.

This possibility is particularly distressing given that the Department of Defense has already recognized and reported a trend that fewer health care providers are accepting new TRICARE patients.³ The National Military Family Association (NMFA) recently warned Congress that a lack of long-term willingness by providers to remain in the TRICARE network could negatively affect beneficiary access in future years. The NMFA noted that providers have complained of uncertainties over the added requirements and expenses that their participation in TRICARE could incur.⁴ The Military Officers Association of America, the nation's largest association of military officers, concurs in this assessment, proclaiming that "action is urgently needed to attract more providers to participate in TRICARE."⁵ Yet despite this appeal, the OFCCP continues to seek to increase the cost of TRICARE participation by requiring some unspecified number of providers to comply with its affirmative action regulations.

Congressional action is needed to ensure that the OFCCP does not overstep its bounds and, in so doing, reduce access to quality and convenient care for service members, federal employees and their families. By clarifying that a hospital or other health care provider will not be subject to a crushing regulatory burden simply because it provides health care services to TRICARE or FEHBP participants, H.R. 3633 removes the disincentives that hospitals now have to treat patients who get their health insurance through a federally funded program.

CONCLUSION

At a time when lowering health care costs is one of the nation's top policy concerns, the OFCCP is making an aggressive jurisdictional land grab that will increase the administrative costs for hospitals and other health care providers. This assertion of jurisdiction runs counter to federal statutes, the regulations of OFCCP's sister agencies, and plain common sense. The AHA urges Congress to end the uncertainty that the OFCCP has created by passing H.R. 3633 and clarifying once and for all that participation in a federally funded health benefit program does not subject health care providers to OFCCP jurisdiction.

² 2013 Testimony, *supra* n. 1, at 9-11 (2013).

³ 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>.

⁴ *Hearing Before the Subcomm. on Personnel, Senate Armed Services Comm.*, 113th Cong. 11-12 (2013) (Statement of the National Military Family Association), available at

<http://www.militaryfamily.org/assets/pdf/Testimony/NMFA-SASC-Personnel-testimony-4-17-13.pdf>.

⁵ Military Officers Association of America, *TRICARE Prime and TRICARE Standard Improvements* (Jan. 8, 2014), available at

https://www.moaa.org/Main_Menu/Take_Action/Top_Issues/Serving_in_Uniform/TRICARE_Prime_and_TRICARE_Standard_Improvements.html.