THE EXPANSION OF FEDERAL SUBCONTRACTOR STATUS TO HEALTH CARE PROVIDERS

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I. INTRODUCTION

The Federal Government imposes significant socioeconomic obligations upon government contractors and subcontractors.[1] The most significant is a suite of equal opportunity and affirmative action requirements.[2] Because of the compliance burden of these requirements, whether a subcontract is "covered" and subject to equal opportunity and affirmative action laws is a crucial issue for potential subcontractors.[3] Health care providers have historically viewed themselves as exempt from these equal opportunity and affirmative action requirements in the absence of direct contractual relationships with federal agencies.[4]

In recent years, the U.S. Department of Labor (DoL) Office of Federal Contract Compliance Programs (OFCCP) has been aggressively enforcing the equal opportunity and affirmative action requirements in federal contracts and subcontracts, while also attempting to expand its jurisdiction.[5] As part of the OFCCP's efforts to expand its jurisdiction, health care providers are now in the OFCCP's crosshairs.[6]

Over the last several years—reflected in litigation and agency guidance—OFCCP has maintained that health care providers under contract to commercial managed care plans, which provide health care benefits and services via the Office of Personnel Management's (OPM) Federal Employees Health Benefits Program (FEHBP) and the Department of Defense's (DoD) TRICARE Program (TRICARE), are subject to socioeconomic requirements.[7] OFCCP's position has been upheld in federal court and by the DoL review board; this occurred despite a long-standing conflicting agency regulation, in the case of the FEHBP,[8] and recently enacted legislation designed to blunt the expan-

1. *See*, *e.g.*, Exec. Order No. 11,246, 3 C.F.R. §§ 167–76 (1966), *reprinted as amended in* 41 C.F.R. § 113 (2009); The Rehabilitation Act of 1973, 29 U.S.C. §§ 701–96 (2006); Vietnam Era Veterans' Readjustment Assistance Act of 1974, 38 U.S.C. § 4212 (2006).

2. The regulations impose a multitude of compliance requirements; the equal opportunity and affirmative action obligations, by far, are considered the most fundamental provisions. *See* Exec. Order No. 11,246, 3 C.F.R. 167–76; *see also* 29 U.S.C. §§ 701–96; 38 U.S.C. § 4212.

3. *See* William Hays Weissman, *A Guide to Determining Covered Federal Government Contractor Status: Helping Businesses Determine if They Must Comply with Affirmative Action and Specific Anti-discrimination Rules*, THE LITTLER REP., Jan. 29, 2013, at 2.

4. *See* Kathleen M. Williams, *Aggressive New Assertions of Jurisdiction by OFCCP over Hospitals and Other Healthcare Providers*, AHLA CONNECTIONS, May 2011, at 38.

5. *See*, *e.g.*, UPMC Braddock v. Harris, 934 F. Supp. 2d 238, 241–42 (D.D.C. 2013); OFCCP v. Fla. Hosp. of Orlando (*Fla. Hosp. III*), ARB No. 11-011, Decision and Order of Remand (Dep't of Labor July 22, 2013); OFCCP v. O'Melveny & Myers, LLP, ARB No. 12-014, Decision and Order of Remand (Dep't of Labor Aug. 30, 2013).

6. *See generally* Jon Zimring & Cheryl B. Bryson, *U.S. Government Contractor/Subcontractor Status: The Danger of Continued Complacency*, 19 Health L. Rep. (BNA) 513 (2010).

7. *See*, *e.g.*, *UPMC Braddock*, 934 F. Supp. 2d at 244; *Fla. Hosp. III*, ARB Case No. 11-011; DEP'T OF LABOR, DIRECTIVE 293, COVERAGE OF HEALTH CARE PROVIDERS AND INSURERS (2010) [hereinafter DIRECTIVE 293].

8. *See UPMC Braddock*, 934 F. Supp. 2d at 244, 261; FEHBAR 1602.170-15.

sion of OFCCP's jurisdiction to providers under TRICARE.[9] Its inexorable march forward appears to contemplate a possible expansion to managed care plans under Medicare Parts C and D, despite case law that Medicare Parts A and B do not trigger such obligations.[10] The irony of expanding OFCCP's jurisdiction to apply the equal opportunity and affirmative action requirements to providers under FEHBP and TRICARE contracts is that these federal programs were designed to provide health care benefits and services through commercial health insurance plans.[11]

Regardless of the merits of the government's socioeconomic policies, it may not be in the public interest for their reach to be so broad and so unpredictable that the effect is to create inadvertent or unknowing government subcontractors. This result would be particularly onerous for a segment of the health care industry that is currently under enormous regulatory and financial pressure in the wake of health care reform and the transition to value-based pay.[12] Increased scrutiny and expansion of the OFCCP's jurisdiction aggravates the problem as health care providers, without advance warning, receive notice to provide affirmative action plans and supporting documentation, the first stage of the compliance evaluation.[13]

This Article will examine recent developments regarding health care providers as covered subcontractors under the equal opportunity and affirmative action requirements. Part II will analyze the statutory and regulatory framework for the OFCCP's enforcement of equal opportunity and affirmative action laws. Part III will discuss the historical basis that led health care providers to conclude they are not subcontractors under OFCCP's jurisdiction. Part IV will review the OFCCP's recent attempts to assert jurisdiction over health care providers. Parts V, VI, and VII will analyze the current state of the law on three central issues that affect whether a health care provider is subject to OFCCP jurisdiction: Part V will examine whether federal health care programs are financial assistance or government contracts; Part VI will explore whether health care providers provide nonpersonal or personal services; and Part VII will discuss whether prime contractors are providing insurance or health care services.

9. *See Fla. Hosp. III*, ARB Case No. 11-011; 10 U.S.C. § 1097b(a)(3) (2012).

10. *See* United States v. Baylor Univ. Med. Ctr., 736 F.2d 1039, 1042–43 (5th Cir. 1984) (Medicare and Medicaid are financial assistance programs such that provider agreements under these programs are covered under section 504 of the Rehabilitation Act).

11. *See* Jessica Lynn Pyle, *The Continued Health Care Benefit Program: The Department of Defense's Guarantee of Lifetime Health Care to All Former Military Spouses*, 56 NAVAL L. REV. 199, 201 n.11 (2008) (describing the legislative intent behind CHAMPUS, the predecessor to TRICARE).

12. *See, e.g.*, Patient Protection and Affordable Care Act (ACA), 42 U.S.C. §§ 18001–121 (Supp. V 2012).

13. Williams, *supra* note 4, at 38. *Braddock* and *Florida Hospital* both were initiated by the Office of Federal Contract Compliance Programs (OFCCP) serving notices to the hospitals for compliance reviews. *See id.* at 39–40.

II. STATUTORY AND REGULATORY FRAMEWORK

The OFCCP administers and enforces three laws (collectively, AA Laws): Executive Order 11246 (EO 11246),[14] as amended; section 503 of the Rehabilitation Act of 1973 (Section 503), as amended;[15] and the Vietnam Era Veterans Readjustment Assistance Act of 1974 (VEVRAA), as amended.[16] Together, the AA Laws "prohibit federal contractors and subcontractors from discriminating in employment decisions on the basis of race, color, religion, sex, national origin, disability or status as a [covered] veteran."[17]

Health care providers are typically required to comply with other federal and state antidiscrimination laws including Title VII, the Americans with Disabilities Act, and any state equivalents.[18] The application, however, of federal contractor or subcontractor status to health care providers for purposes of the AA Laws requires covered contractors and subcontractors to develop and maintain detailed affirmative action plans and imposes additional extensive recordkeeping, posting, and reporting obligations.[19] Additionally, under the AA Laws, federal contractors and subcontractors are subject to a range of OFCCP evaluations, including compliance reviews with a "comprehensive analysis of hiring and employment practices" as well as "on-site reviews conducted at the contractor's establishment."[20] Failure to comply with AA Laws could subject health care providers to sanctions and penalties, including withholding of payments, termination of the contract, or potential debarment.[21]

The AA Laws apply to Federal Government contracts and subcontracts.[22] Implementing regulations define a "government contract" as follows:

> [A]ny agreement or modification thereof between any contracting agency and any person for the purchase, sale or use of personal property or nonpersonal services . . . . The term *Government contract* does not include agreements in which the parties stand in the relationship of employer and employee, and federally assisted contracts.[23]

A threshold issue for OFCCP, therefore, is whether a health care provider is performing a Federal Government contract or subcontract or, alternatively, whether reimbursement for services under its provider agreement is federal financial assistance.[24]

14. Exec. Order No. 11,246, 3 C.F.R. §§ 167–76 (1966), *reprinted as amended in* 41 C.F.R. § 113 (2009).
15. 29 U.S.C. § 793 (2006).
16. 38 U.S.C. § 4212 (2006).
17. *See* Karen M. Buesing & Martin R. Dix, *The OFCCP Rescinds Directive Which Sought to Expand Federal Contractor Status to Many Healthcare Providers*, ABA HEALTH ESOURCE, May 2012.
18. *Cf. id.*
19. *See generally* 41 C.F.R. §§ 60-300.5, 60-300.44, 60-741.5, 60-741.44 (2013).
20. *Id.* §§ 60-300.60(a)(1), 60-741.60(a)(1).
21. *Id.* §§ 60-300.66, 60-741.66.
22. *Id.* §§ 60-741.1(b), 60-250.1(b).
23. *Id.* §§ 60-741.2(i), 60-250.2(i).
24. *See* OFCCP v. Fla. Hosp. of Orlando (*Fla. Hosp. III*), ARB Case No. 11-011, Decision and Order of Remand (Dep't of Labor July 22, 2013). The Administrative Review Board (ARB)

Central to the analysis of whether a health care provider is a subcontractor is the DoL's regulatory definition of a subcontract. The AA Laws' implementing regulations define "subcontract" as

> any agreement or arrangement between a contractor and any person (in which the parties do not stand in the relationship of the 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.[25]

The AA Laws are applicable to neither personal services subcontracts nor those that do not require the performance of any portion of the prime contractor's obligations.[26]

Neither the implementing regulations nor the OFCCP specifically defines the term "nonpersonal services."[27] The regulatory guidance merely provides examples of the type of services the term would encompass, including, inter alia, "[u]tilities, construction, transportation, research, insurance, and fund depository."[28] An entity that enters into a contract with the government to provide insurance services is thus providing nonpersonal services; any entity "with which the contractor subcontracts to provide nonpersonal services necessary to the performance of the prime contract" is therefore a covered subcontractor.[29]

These definitions, established in regulations and interpreted by the courts and agencies, have played a major role in determining whether certain health care providers under OPM's FEHBP and DoD's TRICARE program are covered subcontractors.[30] These interpretations, which are currently being litigated, could have a significant impact on health care providers that support other federal health care programs.[31]

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remanded the case to the administrative law judge (ALJ) to determine whether TRICARE constituted federal financial assistance. *Id.* If TRICARE constituted federal financial assistance, the TRICARE prime contract would not be a covered government contract and there would be no need to analyze whether the hospital was a covered subcontractor. *Id.*

25. 41 C.F.R. §§ 60-741.2(l), 60-250.2(l); *see also* FAR 22.801. The definition of "subcontract" in the Federal Acquisition Regulation (FAR) implementation of the AA Laws is very similar to the subcontract definition implemented in the AA Laws' implementing regulations, which the court in *Braddock* noted. *See* UPMC Braddock v. Harris, 934 F. Supp. 2d 238, 242 (D.D.C. 2013). Subsection 1 will be referred to as "Prong 1" and subsection 2 will be referred to as "Prong 2."

26. *See* 41 C.F.R. §§ 60-741.2(l), 60-250.2(l).

27. *See id.* §§ 60-741.2(i)(4), 60-250.2(i)(4).

28. *See id.*

29. Williams, *supra* note 4, at 38.

30. *See*, *e.g.*, *UPMC Braddock*, 934 F. Supp. 2d at 254; OFCCP v. Fla. Hosp. of Orlando (*Fla. Hosp. III*), ARB Case No. 11-011, Decision and Order of Remand (Dep't of Labor July 22, 2013).

31. *See infra* Part V.

III. HISTORICAL BASIS FOR HEALTH CARE PROVIDERS NOT BEING CHARACTERIZED AS COVERED SUBCONTRACTORS

A. *The Medicare and Medicaid Programs Have Been Determined to Be Federal Financial Assistance*

Prior to 1993, the OFCCP asserted jurisdiction over health care providers that participated in the Medicare and Medicaid programs.[32] However, after the Department of Health and Human Services (HHS) determined that reimbursement under provider agreements under the Medicare and Medicaid programs was "federal financial assistance" and not a "government contract," hospitals challenged OFCCP's jurisdiction.[33] The courts also concluded that Medicare and Medicaid payments to providers for medical services qualified as "federal financial assistance."[34]

In 1993, OFCCP issued formal guidance through Directive Number 189.[35] Directive 189 explained that "OFCCP will not assert jurisdiction over a healthcare entity solely on the basis of its receiving reimbursement for services to Medicare or Medicaid beneficiaries."[36] Health care providers have relied on this directive as precedent that they are not covered subcontractors subject to federal contract requirements.[37]

B. *Health Care Services Subcontracts Were Not Covered Subcontracts Under the FEHBP*

In 2003, health care providers participating in OPM's FEHBP gained assurances that they were not subject to OFCCP jurisdiction as covered subcontractors.[38] In a DoL Administrative Review Board (ARB) decision, *OFCCP v. Bridgeport Hospital*, Blue Cross/Blue Shield Association (Blue), on behalf of its member plans, contracted with the government to provide a fee-for-service insurance plan for federal employees as part of FEHBP.[39] Blue Cross/Blue Shield of Connecticut, Inc. (Connecticut Blue) had previously executed provider agreements with hospitals, including Bridgeport, to reimburse the hospitals for medical services provided to Blue plan or member contracts during the applicable period, including those of federal employees.[40]

32. *See* Williams, *supra* note 4, at 40.
33. *See id.*
34. *See* United States v. Baylor Univ. Med. Ctr., 736 F.2d 1039, 1042–43 (5th Cir. 1984).
35. *See* Williams, *supra* note 4, at 39.
36. Although Directive 189 was rescinded (similar to Directive 293, which also established that Medicare A and B was federal financial assistance), *Baylor* remains good law. *Baylor Univ. Med. Ctr.*, 736 F.2d at 1042–43; *see also* DEP'T OF LABOR, DIRECTIVE 301, NOTICE OF RESCISSION (2012) [hereinafter DIRECTIVE 301].
37. *See* Williams, *supra* note 4, at 38–39.
38. *See* OFCCP v. Bridgeport Hosp., ARB No. 00-034, Final Decision and Order, at 5 (Dep't of Labor Jan. 31, 2003).
39. *See id.* at 2.
40. *Id.*

Blue was a federal contractor subject to the AA Laws; the ARB reviewed whether the contracted health care providers (i.e., the hospitals) were covered subcontractors.[41] Based on contractual terms, the ARB concluded that the contract did not obligate Blue to provide medical services but instead to provide reimbursement to the policyholders for medical care costs.[42] Consequently, the ARB did not reach the question of whether the medical services provided by Bridgeport were "necessary to" or a portion of the prime contract or obligations, as required to meet the OFCCP's regulatory definition of a subcontractor.[43]

The ARB relied on several different provisions of the OPM's FEHBP contract to reach its conclusion.[44] Contract language stated that Blue would not guarantee admission of members to a particular hospital.[45] Additionally, the contract included references to reimbursement and indemnification for "physician, laboratory, hospital, and related charges for care and services," which the ARB found were inconsistent with a contract to provide medical services.[46] Because the hospitals administered medical services but the OPM contract provided insurance, the ARB held that agreements between the insurer and the provider of medical services were not OFCCP-covered subcontracts.[47]

IV. OVERVIEW OF DECISIONS DEMONSTRATING THE OFCCP'S EXPANSION OF OBLIGATIONS TO HEALTH CARE PROVIDERS

The *Bridgeport* decision provided a basis for health care providers' disputes regarding OFCCP's jurisdiction based on services provided to federal employees under health plan network agreements under the FEHBP.[48] Recently, however, the OFCCP has been successful in bringing health care providers under federal health care regimes back into the covered subcontract arena. Two cases, *UPMC Braddock v. Harris* in federal court and *OFCCP v. Florida Hospital of Orlando* before the DoL ARB, ultimately question whether health care providers under contract to FEHBP and TRICARE prime contractors can avoid the AA Laws' obligations.

41. *See id.* at 3.
42. *Id.* at 6.
43. *Id.*
44. *See id.* at 5.
45. *Id.* at 6.
46. *Id.* at 5. In its decision, the ARB made no mention of the definition of subcontractor under the Federal Employee Health Benefits Acquisition Regulation (FEHBAR), which expressly excludes "providers of direct medical services." 48 C.F.R. § 1602.170–15 (2013). Nor did it discuss the statutory requirement for Blue Cross/Blue Shield Association to provide a network for health care delivery. *See* 5 U.S.C. § 8903(1) (2012) (addressing the obligation of a service benefit plan "offering . . . benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services").
47. *See Bridgeport Hosp.*, ARB No. 00-034, at 5.
48. *See id.*; *see also* Karen M. Buesing & Martin R. Dix, *The OFCCP's Expanding Reach—Healthcare Providers as Federal Contractors*, ABA HEALTH ESOURCE, Dec. 2011.

A. *UPMC Braddock v. Harris*

The *Braddock* case was the first federal court decision to address whether health care providers are subcontractors covered by OFCCP's jurisdiction.[49] The U.S. District Court for the District of Columbia held that three hospitals affiliated with the University of Pittsburgh Medical Center (the hospitals) were subcontractors to an affiliated health maintenance organization (HMO), UPMC Health Plan (the Health Plan), and provided medical services and supplies to federal employees under the FEHBP.[50] The basis for the dispute in *Braddock* arose after OFCCP demanded that the three hospitals provide evidence of their affirmative action compliance programs and schedule a compliance review under the AA Laws.[51] The hospitals stated that they did not have affirmative action programs and denied "that they held [any] government subcontracts" that would subject them to OFCCP's jurisdiction.[52]

In 2006, OFCCP filed an action against the hospitals to enforce the AA Laws.[53] A DoL administrative law judge (ALJ) issued a decision and order granting summary judgment to OFCCP, holding that the hospitals were subject to OFCCP's authority because the hospitals were subcontractors.[54] On appeal, the DoL ARB affirmed the ALJ's decision.[55] The ARB held that the hospitals' agreements with the health plan were subcontracts covered by the AA Laws.[56] The hospitals then appealed to the district court asking the court to set aside the ARB's decision.[57]

The hospitals had executed payment agreements with the Health Plan for medical services provided to individuals *under any UPMC plan*.[58] The prime contract at issue was the Health Plan contract with the FEHBP to establish an HMO and offer coverage for supplies and medical services for federal employees.[59] The contract between OPM and the Health Plan included language excerpted from the Federal Employees Health Benefits Acquisition Regulation (FEHBAR) that explicitly excluded health care providers as subcontractors.[60] Specifically, the contract defined subcontractor as "any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, or another subcontractor, *except for providers of*

49. *See UPMC Braddock: Has Anything Changed with OFCCP's Jurisdiction over Subcontractor Hospitals?*, HUSCH BLACKWELL (Apr. 16, 2013), http://www.huschblackwell.com/businessinsights/upmc-braddock-has-anything-changed-with-ofccps-jurisdiction-over-subcontractor-hospitals.
50. *See* UPMC Braddock v. Harris, 934 F. Supp. 2d 238, 240–41, 253, 261 (D.D.C. 2013).
51. *Id.* at 244.
52. *See id.*
53. *Id.*
54. *Id.*
55. *Id.*
56. *Id.*
57. *Id.*
58. *Id.* at 243–44.
59. *Id.*
60. *Id.* at 246, 249. The Federal Employees Health Benefits Acquisition Regulation (FEHBAR) is an agency supplement to the FAR. FEHBAR 1601.101.

direct medical services and supplies pursuant to the Carrier's health benefits plan."[61]

The court rejected the hospitals' argument that they were not federal subcontractors because of the exclusion of health care providers from the OPM's contract definition of "subcontractor."[62] Because the DoL has exclusive authority to administer the AA Laws, OPM and the Health Plan had no authority to adopt a narrower definition; the contract's definition, therefore, had no effect on the application of the AA Laws.[63] Ultimately, the court relied on the definition of subcontract from the OFCCP regulations implementing the AA Laws and the substantially similar definition in FAR Part 37, rather than the more specific definition and application to health care providers in the FEHBAR.[64]

The court gave no weight to the hospitals' argument that they never agreed to be bound by the AA Laws in their agreements with the Health Plan,[65] even while noting that the Court of Appeals for the D.C. Circuit has not adopted the *Christian* doctrine.[66] Relying on case law where clauses have been imposed on prime contractors by operation of law, the court held that the required AA Laws were incorporated by law into government subcontracts.[67]

In holding that health care providers were covered subcontractors, the court determined that the health care provider contracts were for nonpersonal services.[68] Because the hospitals were not in an employer-employee relationship with the Health Plan or under that type of supervision or control, the court concluded that they provided nonpersonal services.[69]

Additionally, the court confirmed that the hospitals' contracts with the Health Plan met the regulatory definition of a subcontract because the medical services the hospitals provided were necessary to the performance of the prime contract between the Health Plan and the OPM.[70] The court distinguished the traditional fee-for-service insurance plan in *Bridgeport* from the HMO

61. *Braddock*, 934 F. Supp. 2d at 249 (quoting FEHBAR 1602.170-15 (emphasis added)).

62. *Id.* at 246–47 ("[N]either the UPMC Health Plan nor a federal contracting agency is empowered to override the mandatory requirements of two federal statutes and an Executive Order.").

63. *Id.* at 246.

64. *Id.* at 247–49.

65. *Id.* at 258–59.

66. *Id.* at 257. Under the *Christian* doctrine, all mandatory contract clauses that express a " 'significant or deeply ingrained strand of public procurement policy' " are incorporated into a contract by operation of law. *See id.* (quoting S.J. Amoroso Constr. Co. v. United States, 12 F.3d 1072, 1075 (Fed. Cir. 1993)).

67. *Id.* at 257–58. The OFCCP regulations require that the clauses implementing the AA Laws " 'shall be considered to be a part of every contract and subcontract required by the [statute or executive] order and the regulations in this part to include such a clause *whether or not it is physically incorporated in such contracts* and whether or not the contract between the agency and the contractor is written.' " *Id.* at 242 (citing 41 C.F.R. § 60-1.4(e) (implementing Exec. Order No. 11246) (emphasis added); 41 C.F.R. § 60-741.5(e) (implementing the Rehabilitation Act); *id.* § 60-250.5(e) (implementing VEVRAA)).

68. *See id.* at 248.

69. *Id.* at 248–49.

70. *Id.* at 254.

Health Plan in *Braddock*.[71] Moreover, the court held that the Health Plan in *Braddock* agreed to function as an HMO and to provide medical services to federal employees.[72] Therefore, the "contract depended on medical providers like the [hospitals] to offer medical services and supplies necessary for the Health Plan to meet a portion of the obligations under the OPM contract."[73]

B. *OFCCP v. Florida Hospital of Orlando*

In another decision expanding the DoL's jurisdiction over health care providers, the ARB reconsidered whether a network participation agreement entered into by Florida Hospital with Humana Military Health Services (HMHS) for the provision of health care services to TRICARE beneficiaries constituted a covered subcontract.[74]

Like *Braddock*, *Florida Hospital* began when the OFCCP asserted jurisdiction and requested a compliance review.[75] On October 18, 2010, the ALJ held that the OFCCP had jurisdiction over the hospital.[76] The ALJ concluded that the hospital was a covered subcontractor because "it performs a portion of the subcontractor's obligations by providing some of the medical services to TRICARE beneficiaries which HMHS has contracted to provide."[77] In response, the hospital appealed to the ARB.[78]

Prior to the ARB hearing, but after the parties had briefed the issues, President Obama signed into law the National Defense Authorization Act for 2012 (FY 2012 NDAA).[79] The FY 2012 NDAA provided that TRICARE managed care contracts that include the requirement to " 'establish, manage, or maintain' " a provider network may not be considered contracts for the performance of health care services or supplies when determining whether such entities are subcontractors for the purposes of the FAR or any other law.[80]

Relying on the FY 2012 NDAA[81] and its express exclusion, the hospital moved to dismiss the case as moot on January 9, 2012.[82] On October 19,

71. *Id.* at 252–53, 255; *see also* discussion *infra* Part VII.
72. *Id.* at 252–53, 255.
73. *Id.* at 255.
74. *See generally* OFCCP v. Fla. Hosp. of Orlando (*Fla. Hosp. III*), ARB Case No. 11-011, Decision and Order of Remand (Dep't of Labor July 22, 2013).
75. *See id.* at 7.
76. *See id.* at 4, 7.
77. *Id.* at 7. The ALJ in the decision relied solely on Prong Two of the subcontract definition and did not address Prong One. *Id.*
78. *Id.*
79. *Id.* at 4.
80. *Id.* at 12–13 (quoting 10 U.S.C.A. § 1097b(a)(3) (2011)).
81. After passage of the National Defense Authorization Act of 2012 (FY 2012 NDAA), on April 25, 2012, the OFCCP rescinded Directive 293 based on the pending appeal in *Florida Hospital* and the recent enactment of section 715 of the FY 2012 NDAA. *See* DIRECTIVE 301, *supra* note 36. However, the OFCCP acknowledged that it would continue to use a "case-by-case approach to make coverage determinations in keeping with its regulatory principles applicable to contract and subcontract relationships and OFCCP case law." *Id.* The Notice of Rescission was silent on the OFCCP's position regarding Medicare Parts C and D. *See id.*
82. *Fla. Hosp. III*, ARB Case No. 11-011, at 13. The ARB permitted additional briefing on the issue based on the passage of the NDAA. *Id.*

2012, the ARB, sitting en banc, unanimously held that FY 2012 NDAA 715 precluded OFCCP jurisdiction over Florida Hospital under Prong Two of the subcontract definition.[83] Based on the NDAA, the ARB determined that because the hospital's agreement with Humana involved the requirement to maintain a network of health care providers pursuant to a managed care prime contract between TRICARE and HMHS, the contract fit within the exclusion in the FY 2012 NDAA.[84] The panel was divided as to whether the OFCCP retained jurisdiction over Florida Hospital under Prong One of the subcontract definition.[85]

On November 13, 2012, the OFCCP filed a motion for reconsideration, arguing that it had Prong One jurisdiction over TRICARE network providers despite FY 2012 NDAA 715.[86] Upon reconsideration, the ARB rejected the hospital's argument that section 715 eliminated Prong One jurisdiction for OFCCP.[87]

The ARB noted that the language of section 715 does not explicitly remove TRICARE network providers from the definition of subcontractor and does not create a "categorical exclusion" of OFCCP's jurisdiction over TRICARE network providers.[88] Rather, section 715 of the NDAA provides that " 'a TRICARE managed care support contract that includes the requirement to establish, manage or maintain a network of providers may not be considered a contract for the performance of health care services or supplies on the basis of such requirement.' "[89] The ARB held that this language created "a singular and narrow limitation," which the ARB applied to the requirement to establish, manage, and maintain a network of providers of TRICARE managed care support contracts.[90] Thus, based on the language in section 715, the ARB held that network providers could still be considered subcontractors in specific instances.[91]

The ARB held that the HMHS hospital provider agreement satisfied both conditions of Prong One of the subcontract definition because the hospital provided nonpersonal services that were necessary for the performance of Humana's contract.[92] Thus, on reconsideration, the ARB held that the

83. OFCCP v. Fla. Hosp. of Orlando (*Fla. Hosp. II*), ARB Case No. 11-011, Final Decision and Order (Dep't of Labor Oct. 19, 2012), at 14–15 (plurality), 16 (Brown, J., concurring in part and dissenting in part), 22 (Corchado, J., concurring in part and dissenting in part).

84. *Id.* at 14–15 (plurality).

85. *Id.* at 16 (Brown, J., concurring in part and dissenting in part), 22 (Corchado, J., concurring in part and dissenting in part).

86. *Fla. Hosp. III*, ARB Case No. 11-011, at 5.

87. *See id.* at 31.

88. *Id.* at 15.

89. *Id.* at 14 (emphasis added) (quoting 10 U.S.C.A. § 1097b(a)(3) (2011).

90. *Id.* at 15 (emphasis omitted).

91. *Id.* at 15–16.

92. *Id.* at 27; *see also* FAR 37.101. The ARB noted that AA Laws do not define "nonpersonal services." OFCCP v. Fla. Hosp. of Orlando (*Fla. Hosp. II*), ARB Case No. 11-011, Final Decision and Order, at 21 (Dep't of Labor Oct. 19, 2012). Instead, the ARB concluded that the definition of "nonpersonal services" for purposes of AA Laws was settled by its decision in *Braddock*. *Id.* at *22.*

OFCCP had jurisdiction over the hospital to assess the hospital's compliance with the AA Laws.[93]

This decision, however, did not entirely settle the jurisdictional issue.[94] The ARB remanded part of the case back to the ALJ to determine whether TRICARE payments constitute federal financial assistance because the record was insufficient to make a determination.[95] If TRICARE payments are federal financial assistance, then OFCCP's jurisdiction could be barred.[96]

V. FEDERAL FINANCIAL ASSISTANCE VERSUS CONTRACT

While the 2003 *Bridgeport Hospital* decision addressed subcontractor status as related to the FEHBP, the decision did not address the distinction between federal financial assistance and a contract.[97] Nonetheless, prior to that time, OFCCP had issued formal guidance in 1993 conceding that health care providers reimbursed through federal financial assistance were not covered contractors and subcontractors.[98] In OFCCP Directive 189, "Health Care Entities That Receive Medicare and/or Medicaid," OFCCP formally adopted the position that health care providers under Medicare Parts A and B were not covered subcontractors because they "solely" received reimbursement for medical services provided as federal financial assistance.[99] Directive 189 relied on *United States v. Baylor University Medical Center*, which examined whether Medicare and Medicaid were federal financial assistance programs under section 504 of the Rehabilitation Act.[100] Based on the Fifth Circuit's analysis of the legislative history of Medicare and section 504, as well as the HHS regulatory interpretation of Medicare as federal financial assistance, OFCCP mandated that provider agreements for the reimbursement of Medicare were not covered subcontracts.[101]

93. *Fla. Hosp. III*, ARB Case No. 11-011, at 3.
94. *Id.* at 31.
95. *Id.* at 36.
96. *See id.*
97. *See* OFCCP v. Bridgeport Hosp., ARB No. 00-034, Final Decision and Order, at 6 (Dep't of Labor Jan. 31, 2003). After the *Bridgeport* decision, the OFCCP issued Directive 262, which stated:

> Based on the ARB decision, OFCCP cannot use FEHBP coverage as a basis to assert jurisdiction over a health care provider. Coverage over such a provider may be established by other means such as a contractual relationship with the U.S. Department of Veterans' Affairs or the Department of Defense. Coverage may also be established for a teaching hospital doing research for a university that has a contract with the Federal government.

U.S. DEP'T OF LABOR, DIRECTIVE 262, COVERAGE OF HEALTH CARE PROVIDERS BASED ON THEIR RELATIONSHIP WITH PARTICIPANTS IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP) 3 (2003).

98. *See* U.S. DEP'T OF LABOR, DIRECTIVE 189, HEALTH CARE ENTITIES THAT RECEIVE MEDICARE AND/OR MEDICAID (1993) [hereinafter DIRECTIVE 189].
99. *Id.*
100. *See id.*; United States v. Baylor Univ. Med. Ctr., 736 F.2d 1039, 1042–43 (5th Cir. 1984).
101. DIRECTIVE 189, *supra* note 98.

While the AA Laws do not define federal financial assistance, the DoL has recognized that federal financial assistance includes "[a]ny Federal agreement, arrangement, or other contract which has as one of its purposes the provision of assistance."[102] On December 16, 2010, OFCCP issued Directive 293.[103] Here, OFCCP reiterated that agreements under which providers are reimbursed for medical services under "Medicare Parts A and B (or Medicaid) are Federal financial assistance, not contracts."[104] Yet, Directive 293 left open the possibility that contracts under Medicare Parts C and D would not be treated as federal financial assistance.[105]

On April 25, 2012, after the passage of section 715 of the NDAA, OFCCP rescinded Directive 293.[106] Additionally, as Directive 293 superseded both Directives 189 and 262, OFCCP acknowledged that both Directives 189 and 262 were effectively rescinded as well.[107] Consequently, there is no operative OFCCP guidance concerning covered contractor and subcontractors; health care providers must rely on agency interpretations reflected in recent and ongoing litigation. Indeed, the state of uncertainty exists as to which federal programs constitute federal financial assistance and which programs fund contracts.[108] Whether a program qualifies as federal financial assistance, and is thus outside the jurisdiction of OFCCP, is a key issue that is expected to be addressed by the ALJ on remand in the *Florida Hospital* case.[109]

A. *TRICARE*

In the initial decision of *Florida Hospital*, in October 2010, the ALJ squarely rejected the argument that TRICARE was federal financial assistance.[110] While the hospitals argued that "TRICARE and Medicare are 'essentially indistinguishable,'" the ALJ concluded that Medicare is an insurance program and does not provide medical services to its beneficiaries; it

102. Nondiscrimination in Federally Assisted Programs of the Dep't of Labor, 29 C.F.R. § 31.2(e)(5) (2013).

103. DIRECTIVE 293, *supra* note 7, at 1.

104. *Id.* at 5.

105. *See id.* at 11. Examples provided within Directive 293 speculate that "Medicare Advantage and Medicare Part D . . . including fee-for-service plans that provide insurance, but not supplies or medical services to plan members and beneficiaries . . . are direct Federal contracts that establish OFCCP jurisdiction over the insurer." *Id.* at 7. Directive 293 also clarified that Medicare reimbursement under Parts A and B could fall under OFCCP jurisdiction "if the health care provider also holds a separate covered Federal contract or subcontract." *Id.* at 11. "Potential covered contracts may include contracts related to Medicare Advantage (Part C) or Part D programs . . . ." *Id.*

106. DIRECTIVE 301, *supra* note 36.

107. *Id.* ("This rescission should not be interpreted as reinstating prior Directive Numbers 189 and 262.").

108. *Id.* ("OFCCP will continue to use a case-by-case approach to make coverage determinations in keeping with its regulatory principles applicable to contract and subcontract relationships and OFCCP case law.").

109. OFCCP v. Fla. Hosp. of Orlando (*Fla. Hosp. III*), ARB No. 11-011, Decision and Order of Remand, at 36–37 (Dep't of Labor July 22, 2013).

110. OFCCP v. Fla. Hosp. of Orlando (*Fla. Hosp. I*), Case No. 2009-OFC-00002, Summary Decision and Order, at 6 (Oct. 18, 2010).

only "pays for such services."[111] The ALJ contrasted Medicare to the functions of TRICARE:

> TRICARE is the uniformed services [health care] program for active duty service members and their families . . . . TRICARE's primary objectives are to optimize the delivery of health care services in the direct care system for all Military Health System (MHS) beneficiaries and attain the highest level of patient satisfaction through the delivery of world-class health care benefits.
>
> TRICARE brings together the [health care] resources of the uniformed services and supplements them with networks of civilian health care professionals, institutions, pharmacies, and suppliers to provide timely access and high-quality health care services . . . .[112]

The ALJ used this distinction—insurance versus medical services—to distinguish between federal financial assistance and subcontracts that would be covered by the AA Laws, as opposed to any regulatory basis.[113] The ALJ's analysis foreclosed the possibility that TRICARE constituted federal financial assistance; thus, the hospitals were covered subcontractors.[114]

On July 22, 2013, in *Florida Hospital III*, the ARB considered the federal financial assistance question and determined that it was a question of congressional intent and that the record before it was insufficient to permit a determination.[115] Accordingly, the ARB remanded the matter to the ALJ "for further findings and/or legal argument by the parties on the issue of federal financial assistance."[116] Given the ALJ's prior decision, strong evidence may be needed to persuade the ALJ to consider TRICARE to be federal financial assistance and thus precluded from the AA Laws.

B. *Medicare Parts A and B*

Although the OFCCP Directives were rescinded, OFCCP continues to seek expansion of its jurisdiction through litigation. Surprisingly, the most recent *Florida Hospital* decision appears to call into question the long-accepted premise that providers under Medicare Parts A and B are excluded from covered contractor and subcontractor status.[117] Specifically, the ARB stated that a preliminary question should be resolved: "neither party has pointed to any statute or regulation indicating that federal financial assistance programs exclude the possibility of coverage under the EO much less that TRICARE cannot be

111. *Id.* at 5.
112. *Id.* at 5–6.
113. *See id.*
114. *See id.* at 6.
115. OFCCP v. Fla. Hosp. of Orlando (*Fla. Hosp. III*), ARB No. 11-011, Decision and Order of Remand, at 34 (Dep't of Labor July 22, 2013).
116. *Id.* at 36. Additionally, TRICARE is not listed in the Catalog of Federal Domestic Assistance. *See* Office of Mgmt. & Budget, Exec. Office of the President, Catalog of Federal Domestic Assistance (2013) [hereinafter Catalog of Federal Domestic Assistance]. Nonetheless, in the *Florida Hospital* decision, the ALJ noted that the Department of Defense characterized it as financial assistance. *Fla. Hosp. I*, Case No. 2009-OFC-00002, at 6.
117. *Fla. Hosp. III*, ARB Case No. 11-011, at 31.

covered by both the EO Laws and Title VI."[118] This language leaves open the possibility of a change in the treatment of providers under Medicare Parts A and B.[119]

However, despite the ARB's statement, federal case law from the 1980s clearly interpreted and established Medicare Parts A and B as federal financial assistance.[120] OFCCP conceded this issue in Directive 189, which, until its recent rescission, had definitively precluded Medicare Parts A and B from OFCCP's jurisdiction.[121]

C. *Comparing Medicare Parts A and B with Medicare Parts C and D*

Uncertainty still exists regarding contractor and subcontractor status under Medicare Parts C (Advantage Plans) and D (Prescription Drug Coverage). As for the direct covered contracts (i.e., prime contracts), OFCCP in Directive 293 drew a flawed distinction between Medicare Parts A and B versus Parts C and D.[122] Medicare Parts C and D are paid with the same funding as Parts A and B (i.e., Part C is funded from the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust fund accounts) and are similarly listed in the Catalog of Federal Domestic Assistance.[123] Although Parts C and D are implemented through contracts modeled on existing commercial plans, the contracts are not considered to be government contracts,[124] and the structure should not trump the funding of the programs.[125]

The intended beneficiary is another critical issue that OFCCP does not consider, but it would support a conclusion that provider payments under any part of the Medicare program should be treated as federal financial assistance. The intended beneficiaries of the Medicare program are the individual beneficiaries under the program, not the government.[126] The Federal Grant and Cooperative Agreement Act explicitly sets forth the intended beneficiary to determine whether the appropriate vehicle is a contract, grant, or

118. *Id.*

119. *See id.*

120. *See* United States v. Baylor Univ. Med. Ctr., 736 F.2d 1039, 1049 (5th Cir. 1984). The court cites a Supreme Court case, *Fleming v. Nestor*, equating Medicare Parts A and B with Social Security benefits and concluding that the precedent "compels finding 'no contract' in Medicare Part A which uses the same funding system as the social security disability program . . . ." *Id.* (citations omitted). Implicit in the court's analysis is that Medicare Parts A and B cannot be both federal financial assistance and government contracts. *Id.*

121. DIRECTIVE 189, *supra* note 98.

122. *See* DIRECTIVE 293, *supra* note 7, at 5, 7; Williams, *supra* note 4, at 41.

123. *See* BDS. OF TRS. OF THE FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TRUST FUNDS, 2013 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE & FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 163–64 (2013) [hereinafter 2013 TRUST FUND REPORT]; CATALOG OF FEDERAL DOMESTIC ASSISTANCE, *supra* note 116, at API-31.

124. *See* DIRECTIVE 293, *supra* note 7, at 10–11; *see also* 2013 TRUST FUND REPORT, *supra* note 123, at 163–64.

125. *See* DIRECTIVE 293, *supra* note 7, at 5.

126. *See* Federal Grant and Cooperative Agreement Act of 1977, 31 U.S.C. § 6304 (2006).

cooperative agreement.[127] The Act states that a procurement contract reflects the relationship between the government and a contractor when "the principal purpose of the instrument is to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the United States Government."[128] When the Federal Grant and Cooperative Agreement Act is considered in conjunction with the funding for Medicare and the intended beneficiaries of the program, the totality supports a conclusion that all parts should be treated equally as federal financial assistance.[129]

Moreover, while covered contractor status is unclear, the status of health care providers is even murkier. Directive 293 provided some guidance on OFCCP's view of its jurisdiction for insurers, but it did not definitively resolve the status of health care providers providing services under Medicare Part C.[130] To treat health care providers under Part C (and Part D, to the extent relevant) inconsistently with health care providers under Parts A and B, despite having the same funding source, appears inconsistent with the federal financial assistance exemption addressed in *Florida Hospital*.

D. *FEHBP and Beyond*

The *Braddock* case did not address the question of federal financial assistance.[131] The FEHBP is the government's employer-sponsored health benefits plan and not an entitlement program,[132] so it is appropriate to characterize FEHBP contracts as government contracts at the prime contract level.[133] If TRICARE is determined to constitute federal financial assistance, it may affect the analysis of covered contractor and subcontractor status under other programs.[134]

A final open question is whether OFCCP will attempt to assert jurisdiction over the qualified health plans offered on health insurance exchanges authorized by the Patient Protection and Affordable Care Act (Affordable Care Act).[135] To the extent that the health plans are in a state where the exchange is operated by the Federal Government, the health plans are executing agreements to offer plans on the federally facilitated exchanges, and to comply

127. 31 U.S.C. §§ 6303–05.

128. *Id.* § 6303. Additionally, OFCCP had issued Directive ADM 78-1/JUR, which was recently rescinded, supporting the principle that the intended beneficiary affects the determination of an appropriate vehicle. *See* DEP'T OF LABOR, DIRECTIVE 311, Notice of Rescission (July 24, 2013) (rescinding, inter alia, OFCCP Directive ADM 78-1/JUR).

129. *See* 31 U.S.C. §§ 6304–05 (2006); *see also* DIRECTIVE 293, *supra* note 7, at 10–11.

130. *See* DIRECTIVE 293, *supra* note 7, at 11; *see also* discussion *infra* Part VII.

131. *See generally* UPMC Braddock v. Harris, 934 F. Supp. 2d 238 (D.D.C. 2013).

132. 5 U.S.C. §§ 8902–03 (2012).

133. *See Braddock*, 934 F. Supp. 2d at 255 n.9.

134. *See* Deena B. Jenab, *Affirmative Action Requirements Come to Hospitals: Are You in Compliance?*, 13 J. HEALTH CARE COMPLIANCE 61, 63 (2011).

135. *See* James W. Kim, *The Past, Present, and Future of Government Contracting in Healthcare*, 19 ANNALS HEALTH L. 141, 146 (2010) (discussing the need for vigilance in the evolving landscape of contracting with the Federal Government to provide health care services).

with certain standards, requirements, and certifications.[136] In addition, all health plans offered on any of the exchanges will receive premium and cost-sharing subsidies directly from the Federal Government for those individuals who enroll and are eligible for such subsidies.[137]

Accordingly, OFCCP could attempt to assert jurisdiction based on the plans' receipt of the subsidies, and, given OFCCP's successful attempts to expand the scope of its authority, this is not an unlikely outcome.

VI. NONPERSONAL VERSUS PERSONAL SERVICES

A critical element in determining the limits of OFCCP's jurisdiction is the distinction between personal services and nonpersonal services.[138] The OFCCP regulations implementing the AA Laws expressly include under its jurisdiction subcontracts for nonpersonal services that are "necessary to the performance" of a prime contract.[139] The absence of a definition, however, in the AA Laws or the implementing regulations has allowed the courts to graft onto the OFCCP regulations certain FAR definitions, ultimately resulting in the expansion of covered contractor and subcontractor status while simultaneously rejecting the agency-specific limitations of the FEHBAR.[140]

In *Braddock*, the court analyzed OFCCP's regulations and decided that the regulatory guidance was merely a list of nonexclusive examples of nonpersonal services.[141] The court adopted, instead, the nonpersonal services definition from the FAR.[142] In FAR Part 37, a "[n]onpersonal services contract means a contract under which the personnel rendering the services are not subject, either by the contract's terms or by the manner of its administration, to the supervision and control usually prevailing in relationships between the

136. *See* 42 U.S.C. § 18041 (Supp. V 2012).

137. Currently, there is a public dispute between the relevant agency and oversight authorities regarding the application of the Anti-Kickback statute to such plans. *See* Letter from Charles E. Grassley, U.S. Senator, to Kathleen Sebelius, Sec'y of the Dep't of Health & Human Servs., & Eric H. Holder, Att'y Gen. (Nov. 7, 2013) (on file with author). Senator Charles E. Grassley noted that the qualified health plans in the federal exchanges "seem the same as Medicare Advantage." *Id.* The senator explained that, despite the Department of Health and Human Services (HHS) not considering the federal exchanges to be federal health care programs, recent guidance asserted HHS's "broad authority to regulate" federal exchanges. *Id.* According to the letter, Secretary Sebelius noted that "Medicare Advantage is a 'private insurance plan where federal dollars are paid directly out of the Medicare trust fund to Medicare Advantage Plans,' while purchasers of [qualified federal plans] are 'individuals who are paying premiums to a private plan on the marketplace.'" *Id.* The secretary claimed that these "two programs are very different." *Id.*

138. *See* UPMC Braddock v. Harris, 934 F. Supp. 2d 238, 247 (D.D.C. 2013); OFCCP v. O'Melveny & Myers, L.L.P., ARB No. 12-014, Decision and Order of Remand, at 9 (Dep't of Labor Aug. 30, 2013). The *Bridgeport* decision did not analyze this distinction.

139. 41 C.F.R. §§ 60-1.3, 60-741.2(l), 60-250.2(l) (2013).

140. *See Braddock*, 934 F. Supp. 2d at 246–47.

141. *Id.* at 247–50. *See also* 41 C.F.R. §§ 60-741.2(i)(4), 60-250.2(i)(4).

142. *Braddock*, 934 F. Supp. 2d at 248–50. The court rejected the hospitals' argument for using the definition of subcontract from FEHBAR Part 16, which specifically excludes medical providers. *Id.*

Government and its employees."[143] By contrast, "a personal services contract is characterized by the employer-employee relationship it creates between the Government and the contractor's personnel."[144] The court reasoned that the nearly identical definition of subcontract in the FAR and AA Laws supported the application of the FAR definitions of nonpersonal and personal services to the OFCCP regulations.[145] The court distinguished between personal and nonpersonal services by analyzing whether there is an employment relationship between the government and the subcontractor's personnel.[146]

The court rejected the hospitals' argument that the personal nature of the interaction between health care providers and patients was relevant to the determination and held that the hospitals were covered subcontractors under OFCCP jurisdiction.[147] The classification of nonpersonal services depends on the relationship between the government and the subcontractor personnel and not the subcontractor personnel with the intended beneficiary.[148] The court explained that "hospitals provided nonpersonal services because their personnel were neither in an employer-employee relationship with the UPMC nor under the supervision and control that an employer would exercise over its employees."[149]

In *OFCCP v. O'Melveny & Myers*, a recent case unrelated to the health care industry, the ARB again considered the distinction between personal and nonpersonal services.[150] Relying on *Braddock*, the ARB adopted the definitions of nonpersonal and personal services from FAR Part 37.[151] The ARB, in examining whether O'Melveny's contract with the Department of Energy (DoE) for litigation services was for personal services, relied on the FAR for guidance.[152] FAR 37.104(d) contains six "elements" to consider in determining whether a contract is personal.[153] The ARB noted that the

143. FAR 37.101.

144. FAR 37.104(a).

145. Indeed, the court noted, "The only difference between the FAR definition and the Labor Secretary's definition is the substitution of the word 'that' for 'which' and the word 'are' for 'is' within prong (1) of the definition." *See Braddock*, 934 F. Supp. 2d at 248 & n.4 (citing FAR 22.801).

146. *Id.* at 248–49.

147. *Id.* The *Florida Hospital* case also supported this legal application. *See* OFCCP v. Fla. Hosp. of Orlando (*Fla. Hosp. III*), ARB Case No. 11-011, Decision and Order of Remand, at 27 (Dep't of Labor July 22, 2013).

148. *Braddock*, 934 F. Supp. 2d at 248–49.

149. *Id.* (internal citations omitted).

150. OFCCP v. O'Melveny & Myers, L.L.P., ARB No. 12-014, Decision and Order of Remand, at 9 (Dep't of Labor Aug. 30, 2013).

151. *Id.* at 9–10 & nn.20–22.

152. *See id.*

153. *See id.* at 9 n.21. The six "descriptive elements" are

(1) Performance on site.

(2) Principal tools and equipment furnished by the Government.

(3) Services . . . applied directly to the integral effort of agencies or an organizational subpart in furtherance of assigned function or mission.

(4) Comparable services, meeting comparable needs, are performed in the same or similar agencies using civil service personnel.

"key question" for determining whether a government contract is for personal services is whether the government will "exercise relatively continuous supervision and control over the contractor personnel in performing the contract."[154]

The ultimate impact of *O'Melveny* is uncertain, as it was remanded back to the ALJ to assess the evidence under two unresolved elements.[155] Subsequent analysis and litigation of those two elements could prove to be a determinative distinction, at least for certain federal programs. For example, under the TRICARE program, government personnel provide similar health care services, although they may be enlisted rather than civilian personnel. Certainly, under TRICARE, FEHBP, Medicare, and Medicaid, the government does not supervise network providers as it would a government employee.[156]

It might be warranted in the cases involving health care providers to engage in further analysis of the element implicating the "furtherance of assigned function or mission."[157] Arguably, both legal services and health care services aid in furthering the mission of the government or prime contractors.[158] In *O'Melveny*, the attorneys were performing work that directly supported the DoE's mission in divesting a Naval Petroleum Reserve and defending the DoE's equity interest.[159] There could be an argument that health care services or benefits provided by an agency in its capacity as an employer (e.g., TRICARE or FEHBP) are distinct from those related to an agency's mission (i.e., Medicare).[160]

But in the event that the services in *O'Melveny* are deemed to involve personal services not covered by OFCCP jurisdiction, this incongruous result would overlook similarities between the health care services and legal services industries. Conversely, if the law firm is deemed a covered contractor

(5) The need for the type of service provided can reasonably be expected to last beyond one year.
(6) The inherent nature of the service, or the manner in which it is provided reasonably requires directly or indirectly, Government direction or supervision of contractor employees in order to—

(i) Adequately protect the Government's interest;
(ii) Retain control of the function involved; or
(iii) Retain full personal responsibility for the function supported in a duly authorized Federal officer or employee.

Id.

154. *Id.* at 9–10.
155. *Id.* at 14. After review, the ARB determined that there was insufficient evidence to make a determination for two of the six elements; specifically, whether comparable services are performed by civil servants and whether the nature of the services should require the government's direction or supervision of contractor employees. *See id.* at 11.
156. *Cf.* FAR 37.104(c).
157. FAR 37.104(d)(3).
158. *See id.*
159. *See O'Melveny & Myers*, ARB No. 12-014, at 2–3.
160. *See id.* at 8–9.

because it provided nonpersonal services, the decision will serve as another example of the courts' continued expansion of the scope of the AA Laws by recognizing more contractors and subcontractors as covered under the OFCCP's jurisdiction.

VII. INSURANCE VERSUS HEALTH CARE SERVICES

The combination of the 2003 *Bridgeport Hospital* decision and the FEHBAR definition of "subcontractor" incorporated into the OPM contracts gave health care providers assurance that they did not have subcontractor status under the FEHBP.[161] The decision in *Braddock*, however, departed from the historical analysis of the traditional fee-for-services health insurers and created a different framework for health care providers under agreement to HMOs contracting with OPM to participate in the FEHBP.[162]

In *Braddock*, the court came to a different conclusion than the ARB in *Bridgeport Hospital*, despite similar contract language.[163] The hospitals in *Braddock* asserted that the UPMC Health Plan contract contained provisions and notifications, similar to those contained in an FEHBP contract for fee-for-service health insurance, that the UPMC Health Plan was to provide insurance, *not* medical or health care services.[164]

The court in *Braddock* concluded that there were fundamental differences between the *Bridgeport Hospital* decision and the facts in *Braddock*.[165] First, *Bridgeport* involved a traditional fee-for-service health insurer, whereas the Health Plan in *Braddock* was an HMO.[166] Despite the hospitals' assertions that the UPMC Health Plan was obligated under the contract only to provide insurance, the court concluded that an HMO for the FEHBP required the Health Plan to provide both insurance and medical services.[167] The court quoted the ARB in explaining that the

> [p]rovision of medical services and supplies was a critical component of the UPMC's contract. The contract depended on medical providers like the [hospitals] to offer medical services and supplies necessary for UPMC to meet its obligations under its contract with OPM. . . . Unlike *Bridgeport Hospital*, [the] hospitals contracted to provide a portion of the contractor's obligation to provide medical

161. *See* OFCCP v. Bridgeport Hosp., ARB No. 00-034, Final Decision and Order, at 6 (Dep't of Labor Jan. 31, 2003); FEHBAR 1602.170-15.

162. UPMC Braddock v. Harris, 934 F. Supp. 2d 238, 252–53 (D.D.C. 2013).

163. *See id.*

164. Plaintiff's Motion for Summary Judgment at 27, UPMC Braddock v. Harris, 934 F. Supp. 2d 238 (D.D.C. 2013) (No. 09-1210). For example, the UPMC Health Plan benefits brochure specifically distinguished itself from the "providers of medical services," explaining that members would receive all medical services, not from the Health Plan itself, but from the third-party providers. *Id.* at 27–28.

165. *Braddock*, 934 F. Supp. 2d at 252–55.

166. *Id.* at 253–55.

167. *See id.* at 254, 255 & n.9.

> services and supplies under its contract with OPM. Therefore, they qualify as subcontractors under the Secretary's regulations, *notwithstanding the fact that the underlying contract between the Health Plan and OPM involves a form of insurance coverage.*[168]

The court explained that HMOs were required to provide "medical services as a precondition for participation in the [FEHBP], and those medical services *must* be available and accessible to each of the HMO's members."[169]

Second, the court addressed how the UPMC Health Plan contracted with individual providers and that the plan required members to see in-network providers with which the HMO has contracts.[170] In *Bridgeport*, however, there were also limitations noted on the members' choice due to cost-sharing obligations associated with preferred providers.[171] For instance, the Blue contract under the FEHBP in *Bridgeport Hospital* provided for different levels of cost-sharing depending on whether the provider had an agreement with a participating Blue plan.[172] Admittedly, there were more network restrictions under the HMO Health Plan considered in *Braddock* than in *Bridgeport*, but the *Braddock* decision overstates these distinctions.

VIII. CONCLUSION

Compliance obligations are significant and burdensome under the AA Laws. Consequently, health care providers will be inclined to continue to analyze and question whether a subcontract is "covered" and thus under OFCCP jurisdiction and subject to AA Laws, unless such coverage is clearly mandated. The district courts and the DoL's ARB have taken different approaches to this analysis. This variation undermines health providers' ability to determine conclusively if their services are subject to the AA Laws. Unfortunately, resolution of this issue is unlikely to be either simple or swift. *Braddock* is on appeal to the U.S. Court of Appeals for the D.C. Circuit; *Florida Hospital* has been remanded back to the ALJ, which may well result in another appeal. Only time and additional adjudication will bring a more complete resolution to the subcontractor status question.

168. *Id.* at 255 (emphasis added) (internal quotation marks and citations omitted).
169. *Id.*
170. *See id.*
171. *See* OFCCP v. Bridgeport Hosp., ARB No. 00-034, Final Decision and Order, at 3 (Dep't of Labor Jan. 31, 2003).
172. *See id.* Additionally, the *Bridgeport* decision failed to address the statutory requirement for OPM contractors to provide a network for health care delivery. *See* 5 U.S.C. § 8903(1) (2012) (addressing the obligation of a service benefit plan "offering . . . benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services"). These issues should figure significantly in subsequent litigation.