

and described educational media and programming.

For these reasons, the Secretary waives the requirements in 34 CFR 75.250, which prohibit project periods exceeding five years, as well as the requirements in 34 CFR 75.261(a) and (c)(2), which allow the extension of a project period only if the extension does not involve the obligation of additional Federal funds. This waiver allows the Department to issue a one-time FY 2020 continuation award to each of the five currently funded 84.327C projects.

Any activities carried out during the year of this continuation award will be consistent with, or a logical extension of, the scope, goals, and objectives of the grantees' applications as approved in the FY 2015 competition. The requirements for continuation awards are set forth in 34 CFR 75.253.

Waiver of Delayed Effective Date

The Administrative Procedure Act requires that a substantive rule must be published at least 30 days before its effective date, except as otherwise provided for good cause (5 U.S.C. 553(d)(3)). A delayed effective date would be contrary to public interest by creating a gap in production of described and captioned educational programming and delays in the availability of programming for children with disabilities. Therefore, the Secretary waives the delayed effective date provision for good cause.

Regulatory Flexibility Act Certification

The Secretary certifies that the waiver and extension of the project periods will not have a significant economic impact on a substantial number of small entities. The only entities that will be affected by the waiver and extension of the project periods are the current grantees. Additionally, the extension of an existing project period imposes minimal compliance costs, and the activities required to support the additional year of funding will not impose additional regulatory burdens or require unnecessary Federal supervision.

Paperwork Reduction Act of 1995

This waiver and extension of the project periods does not contain any information collection requirements.

Intergovernmental Review

These programs are subject to Executive Order 12372 and the regulations in 34 CFR part 79. One of the objectives of the Executive order is to foster an intergovernmental partnership and a strengthened federalism. The Executive order relies

on processes developed by State and local governments for coordination and review of proposed Federal financial assistance. This document provides early notification of our specific plans and actions for this program.

Accessible Format: Individuals with disabilities can obtain this document in an accessible format (e.g., braille, large print, audiotape, or compact disc) on request to the contact person listed under **FOR FURTHER INFORMATION CONTACT**.

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You may also access documents of the Department published in the **Federal Register** by using the article search feature at www.federalregister.gov. Specifically, through the advanced search feature at this site, you can limit your search to documents published by the Department.

Mark Schultz,

Commissioner, Rehabilitation Services Administration. Delegated the authority to perform the functions and duties of the Assistant Secretary for the Office of Special Education and Rehabilitative Service.

[FR Doc. 2020-12954 Filed 7-1-20; 8:45 am]

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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 Providers

AGENCY: Office of Federal Contract Compliance Programs, Labor.

ACTION: Final rule.

SUMMARY: The U.S. Department of Labor's (DOL's or Department's) Office of Federal Contract Compliance Programs (OFCCP) publishes this final rule to amend its regulations pertaining to its authority over TRICARE health

care providers. The final rule is intended to increase access to care for uniformed service members and veterans and to provide certainty for health care providers who serve TRICARE beneficiaries. It is also anticipated that this final rule will result in cost savings for TRICARE providers. In a reconsideration of its legal position, the final rule provides that OFCCP lacks authority over Federal health care providers who participate in TRICARE. In the alternative, the final rule establishes 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. Thus, even if OFCCP had authority over Federal health care providers who participate in TRICARE (which this rule clarifies it does not), OFCCP has determined that special circumstances in the national interest justify granting 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. Under the final rule, OFCCP will retain authority over health care providers participating in TRICARE if they hold a separate covered Federal contract or subcontract that is not for providing health care services under TRICARE. TRICARE providers that fall outside of OFCCP's authority under this final rule remain subject to all other Federal, state, and local laws prohibiting discrimination and providing for equal employment opportunity.

DATES: This regulation is effective August 31, 2020.

FOR FURTHER INFORMATION CONTACT: Tina Williams, 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).

SUPPLEMENTARY INFORMATION:

I. Executive Summary

On November 6, 2019, OFCCP issued a notice of proposed rulemaking (NPRM) to clarify the scope of OFCCP's authority¹ under Executive Order

¹ OFCCP often refers to the scope of its authority to enforce equal employment opportunity

11246, as amended (E.O. 11246),² Section 503 of the Rehabilitation Act of 1973, as amended (Section 503),³ and the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended (VEVRAA);⁴ and, to dispel any legal uncertainty, and 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.

During the 30-day comment period, OFCCP received sixteen comments on the proposed rule.⁵ Comments came from a wide variety of organizations, including health care providers, contractor associations, civil rights organizations, state attorneys general, and members of Congress. The comments addressed various aspects of the NPRM. These comments were considered thoroughly and are addressed in the discussion that follows. Where appropriate, this preamble reproduces some of the portions of the preamble to the proposed rule for ease of reference and to facilitate discussion of the public comments.

This final rule adopts in large part the reasoning and proposed regulatory text as set forth in the NPRM. It concludes that removing TRICARE health providers from OFCCP's authority is appropriate and consistent with previously enacted legislation on the issue and in the national interest.

This final 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.

II. Legal Authority

Federal law requires government contractors to refrain from discriminating on the basis of race, sex, and other grounds.⁶ Additionally, government contractors must take

requirements as its *jurisdiction*. For this final rule, OFCCP believes the word *authority* is more precise, since OFCCP does not have adjudicative power.

² E.O. 11246, 30 FR 12319 (Sept. 24, 1965).

³ 29 U.S.C. 793.

⁴ 38 U.S.C. 4212.

⁵ One of these comments was found to be non-responsive to the NPRM.

⁶ As used in this preamble, the term *contractor* includes, unless otherwise indicated, federal government contractors and subcontractors. When used in reference to E.O. 11246, it also includes federally assisted construction contractors and subcontractors.

affirmative action to ensure equal employment opportunity.⁷ OFCCP, situated in the Department of Labor, 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.⁸

OFCCP enforces three equal employment opportunity laws that apply to covered Federal contractors: E.O. 11246, Section 503, and VEVRAA. 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. Congress covered disability as a protected class through Section 503 of the Rehabilitation Act in 1973. Congress also covered veterans through the Vietnam Era Veterans' Readjustment Assistance Act of 1974, 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.⁹ Additionally, OFCCP has authority to exempt a contract from E.O. 11246, VEVRAA, and Section 503 if the Director of OFCCP determines that special circumstances in the national interest require doing so.¹⁰ OFCCP's regulations allow the Director to grant national interest exemptions to groups or categories of contracts where he or she 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.¹¹ These categorical exemptions follow the

⁷ 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, –2.1 through –2.17; *id.* –60–300.40 through –300.45; *id.* –60–741.40 through –741.47.

⁸ E.O. 11246, section 202(6); 41 CFR 60–1.4(a)(6), –1.43; *id.* –60–300.40(d), –300.81; *id.* –60–741.40(d), –741.81; see also *Chrysler Corp. v. Brown*, 441 U.S. 281, 286 (1979).

⁹ E.O. 11246 section 201; 38 U.S.C. 4212(a)(2); 29 U.S.C. 793(a); E.O. 11758, § 2; Sec'y Order 7–2009, 74 FR 58834 (Nov. 13, 2009).

¹⁰ E.O. 11246 section 204; E.O. 11758 §§ 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 final rule uses the term "exemption" to refer to both.

¹¹ 41 CFR 60–1.5(b)(1), –300.4(b)(1), –741.4(b)(1).

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."¹² These long-standing regulatory provisions allowing for categorical national interest exemptions are owed deference.¹³ 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.¹⁴ The provisions permitting categorical exemptions from VEVRAA and Section 503 are patterned similarly and have been in place for decades as well.¹⁵ 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.¹⁶ OFCCP has granted categorical exemptions in the national interest in the past.¹⁷ OFCCP also may exercise prosecutorial discretion in determining its enforcement priorities.¹⁸

¹² *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)).

¹³ *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)).

¹⁴ See 33 FR 7804, 7807 (May 28, 1968); see also 33 FR 3000, 3003 (Feb. 15, 1968) (notice of proposed rulemaking).

¹⁵ See 39 FR 20566, 20568 (June 11, 1974); 41 FR 26386, 26387 (June 25, 1976).

¹⁶ See E.O. 10925 section 303; 41 CFR 60–1.3(b)(1) (1962).

¹⁷ See OFCCP, COVID–19 National Interest Exemption, <https://www.dol.gov/agencies/ofccp/national-interest-exemption> (last accessed April 23, 2020); OFCCP, Hurricane Recovery National Interest Exemptions, <https://www.dol.gov/ofccp/hurricanerecovery.htm> (last accessed April 23, 2020).

¹⁸ 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).

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.¹⁹ 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 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.²⁰ 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.”²¹ This is true “whether or not the [equal opportunity clause] is physically incorporated in such contracts.”²² Persons who have no contractual (or subcontractual) relationship with the Federal Government, however, have no obligation to adhere to OFCCP's substantive requirements.²³

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.²⁴ Agreements pertaining to programs or activities receiving Federal financial assistance, however, are not considered covered contracts, nor are other noncontract government programs or activities.²⁵ Federally assisted construction contracts, however, do

come within OFCCP's authority under E.O. 11246.²⁶

As defined in regulation, a covered “contract” includes a “contract or a subcontract.”²⁷ 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.²⁸

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 hold only contracts below OFCCP's basic monetary thresholds are exempt.²⁹ 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.³⁰ 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 institutions owned in whole or in part by a particular religion or religious organization; and contracts involving work on or near an Indian reservation.³¹

Additionally, as discussed earlier in this final rule, 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.³²

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

OFCCP has audited health care providers who are government contractors, and it will continue to do so under this final rule.³³ 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. Background on TRICARE

TRICARE is the Federal health care program serving uniformed service members, retirees, and their families.³⁴ 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 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.³⁵

¹⁹ See E.O. 11246 section 202; 29 U.S.C. 793(a); 38 U.S.C. 4212(a)(1).

²⁰ See 48 CFR 52.222–26, –35, –36.

²¹ 41 CFR 60–14(e), –741.5(e), –250.5(e).

²² *Id.*

²³ 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.* –300.1(b), –741.1(b).

²⁴ *Id.* 60–1.3, –300.2(n), –741.2(k).

²⁵ See *id.* 60–1.1, –300.1(b), –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).

²⁶ 41 CFR 60–1.1.

²⁷ *Id.* 60–1.3, –300.2, –741.2.

²⁸ *Id.* 60–1.3, –300.2(x), –741.2(x).

²⁹ *Id.* 60–1.5(a)(1), –300.4(a)(1), –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).

³⁰ 41 CFR 60–1.40, –300.40, –741.40.

³¹ See *id.* 60–1.5, –300.4, –741.4.

³² E.O. 11246, section 204; 29 U.S.C. 793(c)(1); 41 CFR 60–300.4(b)(1).

³³ As noted throughout this final rule, 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.

³⁴ See 32 CFR 199.17(a).

³⁵ *OFCCP v. Fla. Hosp. of Orlando*, No. 2009–OFC–00002, 2010 WL 8453896 (ALJ Oct. 18, 2010).

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.³⁶ 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. 715 of 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 requirement.³⁷

In April 2012, 16 months after it had been issued, OFCCP formally rescinded Directive 293.³⁸ 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.³⁹ 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."⁴⁰

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."⁴¹ 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."⁴²

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.⁴³ 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."⁴⁴ 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."⁴⁵

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.⁴⁶ OFCCP also administratively closed its open compliance reviews of contractors covered by the moratorium, which resulted in the dismissal of the *Florida Hospital* case.⁴⁷ On May 18, 2018, OFCCP issued Directive 2018–02, a two-year extension of the previous moratorium.⁴⁸ 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 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.⁴⁹

IV. Discussion of Public Comments

A. Length of Comment Period

Some commenters criticized the 30-day comment period as impermissibly short. For example, a women's civil rights organization, on behalf of five other civil rights organizations, commented that a 30-day comment period was inconsistent with the APA and applicable executive orders and provided insufficient time given the "breadth and substance of the information sought." The organization also stated that a 30-day comment period is inconsistent with a November 18, 2019 report by DOL's Office of Inspector General regarding rulemaking.

A group of state attorneys general commented that "executive agencies have followed a presumption that a minimum of sixty days is necessary to provide the affected public with a meaningful opportunity to comment on proposed agency regulations[.]" A member of Congress commented that "[a]pproximately 86 percent of rules (12 out of 14) proposed by OFCCP since 2000 have afforded the public an initial comment period of approximately 60 days and has even been extended in several instances."

These commenters also requested an extension to the comment period. After considering their requests, the Department determined that the original 30-day comment period provided adequate time for the public to comment on the proposed rule. Notably, the Administrative Procedure Act (APA) does not set forth a mandatory minimum time for public comments, but rather more generally requires an "opportunity to participate in the rule making through submission of written

³⁶ See OFCCP, Directive 293, Coverage of Health Care Providers and Insurers (Dec. 16, 2010) (rescinded Apr. 25, 2012).

³⁷ Public Law 112–81 section 715, 125 Stat. 1298, 1477 (2011), codified at 10 U.S.C. 1097b(a)(3).

³⁸ See Notice of Rescission No. 301 (Apr. 25, 2012).

³⁹ *OFCCP v. FLA. Hosp. of Orlando*, No. 11–011, 2012 WL 5391420 (ARB Oct. 19, 2012).

⁴⁰ Judge Brown concluded that the question about the first prong was not properly before the Board.

⁴¹ *OFCCP v. Fla. Hosp. of Orlando*, No. 11–011, 2013 WL 3981196 (ARB July 22, 2013).

⁴² *Id.* at *25 (Igasaki & Edwards, JJ., dissenting).

⁴³ 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"].

⁴⁴ *Id.* at 3–5 (Sec'y of Labor Thomas E. Perez, Letter to Congressional Leaders, Mar. 11, 2014).

⁴⁵ *Id.* at 4.

⁴⁶ OFCCP, Directive 2014–01, TRICARE Subcontractor Enforcement Activities (May 7, 2014).

⁴⁷ *OFCCP v. Fla. Hosp. of Orlando*, No. 2009–OFC–00002 (ALJ Apr. 1, 2014).

⁴⁸ OFCCP, Directive 2018–02, TRICARE Subcontractor Enforcement Activities (May 18, 2018).

⁴⁹ *Id.* at 1 n.1.

data, views, or arguments.”⁵⁰ Thirty-day public comment periods are broadly viewed as permissible under the APA, particularly where, as here, the proposal is fairly straightforward and is not detailed or highly technical in nature.⁵¹

B. Reconsidering OFCCP’s Authority Over TRICARE Providers

Since bringing the *Florida Hospital* case over a decade ago, and as reiterated in its 2014 and 2018 moratoria, OFCCP has held the position that it holds authority over TRICARE providers. In preparing this final rule, 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*, Congress’s recent actions, and comments received in response to the NPRM. OFCCP has concluded that its recent assertions of authority over TRICARE providers warrant reconsideration.

Some commenters agreed that Section 715 of the 2012 NDAA removed OFCCP’s authority over TRICARE providers. For example, an employer association commented that “the NDAA specifies that an agreement to provide health care services cannot be necessary to the establishment or maintenance of a health care network; under OFCCP’s regulatory definitions, this means that such an agreement cannot be a subcontract.”⁵² Likewise, a consortium of federal contractors and subcontractors commented that “the proper interpretation of the NDAA excludes TRICARE providers from the definition of [‘subcontractor’] pursuant to the OFCCP’s regulations.”

Other commenters disagreed. An LGBT rights organization contended that the ARB correctly held in *Florida Hospital* that the NDAA did not remove OFCCP’s authority. A women’s civil rights organization, on behalf of seventeen other civil rights organizations, commented that “[t]he legislative history of Section 715 supports” the ARB’s decision in *Florida*

Hospital. Specifically, the organization commented that an earlier draft of the NDAA included language that more clearly removed OFCCP’s authority under both prongs of the subcontractor definition; this language was not included in the final bill. One member of Congress expressed the opinion that the “enacted language, and the express rejection of language stating network providers are not considered subcontractors in the Senate-passed provision, demonstrates that Congress intended to create a narrow exception in certain instances—not a wholesale exemption.”

Other commenters noted the salutary effect the rule change will have on the provision of health care services. A Catholic health care network wrote that it “concur[s] that the proposed regulation amendment will accomplish the intended goal, and will ultimately increase or improve uniformed service members’ and veterans’ access to medical care.” A consortium of federal contractors and subcontractors commented that “[a]n express regulatory provision eliminating coverage for health care providers that provide supplies or services to TRICARE beneficiaries would remove this uncertainty and provide much needed clarity for this industry.” Finally, a group of three members of Congress commented that the proposed rule “will increase access to health care services for TRICARE beneficiaries.”

OFCCP considered these comments. For the reasons set forth below, OFCCP interprets the 2012 NDAA to remove OFCCP’s authority over TRICARE providers, and it is a proper use of OFCCP’s regulatory authority to reconsider its previous position and conform its regulations to that legislative effort.

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.

The text and surrounding context of section 715 itself make clear that Congress sought to reverse OFCCP’s assertion of authority over TRICARE providers. The 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.”⁵³ 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.”⁵⁴ 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.

Some commenters raised section 715’s legislative history. The predominant fact in the legislative history of section 715 is that Congress enacted it in response to OFCCP’s express claim of authority over TRICARE providers. A construction of the statute that would render it a nullity would not be consistent with congressional intent in light of this historical context. Further, little can be drawn from the legislative history noted by commenters, especially the vague Statement of Administration Policy.⁵⁵ At best, it shows that (i) an earlier draft of the bill could have exempted TRICARE providers from OFCCP authority even if they held other, unrelated federal contracts, and (ii) the language was revised to clarify that TRICARE providers would not be subject to OFCCP by virtue of their TRICARE agreements, but could still be subject to OFCCP if they held other agreements outside of TRICARE.

⁵³ *Fla. Hosp.*, 2013 WL 3981196, at *19.

⁵⁴ *Id.* at *29.

⁵⁵ See Statement of Administration Policy, Executive Office of the Pres., Office of Mgmt. & Budget, S. 1867—National Defense Authorization Act for FY 2012 (Nov. 17, 2011), obamawhitehouse.archives.gov/sites/default/files/omb/legislative/sap/112/saps1867s_20111117.pdf.

⁵⁰ 5 U.S.C. 553(c); see also *Phillips Petroleum Co. v. U.S. E.P.A.*, 803 F.2d 545, 559 (10th Cir. 1986) (“The opportunity to participate is all the APA requires. There is no requirement concerning how many days the [agency] must allow for comment or that the [agency] must re-open the comment period at the request of one of the participants.”).

⁵¹ See, e.g., *Conn. Light & Power Co. v. Nuclear Regulatory Comm’n.*, 673 F.2d 525, 534 (D.C. Cir. 1982) (upholding a thirty-day comment period even though the “technical complexity” of the regulation was “such that a somewhat longer comment period might have been helpful”); see also *Conference of State Bank Supervisors v. Office of Thrift Supervision*, 792 F. Supp. 837, 844 (D.D.C. 1992) (upholding the sufficiency of a thirty-day comment period).

⁵² This organization also commented that the 2018 VA Mission Act, 38 U.S.C. 1703A(i)(1), provides additional statutory support to OFCCP’s position.

For these reasons, after careful consideration, OFCCP has reconsidered its position and now concludes that it does not have authority over TRICARE providers.

C. Establishing a National Interest Exemption for Health Care Providers Participating in TRICARE

OFCCP believes that lasting certainty for TRICARE health care providers and patients is in the national interest. Therefore, through this final rule OFCCP is also establishing, as an alternative, an exemption from E.O. 11246, Section 503, and VEVRAA for health care providers with agreements to furnish medical services and supplies to individuals participating in TRICARE. Nothing in this action is intended to interfere with OFCCP's vital mission of enforcing equal employment opportunity in organizations that contract with the government. OFCCP will 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, and comments received in response to the NPRM, 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.⁵⁶ 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

⁵⁶ 2014 Hearing, *supra* note 43; 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).

would make it "much more difficult to build and retain provider networks."⁵⁷ 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 professionals willing to act as network providers even more difficult."⁵⁸ 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.⁵⁹ 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.⁶⁰

Providers' decisions not to participate may exacerbate the well-documented difficulties that uniformed service members, veterans, and their families have accessing health care.⁶¹ 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

⁵⁷ 2014 Hearing, *supra* note 43, at 24–26, 46–47, 149 (Prepared Statement and Testimony of Thomas Carrato, President, Health Net Federal Services).

⁵⁸ 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.").

⁵⁹ 2014 Hearing, *supra* note 43, at 34–35, 47 (Statement and Testimony of David Goldstein, Shareholder, Littler Mendelson P.C.).

⁶⁰ *Id.* at 17–18 (Prepared Statement of the American Hospital Association); 2013 Hearing, *supra* note 56, at 139 (Testimony of Curt Kirschner, Partner, Jones Day, on behalf of the American Hospital Association).

⁶¹ *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.

unable to obtain urgent and life-saving treatment. The willingness of health care providers to participate in TRICARE is thus especially important.

OFCCP requested comments from stakeholders to help it more thoroughly evaluate the potential impact of OFCCP compliance on uniformed service members' and veterans' health care provider networks. In particular, OFCCP sought 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. These comments are discussed later in this section.

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. Given the history in this area, such attempts—which would occur in the absence of this final rule—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.⁶² The Department of Defense also classifies TRICARE as Federal financial assistance in DoD Directive 1020.1.⁶³ A unified approach should reduce confusion for the public and assist coordination in regulating government contracts in the health care field.⁶⁴

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.

Several commenters supported a national interest exemption. For example, a veteran’s health care organization wrote that it “urges the adoption of the National Interest Exemption as described” in the NPRM. An employer association commented that it “agrees with the points OFCCP offers in support of its National Interest Exemption rationale” because the high cost of compliance “take[s] time away from patient care” and causes providers to “simply not participate in TRICARE.” A consortium of federal contractors and subcontractors commented that complying with OFCCP’s requirements “can exponentially increase an organization’s operating expenses. . . . [T]he prospect of complying with these additional regulatory burdens will discourage many valuable and important health care providers from becoming TRICARE providers.” A Catholic health care network commented that the proposed rule “would ultimately provide the desired

outcome” of increasing access to health care for veterans.

Other commenters opposed a national interest exemption. For example, a women’s civil rights organization, on behalf of seventeen other civil rights organizations, disagreed that the NPRM’s rationales support the exemption. The organization viewed as anecdotal OFCCP’s concerns that compliance requirements are unduly burdensome for TRICARE providers. A member of Congress commented that past exemptions have been issued only in response to “earthquakes, wildfires, flooding, and hurricanes” and that there were no such special circumstances here because there is no underlying natural disaster. Finally, an LGBT rights organization commented that the “federal government must be in the business of eradicating discrimination” and that the proposed rule falls short of this mandate.

OFCCP agrees with the comments supporting a national interest exemption as an alternative basis for relieving TRICARE providers from complying with OFCCP’s legal obligations. For the reasons discussed in this section, the Director of OFCCP has determined that the exemption proposed in the NPRM is justified by special circumstances in the national interest because it will increase access to care for uniformed service members and veterans, allow OFCCP to better allocate its resources, and provide uniformity and certainty for the government and for TRICARE health care providers. OFCCP’s conclusions are not supported by insufficient evidence, as one commenter alleged, but rather are supported by evidence which includes Congressional testimony, evidence generated in the *Florida Hospital* litigation, and comments received in response to the NPRM. Finally, OFCCP’s authority to issue national interest exemptions is not limited only to circumstances involving natural disasters. E.O. 11246, VEVRAA, Section 503, and the implementing regulations of all three laws grant OFCCP broad authority to issue exemptions.⁶⁵

The Director of OFCCP has also determined that the requirements have been 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 will substantially contribute

to convenience in the administration of the laws.⁶⁶

A women’s civil rights organization, on behalf of seventeen other civil rights organizations, commented that OFCCP lacks the legal authority to “authorize a categorical exemption of the sort” described in this final rule. The organization argued that E.O. 11246 only allows for categorical exemptions in specifically enumerated circumstances, none of which apply in the instant case. However, as discussed above, the applicable regulations authorize the Director of OFCCP to exempt groups or categories of contracts when it would be impracticable for OFCCP to act on individual requests and where a group exemption would substantially contribute to the convenience in the administration of the laws. See 41 CFR 60–1.5(b)(1), –300.4(b)(1), –741.4(b)(1); see also *supra* discussion at sections II (Legal Authority), III.A (Overview of OFCCP’s Areas of Authority).

D. OFCCP’s Authority Over FEHBP

In the NPRM, OFCCP requested comments on whether health care providers participating in the Federal Employees Health Benefits Program (FEHBP) should not be covered by OFCCP’s authority.⁶⁷ OFCCP was interested in comments from stakeholders and health care providers that serve federal employees, such as FEHBP, about the impact of OFCCP’s requirements and if there is difficulty attracting and retaining participating providers. In the past, some stakeholders have indicated that other government health care programs may face difficulties similar to TRICARE.

Some commenters supported exempting FEHBP. An association of health care organizations commented that many hospitals participate in both TRICARE and FEHBP and that health care providers “could drop out of FEHBP networks to preserve their TRICARE exemption, and access to care

⁶⁶ 41 CFR 60–1.5(b)(1), –300.4(b)(1), –741.4(b)(1).

⁶⁷ FEHBP serves 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).

⁶² *OFCCP v. Fla. Hosp. of Orlando*, No. 2009–OFC–002, 2010 WL 8453896, at *2 (ALJ Oct. 18, 2010).

⁶³ 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).

⁶⁴ 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.

⁶⁵ See notes 10 to 18.

for the federal employee population could be affected.” An association of independent health care plans commented that “a uniform OFCCP exemption for FEHB, similar to what is being proposed for TRICARE, would remove a potential barrier to provider contracting” A consortium of federal contractors and subcontractors commented that “[a] uniform rule that applies to health care providers involved in federal government health care programs is necessary to avoid legal uncertainty for the medical field.” A group of three members of Congress commented that the House Committee on Education and Labor held hearings in 2014 on legislation that would have removed OFCCP’s jurisdiction over FEHBP.⁶⁸ The testimony given during this hearing called on OFCCP to clarify which FEHBP plans require participating providers to be classified as subcontractors; asserted that Department of Defense and Office of Personnel Management regulations do not classify FEHBP participants as federal contractors; and noted the willingness of the then-Secretary of Labor to continue discussing enforcement of FEHBP participants. Congress did not ultimately pass legislation affecting OFCCP’s authority over FEHBP.

Other commenters opposed exempting FEHBP providers. A women’s civil rights organization, on behalf of several other civil rights organizations, commented that the NPRM failed to provide the terms or substance of an FEHBP exemption and that “[a]ny regulation addressing other providers must be the subject of its own notice and comment rulemaking.”

None of the comments received in response to the NPRM identified a legal basis to retain or disclaim jurisdiction over FEHBP providers. Accordingly, OFCCP does not adopt any regulatory change related to FEHBP providers. OFCCP has, however, carefully considered comments regarding the benefits of a uniform approach to all government health care plans and will consider additional sub-regulatory guidance as necessary.

E. OFCCP’s Authority Over Veterans Administration Health Benefits Programs

OFCCP received several comments requesting that it also remove from its authority health care service agreements between the U.S. Department of Veterans Affairs (VA) and various health care entities, including Veteran’s Care Agreements (VCAs). Several

commenters cited broad policy-based concerns. For example, a Lutheran health care provider that has several legacy contracts with the Veteran’s Administration commented that it faces increased financial burdens preparing OFCCP compliance reports: “the added cost and regulatory oversight explains why compliance as a federal contractor is a constraint that requires us to carefully consider each contract we enter into with the Veteran’s Administration.” An association of long-term and post-acute care providers commented that “[t]he result [of government regulations] has been limited long-term care options for veterans in their local communities, with some veterans having to choose between obtaining needed long-term care services in a distant VA facility and remaining near loved ones in their community.” A long-term health care provider that has entered into VCAs commented that “the ability to maintain the data requirements of an Affirmative Action plan would be burdensome and tedious for our facilities to maintain.”

Some of these commenters also cited specific types of agreements they believed should be excluded from OFCCP’s authority, and provided some legal rationale for this belief. Specifically, three commenters sought to have OFCCP exclude Veterans Care Agreements from its authority.⁶⁹ Two of these commenters also wanted additional types of VA agreements excluded from OFCCP’s authority, specifically citing Community Care Networks and legacy VA contracts.” A final commenter supported excluding Veterans Affairs health benefits program providers generally from OFCCP’s authority. As discussed below, OFCCP disagrees that there is a statutory basis for excluding these arrangements from OFCCP’s authority entirely, but many of these arrangements do fall under the moratorium on enforcement that was announced in an OFCCP directive issued in May 2018.

The Veterans Care Agreements (VCAs) referenced by the commenters are arrangements created pursuant to the 2018 VA MISSION Act.⁷⁰ The 2018 VA MISSION Act was intended generally to provide veterans with better access to care in a number of ways, and VCAs

were one of the new arrangements created under the law for that purpose.⁷¹ The inclusion of VCAs in the 2018 VA MISSION Act gave VA the authority to enter into these arrangements to address gaps in care that may arise in hospital care, medical services, and/or extended care services. VCAs are executed when specific care is needed but cannot be obtained within the current VA provider networks. These agreements are intended to be used in limited circumstances when the care necessary for treatment is either insufficient or non-existent.

Some of the commenters raising this issue asserted that statutory language in the 2018 VA MISSION Act divests OFCCP of jurisdiction over VCAs because the Act states that such agreements are not “contracts.”⁷² However, there is an exception to this provision within the same subsection of the statute which provides that entities that enter into VCAs remain subject to “all laws that protect against employment discrimination or that otherwise ensure equal employment opportunities.”⁷³ Accordingly, the statutory language of the 2018 VA MISSION Act, standing alone, does not serve to remove these agreements from OFCCP’s authority.

Two commenters likewise requested that OFCCP remove from its authority VA Community Care Networks (CCNs). Though the term CCN is not consistently defined, the term as used by the commenters generally refers to a third-party network manager that is a prime contractor with VA. However, the CCN is a contract to create a network of providers and coordinate the provision of care, but is not a contract for the provision of care itself. Thus, it is distinguishable from the TRICARE providers that this final rule removes from OFCCP’s authority. Rather, CCNs are typical, competitively bid Federal contracts, and unlike with the 2018 VA MISSION Act and VCAs, there is no statutory language defining the arrangements as non-contractual.

In addition to advocating for an exemption to extend to VCAs and CCNs, one commenter urged the exemption of “legacy VA contracts” as well. Though this term is somewhat vague, our understanding based on discussions

⁷¹ See <https://missionact.va.gov/> (last accessed April 23, 2020).

⁷² See 38 U.S.C. 1703A(i)(1) (“A Veterans Care Agreement may be authorized by the Secretary or any Department official authorized by the Secretary, and such action shall not be treated as . . . a Federal contract for the acquisition of goods or services for purposes of any provision of Federal law governing Federal contracts for the acquisition of goods or services . . .”).

⁷³ *Id.* at 1703A(i)(2)(B)(ii).

⁶⁸ 2014 Hearing, *supra* note 43.

⁶⁹ We note that a fourth commenter supported the TRICARE exemption without asking to expand it; however, they defined TRICARE as a VCA. This is inaccurate, as TRICARE and VCAs are entirely separate programs administered by different agencies. VCAs are agreements entered into by the VA, while TRICARE is a separate and distinct health care program under the Department of Defense (DoD).

⁷⁰ 38 U.S.C. 1703A.

with VA is that the commenter might be referring to any of various procurement instruments used by VA in recent years, prior to when VA began utilizing VCAs and its current generation of third-party administrator contracts, the aforementioned CCNs. Some of those procurement instruments are conventional procurement contracts. VA's previous generation of third-party administrator contracts, which are sometimes called Patient-Centered Community Care, or "PC3," contracts, is one example. Generally, these agreements, like CCNs, are competitively bid Federal contracts without statutory exemptions, and thus there is no statutory basis for OFCCP to disclaim authority. However, to the extent that the comment intended "legacy VA contracts" to refer to Choice Provider Agreements, authorized by the Veterans Access, Choice, and Accountability Act of 2014, section 101(d) of that law provided that such agreements were specifically exempted from OFCCP jurisdiction.⁷⁴

In sum, with the exception of any remaining Choice Provider Agreements, the existing statutory framework does not provide support for removing VA health benefits contracts from OFCCP's authority. However, OFCCP has previously taken action with regard to such VA health benefit provider (VAHBP) agreements when it issued Directive 2018-02 in May 2018. That directive, which extended the moratorium on the review of TRICARE health care providers originally issued in 2014, expanded the moratorium on scheduling to include these VAHBP agreements.⁷⁵ Consistent with the handling of FEHBP, OFCCP will consider additional subregulatory guidance as necessary to provide certainty and clarity to the status of VAHBPs.

Accordingly, after a full review of the comments, OFCCP adopts this final rule incorporating the provisions proposed in the NPRM.

⁷⁴ Public Law 113-146, 101(d) (2014) ("During the period in which such entity furnishes care or services pursuant to this section, such entity may not be treated as a Federal contractor or subcontractor by the Office of Federal Contract Compliance Programs of the Department of Labor by virtue of furnishing such care or services."). We note that the VA no longer has authority to enter into these Choice Provider Agreements given subsequent revisions to the Veterans Choice Act.

⁷⁵ OFCCP Directive 2018-02, TRICARE Subcontractor Enforcement Activities (May 18, 2018), available at https://www.dol.gov/ofccp/regs/compliance/directives/dir2018_02.html (last accessed April 20, 2020).

IX. Section-by-Section Analysis

Section 60-1.3 Definitions

OFCCP proposed adding a subparagraph 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 proposed adding definitions of "agreement," "health care provider," and "health organization." For the reasons set forth above, the final rule adopts these changes as proposed in the NPRM.

Section 60-300.2 Definitions

OFCCP proposed adding a subparagraph 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 proposed adding definitions of "agreement," "health care provider," and "health organization." For the reasons set forth above, the final rule adopts these changes as proposed in the NPRM.

Section 60-741.2 Definitions

OFCCP proposed adding a subparagraph 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 proposed adding definitions of "agreement," "health care provider," and "health organization." For the reasons set forth above, the final rule adopts these changes as proposed in the NPRM.

Regulatory Analysis

E.O. 12866 (Regulatory Planning and Review) and E.O. 13563 (Improving Regulation and Regulatory Review)

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 final rule is a significant action under E.O. 12866 and has reviewed the final rule. Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), OIRA designated that this rule is not a "major rule," as defined by 5 U.S.C. 804(2).

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.

The Need for the Regulation

The regulatory changes in this final rule 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 final 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 exempting 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, OFCCP presents a summary of the costs and savings associated with the changes in this final rule. In line with recent assessments of other rulemakings, the agency has determined that either a Human Resources Manager (SOC 11-3121) or a Lawyer (SOC 23-1011) would review

the rule. OFCCP estimates that 50 percent of the reviewers would be human resources managers and 50 percent would be in-house counsel. Thus, the mean hourly wage rate reflects a 50/50 split between human resources managers and lawyers. The mean hourly wage of a human resources manager is \$62.29 and the mean hourly wage of a lawyer is \$69.86.⁷⁶ Therefore, the average hourly wage rate is \$66.08 $((\$62.29 + \$69.86)/2)$. OFCCP adjusted

this wage rate to reflect fringe benefits such as health insurance and retirement benefits, as well as overhead costs such as rent, utilities, and office equipment. The agency used a fringe benefits rate of 46 percent⁷⁷ and an overhead rate of 17 percent,⁷⁸ resulting in a fully loaded hourly compensation rate of \$107.71 $(\$66.08 + (\$66.08 \times 46 \text{ percent}) + (\$66.08 \times 17 \text{ percent}))$. The estimated labor cost to contractors is reflected in Table 1, below.

TABLE 1—LABOR COST

Major occupational groups	Average hourly wage rate	Fringe benefit rate	Overhead rate	Fully loaded hourly compensation
Human Resources Managers and Lawyers	\$66.08	46%	17%	\$107.71

Public Comments

In this section, OFCCP addresses the public comments specifically received on the Regulatory Impact Analysis. The agency received three comments on the Regulatory Impact Analysis.

One commenter, a Lutheran health care provider, addressed their reluctance to enter into contracts with the Veteran’s Administration and stated, “In some cases, we have reluctantly entered into these agreements because of the regulatory burden but have done so because we want to honor veterans who live close to one of our facilities.”

Some commenters criticized OFCCP for not sufficiently analyzing the effect that removing OFCCP’s authority over TRICARE providers will have on the provision of health care services. For example, a women’s civil rights organization, on behalf of seventeen other civil rights organizations, commented that “OFCCP makes no accounting for the costs to workers of loss of protections against discrimination and the increase in vulnerability to discrimination in the absence of OFCCP’s systemic enforcement activities. It does not seek

to quantify or otherwise address the ways in which discriminatory harassment and exploitation of health care workers can compromise patient care.” A member of Congress echoed this concern, noting that a 2005 employment survey found that “more than 60 percent of surveyed physicians, primarily women and minorities, reported experiencing workplace discrimination.” However, the commenters provided no data that would allow for quantitative cost estimations of this final rule.

Cost of Regulatory Familiarization

OFCCP acknowledges that 5 CFR 1320.3(b)(1)(i) requires agencies to include in the burden analysis 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.

OFCCP believes that a human resources manager or lawyer at each health care contractor establishment or firm within its authority will be responsible for understanding or becoming familiar with the new requirements. The agency estimates that it will take a minimum of 30 minutes (½ hour) for the human resources manager or lawyer to read the final 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 43,654 hours $(87,308 \text{ establishments} \times \frac{1}{2} \text{ hour})$.⁷⁹ OFCCP calculates the total estimated cost of rule familiarization as \$4,701,972 $(43,654 \text{ hours} \times \$107.71/\text{hour})$ in the first year, which amounts to a 10-year annualized cost of \$535,160 at a discount rate of 3 percent $(\$6.13 \text{ per health care contractor firm})$ or \$625,659 at a discount rate of 7 percent $(\$7.17 \text{ per health care contractor firm})$. Table 2, below, reflects the estimated regulatory familiarization costs for the final rule.

TABLE 2—REGULATORY FAMILIARIZATION COST

Total number of health care contractor establishments	87,308.
Time to review rule	30 minutes.
Human Resources Managers and Lawyers, fully loaded hourly compensation	\$107.71.
Regulatory familiarization cost in the first year	\$4,701,972.
Annualized cost with 3 percent discounting	\$535,160.
Annualized cost per health care contractor with 3 percent discounting	\$6.13.
Annualized cost with 7 percent discounting	\$625,659.

⁷⁶ BLS, Occupational Employment Statistics, Occupational Employment and Wages, May 2019, https://www.bls.gov/oes/current/oes_nat.htm (last accessed April 3, 2020).

⁷⁷ BLS, Employer Costs for Employee Compensation, <https://www.bls.gov/ncs/data.htm> (last accessed March 17, 2020). Wages and salaries

averaged \$24.86 per hour worked in 2018, while benefit costs averaged \$11.52, which is a benefits rate of 46 percent.

⁷⁸ 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 (last accessed March 17, 2020).

⁷⁹ The determination of the estimated number of health care contractor establishments is discussed under Cost Savings, below.

TABLE 2—REGULATORY FAMILIARIZATION COST—Continued

Annualized cost per health care contractor with 7 percent discounting	\$7.17.
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The rule does not impose any additional costs because it adds no new requirements.

Cost Savings

While the final rule does not impose any additional costs, the Department does anticipate 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. As explained further below, the agency cannot quantify the cost savings due to lack of data on how many contractors may be obligated to maintain an AAP under contracts that are not exempted by this final rule. However, the information that follows sets forth relevant evidence and other helpful data that can be used to help assess cost savings as a result of changes in the final rule.

To estimate the number of Federal contractors potentially impacted by the final rule, OFCCP identified the number of health care providers participating in TRICARE.⁸⁰ The agency 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.⁸¹ OFCCP then determined the rate of compliance using OFCCP’s compliance evaluation data from Fiscal Years 2012 through 2019. The data show 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 a range of contractors having from 50 to more than 501 employees.

OFCCP 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 (NAICS) 621, 622, and 623. There are 722,291 health care providers of which 29.2 percent or 210,909 have 50 or more employees.⁸²

The Department of Defense’s annual report to Congress stated that there were 155,500 TRICARE Primary Care Network Providers and 143,500 TRICARE Specialist Network Providers in FY2019.⁸³ OFCCP estimates that 29.2 percent of these providers have 50 or more employees. The agency believes that 87,308 providers ((155,500 + 143,500) × 29.2%) are potentially impacted by the final 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, the health care provider would still be required to maintain an AAP if the provider qualified as a Federal contractor due to activities outside what is covered by this final rule or if the provider contracts with states that mandate AAPs for certain employers.⁸⁴ Therefore, the estimate of affected TRICARE providers may overstate the number of entities that would actually realize cost savings as a result of this final rule.

The rule amends § 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 amendment results 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. OFCCP’s currently approved Information Collection Request (ICR) for its supply and service program (OMB Control No. 1250–0003) estimates an average of 91.44 hours per contractor to comply with the E.O. 11246 requirements.

The rule amends § 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 results 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. OFCCP’s currently approved ICR for its VEVRAA requirements (OMB Control No. 1250–0004) estimates an average of 16.86 hours per contractor to comply with the VEVRAA requirements.

The rule amends § 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 results 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 currently approved ICR for its Section 503 requirements (OMB Control No. 1250–0005) estimates an average of 7.92 hours per contractor to comply with the Section 503 requirements.

Summary of Transfer and Benefits

E.O. 13563 recognizes that some rules have benefits that are difficult to

⁸⁰ 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 final rule. Thus, OFCCP relied upon the analysis described herein.

⁸¹ The requirement to develop AAPs is based on having 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).

⁸² Number of Firms, Number of Establishments, Employment, and Annual Payroll by Enterprise Employment Size for the United States, All Industries: 2017, https://www2.census.gov/programs-surveys/susb/tables/2017/us_6digitnaics_2017.xlsx?# (last accessed April 3, 2020).

⁸³ 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 April 3, 2020).

⁸⁴ https://ballotpedia.org/Federal_and_state_affirmative_action_and_anti-discrimination_laws (last accessed March 17, 2020).

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 final 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 health care providers. If the final 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

A women's civil rights organization, on behalf of seventeen other civil rights organizations, commented that an extension of the current moratorium would be a more preferable policy than a "categorical regulatory exclusion of TRICARE providers." OFCCP disagrees with this comment. In proposing this rule, the Department considered a non-regulatory alternative: 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 rejects this alternative, as it would result in much greater uncertainty among the regulated entities. Also, as discussed earlier in the preamble, the 2014 and 2018 moratoria were premised on OFCCP's conclusion that it had authority over TRICARE providers. An extension of the current moratorium is not feasible because OFCCP has concluded it does not have the legal authority to regulate TRICARE providers.

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

The agency did not receive any public comments on the Regulatory Flexibility Analysis.

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 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 final rule would have a significant economic impact on a substantial number of small entities.⁸⁵ If the determination is that it would, then the agency must prepare a regulatory flexibility analysis as described in the RFA.⁸⁶

However, if an agency determines that a 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 for this determination and the reasoning should be clear. OFCCP does not expect this final rule to have a significant economic impact on a substantial number of small entities. The annualized cost at a discount rate of seven percent for rule familiarization is \$7.17 per entity (\$50.33 in the first year) which is far less than one percent of the annual revenue of the smallest of the small entities affected by this final rule. Therefore, OFCCP certifies that this final 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. OFCCP has determined that there is no new requirement for information collection associated with this final 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 final 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)

OFCCP has reviewed this final 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 final rule does not have tribal implications under E.O. 13175 that require a tribal summary impact statement. The final 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.

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

⁸⁵ *See* 5 U.S.C. 603.

⁸⁶ *Id.*

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) Subcontract 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) Subcontract 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 60-741—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) Subcontract 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.

* * * * *

Signed at Washington, DC on May 27, 2020.

Craig E. Leen,

Director, Office of Federal Contract Compliance Programs.

[FR Doc. 2020-11934 Filed 7-1-20; 8:45 am]

BILLING CODE 4510-45-P

GENERAL SERVICES ADMINISTRATION

41 CFR parts 300-3, 300-70, 300-80, 300-90, 301-10, 301-11, 301-13, 301-52, 301-70, 301-72, 301-73, 301-74, 301-75, Appendix A to Chapter 301, Appendix B to Chapter 301, Appendix E to Chapter 301, parts 302-1, 302-4, 302-5, 302-7, 302-8, 304-2, and 304-6

[FTR Case 2020-TA-01; Docket No. GSA-FTR-2020-0008, Sequence No. 1]

Federal Travel Regulation; Technical Amendments

AGENCY: Office of Government-wide Policy (OGP), General Services Administration (GSA).

ACTION: Final rule.

SUMMARY: GSA is amending the Federal Travel Regulation (FTR) to make necessary editorial changes.

DATES: This rule is effective August 3, 2020.

FOR FURTHER INFORMATION CONTACT: For clarification of content, contact Ms. Jill Denning, Program Analyst, Office of Government-wide Policy, at 202-208-7642. Contact the Regulatory Secretariat Division (MVCB), 1800 F Street NW, 2nd Floor, Washington, DC 20405, 202-501-4755, for information pertaining to status or publication schedules. Please

cite FTR Case 2020-TA-01, Technical Amendments.

SUPPLEMENTARY INFORMATION:

A. Background

The General Services Administration is issuing a final rule to make technical amendments to various provisions of the Federal Travel Regulation. These technical amendments correct hyperlinks in accordance with Office of Management and Budget Memorandum M-15-13 "Policy to Require Secure Connections across Federal websites and Web Services" (June 5, 2015), format discrepancies, update legal citations, and make miscellaneous/ editorial revisions.

B. Executive Orders 12866 and 13563

Executive Orders (E.O.s) 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives, and if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This final rule is not a significant regulatory action, and therefore, is not subject to review under section 6(b) of E.O. 12866, Regulatory Planning and Review, dated September 30, 1993. GSA has further determined that this final rule is not a major rule under 5 U.S.C. 804.

C. Executive Order 13771

This final rule is not subject to the requirements of E.O. 13771 (82 FR 9339, February 3, 2017) because it is related to agency organization, management, or personnel and is not a significant regulatory action under E.O. 12866.

D. Regulatory Flexibility Act

This final rule will not have a significant economic impact on a substantial number of small entities within the meaning of the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.* This final rule is also exempt from the Administrative Procedures Act pursuant to 5 U.S.C. 553(a)(2) because this final rule involves matters relating to agency management or personnel.

E. Paperwork Reduction Act

The Paperwork Reduction Act does not apply because the changes to the FTR do not impose recordkeeping or information collection requirements, or the collection of information from offerors, contractors, or members of the

public that require the approval of the Office of Management and Budget (OMB) under 44 U.S.C. 3501, *et seq.*

F. Small Business Regulatory Enforcement Fairness Act

This final rule is also exempt from Congressional review prescribed under 5 U.S.C. 801. This final rule is not a major rule under 5 U.S.C. 804.

List of Subjects

41 CFR Parts 300-3, 300-80, 301-11, 301-52, 301-74, 301-75, Appendices A, B, and E to Chapter 301; and Parts 302-1, 302-4, 302-5, 302-7, 302-8, 304-2, and 304-6

Government employees, Travel and transportation expenses.

41 CFR Parts 300-70, 300-90

Government employees, Reporting and recordkeeping requirements, Travel and transportation expenses.

41 CFR Part 301-10

Common carriers, Government employees, Government property, Travel and transportation expenses.

41 CFR Part 301-13

Government employees, Individuals with disabilities, Travel and transportation expenses.

41 CFR Part 301-70

Administrative practice and procedure, Government employees, Individuals with disabilities, Travel and transportation expenses.

41 CFR Part 301-72

Common carriers, Government employees, Travel and transportation expenses.

41 CFR Parts 301-73

Government contracts, Travel and transportation expenses.

Emily W. Murphy,
Administrator.

For reasons set forth in the preamble, GSA amends 41 CFR parts 300-3, 300-70, 300-80, 300-90, 301-10, 301-11, 301-13, 301-52, 301-70, 301-72, 301-73, 301-74, 301-75, appendix A to Chapter 301, appendix B to Chapter 301, appendix E to Chapter 301, parts 302-1, 302-4, 302-5, 302-7, 302-8, 304-2, and 304-6 as set forth below:

PART 300-3—GLOSSARY OF TERMS

■ 1. The authority citation for 41 CFR part 300-3 continues to read as follows:

Authority: 5 U.S.C. 5707; 40 U.S.C. 121(c); 49 U.S.C. 40118; 5 U.S.C. 5738; 5 U.S.C. 5741-5742; 20 U.S.C. 905(a); 31 U.S.C. 1353;