April 16, 2026

Kim Johnson
Chair, Health Care Affordability Board
2020 W El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments for the April 2026 OHCA Board Meeting**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

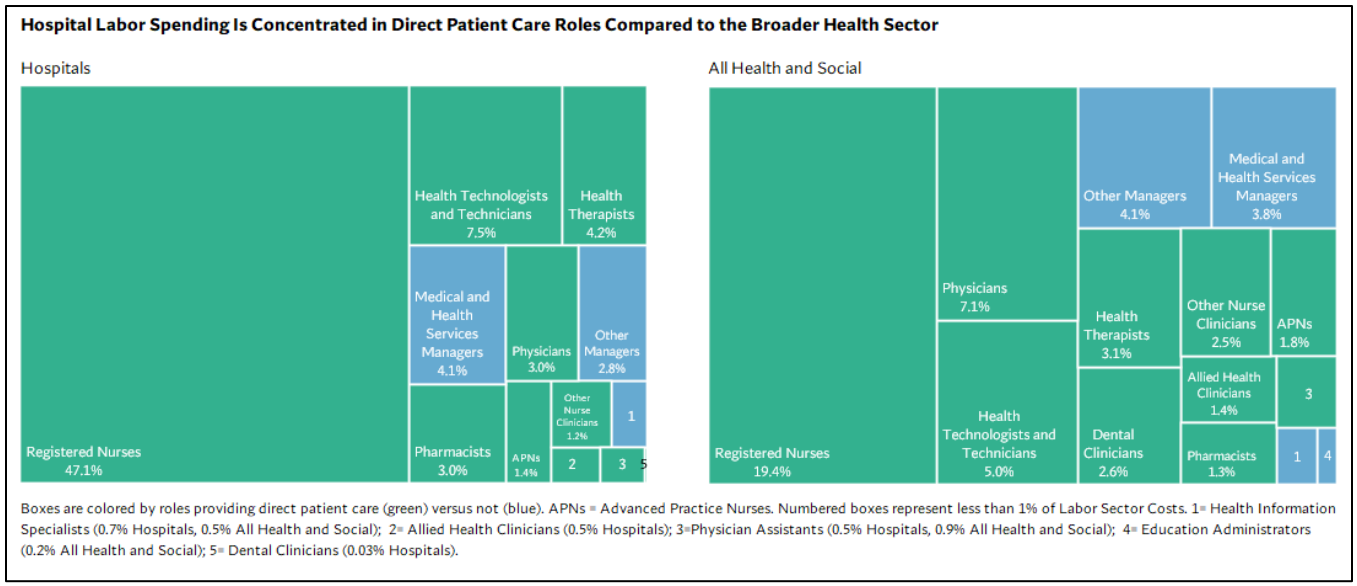
California's hospitals share the Office of Health Care Affordability's (OHCA's) goal to create a more affordable, accessible, equitable, and high-quality health care system. On behalf of nearly 400 hospitals, the California Hospital Association (CHA) appreciates the opportunity to comment ahead of OHCA's April 2026 board meeting.

Labor Costs Are a Key Driver of Hospital and Health Care Spending

Providing lifesaving hospital care, 365 days a year, 24 hours a day, requires a highly skilled and diverse workforce composed of doctors, nurses, and technicians, as well as support and administrative staff. In California hospitals, six staff are needed, on average, to care for each patient who enters their doors. As a result, 56% of hospital spending goes to labor, a far higher share than other sectors of the economy. Hospital labor costs are difficult, if not impossible, to control. In large part, this is due to state laws that mandate minimum staffing **and** compensation levels. Combined with workforce shortages, ever growing care needs as the population ages, and the soaring cost of living, hospitals have no choice but to spend more to attract and retain the highly trained workers on whom care depends.

The Vast Majority of Hospital Payroll Supports Direct Patient Care

The U.S. Bureau of Labor Statistics' (BLS) 2024 Occupational Employment and Wage Statistics data for California show the distribution of hospitals' payroll spending among different classes of health care workers. Nearly half of hospital labor costs (47%) go to nurses, followed far behind by health technologists and technicians, therapists, clinical care supervisors, physicians, and pharmacists. Administrative management workers, including all hospital leadership positions, make up just 2.8% of payroll spending. When combined with clinical managers, supervisory payroll spending accounts for not even 7% of total hospital payroll costs. For health (and social services) spending overall, the picture looks quite different, with nurses and technologists and technicians comprising a much smaller share of spending, and physicians and administrative management workers comprising significantly more spending compared to hospitals.



OHCA Must Protect All Health Care Workers

At the March board meeting, OHCA unveiled a plan to adjust individual health care entities' spending targets based on growth in their nonsupervisory organized labor costs. Unfortunately, this proposal falls short of the Legislature's overarching goals and directives, as well as the policy imperative to treat all workers equitably.

OHCA Has a Statutory Duty to Protect Workforce Stability

The Legislature vested OHCA with several responsibilities, including promoting affordability, maintaining access to quality care, and protecting workforce stability. Moreover, the Legislature tasked OHCA with incorporating all these objectives directly into the setting of spending targets. Specifically, in Section 127502(c)(6) of the Health & Safety Code, state law requires that OHCA's targets "promote the stability of the health care workforce, including the development of the future workforce, such as graduate medical education, training, apprenticeships, and research." This means that OHCA is under an affirmative obligation to ensure that its targets do not undermine health care workforce stability broadly, not for only a subset of workers. To date, OHCA has made no adjustments that would fulfill this responsibility, nor has it conducted analysis demonstrating that the targets are consistent with this prerogative.

Disappointingly, the March 2026 framework for prospectively adjusting spending targets for health care providers is based only on collectively bargained cost increases. The framework is at odds with OHCA's broader workforce stability mandate and fails to protect the hundreds of thousands of health care workers who have elected not to be part of a union. This inequitable treatment would result in some getting a free pass from contributing toward the state's affordability goals, while shifting the burden to workers and their employers not eligible for the organized labor adjustment discussed below. This undoubtedly was not the Legislature's intent in authorizing OHCA's work. Rural health care will be especially challenged, given the lower penetration of organized labor in these areas of the state. **A different approach is needed.**

OHCA's Spending Target Adjustment Methodology Must Equitably Protect ALL Workers

Fortunately, state law affords OHCA the flexibility necessary to make various adjustments to the spending targets to ensure fulfillment of its overarching statutory obligations. Most notably, (d)(4) of Section 127502 establishes that the spending target methodology shall review the following factors for adjusting the targets:

- Health care employment cost index
- Labor costs
- Consumer price index for urban wage earners and clerical workers
- Impacts due to known emerging diseases
- Trends in the price of health care technologies
- Provider payer mix
- State or local mandates such as required capital improvement projects
- Relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs

While OHCA is subject to a more specific legal obligation to adjust targets for organized labor cost growth (see Health & Safety Code § 127502(d)(7)), that more targeted clause for a subset of regulated providers does not absolve OHCA of its overarching directive to consider and promote stability for the entirety of the workforce. The above cited provision on factors for future adjustments (paragraph (d)(4)), alongside OHCA's foundational duty to promote workforce stability broadly in establishing and adjusting spending targets, clearly directs OHCA to consider all labor cost growth when reviewing, and ultimately adopting, adjustments to the spending targets. OHCA **must protect all workers** by exercising this authority and prospectively adjusting providers' spending targets for all nonsupervisory labor cost growth. The methodology could be largely similar to, but of course broader than, what OHCA presented for organized labor cost growth at the March board meeting.

Enforcement Discretion Is Another Essential Tool for Protecting All Workers

As a principle, OHCA should promote access to high-quality care and protect the workforce by incorporating all identifiable, predictable, and uncontrollable or desirable drivers of health care spending increases into the spending targets themselves, including through adjustments. Then, as a fallback and secondary means of assurance, OHCA should account for such drivers, as well as others that may not be readily identifiable or predictable in advance, as considerations in the enforcement process. As with spending target adjustments, the office has significant flexibility as to what factors to consider in the enforcement process. However, that flexibility is ultimately subordinate to OHCA's statutory objectives, including the protection of workforce stability. Accordingly, OHCA can and must use its enforcement discretion to protect and promote high-quality jobs for **all** workers, not only the subset that have elected to organize. All labor cost growth, whether or not it is collectively bargained, must be among the enforcement considerations OHCA uses in the enforcement process.

Conclusion

California's hospitals appreciate the opportunity to comment and look forward to continued engagement toward our shared goals of promoting affordability, access, quality, equity, and workforce stability in California's health care system.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

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