July 13, 2026

Megan Brubaker
Office of Health Care Affordability
2020 W El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments on Draft Regulations for Nonsupervisory Organized Labor Cost Adjustments to the Spending Targets**
(Submitted via email to Megan Brubaker)

Dear Ms. Brubaker:

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 on OHCA's draft regulations implementing the nonsupervisory organized labor cost adjustment (NOLA) to the spending targets, which include rules and procedures for adjusting providers' spending targets based on growth in their nonsupervisory organized labor costs.

Unfortunately, this proposal falls short of the Legislature's overarching goals and directives, fails the office's policy imperative to treat all workers equitably, and creates a policy that is largely unworkable given the realities of collective bargaining. Hospitals urge OHCA to modify this proposal to ensure it protects *all* health care workers. Specifically, OHCA must:

- Ensure all labor costs are accounted for in both the spending target itself, as well as its enforcement
- Prospectively adjust providers' spending targets for all nonsupervisory labor cost growth to ensure **all** workers are protected
- Modify the target adjustment request rules to accurately reflect the realities of how employee compensation is determined, including but not limited to, within the collective bargaining process

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

Providing lifesaving hospital care 24 hours a day, 365 days a year requires a highly skilled and diverse clinical workforce made up of doctors, nurses, and technicians, as well as support and administrative staff. In California hospitals, an average of six staff care for each patient who enters their doors and 56% of hospital operating costs go to labor, a far higher share than other sectors of the economy.

Hospitals have virtually no control over labor costs — between state-mandated staffing ratios and minimum wage requirements, hospitals are left with little, if any, discretion over staffing levels, staffing mix, and employee

compensation. And, like all California businesses, hospitals are at the mercy of broader economic forces — including runaway inflation and workforce shortages — that force them to increase compensation to attract and retain workers. **OHCA must recognize these unavoidable cost pressures within the spending targets themselves, as well as in their enforcement.**

OHCA Has a Statutory Duty to Protect Workforce Stability

The Legislature vested OHCA with multiple 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 (HSC), 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."

Accordingly, OHCA is under an affirmative obligation to ensure that its targets do not undermine health care workforce stability broadly — **not for only one subset of workers**. To date, OHCA has made no adjustments that would fulfill this responsibility, nor has it conducted any analysis demonstrating that the targets are consistent with this prerogative. This is particularly worrisome in light of new research from Christopher Whaley, PhD, and others that shows how Rhode Island's efforts to limit health care spending have led to reduced hospital staffing levels and worker compensation — the exact outcomes the California Legislature directed OHCA to prevent.

The proposed framework for prospectively adjusting spending targets for health care providers is based only on labor cost increases tied to a collective bargaining agreement (CBA). Given its narrow tailoring, 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 health care entities and workers getting a free pass from contributing toward the state's affordability goals, while shifting the entirety of the burden to workers and their employers not eligible for the adjustment. This undoubtedly was not the Legislature's intent in authorizing OHCA's work.

The proposal also fails to reflect the realities of recruiting and retaining workers within the health care setting. When one local hospital increases its workers' wages under a CBA, its neighbors have no choice but to follow suit. Penalizing these hospitals for doing what is right for their organizations and their workers is plain wrong. Finally, rural hospitals will be especially challenged, given the lower penetration of organized labor in these areas of the state. With rural hospitals already facing extreme financial challenges, OHCA must not further disadvantage rural health care in California with spending targets and rules that do not acknowledge the immense challenges they face in maintaining an adequate workforce.

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

Fortunately, state law affords OHCA the flexibility necessary to adjust the spending targets to ensure it fulfills its overarching statutory obligations. Most notably, HSC Section 127502(d)(4) 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 HSC § 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 **entire workforce**.

The above-cited provision on factors for future adjustments (HSC Section 127502(d)(4)), alongside OHCA's foundational duty to promote workforce stability broadly in the 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. Accounting for all labor cost growth in the methodology for adjusting targets could be largely consistent with OHCA's proposed approach, while also fixing the fundamental flaw, described below, that makes the current proposal unworkable for most providers and workers.

Prospective Target Adjustment Process Does Not Reflect the Realities of Collective Bargaining

Hospitals' CBAs often have terms of around three years and are executed (and expire) on a staggered basis. As a result, each year, a hospital or system's CBA with one of their unions may expire; after three years, all of their agreements will likely have expired and been up for renewal. However, OHCA's proposed process would require hospitals to request an adjustment more than two years before the end of a spending target performance year — e.g., an October 2026 request for an adjustment to the target applicable to the 2028 performance year — with documentation showing a CBA is in place as a condition for receiving the adjustment.

Given the three-year term of a typical CBA, there is a more than 50% likelihood that the existing CBA will have expired prior to the end of the applicable spending target performance year and a new CBA would not have been negotiated yet. This would preclude a full and accurate adjustment in all such cases, rendering the process inadequate at best and, at worst, unworkable for the majority of cases where it was intended by the Legislature to apply. **OHCA must establish an alternative approach.**

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 secondary means of assurance, OHCA should account for such drivers, as well as others that may not be readily identifiable or predictable in advance (e.g., acts of God like the COVID-19 pandemic), as considerations in the enforcement process. As with spending target adjustments, the office has flexibility as to what factors to consider in the enforcement process.

However, that flexibility is ultimately subordinate to OHCA's statutory commands, 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. **OHCA's forthcoming enforcement regulations must expressly specify that all labor cost growth, irrespective of whether it is collectively bargained, will be considered a justifiable reason for exceeding the spending target in the enforcement process.**

Conclusion

California's hospitals look forward to continued engagement toward our shared goals of promoting workforce stability in California's health care system.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

cc: Members of the Health Care Affordability Board:
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Donald B. Moulds, Ph.D.
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability