American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

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Roxanne Rothschild
Executive Secretary
National Labor Relations Board
1015 Half Street, S.E.
Washington, D.C. 20570-0001

RE: RIN 3142-AA21; Notice of proposed rulemaking (NPRM), The Standard for Determining Joint-Employer Status

Dear Ms. Rothschild and Members of the National Labor Relations Board:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on this notice of proposed rulemaking (NPRM) regarding the standard for determining joint-employer status. The AHA supports many of the comments provided by other employers detailing concerns about the NPRM, but writes separately to detail our hospital-specific concerns.

Critically, the National Labor Relations Board (NLRB) failed to properly investigate the particular economic and practical effects the proposed rule would have on hospitals and health systems. Had it done so, it would have quickly become clear that the proposed rule would adversely impact an already over-burdened hospital field and create a collective bargaining quagmire that will harm hospitals, their patients, their employees, and the communities they serve. **The NLRB's failure to conduct this hospital-specific analysis requires withdrawal of the proposed rule for noncompliance with the Administrative Procedure Act. At a minimum, the NLRB must, consistent with decades of policy and practice, exempt hospitals from any final rule. Failure to do so risks compromising the hospital field and its very purpose: patient care.**

The Hospital Field Faces Unique Challenges Requiring Reliance on Contract Staff

The NLRB has long recognized that hospitals differ from other employers. Unlike other employers, "the primary function of a hospital is patient care." *St. John's Hospital & School of Nursing, Inc.*, 222 NLRB 1150 (1976). Unlike other employers, the hospital field is heavily regulated by federal and state governments, and by extra-governmental

accrediting bodies such as the Joint Commission. And unlike other employers, much of hospitals' revenue is dictated by federal reimbursement rates; hospitals cannot simply raise prices when costs – including labor costs – increase.

Compounding these unique features, hospitals and health systems are still suffering the economic effects of COVID-19. Because of this once-in-a-century pandemic, hospital revenue has decreased markedly. Projected revenue for 2022 continues to lag behind pre-pandemic levels. *More than half* of all hospitals are projected to have negative operating margins in 2022, even when accounting for economic stimulus funding.[1] At the same time, hospitals' expenses continue to rise, with 2022 expenses expected to eclipse 2021 expenses by approximately $135 billion. The majority of those expenses – approximately $86 billion – result from rising labor costs.

A significant portion of these increased labor costs stem from a lack of available staff. The pandemic worsened an already growing shortage of hospital workers. Job openings in health care have nearly doubled in the last decade.[2] Even before the COVID-19 pandemic, a 2016 analysis predicted a national shortage of over 500,000 registered nurses and 100,000 physicians by 2030.[3] Lack of staff before, during, and after the pandemic has increased competition for workers, which has driven labor costs higher.

Virtually every hospital in the United States now must rely on contract labor provided by subcontractors or staffing agencies to ensure they have sufficient staff to meet patient care and operational needs. Hospitals depend on contract labor in every facet of their operations, including nursing, physicians, environmental services, dietary and food services, security, maintenance and others. Sometimes, contract staff supplement a hospital's existing employees – this is often the case with nurses and staff provided by a staffing agency. But just as often, hospitals subcontract entire departments, such as dietary services, to outside vendors to operate. Consequently, the proposed rule stands to disproportionately harm hospitals and health systems, particularly as compared to employers that are less reliant on contract labor.[4]

For example, the NPRM's focus on reserved and indirect control could render hospitals joint employers of *all* their contract staff, particularly because hospitals' health-related mission requires them to superintend all who work for them. For example, hospital-specific regulatory requirements obligate them to impose certain conditions of employment (*e.g.*, masking, vaccination, licensure, eligibility to participate in federally

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[1] *See* https://www.aha.org/guidesreports/2022-09-15-current-state-hospital-finances-fall-2022-update
[2] *See* https://www.bls.gov/charts/job-openings-and-labor-turnover/opening-industry.htm
[3] *See* https://thehealthcarepeople.com/navigating-major-staffing-shortages/ and the various studies cited therein.
[4] Academic medical centers also present a unique problem for application of the proposed rule. In many such hospitals, hospital-employed registered nurses receive orders from physicians employed by an academic institution. Under the proposed rule, the academic institution risks becoming a joint employer of the hospital's nurses by dint of the control exercised by the physicians, even though the academic institution is not even tangentially involved with setting the nurses' terms and conditions of employment.

funded health care programs) on all workers. Similarly, hospitals themselves choose to create specific policies that are necessary to ensure patient safety, such as policies concerning documentation and medication administration. And state and federal laws require hospitals to promulgate and comply with additional policies, such as those related to the payment of wages or workplace discrimination. Most, if not all, of a hospital's contracts with a vendor, staffing agency, or other contract labor provider require the vendor's employees to, in turn, comply with these various rules.

Under the NLRB's proposed rule, including language in a contract to effectuate these requirements would appear to transform the hospital into a joint employer. If a contractor's employee fails to comply, the hospital retains no right to discharge, or even discipline, the offending employee; instead, it only has the right to request that the employee not return to the hospital's premises. The hospital's reserved control under that contract is no greater than the reserved control it exerts over every other individual entering its premises.[5] But under the NLRB's proposed rule, that reserved control, even if never exercised, could render the hospital a joint employer of the contractor's employee. This, in turn, will force hospitals to spend time and resources that could be devoted to patient care on administrative and management issues as it works to understand the scope of its joint employer liability, revises policies, practices, and contracts to address that liability, and ultimately adapts to the proliferation of hospital bargaining units the proposed rule would inevitably cause.

The proposed rule would exacerbate its impact on hospitals by abandoning the second analytical step of the framework established by the *Board in Browning-Ferris Industries of California, Inc., d/b/a BFI Newby Island Recyclery*, 362 NLRB 1599 (2015) (BFI), which required proof that a putative joint employer possesses sufficient control over employees' essential terms and conditions of employment to permit meaningful collective bargaining. By doing so, the NLRB hinges the entire analysis on the existence of control, without the practical consideration that it will have on employers, especially hospitals, as they are compelled to bargain over the terms and conditions of employment for new groups of employees, over whom they lack sufficient control to bargain meaningfully. The challenges for hospitals are manifest. The NLRB's failure to address them invalidates the proposed rule.

The Proposed Rule Fails to Account for How it Will Impact Federal Health Care Regulations

The NPRM fails to address how the proposed rule would intersect with a variety of federal reimbursement formulas or calculations. These formulas and calculations ultimately determine the amount the government reimburses hospitals and health

[5] Indeed, a hospital's inherent property right to eject from its premises those individuals who fail to comply with Hospital policy, would also appear to have a similar effect. Merely by holding contract labor to the same standards as members of the general public, a hospital risks becoming a joint employer of that contract labor.

systems for the care they provide to patients covered by government-backed health insurance programs.

A perfect example of how complicated and consequential the proposed rule would be for hospitals and health systems' is its impact on the Centers for Medicare & Medicaid Services' (CMS) "market baskets." CMS relies on market baskets to update payments for the various fee-for-service payments systems, such as Medicare, which are important to virtually every type of provider, including hospitals and health systems. Importantly, market baskets reflect input price inflation for hospital services, which has recently grown to historically high levels.[6]

While myriad factors go into calculating the market basket, "[c]hanges in quantity or mix of goods and services do eventually get incorporated into the market basket."[7] Wages, salaries, employee benefits, and contract labor are key cost categories in the market basket. Changing both the quantity and mix of those deemed to be hospital employees, as the proposed rule would do, would affect these inputs that ultimately determine Medicare payments. This will affect reimbursement rates.

The NLRB's proposed rule also would disrupt other inputs used in government reimbursement formulas, calculations, or similar metrics, including:

- ***The Medicare wage index***. The wage index is an important factor used in Medicare hospital payments to account for geographic differences in hospital wage levels. The wage index includes many components, including salaries and other wage-related costs, the use of contract labor, overhead hours and salaries, among others. There are strict rules that dictate which components can be allocated for Medicare reimbursement purposes. Any changes to how hospitals categorize and document labor and its associated components would disrupt the already complex and burdensome wage index system.
- ***Labor-related share***. The labor-related share is a separate component from the wage index used to determine the proportion of hospital payments affected by wages and wage-related costs. While many components go into the calculation of the labor-related share, the share includes labor-related costs and services for support, maintenance, contract labor and other professional services. The labor-related share plays an important role in the calculation of total Medicare reimbursements because it is applied to the Medicare national base payment rate; small changes to the share can have large impacts on reimbursements.
- ***Cost-to-charge ratio***. The cost-to-charge ratios are ratios of total costs to patient and other charges (*e.g.*, gross patient and other operating revenue).

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[6] *See https://www.aha.org/costsofcaring#:~:text=According%20to%20BLS%20data%2C%20hospital, increase%20in%20health%20insurance%20premiums*

[7] *See https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/info.pdf*

Hospitals use these ratios in several important ways. One use is to determine Medicare Severity Diagnosis Related Groups (MS-DRGs) weights, which support hospital inpatient Medicare reimbursement, and are also used to calculate payments for high-cost outlier cases. Because labor and other labor-related costs constitute the majority of total hospital expenses, changes to how labor cost components are allocated may affect these ratios and therefore their application to MS-DRG weights and outlier payments.

- ***Graduate medical education*** *(GME)*. Medicare pays for certain costs associated with training physician residents and other health professions, such as nursing and other allied professionals. Medicare adjusts its payment to hospitals by determining full-time equivalents (FTE) based on the number of interns, residents and other trainees. Changes to the relationship of these FTEs with their hospital employer, and therefore how they are counted for Medicare payment, could have large impacts on hospitals because three-quarters of all GME spending comes from Medicare.

These are critical issues for hospitals. Yet the NPRM fails to address them. The NLRB cannot responsibly implement a rule of this magnitude without investigating, considering and addressing how its own rules co-exist with other federal regulatory regimes governing hospitals and health systems. The NLRB's failure to conduct this necessary due diligence on such a fundamental aspect of the United States' health care system underscores the legal and practical shortcomings of the proposed rule.

The Proposed Rule is Contrary to the Board's Historical Treatment of Hospitals and Congressional Intent

The disproportionate effect the proposed rule will have on the hospital field runs counter to the NLRB's historical efforts to balance the National Labor Relations Act's requirements with the public's need for access to medical care. Since the 1974 Health Care Amendments extended coverage of the Act to non-profit hospitals, the NLRB has consistently tailored the application of Board law and precedent to hospitals. The legislative history of those amendments reveals how Congress recognized that the health care field presented different considerations than other fields subject to the Act, warranting both hospital-specific application of the Act's provisions and precedent, and also the creation of special provisions applicable solely to health care employers. Specifically, Congress believed the public's interest in maintaining continuity of care, not the relationship between the employer and its employees, should dictate the resolution of disputes in the health care field.

In the intervening decades, the NLRB has repeatedly and consistently carved out specific rules for hospitals. The NLRB has permitted hospitals to promulgate and enforce more stringent solicitation and distribution rules, *see*, *e.g.*, *St. John's Hospital & School of Nursing, Inc.*, supra; provided specific guidance about the supervisory status of charge nurses, *Oakwood Healthcare, Inc.*, 348 NLRB 686 (2006); created a unique notification period for termination and modification of a collective bargaining agreement,

29 U.S.C. §158(d); and carved out specific notice requirements for work stoppages designed to allow hospitals sufficient time to plan for and ensure continuity of care if a strike occurs, 29 U.S.C. §158(g). The NLRB has always viewed patient care as paramount. The proposed rule sharply deviates from this long-standing approach, holding hospitals to the same standards as other employers despite the unique challenges hospitals face, their critically important mission and the out-sized impact the proposed rule would have on hospitals.

The largest and most sweeping of the NLRB's health care-specific provisions is its 1989 Health Care Rule, under which the NLRB established the "eight appropriate bargaining units" for acute care hospitals. 29 CFR §103.30. The NLRB promulgated that rule specifically to address congressional admonitions to avoid the proliferation of bargaining units in the hospital setting. The proposed rule, by contrast, with its emphasis on reserved and indirect control, contravenes that admonition and the purpose of the NLRB's health care rule by potentially increasing both the number of bargaining units present at a hospital, but also the number of employers.

For example, a hospital may have an extant bargaining unit of registered nurses employed by the hospital. As described above, that hospital likely must supplement its bargaining unit nurses with additional contract labor. If the contract nurses also are organized, under the proposed rule the hospital could become a joint employer of those staffing agency nurses due to reserved control requirements. The hospital would now have two nurse bargaining units with which it must negotiate. Nursing is just one of the many service areas in which hospitals rely on contract labor. The proposed rule would exponentially increase the number of bargaining units with which a hospital must bargain. This is exactly the scenario Congress and the NLRB have sought to avoid.

Not only would the proposed rule create a proliferation of bargaining units, but it also would lead to a proliferation of *employers*. As a joint employer of contract labor, a hospital would have to bargain with the union representing the contract labor alongside the vendor providing that labor. As discussed below, the hospital and the vendor likely have competing interests in such a negotiation. As a result, the number of bargaining units with which a hospital must negotiate will increase, and those negotiations will be complicated by additional employers with potentially divergent interests. Increasing the number of bargaining units and employers in hospitals, each with their own interests, will decrease labor stability.

A decrease in labor stability portends an increase in work stoppages. Section 8(g) of the Act imposes specific requirements on labor organizations seeking to engage in a work stoppage at a hospital. The NPRM provides no guidance on the application of those requirements in a joint employment context. If the union representing nurses who work for a staffing agency elects to strike, must the union provide the requisite Section 8(g) notice to all hospitals to whom the agency provides staff? If the union fails to provide that notice to all such hospitals, does that render the work stoppage unprotected? The NPRM fails to consider, much less address, these serious issues. The proposed rule

fails to provide the "clarity" the NLRB claims. That lack of clarity invites litigation to address the proposed rule's lack of specificity and guidance.

The Proposed Rule is Inimical to Collective Bargaining and Would Create Chaos for Hospitals

The NPRM fails to account for the practical application of the proposed rule on hospitals and health systems. Even in its most basic application, joint employment presents real conflicts of interest. Collective bargaining that requires the agreement of two parties, the employer, and the union, is complicated enough for hospitals and health systems. Given the stakes, outside regulation, and other complicating factors, bargaining in health care already takes longer than other fields.[8] Injecting additional unions and/or additional employers each with their own specific interests is a recipe for prolonging already lengthy negotiations by introducing confusion and uncertainty into the bargaining process. This will impede parties' ability to reach agreement and increase work stoppages.

The increased complexity of bargaining and the increase in the number of units over which a hospital must bargain will further increase hospitals' soaring labor costs. More bargaining units also means more grievances, more arbitrations, more unfair labor practice charges and more litigation. In fact, because the NPRM and proposed rule fail to provide clear guidance on critical terms, such as the essential terms and conditions of employment, the rule effectively demands unfair labor practice charges and litigation to define its contours.

The ensuing litigation could take years. Hospitals, and the patients they serve, cannot be left in limbo while they wait to learn, for example, whether the hospitals are a joint employer of a bargaining unit of employees. They must continue to adapt as necessary to meet patient care needs. In doing so, the hospital risks additional unfair labor practice charges over any unilateral changes made to improve operations or patient care. If the hospital is ultimately deemed a joint employer, the hospital could have years of changes to rescind, and the employees at issue will have been without a contract.

Hospital unions, too, will suffer from the chaos caused by the proposed rule. Collective bargaining is difficult enough when just one employer sits across the table and approaches issues and proposals with a unitary perspective. When a union must simultaneously bargain with two, three, or four employers whose interests and priorities do not align, finalizing an agreement will be orders of magnitude more difficult. A nursing union that represents a staffing agency's nurses will have to negotiate not just with the agency, but also with the dozens of "joint employer" hospitals for whom the agency provides nurses, each with its own local interests.

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[8] *See* *https://news.bloomberglaw.com/daily-labor-report/analysis-how-long-does-it-take-unions-to-reach-first-contracts*

The conflict is easily envisioned. The union seeks higher wages, but neither the hospitals nor the agency want to bear the economic cost. The hospitals tell the staffing agency to pay higher wages, while the staffing agency tells the hospitals they must contribute, either directly or through higher contract costs. The hospitals each have their own view on the propriety and amount of any such contribution. This creates potentially several impasses within a single negotiation which prevents the parties from reaching agreement and increases the risk of labor unrest and potential work stoppages throughout the country. This risk is in no way theoretical. A hospital in New England recently endured a nine-month long strike. The proposed rule further increases the risk of prolonged and dangerous work stoppages. This jeopardizes patient care.

Conclusion

Ultimately, the proposed rule presents myriad economic or practical consequences that will adversely affect hospitals and health systems, unions, employees, and, especially, patients whose needs remain paramount. It will further increase hospitals' labor costs and make it more difficult to devote limited resources to patient care. **The NLRB must investigate, understand and address these hospital-specific issues fully before implementing a rule that could have dire consequences for this critical field.** ***See generally Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co*****., 463 U.S. 29, 43 (1983) ("[A]n agency [decision is] arbitrary and capricious if the agency ... entirely failed to consider an important aspect of the problem."). Absent these necessary steps, the NLRB should withdraw the proposed rule, or, consistent with its historical approach, exempt hospitals from compliance.**

Sincerely,

/s/

Melinda Hatton
General Counsel and Secretary