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I. INTRODUCTION

Selene Castillo, a certified nurse assistant from Long Beach, California, illustrates the struggles that many healthcare workers faced during the COVID-19 pandemic.[1] She experienced trauma while caring for a dying co-worker who eventually succumbed to the virus.[2] Stories like Selene's were common during the pandemic.[3] In 2021 alone, more than 200,000 health specialists left their jobs because of exhaustion, distress from dying patients, and fear of viral infection.[4] The same is true for support staff such as medical assistants, certified nurse assistants, and medical technicians.[5]

While COVID-19 prompted staffing shortages nationally, the pandemic particularly impacted California's health care workforce.[6] The state is projected to lose 500,000 healthcare workers by 2026 and 1.6 million employees within five years.[7] Further, eighty-three percent of support workers at about 200 California medical facilities report being severely or somewhat understaffed.[8] To make matters worse, the annual employee turnover rate for California community health clinics rose from 9.5% in 2020 to a staggering 31.4% in 2022.[9]

An understaffed workforce is problematic because it diminishes the quality of patient care.[10] Inadequate staffing also overburdens existing staff with a demanding workload and leads to "burnout," further jeopardizing patient care and

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[1] *See generally* Itzel Luna, *More California Cities Are Backing $25-an-Hour Minimum Wages for These Workers. Here's Why*, L.A. TIMES (Aug. 4, 2022), https://www.latimes.com/california/story/2022-08-04/more-california-cities-are-backing-25-an-hour-minimum-wages-for-these-workers-heres-why (on file with the *University of the Pacific Law Review*) (explaining that Castillo is an example of a healthcare worker "who endured . . . unprecedented time[s]" and set her personal needs aside to assist with the increased workload during COVID-19).

[2] *See generally id.* (adding that the trauma, increased workload, and lack of a pay increase led Castillo to feel tired and undervalued, but that a living wage would offset those feelings).

[3] Ethan Popowitz, *Addressing the Healthcare Staffing Shortage*, DEFINITIVE HEALTHCARE 1, 4 (Oct. 2022) (explaining that providers left the health profession partially because of the "emotional toll of [losing] patients [and] colleagues [while] fighting the pandemic").

[4] *Id.* (reporting that 117,000 physicians, 53,295 nurse practitioners, 22,704 physician assistants, 22,032 physical therapists, and 15,578 licensed social workers left the profession by the end of 2021).

[5] *Crisis in Care: How California's Healthcare Worker Shortage Is Affecting Workers and Patient Care*, SEIU-UHW.ORG 1, 2 (2022) (explaining that [sixty percent] of California's healthcare workforce consists of support staff—termed "allied healthcare workers"—which also underwent a staffing shortage due to the pandemic).

[6] Popowitz, *supra* note 3, at 1, 2 ("Since 2020, one in five healthcare workers have quit their jobs and . . . up to [forty-seven percent] of healthcare workers plan to leave their positions by 2025."); Tanner Bateman et al., *US Healthcare Labor Market*, MERCER LLC 1, 4 (2021) ("New York and California will feel the effects of the [healthcare] labor shortage most acutely . . . .").

[7] Bateman et al., *supra* note 6.

[8] SEIU-UHW.ORG, *supra* note 5 (reporting survey results from 33,140 support workers interviewed at 200 different medical facilities).

[9] JAZMIN MARROQUIN, OFF. OF SEN. MARIA ELENA DURAZO, LEGISLATIVE FACTSHEET: $25 MINIMUM WAGE FOR HEALTH CARE WORKERS (2023) (on file with the *University of the Pacific Law Review*).

[10] *See* Enrique Lopezlira & Ken Jacobs, *Proposed Health Care Minimum Wage Increase: What It Would Mean For Workers, Patients, and Industry*, UC BERKELEY LAB. CTR., 2, 5 (2023) (explaining that staffing shortages cause longer wait times and extended hospital stays, which result in mismanagement of illnesses and correlate to higher mortality rates); *see also* Popowitz, *supra* note 3, at 1, 2 (reporting thirty-four percent of doctors surveyed believe staffing shortages contribute to medical errors); S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 7 (2023) (reporting that staffing shortages caused bloodstream infections to rise by twenty-eight percent, patient falls to rise by seventeen percent, and pressure injuries to rise by forty-two percent in 2020).

affecting employee mental health.[11] Finally, staffing shortages result in additional labor costs for employers because high turnover rates result in recruitment and training costs, as well as loss of institutional knowledge.[12] Staffing shortages during COVID-19 led providers to rely on contract labor, which is now unsustainable due to inflation and increased industry costs.[13]

Senate Bill 525 (SB 525) seeks to mitigate these issues by increasing the minimum wage to twenty-five dollars per hour to retain and attract workers.[14] The bill will compensate employees such as nurses, caregivers, medical residents, and service workers.[15] On average, affected employees will receive an "increase of over $5.74 per hour or about a [thirty percent] increase…."[16] Not only does the bill address public health concerns regarding patient care, but also considers employee well-being by providing a living wage and combatting burnout.[17]

However, the bill fails to account for financially burdened facilities that will likely lay off workers or cut services to comply with the wage mandate.[18] On that same thread, the bill fails to protect employees against adverse action.[19] Further, SB 525 fails to implement measures to assist community health centers (CHCs) and other Medi-Cal providers with funding concerns, given Medi-Cal's

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[11] Popowitz, *supra* note 3, at 1, 17 ("[B]urnout is a feeling of long-term emotional exhaustion. [It] can damage morale . . . and . . . lead to depression . . . . [It can also] increase the likelihood of medical errors . . . ."); *see also* Steven R. Johnson, *Staff Shortages Choking U.S. Health Care System*, U.S. NEWS (July 28, 2022), https://www.usnews.com/news/health-news/articles/2022-07-28/staff-shortages-choking-u-s-health-care-system (on file with the *University of the Pacific Law Review*) (explaining that because less clinicians are working, practitioners have more patients to care for and an amplified workload causes burnout).

[12] Lopezlira & Jacobs, *supra* note 10, at 1, 14–15 (adding that the average cost-per-hire is $4,700).

[13] *See* Popowitz, *supra* note 3, at 1, 9–10 (explaining that contract labor, which used staffing agencies to supplement the healthcare workforce during COVID-19, has now become too expensive, accounting for twelve percent of labor expenses in 2022).

[14] S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 2 (2023); *see also* Lopezlira & Jacobs, *supra* note 10, at 1, 5 (arguing that, based on economic theory, an increase in wages will result in an increased labor supply).

[15] S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 4 (Apr. 12, 2023) (explaining that the bill covers workers who provide "patient care-related services" such as "nursing, caregiving, services provided by medical residents, . . . technical and ancillary services, janitorial work, housekeeping, . . . clerical work, food services, laundry").

[16] Lopezlira & Jacobs, *supra* note 10, at 1, 2 ("The proposed policy would result in significant benefits to workers and their families.").

[17] *See* S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 7 (2023) (explaining that SB 525 will help mitigate the harm of inflation); *see also* Lopezlira & Jacobs, *supra* note 10, at 1, 4 (explaining that the average annual income for support workers, such as $39,760 for a nursing assistant, is less than the $44,179 salary needed for basic living expenses); Popowitz, *supra* note 3, at 1, 21 (reporting that twenty-eight percent of participants said insufficient salary contributed to burnout and thirty-seven percent said "increased compensation would help [alleviate] feelings of fatigue and financial stress").

[18] *See* S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 8 (2023) (explaining that COVID-19 caused financial difficulty for certain facilities and that providers will "cut hours, positions, and services" to mitigate increased labor costs); *see also* Alex Scott, *Would $25 Health Care Minimum Wage Help or Hurt Patient Care? California Debates*, BUS. J. (Apr. 10, 2023), https://thebusinessjournal.com/would-25-health-care-minimum-wage-help-or-hurt-patient-care-california-debates/ (on file with the *University of the Pacific Law Review*) (explaining that Kaweah Health in Visalia would experience an increased cost of $25 million per year if the bill passed, while already losing $42 million this year); Popowitz, *supra* note 3, at 1, 3 ("[H]ospitals nationwide lost upwards of [fifty-four] billion [dollars] in net income during the Pandemic.").

[19] SB 525, 2023 Leg. 2023-2024 Sess. (Cal. 2023) (as amended on May 25, 2023, but not enacted) (failing to include provisions that protect employees against adverse action, such as lay-offs or reductions in work hours).

complex pay structure.[20] Finally, the bill lacks provisions regarding effects on Medi-Cal or private insurance costs, considering providers may increase the cost of patient care to comply with the wage mandate.[21] While SB 525 takes notable steps toward protecting healthcare workers, the bill fails to address crucial funding concerns.[22] Therefore, SB 525 should include protection provisions, provide adequate funding for Medi-Cal providers, allow slower implementations for vulnerable facilities, and address increased healthcare costs.[23]

II. LEGAL BACKGROUND

The pandemic was devastating for many Americans; however, essential workers—particularly healthcare workers—faced the brunt of COVID-19's negative effects.[24] The federal government responded by passing the Provider Relief Fund (PRF) and the CARES Act, but these measures largely focused on funding concerns for healthcare providers.[25] COVID-19 legislation focused more on the financial environment of healthcare systems as opposed to relief for employees.[26] While it's true that providers could use PRF funds as "incentive pay or retention bonuses," the PRF did not require nor limit providers to use the fund in this manner.[27]

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[20] *See* S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 9 (2023) (explaining that CHCs serve Medi-Cal patients and are paid by government-determined reimbursement rates, which cannot be modified based on state-mandated wage increases).

[21] *See* S. COMM. ON APPROPRIATIONS, COMM. ANALYSIS OF SB 525, at 1 (2023) ("The bill would result in unknown Medi-Cal costs, to increase payments to health care providers . . . ."); *see also* Carmela Coyle, *Minimum Wage Bill Threatens Access to Care*, CAL. HOSP. ASS'N (Apr. 6, 2023), https://calhospital.org/minimum-wage-bill-threatens-access-to-care/ (on file with the *University of the Pacific Law Review*) ("Increasing labor expenses . . . means higher costs to deliver health care in California, greater costs for employers providing health insurance coverage, and higher costs for individuals purchasing health insurance . . . .").

[22] *See* Brad Williams & Michael C. Genest, *Economic and Fiscal Impacts of SB 525*, CAP. MATRIX CONSULTING 1, 9 (2023) ("[H]igher costs caused by mandated minimum wage increases can be borne by: (1) . . . staffing reductions; (2) . . . reduced profits; or (3) higher [healthcare] billing [and insurance] rates.").

[23] *See* S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 5–6, 9 (2023) (highlighting the CHC funding issue and describing how SB 3 and the Living Wage Act proposed slower wage implementation timelines for employers with twenty-five or less employees); *see also* INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, §§ 8-152(c), 8-158 (2023) (effective Jan. 1, 2024) (including employee protections against unlawful firing or reduced benefits and allowing a one-year compliance waiver for providers with financial hardship); S. COMM. ON APPROPRIATIONS, COMM. ANALYSIS OF SB 525, at 1 (May 1, 2023) (discussing the estimated fiscal impact on Medi-Cal costs in the "hundreds of millions of dollars annually").

[24] *See generally* Joanna Gaitens et al., *COVID-19 and Essential Workers: A Narrative Review of Health Outcomes and Moral Injury*, 18 INT'L J. ENVTL. RES. & PUB. HEALTH 1, 1–2 (2021) (describing healthcare workers as essential frontline workers who could not stop working or work remotely because their services were vital to the community); *see* OFF. OF THE ASSISTANT SEC'Y FOR PLAN. & EVALUATION, *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce*, U.S. DEP'T OF HEALTH & HUM. SERV. 1, 11–12, 14 (2022) (explaining that health workers were "three times as likely to become infected," the pandemic worsened feelings of burnout amongst health professionals, and ninety-three percent of staff felt stressed during this time).

[25] *See* U.S. DEP'T OF HEALTH & HUM. SERV., *supra* note 24 at 1, 15 (explaining that the PRF sought to reimburse "expenses and lost revenue related to COVID-19" and the CARES Act helped "hospitals and ambulatory care" with loans for financing).

[26] *See id.* at 1, 14 (explaining that COVID legislation stabilized the financial environment during a time where "patients [stopped] seeking . . . care" and providers experienced additional costs from treating the virus).

[27] *See id.* at 1, 15 (explaining that PRF funds *could* be used for "staff recruiting, incentive pay, [and] retention bonuses," but some funds were used for "COVID-19 testing, treatment, and vaccination").

Nonetheless, federal legislation was the first step in addressing the national healthcare crisis.[28] Since then, California has also addressed the issue of staffing shortages and hospital closures by passing measures such as SB 184 and AB 112.[29] City officials have also chimed in with efforts to bolster employee compensation by passing wage ordinances.[30] SB 525 is another step in the collective effort to strengthen California's healthcare system by prioritizing employees.[31] Section A examines similar trends to increase the minimum wage for private healthcare workers.[32] Section B discusses the similarities and differences between SB 525 and analogous laws.[33] Section C assesses the Office of Health Care Affordability's (OHCA) efforts to mitigate the rising cost of care—which relates to the bill's potential impact on healthcare costs.[34]

A. The Fight for $25: The Trend to Increase Minimum Wage to Twenty-Five Dollars for California Health Care Workers

As of 2022, at least ten California cities have proposed ordinances to establish a twenty-five dollar minimum wage for healthcare workers.[35] However, opponent referendum petitions stopped ordinances in Los Angeles, Long Beach, and Downey from passing.[36] Alternatively, Lynwood and Inglewood have both

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[28] *See id.* at 1, 18 ("Actions taken in 2020 and 2021 kept the nation's primary care and hospital workforces functioning during a time of crisis . . . .").

[29] *See* Press Release, DHCS, California Begins Issuing $1 Billion in Payments to Health Care Workers (Mar. 28, 2023) (on file with the *University of the Pacific Law Review*) (explaining that SB 184 authorized a one billion dollar fund to issue "one-time worker retention payments" to those who worked at "qualifying [health] facilities during . . . COVID-19"); *see also* OFF. OF GOVERNOR GAVIN NEWSOM, *Governor Newsom Signs Early Action Bills Including Support for California Hospitals*, CA.GOV (May 15, 2023), https://www.gov.ca.gov/2023/05/15/governor-newsom-signs-early-action-bills-including-support-for-california-hospitals/ (on file with the *University of the Pacific Law Review*) (explaining that AB 112 authorized a "$150 million loan program . . . for . . . not-for-profit and public hospitals" who closed or are at risk of closure after COVID).

[30] *See* INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, § 8-152(b) (2023) (effective Jan. 1, 2024) (proposing to increase the minimum wage for Inglewood healthcare workers to twenty-five dollars per hour).

[31] *See* S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 2, 6–7 (Apr. 12, 2023) (explaining that SB 525 will help employees with the high cost of living, help them support their families, and retain workers in the midst of a staffing shortage).

[32] *Infra* Section II.A.

[33] *Infra* Section II.B.

[34] *Infra* Section II.C.

[35] S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 5 (2023) (explaining that the list of cities includes Los Angeles, Long Beach, Downey, Lynwood, and Inglewood); *see also* Jana Bjorklund, *Healthcare Workers Minimum Wage: $25 Trend in California*, GOVDOCS (Aug. 24, 2022), https://www.govdocs.com/healthcare-workers-minimum-wage-25-trend-in-california/ (on file with the *University of the Pacific Law Review*) (adding that the list of cities also includes Anaheim, Baldwin Park, Culver City, Duarte, and Monterey Park).

[36] S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 5 (2023) (explaining that referendum petitions placed the Los Angeles, Long Beach, and Downey ordinances on hold for city voters to decide the matter instead); *see also* Bjorklund, *supra* note 35 ("[Once] the referendum petitions are verified, the respective city councils will need to determine whether to submit the . . . ordinance to the city's voters or to repeal the ordinance.").

implemented the twenty-five dollar minimum wage for healthcare workers.[37] Even private healthcare facilities such as Stanford Medical Center and Kaiser Permanente supported a similar pay increase.[38] Thus, wage increases started at a micro level, applicable solely to private sector employees, and later at a macro level with SB 525.[39] Therefore, SB 525 ensures there is equal pay across the industry and prevents workers from leaving the public sector for better pay.[40]

B. The Commonalities Between SB 525 and Similarly Situated Bills and Ordinances

SB 525 is progressive with its implementation timeline in comparison to the current California minimum wage law.[41] SB 3, later codified on April 2016 in Labor Code Section 1182.12, increased California's minimum wage from ten dollars to $15.50 over the span of six years, from January 2017 to January 2023.[42] Alternatively, SB 525 increases the healthcare worker minimum wage from $15.50 to twenty-one dollars, and again to twenty-five within the span of two years.[43] However, SB 525 fails to include slower timelines for smaller employers in the same way SB 3 did.[44] Further, SB 525 also fails to include provisions on employer misconduct, retaliation, and temporary waivers in the same way other laws do.[45]

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[37] *Inglewood Voters Pass Measure HC, $25 Minimum Wage for Healthcare Workers, Healthcare Industry Spends $1.1 Million to Defeat Fair Wages in Duarte*, SEIU-UHW.ORG (2023), https://www.seiu-uhw.org/press/inglewood-voters-pass-measure-hc-25-minimum-wage-for-healthcare-workers-healthcare-industry-spends-1-1-million-to-defeat-fair-wages-in-duarte/ (on file with the *University of the Pacific Law Review*) (explaining that 53.65% of Inglewood's voters passed Measure HC, the bill to increase healthcare worker minimum wage); S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 5 (2023) (explaining that Inglewood's ordinance will take effect on January 1, 2024 and that Lynwood voters passed a similar ordinance in February 2023 which will take effect on May 22, 2023).

[38] *See* Katie Adams, *Stanford Becomes 2nd California Health System to Grant Workers' Big Raises This Month*, MEDCITYNEWS (Dec. 16, 2022), https://medcitynews.com/2022/12/stanford-becomes-2nd-california-health-system-to-grant-workers-big-raises-this-month/ (on file with the *University of the Pacific Law Review*) (explaining that Stanford's new employment contract sets a twenty-five dollar minimum wage for hospital staff and Kaiser's new contract [for its nursing staff will increase] wages by 22.5% over four years . . . .").

[39] *See* S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 5, 7 (2023) (explaining that the proposed wage increase seen in city ordinances only applies to private-sector employees, while SB 525 applies to all healthcare workers).

[40] *See id.* at 5 (explaining that the proposed ordinances may cause staffing shortages at public health centers since the higher pay in the private sector will attract employees from the public sector).

[41] *See* SB 525, 2023 Leg. 2023-2024 Sess. (Cal. 2023) (as amended on May 25, 2023, but not enacted) (proposing a two year wage implementation timeline); CAL. LAB. CODE ANN. § 1182.12(b)(1) (West 2017) (enumerating a six year wage implementation timeline).

[42] S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 5 (Apr. 12, 2023) (explaining that SB 3 first increased wages by "[fifty] cents when first enacted and then by [one dollar] each year until reaching [fifteen dollars]"); LAB. § 1182.12(b)(1).

[43] S. RULES COMM., S. FLOOR ANALYSIS OF SB 525, at 1–2 (2023) (explaining that the two year timeline starts with an increase to twenty-one dollars in June 2024 and jumps to twenty-five dollars within a year).

[44] S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 5 (2023) ("SB 3 . . . included a slower timeline for the incremental increases for employers of 25 or fewer employees."); *see also* SB 525, 2023 Leg. 2023-2024 Sess. (Cal. 2023) (as amended on May 25, 2023, but not enacted) (failing to include any provision that allows for a slower implementation timeline for smaller-scale health care facilities).

[45] *Compare* SB 525, 2023 Leg. 2023-2024 Sess. (Cal. 2023) (as amended on May 25, 2023, but not enacted) (failing to include any exemptions for struggling healthcare facilities or provisions on employer misconduct), *with* INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, §§ 8-152(c), 8-153, 8-158 (2023) (effective Jan. 1, 2024) (including

For instance, Measure HC, an analogous city ordinance from Inglewood, also increases the healthcare worker minimum wage.[46] However, Measure HC prohibits an employer from funding the minimum wage in a way that adversely affects its employees.[47] The ordinance further forbids employer retaliation and sets a ninety-day rebuttable presumption of retaliation.[48] Finally, Measure HC includes a one-year compliance waiver for struggling healthcare facilities.[49] SB 525 includes no similar provisions.[50]

C. OHCA and the Rising Cost of Care

One concern with SB 525 is the possibility that health insurance rates will rise—specifically, that healthcare providers will increase the cost of care to finance the wage mandate.[51] However, California's Legislature has recently taken steps towards improving private healthcare costs and promoting affordability.[52] Through the OHCA, the Legislature regulates mergers and acquisitions, increases cost transparency, and uses data to establish healthcare cost targets.[53] OHCA assesses market consolidation by reviewing transactions that pose a risk to market competition.[54]

If a transaction seems problematic, OHCA will partner with other agencies to address unlawful consolidations and require the provider submit a performance improvement plan (PIP).[55] The PIP must explain why the provider's prices exceed the requisite benchmark and how they plan to reduce their prices.[56] If a provider fails to comply with the PIP and cannot meet state cost targets, the agency will impose financial penalties.[57] Further, OHCA also uses data to better understand

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provisions on prohibited employer conduct, employer retaliation, and a one-year waiver for employers in financial distress).

[46] INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, § 8-152(b) (2023) (effective Jan. 1, 2024) ("On the effective date . . . the minimum wage [for healthcare workers] shall be no less than [twenty-five dollars] per hour.").

[47] *Id*. § 8-152(c) (declaring that an employer cannot fund the minimum wage increase by reducing non-wage employee benefits, reducing an employee's hours of work, or laying off healthcare workers).

[48] *Id.* § 8-153 (prohibiting employer retaliation against employees who asserts their rights and establishing a presumption of retaliation if adverse action occurs within ninety-days of an employee complaint).

[49] *Id*. § 8-158 ("[A] court may grant a one-year waiver from the minimum wage requirements . . . if an employer can demonstrate . . . that compliance with [the Ordinance] would raise . . . doubt about the Employer's ability to . . . [meet] accepted accounting standards.").

[50] SB 525, 2023 Leg. 2023-2024 Sess. (Cal. 2023) (as amended on May 25, 2023, but not enacted).

[51] Williams & Genest, *supra* note 22, at 9 ("[T]he substantial wage increases mandated by SB 525 would put considerable pressure on health care providers to raise rates.").

[52] CAL. HEALTH & SAFETY CODE § 127501(a), (b) (West 2022) (creating the Office of Health Care Affordability, a state agency which tracks healthcare cost trends and develops policies to lower costs).

[53] *Id*. § 127501(c)(1)–(2), (c)(12).

[54] *Office of Health Care Affordability*, HCAI.CA.GOV, https://hcai.ca.gov/ohca/ (last visited Aug. 5, 2023) (on file with the *University of the Pacific Law Review*).

[55] HEALTH & SAFETY § 127501(c)(12), (c)(6); HCAI.CA.GOV, *supra* note 54.

[56] HEALTH & SAFETY § 127501(c)(6); *see generally* Nicole Rapfogel & Natasha Murphy, *How State Health Care Cost Commissions Can Advance Affordability and Equity*, CAP (Oct. 27, 2022), https://www.americanprogress.org/article/how-state-health-care-cost-commissions-can-advance-affordability-and-equity/ (on file with the *University of the Pacific Law Review*) (describing a similar healthcare cost commission from Massachusetts whose PIP requires explanations for cost increases and plans on cost-saving measures).

[57] HEALTH & SAFETY § 127501(c)(6); HCAI.CA.GOV, *supra* note 54 (explaining that sanctions will initially be imposed for "failure to meet [cost] targets" and will grow for repeated or continuing noncompliance).

spending trends, establish spending targets, and increase transparency in the rising cost of care—thereby encouraging public participation in the rulemaking process.[58]

III. SB 525

California State Senator Maria Elena Durazo introduced SB 525 to compensate overburdened healthcare staff in the aftermath of the pandemic.[59] SB 525 increases the minimum wage to twenty-five dollars per hour for covered workers.[60] The wage increase applies to any paid work performed under an employer who owns a covered health facility or "work performed on the premises" of the facility.[61] The list of covered healthcare facilities and covered employees is expansive.[62]

SB 525 mandates annual wage increases based on the Consumer Price Index (CPI), which calculates adjustments based on inflation.[63] However, the annual wage increase will not commence until August 1, 2025, after the twenty-five dollar rate has been implemented on June 1, 2025.[64] Each following year thereafter, employers must increase wages by the lesser of 3.5% or the annual rate of change in the CPI for urban wage and clerical workers (CPI-W).[65] However, if the rate of change is negative, there will be no wage increase.[66]

SB 525 overlaps with Labor Code Section 1182.12, but only applies to healthcare workers and sets a higher minimum wage.[67] Beginning on June 1, 2024, and continuing through June 1, 2025, the minimum wage will increase to twenty-one dollars per hour.[68] Thereafter, on June 1, 2025, the minimum wage will

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[58] *See* HEALTH & SAFETY § 127501(b), (c)(2), (c)(3) (explaining that the agency must develop "data-informed policies for lowering health care costs" and use data "to establish a statewide healthcare cost target"); HCAI.CA.GOV, *supra* note 54 (explaining OHCA must publicly report health care expenditures and that "public comment will be solicited" when OHCA issues its proposed spending targets).

[59] *See* S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 2 (2023) (explaining that higher wages are important to incentivize employees to work in health care and necessary to combat staffing shortages).

[60] *Id.*

[61] *Id*. at 3.

[62] *See Id*. at 3–4 (explaining that covered facilities include various hospitals, skilled nursing facilities, home health agencies, numerous clinics, elderly residential facilities, mental rehabilitation centers, urgent cares, and county correctional health facilities); *id*. at 4 (explaining that covered employees include nurses, caregivers, medical residents, technicians, janitors, security guards, housekeepers, clerical office workers, and food service workers).

[63] *Id*. at 6 ("CPI is . . . the average change over time in prices paid by urban consumers for a market basket of consumer goods and services.").

[64] S. RULES COMM., S. FLOOR ANALYSIS OF SB 525, at 2–3 (2023).

[65] *See Id*. at 1; S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 6 (2023) ("CPI-W measures spending for families . . . where more than one-half of the household's income comes from clerical or wage occupations . . . ."); SB 525, 2023 Leg. 2023-2024 Sess. (Cal. 2023) (as amended on May 25, 2023, but not enacted) (explaining that wage increases are rounded to the nearest ten cents and will not go into effect until the following January 1st after calculations are made).

[66] S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 2 (2023).

[67] SB 525, 2023 Leg. 2023-2024 Sess. (Cal. 2023) (as amended on May 25, 2023, but not enacted) (explaining that SB 525 is a special statute as opposed to a general statute because of the urgency of the healthcare worker shortage); S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 1 (2023) (explaining that alternatively, Section 1182.12 sets the California minimum wage at $15.50 per hour for *all* employees).

[68] S. RULES COMM., S. FLOOR ANALYSIS OF SB 525, at 2 (2023).

increase to twenty-five dollars per hour.[69] SB 525 also overlaps with Labor Code Section 515, but instead requires a salary of 1.5 times the minimum wage to be exempt from wage and overtime provisions.[70] Finally, SB 525 works in conjunction with Labor Code Section 510, which establishes maximum work hours, overtime pay, and double overtime pay.[71]

SB 525 is "enforceable by the Labor Commissioner or by a covered worker through civil action."[72] The bill has severable provisions.[73] Thus, if any provision is found invalid, the other provisions still stand.[74] If passed, SB 525 will become the new state minimum wage for all covered healthcare workers and will add Section 1182.14 to the California Labor Code.[75]

IV. ANALYSIS

The California Legislature recognizes a need to bolster the state's healthcare system.[76] SB 525 can do that by strengthening the healthcare workforce and improving the quality of patient care.[77] However, if the Legislature fails to address major funding concerns and does not implement employee protection provisions, SB 525 will likely have the opposite of its intended effect.[78] Section A discusses the various benefits of SB 525 and why the bill should be adopted.[79]

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[69] *Id.*

[70] *Id.* at 2–3 (explaining that alternatively, Section 515 requires an executive or professional role, discretion to perform duties, and a salary of at least *twice* the amount of state minimum wage).

[71] S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 1 (2023) (explaining that Section 510 establishes maximum work hours, defines overtime as anything over the maximum hours, and defines double overtime as anything over twelve hours a day).

[72] *See Id.* at 2–3 (explaining that Section 79-107 gives the labor commissioner authority to enforce labor code provisions and ensure adequate compensation).

[73] *Id.* at 4.

[74] *Id.*

[75] SB 525, 2023 Leg. 2023-2024 Sess. (Cal. 2023) (as amended on May 25, 2023, but not enacted).

[76] *See* Sameea Kamal & Alexei Koseff, *What You Need to Know on the California Budget Deal*, CAL MATTERS (June 27, 2023) https://calmatters.org/politics/2023/06/california-budget-deal-what-you-need-to-know/ (on file with the *University of the Pacific Law Review*) (explaining that the state's 2023-24 budget allocates $1 billion towards improving Medi-Cal, providing financial assistance to rural and distressed hospitals, and investing in medical education to attract future physicians); SB 525, 2023 Leg. 2023-2024 Sess. (Cal. 2023) (as amended on May 25, 2023, but not enacted) (proposing to increase healthcare worker minimum wage to twenty-five dollars); DHCS, *supra* note 29 (proposing $1,000–$1,500 retention bonuses for eligible healthcare workers).

[77] *See* S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 8 (2023) (explaining that SB 525 will stabilize a pandemic-induced workforce shortage by retaining and attracting workers and that a stable workforce equates to accessible, equitable care).

[78] *See* Shannon M. Sedgwick et al., *A Proposed Minimum Wage for Private Healthcare Facilities*, INST. FOR APPLIED ECON., ES-ii (Sept. 2022), https://laedc.org/wpcms/wp-content/uploads/2022/09/LAEDC-Report_-Baldwin-Park-City_-PrvtHealthcareMinWage_FINAL_2022.09.04.pdf (on file with the *University of the Pacific Law Review*) (explaining that employers will finance the wage mandate by increasing the cost of patient services and reducing the quality of care); S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 8 (2023) (citing opponent arguments which allege SB 525 will result in employee lay-offs and reductions in hours and patient services); Ana B. Ibarra, *SB 525: Law to Raise Minimum Wage for Health Workers Faces Pushback*, CAL MATTERS (Apr. 25, 2023) https://sd26.senate.ca.gov/news/sb-525-law-raise-minimum-wage-health-workers-faces-pushback (on file with the *University of the Pacific Law Review*) (explaining that after Inglewood's twenty-five dollar ordinance passed, "Centinela Hospital Medical Center . . . laid off [forty-eight] workers and reduced hours for others").

[79] *Infra* Section IV.A.

Section B discusses the numerous ways an employer can finance the wage increase—and what that means in relation to SB 525.[80]

A. SB 525 Is a Long-Overdue Win for Healthcare Workers

SB 525 gives healthcare workers the compensation that they have long deserved.[81] The bill casts a wide net and covers as many health workers as possible.[82] Various types of healthcare workers stand to gain from the proposed wage increase.[83] SB 525 is projected to benefit over 469,000 workers, including employees making slightly more than the twenty-five dollar minimum.[84]

Additionally, the bill will positively impact women and ethnic minorities—who make up a majority of covered healthcare workers.[85] Many of these workers also fall into the top fifty percent of occupations most affected by SB 525, which means they will receive the highest pay increase.[86] The bill would also implement uniform pay across the healthcare sector and prevent disparities caused by city ordinances, which only increased wages for private healthcare workers.[87] Further, SB 525 provides workers with a living wage in the midst of an inflation surge and guarantees a livable wage for years to come.[88]

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[80] *Infra* Section IV.B.

[81] DHCS, *supra* note 29 (citing various California health officials who recognize the need to compensate and honor healthcare staff for the sacrifices they endured during the pandemic); S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 7 (2023) (citing SEIU California who acknowledge that healthcare workers are undervalued).

[82] *See* S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 4 (2023) (highlighting that the bill covers at least over twelve categories of medical staff, including service workers).

[83] *See* Lopezlira & Jacobs, *supra* note 10, at 1, 4 (explaining that support staff such as pharmacy aides, direct care staff such as nursing assistants, and service staff such as housekeepers and janitors earn less than a living wage); *id.* at 1, 3–5 (quoting various healthcare workers, a phlebotomist, a lactation provider, and a medical assistant, who all attest to their financial need for a wage increase); *see also* Teva Brender, *The Best Medicine for Healthcare Workers: A Living Wage*, MEDPAGE TODAY (Apr. 1, 2023) https://www.medpagetoday.com/opinion/second-opinions/103821 (on file with the *University of the Pacific Law Review*) (explaining that medical residents essentially earn minimum wage because their salaries fail to capture the amount of hours they work; stating that a wage increase would alleviate burnout).

[84] *See* Lopezlira & Jacobs, *supra* note 10, at 1, 6 (explaining that 56,100 workers will indirectly receive a "wage increase due to . . . spillover effects" which will extend to anyone presently making three dollars more than the proposed minimum); *see also* S. COMM. ON APPROPRIATIONS, COMM. ANALYSIS OF SB 525, at 1 (May 1, 2023) ("The bill [will] result in . . . pressure to increase wages for [those that] earn slightly more than the [proposed minimum] . . . to avoid salary compaction.").

[85] *See* Lopezlira & Jacobs, *supra* note 10, at 1, 8–9 (reporting that 75.4% of affected workers are women, 45.7% of affected workers are Latino, and seventy-six percent of total affected workers are people of color).

[86] *See id.* at 1, 7 (adding that 10.7% are nursing assistants, 8.9% are medical assistants, and 8.4% are personal care aides and that nursing and home health aides will get the highest pay increases); *see also* JAZMIN MARROQUIN, *supra* note 9 (reporting that ninety-two percent of medical assistants nationwide are women and 26.1% are Latino, while eighty-seven percent of nursing aide staff are women and thirty-two percent are African American).

[87] *See* S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 5 (2023) (explaining that the proposed ordinances may cause staffing shortages at public health centers since the higher pay in the private sector will attract employees from the public sector).

[88] *See id.*, at 6 (explaining that California's 2022 self-sufficiency wage is $21.24 for a single adult, $30.06 for two adults with two kids, and $43.33 for one adult and one kid); S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 7 (2023) ("Following the inflation surge of June 2022, the U.S. minimum wage dipped to its lowest level in real dollars since 1956."); *id.* at 6 (explaining that the bill requires employers to increase wages annually to account for inflation in consumer goods).

Most importantly, the bill has the ability to resolve the healthcare staffing shortage.[89] Many economists agree that increased wages result in an increased labor supply.[90] Apart from empirical findings, even businesses that chose to increase wages in 2021—after the first wave of COVID-19—found it much easier to retain workers amidst the nationwide staffing shortage.[91] Specifically, states with higher minimum wage had faster job growth as of January 2021—a job growth of twenty-five percent—while states with lower wages had a seven percent growth.[92] Thus, SB 525 should be adopted because it broadly compensates all healthcare workers equally, provides a livable wage for minority groups, and strengthens the healthcare workforce.[93]

B. The Four Ways an Employer Can Finance the Wage Mandate and What it Means in Relation to SB 525

Generally, there are four ways that an employer can finance a minimum wage increase.[94] An employer can pass the cost onto the consumer, reduce the quality of goods or services, reduce employment opportunities, or reduce profit margins.[95] Subsection 1 examines the potential increase in health insurance costs as a result of SB 525 and how the Legislature can mitigate its effects.[96] Subsection

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[89] *See* Lopezlira & Jacobs, *supra* note 10, at 1, 15 ("Each 10% increase in . . . state . . . minimum wage decreases turnover among low-wage workers in nursing homes by 2.4%, while a similar increase in sector-specific wages can decrease turnover by up to 14.5%.").

[90] *Id.* at 1, 5 (arguing that, based on economic theory, an increase in wages will result in an increased labor supply); Ian Perry, *California Is Working: The Effects of California's Public Policy on Jobs and the Economy Since 2011*, UC BERKELEY LAB. CTR., 3–4, 6 (2017) (finding that California's interventionist policy model—consisting of fifty-one policy measures from 2011–2016 including the ten dollar wage mandate—resulted in "greater employment growth . . . than . . . Republican-controlled states" during that time); J. Paul Leigh & Juan Du, *Effects of Minimum Wages on Population Health,* HEALTHAFFAIRS (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180622.107025/full/ (on file with the *University of the Pacific Law Review*) (explaining that some economists believe that increased wages lead to reductions in turnover).

[91] Justin Schweitzer & Kyle Ross, *Higher Minimum Wages Support Job Growth As the Economy Recovers from COVID-19*, CAP (Nov. 3, 2021), https://www.americanprogress.org/article/higher-minimum-wages-support-job-growth-economy-recovers-covid-19/ (on file with the *University of the Pacific Law Review*); Eli Rosenberg, *These Businesses Found a Way Around the Worker Shortage: Raising Wages to $15 an Hour or More*, WASH. POST (June 10, 2021), https://www.washingtonpost.com/business/2021/06/10/worker-shortage-raising-wages/ (on file with the *University of the Pacific Law Review*) (explaining that when the owners of twelve different businesses increased wages to fifteen dollars per hour during 2021, they noticed that interest in the position and applications grew exponentially).

[92] Schweitzer & Ross, *supra* note 91.

[93] *See* S. COMM. ON LAB., PUB. EMP. AND RET., COMM. ANALYSIS OF SB 525, at 4 (2023) (highlighting that the bill covers at least over twelve categories of medical staff, including service workers); Lopezlira & Jacobs, *supra* note 10, at 1, 8–9 (reporting that 75.4% of affected workers are women, 45.7% of affected workers are Latino, and seventy-six percent of total affected workers are people of color); *id.* at 1, 5 (arguing that, based on economic theory, an increase in wages will attract new workers and incentivize current workers to stay).

[94] Williams & Genest, *supra* note 22; Sedgwick et al., *supra* note 78.

[95] *See* Sedgwick et al., *supra* note 78 (explaining that employers can finance the minimum wage with an increase in the cost of care, reduction in the quality of care, or reduction in profits); Will Kenton, *Wage Push Inflation: Definition, Causes, and Examples*, INVESTOPEDIA (Jan. 12, 2022), https://www.investopedia.com/terms/w/wage-push-inflation.asp (on file with the *University of the Pacific Law Review*) ("To maintain corporate profits after an increase in wages, employers must increase the prices they charge for the goods and services they provide."); ASSEMBLY COMM. ON LAB. & EMP., COMM. ANALYSIS OF SB 3, at 4 (2015) (citing a congressional budget report which states that wage increases for some may eliminate jobs for others).

[96] *Infra* Subsection IV.B.1.

2 discusses SB 525's probable impact on quality of care and proposed solutions.[97] Subsection 3 evaluates the bill's impact on employment opportunities and how SB 525 can prevent adverse action against employees.[98] Subsection 4 assess the actual impact on profit margins and whether SB 525 imposes too great of a burden on employers.[99]

1. Potential Increases in Health Insurance Costs and Proposed or Existing Solutions

In the health context, passing the cost onto the consumer means an increased cost of care, which results in higher insurance rates.[100] Increased rates are problematic because health insurance costs and pricing disparities are already at an all-time high.[101] A majority of Americans—on all sides of the political spectrum—agree that the government should address the rising cost of healthcare.[102] However, an increase in healthcare rates does not benefit providers who serve Medi-Cal and Medi-Care patients because the government's fixed payment structure prevents these providers from obtaining additional revenues.[103] Subsection a assesses the rising cost of private health insurance and whether current government efforts adequately address the situation.[104] Subsection b discusses the financial struggles that Medi-Cal providers face—including CHCs—and how the Legislature can mitigate SB 525's added labor expenses, while also improving the public healthcare system.[105]

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[97] *Infra* Subsection IV.B.2.

[98] *Infra* Subsection IV.B.3.

[99] *Infra* Subsection IV.B.4.

[100] Williams & Genest, *supra* note 22, at 1, 9 (explaining how the wage mandate will "pressure . . . health care providers to raise rates" and make health insurance more expensive).

[101] Sam Hughes et al., *Health Insurance Costs are Squeezing Workers and Employers*, CAP (Nov. 29, 2022), https://www.americanprogress.org/article/health-insurance-costs-are-squeezing-workers-and-employers/ (on file with the *University of the Pacific Law Review*) (reporting that employer-sponsored insurance (ESI) rates are above the inflation rate, "have outpaced wage growth," and cover 224% of what Medicare pays for the same hospital services).

[102] *Id.* (reporting that sixty-eight percent of Democrats, fifty-five percent of Independents, forty-six percent of Republicans, and business leaders all agree that increased healthcare costs are problematic and unsustainable).

[103] S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 9 (2023) (explaining that CHCs and providers which largely serve Medi-Cal patients are paid through a system which limits the amount they can receive for eligible services); Williams & Genest, *supra* note 22, at 1, 9–10 (explaining that Medi-Cal rates are often only adjusted through legislation and Medicare payments are only adjusted based on national cost increases, not necessarily state cost increases).

[104] *Infra* Subsection IV.B.1.A.

[105] *Infra* Subsection IV.B.1.B.

a. The Rising Cost of Private Health Insurance and Provider Consolidation

Health care consumers cannot presently afford an increase in private insurance costs.[106] Health insurance rates are growing because of the rising cost of care, a lack of competition in provider markets, and provider consolidation.[107] Physician groups have evolved into concentrated markets.[108] Thus, the Legislature should mitigate private insurance costs—especially in light of SB 525—by strengthening its antitrust regulation, supporting consumer collective purchasing power, and setting caps on healthcare costs.[109] While the California Attorney General (AG) has the power "to challenge any anticompetitive health care merger," the AG is often unaware of for-profit organizational mergers.[110] This is because for-profit organizations are not required to submit notice of sale or transfer of assets to the AG.[111] Thus, at present, the AG lacks the tools and procedures necessary to effectively regulate the rising cost of private healthcare.[112]

Fortunately, California's OHCA is already regulating physician market consolidation, establishing healthcare cost targets, and requiring PIPs for providers that fail to meet target goals.[113] Through OHCA, the Legislature is effectively bolstering its antitrust regulation—thereby, mitigating any potential increase in healthcare costs caused by SB 525.[114] Further, OHCA's efforts to increase transparency in costs promotes consumer purchasing power because it reveals cost

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[106] Hughes et al., *supra* note 101 (reporting that "[two] in [five] adults covered by ESI" struggle to afford health care, thirty-three percent postpone treatment, and eighteen percent skip medication doses due to out-of-pocket expenses); *id.* (reporting that individual annual premium rates rose from "$5,049 . . . in 2010 to $7,911 in 2022" and family premiums rose "from $13,770 to $22,463" and health insurance was the second largest expense spent on employee benefits in 2022).

[107] *Id.* (stating that the high cost of care is the "underlying cause of rising ESI costs"); Nicole Rapfogel & Emily Gee, *Employer-and-Worker-Led Efforts to Lower Health Insurance Costs*, CAP (July 28, 2022), https://www.americanprogress.org/article/employer-and-worker-led-efforts-to-lower-health-insurance-costs/ (on file with the *University of the Pacific Law Review*) ("[E]ven large, self-insured employers generally lack the market power to negotiate lower hospital prices."); Emily Gee & Ethan Gurwitz, *Provider Consolidation Drives Up Health Care Costs*, CAP (Dec. 5, 2018), https://www.americanprogress.org/article/provider-consolidation-drives-health-care-costs/ (on file with the *University of the Pacific Law Review*) (defining consolidation as a situation where competitors band together to create one company "through mergers or acquisitions").

[108] Gee & Gurwitz, *supra* note 107 (explaining that in 2017, there were various mergers and acquisitions in the health context); *id.* (adding that there is currently a ninety percent concentration of hospitals, thirty-nine percent concentration of primary care, and sixty-five percent concentration of specialty care in any given metropolitan area).

[109] *Id.* ("Tackling the harms of concentrated provider markets will require that federal and state antitrust authorities slow the pace of consolidation . . . ."); Rapfogel & Gee, *supra* note 107 (explaining that the solution to rising costs is collective market power to negotiate better deals and that employers must leverage their combined buying power); Rapfogel & Murphy, *supra* note 56 (explaining that health care cost commissions—a type of government agency—can enforce benchmark caps on health costs and ensure affordable healthcare).

[110] Samuel M. Chang et al., *Examining the Authority of California's Attorney General in Health Care Mergers*, CHCF 1, 3, 6 (2020) ("[Only] nonprofit entities must notify the AG prior to a sale or transfer of . . . assets . . . [and] the AG must rely on news reports . . . to track consolidation of for-profit [organizations].").

[111] *Id*.

[112] *Id.* at 1, 6 (explaining that once the AG becomes aware of for-profit transactions, it is often too late to challenge and that there is a lack of approval procedures for all consolidation activities).

[113] CAL. HEALTH & SAFETY CODE § 127501(b), (c)(12), (c)(6) (West 2022).

[114] *See generally* Gee & Gurwitz, *supra* note 107 (explaining that lots of research shows that "high levels of market concentration" usually result in a lack of competition).

disparities and incentivizes purchasers to obtain equitable rates.[115] If consumers are more aware of price disparities, they are more likely to band together to fight for equal rates and thus negotiate better deals as a cohesive unit.[116] Finally, OHCA's data-driven approach to establishing price caps will ensure that healthcare cost targets are attainable.[117] Data-driven policy measures are important to ensure that providers are not overburdened by stringent price caps in light of SB 525's increased labor expenses.[118]

b. The Need to Increase Funding for Medi-Cal Providers and Improve the Public Healthcare System

During SB 525's inception, community health centers (CHCs), which largely serve Medi-Cal patients, opposed the bill because of funding concerns.[119] Since CHCs are paid with predetermined rates—set by state and federal laws—CHCs cannot simply offset increased labor costs with an increase in the cost of care.[120] Although CHCs can submit requests to modify their reimbursement rates, the government does not allow modifications based on state-mandated wage increases.[121] As a result, increased labor costs may place clinics at risk of closure.[122] This is problematic because CHCs serve low-income patients who already struggle with access to care.[123]

Opportunely, recent legislation—which renewed the Managed Care Organization (MCO) tax and increased provider reimbursement rates—gives CHCs and Medi-Cal providers the funding they need to comply with SB 525.[124]

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[115] Rapfogel & Gee, *supra* note 107 (asserting that pricing data is key because it shows "variations in [price] for the same services").

[116] *Id.* (explaining that aggregated purchases—whereby "purchasers align their interests and buying power"—result in better deals than what purchasers could get individually).

[117] HEALTH & SAFETY § 127501(b), (c)(2), (c)(3) (explaining that the agency must develop "data-informed policies for lowering health care costs" and use data "to establish a statewide healthcare cost target" and "specific . . . targets by health care sector").

[118] *Id.* § 127501(c)(4) (declaring that the agency shall analyze data in order to "monitor impacts on health care workforce stability"); HCAI.CA.GOV, *supra* note 54 ("OHCA will develop standards to advance the stability of the health care workforce. The Board may consider those standards in setting targets or in approving [PIPs].").

[119] S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 9 (2023).

[120] Ibarra, *supra* note 78 (citing the Vice President of the California Primary Care Association who states that CHCs are prohibited from raising the cost of care); S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 9 (2023) ("CHCs are paid . . . through a complex structure governed by state and federal law. [The] predetermined rate . . . encompasses reimbursement for a set of eligible services provided during a single visit.").

[121] S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 9 (2023) ("The Centers for Medicare and Medicaid Services strictly prohibit a [rate modification request] that is exclusively [based on] increased [wages].").

[122] *See* Ibarra, *supra* note 78 (citing clinic leaders who state they cannot absorb additional labor expenses).

[123] *Id.* (explaining that Medi-Cal serves low-income patients); *see generally* Andrew B. Bindman et al., PHILIP R. LEE INST. FOR HEALTH POL'Y STUD., *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade*, CHCF, 1 (2019) ("[The] state's auditor found that millions of children enrolled in Medi-Cal [weren't] receiving the basic preventive health checkups required by the program."); *MCO Tax Overview: Historic Medi-Cal Budget Bill*, CAL. MED. ASS'N (2023), https://www.cmadocs.org/mco/overview (on file with the *University of the Pacific Law Review*) ("Patients with Medi-Cal . . . routinely wait weeks or months for appointments, and [often need to] travel long distances to receive care.").

[124] *Historic Legislation Renews MCO Tax and Expands Medi-Cal Patient Access to Care*, CAL. MED. ASS'N (June 27, 2023), https://www.cmadocs.org/newsroom/news/view/ArticleId/50203/Historic…slation-renews-MCO-

However, Medi-Cal providers should not be forced to choose between their patients and their employees when deciding how to use the funds, especially because Medi-Cal recipients presently receive substandard care.[125] Instead, increased funding from the MCO tax can help physicians better care for these patients and motivate more doctors to serve these populations, thereby improving access.[126] The Legislature should therefore further assist CHCs and Medi-Cal providers by appropriating a specific quantity of funds from the MCO tax to help with the wage mandate.[127] After all, the MCO tax will generate a total of $4.4 billion for 2023–2024, but only $1 billion will be allocated to the state's healthcare system.[128]

Finally, the state—through the Department of Health Care Services (DHCS)—should implement quality-control measures to ensure that Managed Care Plans (MCPs) use government funds effectively.[129] DHCS can improve the public healthcare system by establishing quality-improvement targets for individual plans.[130] The state can also incentivize target compliance with financial rewards, such as renewed contract offers, and punish noncompliance with financial penalties.[131] Finally, the state should reconsider its existing MCP structure—given the large variation in quality scores based on ownership—by incorporating data, analysis, and feedback from patients and providers.[132]

Tax-and-expands-Medi-Cal-patient-access-to-care (on file with the *University of the Pacific Law Review*) ("Starting in 2024, Medi-Cal provider rates will [increase] to 87.5% of [what] Medicare [pays] for primary care, maternity care, and non-specialty mental health services."); Ana B. Ibarra, *California Wants to Increase Pay for Some Medi-Cal Providers. How it Might Help Patients Access Care.*, CAL MATTERS (May 23, 2023), https://calmatters.org/health/2023/05/medi-cal-providers-pay/ (on file with the *University of the Pacific Law Review*) (explaining that the MCO tax will generate $19.4 billion total over the span of three years, from 2023 through 2026); *Managed Care Organization Tax Update*, DEP'T OF HEALTH CARE SERV., 1 (May 2023), https://www.dhcs.ca.gov/Budget/Documents/DHCS-MCO-Update-052023.pdf (on file with the *University of the Pacific Law Review*) ("[The funds] will help secure access, quality, and equity in the Medi-Cal program over an 8–10 year period, including [an increase in] rates . . . for specified providers.").

[125] Bindman et al., *supra* note 123 (reporting that from 2009–2018, Medi-Cal's quality of care remained stagnant and that quality of care measures over the span of two years either stayed the same or declined).

[126] Ibarra, *supra* note 124 (explaining that many physicians believe that Medi-Cal's low reimbursement rate is the main reason why recruiting doctors to underserved areas—where patients largely have Medi-Cal—is so difficult). *See generally* CAL. MED. ASS'N, *supra* note 123 ("Patients with Medi-Cal . . . routinely wait weeks or months for appointments, and [often need to] travel long distances to receive care.").

[127] *See generally* Williams & Genest, *supra* note 22 ("In the past, the Legislature has augmented the In-Home Supportive Services . . . and the Department of Developmental Services budget[s] to reflect the costs those programs would incur due to general minimum wage increases.").

[128] Kamal & Koseff, *supra* note 76; *see generally* CAL. MED. ASS'N, *supra* note 123 ("Historically, California has used the MCO tax to draw down federal funding and help support the state's General Fund . . . .").

[129] *See* Bindman et al., *supra* note 123, at 1, 2 ("Medi-Cal enrollee's [rate] their experiences with their managed care plans [as being] below the 50th percentile nationally.").

[130] *Id.*

[131] *Id.*

[132] *Id.* (reporting that for-profit MCPs had significantly lower quality scores—when compared to nonprofit and public MCPs—and recommending the state reconsider its use of for-profit plans); *id.* ("[C]ounties that rely on a single public MCP (County Organized Health Systems) had on average better quality scores than counties that furnish Medi-Cal services through . . . a Two-Plan or competing commercial model.").

2. Potential Reductions in the Quality of Care for Financially Vulnerable Facilities and Proposed Solutions

An employer that cannot finance the wage mandate through their profit margins will either cut services or refrain from improving existing operations, thereby diminishing the quality of care.[133] A reduction in the quality of care is not ideal because it runs counter to the bill's goal of improving California's healthcare system.[134] Thus, the Legislature must amend SB 525 so that financially vulnerable facilities have the capacity to fund the wage increase.[135] While the bulk of California hospitals have the financial resources to survive the post-pandemic economic downturn—and thus, an ability to finance the wage mandate—certain hospitals do not.[136] The financial stability of most hospitals stems from emergency government funds they received during the COVID-19 pandemic, which resulted in "positive net operating income" during that time.[137]

Conversely, about 720 hospitals nationwide "experienced new financial distress" during the pandemic, despite receiving COVID-19 relief funding.[138] More specifically, six rural hospitals in California report a high risk of closure, while others have cut services and issued layoffs to stay afloat.[139] Although California's Legislature recently enacted legislation to assist financially vulnerable hospitals, the loan program only applies to certain providers and is not intended to fund a wage increase.[140] For this reason, the bill should allow slower

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[133] *See* Ana B. Ibarra, *Hospital Closures, Cuts in Services Loom for Some Communities. How the State May Step in to Help*., CAL MATTERS (Apr. 6, 2023) https://calmatters.org/health/2023/04/hospital-closures-california/ (on file with the *University of the Pacific Law Review*) (explaining that financially vulnerable hospitals had to suspend home health services and cut the maternity ward to withstand economic deficits caused by COVID-19); Sedgwick et al., *supra* note 78 (explaining that increased labor costs can diminish patient care because providers will have less profits to invest in new equipment and expand health facilities).

[134] S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 8 (2023) (explaining that SB 525 is a mechanism for the state to achieve its goal of improving the quality of care for Californians).

[135] *See* Ibarra, *supra* note 78 (reporting that financially burdened facilities cannot presently afford a wage hike).

[136] *See* Ibarra, *supra* note 133 (citing a health economist who believes "most hospitals in California are in big systems . . . [with] financial resources to get their members through"); Erick Swanson, *National Hospital Flash Report*, KAUFMANHALL 1, 10 (2023) (reporting that hospital profits are on the rise, with profitability reaching twenty percent in 2023 in comparison to nine percent in 2022). *But see* Ibarra, *supra* note 78 (explaining that Madera Community Hospital closed and Montebello Hospital filed for bankruptcy; reporting that some believe a wage increase would worsen the situation); *Hospital Services at Risk Throughout California*, KAUFMANHALL 1, 3 (2023) (explaining that as of December 2022, "one in five hospitals are at risk of closure [due to] "operating losses, declining cash balances, and debt loads").

[137] Risha Gidwani & Cheryl L. Damberg, *Changes in US Hospital Financial Performance During the COVID-19 Public Health Emergency*, JAMA HEALTH F., 1 (July 14, 2023), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2807183 (on file with the *University of the Pacific Law Review*) ("[Out of] 4,423 hospitals, [eighty percent] received public health emergency funds during 2020/2021. Of [that] number . . . 16.3% . . . had financial distress . . . . The majority of hospitals (74.8%) had a positive net operating income . . . .").

[138] *Id.*

[139] *See* Ibarra, *supra* note 133 ("[H]azel Hawkins and Mad River Community Hospital have suspended their home health service[s], Kaweah Health has laid off 130 employees, El Centro Regional has cut its maternity ward . . . .").

[140] CAL. HEALTH & SAFETY CODE § 128740 (amended by Chapter 6) (creating a Distressed Hospital Loan Program which will use $150 million from the General Fund to provide loans for vulnerable *not-for-profit* and *public hospitals*); CA.GOV, *supra* note 29 (highlighting that the loans are intended to help struggling facilities stay open or assist closed facilities with reopening).

implementation timelines—for any provider that can demonstrate financial need—as a way to assist with the wage mandate.[141]

Similarly, small businesses often have slower wage implementations to assist with wage floors, partially because they have less resources to finance a wage mandate as quickly.[142] Although eligibility for slower wage timelines often turns on the number of employees, SB 525's eligibility should be based on financial need.[143] SB 525 should use the methodology listed in Section 129383 of the Health and Safety Code to determine who qualifies for a delayed, phased-in timeline.[144] SB 525 should also require evidence of the employer's financial situation and the monetary impact of compliance with the bill—similar to Inglewood's ordinance.[145]

3. Possible Impact on Employment Opportunities and Proposed Solutions: Employee Protection Provisions

A common critique of SB 525 is that the bill will result in diminished employment opportunities.[146] However, many economists believe that increased wages actually lead to increased productivity, reductions in turnovers, and better work output.[147] The same is true for SB 525—studies confirm that the bill will reduce turnover rates and thus, counterbalance the 12.1% increase in payroll

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[141] *See generally* INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, § 8-158 (2023) (effective Jan. 1, 2024) (giving courts the power to issue one-year compliance waivers for employers who demonstrate financial need); S. COMM. REP., COMM. ANALYSIS OF SB 3, at 8 (2016) ("There would be a one-year lag in the [fifteen dollar minimum wage] increase for small businesses with [twenty-five] or fewer employees."); S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 6 (2023) (explaining that the Living Wage Act—which proposes an eighteen dollar minimum wage—also allows a slower timeline for smaller employers similar to SB 3).

[142] Jesse Wursten & Michael Reich, *Small Businesses and the Minimum Wage* 1–2 (Inst. for Res. on Lab. & Emp., Working Paper No. 102-23, 2023), https://irle.berkeley.edu/wp-content/uploads/2023/03/Small-Businesses-and-the-Minimum-Wage-3-14-23.pdf (on file with the *University of the Pacific Law Review*) (explaining that "small businesses tend to have lower pay", are more often impacted by wage floors, and benefit from delayed phase-ins); *id.* at 2 (adding that nearly fifty cities—most of which are in California—have "longer phase-ins for employers with" 25 or less employees).

[143] CAL. LAB. CODE ANN. § 1182.12(b)(2) (West 2017) (explaining that employers with twenty-five or less employees are eligible for a slower implementation timeline); *see generally* INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, § 8-158 (2023) (effective Jan. 1, 2024) (explaining that employers are eligible for the one-year compliance waiver only if they can demonstrate financial need); CAL. HEALTH & SAFETY CODE § 129383(a)(1)(A) (amended by Chapter 6) (establishing a methodology to evaluate hospital eligibility for the Distressed Hospital Loan Program).

[144] HEALTH & SAFETY § 129383(a)(1)(A) (establishing various factors such as whether the hospital is small, rural, or a critical access area, and whether it treats underserved patients or Medicaid patients).

[145] *See* INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, § 8-158 (2023) (effective Jan. 1, 2024) ("The evidence must include documentation of the Employer's financial condition . . . and evidence of the actual or potential direct financial impact of compliance with this Article.").

[146] *See, e.g.*, Letter from Rony Berdugo, Vice President, Cal. Hosp. Ass'n, to Dave Cortese, Cal. State Sen. (Mar. 21, 2023) (on file with the *University of the Pacific Law Review*) (arguing that the bill will force employers to cut positions and eliminate or reduce services to comply with the increased labor costs).

[147] *See* Wursten & Reich, *supra* note 142, at 3 ("Economic theory no longer predicts that minimum wage increases will necessarily have adverse employment effects."); S. COMM. ON LAB. AND INDUS. REL., COMM. ANALYSIS OF SB 3, at 3 (2016) (citing two studies from 1992 and 2012 which found no evidence that minimum wage hikes reduce jobs, but instead reduce turnover and improve the functionality of the low-wage labor market).

costs.[148] Nonetheless, employers may still be inclined to take adverse actions against their employees due to the wage mandate.[149]

For instance, Centinela Hospital Medical Center reduced employee hours and laid off various workers soon after Inglewood's healthcare worker minimum wage went into effect.[150] At least thirty of the terminated employees were earning less than the twenty-five dollar minimum wage.[151] Fortunately, the Service Employees International Union (SEIU)—advocating on behalf of the employees—had a legal remedy to raise because of the Code's protection and retaliation provisions.[152] Section 8-152(d) declares that an employer violates the statute if the wage mandate influenced adverse action, unless the employer can prove the action would have occurred regardless of the mandate.[153]

Thus, Section 8-152(d) sets a reasonable threshold for purposes of the complaint; specifically, a claimant must point to some causal link between the employer's adverse action and the wage mandate.[154] Section 8-152(d) is also considerate of the employer because it allows them to counter the allegations by presenting an alternative explanation.[155] Conversely, Section 8-153 is more severe since it presumes retaliation if an employer takes adverse action within ninety days of an employee's exercise of their rights under the Code.[156] However, Section 8-153 is similarly considerate of employers because it sets a *rebuttable* presumption, which allows employers to disprove the assumption with contrary evidence.[157]

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[148] Lopezlira & Jacobs, *supra* note 10, at 1, 15; *see also* S. COMM. ON LAB. AND INDUS. REL., COMM. ANALYSIS OF SB 3, at 4 (2016) (citing a Berkeley Policy Brief, which found that increased labor expenses from the thirteen dollar minimum wage would likely be offset by "increased worker productivity [and] declines in recruitment and retention costs").

[149] *See* Ibarra, *supra* note 78 (explaining that after Inglewood's ordinance went into effect, Centinela Hospital Medical Center laid off forty-eight workers and Service Employees International Union (SEIU) sued them as a result).

[150] Complaint for Plaintiff at 10, SEIU United Healthcare Workers-West v. Prime Healthcare Centinela Hospital Medical Center et al., No. 23STCV08047 (Cal. Super. Ct. filed Apr. 11, 2023).

[151] *Id.*

[152] *Id.* at 10–13 (outlining two causes of actions under Sections 8-152(c) and 8-153 of the Inglewood Municipal Code for the employer's improper funding of the minimum wage increase and retaliatory action).

[153] INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, § 8-152(c), (d) (2023) (effective Jan. 1, 2024) (specifying that adverse action against employees includes reductions in pay rates, non-wage benefits, and work hours; laying off workers; and increasing charges for work-related materials).

[154] Complaint for Plaintiff at 10–11, SEIU United Healthcare Workers-West v. Prime Healthcare Centinela Hospital Medical Center et al., No. 23STCV08047 (Cal. Super. Ct. filed Apr. 11, 2023) (arguing that the employer representative's comment that the Ordinance "caused Defendant . . . to reduce . . . hours" proved an improper motive and thus, any alternative explanation is pretextual); *id.* at 10–12 (arguing that the Defendant's letter to its employees, which cited "changes in business conditions" was a causal link because the only significant change in business was the wage mandate).

[155] INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, § 8-152(d) (2023) (effective Jan. 1, 2024).

[156] INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, § 8-153 (2023) (effective Jan. 1, 2024); Complaint for Plaintiff at 13, SEIU United Healthcare Workers-West v. Prime Healthcare Centinela Hospital Medical Center et al., No. 23STCV08047 (Cal. Super. Ct. filed Apr. 11, 2023) (showing that the employer's act of firing the employees within ninety days after they had publicly campaigned for the Ordinance's passage—as members of SEIU—was retaliation).

[157] INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, § 8-153 (2023) (effective Jan. 1, 2024) ("Taking any adverse action against a Healthcare Worker within [ninety] days of [their] exercise of rights . . . under this Article shall raise a *rebuttable* presumption of having done so in retaliation . . . ."); *Glossary: Rebuttable Presumption*, THOMSON REUTERS (2023) https://us.practicallaw.thomsonreuters.com/w-005-5201 (on file with the *University of the Pacific Law Review*) (defining a rebuttable presumption as an "assumption of fact or law" which is "taken . . . as true unless . . . contested and disproved by [the] evidence").

Thus, the Code is sufficiently robust to protect employees, while still being mindful of the employer's defense.[158] SB 525 should strive to do the same by adopting similar protection provisions.[159] The Legislature can achieve such protection by implementing these provisions through individual cities or counties tasked with processing complaints, similar to Section 8-155 of the Inglewood Ordinance.[160] By implementing similar provisions, SB 525 will better protect workers against adverse action, such as if an employer decides to finance the wage mandate through a reduction in workforce.[161]

4. Reductions in Profit Margins & Whether SB 525 is Too Burdensome for Employers

Employers with financial stability can finance the wage mandate themselves, through reduced profits.[162] The question is whether SB 525 will reduce profits at an excessive rate to warrant concern.[163] According to one study, SB 525 will prompt a $8 billion increase in labor costs for both public and private healthcare systems.[164] Further, annual wage increases will lead to greater total costs over time—given the bill's 3.5% annual adjustment provision—and projected employment growth in the health industry.[165] However, the $8 billion increase in labor costs fails to account for savings in reduced turnover costs or acknowledge that some facilities will only experience marginal increases.[166]

Although an estimated $8 billion increase in costs sounds jarring, that number reflects increased costs for all healthcare employers altogether.[167] Further, such estimates fail to acknowledge SB 525's delayed implementation, which begins at twenty-one dollars, stretching total costs over the span of two years.[168] Additionally, employers commonly raise wages by three percent on average per year.[169] Moreover, many California cities and private employers have already

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[158] INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, §§ 8-152(d), 8-153 (2023) (effective Jan. 1, 2024).

[159] *Id.*

[160] *Id.* § 8-155.

[161] *See* Complaint for Plaintiff at 10–13, SEIU United Healthcare Workers-West v. Prime Healthcare Centinela Hospital Medical Center et al., No. 23STCV08047 (Cal. Super. Ct. filed Apr. 11, 2023) (outlining two causes of actions under the Inglewood Municipal Code for the employer's improper funding of the minimum wage increase and retaliatory action).

[162] Williams & Genest, *supra* note 122.

[163] S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 8 (2023) (explaining that the California Chamber of Commerce alleges that the bill is unsustainable due to its "astronomical increase in labor costs").

[164] Williams & Genest, *supra* note 22, at 1 (adding that $4.9 billion will be spent on increased employee wages, $920 million on increased employee benefits, $300 million on increased manager wages, and $1.5 billion on avoiding wage compression).

[165] *Id.* (explaining that SB 525 imposes a 3.5% annual wage increase beginning in 2025 which will result in an estimated total cost of "$11.3 billion by 2030").

[166] Lopezlira & Jacobs, *supra* note 10, at 13–15 (finding that payroll and operating costs will only rise by eight and 4.5 percent, respectively—taking into account savings from reductions in turnovers); *id.* at 1, 14 (adding that operating costs vary by facility—explaining that health service facilities will see the largest increase at 11.6%, while hospitals will see the lowest increase at 1.1%).

[167] Williams & Genest, *supra* note 22, at 1.

[168] SB 525, 2023 Leg. 2023–2024 Sess. (Cal. 2023) (as amended on May 25, 2023, but not enacted).

[169] Adam Hayes, *Average Raise Percentage: What Factors Affect Your Raise?*, INVESTOPEDIA (Mar. 29, 2023), https://www.investopedia.com/articles/personal-finance/090415/salary-secrets-what-considered-big-raise.asp (on file with the *University of the Pacific Law Review*).

approved the twenty-five dollar healthcare worker minimum wage.[170] Ultimately, the $8 billion dollar estimate fails to consider SB 525's reductions in turnover, improvements in quality of care, increases in worker productivity, and improvements in employee satisfaction.[171] Thus, a twenty-five dollar wage mandate is not so burdensome to justify blocking SB 525's enactment, especially in light of its benefits.[172]

V. CONCLUSION

SB 525 is a crucial step towards solving the healthcare staffing shortage—a serious issue that threatens quality of care and employee mental health.[173] The bill is part of a collective movement and comes in the wake of various other measures—passed largely in response to COVID-19—which seek to support the healthcare system.[174] The Legislature recognizes a need to compensate healthcare workers for the sacrifices they made during the pandemic.[175] While the bill provides much needed relief for healthcare workers, SB 525 fails to consider the implications that come from any minimum wage increase.[176] To better account for

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[170] S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 5 (2023) (explaining that Inglewood's ordinance will take effect on January 1, 2024 and that Lynwood voters passed a similar ordinance in February 2023 which will take effect on May 22, 2023); Adams, *supra* note 38 (explaining that Stanford's new employment contract increases wages by fifteen percent over the next three years and increases the hospital's minimum wage to twenty-five dollars per hour).

[171] Lopezlira & Jacobs, *supra* note 10, at 1, 15 (explaining that increased wages results in job retention and reduced turnovers, which ultimately improve the quality of care); *Pay to Stay: Why Higher Wages Make Employees Happy, Loyal and More Productive*, HIRED MAG. (May 26, 2022), https://hiredmagazine.com/pay-to-stay-why-higher-wages-make-employees-happy-loyal-and-more-productive/ (on file with the *University of the Pacific Law Review*) ("Compensation . . . impact[s] employee performance and motivation to work. Compensation offered needs to be attractive . . . to keep morale high. Paying employees well shows [appreciation] and [helps with] employee happiness and satisfaction.").

[172] *See* S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 2 (2023) (explaining that the bill will help retain workers in light of competitive pay in other industries, attract new workers, and help with the healthcare staffing shortage).

[173] *See id.* at 8 (explaining that SB 525 will stabilize a pandemic-induced workforce shortage by retaining and attracting workers with higher pay); Lopezlira & Jacobs, *supra* note 10, at 1, 2, 5, 15 (explaining that staffing shortages correlate to higher mortality rates); Ethan Popowitz, *Addressing the Healthcare Staffing Shortage*, DEFINITIVE HEALTHCARE, 12, 16–17 (2022) (explaining that demanding workloads cause burnout, which impact mental wellbeing).

[174] *See* U.S. DEP'T OF HEALTH & HUM. SERV., *supra* note 24, at 1, 15 (explaining that the Provider Relief Fund and the CARES Act helped alleviate financial struggles that many health facilities faced during COVID); CAL. HEALTH & SAFETY CODE § 128740 (amended by Chapter 6) (creating a Distressed Hospital Loan Program which authorizes $150 million in loans for financially vulnerable hospitals); CAL. WELF. & INST. CODE § 14199.80 (amended by Chapter 13) (renewing the Managed Care Organization tax); CAL. MED. ASS'N, *supra* note 124 (discussing AB 119, which will add chapter 13 to Section 14199.80 of the California Welfare Code, and how it will increase reimbursement rates for Medi-Cal providers).

[175] *See generally* DHCS, *supra* note 29 (citing various California health officials who recognize the need to compensate and honor healthcare staff for the sacrifices they endured during the pandemic); *id.* (explaining that SB 184 authorized a one billion dollar fund to issue "one-time worker retention payments" to those who worked at "qualifying [health] facilities during . . . COVID-19"); SB 525, 2023 Leg. 2023-2024 Sess. (Cal. 2023) (as amended on May 25, 2023, but not enacted) (proposing to increase the healthcare worker minimum wage to twenty-five dollars).

[176] *See* Popowitz, *supra* note 3, at 1, 21 (reporting that twenty-eight percent of participants said insufficient salary contributed to burnout and thirty-seven percent said "increased compensation would help [alleviate] feelings of fatigue and financial stress"); S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 7 (2023)

the repercussions that may result from the wage mandate, the Legislator must consider the various ways in which an employer may finance the added labor costs.[177] To achieve SB 525's goal of strengthening the healthcare workforce, the Legislature must protect employees, assist certain facilities with funding and slower wage implementations, and continue to minimize the rising cost of care.[178]

("Following the inflation surge of June 2022, the U.S. minimum wage dipped to its lowest level in real dollars since 1956."); *id.* at 8 (explaining that certain facilities may need to "cut hours, positions, and services" to mitigate increased labor costs).

[177] *See* Williams & Genest, *supra* note 22 ("[H]igher costs caused by mandated minimum wage increases can be borne by: (1) . . . staffing reductions; (2) . . . reduced profits; or (3) higher [healthcare] billing [and insurance] rates.").

[178] *See* S. COMM. ON LAB., PUB. EMP. & RET., COMM. ANALYSIS OF SB 525, at 8 (2023) (explaining that SB 525 is a mechanism for the state to achieve its goal of improving the quality of care for Californians); INGLEWOOD, CAL., MUN. CODE ch. 8, art. 12, §§ 8-152(c), (d), 8-153 (2023) (effective Jan. 1, 2024) (making it unlawful for an employer to finance the wage mandate with adverse action against employees and establishing a presumption of retaliation if adverse action is taken within ninety days); CAL. LAB. CODE ANN. § 1182.12(b)(2) (West 2017) (enumerating a slower wage implementation timeline for employers with twenty-five or less employees); Williams & Genest, *supra* note 22 ("In the past, the Legislature has augmented the In-Home Supportive Services . . . and the Department of Developmental Services budget[s] to reflect the costs those programs would incur due to general minimum wage increases."); HEALTH & SAFETY § 127501(a), (b) (creating the Office of Health Care Affordability which tracks healthcare cost trends and develops policies to lower costs).

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