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POLICY BRIEF

Proposed health care minimum wage increase: State costs would be offset by reduced reliance on the public safety net by health workers and their families

By Laurel Lucia, Enrique Lopezlira, Ken Jacobs and Savannah Hunter

California Senate Bill 525 proposes a minimum wage increase for health care workers at most medical facilities—general and surgical hospitals, psychiatric hospitals, outpatient clinics, offices of physicians, skilled nursing facilities, and home health agencies—starting at $21 per hour on July 1, 2024, and phasing up to $25 per hour on July 1, 2025.[1] This health care worker minimum wage would replace the current state minimum wage of $15.50 per hour, increasing the incomes of approximately 450,000 low-wage health care workers and their families by more than $10,000 annually once the minimum wage reaches $25 per hour.

This brief updates key findings from an April 2023 Labor Center brief by Lopezlira and Jacobs[2] reflecting amendments to SB 525 in May 2023. While the earlier brief focused on the effect of the proposal on health care workers, patients, and industry, here we also consider its impact on the state budget. We estimate both the new costs to the state resulting from SB 525 as well as the savings it would generate through reductions in safety net program enrollment of affected workers and their family members.

- **Almost half (48.8%) of families with a health care worker affected by the proposed minimum wage increase are enrolled in public safety net programs, including Medi-Cal, CalFresh, CalWORKS, and the Federal Earned Income Tax Credit.** Raising the health care minimum wage would help reduce these working families' need to rely on public safety net programs, in turn reducing state Medi-Cal spending as affected workers become eligible for federally-subsidized insurance through Covered California.
- **Medi-Cal caseload savings would partially or fully offset state cost increases related to potential increased Medi-Cal payments to providers and increased costs for state employee wages and benefits.** By the third year of the policy, the net state budget impact of the bill is estimated to range from $467 million in net savings to $303 million in net costs (2023 dollars), depending on the extent to which the state increases Medi-Cal provider payments and how many workers and dependents experience a change in health insurance eligibility.

Public safety net program enrollment among affected health care workers and families

Many California health care workers do not earn enough to make ends meet, as described by Lopezlira and Jacobs.[3] Exhibit 1 further demonstrates the impact of low earnings by showing the extent to which low-wage health care workers in California need to rely on publicly funded safety net programs for themselves or their family members. Nearly half of the health care workers (48.8%) who would receive increases with a $25 hourly minimum wage are in families with at least one member enrolled in one or more safety net programs, compared to 35.1% of all California workers. This includes workers who would receive indirect wage increases due to the ripple effect from the new health care minimum wage (spillover effects).[4] The state and federal governments spend a combined $2.8 billion annually (2023 dollars) on all the programs for this public safety net program enrollment by affected health care workers and their families.

Exhibit 1: Average annual enrollment in and cost of public safety net programs for families with a health care worker affected by the proposed $25 hourly minimum wage

Safety net program	Number of affected families with at least one person enrolled	Percentage of affected families enrolled (compared to percentage of all working CA families enrolled)	Annual cost (federal/state combined, 2023 dollars)
Federal Earned Income Tax Credit (EITC)	175,000	33.7% (21.7%)	$484,428,000
Medi-Cal for adults	216,000	41.6% (30.6%)	$1,616,268,000
Medi-Cal/CHIP for children	85,000	16.5% (12.5%)	$357,661,000
CalFresh (Supplemental Nutrition Assistance Program)	81,000	15.9% (11.0%)	$276,169,000
CalWORKS (Temporary Aid to Needy Families)	11,000	2.1% (1.4%)	$65,647,000
Any program	**253,000**	**48.8% (35.1%)**	**$2,800,172,000**

Source: UC Berkeley Labor Center calculations based on the 2017-2021 American Community Survey, 2018–2022 March Current Population Survey, and administrative data from Medicaid and CHIP programs. Cost estimates inflated to 2023 dollars using CBO actuals/projections of CPI-U. For a detailed explanation of methodology, please see Appendix A in Sylvia A. Allegretto et al. (2013) "Fast Food, Poverty Wages: The Public Cost of Low-Wage Jobs in the Fast-Food Industry," http://laborcenter.berkeley.edu/fast-food-poverty-wages-the-public-cost-of-low-wage-jobs-in-the-fast-food-industry/.

Note: The analysis is restricted to workers who work at least 27 weeks in a year and 10 or more hours per week. CalWORKS estimates include only the cash assistance portion of TANF.

Impact on workers' earnings

More than 450,000 health care workers would receive wage increases under SB 525 by the time the minimum wage reached $25.00 per hour on July 1, 2025 (Exhibit 2). Together, affected health care workers represent almost 40% of all health care employees in the state, and 3% of California's total workforce. The vast majority of affected workers (85%) are from four facility types: outpatient clinics (116,532), hospitals (114,344), skilled nursing facilities (82,513), and home health agencies (74,617). Appendix Exhibit A1 shows these estimates for each minimum wage level through 2027.

We project that by the time the minimum wage reaches $25.00 on July 1, 2025, the average annualized earnings increase for affected workers will be an estimated $10,352 more than if wages had grown at the rate projected without the policy change (Exhibit 2). The highest average earnings increases would be $11,786 in skilled nursing facilities and $11,672 in home health. Appendix Exhibit A2 shows these estimates for each minimum wage level through 2027.

Exhibit 2: Estimated impacts of a minimum wage increase to $25 for health care workers, by facility type

Facility type	Number of workers affected	Average annual* earnings increase for affected workers compared to no policy change (nominal dollars)
Office of physicians	42,812	$10,320
Outpatient clinics	116,532	$9,602
Home health agencies	74,617	$11,672
Hospitals	114,344	$9,784
Psychiatric hospitals	5,702	$9,230
Skilled nursing facilities	82,513	$11,786
Medical labs	18,556	$10,522
Overall	**455,076**	**$10,352**

* Note: The proposed $25 minimum wage, effective July 1, 2025, would be indexed on January 1, 2026. The earnings estimates in this exhibit are annualized by doubling the 6-month earnings estimates in Appendix Exhibit A2.

Source: UC Berkeley Labor Center analysis of the U.S. Census Bureau's 2020 5-year American Community Survey and the Quarterly Census of Employment and Wages

Impact on the state budget

The current version of SB 525 proposes a $21 hourly minimum wage for covered health care workers on July 1, 2024, growing to $25 per hour on July 1, 2025. The minimum wage would then be indexed to the lesser of the Consumer Price Index (CPI) or 3.5% beginning January 1, 2026, and every January 1 thereafter.[5] In order to provide state budget estimates for the first three years the policy would be in effect–July 1, 2024, through June 30, 2027–we assume projected minimum wage rates of $25.60 on January 1, 2026 and $26.10 on January 1, 2027.[6]

Overview of impacts of SB 525 on the California state budget

Exhibit 3 includes estimates of the net impact of the proposed change in the health care minimum wage on the state budget, with costs increasing in three main areas:

- **Medi-Cal:** The impact of SB 525 on the state's Medi-Cal expenses is the most difficult cost to estimate. If Medi-Cal provider rates paid by the state and/or Medi-Cal managed care plans are increased to reflect the higher labor costs that would occur under the bill, state spending on Medi-Cal would increase. Our estimates reflect the range of possibilities, from only skilled nursing facility reimbursement rates increasing (as mandated in law) to all affected health care sectors being fully reimbursed for the increase in the Medi-Cal share of labor costs.
- **Department of State Hospitals:** State spending would increase for affected Department of State Hospitals workers' wages.
- **CalPERS:** State spending would also increase for CalPERS health insurance premiums assuming that the increase in labor costs is passed through to CalPERS premiums and ultimately the state.

However, these increased costs would be partially or fully offset by state savings:

- **Medi-Cal savings:** SB 525 would reduce the Medi-Cal caseload due to the reduction in program enrollment by affected workers and family members.
- **Increased tax revenue:** SB 525 would increase the state's income tax and sales tax revenues as a result of new federal Medicaid and Medicare dollars coming into the state.

Although affected health care workers and their family members are enrolled in a range of safety net programs, our budget analysis focuses on Medi-Cal savings because funding is shared by the state and the federal government and is directly tied to enrollment. CalFresh benefits are funded by the federal government. CalWORKS is state- and federally-funded but is funded through a block grant structure, not on a per-enrollee basis. While California has a state-level EITC program, we were only able to analyze the federal EITC, so have not quantified those savings.

In the first year of the policy, state costs would increase by an estimated $140 million to $358 million. In the second year of the policy, the net impact on the state budget could range from $74 million in savings to $519 million in increased costs. By the third year of the policy, the estimated state budget net impact ranges $467 million in savings to $303 million in increased costs. The budget estimates throughout this report are all in 2023 dollars to be comparable to today's budget.

Exhibit 3: Estimated state budget impacts of proposed increases in the minimum wage for health care workers ($ millions, 2023 dollars)

	Year 1 July 1, 2024– June 30, 2025	**Year 2** July 1, 2025– June 30, 2026	**Year 3** July 1, 2026– June 30, 2027
State costs			
Medi-Cal providers	$109–326	$203–614	$200–607
State employee wages	$18	$35	$35
State employee health benefits	$13	$51	$50
Subtotal	$140–358	$289–700	$285–692
State savings			
Medi-Cal caseload	$0	($181)–($363)	($389)–($752)
Increase in tax revenue		Exact impact is uncertain	
Net change in state budget	**$140–358**	**($74)–$519**	**($467)–$303**

Source: UC Berkeley Labor Center analysis. See the following sections and Appendix C for sources.

State cost: Medi-Cal providers

Health care facilities' operating costs will rise as a result of the higher minimum wage and the associated increase in payroll taxes and workers' compensation costs, partially offset by savings related to reduced turnover. We have updated the estimates from our April 2023 brief of the impact on facility operating costs by health facility type; these new estimates are provided in Appendix B. Here we focus specifically on the share of health care facility cost increases that would potentially be reimbursed through Medi-Cal, thereby affecting the state budget.

California law on Medi-Cal skilled nursing facility (SNF) reimbursement requires direct pass-through of Medi-Cal costs for new state or federal mandates, including increases in the minimum wage.[7] We assume the pass-through occurs immediately upon implementation of the statewide minimum wage increase, as has occurred with past minimum wage increases.

For all other types of health care facilities, it is uncertain whether, when, and by how much Medi-Cal fee-for-service rates or payments from managed care plans to providers would increase to reflect the higher labor costs. This would be dependent on future decisions by state policymakers and managed care organizations. Supplemental payments, which are typically lump-sum payments paid separate from and in addition to payments made for individual services or enrollees, are a significant source of revenue for hospitals and physicians in addition to base rates paid. Each type of supplemental payment has a different calculation method and updates to these payments due to increased labor costs are generally not automatic.

Given the uncertainty for all other types of health care facilities other than SNFs, this section provides upper-bound estimates of the annual increase in state Medi-Cal expenditures if and when the state Medi-Cal share of increased payroll expenses are fully passed through to the Medi-Cal program. The lower bound assumes no increase in provider payments except for SNFs. In the second year of the policy, increased state spending could range from $203 million to $614 million (2023 dollars).

Exhibit 4: Estimated increase in state Medi-Cal spending ($ millions, 2023 dollars)

Facility type	**Year 1** July 1, 2024– June 30, 2025	**Year 2** July 1, 2025– June 30, 2026	**Year 3** July 1, 2026– June 30, 2027
Office of physicians	$0 – 13	$0 – 24	$0 – 24
Outpatient clinics	$0 – 49	$0 – 96	$0 – 95
Home health agencies	$0 – 93	$0 – 168	$0 – 166
Hospitals	$0 – 54	$0 – 108	$0 – 107
Psychiatric hospitals	$0 – 2	$0 – 5	$0 – 5
Skilled nursing facilities	$109	$203	$200
Medical labs	$0 – 6	$0 – 11	$0 – 11
Total	**$109 – 326**	**$203 -– $614**	**$200 – 607**

Source: UC Berkeley Labor Center analysis. See Appendix C for sources.

Note: Estimates reflect a range from only SNF reimbursement rates increasing to all affected health care sectors being fully reimbursed for increases in the Medi-Cal share of labor costs.

State cost: Direct wage costs for state employers

The California Department of State Hospitals, which oversees five state hospitals and provides services in other programs, has 13,000 employees statewide.[8] If the health care minimum wage increase has the same impact on state hospitals as it is projected to have on California hospitals overall–in terms of the share of employees affected and the average annual wage increase–the increased spending would be $35 million (2023 dollars) in the second year of the policy. The California Department of Corrections and Rehabilitation is another state department that provides health care services, but no state costs are assumed because SB 525 does not list state correctional facilities as a covered health facility (though it does include county correctional facilities that provide health care services).

State cost: Health premiums for state workers

We estimate that state spending on employee health benefits will increase by $51 million (2023 dollars) in the second year of the policy. This is based on a threefold assumption: first, that the health care minimum wage will cause personal health care expenditures to increase by 0.9%;[9] second, that

the employer share of CalPERS premiums will increase at that same 0.9% rate; and third, that the CalPERS employer share of the premium increase will be fully reflected in the state budget. The $51 million figure is comprised of the increased premium spending for active and retired employees of the State of California and the California State University System and their dependents. It does not include any increase in state spending on UC employee health benefits because UC does not participate in CalPERS, and approximately 90% of UC funding comes from sources other than state General Funds.[10]

The extent to which this increase in premiums would be passed through to the state budget is uncertain given that it would require that providers pass on the full cost of the wage increase to CalPERS health plans. It is also uncertain that CalPERS would fully pass this cost onto the state budget given that employer premium contributions are part of workers' total compensation and are a subject of collective bargaining, and health benefits are one of many expenses that impact each department's budget. For these reasons, our assumptions lead to a conservative (high) estimate of increased costs to the state for health premiums for state workers due to SB 525.

State savings: Medi-Cal caseload

Health care workers affected by the proposed minimum wage are less likely to have health coverage from an employer than health care workers with wages that already exceed the proposed minimum;[11] this fact, combined with their relatively low wages, results in many of the affected workers along with their family members being enrolled in Medi-Cal. While higher health care wages would increase Medi-Cal expenditures to providers in the state, they would also generate budget savings related to health care workers and their dependents who are currently enrolled in Medi-Cal.

Most adults in sole-earner households with affected workers earning $25.60 in 2026 would become ineligible for Medi-Cal based on income. (Some indirectly affected workers whose wages increase due to the spillover effect would also experience changes in health insurance eligibility but these examples focus on directly affected workers.) For example, a single worker with no children earning $25.60 per hour in 2026 would have to work fewer than 16 hours per week to maintain Medi-Cal eligibility. To maintain Medi-Cal eligibility while earning $25.60 in 2026, adults in larger households would need to work fewer than 22 hours per week in a household of two, and fewer than 34 hours per week in a household of four. As context, Lopezlira and Jacobs found that affected health care workers under SB 525 were estimated to contribute 58.2% of their family's income and 80.2% were estimated to work 35 hours per week or more.[12] In other words, we can safely assume that the majority of workers affected by the health care minimum wage, along with their spouses, would become ineligible for Medi-Cal.

Most children of sole earners would remain eligible for Medi-Cal, including Medi-Cal coverage funded by the Children's Health Insurance Program (CHIP), if a parent's earnings increased to $25.60. This is because of the higher Medi-Cal income eligibility limit for children (266% of the federal poverty level) compared to the limit for adults (138% of the federal poverty level). For a household with one parent and one child, the child would be eligible for Medi-Cal as long as the parent worked fewer than 43 hours per week. For larger households, children would remain Medi-Cal eligible even if the parent worked significantly more hours.

In most cases, adults and children who lose eligibility for Medi-Cal would become eligible for federally subsidized insurance through Covered California. Households earning between 138% and 150% of the federal poverty level pay no premiums for a benchmark plan[13] in Covered California, and those earning between 150% and 200% of the federal poverty level pay between 0% and 2% of income on premiums for a benchmark plan. Those earning more pay a higher percentage of income, but no more than 8.5%. Not all Californians are eligible for subsidized coverage through Covered California, however; eligibility exceptions include households with an affordable offer of job-based coverage[14] and undocumented immigrants.

While some savings to the state are possible in 2024-2025 when the minimum wage reaches $21 per hour, the largest changes in Medi-Cal eligibility–and thus the largest state savings–would occur at $25 per hour. For this reason, the second and third years of the policy are the focus of our analysis. Medi-Cal eligibility changes are typically determined during the annual renewal process and redeterminations are spread over 12 months; therefore we assume half of annual savings in 2025-26 and full annual savings in 2026-27.

We estimated a range of savings to the state by assuming 50% to 100% of Medi-Cal adult enrollees in households with affected workers would experience a change in eligibility from Medi-Cal to Covered California. Applying this assumption to the state share of Medi-Cal spending on affected workers and their family members,[15] the state would save between $181 and $363 million (2023 dollars) in the second year of the policy and between $389 and $752 million in the third year.

State savings: Increases in state tax revenue

Passage of the health care minimum wage will yield additional federal funding to the extent that Medicaid and Medicare provider rates increase to reflect the higher health care worker wages in the state. These additional federal dollars coming into the state economy would result in increased state tax revenues. Federal Medicaid funding would increase to the extent that Medicaid provider payments increase. Medicare provider payments would also be expected to partially reflect increased labor costs over time due to the Medicare Wage Index that adjusts payments for area wage differences.[16] The impact of increased federal funding on state tax revenues is estimated as a ratio, given the uncertainty of the total federal funding expected for both Medicaid and Medicare. We estimate that every $1 billion in wage increases reimbursed by new federal Medicaid or Medicare dollars via increased provider rates would generate $42.2 million in state taxes revenues–$18.5 million in state income tax revenue and $23.7 million in sales tax revenue in 2023 dollars.[17] This includes the tax impacts of the direct effect of the increased federal health care funding, the indirect effect on health care suppliers, and the induced effect of increased spending by affected health care workers in their communities.

Beyond the federal revenue used to support the increase in health care worker wages, the tax implications for the state of increased wages would depend in large part on who ultimately pays for the increase and how much of the funding comes from within the state versus outside of it.

Conclusion

Nearly half of the health care workers that would be affected by the increase in the minimum wage as proposed in SB 525 are themselves enrolled in safety net programs or have a household member enrolled in the programs. Many affected health care workers and their adult family members who are currently enrolled in Medi-Cal would no longer be income-eligible for Medi-Cal as a result of the minimum wage increase and would instead be eligible for federally-subsidized insurance through Covered California, reducing state spending on Medi-Cal. These Medi-Cal caseload savings would partially or fully offset the increased state spending on Medi-Cal providers and state employee wages and health benefits. In addition to seeing savings from reduced Medi-Cal caseloads, the state would likely see increased sales and income tax revenue, which would further offset the increased state costs. The extent to which the state savings would offset the state costs and when that would occur would partly depend on how much state policymakers and Medi-Cal managed care plans increase Medi-Cal provider payments to reflect the increase in labor costs.

Appendix A: Additional exhibits

Appendix exhibit A1: Estimated number of health care workers affected by minimum wage increase, by facility type and wage level, 2024-2027

Minimum wage	$21.00	$25.00	$25.60	$26.10
Dates effective	**July 1, 2024–June 30, 2025**	**July 1, 2025–Dec. 31, 2025**	**Jan. 1, 2026–Dec. 31, 2026**	**Jan. 1, 2027–Dec. 31, 2027**
Office of physicians	37,135	42,812	42,201	42,880
Outpatient clinics	100,023	116,532	115,150	116,737
Home health agencies	69,631	74,617	73,790	74,689
Hospitals	93,686	114,344	112,374	114,680
Psychiatric hospitals	4,849	5,702	5,619	5,726
Skilled nursing facilities	76,018	82,513	82,179	82,554
Medical labs	16,048	18,556	18,231	18,608
Overall	**397,390**	**455,076**	**449,544**	**455,874**

Source: UC Berkeley Labor Center analysis of the U.S. Census Bureau's 2020 5-year American Community Survey and the Quarterly Census of Employment and Wages

Note: Affected workers include those who would receive indirect wage increases due to the ripple effect from the new health care minimum wage (spillover effects).

Appendix exhibit A2: Average annual earnings increase for affected health care workers compared to no policy change, by facility type and wage level, 2024-2027 (nominal dollars)

Minimum wage	**$21.00**	**$25.00**	**$25.60**	**$26.10**
Dates effective	**July 1, 2024–June 30, 2025**	**July 1, 2025–Dec. 31, 2025** ***(earnings increase for 6 months)***	**Jan. 1, 2026–Dec. 31, 2026**	**Jan. 1, 2027–Dec. 31, 2027**
Office of physicians	$5,970	$5,160	$10,316	$10,518
Outpatient clinics	$5,578	$4,801	$9,560	$9,766
Home health agencies	$6,788	$5,836	$11,710	$11,940
Hospitals	$5,836	$4,892	$9,778	$9,983
Psychiatric hospitals	$5,126	$4,615	$9,149	$9,310
Skilled nursing facilities	$6,699	$5,893	$11,710	$11,934
Medical labs	$6,092	$5,261	$10,553	$10,752
Overall	**$6,060**	**$5,176**	**$10,342**	**$10,552**

Source: UC Berkeley Labor Center analysis of the U.S. Census Bureau's 2020 5-year American Community Survey and the Quarterly Census of Employment and Wages

Note: Affected workers include those who would receive indirect wage increases due to the ripple effect from the new health care minimum wage (spillover effects).

Appendix B: Change in operating costs

The ways in which an increase in the health care minimum wage impacts a facility's operating costs is influenced by several factors, including the proportion of workers who receive a pay raise, the average magnitude of the raise, and the portion of labor costs relative to overall operating expenses. Our estimates of operating costs take into account payroll taxes and workers' compensation as well as cost savings that will result from reductions in turnover as a result of the higher minimum wage.[18] They do not include the additional savings from increased productivity or reductions in hospitalizations due to improvements in care quality. Exhibit B1 shows the percentage change in operating costs for the different types of health care facilities covered by SB 525. The median increase in operating costs would be 3.2%.

Appendix exhibit B1: Percent change in operating costs for health care industries with a $25 minimum wage

Facility Type	Percent change in operating costs
Office of physicians	2.8%
Outpatient clinics	3.2%
Home health agencies	10.8%
Hospitals	1.1%
Psychiatric hospitals	1.9%
Skilled nursing facilities	6.1%
Medical labs	3.8%
Mean percent change	4.4%
Median percent change	3.2%

Source: UC Berkeley Labor Center analysis of the 2020 5-year American Community Survey, California Department of Health Care Access and Information, and the U.S. Census Bureau's 2021 Service Annual Survey

Appendix C: Methodology

Affected workers

We used data from the American Community Survey (ACS) 2016-2020 5-year sample to estimate the proportion of health care workers who would be earning less than $21 an hour in 2024, less than $25 an hour in 2025, less than $25.60 an hour in 2026, and less than $26.10 an hour in 2027, in each of the health care facilities covered by SB 525. (For simplicity in identifying affected workers, our analysis focused on wage levels in each calendar year, though the first two increases to the minimum wage would occur on July 1 in 2024 and 2025.)

The ACS sample is restricted to workers 18-64 years old, who work in California, with non-zero earnings in the past year, who were not self-employed or unpaid family workers, and who were at work last week or had a job but were not at work last week. The ACS does not include an hourly earnings measure; we therefore follow standard practice and construct the hourly wage measure by dividing the worker's annual earnings by the product of usual hours worked per week and weeks worked last year. The ACS annual earnings variable includes wages, salary, commissions, and cash bonuses or tips from all jobs, before tax deductions. We trimmed hourly wage outliers by dropping wages less than $0.50 or greater than $100 in 1989 dollars.[19] We brought wages up to 2023 dollars using the BLS employer and cost index for health care and social assistance,[20] and then brought wages to 2024, 2025, and 2026 using wage growth rate forecasts from the California Employment Development Department,[21] and to 2027 using the forecast of the Consumer Price Index for Urban Wage Earners and Clerical Workers for California.[22]

We refer to workers at these covered facilities making under $21 an hour on January 1, 2024, under $25 an hour on January 1, 2025, under $25.60 an hour on January 1, 2026, and under $26.10 an hour on January 1, 2027, as directly affected workers. We calculate the wage increase to these workers as the difference between the corresponding new minimum wage and their hourly wage at each corresponding calendar year.

We also estimate the proportion of workers at covered health care facilities who would receive small wage increases (spillover effects), even though they are earning at or slightly above the new proposed minimum wage. These workers are referred to as indirectly affected workers. Following Cengiz et al (2019), we cap spillover effects at workers making $3 above each new minimum wage (for example, $28 an hour in 2025).[23] Indirectly affected workers receive a quarter of the difference between their current wage and the new proposed minimum wage.[24]

To obtain the total number of affected workers in each year from 2024 to 2027 (directly affected workers plus indirectly affected workers), we applied the estimated proportions from the ACS to data from the 2021 California Quarterly Census of Employment and Wages (QCEW),[25] for the health care facilities covered by SB 525.

Industry costs

To estimate the impact of SB 525 on the costs of covered health care facilities, we first estimate the percentage change in wages for each type of facility, using our earlier analysis of the ACS. We then determine the percentage change in payroll costs associated with these wage changes. These

calculations adjust payroll costs for reductions in turnover as a result of the higher pay received by workers, following the methodology in Jacobs and Graham-Squire (2010).[26]

Next, to estimate the impact of these payroll changes on operating costs, we first determine labor's share of operating costs for each type of facility. For hospitals (both general and specialty, and psychiatric) and skilled nursing facilities, we use financial disclosure reports from the California Department of Health Care Access and Information.[27] For all other facilities, we use data from the US Census Bureau's 2021 Service Annual Survey.[28] Finally, to estimate the percentage change in operating costs, we multiply the percentage change in payroll costs by the labor's share of operating costs for each type of facility.

Public safety net program use

We rely on several sources of data: the US Census Bureau's American Community Survey (ACS) 2017-2021, the March Supplement of the US Bureau of Labor Statistics Current Population Survey (CPS) 2018-2022, and administrative data from the Medicaid, CHIP, TANF, EITC, and SNAP programs (2017-2021). The March Supplement of CPS, also known as the Annual Demographic Supplement, asks respondents about receipts of cash and noncash transfer payments during the past year and includes questions about the programs we examine in this analysis. Survey databases like the ACS and CPS frequently have safety net program utilization counts that differ from program administrative data. We adjusted the CPS so that its program utilization estimates match the program administrative data. The CPS does not provide a large enough sample size to accurately estimate program utilization for health care workers at the state level. The ACS does have sufficient sample size for this analysis but lacks specific questions about program utilization. To overcome these issues, we built a model using CPS data to predict program utilization based on income, demographics, and family structure. We then used that model to impute program utilization onto the ACS data. Finally, we used that imputed and adjusted ACS data to analyze safety net program utilization in families of health care workers affected by the bill. For a detailed explanation of methodology, please see Appendix A: Methodology from "Fast Food, Poverty Wages: The Public Cost of Low-Wage Jobs in the Fast-Food Industry."[29]

Our sample and analysis of health care workers affected by the bill included only those currently employed or "has job, but not working," were between the ages of 16 and 64, were not self-employed or an unpaid family worker, worked at least 27 weeks a year and at least 10 hours per week, and had non-zero earnings. These restrictions ensure that our sample includes workers whose receipt of public benefits are due to lower earnings rather than underemployment. We identified affected health care workers as those employed in the following industries: office of physicians, outpatient care centers, home health agencies, other health care services (medical and diagnostic laboratories), general medical and surgical hospitals, psychiatric and substance abuse hospitals, and skilled nursing facilities. We restricted our sample to health care workers who currently earn an hourly wage of less than $28 in 2025 dollars or the equivalent of $24.33 in 2021 dollars. We converted from 2025 to 2021 dollars using the Employment Cost Index sourced from CBO's Economic Projections for 2020 to 2030.

Health benefits for state employees

Health premiums for CalPERS subscribers employed by and retired from the state and their dependents are projected to total $6.9 billion in year two of the policy, and employers would pay approximately 83% of the premium based on the employer/worker premium split in 2022.[30] The

CalPERS rate development process occurs between February and July of each year and premiums take effect on January 1, so it is likely that the payroll increase due to the minimum wage would not impact the rates until calendar year 2025 at the earliest. Therefore only six months of increased state spending is included for the July 1, 2024, to June 30, 2025, period in Exhibit 3.

Medi-Cal providers

California law on Medi-Cal skilled nursing facility reimbursement requires an add-on to the daily rate in the event of a statewide minimum wage increase but does not specify a methodology. Therefore, the methodology used to calculate an add-on to daily rates for state minimum wage increases under Senate Bill 3 (2016) is used as the model for how daily rate add-ons might be calculated under this proposal. When the minimum wage reaches a projected $25.60 per hour in calendar year 2026,[31] the annualized payroll increase for skilled nursing facility workers is estimated to be $913 million (2023 dollars). If California continues to have approximately 30.3 million nursing home days as it had in 2021,[32] the estimated daily add-on rate would be $30.13 in 2026 (2023 dollars). Applying that add-on rate to 16.3 million annual Medi-Cal SNF days and assuming that the state share of Medi-Cal expenditures is 40.9%,[33] the increase in annual state Medi-Cal spending would be $201 million (2023 dollars).

To estimate the changes in Medi-Cal costs from a higher minimum wage for facilities other than SNFs, the projected increase in payroll expenses from the higher minimum wage for each facility type is multiplied by the estimated Medi-Cal share of expenses for each facility type.[34] The Medi-Cal share of the payroll increase for each facility type is then multiplied by the state share of Medi-Cal fee-for-service expenditures by facility type.[35] The state share of Medi-Cal varies by facility type because certain Medi-Cal enrollment groups are eligible for a higher federal matching rate, such as Affordable Care Act expansion and Children's Health Insurance Program enrollees, and some enrollment groups use some service types more than others, such as seniors and individuals with disabilities using home health care services and nursing facility care more than other groups. Other factors such as supplemental payments can also drive the federal share of expenditures in each facility type.

Appendix exhibit B1: Medi-Cal assumptions for health care sectors other than SNFs

	Medi-Cal share of expenditures in health sector	State share of total Medi-Cal expenditures in health sector
Office of physicians	14.5%	40.0%
Outpatient clinics	23.8%	38.2%
Home health agencies	41.3%	49.2%
Hospitals	28.7%	35.7%
Psychiatric hospitals	28.7%	35.7%
Medical labs	14.5%	40.8%

Source: UC Berkeley Labor Center analysis of HCAI hospital financial reports, CMS Historical National Health Expenditure Accounts 2021, DHCS November 2022 Medi-Cal Local Assistance Estimate.

Endnotes

1 Bill Text - SB-525 Minimum wage: health care workers. Accessed June 12, 2023. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB525.

2 Lopezlira, Enrique, and Ken Jacobs. "Proposed Health Care Minimum Wage Increase: What It Would Mean for Workers, Patients, and Industry." Accessed June 12, 2023. https://laborcenter.berkeley.edu/proposed-health-care-minimum-wage-increase/.

3 Lopezlira and Jacobs, op. cit.

4 Following Cengiz et al. (2019), we assume that spillover effects extend to workers making up to $3 above the new minimum wage. Cengiz, D., Dube, A., Lindner, A., and Zipperer, B. "The Effect of Minimum Wages on Low-Wage Jobs." *The Quarterly Journal of Economics*, Aug 2019 134(3), 1405–1454. https://doi.org/10.1093/qje/qjz014.

5 Under SB 525, on or before August 1, 2025, and each August 1 thereafter, the Director of Finance would calculate an adjusted minimum wage that would take effect the following January 1. The minimum wage would increase by the lesser of 3.5% or U.S. CPI-W, using United States Bureau of Labor Statistics CPI-W from the most recent July 1 to June 30 over the preceding July 1 to June 30, non-seasonally adjusted. The result would be rounded to the nearest ten cents ($0.10).

6 Projected using Fiscal Year projections of CPI from the Congressional Budget Office. "Budget and Economic Data | Congressional Budget Office." Accessed June 12, 2023. https://www.cbo.gov/data/budget-economic-data#4.

7 California Welfare and Institutions Code 14126-14126.036.

8 "California Department of State Hospitals - About Us." Accessed June 14, 2023. https://www.dsh.ca.gov/about_Us/.

9 The 0.9% increase in personal health care expenditures is estimated based on the $4.68 billion in projected payroll increase in year two of the minimum wage policy divided by the $529.4 billion in projected personal health care expenditures in California in Fiscal Year 2025-26. U.S. Center for Medicare and Medicaid Services. "Health Expenditures by State of Residence, 1991-2020." Accessed June 16, 2023. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsstatehealthaccountsresidence. U.S. Center for Medicare and Medicaid Services. "Projected National Health Expenditure Accounts." Accessed June 14, 2023. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.

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11 Lopezlira and Jacobs, op. cit.

12 Ibid.

13 A benchmark plan is the second lowest-cost Silver plan offered in Covered California. Covered California. "Covered California Silver." Accessed June 22, 2023. https://www.coveredca.com/health/coverage-levels/silver/.

14 U.S. Center for Medicare and Medicaid Services. "Affordable Coverage." Accessed June 22, 2023. https://www.healthcare.gov/glossary/affordable-coverage/.

15 The state share of Medi-Cal spending is assumed to be 44% based on the percentage of Medi-Cal managed care expenditures that are projected to be non-federal in Fiscal Year 2023-24 (Department of Health Care Services, op. cit). Estimated Medi-Cal spending on affected workers and their families is based on the estimates in Exhibit 1, taking into account projected Medicaid growth using national estimates (U.S. Center for Medicare and Medicaid Services. "Projected National Health Expenditure Accounts." Accessed June 14, 2023. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected).

16 The Medicare Prospective Payment Systems for hospitals, skilled nursing facilities, and home health agencies are among the Medicare payment systems that adjust for area wage differences using a Wage Index. "Chapter 9: Reforming Medicare's Wage Index Systems (June 2023 Report) – MedPAC." Accessed June 22, 2023. https://www.medpac.gov/document/chapter-9-reforming-medicares-wage-index-systems-june-2023-report/.

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18 For further discussion of the effects of a minimum wage increase on turnover see Lopezlira and Jacobs, op. cit.

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34 The Medi-Cal share of hospital expenditures is based on 2021 state-level financial reporting data. "Hospital Annual Financial Data - Selected Data & Pivot Tables - California Health and Human Services Open Data Portal." Accessed June 15, 2023. https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables. For all other facility types, the Medi-Cal share of expenditures is based on CMS estimates of the national Medicaid share of Personal Health Care in each health sector in 2021 increased to reflect that Medicaid share of personal health care spending in CA is 20.7% greater than the national Medicaid share. U.S. Center for Medicare and Medicaid Services. "Historical National Health Expenditure Accounts." Accessed June 14, 2023. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.

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