Economic and Fiscal Impacts of SB 525

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About the Authors

The authors are partners with Capitol Matrix Consulting (CMC), a firm that provides consulting services on a wide range of economic, taxation, and state-and-local government budget issues. Together, they have over 80 years of combined experience in economic and public policy analysis.

Brad Williams joined Capitol Matrix Consulting in 2011, after having served in various positions in state government for 33 years. Mr. Williams served for over a decade as the chief economist for the Legislative Analyst's Office, where he was considered one of the state's top experts on the tax system, the California economy, and government revenues. He was recognized by the Wall Street Journal as the most accurate forecaster of the California economy in the 1990s, and has authored numerous studies related to taxation and the economic impacts of policy proposals. Immediately prior to joining CMC, Mr. Williams served as a consultant to the Assembly Appropriations Committee, where he advised leadership of the majority party on proposed legislation relating to taxation, local government, labor, and banking.

Mike Genest founded Capitol Matrix Consulting (originally Genest Consulting) in 2010 after concluding a 32-year career in state government, which culminated as Director of the California Department of Finance (DOF) under Governor Arnold Schwarzenegger. Prior to his four-year stint as the Governor's chief fiscal policy advisor, Mr. Genest held top analytical and leadership positions in both the executive and legislative branches of government. These included Undersecretary of the Health and Human Services Agency, Staff Director of the Senate Republican Fiscal Office, Chief of Administration of the California Department of Corrections and Rehabilitation, and Director of the Social Services section of California's Legislative Analyst's Office.

Table of Contents

Executive Summary

Senate Bill 525 would raise the minimum wage for all paid work in specified health care facilities to $25 per hour beginning in January 2024. The minimum wage would be increased in each subsequent year by the greater of 3.5 percent or the percentage increase in the U.S. Consumer Price Index for Wage and Clerical Workers. The increase would apply to employees and on-site contractors working in public and privately owned health care facilities, including hospitals, outpatient clinics, physician groups, certain residential facilities, skilled nursing facilities (SNFs) and home health agencies owned or controlled by hospitals. The measure would result in major costs to the health care industry that will likely be passed along to purchasers of health care services, including private individuals, businesses, and state and local governments.

Estimated costs to California's health care system. We estimate that total public and private health care expenses for labor will increase by about $8 billion beginning in 2024, consisting of the following components:

- $4.9 billion related to wage increases for workers currently making between $15.50 (the statewide minimum wage) and $25 per hour.
- $920 million related to increased employer payments for benefits such as social security contributions, retirement, and overtime differentials.
- $300 million due to provisions raising the "manager exemption" from California's overtime requirements from $31 per hour to $50 per hour ($104,000 annually).
- $380 million for the increase in minimum wages paid to on-site contractors, such as those providing building and grounds maintenance, security services, and temporary employment services.
- $1.5 billion due to employers being forced to raise pay rates for employees earning more than $25/hr to address "wage compression.

Wage compression estimate may be conservative. Wage compression occurs when mandated minimum-wage increases cause the pay of less-experienced and less-skilled workers to approach the levels of their more experienced and skilled counterparts. This puts pressure on companies to raise salaries further up the wage scale to maintain appropriate separation in wage rates. Our $1.5 billion estimate assumes declining wage adjustments for occupations with average wages ranging up to $50 per hour. However, the extraordinarily large minimum wage increase required by SB 525 could put pressure on wages further up the wage scale. If, for example, employers were compelled to raise wages for occupations with average pay ranging up to $75 per hour, the $1.5 billion estimate would more than double, raising total costs associated with SB 525 to nearly $10 billion. In addition, many state and local employees occupy the same job classifications as the workers in health care facilities and even belong to the same bargaining units. While not quantified in the report, this could result in significant pressure to raise those employees' wages as well. This would likely result in substantial additional costs.

Out-year impacts. Annual costs will increase in future years due to growth in employment in the health care industry and, especially, the provision in the bill setting a 3.5 percent floor on annual adjustments to the minimum wage beginning in 2025. Total costs (in today's dollars) would likely rise from $8 billion in 2024 to $11.3 billion by 2030.

State and local governments impacts. All levels of government would be directly affected by the minimum wage increase, both as employers of workers in state and county hospitals and correctional facilities, and as major purchasers of health care services – through county health care programs, the state's Medi-Cal program, and as purchasers of health insurance for their active and retired employees. We specifically estimate that the annual budgetary cost of the measure will be $4.0 billion annually ($1.4 billion General Fund) and that the counties, cities and special districts (which includes school districts) will incur $771 million in SB 525 costs once systemwide health care cost increases are recovered through the rate-setting and negotiating processes. These costs will grow over time due to employment growth and the annual adjustments to the minimum wage provided for in SB 525.

Background

SB 525 (Durazo) requires a minimum wage of $25 per hour for hours worked in a covered health care facility, or for health care services performed by an entity that owns, controls or operates a covered health care facility, regardless of work location. The minimum wage would be increased each subsequent year by the greater of 3.5 percent or the U.S. Consumer Price Index for Wage and Clerical Workers.

A "covered health care facility" is defined broadly to include a wide variety of entities operated by the public and private sector. Key categories include: integrated health care delivery systems; acute care, psychiatric, or specialty hospitals; skilled nursing facilities; public health entities; physician groups, a patient's home when health care services are delivered by an entity owned or operated by a hospital; licensed home health care agencies; a wide variety of outpatient clinics ranging from walk-in clinics, to urgent care clinics, community clinics, rural health care clinics, and dialysis clinics; and licensed residential care facilities for the elderly if affiliated with an acute care provider or owned by a hospital.

Estimating the Costs of SB 525 to California's Health Care System

SB 525 will increase health care costs in California through several different channels. These include:

- Direct wage increases for those currently earning less than $25 per hour.
- Associated non-wage benefit increases for social security, medicare, unemployment insurance, workers' compensation, retirement benefits, and overtime.
- Wage increases for lower-paid managers due to the increase in the "managerial exemption" from overtime requirements from $31 to $50 per hour.
- Increased costs for contractor services supplied through temporary registries on site, including landscaping, building-and-grounds maintenance, health and clerical services and food preparation.
- Employer efforts to offset wage compression.

We estimate that when these factors are combined, the total annual increase in cost to the health care system will be **$8 billion in 2024**, with annual amounts increasing in future years. This $8 billion represents increases in total health care expenditures of about 3 percent. The estimate covers costs for all elements of the health care system that are covered by SB 525, including both public- and private-sector systems of care. Our estimates for each of these factors are displayed in Figure 1 and discussed below:

Figure 1
Impacts of SB 525 on Aggregate Health Care Costs in California in 2024
(Dollars in Millions)

	Hospitals	Skilled Nursing Facilities	All Other (Clinics, Aging Services Etc.)	Total
Wage and Benefit Increases For Those Making Less than $25 Per Hour.				
Wages	$1,250	$800	$2,870	$4,920
Benefits	$270	$150	$500	$920
- Totals, Wages and Benefits	**$1,520**	**$950**	**$3,370**	**$5,840**
Other Cost Impacts				
Increase in manager exemption threshold	$160	$60	$80	$300
On-site contractor costs	$90	$60	$230	$380
Wage compression	$600	$200	$700	$1,500
Totals - Other	**$850**	**$320**	**$1,010**	**$2,180**
Grand Total	**$2,370**	**$1,270**	**$4,380**	**$8,020**

Direct Wage Increases for those Making Less Than $25 Per Hour

Two sets of data were combined to develop estimates of wage increases in the health care industry due to SB 525. For hospitals and SNFs we relied primarily on administrative data from the Department of Health Care Access and Information (HCAI)[1]. For other categories we relied primarily on the U.S. Bureau of Labor Statistics (BLS) Industry-Occupation Matrix Data[2] for health care industry segments affected by SB 525, as well as wages-by-occupation and employment-by-industry data from the California Employment Development Department (EDD)[3].

Hospital and SNF Estimates - Based on HCAI Data.

HCAI maintains detailed data in its Hospital Annual Financial Disclosure Reports for all California hospitals, including general acute care hospitals, free standing psychiatric hospitals, and psychiatric health facilities. These surveys include information on the number of employees, productive hours worked, and average hourly salary for every job classification in each revenue and non-revenue producing cost center in each reporting hospital. HCAI maintains similarly detailed information for the over 1,400 licensed SNFs in California in its Long-term Care Facility Integrated Disclosure and Medi-Cal Cost Report Data & Pivot Tables. The latest year for which data is currently available is 2021.

Cost Estimate. For each job classification in each cost center category for which the average wage is less than $25 per hour, the difference was multiplied by the number of productive hours worked during 2021 to arrive at the cost of raising the minimum wage to $25 per hour. In aggregate, the mandated wage

[1] https://hcai.ca.gov/

[2] Industry-Occupation Matrix Data, by Industry. U.S. Bureau of Labor Statistics. https://www.bls.gov/emp/tables/industry-occupation-matrix-industry.htm

[3] Wages by occupation data from "Occupational Employment and Wage Statistics (OEWS)," California Employment Development Department (https://labormarketinfo.edd.ca.gov/data/oes-employment-and-wages.html. Employment by industry data from "Quarterly Census of Employment and Wages," California Employment Development Department (https://labormarketinfo.edd.ca.gov/qcew/cew-select.asp).

increase would raise hospital wages by $1.25 billion in 2024, and SNF wage costs by about $805 million. We estimate that about 38 percent of hospital employees and 68 percent of SNF employees would be directly affected by the mandated increase.

Caveats. While this estimate is based on comprehensive and detailed administrative data for each hospital and SNF in the state, it is subject to significant uncertainty from offsetting factors. First, the estimate is based on survey responses for 2021, and thus does not reflect changes in the number of jobs or average wages that have occurred since then. Significant wage increases, in particular, would reduce the costs of establishing a $25 per hour minimum.

A key offsetting factor, however, is that the HCAI data only provides *average* hourly wages for occupations in each cost center, with no information about the *distribution* of wages around that average. This leads to an understatement in costs for occupations with average wages currently at or slightly above the proposed $25 per hour minimum. As a simple example, an occupation with an average wage of $25.01 per hour would show no impact from a minimum wage increase to $25 per hour, even though roughly one-half the workers in that occupation would have been earning less than the new minimum wage, and would in fact receive a wage increase. Our modeling of BLS and EDD based data (discussed in the following section), which has some information on wage distributions, suggests that the use of averages results in an underestimate ranging from 10 percent to 20 percent, depending on the health care category. This underestimate roughly offsets the over estimate created by using 2021 instead of 2024 wage rates. Taking into account these offsetting factors, we believe that the HCAI-based estimates are reasonable for the hospital and SNF categories.

Estimates for Other Categories - Based on BLS and EDD Data

Because detailed HCAI data is *not* available for health care categories other than hospitals and SNFs, we needed to use alternative data sources for calculating wage increases for the remaining categories affected by SB 525. The approach we developed combines industry-occupation matrix statistics from the BLS with the 2022 occupational employment and wage statistics (OEWS) from EDD. The BLS industry-occupation matrix allocates total jobs in each industry to occupations from a list of over 540 categories for the economy as a whole. We used the BLS matrix for 11 health industry categories affected by SB 525. These included private hospitals, public hospitals, psychiatric hospitals, other hospitals, SNFs, residential facilities, physician's offices, outpatient clinics, home-health agencies, and medical laboratories.

Our next step was to match each relevant occupation found in the BLS industry-occupation matrix with the corresponding wage data found in the March 2022 release of the OEWS. For each occupation we obtained the hourly wage rate for the 25th and 75th percentiles.

We then compared the $25 per hour minimum wage to hourly wages at the 25th and 75th percentile for each of these occupations. In making this comparison, we increased reported wages by 4 percent to reflect wage inflation between the survey date (March 2022) and the effective date of SB 525 (January 2024). In cases where the reported wage at the 25th percentile or 75th percentile, as adjusted for inflation, was less than the $25 per hour minimum wage, we multiplied the difference by half the number of employees in the occupation (to reflect the 50 percent weighting given to each the 25th percentile and 75th percentile). We further multiplied the results by average hours worked per employee each year in the industry (using data from American Community Survey for usual hours worked).

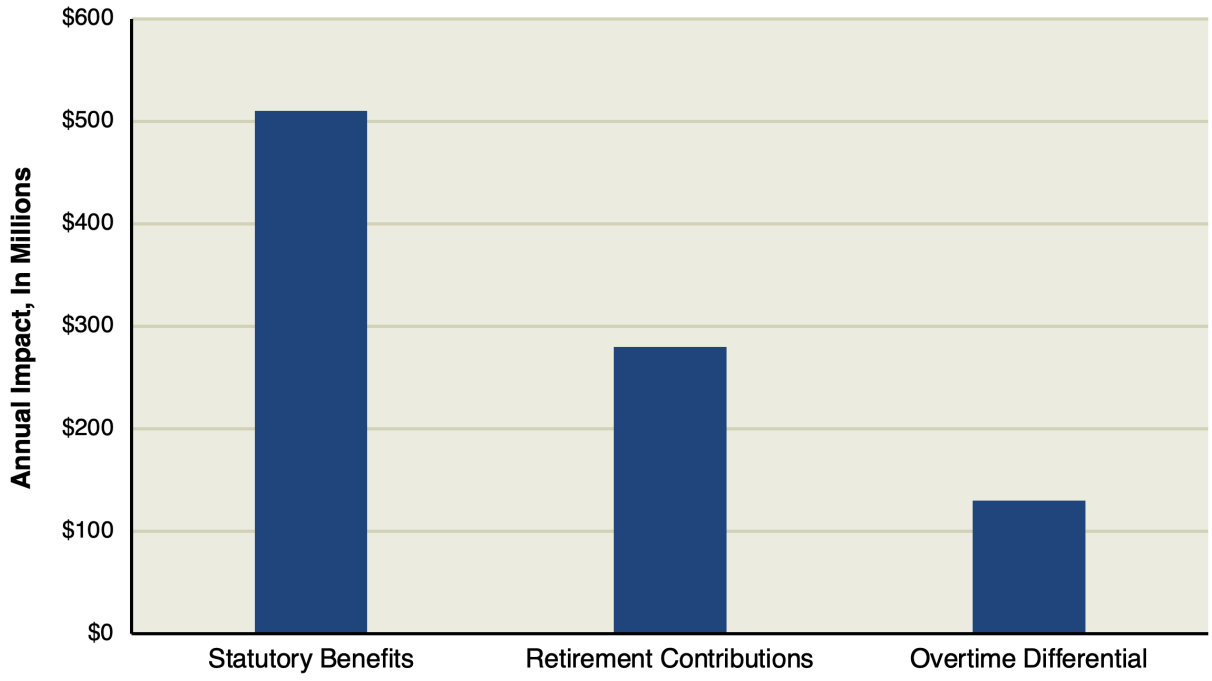
Results for Hospitals and SNFs. Our estimate using BLS and EDD data for hospitals and SNFs combined was very close to the HCAI-based estimates. Specifically, the BLS and EDD-based estimate for hospitals was $1.3 billion in 2024 or about $50 million higher than the HCAI-based estimate, while our BLS and EDD-based estimate for SNFs was $740 million in 2024, or about $60 million lower. The relatively small difference in the combined total both reinforces the HCAI result for hospitals and SNFs and gives us confidence that the BLS- and EDD-based approach for the remaining categories is reasonable.

Estimates for Other Categories. Our combined estimate for the remaining categories affected by SB 525 is $2.9 billion, bringing the combined total to $4.9 billion in 2024. Of the $2.9 billion total, $1.1 billion is related to home health services, where over 70 percent of employees would be directly affected by the minimum wage increase. About $870 million is attributable to offices of physicians, and another $660 million is attributable to outpatient clinics.

Benefit Increases

As shown in Figure 1, SB 525 would raise non-wage benefits by about **$920 million** in 2024. About $520 million of this total is for statutorily required benefits, including employer contributions to social security, medicare, unemployment insurance, and workers' compensation (see Figure 2). About $270 million is related to higher employer contributions to employee retirement plans, and the remaining $130 million is related to supplemental overtime pay. These estimates are based on the BLS *Employer Costs for Employee Compensation* release in December 2022, which has a national breakdown of employer wage and non-wage costs by industry.[4] Not included in these estimates are accrued but unused vacation and sick leave hours, which will further increase employer costs by varying amounts (depending on specific employer policies regarding such factors as allowable carryover of vacation and sick leave benefits from one year to the next).

Figure 2
SB 525 Annual Cost Increases for Non-Wage Benefits in 2024



Interaction with Managers' Exemption from Overtime Laws

Under California labor law, employees engaged in work that is primarily intellectual, managerial, or creative are exempt from overtime provisions if they make more than double the monthly state mimimim

[4] Employer Costs for Employee Compensation. News Release, March 17, 2023. Bureau of Labor Statistics. https://www.bls.gov/news.release/pdf/ecec.pdf

wage for full-time employment.[5] The current operative wage threshold for the exemption is $31 per hour, or $64,480 per year. Under SB 525, the amounts would jump to $50 per hour and $104,000 annually. The bill requires that managers in health care industries earn at least double the proposed $25 hourly rate for health care workers in order to be exempt from overtime. Such an increase would create a significant wage pressure for relatively lower-paid managerial employees, who would become eligible for the overtime pay differentials unless their wages were increased to $50 per hour. Using the BLS industry-occupation matrix and the EDD OEWS surveys described above, we estimate that increasing all managers pay to at least $50 per hour would raise employer wages by $300 million in 2024.

Contractor Wages

Because the minimum wage increase would apply to all "hours worked in a covered health care facility," on-site contractors would be subject to the $25 per hour minimum wage. To estimate the impact of this provision, we used the input-output table for the U.S. economy prepared by U.S. Bureau of Economic Analysis (BEA)[6] to determine the distribution of services purchased by the various health care industries affected by SB 525. We then identified the subset of these suppliers that are likely to have lower-income employees working on-site at health facilities. The key industries fitting this criteria are: the employment services industry, which include registries for nursing, clerical staff, and food service staff; the facilities support services industry; the investigation and security services industry, and the services to building and dwellings industry.

For these industries, we then calculated the portion of workers that receive less than the $25 proposed minimum wage and the increases in wages for these employees under SB 525. These estimates were based on the methodology previously discussed using the BLS Industry-Occupation Matrix and the EDD OEWS. We also discounted the totals to reflect the fact that not all services provided by these industries would be performed on site.

Based on this methodology, we estimate that mandated increases in contractor wages will raise health care employer costs by $380 million in 2024.

Wage Compression

Wage compression occurs when mandated minimum-wage increases cause the pay of less-experienced and less-skilled workers to approach the levels of their counterparts with greater experience and skills, or those with jobs involving more responsibility, independence, and complexity. This puts pressure on companies to raise salaries further up the wage scale to maintain separation in wage rates among workers with different levels of experience, skills, productivity, and job responsibility. These ripple effects are widely recognized in academic studies of minimum wage increases. In general, past studies have found the ripple effects to be most intense for jobs paying modestly more than the new minimum wage, with effects fading at higher wage levels. However, these studies have been based on more modest and gradual minimum wage increases. The 67 percent increase mandated by SB 525 would be dramatic and would occur in one year.

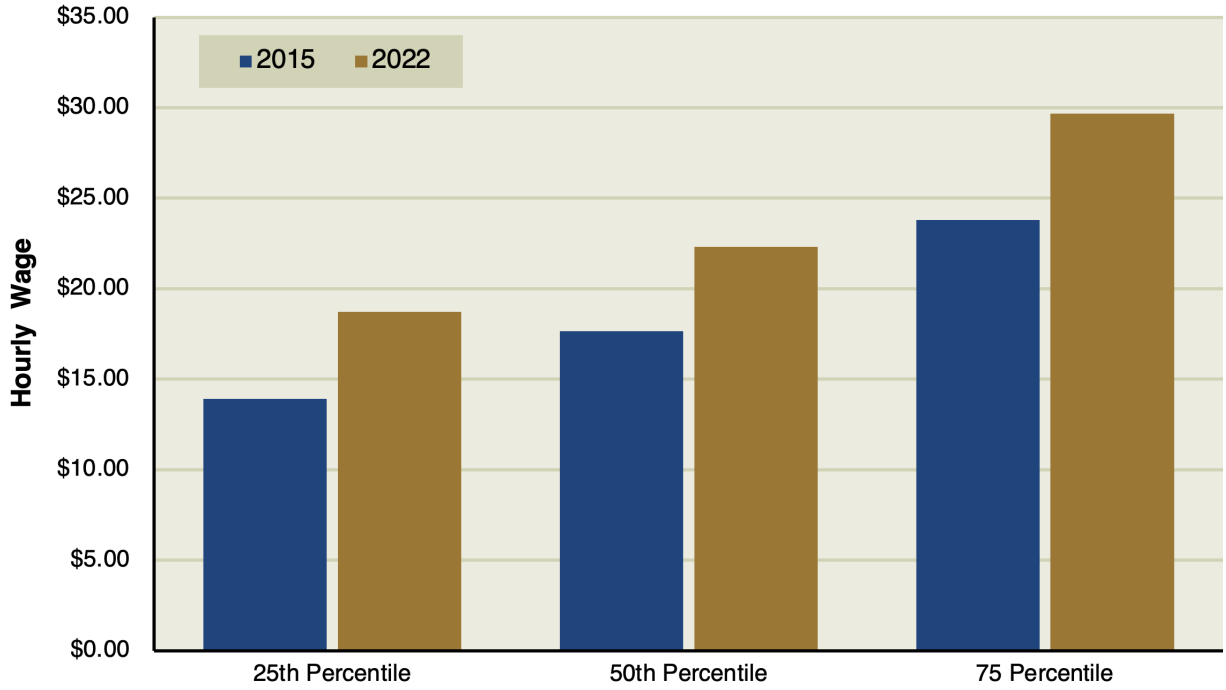
Our review of lower-wage occupations suggests that wage separation was maintained in most lower-income occupations during the period in which California's minimum wage was increased from $10 per hour in 2015 to $15 per hour by 2022. As one example, Figure 3 shows average hourly earnings of hospital orderlies at the 25 percentile – a group that was directly impacted by the minimum wage increase because they were earning less than $15 per hour – as well as the hourly earnings for those at the 50th

[5] California law requires that employers pay overtime at the rate of one-and one-half times the employers regular rate for all hours worked in excess of 8 up to 12 hours in any workday and for the first 8 hours of work on the seventh consecutive day of work in a workweek, and double the employees regular rate of pay for all hours worked in excess of 12 in any workday and for all hours worked in excess of 8 on the seventh consecutive day of work in a workweek.

[6] *Input-Output Accounts Data. Use of Commodities by Industry.* U.S. Bureau of Economic Analysis. https://www.bea.gov/industry/input-output-accounts-data

percentile and 75th percentiles, which were significantly above the $15 minimum wage. It shows that, in dollar terms, wage increases were roughly the same across the board.

Figure 3
Hourly Wage for Hospital Orderlies With Earnings at the 25th, 50th, and 75th Percentiles - 2015 and 2022



This result was typical for most of the low-wage occupations we reviewed, providing evidence that employers took actions in response to recent increases in the statewide minimum wage to ensure that wage separation was maintained among workers with differing skill levels and job responsibilities.

For purposes of our estimates shown in Figure 1, we conservatively assumed that the ripple effects would subside at higher wages. We specifically assumed that wage increases would average $4 for occupations with average wages in the $25 to $30 per hour range, $3 per hour for occupations in the $30 to $35 per hour range, $2 per hour for occupations in the $35 and $50 per hour range, and zero for occupations with average wages of over $50 per hour. Under this assumption, we estimate that wage compression will result in additional compensation costs of $1.5 billion annually.

However, our modeling suggests that compression-related employer costs are highly sensitive to assumptions about how far up the pay scale wages need to be adjusted to maintain a competitive wage structure with proper incentives. For example, if the $2 per hour increase extends up to occupations with average wages of $75 per-hour instead of $50 per hour, total wage compression effects would rise from the $1.5 billion shown in Figure 1 to nearly $3.4 billion. This would increase total costs associated with SB 525 to nearly $10 billion.

In addition, many state and local employees occupy the same job classifications as the workers in health care facilities and even belong to the same bargaining units. This could result in significant pressure to raise those employees' wages as well, resulting in substantial additional costs, possibly as significant as those we quantify. However, this effect is both difficult to quantify and not as direct a result of the bill as compression among workers in health facilities. For better or worse, the premise of the bill is to treat

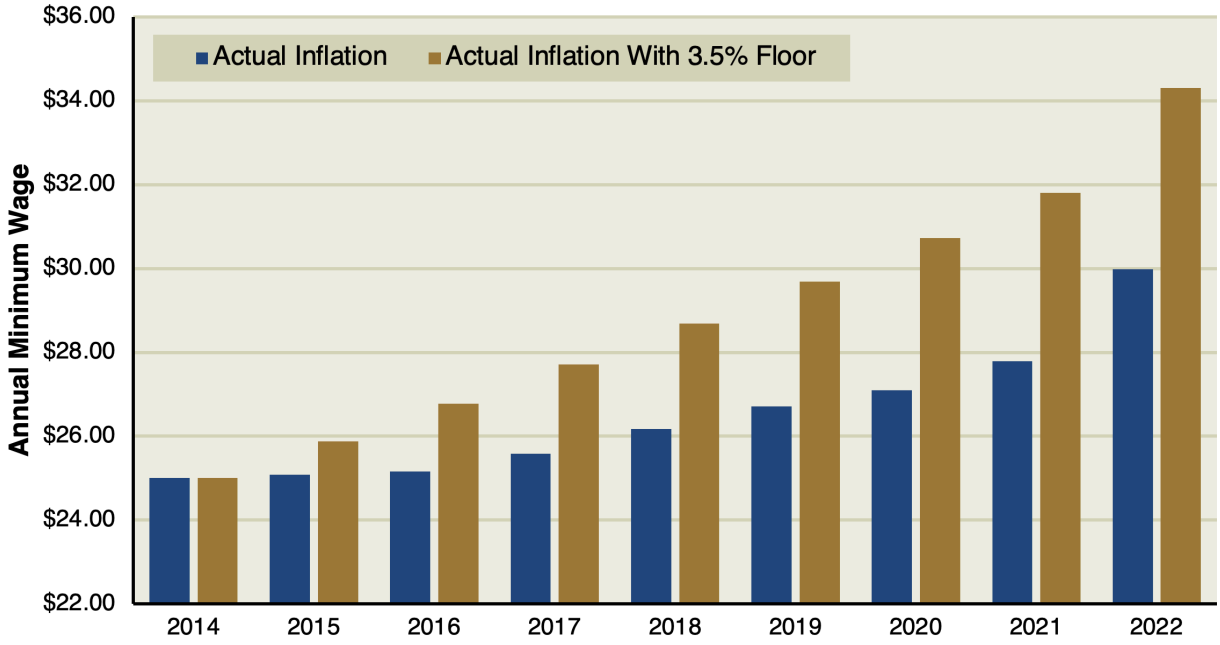
workers in health care facilities differently. Therefore, while it is important to note, we do not include it in these estimates.

SB 525's Expanding Impact on Employer Costs Over Time

SB 525's impact on health care costs will increase sharply over time, rising from $8 billion to $11.3 billion (in constant 2024 dollars) by 2030. About $650 million of the increase is related to employment growth.[7] According to EDD's long term projections of employment by industry, the health care categories affected by SB 525 will increase about 1.3 percent per year between 2020 and 2030.

The remainder of the increase – $2.6 billion – is due to the provision in SB 525 which adjusts the health care minimum wage annually, starting in 2025, by the *greater* of (a) 3.5 percent or (b) the growth in the U.S. CPI for Wage and Clerical Workers. If there were no adjustment to the new minimum wage, we would expect the incremental costs of a $25 minimum wage to decrease in future years as inflation pushes all wages upward over time. If the $25 minimum wage were indexed to a measure that grew in line with health-care industry wages, the impact would increase modestly in constant dollar terms, in line with employment growth in the state over time. However, SB 525 would likely boost the minimum wage by considerably more than inflation over time, due to the 3.5 percent floor on annual adjustments. As an example, if the 3.5 percent floor had been in effect since 2014, a $25 minimum wage implemented in 2014 would have increased to $34.31 by 2022, or about $4.33 more than the minimum wage would be if it had been simply indexed for inflation (see Figure 4).

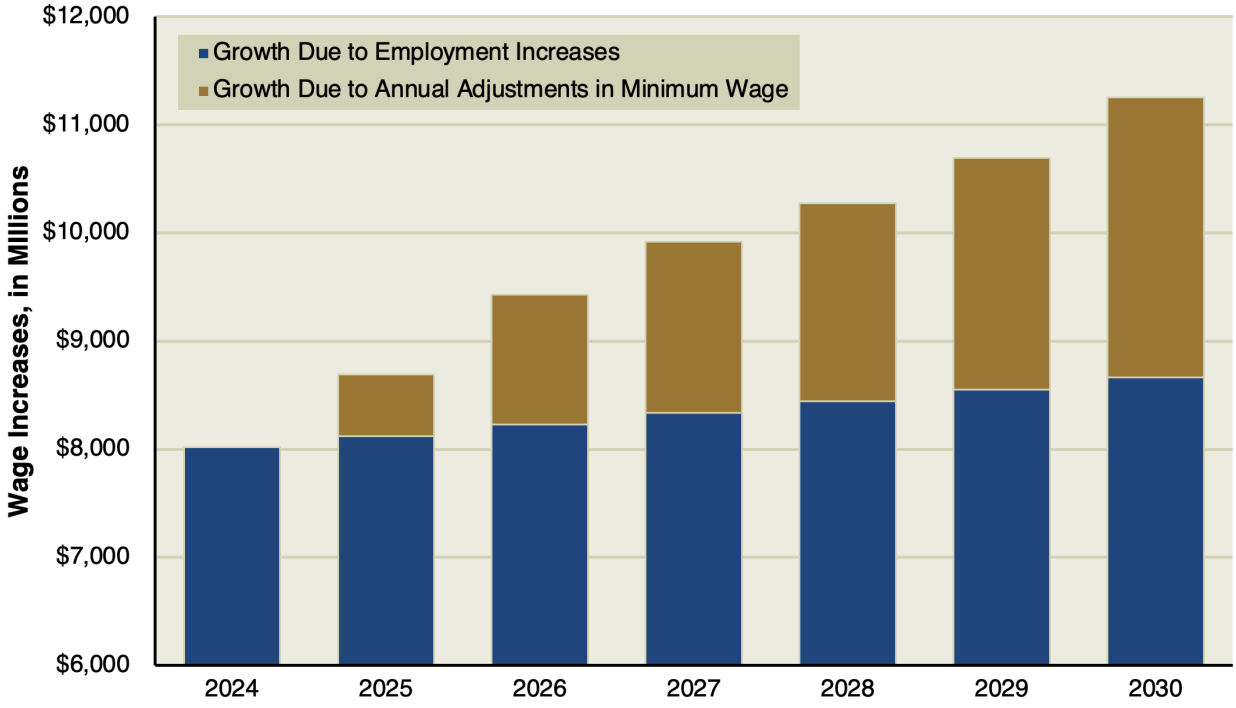
Figure 4
Impact of SB 525 Annual Adjustment on Minimum Wage Over Time



The increase in minimum wage beyond inflation will have an expanding impact over time. Our $2.6 billion increase by 2030 due to the inflation adjustment assumes that future annual changes in the U.S. CPI will exhibit a pattern that is similar to that experienced over the past decade (see Figure 5).

[7] This estimate is based on the current Employment Development Department projections of employment by industry, which project a 1.3 percent average annual increase in jobs in health care categories covered by SB 525 between 2020 and 2030.

Figure 5
Annual Health Care Cost Impact of SB 525 Over Time
(In Millions of Constant 2024 Dollars)



Impact of Higher Costs on Health Care Consumers

In theory, higher costs caused by mandated minimum wage increases can be borne by: (1) labor in health care facilities, through staffing reductions and reduced work hours; (2) business owners, through reduced profits and associated declines in dividends and company share values; or (3) purchasers of health care services, through higher billing rates.

In reality, the substantial wage increases mandated by SB 525 would put considerable pressure on health care providers to raise rates. Limited or nonexistent profit margins are leaving hospitals and other providers with very little room to absorb sharp increases in wages.[8] Similarly, there is already a staffing shortage in health care, leaving providers with few opportunities to reduce staff or hours worked without jeopardizing patient access to medical care.

The speed and extent to which new costs such as those imposed by SB 525 are reflected in increases in rates paid to providers varies by funder:

- Some Medi-Cal payments (e.g., payments to nursing homes) are adjusted annually in response to increases in qualified and audited costs in the prior year. Many rates, however, have been changed, if at all, on an ad hoc basis through legislation or ballot measures. In the past, the Legislature has augmented the In-Home Supportive Services budget and the Department of Developmental Services budget to reflect the costs those programs would incur due to general minimum wage increases. Given that this measure targets its minimum wage increase on workers in health care facilities, it would make sense to budget for rate increases to cover these costs. Without them, providers will face further

[8] According to the Kaufman Hall "National Hospital Flash Report" released in January 2023, approximately 50 percent of U.S. hospitals finished 2022 with negative margins, as growth in expenses outpaced revenue increases during the year. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-january-2023?utm_source=agcy&utm_campaign=kh-nhfr&utm_medium=pr&utm_term=jan-nhfr-230130

financial challenges that could disrupt access to care. But for many Medi-Cal providers there will be no automatic rate increases unless the Legislature provides them. Thus, the actual budgetary costs to the program can not be projected with confidence. Medi-Cal covers about 39 percent of all Californians.[9]

- Medicare payment rates are set by the federal Centers for Medicaid and Medicare Services and are adjusted annually in response to *national* cost increases. Since SB 525 affects only costs incurred in California, it would have only a marginal impact on Medicare billing rates. Medicare covers about 17 percent of all Californians.[10]
- Rates paid by private insurers (including those providing coverage under Covered California) are set by the market, subject to state regulation and may or may not immediately reflect new costs such as those that would result from SB 525. In the longer term, however, market forces would push most of these costs into the consumers' costs for health care. Private insurance covers 36 percent of all Californians.[11]
- About 7 percent of Californians have no health care coverage[12]. To the extent that these individuals incur health care costs, they are generally covered by county programs or absorbed by providers and thus "passed-through" to other health care payers.

Under all circumstances, increased costs resulting from SB 525 will have negative impacts on California consumers of health care. To the extent that the higher costs are passed along to consumers in the form of higher billing rates charged for health care services, the burden of the minimum wage increase will fall on all public and private sector purchasers of health care services in California. In cases where rates are not fully passed along – because of, for example, poor economic and budget conditions, or lags in adjustments to Medi-Cal/Medicare or the rates that private health insurers pay to providers– the consequence would be a reduction in patient access to health care.

State and Local Budget Impacts

The estimates of SB 525 costs presented above are comprehensive, encompassing the entire health care segment of California's economy. A portion of these will fall on state and local governments, requiring increases in their budgets for health care services. Such budgetary impacts of proposed legislation are often included as appropriations in the bills that impose them, or at a minimum are recognized in the fiscal analysis of those bills. Figure 6 presents our estimates of these state and local government costs. The basis for each of these estimates is described below the table.

[9] https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx#:~:text=Medi%2DCal's%20enrollment%20has%20grown,one%2Dthird%20of%20California's%20population.

[10] https://www.healthinsurance.org/medicare/california/#:~:text=Medicare%20enrollment%20in%20California,California%20residents%20had%20Medicare%20coverage

[11] https://www.chcf.org/wpcontent/uploads/2022/10/CAHealthInsurersEnrollmentAlmanac2022QRG.pdf.pdf

[12] https://www.gov.ca.gov/2022/11/02/many-californians-can-get-health-coverage-for-as-little-as-10permonth/#:~:text=An%20estimated%201%20million%20Californians,sign%20up%20receive%20financial%20assistance

Figure 6
Annual State and County Budgetary Costs of SB 525
(Dollars in Millions)

State Costs	Total	General Fund
Medi-Cal	$3,649.4	$1,047.5
Department of Corrections	53.4	42.1
Department of State Hospitals	19.7	19.7
State Employee Health Insurance (includes CSUS)	112.9	65.6
State Retiree Health Insurance	78.5	78.5
CSU Retiree Health Insurance	11.8	11.8
UC Employee Health Benefits	74.6	74.6
UC Retiree Health Benefits	10.3	10.3
Total State Costs	**$4,010.6**	**$1,350.1**
County Health Programs Costs	**$406.0**	**—**
County, City, Special District (Including School District) Employee Health Insurance Costs	**$364.9**	
Total Local Costs	**$770.9**	

Medi-Cal. The Governor's Budget for 2023-24 proposes $132.2 billion ($37.1 billion General Fund) for Medi-Cal services[13]. This amount includes dental and mental health services, which are not affected by SB 525 and funding for State Hospitals (estimated separately in Figure 6). Discounting these, the portion of Medi-Cal that will be affected by the measure is $127.2 billion ($36.5 billion General Fund)[14]. The impact of the measure on Medi-Cal can not be independently estimated at the same level of detail used to estimate the cost of SB 525 in the total health care segment of the California economy because the detailed information needed for such a specific estimate is not available. However, in general Medi-Cal services are comparable to the services provided in the health care sector generally. In fact, most health care facilities that serve Medi-Cal patients serve the full range of health care patients. Therefore, the SB 525 cost estimate assumes that the percentage increase in Medi-Cal costs will be the same as in the estimate above for the general health care sector of the economy, 2.87 percent. It is important to note that, given the delay in building new provider costs into the rates that Medi-Cal pays providers, it could be several years before these costs are fully reflected in the state budget. On the other hand, the Legislature customarily augments the budget to cover the costs of new legislation.

Departments of Corrections and State Hospitals. These two state departments employ state staff to provide a wide range of health care services to the prisoners and patients they serve. The estimate of the measure's cost for these state departments is derived from the Department of Finance publication, "Salaries and Wages"[15], which shows positions, salary ranges and budgeted costs for all state staff. It displays these at the lowest organizational level, so it is possible to identify only those staff that work in medical facilities. For the state hospitals and for a few prisons that are dedicated medical facilities, the estimate is based on all positions in those facilities with salary ranges less than $4,333 per month ($25 per

[13] https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2022_November_Estimate/N22-Medi-Cal-Local-Assistance-Estimate.pdf, BYp.9

[14] Note that throughout these estimates when the only data available is for total health care expenditures, the assumption is that the total can be discounted for dental and mental health using the Medi-Cal percentage for those services. This assumption likely results in an understatement of the total costs because it discounts all mental health services even though some portion of those are provided in psychiatric hospitals, which are, in fact, subject to SB 525.

[15] https://dof.ca.gov/budget/salaries-and-wages/

hour). For most of the prisons, the estimate encompasses only staff that work in the medical portion of the prison or in the central or regional medical organizations.

For staff groups with average salaries of less than $25 per hour, the estimate reflects the difference between the groups' average salary and $25 per hour times 2080 hours (a full year)[16]. For staff groups with average salaries between $25 per hour and $35 per hour, the estimate assumes that the state will provide a wage increase equivalent to the average percentage increase of those earning just less than $25 per hour, or about 2 percent. Finally, the estimate includes an additional 14.45 percent increment to cover the variable benefit costs of these employees.[17] The estimate does not include any costs for contract staff, but given the secure nature of these facilities the use of contract staff is limited.

If either department were tasked with making a detailed estimate of the costs of SB 525, they would use more granular data than are available in the Salaries and Wages document. The departments might also take a more aggressive approach to limiting "wage compaction" (i.e. give greater wage increases to a broader range of staff who currently receive more than $25 per hour). For this reason, the actual budgetary increases resulting from SB 525 would likely be somewhat higher than those displayed on Figure 5.

State Employee And Retiree Health Insurance Costs. The state budget proposes $3.9 billion for Active Employees Insurance[18] and $2.3 billion for Retiree Health and Dental Insurance[19]. The estimate assumes that the costs of SB 525 for these services is comparable to the overall health care sector costs discussed above (2.87 percent). These costs will not be fully reflected in the state budget immediately unless the Legislature appropriates funds to cover them. Without a specific augmentation, the costs will eventually be reflected in the rates that insurers negotiate with the state.

California State University Retiree Health Insurance Costs. The state budget proposes $428 million for CSUS retirees' health care[20]. The SB 525 costs for CSUS retiree health insurance is calculated in the same way as for state retirees, i.e., it is based on the overall health care sector costs discussed above (2.87 percent).

University of California Employee And Retiree Health Insurance Costs. The University of California budget proposes $2.6 billion for active employees health insurance and $359 million for retiree's health insurance in 2023-24[21]. The SB 525 costs for this insurance is estimated in the same way as above.

County Health Program Costs. Counties operate a variety of health care programs with a total cost of $14.1 billion[22]. The estimate assumes the impact of SB 525 on the costs of these programs on a percentage basis will be comparable to the percentage impact on the state's overall health care sector as estimated above (2.87 percent)

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[16] While some units displayed in the Salaries and Wages document are single employees, most are groups of employees occupying the same position category and receiving salaries within the same range. As a result it is not possible in most cases to identify specific individuals' salaries using this data. The use of the average within each position category is therefore the best way to assess the SB 525 impact. If the departments were tasked with providing an actual budget augmentation to cover the costs of the measure, they would have access to more granular data. Still, the averages provide a reasonable approximation of the actual costs.

[17] In addition to the salary costs, the estimate includes 6.2 percent for OASDI, 1.45 percent for Medicare and 6.80 percent for retirement. Source: https://dof.ca.gov/wp-content/uploads/sites/352/budget/budget-letters/BL-22-22.pdf

[18] The budget includes the health benefits for California Universities and Colleges (CSU) employees within the amounts displayed for state employees, but displays CSU retiree health insurance costs as a separate category.

[19] 2023-24 Budget Summary, p.103, dental and mental health services discounted based on Medi-Cal ratios.

[20] ibid.

[21] https://www.ucop.edu/operating-budget/_files/rbudget/2023-24-budget-detail.pdf

[22] State Controllers Office, County raw data file, 20-21: "Total Health General."

County, City and Special/School District Employee Health Insurance Costs. Local governments in California employ about 1.77 million employees, which is about 3.2 times as many as the state employs[23]. While there is no data source for the total costs of these employees' health care, a reasonable approximation is that local governments spend about 3.2 times as much on employee health care as does the state. The estimate therefore simply uses that multiple to estimate the local costs for employee health care. In addition, counties generally cover the costs of retirees' health insurance. However, we found no data available that could be used to provide a specific estimate of these costs.

[23] Source: https://labormarketinfo.edd.ca.gov/file/lfmonth/cal$spds.pdf. We used the average of the last three months of data.