OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

June 2026

Examining Utilization in California's Commercial and Medicare Advantage Markets, 2022-2024

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Abstract: From 2022 to 2024, total medical expense (TME) per member per year in the commercial and Medicare Advantage markets grew 15.8% and 13.3%, respectively. Using California's Health Care Payments Data for calendar years 2022 to 2024, we examine the extent to which changes in enrollee demographics and utilization may have contributed to these trends in accelerated spending growth. We find that, from 2022 to 2024, the average age of commercial and Medicare Advantage enrollees increased 0.6% and 0.4%, respectively. In the commercial market, the utilization rate decreased by 4.2%, while remaining flat in Medicare Advantage. The average number of encounters per member decreased 3.0% in the commercial market and increased 3.5% in the Medicare Advantage market. The share of enrollees with a chronic condition increased 9.6% in the commercial market and 4.1% in the Medicare Advantage market. Finally, while high-cost members – those with $1 million or more in annual spending – represented only around 0.01% of the total enrolled population, their proportion increased 25.4% in the commercial market and 15.9% in the Medicare Advantage market. These findings can inform policymakers seeking to understand the role of enrollee characteristics and patterns of utilization amid rising health care costs in California.

Contents

Key points

- While OHCA's Total Medical Expense (TME) data shows double-digit spending growth in the commercial and Medicare Advantage markets from 2022 to 2024, California's All Payer Claims Database indicates that the share of members with any utilization declined by 4.2% in the commercial market and remained unchanged in the Medicare Advantage market over the same period, suggesting other factors may be driving spending growth.
- In the commercial market, the average number of encounters per member decreased by 3.0% from 2022 to 2024, while increasing by 3.5% in the Medicare Advantage market.
- The share of high-cost members increased 25.4% in the commercial market and 15.9% in the Medicare Advantage market but remained around 0.01% of the enrolled population.
- Chronic condition prevalence increased 9.6% in the commercial market and 4.1% in the Medicare Advantage market.

Background

As part of its ongoing implementation of a statewide spending target, California's Office of Health Care Affordability (OHCA) collects aggregate total medical expense (TME) and enrollment data from private health insurers. These data show that, from 2022 to 2024, TME per member per year in the commercial and Medicare Advantage markets grew 15.8% and 13.3%, respectively. But given the aggregated nature of this data, we have limited visibility into the extent to which changes in enrollee demographics or utilization frequency may contribute to these trends in accelerated spending growth. To address these limitations, we use Health Care Payments Data (HPD) to examine utilization rates, the number of encounters, chronic condition and comorbidity prevalence, and the proportion of high-cost members from 2022 to 2024 across the commercial and Medicare Advantage markets.[1–3]

Data and analytic approach

California's HPD includes payer-submitted claims and utilization data for California residents. This more granular data enables us to examine enrollee age, the number of health care encounters an enrollee had, the share of high-cost members and the share of members with multiple chronic conditions across the commercial and Medicare Advantage markets for calendar years 2022, 2023 and 2024. We restrict our analysis to 14 payers that are required to submit data to OHCA: 11 payers in the Commercial market and 10 payers in the Medicare Advantage market (see Appendix Table A1). Our sample covers between 13.6 to 13.9 million commercial enrollees and between 2.9 to 3.1 million Medicare Advantage enrollees.

We define the utilization rate as the proportion of members who have any service claims in a calendar year, while utilization frequency is measured as the number of encounters per member in a calendar year. All medical claims for a member on the same date or pharmacy claims with the same prescription fill date are treated as one encounter. If a pharmacy claim has a different prescription fill date than the medical claim, we count them as two separate encounters. We report trends in the utilization rate for medical services and pharmacy, both separately and together (see Appendix Figure

A1). Additionally, we calculate the medical services utilization rate when COVID-related claims are excluded (see Appendix Figure A2). High-cost members are defined as those with annual spending of $1 million or more, a threshold consistent with prior approaches.[4,5]

We calculate annual spending using allowed amounts for medical and pharmacy fee-for-service claims, along with estimated fee-for-service equivalents for capitated medical services.[6] Throughout this brief, pharmacy spending refers to gross pharmacy spending, defined as the fee-for-service amount reported on pharmacy claims and does not include rebates or other discounts. We include additional digits when reporting high-cost members due to the low base rates. In addition to the share of high-cost members, we report their share of total spending. In the appendix, we also report an alternative high-cost threshold of annual spending of $100,000 or more (see Appendix Table A2).[7]

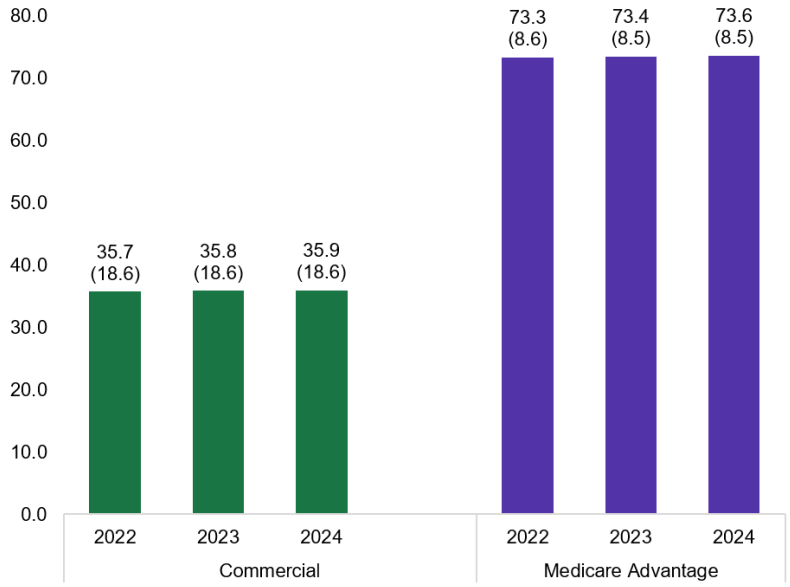
To examine chronic conditions, we calculate the share of members who have a chronic condition diagnosis on the claim for each year and payer. Chronic condition identification is contingent on a member using medical services with a specific payer. We also quantify the number of distinct chronic conditions that a member was diagnosed with within the year. Chronic conditions were defined based on the list of conditions with corresponding diagnosis codes from the Chronic Conditions Data Warehouse developed by CMS.[8] We also examined the overlap between high-cost members and those with chronic conditions (see Appendix Table A3).

Findings

Age distribution

The average age in the commercial market increased from 35.7 years (standard deviation, SD,18.6) in 2022 to 35.9 years (SD 18.6) in 2024, a 0.6% increase. In the Medicare Advantage market, the average age increased from 73.3 years (SD 8.6) in 2022 to 73.6 years (SD 8.5) in 2024, a 0.4% increase (Figure 1).

Figure 1. Average age of members, by market and year, 2022-2024



Notes: Bar labels show average age of members for year and a market with standard deviation in parentheses. Payers included for each market are listed in Table A1.

We observed some changes in the age distribution across years (Table 1). In the commercial market, the share of members aged 40-54 increased from 24.0% in 2022 to 24.5% in 2024, a 2.1% increase, while the share of members aged 19-39 declined from 36.3% in 2022 to 35.9% in 2024, a 1.4% decrease. In Medicare Advantage, the share of members aged 75-84 increased from 28.1% in 2022 to 30.3% in 2024, a 7.8% increase, and the share of members aged 65-74 declined from 51.8% in 2022 to 50.7% in 2024, a 2.1% decrease.

Table 1. Distribution of members by age group and market, 2022-2024

Commercial: Share of Members	**2022**	**2023**	**2024**
0-18 yr	21.0%	20.9%	20.9%
19-39 yr	36.3%	36.2%	35.8%
40-54 yr	24.0%	24.2%	24.5%
55-64 yr	15.4%	15.3%	15.5%
65+ yr	3.3%	3.3%	3.3%

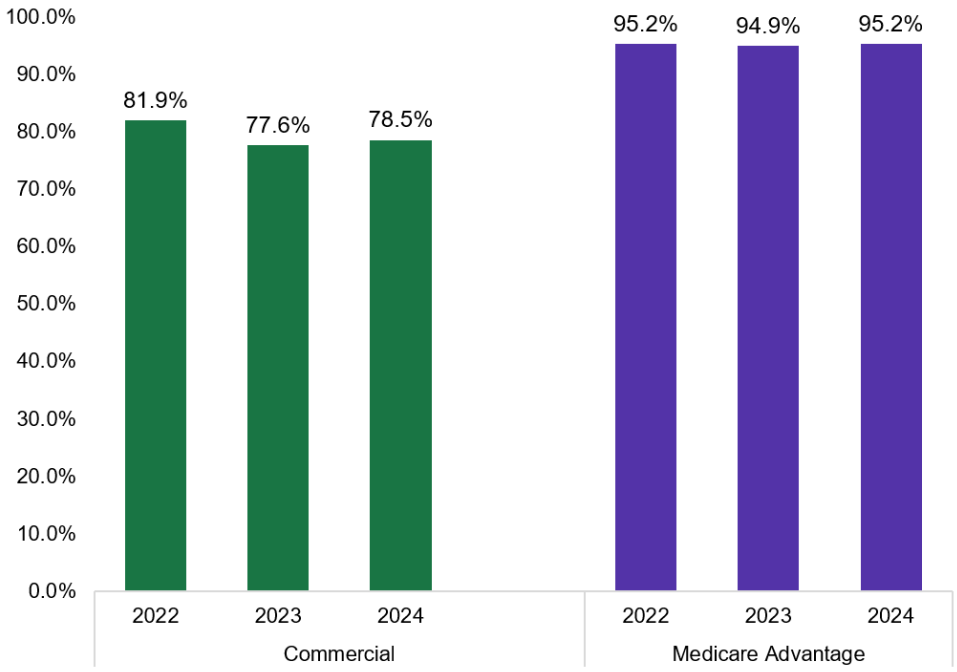
Medicare Advantage: Share of Members	**2022**	**2023**	**2024**
0-54 yr	2.1%	2.0%	1.9%
55-64 yr	7.7%	7.2%	6.8%
65-74 yr	51.8%	51.3%	50.7%
75-84 yr	28.1%	29.3%	30.3%
85+ yr	10.3%	10.3%	10.4%

Notes: Percentages reflect the proportions of the market annual total membership in each age category by year and market. Percentages may not total 100% due to rounding.

Utilization rates and frequency

Figure 2 shows the utilization rate by market category and year. In the commercial market, from 2022 to 2024, the utilization rate fell from 81.9% to 78.5%, a 4.2% decrease. During the same period in the Medicare Advantage market, the utilization rate remained flat at 95.2%.

Figure 2. Utilization Rate, by market and year, 2022-2024



Notes: Figure shows the share of members with at least one encounter, by year and market. Utilization rate includes medical services and pharmacy use. Payers in each market included are listed in Table A1.

In the commercial market, the average number of encounters per year decreased from 10.0 in 2022 to 9.7 in 2024, a 3.0% decrease (Figure 3). Moving beyond the average, we find that the share of enrollees with 1-3 encounters was 24.3% in 2022 and 24.2% in 2024, a 0.4% decrease (Table 3); the share with 4-9 encounters was 24.9% in 2022 and 23.4% in 2024, a 6.0% decrease; and the share of members with 10 or more encounters was 32.8% in 2022 and 30.9% in 2024, a 5.8% decrease.

In the Medicare Advantage market, the average number of encounters per year increased from 23.1 in 2022 to 23.9 in 2024, a 3.5% increase (Figure 3). The share of Medicare Advantage enrollees with 1-9 encounters was 22.1% in 2022, and 21.5% in 2024, a 2.7% decrease (Table 2); the share of members with 10-23 encounters was 35.3% in 2022 and 34.2% in 2024, a 3.1% decrease; and the share of members with 24 or more encounters was 37.8% in 2022 and 39.4% in 2024, a 4.2% increase.

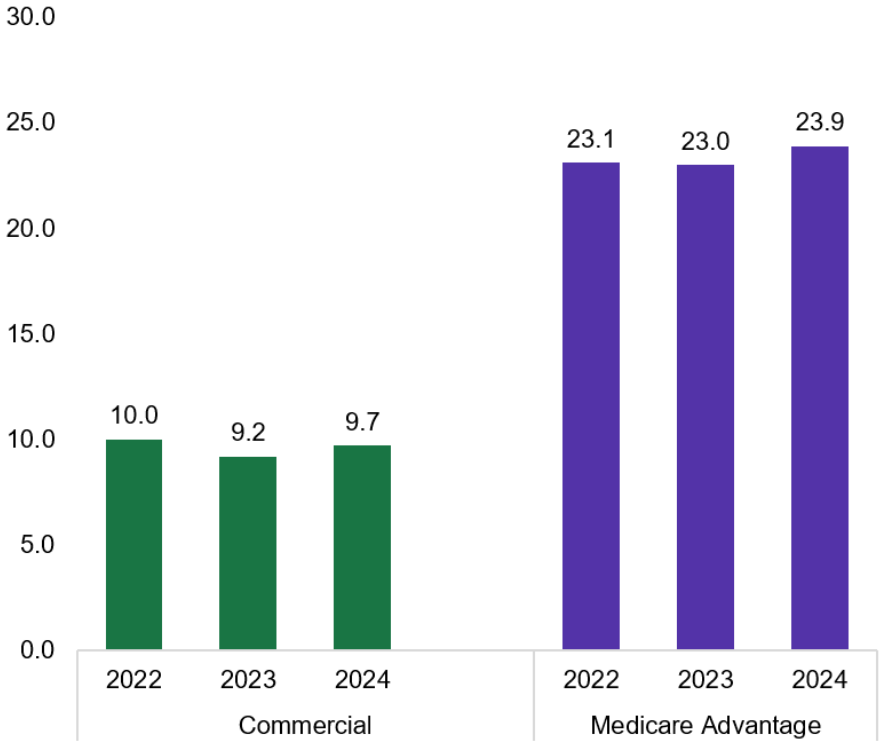
Table 2. Utilization Frequency, market and year, 2022-2024

Commercial: Share of Members	2022	2023	2024
with 0 encounter	18.1%	22.4%	21.5%
with 1-3 encounters	24.3%	24.3%	24.2%
With 4-9 encounters	24.9%	23.4%	23.4%
with 10 or more encounters	32.8%	29.9%	30.9%

Medicare Advantage: Share of Members	2022	2023	2024
with 0 encounter	4.8%	5.1%	4.8%
with 1-9 encounters	22.1%	22.0%	21.5%
with 10-23 encounters	35.3%	35.2%	34.2%
With 24 or more encounters	37.8%	37.7%	39.4%

Notes: Distribution of members by annual number of encounters. Percentages may not total 100% due to rounding.

Figure 3. Average annual encounters per member, by market and year, 2022-2024



Note: Average number of encounters is calculated for all members, including members without any claims or encounters. Encounters include both medical services and prescriptions fills.

High-cost members

The share of high-cost members, those with $1 million or more annual spending, remained low in both markets. In the commercial market, the share of high-cost members was 0.0114% in 2022 and 0.0143% in 2024, a 25.4% increase (Table 3). These members contributed 3.78% of total spending in

2022 and 3.90% in 2024, a 3.2% increase.

In Medicare Advantage, the share of high-cost members was 0.0145% in 2022 and 0.0168% in 2024, a 15.9% increase. Their share of total spending was 2.17% and 2.14%, a 1.4% decrease.

Table 3. Share of high-cost members and their share of total spending, by market and year, 2022-2024

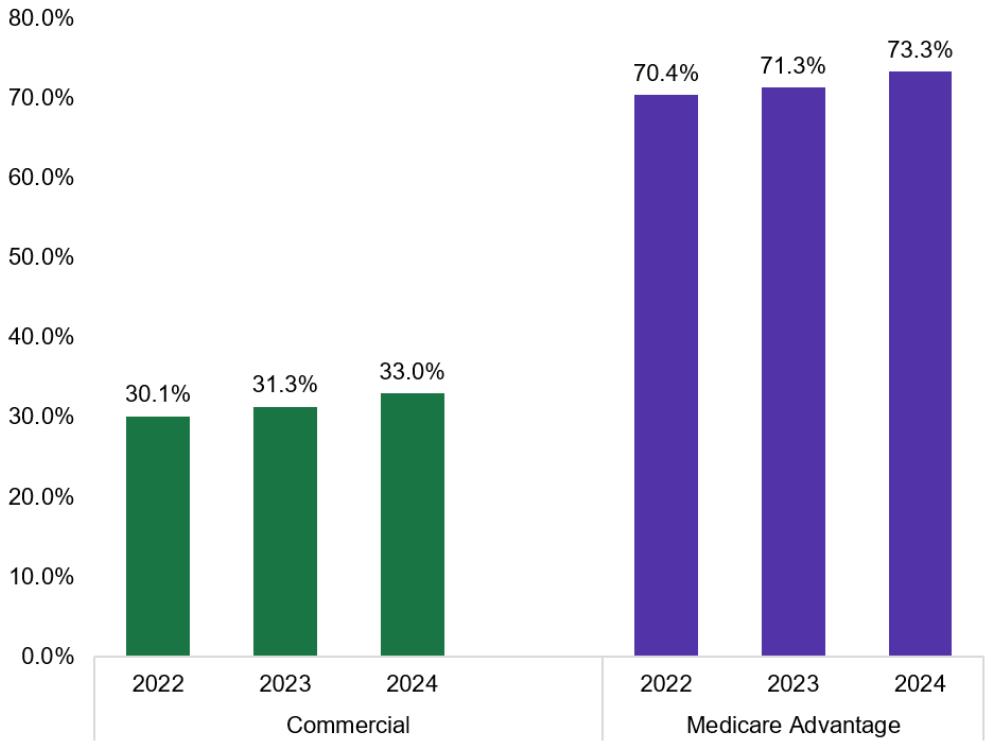
	Commercial			Medicare Advantage		
	2022	**2023**	**2024**	**2022**	**2023**	**2024**
Number of High-Cost Members	1,584	1,633	1,947	422	491	520
Share of High-Cost Members	0.0114%	0.0118%	0.0143%	0.0145%	0.0161%	0.0168%
Share of Total Spending by High-Cost Members	3.78%	3.80%	3.90%	2.17%	2.36%	2.14%

Notes: "Spending" includes both medical and pharmacy spending. Medical spending includes medical services allowed amounts for fee-for-service arrangements and estimated fee-for-service equivalents for capitated payment arrangements. Pharmacy spending is calculated as a sum of fee-for-service allowed amounts.

Chronic conditions

Chronic condition prevalence increased in both markets (Figure 4). In the commercial market, the share of members diagnosed with at least one chronic condition increased from 30.1% in 2022 to 33.0% in 2024, a 9.6% increase. In the Medicare Advantage market, the share of members diagnosed with at least one chronic condition increased from 70.4% in 2022 to 73.3% in 2024, a 4.1% increase.

Figure 4. Share of members with at least one chronic condition, by market and year, 2022-2024



Notes: Member with a chronic condition defined based on the presence of diagnostic codes listed with Chronic Condition Warehouse on claims and encounters.[8]

The share of members with multiple chronic conditions increased in both markets (Table 4). In the commercial market, the share of members with 1 diagnosed condition was 15.8% in 2022 and 16.9% in 2024, a 7.0% increase. The share with 2-3 conditions was 10.5% in 2022 and 11.8% in 2024, a 12.4% increase. The share with 4 or more conditions was 3.8% in 2022 and 4.3% in 2024, a 13.2% increase. Overall, the average number of chronic conditions per member increased from 0.6 in 2022 to 0.7 in 2024, a 16.7% increase (Figure 5).

In the Medicare Advantage market, the share of members with 1 diagnosed condition type was 8.4% in 2022 and 8.1% in 2024, a 3.6% decrease (Table 4). The share with 2-3 conditions was 22.1% in 2022 and 22.6% in 2024, a 2.3% increase. The share with 4 or more conditions was 39.9% in 2022 and 42.7% in 2024, a 7.0% increase. On average, the number of chronic conditions per member increased from 3.2 in 2022 to 3.4 in 2024, a 6.2% increase (Figure 5).

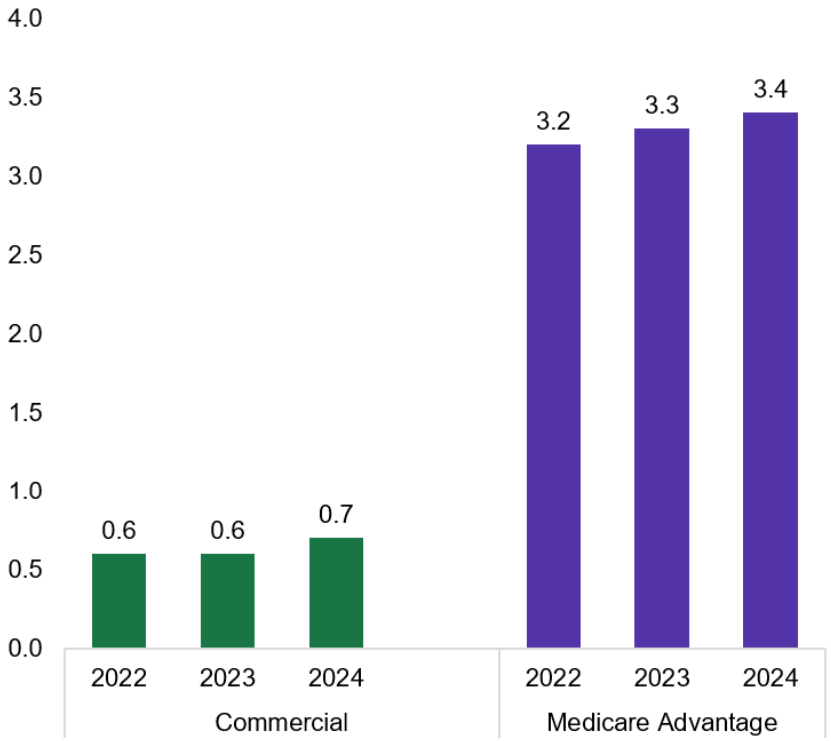
Table 4. Distribution of members by number of chronic conditions, market and year, 2022-2024

Commercial: Share of Members	2022	2023	2024
without chronic conditions	69.9%	68.7%	67.0%
with 1 type	15.8%	16.2%	16.9%
with 2 -3 types	10.5%	11.1%	11.8%
with 4 or more types	3.8%	4.0%	4.3%

Medicare Advantage: Share of Members	2022	2023	2024
without chronic conditions	29.6%	28.7%	26.6%
with 1 type	8.4%	8.2%	8.1%
with 2 -3 types	22.1%	22.3%	22.6%
with 4 or more types	39.9%	40.8%	42.7%

Notes: Member with a chronic condition defined based on the presence of diagnostic codes listed with Chronic Condition Warehouse on claims and encounters.[4]

Figure 5. Average number of chronic conditions, by market and year, 2022-2024

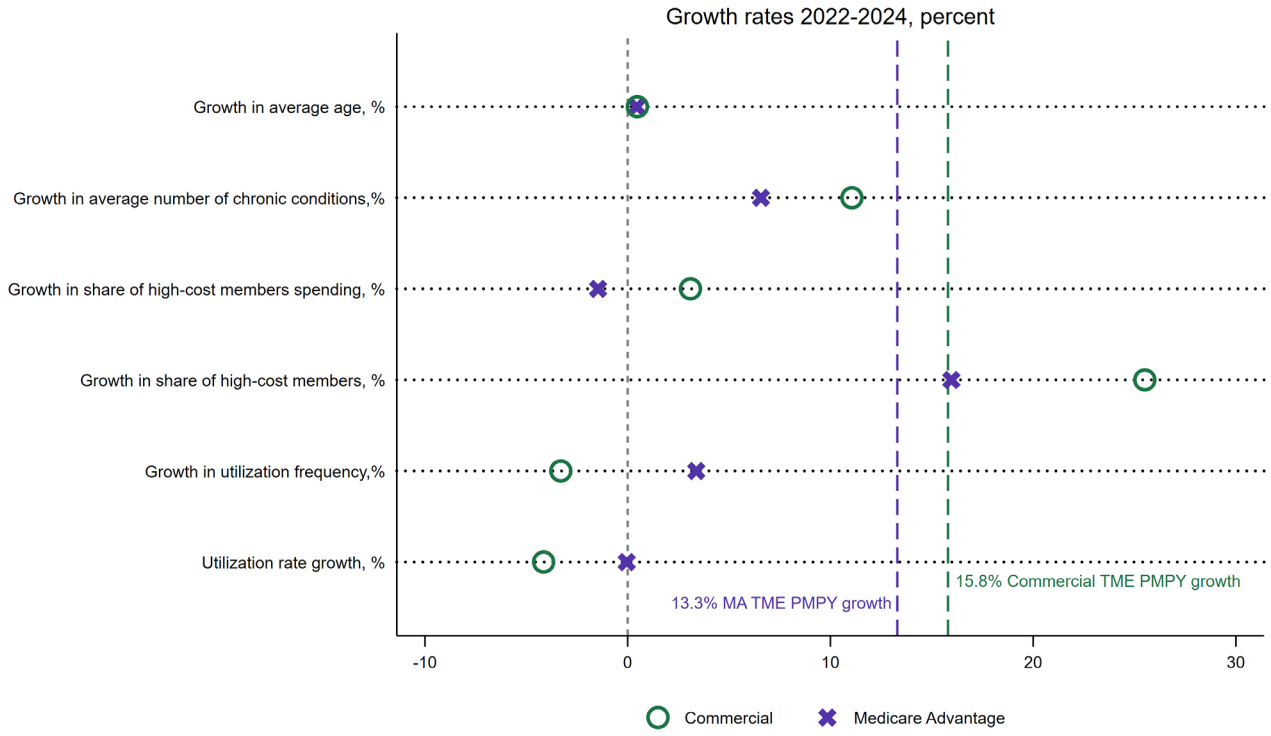


Notes: Averages are calculated with all members, including those without any chronic conditions.

Our analysis reveals several trends in the commercial and Medicare Advantage markets that might contribute to the increase in the total medical expense per member between 2022 and 2024. We plot these growth rates against the growth rate of TME PMPY between 2022 and 2024 (Figure 6). First, the share of high-cost members with annual spending of $1 million or more increased significantly in relative terms in both markets, but still remained only a small fraction of the enrolled population.

Second, the share of members with chronic condition diagnoses increased in the commercial and Medicare Advantage markets. All other measures show stable or small relative increases between 2022 and 2024, and thus, they are unlikely to be significant drivers of spending growth in this period.

Figure 6. Summary of growth rates in TME PMPY and factors examined



Notes: Green circles represent growth rate of each measure between 2022 and 2024 in commercial market. Purple cross represents growth rate of each measure between 2022 and 2024 for Medicare Advantage market. Dashed vertical lines represent growth in TME PMPY between 2022 and 2024 in commercial (green) and Medicare advantage market (purple). Dashed gray line represent 0% growth. TME PMPY in Medicare Advantage includes dual eligible and D-SNP members. Utilization frequency growth is calculated as a change in average number of encounters by market.

Discussion

Between 2022 and 2024, health care spending per person (measured as total medical expenses per member per year or TME PMPY) in California increased by 15.8% in the commercial market and by 13.3% in the Medicare Advantage market. During this three-year period, we found an increase in the share of high-cost members, though it remained a small proportion of the total enrolled population. We also found an uptick in members with chronic condition diagnoses, where the average number of chronic conditions per member increased by 16.7% in the commercial market and 6.2% in Medicare Advantage.

In our analysis of high-cost members, we use the $1 million annual spending threshold that identifies the catastrophic cost tail. Those members contribute around 3.8% of annual spending in the commercial market and around 2.3% in the Medicare Advantage market. While the share of high-cost members increased between 16-25% in relative terms between 2022 and 2024, the share of high-cost members made up only about 0.01% of the enrolled population across both markets.

Our results show that chronic condition and comorbidity prevalence grew by approximately 3 percentage points in both markets, a relative increase of 9.6% in the commercial market and of 4.1% in the Medicare Advantage market. Those trends are consistent with recent surveys in which the share of respondents reporting “fair or poor health” in California increased from 18.1% in 2022 to 21.1% in 2024.[9] Similarly, California Health Insurance Survey (CHIS) data show a small increase in respondents reporting poor health in Medicare and populations with employer-sponsored insurance.[10]

Prior research shows that spending increases with the number of chronic conditions diagnoses;[2] however, our data do not measure a true change in population health or disease burden. Measured chronic condition prevalence can rise because of administrative and diagnostic changes, rather than worsening disease burden.[11,12] In risk-adjusted payment settings, coding intensity, chart reviews, and other documentation practices can increase measured diagnosis burden.[11–14] Lower diagnostic thresholds can also increase the number of chronic condition diagnoses, especially when there isn’t a parallel change in demographics.[12,15] Additionally, previous research finds an association between chronic conditions and shifts in population age structure;[16,17] we, however, do not observe meaningful shifts in age distributions. For these reasons, we suggest interpreting the observed trends in chronic condition prevalence with caution.

Limitations

Our analysis is not without limitations. First, the current analysis compares market-level patterns over time, but it does not quantify the contribution of these factors to spending growth. In addition, we only examine the commercial and Medicare Advantage markets; in future analyses, we intend to incorporate the Medi-Cal managed care plans. Second, our analysis excludes several health plans that submit to OHCA due to either not having data available for the full three-year period or due to data quality (See appendix Payer inclusion section for more detail). Third, we define chronic conditions based on claims, which depend on observed diagnoses and coding practices. Thus, observed prevalence can change even without changes to the underlying health status.[11,14] Fourth, we use encounter counts as a measure of utilization frequency. However, they represent administrative units rather than clinical episodes, which may better approximate the health of the patient population.[18] Fifth, we use a fixed threshold to define high-cost patients. While the share of patients above the threshold shows the cost burden, changes in shares do not explain why spending increased.[7]

Conclusion

In this brief, we analyzed changes in utilization, age, chronic condition prevalence and the share of high-cost members. All of these measures – with the exception of the share of high-cost members – grew more slowly than the double-digit growth in TME PMPY between 2022 and 2024. At the $1 million threshold, high-cost members remained rare in both markets, and their share of total spending showed negligible change over the period. Chronic condition prevalence and the proportion of members with multiple chronic conditions increased in both markets. The commercial market saw declining utilization rates over time, while in the Medicare Advantage market, utilization remained high and stable across the three-year period. These findings can inform policymakers seeking to understand the role of enrollee characteristics and patterns of utilization amid rising health care costs in California.

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Appendix

Data

The main data source is extract 15008 of California's Health Care Payments Data (HPD), which was released on February 27, 2026. The tables used include monthly eligibility files, medical, and pharmacy claims. We only include claims and encounters paid as primary. We exclude denied claims, duplicate claims, and claims with invalid National Drug Codes (NDCs) when calculating spending; however, for utilization rate and frequency calculations, denied claims are included.

Total Medical Expense (TME) calculations are based on OHCA's annual data submissions. OHCA collected aggregate spending data from 17 payers for 2022 data and from 24 payers for 2024. TME per member per year (PMPY) by market is calculated using all data submitted for each respective period. For Medicare Advantage, the TME PMPY values include Duals (members eligible for both Medicare and Medicaid) and D-SNPs (Medicare Advantage plans that provide specialized care for dual-eligible members).

Payer inclusion

24 payers submitted data to OHCA in 2024; however, not all are included in this analysis. Contra Costa Health Plan, Community Health Group, Health Plan of San Mateo, and San Francisco Health Plan do not submit claims data to the HPD and are therefore excluded. Data from Central Health Plan of California, Inland Empire Health Plan, and Molina Healthcare are available in HPD but are incomplete across the three-year study period. In addition, Elevance (formerly Anthem) is excluded due to concerns about data quality.[1] Thus, our market-level analyses are limited to 14 payers that are required to submit data to OHCA: 11 with plans in the Commercial market and 10 in the Medicare Advantage market (See Appendix Table 4).

Table A1. Payer inclusion and total 2024 membership by market

Payer	Commercial	Medicare Advantage
Aetna	√	√
Alignment		√
Blue Shield of California	√	√
Bright Health (Universal Care)		√
Centene / Health Net	√	√

[1] Elevance has since resubmitted their data and the corrected data should be available for use in a future HPD extract.

Payer	Commercial	Medicare Advantage
Cigna Healthcare (Cigna)	√	
Kaiser Foundation Health Plans (Kaiser)	√	√
Local Initiative Health Authority for Los Angeles County (LA Care)	√	
SCAN Health Plan (SCAN)		√
Sharp Health Plan (Sharp)	√	√
Sutter Health Plan (Sutter Health Plus)	√	
UnitedHealthcare	√	√
Valley Health Plan	√	
Western Health Advantage	√	√
Number of THCE Payers included in this analysis	**11**	**10**

Member inclusion

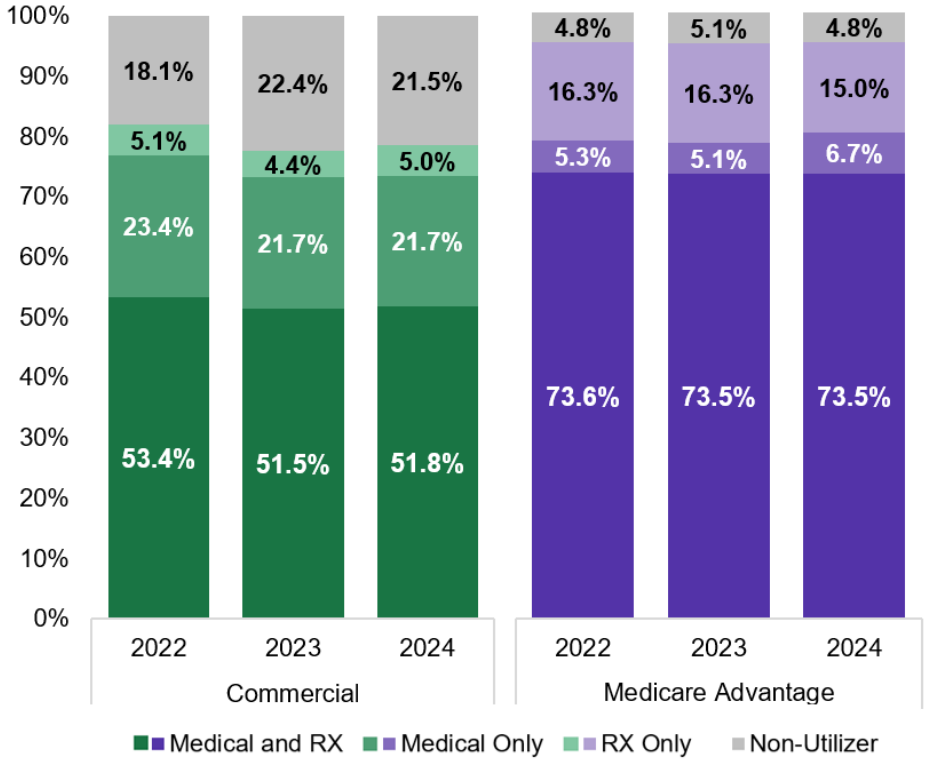
We excluded member-year enrollment records that had more than one sex reported, had an age difference of more than 1 year within each calendar year, and those with missing age and gender. Overall, we excluded about .05% and .02% of records for the Commercial and Medical Advantage markets, respectively. For members who reported one year older during the calendar year, we calculated the midpoint age within the year; for example, we use 31.5 for those members who reported being 31- and 32-years-old in the same year. We also exclude members whose residence is outside California.

Medical versus pharmacy utilizations rates

We analyzed the share of members with medical, pharmacy and combined service use across markets and years. The proportion of medical and pharmacy utilization differed across the two markets, with Medicare Advantage showing a much higher utilization rate both for pharmacy-only and combined medical and pharmacy. In the commercial market, the share of members with both medical and pharmacy use declined between 2022 and 2024, from 53.4% in 2022 to 51.8% in 2024, a 3.0% decrease. Medical-only use also trended downward, from 23.4% in 2022 to 21.7% in 2024, a 7.3% decrease, while pharmacy-only use declined initially and then showed a small rebound in 2024, 5.1% in 2022 and 5.0% in 2024, a 2.0% decrease.

The utilization rate in the Medicare Advantage market showed stability over time: the proportion of members with both medical and pharmacy use was 73.6% in 2022 and 73.5% in 2024, a 0.1% decrease; members with medical-only use was 5.3% in 2022 and 6.7% in 2024, a 26.4% increase; and those with pharmacy-only use was 16.3% in 2022 and 15.0% in 2024, a 8.0% decrease. As expected, Medicare Advantage has a larger share of members with both medical and pharmacy and with pharmacy-only use than in the commercial market.

Figure A1. Distribution of members with medical and pharmacy use, by market and year, 2022-2024

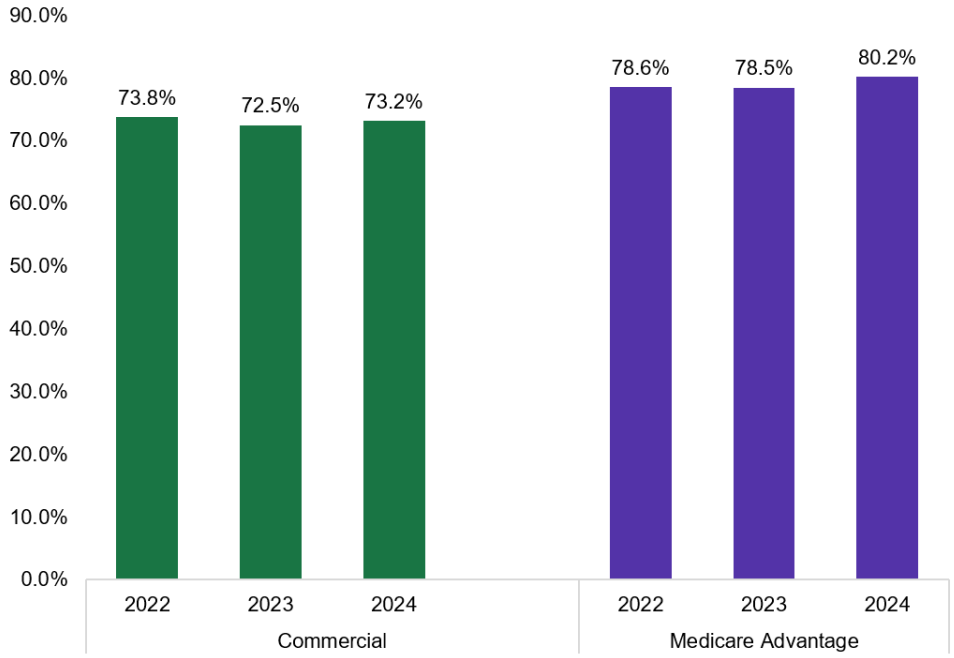


Notes: "RX" denotes pharmacy use (prescriptions filled). "Non-Utilizer" is defined as a member without any medical or pharmacy claims for that calendar year. Payers included in each market are listed in Table A1.

Utilization rate analysis with exclusion of COVID-related claims

We assess trends in medical services utilization without COVID-related medical claims. In the commercial market, the utilization rate was 73.8% in 2022 and 73.2% in 2024, a 0.8% decrease, while in Medicare Advantage, the utilization rate was 78.6% in 2022 and 80.2% in 2024, a 2.0% increase. The trends in the commercial market are similar to analysis with the inclusion of COVID-related claims, although Medicare Advantage shows a small increase in medical utilization by 2024 when excluding COVID-related claims.

Figure A2. Share of members with at least one medical encounter excluding COVID-related claims, by market and year, 2022-2024



Alternative definition of high-cost members

We repeated the high-cost analysis using an annual spending threshold of $100,000. In the commercial market, members at this threshold accounted for 0.64% of members in 2022 and 0.80% in 2024, a 25.0% increase, while their share of total claims spending was 31.0% and 32.7%, a 5.5% increase. In Medicare Advantage, the member share was 1.57% and 1.96%, a 24.8% increase, while their share of total spending was 30.5% and 32.9%, an 8.1% increase (See Appendix Table A2).

Table A2. Share of members with annual spending of $100,000 or more and share of total spending attributed to those members, by market and year, 2022-2024

	Commercial			Medicare Advantage		
	2022	**2023**	**2024**	**2022**	**2023**	**2024**
Share of High-Cost Members	0.64%	0.68%	0.80%	1.57%	1.66%	1.96%
Share of Total Spending by High-Cost Members	31.0%	32.2%	32.7%	30.5%	31.3%	32.9%

Notes: Spending includes both medical and pharmacy spending. Medical spending includes medical serices allowed amounts for fee-for-service arrangements and estimated fee-for-service equivalents for capitated payment arrangements. Pharmacy spending is calculated as a sum of fee-for-service allowed amounts.

Overlap between high-cost members and chronic conditions

We assessed the overlap between high-cost members and members that have at least one chronic condition. Prior research shows that high-cost patients often have multiple chronic conditions and complex care needs, but chronic conditions alone do not fully explain high-cost status.[17,18]
This overlap may inform whether costs are concentrated among people whose spending is connected

to ongoing, clinically intensive needs, and are more likely to remain high-cost in the long term.[19,20]

Among high-cost members with spending above $100,000, the share with chronic conditions was steady in the commercial market, 87.5% in 2022 and 87.9% in 2024, an increase of 0.5%. The share with chronic conditions was also stable for Medicare Advantage, 96.1% in 2022 and 96.0% in 2024, a decrease of 0.1%.

Among those with spending above $1 million, in the commercial market, the share of chronic conditions was 91.3% in 2022 and 90.7% in 2024, a decrease of 0.7%. In Medicare Advantage for this subgroup, the share of members with a chronic condition remained well above 93%, with a slight decrease from 2022 to 2024. As expected, the share of high-cost members with spending above $1 million were diagnosed with more chronic conditions. Taken together, our findings are consistent with prior evidence that chronic conditions are closely related to high-cost spending.

Table A3. High-cost members by chronic condition presentation, by market and year, 2022-2024

	Commercial			Medicare Advantage		
$100K Threshold	**2022**	**2023**	**2024**	**2022**	**2023**	**2024**
Number of Members						
without chronic conditions	11,208	11,478	13,125	1,799	2,016	2,435
with 1 type	13,209	14,043	15,921	849	959	1,080
with 2 -3 types	23,547	25,274	29,430	3,725	4,269	4,814
with 4 or more types	41,483	43,506	50,063	39,521	43,459	52,465
Share of Members						
No chronic condition	12.5%	12.2%	12.1%	3.9%	4.0%	4.0%
Has chronic condition	87.5%	87.8%	87.9%	96.1%	96.0%	96.0%
$1M Threshold						
Number of Members						
without chronic conditions	138	133	181	*	*	*
with 1 type	140	148	182	*	*	*
with 2 -3 types	317	300	382	*	*	*
with 4 or more types	989	1052	1202	400	459	486
Share of Members						
No chronic condition	8.7%	8.1%	9.3%	*	*	*
Has chronic condition	91.3%	91.9%	90.7%	>94.0%*	>93.0%*	>93.0%

*Note: * The asterisk denotes values of 30 or fewer, or those affected by small cell size, that require masking.*