Department of Health Care Access and Information

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

Baseline Report: Health Care Spending Trends in California, 2022–2023

June 5, 2025

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Executive Summary

In accordance with statutory requirements, this report presents health care spending and growth in California for calendar years 2022 and 2023.[1] The report shows overall spending across those two years, as well as spending change between those years at the statewide level and by market, payer, region, and service category. This first report serves as a baseline assessment of health care spending in the years before the statewide spending target. In addition to overall health care spending, the baseline report also includes per capita and per member per year (PMPY) growth rates.

Health care spending in California has been steadily increasing, placing a growing financial burden on households, employers, and public programs, while making coverage less affordable. Premium contributions and out-of-pocket costs for insured individuals have consistently grown year over year, contributing to concerns about affordability and access. In recognition of these challenges, in April of 2024, the Health Care Affordability Board approved a statewide health care spending target to help slow spending growth while maintaining quality and access to care.

Each year, the Office of Health Care Affordability (OHCA) will collect, analyze, and report data from payers and other state and federal data sources to present a comprehensive view of California's health care spending and growth trends over time. These annual reports will be a resource for stakeholders to recognize opportunities and take action to slow the rate at which health care costs are increasing across the state with the aim of making health care more affordable for Californians.

This initial report establishes a foundation for OHCA and the public to understand health care spending and spending growth prior to the implementation of OHCA's statewide spending target, which is effective for performance years 2025-2029. The report summarizes baseline total health care expenditures (THCE) – health care spending including health plan administrative costs and profits – and total medical expense (TME) – health care spending excluding health plan administrative costs and profits, along with their growth from 2022 to 2023 and examines key measures by market, payer, service category, commercial product type, and geographic region. The report further summarizes the OHCA initiatives to improve health system performance through primary care and behavioral health care investment benchmarks, alternative payment models (APM), quality and equity measures, and health care workforce stability standards.

[1] *See* Cal. Health & Saf. Code, § 127501.6, subd. (a).

Between 2022 and 2023, THCE changed as follows for the three major markets: Commercial spending grew 5.8%, Medicare (excluding dual eligibles and dual eligible special needs plans (D-SNP)) spending grew 6.0%, and Medi-Cal spending grew 6.5%. When measured per member per year, THCE varied across the three major markets of Commercial, Medicare and Medi-Cal. Commercial THCE PMPY was $6,966 in 2022 and $7,409 in 2023, an increase of $443 or 6.4%. Medicare had the highest THCE PMPY at $17,879 in 2022 and $18,851 in 2023, an increase of $972 or 5.4%. Medi-Cal THCE PMPY was $8,343 in 2022 and $8,586 in 2023, an increase of $243 or 2.9%.

When aggregating market level spending with other state and federal health care program spending, statewide THCE totaled $377.6 billion in 2022 and $408.6 billion in 2023, an increase of $31.0 billion or 8.2%. (Figure 1). On a per capita basis (THCE divided by California's population), total health care expenditures were $9,676 in 2022 and $10,847 in 2023, an increase of $811 or 8.4%.

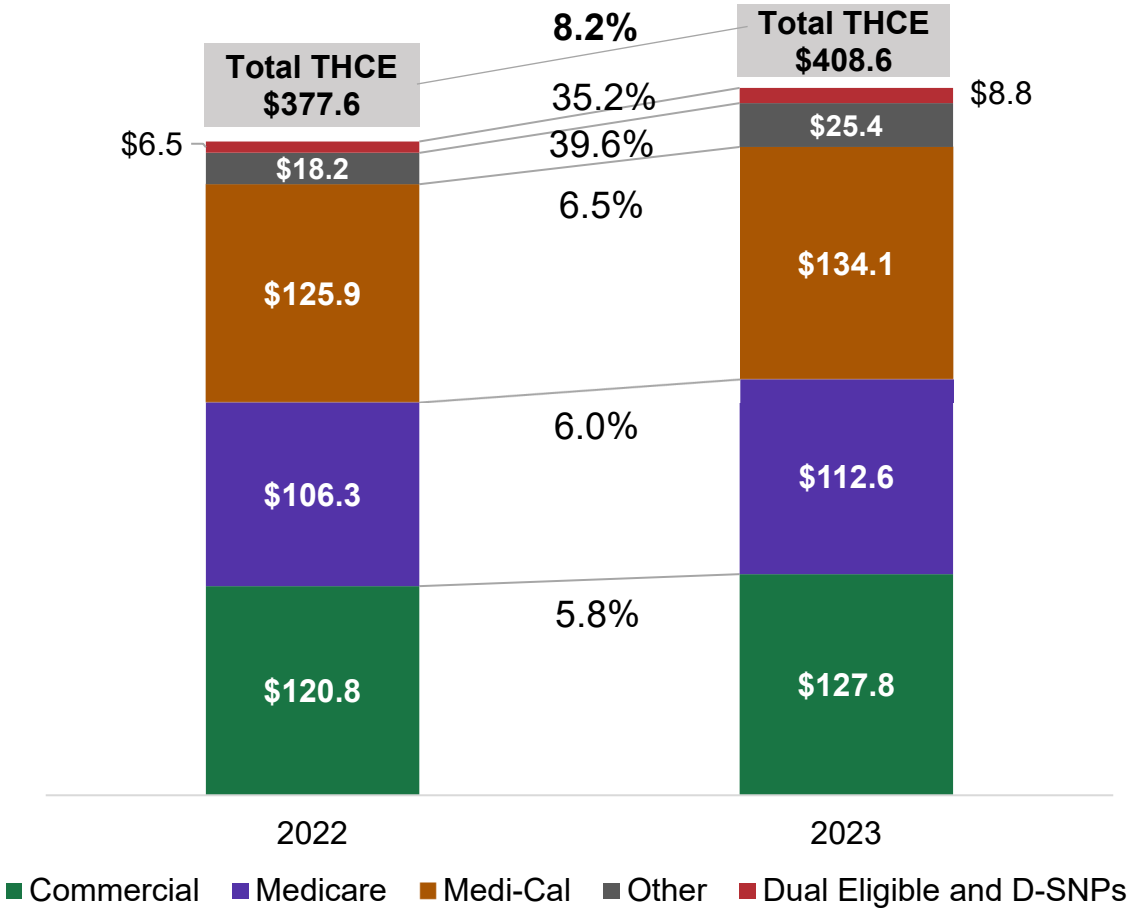
Growth in TME varied across markets, payers, regions, and service categories between 2022 and 2023. Total medical expenses PMPY growth among Medi-Cal and Medicare markets averaged 1.2% and 6.1%, respectively, compared with an average of 5.0% for Commercial (Figure 3).

Figures 1 through 3 highlight spending levels and trends on a statewide basis and per member per year spending by market.

Statewide Health Care Spending Growth from 2022 to 2023

- **Changes in THCE by Market:**
    - **Commercial** spending grew 5.8%.
    - **Medicare** spending (excluding dual eligibles and D-SNPs) grew 6.0%.
    - **Medi-Cal** spending grew 6.5%.
    - **Dual Eligibles and D-SNPs** spending grew 35.2%. Medi-Cal spending on Dual Eligibles is captured in Medi-Cal spending.
- **Other** state and federal health care program spending (Medi-Cal and non-Medi-Cal program spending from Department of Health Care Services, California Correctional Health Care Services, Indian Health Services, and Veterans Health Administration) grew 39.6%.
- When aggregating spending by market and Other spending, **THCE** grew 8.2%.

Figure 1. Statewide Total Health Care Expenditures (in billions) and Percentage Change by Market

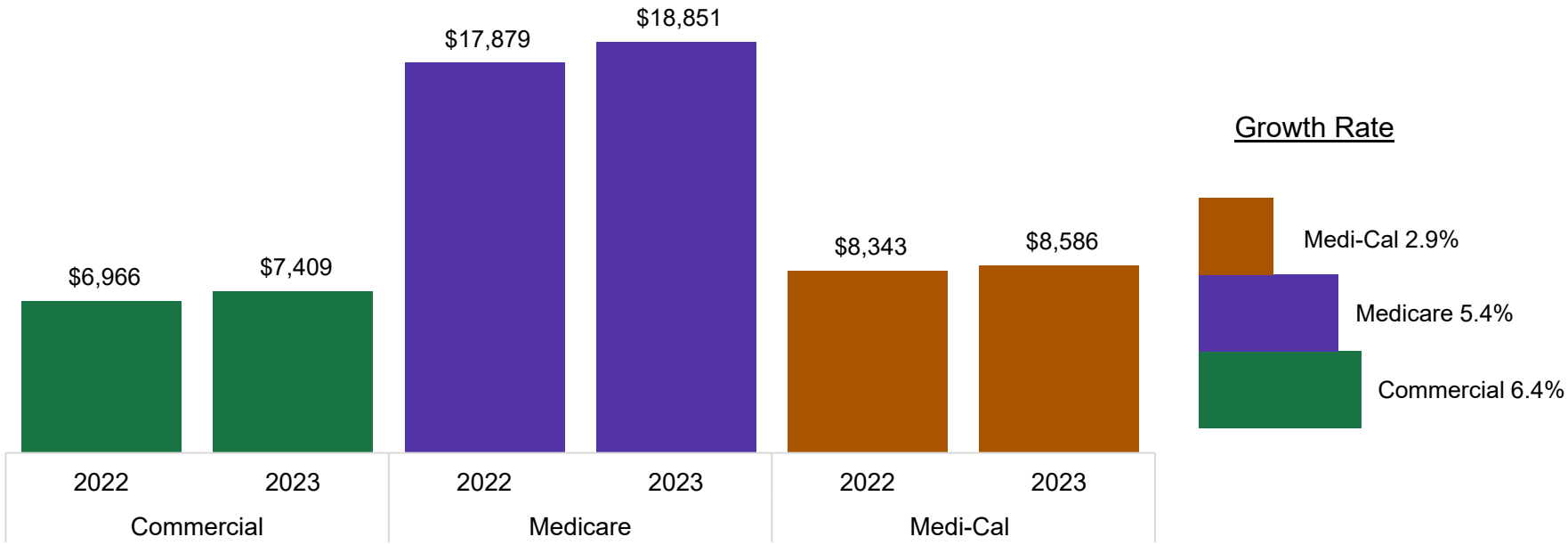


Total Health Care Expenditures Per Member Per Year by Market

Figure 2 shows Total Health Care Expenditures (including health plan administrative costs and profits) per member per year (THCE PMPY) by the three major markets:

- **Commercial** THCE PMPY was $6,966 in 2022 and $7,409 in 2023, an increase of $443 or 6.4%.
- **Medicare** THCE PMPY was $17,879 in 2022 and $18,851 in 2023, an increase of $972 or 5.4%.
- **Medi-Cal** THCE PMPY was $8,343 in 2022 and $8,586 in 2023, an increase of $243 or 2.9%.

Figure 2. Total Health Care Expenditures Per Member Per Year Spending and Spending Growth by Market, 2022-2023



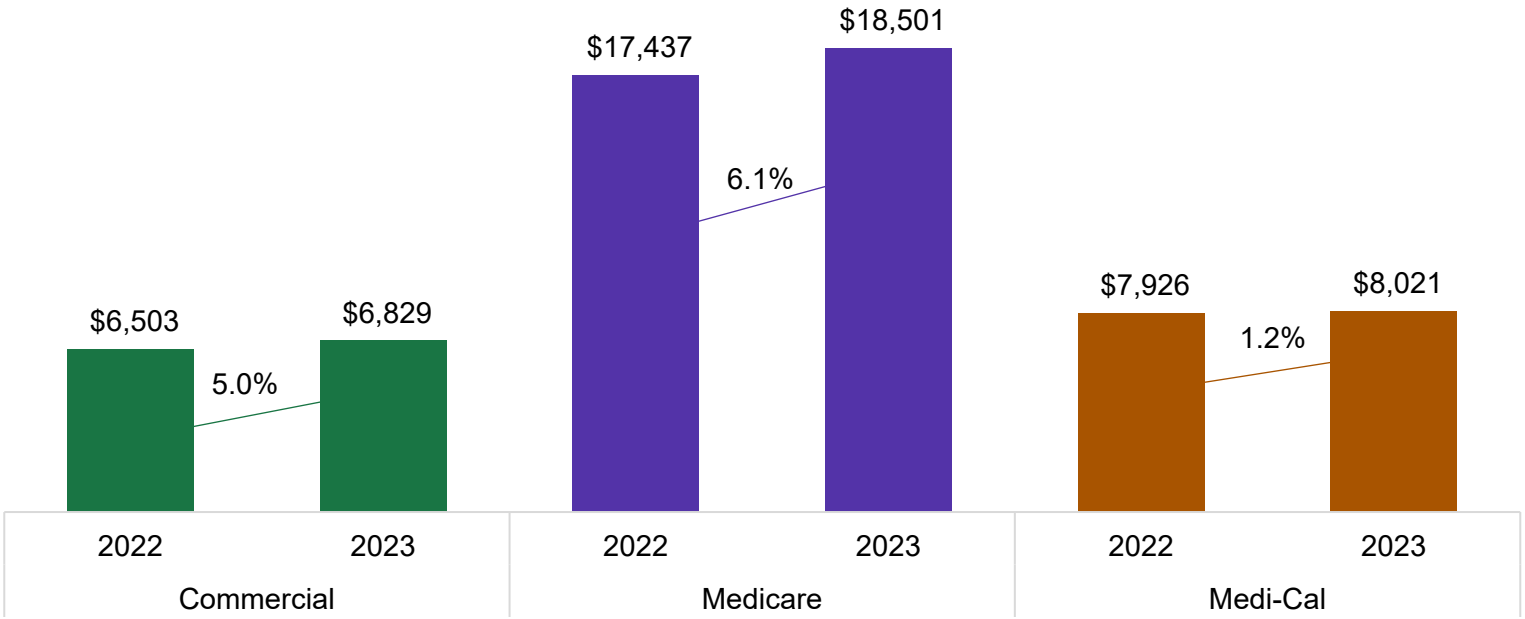
Note: THCE includes spending on medical services and health plan administrative costs and profits. Medicare includes both Medicare FFS (including duals) and Medicare Advantage (including duals and D-SNPs). Spending for Dual Eligibles in Medicare Advantage and D-SNPs, and Medicare FFS excludes administrative costs and profits. Medi-Cal includes both Medi-Cal FFS and Managed Care. Medi-Cal FFS does not include administrative costs. D-SNP = dual eligible special needs plans; FFS = fee-for-service

Total Medical Expenses Per Member Per Year by Market

Figure 3 shows Total Medical Expense (excluding health plan administrative costs and profits) per member per year (TME PMPY) by the three major markets:

- **Commercial** TME PMPY was $6,503 in 2022 and $6,829 in 2023, an increase of $326 or 5.0%.
- **Medicare** TME PMPY was $17,437 in 2022 and $18,501 in 2023, an increase of $1,064 or 6.1%.
- **Medi-Cal** TME PMPY was $7,926 in 2022 and $8,021 in 2023, an increase of $95 or 1.2%.

Figure 3. Total Medical Expense Per Member Per Year Spending and Spending Growth by Market, 2022-2023



Note: TME includes spending on medical services and does not include health plan administrative costs and profits. Medicare includes both Medicare FFS (including Dual Eligibles) and Medicare Advantage (including duals and D-SNPs). Medi-Cal includes both Medi-Cal FFS and Managed Care (including Dual Eligibles). D-SNP = dual eligible special needs plans; FFS = fee-for-service.

About HCAI, OHCA, and Rising Health Care Costs

About the California Department of Health Care Access and Information (HCAI)

HCAI, formerly the Office of Statewide Health Planning and Development, was created in 1978 to provide the state with an enhanced understanding of the structure and function of its healthcare delivery systems. Since that time, HCAI's role has expanded to include delivery of services that promote equitable access to health care for all Californians.

HCAI is a leader in collecting data and disseminating information about California's healthcare infrastructure, promoting an equitably distributed healthcare workforce, and publishing valuable information about healthcare outcomes. HCAI also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's nonprofit healthcare facilities. HCAI works to improve affordability of health care costs including through spending targets and affordable generic drugs. These programmatic functions are advised by several boards and commissions.

HCAI serves as the building department for hospitals and skilled nursing facilities in California. Its primary goal is to promote patient safety by ensuring that each facility remains functional during a natural disaster.

HCAI collects, analyzes, and disseminates information about hospitals, skilled nursing facilities, clinics, and home health agencies licensed within California. Examples of facility information include financial reports and claims data, service utilization data, patient data, and quality of care information.

Another HCAI program addressing healthcare costs is its Hospital Bill Complaint Program, which enforces the Hospital Fair Pricing Act. Under the Act, hospitals are required to have both discount payment and charity care policies to provide financial assistance to qualified patients. HCAI’s Hospital Bill Complaint Program helps patients who have been wrongly denied financial assistance.

To promote a diverse and culturally competent workforce, HCAI analyzes California's healthcare infrastructure and workforce needs. HCAI provides direct grant funding to medical schools, nursing programs, and other healthcare training institutions. HCAI also offers scholarships and loan repayments to students and health professionals who agree to provide patient care in medically underserved areas. Scholarship and loan repayments are offered for allied health, nursing, behavioral health, physicians, dental, and other medical professions.

The California Health Facility Construction Loan Insurance Program (known as the Cal-Mortgage Program) offers loan insurance to nonprofit and public health facilities to develop and expand healthcare services throughout California.

HCAI is also responsible for pharmaceutical policy and programs that aim to improve equitable access and affordability of medications in California by developing strategic partnerships and innovative policy solutions in the pharmaceutical sector. Strategic partnership activities include administering the CalRx program, which empowers the State of California to develop, produce, and distribute generic drugs and sell them at low cost. This program has launched initiatives to both produce its own insulin and to leverage the State of California's purchasing power to buy naloxone at a reduced cost. Future work on the pharmaceutical sector will include data analysis, research, and policy recommendations.

OHCA Background

In enacting the California Health Care Quality and Affordability Act (Health and Safety Code, section 127500, *et seq*. (Act)), the Legislature recognized the health care affordability crisis for Californians struggling with continued and rapid growth in health care costs. The Act established OHCA as a core program within HCAI. OHCA has three primary responsibilities: (1) slow health care spending growth, (2) promote high-value health system performance, and (3) assess market consolidation that may impact market competition and consumer affordability. OHCA accomplishes these goals by collecting, analyzing, and publicly reporting data on total health care spending. OHCA also enforces spending targets that are established by the Health Care Affordability Board. While slowing spending growth, OHCA promotes high value health system performance by measuring quality, equity, adoption of alternative payment models, and by promoting investment in primary care, behavioral health, and workforce stability. Lastly, OHCA reviews and assesses market consolidation, market power, and other market failures through cost and market impact reviews (CMIR) of mergers, acquisitions, or corporate affiliations.

The Impact of Rising Health Care Costs on Consumer Affordability in California

Since 2014, when coverage expansions under the Affordable Care Act (ACA) took effect, California's uninsured rate has declined substantially from 17% to 6% in 2023.[2] In 2024, Medi-Cal provided comprehensive health coverage to over 14 million residents, or 36 percent of the state's population.[3] Most Californians with low and moderate income levels who do

[2] Kaiser Family Foundation (KFF). *Health Insurance Coverage of the Total Population*. State Health Facts. Retrieved from https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population/

[3] Medi-Cal Monthly Eligible Fast Facts. (2025, January). California Department of Health Care Services. https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-October2024.pdf

not qualify for Medi-Cal and do not have employer-based coverage can purchase health insurance through Covered California, the state's insurance marketplace, and receive federal and state subsidies to cover the costs.[4] In February 2025, Covered California reached a landmark achievement with nearly 2 million Californians signed up for 2025 year coverage at the conclusion of open enrollment.[5] Despite the impressive gains in coverage, health care affordability remains a challenge in California. Federal and state subsidies have helped Californians buy Covered California coverage, but federal subsidies are set to expire at the end of 2025, which would dramatically increase marketplace premiums. Californians have long struggled to afford ever-increasing premiums in the individual and employer-based markets, while also facing higher copays and coinsurance when using their coverage – a twofold challenge some have described as "paying twice."

California's rising health care costs have placed a growing financial burden on workers and families. Based on Centers for Medicare and Medicaid Services data, in 2020, total health care spending in the state reached $405 billion, compared with $311 billion in 2015, an increase of 30.3%. Per capita spending in 2020 was $10,299, compared with $7,998 in 2015, an increase of $2,301 or 28.8%.[6] As health care costs outpace wage growth, more Californians are struggling to afford and access care, with over half reporting that they have skipped or delayed medical care due to cost, a number that climbs to 74% among lower-income households. The financial strain is even more pronounced among Black and Latino communities, who are more likely to report difficulty paying medical bills (40% and 36%, respectively, compared with White Californians at 25%).[7]

As health care expenditures have grown, premium contribution rates have also increased, contributing to increased strain on household budgets. From 2003 to 2023, California workers faced higher annual premium contributions both in total dollar amount and percentage of premium for both single (self-only) and family coverage. In 2023, for single coverage premiums, workers in California paid an average of $1,356 annually, compared with $475 in 2003, an increase of $881 or

[4] McConville, Shannon. (2021, May). Health Care Reform in California. Public Policy Institute of California. https://www.ppic.org/publication/health-care-reform-in-california/

[5] Covered California News Release. (2025, February 20). Covered California Reaches Landmark Achievement with Nearly 2 Million Enrolled as Open Enrollment Concludes. Covered California website. https://www.coveredca.com/newsroom/news-releases/2025/02/20/covered-california-reaches-landmark-achievement-with-nearly-2-million-enrolled-as-open-enrollment-concludes/

[6] State Health Expenditure Accounts by State of Residence, 1991-2020, Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence

[7] Joynt, J., Catterson, R., & Alvarez, E. (2024, January 31). The 2024 CHCF California Health Policy Survey. California Health Care Foundation. https://www.chcf.org/publication/2024-chcf-california-health-policy-survey/#related-links-and-downloads

185% (or 5.7% annually). When looking at the average employee contribution, or the share of the premium paid, workers paid 17% for single coverage in 2023, up from 14% in 2003. In 2023, for family coverage premiums, workers paid an average of $7,768 annually, compared with $2,282 in 2003, an increase of $5,486 or 240% (or 6.7% annually). For share of premium paid, workers paid 32% for family coverage in 2023, up from 25% in 2003.

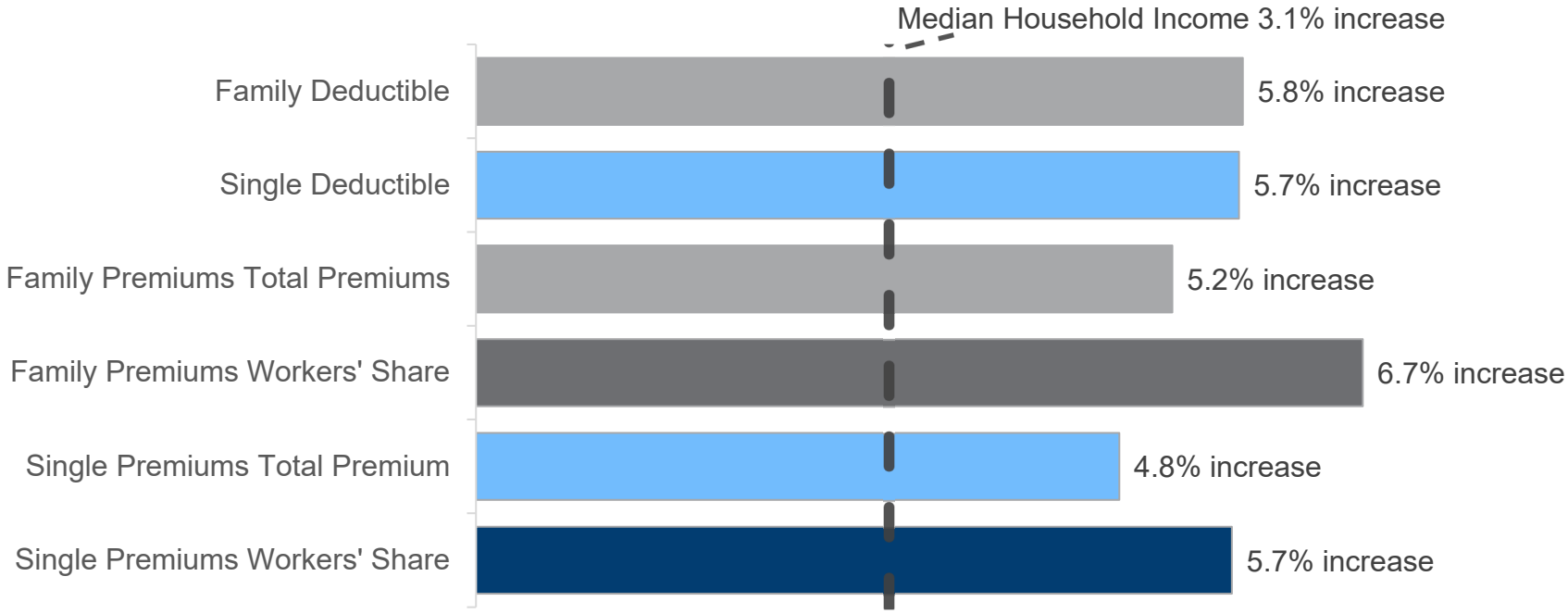
Beyond premium increases, employees are paying more out-of-pocket at the point of care through higher deductibles and copayments. As health care costs increase, many employers have implemented benefit design changes to increase cost-sharing, leading to higher deductibles and copayments for employees. From 2003 to 2023, the share of employees with a deductible increased from 39% to 77%. For single coverage, average deductibles were $1,490 in 2023, compared with $517 in 2003, an increase of $973 or 188% (or 5.7% annually). Family coverage deductibles were $3,167 in 2023, compared with $1,093 in 2003, an increase of $2,074 or 190% (or 5.8% annually).[8]

During this timeframe, median household income increased by only 82%, from $49,300 in 2003 to $89,870 in 2023, which represents an average annual growth rate of 3.1%.[9] The cost of health care for employees has increased significantly over the last two decades, forcing many workers to allocate a larger portion of their income to health insurance or forgo coverage altogether.[10] In 2003, workers contributed 5% of their household income toward family coverage premiums, but by 2023, that share had nearly doubled to 9%.

Figure 4 illustrates the disparity between growth rates for premiums, deductibles, and median household income, highlighting how workers' financial contributions have grown at a faster rate than their household income and total premiums over the past two decades.

[8] Medical Expenditure Panel Survey - Insurance Component (MEPS-IC) Agency for Healthcare Research and Quality. (2023). Medical Expenditure Panel Survey - Insurance Component (MEPS-IC), 2003-2023 California. Retrieved from https://datatools.ahrq.gov/meps-ic/
[9] Federal Reserve Bank of St. Louis. (n.d.). Median household income in California. Retrieved from https://fred.stlouisfed.org/series/MEHOINUSCAA646N
[10] Tolbert, J., Cervantes, S., Bell, C., & Damico, A. (2024, December 18). Key facts about the uninsured population. Kaiser Family Foundation. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

Figure 4. Average Annual Growth Rates for Premiums and Deductibles for Private Sector Workers; and Median Household Income in California, 2003 - 2023



Taken together, the widening gap between incomes and the cost of health care places an increasing burden on Californians. While wages have increased over time, escalating premiums and deductibles have disproportionately outpaced household incomes. This growing disparity places a greater financial strain on workers, making health coverage increasingly unaffordable for many California households.[11]

[11] Dietz, Miranda and Laurel Lucia. Measuring Consumer Affordability is Integral to Achieving the Goals of the California Office of Health Care Affordability. UC Berkeley Labor Center. January 2024. https://laborcenter.berkeley.edu/measuring-consumer-affordability/

OHCA Takes Key Step Towards Improving Health Care Affordability for Californians with Approval of Statewide Spending Target

In April 2024, the California Health Care Affordability Board approved a statewide health care spending target.[12] A health care spending target establishes a shared expectation for health plans and providers to not exceed annual rates of growth for per capita health care spending. A spending target is intended to slow health care spending growth so that spending on health care does not continue to crowd out household budgets for other necessities such as housing, food, and education. California's spending target is based on historical median household income growth, signaling that health care spending should not grow faster than the income of California families.

Table 1 below shows established spending targets for performance years 2025 through 2029.[13,14] Note a performance year is measured as the rate of change from the prior year (e.g., performance year 2025 measures the rate of change from calendar year 2024 to calendar year 2025).

Table 1. California's Statewide Health Care Spending Target

Performance year	Per capita spending target
2025	3.5%
2026	3.5%
2027	3.2%
2028	3.2%
2029	3.0%

[12] https://hcai.ca.gov/statewide-health-care-spending-target-approval-is-key-step-towards-improving-health-care-affordability-for-californians/

[13] *See* Cal. Code Regs., tit. 22, § 97447.

[14] For more information on California's Statewide Health Care Spending Target, see: https://hcai.ca.gov/affordability/ohca/slow-spending-growth.

About this Report

In accordance with statutory requirements, this report presents health care spending and growth in California for calendar years 2022 and 2023.[15] The report shows overall spending across those two years, as well as spending change between those years at the statewide level and by market, payer, region, and service category. This first report serves as a baseline assessment of health care spending in the years before the statewide spending target. In addition to overall health care spending, the baseline report also includes per capita and per member per year (PMPY) growth rates.

Health care spending is calculated at the statewide level and by market, payer, region, and service category to capture the various elements that contribute to overall expenditures. These levels of measurement allow for comparisons of health care spending to understand overall changes in spending and to help identify drivers of spending growth. Due to rounding, numbers presented throughout this report may not add up precisely to the totals provided.

Data Sources

In 2024, OHCA began to collect and analyze health care spending data for this statutorily required Baseline Report on health care spending. To capture spending across the state's health care system, OHCA collected data directly from health care payers (payers) and fully integrated delivery systems[16] (FIDS) with at least 40,000 members in the Commercial or Medicare Advantage markets.[17] Data collected from payers and FIDS includes health care spending for covered benefits received by California residents with Commercial or Medicare Advantage coverage during calendar years 2022 and 2023. This Baseline Report includes spending data submitted to OHCA for 17 Commercial and Medicare Advantage payers (Table 2). This includes data on the total number of member months of coverage, payment

[15] *See* Cal. Health & Saf. Code, § 127501.6, subd. (a).

[16] *See* Cal. Health & Saf. Code, § 127500.2, subd. (h). "Fully integrated delivery system" means a system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services. The only California entity that meets this definition currently is Kaiser Foundation Health Plan and its affiliated medical groups and hospital system.

[17] Reporting requirements for the Medi-Cal managed care market take effect with the annual data file submission due September 1, 2025. *See* Cal. Code Regs., tit. 22, § 97449, subd. (a)(1).

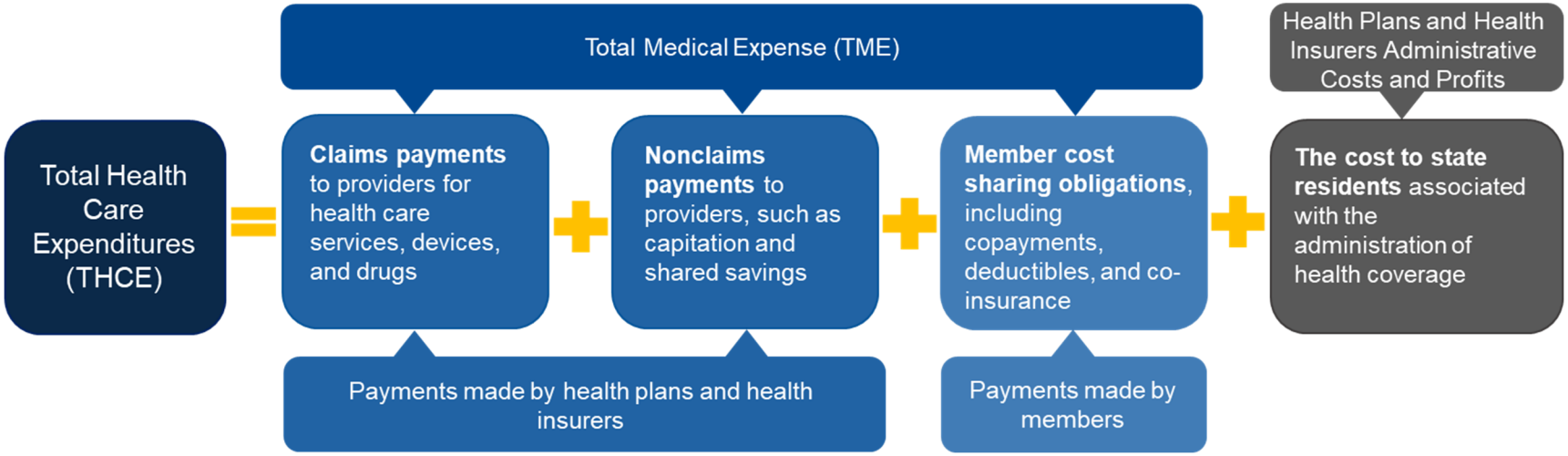
arrangements, total claims across service categories (*i.e.*, inpatient claims, outpatient claims, professional claims, long-term care, retail pharmacy, and other), non-claims-based payments, and member cost-sharing obligations.

In addition to payer submitted data for the Commercial and Medicare Advantage markets, OHCA obtained administrative data on health care spending for Medi-Cal Managed Care and Medi-Cal Fee-for-service, Medicare Fee-for-service (FFS), and other markets (Veterans Health Administration (VHA), California Correctional Health Care Services (CCHCS), etc.) from state agencies and public sources. See Appendix A. Methods and Data Sources for more details.

Definition of Total Health Care Expenditures

As shown in Figure 5, total health care expenditures (THCE) are defined as the sum of total medical expenses (TME) and administrative costs and profits of health plans and health insurers.[18] TME includes all claims payments to providers for health care provided; non-claims-based payments to providers (such as capitation and shared savings); and member cost-sharing obligations, including copayments, deductibles, and coinsurance payments. When THCE data is aggregated across all payers and fully integrated delivery systems, it can be reported on a statewide basis.

Figure 5. Components of Total Health Care Expenditures



[18] This includes fully insured commercial plans, self-insured commercial plans, Medicare Advantage plans, and Medi-Cal managed care plans.

Market Categories

Figure 6 shows levels of reporting in the baseline report, including overall statewide reporting and reporting by market and plan type.

The Commercial market includes members covered by payers that offer employer-sponsored coverage and plans purchased by individuals including through Covered California, the state's health insurance exchange. Most commercially insured Californians are younger than 65. Commercial payers offer multiple types of plans, primarily (1) health maintenance organization (HMO) or point of service (POS) plans, which require a primary care provider to manage the member's care and (2) preferred provider organization (PPO) or exclusive provider organization (EPO) plans, which allow members to schedule visits without a referral.

Medicare is a health coverage program that serves seniors and individuals with disabilities. Medicare spending includes Medicare FFS, as reported by Centers for Medicare and Medicaid Services (CMS), and spending for members enrolled in Medicare Advantage managed care plans, as reported by Medicare Advantage payer data submitted to OHCA.

Medi-Cal is California's Medicaid program that provides needed health care services for low-income individuals. Medi-Cal has both FFS and managed care delivery systems. The majority of Medi-Cal members are enrolled in Medi-Cal managed care plans that provide most members' health care services through established networks of organized systems of care. Some services are "carved out" of Medi-Cal and provided through Medi-Cal FFS such as behavioral health services for people with serious mental health conditions and prescription drugs. As of 2025, approximately 15.2 million Medi-Cal members in all 58 counties receive their health care through five main models of managed care: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Regional Model (RM), and Single-Plan[19].

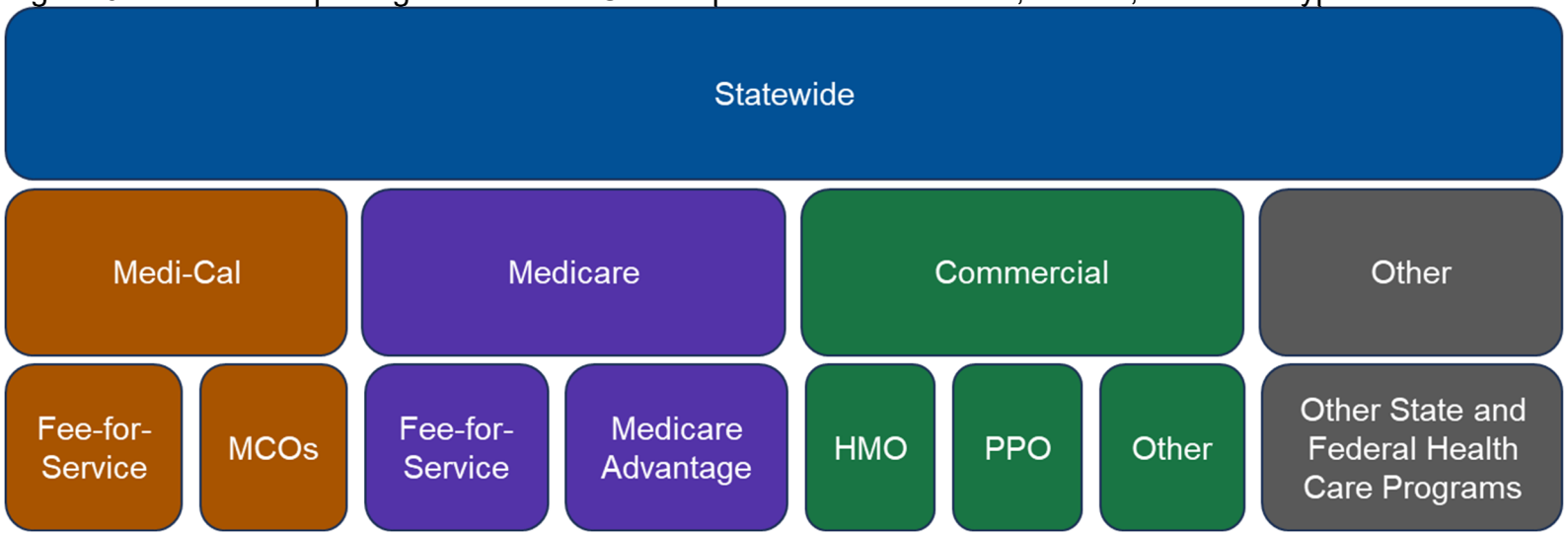
The Dual Eligible and Dual Eligible Special Needs Plans (D-SNPs) market category captures Medicare's portion of health care expenditures for Californians with both Medicare and Medi-Cal. Medicare is the primary payer for dual-eligible members, though Medi-Cal pays for the majority of long-term care services. Medi-Cal payments for dual-eligible members are captured in Medi-Cal spending.

The Other payer category includes other state and federal health care spending in California from programs including the California Correctional Health Care Services (CCHCS), Indian Health Service (IHS) of the U.S. Department of Health and

[19] https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx

Human Services, Department of Veterans Affairs, and Medi-Cal and non-Medi-Cal program spending from the Department of Health Care Services Care Services (DHCS).

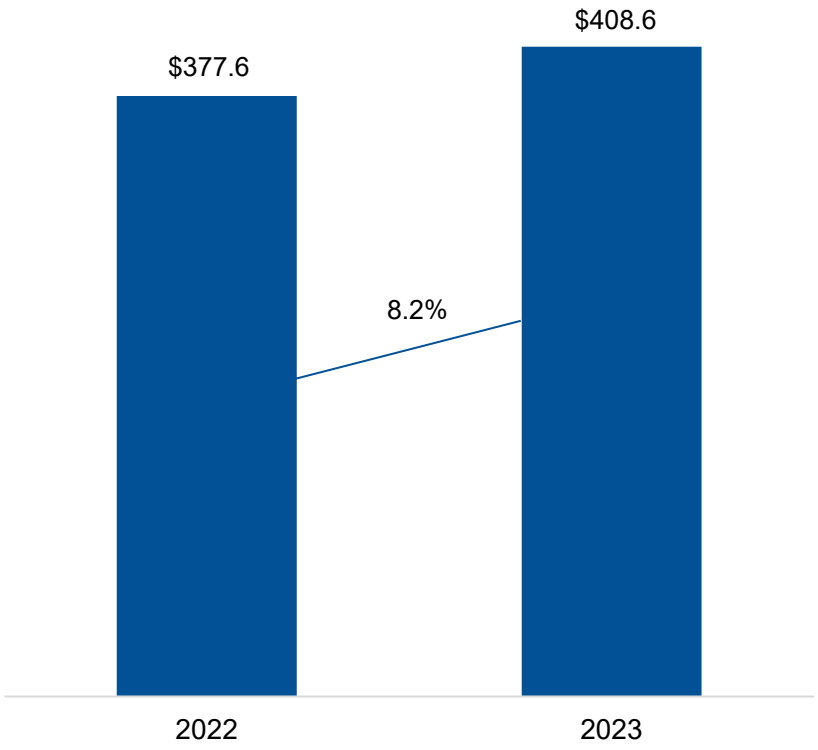
Figure 6. Levels of Reporting Total Health Care Expenditures: Statewide, Market, and Plan Type



Note: The Medicare Advantage market includes dual eligibles and D-SNPs. The Medicare fee-for-service market also includes dual eligibles. "Other" includes CCHCS, IHS, VHA, and Medi-Cal and non-Medi-Cal program spending from DHCS.
CCHCS = California Correctional Health Care Services; DHCS = Department of Health Care Services; D-SNP = dual eligible special needs plans; HMO = health maintenance organization; IHS = Indian Health Services; MCO = managed care organization; PPO = preferred provider organization; VHA = Veterans Health Administration

Statewide Total Health Care Expenditures (THCE) 2022-2023

Figure 7. Statewide Aggregate Total Health Care Expenditures in Billions, 2022-2023



Statewide total health care expenditures (THCE) were $408.6 billion in 2023, compared with $377.6 billion in 2022, an increase of $31.0 billion or 8.2% (Figure 7).

Figure 8 shows THCE by market. The Commercial market represents the largest source of total health care expenditures in California, comprising 31.3% of statewide THCE. In 2023, Commercial spending was $127.8 billion compared with $120.8 billion in 2022, an increase of $6.9 billion or 5.8%.

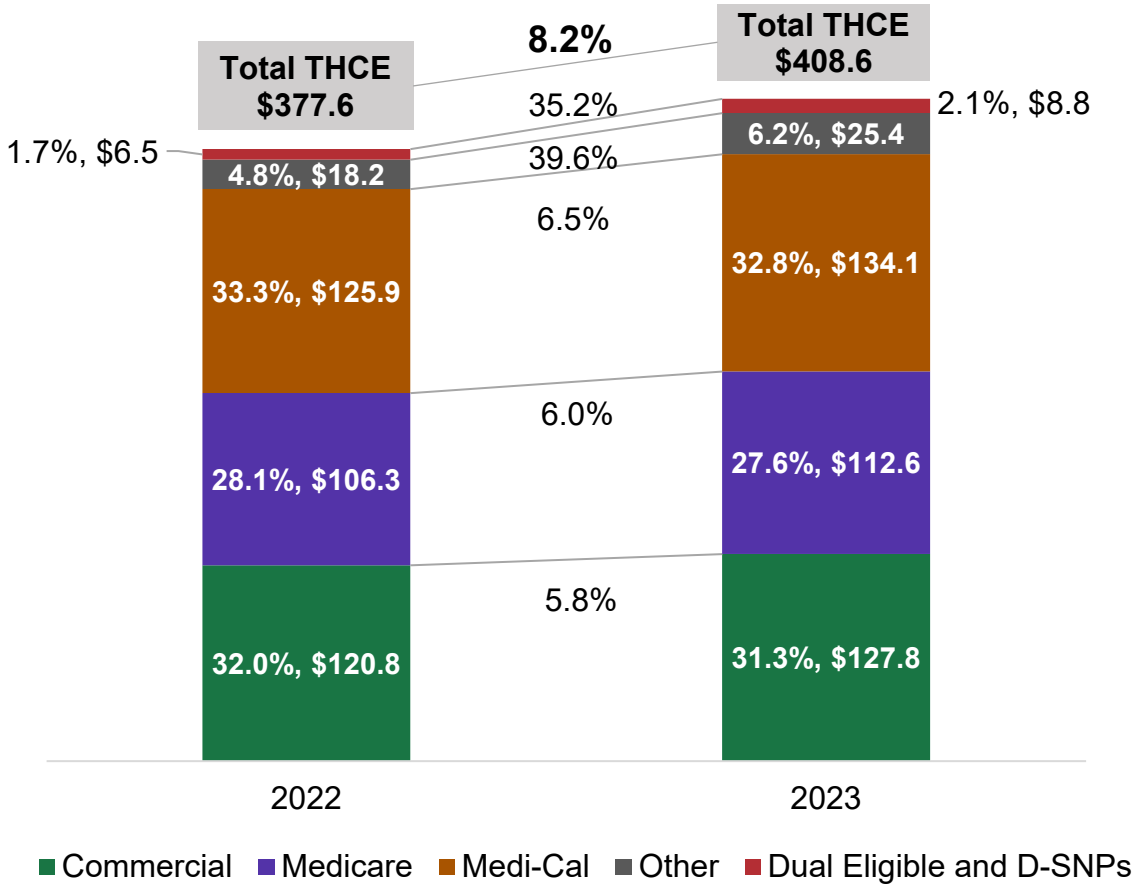
In 2023, total Medicare spending, excluding dual eligible individuals enrolled in Medicare Advantage plans and D-SNPs, was 27.6% of statewide THCE. Medicare spending in 2022 was $106.3 billion and in 2023 was $112.6 billion, an increase of $6.4 billion or 6.0%.

In 2023, total Medi-Cal spending was 32.8% of statewide THCE. Medi-Cal spending grew from $125.9 billion in 2022 to $134.1 billion in 2023, an increase of $8.2 billion or 6.5% between 2022 and 2023.

In 2023, total spending for Dual Eligibles in Medicare Advantage plans and D-SNPs was 2.1% of statewide THCE. Spending grew from $6.5 billion in 2022 to $8.8 billion in 2023, an increase of $2.3 billion or 35.2%.

In 2023, Other spending (such as state correctional health, Indian Health Services, Veterans Affairs and Medi-Cal and non-Medi-Cal program spending from the Department of Health Care Services) totaled $25.4 billion, compared with $18.2 billion in 2022, an increase of $7.2 billion or 39.6%.

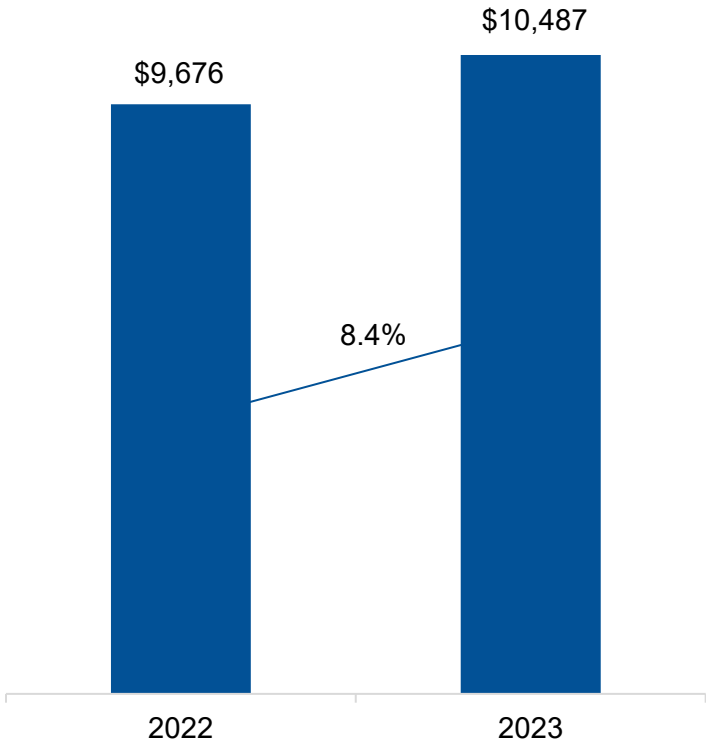
Figure 8. Statewide Aggregate Total Health Care Expenditures in Billions, Percent of Total Health Care Expenditures, and Spending Growth by Market, 2022-2023



Note: Medi-Cal includes Medi-Cal FFS and Medi-Cal Managed Care. Medicare includes Medicare FFS (including dual eligibles) and Medicare Advantage (non-duals).
D-SNP = dual eligible special needs plans; FFS = fee for service

As shown in Figure 9, per capita THCE (or THCE divided by California's population) in 2023 was $10,487, compared with $9,676 in 2022, an increase of $811 or 8.4%.

Figure 9. Per Capita Total Health Care Expenditures, 2022-2023

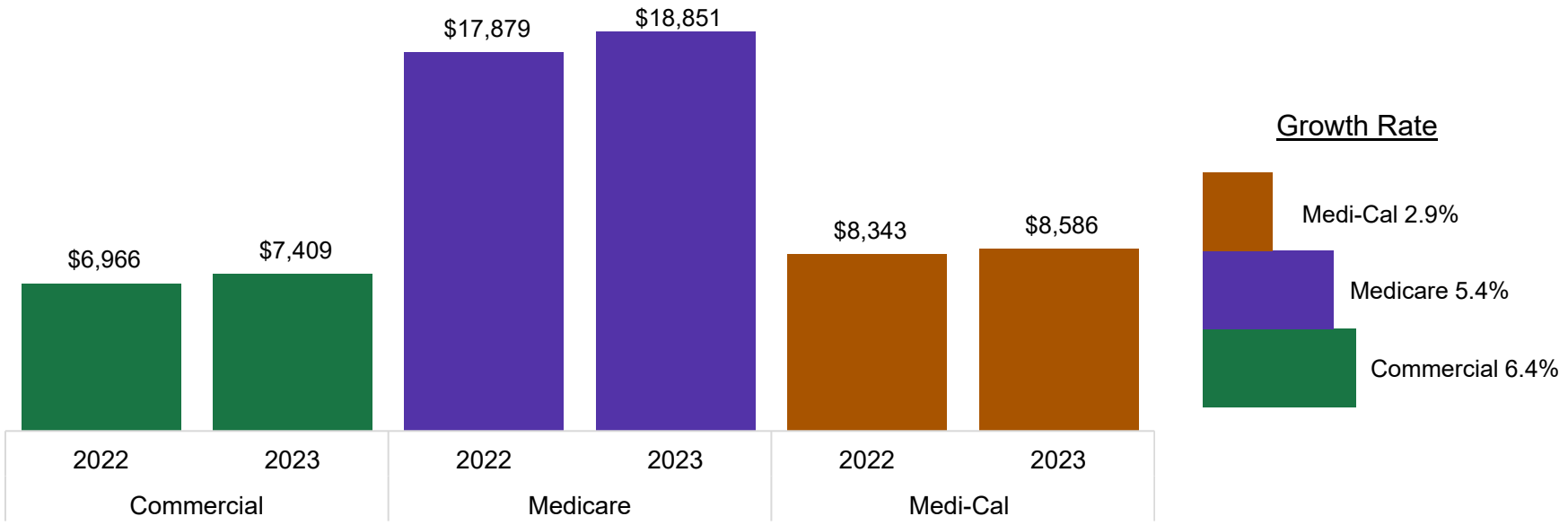


Health Care Spending by Market

Total Health Care Expenditure Per Member Per Year by Market

This section summarizes THCE PMPY spending by the major markets of Commercial, Medicare, and Medi-Cal, which includes spending on medical services (i.e., total medical expenses) and health plan administrative costs and profits. THCE PMPY for the Commercial market was $6,966 in 2022 and $7,409 in 2023, an increase of $443 or 6.4%. Among the three major markets, Medicare had the highest THCE PMPY, at $17,879 in 2022 and $18,851 in 2023, an increase of $972 or 5.4%. Medi-Cal THCE PMPY was $8,343 in 2022 and $8,586 in 2023, an increase of $243 or 2.9%.

Figure 10. Total Health Care Expenditures Per Member Per Year Spending and Spending Growth by Market, 2022-2023

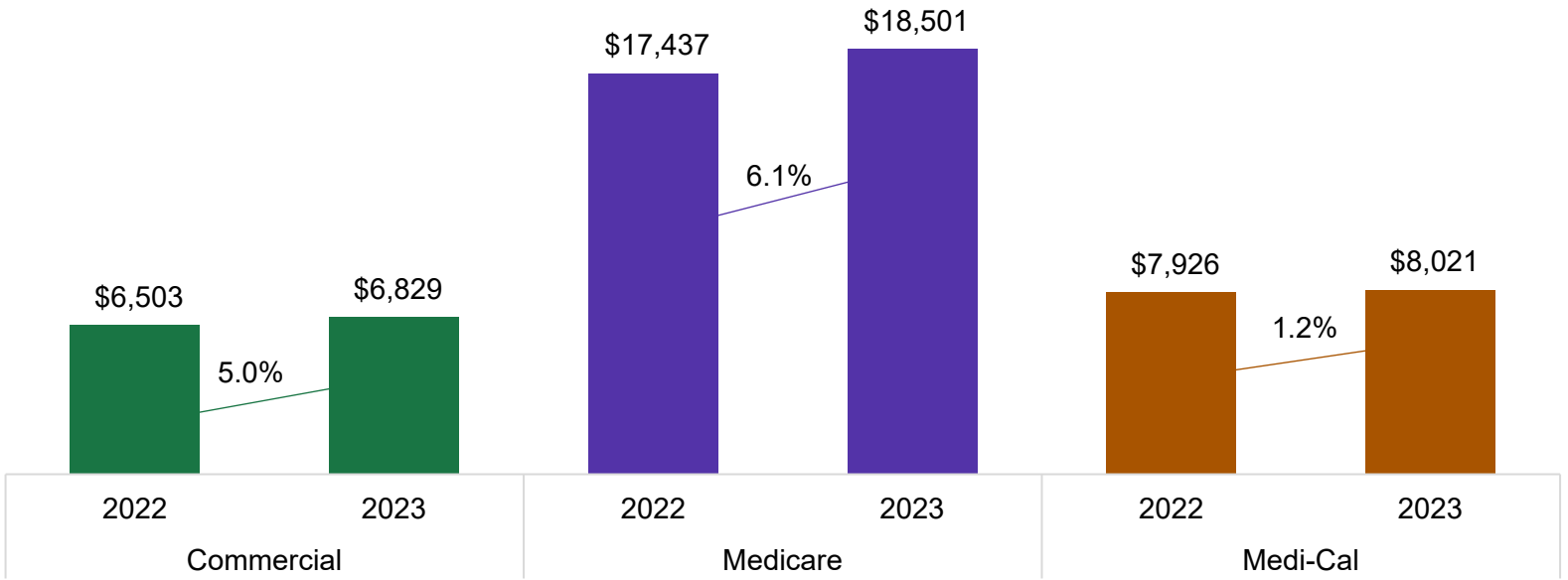


Note: THCE includes spending on medical services and health plan administrative costs and profits. Medicare includes both Medicare FFS (including duals) and Medicare Advantage (including duals and D-SNPs). Spending for Dual Eligibles in Medicare Advantage and D-SNPs, and Medicare FFS excludes administrative costs and profits. Medi-Cal includes both Medi-Cal FFS and Managed Care. Medi-Cal FFS does not include administrative costs. D-SNP = dual eligible special needs plans; FFS = fee-for-service

Total Medical Expense Per Member Per Year by Market

Figure 11 below shows TME by market, including Commercial, Medicare (Medicare Advantage [including duals and D-SNPs] and Medicare FFS [including dual eligibles]), and Medi-Cal (Managed Care and Medi-Cal FFS including dual eligibles). TME includes spending on medical services and does *not* include administrative costs and profits. TME PMPY for the Commercial market was $6,503 in 2022 and $6,829 in 2023, an increase of $326 or 5.0%. For Medicare, the figure was $17,437 in 2022 and $18,501 in 2023, an increase of $1,064 or 6.1%. Medi-Cal TME PMPY was $7,926 in 2022 and $8,021 in 2023, an increase of $95 or 1.2%.

Figure 11. Total Medical Expense Per Member Per Year Spending and Spending Growth by Market, 2022-2023



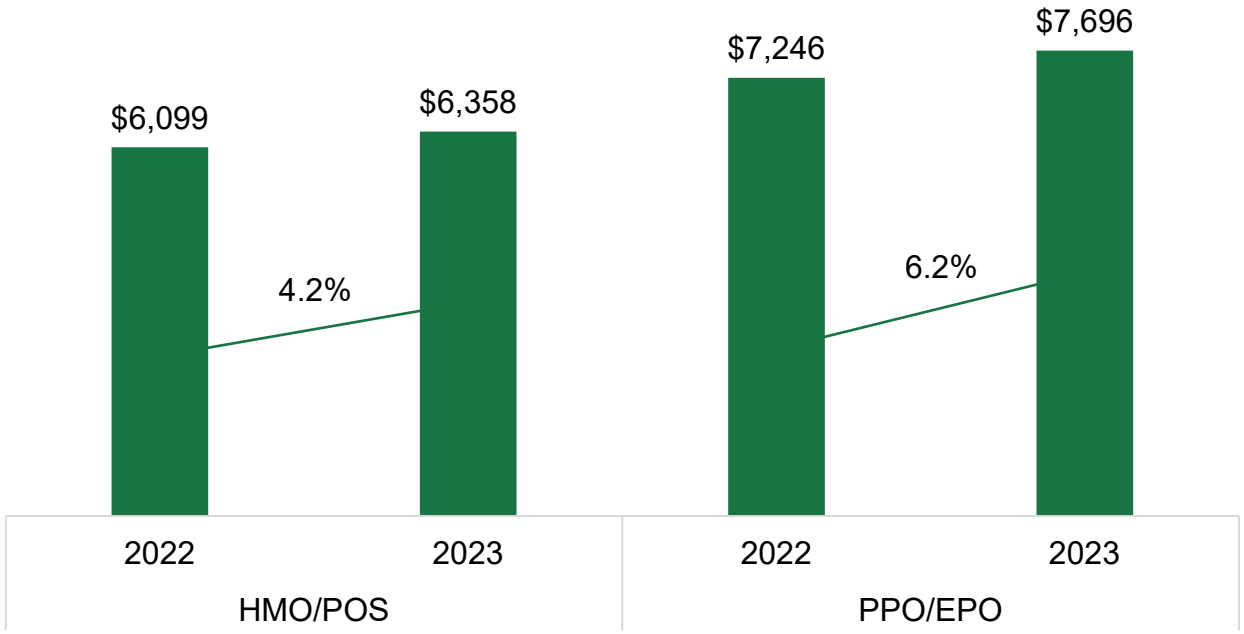
Note: TME includes spending on medical services and does not include health plan administrative costs and profits. Medicare includes both Medicare FFS (includes dual eligibles) and Medicare Advantage (includes duals and D-SNPs). Medi-Cal includes both Medi-Cal FFS and Managed Care including dual eligibles. D-SNP = dual eligible special needs plans; FFS = fee-for-service.

Total Medical Expense Per Member Per Year by Commercial Plan Type (HMO/PPO)

Total medical expense PMPY spending and spending growth were higher in Commercial PPO/EPO plans than in Commercial HMO/POS plans. Across Commercial payers, total medical expense PMPY for HMO/POS plans was $6,099 in 2022 and $6,358 in 2023, an increase of $259 or 4.2%. Total medical expense PMPY for PPO/EPO plans was $7,246 in 2022 and $7,696 in 2023, an increase of $450 or 6.2% (Figure 12).

Across HMO/POS plans, total medical expense PMPY ranged from approximately $3,600 to $9,000 compared with $4,900 to $9,000 for PPO/EPO plans. All thirteen payers in the Commercial market offered HMO/POS plans with six payers also offering a PPO/EPO plan.

Figure 12. Total Medical Expense Per Member Per Year Spending and Spending Growth by Commercial Plan Type, 2022-2023



Note: Data exclude plans that map to other plan types. Excluded plans account for 1.9% of TME.
EPO = exclusive provider organization; HMO = health maintenance organization; POS = point of service; PPO = preferred provider organization

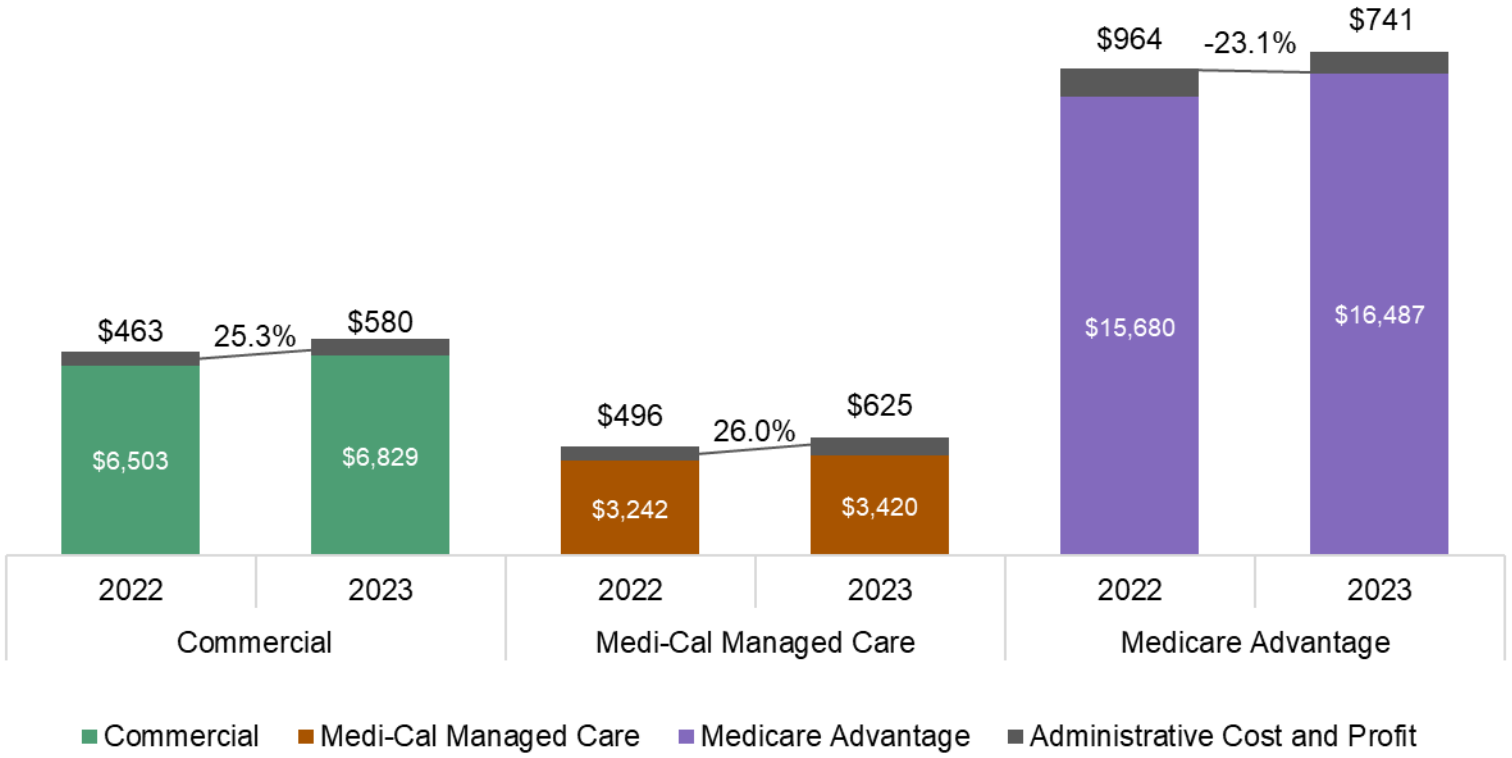
Administrative Costs and Profits

This section summarizes spending on administrative costs and profits from 2022 to 2023 for the following markets: Commercial, Medicare Advantage, and Medi-Cal Managed Care. Administrative costs include payer expenses such as claims processing, marketing, enrollment, customer service, billing, taxes, and fees. It also captures any profit or loss the payer experiences.

As shown in Figure 13, annual growth in administrative costs and profits vary by market:

- **Commercial** administrative costs and profits PMPY spending was $463 in 2022 and $580 in 2023, an increase of $117 or 25.3%. Commercial administrative costs and profits PMPY spending accounted for 8% of Commercial THCE in 2023, up from 7% in 2022.
- **Medi-Cal Managed Care** administrative costs and profits PMPY spending was $496 in 2022 and $625 in 2023, an increase of $129 or 26.0%. Medi-Cal Managed Care administrative costs and profits PMPY spending accounted for 15% of Medi-Cal Managed Care THCE in 2023, up from 13% in 2022.
- **Medicare Advantage** administrative costs and profits PMPY spending was $964 in 2022 and $741 in 2023, a decrease of $223 or -23.1%. Medicare Advantage administrative costs and profits PMPY spending accounted for 4% of Medicare Advantage THCE in 2023, down from 6% in 2022.

Figure 13. Total Medical Expense and Administrative Costs and Profits Per Member Per Year and Spending Growth by Market, 2022-2023



Note: Commercial administrative costs and profits spending is understated due to underreporting of self-insured administrative costs and profits. Medicare Advantage PMPY spending includes dual eligibles and D-SNPs because administrative costs and profits were reported collectively for Medicare Advantage payers and thus cannot be allocated by dual eligibility or D-SNP status. Medicare Advantage PMPY administrative costs and profits spending is missing data from a small number of plans. See Appendix A.3 for more information.
D-SNP = dual eligible special needs plans

Health Care Spending by Payer

This section presents changes in health care spending from 2022 to 2023 by payer in three markets in California: (1) Commercial, (2) Medicare Advantage, and (3) Medi-Cal Managed Care. Due to recent state policy changes to transition Medi-Cal enrollees eligible for both Medi-Cal and Medicare from Cal MediConnect plans to Medicare Medi-Cal plans, dual eligible members in Medicare Advantage and dual eligible special needs plans (D-SNP) are excluded from Medicare Advantage results.[20] However, dual eligible members are included in Medi-Cal Managed Care data.

Table 2. Payers by Market, 2023

Payer	Commercial	Medicare Advantage	Medi-Cal Managed Care
Aetna	✓	✓	✓
Alameda Alliance			✓
Alignment		✓	
Blue Shield of California	✓	✓	✓
CalOptima			✓
CalViva Health (CalViva)			✓
CenCal Health (CenCal)			✓
Centene / Health Net	✓	✓	✓
Central Coast Alliance for Health (Central Coast Alliance)			✓
Central Health Plan of California		✓	
Cigna Healthcare (Cigna)	✓		
Community Health Group			✓
Contra Costa Health Plan			✓

[20] California Department of Health of Health Care Services, Notice of Cal MediConnect to D-SNP transition

Payer	Commercial	Medicare Advantage	Medi-Cal Managed Care
Elevance Health / Anthem Blue Cross (Anthem Blue Cross)	✓	✓	✓
Gold Coast Health Plan (Gold Coast)			✓
Health Plan of San Joaquin			✓
Health Plan of San Mateo			✓
Inland Empire Health Plan			✓
Kaiser Foundation Health Plans (Kaiser)	✓	✓	✓
Kern Family Health Care (Kern Health Systems)			✓
Local Initiative Health Authority for Los Angeles County (LA Care)	✓		✓
Molina Healthcare of California (Molina)	✓	✓	✓
Partnership Health Plan of California			✓
San Francisco Health Plan			✓
Santa Clara Family Health Plan			✓
SCAN Health Plan (SCAN)		✓	✓
Sharp Health Plan (Sharp)	✓	✓	
Sutter Health Plan dba Sutter Health Plus (Sutter)	✓		
UnitedHealthcare	✓	✓	
Universal Care, Inc. (Universal Care)		✓	
Valley Health Plan	✓		
Western Health Advantage	✓	✓	
Total submitters	**13**	**13**	**23**

Note: Shortened versions of some payer names, as indicated in parentheses, are used in the remainder of the baseline report.

Commercial

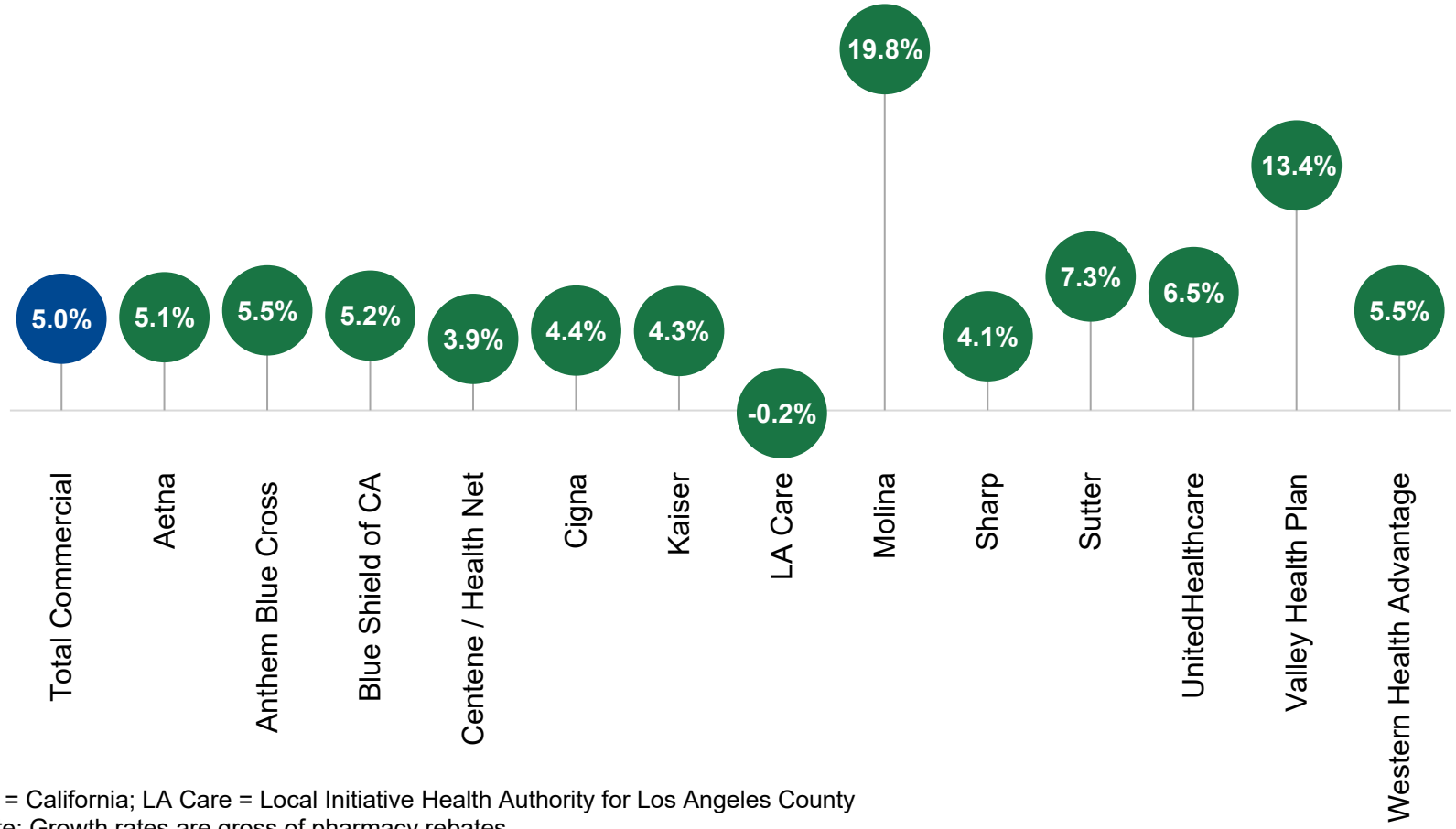
As shown in Figure 14, about 17.2 million Californians had commercial coverage in 2023. Kaiser (41.2%), Blue Shield of California (15.6%), and Anthem Blue Cross (14.3%) collectively accounted for about 71% of the Commercial market share.

Figure 14. Commercial Payer Market Share, 2023

Commercial Payers	2023 Market share
Kaiser	41.2%
Blue Shield of CA	15.6%
Anthem Blue Cross	14.3%
UnitedHealthcare	8.1%
Aetna	7.3%
Cigna	7.1%
Centene / Health Net	2.9%
LA Care	1.0%
Sharp	0.8%
Western Health Advantage	0.6%
Sutter	0.6%
Molina	0.3%
Valley Health Plan	0.3%
Total members	**17,243,069**

Figure 15 illustrates the range of TME PMPY growth rates across payers in the Commercial market. Total Commercial TME PMPY was $6,503 in 2022 and $6,829 in 2023, an increase of $326 or 5.0%. Among Commercial payers, TME PMPY growth rates ranged from -0.2% (LA Care) to 19.8% (Molina), with most payers experiencing growth between 4.0% and 6.0%. TME PMPY growth rates for Kaiser and Blue Shield of California, which combined account for more than half of the Commercial market, were 4.3% and 5.2%, respectively.

Figure 15. Commercial Payer Total Medical Expense Per Member Per Year Spending Growth, 2022-2023

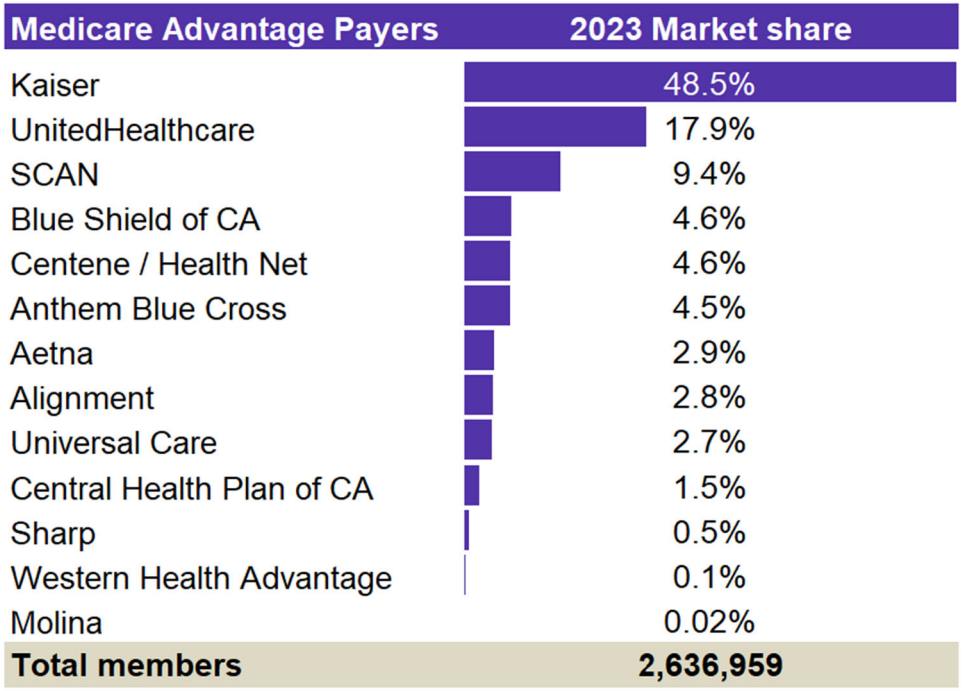


CA = California; LA Care = Local Initiative Health Authority for Los Angeles County
Note: Growth rates are gross of pharmacy rebates.

Medicare Advantage

As shown in Figure 16, Medicare Advantage plans covered about 2.6 million Californians in 2023. Kaiser accounted for 48.5% of the Medicare Advantage market, UnitedHealthcare for 17.9%, and SCAN for 9.4%, collectively comprising approximately 76% of the Medicare Advantage market share.

Figure 16. Medicare Advantage Payer Market Share, 2023



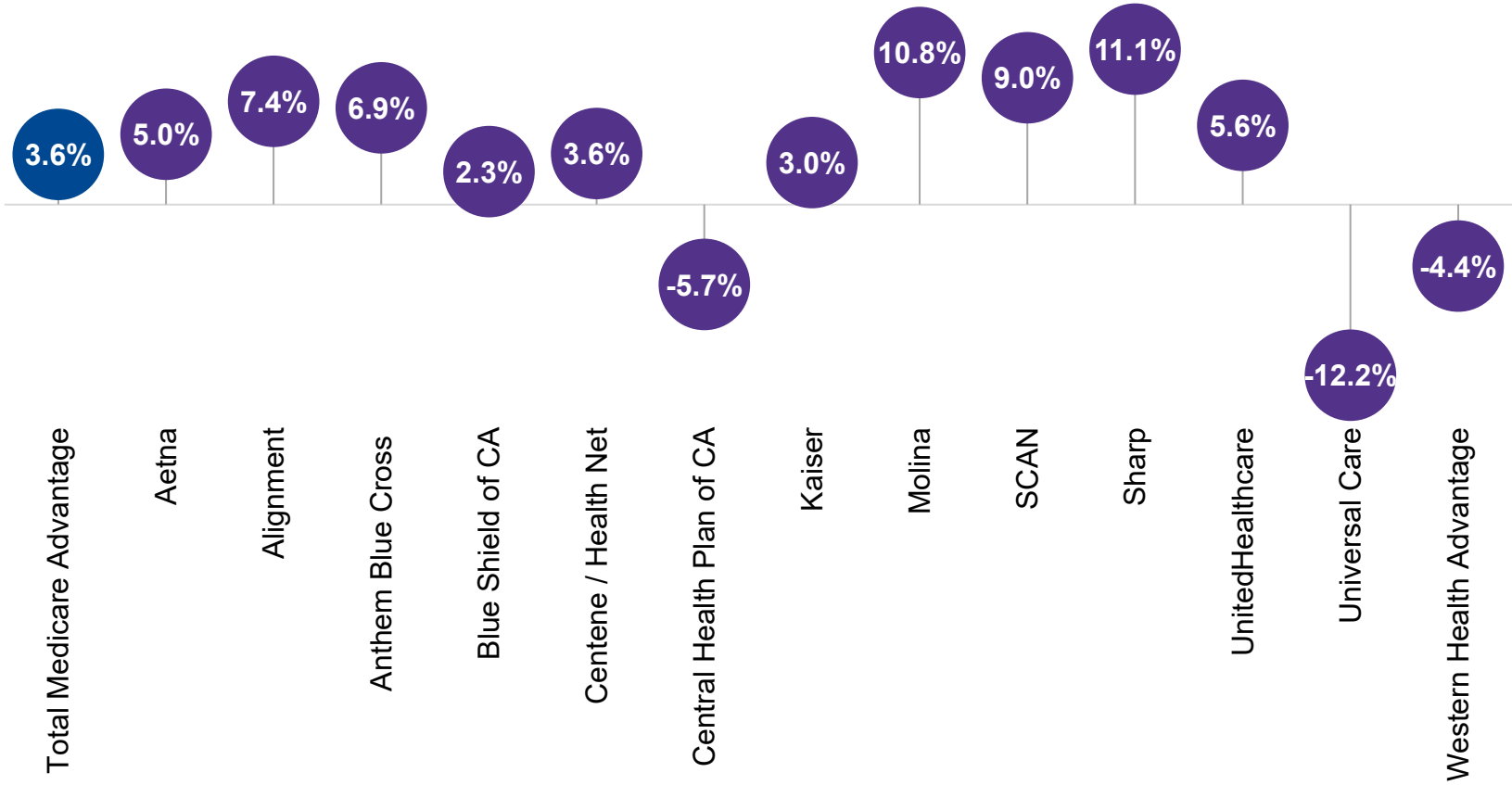
CA = California

As noted above, due to recent state policy changes to transition Medi-Cal enrollees eligible for both Medi-Cal and Medicare from Cal MediConnect plans to Medicare Medi-Cal plans, dual eligible members and members in D-SNP plans are excluded from Medicare Advantage PMPY spending calculations.[21] As shown in Figure 17, compared with payers in the Commercial market, Medicare Advantage payers exhibited higher variation in TME PMPY spending growth. Medicare

[21] California Department of Health of Health Care Services, Notice of Cal MediConnect to D-SNP transition

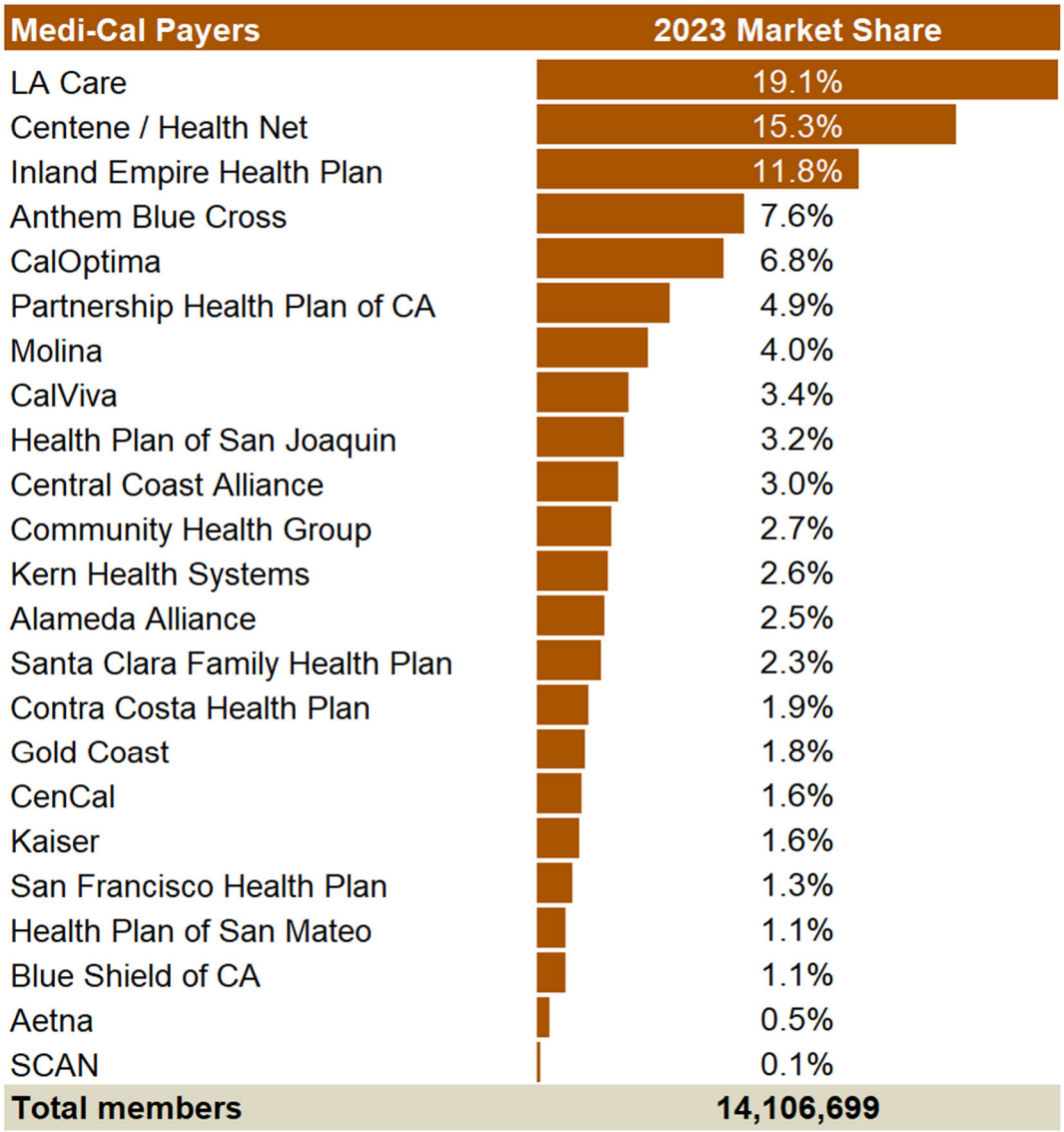
Advantage TME PMPY increased 3.6% between 2022 and 2023. Within the Medicare Advantage market, payer TME PMPY growth rates ranged from -12.2% (Universal Care) to 11.1% (Sharp). Kaiser and UnitedHealthcare, which when combined account for two-thirds of the Medicare Advantage market, experienced TME PMPY growth rates of 3.0% and 5.6%, respectively.

Figure 17. Medicare Advantage Total Medical Expense Per Member Per Year Spending Growth, 2022-2023



Note: Medicare Advantage data do not include spending for dual eligible members enrolled in both Medicare Advantage and D-SNPs.
CA = California; D-SNP = dual eligible special needs plans

Figure 18. Medi-Cal Managed Care Payers by Market Share, 2023



Medi-Cal Managed Care

Twenty-three payers served Medi-Cal Managed Care enrollees in 2022 and 2023.[22] As illustrated in Figure 18, LA Care holds the largest share of Medi-Cal Managed Care enrollment at 19.1%, followed by Centene / Health Net at 15.3%, Inland Empire Health Plan at 11.8%, and Anthem Blue Cross at 7.6%. Collectively, these four plans account for just over 50% of total Medi-Cal Managed Care enrollment.

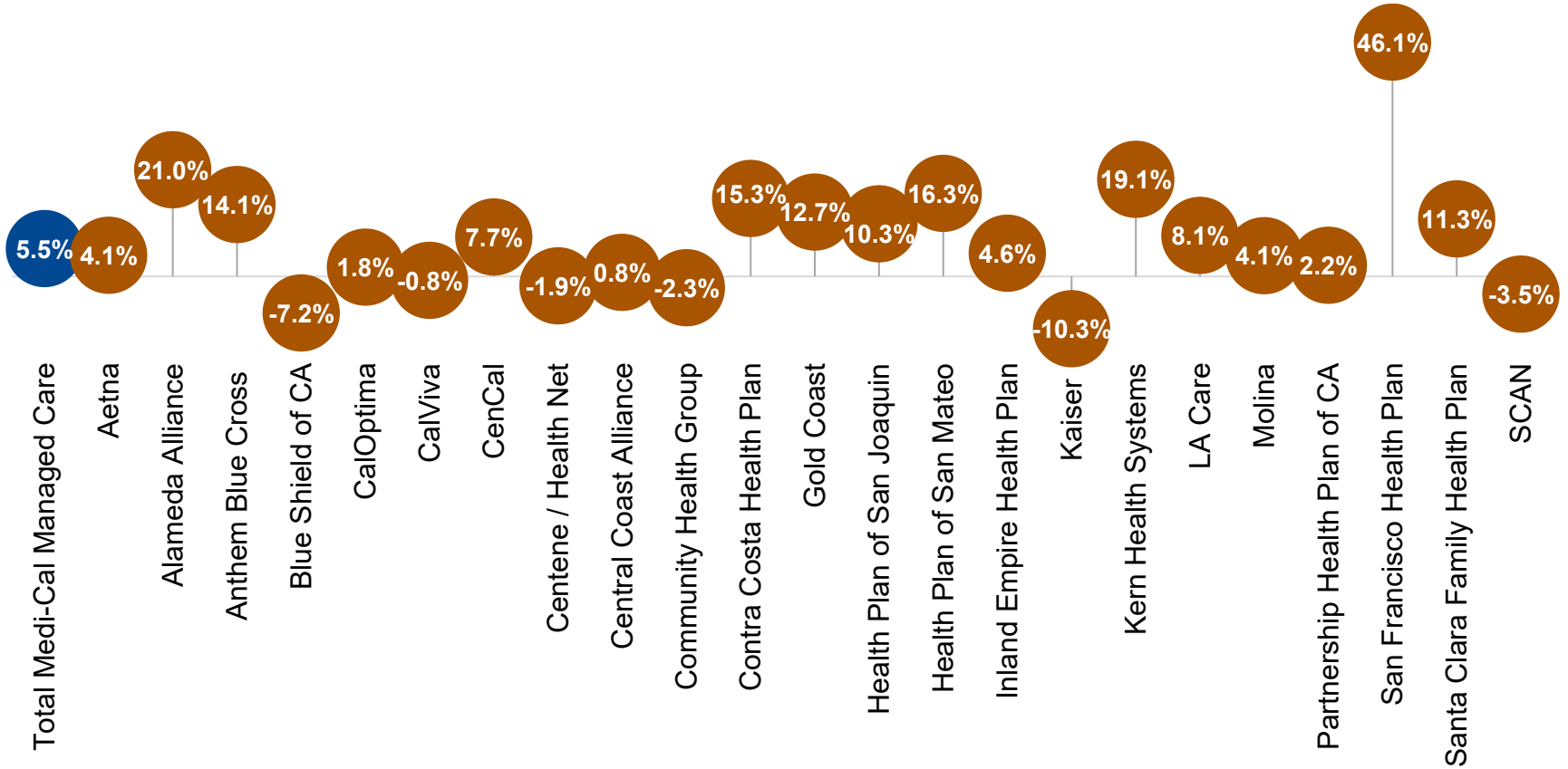
Medi-Cal Managed Care payers experienced an average TME PMPY growth rate of 5.5% from 2022 to 2023. As illustrated in Figure 19, growth varied considerably across individual plans, with San Francisco Health Plan reporting the largest increase at 46.1%. Other plans with large increases include Alameda Alliance (21.0%), Kern Health Systems (19.1%), and Health Plan of San Mateo (16.3%). Conversely, some plans saw reductions in TME, notably Kaiser (-10.3%) and Blue Shield of California (-7.2%). Unlike the Medicare Advantage market, dual eligible members are included in Medi-Cal Managed Care spending data below.

CA = California; LA Care = Local Initiative Health Authority for Los Angeles County.

[22] One additional Medi-Cal plan, AIDS Healthcare Foundation, is not shown given its small market share and specialized population.

Variation in Medi-Cal Managed Care Plans' TME may reflect statewide policy changes, including shifts in how DHCS administers covered benefits from year to year.

Figure 19. Medi-Cal Managed Care Total Medical Expense Per Member Per Year Spending Growth, 2022-2023



CA = California; LA Care = Local Initiative Health Authority for Los Angeles County

Health Care Spending by Category

This section shows TME by claims and non-claims spending categories, which may be used to identify areas of spending growth and inform analyses of cost drivers and variation.

Table 3 includes more detailed descriptions for claims and non-claims spending categories. Claims spending includes data for the following service categories: hospital inpatient, hospital outpatient, professional, long-term care, retail pharmacy (gross and net of rebates), and other claims services. Non-claims spending includes data for the following categories: capitation, population health and practice infrastructure payments, performance payments, payments with shared savings and recoupments, and other non-claims payments.

This section is limited to Commercial and Medicare data. Medicare FFS data is represented in claims spending categories, but Medicare FFS data are not available for non-claims spending categories. Medi-Cal data are not shown in this section because spending data are not available by the same categories as the data OHCA collected for Commercial and Medicare markets. Lastly, claims spending and non-claims spending categories are not available for Other spending (such as state correctional health, IHS, VHA and Medi-Cal and non-Medi-Cal program spending from the Department of Health Care Services).

Table 3. Claims and Non-claims Spending Categories

Category	Description
Claims Data	
Hospital inpatient services	Includes facility payments for inpatient services from claims. Includes all room and board and ancillary payments, emergency department visits that result in a hospital stay, and hospitalizations.
Hospital outpatient services	Includes facility payments for outpatient services from claims. Includes all hospital types and hospital-licensed satellite clinics, and emergency department visits that do not result in a hospital stay. This category does not include payments made for physician services during the outpatient service that were billed on a professional claim.
Professional services	Includes payments for services provided by a licensed practitioner, including but not limited to, services provided by a community health center, freestanding ambulatory surgical center, licensed physician and surgeon, nurse practitioner, physician assistant, physical therapist,

Category	Description
	occupational therapist, speech therapist, psychologist, licensed clinical social worker, dietician, dentist, and chiropractor.
Retail pharmacy services (gross and net of rebates)	Includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit, net of any coverage gap discount. This category does not include any prescription drugs covered under a medical benefit.
Long-term care services	Includes payments for long-term care services from claims. Includes skilled nursing facilities, nursing homes, intermediate care facilities, assisted living facilities, providers of home- and community-based services, and programs designed to assist individuals with long-term care needs who receive care in their home and community.
Other claims services	Includes claims not included in other claims categories (for example, durable medical equipment, optical services, transportation, and hospice).
Non-claims Data	
Capitation	Non-claims payments paid to health care providers and organizations to provide a defined set of services to a designated population of patients.
Population health and practice infrastructure payments	Non-claims payments paid to health care providers and organizations to support care delivery goals; not tied to specific performance metrics. This category does not include costs associated with payer personnel, payer information technology systems, or other internal payer expenses.
Performance payments	Non-claims bonus payments paid to health care providers and organizations for reporting data or achieving specific predefined goals for quality, cost reduction, equity, or another performance achievement domain.
Payments with shared savings and recoupments	Non-claims payments made to health care providers and organizations (or recouped from health care providers and organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including, but not limited to, episodes of care and total cost of care.
Other	Other non-claims-based payments paid for the reporting year.

Claims and Non-claims Spending

This section shows trends in claims and non-claims spending. Data presented are for the Commercial and Medicare Advantage markets, including dual eligible Medicare Advantage members and members in D-SNPs.

As shown in Figure 20, across Commercial and Medicare Advantage markets, claims spending grew from $107.7 billion in 2022 to $114.0 billion in 2023, an increase of $6.3 billion or 5.9%. Non-claims spending grew from $50.4 billion in 2022 to $53.9 billion in 2023, an increase of $3.5 million or 6.9%.

Figure 20. Commercial and Medicare Advantage Claims and Non-Claims Aggregate Spending in Billions and Spending Growth, 2022-2023

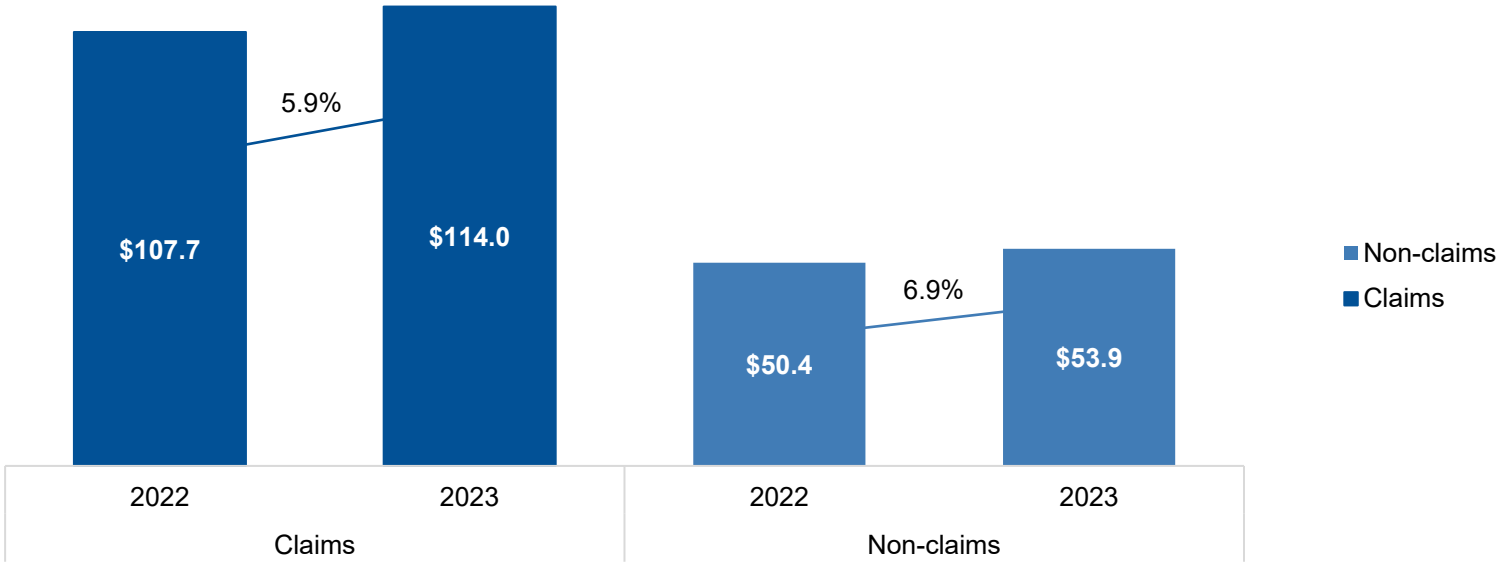
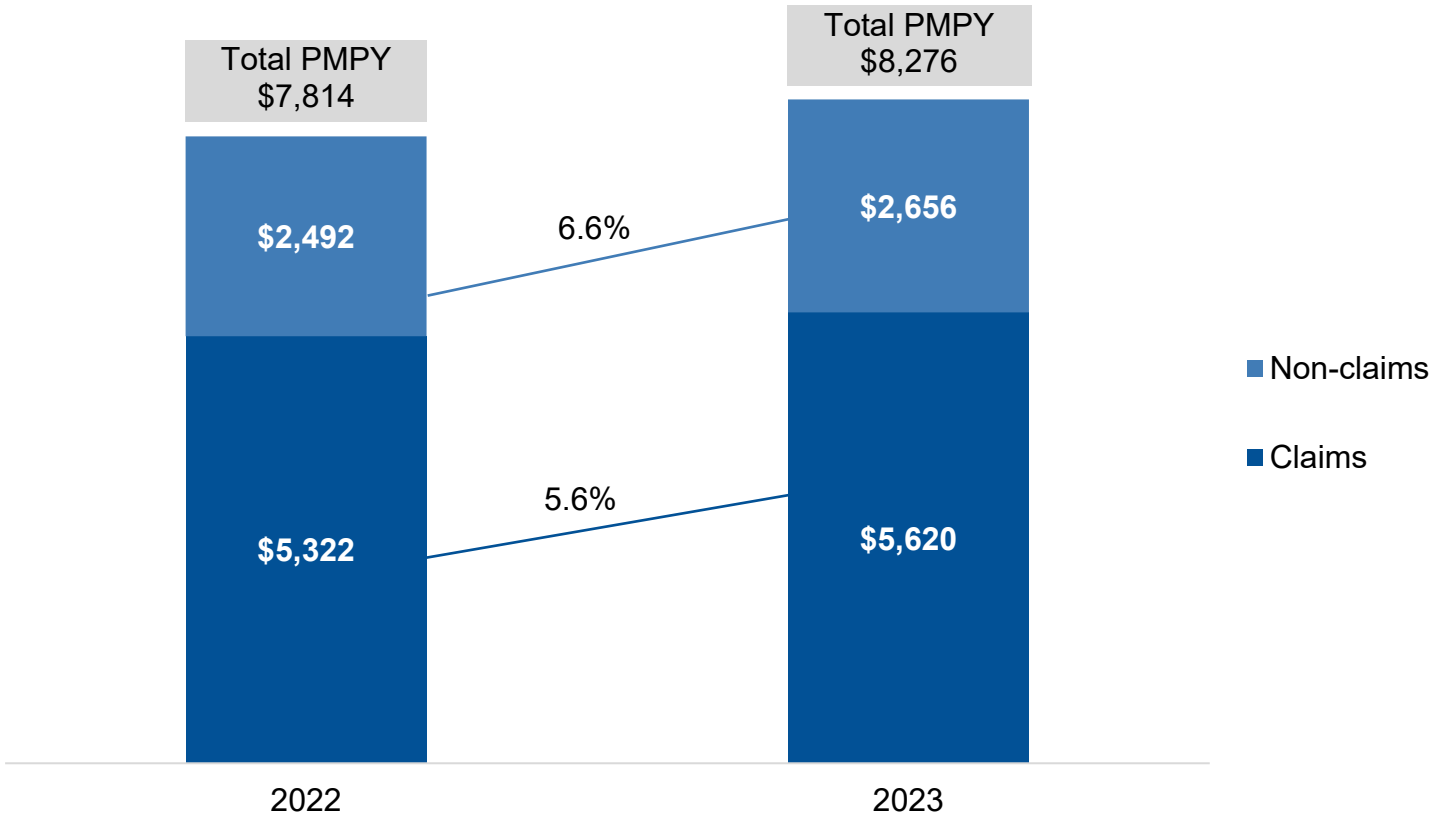


Figure 21 shows claims and non-claims PMPY spending across the Commercial and Medicare Advantage markets. Claims spending PMPY in 2022 was $5,322 and $5,620 in 2023, an increase of $298 or 5.6%. Non-claims spending PMPY in 2022 was $2,492 and $2,656 in 2023, an increase of $164 or 6.6%.

Figure 21. Commercial and Medicare Advantage Claims and Non-claims Per Member Per Year Spending and Trend, 2022-2023



Note: Because data is limited to Commercial and Medicare Advantage markets, total PMPY shown in this figure differs from statewide PMPY spending reported earlier.

Non-claims Spending

Table 4 shows the breakdown of all non-claims spending across the Commercial and Medicare Advantage markets, including D-SNPs. All non-claims spending was $50.42 billion in 2022 and $53.88 billion in 2023, an increase of $3.46 billion or 6.9%.

- Non-claims capitation spending represented the largest share of all non-claims spending at 96%. Non-claims capitation spending was $48.14 billion in 2022 and $51.58 billion in 2023, an increase of $3.44 billion or 7.1%
- Other non-claims spending represented the second largest share of all non-claims spending at almost 4%. Other non-claims spending was $2.09 billion in 2022 and $2.12 billion in 2023, an increase of $24.4 million or 1.2%.
- Spending for shared savings payments was $69.6 million in 2022 and $78.3 million in 2023, an increase of $8.7 million or 12.5%.
- Performance payment spending was $91.2 million in 2022 and $77.0 million in 2023, a decrease of $14.1 million or 15.5%.
- Population health spending was $26.2 million in 2022 and $31.1 million in 2023, an increase of $4.9 million or 18.8%.

Table 4. Commercial and Medicare Advantage Non-claims Spending in Billions, 2022-2023

Non-claim Category	2022	2023	% Change
Non-claims capitation	$48.1417	$51.5789	7.1%
Other non-claims	$2.0909	$2.1153	1.2%
Shared savings	$0.0696	$0.0783	12.5%
Performance payments	$0.0912	$0.0770	-15.5%
Population health	$0.0262	$0.0311	18.8%
All non-claims	**$50.4196**	**53.8806**	**6.9%**

Note: Data are pooled across the Commercial and Medicare Advantage markets, including dual eligible members and members in D-SNPs. Medicare Fee-for-Service non-claims spending is not included.

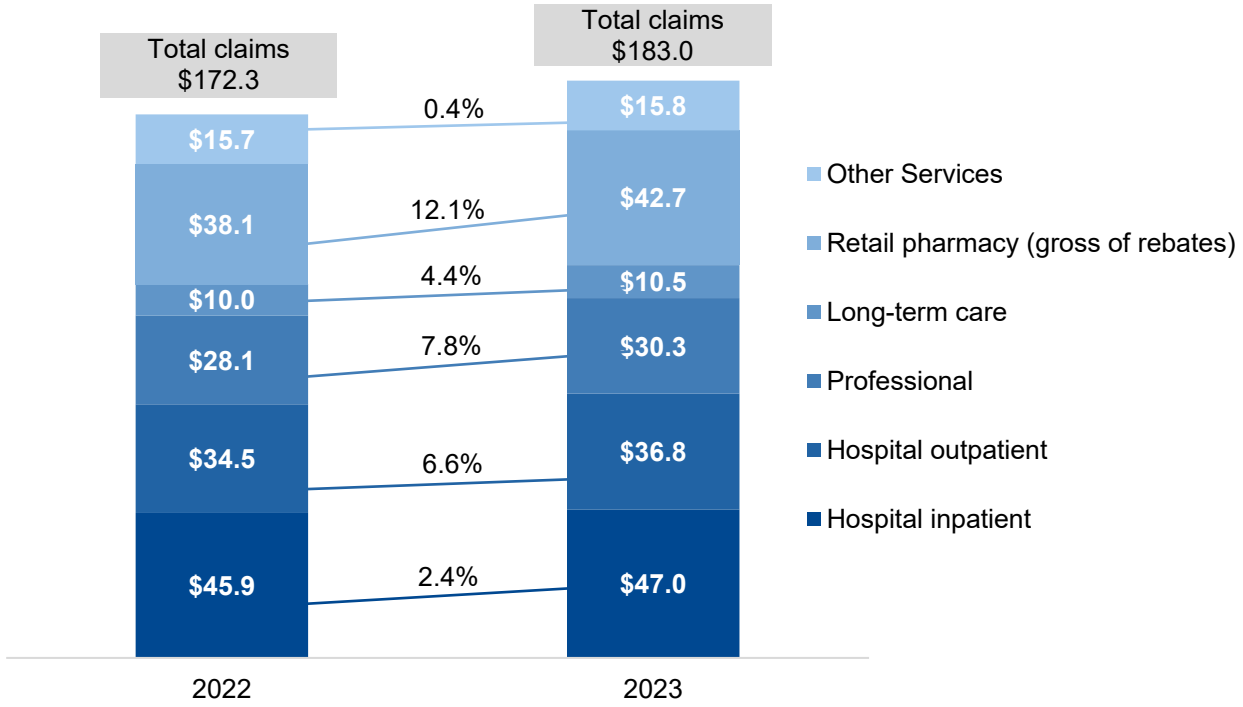
Claims Spending, by Service Category

Figure 22 shows total claims spending by service category across the Commercial and Medicare markets. In 2023, claims spending was distributed across the six service categories as follows:

- **Hospital inpatient services** represented the largest share of claims spending at 26%. Claims spending for hospital inpatient services in 2022 was $45.9 billion and $47.0 billion in 2023, an increase of $1.1 billion or 2.4%.
- **Retail pharmacy services** (gross of pharmacy rebates) represented the second largest share of claims spending at 23%. Claims spending for retail pharmacy services in 2022 was $38.1 billion and $42.7 billion in 2023, an increase of $4.6 billion or 12.1%.
- **Hospital outpatient services** accounted for 20% of claims spending. Claims spending for hospital outpatient services in 2022 was $34.5 billion and $36.8 billion in 2023, an increase of $2.3 billion or 6.6%.
- **Professional services** accounted for 17% of claims spending. Claims spending for professional services in 2022 was $28.1 billion and $30.3 billion in 2023, an increase of $2.2 billion or 7.8%.
- **Other claims services** accounted for 9% of claims spending. Claims spending for other claims services in 2022 was $15.7 billion and $15.8 billion in 2023, an increase of $69.5 million or 0.4%.
- **Long-term care services** accounted for 6% of claims spending.[23] Claims spending for long-term care services in 2022 was $10.0 billion and $10.5 billion in 2023, an increase of $438 million or 4.4%.

[23] The baseline report does not include standalone long-term care insurance and Medi-Cal Managed Care spending was not reported by service category. As a result, long-term care services account for a small proportion of total medical expense in the markets shown.

Figure 22. Commercial and Medicare Aggregate Claims Spending in Billions by Service Category, 2022-2023



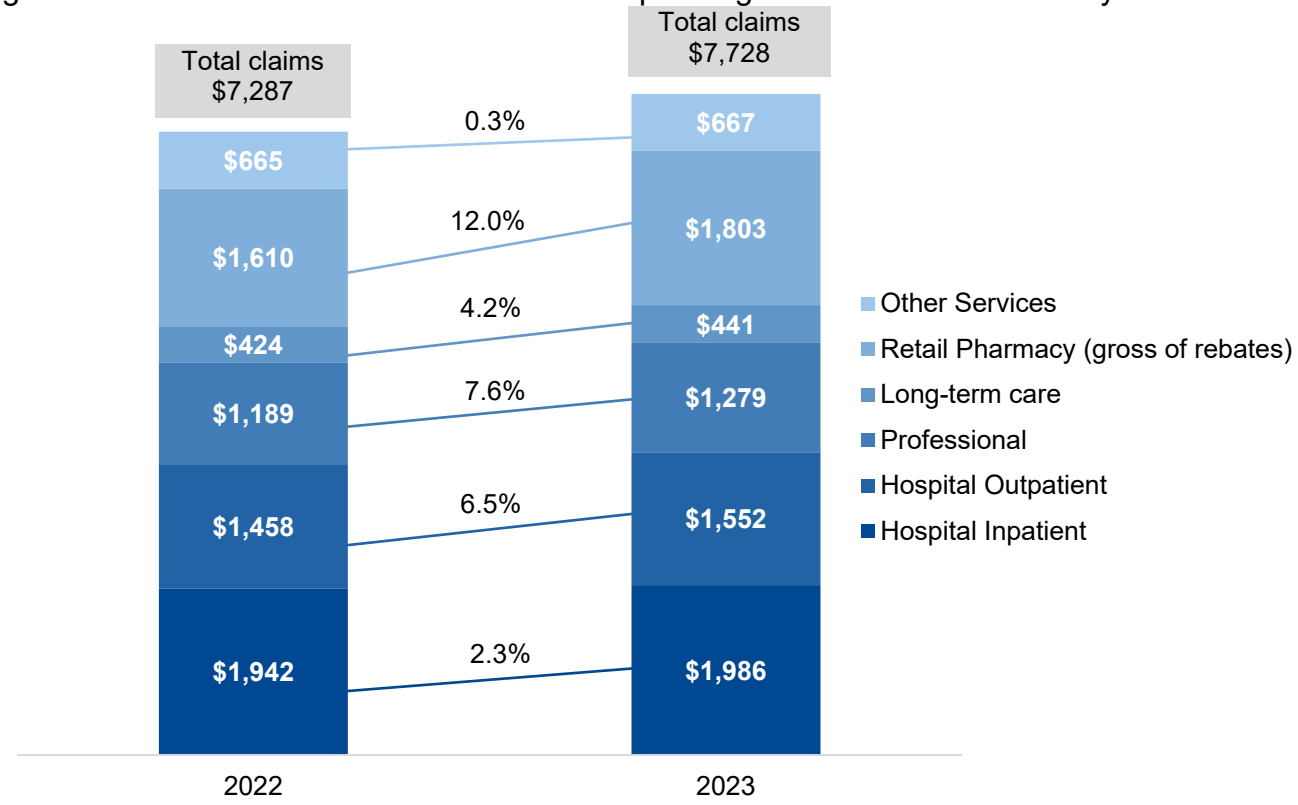
Note: Includes commercial and Medicare spending, including Medicare FFS, Medicare Advantage, and D-SNPs.
FFS = fee for service; D-SNPs = dual eligible special needs plans

Figure 23 shows the Commercial and Medicare claims spending PMPY by service category for 2022 and 2023. Total claims spending PMPY in 2022 was $7,287 and $7,728 in 2023, an increase of $441 or 6.1%. The following service categories had the highest spending growth:

- **Retail pharmacy** PMPY claims spending (gross of rebates) in 2022 was $1,610 and $1,803 in 2023, an increase of $193 or 12.0%.
- **Professional services** PMPY claims spending in 2022 was $1,189 and $1,279 in 2023, an increase of $90 or 7.6%.

- **Hospital outpatient services** PMPY claims spending in 2022 was $1,458 and $1,552 in 2023, an increase of $94 or 6.5%.

Figure 23. Commercial and Medicare Claims Spending Per Member Per Year by Service Category, 2022-2023



Note: Includes Commercial and Medicare spending, including Medicare FFS, Medicare Advantage, and D-SNPs.
D-SNP = dual eligible special needs plans; FFS = fee for service

Comparing TME PMPY and Spending Categories by Market

This section shows how spending categories varied across markets, highlighting the Commercial and Medicare markets, with Medicare broken out by Medicare Advantage non-duals and Medicare FFS markets. Dual eligible members and members in D-SNPs are excluded from Medicare Advantage data but are included in statewide figures.

Table 5 shows TME PMPY by market and disaggregated by claims and non-claims spending categories between 2022 and 2023. Medicare FFS data is represented in claims spending categories, while there is non-claims spending under Medicare FFS, data are not available for non-claims spending categories.

In 2023, Medicare FFS had the highest TME PMPY spending ($20,301), followed by Medicare Advantage non-duals ($15,679) and Commercial plans ($6,829).

The following highlights the larger categories of TME PMPY claims spending by market in 2023:

- **Commercial:** Hospital inpatient and outpatient spending represented the largest share of TME PMPY ($1,389 or 20% of spending, each) in 2023, followed by pharmacy spending (gross of rebates) ($1,125 or 16% of spending).
- **Medicare Advantage (non-duals):** Pharmacy spending (gross of rebates) represented the largest claims spending category in 2023 ($2,706 or 17% of spending), followed by hospital inpatient spending ($2,373 or 15% of spending) and hospital outpatient spending ($1,339 or 9% of spending).
- **Medicare FFS:** Hospital inpatient ($4,615 or 23% of spending), professional ($4,179 or 21% of spending), and pharmacy (gross of rebates) ($4,165 or 21% of spending) represented nearly two-thirds of TME PMPY in 2023.

For TME PMPY by market for non-claims spending, capitation represented the largest share of TME PMPY in 2023 for both the Medicare Advantage non-dual market ($6,946 or 44% of spending) and Commercial market ($1,696 or 25% of spending).

Table 5. Total Medical Expense Per Member Per Year Claims Spending by Market and Category, 2022-2023

Category	Statewide		Commercial		Medicare Advantage		Medicare FFS	
	2022	2023	2022	2023	2022	2023	2022	2023
Claims								
Hospital inpatient	$1,942	$1,986	$1,368	$1,389	$2,326	$2,373	$4,465	$4,615
Hospital outpatient	$1,458	$1,552	$1,295	$1,389	$1,249	$1,339	$2,474	$2,593
Professional	$1,189	$1,279	$752	$802	$732	$757	$3,800	$4,179
Long-term care	$424	$441	$62	$67	$405	$459	$2,255	$2,314
Pharmacy (gross of rebates)	$1,610	$1,803	$1,008	$1,125	$2,482	$2,706	$3,756	$4,165
Other	$665	$667	$380	$328	$556	$573	$2,174	$2,434
Non-claims								
Capitation	$2,379	$2,543	$1,606	$1,696	$6,744	$6,946	-	-
Other non-claims	$113	$113	$31	$32	$645	$526	-	-
Total (gross of rebates)	**$9,780**	**$10,384**	**$6,503**	**$6,829**	**$15,139**	**$15,679**	**$18,924**	**$20,301**

Note: Medicare FFS is not included in non-claim results. The Medicare Advantage market excludes dual eligible members and members in D-SNPs, though these members are included in statewide results and Medicare fee for service.
D-SNP = dual eligible special needs plans; FFS = fee-for-service

Figure 24 shows growth rates in TME PMPY and categories on a statewide basis and for the Commercial and Medicare markets between 2022 and 2023.

On a statewide basis, TME PMPY increased by 6.2% in 2023. TME PMPY grew in all service categories, particularly gross retail pharmacy spending (12.0%), professional spending (7.6%), and capitation spending (7.0%). These three categories accounted for 73% of the Statewide TME spending growth. Retail pharmacy spending represented the largest growth rate and was a consistent driver of growth in all markets.

Below are TME PMPY growth rates by market and category:

- **Commercial**: TME PMPY increased from $6,503 in 2022 to $6,829 in 2023, an increase of $326 or 5.0%. For the increase in TME PMPY, $94 or 28.8% of the growth was driven by increases in hospital outpatient spending. Commercial retail pharmacy spending (gross of rebates) increased TME PMPY by $117, accounting for 36% of commercial PMPY spending growth.
- **Medicare Advantage (non-duals)**: TME PMPY increased from $15,139 in 2022 to $15,679 in 2023, an increase of $540 or 3.6%. Gross retail pharmacy and capitation spending each contributed significantly to overall growth, increasing by $224 and $202 respectively, accounting for 42% and 37% of the total increase. Non-claims spending decreased by 18.6%, or $120.
- **Medicare FFS**: TME PMPY spending increased from $18,924 in 2022 to $20,301 in 2023, an increase of $1,377 or 7.3%. Retail pharmacy spending accounted for $410 or 30% of Medicare FFS TME PMPY spending growth.

Figure 24. Total Medical Expense Per Member Per Year Spending Growth by Market and Category, 2022-2023

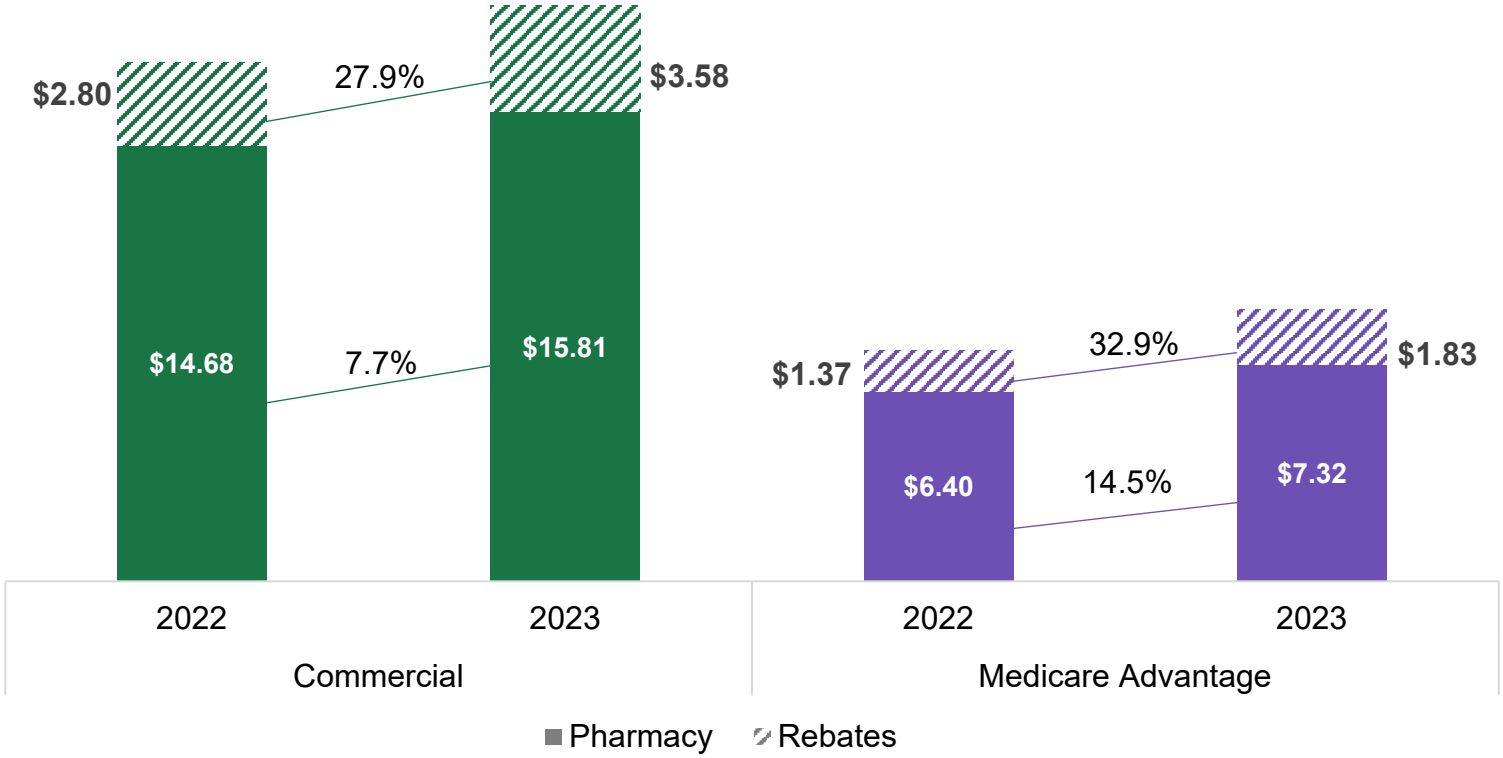
Category	Statewide	Commercial	Medicare Advantage, non-Duals	Medicare FFS
Hospital inpatient	2.3%	1.5%	2.0%	3.4%
Hospital outpatient	6.5%	7.3%	7.2%	4.8%
Professional	7.6%	6.6%	3.4%	10.0%
Long-term care	4.2%	8.5%	13.5%	2.6%
Pharmacy (gross of rebates)	12.0%	11.6%	9.0%	10.9%
Other	0.3%	-13.7%	3.0%	12.0%
Capitation	7.0%	5.6%	3.0%	
Non-claims, non-capitation	0.9%	4.2%	-18.6%	
Total	**6.2%**	**5.0%**	**3.6%**	**7.3%**

Note: Medicare FFS did not provide capitation, non-claims, or pharmacy rebate payments. Dual eligible members in Medicare Advantage plans and D-SNPs are excluded from Medicare Advantage results. Non-claims results exclude capitation.
D-SNP = dual eligible special needs plans; FFS = fee-for-service

Pharmacy Rebates

Figure 25 shows payers in the Commercial and Medicare Advantage markets received pharmacy rebates from drug manufacturers totaling $4.17 billion in 2022 and $5.40 billion in 2023, an increase of $1.23 billion or 29.5%. The rebate amounts in the Commercial market in 2022 were $2.80 billion and $3.58 billion in 2023, an increase of $780 million or 27.9%. The rebate amounts in the Medicare Advantage market in 2022 were $1.37 billion and $1.83 billion in 2023, an increase of around $450 million or 32.9%.

Figure 25. Commercial and Medicare Advantage Pharmacy Spending Gross and Net of Rebates in Billions by Market, 2022-2023



Note: The Medicare Advantage market includes dual eligible members and members in D-SNPs.
D-SNP = dual eligible special needs plans

Health Care Spending by Geographic Region

This section presents health care spending by region to identify areas with the highest growth rates. Geographic regions shown in this section include the 19 Covered California Rating Regions (RRs), with the Los Angeles County area (RR15 and RR16) further divided into eight sub-regions, or service planning areas (SPAs). Spending is assigned to regions based on members' residence address—for example, medical spending for a member who lives in Sacramento County is assigned to Rating Region 3 (RR03). Payers reported about 1% of enrollees living in unknown or unspecified regions, which are not shown. See Appendix A.5 for a crosswalk of Covered California Rating Regions to California Counties.

In this section, data is reported only for claims and capitation PMPY spending because these categories of spending can be attributed to specific members and in turn specific geographic regions. Note in earlier sections of this report, data on TME PMPY encompasses all claims and non-claims spending.[24]

Regional data include the Commercial and Medicare Advantage markets, including dual eligible members and members in D-SNP plans. This section does not include claims and capitation spending by region for Medi-Cal or Medicare FFS. OHCA obtained spending data for Medi-Cal and Medicare FFS from the Department of Health Care Services and the Centers for Medicare and Medicaid Services, respectively, and the data are not available at the level of region.

Claims and Capitation PMPY Spending and Growth by Geographic Region

Table 6 shows 2022 and 2023 PMPY spending trends by RR and SPA, pooled across the Commercial and Medicare Advantage markets. Spending was highest in the Los Angeles Antelope Valley SPA, at $10,934 PMPY in 2022 and $11,954 PMPY in 2023, an increase of $1,020 or 9.3% (the second highest regional growth rate). The Eastern Counties rating region experienced the highest regional PMPY spending growth rate, increasing from $7,315 in 2022 to $8,125 in 2023, a difference of $810 or 11.1%. The lowest PMPY spending and growth rate occurred in the Los Angeles-East SPA, increasing from $6,765 in 2022 to $7,024 in 2023, a difference of $259 or 3.8%.

[24] Non-claims payments, such as shared savings payments and incentive payments, are usually lump sum payments to the provider of medical care and therefore not attributed to specific members or, in turn, specific regions.

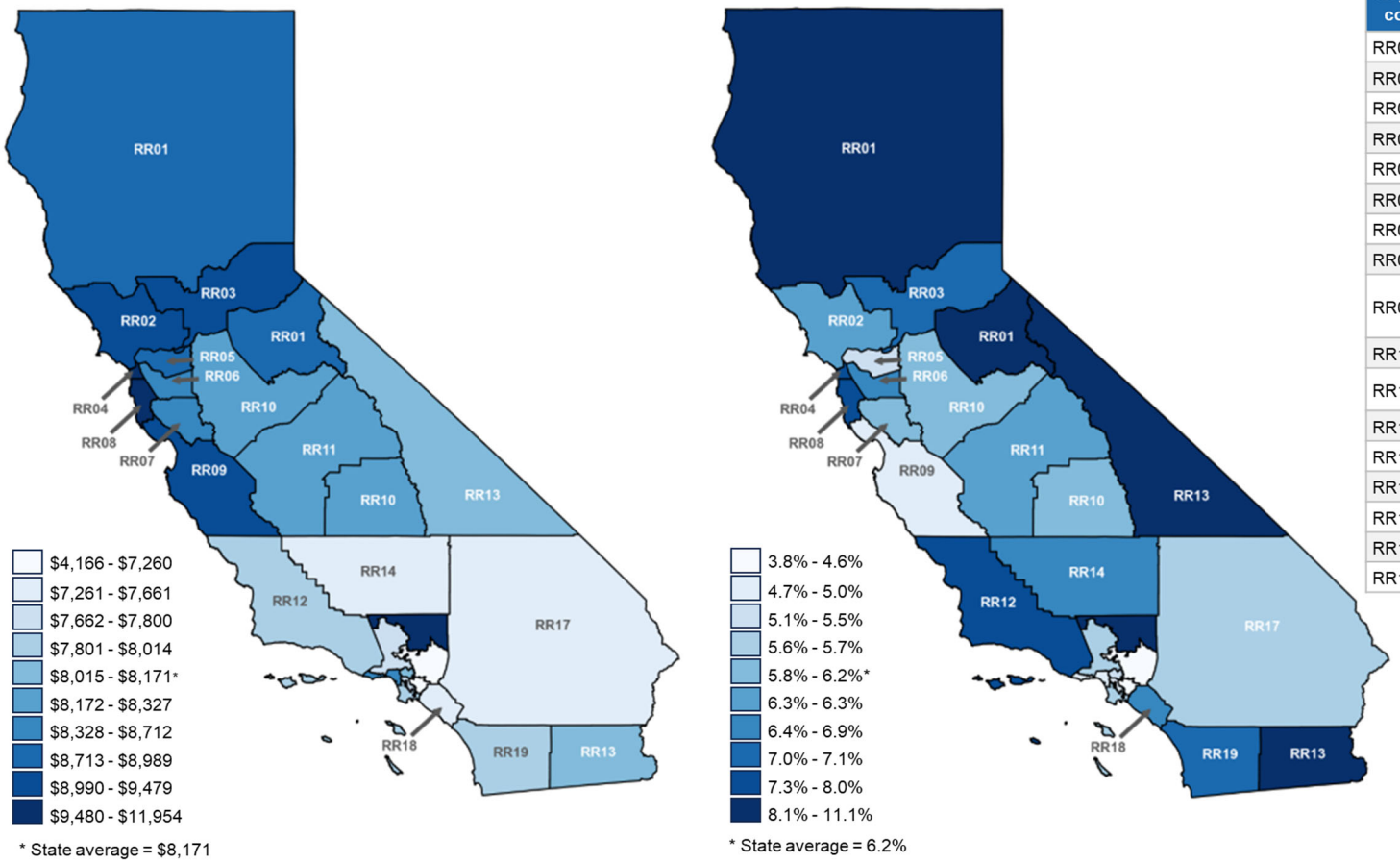
Table 6. Claims and Capitation Per Member Per Year Spending and Growth Rate by Geographic Region, 2022-2023

Region code	Region	PMPY		PMPY dollar change	PMPY growth rate
		2022	2023		
SPA1	Los Angeles: Antelope Valley	$10,934	$11,954	$1,020	9.3%
RR04	San Francisco County	$8,957	$9,600	$643	7.2%
RR08	San Mateo County	$8,849	$9,480	$631	7.1%
RR02	North Bay Area	$8,929	$9,478	$549	6.2%
RR03	Greater Sacramento	$8,665	$9,271	$606	7.0%
RR09	Santa Cruz, San Benito, Monterey counties	$8,583	$9,009	$426	5.0%
RR05	Contra Costa County	$8,485	$8,907	$422	5.0%
RR01	Northern counties	$8,126	$8,869	$743	9.1%
SPA5	Los Angeles: West	$8,298	$8,672	$374	4.5%
RR07	Santa Clara County	$7,995	$8,458	$463	5.8%
RR06	Alameda County	$7,860	$8,404	$544	6.9%
RR11	Fresno, Kings, Madera counties	$7,724	$8,211	$487	6.3%
RR10	Central Valley	$7,720	$8,176	$456	5.9%
SPA4	Los Angeles: Metro	$7,754	$8,148	$394	5.1%
RR13	Eastern counties	$7,315	$8,125	$810	11.1%
RR12	Central Coast	$7,406	$7,940	$534	7.2%
SPA8	Los Angeles: South Bay	$7,480	$7,874	$394	5.3%
RR19	San Diego County	$7,299	$7,810	$511	7.0%
SPA6	Los Angeles: South	$7,415	$7,761	$346	4.7%
SPA2	Los Angeles: San Fernando Valley	$7,328	$7,733	$405	5.5%
RR17	Inland Empire	$7,230	$7,643	$413	5.7%
RR18	Orange County	$7,000	$7,443	$443	6.3%
RR14	Kern County	$6,860	$7,322	$462	6.7%
SPA3	Los Angeles: San Gabriel Valley	$6,903	$7,168	$265	3.8%
SPA7	Los Angeles: East	$6,765	$7,024	$259	3.8%

Note: Regional PMPY spending and growth rates are based on claims and capitation spending; non-claims, administrative cost and profit, and pharmacy rebates are not included. RR15 and RR16 are broken out into Los Angeles SPAs. PMPYs are pooled across the Commercial and Medicare Advantage markets, including dual eligible members in D-SNPs. Regions are sorted from highest to lowest 2023 PMPY.
D-SNP = dual eligible special needs plans; PMPY = per member per year; RR = rating region; SPA = service planning area

Figure 26 shows variation in 2023 claims and capitation spending PMPY by region (left) and PMPY growth between 2022 and 2023 (right). Except for some select SPAs within Los Angeles County, PMPY spending tends to be higher in Northern California and lower in Southern California.

Figure 26. Claims and Capitation Per Member Per Year Spending (left) and Growth Rate (right) by Geographic Region, 2022-2023



Region code	Region name
RR01	Northern counties
RR02	North Bay Area
RR03	Greater Sacramento
RR04	San Francisco County
RR05	Contra Costa County
RR06	Alameda County
RR07	Santa Clara County
RR08	San Mateo County
RR09	Santa Cruz, San Benito, Monterey counties
RR10	Central Valley
RR11	Fresno, Kings, Madera counties
RR12	Central Coast
RR13	Eastern counties
RR14	Kern County
RR17	Inland Empire
RR18	Orange County
RR19	San Diego County

Note: PMPY spending and growth rates are based on claims and capitation spending; non-claims and pharmacy rebates are not included. Rates are pooled across the Commercial and Medicare Advantage markets, including dual eligible members in Medicare Advantage plans and D-SNPs. SPAs are not labeled.
D-SNP = dual eligible special needs plans; PMPY = per member per year; RR = rating region; SPA = service planning area

Promoting High Value System Performance

To promote high value health system performance, OHCA is responsible for performing several statutory requirements that reorient the health care system towards greater value, with the vision of creating a sustainable health care system that provides high-quality, equitable care to all Californians.[25] To that end, OHCA will:

- Measure the percentage of total health care spending allocated to primary care and set primary care investment benchmarks.
- Measure the percentage of total health care spending allocated to behavioral health and set behavioral health investment benchmarks.
- Set statewide goals for alternative payment model (APM) adoption and develop contracting standards to promote greater APM adoption.
- Adopt a single set of standard measures for assessing health care quality and equity across payers, fully integrated delivery systems, hospitals, and physician organizations.
- Develop standards to advance the stability of the health care workforce and monitor the effects of spending targets on workforce stability.
- Identify best practices for improving affordability while maintaining access, quality, and equity of care.

For each of the health system performance areas, OHCA receives regular input from sibling state departments, consumer advocates, health plans and insurers, providers, labor representatives, and other stakeholders. To inform the areas of APM and primary care and behavioral health investment, OHCA launched the Investment and Payment Workgroup[26] in June 2023, bringing together stakeholders representing providers, patients, academics and subject matter experts, state and private purchasers, sibling state departments, consumer advocates, hospitals and health systems, and health plans. OHCA presents proposals and recommendations for each area to the Health Care Affordability Advisory Committee and Health Care Affordability Board, and all proposals are shared for public comment.

[25] More information is available on OHCA's website: https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/
[26] https://hcai.ca.gov/affordability/ohca/ohca-investment-and-payment-workgroup/

When OHCA begins to publish annual reports, OHCA is required to report performance by health care entities on primary care and behavioral health spending, APM adoption, quality and health equity measures, and include a summary of best practices for improving affordability. The subsequent sections describe OHCA's efforts in these areas in more detail.

Primary Care Investment

In October 2024, the California Health Care Affordability Board approved the OHCA Primary Care Investment Benchmarks[27] to address historic underinvestment and shift greater health care resources toward primary care, and to promote improved health outcomes. The Board approved a statewide investment benchmark of 15 percent of total medical expense allocated to primary care for all payers by 2034 and an annual improvement benchmark of 0.5 percentage points to 1 percentage point per year increase in primary care spending during 2025-2033. The two related benchmarks for increasing primary care investment are shown in Table 7.

Table 7. Primary Care Annual Improvement Benchmark and 2034 Investment Benchmark

Performance Years	Annual Improvement Benchmark
2025-2033	0.5 – 1 percentage point per year for each payer by line of business and product type
Performance Year	**Investment Benchmark**
2034	15 percent statewide across all payers, lines of business, and product types

OHCA plans to report on baseline primary care spending in 2026, based on data for the 2023 and 2024 performance years, which will be collected in 2025. In 2027, OHCA will publish the first annual report of performance against the annual improvement benchmark, based on data for the 2024 and 2025 performance years, which will be collected in 2026. OHCA will continue to publish annual primary care spending reports thereafter. To guide its primary care policy and program development, OHCA plans to conduct additional analyses on primary care spending, such as by patient characteristics like age, and evaluate additional provider types for potential inclusion in OHCA's primary care spending definition.

[27] https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/primary-care-investment-benchmark/

Behavioral Health Investment

OHCA's work to establish a methodology for measuring behavioral health spending as a percentage of total health care spending and to set a behavioral health investment benchmark is ongoing in 2025. The behavioral health investment benchmark is intended to promote systemwide investment and improved outcomes in behavioral health. OHCA anticipates presenting a proposed behavioral health investment benchmark to the Board for approval in summer 2025.

OHCA anticipates beginning data collection for behavioral health spending in 2026, for 2024 and 2025 performance years. Spending measurement and benchmark performance will be reported in 2027 as part of OHCA's first annual report. Reports will be published annually thereafter.

APM Adoption

The Health Care Affordability Board approved the OHCA Alternative Payment Model (APM) Standards and Adoption Goals[28] in June 2024 to promote the shift from fee-for-service payments to APMs that provide financial incentives for equitable, high-quality, and cost-efficient care. The APM Adoption Goals are described in Table 8. The APM Standards provide a set of ten best practices to approach contracting decisions between payers and providers that are common across APMs. In 2027, OHCA plans to report progress towards the APM Adoption Goals for the 2026 performance year. In addition to reporting the percent of members in APMs, reporting may include measures such as percent of dollars paid via APMs, and percent of primary care spend paid via capitation.

[28] https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/apm-standards-and-adoption-goals/

Table 8. APM Adoption Goals*

Year	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	25%	55%	55%
2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	45%	65%	75%
2034	95%	60%	75%	95%

*Percent of Members Attributed to Health Care Payment Learning & Action Network (HCP-LAN) Category 3 (APMs with Shared Savings or Risk) and Category 4 (Population-Based Payment) by Payer and Product Type.
APM = alternative payment model; HMO = health maintenance organization; PPO = preferred provider organization

Workforce Stability

OHCA is charged with monitoring the effects of spending targets on health care workforce stability, high-quality jobs, and training needs of health care workers, with the goal that workforce shortages do not undermine health care affordability, access, quality, equity and culturally and linguistically competent care. OHCA adopted its Workforce Stability Standards,[29] with input from the Board in June 2024. The Workforce Stability Standards are a set of six best practices that health care entities should adopt to ensure stability of the health care workforce in the context of spending targets.

OHCA will monitor the effects of spending targets on the health care workforce using its Workforce Stability Metrics.[30] OHCA is exploring additional data sources to complement its Workforce Stability Metrics including enhancing HCAI's workforce data collection. OHCA plans to release a report in 2026 summarizing findings from its workforce monitoring and will continue to report annually thereafter.

[29] https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/workforce-stability/
[30] https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/workforce-stability/

Quality and Equity Performance

OHCA will use its Quality and Equity Measure Set, adopted in April 2025, to monitor changes in quality and equity as health care entities work to meet spending targets, promote high quality and more equitable care, and track progress towards OHCA's goals to improve access, affordability, and equity for all Californians. OHCA adopted all or a subset of three publicly available measure sets and their stratification requirements, and combined, these measure sets make up the OHCA Quality and Equity Measure Set.[31] The measure set relies on publicly available data and uplifts measure sets developed through intensive multi-stakeholder processes.

In 2027, OHCA will publish the first annual report with quality and equity performance. OHCA will continue to publish annual quality and equity performance reports thereafter. OHCA will explore including additional equity analyses such as analyses on population health measures by other state departments, data from California-specific reports, information from social drivers of health indices, and data from national reports to provide additional context for interpreting and understanding performance on the OHCA Quality and Equity Measure Set.

Cost-Reducing Strategies

OHCA is working with health plans, hospitals, physician organizations, and other health care entities to highlight examples of cost-reducing strategies[32] – efforts to reduce costs while maintaining access, quality, and equity of care. In 2024, OHCA collaborated with various health care entities to present their cost-reducing strategies to the Health Care Affordability Board and the Health Care Affordability Advisory Committee. Two health plans, two health systems, one medical group, and one Federally Qualified Health Center (FQHC) presented to the Board and Advisory Committee. The strategies presented ranged from advanced primary care models and using doulas for better birth outcomes to selecting the most appropriate site of care for a patient to have a procedure (e.g., performing a colonoscopy in a community-based outpatient center versus a hospital outpatient department, if clinically appropriate). OHCA continues to solicit cost-reducing strategies from health care entities to present to its Board and Advisory Committee.

[31] For payers, OHCA adopted the full Department of Managed Health Care's Health Equity and Quality Measure Set and stratification requirements. For physician organizations, OHCA adopted a subset of the Center for Data Insights and Innovation's Office of the Patient Advocate Health Care Quality Report Card measures. For hospitals, OHCA adopted the full HCAI Hospital Equity Measures Reporting Program measure set and stratification requirements. Fully integrated delivery systems will be measured across all three measure sets.

[32] https://hcai.ca.gov/affordability/ohca/cost-reducing-strategies/

Conclusion

Rising health care costs place significant financial strain on consumers, employers, and the state and federal government, underscoring the need to create a more sustainable health care system that prioritizes affordability, access, quality, and equity. This Baseline Report increases public transparency on spending levels and trends prior to the implementation of OHCA's statewide spending target, which is effective for performance years 2025-2029. California's per capita total health care expenditures increased by 8.4% for the baseline period from 2022 to 2023. Growth in spending varied across markets, payers, regions, and service categories between 2022 and 2023. Total health care expenditures per member per year growth for Medi-Cal and Medicare averaged 2.9% and 5.4%, respectively, compared with an average of 6.4% for Commercial payers. Retail pharmacy, professional, and hospital outpatient services contributed to the largest increases in spending growth across service categories for both Commercial and Medicare markets, similar to trends observed in other states. In future reports, OHCA will further analyze cost drivers and variation in health care spending and contextualize trends in California.

Because the spending target is a shared expectation to meet annual rates of growth for per capita health care spending, slowed spending growth will require complementary actions by health care entities to partner on cost-reducing strategies while maintaining or improving quality and equity. OHCA is steadfastly implementing efforts that work in tandem with the spending target to advance a high value health system, include measuring quality, equity, adoption of alternative payment models, and promoting investment in primary care, behavioral health, and workforce stability. As health care entities collectively focus on achieving cost-effective, high-quality care, the goal is for California to achieve a more sustainable and equitable health care system for all.

Appendix A. Methods and Data Sources

A.1 Data Sources

Total Health Care Expenditures Data Submissions

Commercial, Medicare Advantage, and D-SNP payers and fully integrated delivery systems (FIDS) directly submitted total medical expense (TME) and enrollment data to OHCA via OHCA's data submission process. Mandatory data submitters provided these files in the fall of 2024. Mandatory submitters are those with at least 40,000 members in either the Commercial or Medicare Advantage markets, where D-SNPs are part of Medicare Advantage.[33] In addition to TME data, select submitters also reported administrative costs and profits data for self-insured commercial plans.

Other Data Sources

For the commercial fully insured market, OHCA collected administrative costs and profits amounts from CMS Center for Consumer Information and Insurance Oversight (CCIIO) Medical Loss Ratio data.

For the Medicare Advantage market, OHCA used two data sources to calculate administrative costs and profits. For large insurers, OHCA used Medical Loss Ratio data collected by CCIIO. For small Medicare Advantage payers, who are not required to submit data to CCIIO, OHCA used data from plans' annual financial filings (Schedule L, in particular) with the California Department of Managed Health Care (DMHC).

For Medi-Cal Managed Care data—including TME, administrative costs and profits, and member-level data—OHCA used Medical Loss Ratio reports that plans submit annually to the California Department of Health Care Services (DHCS).

For Medi-Cal fee-for-service (FFS) TME data, OHCA used Form CMS-64 (Quarterly Medicaid Statement of Expenditures) from the Medicaid Budget and Expenditure System (MBES).

[33]Reporting requirements for the Medi-Cal Managed Care market take effect with the annual data file submission due September 1, 2025. See Cal. Code Regs., tit. 22, § 97449, subd. (a)(1).

CMS provided Medicare FFS TME[34], including data for both Medicare FFS (Parts A and B) plans and TME from Medicare Drug Plans (Part D).[35]

Total Medi-Cal enrollment comes from data that DHCS publishes online.

For the category of Other spending for state and federal health care programs, the report includes TME data provided by the Veterans Health Administration (VHA), Indian Health Service (IHS), and California Correctional Health Care Services (CCHCS). The Other spending category also includes Medi-Cal and non-Medi-Cal program spending from the Department of Health Care Services.

Summarized data sources for all applicable markets are provided in Table 9.

Table 9. Data Sources

Market	Submarket	TME	Admin Costs & Profits	Population
Statewide	Not applicable	Sum of sources	Sum of sources	Census
Commercial	Not applicable	OHCA Payer Submissions	OHCA Payer Submissions (Self-insured only) and CCIIO MLR data	OHCA Payer Submissions
Medi-Cal [36]	Total	Sum of Managed Care and FFS	DHCS MLR reports (Managed Care only)	Data.cchs.ca.gov
	Managed Care	DHCS MLR reports	DHCS MLR reports	DHCS MLR reports[37]

[34] Dual eligibles and D-SNPs were excluded from Medicare Advantage and reported separately. However, Medicare FFS data includes dual eligibles, as they could not be disaggregated. As a result, some Medicare market totals may not be fully comparable.
[35] Note that Medicare Advantage plans included all associated Part D expenditures as pharmacy expenditures in their submission to OHCA. OHCA used data acquired from CMS to identify and report expenditures from standalone Part D plans.
[36] Medi-Cal data include dual eligible beneficiaries, as the available data did not allow for separation of duals from the broader Medi-Cal population.
[37] As of data submitted to DHCS by March 18, 2024

Market	Submarket	TME	Admin Costs & Profits	Population
	FFS	Form CMS-64 (Quarterly Medicaid Statement of Expenditures)	Not available	Not available[a]
Medicare	Advantage	OHCA Payer Submissions	CCIIO MLR data and DMHC Schedule L	OHCA Payer Submissions
	FFS	CMS FFS Expenditure File	Not available	CMS FFS Enrollment File – Parts A and/or B
D-SNP	Not applicable	OHCA Payer Submissions	Not available[b]	OHCA Payer Submissions
Other	CCHCS	Data extract from CCHCS dashboard	Not available	Data extract from CCHCS dashboard
	IHS	Congressional justification	Not available	Not available
	Medi-Cal and non-Medi-Cal program spending from DHCS	CA enacted budget	Not available	Not available
	VHA	VA Expenditure Report	Not available	VHA Expenditure Report

Note: All publicly available data sources are linked above.
[a] Medi-Cal FFS enrollment figures are not reported separately: Because Fee-for-Service (FFS) spending applies to both managed care and FFS enrollees, a distinct count of FFS-only enrollees is not available.
[b] D-SNP administrative costs and profits are included within Medicare Advantage.
CA = California; CCHCS = California Correctional Health Care Services; CCIIO = Center for Consumer Information and Insurance Oversight; CMS = Centers for Medicare and Medicaid Services; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care; D-SNPs = Dual Eligible Special Needs Plans; FFS = fee-for-service; IHS = Indian Health Service; MLR = Medical Loss Ratio; OHCA = Office of Health Care Affordability; TME = total medical expense; VHA = Veteran's Health Administration

A.2 Key Measures and Components of Spending

Total Medical Expense

TME is a comprehensive metric of health care spending that incorporates both claims and non-claims expenditures among accountable health plans. In short, TME includes payments made to providers of medical services, devices, and drugs. Payer-submitted TME data include payments through at least June 30, 2024 for services provided in 2022 and 2023.

TME is presented in terms of both total dollars spent and per member per year (PMPY) spending. PMPY allows for a more accurate comparison of year-over-year growth to smooth out any significant changes in underlying enrollment. TME can be categorized as either gross or net of pharmacy rebates for applicable markets and payers. In this report, TME is generally categorized gross of pharmacy rebates, except in the pharmacy rebates overview. The annual growth rate for both total dollars and PMPY is calculated for 2022 and 2023.

In addition to the expenditures captured in TME, THCE includes the costs to state residents associated with administration of health coverage, including payer profits. OHCA includes administrative costs and profits for Commercial, Medicare Advantage, and Medi-Cal Managed Care accountable plans – that is, plans administered by commercial rather than public entities. Like TME, THCE annual growth is calculated both for total dollars spent and PMPY spending.

Table 10 summarizes key measure calculations for each market.

Table 10. Key Measures

Market	Submarket	TME Gross	TME Net	Admin Costs & Profits	THCE
Commercial	Not applicable	Total Claims + Capitation and Full Risk payments + Total Non-Claims	TME Gross - Pharmacy Rebates	[Premiums earned – (incurred claims + fraud reduction expenses) + advanced payment of shared savings reductions[a] – MLR rebates – quality improvement expenses]	TME Gross + Admin Costs and Profits

Market	Submarket	TME Gross	TME Net	Admin Costs & Profits	THCE
				+ Admin Costs and Profits (Self-insured)[b]	
Medicare	Advantage	Total Claims + Capitation and Full Risk payments + Total Non-Claims	TME Gross - Pharmacy Rebates	Premiums earned – (incurred claims + fraud reduction expenses) + advanced payment of shared savings reductions – quality improvement expenses	TME Gross + Admin Costs and Profits
	FFS	Total program payments + cost sharing	TME Gross[c]	Not available	TME Gross
Medi-Cal	Managed Care	MLR Numerator - Pharmacy Rebates[d]	MLR Numerator	Total Revenue – Pass Through Payments – Managed Care Tax – TME Gross	TME Gross + Admin Costs and Profits
	FFS	Total FFS Claims + Total FFS Non-Claims - Pharmacy Rebates[d]	TME Gross + Pharmacy Rebates[d]	Not available	TME Gross
D-SNP	Not applicable	Total Claims + Capitation and Full Risk payments + Total Non-Claims	TME Gross - Pharmacy Rebates	Not available	TME Gross
Other	CCHCS	Total non-labor costs	Same as TME Gross[e]	Not available	Same as TME Gross[e]
	IHS	Total Program Expenditures	Same as TME Gross[e]	Not available	Same as TME Gross[e]

Market	Submarket	TME Gross	TME Net	Admin Costs & Profits	THCE
	Medi-Cal and non-Medi-Cal program spending from DHCS	Total DHCS Expenditures – THCE (Medi-Cal Managed Care) – THCE (Medi-Cal FFS)	Same as TME Gross[e]	Not available	Same as TME Gross[e]
	VHA	Total Medical Care Expenditures	Same as TME Gross[e]	Not available	Same as TME Gross[e]

Notes: Pharmacy rebates are netted out of TME consistent with respective data sources. For example, commercial payers submit rebates as positive values, which are subtracted from gross TME to calculate net TME. Alternatively, Medi-Cal Managed Care plans report pharmacy rebates as negative numbers in MLR reports and the amounts are then added to gross TME to calculate Net TME. Pharmacy rebates are not applicable to Medicare FFS or to markets in the 'Other' category.
[a] Expected to be $0.
[b] Included as an answer to mandatory questions in the payer data submissions.
[c] Pharmacy rebates not available.
[d] Pharmacy Rebates are reported as negative values for Medi-Cal FFS in Form CMS-64 and in Medi-Cal Managed Care Organization Medical Loss Ratio reports, unlike pharmacy rebates in payer submission data for the Commercial and Medicare Advantage Market where pharmacy rebates are reported as positive values.
[e] Pharmacy rebates and/or administrative costs and profits are not applicable or not available due to data source restrictions. Therefore, THCE = TME Net = TME Gross.
CCHCS = California Correctional Health Care Services; DHCS = Department of Health Care Services; D-SNP = dual eligible special needs plans; FFS = fee-for-service; IHS = Indian Health Service; MLR = Medical Loss Ratio; TME = total medical expense; THCE = total health care expenditures; VHA = Veterans Health Administration

Claims and Non-claims Spending Categories

For payers that submitted data directly to OHCA, claims spending is reported for each service category and non-claims category as defined in Table 3. Medicare FFS data were also reported by service category.

A.3 Exclusions

OHCA's statewide total health care expenditures exclude the following:

- Expenditures from non-accountable health plans. These are health plans with fewer than 40,000 covered lives in any market, i.e., Commercial, Medicare Advantage, or Medi-Cal managed care.
- Consumer payments for non-covered health care services, e.g., self-pay for California residents without health coverage and self-pay for services and providers not covered by a health plan or insurer.[38]
- Risk transfer payments among small and individual group plans within the fully insured commercial market.
- Medicare FFS Shared Savings and other Medicare FFS non-claims payments.
- Reinsurance recoveries.
- Medicare Advantage Risk Adjustment Data Validation payments.
- Medi-Cal Managed Care final hospital true up payments. At the end of the year, Medi-Cal provides true up payments to hospitals that adjust prospective payments to reflect actual costs incurred by the hospital.
- One Medi-Cal payer that only offered coverage in one of the two reporting years was excluded from payer-level reporting.
- Administrative costs and profits totals do not include costs from all self-funded commercial plans due to incomplete reporting.
- Administrative costs and profits for three accountable Medicare Advantage plans due to incomplete data availability.
- A portion of Commercial self-insured and Medicare Advantage THCE spending due to incomplete reporting.
- Medicare supplemental insurance.

[38]OHCA will evaluate the feasibility of a supplemental analysis that estimates consumer out of plan expenditures.

A.4 Data Validation

OHCA developed a submission process with automated within-file and cross-file validation checks that would reject files with invalid data—such as if the sum of spending by service category does not equal the value reported in total claims spending—or trigger a discussion with the payer if data failed programmed reasonableness checks—such as if capitation spending was reported on rows for non-capitation plan types. After completing automated validations, OHCA also conducted manual validations for reasonableness. Finally, OHCA held regular technical assistance workgroups and one-on-one meetings with data submitters to ensure data accuracy.

Data collected outside of payer submissions were compared with data from other secondary sources when available to confirm the accuracy of OHCA's approach. OHCA also assessed values for reasonableness before reporting.

A.5 Demographic Adjustment

The California Health Care Cost Trends Report 2022-2023-Databook (slated for publication in the summer of 2025) includes payer-level TME growth adjusted for age and sex, which can help account for population changes in the payer growth rates. For example, if the payer's population became older during year 2, applying age-sex adjustment would lower the payer's growth rate to account for the additional potential acuity of the aging population.

Payers submitted member month and expenditure data by age and sex categories to facilitate demographic adjustment. The following provides an illustrative example to demonstrate OHCA's approach to demographic adjustment.

To demographically adjust spending, OHCA first calculated weights based on the distribution of a submitter's members in 2022 within a given market, as reported in the payer-submitted data. For example, if females aged 18-44 comprised 20% of a submitter's commercial market population in 2022, that commercial group was assigned a weight of 0.20, as illustrated in Table 11.

OHCA then calculated PMPY payments for each age-sex group for each submitter within each market and year by dividing the sum of claims and capitation spending for that age-sex group by the number of members in the group.

OHCA then calculated adjusted PMPY for each age-sex group by multiplying the plan's spending PMPY from Step 2 by the weight from Step 1, as illustrated in

Table 12. Because weights are based on a submitter's member distribution in 2022, age-gender adjustment only changes 2023 PMPY values.

Because generally only claims and capitation payments are attributable to age-sex categories, unadjusted non-claims PMPY values were added to adjusted PMPY values to arrive at adjusted TME.[39] Adjusted TME PMPY values do not include pharmacy rebates.

Table 11. Age-sex Adjustment Weighting Example

Age group	Sex	2022 Members	Payer population weight
Ages 1-17	M	1,950	0.15
	F	1,950	0.15
Ages 18-44	M	2,600	0.20
	F	2,600	0.20
Ages 45-64	M	1,950	0.15
	F	1,950	0.15
Total		13,000	**1.00**

Note: Population counts presented here are for illustrative purposes only and do not reflect the true commercial population.

[39] Claims and capitation payment amounts reported on rows with 0 member months were also added to adjusted PMPY calculations at this step. Similarly, non-claims values reported on rows with >0 member months were included in adjusted PMPY values.

Table 12. Age-sex Payer Per Member Per Year Adjustment Example

Age group	Sex	2023 Members (A)	2023 Claims and Capitation spending (B)	Unadjusted 2023 Spending PMPY (C = B/A)	Payer 2022 population weight [a] (D)	Adjusted 2023 spending PMPY Total = sum(C × D)
Ages 1-17	M	1,900	$1,900,000	$1,000	0.15	$150
	F	1,800	$1,800,000	$1,000	0.15	$150
Ages 18-44	M	2,700	$2,430,000	$900	0.20	$180
	F	2,700	$3,240,000	$1,200	0.20	$240
Ages 45-64	M	2,000	$3,000,000	$1,500	0.15	$225
	F	2,000	$2,800,000	$1,400	0.15	$210
Total		13,100	$14,870,000	$1,135.11		$1,155

Note: Population counts and spending PMPY presented here for illustrative purposes only and do not reflect the true commercial population. Adjusted spending PMPY includes claims and capitation spending which are attributable to members based on their age and sex. Unattributable spending—such as non-claims spending—PMPY is added after calculating adjusted spending PMPY.

[a] From Table 11

A.6 Covered California Rating Regions to County Crosswalk

Table 13 shows which California counties map to each Covered California Rating Region in the Baseline Report regional analysis.

Table 13. Covered California Rating Region to California County Crosswalk

Rating Region	Counties
RR01	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
RR02	Marin, Napa, Solano, Sonoma
RR03	El Dorado, Placer, Sacramento, Yolo
RR04	San Francisco
RR05	Contra Costa
RR06	Alameda
RR07	Santa Clara
RR08	San Mateo
RR09	Monterey, San Benito, Santa Cruz
RR10	Mariposa, Merced, San Joaquin, Stanislaus, Tulare
RR11	Fresno, Kings, Madera
RR12	San Luis Obispo, Santa Barbara, Ventura
RR13	Imperial, Inyo, Mono
RR14	Kern
RR15	Los Angeles
RR16	Los Angeles
RR17	Riverside, San Bernardino

Rating Region	Counties
RR18	Orange
RR19	San Diego

Appendix B. Key Terms

Key Terms

Administrative costs and profits: A component of the total health care expenditures (THCE) calculation. The total sum of all expenses not included in the numerator of the medical loss ratio calculation under state or federal law, including, but not limited to, all of the following: (A) All categories of administrative expenditures; (B) Net additions to reserves; (C) Rate dividends or rebates; (D) Profits or losses; and (E) Taxes and fees.[40]

Attributed total medical expense: Total medical expense for covered health benefits during the reporting period attributed to physician organizations and broken out by market category, age, and sex.[41]

Capitation: A way of paying health care providers or organizations in which they receive a predictable, upfront, set amount of money to cover the predicted cost of providing care to a specified set of services for a given patient over a defined period.[42]

Claim: A request for payment that a provider sends to a health plan or insurer.[43]

Cost sharing: The amounts that members pay for covered health care services. Cost sharing includes copayments, deductibles, and co-insurance. Premium payments are not included in cost-sharing totals.[44]

Department: The Department of Health Care Access and Information (HCAI).[45]

Dual eligible special needs plans (D-SNPs): Medicare Advantage plans that provide specialized care and wrap-around services for dual eligible beneficiaries (eligible for both Medicare and Medicaid). D-SNPs must have a State Medicaid Agency Contract (SMAC) with DHCS and DHCS can choose whether to contract with D-SNPs. [46]

[40] Health & Saf. Code, § 127500.2, subd. (a).
[41] Category under which payers submitted spending data according to the Data Submission Guide, v.1.1.
[42] Adapted from Centers for Medicare and Medicaid Services (CMS) Key Concepts.
[43] Adapted from Oregon Health Authority's 2024 Sustainable Health Care Cost Growth Target Annual Report.
[44] Adapted from Oregon Health Authority's 2024 Sustainable Health Care Cost Growth Target Annual Report.
[45] Title 22, Division 7, Chapter 11.5, Article 2 of the California Code of Regulations.
[46] https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Eligible-Special-Needs-Plans-in-CA.aspx.

Fee-for-service (FFS): A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.[47]

Fully integrated delivery system: A system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services.[48] Currently, in California Kaiser Foundation Health Plan and affiliated medical groups and hospital system is the only entity that meets the definition.

Health insurer: An entity licensed to provide health insurance or specialized behavioral health-only policies, as defined in Section 106 of the Insurance Code.[49]

Health plan: A health care service plan or a specialized mental health care service plan as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). "Health plan" does not include a health care service plan that holds only a restricted or limited license under subdivision (a) of Section 1300.49 of Title 28 of the California Code of Regulations.[50]

Medi-Cal Managed Care plan: Medi-Cal Managed Care plans are HMOs which receive a set per member per month (capitation) payment to provide health services to Medi-Cal members through their network of providers.[51,52]

Market: The highest levels of categorization of the health insurance market. For example, Medicare FFS and Medicare Advantage plans are collectively referred to as the "Medicare market." Medi-Cal Fee-for-Service and Medi-Cal Managed Care are collectively referred to as the "Medi-Cal market." Individual, self-insured, small and large group, and student health insurance plan types are collectively referred to as the "commercial market."[53] In this report, other plan types are grouped into an "other" market category, including California Correctional Health Care Services (CCHCS), Indian Health Service (IHS), and Veterans Health Administration (VHA).

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[47] HealthCare.gov.
[48] Title 22, Division 7, Chapter 11.5, Article 2 of the California Code of Regulations.
[49] Ibid.
[50] Ibid.
[51] Adapted from DHCS.ca.gov
[52] Adapted from Medicaid.gov
[53] Adapted from the Connecticut Office of Health Strategy Cost Growth Benchmark Report CY 2022.

Members: The number of people served by a given payer or market. Payers that submitted data through the Total Health Care Expenditures (THCE) data portal submitted member months, or the number of months each member is enrolled. Using this variable, the number of members is calculated as member months divided by 12.

Non-claims spending: Includes payments from payers to providers outside of claims for specific health care services. These may include performance incentive payments, prospective payments (for example, capitation), payments to support care transformation (for example, patient-centered primary care home payments), shared savings, and other value-based payments. See Table 3 for list of non-claims spending categories and their definitions.[54]

Office: The Office of Health Care Affordability (OHCA) established by Section 127501 of the Health and Safety Code.[55]

Payer: A private or public health care payer, including the following:

(1) A health care service plan or a specialized mental health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 [commencing with Section 1340] of Division 2), or a Medi-Cal managed care plan contracted with the State Department of Health Care Services to provide full scope benefits to a Medi-Cal enrollee pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) A health insurer licensed to provide health insurance or specialized behavioral health-only policies, as defined in Section 106 of the Insurance Code.

(3) A publicly funded health care program, including, but not limited to, Medi-Cal and Medicare.

(4) A third-party administrator.

(5) Any other public or private entity, other than an individual, that pays or arranges for the purchase of health care services on behalf of employees, dependents, or retirees.[56]

Per capita: A measure of a given value for each person in a given population. This report looks at health care spending per California resident.

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[54] Adapted from Oregon Health Authority's 2024 Sustainable Health Care Cost Growth Target Annual Report.
[55] Title 22, Division 7, Chapter 11.5, Article 2 of the California Code of Regulations.
[56] Division 107, Part 2, Chapter 2.6 of the California Health and Safety Code.

Per member per year (PMPY): Health care spending per insured person per year. Members are included in the denominator regardless of whether they utilized services. Expressing spending as PMPY makes it more comparable across entities, regardless of the number of people served.

Pharmacy rebates: Statewide medical and retail pharmacy rebate data broken out by market category.[57]

Premium: The amount payers collect every month to provide health coverage.

Professional services: Medical services provided by professional practitioners, such as primary care physicians, nurse practitioners, therapists, and other specialists. Services include preventative care, diagnostics, and treatment.

Rating region: The geographic regions across which health plans can vary premiums. Beginning in 2014, the Affordable Care Act (ACA) allowed non-grandfathered health plans to vary the premiums they charge based only on the following factors: age, geographic rating area, and whether coverage is for an individual or a family. California has 19 geographic rating regions.

Regional total medical expense: Total medical expense for covered health care benefits during the reporting period broken out by geographic region (rating region or service planning area) and market category.[58]

Reporting year: The service year for which data files are being reported.[59]

Service category: A classification of health care services based on the type of care provided or how the care is delivered, such as hospital inpatient, hospital outpatient, retail pharmacy, long-term care, and professional services. See Table 3 for service category definitions.

Service planning area (SPA): Los Angeles County is divided into eight SPAs, each with its own Area Health Office. These distinct regions allow the Department of Public Health to develop and provide more relevant public health and clinical services targeted to the specific health needs of the residents in these different areas.[60]

[57] Category under which payers submitted spending data according to the Data Submission Guide, v.1.1.
[58] Category under which payers submitted spending data according to the Data Submission Guide, v.1.1.
[59] Title 22, Division 7, Chapter 11.5, Article 2 of the California Code of Regulations.
[60] County of Los Angeles Public Health Service Planning Areas.

Statewide total medical expense (TME): Total medical expense for covered health benefits during the reporting period across all market categories and contracting arrangements.[61]

Total health care expenditures (THCE): Total medical expense plus administrative costs and profits. The annual change in THCE PMPY or per capita is used to assess the overall growth rate of health care costs.[62]

THCE Data Submission Guide (or "the Guide"): The Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 1.1), dated June 2024. The Guide is available on, and may be downloaded from, the Department's website.[63]

Total medical expense (TME): All payments from payers to providers for reimbursement of the cost of health care, including medical claims, pharmacy claims, and non-claims payments.[64]

[61] Category under which payers submitted spending data according to the Data Submission Guide, v.1.1.
[62] Ibid.
[63] Ibid.
[64] Ibid.