Department of Health Care Access and Information

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

Interim Report: Health Care Spending Trends in California, 2023–2024

October 7, 2026

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Contents

Section 1. Executive Summary 5
Section 2. About HCAI, OHCA, and Rising Health Care Costs 7
Section 3. About this Report 14
Section 4. Health Care Spending Across Major Markets 2023-2024 18
Section 5. Total Non-Medical Expense (TNME) 20
Section 6. Health Care Spending by Payer 26
Section 7. Health Care Spending by Physician Organization 34
Section 8. Health Care Spending by Category 41
Section 9. Health Care Spending by Geographic Region 55
Section 10. Conclusion 64
Appendix A. Methods and Data Sources 65
A.1 Data Sources 65
A.2 Key Measures and Components of Spending 67
A.3 Exclusions 70
A.4 Data Validation 71
A.5 Process Attributed TME Data for Reporting Physician Organizations 71
A.6 Covered California Rating Regions to County Crosswalk 75
A.7 Total Non-Medical Expense Calculation 76
Appendix B. Key Terms 77

Tables

Table 1. California's Statewide Health Care Spending Target 13
Table 2. Commercial Market Use of Premiums by Line of Business, 2023-2024 24
Table 3. Payers by Market, 2024 26
Table 4. Physician Organizations by Market, 2024 35
Table 5. Share of Attributed TME and Members 36
Table 6. Claims and Non-claims Spending Categories 41
Table 7. Commercial and Medicare Advantage Non-claims Spending in Billions, 2023-2024 46
Table 8 Commercial and Medicare Claims Spending by Category in Billions, 2023-2024 46
Table 9. Total Medical Expense Per Member Per Year Spending by Market and Category, 2023-2024 49
Table 10. Commercial Claims and Capitation Per Member Per Year (PMPY) Spending and Growth Rate by Rating Region, 2023-2024 56
Table 11. Medicare Advantage Claims and Capitation Per Member Per Year (PMPY) Spending and Growth Rate by Rating Region, 2023-2024 61
Table 12. Data Sources 66
Table 13. Summarizes Key Measure Calculations for Each Market 68
Table 14. Sample Data Submission Guide Physician Organization Attribution Addendum 72
Table 15. Attribution Match Quality Results 73
Table 16. Covered California Rating Region to California County Crosswalk 75

Figures

Figure 1. Aggregate Health Care Expenditures Across Major Markets in Billions, Spending TME and TME Growth by Market 6

Figure 2. Total Medical Expense Per Member Per Year Spending and Spending Growth by Market, 2023-2024 7

Figure 3. Average Annual Growth Rates for Premiums and Deductibles for Private Sector Workers; and Median Household Income in California, 2004 – 2024 12

Figure 4. Components of Total Health Care Expenditures 15

Figure 5. Levels of Reporting: Major Markets, Plan Type and Other State and Federal Health Care Programs 17

Figure 6. Statewide Aggregate Total Health Care Expenditures in Billions, Spending TME and TME Growth by Market and Statewide Total Non-Medical Expense, 2023-2024 18

Figure 7. Total Medical Expense Per Member Per Year Spending and Spending Growth by Market, 2023-2024 19

Figure 8. Total Medical Expense Per Member Per Year Spending and Spending Growth by Commercial Plan Type, 2023-2024 20

Figure 9. Annual TNME in Billions by Market 21

Figure 10. Commercial Market Use of Premiums, 2023-2024 22

Figure 11. Total Commercial Non-Medical Expenses Per Member Per Year 23

Figure 12. Total Commercial Non-Medical Expenses 23

Figure 13. Distribution of Commercial Enrollment Across Large Group, Small Group and Individual Lines of Business 24

Figure 14. Commercial Payer Market Share, 2024 28

Figure 15. Commercial Payer Total Medical Expense Per Member Per Year Spending Growth, 2023-2024 29

Figure 16. Medicare Advantage Payer Market Share, 2024 30

Figure 17. Medicare Advantage Total Medical Expense Per Member Per Year Spending Growth, 2023-2024. 31

Figure 18. Medi-Cal Managed Care Plans by Market Share, 2024 32

Figure 19. Medi-Cal Managed Care Total Medical Expense Per Member Per Year Spending Growth, 2023-2024 33

Figure 20. Commercial Physician Organization Market Share, 2024 37

Figure 21. Commercial TME PMPY Spending Growth by Selected Physician Organizations, 2023-2024 38

Figure 22. Medicare Advantage Market Share of Selected Physician Organizations, 2024 39

Figure 23. Medicare Advantage TME PMPY Spending Growth by Selected Physician Organizations, 2023-2024 40

Figure 24. Commercial and Medicare Advantage Claims and Non-Claims Aggregate Spending in Billions and Spending Growth, 2023-2024 44

Figure 25. Commercial and Medicare Advantage Claims and Non-claims Per Member Per Year Spending and Trend, 2023-2024 45

Figure 26. Total Medical Expense Per Member Per Year Spending Growth by Market and Category, 2023-2024 50

Figure 27. Commercial and Medicare Advantage Pharmacy Spending Gross and Net of Rebates in Billions by Market, 2023-2024 51

Figure 28. Commercial Rebate Share of Pharmacy Expenditures, 2023-2024 52

Figure 29. Medicare Advantage Rebate Share of Pharmacy Expenditures, 2023-2024 53

Figure 30. Commercial Member Responsibility and Insurance Covered Spending by Product Type, PMPY, 2023 - 2024 54

Figure 31. Commercial Claims and Capitation Per Member Per Year (PMPY) Spending by Rating Region, 2024 58

Figure 32. Commercial Claims and Capitation Growth Rate by Rating Region, 2023-2024 59

Figure 33. Medicare Advantage Claims and Capitation Per Member Per Year (PMPY) Spending by Rating Region, 2024 62

Figure 34. Medicare Advantage Claims and Capitation Growth Rate by Rating Region, 2023-2024 63

Section 1. Executive Summary

Building on OHCA's Baseline Report released in June 2025, which covered calendar years 2022 and 2023, this interim report provides a second assessment of health care spending in California prior to the statewide spending target taking effect for performance year 2025. Focusing on trends from 2023 to 2024, the interim report shows spending and changes in spending by region, market, payer, physician organization, and service category. Importantly, market-level totals are not directly comparable to the Baseline Report due to the exclusion of several categories of Medi-Cal spending, including Managed Care Organization (MCO) tax, pass-through payments, certain amounts related to state directed payments, Medi-Cal FFS, and other non-Medi-Cal spending from DHCS.

Health care spending in California has been steadily increasing, making health coverage less affordable and placing a growing financial burden on households, employers, and public programs. Premium contributions and out-of-pocket costs for insured individuals have consistently grown every year, exacerbating continued challenges to affordability and access to health care. To address this trend, in April 2024, the California Health Care Affordability Board approved a statewide health care spending target to help slow spending growth while maintaining quality and access to care. The Board based the target on historical changes to median household income to emphasize that health care costs should not grow faster than the income of California families.

Each year, the Office of Health Care Affordability (OHCA) collects, analyzes, and reports data from payers and other state and federal data sources to present California's health care spending levels and growth trends. These annual reports serve as a resource for stakeholders to recognize opportunities 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 report on calendar years 2023 and 2024 describes changes in health care spending across the three major markets (i.e., Commercial, Medicare and Medi-Cal Managed Care), including total medical expense (TME) and health plan total non-medical expenses (TNME) Later this year, OHCA will publish a report that addresses initiatives to improve health system performance, including primary care spending and alternative payment model adoption in California.

Between 2023 and 2024, aggregate TME changed as follows for the three major markets: Commercial spending grew 7.1%, Medicare spending grew 9.4%, and Medi-Cal Managed Care spending grew 19.0%. When measured per member per year, TME varied across the three major markets. Commercial TME PMPY was $6,984 in 2023 and $7,532 in 2024, an

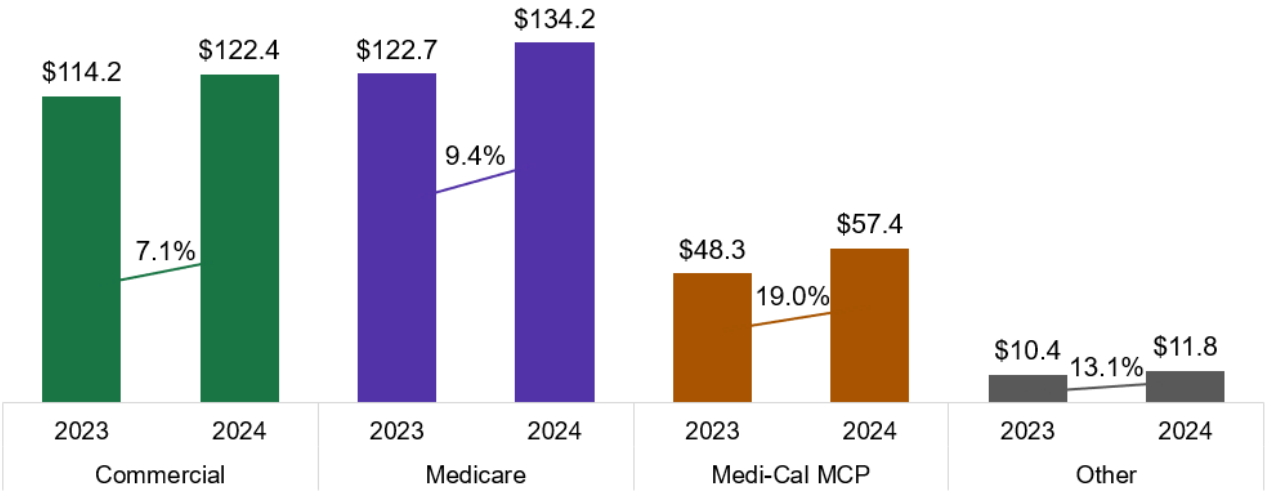
increase of $548 or 7.8%. Medicare TME PMPY was $18,532 in 2023 and $19,830 in 2024, an increase of $1,298 or 7.0%. Medi-Cal Managed Care TME PMPY was $3,420 in 2023 and $4,108 in 2024, an increase of $688 or 20.1%.

Health Care Spending Growth from 2023 to 2024

Changes in Aggregate TME by Market:

- **Commercial** spending grew 7.1%.
- **Medicare** spending grew 9.4%.
- **Medi-Cal Managed Care** spending grew 19.0%.
- **Other** state and federal health care program spending (California Correctional Health Care Services, Indian Health Services, and Veterans Health Administration) grew 13.1%.

Figure 1. Aggregate Health Care Expenditures Across Major Markets in Billions, Spending TME and TME Growth by Market



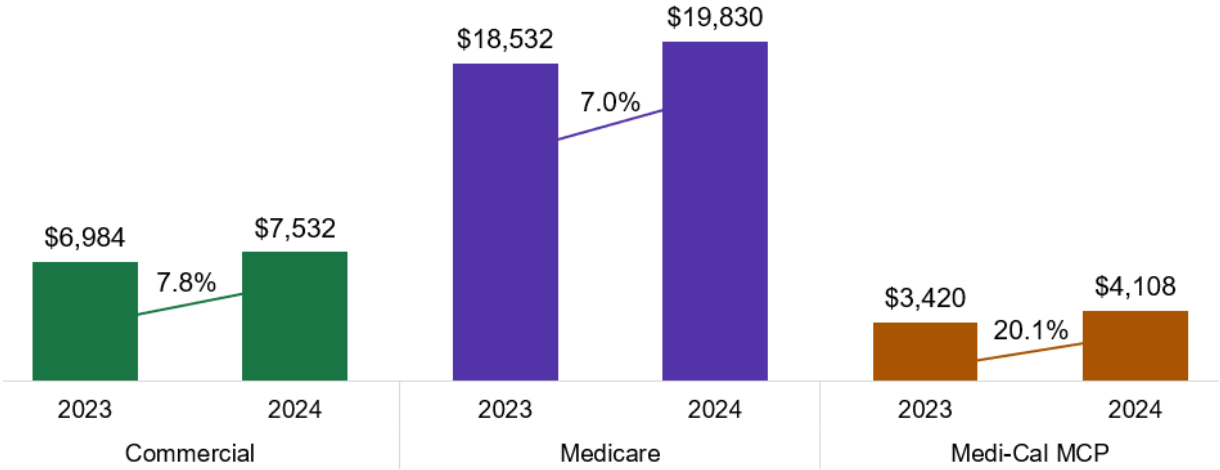
Total Medical Expenses Per Member Per Year by Market

Figure 2 shows Total Medical Expense per member per year (TME PMPY) across the Commercial, Medicare and Medi-Cal Managed Care markets:

- **Commercial** TME PMPY was $6,984 in 2023 and $7,532 in 2024, an increase of $548 or 7.8%.

- **Medicare** TME PMPY was $18,532 in 2023 and $19,830 in 2024, an increase of $1,298 or 7.0%.
- **Medi-Cal Managed Care** TME PMPY was $3,420 in 2023 and $4,108 in 2024, an increase of $688 or 20.1%.

Figure 2. Total Medical Expense Per Member Per Year Spending and Spending Growth by Market, 2023-2024



Section 2. About HCAI, OHCA, and Rising Health Care Costs

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

The Department of Health Care Access and Information (HCAI) expands access to quality, equitable, affordable health care for all Californians by supporting high value de-livery systems, resilient health facilities and workforces, and actionable health information and strategies. A range of boards and commissions advise on these program areas, with some certain boards empowered to decide on specific responsibilities. HCAI carries out its mission across five major program areas.

Affordability

HCAI promotes affordability of health care costs through multiple strategies, including spending targets, distribution of affordable generic drugs, and 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. CalRx has launched initiatives around insulin production and leveraging the state's purchasing strategies for medications such as naloxone and albuterol.

The Hospital Bill Complaint Program enforces the Hospital Fair Pricing Act. Under this law, 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.

Workforce

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. Scholarships and loan repayments are offered for nursing, behavioral health, primary care, dental, and other medical professions. To diversify those entering health care professions, HCAI funds pipeline and pathway programs.

Data

HCAI collects, analyzes, and disseminates information about hospitals, skilled nursing facilities, clinics, health plans, 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.

Built on the principle that every Californian should have access to their health information, HCAI's Data Exchange Framework (DxF) is a statewide initiative aimed at improving the secure, real time data sharing among health and social services entities throughout California. DxF gives providers a timely, full picture of a patient's health history and the information for effective whole person care while maintaining data privacy and security.

The Office of Patient Advocate rates health care organizations using performance measures based on the quality of medical care and patient experience, and it publishes data on health consumer complaints.

Facilities

HCAI serves as the building department for hospitals and skilled nursing facilities in California, monitoring the construction, renovation, and seismic safety of these vital health care

facilities. Its primary goal is to promote patient safety by ensuring that each facility remains functional following a natural disaster.

Financing

HCAI administers a suite of programs to stabilize financially distressed hospitals, strengthen rural healthcare access, and support long term health facility infrastructure across California. This includes no interest loans and grants to nonprofit and public hospitals experiencing significant financial distress and seismic safety grants and technical assistance to small, rural, and Critical Access Hospitals so they can remain open and safely deliver acute care services following an earthquake. HCAI also ensures long term capital financing for eligible health facilities, guaranteeing loans with the full faith and credit of the State of California.

Rural Health Transformation

HCAI leads the California Rural Health Transformation program, which is a statewide strategy to strengthen access, quality, and sustainability across rural and frontier communities to improve health outcomes. The program envisions a connected, resilient rural health system that delivers responsive person-centered care.

Office of Health Care Affordability 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 advances 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 seeking to slow spending growth, OHCA promotes high value health system performance by measuring quality, equity, adoption of alternative payment models, workforce stability, and by promoting investment in primary care and behavioral health. Lastly, OHCA reviews and assesses market consolidation, market power, and other market failures through cost and market impact reviews 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 declined substantially from 17% to 6% in 2024.[1] In 2025, Medi-Cal provided comprehensive health coverage to over 14 million residents, or 36% of the state's population.[2] Most Californians with low and moderate income levels who do not qualify for Medi-Cal and do not have employer-based coverage can purchase health insurance through Covered California, the state's ACA marketplace, and receive federal and state subsidies to cover the costs.[3] In February 2025, Covered California reached landmark enrollment with nearly 2 million Californians signed up for the 2025 coverage year.[4] 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 enhanced federal subsidies expired at the end of 2025, which increased marketplace premiums for all. 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%.[5]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

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

[2] Medi-Cal Monthly Eligible Fast Facts. (2025, November). California Department of Health Care Services. Medi-Cal Monthly Enrollment Fast Facts

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

[4] 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/

[5] 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

communities, who are more likely to report difficulty paying medical bills (40% and 36%, respectively, compared with White Californians at 25%).[6]

As health care expenditures have grown, premium contribution rates have also increased, contributing to increased strain on household budgets. From 2004 to 2024, California workers faced higher year-over-year annual premium contributions both in total dollar amount and percentage of premium for both single (self-only) and family coverage. In 2024, for single coverage premiums, workers in California paid an average of $1,947 annually, compared with $554 in 2004, an increase of $1,393 or 251% (or 6.8% annually). When looking at the average employee contribution, or the share of the premium paid, workers paid 22% for single coverage in 2024, up from 16% in 2004. In 2024, for family coverage premiums, workers paid an average of $9,148 annually, compared with $2,430 in 2004, an increase of $6,718 or 277% (or 7.2% annually). For share of premium paid, workers paid 38% for family coverage in 2024, up from 25% in 2004.[7]

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 2004 to 2024, the share of employees with a deductible increased from 42% to 60%. For single coverage, average deductibles were $1,787 in 2024, compared with $598 in 2004, an increase of $1,189 or 199% (or 5.9% annually). Family coverage deductibles were $3,882 in 2024, compared with $1,129 in 2004, an increase of $2,753 or 244% (or 6.7% annually).[8]

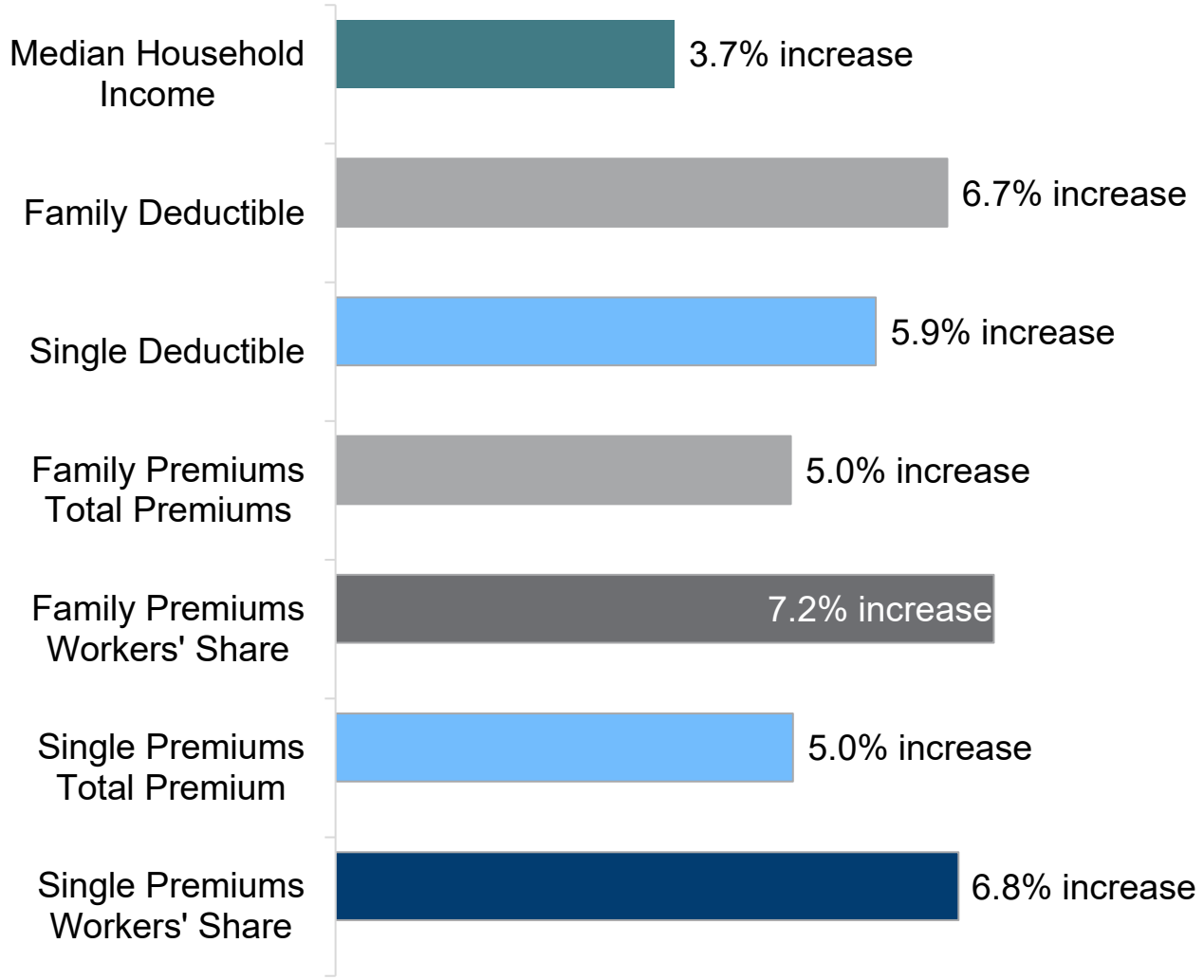
During this timeframe, median household income increased by only 104%, from $49,220 in 2004 to $100,600 in 2024, which represents an average annual growth rate of 3.7%.[9] The cost of health care for employees has increased significantly over the last two decades, forcing many workers to allocate a larger portion of their income to health insurance or forgo

[6] 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
[7] Medical Expenditure Panel Survey - Insurance Component (MEPS-IC) Agency for Healthcare Research and Quality. (2024). Medical Expenditure Panel Survey - Insurance Component (MEPS-IC), 2004-2024 California. Retrieved from https://datatools.ahrq.gov/meps-ic/
[8] Medical Expenditure Panel Survey - Insurance Component (MEPS-IC) Agency for Healthcare Research and Quality. (2024). Ibid.
[9] Federal Reserve Bank of St. Louis. (n.d.). Median household income in California. Retrieved from https://fred.stlouisfed.org/series/MEHOINUSCAA646N

coverage altogether.[10] In 2004, workers contributed 5% of their household income toward family coverage premiums, but by 2024, that share had nearly doubled to 9%.[11]

Figure 3 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.

Figure 3. Average Annual Growth Rates for Premiums and Deductibles for Private Sector Workers; and Median Household Income in California, 2004 – 2024



[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/

[11] Medical Expenditure Panel Survey - Insurance Component (MEPS-IC) Agency for Healthcare Research and Quality. (2024). Ibid.

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.[12]

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. 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. 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] 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/

Section 3. About this Report

Building on OHCA's Baseline Report released in June 2025, which covered calendar years 2022 and 2023, this report presents health care spending and growth in California for calendar years 2023 and 2024. Importantly, however, market-level totals are not directly comparable to the Baseline Report due to the exclusion of several categories of Medi-Cal spending, including the MCO tax, pass-through payments, certain amounts related to state directed payments, Medi-Cal FFS, and other non-Medi-Cal spending from DHCS. Focusing on calendar years 2023 and 2024, this report shows spending and changes in spending by region, market, payer, physician organization, and service category.

Due to rounding, numbers presented throughout this report may not add up precisely to the totals provided.

OHCA will release a separate, complementary report in Fall 2026 summarizing its initiatives to promote high value health system performance. This report will present baseline information on alternative payment model adoption and primary care spending in California for calendar years 2023 and 2024. Results will be presented at the statewide level and, where applicable, by market and payer. The report will also summarize OHCA's progress in the areas of measuring health equity and quality performance, sharing cost-reducing strategies, promoting investment in behavioral health, and monitoring workforce stability.

Data Sources

To capture spending across the state's health care system, OHCA collected data directly from payers with at least 40,000 members in the Commercial or Medicare Advantage markets. Data collected from payers includes health care spending for covered benefits received by California residents with Commercial or Medicare Advantage coverage during calendar years 2023 and 2024. This Interim Report includes spending data submitted to OHCA for 17 Commercial and 19 Medicare Advantage payers (Table 3). This includes data on the total number of member months of coverage, payment arrangements, total claims across service categories (*i.e.*, inpatient claims, outpatient claims, professional claims, long-term care, retail pharmacy, and other), non-claims payments, and member cost-sharing obligations.

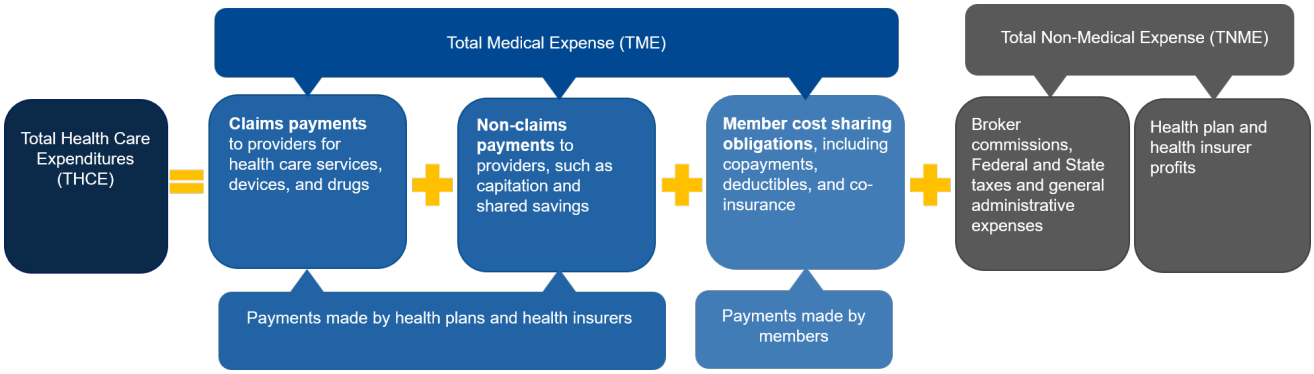
In addition to payer-submitted data for the Commercial and Medicare Advantage markets, OHCA obtained administrative data on health care spending for Medi-Cal Managed Care, Medicare fee-for-service (FFS), and other markets (state correctional health, Indian Health Services (IHS), and Veterans Affairs) from state and federal agencies and public sources.

See Appendix A. Methods and Data Sources for more details.

Definition of Total Health Care Expenditures

As shown in **Figure 4**, total health care expenditures (THCE) are defined as the sum of total medical expenses (TME) and total non-medical expenses (TNME) of health plans and fully integrated delivery systems. TME includes all claims payments to providers for health care provided; non-claims payments to providers, such as capitation and shared savings; and member cost-sharing obligations, including copayments, deductibles, and coinsurance payments. TNME includes health insurer profits as well as broker commissions, federal and state taxes and fees, and general administrative expenses.

Figure 4. Components of Total Health Care Expenditures



Market Categories

Figure 5 shows the levels of reporting, which includes reporting by major market and plan type.

The Commercial market includes members covered by employer-sponsored group coverage and plans purchased by individuals including through Covered California, the state's ACA marketplace. 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.

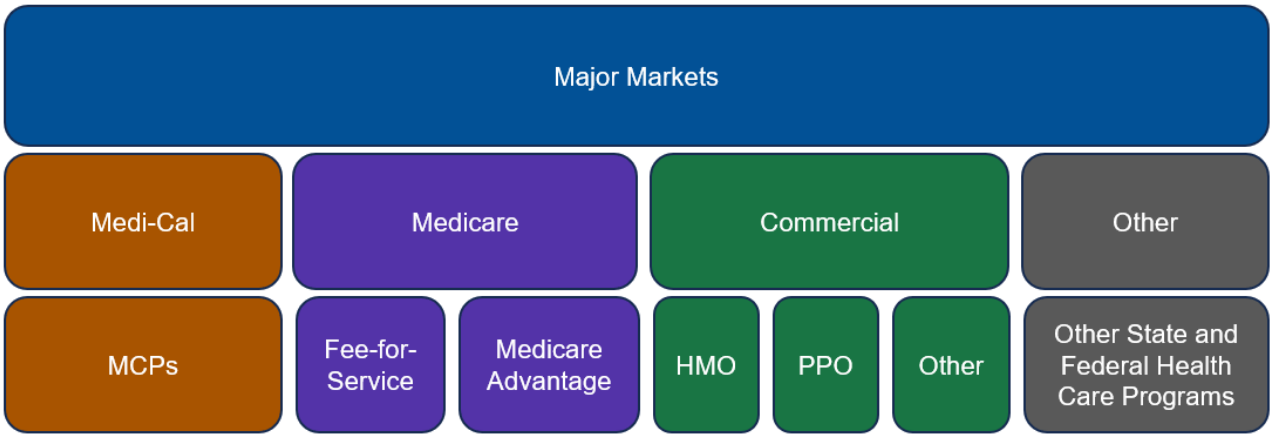
Medicare is a health coverage program that serves seniors and individuals with disabilities. Medicare spending includes Medicare FFS, as reported by Centers for Medicare and Medicaid Services (CMS), and spending for members enrolled in Medicare Advantage plans, as reported by Medicare Advantage payer data submitted to OHCA. Dual Eligible and Dual Eligible Special Needs Plans (D-SNPs) are captured in the Medicare Advantage totals.

Medi-Cal is California's Medicaid program that provides health care services for low-income individuals. Medi-Cal delivers services through both FFS and managed care plans. 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 managed care and provided through Medi-Cal FFS, such as behavioral health services for people with serious mental health conditions and prescription drugs. As of 2024, approximately 15 million Medi-Cal members across all 58 counties receive their health care through main models of managed care: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Regional Model (RM), and Single-Plan.[13] This report excludes all Medi-Cal FFS spending as well as spending on MCO Tax, pass-through payments, and certain amounts related to state directed payments. Medi-Cal managed care covers various services which are not typically covered in the Commercial and Medicare markets, including but not limited to, long-term custodial care, enhanced care management, and community supports. These services are generally included in this report.

[13] State of California, Department of Health Care Services, Research and Analytic Studies Division. (2025, September). *Statewide Medi-Cal Certified Eligible Individuals, by Aid Code, 2010 to the Most Recent Reportable Month* [Dataset]. California Health and Human Services Open Data Portal. https://data.chhs.ca.gov/dataset/statewide-medi-cal-certified-eligible-individuals-by-aid-code-2013-2017

The Other market 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 Human Services, and U.S. Department of Veterans Affairs. This report excludes spending on DHCS non-Medi-Cal programs.

Figure 5. Levels of Reporting: Major Markets, Plan Type and Other State and Federal Health Care Programs



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, and VHA.*

CCHCS = California Correctional Health Care Services; D-SNP = dual eligible special needs plans; HMO = health maintenance organization; IHS = Indian Health Services; MCP = managed care plan; PPO = preferred provider organization; VHA = Veterans Health Administration

Section 4. Health Care Spending Across Major Markets 2023-2024

Figure 6 shows aggregate TME by major market as well as health care spending across the Other category health plan experiences.

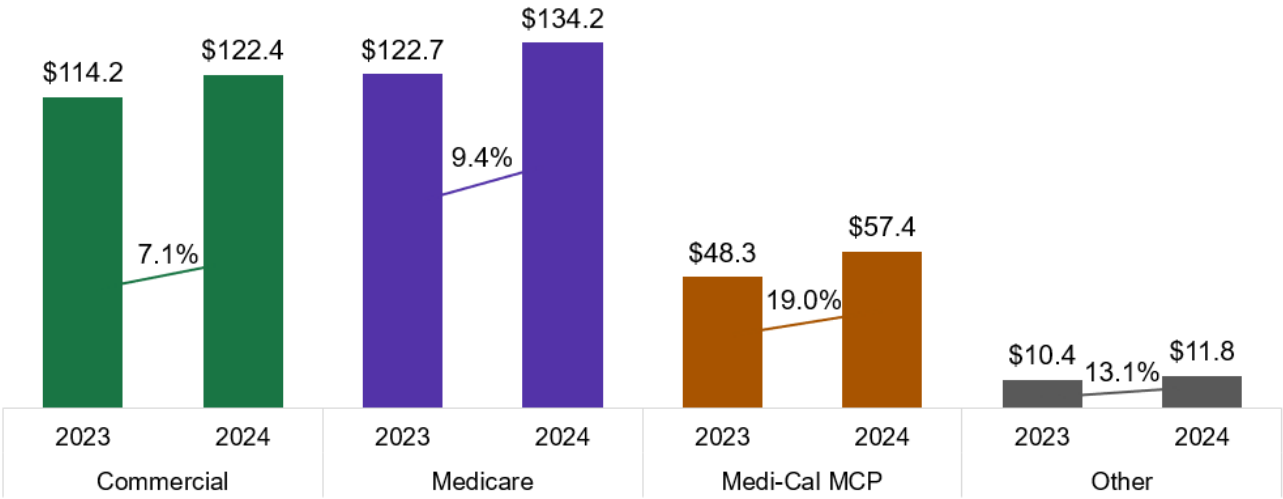
In 2024, Commercial spending was $122.4 billion compared with $114.2 billion in 2023, an increase of $8.1 billion or 7.1%.

In 2024, Medicare TME was $134.2 billion and in 2023 was $122.7 billion, an increase of $11.5 billion or 9.4%.

In 2024, Medi-Cal Managed Care spending was $57.4 billion compared with $48.3 billion in 2023, an increase of $9.2 billion or 19.0%.

In 2024, spending in the Other market, which includes state correctional health, Indian Health Services, and Veterans Affairs totaled $11.8 billion, compared with $10.4 billion in 2023, an increase of almost $1.4 billion or 13.1%.

Figure 6. Statewide Aggregate Total Health Care Expenditures in Billions, Spending TME and TME Growth by Market and Statewide Total Non-Medical Expense, 2023-2024

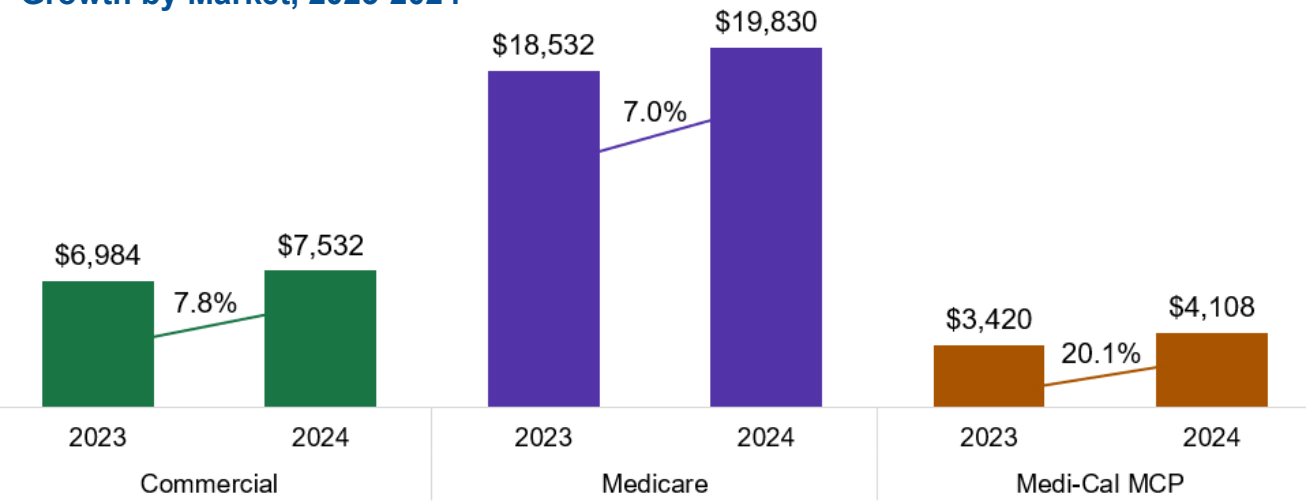


Note: *Medi-Cal Managed Care does not include spending from Managed Care Organization (MCO) Tax, pass-through payments, or Medi-Cal FFS. Medicare includes Medicare FFS and Medicare Advantage (including dual eligibles and D-SNPS). D-SNP = dual eligi-*

Total Medical Expense Per Member Per Year by Market

Figure 7 below shows TME per member per year by market, including Commercial, Medicare (Medicare Advantage including duals and D-SNPs, and Medicare FFS including dual eligibles), and Medi-Cal Managed Care. TME PMPY for the Commercial market was $6,984 in 2023 and $7,532 in 2024, an increase of $548 or 7.8%. For Medicare, the figure $18,532 in 2023 and $19,830 in 2024, an increase of $1,298 or 7.0%. Medi-Cal Managed Care TME PMPY was $3,420 in 2023 and $4,108 in 2024, an increase of $688 or 20.1%.

Figure 7. Total Medical Expense Per Member Per Year Spending and Spending Growth by Market, 2023-2024



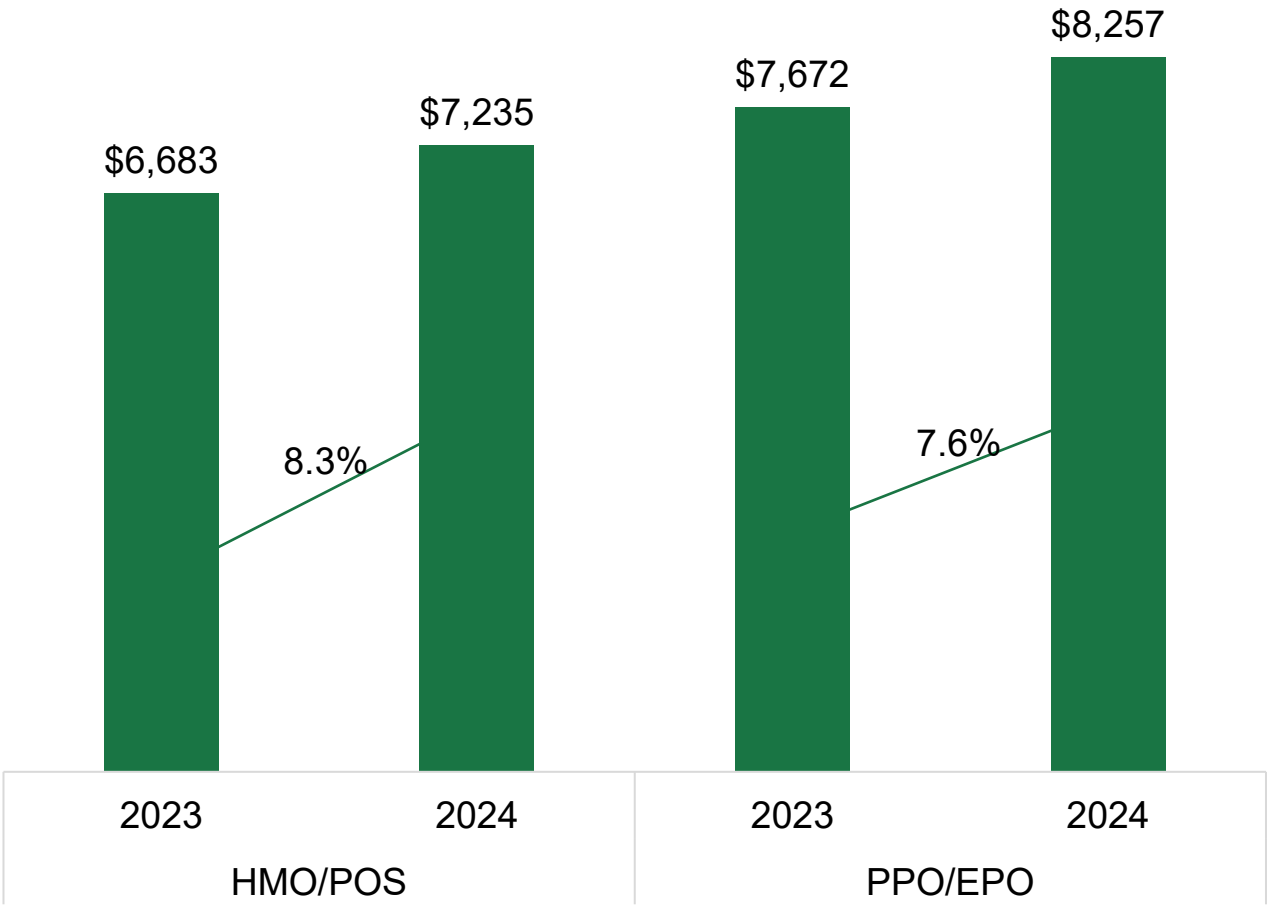
Note: *TME includes total spending on medical services and does not include total non-medical expense (TNME). Medicare includes both Medicare FFS (includes dual eligibles) and Medicare Advantage (includes duals and D-SNPs). Medi-Cal Managed Care does not include spending from Managed Care Organization (MCO) Tax, pass-through payments, or Medi-Cal FFS .*
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 was higher in Commercial PPO/EPO plans than in Commercial HMO/POS plans with growth slightly higher in HMO/POS plans. Across Commercial payers, TME PMPY for HMO/POS plans was $6,683 in 2023 and $7,235 in 2024, an increase of $552 or 8.3%. TME PMPY for PPO/EPO plans was $7,672 in 2023 and $8,257 in 2024, an increase of $585 or 7.6% (**Figure 8**).

Across HMO/POS plans, TME PMPY ranged from approximately $3,700 to $11,300 compared with $5,300 to $14,400 for PPO/EPO plans. In 2024, seventeen payers in the Commercial market offered HMO/POS plans with eight payers also offering a PPO/EPO plan.

Figure 8. Total Medical Expense Per Member Per Year Spending and Spending Growth by Commercial Plan Type, 2023-2024



Note: *Data exclude plans that map to other plan types. Excluded plans account for 0.1% of TME.*

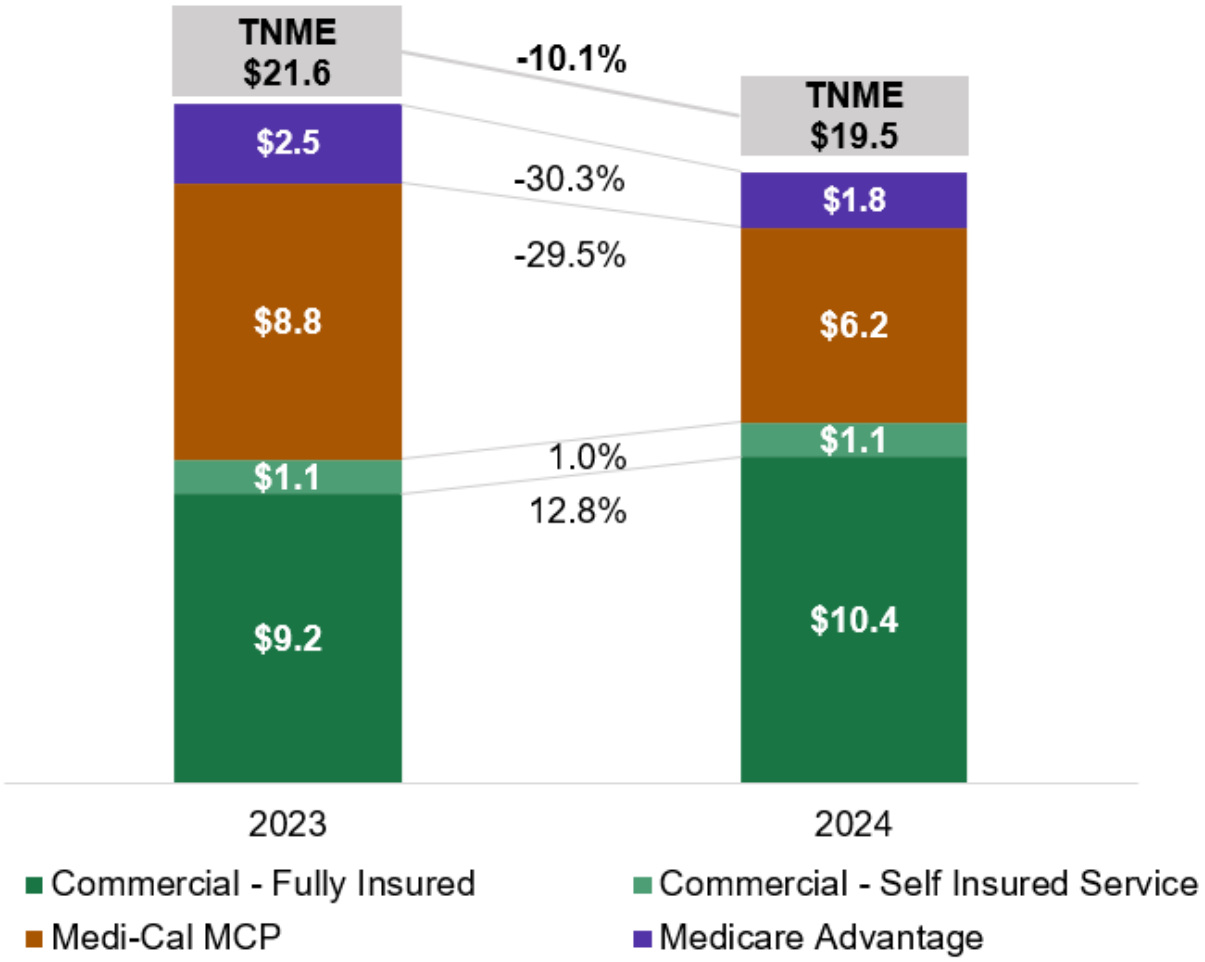
Section 5. Total Non-Medical Expense (TNME)

This section summarizes spending on Total Non-Medical Expense (TNME) from 2023 to 2024 for the following markets: Commercial, Medicare Advantage, and Medi-Cal Managed Care. TNME includes broker commissions, federal and state taxes, and general

administrative expenses such as claims processing, marketing, enrollment, customer service, and billing. It also includes any profit or loss that payers experienced.

As shown in **Figure 9**, aggregate TNME decreased by 10.1%, from $21.6 billion in 2023 to $19.5 billion in 2024.

Figure 9. Annual TNME in Billions by Market



Within the Commercial market, there are two types of TNME: spending associated with payers' fully insured plans and spending related to services provided to self-insured employers. Commercial fully-insured TNME grew 12.8%, from $9.2 billion in 2023 to $10.4 billion in 2024. Commercial self-insured TNME remained steady at $1.1 billion. Medi-Cal Managed Care TNME decreased by almost 29.5%, from $8.8 billion in 2023 to $6.2 billion in 2024. Medicare Advantage TNME decreased by 30.3%, from $2.5 billion in 2023 to $1.8 billion in 2024.

Fully Insured Commercial Market Use of Premiums[14] [15]

In the fully insured commercial market, average premium revenue reached $7,366 per member per year in 2024, up from $6,715 dollars in 2023, reflecting an increase of $652 or 9.7%. As shown in **Figure 10**, the share of premium revenue allocated to medical expenses declined slightly to 89.9%, a decrease of 0.4 percentage points from 90.3% in 2023. The portion of premium revenue used for non-medical expenses excluding profit also declined from 9.3% to 8.6%, a reduction of 0.6 percentage points. In contrast, profits increased by 1 percentage point, rising from 0.5% to 1.5% of premium revenue.

Figure 10. Commercial Market Use of Premiums, 2023-2024

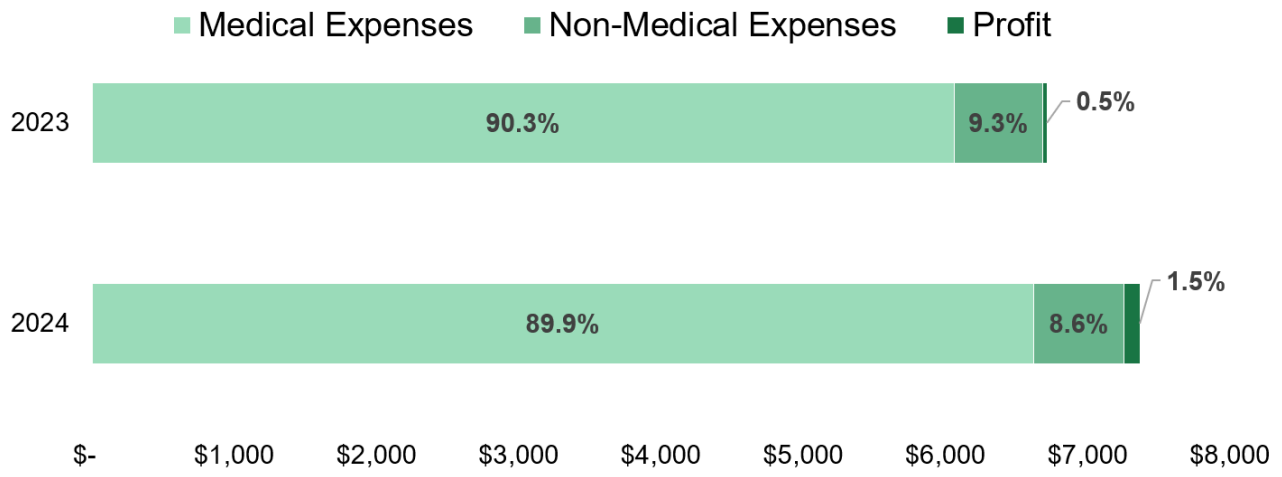
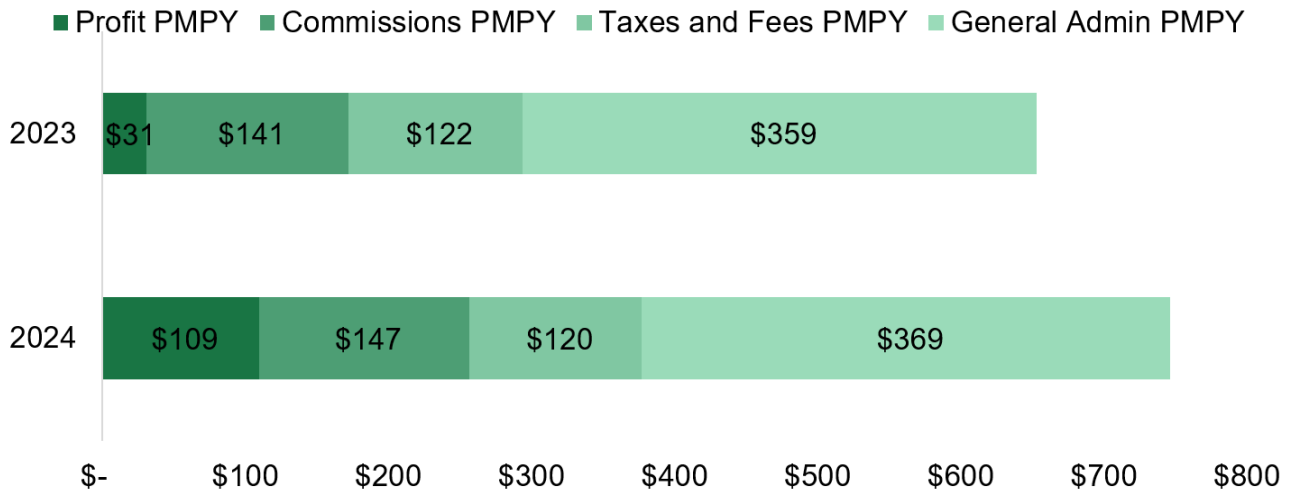


Figure 11 presents TNME on a PMPY basis for the fully insured commercial market disaggregated by non-medical expenses and profits. Total non-medical expenses increased by $94 PMPY or 14.3%, rising from $653 in 2023 to $746 in 2024. General administrative costs remained the largest category and grew by $10 PMPY or 2.8%. Commissions were the second largest category and increased by $7 PMPY or 4.7%. Taxes and fees followed, decreasing a little more than $1 PMPY or 1.2%. Profits represented the smallest share but saw the largest relative increase, rising by $78 PMPY or 251.6%.

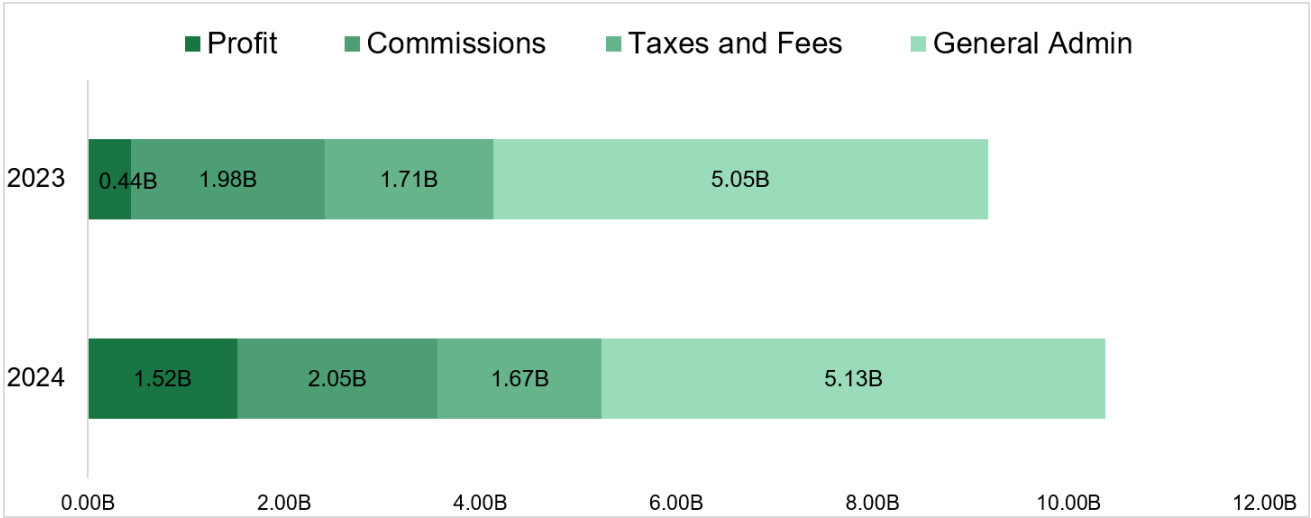
[14] Centers for Medicare & Medicaid Services. (2023–2024). Medical Loss Ratio (MLR) public use files. Center for Consumer Information & Insurance Oversight (CCIIO). Retrieved from: https://www.cms.gov/marketplace/resources/data/medical-loss-ratio-data-systems-resources
[15] See Appendix A.8 for calculation details

Figure 11. Total Commercial Non-Medical Expenses Per Member Per Year



Error! Reference source not found. presents the same disaggregated components in total dollars for each of the components. Total non-medical expenses increased by $1.2 billion or 13.0%, rising from $9.2 billion in 2023 to $10.4 billion in 2024. General administrative costs remained the largest category and grew by $80 million or 1.6%. Commissions were the second largest category and increased by $70 million or 3.5%. Taxes and fees followed, decreasing by 40 million or 2.3%. Profits represented the smallest share but saw the largest relative increase, rising by $1.08 billion or 247.5%.

Figure 12. Total Commercial Non-Medical Expenses



The aggregate fully insured commercial results combine experience across the large group, individual, and small group market segments. To provide additional context for these aggregate results, **Figure 13** presents the 2024 enrollment distribution across the three segments, and **Table 2** outlines how premium revenue was allocated to medical expenses, non-medical expenses, and profit within each segment. The table includes 2024 PMPY amounts and shares of premium, along with year over year changes from 2023. PMPY changes are shown in both dollar and percentage terms, while changes in each component's share of premium are expressed in percentage points.

Figure 13. Distribution of Commercial Enrollment Across Large Group, Small Group and Individual Lines of Business

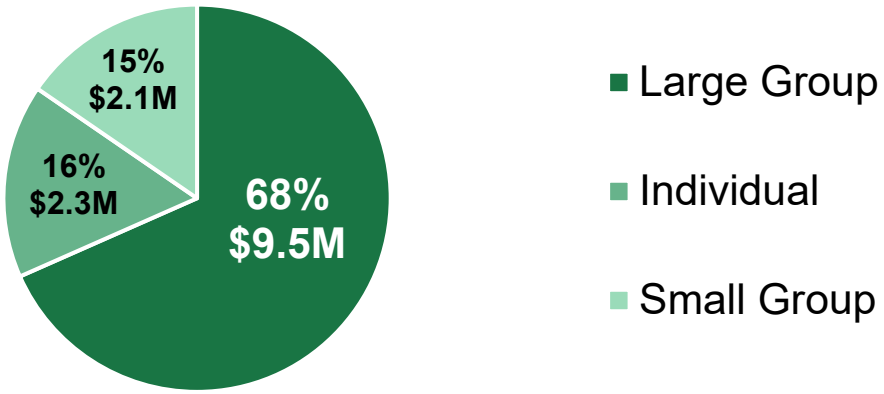


Table 2. Commercial Market Use of Premiums by Line of Business, 2023-2024

	Medical Expenses		Non-Medical Expenses		Profit	
	PMPY	% of Premium	PMPY	% of Premium	PMPY	% of Premium
Large Group	$6,513 (+10.4%)	89.9% (-0.2 pp)	$524 (+2.0%)	7.2% (-0.6 pp)	$204 (+59.0%)	2.8% (+0.9 pp)
Individual	$7,104 (+4.8%)	91.4% (-1.9 pp)	$764 (+3.4%)	9.8% (-0.3 pp)	-$96 (+61.6%)	-1.2% (+2.2 pp)
Small Group	$6,589 (+8.3%)	87.9% (+0.3 pp)	$1,003 (+1.9%)	13.4% (-0.8% pp)	-$95 (+22.8%)	-1.3% (+0.5 pp)

Note: Percentage point is the abbreviation pp.

Figure 13 illustrates that the aggregate results reflect segments of varying sizes, with large group coverage representing the greatest share at 68% of the market, followed by the individual market at 16% and the small group market at 15%.

Table 2 shows that the use of premium revenue varied across these segments and offers important context for interpreting the aggregate percentage increase in profits. Although profits increased across all three segments, only the large group segment reported positive profit levels; profits in the small group and individual markets improved but remained negative.

Section 6. Health Care Spending by Payer

This section presents changes in health care spending from 2023 to 2024 by payer in three markets in California: (1) Commercial, (2) Medicare Advantage, and (3) Medi-Cal Managed Care. **Table 3** shows the markets in which each payer participates.

Table 3. Payers by Market, 2024

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

Payer	Commercial	Medicare Advantage	Medi-Cal Managed Care
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	✓	✓	
Valley Health Plan	✓		
Western Health Advantage	✓	✓	
Total payers	**17**	**19**	**23**

Commercial

As shown in **Figure 14**, commercial enrollment reported to OHCA included approximately 16.2 million lives in 2024.[16] Kaiser (42.8%), Anthem Blue Cross (15.1%), and Blue Shield of California (11.1%) collectively accounted for about 69% of the Commercial market.

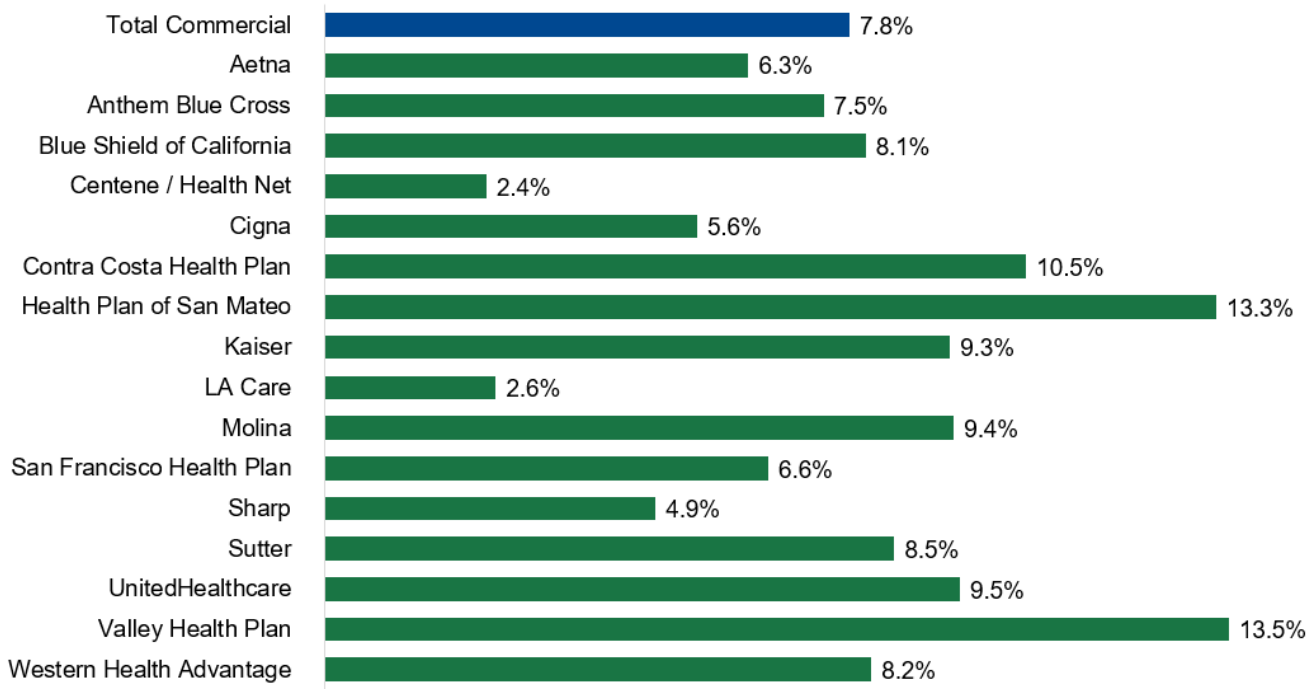
Figure 14. Commercial Payer Market Share, 2024

Commercial Payers	2024 Market Share
Kaiser	42.8%
Anthem Blue Cross	15.0%
Blue Shield of CA	11.1%
UnitedHealthcare	8.6%
Aetna	7.9%
Cigna	6.9%
Centene / Health Net	3.1%
LA Care	1.43%
Sharp	0.8%
Western Health Advantage	0.7%
Sutter	0.7%
Molina	0.3%
Valley Health Plan	0.3%
Inland Empire Health Plan	0.1%
San Francisco Health Plan	< 0.1%
Contra Costa Health Plan	< 0.1%
Health Plan of San Mateo	< 0.1%
Total Members	**16,246,642**

[16] For calendar year 2024, the California Health Care Foundation's Enrollment Almanac shows 13.7 million commercial enrollees and 5.9 million enrolled through administrative services only arrangements for self-insured employers: https://www.chcf.org/resource/california-health-insurers-enrollment-almanac/.

Figure 15 illustrates the range of TME PMPY growth rates across payers in the Commercial market. Total Commercial TME PMPY was $6,984 in 2023 and $7,532 in 2024, an increase of $548 or 7.8%. Among Commercial payers, TME PMPY growth rates ranged from 2.4% (Centene/Health Net) to 13.5% (Valley Health Plan), with most payers experiencing growth greater than 7.0%. TME PMPY growth rates for Kaiser and Anthem Blue Cross, which when combined account for more than half of the Commercial market, were 9.3% and 7.5%, respectively. In 2024, PMPY spending varied substantially, ranging from $3,964 at the lower end to $11,268 at the upper end.

Figure 15. Commercial Payer Total Medical Expense Per Member Per Year Spending Growth, 2023-2024



Medicare Advantage

As shown in **Figure 16**, Medicare Advantage enrollment[17] reported to OHCA included approximately 3.3 million lives in 2024.[18] Kaiser accounted for 42.1% of the Medicare Advantage market, UnitedHealthcare for 16.4%, and Anthem Blue Cross for 8.7%, collectively comprising approximately 67% of the Medicare Advantage market.

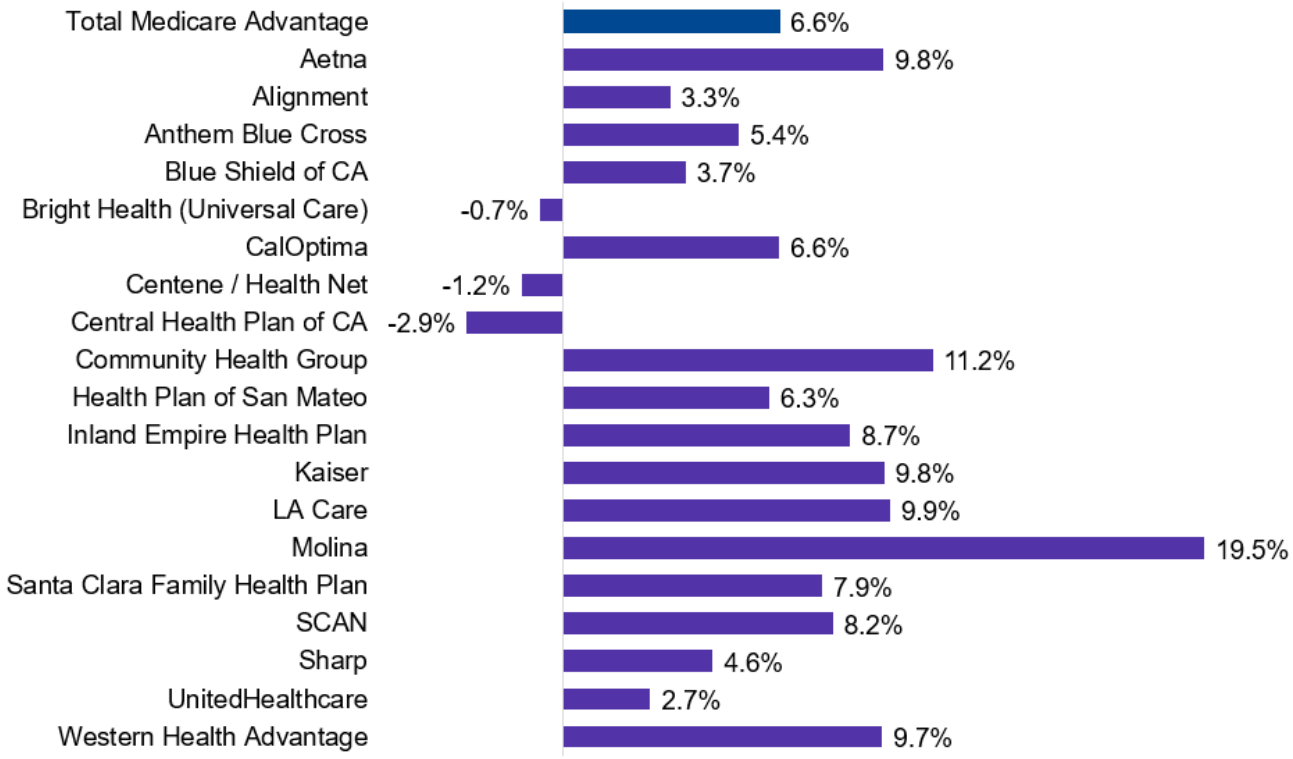
Figure 16. Medicare Advantage Payer Market Share, 2024

Medicare Advantage Payers	2024 Market Share
Kaiser	42.1%
UnitedHealthcare	16.4%
Anthem Blue Cross	8.7%
SCAN	8.2%
Blue Shield of California	5.0%
Alignment	4.7%
Centene / Health Net	4.4%
Aetna	3.6%
Bright Health (Universal Care)	1.7%
Central Health Plan of CA	1.2%
Inland Empire Health Plan	1.1%
LA Care	0.6%
Molina	0.5%
CalOptima	0.5%
Sharp	0.4%
Santa Clara Family Health Plan	0.3%
Health Plan of San Mateo	0.3%
Community Health Group	0.2%
Western Health Advantage	0.1%
Total Members	**3,350,003**

[17] Medicare Advantage includes members dually eligible for Medicare and Medi-Cal enrolled in Dual Eligible Special Need Plans (D-SNPs).
[18] For calendar year 2024, the California Health Care Foundation's Enrollment Almanac shows 3.3 million Medicare enrollees: https://www.chcf.org/resource/california-health-insurers-enrollment-almanac/.

As shown in **Figure 17**, compared with payers in the Commercial market, Medicare Advantage payers exhibited higher variation in TME PMPY spending growth. Total Medicare Advantage TME PMPY was $16,669 in 2023 and $17,767 in 2024, an increase of $1,098 or 6.6%. Within the Medicare Advantage market, payer TME PMPY growth rates ranged from -2.9% (Central Health Plan of CA) to 19.5% (Molina). Kaiser and UnitedHealthcare, which when combined account for about 58% of the Medicare Advantage market, experienced TME PMPY growth rates of 9.8% and 2.7%, respectively. In 2024, Medicare Advantage PMPY spending ranged from $10,644 to $35,256, indicating a more than threefold variation in spending levels.

Figure 17. Medicare Advantage Total Medical Expense Per Member Per Year Spending Growth, 2023-2024



Medi-Cal Managed Care

Twenty-three payers served Medi-Cal Managed Care enrollees in 2024.[19] As illustrated in **Figure 18**, LA Care holds the largest share of Medi-Cal Managed Care enrollment at 16.9%, followed by Centene / Health Net at 11.4%, Inland Empire Health Plan at 10.7%, and Kaiser at 8.0%. Collectively, these four plans account for just under 50% of total Medi-Cal Managed Care enrollment.[20]

Figure 18. Medi-Cal Managed Care Plans by Market Share, 2024

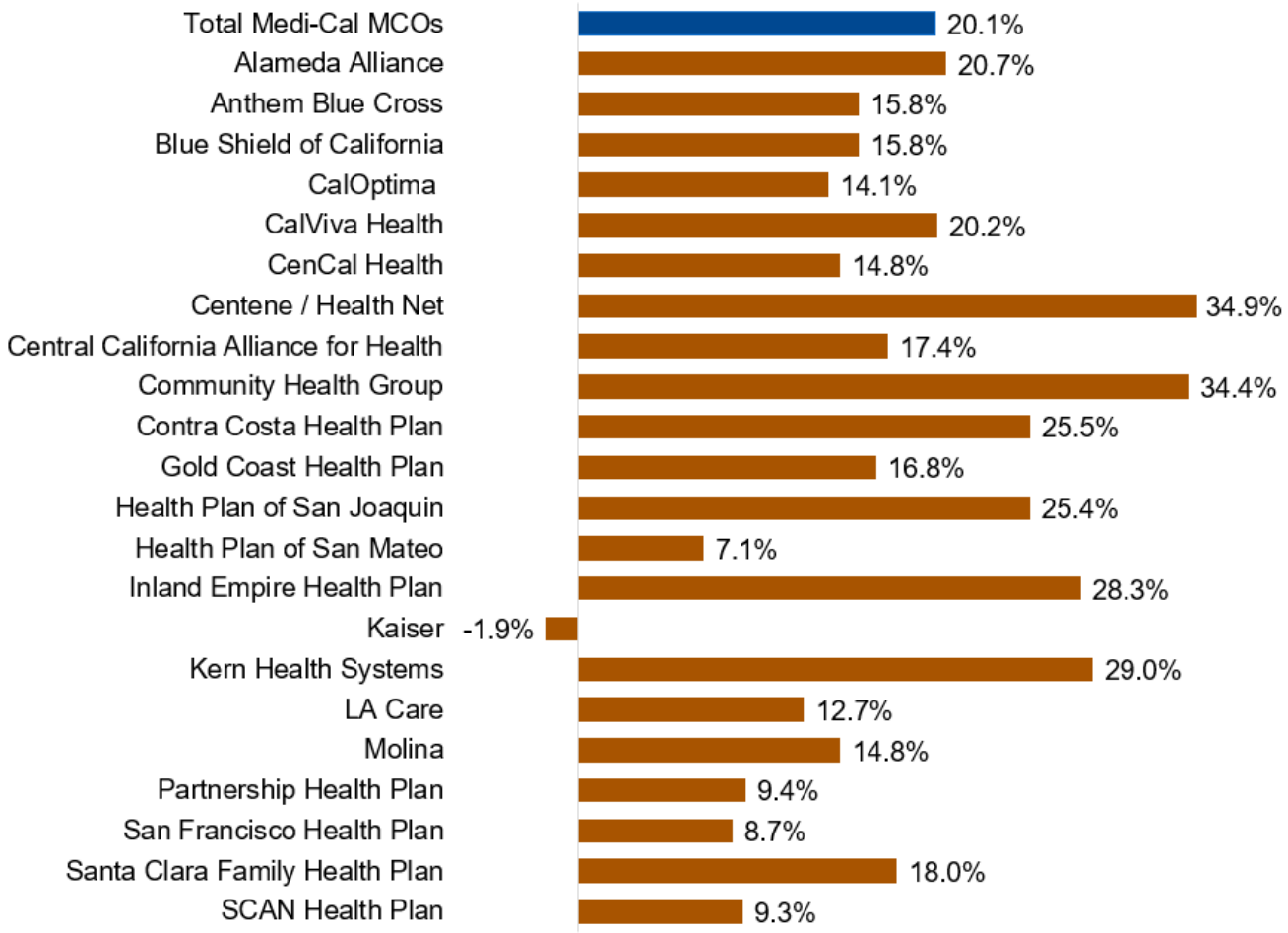
Medi-Cal MCOs	2024 Market Share
LA Care	16.9%
Centene / Health Net	11.4%
Inland Empire Health Plan	10.7%
Kaiser	8.0%
Partnership Health Plan	6.5%
CalOptima	6.5%
Anthem Blue Cross	5.9%
Molina	4.2%
Central California Alliance for Health	3.2%
CalViva Health	3.1%
Health Plan of San Joaquin	3.0%
Kern Health Systems	2.9%
Community Health Group	2.9%
Alameda Alliance	2.9%
Santa Clara Family Health Plan	2.1%
Contra Costa Health Plan	1.9%
Gold Coast Health Plan	1.8%
CenCal Health	1.7%
Blue Shield of CA	1.4%
San Francisco Health Plan	1.3%
Health Plan of San Mateo	1.0%
Community Health Plan of Imperial Valley	0.7%
SCAN	0.1%
Total Members	**13,973,216**

[19] One additional Medi-Cal plan, AIDS Healthcare Foundation, is not shown or included in payer level calculations given its small market share and specialized population, but is included in Medi-Cal market level calculations. Community Health Plan of Imperial Valley, a new Medi-Cal plan in 2024, is included in the payer section enrollment graph and in Medi-Cal market-level calculations but is not included in payer-level total medical expense (TME) calculations because only one year of data is available.

[20] For calendar year 2024, the California Health Care Foundation's Enrollment Almanac shows 13.5 million Medi-Cal enrollees: https://www.chcf.org/resource/california-health-insurers-enrollment-almanac/.

Medi-Cal Managed Care Plans (MCP) TME PMPY was $3,420 in 2023 and $4,108 in 2024, an increase of 20.1%, reflecting a similar national pattern where Medicaid spending per capita grew by 16.6%.[21] As shown in **Figure 19**[22], growth rates varied significantly across individual plans. Centene/Health Net reported the largest increase at 34.9%, followed by Community Health Group (34.4%), Kern Health Systems (29.0%), and Inland Empire Health Plan (28.3%). In contrast, Kaiser was the only plan to report a decrease in TME, with a reduction of 1.9%. In 2024, MCP PMPY expenditures ranged from $3,141 to $5,476

Figure 19. Medi-Cal Managed Care Total Medical Expense Per Member Per Year Spending Growth, 2023-2024



[21] Hartman, M., Martin, A. B., Benson, J., Catlin, A., & the National Health Expenditure Accounts Team. (2026). National health care spending increased 7.2 percent in 2024 as utilization remained elevated. *Health Affairs*, 45(1), 10–20. https://doi.org/10.1377/hlthaff.2025.01683

[22] Community Health Plan of Imperial Valley is not included because it was introduced as a new plan in 2024.

Section 7. Health Care Spending by Physician Organization

This section examines changes in health care spending from 2023 to 2024 among select physician organizations in the Commercial and Medicare Advantage markets. As part of OHCA's annual data collection, the Office asks payers to submit an Attributed TME file that attributes members and their health care spending to physician organizations according to an attribution methodology (see Section 4.5 of the THCE Data Submission Guide) that places primacy on capitated, delegated arrangements, followed by ACO arrangements and finally payer-developed attribution (e.g., primary care-based assignment).

Importantly, the payer-reported TME includes all spending for an attributed member, regardless of rendering provider. Put another way, if an individual is delegated to a medical group for primary care but is hospitalized and subsequently accesses diagnostic imaging, payers are instructed to aggregate all of that individual's expenses and to attribute it to the medical group since the individual's professional care is capitated and delegated. In addition, payers may choose to omit self-insured lines of business; as a result, membership attributed to a given physician organization may not represent their full attributed population and match the spending the physician organization is internally tracking. This context is important when interpreting physician organization-level growth rates.

To support accurate attribution of members and health care spending, OHCA provided an Attribution Addendum as part of the Data Submission Guide. Physician organization-level results in this section are reported as defined in the Data Submission Guide Attribution Addendum (April 2025 revision). For example, Sutter Bay Medical Foundation (Org. Code 1270) and Sutter Independent Physicians Medical Group (Org. Code 1273) are reported separately despite having the same parent organization, and Optum (Org. Code 1493) is reported separately from Optum Health Plan of California (Org. Code 1182). Additional details on attribution and data processing are provided in the Appendix.

Of the 144 physician organizations included in the Attribution Addendum, this section reports results for 27 physician organizations individually (**Table 4**). These physician organizations were selected based on either (1) having confirmed tax identification numbers (TINs) published in the Attribution Addendum or (2) having more than 1 million attributed member months (approximately 83,000 attributed members) in either 2023 or 2024. In addition, several smaller organizations with well-defined attributed populations were included.

Table 4. Physician Organizations by Market, 2024

Physician Organization	Commercial	Medicare Advantage
Aledade Accountable Care	✓	
Allied Pacific IPA	✓	✓
Beaver Medical Group	✓	✓
Brown & Toland Health Services Inc.	✓	✓
Dignity Health Medical Foundation	✓	✓
HealthCare Partners Affiliates Medical Group	✓	✓
Hill Physicians Medical Group	✓	✓
MemorialCare Medical Foundation	✓	✓
Optum Health Plan of California	✓	✓
PRIMECARE Medical Network Inc	✓	✓
Prospect Medical Group Inc.[23]	✓	✓
Providence Health Network	✓	✓
Providence Medical Foundation	✓	✓
Regal Medical Group	✓	✓
Sante Community Physicians IPA Medical Corporation	✓	✓
Sharp Community Medical Group Inc.	✓	✓
Sharp Rees Stealy Medical Group	✓	✓
Southern California Permanente Medical Group	✓	✓
St. Joseph Heritage Healthcare	✓	✓
Sutter Bay Medical Foundation	✓	✓
Sutter Independent Physicians A Medical Group	✓	✓
The Permanente Medical Group Inc.	✓	✓
UC Davis Health	✓	
UC Irvine Health	✓	
UC San Diego Health	✓	✓
UCLA Health	✓	✓
UCSF Health	✓	✓
Number of Selected Physician Organizations	**27**	**24**

[23] Prospect Medical Group ceased to exist as of 2025

Overview of Attributed TME and Members

Although the Data Submission Guide allows payers to attribute members to physician organizations not listed in the Attribution Addendum, approximately one-quarter of total medical expenditures and member months could not be attributed to any specific physician organization (**Table 5**). The figures in **Table 5** represent the combined Commercial and Medicare Advantage markets; the breakdown for each market is presented in the following pages. For the purposes of this section, these are referred to as unattributed members.

Table 5. Share of Attributed TME and Members

Attribution Status	Share of TME	Share of Members
Attributed to specific physician organizations	73%	74%
Unable to attribute to any specific physician organizations	27%	26%

Commercial

As shown in **Figure 20**, Southern California Permanente Medical Group (21.7%) and The Permanente Medical Group (21.1%) (Kaiser physician organizations) together accounted for more than 42% of attributed members in the Commercial market. Among the larger non-Kaiser physician organizations shown in the figure, Hill Physicians Medical Group (1.4%) through Providence Medical Foundation (0.6%) each had more than 100,000 attributed members. Smaller non-Kaiser physician organizations, ranging from Prospect Medical Group (0.6%) to UC Irvine Health (0.1%), each had fewer than 100,000 attributed members. In addition, more than 30% of Commercial market members were unattributed.

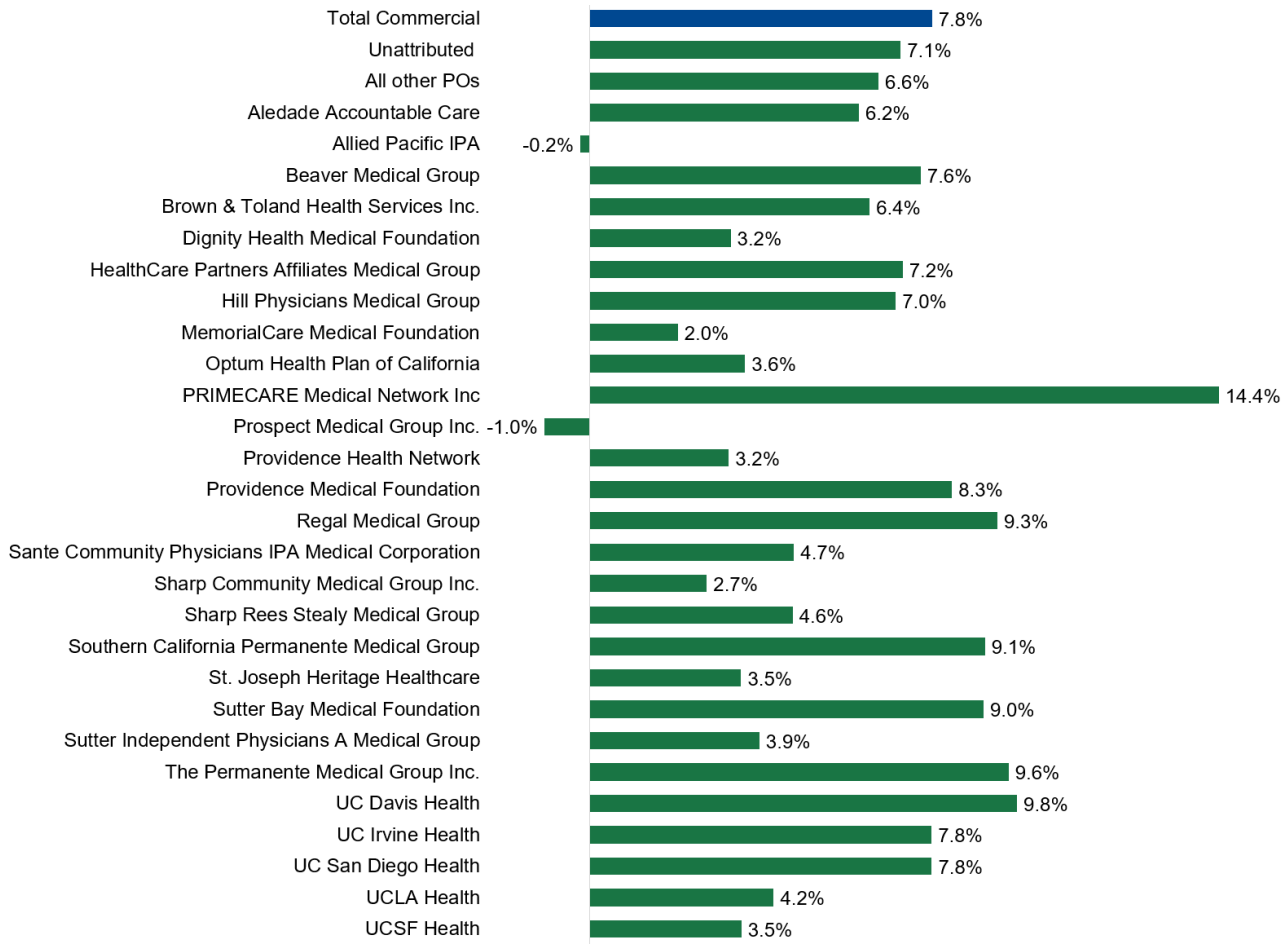
Figure 20. Commercial Physician Organization Market Share, 2024

Commercial Physician Organizations	2024 Market share
Southern California Permanente Medical Group	21.7%
The Permanente Medical Group Inc.	21.1%
Hill Physicians Medical Group	1.4%
Sutter Bay Medical Foundation	1.0%
Sharp Rees Stealy Medical Group	0.9%
UCLA Health	0.9%
HealthCare Partners Affiliates Medical Group	0.8%
Allied Pacific IPA	0.7%
Optum Health Plan of California	0.7%
Dignity Health Medical Foundation	0.7%
Providence Medical Foundation	0.6%
Prospect Medical Group Inc.	0.6%
Aledade Accountable Care	0.5%
Providence Health Network	0.4%
Sharp Community Medical Group Inc.	0.4%
MemorialCare Medical Foundation	0.4%
Sante Community Physicians IPA Medical Corporation	0.4%
UC Davis Health	0.3%
Regal Medical Group	0.3%
UCSF Health	0.3%
PRIMECARE Medical Network Inc	0.3%
St. Joseph Heritage Healthcare	0.3%
UC San Diego Health	0.2%
Brown & Toland Health Services Inc.	0.2%
Sutter Independent Physicians A Medical Group	0.2%
Beaver Medical Group	0.2%
UC Irvine Health	0.1%
All Other Providers	14.2%
Unattributed	30.1%
Total members	**16,246,642**

Figure 21 illustrates the range of TME PMPY growth rates across physician organizations in the Commercial market. Overall, Commercial TME PMPY increased by 7.8% ($548), rising from $6,984 in 2023 to $7,532 in 2024.

Among the physician organizations shown, both Permanente Medical Groups experienced TME PMPY growth rates exceeding 9%. Within the group of larger physician organizations, Sutter Bay Medical Group recorded the highest increase (9.0%), while Allied Pacific Medical Group remained relatively flat. Smaller physician organizations exhibited greater variation, with TME PMPY growth ranging from −1.0% for Prospect Medical Group Inc. to 14.4% for PRIMECARE Medical Network, Inc. All other physician organizations, which are generally smaller than those listed in this section, recorded an average increase of 6.6%. Unattributed members, representing more than 30% of the Commercial market, experienced a TME PMPY increase of 7.1%.

Figure 21. Commercial TME PMPY Spending Growth by Selected Physician Organizations, 2023-2024



Medicare Advantage

As shown in **Figure 22**, Medicare Advantage plans covered approximately 3.3 million Californians in 2024. Combined, the two Permanente Medical Groups accounted for more than 42% of the Medicare Advantage market. HealthCare Partners Affiliates Medical Group and Optum Health Plan of California followed with market shares of 2.2% and 2.0%, respectively; each had more than 50,000 attributed members. All remaining physician organizations had fewer than 50,000 attributed members. Unattributed members accounted for approximately 14% of the Medicare Advantage market.

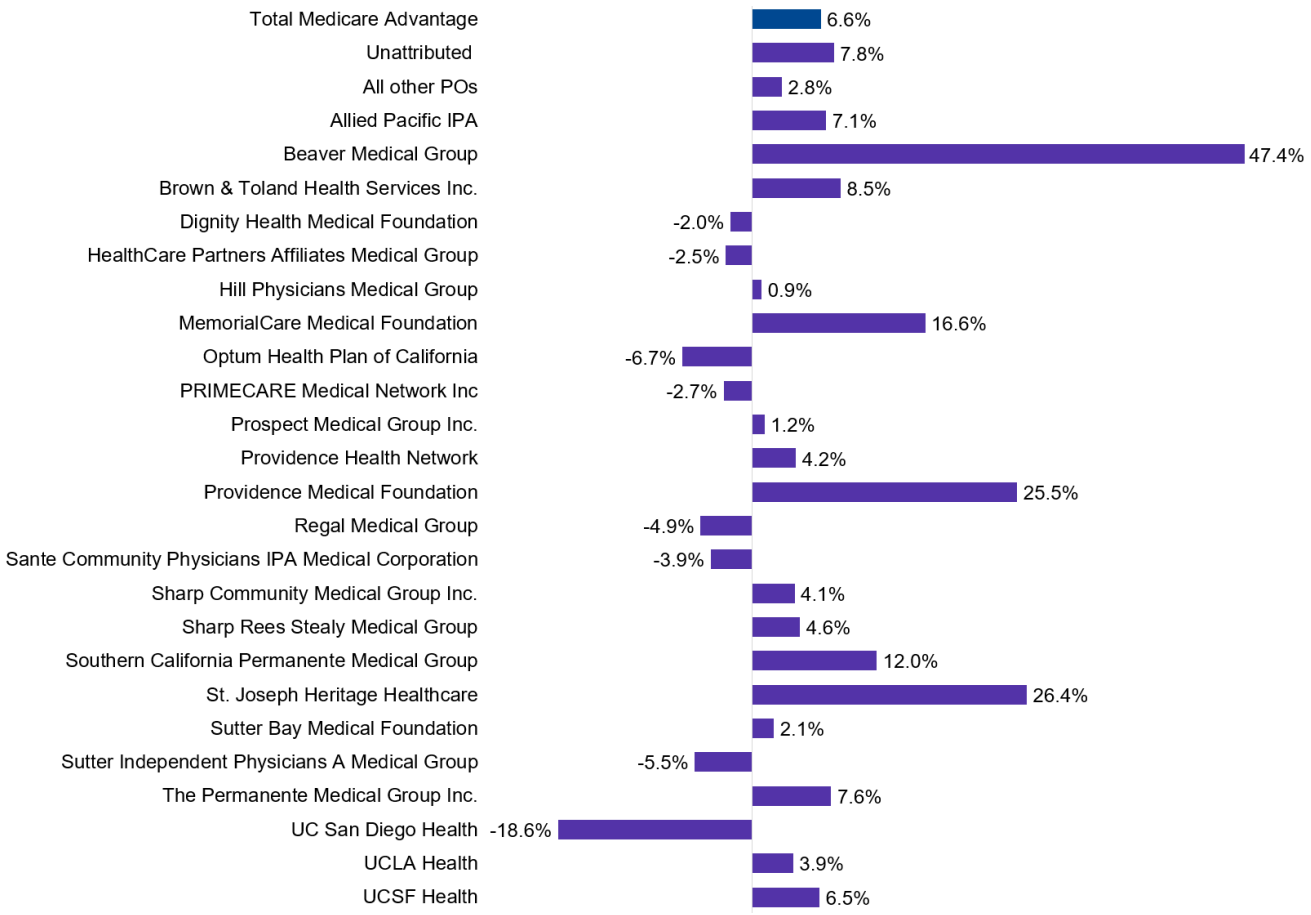
Figure 22. Medicare Advantage Market Share of Selected Physician Organizations, 2024

Medicare Advantage Physician Organizations	2024 Market share
Southern California Permanente Medical Group	21.1%
The Permanente Medical Group Inc.	21.0%
HealthCare Partners Affiliates Medical Group	2.2%
Optum Health Plan of California	2.0%
St. Joseph Heritage Healthcare	1.2%
Sharp Community Medical Group Inc.	1.1%
Regal Medical Group	1.0%
Sharp Rees Stealy Medical Group	1.0%
Sutter Bay Medical Foundation	0.9%
Hill Physicians Medical Group	0.8%
MemorialCare Medical Foundation	0.7%
Brown & Toland Health Services Inc.	0.7%
Sante Community Physicians IPA Medical Corporation	0.7%
Providence Health Network	0.6%
Beaver Medical Group	0.6%
PRIMECARE Medical Network Inc	0.6%
UCLA Health	0.6%
UCSF Health	0.5%
Sutter Independent Physicians A Medical Group	0.5%
Dignity Health Medical Foundation	0.5%
Providence Medical Foundation	0.4%
Allied Pacific IPA	0.3%
Prospect Medical Group Inc.	0.3%
UC San Diego Health	0.3%
All Other Providers	26.8%
Unattributed	13.7%
Total members	**3,350,003**

Figure 23 compares TME PMPY growth rates among select physician organizations in the Medicare Advantage market. Overall, total Medicare Advantage TME PMPY increased by 6.6% between 2023 and 2024. Among physician organizations with the largest market shares, Southern California Permanente Medical Group recorded a 12.0% increase in TME PMPY, while The Permanente Medical Group experienced a 7.6% increase. In contrast, HealthCare Partners Affiliates Medical Group (−2.5%) and Optum Health Plan of California (−6.7%) saw declines in TME PMPY over the period.

Smaller physician organizations exhibited substantial variation, with TME PMPY changes ranging from -18.8% (UC San Diego Health) to 47.4% (Beaver Medical Group). TME PMPY for all other physician organizations not individually listed increased by 2.8%, while unattributed members experienced a 7.8% increase.

Figure 23. Medicare Advantage TME PMPY Spending Growth by Selected Physician Organizations, 2023-2024



Section 8. 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 6 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 and full risk payments, 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 some 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 market spending (such as state correctional health, IHS, and VHA).

Table 6. 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.

Category	Description
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, 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 and full risk payments	Per capita 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	Prospective 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.

Category	Description
Shared savings payments 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 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.

As shown in **Figure 24**, Commercial claims spending grew from $83.8 billion in 2023 to $91.0 billion in 2024, an increase of $7.2 billion or 8.6%. Commercial non-claims spending grew from $30.4 billion in 2023 to $31.3 billion in 2024, an increase of $914 million or 3.0%. Medicare Advantage saw higher growth with claims spend-ing growing from $28.9 billion in 2023 to $33.2 billion in 2024, an increase of $4.3 billion or 14.8%. Medicare Advantage non-claims spending grew from $24.8 billion in 2023 to $26.4 billion in 2024, an increase of $1.5 billion or 6.1%.

Figure 24. Commercial and Medicare Advantage Claims and Non-Claims Aggregate Spending in Billions and Spending Growth, 2023-2024

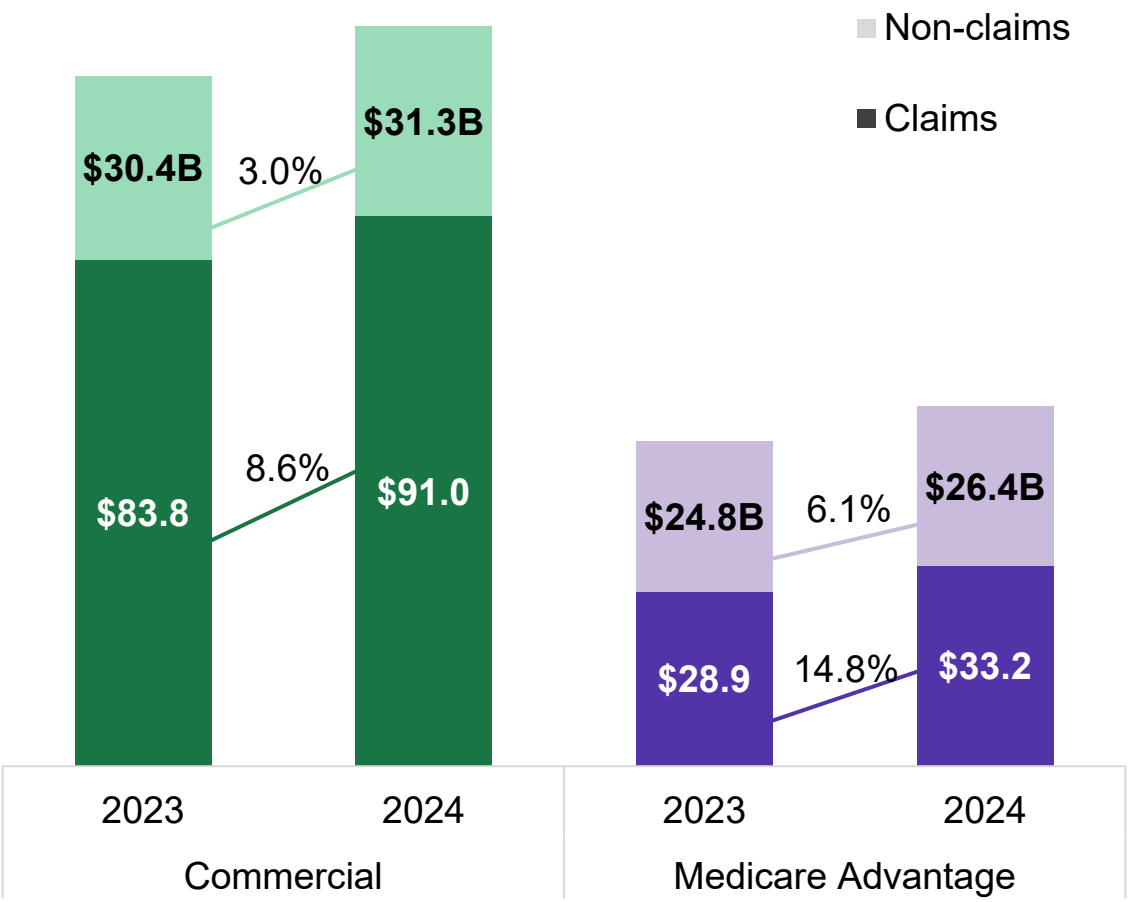
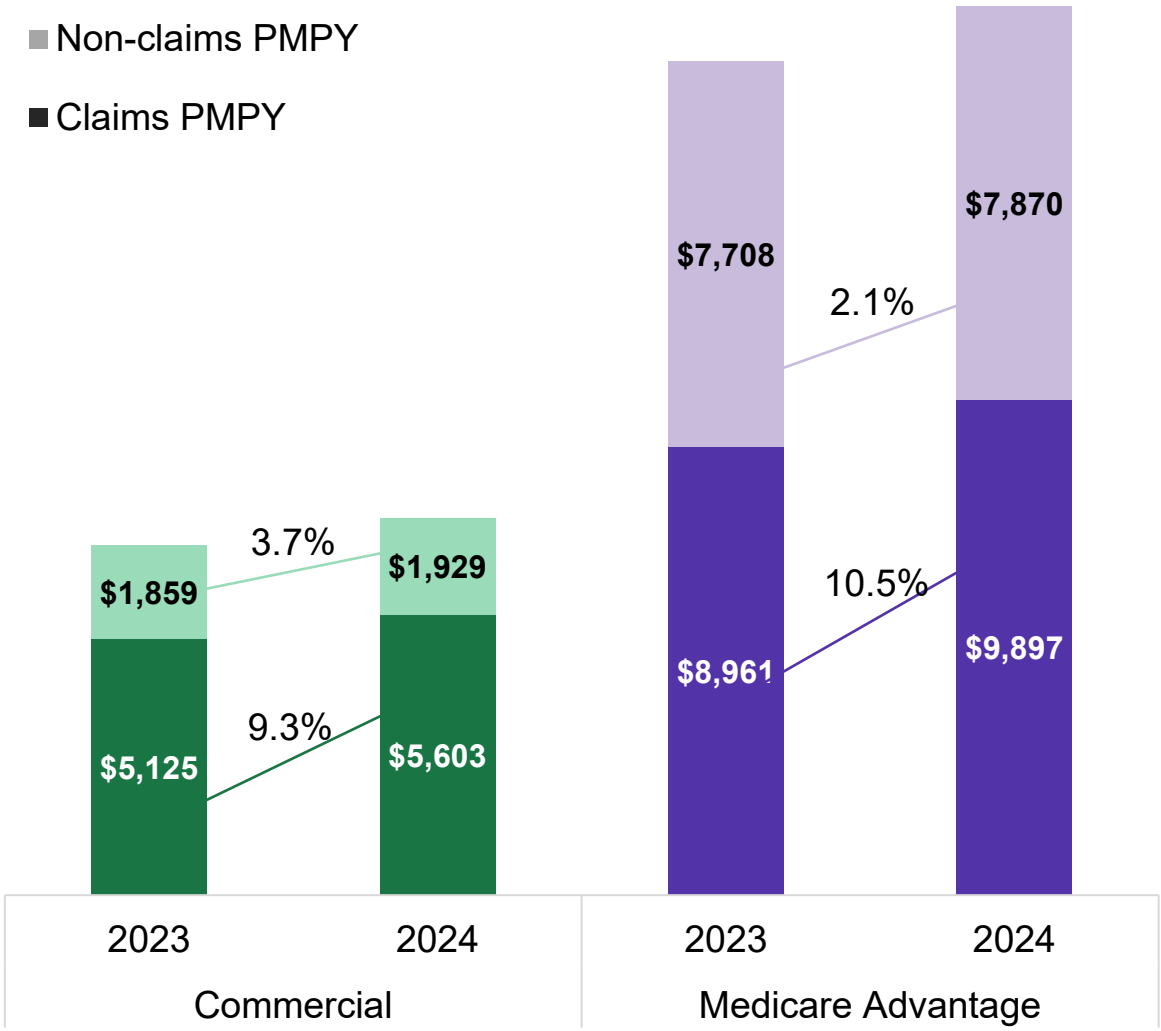


Figure 25 shows claims and non-claims PMPY spending in the Commercial and Medicare Advantage markets. Commercial claims spending PMPY in 2023 was $5,125 and $5,603 in 2024, an increase of $478 or 9.3%. Commercial non-claims spending PMPY in 2023 was $1,859 and $1,929 in 2024, an increase of $70 or 3.7%. Medicare Advantage claims spending grew from $8,961 PMPY in 2023 to $9,897, an increase of $936 or 10.5%. Medicare Advantage non-claims spending PMPY in 2023 was $7,708 and $7,870 in 2024, an increase of $162 or 2.1%.

Figure 25. Commercial and Medicare Advantage Claims and Non-claims Per Member Per Year Spending and Trend, 2023-2024



Non-claims Spending

Table 7 shows the breakdown of all non-claims spending in the Commercial and Medicare Advantage markets. Non-claims capitation spending represented the largest share of all non-claims spending at slightly over 98% for both Commercial and Medicare Advantage.

Table 7. Commercial and Medicare Advantage Non-claims Spending in Billions, 2023-2024

Non-claim Category	Commercial			Medicare Advantage		
	2023	2024	% change	2023	2024	% change
Capitation	$30.1427	$30.9524	2.7%	$24.4229	$25.8919	6.0%
Other non-claims	$0.0139	$0.0121	-13.0%	$0.2880	$0.3329	15.6%
Shared savings	$0.0821	$0.0677	-17.6%	$0.0980	$0.1041	6.2%
Performance payments	$0.1552	$0.2766	78.2%	$0.0235	$0.0234	-0.2%
Population health	$0.0244	$0.0233	-4.5%	$0.0052	$0.0109	108.3%
All non-claims	**$30.4183**	**$31.3321**	**3.0%**	**$24.8376**	**$26.3632**	**6.1%**

Note: Medicare Fee-for-Service non-claims spending is not included.

Claims Spending, by Service Category

Table 8 shows total aggregate claims spending by service category in the Commercial and Medicare markets.

Table 8 Commercial and Medicare Claims Spending by Category in Billions, 2023-2024

Category	Commercial			Medicare Advantage			Medicare FFS		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Hospital inpatient	$23.5	$24.5	4.2%	$8.0	$9.2	14.1%	$15.7	$16.9	7.4%
Hospital outpatient	$22.8	$25.4	11.6%	$4.2	$5.1	21.5%	$8.8	$9.9	12.2%

Category	Commercial			Medicare Advantage			Medicare FFS		
	2023	2024	% change	2023	2024	% change	2023	2024	% change
Professional	$12.6	$13.6	7.9%	$2.6	$3.1	19.6%	$14.2	$16.6	16.9%
Long-term care	$1.1	$1.2	7.4%	$1.9	$2.2	18.1%	$7.9	$8.8	11.3%
Pharmacy (gross of rebates)	$18.6	$20.7	11.1%	$10.1	$11.1	10.1%	$14.2	$13.3	-6.2%
Other	$5.3	$5.7	7.9%	$2.1	$2.4	18.4%	$8.3	$9.3	12.7%
Total	**$83.8**	**$91.0**	**8.6%**	**$28.9**	**$33.2**	**14.8%**	**$69.0**	**$74.7**	**8.2%**

- **Commercial:** In 2024, hospital outpatient services grew the fastest at 11.6% and represented the largest share of claims spending at $25.4 billion (28% of claims spending), closely followed by hospital inpatient services representing $24.5 billion (27% of claims spending) and growing by 4.2%. Pharmacy spending, gross of rebates, grew 11.1% and totaled $20.7 billion or 23% of claims spending.
- **Medicare Advantage:** Pharmacy spending, gross of rebates, represented the largest claims spending category in 2024 at $11.1 billion (33% of claims spending), followed by hospital inpatient spending at $9.2 billion (28% of claims spending) and hospital outpatient spending at $5.1 billion (15% of claims spending). Hospital outpatient service had the highest growth rate at 21.5%.
- **Medicare FFS:** Hospital inpatient services accounted for the largest share of claims spending at $16.9 billion (23% of claims spending), followed by professional services at $16.6 billion (22% of claims spending) and pharmacy spending, gross of rebates, at $13.3 billion (18% of claims spending), with total pharmacy spending decreasing from 2023. Professional services grew the fastest at 16.9% and represented 22% of claims spending.

Comparing TME PMPY and Spending Categories by Market

Table 9 shows TME PMPY by market and disaggregated by claims and non-claims spending categories between 2023 and 2024. 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 2024, Medicare FFS had the highest TME PMPY spending ($21,850), followed by Medicare Advantage ($17,767) and Commercial plans ($7,532).

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

- **Commercial:** Hospital inpatient and outpatient services accounted for the largest share of claims spending, with TME PMPY of $1,506 and $1,564 respectively, each representing approximately 20% of spending, followed by pharmacy spending (gross of rebates) ($1,273 TME PMPY or 17% of spending).
- **Medicare Advantage:** Pharmacy spending (gross of rebates) represented the largest claims spending category in 2024 ($3,309 TME PMPY or 19% of spending), followed by hospital inpatient claims spending ($2,737 TME PMPY or 15% of spending) and hospital outpatient claims spending ($1,527 TME PMPY or 9% of spending).
- **Medicare FFS:** The claims spending categories of hospital inpatient ($4,927 TME PMPY or 23% of spending), professional ($4,856 TME PMPY or 22% of spending), and pharmacy (gross of rebates) ($3,887 TME PMPY or 18% of spending) represented nearly two-thirds of TME PMPY in 2024.

For TME PMPY by market for non-claims spending, capitation represented the largest share of TME PMPY in 2024 for both the Medicare Advantage market ($7,729 TME PMPY or 44% of spending) and Commercial market ($1,905 TME PMPY or 25% of spending).

Table 9. Total Medical Expense Per Member Per Year Spending by Market and Category, 2023-2024

Category	Commercial		Medicare Advantage		Medicare FFS	
	2023	2024	2023	2024	2023	2024
Claims						
Hospital inpatient	$1,435	$1,506	$2,495	$2,737	$4,614	$4,927
Hospital outpatient	$1,392	$1,564	$1,306	$1,527	$2,592	$2,893
Professional	$769	$835	$815	$938	$4,178	$4,856
Long-term care	$66	$71	$578	$656	$2,314	$2,560
Pharmacy (gross of rebates)	$1,138	$1,273	$3,125	$3,309	$4,165	$3,887
Other	$325	$353	$641	$730	$2,434	$2,727
Non-claims						
Capitation	$1,843	$1,905	$7,580	$7,729	-	-
Non-claims, non-capitation[24]	$17	$23	$129	$141	-	-
Total (gross of rebates)	**$6,984**	**$7,532**	**$16,669**	**$17,767**	**$20,297**	**$21,850**

Figure 26 shows growth rates in TME PMPY and categories for the Commercial and Medicare markets between 2023 and 2024.

Below are TME PMPY growth rates by market and category:

- **Commercial:** TME PMPY increased from $6,984 in 2023 to $7,532 in 2024, an increase of $548 or 7.8%. For the increase in TME PMPY, $173 or 31.5% of the growth was driven by increases in hospital outpatient spending. Commercial retail pharmacy spending (gross of rebates) increased TME PMPY by $135, accounting for 24.7% of commercial PMPY spending growth. Hospital inpatient followed, increasing TME PMPY by $71 or 13.0%. Together, these three areas (hospital outpatient, commercial retail pharmacy, and hospital inpatient) contributed nearly 70% of the overall increase for Commercial.

- **Medicare Advantage:** TME PMPY increased from $16,669 in 2023 to $17,767 in 2024, an increase of $1,098 or 6.6%. Hospital inpatient and hospital outpatient spending each contributed significantly to overall growth, increasing TME PMPY by $242

[24] Non-claims, non-capitation is a consolidated reporting category comprising Population Health and Practice Infrastructure Payments, Performance Payments, Shared Savings Payments and Recoupments, and Other Non-Claims.

and $221 respectively, accounting for 22% and 20% of the total increase. Pharmacy (gross of rebates) spending increased TME PMPY by $184 representing 17% of the increase. These three categories comprised almost 60% of the total increase for Medicare Advantage.

- **Medicare FFS:** TME PMPY spending increased from $20,297 in 2023 to $21,850 in 2024, an increase of $1,553 or 7.7%. Professional service spending increased $678 TME PMPY or 44% of spending growth, followed by hospital outpatient and inpatient contributing approximately 20% each. These three categories comprised 83% of TME PMPY growth for Medicare FFS. Meanwhile, pharmacy spending (gross of rebates) decreased by $278 or a -6.7% change to overall growth.

Figure 26. Total Medical Expense Per Member Per Year Spending Growth by Market and Category, 2023-2024

Category	Commercial	Medicare Advantage	Medicare FFS
Hospital inpatient	5.0%	9.7%	6.8%
Hospital outpatient	12.4%	16.9%	11.6%
Professional	8.6%	15.0%	16.2%
Long-term care	8.1%	13.6%	10.7%
Pharmacy (gross of rebates)	11.9%	5.9%	-6.7%
Other	8.6%	13.9%	12.0%
Capitation	3.4%	2.0%	-
Non claims, non capitation	38.7%	9.3%	-
Total (gross of rebates)	7.8%	6.6%	7.7%

Note: Medicare FFS did not provide capitation, non-claims, or pharmacy rebate payments
FFS = fee-for-service.

Non-claims, non-capitation includes Population Health and Practice Infrastructure Payments, Performance Payments, Shared Savings Payments and Recoupments, and Other Non-Claims.

Pharmacy Rebates

Figure 27 shows payers in the Commercial and Medicare Advantage markets received pharmacy rebates from drug manufacturers totaling $6.04 billion in 2023 and $6.96 billion in 2024, an increase of $915 million or 15.1%. The rebate amounts in the Commercial market in 2023 were $4.05 billion and $4.64 billion in 2024, an increase of $590 million or 14.6%. The rebate amounts in the Medicare Advantage market in 2023 were $2.00 billion and $2.32 billion in 2024, an increase of around $325 million or 16.3%.

Figure 27. Commercial and Medicare Advantage Pharmacy Spending Gross and Net of Rebates in Billions by Market, 2023-2024

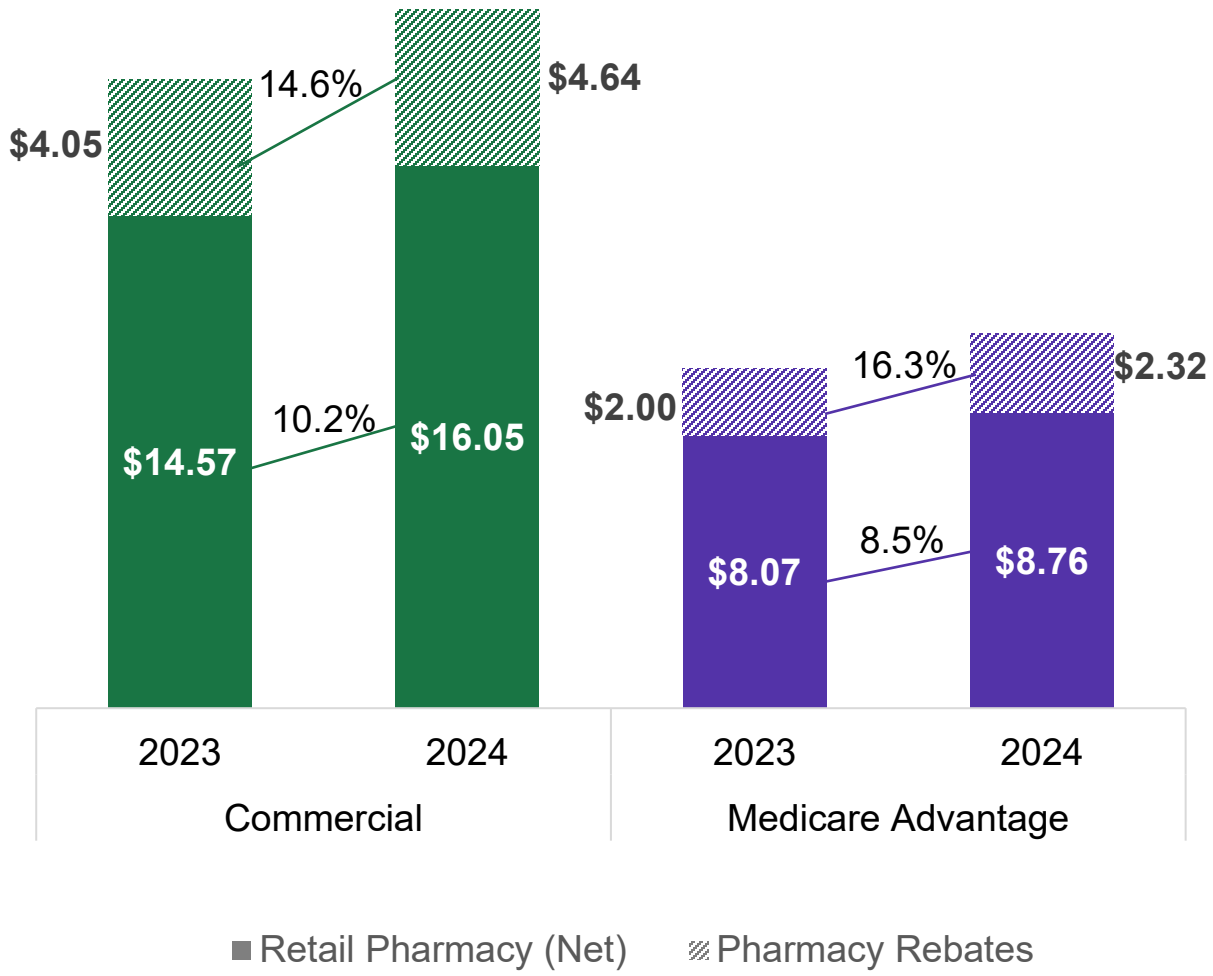
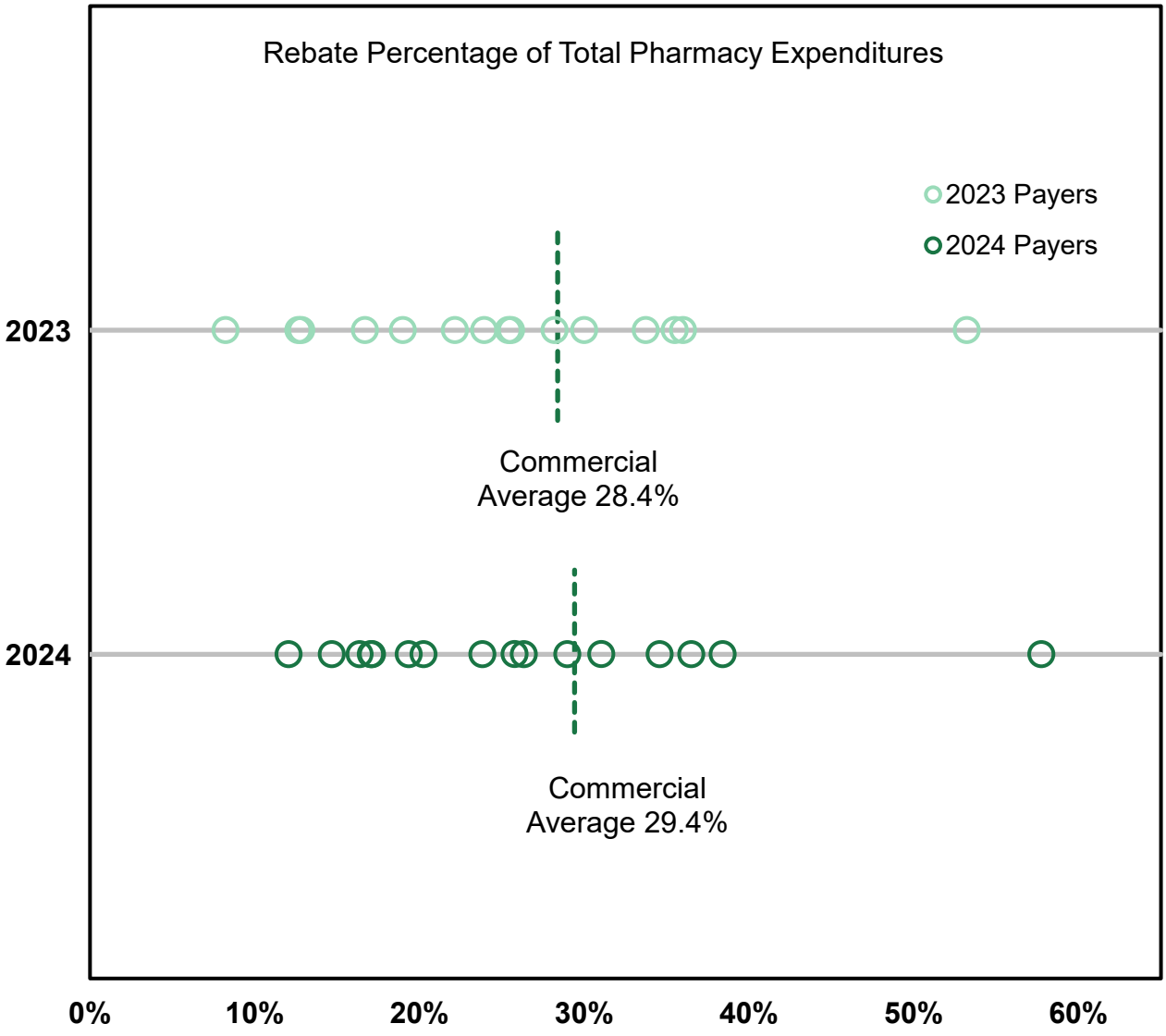


Figure 28 illustrates the distribution of prescription drug rebates as a share of total pharmacy spending in the Commercial market. In 2024, sixteen[25] Commercial payers received rebates averaging 29.4% of pharmacy spending, representing a 1-percentage-point increase from 2023. In 2024, rebate levels varied substantially across Commercial payers, ranging from a low of 12.1% to a high of 57.7% of pharmacy spending.

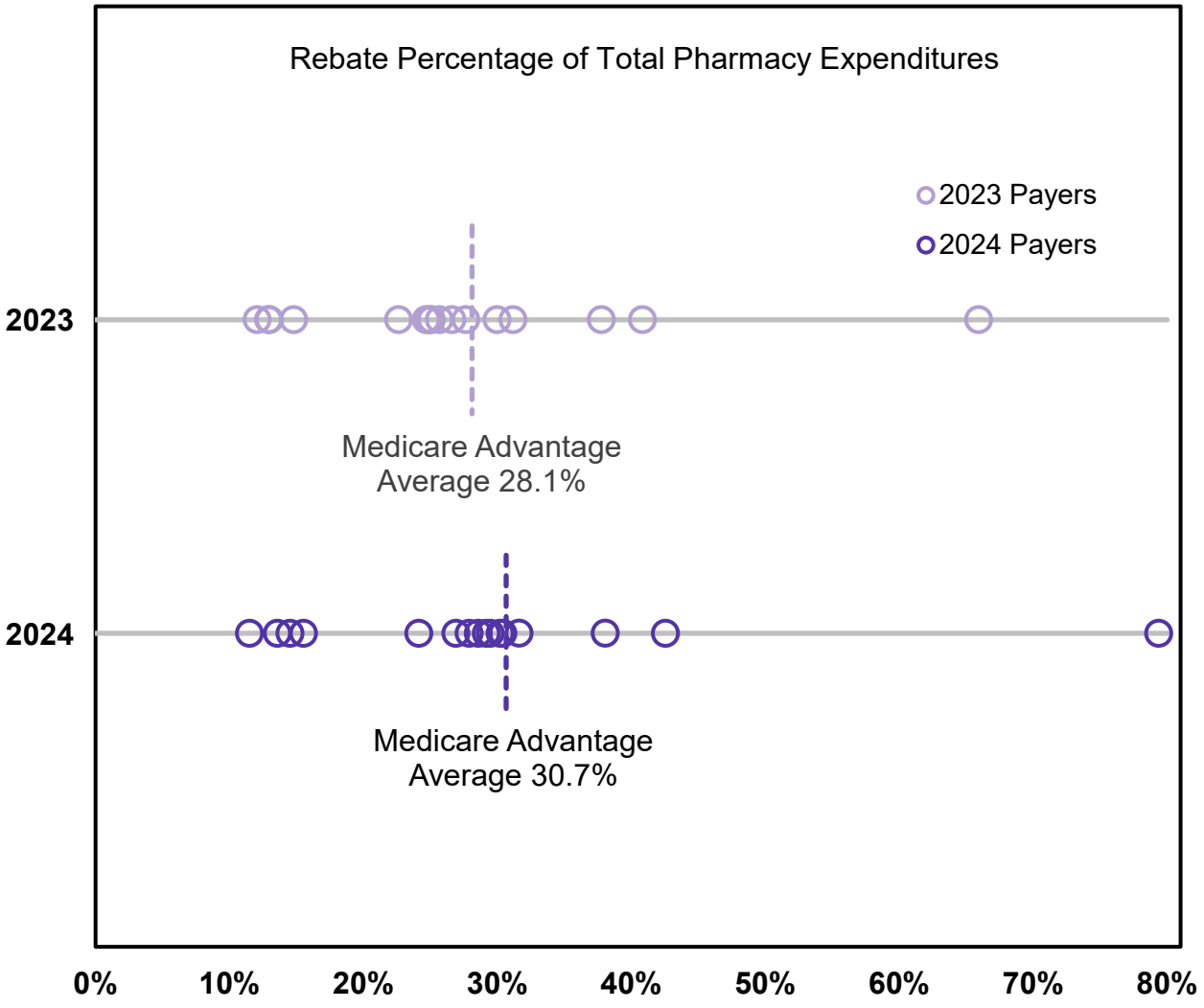
Figure 28. Commercial Rebate Share of Pharmacy Expenditures, 2023-2024



[25] Plans with zero rebates are excluded from analysis.

Figure 29 illustrates the distribution of pharmacy rebate percentages across Medicare Advantage payers in 2024. In the Medicare Advantage market, sixteen[26] payers received on average 30.7% of pharmacy expenditures back in the form of rebates, an increase of 2.5 percentage points over 2023. Rebate levels varied substantially across Medicare Advantage payers in 2024, ranging from 11.5% at the low end to 79.4% at the high end.

Figure 29. Medicare Advantage Rebate Share of Pharmacy Expenditures, 2023-2024



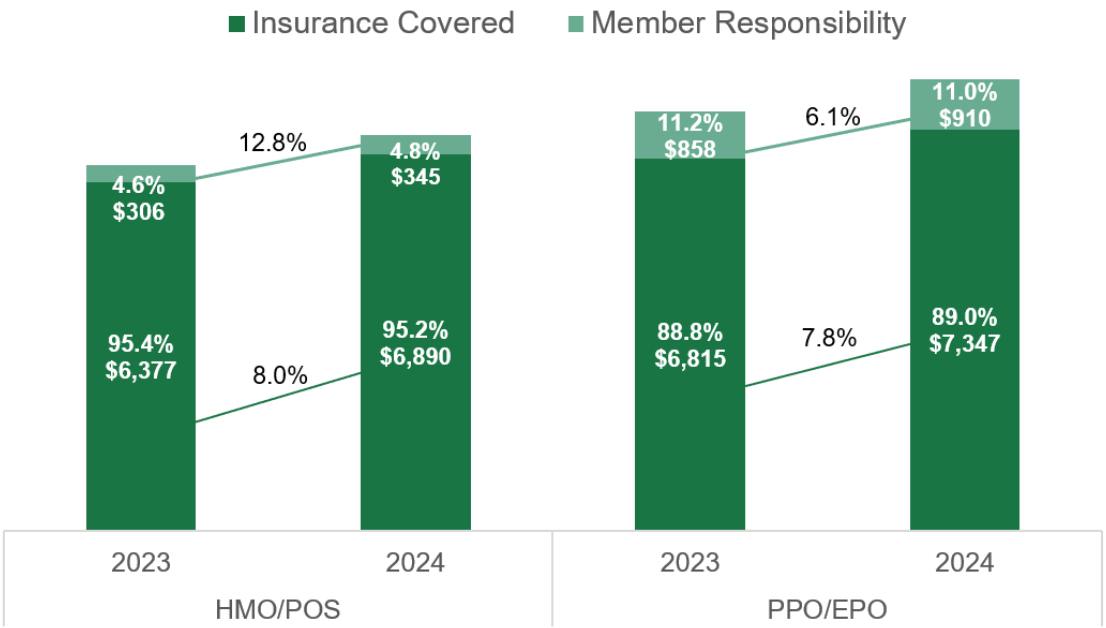
[26] Plans with zero rebates are excluded from analysis.

Member Responsibility

In 2024, member cost sharing for commercial TME including copayments, coinsurance, and deductibles averaged $525 per member per year (PMPY), representing an 8.4% increase from $484 PMPY in 2023. Despite this growth in absolute dollars, member cost sharing remained stable as a share of total spending, accounting for approximately 7% of commercial TME PMPY in both 2023 and 2024.

Figure 30 shows that growth varied by product type, with HMO/POS member responsibility increasing 12.8% from $306 to $345 PMPY, compared with a 6.1% increase from $858 to $910 PMPY for PPO/EPO products. Although HMO member responsibility increased at a faster rate, PPO/EPO products continued to have higher member cost sharing in both absolute dollars and as a share of TME.

Figure 30. Commercial Member Responsibility and Insurance Covered Spending by Product Type, PMPY, 2023 - 2024



Medicare Advantage member cost sharing increased modestly from $483 to $487 PMPY over the same period, while slightly declining as a share of TME from 2.9% in 2023 to 2.7% in 2024.

Section 9. Health Care Spending by Geographic Region

This section presents health care spending by region to identify regions with the highest growth rates. Geographic regions shown in this section consist of the 19 Covered California Rating Regions (RRs). 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 (RR 03). Payers reported about 1.6% of enrollees living in unknown or unspecified regions, which are not shown. See Appendix A.6 for a crosswalk of Covered California Rating Regions to California Counties.

In this section, data are 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.[27]

Regional data include the Commercial and Medicare Advantage markets. 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 by region.

Commercial Claims and Capitation PMPY Spending and Growth by Rating Region

Table 10 shows 2023 and 2024 PMPY spending trends by rating region across the Commercial market. Among California's 19 rating regions, changes in Commercial PMPY spending growth from 2023 to 2024 ranged from 2.2% to 13.0%. In dollar terms, changes in Commercial PMPY spending from 2023 to 2024 ranged from $124 to $931.

[27] 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 10. Commercial Claims and Capitation Per Member Per Year (PMPY) Spending and Growth Rate by Rating Region, 2023-2024

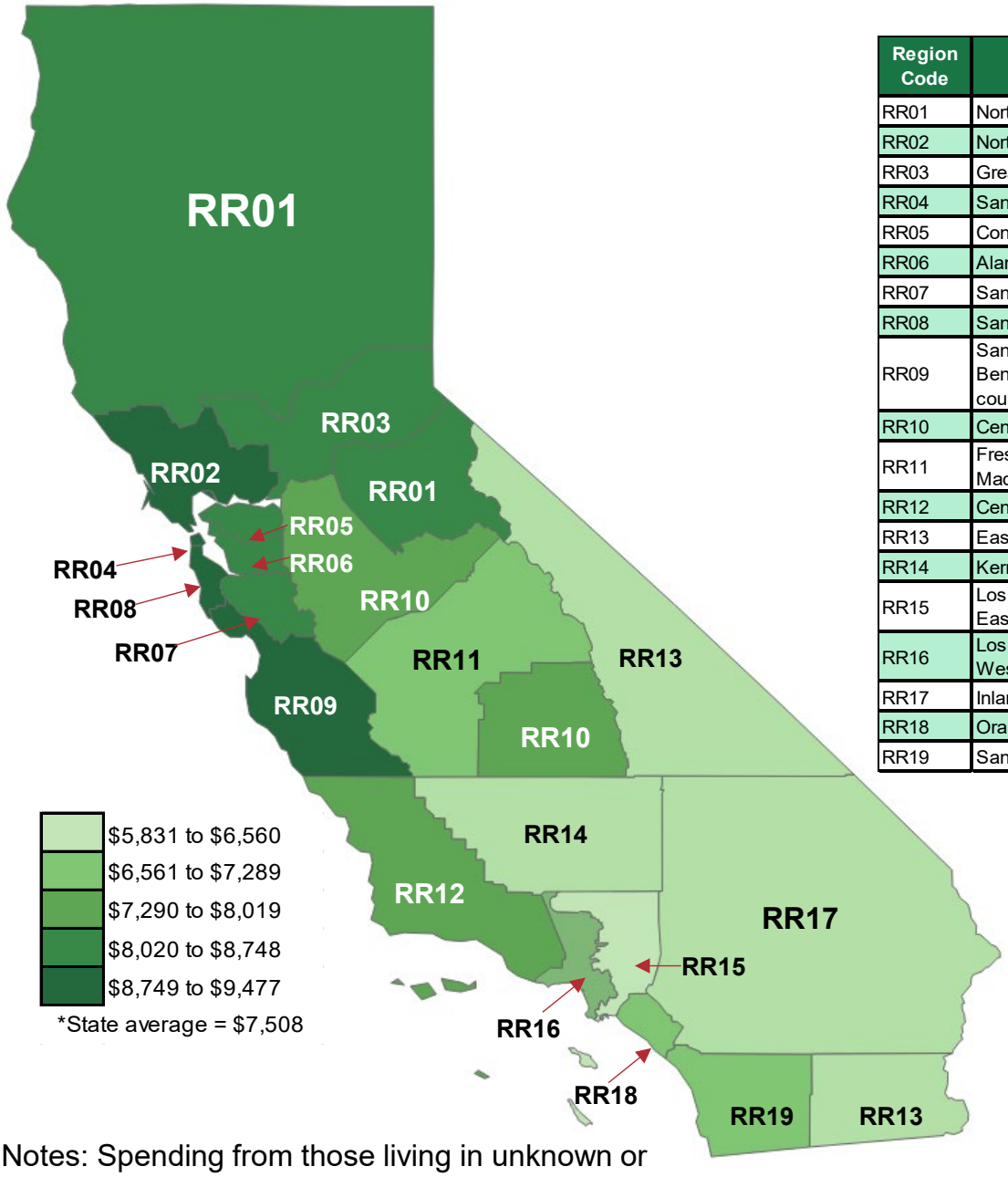
Region Code	Region	PMPY		PMPY Dollar Change	PMPY Growth Rate
		2023	2024		
RR08	San Mateo County	$8,673	$9,477	$805	9.3%
RR09	Santa Cruz, San Benito, and Monterey counties	$8,597	$9,083	$486	5.7%
RR04	San Francisco County	$8,398	$9,026	$628	7.5%
RR02	North Bay Area	$8,214	$8,962	$747	9.1%
RR05	Contra Costa County	$7,721	$8,487	$766	9.9%
RR01	Northern counties	$8,102	$8,455	$353	4.4%
RR07	Santa Clara County	$7,832	$8,391	$559	7.1%
RR03	Greater Sacramento	$7,520	$8,383	$863	11.5%
RR06	Alameda County	$7,188	$8,119	$931	13.0%
RR10	Central Valley	$7,025	$7,826	$800	11.4%
RR16	Los Angeles County West	$6,869	$7,348	$479	7.0%
RR12	Central Coast	$6,635	$7,324	$689	10.4%
RR19	San Diego County	$6,718	$7,221	$503	7.5%
RR18	Orange County	$6,545	$6,985	$439	6.7%
RR11	Fresno, Kings, and Madera counties	$6,743	$6,896	$153	2.3%
RR15	Los Angeles County East	$5,937	$6,409	$472	8.0%
RR17	Inland Empire	$5,865	$6,212	$347	5.9%
RR14	Kern County	$5,645	$6,097	$452	8.0%
RR13	Eastern counties	$5,707	$5,831	$124	2.2%

Of the 19 rating regions, none of the rating regions experienced a drop in Commercial PMPY spending. At the higher end, 4 of the 19 rating regions experienced increases of greater than 10%.

- The Alameda County rating region (RR 06) saw spending growth increase 13.0% or $931, growing from $7,188 Commercial PMPY in 2023 to $8,119 Commercial PMPY in 2024.
- The Greater Sacramento rating region[28] (RR 03) saw spending growth increase 11.5% or $863, growing from $7,520 in 2023 to $8,383 in 2024.
- The Central Valley rating region[29] (RR 10) saw spending growth increase 11.4% or $800, growing from $7,025 in 2023 to $7,826 in 2024.
- The Central Coast rating region[30] (RR 12) saw spending growth increase 10.4% or $689, growing from $6,635 in 2023 to $7,324 in 2024.

[28] The Greater Sacramento rating region (RR 03) encompasses the four California counties of El Dorado, Placer, Sacramento, and Yolo.
[29] The Central Valley rating region (RR 10) encompasses the five California counties of Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.
[30] The Central Coast rating region (RR 12) encompasses the three California counties of San Luis Obispo, Santa Barbara, and Ventura.

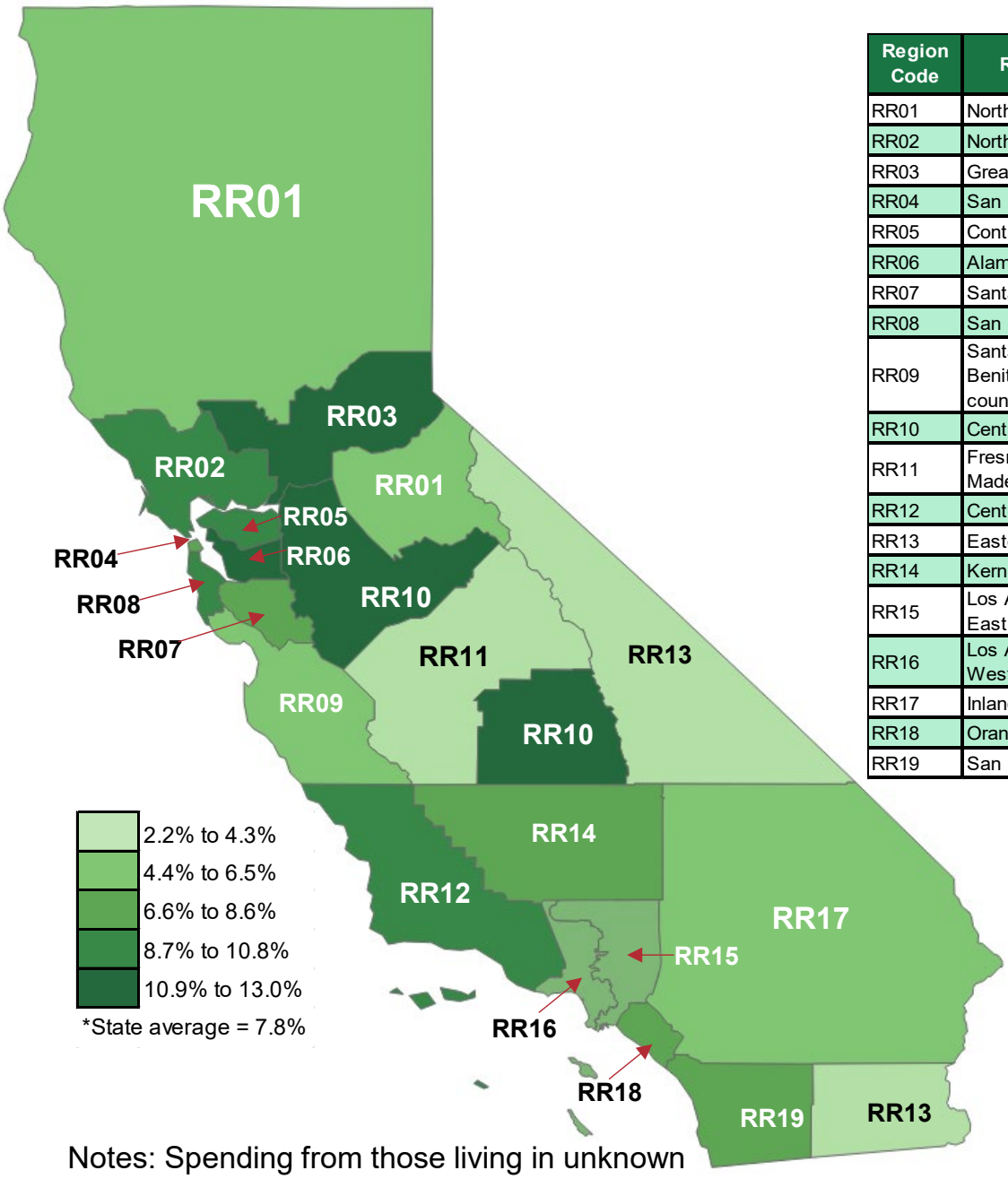
Figure 31. Commercial Claims and Capitation Per Member Per Year (PMPY) Spending by Rating Region, 2024



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
RR15	Los Angeles County East
RR16	Los Angeles County West
RR17	Inland Empire
RR18	Orange County
RR19	San Diego County

Notes: Spending from those living in unknown or unspecified regions are included in the calculation of the state average.

Figure 32. Commercial Claims and Capitation Growth Rate by Rating Region, 2023-2024



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
RR15	Los Angeles County East
RR16	Los Angeles County West
RR17	Inland Empire
RR18	Orange County
RR19	San Diego County

Notes: Spending from those living in unknown or unspecified regions are included in the calculation of the state average.

Medicare Advantage Claims and Capitation PMPY Spending and Growth by Rating Region

Table 11 shows 2023 and 2024 PMPY spending trends by rating region across the Medicare Advantage market. Among California's 19 rating regions, Medicare Advantage PMPY spending growth ranged from -0.6% to 24.6%. In dollar terms, changes in Medicare Advantage PMPY spending from 2023 to 2024 ranged from -$120 to $3,668.

Of the 19 rating regions, 1 rating region—the Eastern Counties rating region[31] (RR 13)—saw a drop in Medicare Advantage PMPY spending growth, decreasing from $18,522 PMPY in 2023 to $18,402 PMPY in 2024, a decline of -0.6% or -$120.

At the higher end, 4 of the 19 rating regions experienced increases of greater than 10%.

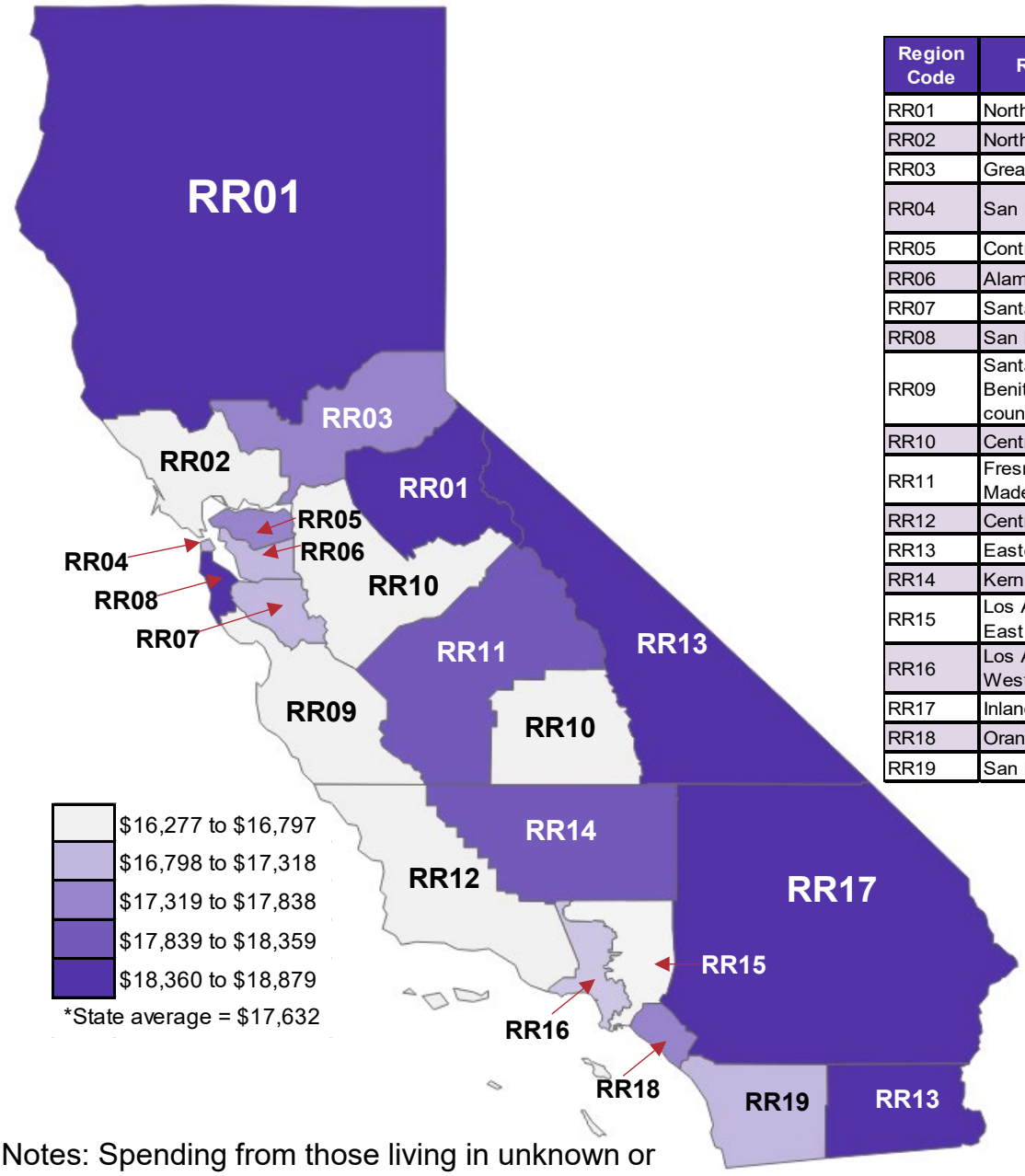
- The Inland Empire rating region[32] (RR 17) saw spending growth increase 24.6% or $3,668, growing from $14,896 in 2023 to $18,564 in 2024.
- The Contra Costa County rating region (RR 05) saw spending growth increase 18.3% or $2,720, growing from $14,828 in 2023 to $17,549 in 2024.
- The Santa Cruz, San Benito, and Monterey counties rating region (RR 09) saw spending growth increase 13.4% or $1,926, growing from $14,411 in 2023 to $16,337 in 2024.
- The Alameda County rating region (RR 06) saw spending growth increase 12.0% or $1,829, growing from $15,216 in 2023 to $17,046 in 2024.

[31] The Eastern Counties rating region (RR 13) encompasses the three California counties of Imperial, Inyo, and Mono.
[32] The Inland Empire rating region (RR 17) encompasses the two California counties of Riverside and San Bernardino.

Table 11. Medicare Advantage Claims and Capitation Per Member Per Year (PMPY) Spending and Growth Rate by Rating Region, 2023-2024

Region Code	Region	PMPY		PMPY Dollar Change	PMPY Growth Rate
		2023	2024		
RR08	San Mateo County	$17,722	$18,879	$1,157	6.5%
RR17	Inland Empire	$14,896	$18,564	$3,668	24.6%
RR01	Northern counties	$17,335	$18,463	$1,128	6.5%
RR13	Eastern counties	$18,522	$18,402	-$120	-0.6%
RR14	Kern County	$17,689	$18,289	$600	3.4%
RR11	Fresno, Kings, and Madera counties	$17,466	$18,168	$702	4.0%
RR05	Contra Costa County	$14,828	$17,549	$2,720	18.3%
RR03	Greater Sacramento	$16,619	$17,532	$913	5.5%
RR18	Orange County	$16,000	$17,353	$1,354	8.5%
RR04	San Francisco County	$16,650	$17,292	$641	3.9%
RR06	Alameda County	$15,216	$17,046	$1,829	12.0%
RR07	Santa Clara County	$15,879	$16,948	$1,069	6.7%
RR19	San Diego County	$15,540	$16,895	$1,355	8.7%
RR16	Los Angeles County West	$15,953	$16,821	$868	5.4%
RR10	Central Valley	$15,313	$16,734	$1,421	9.3%
RR02	North Bay Area	$15,182	$16,578	$1,396	9.2%
RR09	Santa Cruz, San Benito, and Monterey counties	$14,411	$16,337	$1,926	13.4%
RR12	Central Coast	$15,129	$16,307	$1,177	7.8%
RR15	Los Angeles County East	$15,255	$16,277	$1,023	6.7%

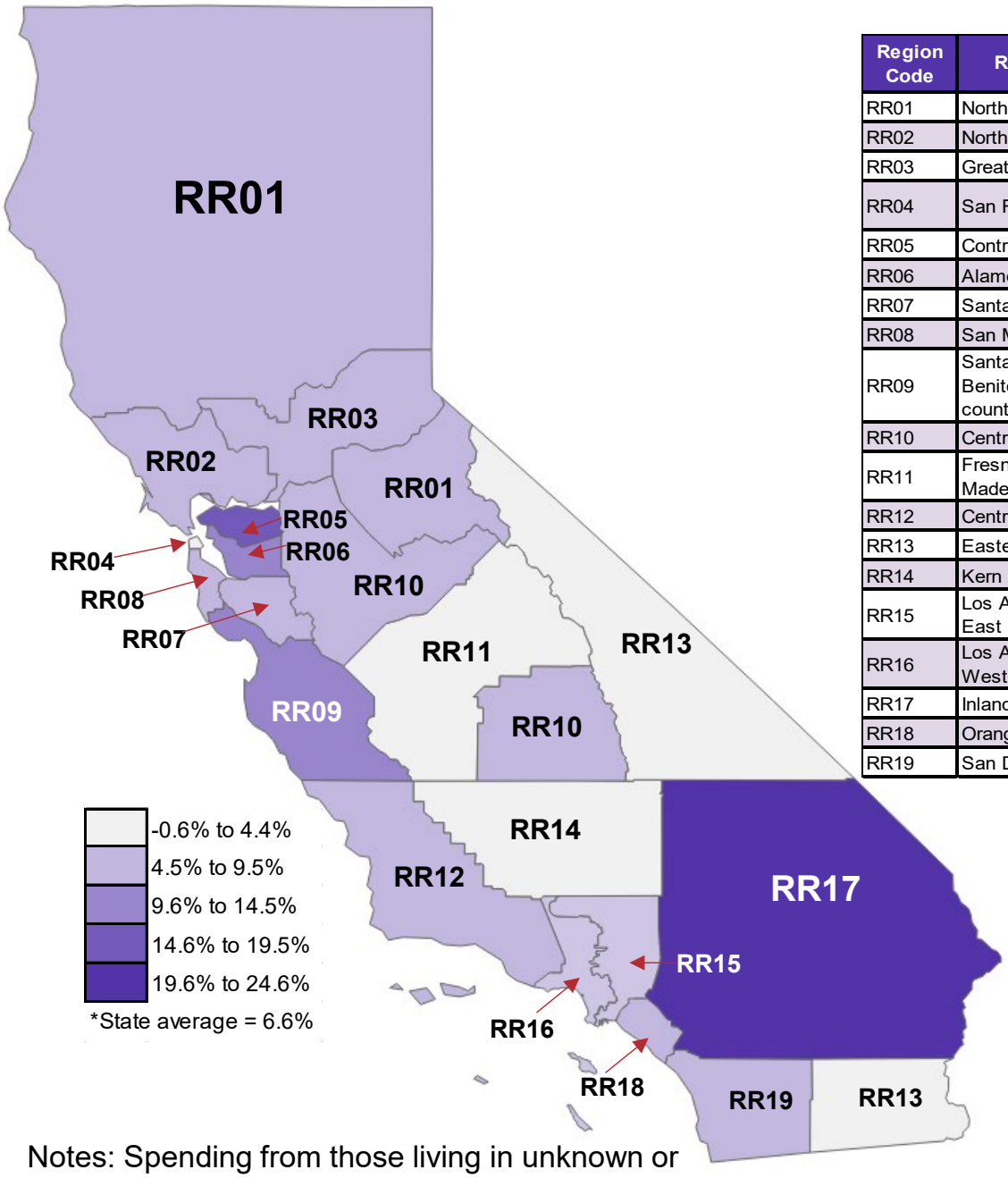
Figure 33. Medicare Advantage Claims and Capitation Per Member Per Year (PMPY) Spending by Rating Region, 2024



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
RR15	Los Angeles County East
RR16	Los Angeles County West
RR17	Inland Empire
RR18	Orange County
RR19	San Diego County

Notes: Spending from those living in unknown or unspecified regions are included in the calculation of the state average.

Figure 34. Medicare Advantage Claims and Capitation Growth Rate by Rating Region, 2023-2024



Region Code	Region Name
RR01	Northern counties
RR02	North Bay Area
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RR04	San Francisco County
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RR06	Alameda County
RR07	Santa Clara County
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RR10	Central Valley
RR11	Fresno, Kings, Madera counties
RR12	Central Coast
RR13	Eastern counties
RR14	Kern County
RR15	Los Angeles County East
RR16	Los Angeles County West
RR17	Inland Empire
RR18	Orange County
RR19	San Diego County

Notes: Spending from those living in unknown or unspecified regions are included in the calculation of the state average.

Section 10. 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 report builds on OHCA's inaugural 2025 baseline report, increasing public transparency on spending levels across major markets prior to the implementation of OHCA's statewide spending target, which is effective for performance years 2025-2029. Total medical expenses per member per year growth among Medi-Cal Managed Care and Medicare Advantage payers averaged 20.1% and 6.6%, respectively, compared with an average of 7.8% for Commercial payers. Retail pharmacy, professional, and hospital services contributed to the largest increases in spending growth across service categories for both Commercial and Medicare markets. To complement OHCA's THCE data collection, the Office will continue to draw upon the Health Care Payments Data (HPD) to analyze cost drivers and contextualize trends in California.

Appendix A. Methods and Data Sources

A.1 Data Sources

Total Health Care Expenditures Data Submissions

Commercial and Medicare Advantage 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 2025. Mandatory submitters are those with at least 40,000 members in either the Commercial or Medicare Advantage markets. In addition to TME data, select submitters also reported total non-medical expense data for self-insured commercial plans.

Other Data Sources

For the commercial fully insured market, OHCA collected total non-medical expense 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 total non-medical expense. 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, TMNE, and member-level data – OHCA used Medical Loss Ratio reports that plans submit annually to the California Department of Health Care Services (DHCS).

CMS provided Medicare FFS TME, including data for both Medicare FFS (Parts A and B) plans and TME from Medicare Drug Plans (Part D).[33]

[33] 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.

For the category of Other spending for state and federal health care programs, the report includes TME data provided by California Correctional Health Care Services (CCHCS), Indian Health Service (IHS), and the Veterans Health Administration (VHA).

Summarized data sources for all applicable markets are provided in **Table 12**.

Table 12. Data Sources

Market	Submarket	TME	TNME	Population
Statewide	Not applicable	Sum of sources	Sum of sources	US Census Bureau
Commercial	Not applicable	OHCA Payer Submissions	CCIIO MLR data and OHCA Payer Submissions (Self-insured only)	OHCA Payer Submissions
Medi-Cal	Managed Care	DHCS MLR reports	DHCS MLR reports	DHCS MLR reports
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
Other	California Correctional Health Care Services (CCHCS)	Data extract from CCHCS dashboard	Not available	Not available
	Indian Health Service (IHS)	Congressional Justification	Not available	Not available

Market	Submarket	TME	TNME	Population
	Veterans Health Administration (VHA)	Geographic Distribution of VA Expenditures (GDX) Report	Not available	Not available

Note: *All publicly available data sources are linked in the table above.*

a Medi-Cal FFS enrollment figures are not reported separately. Because Fee-for-Services (FFS) spending applies to both managed care and FFS enrollees, a distinct count of FFS-only enrollees is not available.

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, 2025 for services provided in 2023 and 2024.

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 section. The annual growth rate for both total dollars and PMPY is calculated for 2023 and 2024.

In addition to the expenditures captured in TME, THCE includes the costs to state residents associated with administration of health coverage, including payer profits (TMNE). OHCA includes total non-medical expense 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 13**).

Table 13. Summarizes Key Measure Calculations for Each Market

Market	Submarket	TME Gross	TME Net	TMNE	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] + Total Non-Medical Expense (self-insured) [b]	TME Gross + TMNE
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 + TMNE
	FFS	Total program payments + cost sharing	TME Gross [c]	Not available	TME Gross
Medi-Cal	Managed Care	MLR Numerator	MLR Numerator [e]	Total Revenue – Pass Through Payments – Managed Care Tax – TME Gross	TME Gross + TMNE
Other	CCHCS	Total non-labor costs	TME Gross [e]	Not available	TME Gross [e]
	IHS	Total Program Expenditures	TME Gross [e]	Not available	TME Gross [e]

Market	Submarket	TME Gross	TME Net	TMNE	THCE
	VHA	Total Medical Care Expenditures	TME Gross [e]	Not available	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 Reported in response to a mandatory question in payer data submissions.

c Pharmacy rebates not available.

d Pharmacy Rebates are reported as negative values for Medi-Cal FFS in Form CMS-64, 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 total non-medical expense are not applicable or not available due to data source restrictions. Therefore, THCE = TME Net = TME Gross.

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 6**. Medicare FFS data were also reported by service category.

A.3 Exclusions

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

- Medi-Cal fee-for-service spending including Medi-Cal Rx
- Managed Care Organization (MCO) tax, pass-through payments, and certain amounts related to state directed payments that are financed using separate payment terms.
    - The following state directed payments are fully excluded because the expenditures had not yet occurred at the time of reporting: Designated Public Hospital Quality Incentive Pool, District and Municipal Public Hospital Quality Incentive Pool, District and Municipal Public Hospital Directed Payment, Private Hospital Directed Payment, and Designated Public Hospital Enhanced Payment Program.
    - Interim amounts paid for the following state directed are included. However final payment amounts are not included because expenditures had not yet occurred at the time of reporting: Skilled Nursing Facility Workforce & Quality Incentive Program.
- DHCS spending on non-Medi-Cal health programs
- 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).
- 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.
- Payers that only offered coverage in one of the two reporting years were excluded from payer-level reporting.

- Total non-medical expense totals do not include costs from all self-funded commercial plans due to incomplete reporting.
- Total non-medical expense for three accountable Medicare Advantage and one commercial plans due to incomplete data availability.
- A portion of Commercial self-insured and Medicare Advantage THCE spending due to incomplete reporting.
- Medicare supplemental insurance.

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 Process Attributed TME Data for Reporting Physician Organizations

Although OHCA provided an Attribution Addendum (**Table 14**) as part of the Data Submission Guide (DSG) to standardize the identification of physician organizations in attributed data submissions, variations in how physician organizations were identified remained and required additional data processing.

Table 14. Sample Data Submission Guide Physician Organization Attribution Addendum

Organization Code	Organization Name	Parent Organization (if applicable)	DMHC # (if applicable)	Taxpayer Identification Number(s) (if available)	National Provider Identifier (if available)
1045	Brown & Toland Health Services, Inc.	Altais		45-5621621	
1053	Cedars-Sinai Medical Care Foundation	Cedars-Sinai Medical Center	10078		
1333	Centric Health				
1063	CHOC Physicians Network, Inc.		10088		
1064	Choice Medical Group		10428		

Data Processing

Because multiple data submitters attribute TME to the same physician organizations, a single organization may appear under multiple name variations in the data. In addition, multiple physician organizations may share the same Tax Identification Number (TIN) when they are affiliated under a common parent organization.

For reporting purposes, the objective is to associate each attributed data record with one and only one organization name as defined in the Attribution Addendum (April 2025 revision). Physician organizations are treated as distinct entities according to this definition.

For example, Sutter Bay Medical Foundation (Organization Code 1270) and Sutter Independent Physicians Medical Group (Organization Code 1273) are reported separately despite having the same parent organization, and Optum (Organization Code 1493) is reported separately from Optum Epic Beaver Medical Grp (Organization Code 1497).

Due to variations in organization names and shared Tax Identification Numbers (TINs), a given record may have multiple potential matches to organizations listed in the Attribution Addendum.

To address this, the data processing methodology evaluated Organization Code, Organization Name, and TINs for each record and selected the best match based on a defined ranking framework. A ranking of 1 represents the highest level of confidence in matching a record to a physician organization in the Attribution Addendum.

1. Match all three (those with TIN)
2. Match two, TIN & Name (those with TIN)
3. Match two, Code & Name (those with TIN)
4. Match two, Code & Name (those without TIN)
5. Match two, TIN & Code but not Name (those with TIN)

6. Match one, TIN only (those with TIN)
7. Match one, Name only
8. Match one, Code only

If a record matched two organization names in the Attribution Addendum at different confidence levels (for example, one at match level 2 and another at match level 3), the record was attributed to the organization with the higher-confidence match. In this example, the record would be assigned to the organization with a match level of 2.

Match Quality Results

Overall, approximately 80% of members and attributed TME among physician organizations featured individually in this report were matched on all three data elements (Organization Code, Organization Name, and TIN) in the Attribution Addendum. An additional 15% were matched based on Organization Code and Organization Name; these were those without confirmed TIN (**Table 15**).

Table 15. Attribution Match Quality Results

Quality the Data Process	Share of Members	Share of TME
1: Match all three (those with TIN)	80.5%	79.4%
4: Match two, Code & Name (those without TIN)	11.1%	11.0%
3: Match two, Code & Name (those with TIN)	4.2%	4.5%
2: Match two, TIN & Name (those with TIN)	1.9%	2.4%
6: Match one, TIN only (those with TIN)	1.4%	1.8%
7: Match one, Name only	0.8%	0.9%
5: Match two, TIN & Code but not Name (those with TIN)	0.03%	0.04%
8: Match one, Code only	0.02%	0.03%

Quality the Data Process	Share of Members	Share of TME
Total Among Featured Physician Organizations	100.0%	100.0%

A.6 Covered California Rating Regions to County Crosswalk

Table 16 shows which California counties map to each Covered California Rating Region in regional analyses.

Table 16. Covered California Rating Region to California County Crosswalk

Covered California 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 - East
RR16	Los Angeles - West
RR17	Riverside, San Bernardino
RR18	Orange
RR19	San Diego

A.7 Total Non-Medical Expense Calculation

Calculation for TNME from CCIIO MLRs.			
Start	**Premium Earned**	Part 1	**1.1 Total direct premium earned**
Subtract	Incurred Claims	Part 2	2.17 Total incurred claims
Subtract	Quality Improvement Expenses	Part 1	4.6 Total allowable quality improvement expenses
Subtract	MLR Rebate	Part 3	5.4 Rebate amount if credibility-adjusted MLR is less than MLR standard (Lines (5.1 - 5.2) x 5.3)
Subtract	Fraud recoveries/expenses	Part 2	2.18 Allowable claims recovered through fraud reduction efforts (the smaller of Lines 2.18a or 2.18b)
Add	CSR	Part 2	2.19 Reconciled payments of cost-sharing reductions
Total	**TNME**		
	EXPENSES		
Subtract	Cost Containment	Part 2	5.1 Cost containment expenses not included in quality improvement expenses in Section 4
Subtract	Other claim adjustment exp	Part 2	5.2 All other claims adjustment expenses
Subtract	Direct Salaries / Benefits	Part 2	5.3 Direct sales salaries and benefits
Subtract	Commissions	Part 2	5.4 Agents and brokers fees and commissions
Subtract	Other General Admin	Part 2	5.6 Other general and administrative expenses
	TAXES and FEES		
		Part 3	2.2 Federal and State taxes and licensing or regulatory fees
Total	**Profit**		**TNME – Expenses – Taxes and fees**

Appendix B. Key Terms

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.

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

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

Department: The California Department of Health Care Access and Information (HCAI).

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.

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.

Fully integrated delivery system (FIDS): 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.[34]

Health insurer: An entity licensed to provide health insurance or specialized behavioral health-only policies, as defined in Section 106 of the Insurance Code.[35]

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.[36]

[34] Health & Safety Code § 127500.2(h).
[35] 22 CCR 97445(g).
[36] 22 CCR 97445(h).

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.

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." 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).

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 report 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 6 for a list of non-claims spending categories and their definitions.

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

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 of the Health and Safety Code), 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 for or arranges for the purchase of health care services on behalf of employees, dependents, or retirees.[37]

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 comparable across entities, regardless of the number of people served.

Pharmacy rebates: Payments, regardless of how categorized, paid by the pharmaceutical manufacturer or pharmacy benefits manager (PBM) to a payer or fully integrated delivery system.

Physician organization: As referenced in the Health and Safety Code, any of the following:

(1) An organization described in paragraph (2) of subdivision (g) of Section 1375.4.

(2) A risk-bearing organization, as defined in Section 1375.4.

(3) A restricted health care service plan and limited health care service plan under subdivision (a) of Section 1300.49 of Title 28 of the California Code of Regulations. The inclusion of restricted health care service plans and limited health care service plans in the definition of "physician organization" does not narrow, abrogate, or otherwise alter the regulatory authority of the Department of Managed Health Care over these entities.

(4) A medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206.

(5) A medical group practice, a professional medical corporation, a medical partnership, or any lawfully organized group of physicians and surgeons that provides, delivers, furnishes, or otherwise arranges for health care services and is comprised of 25 or more physicians.

[37] Health & Safety Code § 127500.2(g).

(6) Notwithstanding paragraph (5), an organization of less than 25 physicians, but that is a high-cost outlier whose costs for the same services provided are substantially higher compared to the statewide average, as identified through data sources that include, but are not limited to, data from state and federal agencies, other relevant supplemental data, such as financial data on providers that is submitted to state agencies, or data reported to HCAI under the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671). The cost of delivering the same services in a geographic region shall be considered to the extent that cost substantially deviates from the statewide average and reflects higher costs in that region unrelated to the market dominance of providers in that region or unrelated to the ownership, management, or asset structure chosen by the organization.[38]

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.

Reporting year: The service year for which data files are being reported.[39]

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 6 for service category definitions.

Total health care expenditures (THCE): The sum of total medical expense and total non-medical expense.

THCE Data Submission Guide (DSG): The Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 2.0), dated April 2025. The DSG is available on, and may be downloaded from, the Department's website.[40]

[38] Health & Safety Code § 127500.2(r).
[39] 22 CCR 97445(n).
[40] Data Submission Guide (Version 2.0), dated April 2025.

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.

Total Non-Medical Expense (TMNE): A component of the total health care expenditures (THCE) calculation, also referred to as administrative costs and profits. 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. [41]

[41] Health & Safety Code § 127500.2(a).