METHODOLOGY FOR COVERED CALIFORNIA UTILIZATION REPORTS

October 2025

BACKGROUND

California law, as amended by Assembly Bill (AB) 929 (2019), confirms Covered California's capacity as a health care oversight agency and, to this end, grants access to individual and small group market health data. Developed in partnership with Qualified Health Plans (QHP), Covered California's claims data warehouse, known as the Health Evidence Initiative (HEI), is used to both inform Covered California's policy choices and requirements as an active purchaser and inform public and private policy more broadly.

Covered California has compiled key utilization performance indicators from HEI data into an annual public report, disaggregated by enrollee demographics of interest. While these reports have similarities to the Plan Performance Report (PPR), their intended purpose is to supplement the PPR with detailed health care utilization metrics, along a full set of demographic characteristics.[1] For a more plan-performance focus, the annual PPR is available on Covered California's website.

SUMMARY

The Covered California Utilization Reports are a public-facing set of tables that show health utilization by service category, health status and demographic subdivisions for on-exchange individual health plan enrollees on a calendar year basis.

METHODOLOGY

The report is divided into four tabs based on members status with various health conditions: (1) the overall on-exchange individual market enrollee population, (2) members with a chronic medical condition, (3) members with a chronic behavioral health condition, and (4) members with both a chronic medical and behavioral health condition.

Utilization metrics are in the following headers: Members, Primary Care, Behavioral Health, Specialist (including OBGYN), Emergency, Admissions, Pharmacy and Vaccination/Immunization. Within each header (except Members and Pharmacy) are the following utilization metrics: visits, visits per 1000, patients, and patients per 1000. The pharmacy section contains prescription counts (scripts), days-supply, and days-supply per-

[1] Measure definitions, continuous enrollment criteria, or other factors may contribute to variances between the Utilization Report and the Plan Performance Report.

member-per-month (PMPM). Calculated measures control for population size when comparing across disparate populations.

Utilization is reported by the following enrollee characteristics or demographic groups: Network Type, Metal Tier, Subsidy Eligibility (eligibility for premium tax credits), Household income as measured by percent of the Federal Poverty Level (FPL), Gender, Age, Race/Ethnicity Group (a rollup of Race and Ethnicity), Race, Ethnicity, Language Written, Language Spoken and Urban/Rural location.

All member counts, patient counts, and utilization counts (visits, admits, scripts, days and claims) have been rounded to the nearest 10, and all dependent cells are calculated using these rounded numbers.

Additionally, if the unique member count for any row is less than 10, the entire row is left blank.

HEALTH POPULATIONS

There are four population groups available for analysis within the Utilization Reports. They are (1) the overall on-exchange individual market enrollee population, (2) members with a chronic medical condition only, (3) members with a chronic behavioral health condition only, and (4) members with both a chronic medical and behavioral health condition. Groups 2, 3 and 4 are mutually exclusive and were created using the MEG episode grouper (see Episodes of Care).

1. The overall on-exchange individual market enrollee population excludes off-exchange and small business enrollees and encompasses the three chronic condition subgroups plus any members without any chronic condition.

2. The chronic medical condition population includes patients with one or more episodes that have been classified as chronic by the grouper (excluding psychiatric).

3. The chronic behavioral health study population is made up of patients with at least one chronic psychiatric episode.

4. The chronic medical and behavioral health condition population includes members who have both a chronic medical condition and a chronic behavioral health condition.

On- and off-exchange, individual market and small business claims data is used to determine placement into one of the above groups, with a lookback period of two years prior to the report year. This is done to ensure that members are counted in the proper population regardless of their current utilization or previous enrollment. Exclusion logic is used to ensure that members are only counted in one of the chronic condition groups.

For example, a member with a chronic medical episode in 2022 and a chronic behavior health episode in 2023 will be counted in the chronic medical condition population for 2022 and be placed in the chronic medical condition and behavioral health condition population for 2023 and 2024. With no further qualifying episodes, they will be in the behavioral health condition population in 2025, and the overall population in 2026.

Report Year	2022	2023	2024	2025	2026
Medical Episode	X				
Beh. Health Episode		X			
Chronic Condition Group	Medical	Medical & Beh. Hlth	Medical & Beh. Hlth	Beh. Hlth	None

The lookback is two years prior to the report year. A chronic episode in any of those three years can place members into one of the chronic condition populations. The shaded areas are the report years affected by the episode.

EPISODES OF CARE

Episodes of care are used in the development of chronic health population groups in the report. The Truven Medical Episode Grouper (MEG) is a proprietary episode grouping methodology created by Covered California's Healthcare Evidence Initiative database vendor. Health conditions are classified as chronic within the grouper by major diagnostic category.

An episode of care is:

- A summary of the care related to a given occurrence of a condition or disease for a particular patient
- A combination of inpatient, outpatient, and prescription drug treatment for that condition
- Triggered by the first encounter with a health care provider (not a pharmacy drug claim).

Chronic episodes are identified as issues that don't generally resolve (e.g., diabetes) or resolve over a long period of time (e.g., cancer).

REPORT METRICS

This section contains general information on the metrics used in this report. There is a complete list of metrics with their calculations (where appropriate) at the end of this memo.

Visits are a count of how many times members visited doctors or facilities based on unique combinations of a provider identifier, member identifier and service date. Since this is a utilization metric, the Grand Total is a simple aggregate of all visits.

Visits per 1000 are calculated by dividing the total number of visits by the size of the population and then multiplying the result by 1,000. Since the Utilization Report is an annual report, our visits per 1000 are calculated by dividing visits by average membership (member months divided by 12) and multiplying by 1,000. This metric is commonly used in healthcare to measure the utilization of services, such as emergency room visits or hospital admissions, by a specific population.

Patients are a unique count of members who visited a provider or facility. Patients are counted within categories depending on member status at the time of service. It is possible for a member to be counted in more than one category if appropriate to their circumstances. However, the Grand Total of patients is unique, meaning members are only counted once in the total row.

Patients per 1000 metrics are calculated by dividing patient counts by unique member counts. Counting unique patients accurately reflects the number of individuals receiving care for a specific service or condition.

Since patients are unique within groups and in total, it is more appropriate to use Members Unique Count as a denominator in the calculation of patients per 1000. Calculating patients per 1,000 based on unique member counts provides a more accurate and meaningful measure of population health and healthcare utilization.

MEMBER COUNTS

There are three different counts of members in the report. They are Unique Count, Member Months and Member Average.

Unique Count counts each member once per coverage year. This number tends to be lower than average membership because members are counted regardless of their tenure in the program. Members with 12 months of membership in the year are counted once as well as members who were in the program for only one month.

Member Months counts each member once per month of coverage. This is typically used in calculating average membership and per member per month (PMPM) metrics.

Member Average is calculated by dividing total members months for the calendar year by 12. This is used in the calculation of visits per 1000

UTILIZATION METRICS

This section provides a general description of utilization metrics within the report. A complete set of metrics and their descriptions, with calculations, is included at the end of this memo. All patient and utilization metrics (visits, admissions, scripts, days and claims) are rounded to the nearest 10, and subsequent calculated fields are based on the rounded values. This includes all visits per 1000, patients per 1000, admission and Rx days per 1000, and vaccination claims per 1000.

Primary Care In-Person Visits: an in-person office visit that is classified as a primary care service, based on procedure codes, and is delivered by a provider who is classified as a primary care practitioner, based on taxonomy codes.

Primary Care Telehealth Visits: an ambulatory telehealth service that is classified as a primary care service, based on procedure codes, and is delivered by a provider who is classified as a primary care practitioner, based on taxonomy codes.

Primary Care Patients: members who receive an in-person or telehealth office visit that is classified as a primary care service, based on procedure codes, and delivered by a provider who is classified as a primary care practitioner, based on taxonomy codes.

Behavioral Health In-Person Visits: an in-person office visit that is classified as a behavioral health service, based on procedure codes, and is delivered by a provider who is classified as a behavioral health practitioner, based on taxonomy codes. Note that in-person behavioral

services delivered by a primary care practitioner, or any other non-behavioral health practitioner, are not included in this definition.

Behavioral Health Telehealth Visits: an ambulatory telehealth service that is classified as a behavioral health service, based on procedure codes, and is delivered by a provider who is classified as a behavioral health practitioner, based on taxonomy codes. Note that behavioral telehealth services delivered by a primary care practitioner, or any other non-behavioral health practitioner, are not included in this definition.

Behavioral Health Patients: members who receive an in-person or telehealth service, based on procedure codes, that is classified as a behavioral health service and is delivered by a provider who is classified as a behavioral health practitioner, based on taxonomy codes.

Specialist Office Visits: the average number of professional office visits constrained to specialists based on provider type. This is a standard office visit metric constrained by provider taxonomy that excludes primary care and Mental Health Services Act (MHSA) claims but includes Obstetrician-Gynecologist (OB/GYN) claims.

Ambulatory ER Visits: the count of unique patient and service date combinations across all claims for Ambulatory Emergency Room Services that do not result in a facility admission. Emergency Room Services identifies all outpatient services provided in an emergency room (ER) setting or involving the activation of an emergency trauma team. It is based on Service Categories, which identifies ER services from both facility and professional claims, using place of service codes, revenue codes, and procedure codes.

Admissions: the number of acute admissions, based on Bill Type Code (UB-04). Acute admissions refer to hospital admissions for patients who require immediate and intensive medical care for a sudden onset of illness, injury, or other health condition. Acute inpatient settings include inpatient hospitals, birthing centers, inpatient psychiatric facilities, and residential substance abuse treatment facilities. Non-acute inpatient visits typically involve ongoing monitoring, therapy, or recovery support rather than immediate medical intervention for a severe or life-threatening condition.

Admission Days: the number of days from admissions that took place in an acute inpatient setting. Acute inpatient settings include inpatient hospitals, birthing centers, inpatient psychiatric facilities, and residential substance abuse treatment facilities. The number of days is based on the days that were reported on facility claims containing room and board services that are included in the admission.

Scripts Rx: the number of prescriptions filled. The number of prescriptions filled is generally equal to the number of original or replacement pharmacy claims minus the number of voided pharmacy claims.

Rx Days-Supply: the number of days for which drugs were supplied for prescriptions filled. It represents the number of days of drug therapy covered by a prescription.

Vaccinations/Immunizations: the count of vaccination or immunization services, based on the count of unique claims for either pharmacy-based claims (Rx script) or office visits. Vaccination and immunization claims are determined based on procedure codes for office visits or therapeutic class for pharmacy claims.

METRIC DEFINITIONS

The following is a complete list of metrics found in the report, with codes that aid in the description of calculations.

Category	Metric Name	Metric Code	Metric Definition (Calculation)
Members	Unique Count	UMC	Unique Member Count is a unique count of members with medical coverage. Each member is counted once per year, regardless of how many months they were in the program. This field is rounded to the nearest 10, and all metrics calculated using this field are based on the rounded value.
	Months	MM	Member Months is the count of members for each month of active enrollment. Each member is counted once for each month enrolled in the program.
	Average	AM	Members Average is calculated by dividing total Members Months for the calendar year by 12. (MM/12)
	% of Total Average	AMP	Average Member Percent is the percentage of the total average members. [AM/AM (Grand Total)]
	Patient Count	PC	Patient Count is the unique count of members who received facility, professional, or pharmacy services. This field is rounded to the nearest 10, and all metrics calculated using this field are based on the rounded value.
	Patients per 1000	PP	Patients per 1000 is calculated using Patient Count and Members Unique Count. (PC/UMC*1000)
	% of Patients	PM	Percent of Patients is the percent of total patient count. [PC/PC(Grand Total)]
Primary Care	Office Visits	PCV	Primary Care Office Visits is the number of professional visits provided in an office setting under medical coverage constrained by taxonomy code and procedure code to align with the Covered CA standard benefit design definition of primary care. The number of visits is based on the count of unique patient, service date, and provider combinations.
	Visits per 1000	PCVT	Primary Care Visits per 1000 is calculated using Primary Care Office Visits and Members Average. (PCV/AM*1000)
	% Telemed	PCTM	Primary Care Office Visits % Telemed is the percentage of primary care office visits that were conducted through one of several telemedicine routes (audio only, audio/visual, patient monitoring, email or provider-provider consultation).
	Patient Count	PCPC	Primary Care Patient Count is the unique count of members who received professional services constrained by taxonomy code and procedure code to align with the Covered CA standard benefit design definition of primary care. This field is rounded to the nearest 10, and all metrics calculated using this field are based on the rounded value.
	Patients per 1000	PCPT	Primary Care Patients per 1000 is calculated using Primary Care Patient Count and Members Unique Count. (PCPC/UMC*1000)
	% of Patients	PCPP	Primary Care Percent of Patients is the percent of total patient count. [PCPC/PCPC(Grand Total)]

Behavioral Health	Office Visits	BHV	Behavioral Health Office Visits is the number of professional visits provided in an office setting under medical coverage constrained by taxonomy code and procedure code to align with the Covered CA standard benefit design definition of behavioral health. The number of visits is based on the count of unique patient, service date, and provider combinations.
	Visits per 1000	BHVT	Behavioral Health Visits per 1000 is calculated using Behavioral Health Office Visits and Members Average. (BHV/AM*1000)
	% Telemed	BHTM	Behavioral Health Office Visits % Telemed is the percentage of Behavioral Health office visits that were conducted through one of several telemedicine routes (audio only, audio/visual, patient monitoring, email or provider-provider consultation).
	Patient Count	BHPC	Behavioral Health Patient Count is the unique count of members who received professional services constrained by taxonomy code and procedure code to align with the Covered CA standard benefit design definition of behavioral health. This field is rounded to the nearest 10, and all metrics calculated using this field are based on the rounded value.
	Patients per 1000	BHPT	Behavioral Health Patients per 1000 is calculated using Behavioral Health Patient Count and Members Unique Count. (BHPC/UMC*1000)
	% of Patients	BHPP	Behavior Health Percent of Patients is the percent of total patient count. BH[PC/BHPC(Grand Total)]
Specialist	Office Visits	SV	Specialist Office Visits is the number of professional visits provided in an office setting under medical coverage constrained by taxonomy code and procedure code to align with the Covered CA standard benefit design definition of specialist, including obstetrician gynecologists. The number of visits is based on the count of unique patient, service date, and provider combinations.
	Visits per 1000	SVT	Specialist Visits per 1000 is calculated using Specialist Office Visits and Members Average. (SV/AM*1000)
	Patient Count	SPC	Specialist Patient Count is the unique count of members who received professional services constrained by taxonomy code and procedure code to align with the Covered CA standard benefit design definition of specialist, including obstetrician gynecologists. This field is rounded to the nearest 10, and all metrics calculated using this field are based on the rounded value.
	Patients per 1000	SPT	Specialist Patients per 1000 is calculated using Specialist Patient Count and Members Unique Count. (SPC/UMC*1000)
	% of Patients	SPP	Specialist Percent of Patients is the percent of total patient count. [SPC/SPC(Grand Total)]
Emergency	ER Visits	ERV	Emergency Visits is the number of emergency room visits provided under medical coverage. The number of visits is based on the count of unique patient and service date combinations. This does not include ER visits that resulted in an admission.
	Visits per 1000	ERVT	Emergency Visits per 1000 is calculated using Emergency Visits and Members Average. (ERV/AM*1000)
	Patient Count	ERPC	Emergency Patient Count is the unique count of members who received emergency room services not resulting in an admission. This field is rounded to the nearest 10, and all metrics calculated using this field are based on the rounded value.
	Patients per 1000	ERPT	Emergency Patients per 1000 is calculated using Emergency Patient Count and Members Unique Count. (ERPC/UMC*1000)
	% of Patients	EPP	Emergency Percent of Patients is the percent of total patient count. [ERPC/ERPC(Grand Total)]

Admissions	Admissions	AA	Admissions identifies admissions that took place in an acute inpatient setting. Acute inpatient settings include inpatient hospitals, birthing centers, inpatient psychiatric facilities, and residential substance abuse treatment facilities.
	Admits per 1000	AT	Admits per 1000 is calculated using Admissions and Members Average. (AA/AM*1000)
	Days	AD	Admission Days is the number of inpatient days in a hospital or other inpatient facility resulting from acute admissions.
	Days per 1000	ADT	Admission Days per 1000 is calculated using Admission Days and Average Member Count. (AD/AM*1000)
	Patient Count	APC	Admission Patient Count is the unique count of patients with an acute admission. This field is rounded to the nearest 10, and all metrics calculated using this field are based on the rounded value.
	Patients per 1000	APT	Admission Patients per 1000 is calculated using Admission Patient Count and Unique Member Count. (APC/UMC*1000)
	% of Patients	APP	Admission Percent of Patients is the percent of total patient count. [APC/APC(Grand Total)]
Pharmacy	Scripts	RXS	Pharmacy prescriptions (Scripts Rx) is the number of prescriptions filled.
	Scripts per 1000	RXST	Scripts per 1000 is calculated using Scripts Rx and Average Members. (RXS/AM*1000)
	Days Supply	RXDS	Rx Days Supply is the total days supply for prescriptions filled. Days-supply represents the number of days of drug therapy covered by a prescription.
	Days Supply PMPM	RXDPM	Rx Days Supply PMPM is calculated by dividing Rx Days Supply by member months (RXDS/MM).
	Patient Count	RXPC	Rx Patient Count is the unique count of members who had a prescription filled. This field is rounded to the nearest 10, and all metrics calculated using this field are based on the rounded value.
	Patients per 1000	RXPT	Rx Patients per 1000 is calculated using Rx Patient Count and Unique Member Count. (RXPC/UMC*1000)
	% of Patients	RXPP	Pharmacy Percent of Patients is the percent of total patient count. [RXPC/RXPC(Grand Total)]
Vaccination/ Immunization	Claims	VC	Vaccination/Immunization Claims is a count of claims for vaccination or immunization based on procedure codes or therapeutic class.
	Claims per 1000	VCT	Vaccination/Immunization Claims per 1000. (VC/AM*1000)
	Patient Count	VPC	Vaccination/Immunization Patient Count is the unique count of members who received a vaccination or an immunization. This field is rounded to the nearest 10, and all metrics calculated using this field are based on the rounded value.
	Patients per 1000	VPT	Vaccination/Immunization Patients per 1000 is calculated using Vaccination/Immunization Patient Count and Unique Member Count. (VPC/UMC*1000)
	% of Patients	VPP	Vaccination/Immunization Percent of Patients is the percent of total patient count. [VPC/VPC(Grand Total)]