

Assessing Cost-Effectiveness and Member Choice Across Medi-Cal Health Plan Models

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I. Introduction

The Menges Group was enlisted by the Elevance Health Public Policy Institute to assess the cost-effectiveness of the different models of Medicaid managed care deployed under California’s Medi-Cal (Medicaid) program. A central policy question motivating this analysis is whether the limited competitive structure of certain Medi-Cal models — particularly the county-organized health plans (COHS), Single-Plan, and aspects of the Two-Plan model — is producing outcomes as cost-effective as models that allow for greater private plan participation and competition.

Medi-Cal is administered by the Department of Health Care Services (DHCS) and financed jointly by the state and the federal government under Titles XIX and XXI of the Social Security Act. It is by a wide margin the largest Medicaid program in the country. As of May 2026, roughly 11.8 million Californians, roughly 30% of the state’s population, were enrolled.¹ Los Angeles County alone enrolls more Medi-Cal beneficiaries than the entire Medicaid population of all but three states. Program expenditures are budgeted at approximately \$196.7 billion (all funds) for state fiscal year 2025-26, including \$46.4 billion in state General Fund spending.²

Medi-Cal covers low-income children and adults, pregnant individuals, seniors, persons with disabilities, and adults up to 138% of the federal poverty level under the Affordable Care Act expansion. California has also extended full-scope coverage to income-eligible residents regardless of immigration status, phased in by age group between 2020 and 2024.³ Enrollment peaked during the COVID-19 continuous coverage period and has declined since eligibility redeterminations resumed in 2023. This dynamic, which is discussed later in this report, influenced per capita cost trends because the enrollees who lost coverage were disproportionately low-cost.

Approximately 95% of Medi-Cal beneficiaries receive their benefits through managed care rather than fee-for-service.⁴ DHCS contracts with managed care plans (MCPs) on a full-risk basis, paying each plan a monthly capitation rate for every enrolled member. Capitation rates are set separately by county, by rating period, and by category of aid (the “rate cell” — for example, Adult, Child, Adult Expansion, and Maternity), and are published by DHCS as a range with a lower bound, midpoint, and upper bound. These published rates are the principal cost measure used throughout this report.⁵

Three broad categories of health plans participate in Medi-Cal managed care. Local plans, often referred to as “Local Initiatives” or COHS — are public, non-profit entities established under county sponsorship and are typically governed with substantial county involvement. Private plans are private/commercial MCPs that typically must win the right to serve a county’s Medi-Cal population through a competitive

¹ Kaiser Family Foundation website data: <https://www.kff.org/medicaid/state-indicator/medicaid-and-chip-monthly-enrollment>

² California Governor’s Budget 2026-27, Health and Human Services, <https://ebudget.ca.gov/2026-27/pdf/BudgetSummary/HealthandHumanServices.pdf>.

³ California Department of Health Care Services, “Ages 26 through 49 Adult Full Scope Medi-Cal Expansion,” <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Adult-Expansion.aspx>.

⁴ DHCS, “Medi-Cal Monthly Eligible Fast Facts,” <https://www.dhcs.ca.gov/dataandstats/reports/Documents/Fast-Facts.pdf>.

⁵ DHCS published Medi-Cal capitation rate files, compiled by The Menges Group.

procurement conducted by DHCS.⁶ Kaiser Permanente (Kaiser) occupies a third, distinct position: effective January 1, 2024, it entered into a statewide direct contract with DHCS, negotiated outside the competitive procurement process. This expanded their Medi-Cal participation from five counties to 32 serving enrollees across every model type, with more than 1.2 million members as of December 2025.

California’s managed care structure is not uniform statewide. Instead, each county largely determines how many Medi-Cal plans it will contract with, and the mix between local and private plans. Many local plans subcontract extensively with private plans to serve their enrollees. In many counties, the Medi-Cal managed care contracting landscape was substantially reshaped by the 2022 procurement and the resulting contracts that took effect in January 2024. Several counties changed models, the COHS model expanded, and Kaiser extended its Medi-Cal presence to serve most of the state.

Medi-Cal Managed Care Model Types

DHCS designates five managed care models — Two-Plan, COHS, Geographic Managed Care, Regional, and Single Plan.⁷ This report treats Los Angeles County’s subcontracted variation as a sixth model, the Modified Two-Plan model, because its competitive dynamics differ materially from the standard Two-Plan arrangement. Each model is summarized in the ensuing narrative and in **Exhibit 1**, which also identifies the counties assessed under each model. Our assessment focused on 17 counties: 12 of California’s largest counties along with five smaller counties that brought additional Medi-Cal managed care approaches into our assessment. Collectively, these 17 counties encompass nearly 80% of all Medi-Cal enrollees. Each county’s enrollment is shown in **Appendix 1**.

Exhibit 1: Six Primary Medi-Cal Models

Model Type	Key Feature	Counties Using This Model During 2025 That are Included in This Assessment
Two-Plan Model	One public/local MCP and one private MCP serve the county’s entire Medi-Cal population. This approach is used in many counties, and plans are selected via competitive procurements.	Fresno, Kern, Riverside, San Bernardino, Santa Clara, San Joaquin
Modified Two-Plan Model (with Subcontractors)	Both MCPs also delegate many of their enrollees to subcontracted private MCPs. This approach is used in Los Angeles County where LA County directly contracts with LA Care and HealthNet, both of whom utilize pass-through subcontractors. LA Care subcontracts with Anthem Blue Cross and with Blue Shield Promise, HealthNet subcontracts with Molina.	Los Angeles

⁶ California Department of Health Care Services, Medi-Cal Managed Care Division, “Managed Care Models Fact Sheet,” <https://www.dhcs.ca.gov/services/Documents/MMCD/MMCD-Model-Fact-Sheet.pdf>.

⁷ DHCS, “Managed Care Models Fact Sheet,” <https://www.dhcs.ca.gov/services/Documents/MMCD/MMCD-Model-Fact-Sheet.pdf>.

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County Organized Health System (COHS)	A single public health plan serves the county's entire Medi-Cal population with no private MCP involvement.	Orange, San Mateo, Santa Barbara
Geographic Managed Care (GMC)	There is no public/local plan and several private MCPs collectively serve the county's Medi-Cal population.	Sacramento, San Diego
Regional Model	Private plans serve groups of relatively rural counties as the only Medi-Cal health plans that operate in each of these counties.	Calaveras, Tuolumne
Single Plan	The full Medi-Cal population within a county is served by one local plan. The local plan – while not a private MCP – is not as closely tied to the county government as occurs under the COHS model.	Alameda, Contra Costa, Imperial

Note that Kaiser Permanente serves Medi-Cal enrollees under all the above models, with more than one million Medi-Cal enrollees as of January 2025. Kaiser is assessed in this report but categorized neither as a private plan nor as a local plan.

The largest counties by Medi-Cal enrollment are Los Angeles (3.9 million in January 2025), Riverside (972,733), Orange (966,960), San Diego (941,397), and San Bernardino (928,395). Three of the five largest counties — Riverside, Orange, and San Bernardino — operate models where either the local plan holds vast market share (Riverside/San Bernardino at 79%) or private competition is absent (Orange under COHS). Notably, a select number of California counties have recently changed their model. For example, Alameda County, Contra Costa, and Imperial County now use a Single Plan approach relying entirely on a local plan.

Each of the above model types offer distinct implications for health plan competition, cost-efficiency, and value delivered to enrollees. This report assesses the comparative performance of private health plans versus local and county-operated health plans across these managed care models, with a focus on capitation rate trends, cost-effectiveness, enrollment dynamics and MCP choice among individuals.

II. Key Findings

The key findings from this project are summarized below and are described in detail throughout the report. **The overarching theme of our findings is that California's private⁸ plans provide significant cost containment value to the Medi-Cal program.**

Two-Plan Model Findings

Across every Two-Plan county and year examined, private plans receive capitation rates that are below those of the local plan counterpart operating in the same county. These differentials are large and have widened in recent years. **During 2025, private plan capitation rates were roughly 30% lower than the local plans for adult enrollees and 20% lower for children.**

- On average, across the Two-Plan counties analyzed, private plan capitation rates for the adult aid category were approximately 81% of local plan rates in 2019, 76% in 2022, and **71% in 2025**.
- For the child aid category, private plan rates averaged approximately 90% of local plan rates in 2019, 89% in 2022, and **79% in 2025**.

County-Wide Per Capita Costs Were Lowest When Using Managed Care Models Featuring Extensive Private Plan Enrollment

- When aggregating average capitation rates by Medi-Cal managed care model, the two models with the **highest** Medi-Cal per capita costs during 2025 were those with **no private MCP involvement** -- COHS and Single Plan. This finding occurred for both the adult and child rate categories.
- Los Angeles had the **lowest** 2025 Medi-Cal per capita costs in the adult rate category. The Geographic Managed Care model also had relatively low Medi-Cal per capita costs during 2025 in both the adult and child rate cells. In both models, private plans served more than 50% of all Medi-Cal enrollees.

Kaiser Permanente's Capitation Rates are Particularly High

- We compared Kaiser's capitation rates to private plans and to local plans serving Medi-Cal in the same county. On average during 2025 across these "head-to-head" comparisons, Kaiser's capitation rates in the same counties were **29% higher than the private plans and 8% higher than the local plans**.

The Highest Medi-Cal Costs Relative to Other Covered Populations Occurred Largely in COHS Model Counties

- For adults, the three counties with the highest 2023 ratio of Medi-Cal to Medicare per capita costs were Santa Barbara, San Mateo, and San Diego.

⁸ Since the inception of California's Medi-Cal Managed Care Program, health plans that also serve in the employer-based market have participated in Medi-Cal. These "commercial" health plans are referred to as "private" plans in this report.

- For children, the three counties with the highest Medi-Cal to Medicare cost ratios were Imperial, Santa Barbara, and San Mateo. COHS counties with no private plan market share were among the highest counties for both the adult and child rate cells.
- Comparisons of Medi-Cal to Marketplace premiums yielded a similar outcome. For adults, the three counties with the highest 2025 ratio of Medi-Cal to Marketplace per capita costs were San Bernardino, Kern, and Riverside – all counties with modest private plan market share.
- For children, this pattern also occurred. The three counties with the highest Medi-Cal to Marketplace cost ratios were San Bernardino, Riverside, and Orange.

Cost Trends From 2023-2025 Were Relatively High in Counties Switching to Single Plan Model

Alameda, Contra Costa, and Imperial counties all switched from the Two-Plan model to a Single Plan model effective January 2024. (Note that this assessment for Imperial County was not included as 2023 capitation rates were not available.)

After switching to the Single Plan model in 2024, per capita costs rose more sharply in the two Single Plan counties than occurred in the other counties we assessed. This adverse trend rate differential between 2023 and 2025 was **four percentage points** in the adult rate category and **15 percentage points** in the child rate category. These findings suggest that these counties' transition to the Single Plan model, at least initially, has not been cost-effective.

California Provides Limited Health Plan Choice to Medi-Cal Enrollees

We assessed the number of health plan options available in each program in 11 large counties – Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, and Santa Clara. **On average across these 11 counties, Medi-Cal enrollees can choose among 3.2 Medi-Cal health plans, 8.6 Marketplace (Covered California health plans) and 32.5 Medicare Advantage health plan options.** In comparing California's larger counties with other states of a similar Medicaid enrollment size, we found that roughly twice the number of managed care plan (MCP) options were typically available in the other states relative to a Medi-Cal enrollee's level of choice.

The report concludes with a set of recommendations – based on the findings – to take advantage of the opportunities to strengthen the Medi-Cal program's cost-effectiveness while continuing the push for strong access and quality performance.

III. Data Sources and Analytic Approach

This section describes in detail the data sources and methodological approaches used in each component of the analysis.

A. Medi-Cal Capitation Rate Dataset

The primary quantitative dataset used in this report is a compilation of Medi-Cal capitation rate files drawn from California's Department of Health Care Services' (DHCS) [website](#). These files, previously housed in dozens of separate documents, have been consolidated into a single working Excel file containing nearly 20,000 rows of data. Each row reflects each MCP, county, rating period, state fiscal year, managed care model type, and category of aid, along with the lower bound, midpoint, and upper bound capitation rate. The primary analytical metric used is the capitation rate midpoint.

The dataset spans rating periods from the 2015 state fiscal year through 2025, providing approximately a decade of trend data. Rate cells analyzed include the Adult, Child, Adult Expansion, and Maternity aid categories, with Adult and Child serving as the primary focus given their enrollment magnitude and policy relevance. We focused on two highly populated rate cells, Adult and Child, to avoid distortions that could be caused by a different demographic mix (by rate cell) between different counties' Medi-Cal populations.

The analysis tracks rate progression across MCPs, counties, and aid categories — comparing cost trends for private versus local plans, and benchmarking Medi-Cal costs against Medicare fee-for-service (FFS) and Marketplace per capita costs in the same counties. Our analytical objectives were twofold:

- In the Two-Plan environment, we compared Medi-Cal's payment rates for the private plans with corresponding costs for the "local plan," which is typically a county-operated managed care organization.
- To assess cost-effectiveness across Medi-Cal managed care models, we compared each county's overall Medi-Cal per capita costs (in the Adult and Child rate cells) with the Medicare FFS per capita costs and the Marketplace (Covered California) per capita costs in the same county.

Medicare FFS per capita costs by county were obtained from the Centers for Medicare & Medicaid Services (CMS). These data provide a benchmark for the relative cost of providing healthcare services in each county, reflecting underlying healthcare market costs, provider prices, and utilization patterns. By expressing Medi-Cal capitation rates as a percentage of Medicare FFS per capita costs in the same county, the analysis produces a normalized measure of cost-effectiveness that accounts for geographic cost variation.

We conducted a similar set of analyses creating a ratio of each county's adult and child Medi-Cal capitation rates to Marketplace premiums. Marketplace premium data for each year are published on the Covered California website at: <https://hbex.coveredca.com/data-research/>

B. Enrollment Data and MCP Selection Options

Enrollment data by county, model type, and plan are assessed to establish the population context, market shares, and the degree of health plan competition (or lack thereof) across California's 58 counties.

Enrollment data were obtained from the DHCS enrollment reporting files, which provide monthly enrollment counts by plan, county, and plan type. These data were used to establish market shares by plan and model type, to contextualize capitation rate findings with enrollment weights, and to examine

auto-assignment rate trends over time. Enrollment data are available for the period 2007 through early 2025, spanning the full range of managed care model evolution in California.

The enrollee MCP choice assessment was calculated using the above enrollment data and DHCS's Medi-Cal, Medicare Advantage, and Marketplace options lists. MCP choice analyses for other states were calculated using publicly available state-population figures, individual state enrollment data figures, and lists of contracted Medicaid MCPs.

IV. Capitation Rate Findings

A. Medi-Cal Per Capita Cost Comparisons by Managed Care Model

Medi-Cal’s capitation rates are generally lower in counties with a relatively high share of private plan enrollment. **Exhibit 2** conveys tabulations across counties -- rolled up by managed care model. More detailed data on the capitation rates are presented in **Appendices 2-4**.

Key Takeaway: A strong “inverse correlation” is evident between the average capitation rate and the percentage of Medi-Cal beneficiaries enrolled in private plans. Rates were higher under models not using private plans and lower in models that extensively involve partnerships with private plans.

The three models with highest average per capita costs – COHS, Single-Plan, and Two-Plan, had little private plan enrollment (and often none). Conversely, the three models with the most favorable per capita costs – Los Angeles, Regional, and Geographic Managed Care – all had a majority of the Medi-Cal enrollees served by private plans. This is especially relevant because some California counties have recently moved in the opposite direction—toward models with less private participation. The state is therefore shifting enrollment toward the managed-care structures that this analysis associates with higher per-enrollee cost.

Exhibit 2: Association Between Average Capitation Rates and Private Plan Enrollment Share

Medi-Cal Managed Care Model	Rank in 2025 Capitation Rate (1=Highest Average Rate)		% Enrolled in Private Health Plans, 2025
	Adult Rank	Child Rank	
COHS	1	2	0%
Single-Plan	2	1	0%
Two-Plan	3	3	15%
Geographic Managed Care	4	4	87%
Regional	5	6	100%
Los Angeles	6	5	59%

Note: Average rates were derived on an enrollment-weighted basis across each county’s Medi-Cal health plans.

B. Medi-Cal Per Capita Cost Comparisons at the County Level

The inverse relationship between capitation rates and private plan enrollment was also visible at the county level. Key county-level findings are summarized below.

- In 2025, the three counties with the **highest** average *adult* capitation rates were Santa Barbara, Contra Costa, and Kern. Two of these counties did not contract with private plans during 2025 and the third (Kern) had less than 10% private plan penetration.
- Conversely, two of the three counties with the **lowest** average *adult* capitation rates during 2025 had large-scale private plan penetration – Los Angeles (59% penetration) and Sacramento (78%). The county with the lowest 2025 average adult capitation rate, Imperial, had 0% private plan activity during 2025 but 100% private plan penetration through 2023 (prior to converting to a Single Plan model in 2024).
- Similarly, the counties with the **highest** *child* capitation rates during 2025 were Alameda (\$182), then Contra Costa, Riverside, and San Bernardino (all at \$180). Alameda and Contra Costa counties did not contract with private plans during 2025 (switching to the Single Plan model in 2024, although private health plans held less than 20% market share in each county prior to the transition). Riverside and San Bernardino counties each had modest private plan market share (11%) during 2025.
- Conversely, the counties with the **lowest** average *child* capitation rate during 2025 -- Fresno (\$113), Sacramento (\$131), and Los Angeles (\$136) -- all had considerable private plan market share during 2025.

The county-level results reinforce our previous observations: Medi-Cal costs tend to be highest where private-plan participation is absent or limited and lower where private plans serve a substantial share of beneficiaries. The same relationship appears both across models and within individual counties.

C. Private Plan Rate as a Percentage of the Local Plan Rate in Five Large Counties Using the Two-Plan Model

We conducted a set of comparisons for the five largest California counties where the Two-Plan model was used, comparing private plan rates to local plan rates for the Adult and Child aid categories. The five counties are Fresno, Kern, Riverside, San Bernardino, and Santa Clara. Three reference years are used: State Fiscal Year 2019 (pre-COVID baseline) State Fiscal Year 2022 (a COVID-impacted year with regard to Medi-Cal enrollment), and State Fiscal Year 2025 (the most recent year where all needed capitation rate data are available).

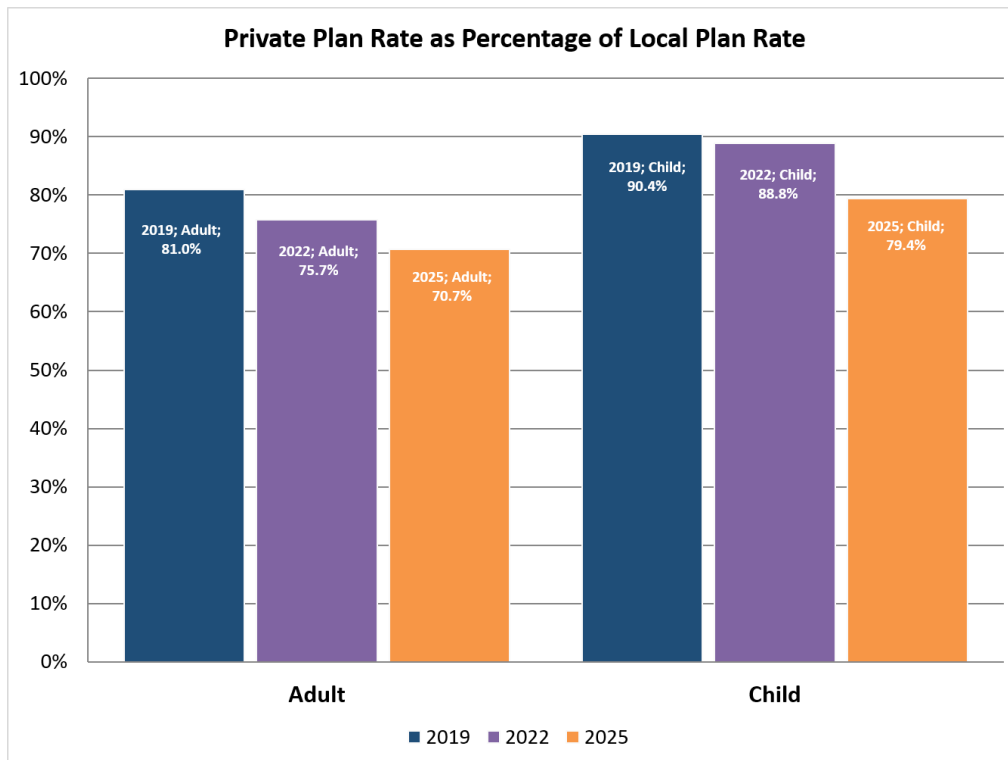
Key Takeaway: Under the Two-Plan model, large capitation rate differentials consistently exist, with the private plan's rate consistently being lower than the local plan's rate. This payment gap widened considerably over the study period.

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For **all 30** of these comparisons (across three different years, the adult and child rate cells, and five counties) the private plan's capitation rate was below the corresponding capitation rate for the local plan. The rate differential was usually substantial – it was fewer than five percentage points in only two of the 30 comparisons.

Exhibit 3: Average Capitation Rate Differentials Across Five Large Two-Plan Model Counties Reflects Lower Costs for Private Plans, 2019-2025



Note: Average capitation rates were derived on an enrollment-weighted basis across the private and local health plans serving each of the five counties assessed.

The differential ranged from a low of 1.2 percentage points in Kern for the Child rate cell during 2025 to a high of 41.1 percentage points for the Adult rate cell during 2025 in both Inland Empire counties (Riverside and San Bernardino). The private plans' average capitation rates are considerably lower than the local plans, with the 2025 differential averaging roughly 20% in the Child rate cell and approximately 30% in the Adult rate cell.

The identified Rate differentials were not isolated to a certain geography or single-year. Across every county, year and population group examined, DHCS paid the private plan less than the local plan serving the same county. The consistency and magnitude of this pattern raise a legitimate question of whether differences in enrollee health status alone can explain the payment differential.

More detailed data regarding these comparisons are shown in **Appendix 2**.

D. Ratio of Medi-Cal Per Capita Costs to Marketplace and Medicare FFS

We assessed Medi-Cal cost-efficiency across counties and under different Medi-Cal managed care models by calculating county-wide adult and child capitation rates and comparing these Medi-Cal payment rates to average Medicare FFS costs and average Marketplace premiums in these counties. The county-specific figures were “rolled up” into groups of counties to align with the key models of Medi-Cal managed care being used.

Medicare FFS serves as a valuable benchmark for comparison with Medi-Cal costs for the following reasons:

- Medicare FFS has an identical benefits package in each county.
- The demographic mix of the Medicare FFS population is closely similar between counties.
- Large numbers of Medicare FFS enrollees exist in each large California county, creating a large sample size with regard to the average Medicare FFS rate.
- By definition, Medicare FFS is an equally “unmanaged” coverage setting from county to county.
- Considerable Medicare per capita cost variations exist between counties. Many of the key factors driving these Medicare cost differences (e.g., provider capacity and mix, presence of teaching hospitals, provider prices, resident health care seeking behaviors, resident health status, etc.) exist for all county residents.

County variations in Medicare FFS per capita costs can serve as a reasonable proxy for how the collection of factors in a county are making its per capita costs different (whether in an upward or downward direction) than another county’s per capita costs.

Given that Medi-Cal costs could be managed in different ways (and at a different level of acumen) in some counties than others – and within different models of Medi-Cal managed care, the ratio of Medi-Cal per capita costs to Medicare FFS costs could be highly informative as to how well Medi-Cal costs are being managed in the different counties and models. These comparisons test whether higher Medi-Cal rates simply reflect counties that are inherently more expensive healthcare markets.

The Covered California “Marketplace” program also serves as a valuable benchmark for comparison with Medi-Cal costs. Key advantages of using Marketplace premiums to assess the effectiveness of Medi-Cal cost management include:

- California’s Marketplace population has fairly consistent demographic mix from county to county, with the age mix being reasonably aligned with Medi-Cal’s Adult rate cell.
- While minor differences exist between the Marketplace benefits packages in each county, these are not expected to be significant drivers of overall premium rates.
- The degree to which Marketplace expenditures are being managed is anticipated to be consistent between health plans and counties, with many health plans serving the Marketplace population across dozens of counties (presumably in a consistent manner with regard to cost containment techniques).

County-Specific Tabulations

The key county-level findings from these tabulations are summarized in the text box below and the ensuing narrative. A detailed data table is conveyed in **Appendix 3**.

Key Takeaway: Los Angeles County's Medi-Cal costs are highly cost-effective when viewed in the context of the county's exceptionally high underlying Medicare per capita costs. The counties with the highest ratios of Medi-Cal per capita costs to Medicare FFS all had modest (or zero) private plan enrollment.

Los Angeles has relatively low Medi-Cal capitation rates despite having exceptionally high Medicare FFS per capita costs. The Medicare FFS cost per capita during 2023 was over \$1,600, which is more than 30 percentage points above all the other counties we assessed. The underlying forces driving high Medicare FFS costs in Los Angeles County do not appear to be increasing Medi-Cal spending in the same way. Los Angeles' 2023 Medi-Cal per capita costs were among the lowest in the state for adult and child enrollees, suggesting that broader geographic cost patterns alone cannot explain the Medi-Cal cost variation. As of 2025, a high proportion of Los Angeles' Medi-Cal enrollees were served by private health plans (58%).

Two COHS model counties, Santa Barbara and San Mateo, had the highest ratio of Medi-Cal adult capitation rates to Medicare per capita costs during 2023. These two counties, along with Imperial, also had the highest ratios of Medi-Cal child capitation rates to Medicare per capita costs during 2023. Of these counties, only Imperial had sizable private plan market share during 2023 (20%).

The Inland Empire counties, Riverside and San Bernardino – along with Kern County – had the three highest adult Medi-Cal cost ratios relative to Marketplace premium rates during 2025. All these counties have a modest level of private health plan enrollment (roughly 9-11% of enrollees). Riverside, San Bernardino, and Orange (a COHS county) had the three highest ratios of child Medi-Cal costs to Marketplace premium rates during 2025.

Model-Wide Tabulations

Exhibit 4 rolls up the county-specific tabulations into the six Medi-Cal managed care models for the comparisons of Medi-Cal to Medicare and **Exhibit 5** does the same for the comparisons of Medi-Cal to the California Marketplace. The results of these tabulations were mixed in terms of the relationship of the cost ratios with private plan enrollment.

- For adults, while Los Angeles had the lowest ratio of Medi-Cal costs to Medicare, the Regional Model, with 100% private plan market share, had the highest ratio.
- For children, Los Angeles also had the most favorable (lowest) ratio of Medi-Cal costs to Medicare, while the COHS and single-plan models had the highest ratios.
- In comparing Medi-Cal premiums to Marketplace premiums, for both adults and children the Regional Model had the lowest ratio, and the Two-Plan model had the highest ratio.

Detailed data regarding these comparisons to other California populations are shown in **Appendix 4**.

Exhibit 4: Medi-Cal to Medicare Cost Comparisons by Managed Care Model

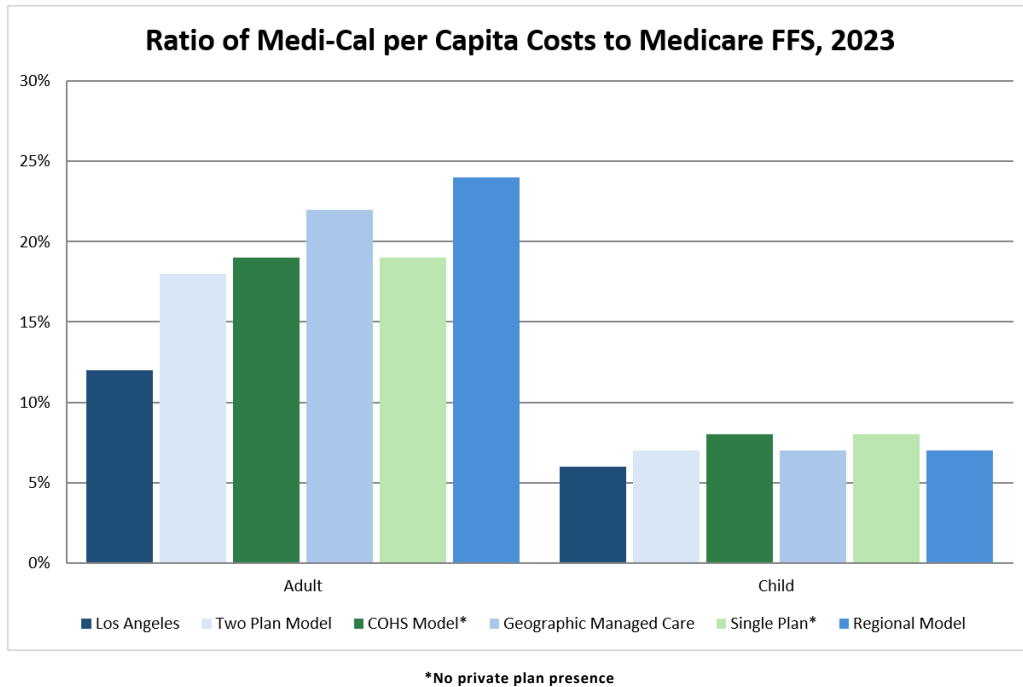
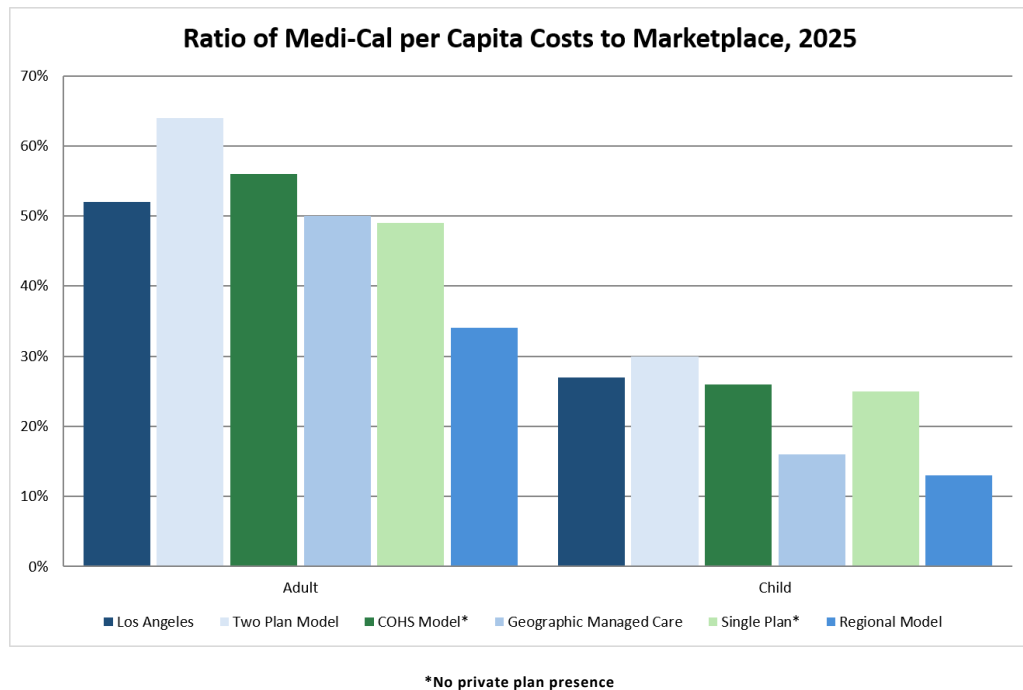


Exhibit 5: Medi-Cal to Marketplace Cost Comparisons by Managed Care Model



E. Early Assessment of Cost Trends in Counties Switching to Single Plan Model

Three counties that had been contracting with private plans moved away from this approach in January 2024, moving all enrollment to the local plan (with Kaiser also entering the county and attracting some Medi-Cal enrollment). These three counties are Alameda, Contra Costa, and Imperial.

This section reviews how Medi-Cal per capita costs in two of these “Single Plan” counties progressed between 2023 (the last year when private plans were involved) and 2025 (the most recent year where data are available). **Exhibit 6** summarizes these tabulations.

Key Takeaway: Following their transition to the Single Plan model, Alameda and Contra Costa experienced larger capitation-rate growth than the average for counties that remained under other models, with the greatest divergence in the child rate cell. This suggests that these counties slipped backwards in terms of their Medi-Cal cost containment performance after moving to the Single-Plan approach.

Exhibit 6. Cost Trends in Counties Switching to Single Plan Model

Jurisdiction	Average 2023 Capitation Rate		Average 2025 Capitation Rate		% Capitation Rate Increase Between 2023 and 2025	
	Adult	Child	Adult	Child	Adult	Child
All Counties Assessed Other Than Single Plan Counties	\$222	\$89	\$310	\$148	39%	66%
Single-Plan Counties (Alameda and Contra Costa)	\$253	\$100	\$362	\$181	43%	81%

Note that capitation rates for 2023 were not available for Imperial County. As a result, our assessment of Single Plan counties was limited to Alameda and Contra Costa. Note also that the per capita cost trends throughout California during the 2023-2025 timeframe were unusually high, partially due to low-cost (and no-cost) enrollees disproportionately losing coverage when the eligibility redetermination process was reinstated after being paused during the COVID-19 Public Health Emergency years.

After switching to the Single Plan model in 2024, per capita costs rose more sharply in the two Single Plan counties than occurred in the other counties we have assessed. This adverse trend rate differential between 2023 and 2025 was four percentage points in the adult rate category and 15 percentage points in the child rate category. These findings provide an important before-and-after test of California’s move away from private plan competition, indicating that **these counties’ transition to the Single Plan model has not been cost-effective in the initial years.**

F. Kaiser Permanente Capitation Rates

Kaiser was awarded its five-year, no-bid statewide Medi-Cal contract in February 2022. Kaiser's statewide market share increased, moving from approximately 200,000 Medi-Cal enrollees in 2023 to just over 1,000,000 enrollees as of January 2025. Kaiser has participated in Medi-Cal for many years in Sacramento and San Diego counties. Each county's highest capitation rates also contributed to the state's sharp cost trends during this timeframe. In 2024, Kaiser broadened its participation in the program to include 32 counties including all of California's counties with large populations.

Kaiser plays a unique role, operating largely independent of the Medi-Cal managed care model in place in a given county. For example, Kaiser now serves Medi-Cal enrollees in Orange and San Mateo, counties that have operated the COHS model for decades.

Kaiser contracts with DHCS in a non-competitive manner. In contrast, California's private plans must win a contract through a competitive procurement process in order to serve Medi-Cal eligible beneficiaries in a given county.

This section compares the capitation rates paid to Kaiser in a county with the rates paid to the private and local plans also serving that county – focusing on the same set of counties included in the above analyses. **Exhibit 7** summarizes some of these comparisons. The capitation rates paid to Kaiser during 2025, on average, were 20% above the rates paid to the other Medi-Cal health plans operating in the same counties. This 2025 differential was similar to, but larger than, the 2024 average differential of 18%.

Exhibit 7 also shows Kaiser's average capitation rate differentials in comparison to private plans serving Medi-Cal in the same county, and then in comparison to local plans. On average during 2025, Kaiser's capitation rates were 29% higher than the private plans and 8% higher than the local plans.

Exhibit 7. Kaiser Capitation Rates as Percentage of Other Health Plans in Same County

	2024	2025
Number of Rate Comparisons Made with Other Medi-Cal Health Plans (across 12 counties and the Adult and Child rate cells)	44	44
Range, Kaiser's Rate as Percentage of Comparison Health Plans	92% to 164%	94% to 164%
Average Kaiser Rate as % of Comparison Health Plans (across all comparisons)	118%	120%
Average Kaiser Rate as % of Private Health Plans	123%	129%
Average Kaiser Rate as % of Local Health Plans	107%	108%

Kaiser's high capitation rates could be attributable to a combination of the following factors:

- **Exemption from the competitive procurement process.** Kaiser's participation in Medi-Cal has been determined through direct negotiations with DHCS.

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- **The absence of auto-assignment enrollees.** Kaiser receives almost no auto-assigned Medi-Cal enrollments. To the extent auto-assignees have lower health needs and costs than “choice” enrollees, Kaiser would need a higher capitation rate to accommodate this health selection differential.
- **Cost structure.** It is possible that Kaiser’s model – either on the clinical side, the health plan side, or both, is more costly to operate than the “network” model used by private and local plans.

Two of the above three factors would result in DHCS paying more for Kaiser enrollees than if they were served by California’s private or local plans.

Using an average capitation rate of \$250 per member per month, 1 million enrollees, and the average rate differential of 20% observed in 2025, DHCS paid Kaiser **\$600 million more** during 2025 than would have been paid for the same enrollees had they been served by an average-priced competing Medi-Cal health plan. This estimate assumes the Kaiser enrollees’ average health status within rate cells is not meaningfully different than the average health status of enrollees of the comparison health plans.

Key Takeaway: DHCS paid Kaiser \$600 million more during 2025 than would have been paid for the same enrollees had they been served by an average-priced competing Medi-Cal health plan.

V. Member Choice Findings

Our assessment of MCP choice quantifies and compares the degree of plan choice available to Medi-Cal enrollees against other states' Medicaid programs and other large coverage programs in California.

Key Takeaway: California's most highly populated counties offer substantially fewer managed care plan choices (on a per enrollee basis) than is typical of other states' Medicaid programs – and vastly fewer MCP options than are available to Marketplace and Medicare enrollees in each of these same counties.

A. Medi-Cal, Medicare, and Marketplace MCP Options Available in Large Counties

Exhibit 8 compares the number of Medi-Cal MCP options available in each of California's 11 largest counties with the number of health plan options available through the Marketplace (Covered California) and through Medicare Advantage.

Exhibit 8: Choice Comparison between Medi-Cal, Marketplace, and Medicare Advantage Plans

Entity	Medi-Cal Plans	ACA Marketplace Plans	Medicare Advantage Plans
Los Angeles	6	10	54
San Diego	4	10	41
Sacramento	4	8	24
Riverside	3	10	43
San Bernardino	3	8	34
Santa Clara	3	11	24
Fresno	3	9	25
Kern	3	5	22
Alameda	2	8	25
Contra Costa	2	7	21
Orange	2	9	44

Los Angeles Two-Plan Model COHS Model Geographic Managed Care Single Plan Model Regional Model

Marketplace enrollees – and especially Medicare enrollees – have far wider plan choices available than do Medi-Cal enrollees in each of California's large counties. On average across these 11 counties, there are **3 times** as many Marketplace health plans than Medi-Cal MCPs, and **11 times** more Medicare Advantage plans than Medi-Cal MCPs. California's limited Medi-Cal plan choice cannot readily be explained by market size. Several California counties have Medicaid populations larger than entire state programs that sustain more competing MCPs (see next section). Limited choice therefore appears principally to be a program-design decision, not an unavoidable market constraint.

B. Comparisons with Other States

Eleven of California’s counties are more populated than many states. The most extreme example, Los Angeles County, has more Medicaid (Medi-Cal) enrollees than reside in all but three states – California itself, New York, and Texas. The smallest of these eleven counties, Contra Costa, has more Medi-Cal enrollees than the total Medicaid population in 9 states.

For each of these eleven counties, the number of Medi-Cal MCPs and the ratio of Medi-Cal enrollees per MCP are shown in **Appendix 5** and **Appendix 6**.

Exhibits 9 through 12 convey the number of MCPs across five counties in California compared with states of similar enrollment size. The counties assessed include Alameda, Contra Costa, Los Angeles, and Riverside/San Bernardino (which contract with health plans as if they were a single county). Based on this comparison in each of these counties, roughly half the number of Medi-Cal health plan options are available to their Medi-Cal residents than are available in the “size peer” comparison states.

Exhibit 9: Choice Comparison between Alameda County and Similar-Sized States

Entity	Medicaid Enrollees	# of MCPs	# Enrollees per MCP	Key Takeaway
Alameda County	481,201	2	240,600	
<i>States with similar enrollment & equal or more MCPs</i>				
Oklahoma	567,698	3 (all are statewide)	189,233	18% more Enrollees, 1 more MCP
Mississippi	478,746	3 (all are statewide)	159,582	1% fewer Enrollees, 1 more MCP
Iowa	603,975	3 (all are statewide)	201,325	26% more Enrollees, 1 more MCP
Nevada	613,298	4 (all are statewide)	153,325	27% more Enrollees, 2 more MCPs
Hawaii	432,125	5 (all are nearly statewide)	86,425	10% fewer Enrollees, 3 more MCPs
Comparison-State Average	539,168	3.6	157,978	12% more Enrollees, 1.6 more MCPs

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Exhibit 10: Choice Comparison between Contra Costa County and Similar-Sized States

Entity	Medicaid Enrollees	# of MCPs	# Enrollees per MCP	Key Takeaway
Contra Costa County	320,563	2	160,282	
<i>States with similar enrollment & equal or more MCPs</i>				
Nebraska	350,237	3 (all are statewide)	116,745	9% more Enrollees, 1 more MCP
Rhode Island	267,202	3 (all are statewide)	89,067	16% fewer Enrollees, 1 more MCP
Kansas	358,532	3 (all are statewide)	119,510	12% more Enrollees, 1 more MCP
West Virginia	407,316	4 (3 are nearly statewide)	135,772	27% more Enrollees, 1 more MCP
Mississippi	478,746	3 (all are statewide)	159,582	49% more Enrollees, 1 more MCP
Comparison-State Average	372,407	3.2	124,135	16% more Enrollees, 1.2 more MCPs

Exhibit 11: Choice Comparison between Los Angeles County and Similar-Sized States

Entity	Medicaid Enrollees	# of MCPs	# Enrollees per MCP	Key Takeaway
Los Angeles County	3,887,984	6 (including subcontractors)	647,997	
<i>States with similar enrollment & equal or more MCPs</i>				
Michigan	2,272,434	9 (all of which serve Detroit area at minimum)	252,492	42% fewer Enrollees, 3 more MCPs
New York	4,751,430	21 (10 of which serve New York City area at minimum)	226,258	22% more Enrollees, 15 more MCPs
Texas	3,842,754	15 (five of which serve Houston area at minimum)	256,183	1% fewer Enrollees, 9 more MCPs
Florida	3,050,800	10 (six of which serve Miami area at minimum)	305,080	22% fewer Enrollees, 4 more MCPs
Pennsylvania	2,738,844	7 (five of which serve Philadelphia area at minimum)	391,263	30% fewer Enrollees, 1 more MCP
Comparison-State Average	3,331,252	12.4	268,649	14% fewer Enrollees, 6 more MCPs

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Exhibit 12: Choice Comparison between Inland Empire Counties and Similar-Sized States

Entity	Medicaid Enrollees	# of MCPs	# Enrollees per MCP	Key Takeaway
Inland Empire (San Bernadino and Riverside combined)	1,901,128	3	633,709	
<i>States with similar enrollment & equal or more MCPs</i>				
Arizona	1,843,297	9 (six of which serve Phoenix area at minimum)	204,811	3% fewer Enrollees, 6 more MCPs
Virginia	1,810,041	5 (all are statewide)	362,008	5% fewer Enrollees, 2 more MCPs
Washington	1,660,905	5 (all are statewide)	332,181	13% fewer Enrollees, 2 more MCPs
Indiana	1,608,993	6 (all are statewide)	268,166	15% fewer Enrollees, 3 more MCPs
Maryland	1,665,870	9 (all serve Baltimore area at minimum)	185,097	12% fewer Enrollees, 6 more MCPs
Comparison-State Average	1,717,821	6.8	270,453	10% fewer Enrollees, 3.8 more MCPs

The above Exhibits demonstrate that there is ample room for additional health plan participation in California's larger counties.

The average number of Medi-Cal enrollees served by California's health plans is typically far above the corresponding average in each "size peer state" comparison.

States with a similar or smaller Medicaid enrollee population operate with the same or greater number of MCPs as are available in California's large counties. As a result, Medi-Cal enrollees have less MCP choice than enrollees in the above comparison states.

VI. Policy Recommendations

Based on the above tabulations and Medi-Cal program dynamics, we offer the following policy recommendations:

- 1) **Recommendation 1: In counties with multiple participating Medi-Cal health plans, DHCS should consider incorporating both cost and quality performance into the auto-assignment methodology to better align member assignment with overall value.** Cost should be assessed using enrollment-weighted capitation rates, alongside established quality and access measures. DHCS should also consider whether plans with more limited provider networks are appropriate for routine auto-assignment, while preserving beneficiary choice for members who actively select those plans.

Rationale: Large capitation rate differentials have been quantified in this report, such as between private plans and local plans in the Two-Plan model. Auto-assignment represents a key mechanism/opportunity to motivate and reward MCPs that deliver lower costs to DHCS and to California’s taxpayers. Steering more enrollment to lower-premium plans will amplify the savings these MCPs create. For example, for every additional 4,000 persons enrolled in an MCP with a \$25 lower capitation rate a Medi-Cal savings of \$1.2 million will occur in that year – and further savings will accumulate as these persons remain enrolled.

Quality performance should continue to be included in the auto-assignment algorithm, but not as the lone factor.

- 2) **Recommendation 2: DHCS should use both rate and market-share guardrails for Kaiser and pursue broader cost-effective competition.** Kaiser’s county-level market share should be limited where its enrollment-weighted capitation rates exceed those of other Medi-Cal plans, and its rates should not materially exceed the county average. In COHS and Single Plan counties, DHCS should prioritize adding plans that can lower state capitation costs and improve value, rather than defaulting to Kaiser as the principal alternative plan at higher cost.

Rationale: DHCS has recently added Kaiser as a Medi-Cal MCP option in 30 counties, although always at a higher premium cost than the other plans serving the same county. Kaiser’s capitation rates are on average 29% above the private plans and 8% above the local plans (based on “head-to-head” comparisons within each county). Large-scale financial savings will occur by lowering the size of these rate differentials and/or lowering the number of enrollees enrolled in the highest-priced MCP. Also, if DHCS is willing to add a higher-cost MCP option in a county, it seems reasonable for DHCS to also add lower-cost MCP options.

- 3) **Recommendation 3: Expand private plan participation in counties where meaningful competition does not currently exist.** DHCS should prioritize introducing additional private plan participation in Single Plan and COHS counties, where members have limited plan choice and competition is absent or minimal. Expansion decisions should consider county-specific factors—including enrollment, provider network capacity, and market readiness—and should be designed to enhance member choice, encourage innovation, and promote value while preserving local plans’ presence.

Rationale: Capitation rates are currently highest in the COHS and Single Plan settings. Based on the considerable degree to which the private plan premiums are below the local plan in the Two-Plan model, significant cost savings opportunities likely exist in adding private plans to the COHS and Single Plan counties. An injection of competition in these counties is also likely to improve the cost-effectiveness that local plans are delivering. California has many large counties with “state-sized” population levels where more MCPs can become involved – with all participating MCPs (including the local plans) having sufficient enrollment to operate viably.

- 4) **Recommendation 4: Continue to evaluate whether counties that have transitioned to Single Plan models have achieved the anticipated improvements in cost, quality, and access before expanding that model elsewhere.** The evaluation should also consider whether growth in Medi-Cal enrollment and provider capacity could support additional private plan participation, and whether current reliance on a single private option (or Kaiser as the only additional option) is providing sufficient competition to achieve the state's goals.

Rationale: Numerous findings from this report raise concern with efforts to shift Medi-Cal enrollment away from private plans. Local plans have are often delivering strong quality results but are cost-disadvantageous relative to the private plans.

Collectively, these recommendations are expected to significantly widen competition and enrollee choice, creating substantial ongoing savings to the Medi-Cal program. The recommendations also inject cost-effectiveness accountability for the local plans and Kaiser, without jeopardizing their involvement in Medi-Cal.

VII. Conclusion

Key Findings:

The report's key finding is that the private Medi-Cal plans are highly cost-advantageous to the Medi-Cal program and to California taxpayers. Our tabulations yielded the following specific results:

- Large-scale capitation rate differentials exist between the private plans and the local plans when they serve the same county (e.g., in the Two- Plan model). The private plans' rates are consistently lower and this differential widened to 20-30 percentage points on average as of 2025.
- The capitation rate differentials between the private plans and Kaiser is wider still – again comparing rates “head-to-head” in the same counties.
- County-wide capitation rates tend to be higher in the COHS, Single-Plan, and Two-Plan models where the private plan share of Medi-Cal enrollment is zero or quite low.
- Despite the above, the program's policy trend in recent years has been in the direction of reducing the private plans' role – adding Kaiser in 30 counties at a high capitation rate cost and without a competitive procurement award (as all private plans need to earn), and with three counties moving to a Single-Plan model that includes only a local plan. Cost trends in the early years of these single plan counties have been adversely high.

The report has also quantified the relatively small number of Medi-Cal health plan options available to enrollees, focusing on California's 11 largest counties which all have larger populations than are available in many *states*.

- Looking inside of California, on average across these 11 counties, prospective Marketplace enrollees have **three times** as many health plan options to choose among than do Medi-Cal enrollees. Medicare enrollees have, on average, **11 times** more health plan options to choose among than do Medi-Cal enrollees.
- Looking at states that have similar-sized Medicaid enrollment as each of the five largest California counties, roughly half the number of Medi-Cal health plan options are available to Medi-Cal residents than are available to Medicaid enrollees in each of these California counties' “size peer” comparison states.

Potential Limitations:

The assessment's key limitation is that its focus is entirely on cost and on the number of Medi-Cal health plan options being made available in each California county. Other important dimensions of health plan performance need to be considered in determining an optimal number and composition of MCPs in a county. These include, for example, access to preventive and indicated treatment services, staff responsiveness, enrollee and provider satisfaction, provider network depth, and health outcomes. That

said, cost-effectiveness is critically important and represents an area of significant opportunity in the Medi-Cal program.

Some of the capitation rate differentials identified in this report could be partially or largely attributable to health needs differences between MCPs. Average health status was not assessed in this report, with the exception that the assessments focused on the same two rate cells throughout. (Therefore, a health plan with a higher proportion of enrollees with disabilities and/or older enrollees would not be distorting our assessment.) The health status differences between different health plans' enrollees within the adult and child rate cohorts are not likely to be large and could swing in either direction. The findings suggest that the substantial and persistent cost differences identified in this report are unlikely to be attributed to a disproportionate concentration of individuals with poorer health status within the local plans and Kaiser.

Key Recommendations:

Four specific policy recommendations were offered in Section VI including their rationale and a linkage as to how the report's findings support each recommendation. The common theme to these recommendations is that because Medi-Cal's private plans are delivering such large-scale financial value relative to the local plans and relative to Kaiser, California's policymakers should widen the private plans' involvement in the program. In so doing, significant savings will accrue to the state (via the additional enrollment served by the more cost-effective plans). In addition, in a setting with an injection of competitive dynamics, all Medi-Cal health plans will have greater motivation to operate cost-effectively.

VIII. Appendix Tables

Appendix 1: Managed Care Models and Counties Included in our Assessment

Rank by Enrollment	County	Enrollees, Jan 2025	Model During 2019 and 2022	Model During 2025
1	Los Angeles	3,887,984	Modified Two-Plan (multiple MCP subcontractors)	Modified Two-Plan (multiple MCP subcontractors)
2	Riverside	972,733	Two-Plan	Two-Plan
3	Orange	966,960	County Organized Health System	County Organized Health System
4	San Diego	941,397	Geographic Managed Care	Geographic Managed Care
5	San Bernardino	928,395	Two-Plan	Two-Plan
6	Sacramento	617,201	Geographic Managed Care	Geographic Managed Care
7	Fresno	506,407	Two-Plan	Two-Plan
8	Alameda*	481,201	Two-Plan	Single Plan
9	Kern	467,458	Two-Plan	Two-Plan
10	Santa Clara	439,780	Two-Plan	Two-Plan
11	Contra Costa*	320,563	Two-Plan	Single Plan
12	San Joaquin	300,167	Two-Plan	Two-Plan
18	Santa Barbara	173,658	County Organized Health System	County Organized Health System
19	San Mateo	164,509	County Organized Health System	County Organized Health System
23	Imperial*	97,715	Imperial Model (Two-Plan)	Single Plan
44	Tuolumne	14,173	Regional Model	Regional Model
46	Calaveras	12,789	Regional Model	Regional Model
Statewide Total		14,028,098		
Subtotal, 17 Counties Included in This Assessment		11,293,090		

*County Transitioned Models During this Timeframe

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Appendix 2: Capitation Rate Differentials in Five Large Two-Plan Model Counties

Rate Cell / Year	Riverside	San Bernardino	Fresno	Santa Clara	Kern	Enrollment Weighted Avg
Child, 2019	90.9%	89.8%	92.1%	85.9%	92.2%	90.4%
Child, 2022	87.3%	87.3%	94.7%	87.7%	89.4%	88.8%
Child, 2025	69.0%	69.0%	96.6%	83.8%	98.8%	79.4%
Adult, 2019	73.0%	76.7%	88.6%	89.1%	90.3%	81.0%
Adult, 2022	68.0%	68.0%	89.1%	83.4%	85.5%	75.7%
Adult, 2025	58.9%	58.9%	79.9%	84.6%	95.1%	70.7%
Medi-Cal Enrollment						
2019	691,836	684,925	394,598	305,362	325,693	
2022	877,564	867,577	470,048	386,904	422,557	
2025	968,400	924,572	504,308	439,133	466,898	

Figures Convey Private Plan Rate as a Percentage of the Local Plan Rate (based on mid-point of published rate ranges)

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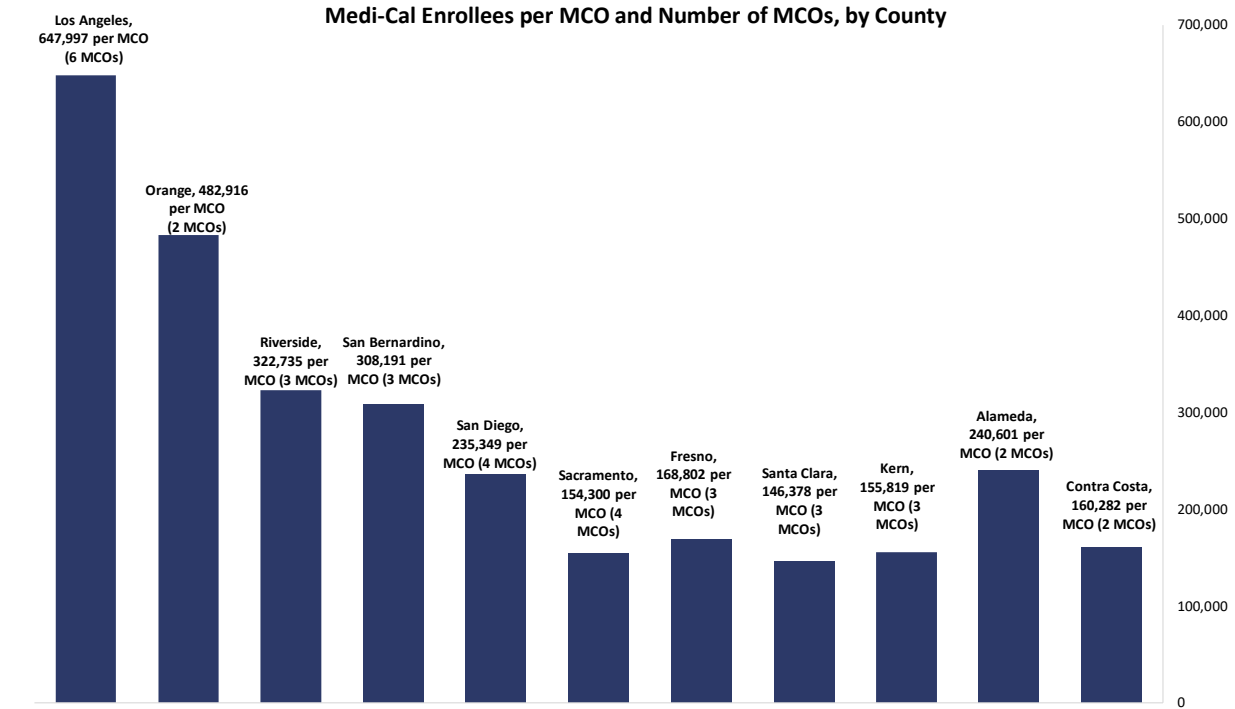
Appendix 3: County-Wide Average Capitation Rates and Ratios to Medicare FFS and Marketplace

Jurisdiction and Medi-Cal Managed Care Model	2025 County-Wide Capitation Rate (enrollment-weighted average across Medi-Cal health plans serving the county)		Ratio of Medi-Cal Per Capita Costs to Medicare FFS, 2023		Ratio of Medi-Cal Per Capita Costs to Marketplace, 2025		Medi-Cal Enrollment, January 2025	Percent of Medi-Cal Population Enrolled in Private Health Plans, 2025
	Adult	Child	Adult	Child	Adult	Child		
Los Angeles	\$262	\$136	11.9%	5.5%	52.2%	27.0%	3,868,434	58.5%
Two Plan Model								
Fresno	\$271	\$113	18.1%	5.8%	51.4%	21.4%	504,308	30.3%
Kern	\$378	\$141	19.6%	6.2%	68.7%	25.7%	466,898	8.7%
Riverside	\$355	\$180	18.6%	7.0%	68.3%	34.6%	968,400	11.2%
San Bernardino	\$356	\$180	18.5%	7.0%	70.8%	35.8%	924,572	10.8%
Santa Clara	\$334	\$154	17.4%	7.1%	47.2%	21.7%	439,133	22.2%
COHS Model								
Orange	\$351	\$164	16.8%	7.9%	59.7%	27.8%	965,831	0%
San Mateo	\$336	\$155	24.8%	9.0%	38.9%	17.9%	164,509	0%
Santa Barbara	\$398	\$166	25.4%	9.9%	52.7%	22.1%	173,658	0%
Geographic Managed Care								
Sacramento	\$297	\$131	20.9%	6.5%	47.1%	14.3%	616,285	78.0%
San Diego	\$337	\$150	22.4%	7.8%	52.1%	17.5%	934,874	92.2%
Single Plan								
Alameda	\$352	\$182	18.9%	7.9%	48.9%	25.2%	479,943	0.0%
Contra Costa	\$378	\$180	20.5%	7.4%	49.7%	23.6%	320,201	0.0%
Imperial	\$248	\$136	18.5%	10.1%	44.5%	24.4%	97,715	0.0%
Regional Model								
Calaveras	\$308	\$113	24.5%	6.8%	33.2%	12.2%	12,789	100.0%
Tuolumne	\$309	\$113	23.8%	6.7%	35.4%	13.0%	14,173	100.0%

Appendix 4: Average Capitation Rates by Medi-Cal Managed Care Model, Including Ratios to Medicare FFS and Marketplace

Jurisdiction and Medi-Cal Managed Care Model	2025 County-Wide Capitation Rate		Ratio of Medi-Cal Per Capita Costs to Medicare FFS, 2025		Ratio of Medi-Cal Per Capita Costs to Marketplace, 2025		Medi-Cal Enrollment, January 2025	Percent of Medi-Cal Population Enrolled in Private Health Plans, 2025
	Adult	Child	Adult	Child	Adult	Child		
Los Angeles	\$262	\$136	12%	6%	52%	27%	3,868,434	59%
Two Plan Model	\$343	\$161	18%	7%	64%	30%	3,303,311	15%
COHS Model	\$355	\$163	19%	8%	56%	26%	1,303,998	0%
Geographic Managed Care	\$321	\$142	22%	7%	50%	16%	1,551,159	87%
Single Plan	\$350	\$176	19%	8%	49%	25%	897,859	0%
Regional Model	\$309	\$113	24%	7%	34%	13%	26,962	100%

Appendix 5: Medi-Cal Enrollees Per MCP in California's 11 Largest Counties



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Appendix 6: Choice Comparison between California's Highest Populated Counties (Jan 2025)

County	Medi-Cal Enrollees	# of Medi-Cal MCPs	# of ACA Marketplace Plans	# of Medicare Advantage Plans	Medi-Cal Enrollees Per MCP	Rank in Medicaid Enrollees if this County were a State
Los Angeles	3,887,984	6 (including primary MCPs and their subcontractors)	10	54	647,997	4 th
Orange	965,831	2	9	44	482,916	28 th
Riverside	968,204	3	10	43	Riverside: 322,735 San Bernardino: 308,191 Combined -- Inland Empire Region: 630,925	Riverside: 27 th San Bernardino: 29 th
San Bernardino	924,572	3	8	34		Combined -- Inland Empire Region: 10 th
San Diego	941,397	4	10	41	235,349	28 th
Sacramento	617,201	4	8	24	154,300	34 th
Fresno	506,407	3	9	25	168,802	35 th
Santa Clara	439,133	3	11	24	146,378	36 th
Kern	467,458	3	11	24	155,819	36 th
Alameda	481,201	2	8	25	240,601	36 th
Contra Costa	320,563	2	7	21	160,282	41 st

Regional model counties are omitted from Exhibit 9 due to low enrollment numbers.

Los Angeles Two-Plan Model COHS Model Geographic Managed Care Single Plan Model Regional Model