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The Organizational Design of the Modern Health Plan

The next generation of health plans will compete on their ability to turn evidence into better decisions—and better decisions into better outcomes.

Letter from the Editor

What Kind of Health Plan Are We Actually Building?

Over the past several months, I have found myself returning to the same question.

[What kind of health plan are we actually building?](#)

It surfaced while looking at earnings and the continued pressure on margins. It appeared again in conversations about interoperability, risk adjustment, quality, prior authorization, and the growing availability of clinical data. And it became harder to ignore as artificial intelligence moved from experimentation toward the workflows where real decisions are made.

Each of these developments can be examined independently. Health plans have teams responsible for doing exactly that.

But viewed together, I think they are telling us something more important.

The capabilities required to run a successful health plan are changing—and many of those capabilities no longer fit neatly within the organizational boundaries we inherited.

Clinical information increasingly affects financial performance. Regulatory investments can create infrastructure that serves multiple business purposes. AI can influence decisions across functions. Evidence acquired for one workflow can have value in several others. And decisions made in one part of the organization increasingly affect outcomes somewhere else.

That creates an interesting challenge for operators.

We can continue improving individual functions—and we should. But at some point, optimizing the pieces is not the same thing as improving the enterprise.

In the first issue of *The Health Plan Operator's Brief*, I wrote that projects consume funding while capabilities create options. Last month, after reviewing Q2 earnings across the major publicly traded health plans, I argued that the industry appeared to be moving beyond a cyclical response to medical-cost pressure and beginning to redesign how it operates.

This issue takes the next step.

I have been working on a way to describe the operating model I believe is beginning to emerge—one that connects clinical evidence, intelligence, workflow, governance, and organizational learning around something health plans do millions of times every day:

Make decisions.

Some are clinical. Some are financial. Some are administrative. Some happen in milliseconds; others unfold over months or years. **Different parts of the enterprise operate on different clocks, with different responsibilities and different forms of accountability.** But collectively, the quality and consistency of those decisions determine an extraordinary amount about how a health plan performs—and increasingly, how effectively it can improve health.

The organizational challenge is not to make all of those decisions the same. It is to create an enterprise in which the capabilities supporting them can increasingly work together.

I call the model **the Decision Enterprise**.

The idea is still evolving, and I expect it will continue to do so. But the premise is straightforward: the next generation of health-plan performance will depend less on how many individual capabilities an organization possesses and more on whether it can connect those capabilities to consistently produce better decisions and better outcomes at scale.

That is the argument I want to explore in this issue.

—John G. Murtha

Section I – The Operating Environment What the Market is Telling Us

Observation 1: The pressures facing health plans are converging.

Evidence

Several developments over the past few months point in the same direction.

On August 28, CMS initiated payment-year 2024 RADV audits, notifying Medicare Advantage organizations with contracts selected for audit. The move increases the importance of being able to retrieve the clinical evidence supporting historical risk-adjustment submissions—not simply maintaining an accurate longitudinal record today.

Interoperability is entering a similar transition. The major API requirements of CMS-0057-F take effect in **January 2027**, but the larger operational question is already moving beyond endpoint compliance: whether incoming clinical information can be identified, normalized, governed, and incorporated into the workflows where decisions are made.

A recent RISE survey of 133 healthcare leaders found that 44% reported scaling AI across functions or enterprise-wide, while substantially fewer reported having a documented AI strategy tied to Medicare Advantage performance. When asked which measures AI had improved, the most common answer was none.

Meanwhile, the underlying financial pressure has not disappeared. As last month's earnings review showed, health plans continue to operate in an environment of elevated medical costs, tighter margins, and increasing pressure to extract more value from existing investments and operating capacity.

Risk adjustment. Interoperability. AI. Medical-cost management. Quality. Administrative efficiency.

Each can be treated as an independent management problem.

Increasingly, however, they depend upon many of the same underlying capabilities: reliable clinical evidence, normalization, shared intelligence, workflow integration, governance, and measurement.

This changes the interoperability question in particular. For years, the industry has focused appropriately on the difficult problem of moving information between organizations. That work remains essential.

But the value of interoperability is ultimately determined by what happens **after the information arrives**.

Can it be trusted? Can it be normalized? Can its provenance be established? Can clinical and business rules be applied consistently? Can the resulting intelligence reach the workflow where someone—or increasingly something—must act?

Those are no longer simply data questions.

They are operating-model questions.

Operator Implication

The major pressures facing health plans may not require a series of independent transformations. They may be exposing a common limitation in how the enterprise is organized to turn information into action.

The operating model of the health plan itself is beginning to change.

Section II – The Organizational Problem – Connected Does Not Mean Integrated

Observation 2: A health plan can be technically connected and still be operationally fragmented.

Evidence

Most health plans were not designed as integrated decision systems. They evolved.

New functions emerged as the business became more complex. New regulatory requirements created new processes. Acquisitions introduced new platforms. Individual business units purchased technology to solve specific problems. Specialized teams developed their own analytics, rules, terminology, data stores, and workflows.

Much of this development was rational. Local optimization solved immediate business problems.

But the accumulated result can be an organization with enormous capabilities that remain difficult to coordinate.

The same clinical record may be acquired more than once. The same information may be normalized differently. Separate teams may independently determine what constitutes sufficient evidence. Business rules may be embedded inside individual applications. Similar clinical questions may be answered through different processes.

The consequence is not merely technical duplication.

It is **decision variation**.

Consider one member moving through the enterprise.

Utilization Management may need clinical evidence to make an authorization decision. Care Management may need the same evidence to determine an intervention. Risk Adjustment may need it to understand disease burden. Quality may use it to identify or close a care gap. Appeals or Customer Service may encounter it at an entirely different moment.

Those functions should operate differently. They have different responsibilities, apply different rules, and make different decisions.

But the member did not change. And the underlying clinical evidence did not change.

The organizational problem begins when each function must independently reconstruct what is true about that member before it can decide what to do.

Operator Implication

The problem is not organizational specialization. The problem is fragmentation underneath the specialization.

The objective is not for every function to reach the same decision. It is for those decisions to begin from a common, trusted understanding of the evidence.

Different workflows are appropriate. Different underlying truths are not.

Section III – The Capability Shift – From Functional Optimization to Enterprise Capability

Observation 3: The modern health plan needs capabilities that transcend individual functions.

Evidence

Historically, a business function might acquire information, interpret it, apply its own rules, build a workflow, make a decision, and measure the result largely within the boundaries of that function.

The emerging model separates capabilities that should be enterprise-wide from workflows and decisions that appropriately remain specialized. Clinical evidence is an obvious example.

If authenticated clinical information about a member has already been acquired, normalized, and made usable, another function should not need to rediscover and reconstruct that evidence when it needs it.

The same principle applies to terminology, provenance, identity, selected business and clinical logic, governance, and increasingly decision services. This does not mean Utilization Management and Risk Adjustment should operate identically. Nor should Quality and Customer Service.

They operate on different clocks, answer different questions, and have different responsibilities. A national health plan and a local market may also require different degrees of operating authority because networks, populations, products, regulatory environments, and market conditions differ.

The opportunity is therefore not to centralize every decision. It is to determine which capabilities should be shared and which decisions should remain closest to the function or market accountable for the outcome. That distinction matters...

Centralization can reduce fragmentation, but poorly designed centralization can simply replace fragmentation with bureaucracy. The objective is not to move every decision upward or force every workflow into a common process. It is to create reusable enterprise capabilities while preserving the specialized expertise, accountability, and local authority required to act effectively.

Operator Implication

Standardization does not require identical workflows. Enterprise capability does not require centralized control.

Clinical evidence can be shared while the decisions made from it remain different. Definitions and governance can be common while execution remains local. Decision services can be reusable while accountability remains with the function responsible for the outcome.

Centralize the capability, not necessarily the decision.

Instead of every function assembling its own vertical technology and data stack, selected capabilities can begin to sit horizontally across the enterprise.

The health plan becomes less a collection of independently optimized functions and more a coordinated system for producing decisions.

Functions will remain. Their independence will not.

The Health Plan Decision Enterprise

From Fragmented Data to Trusted, Consistent Decisions Across the Enterprise

Better Evidence. Shared Once. Used Everywhere. Decisions That Matter.

“Data doesn’t create consistency—operating models do.”

TODAY: SILOS. DUPLICATION. VARIATION.



! Same member. Same evidence.
Different conclusions.

THE FUTURE: A CONNECTED DECISION ARCHITECTURE



Shared Enterprise Capabilities. Specialized Workflows. Accountable Decisions.

POWERED BY INTEROPERABILITY STANDARDS



THE OUTCOME: MEASURABLE IMPACT

- ✓ **More Accurate Risk Adjustment**
Better revenue integrity and audit defensibility.
- ✓ **Operational Efficiency**
Eliminate redundant effort and manual chart chase.
- ✓ **Consistent Member Experience**
Aligned decisions across all touchpoints.
- ✓ **Better Quality & Outcomes**
Actionable insights drive better care.
- ✓ **Ready for AI**
AI amplifies outcomes when built on trusted, governed data.

From Information to Insight.
From Insight to Impact.

THE FOUNDATIONS THAT MAKE IT WORK

✓ **Trusted Clinical Evidence**
Authenticated.
Normalized. Reusable.

✓ **Governance & Stewardship**
Clear ownership.
Accountability.
Policy-driven.

✓ **Interoperability by Design**
Standards-based.
Secure. Scalable.

✓ **Operational Integration**
Embedded in workflows.
Decision-ready.

✓ **Continuous Learning**
Measure, adapt, improve.

THE SHIFT THAT MATTERS

Claims-First
(Backward Looking)
✗ Fragmented
✗ Manual
✗ Inconsistent
✗ Reactive

Clinical-First
(Forward Looking)
✓ Integrated
✓ Automated
✓ Consistent
✓ Proactive

“The next advantage in healthcare won’t come from more data.
It will come from making **better, more consistent decisions—together.**”

✓ **Right Evidence**
From the start.

✓ **Right Decision**
Every time.

★ **Right Outcome**
For every member.

✓ **Right Future**
For every organization.

Section IV – The Emerging Operating Model – The Decision Enterprise

Observation 4: The health plan is becoming a Decision Enterprise.

Evidence

A **Decision Enterprise** is an organization designed to consistently turn trusted evidence into action across the enterprise.

It is not one system, one workflow, or one centralized decision maker.

It is an operating model that connects the capabilities required to move from evidence to action while preserving the specialized expertise, workflows, and decision rights required across the organization.

Information is acquired from across the ecosystem and normalized into trusted representations. Clinical and business intelligence enrich that information. Reusable services make evidence and selected decision logic available across the organization. Decisions are embedded into the workflows where action occurs. Governance establishes accountability. Outcomes create feedback that allows the enterprise to learn.

The operating cycle becomes:

SIGNAL → EVIDENCE → DECISION → ACTION → OUTCOME → LEARNING

Most organizations already perform every one of these activities somewhere.

The difference is whether they operate as a connected enterprise system.

A signal without reliable evidence creates uncertainty. Evidence without decision logic creates information. A decision disconnected from workflow creates another recommendation someone must find and interpret. Action without measurement prevents learning. And learning confined to one function prevents the enterprise from improving.

Connect the cycle and something important begins to happen.

Clinical evidence acquired for one purpose can support another. A policy or clinical rule established once can be reused where appropriate. An improvement discovered in one workflow can inform related decisions elsewhere.

The enterprise begins to learn across functions rather than only within them.

Operator Implication

The Decision Enterprise is not simply a technology architecture.

Architecture makes it possible. Organizational design determines how those capabilities are governed, where decisions are made, who is accountable for them, and how the enterprise learns from the outcomes.

The objective is one enterprise capable of making trusted decisions from a common foundation—without requiring every decision to be made in the same place, in the same way, or on the same clock.

Section V – The Architecture – What the Modern Health Plan Must Be Able to Do

Observation 5: Durable enterprise capabilities matter more than individual applications.

Evidence

Health plans operate on dramatically different clocks.

A digital interaction may require an immediate response. A prior-authorization request may need a decision within a defined operational window. Care Management may follow a member longitudinally. Quality performance accumulates over a measurement year. Risk Adjustment depends on evidence gathered across an annual cycle. Network and capital decisions may extend across multiple years.

The enterprise therefore does not need one workflow or one operating cadence. It needs shared capabilities capable of supporting many workflows operating across many clocks.

Applications will change. AI models will change even faster. Business priorities and regulations will change.

But certain enterprise requirements endure: trusted evidence, common definitions, explicit decision logic, interoperability, governance, provenance, measurement, and the ability to place intelligence into the workflow where it is needed.

These become durable capabilities of the enterprise rather than features of a particular application.

A Decision Enterprise does not synchronize the organization by forcing every function onto the same clock. It synchronizes the capabilities and handoffs between them.

The Decision Stack...

THE HEALTH PLAN DECISION STACK™

From Disconnected Data to Trusted Decisions, Consistently.



One Member.
Many Interactions.
One Truth.



One Enterprise.
Aligned Decisions.
Better Outcomes.



Trusted Evidence.
Smart Governance.
Confident Action.



AI Accelerates.
Consistency
Creates Trust.

Speed creates
efficiency.

Consistency
creates trust.

That's lasting
advantage.

THE 7-LAYER ENTERPRISE FOUNDATION

Each layer builds on the one below. Together, they enable trusted, consistent decisions.



BETTER DECISIONS DRIVE BETTER OUTCOMES



BETTER MEMBER EXPERIENCE

Coordinated care.
Fewer handoffs.
Stronger trust.



BETTER CLINICAL OUTCOMES

Timely interventions.
Appropriate care.
Healthier lives.



BETTER FINANCIAL PERFORMANCE

Accurate risk.
Reduced leakage.
Lower total cost.



BETTER OPERATIONAL EFFICIENCY

Less duplication.
Automated workflows.
More capacity.



STRONGER ORGANIZATION

Aligned teams.
Trusted data.
Sustainable advantage.

WHAT MAKES IT POSSIBLE



Interoperability
Standards



Modern Data
Infrastructure



AI & Advanced
Analytics



People, Process
& Culture



Strong Governance
& Stewardship



OUR PURPOSE: ENABLE TRUSTED, CONSISTENT DECISIONS AT ENTERPRISE SCALE

When every part of the organization works from the same trusted evidence and the same decision logic, members benefit, clinicians are empowered, and the enterprise performs.

One Truth. One Enterprise. One Decision at a Time.

The Decision Stack makes the architecture more concrete.

Clinical evidence forms the foundation. Normalization and interoperability make that evidence consistently usable. Business and clinical rules add context and intelligence. Shared decision services make evidence and logic reusable. Operational workflows place decisions where action occurs. Governance establishes accountability and control. Trusted decisions are the result.

But the more important point is not any individual layer.

The stack is cumulative.

A sophisticated AI model cannot compensate for unreliable evidence.

Interoperability alone cannot ensure consistent interpretation.

Common data without common rules can still produce different answers.

Good analytics disconnected from workflow may never affect an outcome.

Automation without governance can scale mistakes.

And decisions without feedback cannot systematically improve.

Operator Implication

The health plan is developing a capability larger than technology modernization:

the ability to make better decisions consistently at enterprise scale.

Section VI – The Performance Consequence – Better Decisions. Better Outcomes.

Observation 6: Better decisions are not the endpoint. Performance is.

Evidence

A health plan occupies an unusual position in healthcare. It finances care, manages risk, administers benefits, contracts with providers, serves members, responds to regulators, manages clinical programs, and increasingly participates in the information flows connecting the healthcare system.

Its decisions therefore have consequences.

Consider a member discharged from the hospital following an exacerbation of congestive heart failure.

New clinical information enters the health plan. In a fragmented model, that information may arrive separately—or at different times—to several functions. Care Management may identify the member for outreach. Quality may determine whether recommended follow-up

occurred. Utilization Management may encounter the same clinical history during a subsequent authorization request. Customer Service may later respond to a member question without visibility into any of those interactions.

In a Decision Enterprise, the functions do not become one workflow. **The evidence becomes reusable across them.**

The discharge information can be normalized and associated with the correct member once. Care Management can use it to determine whether outreach is warranted. Quality can apply its own measures and timeframes. A later authorization decision can incorporate the relevant clinical history. Each function retains its own rules, responsibilities, decision rights, and clock—but operates from a more consistent understanding of the member.

The result is not simply better data.

It is the possibility of earlier intervention, fewer contradictory interactions, less duplicated work, and decisions that are better informed by what the enterprise already knows.

A better decision can identify a member who needs intervention earlier. It can reduce unnecessary administrative friction for a provider. It can prevent an avoidable denial. It can identify clinical evidence that changes the understanding of risk. It can close a meaningful gap in care. It can route a member toward an appropriate service.

Multiplied across millions of members and millions of interactions, relatively small improvements in decision quality can become significant.

The modern health plan should therefore be capable of producing:

Better Member Experiences

Fewer contradictory interactions, more coordinated engagement, and decisions informed by a more complete understanding of the member.

Better Clinical Outcomes

Earlier identification of need, more timely interventions, and fewer gaps created by missing or delayed information.

Better Financial Performance

More accurate understanding of risk, lower administrative friction, improved allocation of resources, and greater ability to manage medical cost.

Greater Operational Efficiency

Less duplication, fewer manual reconciliations, reusable capabilities, and greater capacity from existing resources.

A Stronger Organization

More consistent decisions, greater adaptability, and an enterprise capable of learning across functional boundaries.

These outcomes are often discussed as competing objectives.

Increasingly, [the capabilities required to produce them are shared.](#)

Operator Implication

The most important efficiency may not come from asking each department to do the same work slightly faster.

[It may come from eliminating the need for multiple departments to independently perform the same underlying work at all.](#)

Section VII – The AI Test – AI Will Expose the Operating Model Beneath It

Observation 7: AI makes organizational consistency more important, not less.

Evidence

The first wave of enterprise AI discussion has understandably focused on productivity: how much work can be automated, how quickly information can be summarized, and how many administrative tasks can be removed.

But AI is already moving beyond isolated experimentation. In a recent survey of 133 healthcare leaders, 44% reported scaling AI across functions or enterprise-wide. Yet substantially fewer reported having a documented AI strategy tied to Medicare Advantage performance, and when asked which measures AI had improved, the most common answer was none.

That gap matters.

The larger opportunity—and risk—emerges when AI begins participating directly in decisions.

At that point, AI inherits the operating environment around it: the evidence available, the definitions and policies applied, the workflow in which the decision occurs, the governance surrounding it, and the ability to observe what happened afterward.

[AI does not resolve fragmentation. It can amplify it.](#)

A fragmented enterprise deploying AI function by function could create extraordinarily sophisticated silos.

Different functions could become faster and more intelligent while still operating from different representations of the member, different interpretations of evidence, and disconnected decision logic.

A Decision Enterprise offers another possibility: AI amplifies capabilities already connected through trusted evidence, reusable intelligence, workflow integration, governance, and feedback.

Operator Implication

The strategic AI question is no longer simply:

Where can we deploy AI?

It is also:

What kind of enterprise are we asking AI to accelerate?

Speed creates efficiency. Consistency creates trust.

Section VIII – The Competitive Divide – Capabilities Compound

Observation 8: Operating-model capability is becoming a basis of competition.

Evidence

Health plans will continue to compete through products, networks, pricing, brand, service, distribution, capital, and local market position.

Increasingly, they will also compete through organizational capability.

Two health plans may possess similar technology, data, and talent while developing very different capabilities.

One repeatedly assembles evidence, rules, integrations, governance, and workflows for individual initiatives.

The other increasingly reuses trusted evidence, intelligence, decision services, governance, and learning across the enterprise.

Initially, the difference may be difficult to see.

Over time, it compounds.

A capability built for one purpose can lower the cost and complexity of the next. Clinical evidence acquired and normalized for one workflow can support another. Governance established around one decision process can provide a foundation for others. A reusable decision service can be applied in additional workflows. Learning from one part of the enterprise can improve decisions elsewhere.

The advantage is therefore not simply reuse. **Each capability can make the next capability easier to build and the next problem easier to solve.**

Organizations that can learn across the enterprise should improve faster. Organizations that can reuse capabilities should operate with less duplication. Organizations working from shared evidence should produce greater consistency. Organizations capable of placing

better intelligence into workflows should make better decisions closer to the moment those decisions matter.

Operator Implication

The emerging competitive divide may be between organizations capable of compounding enterprise capabilities and those that must continue rebuilding them one initiative at a time.

Operating-model fragmentation is becoming a competitive disadvantage.

Section IX – The Leadership Agenda – Five Questions for the Modern Health Plan

The transition to a Decision Enterprise does not begin with a technology purchase. It begins with understanding how the organization makes decisions today.

I would ask five questions:

1. Where are we making materially similar decisions from different versions of the truth?
2. Which capabilities are we repeatedly rebuilding inside individual functions?
3. Where could trusted evidence and decision intelligence become reusable enterprise assets?
4. Are our AI investments reinforcing a coherent operating model—or automating fragmentation?
5. What would we have to change organizationally to make better decisions consistently at scale—while preserving the decision rights and local authority that matter?

The answers will reveal a great deal about the current operating model.

They may also reveal where the next generation of health-plan capability needs to be built.

The Operator's View

What Great Operators Build

Great operators do more than run today's organization efficiently.

They build the capabilities the organization will need tomorrow.

For the modern health plan, that means looking beyond individual technologies and individual functions toward the system that connects them.

The objective is not to eliminate specialization.

It is not to centralize every decision.

And it is certainly not to replace human judgment with technology.

The objective is to create an enterprise in which people, data, technology, clinical knowledge, business policy, and increasingly AI can work from a common foundation.

One member.

Many interactions.

Shared evidence.

Specialized workflows.

Governed decisions.

Continuous learning.

Better outcomes.

The health plans that build this capability will have more than better technology. They will have greater capacity to manage complexity, absorb change, deploy intelligence, improve operations, and produce better health and financial outcomes at scale.

And that capacity will matter competitively.

Projects consume funding. Capabilities create options. Capabilities compound.

The next advantage in healthcare will not come simply from having more data.

It will come from building organizations capable of turning that data into better, more consistent decisions—and improving those decisions every time the enterprise learns.

That is the Decision Enterprise.

About The Health Plan Operator's Brief

A monthly executive briefing examining the strategic, operational and technological forces reshaping health plans. Written to inform discussion—not to promote products or predict the future. The views expressed are my own.

—John G. Murtha