THE HEALTH PLAN OPERATOR'S BRIEF Issue No. 002

August 2026 | Q3

What Q2 Earnings Tell Us About the Health Plan the Future Requires

Synthesizing the signals shaping the next generation of health plan leadership
An executive briefing on the emerging operating model of health plans.

Letter from the Editor

Seven publicly traded health plans reported second-quarter results by the end of July.

Most executives experienced those results as seven separate earnings calls: different management teams, different portfolios, different analyst questions and different explanations for the quarter.

I have treated them as one conversation.

Read together, the calls reveal more than the direction of medical costs or the quality of quarterly execution. They show an industry attempting to redesign itself while continuing to operate at full scale.

The pressure is familiar. Medical costs remain elevated. Government programs are less forgiving. Administrative costs remain stubborn. Technology environments remain fragmented. Providers and members expect decisions to move faster. Regulators increasingly expect the same.

The response, however, is changing.

Clinical operations are becoming a financial discipline. Artificial intelligence is entering production workflows. Prior authorization is being redesigned around automation, exceptions and provider performance. Clinical data is moving closer to the point of decision. Plans are becoming more selective about markets, membership and capital. Capabilities once developed inside departments are being reconstructed as enterprise infrastructure.

This edition synthesizes the recurring signals, identifies the patterns beneath them and considers their implications for executive leadership.

It does not ask which plan won the quarter.

It asks what the quarter taught us about the institution the health plan is becoming.

The answer is not a finished model. It is a direction of travel.

The future health plan will be less a collection of insurance functions and more a coordinated decision enterprise: continuously sensing change, translating evidence into action and aligning decisions made across different operating horizons.

That transition is already under way.

Section I — Executive Intelligence What Q2 Earnings Tell Us

Observation 1: Margin pressure has become structural.

Evidence

- Medical-cost ratios remained near or above 90% in several government-program lines of business, including among plans that exceeded earnings expectations.
- Several management teams described recovery paths extending through 2028 or 2029 rather than expecting one annual pricing cycle to restore historical margins.
- Across government programs, management teams increasingly prioritized sustainable unit economics over membership retention, exiting or retrenching where rates, acuity and operating requirements could not be reconciled.

Implication

Margin recovery can no longer be treated principally as a pricing exercise. It requires coordinated action across product design, clinical operations, network strategy, risk adjustment, administration and market participation.

Observation 2: Clinical operations have become financial strategy.

Evidence

- One large-scale complex-care model reported inpatient admissions approximately 12% lower and emergency-department use approximately 13% lower, with expected medical savings in the mid-teens.
- Utilization management, transitions of care, site-of-service management and earlier identification of clinical needs were repeatedly presented as margin-recovery levers.
- Leading plans are beginning to detect emerging medical-cost trends in days and hours rather than waiting for completed claims and monthly reporting cycles.

Implication

Clinical operating performance is now an earnings variable. The agendas of the chief medical officer, chief operating officer and chief financial officer are increasingly inseparable.

Observation 3: AI has entered execution.

Evidence

- Several multi-year AI programs now carry productivity ambitions measured in 100–200 basis points.
- Current deployments are concentrated in prior authorization, claims, payment integrity, clinical-document review, care-gap identification, contact centers and member navigation.
- Management teams are increasingly distinguishing between automating existing work and redesigning the process itself.

Implication

The leadership question is no longer whether to experiment with AI. It is which workflows should change, what work should disappear, where human authority remains and how the clinical and financial effects will be measured.

Observation 4: Government programs continue reshaping enterprise priorities.

Evidence

- Medicare Advantage performance remains tied to pricing, Stars, risk-model changes, provider performance and earlier condition identification.
- Medicaid redeterminations produced smaller, often higher-acuity populations while intensifying pressure for adequate state rates.
- ACA exchange performance diverged materially, prompting some plans to expand, others to retrench and others to exit.

Implication

Government programs are not operating at the edge of the enterprise. Their rules increasingly determine data priorities, clinical workflows, market portfolios, technology roadmaps and capital requirements.

Observation 5: Administrative simplification remains elusive.

Evidence

- Several plans improved administrative-cost ratios while establishing further multi-year productivity targets.
- In advanced connected workflows, plans are reporting material reductions in avoidable denials, manual contacts and authorization volume—not simply faster processing of the same work.
- Yet manual documentation requests, delayed claims, fragmented clinical data, repeated reconciliation and regional variation remain widespread.

Implication

Automation is producing local gains faster than the enterprise is becoming simpler. The next stage requires retiring work, consolidating platforms and removing the organizational causes of duplication.

Observation 6: Capital allocation is becoming more disciplined.

Evidence

- Several plans accepted near-term earnings pressure to fund provider connectivity, clinical capabilities, platform modernization and operating-model change.
- Market exits and portfolio pruning were increasingly justified by the absence of sustainable economics rather than membership considerations alone.
- Acquisitions were more often framed around missing capabilities—specialty care, home-based services, clinical data and provider enablement—rather than revenue growth alone.

Implication

Capital allocation is becoming an operating-model decision. Boards must compare repurchases, modernization, capability acquisitions and market exits within one enterprise architecture.

Observation 7: Enterprise capabilities are replacing departmental optimization.

Evidence

- PIans are centralizing selected clinical and administrative functions while preserving necessary local market adaptation.

- Common data platforms, provider-connectivity networks, shared clinical policies and enterprise AI environments are becoming recurring investment priorities.
- Management teams increasingly described data, automation and decision logic as reusable enterprise assets rather than departmental tools.

Implication

The future health plan will not be built by making every department better in isolation. It will be built by creating capabilities that allow the enterprise to sense, decide and act across departmental boundaries.

The throughline

The quarter did not reveal seven unrelated strategies.

It revealed variations of the same structural response:

> *The health plan is moving from a portfolio of functions toward an enterprise system of trusted decisions.*

The implications extend beyond quarterly performance. Taken together, the signals point to the operating model the future will require: one capable of detecting change earlier, establishing shared evidence, producing trusted decisions and coordinating action across functions that operate on different horizons.

That is the architecture now beginning to emerge.

The Emerging Operating Model

The health plan the future requires will depend on five connected capabilities.

1. SENSING

Recognize meaningful changes in utilization, acuity, provider behavior, clinical events, policy and market economics while there is still time to act.

2. SHARED EVIDENCE

Normalize, reconcile and make traceable the clinical, claims, pharmacy, authorization, quality, risk and provider information needed to support action.

Different functions may ask different questions. They should not begin with different facts.

3. TRUSTED DECISIONS

Apply consistent clinical and business logic through explicit decision rights, transparent evidence and appropriate governance.

A trusted decision is explainable, context-aware, defensible and understood by the people expected to act on it.

4. COORDINATED EXECUTION

Embed decisions where work occurs: in provider workflows, care teams, claims operations, contact centers and member channels.

Automate the routine. Route exceptions to qualified people with the relevant evidence attached.

5. CONTINUOUS LEARNING

Measure whether decisions improved cost, quality, experience or operating capacity.

Return outcomes to the system so that local learning becomes enterprise knowledge.

The Structural Shift

FROM: A portfolio of functions

- Separate data
- Departmental logic
- Sequential hand-offs
- Local optimization
- Retrospective learning

TO: A coordinated decision enterprise

- Shared evidence
- Trusted decisions
- Embedded execution
- Enterprise capabilities
- Continuous learning

Transformation moves at the speed of trust

Organizations move slowly when leaders dispute the evidence, question the logic or lack confidence in how a decision was reached.

Shared evidence reduces debate about the facts.

Trusted decisions reduce hesitation, escalation and rework.

Coordinated execution allows the enterprise to move.

Observed outcomes either reinforce that trust or reveal where the system must change.

The health plan the future requires is less a collection of functions and more a system for producing trusted decisions at enterprise scale.

SENSE → ESTABLISH EVIDENCE → DECIDE → EXECUTE → LEARN

Section II – Operator's Observation – The Enterprise Doesn't Operate on One Calendar

Health plans often speak as if the enterprise shares a planning horizon.

It does not.

Actuarial teams are pricing future populations. Product leaders are designing benefits for a year that has not begun. Sales teams are preparing for enrollment. Clinical operations are managing needs that are changing now. Risk adjustment and quality teams are validating care already delivered. Finance is closing a quarter. Technology is building capabilities that may not reach scale for several years.

Each function is rational within its own calendar.

The difficulty begins when the enterprise mistakes those calendars for one another.

A rate decision may have a twelve-to-twenty-four-month horizon. A clinical intervention may have a useful life measured in hours. A quality measure can affect care today, a Star Rating next year and revenue after that. A new data platform may require years of investment before it changes the cost structure.

These are not different descriptions of the same clock. They are different decision windows.

The answer is not to force every function onto one calendar. That would be impossible and undesirable.

The answer is to design the enterprise around the hand-offs between clocks.

A change in utilization detected through clinical operations must reach actuarial leadership before the next pricing decision closes. A new benefit design must reach member and provider workflows before the product takes effect. A diagnosis documented during an encounter must move through quality, risk and revenue processes without being reconstructed months later. A technology investment must carry an explicit path from platform delivery to workflow adoption and financial effect.

Most operating failures occur at these boundaries.

The plan may possess accurate information but receive it after the opportunity to intervene has passed. It may identify a care gap but fail to deliver it inside the clinical encounter. It may centralize utilization management without standardizing the evidence available to reviewers. It may automate one step of a process while leaving the surrounding work intact. It may approve a transformation program without assigning authority over the cross-functional changes required to realize its value.

The essential leadership task is synchronization. Not coordination in the ceremonial sense of meetings, committees and status reports.

Synchronization means that the output of one operating clock becomes usable input for another before its decision window closes.

That requires three disciplines.

First, define the decisions that matter.

"Improve interoperability" is not a decision. "Determine whether this request can be approved without manual review" is.

"Modernize risk adjustment" is not a decision. "Determine which clinically supported condition has not reached the encounter record" is.

Second, establish the maximum tolerable latency for each decision. A quarterly report, a thirty-day claim, a same-day clinical event and a sub-minute authorization are not interchangeable information products.

Third, assign accountability across the boundary. When a clinical signal fails to influence pricing, the failure belongs neither solely to clinical operations nor to actuarial. It belongs to the operating system connecting them.

The enterprise does not need one calendar. It needs shared evidence capable of supporting trusted decisions across many calendars.

The clocks do not need to run at the same speed. They need to move the enterprise in the same direction.

Section IV – Working Paper Preview

Working Paper 003: The Decision Enterprise

The clocks illustrate the problem.

The Decision Enterprise will examine the operating system required to connect them.

SIGNAL → EVIDENCE → DECISION → ACTION → OUTCOME → LEARNING

Three key insights

1. Data creates value only when it changes a decision.
   The objective is not to accumulate information. It is to shorten the distance between evidence and action.
2. Decision rights matter as much as analytical capability.
   An enterprise may identify the correct action and still fail because authority, accountability or workflow is unclear.
3. The enterprise learns only when outcomes return to the system.
   Without a closed loop, every department and market repeats the same experiment.

Coming this fall.

Questions Leadership Teams Should Be Asking

1. Which portion of current margin pressure reflects inadequate pricing, and which reflects delayed or inconsistent operating decisions?
2. Where do clinical, actuarial and financial teams rely on different versions of the same member, provider or market reality?
3. Which AI deployments have removed work rather than accelerating one step inside an unchanged process?
4. Where does information lose its value before crossing from one operating clock to another?
5. Who owns decisions that cross clinical, actuarial, technology and market boundaries—and do they possess the authority to change the system connecting them?

Section V — Operator's Prediction

By 2030…

By 2030, the leading health plans will be managed as enterprise decision systems rather than portfolios of insurance functions.

The evidence is already visible.

Pricing is becoming inseparable from clinical intelligence. Clinical operations are becoming inseparable from margin. Provider connectivity is becoming inseparable from administrative cost. Risk adjustment and quality are becoming inseparable from care delivery. AI is becoming inseparable from workflow design. Capital allocation is becoming inseparable from capability architecture.

The departmental model was built for an environment in which information moved slowly and work could be handed sequentially from one function to another.

That environment is disappearing.

The leading health plan will maintain shared evidence about members, providers and markets. It will apply that evidence through explicit decision rights. It will execute decisions inside clinical and administrative workflows. It will measure whether those decisions improved cost, quality, experience or operating capacity.

Functions will remain. Their independence will not.

The structural advantage will belong to the enterprise that can establish confidence in its evidence, trust in its decisions and speed in its execution.

Evidence Tracker

- ✓ Seven Q2 earnings calls and quarterly-result sets
- ✓ Wall Street analyst and broker research
- ✓ Company filings, releases and investor materials
- ✓ CMS and state regulatory developments
- ✓ Industry and executive expert interviews

Next Issue

The Organizational Design of Modern Health Plans

September will examine how enterprise platforms, centralized capabilities and local market authority can be combined without replacing fragmentation with bureaucracy.

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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