

NLC NATIONAL LEAGUE OF CITIES

RISC RISK INFORMATION SHARING CONSORTIUM

DEVELOPING HEALTHIER BUDGETS & HEALTHIER COMMUNITIES THROUGH SMARTER USE OF HEALTHCARE DATA

Mary Delaney

October 27 | 11:15 a.m. - 12:15 p.m.

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Developing Healthier Budgets and Healthier Communities

leveraging healthcare data

Mary Delaney, Managing Partner, Vital Incite

One Chain Connects Community Health to the Budget



Better data upstream = better decisions downstream

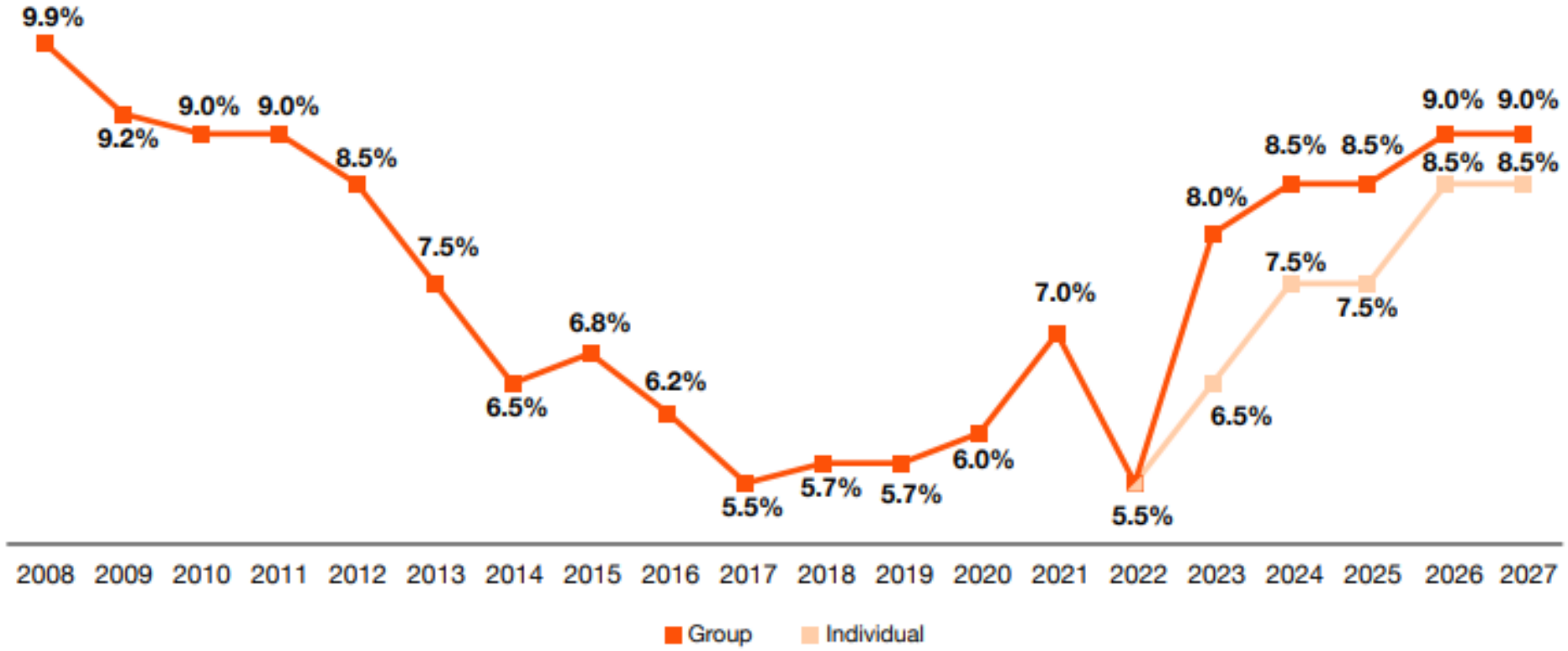
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The Challenge

Figure 1. PwC medical cost trends, 2008–2027

PwC projects medical cost trend to be 9.0% for Group and 8.5% for Individual in 2027, in line with restated 2026 trends



Source: PwC analysis

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Primary Care: A System Under Strain

92.3M

Americans in Shortage Areas

More than 92 million Americans live in a federally designated Primary Care Health Professional Shortage Area

71K

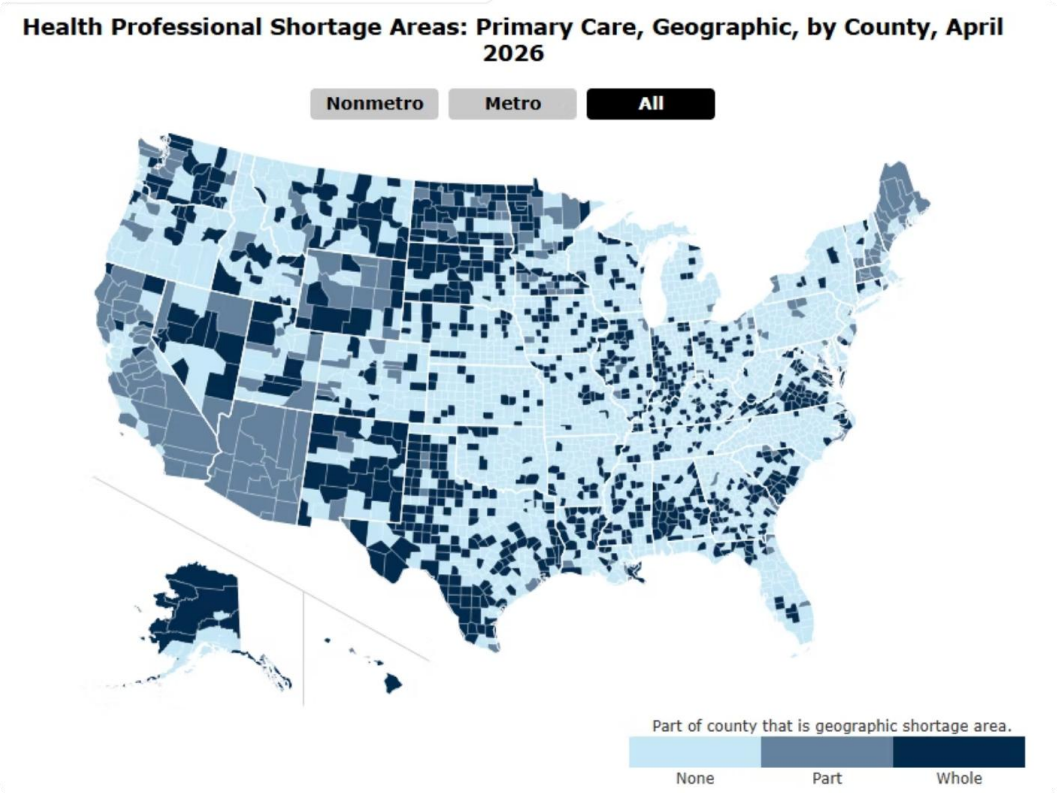
Projected Physician Shortfall by 2038

The U.S. is on track to face a shortage of nearly 71,000 primary care physicians within 15 years

80%

ER Visits Are Primary Care Treatable

$179 for a primary care visit vs. **more than $3,000** for the same condition treated in the ER



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Primary Care Is Breaking Down — and the ER Is Absorbing the Cost

92.3M

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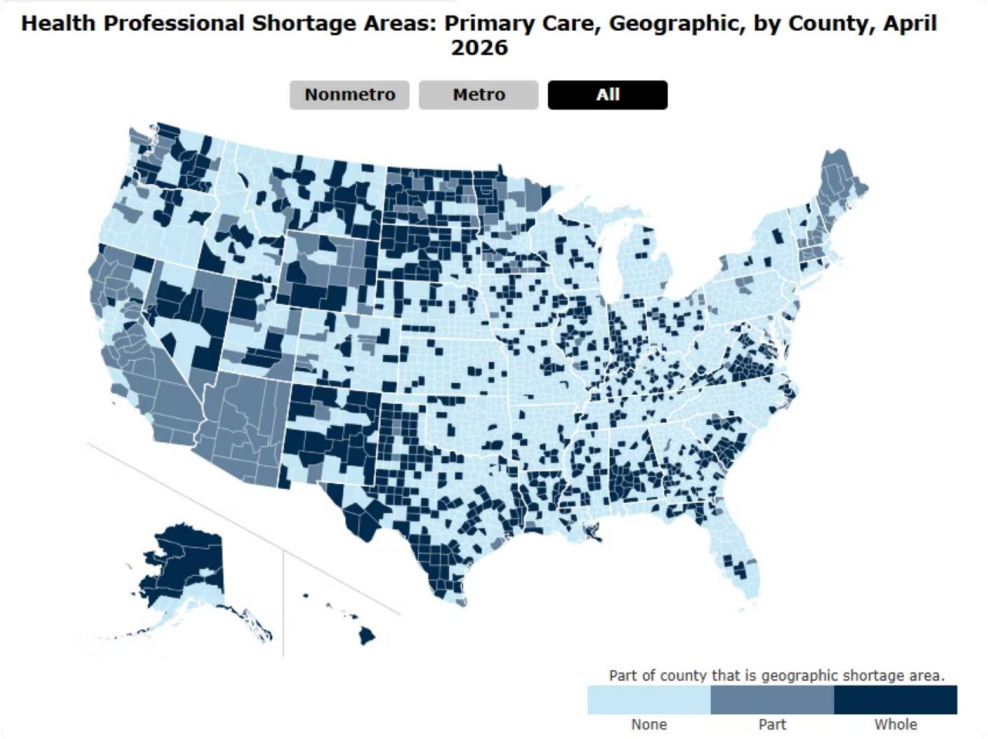
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of ER visits are primary care treatable

$179 for a primary care visit vs. **more than $3,000** for the same condition treated in the ER



So what: Every access gap upstream shows up as avoidable ER spend in your budget — at roughly 17x the cost of the same visit.

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Physicians Are Leaving Nine Years Earlier

48

Average exit age today

57

Average exit age in 2008

11% never practice after residency



https://www.medicaleconomics.com/view/physicians-are-leaving-clinical-practice-nine-years-earlier-than-they-did-in-2008-ama-study-finds

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Your Unique Community

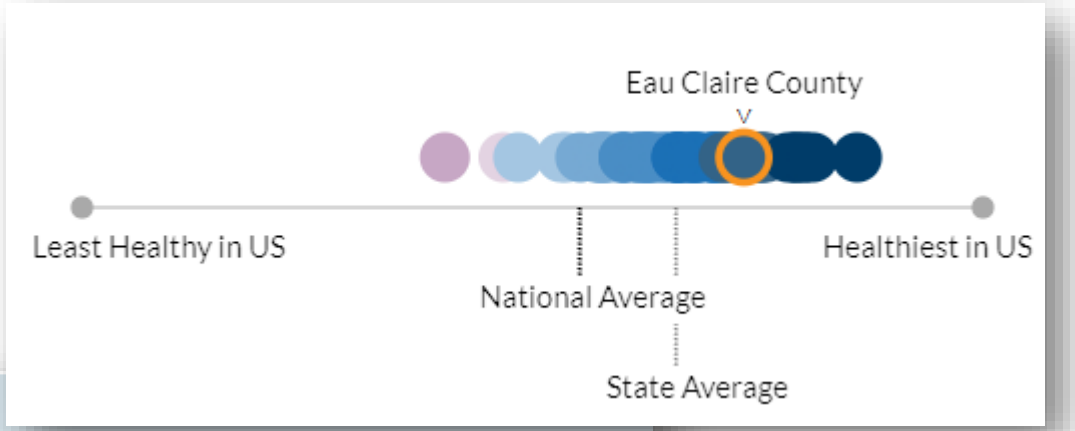
- Understand the unique issues in your area.



Countyhealthrankings.org

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Eau Claire County



Community Conditions

Health infrastructure		Eau Claire County	Wisconsin	United States
Flu Vaccinations		56% §	50% §	44% §
Access to Exercise Opportunities		82%	84%	84%
Food Environment Index		8.4 §	8.8 §	7.6 §
Primary Care Physicians		700:1 †	1,220:1 †	1,310:1 †
Mental Health Providers		230:1 †	350:1 †	290:1 †
Dentists		990:1 †	1,340:1 †	1,340:1 †
Preventable Hospital Stays		3,522 §	2,596 §	2,769 §
Mammography Screening		62% §	53% §	46% §
Uninsured		5% §	6% §	9% §

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The Good News from AI

1 — Clinical Documentation

AI scribes cut documentation time.

More time with patients; less burnout.

2 — Decision Support

Identifies care gaps.

Suggests evidence-based treatment.

3 — Remote Monitoring

Continuously evaluates patient data.

Flags deterioration sooner.

4 — Population Health

Predicts future risk.

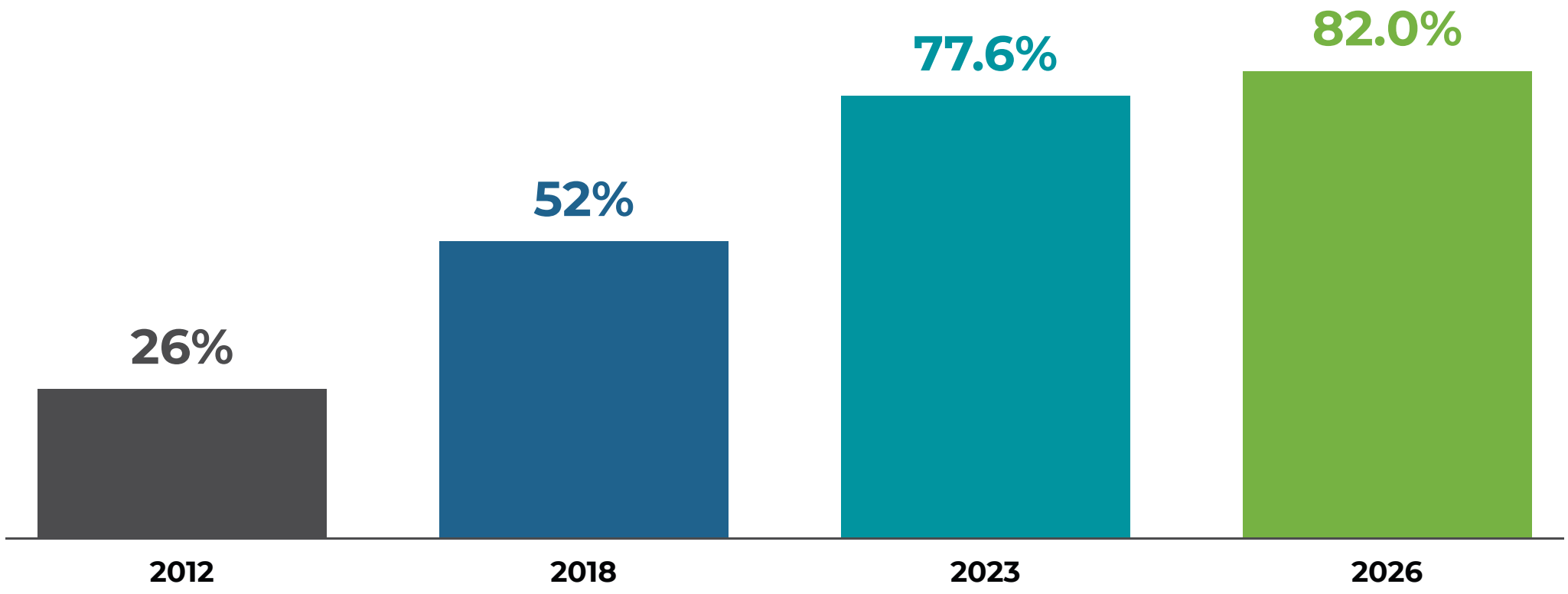
Supports proactive outreach.

Less time gathering information — more time making decisions.

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Physician Employment by Hospitals and PE



Independent practice is now the exception.

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AI Influence: Healthcare Monetizes Innovation

Higher Acuity Coding

- AI surfaces every possible diagnosis.
- Higher risk scores, higher reimbursement, higher employer cost.

New Billable Activities

- If AI reads the MRI, who gets paid?
- Should AI record review have its own code?

More Utilization

- More screenings, procedures, referrals.
- Every finding is a treatment opportunity.
- Think like hospital admin wants them to!

Better care does not automatically equal lower cost.
Blue Cross Blue Shield Association- AI enabled coding in hospitals added $2.3B in excess spending.

https://www.bcbs.com/about-us/association-news/new-bcbsa-research-on-ai-hospital-billing-driving-higher-health-care-costs

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The Fiduciary Role

🏛️ The Public Fiduciary Role

- **Public trust:** Officials hold power delegated directly by citizens.
- **Resource management:** They must protect and manage public money with care.
- **Best interests:** Decisions must benefit the community, not personal or political gains.

⚖️ Core Duties Owed

- **Duty of care:** Researching and making informed choices before voting or spending.
- **Duty of loyalty:** Putting public needs ahead of private or special interests.
- **Transparency:** Keeping clear, honest records of transactions and meetings.

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Obligation to Act in the Best Interest of Plan Participants

That requires discipline, documentation, and a willingness to make difficult decisions.
A rigorous fiduciary process is your best defense — and your greatest opportunity to drive real cost savings.

Identify and Control Admin Fees

- Conduct a thorough audit of all fees charged to the health plan — including TPA fees, PBM spread pricing, shared savings arrangements, advisor fees and ancillary carve-outs.
- Hidden fees erode plan value and must be surfaced and challenged.

Make Objective Decisions — and Adapt

- Base all plan design and vendor decisions on data, not relationships.
- Regularly reassess whether existing contracts and programs are delivering measurable value.
- Be willing to change course when evidence demands it.

Track and Document the Process

- Maintain a clear, defensible record of all decisions made on behalf of the health plan.
- Documentation protects the plan sponsor from liability and creates accountability across all vendor relationships.

Critical Areas to Manage

Achieving meaningful, sustained reductions in healthcare spend requires a focused strategy across 6 interconnected domains. Each area represents both a significant cost driver and a real opportunity for intervention when approached with the right data and the right partners.



Healthcare Affordability



Carrier Admin Fees



Pharmacy



Poor Vendor Management



High-Cost Claimants & Complex Conditions



Primary Care Access

Healthcare Affordability: A Crisis Hiding in Plain Sight

Personal Healthcare Spending Per Person

$943

1980 Per Capita

Equivalent to $3,590 adjusted for inflation

$13,265

2024 Per Capita

More than **3x** the inflation-adjusted 1980 figure

Key Indicators

- PwC projects an **8.5% individual trend** for 2026 — with no signs of deceleration
- **< 50% of U.S. adults** are considered "cost secure" when it comes to healthcare expenses
- Rising out-of-pocket costs are directly **impacting employee productivity, retention, and well-being**

Sources: USAFacts.org; news.gallup.com/poll/710942



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CARRIER ADMIN FEES

Admin Fees: Where Hidden Costs Live

Carrier and TPA administrative fees are one of the least-scrutinized areas of health plan management — and one of the most financially consequential. Employers must develop a comprehensive, line-by-line understanding of every fee their plan is paying.

Direct Admin Fees

- Base administrative fee (PEPM)
- Carve-out fees for pharmacy
- Carve-out fees for stop-loss
- File transmission fees to stop-loss carrier
- File transmission fees to the employer

Shared Savings Arrangements

When carriers negotiate discounts on claims, they often retain a percentage as a "shared savings" fee. These amounts can be significant — and are rarely proactively disclosed to plan sponsors.

Spread Pricing on Claim Lines

Spread pricing occurs when a TPA or PBM charges the plan more than it pays the provider or pharmacy — keeping the difference as undisclosed revenue. This is one of the most opaque and costly practices in the industry.

Identify Every Amount the TPA Charges the Health Plan

Beyond the base administrative fee, TPAs layer on a range of charges that are often buried in contract exhibits or remittance reports. Employers must demand a complete, transparent accounting of every dollar flowing through the plan.

Payment Integrity Fees

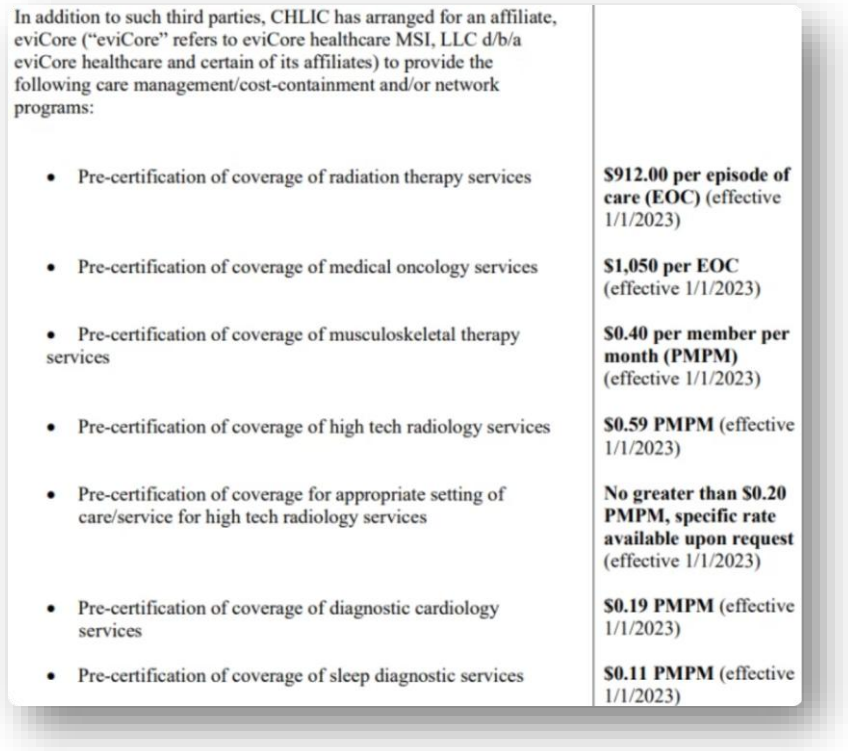
Fees charged for claims editing, fraud detection, and billing error identification — services that may already be included in the base admin fee.

Shared Savings Fees

Percentage of negotiated savings retained by the TPA — sometimes 25–35% of identified savings, often without explicit employer approval.

Care Management Fees

Fees for case management, disease management, and utilization review programs — which must be evaluated against measurable, plan-specific outcomes.



In addition to such third parties, CHLIC has arranged for an affiliate, eviCore ("eviCore" refers to eviCore healthcare MSI, LLC d/b/a eviCore healthcare and certain of its affiliates) to provide the following care management/cost-containment and/or network programs:

• Pre-certification of coverage of radiation therapy services	**$912.00 per episode of care (EOC)** (effective 1/1/2023)
• Pre-certification of coverage of medical oncology services	**$1,050 per EOC** (effective 1/1/2023)
• Pre-certification of coverage of musculoskeletal therapy services	**$0.40 per member per month (PMPM)** (effective 1/1/2023)
• Pre-certification of coverage of high tech radiology services	**$0.59 PMPM** (effective 1/1/2023)
• Pre-certification of coverage for appropriate setting of care/service for high tech radiology services	**No greater than $0.20 PMPM, specific rate available upon request** (effective 1/1/2023)
• Pre-certification of coverage of diagnostic cardiology services	**$0.19 PMPM** (effective 1/1/2023)
• Pre-certification of coverage of sleep diagnostic services	**$0.11 PMPM** (effective 1/1/2023)

Shared Savings

Poorly designed shared savings agreements can also create hidden conflicts of interest, where fees are layered onto claim lines without the employer's awareness.

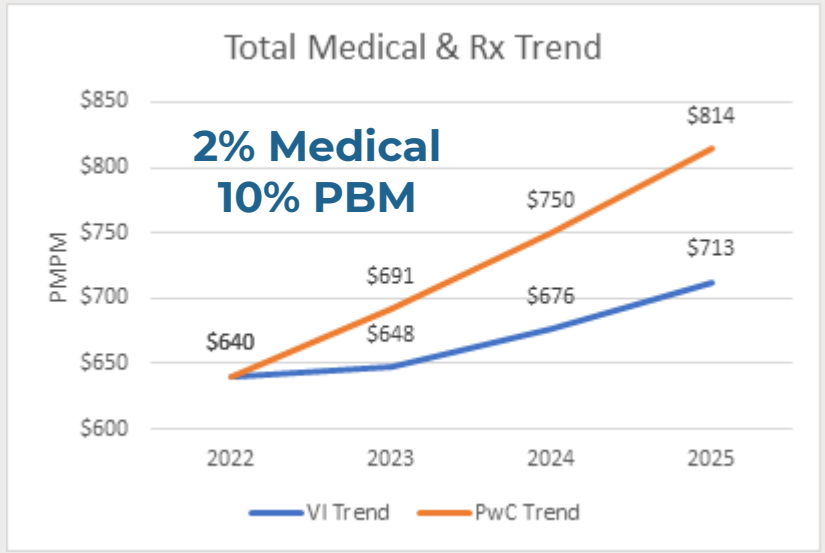
Claim lines mostly denied but carrier was paid.	• 7 visits with the same provider- all were denied but $35 paid on one visit • Carrier took 30% of billed charges
OON with billed amounts far exceeding expected amounts and should have been billed as a bundled service	• Carrier treated the claims as unbundled • Carrier took 23% of billed charges- more than was paid to the provider
No information to reconcile with bank account	• Fiduciary responsibility • Need access to a system that allows us to connect data to claim lines.

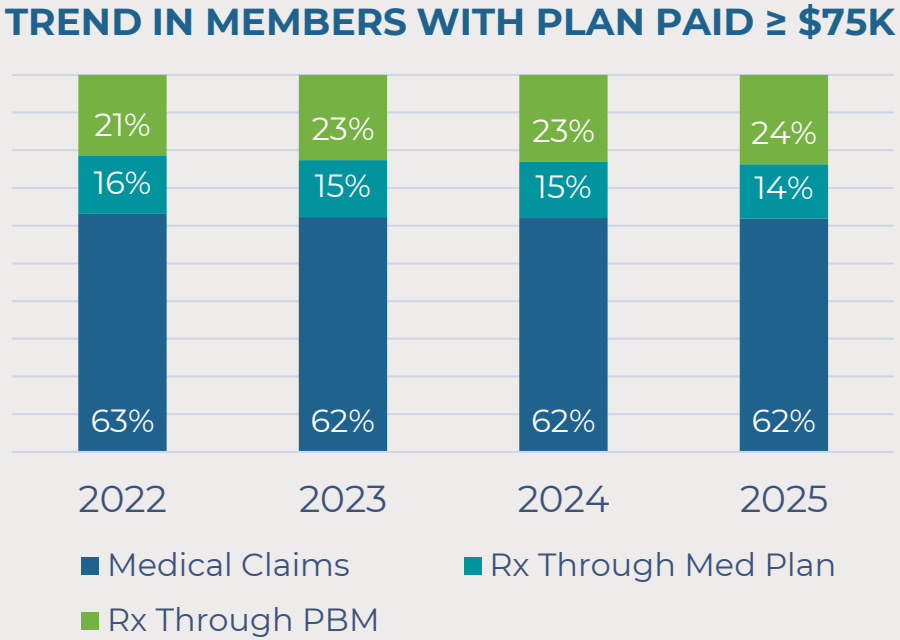
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PHARMACY COSTS

Pharmacy trend is real





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PHARMACY

Blockbuster Hits for the Pharmacy Industry

A series of high-cost therapies has reshaped the pharmacy benefit landscape — and more are coming. Each represents a significant financial exposure for self-funded employers who are unprepared.

Alzheimer's — Aduhelm (Aducanumab)

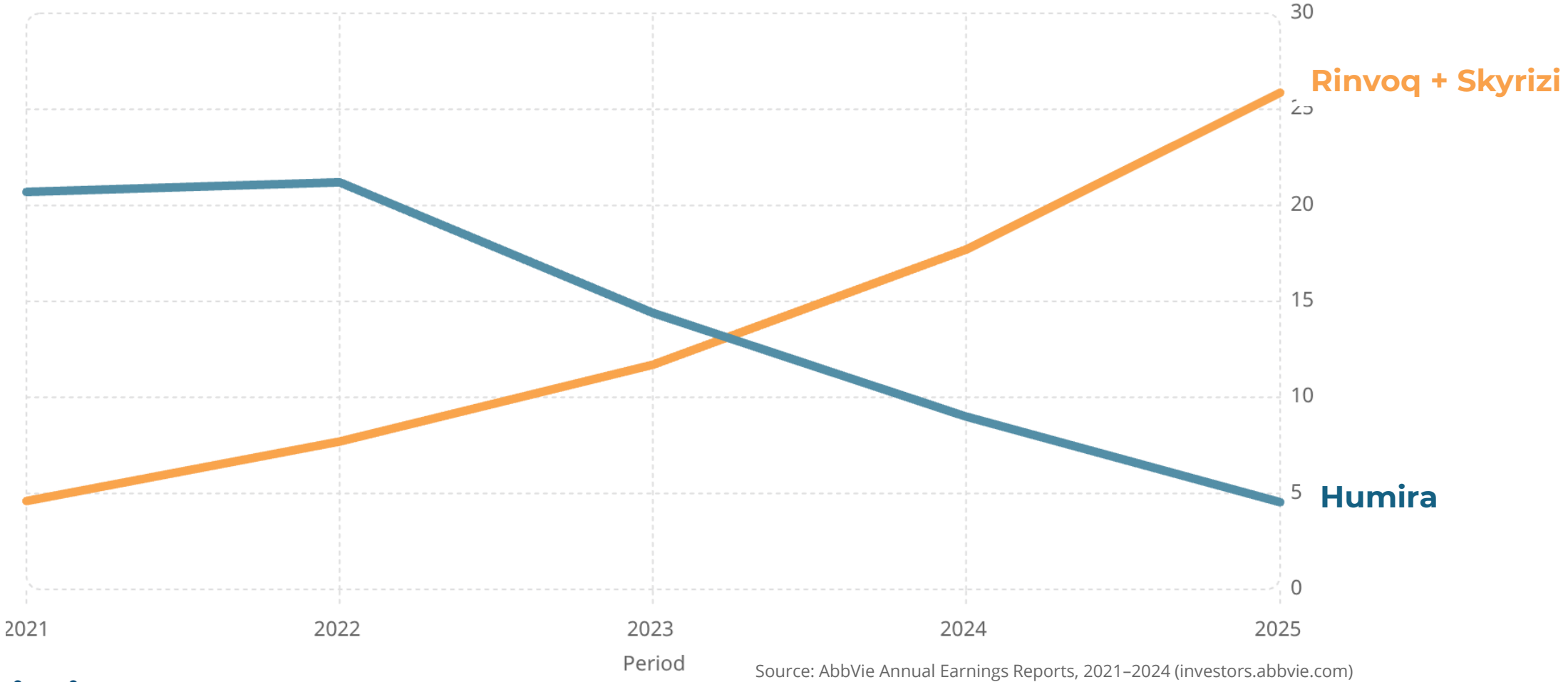
2021

- Expected price- $25k a year
- Priced at $56,000/year

Biosimilars For Humira

Biosimilar Hope!

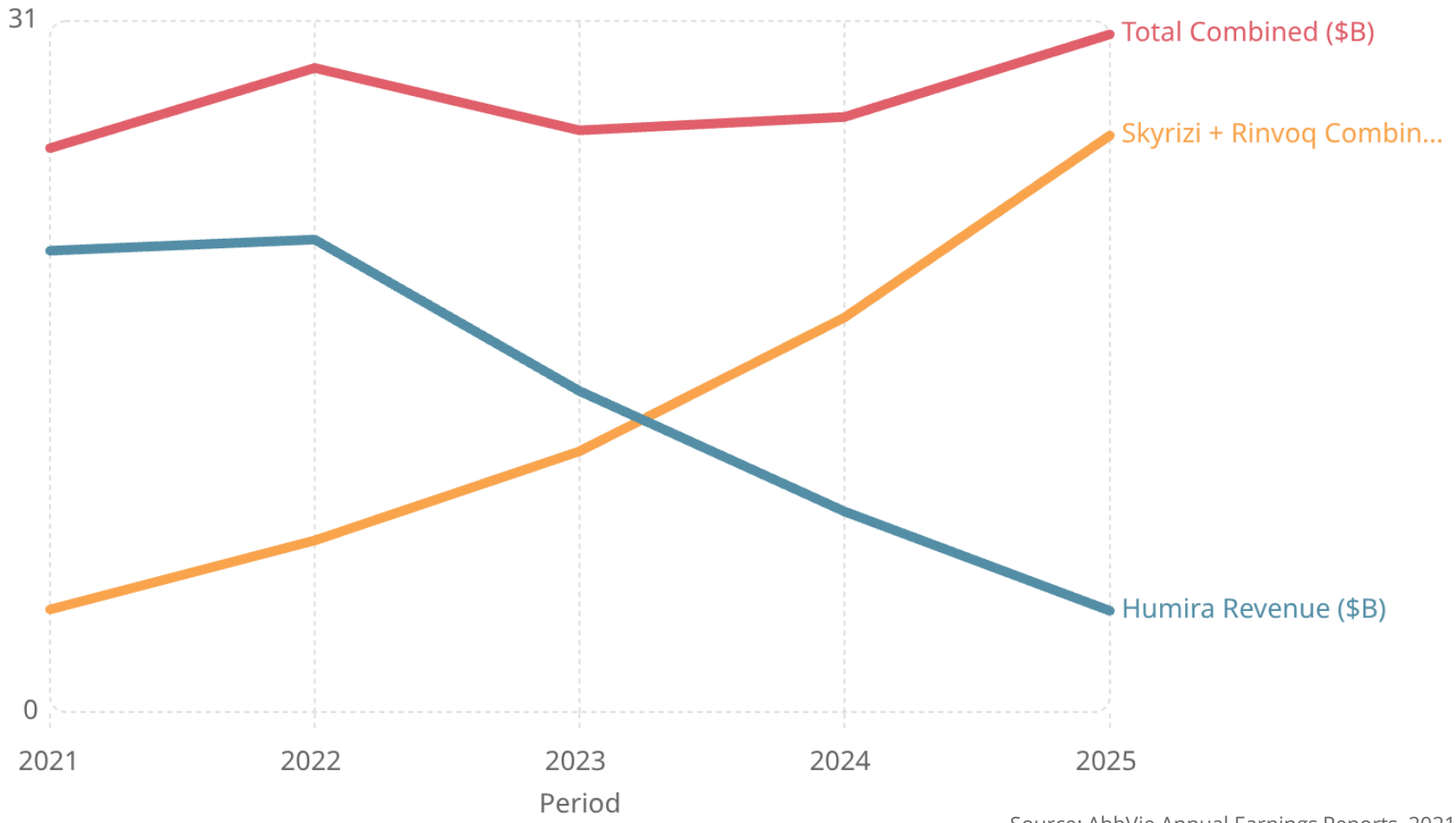
Rinvoq & Skyrizi Revenues surpass Humira (Global Net Revenues, $B)



Source: AbbVie Annual Earnings Reports, 2021–2024 (investors.abbvie.com)

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Source: AbbVie Annual Earnings Reports, 2021–2024 (investors.abbvie.com)

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PHARMACY

Blockbuster Hits for the Pharmacy Industry

There are strategies to improve pharmacy spend- the employer/ payor needs to make those decisions
RFP and Contract Language is critical

Alzheimer's — Aduhelm (Aducanumab)

2021

- Expected price- $25k a year
- Priced at $56,000/year

Cell & Gene Therapies

- $1M–$4M per patient
- Stop-loss carve-outs and reinsurance strategies
- Opportunities treatment 40% cost savings

Humira & Biosimilars

- PBMs were slow to transition members to lower-cost biosimilars - taking several years to organize a coherent approach.
- The delay cost employers hundreds of millions in unnecessary spend industry-wide.

GLP-1s (Ozempic, Wegovy, Mounjaro)

- Available for $50/month in other countries — priced at $1,200/month in the U.S.
- New manufacturers are entering the market
- PBMs are introducing their own vendor solutions, creating new conflicts of interest around rebates and approvals.

VENDOR MANAGEMENT

Poor Vendor Selection & Management

Vendor proliferation without accountability is one of the most common and costly mistakes in employer health plan management.

01

Understand Root Cause First

Before evaluating any vendor, use data to identify the specific drivers of cost and poor health outcomes in your population. Never buy a solution before you've defined the problem.

02

Establish Health Plan Priorities and Goals

Define measurable, time-bound goals aligned to your specific population needs — not generic industry benchmarks.

03

Select Vendors Based on Goals

Match vendor capabilities to your defined priorities. Avoid solutions looking for problems. Evaluate vendors on their ability to address your specific cost and quality drivers.

04

Include Performance Guarantees in Contracts

Every vendor contract should include clearly defined performance guarantees (PGs) with financial consequences for non-performance.

05

Report on Progress Consistently

Establish a regular cadence of data-driven reporting. If a vendor cannot provide population-level outcomes data, that is itself a red flag.

Create an Objective Roadmap

An effective population health strategy maps specific clinical and financial goals to the real needs of the plan population — and assigns accountability for improvement over time. Below are the key areas and interventions that should be included in every employer's roadmap.

Cost of Care

Cause: Influenced by later stage diagnosis

Strategy: Catch conditions early

- Adult Physical Compliance
- Colonoscopy/ Mammogram Compliance

ER Spend

Cause: High utilization of non-emergent ER

- Non-English speaking/ new employees

Strategy:

- Plan member education
- Targeted communication

MSK: A High-Cost, ~~High-Opportunity~~ Category

Benchmark & Trend

Define the Population

Define Performance Guarantees

Select Vendor – If needed

EDC	2025	2026	Average	% of Total Spend
Acquired foot deformities	$1	$1	$1	2%
Acute sprains and strains	$5	$5	$3	7%
Amputation status	$0	$0	$0	1%
Bursitis	$4	$4	$3	6%
Cervical pain syndromes	$3	$3	$4	4%
Congenital anomalies of limbs	$0	$0	$0	0%
Congenital hip dislocation	$0	$0	$0	0%
Degenerative joint disease	$13	$13	$8	18%
Fracture of neck of femur (hip)	$0	$0	$0	1%
Fractures (excluding digits)	$8	$6	$3	12%
Fractures and dislocations/digits	$0	$0	$0	0%
Joint disorders	$4	$3	$4	5%
Kyphoscoliosis	$1	$0	$0	1%
Low back pain	$9	$6	$9	13%
Musculoskeletal disorders	$17	$18	$3	24%
Musculoskeletal signs and	$4	$3	$4	6%
Torticollis	$0	$0	$0	0%

Create an Objective Roadmap

An effective population health strategy maps specific clinical and financial goals to the real needs of the plan population — and assigns accountability for improvement over time. Below are the key areas and interventions that should be included in every employer's roadmap.

MSK Spend

Cause: Spine and Total Joint Surgery Costs

- Spinal Fusion Rates —appropriateness concerns
- Total Joint Cost — direction of care and population age

Strategy:

- Top tier high-quality providers
- Access to in-person PT

Objective Roadmap: Tracking What Matters

The following scorecard tracks plan performance across cost, quality, and clinical outcomes — and holds every initiative accountable to measurable results.

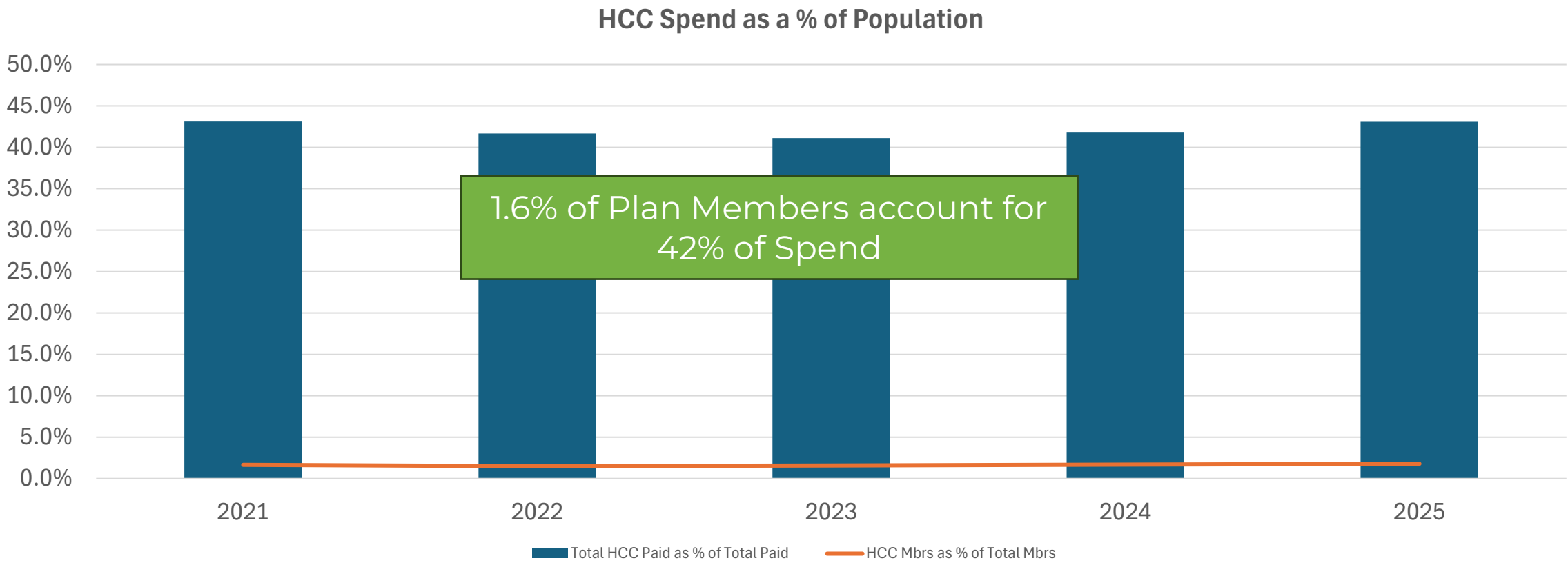
Goal Category	Metric (EE + Spouse)	2024	2025	2025 Benchmark	Goal (2026)
MSK	PMPM for Members with MSK	$119	$116	$62	$110
	PMPM —DJD	$27	$26	$11	$24
Condition Control	PMPY — Hypertension	$29,139	$26,244	$20,440	$24,000
	% Members with Controlled BP	65%	75%	82%	80%
Mental Health	# Participants	16	51	73	191 (1% pop.)
	ER Use — Mental Health (per 1,000)	5.9	7.66	7.32	6.5
	IP Bed Days — Mental Health (per 1,000)	29	42	41	30

High Cost Claimant Management

How many have engaged a care management services?

HCC MANAGEMENT

New Resources — Improved Outcomes?



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HIGH-COST CLAIMANT MANAGEMENT

HCC: Where the Most Dollars Are at Stake

A small fraction of plan members drives the overwhelming majority of plan spend — and many of those costs are preventable with earlier identification and coordinated intervention.

Future Cost Drivers

7–9% of the population accounts for **more than 50%** of plan spend. Predictive analytics can identify these members before costs escalate.

Pivotal Future Cost Drivers

1–3% of the population drives **over 30%** of plan spend.

These are the highest-priority individuals for proactive care management engagement.

Inappropriate Cost Drivers

40% delta in medical plan costs Infusion site-of-care
50% cost delta Radiology oncology shows a based on site.
Poor Care: formulary management, sepsis, untreated mental health....

Earlier identification enables earlier intervention

Vendors to Support Change: Are They Delivering?

The vendor landscape is crowded with point solutions promising ROI that is rarely measured, rarely delivered, and rarely challenged. Before adding another vendor to the ecosystem, employers must ask hard questions about value, fees, and member impact.

→ No Real ROI

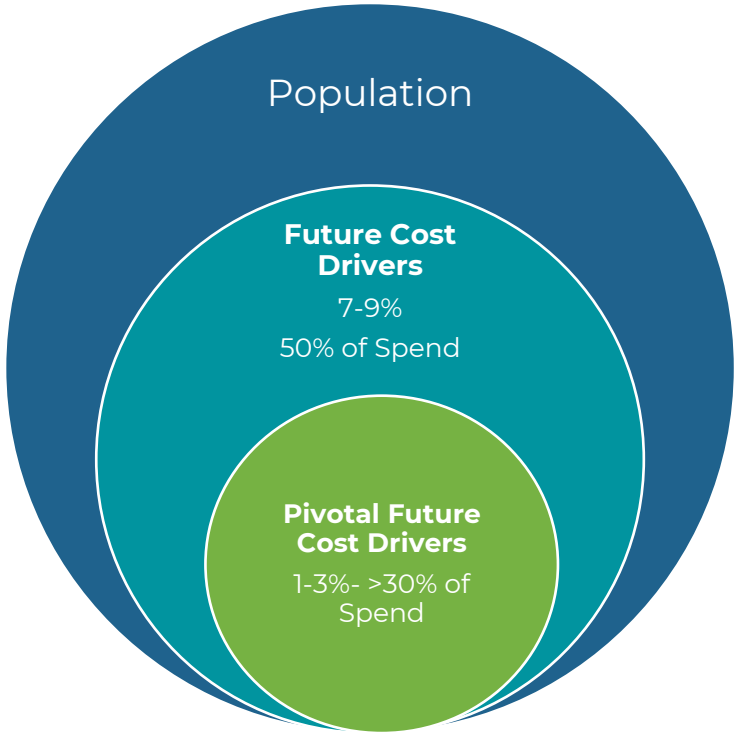
Many vendors cannot produce credible, independently validated return-on-investment data tied to your specific population.

→ Member Confusion & Lack of Trust

Health plan members are overwhelmed by fragmented point solutions. Confusion undermines engagement, and without motivation, even the best programs fail to produce results.

→ Does the Impact offset the Fees?

More investment doesn't always mean better outcomes.
Are all fee layers — including those buried in claim lines — being identified and accounted for?



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HCC MANAGEMENT

Why Doesn't the Carrier Fix This?

The gap between what carriers are contractually obligated to do and what they actually deliver is a central driver of plan waste. Understanding these gaps is the first step to closing them.

1

Carrier Contract Language

Contracts often contain:

- Limited performance guarantees
- No responsibility to repay the health plan for errors
- Insufficient audit provisions.

These gaps must be negotiated proactively.

2

Case Management (CM) — Poorly Defined

- Contracts rarely specify who will be contacted
- What are CM's responsibilities
- Performance guarantees for non-engagement
- How "engagement" is even defined.

3

Utilization Management (UM)

UM programs often approve only what is medically necessary — but do *not redirect:*

- Cost-efficiency
- Higher-quality settings.

Approval without redirection is a missed opportunity.

HCC MANAGEMENT

Leveraging Predictive Analytics

Predicted risk and cost scores allow plan sponsors to identify future cost drivers *before* they become catastrophic — and to evaluate which intervention strategies are the most powerful levers for bending the cost curve.

Care Coordination Outcomes

Segment	Optimally Coordinated	Not Optimally Coordinated
Total Members (Future Cost Drivers)	341 (87%)	53 (13%)
Generalist Seen	237 (88%)	32 (12%)
No Generalist Seen	67 (54%)	58 (46%)
Case Management Engaged	2 (67%)	1 (33%)

Members who see a generalist are **far more likely** to be optimally coordinated — reinforcing the critical value of primary care access and proactive engagement strategies.

HCC MANAGEMENT

Technology to Identify Billing Errors

Advanced claims auditing technology surfaces overpayments that would otherwise go undetected. These are not edge cases — they are systemic errors with significant dollar impact. Every example below represents a real opportunity to recover funds and protect the plan.

Outpatient Neck Fusion

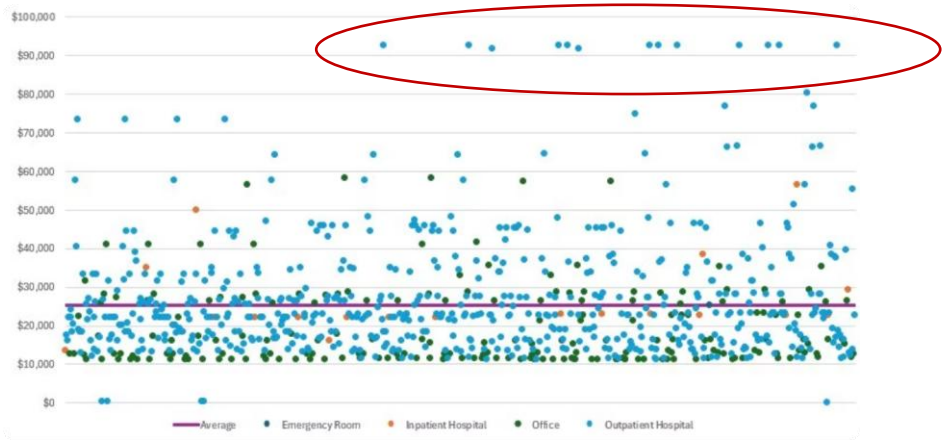
- Billed as a DRG when it should have been unbundled
- Paid for $0 RVU events
- Paid 5 surgery room fees on a single procedure
- **Overpayment identified: $42,500**

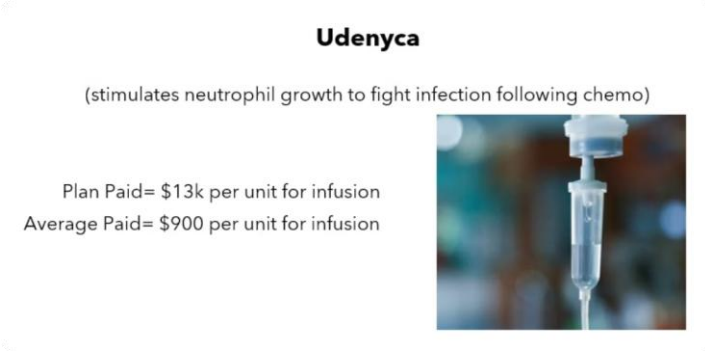
Implant Billing Error

- 8 charges billed at $23,800 per implant on the same day
- **Overpayment identified: $166,000**

Chiropractic Injury — HCC Flag

- High-cost claimant analysis identified $162K in charges linked to a chiropractic treatment injury





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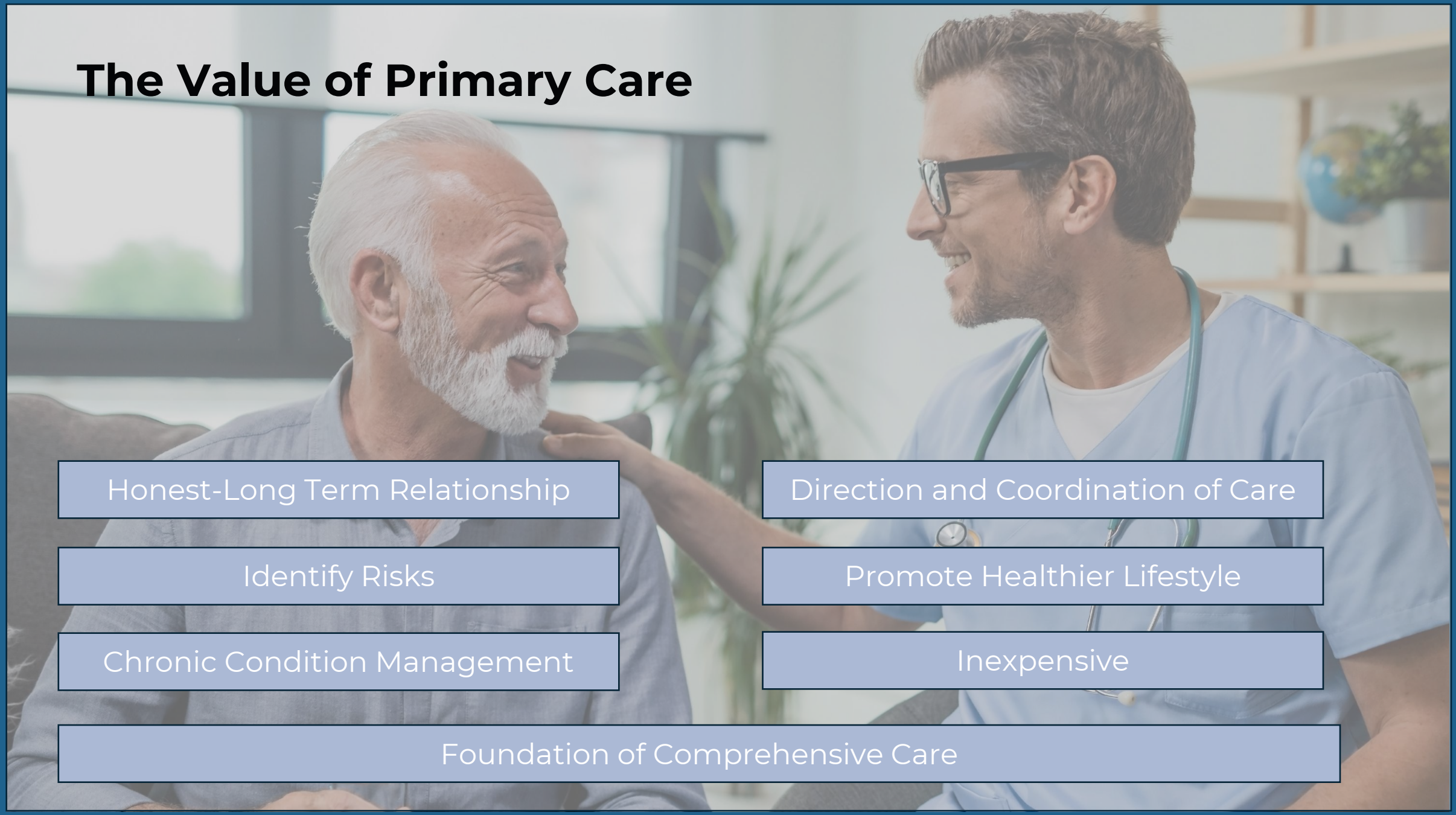


High-Cost Claimants & Complex Conditions



Primary Care Access

The Value of Primary Care



- Honest-Long Term Relationship
- Direction and Coordination of Care
- Identify Risks
- Promote Healthier Lifestyle
- Chronic Condition Management
- Inexpensive
- Foundation of Comprehensive Care

Primary Care: A System Under Strain

92.3M

Americans in Shortage Areas

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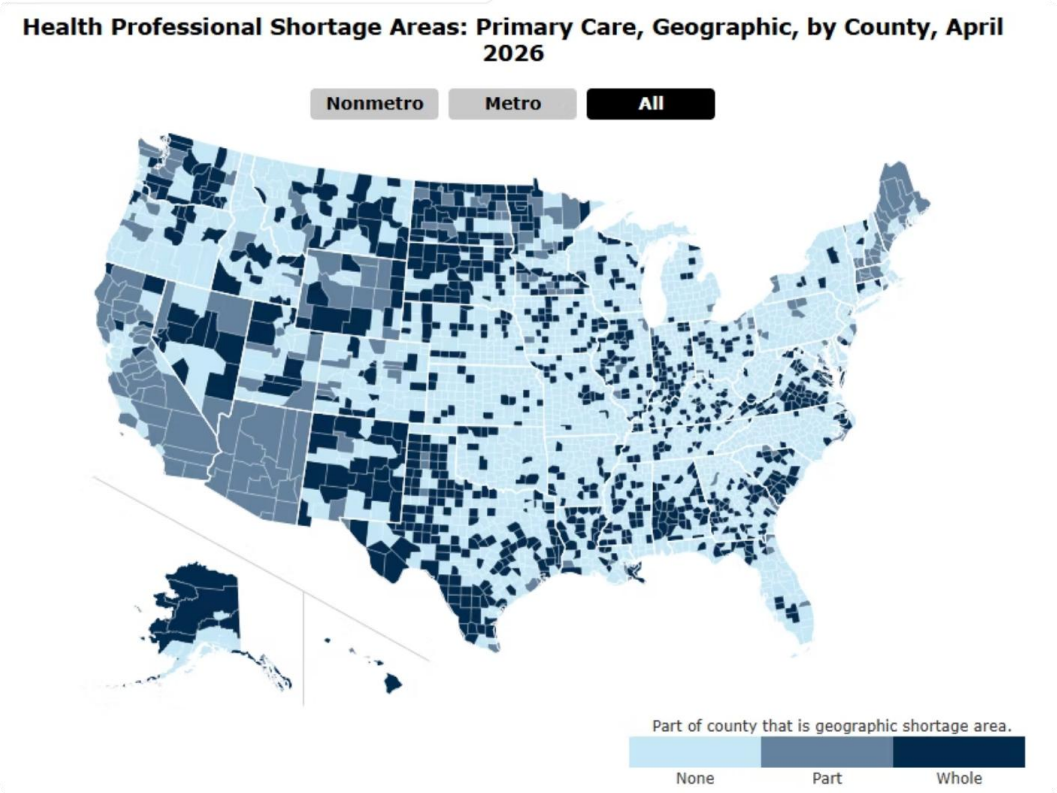
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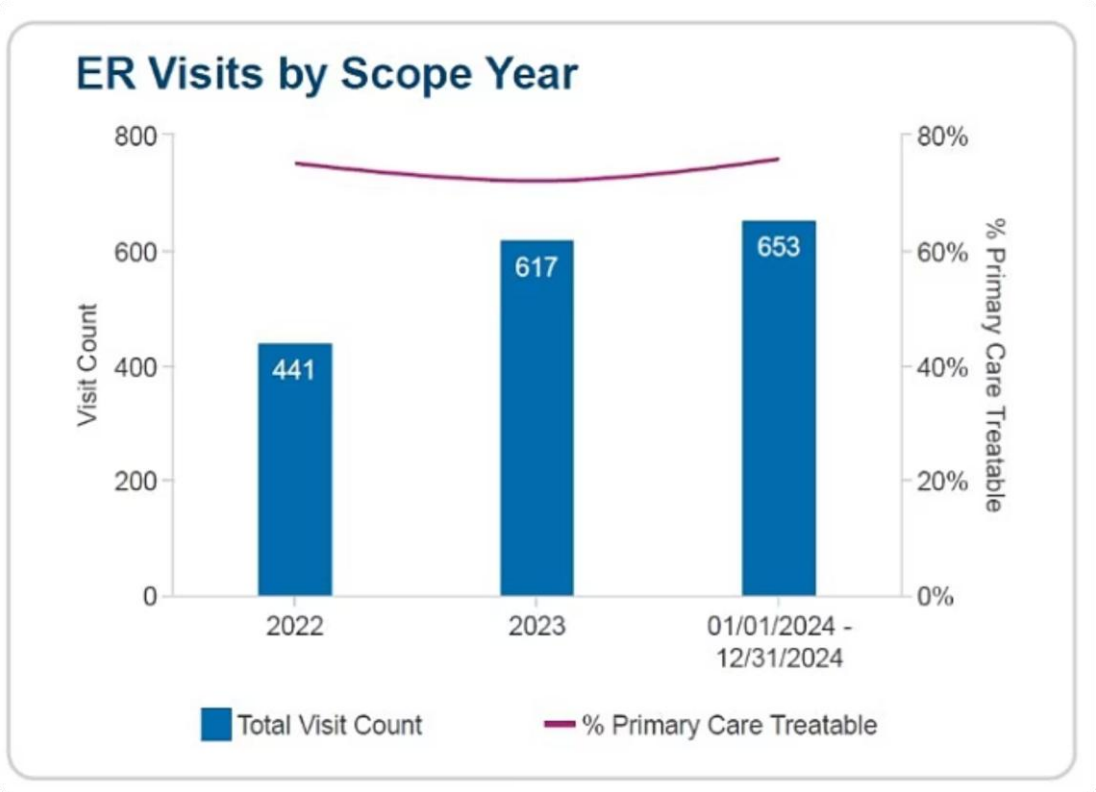
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ER Cost: The Most Expensive Front Door





Emergency room utilization for non-emergent conditions is one of the most significant and addressable sources of waste in employer health plans.

When members lack a trusted primary care relationship and face access barriers, the ER becomes their default — at a cost that is **10–17x higher** than a primary care visit for the same condition.

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The Impact of Later-Stage Diagnosis: Breast Cancer

Early detection is not only a clinical imperative — it is a financial one. The cost differential between Stage 0 and Stage 4 breast cancer is dramatic, and the survival rate difference is devastating. Preventive care compliance directly determines where on this curve your members are diagnosed.

Stage 0	Stage 1	Stage 2
$60,000	**$82,000**	**$85,000**
5-yr survival: **>99%**	5-yr survival: **>99%**	5-yr survival: **87%**

Stage 3	Stage 4
$129,000	**$135,000+**
5-yr survival: **87%**	5-yr survival: **32%**

- Mammogram compliance rates in the 47–58% range



Most employers are floating today — but they don't realize they're slowly losing air.

How Are We Patching the Hole?

The primary care crisis demands a deliberate, population-aware employer strategy — not just access to a provider panel. Employers must think carefully about the type of relationship, the coverage model, and the specific characteristics of their workforce.

What Members Need From Primary Care

- A longitudinal relationship — not episodic, transactional encounters
- Access at all times — including evenings, weekends, and telehealth
- Sound clinical judgment — with thoughtful oversight of mid-level provider utilization
- Hands-on care that builds trust and promotes early help-seeking behavior

Employer Strategy Must Consider

- **Impact required** — What outcomes are you trying to achieve?
- **Zip codes** — Where do your employees live and work? Access varies dramatically by geography.
- **Dependent type** — Spouses and children have different care needs and utilization patterns
- **Age and expected risk** — Younger populations need different supports than aging workforces
- **Turnover** — High-turnover populations require more scalable, lower-touch engagement models

Efficient Care Influenced by Direction of Care

Mammogram

Low-cost site: **$132**
High-cost site: **$801**
Potential savings per service: **$669 (84%)**

Lipid Panel

Low-cost site: **$2**
High-cost site: **$422**
Potential savings per service: **$420 (99%)**

A1c Test

Low-cost site: **$2**
High-cost site: **$591**
Potential savings per service: **$589 (99%)**

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The Path Forward: Take Control of Your Plan

The tools exist → The data is available → The legal framework is in place.

01

Audit Your Fees — All of Them

Surface every dollar flowing through your TPA, PBM, and vendor ecosystem. Transparency is the starting point for every other improvement.

02

Build a Data-Driven Roadmap

Use predictive analytics and population health data to identify your specific cost drivers and define measurable goals for improvement.

03

Demand Accountability from Every Partner

Performance guarantees, outcome reporting, and documented decision-making are non-negotiable elements of every vendor relationship.

04

Invest in Primary Care Access

Make primary care the cornerstone of your health plan design. It is the most cost-effective intervention available — and the foundation of everything else that works.

Critical Areas to Manage

Achieving meaningful, sustained reductions in healthcare spend requires a focused strategy across 6 interconnected domains. Each area represents both a significant cost driver and a real opportunity for intervention when approached with the right data and the right partners.



Healthcare Affordability



Carrier Admin Fees



Pharmacy



Poor Vendor Management



High-Cost Claimants & Complex Conditions



Primary Care Access

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Questions?



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