SOLVING FRAGMENTED, FLAWED HEALTHCARE DATA

Written By Laura Carabello

When patient care goes sideways with adverse events resulting in less-than-optimal member outcomes, plan sponsors can often lay the blame on scattered, inaccurate, or incomplete data. Something as simple as duplicate medical charts has increased the odds of adverse patient outcomes, including 30-day readmission and intensive care unit level of care, as well as prolonged hospitalization, according to a study published in BMJ Quality & Safety.

While accurate data can be a great ally in generating better health outcomes, flawed healthcare data severely compromise patient safety and operational efficiency. Yet the deeper issue is not merely data quality or availability — it is the lack of a unified, clinically informed intelligence layer capable of interpreting what fragmented data actually means for care decisions, risk exposure and downstream cost.

Without this interpretive layer, unreliable or incomplete data lead to misdiagnoses, medication errors, poor care coordination, and rising administrative costs—ultimately eroding both member outcomes and financial performance.

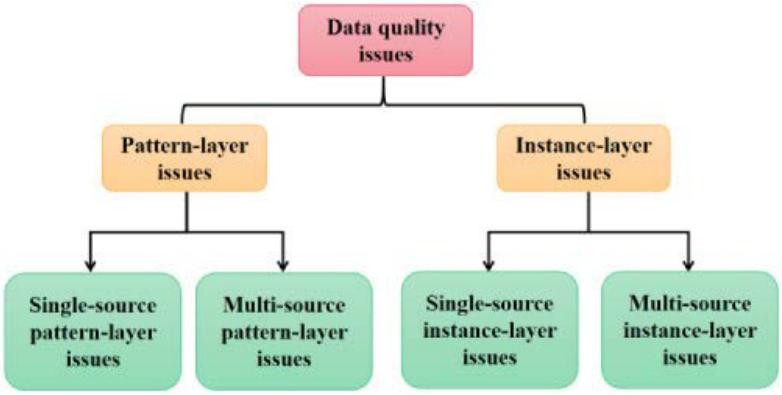
It is documented that accurate diagnoses lead to better patient outcomes. The Agency for Healthcare Research and Quality (AHRQ) reported that "failures in diagnoses plague the general patient population across all settings of care." The report also calls out that "knowledge of the harms associated with missed, delayed, or inaccurate diagnoses is emerging." Diagnosis failures cost healthcare $100 billion annually, according to AHRQ.

CLASSIFYING ISSUES WITH DATA QUALITY

Data quality is the degree to which the accuracy, completeness, consistency, and timeliness of the data satisfy the expected needs of specific users, explains researchers at the Interactive Journal of Medical Research. Issues with data quality can be categorized as:

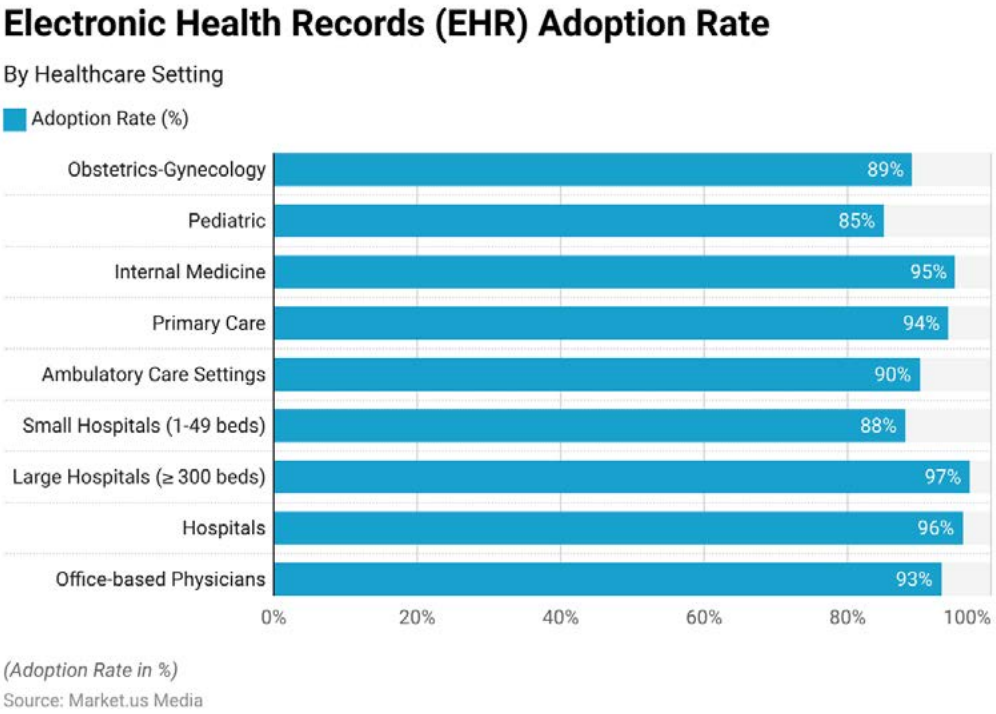
- Pattern-layer or instance-layer, depending on the level at which the issues are observed.
- Single-source or multi-source, depending on the data source.

Classification of Data Quality Issues



Source: Interact J Med Res. 2023 Sep 21;12:e44310. doi: 10.2196/44310

Data quality is no longer a postscript as EHRs have become a common feature in modern healthcare, offering improved access to data and the ability to provide better patient care. The National Electronic Health Records Survey shows that 95.0% of U.S. office-based physicians have adopted electronic health record (EHR) systems, with 83.6% using a certified EHR system. (NEHRS operates within The Centers for Disease Control and Prevention/National Center for Health Statistics.)



Given this rate of EHR adoption, there is a proliferation of unreliable, "dirty data": a term that describes inconsistent, confusing records, signifying duplicates, outdated information and even corrupted data. It is data that is no longer relevant -- essentially, unusable. Unfortunately, it can lead to misdiagnoses and medication errors, poor care coordination and increased administrative costs, all key contributors to diminished member health and well-being.

Electronic Health Records (EHR)

According to market.us, the global electronic health records market size is expected to grow to USD 43.62 billion by 2032 from USD 27.74 billion in 2021. It is expected to grow at a 4.2% CAGR from 2023 to 2032.

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When data is assigned to the wrong health record, clinicians and patients bear the brunt of incomplete, disconnected data that pose safety risks. What's more, staff members are forced to spend significant time fixing data errors, consuming precious resources that deplete time spent with patients.

Frequently, deficient data is the result of human error attributed to inaccurate inputting, spelling errors and missing information that is tied to inconsistent patient registration. Compounding these issues, self-insured plans depend on multiple vendors across services such as medical, pharmacy, vision, and behavioral health, each providing data feeds from their own systems and reporting standards.

The consequence is not only fragmented data feeds, but fragmented insight. Consolidation becomes a technical exercise rather than an analytical one, resulting in coding errors, delayed strategic planning, and limited clinical or financial foresight. This fragmentation inhibits plan-wide analysis, obscures emerging care gaps, and prevents organizations from making confident, forward-looking decisions about risk and intervention.

Finally, there's the challenges of regulatory compliance and legal requirements. Care coordination specialists at Ursamin fault data fragmentation for raising valid privacy and security concerns as patient information becomes vulnerable to breaches and unauthorized access when it's dispersed among different systems. They warn that disjointed data may jeopardize patient confidence and trust in the healthcare system and underscore the importance of addressing the issue as vital for collaboration and effectively safeguarding patient privacy.

High-quality data management, aligned with regulatory standards like HIPAA, ensures consistent security protocols across departments. This is particularly important if a healthcare organization suffers a data breach due to inconsistent security practices which carry significant consequences, including fines and reputational damage.

Collectively, these issues impede clinical and financial forecasting that impact plan performance and risk mitigation.

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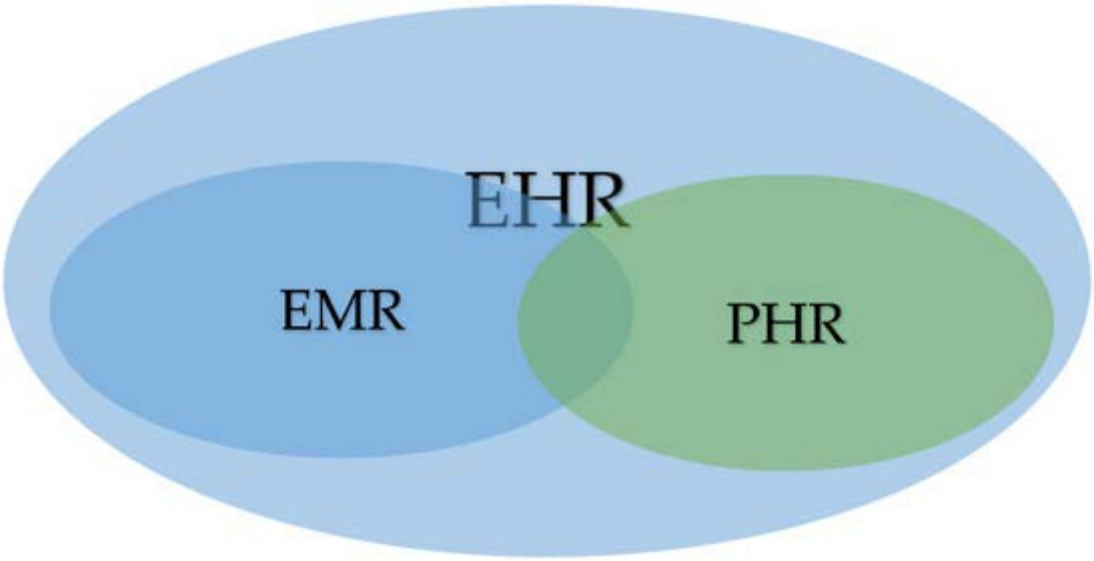
WHAT'S THE DIFFERENCE?

In the concept of health or medical records, there is a slight difference between EHR, EMR, and PHR which could be confusing.

Electronic Medical Record (EMR) is all the records a single healthcare provider provides.

Personal Health Record (PHR) is the records patients provide.

Therefore, if a patient has a personal copy of their records from a healthcare provider, the records would be PHR and EMR, respectively.



Conversely, all electronic health records are called EHR, a more general term.

Source: Information 2025, 16(2), 106; https://doi.org/10.3390/info16020106

FLAWED DATA IMPACTS REINSURANCE AND STOP-LOSS


Wian Stipp

While the untapped growth potential of the industry as captured in a 2021 AON report is now materializing, reinsurance and stop-loss providers must play a more preemptive role—shifting from passive risk transfer toward active risk insight that enables earlier identification of emerging medical risk and more informed intervention strategies.

This dictum is even truer today, as explained by Wian Stipp, Lead ML Research Engineer at Evidium, a computational medical knowledge platform that fills a market gap for risk-bearing and other organizations to manage both clinical and financial risk.

"While reinsurers are not strangers to data, having used it for 100+ years to run their businesses, risk has gotten meaningfully more complex in the healthcare domain," says Stipp. "As reinsurers struggle to move beyond basic risk exposures and make meaningful improvements for innovation, partnership or collaboration, they are tasked to better address the plethora of key data sources that are even richer now vs. five years ago."

He stresses that data is often overwhelming, bringing complexity to healthcare delivery and challenging stakeholders with fragmented, unusable information: "The challenge is no longer access to data, but the ability to synthesize diverse clinical, financial, and evidence-based sources into coherent insight that explains risk, forecasts outcomes, and informs action. Few technology solutions truly capture both the scope of available data and its clinical meaning."

Healthcare data sources and types are extensive, reflecting the growing importance of evidence-informed policymaking and evidence-based medicine. However, the true challenge lies not in the volume or diversity of data, but in transforming these disparate inputs into a longitudinal, clinically grounded understanding of disease progression, care pathways and financial exposure.

EHRs and Clinical Data: Every visit, note, and medication must be recorded and accessible in real-time. This spans patient histories, symptoms, lab and test results, imaging, medications and outcomes. Doctor visits and hospital admissions and pharmacy records are vital. These data points are critical for diagnostics and chronic condition tracking.

Financial and Administrative Data: Insurance claims, billing records, costs and reimbursements.

Biomedical and genetic data: this pertains to inherited or acquired characteristics (DNA/RNA) analyzed from biological samples. Biomedical data also includes clinical, lifestyle and socioeconomic environmental factors influencing health.

Physician notes: Unstructured narrative notes hold key insights but are often difficult to search or use.

Secure messaging: More engaged patients translate into more inbound messages, tasks and questions to track.

Remote monitoring tools: Wearables and sensors now feed continuous streams of data into care environments.

Patient-reported outcomes: Subjective feedback and surveys add depth but require structure to be usable.

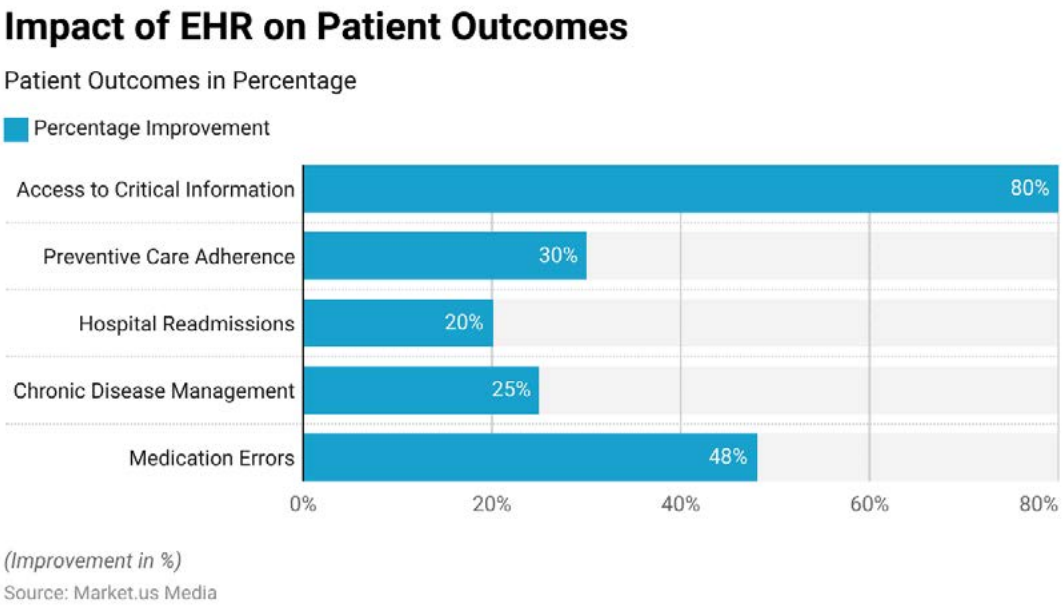
Research & Literature: Clinical trials including data from research studies on new treatments. Scientific literature with evidence-based data from peer-reviewed journals and reports.

Government & Organizational Portals: CDC (NCHS): National Center for Health Statistics; NIH (NLM): National Institutes of Health, National Library of Medicine; AHRQ: Agency for Healthcare Research and Quality (HCUP, MEPS); HHS HealthData.gov: Central hub for US health data; WHO: World Health Organization.

Source: National Library of Medicine https://www.nlm.nih.gov/oet/ed/stats/01-000.html

HIGH STAKES FOR RISK MANAGEMENT

For a variety of reasons, Stipp says many insurers and reinsurers continue to have a risk-averse mindset. However, cohesive organizational strategies surrounding the analysis and use of different kinds of data still leave buyers wanting.



Stipp asserts that for decades, risk management on behalf of self-insured health plans has relied upon lagging indicators, manual analysis and backward-looking assessments.

"This is changing rapidly, primarily due to advances in artificial intelligence (AI), including generative and agentic AI," he continues. "These technologies are enabling a shift away from retrospective analysis toward predictive, clinically informed models that identify risk earlier and connect medical decisions to future cost and outcomes."

He explains that this is precisely where accurate data and the use of advanced data analytics and AI allow for proactive risk management and targeted interventions to mitigate high-cost claims which impact financial performance and stop-loss premiums.

"By applying advanced machine learning to claims and clinical data and implementing the use of AI to deliver actionable insights at both the population and member level, stakeholders in risk management will gain a foundation for sound decision-making. The adoption of innovative technology that makes medical knowledge accessible, usable and extrapolative enables better risk analysis for the many conditions that are growing in occurrence and cost."

He projects that the future risk assessor and underwriter will look a little different than has traditionally been the case, adding, "They will better represent a combination of someone who operates in a much more strategic way, better understanding strategy, technology, operations, and pricing. These are all tied to structured, evidence-based data that result in measurable clinical and financial performance improvements."

Clinically explainable intelligence does more than identify high-cost members—it clarifies why risk is emerging, which clinical decisions matter most, and how alternative care pathways may change both outcomes and financial exposure.

"This level of insight enables precision targeting and drives more stable, predictable financial performance," emphasizes Stipp. "By forecasting the health status, care needs, and cost trajectories of high-risk members—and by optimizing treatment pathways before costs escalate. Organizations can move from reactive protection to proactive strategy. The future of healthcare risk management will belong to those who can transform complex medical data into actionable, predictive, and clinically grounded insight—while decisions still matter."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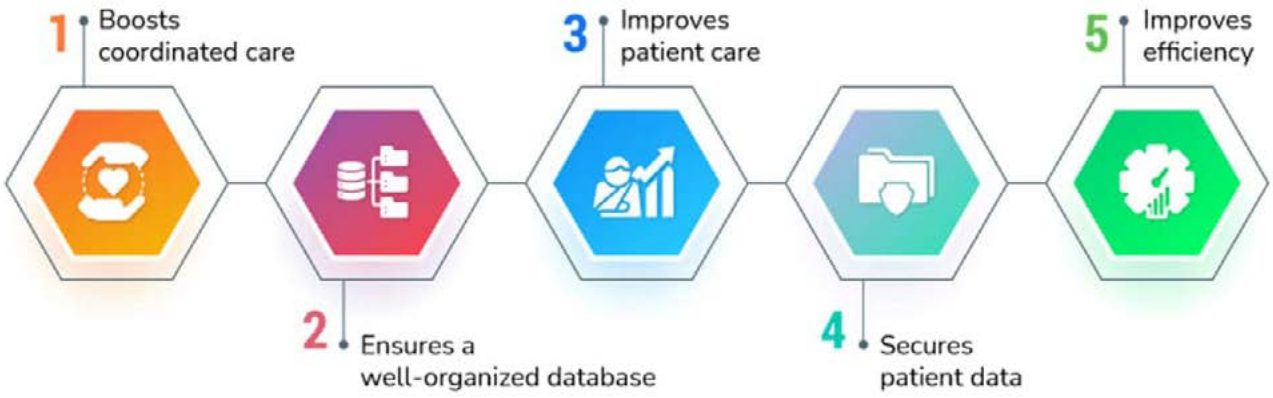
ELECTRONIC HEALTH RECORDS STATISTICS – BENEFITS



Sources: The Journal of Healthcare Information Management, American Journal of Managed Care, Journal of Medical Internet Research, Health Affairs, ONC Health IT Quick-Stat, Capterra, Agency for Healthcare Research and Quality

Data integrity emerges as a clinical mandate for closing the loop on plan risk. Vanessa Guzman, MS, ME, President, SmartRise Health, LLC cautions, "Data fragmentation is a clinical risk leading to misdiagnosis and unmanaged spend. We believe plan sponsors must shift toward leading indicators that connect clinical, social and risk data."

She suggests three pillars to advance data management:

- Unified Ecosystem: We recommend a model that integrates social resource navigation with clinical oversight to ensure data flows between providers and the community.
- National QE Networks: We advise collaborating with National Qualified Entity (QE) networks to leverage multi-payer data, benchmarking provider quality with unprecedented accuracy.
- AI and Continuous Learning: Our organization utilizes AI within a learning framework to convert fragmented data into insights—essential for managing the 11–12% spike in pharmacy spend driven by GLP-1s.

AVOIDING REVENUE LOSS

Inaccurate data can equate to missed profitability. A study by Black Book Market Research found that healthcare providers lose over $3.1 trillion annually in the U.S. due to poor data management, much of it from rejected claims or billing mistakes caused by dirty data. Withum Advisory attests that for self-insured employers, these rising medical claim denials are no longer a back-office nuisance, they represent a direct fiduciary risk under the Employee Retirement Income Security Act of 1974 (ERISA) and can expose plan sponsors to financial volatility, regulatory scrutiny, and litigation.

They point out that self-insured plans bear the full cost of approved claims and challenges arise when denials increase due to avoidable issues such as coding errors, documentation gaps, or inconsistent application of plan rules. In these situations, employers may face:

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Shawn Evans

Shawn Evans, CEO, Integrated Payor Solutions, a DC Risk Solutions company, observes, "As a multifaceted claims adjudication and network management platform, data integrity is the most important issue we face with clients and prospects. This is also critical for the tertiary providers who are working various forms of cost containment as they quickly realize the inability to receive the data they need in real time severely hinders their ability to deliver the results their clients expect."

Evans emphasizes that his company has many clients who are being asked to run their TPA as an integrated system rather than as a jumble of point solutions, adding, "For this to work at maximum efficiency the data needs to be standardized and clean. If we take the industry's first pain point, the enrollment file is an example. There is everything from home grown custom built to industry standard solutions. However, they are all different in subtle ways and require custom mapping and integrations for every instance. This is very costly and inefficient especially when we already have an industry standard (834) file format we should be using at a minimum."

He further explains that to understand in the real world why this is critical, "Follow the claims path at a TPA. The provider sends a claim that needs to be matched with a member. When the member matching fails the claim cannot process at the TPA. We then send this to the network for repricing. Again, the network has a different file format for enrollment files which necessitated another file mapping. If they cannot identify the member then the repricing likely fails as the particular network to be used cannot be identified. This process repeats itself for the PBM, card printing, case management and all other vendors."

For this reason, he stresses that getting the employer/ plan sponsors to adopt a standard ingestion file format would reduce errors as well as speed up implementation and increase interoperability across the ecosystem.

Bottom line: data disorder is a financial drain. Poor data quality invites significant costs across industries, with healthcare facing magnified challenges due to high-volume, fragmented, and often legacy data systems. Gartner estimates the average annual cost of poor data quality for organizations is $12.9 million, with recommendations to treat data as a product and invest in governance can reduce these costs.


Austin Scott

Austin Scott, EVP, Data & Insights, Premise Health supports this finding and reports, "Having navigated data fragmentation across multiple healthcare organizations, I've seen firsthand how destructive it can be — not just operationally, but strategically. Data silos don't just slow things down; they obscure the full picture of a person's care, leaving clinical and operational leaders without the insights they need to act decisively."

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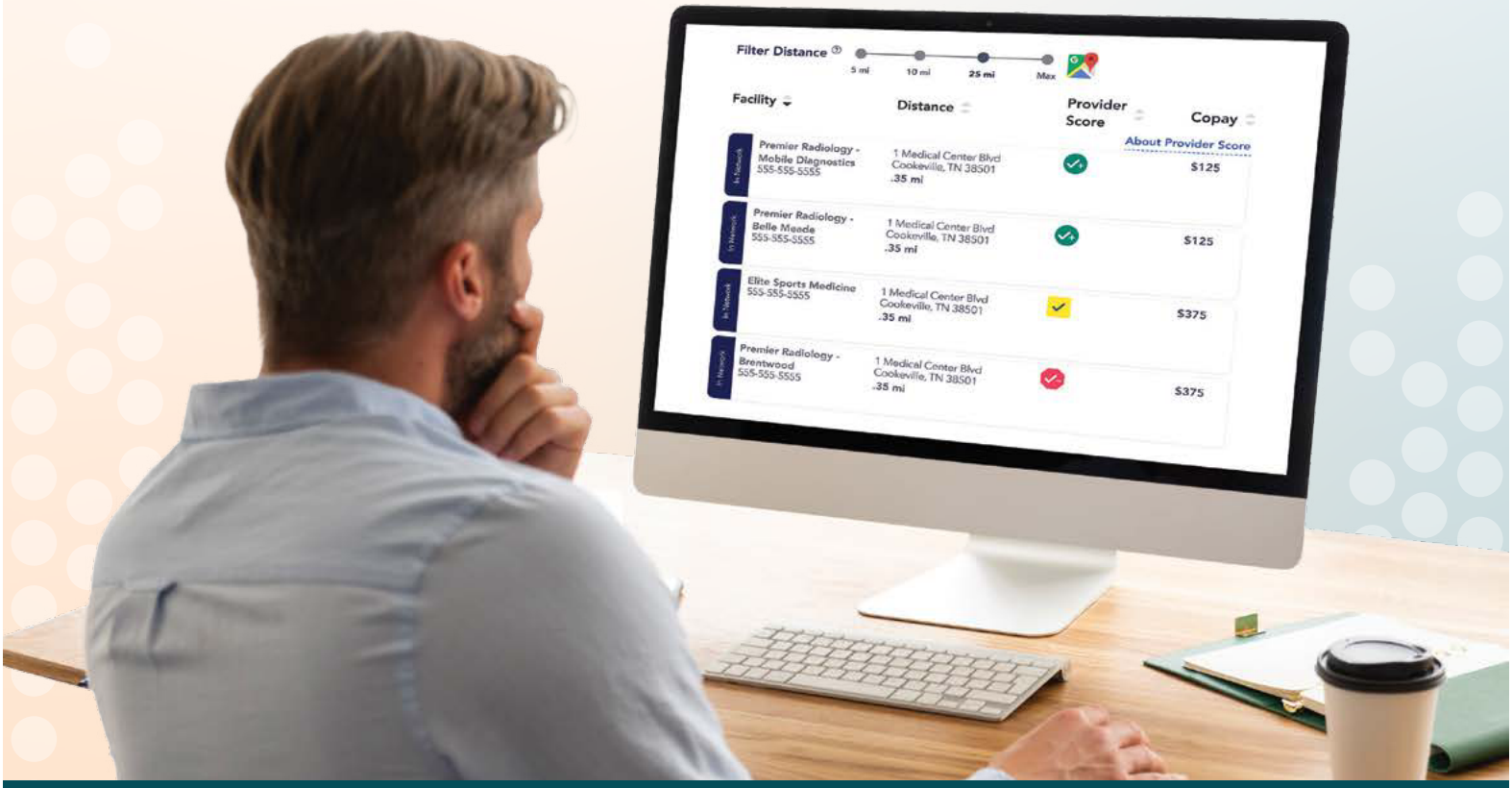

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The antidote is a deliberate, well-architected data integration strategy, as he explains, "At Premise Health, that's not an afterthought. It's foundational to how we deliver whole-person care. When data flows seamlessly across our ecosystem, the employers we work with gain a clearer view of their populations, our care teams can coordinate more effectively, and members receive better outcomes at a lower cost."

For example, he says many of their employer clients share claims data, noting that integration allows for the construction of a comprehensive picture of how care is delivered at Premise compared to what members receive in the broader community.

"Without a structured data strategy to harmonize that complex, varied data, we simply couldn't measure our own performance or demonstrate the value we create," he closes.

IMPACT ON BEHAVIORAL HEALTH

Fragmented data issues extend to behavioral health clinicians.

Myron Unruh, LPC, Chief Operating Officer, MINES and Associates, Inc. contends that although data fragmentation is a concern, "Our main priority as an MBHO is supporting individuals to achieve their highest level of functioning and engage with services essential for mental wellbeing. Employers need to use data extensively to understand employee needs and determine which services will best support them, while also prioritizing high-quality, cost-effective services that can be negotiated or better managed."

To effectively address stakeholder needs, he maintains that every participant – including TPAs, brokers and benefits consultants -- should possess experience in data analytics and how it drives decisions for their plan.

RESOLVING DATA PAIN POINTS

Recent statistics based upon figures from the US Attorney show that dirty data costs the US healthcare industry around $300 billion each year. Data problems arise from the sheer number of pressure points as the strategy team at data platform aggregator Eularis estimates that there are more than 1,300 different medical databases in the US, not including data.gov medical repositories, which are more likely to number about 85,000.

Evans attests, "Plan sponsors, TPAs, brokers and benefits consultants play a foremost role to promote data integrity and educate the people who are creating the data of the importance of accuracy. Most times, the most junior staff member is given the data entry and maintenance projects almost as a punishment because no one else wants to do it. This to me is setting up for failure from the beginning. From there the bad data seems to get disseminated without anyone reviewing the accuracy until something fails much further down the line and then we are doing a full root cause analysis through the system when it was just bad data or lack of required fields in the file."

Depending upon what your organization is asking AI and Machine Learning to do will impact their capability to generate quality data.

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Evans continues, "There are engines that can review large data models and identify problems -- so in these cases it is helpful. On the other hand, we have been approached by others who have built Agents only to find the agents don't really work without real time inputs that are not available from most of the claims adjudication systems on the market currently. In this case, they are rendered useless due to lack of data. "

KMS Technology confirms that inaccurate patient billing information, coding errors or incomplete documentation can lead to significant financial losses for healthcare organizations. The fall-out from these issues disrupts revenue cycles and leads to claim denials or delayed reimbursements which strain financial sustainability. Conversely, high-quality data ensures accurate billing and coding, minimizing revenue leakage and optimizing financial performance.

Clinicians that implement automated data validation tools and conduct regular audits can identify and correct errors before they impact revenue. By aligning data quality initiatives with financial goals, organizations can enhance operational performance, boost efficiency, reduce costs and free-up the resources needed to deliver exceptional care.

Here's some tips to assess the data integrity of your organization:

Accuracy

- **Cross-verification:** Compare data across systems (e.g., EHR vs. lab reports) to identify discrepancies.
- **Chart audits**: Periodically review a sample of patient records to verify the accuracy of key fields.
- **Validation rules:** Implement real-time checks at the point of data entry to catch anomalies before data is saved.

Validity

- **Content validity:** Ensure the data captures all necessary elements.
- **Construct validity:** Verify whether the data accurately measures what it should (e.g., a depression score reflecting actual mental health status).
- **Criterion-related validity:** Compare values against external standards or benchmarks, such as lab result ranges or regulatory guidelines.

Reliability

- **Temporal stability**: Monitor if the same values persist over time when they should remain unchanged (e.g., birthdate).
- **Inter-rater reliability**: Evaluate whether different staff members' input or interpretation of data is consistent.
- **Test-retest reliability:** Check whether repeated assessments under the same conditions produce the same results.

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Employers are well-advised to utilize structured data for plan design, benefit planning and risk mitigation, as Chris Harber, Chief Operating Officer, Vālenz Health® explains, "Strong structured data is the key to creating benefits strategies that work in today's high-cost healthcare environment. When plan designers have comprehensive data at hand — about a covered population's risk potential, previous plan performance, overarching industry trends — they can proactively create a strategy that addresses those needs in a tailored manner."

There will always be some degree of unpredictability in health insurance, but he advises that the more data that is deployed during the plan design stage, the more effectively teams can deploy risk-management and cost-containment solutions, while simultaneously supporting the members covered with high-quality, low-cost care options.

Harber maintains that all stakeholders in the self-insurance community have a responsibility to work together to support better data management and, more importantly, a collaborative interchange of that data.

"We've seen that traditional, siloed approaches to data management and interchange haven't worked, which is why the federal government has stepped in with data transparency regulations and mandates over the last decade," he continues. "But there's still a disconnect for plan members, who are not using that data to make smarter, more informed healthcare decisions. Therefore, everyone involved in the plan design process must advocate for solutions that not only deploy a higher level of data-driven strategy but also empower members with that data as we embrace a more member-led, cost-sharing healthcare model."

Austin Scott at Premise Health confirms the absolute value of data structure, advising, "Employers that aren't yet doing this are leaving significant value on the table. Structured data transforms benefit planning from an exercise in intuition and benchmarking into a precision discipline. When employers can see actual utilization patterns, care gaps, and cost drivers within their own population, they stop designing for a hypothetical and start designing for the real people they employ."

He describes the importance of working alongside with clients to make sure that the data generated -- from clinical encounters to health risk assessments -- feeds directly into their broader benefit strategy. Clients that share their claims data further benefit from a relationship with Premise and enhance capabilities to provide on-site healthcare feasibility studies that provide employers with an analysis of their existing claims-based cost drivers in the community.

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What's more, he says that every stakeholder in the benefits ecosystem has both an opportunity and a responsibility in this regard.

"Fundamentally, all parties are responsible for ensuring there's transparency in the relationship," he instructs. "Data management is complex, and plan sponsors have the opportunity to set the tone. When an employer treats data as a strategic asset rather than a compliance obligation, it cascades through every relationship with their partners."

Data must be utilized in a way that reduces partnership silos and flows across the ecosystem in a way that benefits members.

"Advancing better data management requires these stakeholders to align on shared standards, data sharing agreements, and a common commitment to using data in a service of the member," he counsels. "At Premise, we actively cultivate those partnerships because we know the value of our data multiplies when it's connected to the broader picture of our clients and their other partners."

THE IMPORTANCE OF DATA CLEANING

Creating a culture around quality data-driven healthcare decision-making begins with data cleansing and data scrubbing. Tableau, a division of Sales Force, defines this as "the process of fixing or removing incorrect, corrupted, incorrectly formatted, duplicate, or incomplete data within a dataset. There is no one absolute way to prescribe the exact steps in the data cleaning process because the processes will vary from dataset to dataset. But it is crucial to establish a template for your data cleaning process, so you know you are doing it the right way every time."

They suggest following these basic steps to map out a framework for your organization:

Step 1: Remove duplicate or irrelevant observations.

Step 2: Fix structural errors may occur when you measure or transfer data and notice strange naming conventions, typos, or incorrect capitalization. These inconsistencies can cause mislabeled categories or classes. For example, you may find "N/A" and "Not Applicable" both appear, but they should be analyzed as the same category.

Step 3: Filter unwanted outliers Often, there will be one-off observations where, at a glance, they do not appear to fit within the data you are analyzing. If you have a legitimate reason to remove an outlier, like improper data-entry, doing so will help the performance of the data with which you are working.

Step 4: Handle missing data You can't ignore missing data because many algorithms will not accept missing values.

Step 5: Validate and QA At the end of the data cleaning process, you should be able to answer these questions as a part of basic validation:

- Does the data make sense?
- Does the data follow the appropriate rules for its field?
- Does it prove or disprove your working theory, or bring any insight to light?
- Can you find trends in the data to help you form your next theory?
- If not, is that because of a data quality issue?

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For plan sponsors, ensuring the cleansing process of "dirty" data is critical since incorrect data can inform poor business strategy and compromised healthcare decision-making. It could also lead to false conclusions regarding plan design or coverage which can impact clinical and financial performance.

NO SURPRISE -- GROWING ROLE OF AI

Looking ahead, it appears that AI is firmly moving into live healthcare workflows. Innovaccer Inc., a leading healthcare AI company, recently released its State of Revenue Lifecycle in Healthcare 2026 report confirming this trend, based upon a survey of 150 US healthcare professionals across 103 organizations.

The peer-reviewed report, validated by Frost & Sullivan, finds that healthcare organizations are moving from AI experimentation to real-world deployment, while highlighting how fragmented data environments are increasingly limiting consistent, enterprise-scale impact across documentation, access and revenue cycle operations.

Employers can either stay the course by accumulating disconnected tools that limit scale, increase complexity, add governance burden and variability or consolidate around platform-based AI that unifies data, governance and workflow execution.

Leaders throughout the self-insured community now recognize that data fragmentation is acknowledged as the top barrier to enterprise-scale impact across documentation, access and revenue cycle operations. AI is clearly in their future.

Chris Harber at Vālenz Health® believes that AI and machine learning can be helpful tools for analyzing quality data, with this caveat: "They cannot act independently without expert human overview. We use a certain phrase to describe our approach: "responsible urgency." As just one example, we've installed some automation and AI into the utilization process, not for decision-making, but to take a 200-page itemized bill and synthesize it down in 15 minutes versus taking two days or 15 hours to get through it — supporting our promise of smarter, better, faster healthcare decision making."

At Premise, Austin Scott also supports this trend, but with a big asterisk: While AI and machine learning are predictive models that have taken the world by storm over the last several years, they generally lack your custom business context. They promise massive productivity increases and efficiencies, but in the data world, context is key.

“We are establishing our business rules and giving our data context using industry leading semantic layer and business intelligence platforms,” he shares. “These tools will allow our business to be well documented and allow the data to have context. This context is useful for enhancing the capabilities of both humans and our AI counterparts.”

Scott and colleagues refer to their AI team as “Applied AI” because “We want to apply the latest in generative AI to enable success. We are investing in a platform to extend the reach of AI into our business workflows to create value for our customers and clients. During the development of our AI platform, our analytics teams will be the first users of these capabilities to help us complete tasks that increase the quality of our data. For example, we can develop agents that normalize our data based on rules or check our code supporting our data platform for inconsistencies.”

He recommends that before AI and machine learning are used to transform your business, it’s important to have core principles defined that ensure privacy, transparency, reliability and safety, accountability, and data protection.

“These are fundamentals that cannot be ignored by any enterprise when developing AI at scale,” he states.

IT ALL COMES DOWN TO DATA

Fragmented and flawed healthcare data continues to drive unnecessary cost, risk and operational inefficiency in healthcare.

April Gill, CCO, Smart Data Solutions, shares, "Disconnected clinical, administrative and benefits data contribute to misdiagnosis, duplicate services, medication errors, compliance challenges and avoidable high-cost claims. The issue isn't data availability; it's data quality, structure, and flow."

She attests that while interoperability has improved connectivity, simply moving data between endpoints alone does not solve the problem.

"Without structure, validation, and context, fragmented data simply moves faster," adds Gill.

"Employers, plan sponsors, TPAs, brokers, and consultants must prioritize platforms that embed intelligence into upstream and downstream data flows; structuring, validating, and normalizing information before decisions are made. When AI and automation are applied to trusted, decision-ready data, organizations can enhance plan design, mitigate risk, reduce cost and drive better outcomes across the healthcare ecosystem."

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