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Measuring the Full Value of Population-Based Care Management

Why ROI Reporting Is Changing

Employer-Sponsored Premium Costs in 2025

$9,325
Average premium cost for single coverage

$26,993
Average premium cost for family coverage

Employer health care costs continue to rise faster than organizations can absorb with family premiums rising 6% in one year.

Employer health care costs continue to rise faster than organizations can absorb without changing plan design, vendor strategy, or employee cost sharing. In 2025, average employer-sponsored premiums[1] reached $9,325 for single coverage and $26,993 for family coverage, with family premiums rising 6% in one year[2]. For 2026, employers projected cost growth of about 9%[3] before mitigation, while Mercer estimated a 6.5% increase[4] after planned cost reduction measures.

This pressure has raised the standard for care management reporting and changed what employers expect to see. Outreach totals and enrollment rates show that a program operated, but they don't show whether members received better care, avoided preventable escalation, or experienced lower total cost over time. Employers expect financial validation, but they also need to understand the pathway that produced the result.

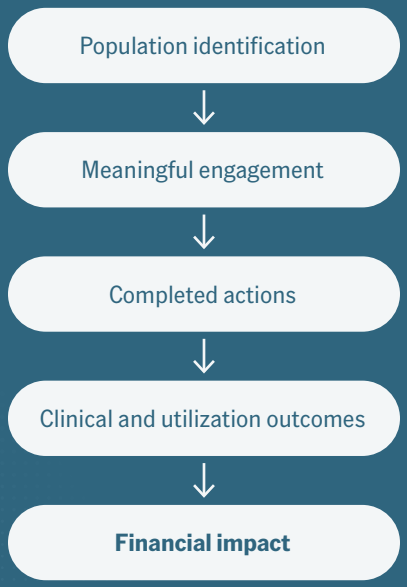
That is the central argument for measuring the full impact of population-based care management: ROI validates the program, while engagement reveals why it works. Understanding both enables organizations to evaluate performance more accurately, refine their approach, and replicate successful programs at scale.

Engagement Explains How Value Develops

Population-based care management begins by identifying members with high or rising risk. But identification only creates an opportunity, not an outcome. To make a measurable difference, the program must reach those members, earn their trust, understand their needs, and help complete actions that improve their care.

This is what separates meaningful engagement from routine activity. An email, attempted call, or enrollment agreement may document a touchpoint, but meaningful engagement produces a tangible result. That may include a completed assessment, a resolved medication or access barrier, a completed referral, a scheduled follow-up, or a

Effective Population-Based Care Management Drives Value



decision to use a more appropriate care setting. Sustained engagement builds on those results over time as the member's condition, treatment plan, and personal circumstances evolve.

An effective engagement strategy centers on personalized support from dedicated health nurses. Rather than relying on one-size-fits-all communication, this model prioritizes ongoing dialogue, clinical guidance, accountability, and coordination across health conditions and benefits. While not every interaction generates immediate savings, engagement becomes a meaningful business metric when it drives completed actions and helps predict clinical, utilization, and financial outcomes.

A Credible Framework for Measuring Care Management ROI

Financial ROI is important, but a single savings estimate doesn't explain how a care management program creates value. Employers need a framework that links program participation to changes in care utilization, clinical outcomes, and member experience.

Care management value is best reported across five domains.

Value domain	Employer question	Core outcomes
Financial	Did the program moderate spending after accounting for its full cost?	Total cost of care PMPM, net savings, net ROI, break-even period
Utilization	Did members receive appropriate care while avoiding preventable acute use?	Admissions, emergency department visits5, readmissions, site of care
Clinical	Did care quality, condition control, or functional status improve?	Condition-specific clinical and care process outcomes
Engagement	Did members receive enough meaningful intervention to affect outcomes?	Sustained engagement, completed actions, barrier resolution
Experience and workforce	Did members receive useful support, and did the employer see broader workforce value?	Navigation confidence, trust, absence, disability duration

Financial measures show whether the value generated exceeded the cost of the program. Utilization and clinical measures show what changed in care, while engagement indicates whether members received enough support to influence those outcomes. Member experience adds another essential dimension by showing whether that support was useful, understandable, and trusted.

Financial reporting should also clearly distinguish between gross and net savings. Net savings are calculated by subtracting the program's total cost from the estimated medical and pharmacy spending avoided. ROI is then calculated by dividing net savings by the program's total cost.

Net savings = (Estimated avoided medical and pharmacy spending) – (total program cost)

ROI = (Net savings) ÷ (total program cost)

The measures must reflect the intervention delivered. A navigation program shouldn't take credit for every change in disease control, and a medication access intervention has a more defensible relationship to treatment initiation or adherence. Workforce outcomes belong in the financial model only when the employer provides reliable data and agrees on the valuation method.

What Makes an ROI Claim Credible

A credible evaluation distinguishes between two questions: whether offering the program improved population outcomes and whether engaged members experienced better results than comparable members who didn't engage. Those questions are related, but they aren't interchangeable.

Engaged members differ from nonparticipants in motivation, disease severity, work flexibility, trust, and access to care. A direct comparison therefore reflects both selection and program impact. Employers should require a credible comparison population before accepting a savings claim.

Stronger evaluations compare similar populations[6], account for baseline risk and utilization, and examine how outcomes changed over time. Propensity score matching or weighting improves comparability. Difference-in-differences analysis then compares how outcomes changed in the intervention and comparison groups. At least 12 months of baseline data helps establish the starting point and determine whether both groups followed similar trends before the program began.

Care management programs also identify members after hospitalizations, high-cost episodes, or periods of heavy emergency department use. Costs may decline after those events without intervention. A simple pre- and post-comparison will therefore label regression to the mean as program savings. The stronger analysis shows whether the program changed the expected trajectory rather than whether costs merely fell after an expensive year.

Value Takes Time and Varies by Population

Care management doesn't follow one financial timeline. A member may need additional primary care, pharmacy support, behavioral health treatment, or diagnostic follow-up before avoidable acute use declines[7]. That appropriate outpatient care may increase short-term[8] spending while addressing untreated needs.

Period	What Employers Evaluate
First 12 months	Engagement, barriers resolved, access, and early clinical outcomes
12 to 24 months	Utilization changes and preliminary financial impact
24 months and beyond	Cost trend, durability, and cumulative ROI

A 12-month report provides an early view of engagement, barrier resolution, access, clinical progress, and initial utilization. It doesn't provide the strongest basis for judging whole-population financial performance. A 24-month assessment provides a stronger decision point by reducing the influence of claims runout, seasonal variation, low event rates, and a single expensive quarter. Longer follow-up shows whether the results last.

The timing also varies by condition and intervention[9]. Heart failure programs may show an earlier signal through admissions and readmissions. Diabetes programs may

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first improve testing, medication access, or disease control. Behavioral health programs may increase appropriate treatment before reducing physical health spending. Cancer, maternity, and musculoskeletal programs follow different clinical and financial timelines.

Whole-population results remain necessary because employers need to know how the total investment performed. Cohort results then show where to expand the model, refine the intervention, or reconsider resource allocation.

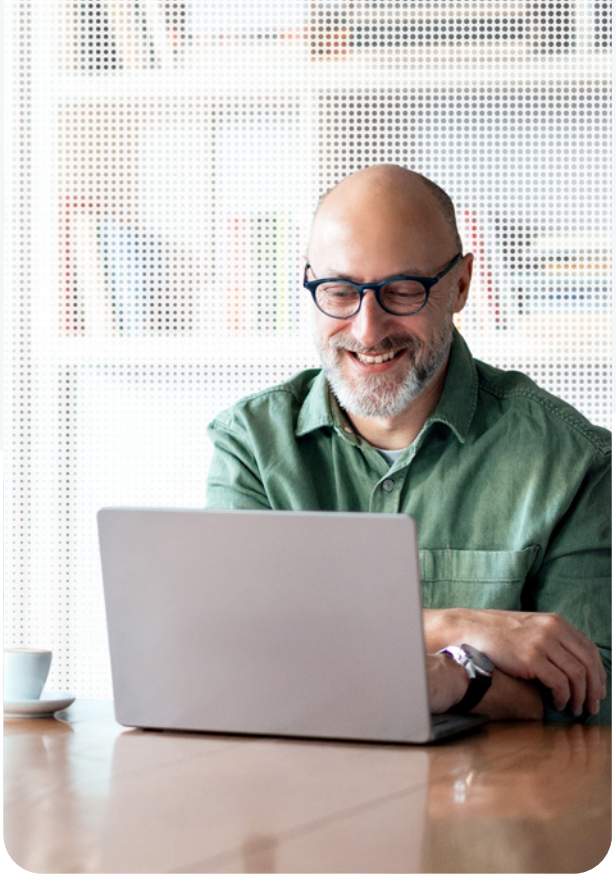
What Employers Need from Care Management Reporting

A trustworthy report shows who qualified for the program, who received a meaningful intervention, and how outcomes changed relative to a credible comparison population. It identifies the measurement period, includes the full program cost, and separates gross savings from net savings.

The financial result should lead the report, supported by utilization, clinical, engagement, and member-experience outcomes. One ROI number can't show where a program worked or why. A balanced scorecard strengthens the financial result by showing whether the program changed care or merely coincided with a change in claims.

Domain	Primary reported result	Required context
Financial	Net savings and net ROI	Program cost, expected cost, confidence interval
Utilization	Admissions and emergency department trend	Baseline rate, comparison rate, absolute change
Clinical	Priority condition outcome	Measure definition, cohort size, follow-up period
Engagement	Sustained meaningful engagement	Survey instrument, response rate
Experience	Navigation confidence and perceived support	Navigation confidence, trust, absence, disability duration
Workforce	Absence or disability outcome	Data source, valuation method

Every report should identify the population studied, the measurement period, the comparison method, the program cost, the sample size, and the key limitations. It should also report absolute results alongside percentage changes so that employers judge both the size and credibility of the effect.



From Program Activity to Demonstrated Value

Care management earns its place in an employer's benefits strategy when it turns identified risk into meaningful action and measurable results. Employers need more than a headline savings figure or a high volume of outreach attempts. They need evidence that members received effective support, made more informed care decisions, and achieved better outcomes at a sustainable cost.

Population-based care management creates value by connecting risk identification with sustained engagement, improved care decisions, and measurable clinical and financial outcomes. ROI remains essential, but it is most meaningful when employers can also see who engaged, what changed, and whether those changes reduced avoidable utilization or moderated long-term healthcare costs.

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