# Are payers defending a cost position they can't sustain?

To solve the administrative cost crisis, healthcare payers must move beyond linear automation to an agentic AI operating model.

**Traditional automation in healthcare has reached its ceiling. To survive tightening margins, payers must abandon siloed tasks and transition to an agentic operating model driven by journey-centric design and autonomous AI orchestration.**

## Structural and administrative pressures faced by healthcare payers

- **Rising administrative burden:** Despite years of investment, 20 to 30 cents of every premium dollar is still consumed by administrative friction before touching patient care.
- **Margin compression:** As Medicare Advantage margins tighten and premium growth slows, plans can no longer absorb the cost of manual reviews and fragmented workflows.
- **Direct revenue impact:** CMS increasingly links operational performance—particularly prior authorization timelines—directly to ratings and financial outcomes.
- **The automation ceiling:** Traditional, rules-based automation systems perform well in stable scenarios but fail in the multi-step, exception-driven workflows that define modern healthcare.
- **The imperative to act:** Organizations that move decisively to an agentic model will define the new industry benchmark, while laggards will defend an unsustainable cost position.

## The administrative cost crisis in healthcare

Administrative overhead at national payers has not materially improved in fifteen years. At its core, running a health plan has always been administratively intensive. What's changed is the cost of staying that way. For most healthcare payers, a meaningful portion of every premium dollar is spent before it ever touches care. For a plan processing millions of claims annually, 20 to 30 cents of every premium dollar goes to administration. Prior authorizations still move through layered manual reviews. Claims often cycle through rework before they're finalized. Credentialing delays slow down provider onboarding. And when any of these processes break, the impact immediately hits contact center volumes.

Historically, plans could absorb this. Premium growth created enough cushion that administrative inefficiency, while understood, wasn't urgent. That dynamic is now shifting. As Medicare Advantage margins tighten and CMS increasingly links operational performance, particularly prior authorization timelines to ratings and revenue, these inefficiencies are no longer easy to absorb. What was once operational friction now has direct financial impact.

> **The organizations that move decisively now will define the benchmark. Those that treat this as the next incremental upgrade will find themselves defending a cost position they can no longer sustain.**

# Why traditional automation has plateaued

Healthcare payers have not ignored the efficiency opportunity. Over time, most large health plans have invested heavily in automation: EDI standardization, rules-based adjudication, and process-level automation across core workflows. These efforts have delivered real gains, improved throughput and reduced manual effort. But the ceiling is now visible. Despite sustained investment, many high-friction workflows remain only partially automated not for lack of effort but because traditional automation is structurally limited.

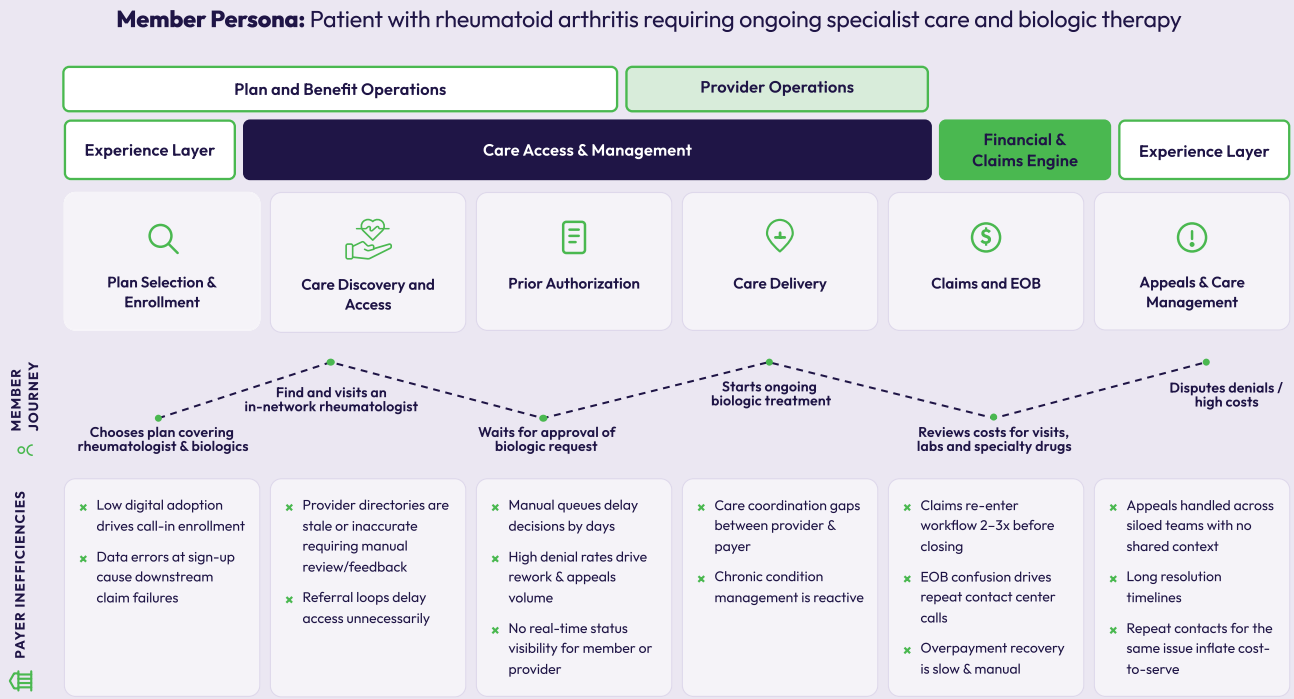
These systems are built to execute predefined rules and tasks. They perform well in stable scenarios but struggle with multi-step, exception-driven workflows that require coordination across systems. As complexity increases, so does reliance on manual intervention. The result is a system that is automated in parts, but not in flow. This limitation becomes most visible across the member journey. What appears as a single interaction is often a series of disconnected steps. Automation exists within each step, but not across them, leaving gaps that operations teams, and often members themselves, must navigate.

# Fragmented member journey: Where friction is created

What looks seamless to a member is, on the payer side, a relay race across five or six functionally siloed systems. Each with its own data model, its own workflow logic, and its own team, passing a baton that has high risk of frequently getting dropped. Consider a typical member journey: selecting a plan, verifying eligibility, accessing care, navigating prior authorization, receiving services, processing claims, and resolving post-service inquiries. At each stage, the member encounters friction:

- Information provided during enrollment must be revalidated during care access.
- Prior authorization decisions are delayed due to incomplete data or manual reviews.
- Claims processing lacks transparency, leading to confusion and follow-up calls.
- Contact center interactions often involve multiple transfers before resolution.

Now we translate the key moments of the member journey into five domains—rewiring the operational pillar that owns each moment and addressing the efficiency challenges embedded in every handoff.




These are not isolated failures. They are symptoms of fragmentation across operational domains. Plan configuration decisions affect eligibility workflows. Provider network gaps influence access and routing. Care management processes impact claims outcomes. Yet each function operates independently, with limited coordination.

The member, in effect, becomes the integrator—navigating a system that is complexly designed when operating as a cohesive whole. Solving this challenge requires more than incremental fixes. It requires redefining the operating model built around journeys, not more automations within functions.

## What it means to be an efficient payer?

An efficient payer is not simply one that reduces administrative cost. It is one that minimizes friction across the member journey by enabling intelligent, real-time coordination of decisions and workflows. In this model, **decisions are no longer confined to individual functions.** They follow the member across the lifecycle, informed by context and data that flows seamlessly across systems. Manual intervention is reduced not by eliminating complexity, but by managing it more intelligently.

| Traditional Payer | Efficient Payer |
|---|---|
| **Claims:** 15–20%[1] manual touch, linear workflow | **Claims:** <5%[1] human review, intelligent triage in real time |
| **Prior auth:** 3–5-day[2] turnaround, portal-plus-manual | **Prior auth:** Same-day determination for standard cases |
| **Contact center:** Reactive, $5 per call[3] | **Contact center:** AI-deflected, <$1 per interaction[1] |
| **Provider ops:** 90-day[4] credentialing, 30–60-day data[1] lag | **Provider ops:** Continuous validation, real-time accuracy |
| **Human role:** Process executor, exception handler | **Human role:** Decision authority on genuinely complex cases |

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The efficient payer operates with a fundamentally different set of principles. It prioritizes journey-centric design over functional optimization. It replaces static rules with dynamic decision intelligence. It leverages AI not just to automate tasks, but to orchestrate outcomes. The most significant shift is the role of human expertise. In the efficient payer, it is concentrated exactly where it creates differential value: the ambiguous clinical case, the member relationship that requires empathy, the governance decision that requires accountability. Everything else flows through an intelligent system that can reason and act without a hand-off.

## Agentic AI: The enabling engine

Agentic AI systems can plan, execute multi-step tasks, use tools, collaborate with other agents, and act autonomously within defined parameters. In payer operations, this distinction is decisive, because the unsolved problems—PA judgment, claims complexity, provider communication—require multi-step reasoning across multiple data sources, not single-turn outputs.

| **Assist**<br>AI surfaces insight | **Augment**<br>AI acts with approval | **Orchestrate**<br>AI manages workflows | **Autonomous**<br>AI decides end-to-end |
|---|---|---|---|
| Claim flags, PA decision support | Draft PA letters, EOB explanations | PA triage, end-to-end claims routing | Full adjudication; real-time auth |

Most national payers today operate between Assist and early Augment. The step change in value occurs at Orchestrate, where AI manages entire workflow chains without a human at each step. Routing a PA request, pulling clinical criteria, cross-referencing the formulary, drafting the determination, and updating the provider portal. Escalating to humans only when confidence falls below a configured threshold. Much of the capability is emerging in constrained workflows with defined guardrails. What is scarce is not technology. It is organizational readiness to design workflows that trust it appropriately and govern it rigorously.

## Envisioning the efficient payer across the member journey

Achieving meaningful efficiency requires transformation across five interconnected operational domains, each aligned to a stage of the member journey.

- Plan and benefit operations govern how products are designed, configured, and made available to members. In an agentic model, AI can validate benefit configurations, ensure consistency across systems, and dynamically tailor plans based on member needs and historical data.

- Provider operations shape how members access care. Intelligent systems can match members to the most appropriate providers based on clinical, geographic, and network considerations, while automating credentialing and identifying network gaps before they impact access.

- Care and access management sits at the heart of clinical decision-making. Agentic systems can enable real-time prior authorization decisions, recommend care pathways, and coordinate across stakeholders to reduce delays and improve outcomes.

- The financial and claims engine manages adjudication and payment. AI can auto-adjudicate clean claims, flag anomalies in coding and billing, and reduce rework from denials and resubmissions.

- The experience layer governs member interaction. AI can unify journeys across app, call, and in-person touchpoints, resolve common issues end-to-end, and guide next best actions, reducing contact center volume, repeat interactions, and cost-to-serve.

These pillars are not independent. They are interconnected components of a single system that must operate in coordination. For payers, the immediate opportunity lies in identifying high-friction journeys such as prior authorization or claims disputes and deploying agentic capabilities where coordination costs are highest and member impact is most visible. When these domains begin to operate as a unified system, the impact extends far beyond individual functions.

### Automation without strategy is a threat

Small, incremental changes aren't enough. Without rethinking fragmented operating models and aligning incentives, even the most advanced AI will perpetuate inefficiencies, creating smarter silos instead of seamless, journey-driven systems.

## Ready to lead. Here's how healthcare payers can act now

- Orchestrate workflows across functions—not just within silos—to achieve material reductions in administrative overhead and cycle times.

- Prioritize real-time, journey-centric coordination to actively minimize member friction and elevate satisfaction throughout the lifecycle.

- Proactively align your operations and data models with emerging regulatory, ratings, and revenue imperatives to turn compliance into competitive advantage.

- Shift human capital to manage complex, high-value cases and governance while deploying agentic AI to handle routine, exception-heavy, and cross-system tasks.

# What's next for payers? Here's what to expect and how to prepare

**Transforming payer operations with agentic AI**

As agentic capabilities are applied across these domains, payer operations will evolve in fundamental ways. Claims processing will shift from rules-based adjudication to context-aware decisioning. Prior authorization will move from reactive approvals to predictive enablement.

**Proactive solutions: The future of contact centers**

Contact centers will transition from handling inquiries to resolving issues proactively. These changes will reduce cost and cycle time and improve accuracy and member experience. The gains are not incremental; they represent step-change improvements driven by coordination across domains rather than optimization within them.

**A roadmap to building an efficient payer model**

Transitioning to an efficient payer model requires a staged approach that starts with strong data foundations and interoperability, followed by the introduction of AI-assisted workflows. As organizations build confidence, these capabilities expand into cross-functional orchestration and, ultimately, selective autonomy—where systems can execute decisions within defined guardrails. This journey is as much about operating model change as it is about technology, requiring alignment of roles, incentives, and governance to focus on outcomes rather than tasks.

**Balancing innovation with regulatory compliance**

At the same time, healthcare's regulatory and ethical landscape demands robust governance. Agentic systems must ensure privacy, explainability, and auditability, with humans positioned strategically for oversight and complex decision-making. When implemented with these safeguards, agentic AI can scale and responsibly unlock a future where payer operations are real-time, coordinated, and largely frictionless.

1. Based on the authors' observations across health plan operations engagements https://www.fiercehealthcare.com/providers/providers-potentially-wasted-almost-18b-2023-overturning-claims-denials-premier-estimates
2. Centers for Medicare & Medicaid Services, CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) fact sheet (2024).
3. DialogHealth, Healthcare Call Center Statistics (2025) - https://www.dialoghealth.com/post/healthcare-call-center-statistics
4. National Committee for Quality Assurance (NCQA), Credentialing Standards (2025), Verisys (2025). How Long Does Credentialing Take in Healthcare. - https://verisys.com/blog/how-long-does-credentialing-take/

## ABOUT BRILLIO

Brillio is The Enterprise AI Accelerator helping Fortune 1000 companies move from AI ambition to scaled impact, faster. Powered by our AI accelerator platform – Agentic Data and Application Management (ADAM), Brillio is one of the fastest-growing digital technology service providers, delivering transformation across five core workstreams: business-led transformation, customer experience transformation, AI and data engineering, digital engineering, and infrastructure engineering.

With 14 delivery locations across North America, Europe, and Asia and a team of over 6,000 customer-obsessed professionals, Brillio combines deep industry expertise, modern engineering, and accelerators to deliver measurable outcomes. Headquartered in Dallas, Texas, Brillio serves clients globally with a commitment to speed, scale, and measurable impact.

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