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WHITEPAPER

Outlook 2026: The Agentic Healthcare Payer

Introduction:
The Current State of Play

Healthcare payers are caught in a vice: costs are rising on every front as pressure to deliver better member experiences intensifies.

Claims volume continues to climb, and with it, the cost of processing.[1] Manual adjudication remains the norm for complex claims, tying up skilled staff in repetitive work while errors and delays frustrate providers and members alike.[2] Meanwhile, fraud, waste, and abuse drain billions annually,[3] and legacy detection methods can't keep pace with increasingly sophisticated schemes.[4] Every inefficiency in claims operations shows up in the medical loss ratio.

At the same time, members have come to expect consumer-grade experiences. They want seamless digital interactions, transparent benefits information, and fast resolution when something goes wrong. As many members are frustrated with increasing costs and claims denials, retention becomes more challenging.[5] In a market where member acquisition costs are high and retention is everything, experience has become a competitive battleground.

Yet most payers are still operating with fragmented systems and reactive service models that can't deliver personalization at scale. Member data, claims data, and service interactions live in silos, leaving service teams responding to issues after dissatisfaction has already set in.

And the regulatory environment keeps tightening. The No Surprises Act (NSA) demands accurate provider directories and transparent pricing.[6] CMS quality programs require meticulous documentation and reporting, and state and federal audits scrutinize network adequacy, credentialing, and payment practices. Compliance isn't optional, but the manual processes most payers rely on make it expensive and error prone.

Roughly 25% of healthcare payers say they have an established AI strategy, even as financial pressure, workforce shortages, and member expectations accelerate.[7]

1 https://www.nacha.org/news/ach-healthcare-claim-payments-rise-again-2024-continuing-11-year-climb
2 https://www.pwc.com/us/en/industries/health-industries/library/health-plan-complex-claims.htmlr
3 https://pubmed.ncbi.nlm.nih.gov/37770866/
4 https://pmc.ncbi.nlm.nih.gov/articles/PMC9013219/
5 https://phrma.org/blog/patient-experience-survey-americans-speak-out-on-health-insurance-barriers-and-need-for-policy-change
6 https://www.cms.gov/nosurprises
7 https://www.bain.com/about/media-center/press-releases/2024/us-healthcare-spending-more-on-ai-cybersecurity-other-it-investments-bain--company-and-klas-research/?

The answer isn't incremental process improvement that hardly seems to make a difference; it’s also not more headcount when acquisition and claims processing costs are already so high. Instead, payers must rethink how work gets done, shifting from insight to action and from reactive operations to autonomous ones.

This is where agentic AI comes into play – the intelligent systems that sense, decide, and act autonomously across claims operations, member engagement, and provider network management.

Unlike traditional automation, which follows scripts, agentic AI adapts continuously. It learns from each interaction, improving accuracy over time. It connects fragmented workflows into a single intelligent flow, acting without waiting for manual handoffs.

The following sections explore three high-impact opportunity areas where healthcare payers can transform, with practical starting points to build momentum safely and intentionally.

Three Agentic Opportunities for Healthcare Payers

Opportunity 1:
Agentic Claims Operations and Payment Integrity

The Challenge

Claims are the core transaction of every health plan but processing them remains stubbornly expensive and inconsistent.

Straightforward claims often auto-adjudicate, but anything requiring judgment, such as medical necessity reviews, coordination of benefits, or complex coding scenarios, lands in a queue for manual review. Skilled examiners spend their days on repetitive decisions while backlogs grow. Turnaround times slip, and provider abrasion increases.

Compounding the challenge are fraud, waste, and abuse (FWA), which represent a massive and growing drain. Industry estimates, for instance, put FWA at as much as 10% of total healthcare spending.[8] Traditional rules-based detection catches obvious patterns but misses sophisticated billing schemes, upcoding, and emerging fraud vectors. By the time issues surface in post-payment audits, money has already gone out the door.

Legacy claims platforms weren't built for this complexity. The result is high cost-per-claim, inconsistent decisions, payment leakage, and growing tension between payers and providers.

8 https://www.justice.gov/archives/jm/criminal-resource-manual-976-health-care-fraud-generally

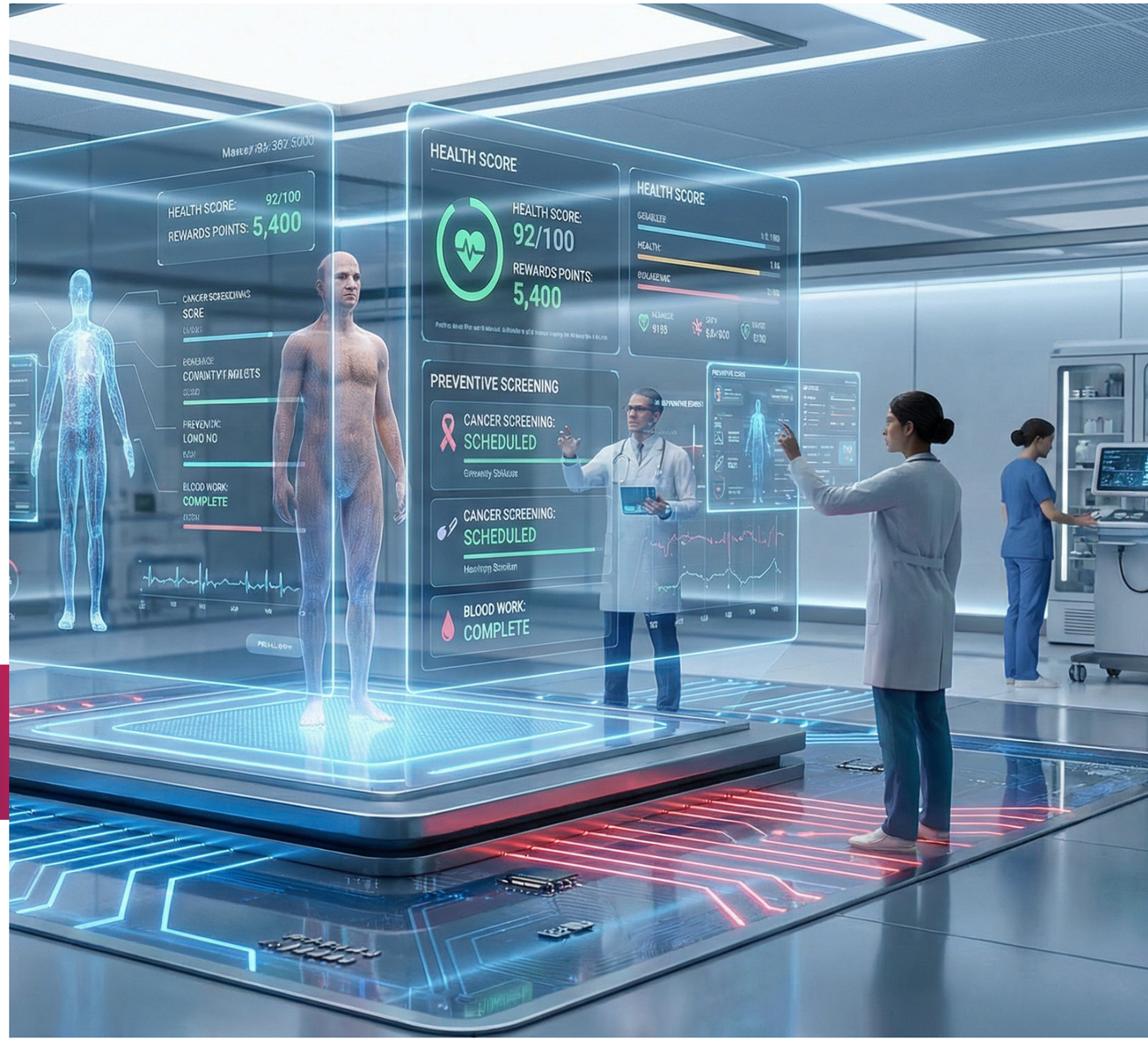
The Agentic AI Opportunity

Agentic claims operations don't stop at flagging issues. Rather, they act autonomously across the entire payment lifecycle.

- Intelligent adjudication agents can review clinical documentation, apply medical policies, and make payment determinations on complex claims that previously required manual review, learning from examiner decisions to improve accuracy over time.
- Payment integrity agents operate upstream, analyzing claims in real time to identify anomalies, fraud indicators, and billing irregularities before payment is issued. Rather than chasing dollars after the fact, payers are equipped to intervene early, reducing leakage and administrative rework.
- Appeals and grievances agents can gather relevant documentation, apply policy criteria, and prepare determinations, routing only genuinely ambiguous cases to human reviewers.

> Sutherland helps healthcare payers lower operational costs by 30% with 25% faster turnaround times.[9]

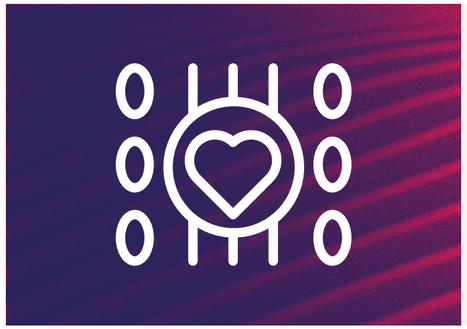
These agents don't operate in isolation. An orchestration layer coordinates end-to-end, so that when a claim is flagged for review, the system automatically gathers supporting documentation, applies relevant policies, and either resolves the issue or escalates it with full context. The goal is zero-touch processing for routine claims and intelligent augmentation for complex ones.



9 https://www.sutherlandglobal.com/industries/healthcare/payer

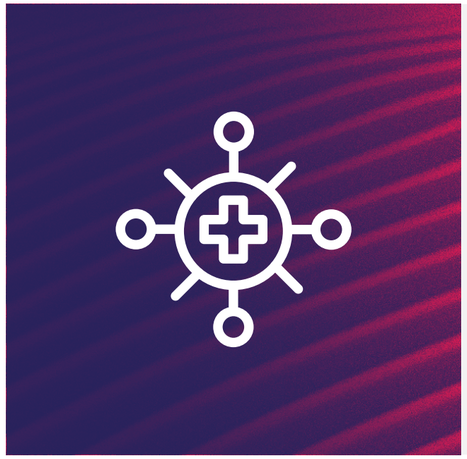
Practical Actions for Payer Leaders:

Target high-volume manual queues. Use **predictive modeling and forecasting techniques** to identify claim types that consistently require human review but follow predictable patterns. These are strong candidates for agentic adjudication, with autonomy applied to routine cases and escalation reserved for true exceptions.



Shift payment integrity upstream. Deploy **AI models** that score claims for fraud and abuse risk before payment, not after. Pre-payment intervention is far more cost-effective than pay-and-chase recovery.

Unify claims data. AI agents need complete, connected information to act effectively. Consolidate fragmented claims, clinical, and provider data using strong **data engineering** foundations to eliminate blind spots.



Integrate with core systems. AI agents must connect to claims platforms, clinical review systems, and payment engines. Legacy integration is often the first hurdle – **modernization and migration** strategies can address this systematically.

Measure outcomes that matter. Track cost-per-claim, auto-adjudication rates, turnaround time, and payment accuracy. These metrics translate directly to operational savings and provider satisfaction.

Opportunity 2:
Agentic Member Experience and Retention

The Challenge

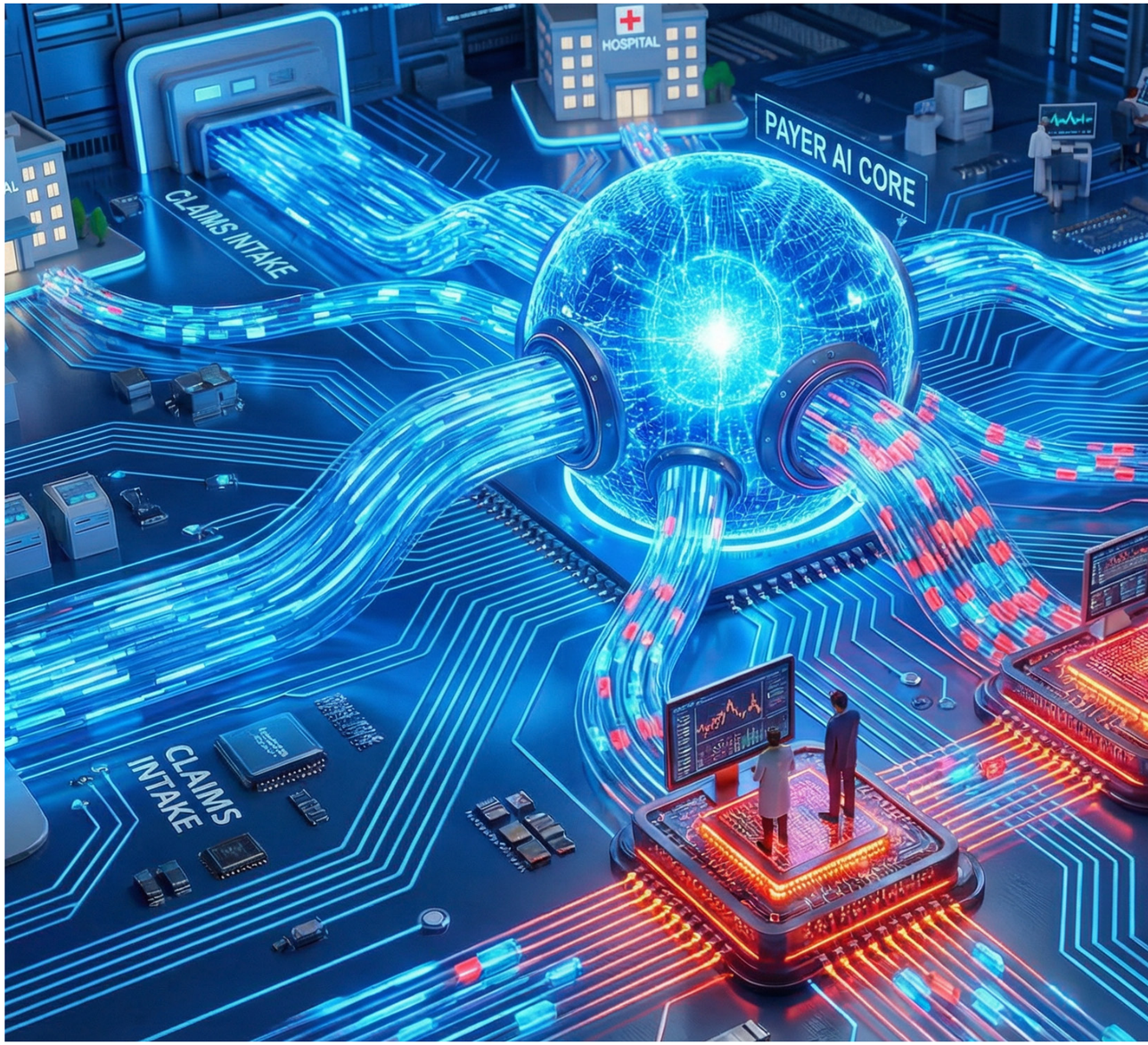
Members expect the same seamless digital experiences from their health plan that they get from retail and banking. However, many payers aren't delivering.[10]

On top of this, benefits are confusing. Members struggle to understand what's covered, how much they'll owe, and which providers are in network.[11] When they call for help, they wait on hold. And when they finally do reach someone, they often get transferred. Every friction point erodes trust and satisfaction.

Worse, most engagement is reactive. Payers typically hear from members when something goes wrong. That is, when a claim is denied, a bill is unexpected, or a provider isn't covered. By then, dissatisfaction has already set in. Proactive outreach, the kind that helps members navigate care, close gaps in preventive services, or manage chronic conditions, remains rare and difficult to scale.

The cost of getting this wrong is high. Member acquisition is expensive. Retention is everything, particularly in Medicare Advantage and individual markets where switching is easy. Yet fragmented systems mean that there is no single view of the member, leaving service teams responding to issues instead of anticipating them.

Put simply, traditional CRM and contact-center models were not designed for continuous, personalized engagement at scale.



10 https://www.kff.org/affordable-care-act/kff-survey-of-consumer-experiences-with-health-insurance/
11 https://www.benefitnews.com/research-report/continuing-care-in-the-face-of-costs-complexity-and-concerns

The Agentic AI Opportunity

Agentic member engagement orchestrates personalized experiences across channels, 24/7.

- Benefits navigation agents can help members understand coverage in plain language, estimate costs for planned procedures, and find in-network providers, all through conversational interfaces available anytime.
- Service resolution agents can handle common inquiries, from claim status to ID card requests to prior authorization questions, without human intervention, escalating seamlessly when complexity requires it.
- Proactive engagement agents can identify members at risk of disengagement or poor health outcomes, intervening with personalized outreach before problems escalate.
- Care gap agents can nudge members toward preventive services, medication adherence, and chronic condition management, improving outcomes while supporting quality scores.

These agents learn over time. They adapt communication channel, timing, and tone based on member behavior and preferences, and they coordinate across touchpoints so handoffs to human representatives happen with full context preserved.

Sutherland's payer member services engagements have delivered measurable improvements in contact center performance and member support outcomes, including 25% reduction in average handle time, 10–20% increase in Net Promoter Score (NPS) and 65% faster after-call work via AI.[12]

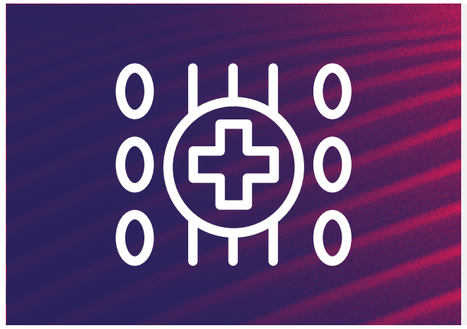
12 https://www.sutherlandglobal.com/industries/healthcare/payer/healthcare-payer-experience/healthcare-member-services

Practical Actions for Payer Leaders

Deploy conversational AI for high-volume inquiries. Benefits questions, claim status, provider search, and ID card requests are ideal starting points for **automated self-service interactions**. This frees service representatives to handle complex issues while giving members immediate, always-available support.

Build a unified member view. Integrate enrollment, claims, clinical, and service interaction data so AI agents have full context at every touchpoint using AI-powered analytics software. **Data engineering** foundations are essential to breaking down silos and enabling personalization at scale.

Shift from reactive to proactive. Use **AI** to identify members showing signs of disengagement or care gaps, then intervene with personalized outreach before they call with complaints or switch plans.



Customize channel and timing. Some members prefer app notifications, others want phone calls. Let AI agents learn preferences and adapt outreach accordingly with rich, **AI-powered customer engagement**.

Ensure seamless escalation. When AI can't resolve an issue, handoff to human representatives should include full context. Members should never have to repeat themselves.

Track experience metrics. Monitor NPS, first-contact resolution, service costs, and retention rates. In competitive markets, these numbers predict growth.

Opportunity 3:
Agentic Provider Network Management and Compliance

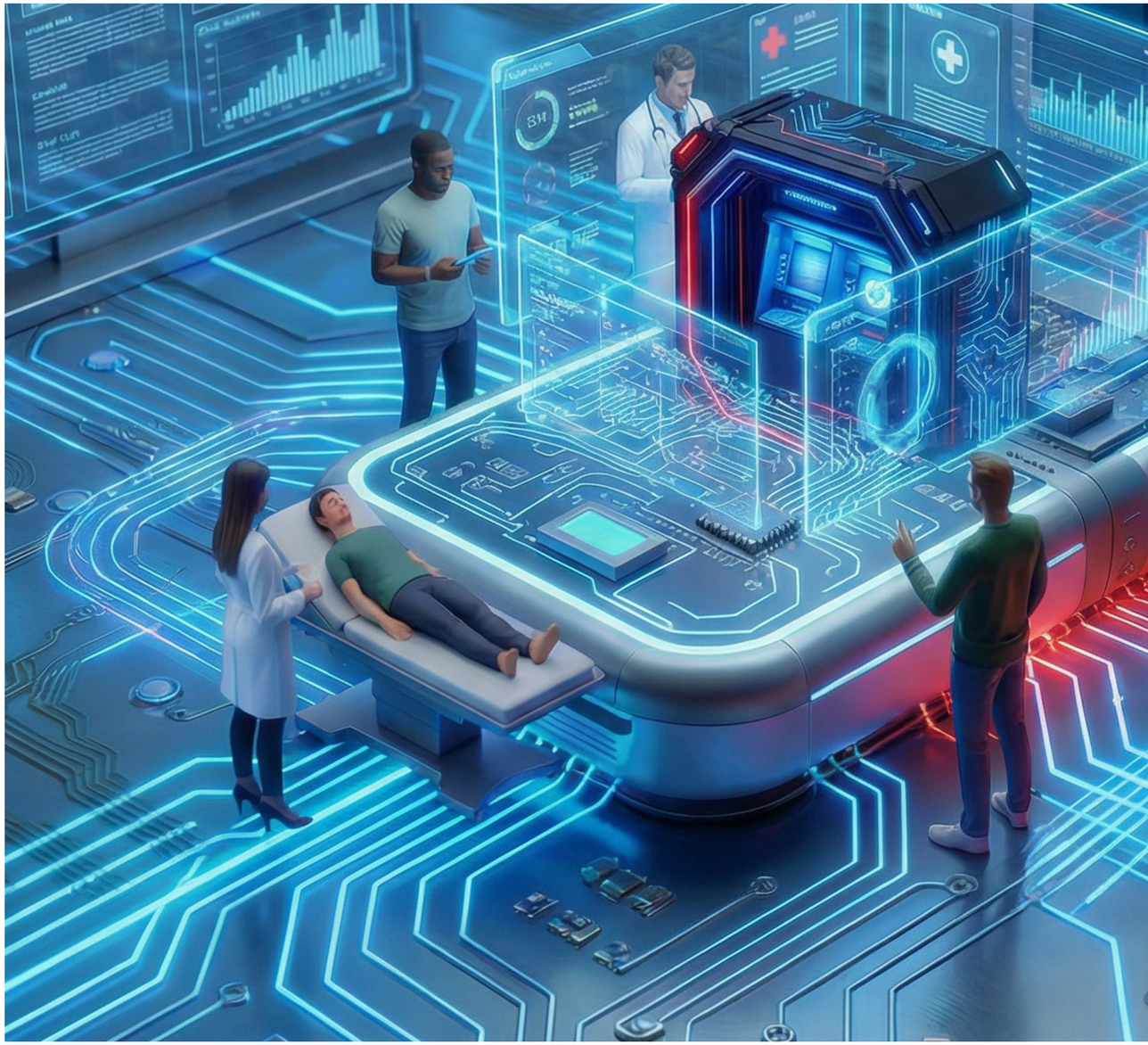
The Challenge

Provider networks are the backbone of every health plan but managing them has become a compliance minefield.

The No Surprises Act (NSA) demands accurate, up-to-date provider directories. CMS network adequacy standards require demonstrable access across specialties and geographies, and state regulators audit credentialing processes.[13] The penalties for non-compliance are strict, and the reputational damage from inaccurate directories erodes member trust.

Yet most payers still manage provider data through manual outreach and fragmented systems. Directory information decays quickly as providers change addresses, affiliations, and panel status. Credentialing backlogs delay provider onboarding, frustrating both providers and members. And on top of it all, compliance teams scramble to prepare for audits, pulling data from multiple sources which leads to reconciling inconsistencies.

The operational burden is enormous. And every error, whether a wrong address in a directory or a lapsed credential, creates risk.



13 https://www.cms.gov/medicare/health-drug-plans/network-adequacy

The Agentic AI Opportunity

Agentic network management keeps provider data accurate and credentialing current, continuously.

- **Directory integrity agents** can monitor provider information across sources, detect discrepancies, initiate outreach to verify changes, and update records automatically.
- **Credentialing agents** can orchestrate the verification process across multiple data sources, track documentation, manage follow-ups, and flag exceptions for human review.
- **Compliance monitoring agents** can continuously assess network adequacy, identify gaps before they become audit findings, and generate the documentation regulators require.

> Sutherland's SmartCred® platform cut credentialing turnaround by approximately 70% for a major health system, transforming a cumbersome, paper-based process into an efficient, standardized workflow. The same approach applies to payer credentialing at scale.[14]

These agents work together, coordinated by an orchestration layer that ensures provider data flows seamlessly from initial credentialing through ongoing directory maintenance. When a provider's status changes, the system detects it, verifies it, and updates all downstream systems without the need for manual intervention.

14 https://www.sutherlandglobal.com/products-x-platforms/smartcred

Practical Actions for Payer Leaders

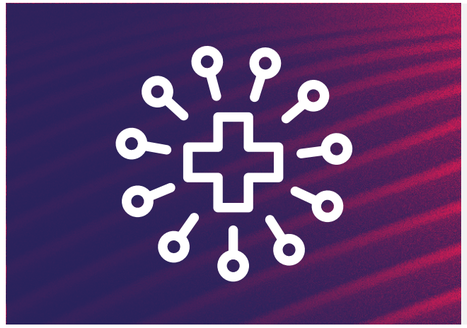
Automate ongoing credentialing and monitoring using end-to-end **credentialing services** to automate primary source verification, sanctions monitoring, and committee preparation while freeing specialists to focus on complex cases.

Automate directory verification. Deploy AI agents that continuously monitor and verify provider information, reducing reliance on periodic manual outreach. Accurate directories are a regulatory requirement and a member expectation.

Build continuous compliance monitoring. Shift from periodic audit prep to continuous monitoring by embedding regulatory requirements (e.g., NCQA, CMS network adequacy standards) into autonomous workflows that detect and escalate exceptions in real time. **Digital assurance** capabilities can validate data quality at scale.

Integrate provider data systems. Credentialing, contracting, and directory systems often operate in silos. **Application modernization** can connect these systems so changes flow through automatically.

Use shared credentialing models where applicable: Where multiple plans share overlapping networks, adopt **multi-payer credentialing** models to reduce redundant outreach, lower costs, and improve data consistency across payer partners.



Ensure secure, scalable infrastructure. Provider data is sensitive and voluminous. **Cloud infrastructure** optimization ensures your environment can handle AI workloads while maintaining compliance.

Measure network health. Track directory accuracy rates, credentialing turnaround time, and network adequacy metrics. These leading indicators predict compliance risk and provider satisfaction.

The Road to the Agentic Healthcare Payer

The agentic healthcare payer is already here, and it can help resolve critical issues impacting the industry and its customers right now. Managing claims complexity at scale, meeting member expectations for seamless experiences, and staying ahead of compliance requirements, are daunting. But they present an opportunity to lead the next evolution in the healthcare payer industry. In every era of healthcare transformation, organizations that innovated in operational efficiency and member value seized the advantage. This era is no different, except the innovation isn't a new product or distribution channel. It's a new mode of operating, where intelligence becomes operational and adaptive in every process.

Agentic capability relies on the right foundational elements. Explore Outlook 2026: The Road to the Agentic Enterprise **for the fundamentals every organization needs.**

Start with high-impact pilots:

- Deploy an AI-powered payment integrity model on a high-volume claim category.
- Pilot a conversational AI agent for member benefits inquiries.
- Roll out automated directory verification for a segment of your provider network.

Tangible wins in efficiency, accuracy, and experience will build momentum for broader transformation. Targeted initiatives will yield immediate ROI while laying the groundwork for scaled capabilities.

Healthcare payers that thrive in 2026 and beyond will be the ones driving change, not reacting to it. Agentic AI turns claims operations, member experience, and network management in your favor, if you're willing to pull the lever.

Disruption is inevitable. Make it intentional.