A Playbook for Healthcare Payers

Modernizing Health Plan Operations

Accuracy First. Faster Service. Lower Cost to Serve.

Members *remember* the answer

Health plans handle constant questions about coverage, benefits, claims, and prior authorizations. Members judge the plan by clarity and consistency. When the same question gets a different answer depending on who they reach, trust starts to break.

Am I covered? Why was this denied? What is my co-pay? Has my prior authorization gone through?

These questions should be resolved quickly. Instead, they often trigger repeat-contact loops. A portal shows one status. A representative says something else. A provider office calls again to confirm what the member was told. Each loop increases handle time, adds cost, and puts more work on already busy teams. Coverage explanations, required disclosures, and documentation have to stay consistent across internal teams and BPO partners. When answers drift, service slows down and risk goes up.

System and Hanoff

The same question can produce different answers because the work is split across systems, scripts, and teams. Eligibility, benefits, claims, and prior authorizations sit in separate workflows and tools. Representatives and BPO partners often have to pull information from multiple systems while the member is waiting on the line.

Scripts, language, and documentation change across channels and representatives. Notes depend on who handled the interaction and how they summarized it. When the member calls back, the next representative starts with a different context, and the answer changes again.

Provider offices call for updates and confirmations, often covering the same ground because statuses change across systems or get interpreted differently. Handoffs multiply there.

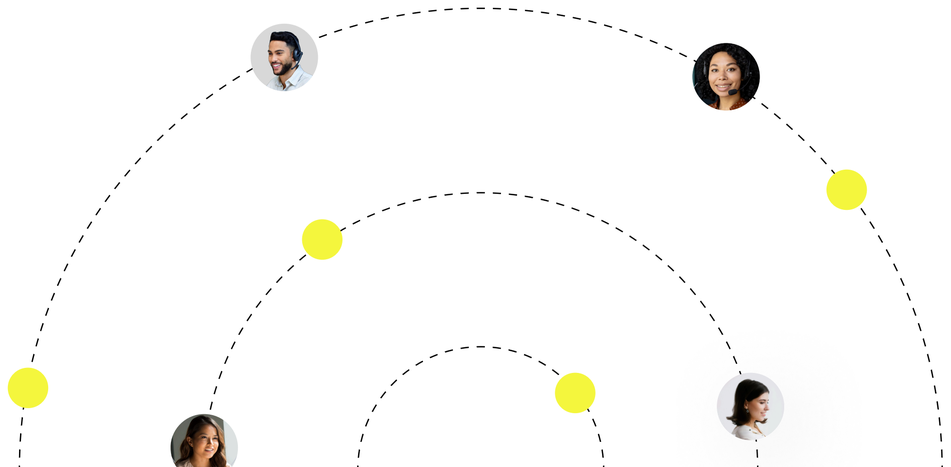
Supervisors can review only a small portion of interactions, so inconsistencies spread across teams and partners. Problems get noticed late when audits or member complaints force attention.

Accuracy under *strict compliance*

Health plan support runs under strict requirements because these conversations involve sensitive health information and regulated communication. Coverage explanations, denial language, and prior authorization updates have to align with HIPAA, CMS expectations, and plan-specific policies.

Small wording differences create extra work later. When a denial is explained one way on the phone and another way in a portal, it triggers confusion and call-backs. Provider offices call again to confirm what they should tell the member. Appeals and complaints increase when members feel the rules change depending on who they reach.

Consistency matters as much as speed. Health plans need routine answers that stay aligned across internal teams and BPO partners, supported by documentation that matches what was actually said.



Volume grows *in the gaps*

Portals and IVRs usually provide a status without explaining the logic behind it. Payer workflows often carry multiple versions of the truth at once. A member sees a pending notification. A provider sees a request for medical necessity. A representative sees a coding error or a missing document. Each party is looking at a different fragment of the same event.

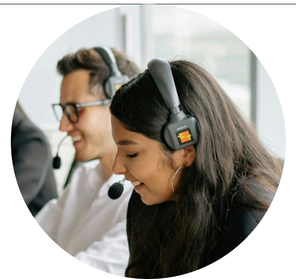
Calls rise as those fragments pull apart. A simple prior authorization check turns into a clinical documentation discussion because the self-service view cannot connect the dots. By the time the interaction reaches a person, the representative often lacks the full story or the specific reason for the delay. The member repeats details. Provider offices call back because they are stuck between the plan and the patient with no clear next step.

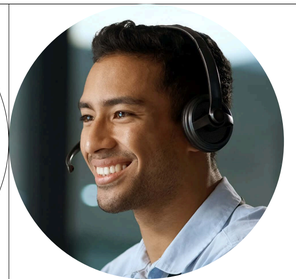
Accolade reduced after-call work by more than 50 percent by improving documentation and QA. Representatives spent less time rebuilding notes and more time resolving member problems.(1)

Automation that helps Payers

Members, providers, and representatives often get different answers to the same question. Answer the frequent questions the same way every time. When basic calls stop producing different answers, volume starts to drop.

Identity verification, eligibility, benefit limits, claim status, and simple updates should end with the member and provider on the same page, without a second call. Verification steps and disclosures stay the same. The documentation reflects what was actually said.





Support to *carry weight*

Some calls carry more weight. Coverage decisions, coordination of benefits, appeals, and complaints. These conversations move quickly from what happened to what it means. Representatives need the last interaction, the language already used, and the documentation tied to the status. The next call starts from the same facts. That reduces repeat calls, lowers provider callbacks, and cuts the cleanup work behind the scenes.

Signify Health used real-time AI Copilots and automated QA in high-volume scheduling and insurance-update work. New hires reached proficiency 12 percent faster. Proficiency rose from 70 percent to 82 percent in a year. QA coverage expanded from around 70,000 calls annually to about 65 million. (3)

Oversight *day to day*

Health plan support runs under strict requirements because these conversations involve sensitive health information and regulated communication. Coverage explanations, prior authorization updates, and plan-policy language have to align with HIPAA, CMS expectations, and plan-specific rules. That standard has to hold across internal teams and BPO partners.

MaxorPlus is a pharmacy benefit manager that needs speed without losing accuracy. They added real-time guidance and conversation intelligence to support member calls. Average handle time dropped by 7 percent, while QA scores improved and member satisfaction rose. (4)

Verida coordinates Medicaid and Medicare transportation and handles around 3 to 4 million calls annually. They added real-time agent assistance and automatic redaction to protect sensitive data. Leaders gained clearer visibility into calls while keeping patient information secure. (5)

One answer across *every channel*

Lower cost to serve comes from less reconciliation work. One answer has to hold across channels. The explanation a provider office receives should match what the member hears, using the same policy language and the same status interpretation.

Routine demand carries most of the daily load. Identity verification, eligibility, and claim status should close cleanly without extra interpretation in the middle. Automation helps most here when verification steps and disclosure handling stay consistent, so the result does not depend on who picked up the interaction.

Complex cases move faster when the last touchpoint and the current status are visible, with the language already used and documentation attached. Broad visibility across interactions helps leadership spot where answers are drifting across teams and partners early enough to correct it.

Personify Health expanded QA coverage from about 2 percent of calls to full coverage across all interactions. Leaders got a consistent view of agent performance, and coaching became more effective.(2)

Fast and consistent

Health plans shape how affordable and reliable care feels long before treatment begins. By clearing repetitive administrative work, supporting teams during complex conversations, and keeping continuous visibility into quality and compliance, health plans can remove the bottlenecks that frustrate members and drive up costs.

The result is faster answers, less administrative load, and experiences built on clarity, consistency, and trust.

Accolade
PERSONALIZED HEALTHCARE

Accolade uses Observe.AI to automate after-call work and deploy AI Agents that route calls and contain common member inquiries before they reach a human, reducing after-call work by more than 50%. By handling routine topics up front and directing more complex needs to the right Care Advocate, the team spends less time on admin and more time engaging members. The result is faster resolution, higher productivity, and a more consistent experience across every interaction.

50%
Over 50% reduction in after-call work

100%
Visibility into customer conversations

20%
Faster routing time with AI Agents

signifyhealth

Signify Health adopted Observe.AI's Real-time Agent Assist and Auto QA to support onboarding and coaching at scale, which boosted new-hire proficiency by around 12% and helped audit far more calls than before. The tools also improved how agents handle objections, driving a roughly 4-point lift in conversion rates and giving quality teams deep insights across millions of interactions

12%
Increase in speed to proficiency

65M
Calls audited annually, up from 70K

34%
Conversion rate, up from 30%

Get started today