Insurance Vertical

Health Insurance Payers

(Sub-vertical)

Top 10 Customer Questions

FY27 GTM | Updated Feb 2026

These are the top 10 questions we are hearing from health plan executives, managed care organizations, and payer IT leaders — drawn from field intelligence, the Insurance Industry Overview FY27, and healthcare regulatory trends. Questions are in the **customer's voice**. Answers are in the **Workato seller / partner voice**.

Questions at a Glance

01 "Claims adjudication is our biggest cost center. Can AI auto-adjudicate clean claims?" *(Health plans)*

02 "CMS is mandating FHIR-based prior authorization APIs. We're not ready." *(Medicare Advantage)*

03 "Our member experience scores (CAHPS) are below target. Call center is overwhelmed." *(Commercial/MA plans)*

04 "Provider directory accuracy is a compliance nightmare. CMS audits are coming." *(All health payers)*

05 "We need to close care gaps for Star Ratings but can't do outreach at scale." *(Medicare Advantage)*

06 "Our systems are a patchwork — FACETS, Salesforce, Workday, clearinghouses..." *(Health payer IT)*

07 "How do we use AI for member services without violating HIPAA?" *(All health payers)*

08 "Medical costs are rising faster than premiums. We need to cut admin costs." *(Commercial plans)*

09 "Credentialing new providers takes weeks. It's blocking network adequacy." *(Managed care orgs)*

10 "We're a regional health plan. How fast can we deploy with a lean IT team?" *(Regional payers)*

Data Sources: Salesforce CRM (Healthfirst $733K, Oscar Health $92K, HealthEquity $99K, Bind Benefits $88K, Everlake Services $130K, Iowa Bankers Insurance $69K), Gong calls (Fullerton Health), Insurance Industry Overview FY27 (health payer sections), WSS Value Framework.

Question 01

“Claims adjudication is our biggest cost center. 25-30% of our spend is administrative. Can AI auto-adjudicate clean claims and route only exceptions to human reviewers?”

Heard from: Health plan operations leaders, claims VPs seeking to reduce cost-per-claim

Claims auto-adjudication is the highest-ROI automation in health insurance. The math is simple: if 60-70% of your claims are “clean” (match policy rules, have valid codes, pass edits), they shouldn’t require human touch.

Workato’s claims automation:

- Claim received → IDP extracts data from HCFA/UB-04 forms, medical records, and supporting documents
- Auto-adjudication engine applies your benefit rules, medical policies, and coding edits (CPT, ICD-10, DRG)
- Clean claims auto-pay with proper EOB generation and member notification
- Exception claims route to appropriate review queue (medical review, coding review, SIU) with all supporting data pre-assembled
- Every decision logged with immutable audit trail — CMS can see exactly how each claim was processed

The industry benchmark: reducing cost-per-claim by 30-40% through straight-through processing of clean claims. Enterprise MCP extends this by enabling AI agents that can answer member questions about claims status in real time.

Question 02

“CMS is mandating API-based prior authorization with FHIR R4 compliance. The deadline is approaching and we’re not ready. How fast can you help us get compliant?”

Heard from: Medicare Advantage plans, commercial payers facing CMS interoperability mandates

This is one of the most urgent regulatory drivers in health insurance. CMS’s Prior Authorization Rule (CMS-0057) requires payers to implement FHIR-based prior auth APIs. Non-compliance means penalties and CMS scrutiny.

Workato’s CMS compliance solution:

- FHIR R4 API layer connecting your UM/prior auth system, clinical rules engine, and provider-facing portal
- Automated prior auth workflow: request intake → clinical criteria check → auto-approve or route for medical director review
- Provider access APIs per CMS requirements — real-time prior auth status, formulary data, cost transparency
- Patient Access API for member-facing data (claims, EOBs, provider directory)
- Full audit trail for CMS audit readiness

Pre-built connectors for HealthEdge, FACETS, TriZetto, Availity, and Change Healthcare mean you’re not building from scratch. Weeks to compliance, not the 12-18 months a custom build requires.

Question 03

“Our CAHPS scores are below target and our call center is overwhelmed with routine inquiries — claims status, benefits questions, prior auth status. How do we improve member experience without doubling staff?”

Heard from: VP of Member Experience, Medicare Advantage plans where Star Ratings impact bid premiums

Member experience is directly tied to revenue in Medicare Advantage — every Star Rating point impacts CMS quality bonus payments. AI-powered member support is the fastest path to improvement.

Enterprise MCP for member support:

- Member Support Genie handles 60%+ of routine inquiries: claims status, benefit questions, ID card requests, PCP changes
- AI agent connects to claims, eligibility, PBM, and care management systems through governed MCP servers
- HIPAA-compliant: PHI automatically obfuscated, member authenticated before any account data is accessed
- Complex inquiries escalate to human agents with full member context pre-assembled — reducing handle time
- Proactive outreach: Automated care gap reminders, preventive screening notifications, enrollment period communications

Healthfirst ($733K ARR) runs mission-critical operations on Workato. The platform handles the complexity of health payer operations at scale.

Question 04

“Provider directory accuracy is a compliance nightmare. CMS is auditing directories and we have data in 5 different systems that never matches. How do we fix this?”

Heard from: Health payers facing CMS Directory Accuracy requirements, network management teams

CMS provider directory accuracy mandates are creating real consequences for non-compliant payers. The root cause is always the same: provider data lives in your credentialing system, your claims system, your provider portal, your CRM, and your public directory — and they’re never in sync.

Workato’s provider data management:

- Single source of truth: Orchestrate provider data across all systems so updates propagate in real time
- Automated credentialing workflows: Application intake, primary source verification, committee routing, approval, and directory publication
- Automated outreach: Verify provider contact info, hours, and accepting-new-patients status on CMS-required cadence
- Directory publication: Approved changes automatically publish to member-facing directory, CMS submission files, and provider portal

Every update is logged with audit trail for CMS examination. The alternative — manual quarterly directory reviews — is slow, expensive, and still produces inaccurate data.

Question 05

"Our Star Ratings depend on closing care gaps — preventive screenings, chronic disease management, wellness visits. But we can't do proactive outreach at scale with our current team."

Heard from: Medicare Advantage plans, quality improvement teams, HEDIS coordinators

Care gap closure directly impacts Star Ratings, which directly impact CMS quality bonus payments — potentially tens of millions of dollars for a mid-size MA plan.

Workato's care gap playbook:

- Aggregate member data from claims, clinical, lab, pharmacy, and HRA sources to identify who needs outreach
- Automated, personalized outreach via member's preferred channel — SMS, email, member portal, IVR
- AI-powered Genies handle member responses: schedule appointments, answer questions, update care plans
- Real-time HEDIS measure tracking: Monitor closure rates, identify at-risk measures, prioritize outreach
- Enterprise MCP ensures all PHI handling is HIPAA-compliant with full audit trails

The ROI calculation: If closing one additional Star Rating point generates $X million in CMS bonus payments, even a 5% improvement in care gap closure rates can deliver massive returns.

Question 06

"Our systems are a patchwork — FACETS for claims, Salesforce Health Cloud for CRM, Workday for HR, multiple clearinghouses, pharmacy benefit carve-outs. Nothing talks to anything else."

Heard from: Health payer CIOs managing legacy-heavy IT estates

Health payer IT estates are among the most complex in any industry. Decades of acquisitions, regulatory mandates, and vendor-specific solutions have created massive integration debt.

Workato connects the health payer stack:

- Claims/core: FACETS, HealthEdge, TriZetto/Cognizant, QNXT — pre-built connectors
- CRM: Salesforce Health Cloud, Microsoft Dynamics
- HR/Finance: Workday, ADP, Oracle, SAP, NetSuite
- EDI/Clearinghouses: Availity, Change Healthcare, Emdeon — 837/835/834/820 transactions
- Care management: Arcadian, Health Catalyst, Salesforce Health Cloud
- PBM: Express Scripts, CVS Caremark, OptumRx

Workato replaces the patchwork of point-to-point interfaces with a single orchestration layer. New integrations take weeks, not the months your current custom development requires.

Question 07

“We want to use AI for member services, prior auth, and claims processing. But HIPAA is non-negotiable. How do you handle PHI with AI agents?”

Heard from: All health payers, CISOs and compliance officers evaluating AI platforms

HIPAA compliance is the absolute prerequisite for any AI deployment in health insurance. Enterprise MCP was built with healthcare-grade security:

- Automatic PHI obfuscation: Member names, IDs, diagnosis codes, and clinical data masked before reaching any AI model
- HIPAA-ready architecture with Business Associate Agreement (BAA) support
- Patented runtime user authentication: AI agents inherit the specific staff member’s access permissions
- Immutable audit trails for every AI action — required for HIPAA breach investigation and OCR reviews
- SOC 2 Type II, ISO 27001, HIPAA-ready, GDPR compliant

The result: Your AI member support agent can check claims status, verify eligibility, and schedule appointments — but only for authenticated members, only with authorized data, and with every access logged.

Question 08

“Medical loss ratio pressure is real — medical costs rising faster than premiums. Where does automation cut our administrative spend without impacting member care?”

Heard from: Commercial health plan CFOs, payer operations leaders focused on admin cost reduction

Administrative costs represent 25-30% of health insurance spending. Automation targets the administrative spend without touching medical costs:

Highest-impact admin automation:

- Claims auto-adjudication: 60-70% straight-through processing for clean claims (30-40% cost-per-claim reduction)
- Prior authorization automation: Reduce PA turnaround from days to hours, cut denial rework
- Member enrollment and eligibility: Automated 834 processing, eligibility verification, ID card generation
- Provider credentialing and contracting: Weeks to days for new provider onboarding
- Shared services: HR, finance, IT back-office — the unglamorous automation that compounds savings

Every point of admin cost reduction either improves your MLR or drops to the bottom line. Workato delivers weeks-to-production for these workflows.

Question 09

“Credentialing new providers takes 4-6 weeks. It’s blocking our ability to build adequate networks, especially in underserved areas where we need providers fast.”

Heard from: Managed care organizations, Medicaid MCOs, health plans expanding networks

Provider credentialing is one of the most process-heavy, document-intensive workflows in health insurance — and automation delivers dramatic improvements:

Automated credentialing workflow:

- Application intake: Provider submits through portal → Workato captures and validates completeness
- Primary source verification: Automated checks against NPDB, state licensing boards, DEA, malpractice carriers, education verification
- Committee routing: Clean applications auto-advance through credentialing committee workflow with pre-assembled dossier
- Approval triggers: Directory update, contract execution, system access provisioning — all automated

Vituity (healthcare provider) used Workato to automate physician credentialing and saved up to 10 hours per hire, accelerating onboarding by 40%. The same pattern applies to health plan credentialing from the payer side.

Question 10

"We're a regional health plan with 500K members. We don't have the IT budget or team size of a UnitedHealth or Anthem. Can we realistically deploy this?"

Heard from: Regional health plans, Medicaid MCOs, mid-market payers with lean IT

Regional health plans are actually ideal Workato customers because the pain is acute and the ROI is proportionally larger — you can't afford the inefficiency of manual processes OR the cost of custom development.

Realistic timeline for a regional health plan:

- Week 1: Environment provisioned, FACETS/claims and Salesforce connectors configured
- Week 2-3: First workflows live (enrollment processing, eligibility sync, claims routing)
- Week 3-4: Prior auth automation and provider data management
- Month 2: Enterprise MCP for AI member support agents

Why it works for regional plans:

- Low-code: Your existing team builds and maintains — no integration specialist headcount
- Pre-built connectors for FACETS, HealthEdge, Availity, Salesforce Health Cloud, Workday
- HIPAA-ready from day one — no additional security architecture

Healthfirst ($733K ARR), Oscar Health ($92K), HealthEquity ($99K), and Everlake ($130K) run health payer operations on Workato today. Enterprise MCP is GA and included with Workato ONE.