

# The Future of Health Operations: 2030 and Beyond



# Executive summary

## How smarter systems will shape better care

Healthcare is entering a decade of transformation. By 2032, U.S. healthcare spending is projected to reach \$7.7 trillion — growing faster than the economy and intensifying pressure on payers to do more with less.<sup>1</sup> Meanwhile, workforce shortages, regulatory demands, and legacy systems continue to stretch operational capacity and erode trust among members and care providers.

The industry's future will be defined by those who act now. Health plans that modernize operations, integrating automation, analytics, and human-centered design, will set the standard for affordability, accuracy, and experiences.

Carelon Global Solutions was built for this moment. As part of a leading healthcare enterprise, we bring the deep payer expertise and global scale necessary for smarter, connected operations.

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### Our results to date<sup>2</sup>

**12%** annual savings in claims operations

**99%** quality compliance in clinical services

**20%** faster turnaround across critical processes

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By partnering with us, health plans can achieve measurable value and build connected, intelligent operations to thrive in 2030 and beyond.

### The five core hallmarks of transformation



Platform-agnostic systems



Automation-first workflows



Data-driven precision



Global, skilled talent



Human-centered design

# The 2030 imperative: operational change can't wait

The healthcare system stands at a critical inflection point. By 2032, U.S. healthcare spending is projected to reach **\$7.7 trillion, growing 5.6% annually — roughly 1.3 percentage points faster than GDP growth.**<sup>1</sup>

To make matters more complex, administrative costs are rising, regulatory expectations are tightening, and an aging population is intensifying the demand for care, even as the workforce continues to shrink. These converging forces have created an unsustainable equation for health plans: higher costs, greater complexity, and shrinking capacity.

For payers, the next five years will define the next 15. The question is no longer whether operations will transform, but how quickly and how intelligently that transformation happens. Organizations that invest now in smarter, connected operations will be positioned to deliver more affordable, more human, and higher-quality healthcare experiences in the future.

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We can't wait for healthcare to right itself. To lower administrative costs and elevate customer experiences, health plans have to evolve their operations now.”

— Christiane Shah, Vice President,  
Carelon Global Solutions U.S.

# A closer look at the macro shifts reshaping operations



## Rising costs and unsustainable complexity

A significant portion of every health dollar goes to administrative overhead, much of it tied to redundant systems and manual workflows. The resulting operational drag inflates costs, slows innovation, and strains trust among members, care providers, and partners.

## Workforce shortages and skill gaps

By 2030, the U.S. healthcare industry may face a shortage of up to 3.2 million workers, from nurses to specialized operational staff.<sup>3</sup> These gaps threaten payer service quality and compliance as experienced talent becomes harder to hire and retain.

## Regulatory pressure and compliance risk

Compliance-related administrative costs for health plans are rising significantly, driven by complex regulatory changes, increased reporting requirements, and high labor expenses. In fact, administrative costs for plans grew from roughly \$72 billion in 2014 to \$131 billion in 2024.<sup>4</sup>

## Digital disruption and the rise of intelligent automation

Data integration, advanced analytics, and digital tools are redefining operational efficiency. However, many health plans remain constrained by legacy platforms that limit scalability and insight.

**\$59B**

Estimated increase in administrative costs from 2014 to 2024

**3.2M**

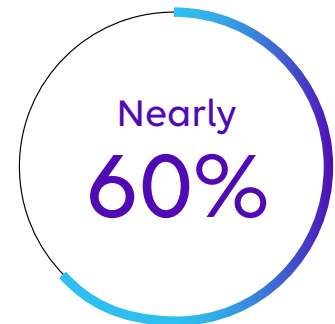
The shortage of workers the U.S. healthcare industry may face by 2030

# The specifics: where the system is breaking down

Most operational architectures were designed for a healthcare system that no longer exists — one defined by siloed data, fragmented workflows and technology environments that evolved faster than they were integrated.

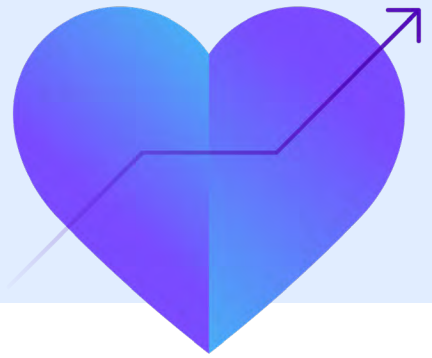
As transaction volumes grow, health plans are managing increasing complexity across claims, networks, and member interactions. Still, inefficiency remains embedded in core operations. Understanding where these breakdowns occur is essential to designing a system that can scale for the future.

Let's explore the operational fractures preventing payer progress.



Payers who cite legacy technology as their top barrier to operational efficiency<sup>5</sup>

# 5 operational fractures limiting progress



## 1.

### **Fragmented technology systems**

Health plans often operate across numerous core and ancillary systems that do not communicate with each other in real time. Over time, mergers, acquisitions, and system layering have produced siloed data environments that slow decision making and duplicate effort. The absence of a unified operational backbone limits transparency across claims, care provider, and clinical workflows, increasing error rates and rework.

### **The takeaway:**

Legacy technology systems remain one of the most frequently cited barriers to operational efficiency, limiting visibility and making interoperability difficult to achieve particularly as Centers for Medicare & Medicaid Services (CMS) requirements continue to evolve.<sup>5</sup>

## 2.

### **Manual processes and limited automation**

Across payer operations, a significant share of administrative work remains manual, even in functions that could be automated today. Manual claims edits, care provider data updates, and utilization review steps consume staff time and introduce variability in speed and accuracy.

### **The takeaway:**

Many organizations have launched automation initiatives, but they frequently stall due to governance gaps, data quality challenges, or the absence of an enterprise-wide strategy. The results are incremental and not the transformation payers need.

## 3.

### **Data quality and accuracy challenges**

Poor data integrity remains one of the most persistent and costly operational challenges. Inaccurate care provider data, outdated rosters, and inconsistent member information lead to denied claims, delayed payments, and increased compliance exposure. Regulatory scrutiny has intensified as a result. CMS has expanded enforcement around care provider directory accuracy and related requirements, with penalties that can be significant in Medicare Advantage compliance cases.<sup>6</sup>

### **The takeaway:**

These pressures have elevated data governance from an operational concern to a board-level priority.

## 4.

### **Disconnected member and care provider experiences**

For members and care providers, operational inefficiency is personal. Long call wait times, inconsistent information, and limited first-contact resolution erode trust and satisfaction. Industry research consistently shows that a meaningful portion of health plan inquiries require multiple interactions to resolve, driving frustration and avoidable cost.<sup>8</sup>

Care providers experience similar friction, with administrative burden frequently cited as a leading contributor to dissatisfaction and burnout.

### **The takeaway:**

When operational processes break down, experience suffers and with it, retention, Star Ratings, and financial performance.

## 5.

### **Limited accountability and unclear measurements**

Even with dashboards and key performance indicators, many plans lack end-to-end visibility into operational performance. Metrics are often siloed by department, preventing a single source of truth for accuracy, turnaround time, and satisfaction. Without standardized benchmarks, it becomes difficult to quantify progress or hold vendors accountable for outcomes.

### **The takeaway:**

Without clear ownership and unified governance, transformation efforts struggle to scale and sustain impact. Improvement initiatives may show early promise, but without alignment across technology, process, and accountability, impact is difficult to maintain.

# The future operating model



The health plans of 2030 will look, operate, and perform very differently from the plans of today. To meet new expectations around affordability, simplified processes, accuracy, and access, operations must evolve beyond fragmented transactions into unified, intelligent systems that seamlessly connect members, care providers, and partners.

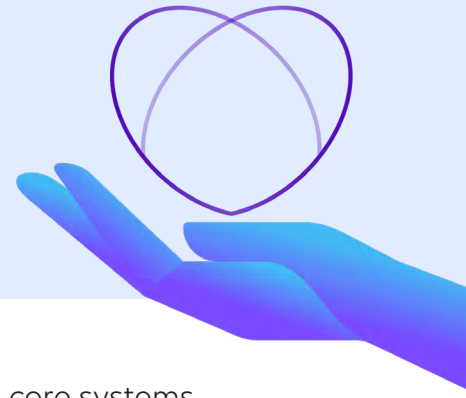
The key to doing so is implementing five hallmarks of a successful operating model.

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**A future-ready operating model is platform agnostic, automation first, and driven by real-time insight, but it's ultimately measured by the human experience it enables. When we combine global talent with human-centered design, we deliver speed and accuracy without losing empathy.”**

— Nicki Agcaoili, Vice President, Chief Country Executive, Carelon Global Solutions Philippines

# 5 hallmarks of the 2030 operating model



## Platform-agnostic systems

Payers will move beyond dependence on single core systems to embrace platform-agnostic interoperability. Integration across claims, clinical, care provider, and experience functions will become the norm, not the aspiration.

Through open Application Programming Interfaces and data lakes, leading organizations will connect legacy and cloud systems into a cohesive operational layer that supports real-time transparency, governance, and analytics. Organizations that achieve strong data interoperability consistently report meaningful reductions in administrative cost and improvements in turnaround time and compliance accuracy.



## Automation-first workflows

Automation will no longer be a project. It will be the operating default. Repetitive, rules-based tasks — from claims adjudication to care provider data validation — will be fully automated through intelligent bots and decisioning engines, while human expertise focuses on exceptions, problem solving, and continuous improvement.

This shift can deliver measurable results, including double-digit administrative cost savings, faster cycle times, and significant error reduction.<sup>7</sup> Automation-first models create agility and scalability, allowing payers to adapt to new mandates, pricing models, and market shifts without reengineering entire systems.



## Data-driven precision and insight

Future-ready payers will rely on data as infrastructure, not just as a reporting tool. Predictive analytics and advanced models will anticipate utilization trends, identify anomalies, and guide decision making in real time.

Automated data reconciliation and anomaly detection have helped payers materially reduce claim rework and improve accuracy by reinforcing the role of analytics as a performance enabler rather than a retrospective lens. This shift allows health plans to move from reactive problem solving to proactive, insight-led performance management.



Global, skilled,  
and scalable talent

Healthcare’s workforce challenge will be solved not by working harder, but by working smarter — through right-shored, specialized teams that blend domain expertise, clinical training, and digital fluency.

Global delivery models allow payers to maintain continuity, responsiveness, and quality while managing costs. Organizations using hybrid delivery approaches consistently report meaningful efficiency gains and stronger talent retention compared to fully onshore models.<sup>6</sup> Continuous upskilling — including nurse, coder, and operations academies — ensures quality is sustained even as technology and regulatory requirements evolve.



Human-centered  
design and empathy

In 2030, technology and experience will each play a role. Leading health plans will design workflows around the people they serve: members seeking clarity, care providers navigating authorizations, and employees managing complex cases.

Organizations that embed empathy training and feedback loops into contact center operations consistently achieve higher member satisfaction, supported by AI-assisted guidance and unified desktops that make interactions simpler and faster.<sup>8</sup> Human-centered design ensures that automation enhances rather than replaces trust, clarity, and connection.

## Outcomes of smarter operations

When these five hallmarks come together, payers can achieve a system that is not only more efficient but also more human. At Carelon, we’re leading that evolution today, helping health plans modernize at scale through intelligent automation, analytics, and global expertise.

Outcome	Projected impact by 2030 <sup>2</sup>
<b>Affordability</b>	10–15% administrative cost reduction through automation and global delivery
<b>Accuracy</b>	Over 99% claim and coding precision with fewer denials and rework
<b>Speed</b>	20% faster turnaround across claims and authorizations
<b>Experience</b>	Over 20% improvement in member and care provider satisfaction
<b>Compliance</b>	Continuous audit readiness and reduced regulatory risk

# Proof in practice

The 2030 operating model is improving health plan performance. The following examples illustrate proven outcomes, powered by Carelon technology, analytics, and talent.



## Customer experience: empathy at scale

### Challenge

A national health plan needed to modernize contact center operations after member satisfaction dropped due to long hold times and inconsistent call resolution.

### Solution

We deployed an omnichannel solution that unified voice, chat, and secure messaging through a single platform. Agents received targeted training to strengthen empathy and problem resolution. Intelligent automation deflected 20% of routine calls through a virtual assistant, while digital dashboards provided real-time visibility into quality metrics.

### Outcome

- 23% reduction in average handle time
- 20% decrease in call volume through automation
- 98% issue resolution rate across 18 million inquiries annually
- Improved member satisfaction scores (+18 Net Promoter Score points)

### Impact

By blending human empathy with digital enablement, we helped the health plan deliver faster, consistent, and human-centered experiences.

Source: Carelon Global Solutions: *Client Case Study: U.S. Health Plan CX Transformation (2024)*.



## Claims management: accuracy that pays

### Challenge

The client's claims operation was managing over 25 million manual claims annually but struggled with inconsistent adjudication accuracy, high rework volumes, and extended turnaround times. This led to increased administrative costs, delayed care provider payments, and elevated compliance risk — putting pressure on both operational margins and customer experience.

### Solution

We implemented digital tools, integrating automation across intake, pricing validation, and audit functions. The program leveraged predictive models to identify anomalies, reduce duplicate reviews, and streamline manual rework.

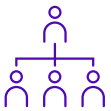
Source: Carelon Global Solutions: *Client Case Study: Claims Modernization Initiative* (2024).

### Outcome

- 12% year-over-year cost savings in claims operations
- 99.4% financial accuracy and 99.3% of claims processed within 30 days
- 20% improvement in workflow efficiency
- 600+ automation bots deployed across claims functions

### Impact

The client achieved faster, more accurate payments while reducing administrative burden and compliance risk. The transformed claims operation is now scalable, audit ready, and insight driven, enabling improved care provider satisfaction and positioning the organization for future growth and regulatory change.



## Care provider network operations: precision and compliance

### Challenge

A regional payer faced recurring CMS penalties for inaccurate care provider directories and long onboarding timelines.

### Solution

We implemented models to automate updates across 15+ roster formats and standardize data intake, validate data, and accelerate care provider onboarding across multiple roster formats.

Source: Carelon Global Solutions: *Provider Network Optimization Engagement* (2024).

### Outcome

- 500% reduction in onboarding time (30 days to less than five days)
- 73% error elimination through automation
- 99.4% care provider data accuracy maintained across 5.2 million records
- 93% directory accuracy, surpassing CMS compliance thresholds

### Impact

The client not only avoided regulatory fines, but also improved care provider satisfaction and network accessibility for members.



## Clinical operations: speed to care

### Challenge

A large multistate health plan needed to improve prior authorization turnaround times and reduce nurse attrition rates in its utilization management operations.

### Solution

We built a digitally enabled clinical operations model with a scalable workforce of U.S. and Philippines registered nurses (RNs), supported by a proprietary nurse training academy and digitally assisted triage tools.

Source: Carelon Global Solutions: *Clinical Operations Transformation* (2024).

### Outcome

- 130,000 prior authorizations reviewed per month
- 99% turnaround time compliance
- 60% U.S. RN retention, exceeding market averages by 20%
- 10% reduction in average request handle time

### Impact

The client achieved faster decisions, higher nurse satisfaction, and improved care quality — proving smarter operations also elevate care delivery.



## Risk adjustment and quality performance: revenue and ratings

### Challenge

A health plan with Affordable Care Act (ACA) and Medicare Advantage lines needed to reduce revenue leakage and improve its HEDIS performance.

### Solution

We deployed a digital coding and quality analytics engine with digitally enabled chart validation and predictive suspecting models. Integrated member outreach improved documentation accuracy and closed care gaps.

Source: Carelon Global Solutions, *Risk & Quality Performance Case Study* (2024).

### Outcome

- 98% coding accuracy
- 99% CMS acceptance rate
- 86% automation in ACA/Health Insurance Marketplace (HIX) testing
- 77% engagement rate in chronic care outreach programs

### Impact

By uniting risk adjustment and quality functions, the plan strengthened financial integrity and enhanced member health outcomes.

# The Carelon perspective



The organizations that will lead the next decade of healthcare aren't those reacting to change — they're designing for it. That's where Carelon comes in. With decades of payer and operational experience, we partner with health plans to modernize their infrastructure, making operations smarter, faster, and more connected.

Our approach is grounded in four core strengths.

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**The future belongs to health plans that modernize now — connecting automation, data, and human-centered design to build intelligent operations that are smarter, scalable, and unmistakably human.”**

— Sundar Krishnan, Director, Carelon Global Solutions Commercialization and Health Operations

## 4 core strengths of our approach



1.

### **Connected systems**

We create a seamless digital backbone for health plan operations, connecting people, platforms, and data across claims, networks, clinical, and customer experience. In addition, our platform-agnostic model allows health plans to retain existing technology while layering automation, analytics, and governance to deliver measurable improvements.

3.

### **Human-centered design**

We bring a human-first philosophy to operations. Across contact center, clinical, and operational services, we balance efficiency with empathy, ensuring technology enhances experiences. Our global workforce combines deep healthcare experience with a strong culture of service, enabling consistent, high-quality delivery at scale. We further strengthen our human-centered service model through continuous upskilling, investing in education for nurses, coders, and operational specialists to sustain quality and performance as technology evolves.

2.

### **Operational intelligence**

We embed automation, analytics, and real-time dashboards into every workflow, helping payers predict needs, prevent errors, and measure performance continuously. Our delivery model ensures that automation doesn't replace people. It amplifies them. Every process improvement is grounded in measurable outcomes: accuracy, turnaround, cost savings, and satisfaction.

4.

### **Transformation by partnership**

We operate as an extension of each client's enterprise, aligning governance, incentives, and continuous improvement to shared outcomes. This partnership model has enabled us to deliver value across more than 30 health plans and support millions of members and care providers in the U.S.

# Preparing for 2030

Smarter operations don't just make health plans more efficient — they make healthcare more human. By combining connected systems, operational intelligence, and human-centered design, we help payers deliver the kind of experiences that members and care providers expect, and that the future demands.

**Contact us** to start the conversation.



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