pagerhealth℠

Build vs. buy: the AI care navigation decision payers can't afford to get wrong

How healthcare payers close the gap between AI ambition and trusted, production-grade navigation that drives real outcomes

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What's inside

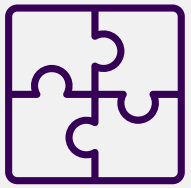
Executive summary

AI in care navigation is inevitable. Getting it right isn't.

AI in healthcare has moved past experimentation. For healthcare payers, the debate is no longer whether to adopt AI in care navigation. The question now is how to do it safely, at scale, and in a way that doesn't put members, network performance, or revenue at risk.

Most organizations face a challenge of two extremes: overconfidence in building internally, and underutilization of purpose-built solutions that could accelerate time to value.

The payers that succeed will be those that **approach AI as an operational system**, not a feature, and that **partner strategically** to move faster while managing risk.



Key takeaway

The right answer isn't always build *or* buy. It's knowing where to build for competitive advantage and where to buy for speed, safety, and scale.

AI imperative in healthcare

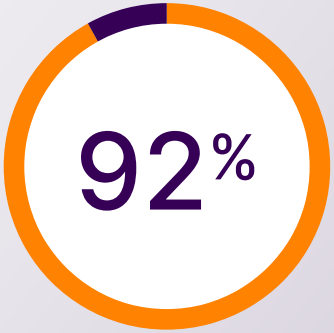
Healthcare AI investment has reached an inflection point. The estimated market spend was **more than $36 billion in 2025**, and adoption is only accelerating.[1] Furthermore, 62% of payers are already exploring how to adopt agentic AI capabilities, while only 10% say they're waiting to see how others perform.[2] The expected savings potential is enormous: AI adoption across the US healthcare system could unlock **$200 billion to $360 billion**.[3]

But the gap between expectation and reality is widening. Gartner estimates that fewer than 30% of agentic AI use cases will deliver their expected value, not because the technology doesn't work, but because of a lack of rigorous financial, business, and change management.[4]

$36B+

Healthcare AI spending in 2025

Agentic AI use cases that will deliver expected value



Healthcare executives who believe AI will provide a competitive edge[5]

Payers focused on elevating Star Ratings, CAHPS scores, medical loss ratios (MLRs), and member retention have a powerful opportunity and getting AI right can make all the difference.

Why care navigation is the critical use case

Care navigation is one of the highest-value AI use cases as it sits at the intersection of member experience, network performance, and cost. When it works well, it drives in-network utilization, improves access, and reduces avoidable high-cost utilization. When it breaks down, it can result in a loss of member trust.

It touches every dimension of payer performance that matters

Cost of care: out-of-network spend carries a significant cost compared to in-network

Network utilization: accurate, real-time directories and seamless scheduling keep members in network

Access and timeliness: "getting needed care" and "getting care quickly" are measured CAHPS domains with direct ties to revenue

Member satisfaction and retention: 46% of patients report using their payer's provider directory to find in-network care, but outdated data erodes trust quickly[6]

Quality measure performance: gaps in care, HEDIS scores, and Star Ratings are all influenced by how well members can access care

Ghost network problem

The No Surprises Act mandates 90-day provider verification, yet 40% of directory errors persist after a year, leaving "ghost networks" visible and actively damaging member trust in the plan.[7]

Why most AI initiatives stall before they scale

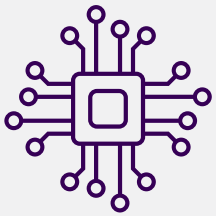
The gap between what works in a controlled care navigation pilot and what works in a live payer environment is where most initiatives fail. This is also where the costs, both financial and reputational, accumulate.

Pilot vs. production gap

Pilots succeed because every condition is controlled: the data is clean, the scenarios are scripted, and the audience wants to be impressed.

In production, data is incomplete and inconsistent, edge cases are the norm, and errors carry clinical, financial, and operational risk that a pilot environment simply cannot surface. **In healthcare, a failed pilot can be a liability,** as the gap between controlled pilot conditions and live payer environments is wider, and the consequences of underestimating it are steeper. This is why AI pilots stall and costly rebuilds happen.[8]

A successful pilot proves that AI can work. It doesn't prove that it should be deployed or that it will work at scale.



What a pilot doesn't answer

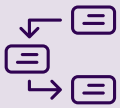
Before any AI capability is production-ready for your environment, there are some questions that need honest answers:

- What's the failure mode?
- Does this fit user workflows?
- Can you monitor this in production?
- How do you build trust?
- What does this cost at scale?

Structural barriers

Most AI initiative failures come from how the AI solution was designed and deployed, and aren't caused by model performance. The most common structural barriers are:

Fragmented and unreliable data sources



Misalignment with real clinical and operational workflows

No clear human-in-the-loop architecture or escalation pathways

Lack of monitoring, evaluation, and governance

Cost of getting it wrong

In care navigation, failure isn't a user experience issue. Trust and safety are key, with direct consequences for payer performance metrics and member relationships. The downstream effects of a broken AI navigation experience are concrete:

- **Misrouting delays care**
- **Poor recommendations drive network leakage**
- **Inconsistent experiences erode member and provider trust**

One bad outcome can outweigh dozens of successful interactions. In a regulated, high-stakes environment, the reputational and liability cost of a single clinical miss is sizable.

Governance risk: By 2027, only

of organizations will realize anticipated AI value due to incohesive ethical governance.[9]

Build vs. buy: what it really means

The decision isn't fundamentally about technology but about **speed, risk tolerance, and long-term capability**. For most payers, the answer requires a clear-eyed view of organizational readiness.

Understand the full cost of building

Building AI for care navigation requires far more than models. Payers who've attempted it discover a long tail of requirements that rarely show up in the initial business case.

Beware of hidden costs

Business change and transformation costs for agentic AI can be several times higher than for traditional Enterprise Resource Planning (ERP) projects, which is a figure most initial build estimates don't include.[10]

What building requires

- ☑ Continuous model iteration and clinical validation
- ☑ Real-time data integration across disconnected systems
- ☑ Workflow orchestration across digital and human channels
- ☑ Monitoring, alerting, and incident response infrastructure
- ☑ Safety guardrails and clinical risk management
- ☑ AI/ML talent acquisition and retention
- ☑ Governance frameworks to satisfy regulatory scrutiny
- ☑ Business change management

When building may make sense

Building can be appropriate when three conditions are true simultaneously: AI is a core differentiator and a genuine strategic asset, the organization has a unique data advantage that a partner can't replicate, and there's long-term investment capacity and deep internal AI expertise.

For most payers, these conditions aren't in place simultaneously.

When buying wins

Buying from a purpose-built partner isn't outsourcing innovation strategy but instead accelerating it responsibly. The organizations that succeed with AI in care navigation typically distinguish between where they need proprietary control and where they need proven infrastructure.

Dimension	Building internally	Buying from a purpose-built partner
Time to value	2-3+ years to production scale	Months, with tested infrastructure
Upfront investment	High: talent, infrastructure, governance, monitoring	Structured, predictable implementation costs
Clinical safety	Must build guardrails and validation from scratch	Clinical guardrails and emergency detection built in
Provider data accuracy	Dependent on internal data management capability	Real-time agents validate availability and help improve provider data
EHR integration burden	Complex, time-consuming, expensive	No EHR integration required for scheduling
Regulatory/ governance risk	Full accountability on the plan; frameworks built from scratch	Shared accountability; established governance frameworks
Ongoing optimization	Internal team must maintain, retrain, and monitor	Continuous optimization as part of the partnership
Internal focus	Engineering resources pulled from core competencies	Internal teams stay focused on clinical and strategic priorities

When doing both is the right answer

For many payers, the strongest path won't be a binary choice. **Build** where there's a genuine, defensible advantage such as proprietary data assets, unique clinical protocols, or strategic capability. **Buy** where speed, safety, and proven infrastructure matter more. The organizations gaining ground fastest are being deliberate about which side applies where, instead of picking a side.

Real cost of inaction

Payers lacking a clear AI strategy for member-facing functions limit their ability to modernize and compete. The gap between innovation leaders and the rest is widening faster than most plans' internal roadmaps can close it.

Pillars of best-in-class AI navigation for payers

Effective AI care navigation rests on four non-negotiable pillars. These are the foundational system-level requirements that determine whether the deployment contains costs and earns long-term member and operational trust.

Clinical safety and guardrails

In care navigation, failure is a clinical and liability issue. A trust layer requires:

- Robust guardrails for high-risk scenarios, including emergency and crisis detection
- Human-in-the-loop escalation pathways at every stage
- Confidence handling and uncertainty detection

Real-time data integration

Provider directory accuracy is a fundamental payer compliance and trust issue. Best-in-class navigation requires:

- Accurate, real-time provider directory validation
- AI agents that actively call providers to confirm availability and reduce ghost network exposure

Workflow orchestration

Members want faster access to care, and a better experience getting there. This requires:

- Coordination across digital touchpoints and live clinical support teams within a single, cohesive workflow
- Ability to handle multi-step navigation journeys

Security and governance

In a regulated environment, governance is foundational to trust and long-term viability. This requires:

- Security frameworks built in from day one to meet healthcare data handling and privacy requirements
- Defined ownership and accountability across AI decision-making pathways

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Clinical safety and guardrails

- Ongoing bias monitoring and mitigation
- Continuous auditing, evaluation, and rollback capability

Real-time data integration

- Integration with scheduling and eligibility systems without heavy EHR integration
- Continuous validation of dynamic data sources to maintain accuracy at scale

Workflow orchestration

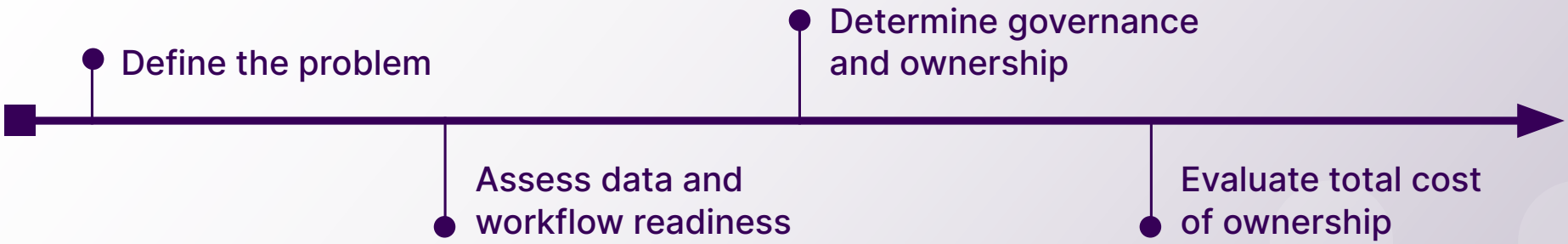
- Seamless, consistent escalation from AI to human care teams
- Design centered on task completion, not conversation length
- Full integration into the payer's existing member experience

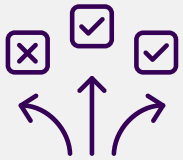
Security and governance

- Audit-ready documentation of model behavior, training data, and escalation logic
- Governance structures that can evolve alongside regulatory requirements

A practical decision framework for payers

Before you commit to a build or buy path, work through four evaluation steps. This can help you identify your organization's readiness and the right path forward.





Payers that succeed with AI navigation deploy faster, with shared accountability, and proven infrastructure. This allows internal teams to focus on what they do best: clinical and strategic priorities that a technology partner can't replace.

Step 1: Define the problem

Before evaluating technology or interface decisions, get clarity on where navigation is breaking today. The right questions to ask:

- Can you effectively engage members, and what's standing in the way?
- Once a member is engaged, where are they dropping off and why?
- What's the clear definition of success, and the measurement infrastructure to know when it's been achieved?
- What's the measurable cost of inaction in terms of Star Ratings, CAHPS scores, MLR, or retention?
- Which employer groups or broker relationships are at risk due to a lack of innovation?

Step 2: Assess data and workflow readiness

Be honest about where you're starting. Evaluate:

- **Data quality and accessibility:** is your provider data clean enough to be the foundation for AI?
- **AI and engineering capabilities:** do you have the specialized talent to build, maintain, and govern clinical AI at scale?
- **Budgetary readiness and investment appetite:** have you modeled the full lifecycle cost of building and maintaining AI against a buying model? Do leadership and finance have aligned expectations on what it actually costs to reach production scale?

Step 3: Determine governance and ownership

Before committing to either path, establish clarity on who will own the outcomes, and what's required to protect the organization:

- **Governance and compliance maturity**: do you have established frameworks that will satisfy regulators and your internal compliance team?
- **Clear ownership of AI decision-making:** who's accountable when the model gets something wrong? What's the escalation path?
- **Audit readiness:** can you document and explain your AI's behavior, training data, and logic to internal and external stakeholders?

Step 4: Evaluate total cost of ownership

A fair financial comparison requires the full lifecycle, not just the headline numbers.

Cost category	Build	Buy
Talent	High, ongoing	Minimal
Infrastructure	Build and maintain	Shared / included
Governance and safety	Build from scratch	Established frameworks
Monitoring	Build and staff	Included
Time to value	2–3+ years	Months

AI-first, human-always care navigation

Pager Health Navigator is purpose-built for payers who want to move fast without taking on the full risk of building from scratch. It sits inside your existing tech stack, connects with your current systems and partners, and immediately delivers a seamless AI-powered navigation experience backed by real clinicians, available 24/7.

Navigator brings together everything members need in one connected experience: AI-powered symptom triage, in-network provider matching and scheduling, benefit and coverage guidance, digital health program matching, and clinical escalation when it matters most.

The outcomes speak for themselves:[11]

25%
Lower care costs

99%
Of health issues resolved after a single nurse interaction

3.3x
Return on investment

Navigator addresses the four pillars of best-in-class AI navigation

Clinical safety and guardrails

Navigator delivers outcomes-driven orchestration with clinical-grade safety built in from day one, including human escalation pathways and continuous monitoring throughout the navigation journey.

Real-time data integration

AI voice agents actively call providers to identify appointment availability, eliminating the heavy burden of EHR integration while giving members real-time scheduling access. Provider directory accuracy improves continuously, and ghost networks shrink.

Workflow orchestration

Navigator engages members at the right moment and manages the entire journey: from search and scheduling through post-visit follow-up, within a single cohesive workflow, fully integrating into the payer's existing member experience.

Security and governance

Navigator is designed for the regulatory realities payers face, with security frameworks, audit-ready documentation, and governance structures built to evolve alongside compliance requirements.

Measurable outcomes for payers

- ↓ Out-of-network spend
- ↓ Time to appointment
- ↓ Call center volume
- ↑ In-network utilization
- ↑ Directory accuracy
- ↑ Member retention

Partnership model, not vendor model

The models powering AI will keep improving. Pager Health operates as a strategic partner to collaboratively build clinical governance, workflow integration, and member experience layers that translate AI capability into measurable outcomes for payers.

Conclusion

The path forward

Payers that succeed with AI in care navigation will be the ones that deploy safely, govern deliberately, and know exactly where to build and where to buy. That means knowing where to buy, where to govern, and where to let the underlying technology evolve without continuously having to redesign and rebuild.

The foundation of AI is being built by companies investing billions in frontier models. Your competitive advantage comes from what sits on top: the navigation experience, the clinical safeguards, the workflow integration, and the member trust that converts AI capability into measurable outcomes.

The cost of getting AI wrong in care navigation is too high. And for most organizations, the cost of trying to build it all internally is even higher.

The key signals it's time to act

- ☑ Declining Star Ratings
- ☑ High avoidable ED utilization
- ☑ Persistent gaps in care
- ☑ Call center volume driven by navigation failures
- ☑ Rising MLR without a cost reduction strategy
- ☑ Losing employer groups or broker confidence to competitors with better AI capabilities

The right question to ask

The strategic question isn't "build or buy." For most payers it's: "where do we build for competitive advantage, and where do we buy to accelerate impact safely, at scale, and without taking on risk we're not equipped to manage?"

Ready to take the next step?

See Pager Health Navigator in action

Schedule a 30-minute conversation with our team to see how Pager Health Navigator delivers AI-first, human-always care navigation, and what the outcomes could look like for you.

Request a demo

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Sources

1. Grand View Research
2. McKinsey & Company
3. McKinsey & Company
4., 9., 10. Gartner
5. KPMG
6. TechTarget
7. The American Journal of Managed Care
8. Sunny Webb, “Your AI Demo Isn’t a Product (And Why That Matters)”
11. Stats based on internal performance metrics