

The Advocacy Horizon

Making patient and member advocacy the default —
when AI collapses the cost of navigating, explaining, and appealing.

The thesis in one line — *advocacy has always been rationed by the cost of a human doing it; when AI makes navigating, explaining, and appealing nearly free, advocacy stops being a scarce service and becomes the default for every patient and member.*

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Version 1.3 • July 2026 • For Public Distribution

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Executive Summary

Healthcare advocacy — the work of helping a patient or member actually get the care and coverage they are entitled to — has always run on people. Patient navigators, case managers, financial counselors, member-services representatives, and appeals specialists spend their days translating a system that is too complex for the people inside it. It is valuable work, and it does not scale: every advocated case costs human hours, so advocacy reaches the few who know to ask and arrives only after something has gone wrong.

The data exposes the cost of that scarcity. In ACA marketplace plans, insurers denied 19% of in-network claims in 2024 — tied with 2023 for the highest rate on record, still roughly one in five — yet consumers appealed less than 1% of denials, and insurers upheld about two-thirds of the few appeals they received. In Medicare Advantage, insurers made nearly 53 million prior-authorization determinations in 2024 and fully or partially denied about 4.1 million (a rate near 8%), while more than 80% of the small share that were appealed were overturned. The pattern is consistent and damning: where denials are challenged they are frequently reversed — overwhelmingly so in Medicare Advantage — yet almost no one challenges them.

That is not a clinical problem or a coverage problem. It is an advocacy-cost problem — and it is exactly the kind of problem AI dissolves. Generative and agentic systems collapse the marginal cost of navigating, explaining, and appealing toward zero. When advocating becomes nearly free, it stops being rationed to the few and becomes the default for the many. This paper traces that shift — from the human-intensive recent past to the AI horizon — names the structural opportunity (the advocacy gap), maps what changes for providers and payers, and connects advocacy to the rest of this series: it is an agentic, cross-boundary workflow, governed by the Write-Back Autonomy Ladder™ (Paper No. 2) and metered by the Interoperability Tariff™ (Paper No. 1).

1. The Recent Past: Advocacy as a Scarce Human Service

For two decades the advocacy strategy was, in effect, to hire advocates. Provider organizations stood up patient navigators and financial counselors; health plans built member-services centers and care-management teams; employers bought third-party advocacy and navigation services to absorb the overflow their carriers could not. The model was fundamentally reactive — it waited for a patient to be confused, denied, or lost, and then dispatched a person to help.

Two facts defined this era. First, the friction was enormous and growing: providers report initial claim denial rates around 15%, private-payer denials rose from roughly 8% to 11% between 2021 and 2023, and the annual value of denied U.S. claims is estimated near \$262 billion, of which roughly 86% is considered potentially avoidable. Second, the people meant to navigate that friction were largely unequipped — more than 43.5 million Americans provide unpaid care while facing heavy administrative burden and no training to navigate the system on a loved one's behalf.

Advocacy worked when it was applied. It simply could not be applied at scale, because every case consumed a person's time.

2. The Advocacy Gap

The clearest way to see the cost of scarce advocacy is to compare how often denials are reversed when challenged with how often they are challenged at all.

Setting	Denied	Appealed	Overtured if Appealed
ACA marketplace (in-network, 2024)	19% of claims	<1%	~34% (internal review)
Medicare Advantage prior auth (2024)	~8% of ~53M (~4.1M)	~11.5%	>80%
Independent external review	—	—	~40–50%
New York appeals trend (2019→2025)	—	—	38% → ~53%

Appeal and overturn rates are segment-specific and are not interchangeable. The <1% appeal rate is an ACA marketplace figure; the >80% overturn rate is a Medicare Advantage prior-authorization figure.

FRAMEWORK • The Advocacy Gap

The advocacy gap is the distance between the care and coverage a person is entitled to and what they actually receive — a distance created not by policy but by the cost of advocating across it.

Overturn rates on appeal run from ~34% in ACA internal review to more than 80% in Medicare Advantage prior authorization — yet almost none are challenged (<1% in ACA). Where challenge is cheap enough to happen, a large share of denials do not survive it. **The binding constraint is not entitlement — it is advocacy effort.** Lower the cost of that effort toward zero and the gap closes on its own.

3. What Changed: AI Collapses the Cost of Advocating

Three forces have converged to make advocacy cheap enough to give everyone. Consumers are ready: by late 2024, one in six U.S. adults — and a quarter of those under 30 — used an AI health chatbot monthly, and about 34% of adults had used a general AI system for health questions by early 2025, roughly double the prior share. The technology is ready: generative AI can explain a benefit or draft an appeal in seconds, and agentic AI can navigate multi-step processes — find an in-network provider, estimate a cost, assemble an appeal packet — end to end. And the market is moving: the AI-driven care-navigation services market is projected to grow from \$1.22 billion in 2025 to \$6.18 billion by 2033 (a ~22.5% CAGR), within a broader navigation-platform market on track from roughly \$13 billion in 2025 toward \$22 billion by 2030.

The moves are already concrete. Transcarent announced its acquisition of Accolade for approximately \$621 million in January 2025 and completed the merger in April 2025, creating a combined AI-enabled navigation and advocacy platform serving more than 20 million members. Included Health has continued to expand its AI-enabled, clinician-overseen navigation model; CVS Health's Aetna introduced AI-supported Care Paths for members and providers in 2025; and AI-native entrants such as Understood Care — which raised \$8.4 million in March 2026 and reports relationships with three of the nation's largest Medicare Advantage plans — are building advocacy for older and more complex populations. These examples illustrate the accelerating shift toward AI-enabled healthcare navigation rather than implying equivalent capabilities or market maturity. A parallel wave of AI appeals tools now lets a patient contest a denial in minutes rather than abandon it. Digital advocacy has shifted, in the words of one market analysis, from an optional benefit to a primary risk-management strategy.

4. The Shift, Dimension by Dimension

Dimension	Recent Past	AI Horizon
Posture	Reactive — waits for a problem	Proactive — detects and acts ahead of it
Capacity	Bound by human headcount	Scales with compute
Cost to advocate	High (human hours per case)	Near-zero marginal cost
Reach	The few who know to ask	Every patient and member, by default
Trigger	Patient initiates the request	The system surfaces the need
Form	Call center, case manager, vendor	Agentic navigator with human escalation

The strategic point is not that humans disappear — the strongest models pair AI reach with clinician and specialist oversight. The point is that advocacy stops being rationed. The question shifts from “who qualifies for an advocate?” to “why would any member not have one?”

5. The New Horizon Across Providers and Payers

Segment	Advocacy Plays with AI	What to Watch
Providers	Patient navigation; financial advocacy and cost transparency; automated denials and appeals; proactive care-gap closure; discharge and social-needs navigation	Accuracy, trust, and equity of access
Payers	Member advocacy and benefits navigation; proactive care management and outreach; modernized utilization management and appeals	The payer paradox (see below)

For providers, advocacy AI is increasingly inseparable from revenue: the same engine that helps a patient understand a bill and appeal a wrongful denial also recovers earned revenue and closes care gaps. For payers, advocacy is becoming a differentiator — members judge a plan by how easy it makes their lives — and a retention strategy, with active digital engagement linked to measurable gains in member activation.

FRAMEWORK • Advocacy Is an Agentic, Cross-Boundary Workflow

An advocacy agent reads from one party's systems and acts on another's — it crosses the provider-payer boundary on every task (eligibility, benefits, prior auth, appeal). That makes advocacy a direct instance of the two prior papers in this series:

It pays the **Interoperability Tariff™** on every crossing, so the same metering discipline applies; and it must climb the **Write-Back Autonomy Ladder™** (Paper No. 2, *When the Loop Runs Itself*) — from drafting an appeal for human sign-off (T1) to acting within a bounded policy with post-hoc review and instant rollback (T3) — because an agent acting on a patient's behalf carries real consequences.

6. The Payer Paradox and Other Honest Tensions

The Payer Paradox

The same AI that advocates for a member can be used to deny faster. A health plan that deploys advocacy AI while its utilization-management AI drives avoidable denials will not be trusted, and regulators are already moving on AI-driven denials. The credible position is alignment: use AI to reduce wrongful denials at the source — not to win an arms race of automated denials versus automated appeals.

“Won't universal advocacy just raise payer costs?”

In the near term, more appeals will succeed. But most overturned denials were wrongful to begin with — HHS OIG found a meaningful share of Medicare Advantage prior-authorization denials met coverage rules and should have been approved — so AI advocacy largely corrects error rather than extracting unearned value. And closing the advocacy gap reduces the downstream cost of deferred care that escalates into acute episodes.

Equity and Trust

AI advocacy can narrow or widen disparities depending on design. Built for the digitally fluent only, it widens the gap; built mobile-first, multilingual, and caregiver-enabled — for the 43.5 million Americans navigating on someone else's behalf — it narrows it. And because advocacy guidance can be wrong, human oversight is not optional; it is the top rungs of the Autonomy Ladder doing their job.

When the Advocate Is Wrong: Blast Radius

An always-on AI advocate is only as safe as its worst action. Reliability compounds: chain five 95%-reliable steps and end-to-end reliability falls to ~77% ($0.95^5 \approx 0.774$). But the number that should govern autonomy is not accuracy — it is *blast radius*, the scope of harm when the agent is wrong. A wrong summary of a benefit is a nuisance; a wrongly abandoned appeal, a misstated out-of-pocket cost, or an erroneous benefits action is direct member harm — and, for a provider, a compliance and reputational exposure. The Detect → Explain → Act → Resolve arc concentrates that risk in the Act and Resolve steps, where the agent moves from informing to doing.

Contain it by weighting evaluations to blast radius. Test the Act/Resolve seams hardest, evaluate the handoffs rather than only the endpoints, and treat the eval suite as the evidence you hand to compliance. This is why advocacy agents should run on the Write-Back Autonomy Ladder™ (Paper No. 2) — earning authority to act only where the blast radius is bounded and proven, with an audit-and-rollback spine and confirmation gates that keep a wrong action small and reversible. Universal reach without contained blast radius is not advocacy at scale; it is liability at scale.

7. What Executives Should Do Now

1. **Measure your advocacy gap.** Quantify denial, appeal, and overturn rates and the share of eligible members who ever engage advocacy. The gap is your opportunity, sized.
2. **Start where the gap is widest and the risk is bounded.** Benefits navigation and appeals drafting are high-volume, high-value, and low-clinical-risk — ideal first agentic advocacy workflows at a low autonomy tier.
3. **Pair reach with oversight.** Give every member an always-on AI advocate, with clinicians and specialists on the escalation path — the model the market leaders are already using.
4. **Align incentives before you scale.** Payers: commit to reducing wrongful denials, not just processing appeals faster. Providers: connect advocacy to both patient experience and earned revenue.
5. **Govern and meter it.** Run advocacy agents on the Autonomy Ladder with audit and rollback, and meter the cross-boundary crossings as a managed unit cost.

Conclusion

For a generation, the healthcare advocacy strategy was to hire more advocates and hope the people who needed them most knew to call. The result was a system where being right was not enough — you had to be persistent, informed, and lucky. AI changes the underlying economics: it makes advocating nearly free, which means it can finally be universal. The organizations that win the next decade will be the ones that stop treating advocacy as a scarce service and start treating it as a default capability — proactive, continuous, governed, and offered to everyone.

Being right should be enough. AI is what finally makes it so.

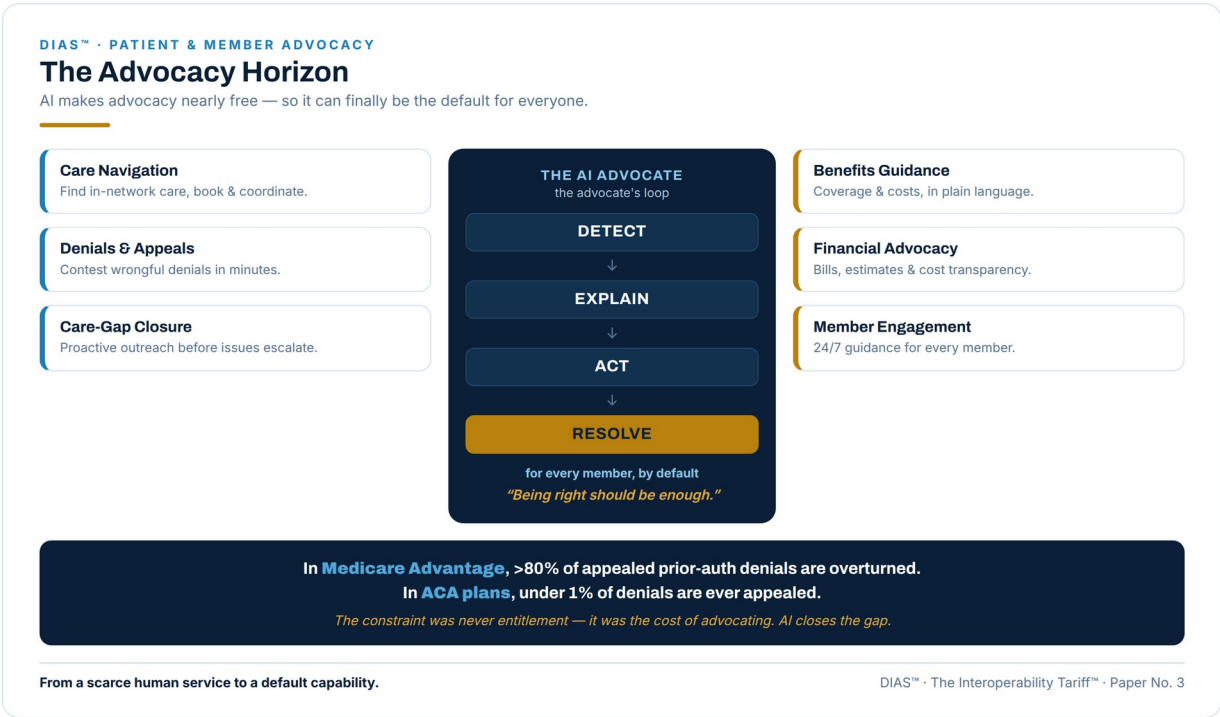


Figure 1 · The advocacy ecosystem — from scarce human advocacy to AI-driven, continuous advocacy across providers and payers.

Sources, Methodology & Validation

Methodology

Every quantitative claim is drawn from a primary or recognized secondary source dated 2024–2026 and cited below. Framework elements attributed to the author (the advocacy gap, and the mapping of advocacy onto the Interoperability Tariff™ and the Write-Back Autonomy Ladder™) are original analytical contributions, not sourced claims, and are labeled as such. Market-size figures vary by analyst and definition; cost statements are directional. Appeal and overturn rates are reported by segment and are not combined across segments.

All regulatory and payer-data claims (KFF, HHS OIG, CMS) were verified against primary government sources. Quantitative market, adoption, and implementation figures were verified against the best available 2025–2026 industry, peer-reviewed, or recognized secondary sources; commercial market forecasts and vendor-reported metrics are identified as directional estimates. Tiers — **Verified** (confirmed against the issuing organization's own publication), **As reported** (accurately attributed to the source that reported it), and **Directional** (market forecast or vendor-derived estimate) — are marked on each reference entry. **Of 13 sourced claims: 6 verified against a primary or issuing source, 4 accurately attributed as reported, and 3 identified as directional market estimates.** Every regulatory and payer-data claim on which the argument depends is Verified. The $0.95^5 \approx 0.774$ arithmetic and the blast-radius framing are original or independently verifiable and are excluded from the count.

Version 1.3 (July 2026) corrections: the \$2 advocacy-gap table was aligned with the v1.2 refresh (ACA denial rate 19% / 2024; ACA internal overturn ~34%); the framework range is stated as ~34% to >80% by segment; the ACA appeal rate and the Medicare Advantage overturn rate are separated wherever they appear together; and the Transcarent-Accolade transaction date was corrected (announced January 2025, completed April 2025). Market examples are framed to illustrate direction of travel rather than equivalent capability or maturity.

Sources

[**Verified**] KFF — *Claims Denials and Appeals in ACA Marketplace Plans in 2024* (March 2026). ACA insurers denied 19% of in-network claims in 2024 (tied with 2023 for the highest on record); consumers appealed <1% of denied claims and insurers upheld ~66% of those appeals; June 2025 insurer pledge to reform prior authorization (reduced scope by Jan 1, 2026).

[**Verified**] KFF — *Medicare Advantage Prior Authorization* (2024 data; 2026). MA insurers made ~53M prior-authorization determinations in 2024 and fully or partially denied ~4.1M (denial rate near 8%); a small share were appealed and >80% of those were overturned; ~1.7 PA requests per beneficiary.

[**Verified**] HHS OIG (OEI-09-16-00410; MA denials report). ~82% of appealed MA prior-auth denials fully or partially overturned; a meaningful share of MA PA denials met Medicare coverage rules (wrongly denied).

[**As reported**] JAMA via Healthcare Dive (Apr 2026). In New York, denial overturn-on-appeal rose from 38% (2019) to ~53% (2025).

[**Directional**] Change Healthcare / Optum Revenue Cycle Denials Index (via ClaimCure, 2026). ~\$262B annual value of denied U.S. claims; ~86% considered potentially avoidable; external-review overturn ~40–50%.

[**As reported**] Aptarro / Premier / MDClarity (2025–2026). Initial provider denial rates ~15%; private-payer denials rose ~8%→11% (2021–2023); 68% of providers cite inaccurate intake data as a primary denial driver.

[**Directional**] Data Bridge Market Research (Mar 2026). AI-driven care-navigation services market ~\$1.22B (2025) → ~\$6.18B (2033), ~22.5% CAGR; Included Health (Jan 2026) and Transcarent WayFinding (Oct 2025) expansions.

- [Verified]** Transcarent / SEC filing (2025). Transcarent announced the acquisition of Accolade on January 8, 2025 at \$7.03 per share (~\$621 million) and completed the merger on April 8, 2025.
- [Verified]** Understood Care, PRNewswire (March 16, 2026). \$8.4 million raised; launched patient care March 2025; reports relationships with three of the nation's largest Medicare Advantage plans. Early-stage company cited as a directional market signal, not a scaled comparator.
- [As reported]** PharmExec (Jul 2025). CVS Health's Aetna introduced AI-supported Care Paths for members and providers. CVS does not describe Care Paths as fully agentic.
- [Directional]** healthcare.digital (2026). Navigation-platform market ~\$13.4B (2025) → ~\$22.2B (2030); digital advocacy reframed from optional benefit to primary risk-management strategy; active digital engagement linked to a 5.3-point Health Activation Index gain.
- [As reported]** Redesign Health (2025). >43.5M Americans provide unpaid care amid heavy administrative burden; ~1 in 6 U.S. adults (25% under 30) use an AI health chatbot monthly; ~34% of adults used a general AI system for health questions by early 2025.
- [Verified]** Series context (prior papers, primary sources). ~\$1.6T total U.S. healthcare waste across six categories, of which administrative complexity is the largest addressable share at ~\$350B (Shrank et al., JAMA, restated to current CMS expenditure); CMS-0057-F FHIR prior-authorization APIs effective Jan 1, 2027; agentic models use 5–30× more tokens per task (Gartner); 80% of healthcare executives expect agentic AI to deliver value (Deloitte).
- [Analytical, excluded from the count]** Multi-agent reliability & blast radius (2026). End-to-end reliability of chained agents compounds multiplicatively ($0.95^5 \approx 0.774$; independently verifiable). “Blast radius” is a standard site-reliability and security term for the scope of impact of a failure, applied here to agentic handoffs. Analytical framing, not a sourced statistic.