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The denial problem (and is AI the answer?)

2025 State of Claims

Health claims are [still] stuck in a cycle of denials, delays and data errors. Artificial Intelligence could break the loop, but is healthcare ready to trust it? Can healthcare survive without it?

An Experian® Health survey of healthcare providers

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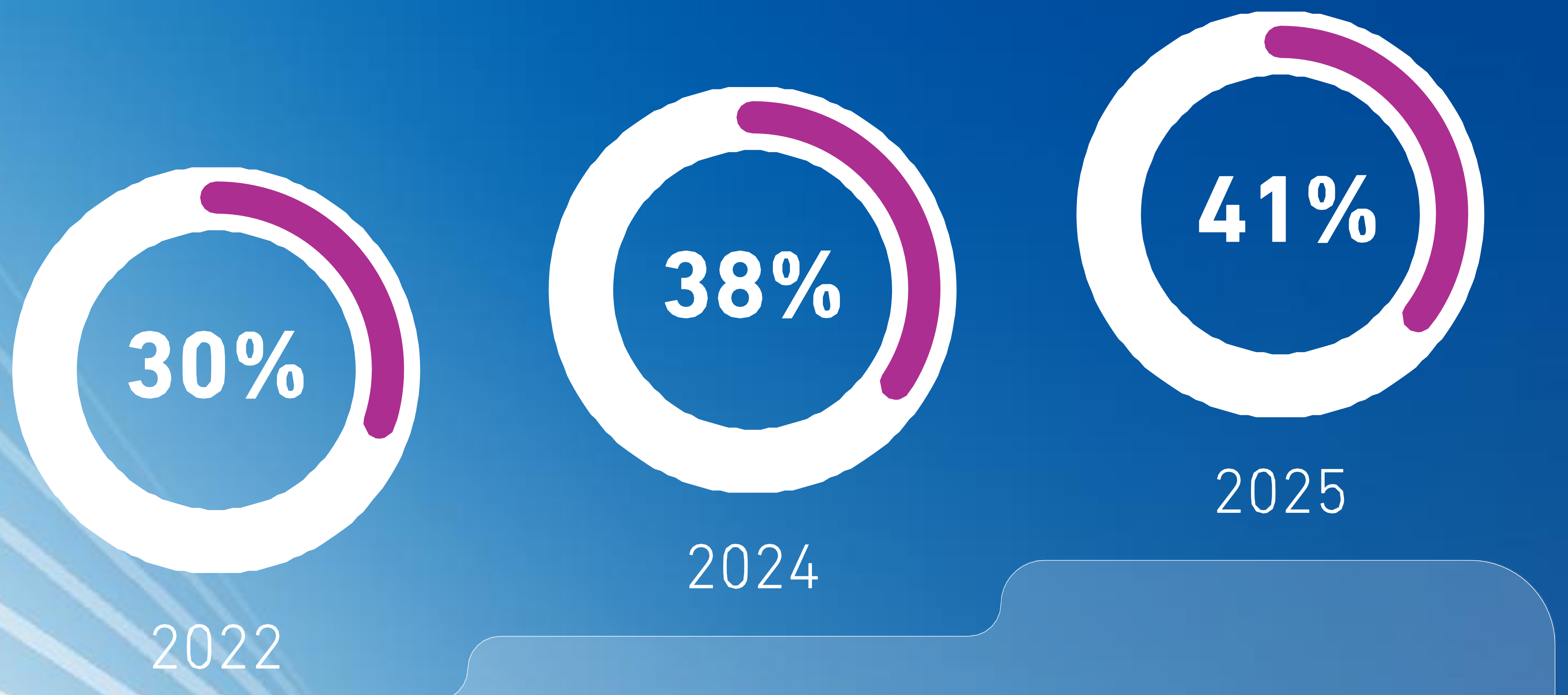
Denials on the rise — when will it end?

More providers are saying that **10 percent or more** of their claims are **denied.** The unchecked increase continues since our first survey in 2022.



Who's going to pay?

With denials increasing and reimbursements delayed or rejected, the burden to pay falls on the patient. Providers aren't very confident in that revenue source, either.

Respondents who are very/extremely concerned that payers will pay: **44%** *(+1% from 2024)*

Respondents who are very/extremely concerned that patients will pay: **50%** *(+6% from 2024)*

What’s to blame for denials?

You’ve seen this list before

Across both 2024 and 2025, rankings for primary denial triggers are unchanged. The percentages did change, however, and some are worse.

	2024	2025
No.1 – Missing or inaccurate claim data	46%	50%
No.2 – Authorizations	36%	35%
No.3 – Incomplete or incorrect patient registration data	30%	32%
No.4 – Code inaccuracy	27%	24%
No.5 – Services not covered	26%	23%

The denial accelerator: [bad] data quality

Getting all the information correct the first time is critical to the speed and accuracy of claims. Unfortunately, the statistics show data quality is declining.

54%

say claim errors are increasing.

#3

cause of denials is incomplete/incorrect data collected at registration *(behind authorizations).*

68%

say submitting "clean" claims is more challenging than a year ago.

26%

say that 10% or more of denials result from inaccurate or incomplete data collected at patient intake.

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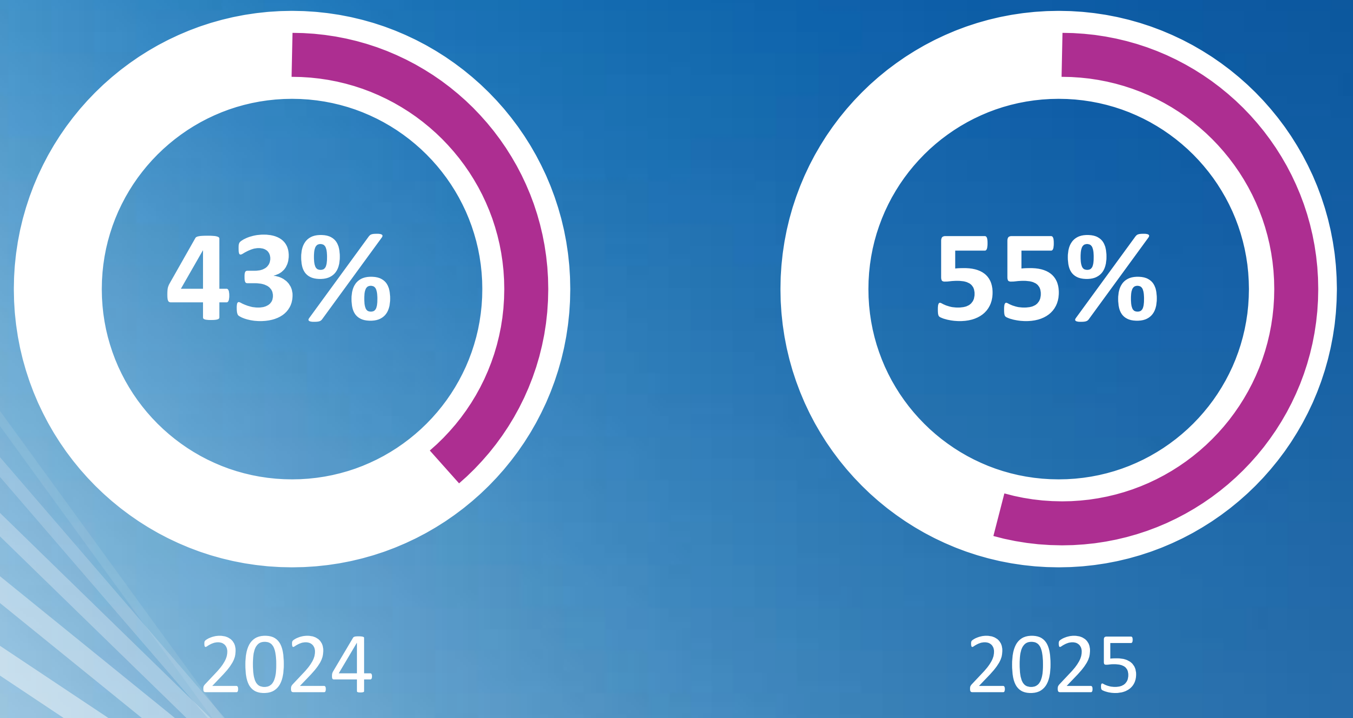
[*Blog – How data and analytics in healthcare can help maximize revenue*]

Tick tock: time drains and bottlenecks

It's often necessary to re-run eligibility checks after an incomplete result. More providers are saying the process is taking longer.

Time needed to re-run eligibility checks:
(10 minutes or more)



Fragmented check-in systems

One reason for longer times spent re-running eligibility checks might be the multiple solutions regularly used to collect patient information:

In 2024, **79%** said their organization uses two or more solutions to collect patient information needed for a claim submission.

That went up in 2025, with **81%** confirming multiple systems used for check-in, highlighting the inefficiency and redundancy challenging intake workflows.

The staffing squeeze: too few hands, too many claims

The complexities and volume of claim submissions and denial resubmissions expose the liability of understaffed teams. Errors and delays directly affect revenue and cash flow and make the need for people and technology more urgent than ever.

43% are understaffed

60% have fewer fewer than 25 people managing claims

36% say staffing shortages drag on claim submission speed and resubmission of denials

70% claim to quickly and accurately collect required information at patient intake*

*(meaning 30% don't and could be feeling the drag of staffing challenges and manual processes)

Denials still require human hands

90% of claim denials are reworked with at least some human review before resubmission:

47%: reviewed manually, then assigned to work queue for resubmission.

42%: automated review, then assigned to a manual work queue for resubmission.

10%: completely automated process and leverages AI to correct and resubmit denied claims.

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Blog – Impact of healthcare stafng shortages on revenue cycle management

Anxiety leads to action (sometimes)

Economic rumblings

73% of respondents *"strongly"* or *"somewhat"* agree that the economy and declining collections add urgency to payer reimbursements (up from 68% in 2024).

"It's the denials, stupid!"

82% say that reducing denials is a priority for the organization.

A sign of things to come?

41% upgraded or replaced their claims management technology in the last year.
BUT … only **56%** say that their current claims technology is sufficient to address revenue cycle demands (far below the 77% in 2022).

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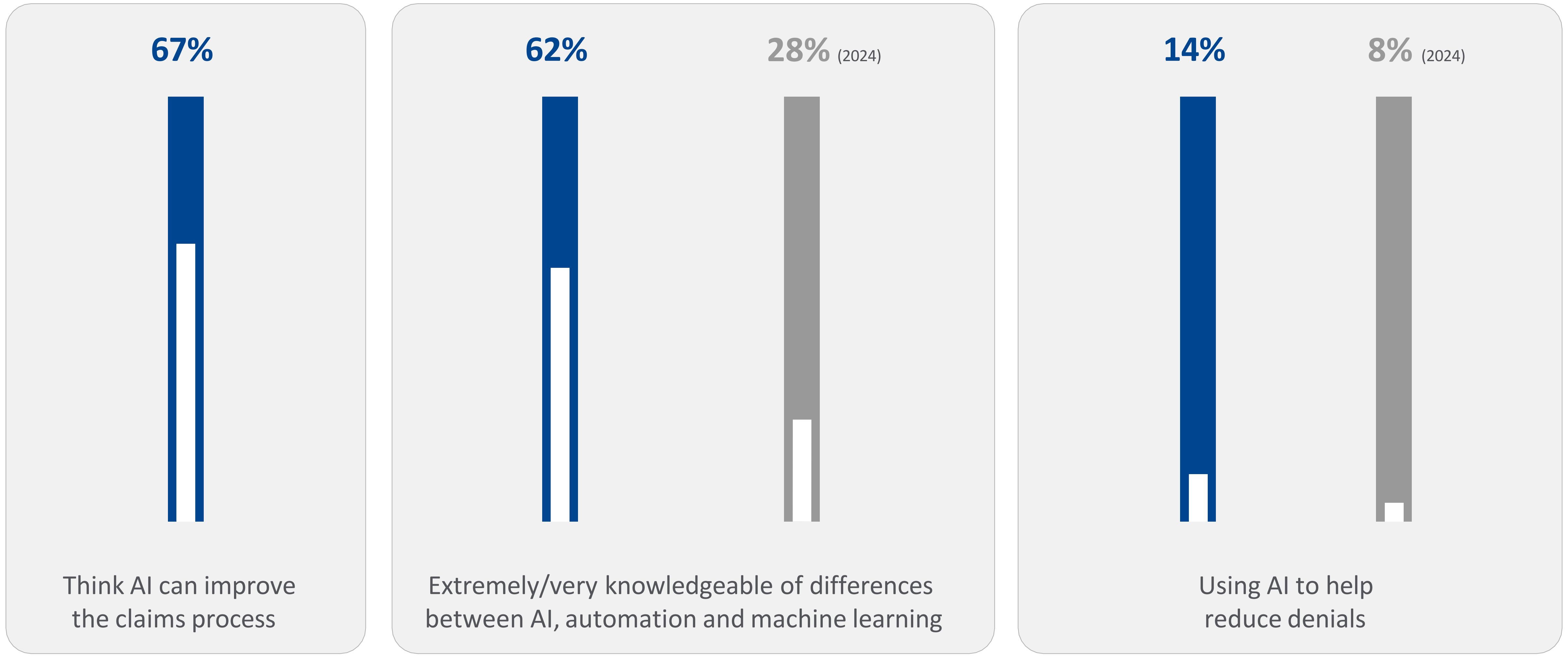
RCM and AI: to trust or not to trust?

The numbers are a headscratcher. Solid understanding of potential and optimistic expectations — but those using AI are a small minority.



Blog – Leveraging artificial intelligence for claims management

Fear of the unknown?

Enthusiasm for AI is tempered by many concerns:

- Unproven accuracy
- Unproven HIPAA compliance
- Daunting training for teams
- Skeptical of AI “understanding” payer-specific rules

Homegrown or vendor-supplied, AI is working

Of the 14% who said their organization is currently using AI:

10% developed their solution in house. **40%** are using the product of a technology vendor.

49% are using a combination of in-house and vendor solutions.

69% say that AI solutions have reduced denials and/or increased the success of resubmissions.

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Always changing

Managing claims within the revenue cycle process is a moving target. Policies are changed, contracts updated, authorizations modified, codes added and removed, security concerns arise, and what worked last year may not be working this year.

Last time claims management technology was evaluated:

38% Less than a year ago

43% 1 to 2 years ago

16% 3 to 5 years ago

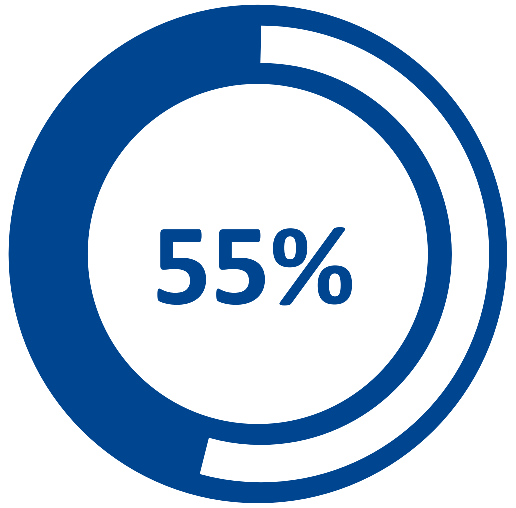
2% 5+ years ago

Annual checkups are the norm

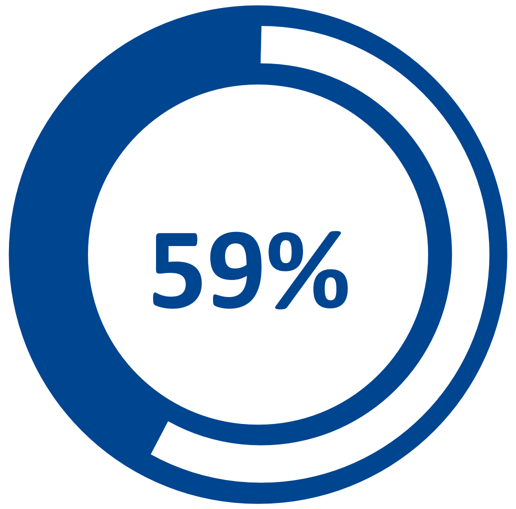
54% More than half of providers review/evaluate their claims management process annually.

Rip and replace

The prospect of replacing an entire claims management platform is far from appealing, but it's become a serious consideration in the revenue cycle space. As denials increase, pressure builds to counter the trend.



Willing to completely replace existing claims management platform if presented with compelling ROI.



Plan to invest in claims processing and/or denial reduction technology in the next six months.

Top 5 Reasons for reassessing claims processes & technology

1. Denials continue to increase: 39%
2. The possibility that better-performing technology is available: 29%
3. Regular evaluations are standard procedure: 27%
4. Security concerns: 26%
5. Most processes are still manual in organization: 21%

This could be a turning point for claims management

Data accuracy and submitting clean claims as quickly as possible have always been key objectives for revenue cycle leaders. If a claim is denied, determining why and either resubmitting it correctly or contesting the denial with accurate information needs to be expedited. Technology is a critical component of improving these processes, and the last few years have seen the tempo of adoption increase. Automation is amplified by AI, and providers hope that it leads to better claims and reimbursement results. The next few years are likely to see significant changes in the revenue cycle process, particularly in claims management.

[Learn more]

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The 2025 Experian Health State of Claims Report was based on a quantitative survey of 250 healthcare professionals responsible for financial, billing or claims management decisions. The online survey was fielded through a third-party panel provider between June 23 and July 3, 2025.

Participants represented a blend of tactical and executive roles, ensuring the data reflects both operational realities and strategic decision-making.

Survey objective: Experian Health's State of Claims survey is intended to determine the current state of claims management within provider operations, reasons for the current state and actions being taken to address the challenges that exist within the claims management function. Additionally, questions were designed to determine awareness of emerging technologies that can optimize the claims process and generate more reimbursement revenue.

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