2026
The State of Claims

Still an uphill climb

Pressure mounts on providers to counter the impacts of changing regulation and payer rules.



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Table of Contents

The denial burden

4. Denials are still a regular (and increasing) part of the healthcare revenue cycle
5. Payer friction and bad data are a bad combination
6. Reducing denials is now a near-universal priority
7. “Services not covered” is the new king of pain
8. Signs of a struggle
9. Economic pressure makes reimbursement more urgent
10. Resubmission success does not guarantee full revenue recovery

How providers are responding

12. The tactics to reduce denials
13. Technology at a glance
14. The big picture
15. Survey methodology

The Denial Burden

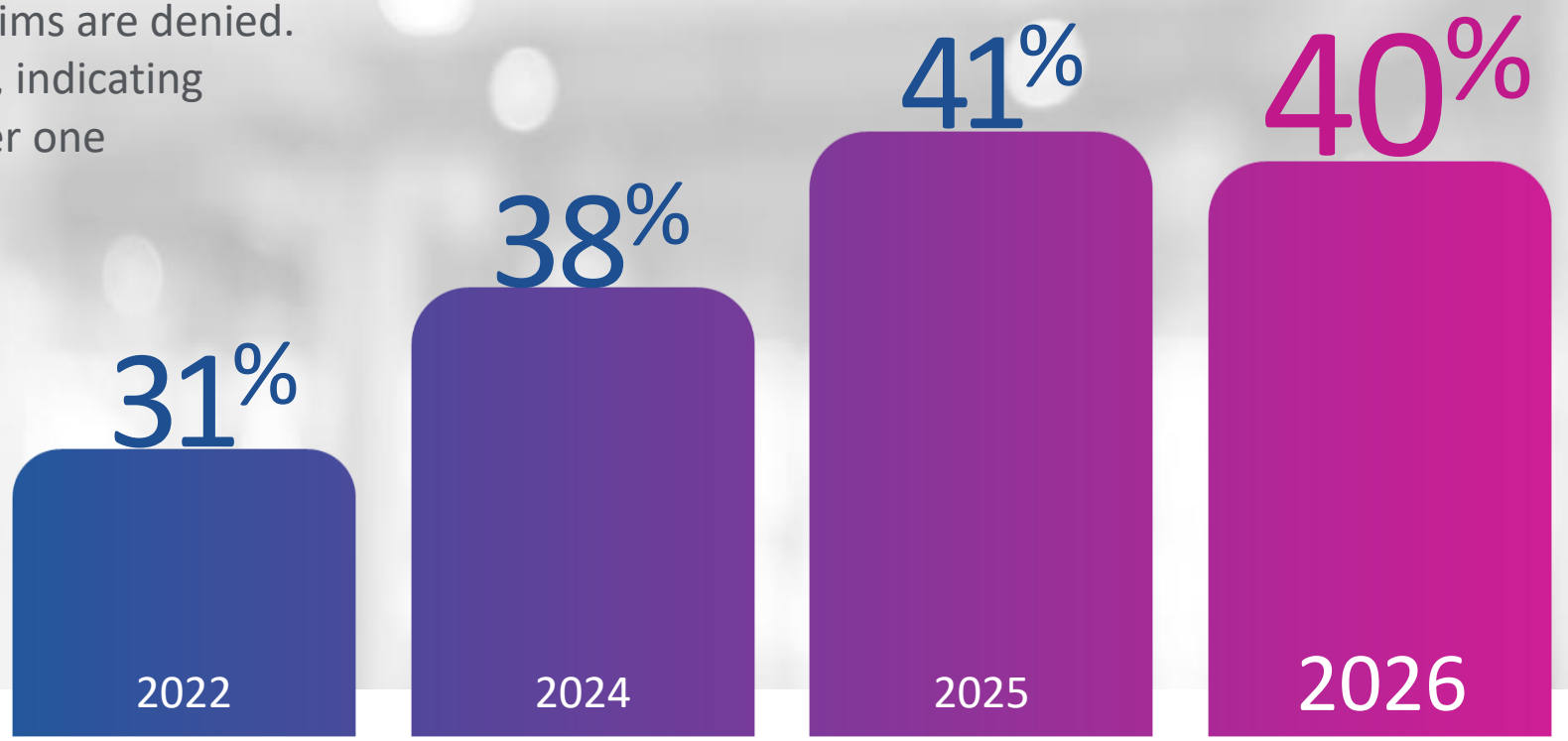
Healthcare providers are on a quest to consistently submit clean claims and generate payer reimbursement revenue as quickly as possible.

It continues to be a long quest.



Denials are still a regular (and increasing) part of the healthcare revenue cycle

Many providers say more than 10% of claims are denied. The percentage has increased since 2022, indicating providers are losing ground to the number one problem in revenue cycle management.



Share reporting that 10% or more of claims are denied

Payer friction and bad data are a bad combination

The numbers barely wavered in a year as the race to keep pace with payer policy changes heats up. Artificial intelligence (AI) is playing a role in both payer and provider efforts to get ahead, but the pressure is on providers to submit error-free claims.

79%
Payer reimbursement is more challenging
76% in 2025

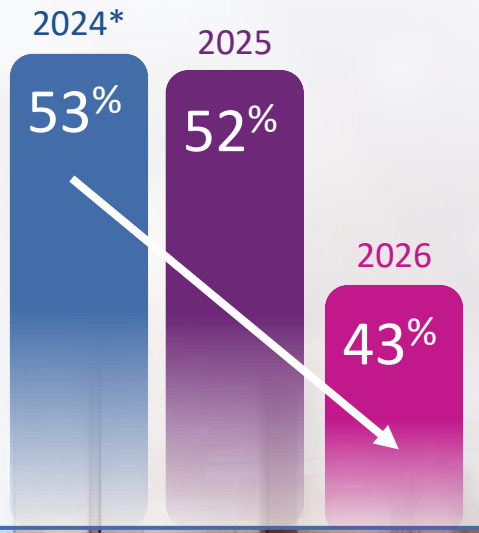
78%
Payer policy changes are more frequent
77% in 2025

64%
Time to reimbursement is increasing
68% in 2025

53%
Errors in submitted claims are increasing
54% in 2025

Front-end data is improving

Inaccurate data originates from several places within the revenue cycle. Many providers say between 5%-15%+ of denials are a result of inaccurate data collected at patient registration and intake. Year-over year, this has improved, reflecting how focus on “front-end” operations impact claim reimbursement success.



*Percentage of providers who say denials resulting from inaccurate data collected during patient registration and intake is between 5%-15%+.

Reducing denials is now a near-universal priority

Denial frequency and financial pressure continue to rise.

89% say reducing denials is a priority for their organization in 2026

Denials are focus No. 1

- **75%** agree denials are increasing
- **40%** say at least 10% of claims are denied
- **14%** say more than 15% of claims are denied





“Services not covered” is the new king of pain

Top 3 reasons for denials*

No. 2

31%

Frequently changing payer policies

First time as No. 1

53%

Services not covered

Tied for No. 3

25%

Code inaccuracy errors

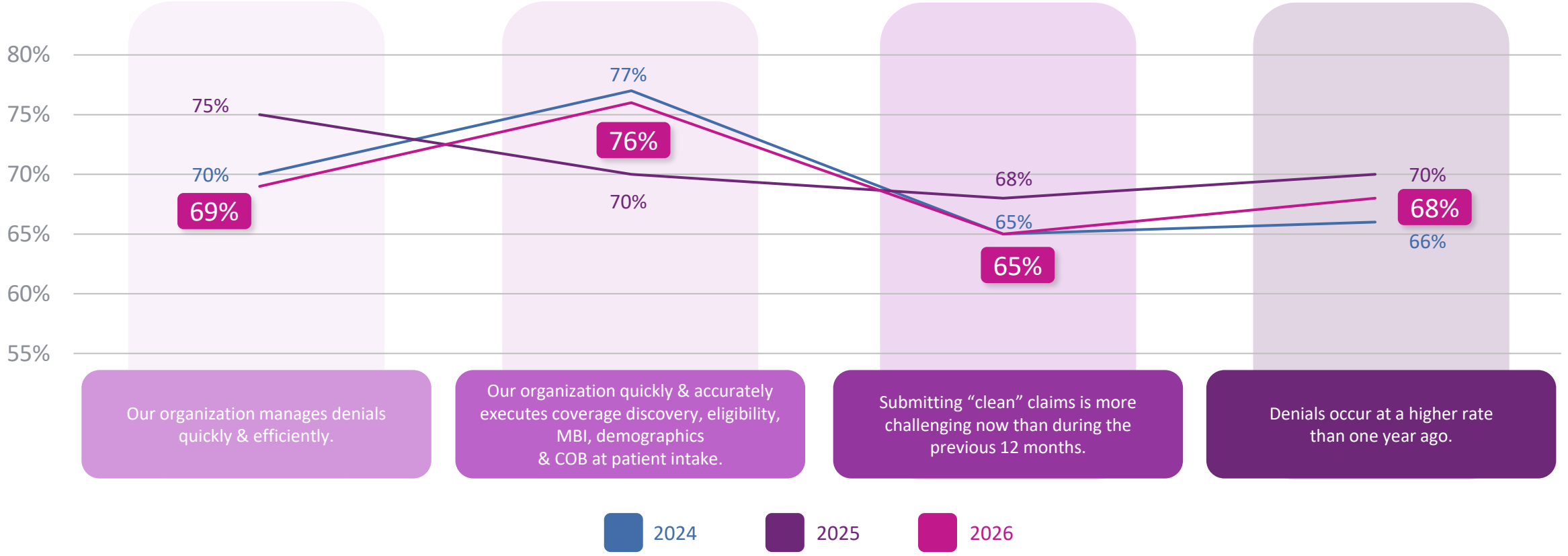
Difficulty obtaining prior authorization

*How often each reason appeared in respondents’ top three choices

Read the blog: AI helps cut denials by 38%

Signs of a struggle

Technology investment to address rising denials accelerated during the pandemic. Now AI is making the argument for more investment. The numbers show progress and setbacks, but the bottom line is that avoiding denials remains difficult.



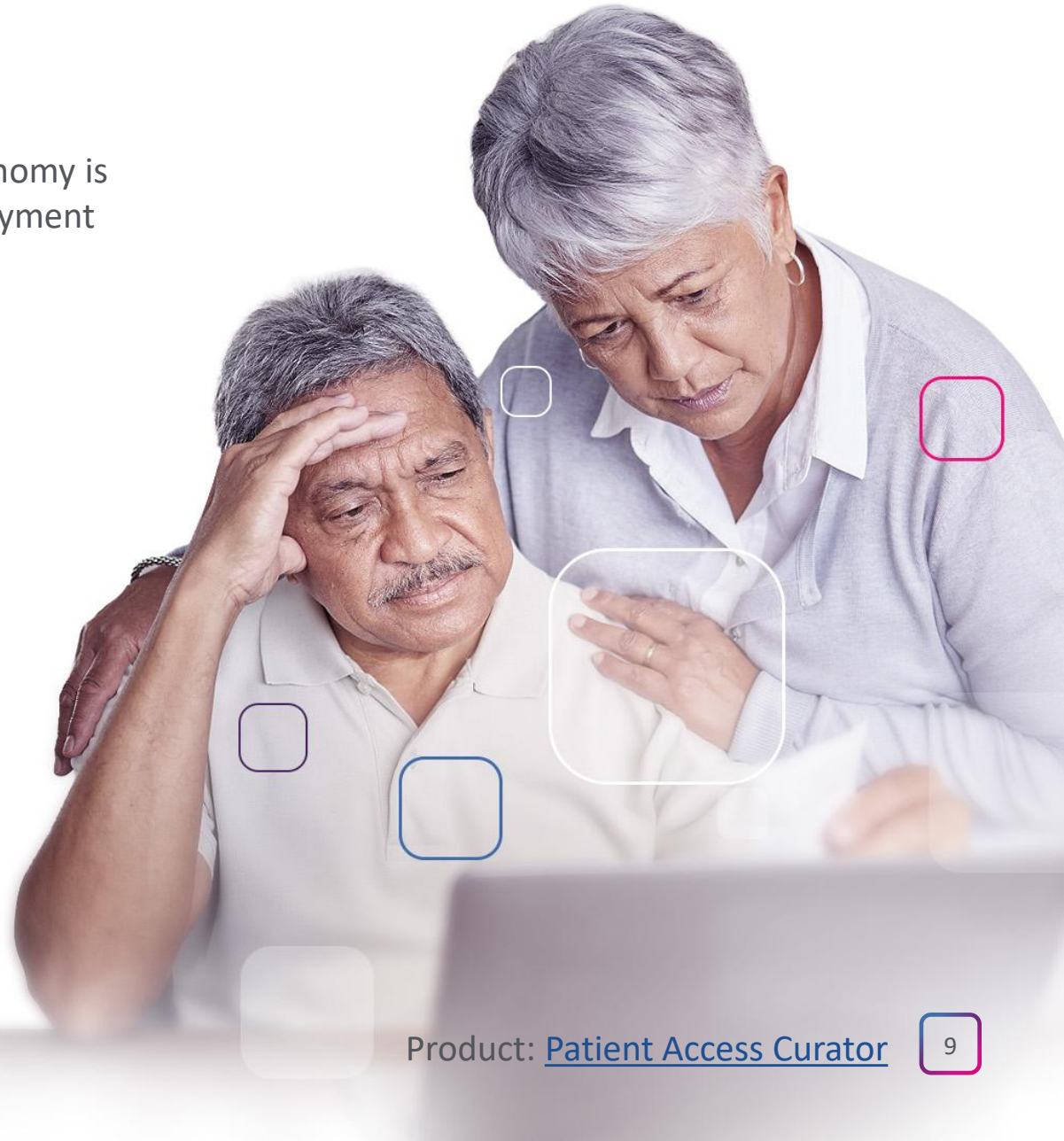
Product: Patient Access Curator

Economic pressure makes reimbursement more urgent

People get sick whether they can afford to or not. Concerns that the economy is impacting patient payments continue to grow. Both payer and patient payment reliability are equal concerns over the next 12 months.

79%
agree the economy adds urgency to payer reimbursements — the highest result since the survey began in 2022

75%
are very to somewhat concerned about reimbursement from both payers & patients over the next 12 months



Resubmission success does not guarantee full revenue recovery

The upside of so many denied claims? Providers are pretty good at resubmitting them. Successful resubmission doesn't mean 100 percent of the revenue is recovered, however.



86%

successfully resubmit denied claims 50% or more of the time

only

30%

successfully recover 80%-100% of denied revenue

52% recovered only 50%–70% of denied revenue

Read the blog: [Reimbursement issues in healthcare]

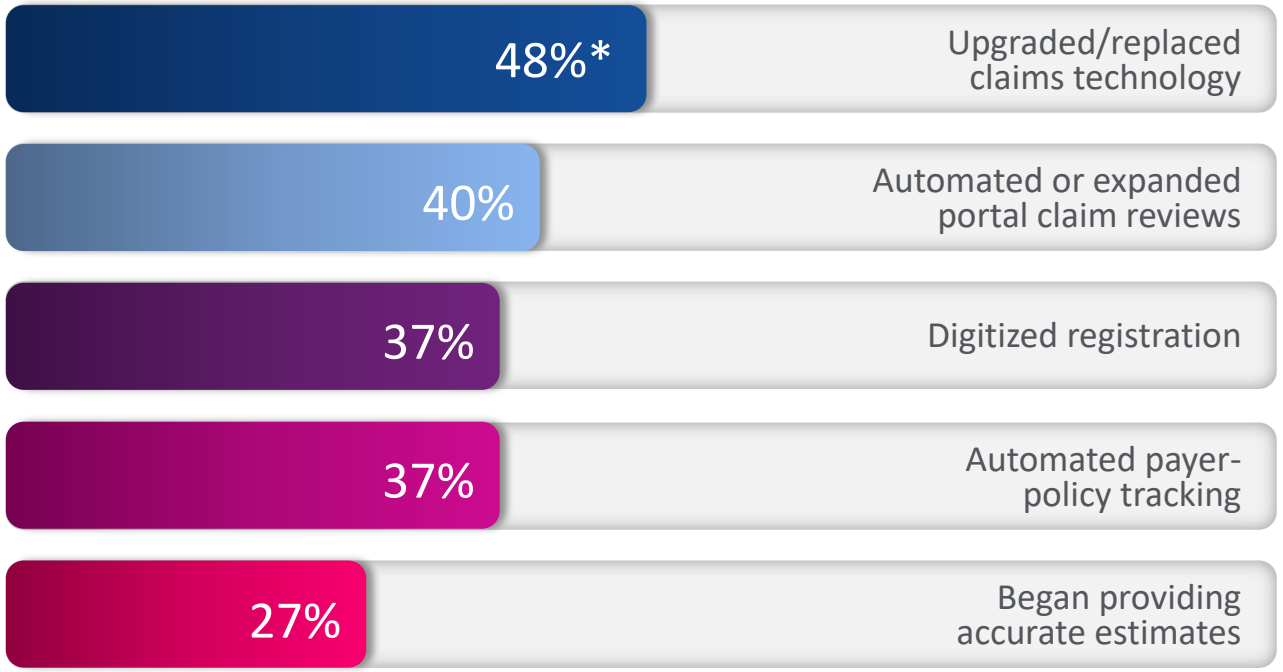
How providers are responding

Pressure to stay ahead of denials requires evaluation of a provider's revenue cycle — and the technology that powers it.



The tactics to reduce denials

Many factors can lead to a denied claim. Where to focus varies from provider to provider, based on things like location, budget, staffing issues and use of technology. The technology part touches everything, however, and AI will make it more relevant in the future.



*How has your organization reduced denials in the last year?

How are we doing?

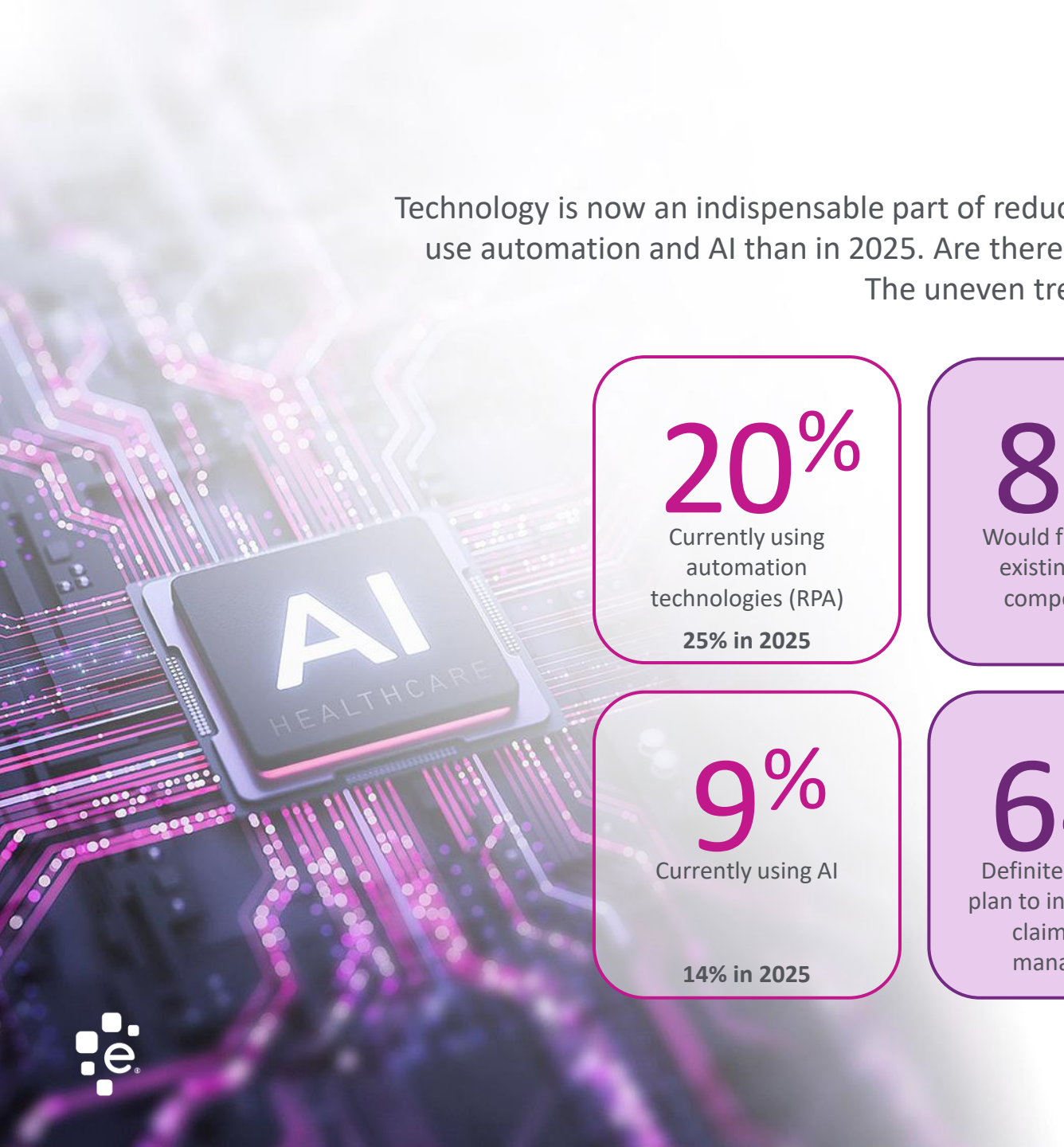
Tracking progress against reducing denials can be difficult. Here's what providers look at to know they are moving the needle:

31%	Time spent on appeals vs. amount recovered
31%	Clean claims rate
23%	Denial rate
16%	Time on appeals only

Product: Claims management

Technology at a glance

Technology is now an indispensable part of reducing denials. Despite that, there are fewer providers saying they use automation and AI than in 2025. Are there concerns? Is AI "embedded" and not visible? Was AI removed? The uneven trendline suggests providers adopting new technology cautiously.



20%
Currently using automation technologies (RPA)
25% in 2025

83%
Would fully replace existing tech for compelling ROI

9%
Currently using AI
14% in 2025

64%
Definitely/probably plan to invest in AI for claims/denial management

Top 3 reasons to evaluate existing technology:

57%	Because denials keep rising — No. 1*
35%	Manual processes are still dominant at our organization — No. 2
31%	Interest in leveraging AI to optimize claims — No. 3

*Percentage reflects how often choice was selected in top 3

Read the blog: Revenue cycle management and AI

The Big Picture

Denial frequency is unsustainable at the levels providers say currently occur. In 2022, 31% of providers said 10% or more of their claims were denied. In 2025: 41%; in 2026: 40%. Consider that denials cost healthcare providers more than $20 billion[1] annually in administrative rework alone, before actual denial revenue losses are factored in. All this makes it possible to imagine a future where half of survey respondents report 10% or more of their claims being denied.

Providers can't let that happen; the consequences would be extreme. Technology is strongly positioned to help providers reverse the trend, but the State of Claims survey reflects uncertainty and slow adoption. Is hesitation due to the technology being new? Expensive? Immature ROI projections? Fear of better technology emerging?
In the fast-moving world of AI, these are valid questions, but a more critical question remains:

What is the cost of doing nothing?



AI is a source of optimism

Asked if AI can dramatically change the claims process, a majority said yes, with some indicating results will be realized only by organizations capable of the investment required.

38% Yes	8% Likely, but only for organizations able to invest
38% Yes, but it will take a while	11% No

[1] Becker's Hospital Review cited for $20B annual administrative rework estimate

Survey methodology

Fielded August 5–23, 2026

Survey sample

204 healthcare staff responsible for finance, billing, registration, reimbursements, claims and collections. Participants included chief officers, presidents, vice presidents and directors.

Survey objective

Assess the current state of claims management, the reasons behind today's challenges, actions providers are taking, and awareness of emerging technologies that can optimize claims and reimbursement.





Learn more about automation, machine learning and artificial intelligence, and how Experian Health solutions leverage these technologies to prevent denials and quickly address denied claims.

Ready for a demo? **Contact us**.

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