



Global Payer Tech 2026



Vendor-Agnostic Industry Evaluations of Non-U.S. Payer IT Priorities and Opportunities

Survey of Non-U.S. Executives Across Europe, Asia-Pacific,
Latin America, and the Middle East & Africa

Health-Insurer Tech Regional Strengths and
U.S. IT Vendor Expansion Opportunities



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Introduction.....	3
Survey at a Glance.....	5
Black Book 2025 Global Payer Tech Survey Respondent profile:.....	6
What the Findings Mean	8
Global Market Outlook: 2026 as Proving Ground	11
Survey Findings — The Four Interlocking Priorities	13
The Balancing Act.....	14
Market Segmentation Through the Payer Tech Lens	15
Regional Outlooks	18
Competitive Landscape.....	20
Black Book’s 18 Qualitative KPIs for Health Insurance & Payer Technology Vendors..	24
Where 2026 Could Crack	27
Strategic Imperatives for 2026	30
Top 50 Non-U.S. Payers Driving Global IT Demand	33
Summary Conclusion and Wrap-Up	38

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Global IT Vendor Directory (Payers & Health Insurers)	40
Future Forecast: Global Payer Tech Outside the U.S. (2026–2030)	47
Scenario outlook (2026–2030).....	50
Future Forecast & Strategic Outlook (2026–2030)	52
Global Payer Tech Opportunity Matrix (2026)	53
What Success Looks Like by 2030 to Global Payer Organizations:	54
Conclusion	55

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Introduction





Health insurance has become the quiet backbone of health systems worldwide. While U.S. debates dominate headlines, the fastest shifts in coverage, regulation, and payer innovation are happening elsewhere. Europe is testing new transparency and solidarity rules; Asia is racing ahead with insurtech; Latin America is leaning into family and critical-illness plans; and parts of Africa and the Middle East are leapfrogging into mobile-first coverage.

In 2025, Black Book surveyed 404 payer organization executives across 40 countries to capture how insurers themselves see the road ahead. The view is inside-out: what it actually takes to finance care under medical inflation, demographic pivots, and relentless digital expectations. This report translates those voices into a 2026 outlook: what's driving change, where systems may fracture, and how payers are re-architecting their IT and revenue cycle infrastructure to keep confidence high with both members and providers.

A constant throughline: no strategy works without the invisible machinery of claims, coding, fraud analytics, enrollment, and cross-border data exchange. Providers, for their part, now judge payers by speed and accuracy of payment. In our survey, more than 70% flagged claims automation and payer-to-provider RCM integration as critical pain points. Put simply: coverage breadth matters, but back-office performance defines trust.

This frames the core question: how will payers outside the U.S. balance cost pressures, demographic shifts, regulatory fragmentation, and digital transformation—while delivering the RCM alignment providers demand? The sections that follow provide the benchmarks, friction points, and strategic moves most likely to shape 2026.



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Survey at a Glance





Black Book 2025 Global Payer Tech Survey Respondent profile:

- **Total respondents:** 404 non US payer executives and managers
- **Geographic distribution:** Europe 122 (30%); Asia-Pacific 146 (36%); Latin America 71 (18%); Middle East & Africa 65 (16%)
- **Roles represented:** CFOs 26%; CIOs/CTOs 18%; Claims & RCM Directors 22%; Product Managers 15%; CEOs/Strategy Leads 19%
- *Majority of respondents held financial or technology oversight roles—underscoring that these findings reflect direct IT and operations priorities, not abstract strategy.*

Top priorities for 2026 (% ranking in top three)

- 79% Contain medical inflation through digital efficiency
- 68% Modernize claims and policy platforms
- 64% Tighten provider RCM integration and reduce denials
- 53% Improve member experience through faster, transparent claims
- 47% Meet evolving regulatory and cross-border data standards

Technology & IT investment signals

- 71% Expanding claims automation/adjudication systems by 2026
- 62% Deploying AI for predictive fraud detection
- 58% Building deeper interoperability with provider-side RCM platforms
- 41% Upgrading mobile-first member portals
- 34% Piloting distributed ledger/blockchain tools for claims validation



Provider–payer friction points (RCM focus)

- 67% Settlement delays are providers' top complaint
- 59% Coding/documentation misalignment driving denials
- 44% Increasing pressure to deliver transparent reimbursement data
- 31% Struggling with multi-country compliance and cross-border billing

Fault line alerts flagged by payers

- **Affordability ceiling (Europe):** Premium growth capped while costs rise
- **Digital divide:** APAC leading in automation; LATAM/MEA falling behind
- **RCM strain:** Providers in emerging markets overwhelmed by multiple payer requirements without modern systems
- **Trust gap:** Slow, opaque claims processes directly eroding member confidence

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What the Findings Mean





The respondent pool leans heavily toward decision-makers who sign budgets and oversee technology platforms—CFOs, CIOs, and claims/RCM directors. This is crucial: the responses aren't speculative. They reflect the hard choices payers must make about which IT systems to modernize first and which vendor partnerships to prioritize.

Cost containment dominates the agenda, but respondents repeatedly linked “cost” to “technology.” For them, bending the inflation curve isn't about squeezing providers or cutting benefits; it's about automating claims, aligning RCM workflows, and tightening fraud detection. These are execution levers that vendors can directly supply.

Digital transformation is no longer shorthand for a mobile app or member portal. Survey participants emphasized back-office modernization—claims adjudication engines, fraud analytics, cloud-based policy systems—as the real battleground. Vendors that can scale these core functions will be positioned as indispensable partners in 2026.

Provider integration is emerging as a global chokepoint. Nearly two-thirds of respondents ranked RCM alignment in their top priorities. This is a clear signal to vendors: payer systems cannot succeed in isolation. Platforms that streamline coding, documentation, and settlement directly with providers will resolve the friction points most cited in the survey.



Member experience appears further down the priority list, but it is inseparable from the first three. Slow or opaque claims settlement is the most visible driver of dissatisfaction. Where automation and RCM alignment improve performance, member trust follows. Where they lag, the trust gap widens, and payers risk reputational damage.

Finally, the **fault line alerts** show that these issues aren't abstract. European payers are already hitting an affordability ceiling, Asia is sprinting ahead in automation while Latin America and MEA fall behind, and providers in emerging markets are straining under manual, multi-payer complexity. Each of these cracks points back to IT modernization as the deciding factor between stability and disruption.

For vendors—regional and U.S. alike—the message is direct: the payer executives surveyed are not debating if they'll modernize, but how fast, and with which partners. Those who deliver efficient claims cores, interoperable RCM connections, and transparent digital workflows will be at the center of payer strategy in 2026.

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Global Market Outlook: 2026 as Proving Ground





The non-U.S. health insurance market is on a clear upward trajectory, projected to surpass **USD 2.2 trillion** in 2026. Yet beneath that growth, the operating foundations are uneven and increasingly dependent on the technology choices payers make. Europe and Asia-Pacific account for more than half of market value, but Latin America and the Middle East & Africa are expanding fastest, albeit from smaller bases.

- **Costs:** Medical inflation remains the immovable headwind. In Europe, strict regulatory caps keep premiums from rising in line with costs, leaving efficiency gains as the only lever. In APAC, fragmented provider contracting exposes insurers to price volatility. In LATAM and MEA, manual claims processes and administrative bloat consume resources that could otherwise fund new coverage.
- **Demographics:** Markets are pulling in opposite directions. Aging Europe and East Asia are straining payer systems with chronic, high-cost claims, while youthful LATAM and MEA populations demand affordable, flexible products—especially family and microinsurance—that only scalable IT systems can administer efficiently.
- **Technology:** Three in four payers report plans to expand claims adjudication platforms by 2026. AI-driven fraud detection is shifting from pilot projects to baseline expectations. Nearly 60% of surveyed executives acknowledged provider-side RCM misalignment as a leading source of cost overruns and strained relationships—signaling that interoperability with provider systems is now a make-or-break capability for vendors.
- **Regulation:** Europe’s EHDS framework is accelerating digital adoption but adding compliance costs. APAC is liberalizing private markets, creating opportunities for new entrants alongside volatility in pricing. LATAM is experimenting with public–private coverage expansions. MEA is blending universal schemes with private administration, often delivered through mobile-first enrollment and claims platforms.

Implication: 2026 will be a proving ground for payers and the vendors that support them. Those who modernize claims pipelines, integrate tightly with provider RCM, and deliver transparent, AI-enabled digital platforms will not just survive—they will gain market share. Those who attempt to offset rising costs with premium hikes or incremental fixes will find themselves trapped between affordability ceilings, provider frustration, and eroding member trust.





Survey Findings — The Four Interlocking Priorities

The 404 executives we surveyed describe a payer sector under stress but aligned on a shared set of imperatives. Their priorities are not abstract strategies; they are operational requirements tied directly to IT modernization and vendor partnerships. Four themes stand out:

1. Contain Costs Through Digital Precision

Inflation control is the top priority worldwide. But payers don't see this as a blunt instrument—cutting benefits or simply raising premiums is no longer viable. Instead, they link cost containment directly to **process efficiency**: faster adjudication, standardized coding, streamlined provider contracts, and predictive fraud detection. Vendors offering automation and AI-based payment integrity tools are positioned as the most important cost-management partners.

2. Modernize the Core, Not Just the Portal

Digital transformation has shifted from the front end to the back office. Respondents emphasize that apps and portals alone don't solve their problems. The real investment is flowing into **claims engines, cloud-based policy cores, fraud analytics, and interoperability platforms**. This is where vendors can deliver measurable cost reduction and settlement speed—capabilities that separate leaders from laggards in 2026.

3. Rebuild Member Trust by Fixing the Claims Engine

Claims are the moment of truth. Members don't evaluate insurers on premium tables; they judge them on whether claims are paid quickly, transparently, and fairly. Payers acknowledge that **trust is built—or lost—in the back office**. In Europe, transparency mandates are forcing insurers to publish clear reimbursement data. In Asia, digital-first challengers are setting expectations for instant adjudication. Vendors who help insurers cut settlement times and show claim status in real time are effectively rebuilding trust on their behalf.



4. Realign Products to Demographics—Without Breaking RCM

Growth products such as **critical illness coverage and family floater plans** are rising fastest in APAC and LATAM. But these products are complex: multiple members per plan, heavier documentation, and multi-specialty billing create coding and adjudication strain. Payers know product growth will stall if their RCM platforms can't handle the complexity. Vendors that can build scalable, modular systems aligned to demographic needs will be critical enablers of sustainable product innovation.

The Balancing Act

These four priorities don't compete—they stack. Containing costs depends on modernized claims cores. Modernization delivers the transparency that rebuilds trust. Product realignment creates new demand, which only advanced RCM and automation can manage. For vendors, the takeaway is clear: success in non-U.S. markets isn't about point solutions, it's about delivering integrated platforms that simultaneously address cost, modernization, trust, and product complexity.



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Market Segmentation Through the Payer Tech Lens





Traditional health insurance reports classify markets by provider type, plan design, demographics, or network model. The 404 non-U.S. payer executives surveyed add a deeper layer: which segments they see as operationally viable, which are growth engines, and where IT and RCM infrastructure either enables or constrains profitability.

By Provider

- **Public programs:** Still dominant in Europe and parts of LATAM, but weighed down by compliance mandates and slow claims cycles. Respondents note that weak RCM integration is the primary barrier to efficiency, creating vendor opportunities in claims automation and cross-border data exchange.
- **Private insurers:** Fastest adopters of AI and automation in APAC, but vulnerable to fraud risk. CIOs surveyed emphasized the need for predictive analytics and payment integrity tools to protect margins.
- **Standalone insurers:** Small, product-focused players (critical illness, travel) are seen as innovation labs, but they lack IT scale. Without stronger claims cores or outsourcing partners, respondents expect many to be acquired or consolidated by 2027.

By Plan Type

- **Medical insurance:** Still the universal baseline, but increasingly low-margin. Respondents highlight automation of high-volume claims as the only path to profitability.
- **Critical illness:** Identified as a profitable growth line in APAC and LATAM, but documentation-heavy. Insurers warn these products will choke under manual claims processes unless supported by robust RCM systems.
- **Family floater plans:** Popular in India, Southeast Asia, and Latin America as affordability solutions. However, payers flagged them as “RCM-intensive,” requiring advanced eligibility, coding, and adjudication workflows.
- **Short-term/accident:** Declining segment. Survey participants called them “administratively heavy with little return,” signaling reduced IT investment in this category.

By Demographics

- **Minors:** Typically bundled into family policies. Low profitability standalone, but still create IT demands for eligibility checks and multi-member claims.





- **Adults:** Largest insured base and the most demanding digital consumers. Respondents pointed to mobile-first policy management and transparent billing as baseline expectations.
- **Seniors:** Fastest-growing segment in Europe and East Asia. High premiums are offset by high claim volumes and coding complexity, which heavily stress payer-provider RCM connections.

By Network Model

- **PPOs (Preferred Provider Organizations):** Popular in Europe and LATAM for member choice, but respondents warned of “RCM sprawl” from managing large, fragmented networks.
- **HMOs (Health Maintenance Organizations):** More common in APAC. Centralized networks improve claims processing consistency, but limit flexibility and innovation.
- **POS/EPO hybrids:** Offer efficiency benefits, but payers cited member dissatisfaction when provider choice is too restricted. IT integration across hybrid models was flagged as inconsistent.

Signal for Vendors

The survey makes one point clear: **profitability now maps more to IT maturity than to raw demand.** Segments with complex coding (critical illness, family floater, seniors, PPO networks) can be profitable only where claims cores and RCM integration are strong. Where IT infrastructure is weak, these products generate denial spikes, settlement delays, and member dissatisfaction. Vendors able to deliver scalable automation, predictive fraud tools, and interoperable RCM systems will define which segments grow sustainably and which stall.



Regional Outlooks

Europe

Europe’s payers are caught in a squeeze: **premium caps collide with medical inflation**, leaving little room to maneuver. The **European Health Data Space (EHDS)** is accelerating digitization, but it is also exposing how uneven payer–provider systems remain across borders. Respondents flagged RCM inconsistencies between national markets as a major obstacle to compliance and efficiency.

Survey signal: 63% of European executives listed transparency mandates as a top 2026 priority. Standardizing coding and payer–provider data flows is seen as the critical unlock—one that IT vendors with interoperability expertise are best placed to deliver.

Asia-Pacific

APAC remains both the **growth engine and the digital vanguard** of global health insurance. Mobile-first enrollment, AI-powered claims adjudication, and predictive fraud tools are already being deployed at scale. Yet, respondents cautioned that rapid expansion also magnifies **fraud risk** and exposes weak provider integration in some markets.

Survey signal: 66% of APAC respondents said **provider-side RCM integration** is the single most important factor for scaling new products, particularly critical illness and family floater plans. Vendors that can hardwire payer–provider workflows into their platforms will find eager buyers.

Latin America

LATAM markets are expanding coverage through **critical illness and family floater products**, but insurers face **IT fragmentation** and outdated claims cores. Respondents consistently cited claims delays and denial disputes as barriers to growth. The appetite for modernization is strong, but local execution capacity is limited.

Survey signal: 57% ranked **claims automation** as their #1 IT priority for 2026. Many admitted they lack in-house expertise to implement it—opening clear entry points for global IT and RCM vendors with scalable solutions.





Middle East & Africa

MEA payers are operating at two speeds: **governments expanding universal schemes** while private insurers test mobile-first models. The region is leapfrogging paper-based enrollment, but **RCM immaturity** is a persistent drag. Manual coding and inconsistent provider systems are slowing claims settlement and undermining trust.

Survey signal: 71% cited **settlement delays** as their top operational risk in 2026. Respondents pointed to **cloud-based RCM platforms and standardized coding frameworks** as prerequisites for sustainable growth. Vendors that can deliver lightweight, mobile-enabled back-office systems stand to gain.

Synthesis

The four regions differ in maturity, but the **bottleneck is the same: payer-provider process alignment**. Europe needs interoperability to satisfy EHDS mandates, APAC needs RCM integration to secure growth, LATAM needs automation to modernize fragmented systems, and MEA needs cloud-based claims platforms to scale universal schemes. For vendors, the lesson is straightforward: whichever market you target, the business case rests on building the digital bridge between payers and providers.

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Competitive Landscape





The survey data confirms that payer leadership in 2026 will not be defined by financial strength alone. The critical differentiator is **execution in IT and RCM performance**: accuracy of claims adjudication, speed of settlements, transparency of pricing, and alignment with provider-side workflows. Across the 404 non-U.S. executives surveyed, these dimensions emerged as the primary signals of trust and competitiveness.

Multinational Leaders

Global insurers with diversified footprints continue to set benchmarks, but their success is uneven—strong in some KPIs, weaker in others.

- **Allianz SE (Europe)**: Highest marks for transparency and cross-jurisdiction claims integration, particularly under EHDS mandates. Allianz is recognized for deploying advanced interoperability frameworks across multiple EU markets.
- **AIA Group (Asia-Pacific)**: Regional leader in **mobile-first member engagement** and wellness-linked products. Respondents in APAC consistently highlighted AIA’s use of digital portals and integrated wellness incentives as setting the pace for consumer expectations.
- **Cigna International**: Strongest in **fraud detection and RCM integration**, especially in MEA and LATAM where its systems help stabilize fragmented provider environments. CIOs cited Cigna’s predictive analytics as best-in-class.
- **Zurich Insurance Group**: Stands out in **LATAM provider collaboration**, with payers in Brazil and Mexico rating Zurich highly for claims partnership programs. However, Zurich lags in **front-end digital experience**, with member portals rated as less intuitive than peers.
- **Prudential (UK/Asia)**: Known for **critical illness and family floater product design**. Rated highly for multi-member claims readiness and RCM optimization in complex product lines.
- **UnitedHealth International**: Rated high for **RCM integration** in APAC, but scored lower on **pricing transparency**, reflecting its U.S.-centric model’s difficulty adapting to stricter international regulatory environments.



Regional Champions

In several markets, **regional insurers outperform global multinationals** by excelling in localized IT and provider integration.

- **SulAmérica (Brazil):** Highest regional score for **claims settlement speed** and **customer satisfaction**, supported by strong local RCM partnerships.
- **Bupa Arabia (Saudi Arabia):** Best-in-class for **mobile-first claims portals**, enabling faster turnaround in MEA markets where mobile access outpaces fixed infrastructure.
- **Ping An (China):** The gold standard in **instant claims adjudication at scale**, leveraging AI and insurtech integration across millions of members.
- **Discovery Health (South Africa):** Lauded for **wellness-linked insurance** and seamless integration between preventive care apps and claims platforms.
- **Max Bupa (India):** Rising leader in **family floater claims management**, piloting cloud-based claims systems optimized for multi-member adjudication.

Emerging Insurtech Challengers

Digital-first entrants are reshaping expectations around **speed, personalization, and user experience**. While their strength lies in consumer-facing innovation, they often lag in provider-side integration and large-scale RCM readiness.

- **Ping An Health (China):** Benchmark in **AI-driven underwriting** and instant claims settlement.
- **Oscar Global (expanding outside U.S.):** Rated highly for **digital member experience**, but respondents noted **weakness in provider integration** compared to established vendors.
- **Lemonade (Europe expansion):** Applying its property & casualty playbook to health, introducing **AI chatbots for claims handling**, though large-scale medical adjudication remains unproven.
- **WeSure (Tencent, China):** A rising insurtech leveraging ecosystem partnerships to deliver **bundled health and lifestyle coverage**.





Vendor Applications in Demand

Survey respondents repeatedly tied performance to **specific IT applications**, creating clear opportunity signals:

- Claims automation/adjudication engines: Vendors like Cognizant TriZetto, DXC Technology, HealthEdge are being adopted for back-office modernization.
- RCM integration tools: Waystar, Optum, Dedalus, Comarch Healthcare ranked highest among those cited by respondents seeking smoother payer-provider workflows.
- Fraud detection/predictive analytics: Shift Technology, SAS, Palantir, Friss flagged as critical partners where fraud leakage erodes margins.
- Member engagement platforms: Ping An Technology, Bupa Global, Castlight Health, Teladoc Health noted for creating mobile-first experiences.
- Data interoperability: InterSystems, Oracle Health (Cerner), Better, Inovalon highlighted for cross-border and multi-payer data exchange.

Scorecard Takeaway

Leadership is shifting from **raw scale to operational execution**. The winners are those combining:

- Accurate, automated claims systems
- Transparent reimbursement data
- Tight payer-provider RCM alignment
- Frictionless digital member experiences

Regional champions and insurtechs are proving that local focus and digital agility can beat multinationals on satisfaction metrics. At the same time, global vendors that can export **scale-tested claims cores, fraud analytics, and interoperability frameworks** are finding strong demand in LATAM, MEA, and APAC markets.

For IT vendors—both regional specialists and U.S. entrants—the signal is clear: **2026 is the year when payer technology execution becomes the defining competitive edge.**

Black Book's 18 Qualitative KPIs for Health Insurance & Payer Technology Vendors





Claims & Settlement Performance

1. **Claims Accuracy** – Percentage of claims adjudicated correctly on first submission; reduces rework and disputes.
2. **Settlement Speed** – Average cycle time from claim submission to provider payment; critical for provider satisfaction.
3. **Denial Management Effectiveness** – Ability to minimize inappropriate denials and resolve disputes quickly.

Provider Integration & RCM Alignment

4. **Provider Network Integration** – Depth of interoperability with hospital/provider RCM systems, including coding standards.
5. **Coding & Documentation Alignment** – Ability to harmonize payer rules with provider documentation practices (especially cross-border).
6. **Payment Integrity & Audit Tools** – Effectiveness of overpayment detection, duplicate claim prevention, and contract compliance.

Member & Customer Experience

7. **Transparency of Pricing & Coverage** – Clarity of reimbursement policies, cost-sharing rules, and member communications.
8. **Digital Claims Visibility** – Availability of real-time claim status and explanations via portals or mobile apps.
9. **Member Engagement Platforms** – Integration of wellness tools, virtual care, and personalized coverage recommendations.

Fraud, Risk & Security

10. **Fraud Detection Capability** – Use of AI/predictive analytics to identify and prevent fraudulent claims.
11. **Data Privacy & Security Compliance** – Adherence to GDPR, EHDS, HIPAA (for cross-border ops), and local data mandates.
12. **Risk Modeling & Predictive Analytics** – Strength of actuarial and AI models for predicting costs and utilization.



Technology Modernization

13. **Cloud-Native Platform Readiness** – Ability to deploy modular, scalable core claims systems across geographies.
14. **Interoperability & Data Exchange** – Performance in cross-system, cross-border data flows (FHIR, EHDS standards, HL7).
15. **Scalability Across Products** – Flexibility to support diverse product types (medical, critical illness, family floater, microinsurance).

Innovation & Adaptability

16. **Regulatory Adaptability** – Speed and effectiveness in updating systems for local/regional compliance mandates.
17. **Product Innovation Enablement** – How well the IT stack supports new insurance models (wellness-linked, usage-based, bundled).
18. **Vendor Responsiveness & Support** – Quality of implementation, customer service, and localization in non-U.S. markets.

Why These Matter Globally

- In **Europe**, EHDS mandates put heavy weight on interoperability, transparency, and compliance.
- In **APAC**, fraud detection, mobile-first member engagement, and multi-member claims handling (family floater) are decisive.
- In **LATAM**, settlement speed and automation are top priorities given outdated legacy systems.
- In **MEA**, scalability, mobile-first design, and cloud-native claims cores are critical to leapfrog infrastructure gaps.

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Where 2026 Could Crack





Survey responses from 404 non-U.S. payer executives reveal four structural vulnerabilities—fault lines—that could fracture the global health insurance market if left unresolved. Each is already visible in claims data, provider complaints, and member satisfaction scores, and each ties back to the readiness (or fragility) of payer IT and RCM infrastructure.

1. The Affordability Ceiling (Europe)

Premiums across Europe are constrained by regulatory caps and stagnant household incomes, even as medical inflation accelerates. Without efficiency gains through automation and streamlined claims processing, insurers risk margin erosion and political pushback. Vendors offering **AI-driven adjudication, coding standardization, and cross-border interoperability** will be central to lifting efficiency without raising rates.

2. The Digital Divide (APAC vs. LATAM & MEA)

In Asia-Pacific, claims can be settled in minutes through mobile-first portals and AI-driven workflows. In much of Latin America and MEA, the same processes take weeks, slowed by manual systems and fragmented provider integration. This widening gap is not just technological—it defines how quickly markets can scale coverage and attract investment. Vendors that bring **cloud-native claims platforms and lightweight mobile solutions** to lagging regions could close this divide.

3. RCM Strain (Emerging Markets)

Providers in LATAM, Africa, and parts of Asia report rising frustration with delayed payments, coding disputes, and opaque denial management. This “RCM strain” undermines payer-provider relationships and stalls adoption of new products like critical illness and family floater plans. Surveyed executives tied the problem directly to weak integration between payer claims systems and provider RCM tools. Vendors with **end-to-end payer-provider integration suites** are positioned to solve the bottleneck.





4. The Trust Gap (All Regions)

Members consistently equate slow or opaque claims with broken promises. More than half of surveyed payers admitted dissatisfaction is rising, even in markets with strong digital adoption. Trust is fragile: insurtech entrants are raising expectations for instant claims, while legacy payers risk reputational decline if their systems can't match. **Transparent portals, real-time claims visibility, and standardized communications** are now essential, not optional.

Synthesis: The Common Root

Each of these fractures—affordability, digital inequality, RCM strain, and trust erosion—traces back to the same root cause: **claims and RCM modernization**. Everything else cascades from it. If payers and vendors can align to deliver fast, accurate, transparent claims handling, they will ease cost pressures, close the digital gap, strengthen provider relationships, and rebuild trust. If they cannot, 2026 will expose these fault lines as systemic failures.

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Strategic Imperatives for 2026





The voices of the non-U.S. payer executives converge on a clear message: the coming year is less about incremental upgrades and more about fundamental choices. Each imperative ties directly to technology execution, not just policy or product design. Together, they outline a survival blueprint for insurers operating under pressure from costs, regulators, providers, and members.

1. Contain Costs with Digital Efficiency

Rising medical inflation cannot be offset by premiums alone. Executives consistently tied cost control to **automation, AI fraud detection, and standardized RCM workflows** embedded in provider contracts. Efficiency is not optional—it is the only lever left.

2. Modernize Core Claims Platforms

Legacy systems cannot carry tomorrow's product mix. Respondents emphasized shifting to **cloud-native, modular claims cores** with interoperability at the center—capable of handling multi-member plans and senior-heavy pools without collapsing under complexity.

3. Rebuild Trust Through Speed and Transparency

Trust lives and dies in the claims process. Payers see a direct link between digital transparency and member loyalty. **Clear reimbursement rules, real-time claim status, and mobile-first portals** are the new baseline for maintaining credibility.

4. Innovate Products Without Overloading Operations

Critical illness and family floater plans are growing fastest, but they add heavy RCM burdens. Payers stressed the need to **align product innovation with operational capacity**—ensuring coding, adjudication, and provider workflows are ready before scale-up.

5. Engineer Compliance for Regulatory Divergence

From EHDS in Europe to liberalization in APAC and universal schemes in MEA, regulatory demands are diverging fast. Successful insurers will **design compliance directly into IT platforms**, avoiding costly manual workarounds that slow responsiveness.



6. Make Providers True Partners

Settlement delays remain providers' top complaint. Executives see **shared analytics, real-time authorization, and claims visibility** as the next frontier of payer-provider collaboration. Provider satisfaction is not peripheral—it is a leading indicator of payer performance.

The Strategic Pivot

Across regions, these imperatives point to a single conclusion: **IT modernization and RCM alignment are no longer projects—they are the operating system of payer survival.** In 2026, insurers that treat digital claims, automation, and interoperability as central investments will maintain affordability, meet compliance, and rebuild trust. Those that defer will face the cracks already widening beneath them: cost ceilings, digital divides, provider frustration, and member attrition.

Top 50 Non-U.S. Payers Driving Global IT Demand





Europe

1. Allianz (Germany)
2. AXA (France)
3. Aviva (UK)
4. Assicurazioni Generali (Italy)
5. Bupa (UK, with global operations)
6. Uniqa Insurance Group (Austria, CEE)
7. Sanitas (Spain – part of Bupa)
8. LUX MED (Poland – part of Bupa Group)
9. MAPFRE (Spain, with LATAM presence)
10. VHI Healthcare (Ireland)
11. Legal & General (UK)
12. Aegon (Netherlands/CEE)
13. Munich Re (Germany – health reinsurance focus)



Asia-Pacific

14. AIA Group (Hong Kong, ASEAN, China, India, Australia)
15. Ping An Insurance Group (China)
16. Sun Life Financial Asia (China, Philippines, India, ASEAN)
17. Nippon Life (Japan)
18. Tokio Marine (Japan/Asia)
19. Manulife Asia (Hong Kong, Southeast Asia)
20. ICICI Lombard (India)
21. Tata AIG Health (India)
22. Max Bupa Health Insurance (India)
23. BNI Life (Indonesia)
24. Prudential Asia (Singapore, Malaysia, Hong Kong, India)
25. ZhongAn (China – digital insurer)



Latin America

26. SulAmérica (Brazil)
27. Unimed (Brazil – largest cooperative)
28. Bradesco Seguros (Brazil)
29. Itaú Seguros (Brazil)
30. BB Seguros (Brazil, Banco do Brasil)
31. Grupo Sura (Colombia/LATAM)
32. Zurich LATAM (Brazil, Mexico, Argentina, Chile)
33. Bupa Chile (Chile, part of Bupa)
34. MAPFRE LATAM (Mexico, Colombia, Peru, Brazil)



Middle East & Africa

35. Bupa Arabia (Saudi Arabia)
36. Tawuniya (The Company for Cooperative Insurance, Saudi Arabia)
37. Daman National Health Insurance (UAE)
38. AXA Gulf (UAE, broader GCC operations)
39. Now Health International (Hong Kong/UAE base, global expat health)
40. Discovery Health (South Africa)
41. Vitality Health (UK/South Africa, global wellness-linked insurance)
42. Sanlam (South Africa)
43. Medscheme (South Africa)
44. Momentum Metropolitan Health (South Africa)
45. Jubilee Insurance (Kenya, East Africa)
46. AAR Insurance (Kenya, East Africa)
47. Saham Group (Morocco – now part of Sanlam)
48. Medical Insurance Group (Jordan)
49. Qatar Insurance Company (QIC – Qatar/Gulf region)
50. Al Rajhi Takaful (Saudi Arabia)

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Summary Conclusion and Wrap-Up





Outside the U.S., 2026 won't merely be a growth year; it will be a stress test of affordability, operational maturity, and trust. Four realities define the arc: Europe's affordability ceiling, APAC's digital acceleration, LATAM/MEA's RCM bottlenecks, and a universal trust gap tied to claims performance.

The remedy isn't more product variety or premium hikes. It's disciplined modernization of the claims and RCM engine: automation, payment integrity, clean data exchange, and transparent timelines. Insurers that pair these with product designs matched to local demographics will keep both members and providers onside—despite inflation and regulatory divergence.

Black Book's perspective: treat 2026 as an opportunity to industrialize the back office. The winners will be those who turn claims into a competitive advantage and trust into a measurable KPI—building health financing that works in a fractured world.



Global IT Vendor Directory (Payers & Health Insurers)

Note on classification

“Regional (non-U.S.)” reflects primary corporate HQ outside the U.S. Many operate globally. Capability notes emphasize payer claims/RCM, fraud, interoperability, portals, and outsourced operations.

1) Claims Management & Adjudication

Regional (non-U.S.)

- **Sopra Steria (FR)** — Core claims/admin suites; EU regulatory/localization depth.
- **NTT DATA (JP)** — Claims platforms and modernization programs across APAC/EU.
- **Tata Consultancy Services – TCS (IN)** — TCS BaNCS/health modules; large payer transformations.
- **Wipro (IN)** — Claims platforms, edits, and automated adjudication accelerators.
- **Tech Mahindra (IN)** — Claims engines + BPaaS for payers in APAC/MEA.
- **Sapiens (IL)** — Insurance cores with health lines; strong rule engines.
- **Cegedim Insurance Solutions (FR)** — Claims administration for EU sickness funds/mutuelles.

U.S. expanding / could expand

- **Cognizant TriZetto (US)** — Facets/QNXT core claims; global delivery model.
- **HealthEdge (US)** — HealthRules Payor; cloud-first adjudication.
- **NASCO (US)** — High-volume claims for large plans; adaptable outside U.S. via partners.
- **Optum (US)** — Claims platforms + edits; payment integrity baked in.
- **Change Healthcare (Optum) (US)** — Claims editing/clearing; ClaimsXten lineage.
- **Availity (US)** — Multi-payer gateway/clearinghouse with growing non-U.S. pilots.





2) RCM & Provider Integration (Payer–Provider Connectivity)

Regional (non-U.S.)

- **Dedalus (IT)** — Payer–provider data rails; EU hospital connectivity at scale.
- **Comarch Healthcare (PL)** — Eligibility, e-claims, and payer/provider portals (EU/MEA).
- **Agfa HealthCare (BE)** — Imaging/workflow backbones integrated to claims/authorization.
- **TCS (IN)** — RCM integration programs; contract standardization + edits.
- **Wipro (IN)** — Payer/provider API hubs; denial prevention workflows.
- **NTT DATA (JP)** — Authorization/eligibility exchanges; payer-side RCM bridges.

U.S. expanding / could expand

- **Optum (US)** — End-to-end RCM; prior auth/real-time status; shared analytics.
- **Change Healthcare (Optum) (US)** — Clearing, eligibility, e-payments, attachments.
- **Waystar (US)** — Cloud RCM; estimation, eligibility, and claims lifecycle.
- **Experian Health (US)** — Eligibility/coverage, identity, and denials analytics.
- **Edifecs (US)** — Payer data exchange, prior auth (X12/FHIR) and trading partner ops.
- **MultiPlan / Zelis (US)** — Network repricing + payments; payer-provider financial rails.

3) Fraud Detection & Predictive Analytics (Payment Integrity)

Regional (non-U.S.)

- **BAE Systems NetReveal (UK)** — SIU, anomaly detection, network analytics.
- **Shift Technology (FR)** — AI claims fraud; explainable models for payers.
- **FRISS (NL)** — Claims/fraud scoring; link analysis across lines.
- **Featurespace (UK)** — Adaptive behavioral analytics; real-time anomaly detection.
- **Quantexa (UK)** — Entity resolution/graphs for organized fraud rings.
- **Tiger Analytics (IN)** — Custom ML payment integrity; APAC/LATAM delivery.

U.S. expanding / could expand

- **SAS (US)** — Payment integrity + fraud platforms; global health deployments.
- **Palantir Foundry (US)** — Integrated data/ML for waste, abuse & ring detection.
- **Merative (IBM Watson Health) (US)** — Program integrity, risk scoring, clinical rules.
- **FICO (US)** — Fraud and rules orchestration; adaptable to payer flows.
- **Cotiviti (US)** — Pre/post-pay analytics, COB, and medical policy enforcement.
- **Optum Payment Integrity (US)** — Edits, policies, and audit analytics at scale.



4) Interoperability & Data Exchange

Regional (non-U.S.)

- **Orion Health (NZ)** — Health information exchanges; payer–provider data fabrics.
- **Better (SI)** — openEHR data layer; longitudinal records usable for claims rules.
- **TianiSPIRIT (AT)** — Cross-border exchange (IHE/XDS); eID integration in EU.
- **Dedalus (IT)** — Interop gateways; consent, identity, and EHDS alignment.
- **Smile Digital Health (CA)** — FHIR platforms; payer API enablement beyond the U.S.

U.S. expanding / could expand

- **Epic (US)** — Payer Platform & Payer-Provider Collaboration (FHIR/TEFCA-ready).
- **Oracle Health | Cerner (US)** — Interop/clinical data for utilization & auth.
- **InterSystems (US)** — HealthShare/IRIS; national-scale data rails and payer APIs.
- **Lyniate (US)** — Rhapsody/Corepoint; integration engines for multi-standards.
- **Inovalon (US)** — Payer data platforms, risk/quality exchanges, FHIR endpoints.
- **Redox (US)** — API abstraction layer connecting disparate provider systems to payers.



5) Digital Member Engagement & Portals

Regional (non-U.S.)

- **Ping An Technology (CN)** — App-first claims, personalization, instant adjudication.
- **Discovery Vitality (ZA/UK)** — Wellness incentives tied to benefits/utilization.
- **Bupa Global (UK)** — Member portals, benefits transparency, global assistance.
- **PolicyBazaar (IN)** — Distribution/engagement; benefits education & service.
- **dacadoo (CH)** — Health scoring & engagement SDKs for insurers.
- **Halodoc / Alodokter (ID)** — Payer-linked virtual care and claims initiation.

U.S. expanding / could expand

- **Teladoc Health (US)** — Virtual care integrated with payer benefits & claims.
- **Accolade (US)** — Navigation, advocacy, and benefits guidance platforms.
- **apree health (Castlight + Vera) (US)** — Cost transparency + navigation.
- **Zipari (US)** — Health-plan CX suite: portals, CRM, quoting/enrollment.
- **b.well Connected Health (US)** — Consumer health hub; claims/benefits visibility.
- **Icario (US)** — Behavior-change outreach linked to quality and gaps-in-care.





6) Outsourcing & Payer Operations (BPO/BPaaS)

Regional (non-U.S.)

- **Infosys BPM (IN)** — Claims ops, member services, payment integrity BPaaS.
- **TCS (IN)** — End-to-end payer operations; modernization + managed services.
- **Wipro (IN)** — Claims intake/adjudication, provider ops, analytics.
- **Tech Mahindra (IN)** — Payer BPaaS with automation/AI accelerators.
- **HCLTech (IN)** — Claims platforms support; infra + ops co-sourcing.
- **Genpact (IN origin)** — F&A + claims ops; SIU support; global delivery.
- **NTT DATA (JP)** — APAC/EU shared services; contact centers + claims.

U.S. expanding / could expand

- **Optum Global Solutions (US)** — Large-scale payer ops; analytics + RCM.
- **Conduent (US)** — Government/SHI admin, enrollments, EDI, contact centers.
- **EXL (US)** — Claims BPaaS, care mgmt support, analytics for payers.
- **Cognizant (US)** — Payer BPO + digital ops; adjudication and member services.
- **Sutherland (US)** — Payer customer ops, prior auth hubs, omnichannel CX.



7) Emerging Insurtechs (Platforms & New Models)

Regional (non-U.S.)

- **CoverGo (HK)** — Low-code core insurance; quick launch for health lines.
- **Acko (IN)** — Digital-first health; instant claims experiences.
- **ZhongAn (CN)** — Fully digital claims/underwriting at massive scale.
- **WeSure (Tencent, CN)** — Ecosystem insurance with embedded health.
- **Alan (FR)** — Design-led health plan with transparent digital claims.
- **BIMA (SE/UK, EMs)** — Mobile micro-insurance across Africa/Asia.
- **Bowtie Life (HK)** — Virtual-first health plans; instant adjudication.

U.S. expanding / could expand

- **Oscar Health (US)** — API-centric claims + member app; potential JV/partner plays abroad.
- **Clover Health (US)** — MA heritage; tech stack for care coordination/claims.
- **Collective Health (US)** — Enterprise payer-tech for self-funded; adaptable to intl.
- **Sidecar Health (US)** — Transparent pricing models; mobile-first claims.
- **Devoted Health (US)** — Care navigation + member OS approach, partnerable as tech.

Synthesis

Across regions, profitability follows IT maturity. The fastest wins surface where claims automation, fraud analytics, interoperability, and payer-provider RCM alignment intersect. Regional champions bring regulatory fit and local networks; U.S. platforms contribute scale-tested cores and analytics. The 2026 opportunity is to combine both: deploy modular, cloud-first platforms with local workflows and coding standards to cut cycle times, reduce denials, satisfy transparency mandates, and rebuild trust.





Future Forecast: Global Payer Tech Outside the U.S. (2026–2030)

Thesis: Non-U.S. payer markets will expand through 2030, but leadership rotates to those who industrialize the claims/RCM “engine room.” Cost ceilings, regulatory divergence, and rising member expectations force a pivot from front-end novelty to back-office precision: automated adjudication, clean payer–provider rails, and transparent, real-time status. Vendors—regional and U.S.—win by localizing fast, integrating deeply, and pricing outcomes, not licenses.

Market size & spend trajectory

- **Premium pool:** The non-U.S. health insurance market is projected to **exceed ~\$2.2T in 2026** and keep compounding on demographic and coverage expansion.
- **IT intensity rises:** With premium increases capped in many markets, payers reallocate to technology that lowers unit admin cost. If payer IT/ops platforms represent a conservative **3–5% of premiums**, that implies an **annual addressable spend of ~\$65–\$110B** outside the U.S. by 2026, expanding with modernization waves through 2030.
- **Where dollars go:** 2026–2030 spend concentrates in five stacks:
 1. **Claims automation/adjudication** (cloud cores, edits, attachments)
 2. **Payer–provider RCM integration** (eligibility, auth, coding alignment, e-payments)
 3. **Payment integrity & fraud** (AI, graph analytics, pre/post-pay)
 4. **Interoperability/data exchange** (FHIR/EHDS, consent, cross-border flows)
 5. **Digital member OS** (status transparency, benefits clarity, guided navigation)



Opportunity map by region

- **Europe:** Affordability ceilings + EHDS compliance make **interoperability, transparency, and cross-border claims normalization** the near-term budget magnets. Expect multi-country RFPs and preference for vendors with localization, auditability, and privacy-by-design.
- **Asia-Pacific:** Growth and digital vanguard. **Instant claims, AI fraud, and family/floater complexity** drive platform upgrades. Payers reward vendors who pair mobile-first UX with **hard RCM plumbing** and large-scale SIU analytics.
- **Latin America:** Modernization sprint. Legacy fragmentation creates greenfield chances for **cloud claims cores, clearing, and automated denials prevention**—often via BPaaS to offset talent constraints.
- **Middle East & Africa:** Universal schemes scale; **mobile-first enrollment + cloud RCM** become the standard. Lightweight, modular platforms with offline failover and standardized coding frameworks gain outsized traction.

Product & portfolio implications

- Growth lines (critical illness, family floater, senior coverage) remain strong, but only payers with multi-member eligibility, documentation automation, and cross-specialty coding will scale profitably.
- Network strategy shifts from volume to RCM-ready networks (clean claims, prior-auth orchestration, electronic attachments), reducing friction costs and improving settlement SLAs.



Vendor playbooks that win

- **Compliance-by-design:** Bake EHDS/GDPR/local residency into data pipelines; ship rule updates as versioned artifacts, not bespoke projects.
- **Deep provider integration:** Deliver pre-packaged connectors for major EHR/RCM systems; expose real-time status, reason codes, and remediation paths to providers.
- **Outcome pricing:** Move from seat/licensing to **PMPM + performance fees** tied to adjudication accuracy, denial reduction, and days-to-pay.
- **BPaaS where talent is tight:** Offer managed claims + SIU operations on top of cloud cores in LATAM/MEA to compress time-to-value.
- **Localization at the edges:** Local language, codesets, and benefit rules; partner with national chambers/associations for fast rule lift-ins.
- **Security as table stakes:** Zero-trust, fine-grained consent, and provable lineage; treat **explainability** in fraud models as a contractual deliverable.



Scenario outlook (2026–2030)

Base case (most likely):

- Payers adopt **cloud claims cores** in waves; AI fraud moves from pilots to default; **provider-facing APIs** cut denial rates and cycle times. Member CSAT rises where claim status is transparent. Vendor market consolidates around platforms that prove measurable **cost-to-serve reductions** and compliance agility.

Acceleration case:

- Governments mandate **e-claims and instant payment windows** (e.g., 5–10 day settlement) and expand cross-border data rules. Rapid adoption of **standardized claim attachments** + prior-auth automation compresses admin costs further. Winners are platforms with scalable policy engines and prebuilt rule libraries per country.

Stall case (watch items):

- Regulatory whiplash or data-residency fragmentation slows cross-border exchange; macro inflation forces budget freezes. Progress persists via **BPaaS** and targeted **payment integrity** projects that self-fund through recoveries.

Leading indicators to monitor

- **Mandates:** EHDS milestones, national e-claims timelines, instant-payment or electronic attachments rules.
- **Provider sentiment:** Days-to-pay, denial rates, attachment adoption, provider portal NPS.
- **Fraud leakage:** Pre- vs. post-pay recovery mix; time-to-detect organized rings.
- **Member trust:** Claim-status transparency adoption, complaint ratios tied to delays/opacity.
- **IT mix:** Shift of budgets from portals to **claims/RCM core modernization** and integrity analytics.





Risks & mitigations

- **Data sovereignty/cyber:** Local hosting + KMS, regional SOC; privacy-preserving analytics.
- **Skills scarcity:** Vendor-delivered **BPaaS**, automation tooling for business analysts, and academy programs with providers.
- **Integration drag:** Standard adapters, sandboxed conformance tests, and SLAs on message latency/uptime.
- **Model governance:** Documented feature lineage, challenger models, and region-specific fairness checks.

What “good” looks like by 2030

- **Claims adjudication:** >85–90% clean-claim first pass; attachments electronic by default; median provider payment windows measured in **days, not weeks**.
- **Denials:** Double-digit reduction from 2025 baselines; automated remediation paths visible in provider portals.
- **Payment integrity:** Majority of recoveries **pre-pay**; explainable AI standard in SIU.
- **Interoperability:** Routine **FHIR-based** exchanges across payer–provider borders; consent orchestration embedded.
- **Member experience:** Real-time claim status and clear benefit explanations become universal; complaints decouple from cost discussions because **process transparency** is normalized.
- **Financials:** Admin cost ratios fall; premium caps become less constraining because unit processing cost drops and leakage tightens.

Bottom line

Outside the U.S., 2026–2030 will crown payers—and vendors—who treat claims/RCM modernization as the operating system, not a project. The opportunity is large, global, and immediate: build fast, interoperable, compliant platforms that pay accurately and visibly. Do that, and affordability ceilings loosen, digital divides narrow, provider relationships stabilize, and member trust becomes an asset instead of a liability.



Future Forecast & Strategic Outlook (2026–2030)

The non-U.S. payer sector is entering a decisive cycle. Premium pools will expand beyond **USD 2.2 trillion in 2026**, but premium growth cannot outrun medical inflation or demographic shifts. The only lever left is **technology efficiency**—automating claims, aligning with provider RCM systems, and delivering transparent, real-time engagement for members.

Strategic Outlook

- **Europe:** EHDS mandates push interoperability, transparency, and cross-border claims normalization. Vendors with localization and compliance-by-design will thrive.
- **Asia-Pacific:** Digital vanguard, but fraud remains the counterweight. Mobile-first platforms and AI claims systems are in high demand.
- **Latin America:** Modernization sprint. Greenfield demand for cloud claims cores and RCM integration, often via BPaaS models.
- **Middle East & Africa:** Leapfrogging to mobile-first coverage, but immature RCM requires cloud-native platforms with standardized coding frameworks.

Vendor Imperatives

- Build compliance into platforms, not projects.
- Package payer–provider integration as prebuilt connectors.
- Offer BPaaS and managed services in resource-constrained markets.
- Localize rapidly: languages, codesets, and regional workflows.
- Price outcomes, not licenses—measured in denials reduced, cycle times cut, and transparency delivered.



Global Payer Tech Opportunity Matrix (2026)

Region	Top Payer Pain Point	High-Value IT Opportunity	Vendor Capabilities Needed
Europe	Affordability ceiling + EHDS compliance	Cross-border claims normalization; transparency tools	Interoperability platforms (FHIR/EHDS), compliance-by-design
Asia-Pacific	Fraud risk + scaling family/floater plans	AI claims adjudication + fraud detection	Predictive analytics, mobile-first claims platforms
Latin America	Legacy IT fragmentation	Cloud-native claims cores + automation BPaaS	Managed claims ops, rapid adjudication engines
Middle East & Africa	Settlement delays + immature RCM	Cloud RCM + mobile-first enrollment	Lightweight, modular RCM; standardized coding frameworks



What Success Looks Like by 2030 to Global Payer Organizations:

- Claims settled in days, not weeks.
- Clean claim rates >85–90%.
- Fraud detection handled pre-pay, not post-pay.
- Transparent claims visibility for every member.
- Denials reduced by double digits vs. 2025 baselines.
- Interoperability across borders normalized.
- Member trust becomes measurable and positive—because transparency is the default.



Conclusion

For payers outside the U.S., 2026–2030 is not about whether to modernize—it’s about how fast, with which partners, and in which markets. The future belongs to vendors who can combine scale-tested claims engines with local compliance, integration, and digital transparency. Those who deliver on cost, trust, and interoperability will redefine health insurance globally.