FROM THE TEAM AT PAYERSET

the price transparency project

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The 2026 Price Transparency Field Guide

COMPILED BY PAYERSET

An Annual Playbook for Data-Driven Leaders in U.S. Healthcare

BENCHMARKING STRATEGIES

REAL SUCCESS STORIES

LATEST CMS STANDARDS

A Note from the Founder of Payerset

By Jerry DiMaso
CHIEF EXECUTIVE OFFICER, PAYERSET

When we started, price transparency in healthcare was mostly an idea. Watching it turn into something real, something you can actually pull up and analyze, has been one of the most rewarding things I've been part of. It hasn't exactly been a straight line. There have been false starts, messy data, and stretches where the whole thing felt more aspirational than achievable. But I'm proud of where it stands today, and even prouder of the people who got it here.

We're also clear-eyed about how far there is to go. Price transparency is one piece of a much larger puzzle. The revenue cycle, the pricing, the entire care journey all have to improve for the American healthcare system to become what it should be. We're honored to play a part at the front end of that journey, helping make pricing visible to the people it affects most: employers, employees, and the care delivery organizations doing the work.

We've had the rare gift of living and breathing this data alongside some of the leading health systems and consulting firms in the country, and we learn from them every day. This field guide is our way of sharing some of what we've picked up, because the future of healthcare we all want gets built the only way it can. Piece by piece, day by day.

— Jerry

Five years in, the data has crossed a threshold.

LARGEST STRUCTURAL UPGRADE

February 2, 2026

The biggest structural improvements to the Transparency in Coverage data since its inception.

ATTESTATION ENFORCEMENT

April 1, 2026

A named senior executive at every U.S. hospital must now be encoded in their machine-readable file, alongside a formal attestation that the data is true, accurate, and complete.

For those who have rolled up their sleeves to work with it, price transparency data has created a new wave of market intelligence.

Carriers & health systems

Benchmarking competitor rates before renewals.

Employers

Comparing what their carrier delivers against what the same carrier pays elsewhere — and pursuing legal action when the gap raises fiduciary-duty questions under ERISA.

Benefits advisors

Building networks around rate data that was invisible three years ago.

This report covers where that data came from, what it contains now, how leaders and innovators are putting it to work, and what the next twenty-four months can change.

01

SECTION ONE

It's 2026. Is the data good now?

The infrastructure that makes price transparency possible took years to develop. But most recently, the issue of data reliability has moved into the spotlight.

From mandate to usable dataset: how the data got reliable

The path from policy idea to analyst-ready data ran through fifteen years of mandates, lawsuits, and schema upgrades. Each milestone added a piece; only recently did they add up to something teams can rely on.

2010

ACA Section 2718

The first transparency mandate. Toothless for a decade, chargemasters posted in obscure corners of hospital websites, available on request.

2019

Hospital Price Transparency Rule

Negotiated rates required in machine-readable files, effective January 1, 2021. This is the first time payer-specific rates go public. Hospital groups sued; the D.C. Circuit rejected the challenge.[1]

2022

Payer MRFs Go Live

Transparency in Coverage enforcement begins July 1.[2] The most comprehensive rate dataset in U.S. healthcare history becomes downloadable. RAND documents employers paying 254% of Medicare on average.[3]

2024

Data Quality Upgrade

CMS adds required fields, raises the maximum civil monetary penalty, and standardizes MRF formats. Data begins to be good enough for analytical use, not just disclosure.[4]

2026

Current State

Universal hospital posting. TiC Schema 2.0 launches February 2 and hospital attestation enforcement begins April 1. The field moves from accuracy and basic use to strategic advantage.

Once the infrastructure finally came to fruition, if you used this data early on, you know the limitations were real.

The good news: the data in 2026 is closer to what the regulations were designed to produce than anything that existed in the first few years of compliance. We've moved from *how do we get it accurate* to seeing tangible enhancements to usability driven by legislation.

> If you're not using price transparency data today, whatever party is on the other side of the table definitely is.

So where does the data actually stand?

It comes from two sources that matter most: the payer Transparency in Coverage files and the Hospital Price Transparency files.

Payer TiC MRFs
TRANSPARENCY IN COVERAGE RULE

Hospital MRFs
HOSPITAL PRICE TRANSPARENCY RULE

Payer TiC MRFs

TRANSPARENCY IN COVERAGE RULE

Hospital MRFs

HOSPITAL PRICE TRANSPARENCY RULE

SOURCE OF THE DATA

Published by the insurer, drawn from the payer's own transaction systems built to hold contract information and process claims. Payers are operationally transactional by design. The systems generating these files exist specifically to track what was contracted and what was paid.

Self-reported by the hospital. Encoding contract terms accurately into a machine-readable file is a requirement layered on top of existing operational infrastructure. Quality varies materially across filers.

PROVIDER COVERAGE

Every provider with a commercial contract: roughly 1.7 million care-delivery NPIs[5] — hospitals, SNFs, imaging centers, ambulatory surgery centers, independent physician groups, and small practices. Most care happens outside hospital walls, and payer TiC files are the only transparency source that captures all of it.

WHAT HAS STRENGTHENED IT

Schema 2.0 introduced a **Setting** field, making rate variation between inpatient and outpatient settings far easier to see than parsing strings of numerical codes.

About 6,100 registered hospitals per the 2024 AHA Annual Survey.[6] In practice it covers more: systems that acquired imaging centers, ASCs, or specialty facilities under the hospital's tax ID carry those rates in their MRF too.

WHAT HAS STRENGTHENED IT

As acquisitions continue, the scope of a given hospital's MRF expands with them (no additional regulatory changes required).

PLAN-LEVEL SPECIFICITY

Plan-sponsor name and employer EIN have been required since the original 2020 rule,[2] giving direct visibility into self-insured employer plans alongside TPA-administered coverage. Grouping is permitted when rates are identical, with an optional table-of-contents file for traceability, so traceability is strongest at carriers that adopt structured file organization.

WHAT HAS STRENGTHENED IT

Schema 2.0 added **network identifiers** as a required field, a consistent way to identify which rates belong to which provider network, rather than relying on payer-published plan names.

Payer rates are included, but broad category grouping such as "all PPO plans" is permitted at the hospital's discretion, with no rate-equivalence requirement. No plan-sponsor visibility: hospitals often don't know which specific employer plan they're contracted with, so that layer of granularity is simply absent.

WHAT HAS STRENGTHENED IT

New allowed-amounts elements show actual payment distributions across payers, partially offsetting missing plan-level detail for percent-of-charge and algorithm-based contracts.[7]

Payer TiC MRFs

TRANSPARENCY IN COVERAGE RULE

Hospital MRFs

HOSPITAL PRICE TRANSPARENCY RULE

PROVIDER IDENTIFIERS

Both TIN and NPI are included from the start. Having both in one file makes provider-entity identification reliable and cross-file linking feasible without manual guesswork.

WHAT HAS STRENGTHENED IT

Schema 2.0 added business-name fields tied to NPIs, reducing identification errors from inconsistent naming. NPI and TIN together allow reliable linking to claims data and, now that hospital NPI enforcement is in effect, to hospital MRFs as well.[8]

NPI enforcement began April 1, 2026. No TIN is included. Before April 2026, linking hospital MRF data to payer data accurately required manual matching and was error-prone at scale.

WHAT HAS STRENGTHENED IT

Hospital MRFs now require organizational Type 2 NPIs,[7] the facility-level identifier, making cross-file linking to payer TiC data on NPI and billing code meaningfully reliable for the first time. TIN-level matching still sits on the payer side.[7]

RATE COVERAGE & FILE ACCESSIBILITY

Covers fee-schedule rates, percent-of-charge structures, per diems, and case rates across every billing code — CPT®, HCPCS, DRG, and revenue codes. Schema 2.0 added inpatient/outpatient setting codes that previously had to be inferred from billing class.

WHAT HAS STRENGTHENED IT

As of May 2026, Payerset is observing file-size reductions of up to 90% for files properly restructured under the new schema. A proposed utilization file would add an annual record of which providers actually received reimbursement, directly addressing the "ghost rate" problem.[8]

As of April 1, 2026, hospital MRFs must include median, 10th, and 90th percentile allowed amounts derived from actual 835 remittance data over a 12–15 month lookback, for any code with a percentage or algorithm-based rate. NDC drug codes are also required, which payer TiC files do not mandate.

WHAT HAS STRENGTHENED IT

The recent shift from estimated allowed amounts to actual payment distributions is the most consequential improvement to hospital file quality since the rule took effect. Managed-care teams find the distributions track meaningfully against internal remittance data.[7]

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02

SECTION TWO

Beyond basic benchmarking

Price transparency data has come a long way since first being published. Care delivery organizations are using this for competitive benchmarking and arming themselves for contract negotiations. On the other hand, payers are also bringing price transparency data to contract discussions. Simply having access to this data and producing anecdotes has become table stakes.

Organizations that are getting the most value out of price transparency are thinking beyond basic benchmarking. Here are the key themes emerging from these leaders in how they are using price transparency to not only protect, but grow margins in a tightening environment.

Strategy 1

Benchmark by bundles, not single codes

Single billing codes rarely tell the full story when benchmarking. We are going to use Emergency visits as an example, but the lessons apply to almost every service line. A basic analysis might start by pulling rates for CPT 99284 across the local market. That seems like a reasonable starting point, but it is flawed for two reasons.

01

It captures only a piece of total charges

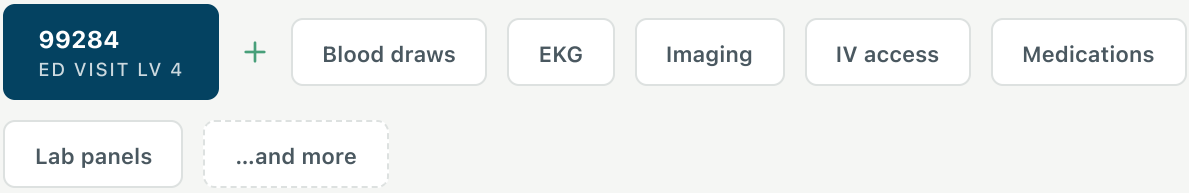
An emergency visit generates two separate components: a facility fee and a professional fee. The facility fee covers the hospital's resources, including the room, the nursing staff, and the equipment. The professional fee covers the physician or clinician who evaluates and treats the patient. These can appear on separate claims, be negotiated separately, involve physician groups, and vary independently from one organization to another.

02

A 99284 is rarely the only code billed

It's often one line item. When a patient comes in with chest pain, the 99284 is just the starting point. What follows is a cascade of additional services, each generating its own billing code that can be negotiated separately. The reimbursement differences across those codes (especially in labs) can end up being far larger than anything you would see on the E/M code alone.

ONE CHEST-PAIN VISIT · WHAT ACTUALLY GETS BILLED



Define what really happens before you touch the data

As the data has matured, so has the depth of the analysis. Analysts are now defining bundles that represent what happens in the real world before touching any data. For an emergency visit, that means building a clinically grounded bundle of billing codes that reflects how a real visit is billed. For a standard Level 4 ED visit with a chest pain and cardiac workup presentation, here's an example of a core bundle.

CODE	SERVICE	FEE TYPE
99284	ED Visit Level 4	Professional + Facility
85025	CBC	Facility only
80048 / 80053	Basic / Comprehensive Metabolic Panel	Facility only
93005 / 93010	EKG Technical + Interpretation	Professional + Facility
71046	Chest X-ray (2 view)	Facility only
84484	Troponin	Facility only

A note on how organizations bill

Several of those codes split into both a professional and a facility component, specifically the E/M visit itself. Some hospitals bill EKGs globally using 93000, while others split them into the technical (93005) and interpretation (93010) components. Understanding how each organization bills is part of moving beyond the single-code comparisons.

The full bundle flips the conclusion entirely

A hospital system in North Carolina (Hospital A) was viewing a comparison of their key competitor (Hospital B) in the market, both serving a similar commercial payer mix. They focused on commercial PPO reimbursement using a similar bundle to the one above. A rudimentary view, simply comparing the facility component of a 99284, would show Hospital A received more than Hospital B, hurting their negotiation strategy. That's a small part of the complete picture and, as it turns out, is incorrect.

BILLING CODE	BILLING CLASS	HOSPITAL A	HOSPITAL B	DIFFERENCE
99284	Facility	**$1,360.90**	**$1,292.00**	+$68.90
99284	Professional	**$216.00**	**$260.44**	−$44.44
85025	Facility	**$6.53**	**$72.25**	−$65.72
80048	Facility	**$7.11**	**$161.60**	−$154.49
93005	Facility	**$159.59**	**$136.46**	+$23.13
93010	Professional	**$14.65**	**$21.17**	−$6.52
84484	Facility	**$10.47**	**$133.82**	−$123.35
71046	Facility	**$203.26**	**$182.49**	+$20.77
71046	Professional	**$57.82**	**$25.80**	+$32.02

	HOSPITAL A	HOSPITAL B	DIFFERENCE
Facility Total	**$1,747.86**	**$1,978.62**	−$230.76
Professional Total	**$288.47**	**$307.41**	−$18.94
Grand Total	**$2,036.33**	**$2,286.03**	−$249.70

Strategy 2

Use all the depth available (the devil is in the details)

TiC data now makes it possible to examine rates with a specificity that was largely inaccessible before this year. While the data has always been available at the plan level, it could be difficult to decipher what seemingly ambiguous plan names translate to in the real world. Earlier this year in Schema 2.0, payers are now required to publish a "Network Name" field, which is a more descriptive and "commonly referred to" name vs. relying only on the payer-published plan name. Think "HMO" vs. "Gold Options Choice Plus."

PHYSICIAN-RETENTION CAMPAIGN

10–15%

higher in key service areas than the top three competitors — proven to physicians using TiC data.[10]

The detail available now also helps answer questions around special arrangements with certain physicians or services. Organizations are using this not only for benchmarking, but for engaging and retaining their own physicians. The law requires data to be published at the Type 2 Organizational NPI level,[7] but major payers also publish data at the Type 1 Individual Physician level. Oftentimes this may not reveal much as contracts usually are arranged at the organization level. However, certain physicians can demand higher rates and this is clearly visible in the data along with variations in where they perform the services. Standard commercial rates and arrangements dominate the discussion, but the files reveal which employer plans sit inside which TPA-administered arrangement, making self-funded employer rates visible as a distinct category within commercial contracting. Employers and organizations creating direct-to-employer offerings are looking beyond their own commercial rates. They are accessing the payer-published employer plan details to pinpoint peers' contracted reimbursement rates, which can differ significantly from their commercial rates. Self-funded employers are taking action due to healthcare being one of the largest line-item expenses in their business. Other new fields like Setting allow easier comparisons of place of service variation.

While it takes getting into the weeds, the detail is there. The information advantage that payers held for decades, knowing competitor rates while providers negotiated in the dark, is no longer one-sided.

Strategy 3

Uncover the high-dollar carve-outs

As transparency data began being used across the country, most analyses focused on HCPCS, CPT, MS-DRG, and Revenue Codes. That made sense given the volume of data being processed, and those code sets cover the majority of services. What analysts kept finding, though, was that some of the highest-dollar services were absent from the results entirely.

The highest-cost services in commercial contracting are sometimes negotiated in carve-out or bundled arrangements, separate from a health system's standard fee schedule. These often sit outside the standard fee schedule in both structure and coding, making them easy to miss in a routine analysis, even though their rates are often among the highest in the entire contract. In some cases, the carve-out rate represents the single largest leverage point in the payer-provider relationship.

- Transplants
- Cancer treatments
- High-risk maternity care

Field Story · NY Metro Maternity Benchmark

One of the largest hospital systems in the NY metro area was diving into maternity rates in preparation for a negotiation. Their market analysis included the five largest NY metro systems. Four had maternity and OBGYN rates published under typical CPT, HCPCS, and MS-DRG structures. At first glance, one of those top five systems had **zero** maternity and OBGYN rates published. They were completely missing.

Because that competitor potentially carried some of the highest rates in the market, its absence skewed the benchmark significantly. It turned out all those services existed in a rarely used **AP-DRG structure** that had never been visible to anyone without hands on the contract. This competitor's maternity and OBGYN rates were 3–4× higher than the market benchmark.

FROM 15% above market → 5–10% below market [11]

As the data has matured, it's rare for rates to be nonexistent. However, finding them can require knowing how to look in non-standard code sets, case-rate structures, or DRG classifications that fall outside routine workflows. Organizations that have mapped their high-cost service lines and their competitors against the full range of billing code structures are finding insights and opportunities that have only ever been theoretical.

The new contract negotiation playbook

> ⚠ As the information asymmetry narrows, the data is out in the open for everyone. Stories are emerging of payers proactively reaching out to lower "above-market" rates leveraging price transparency data. Bringing a few anecdotes won't be enough anymore — you can guarantee the payer will have their own.

All is not lost. The data is available, and marrying that with your own strategy, stories, and experience will allow for an even playing field. Taking best practices from leading managed care teams throughout the country, here is a process you can start using today.

1 Benchmark against peer rates

Start by looking at where each carrier sits relative to market, and relative to provider peers with a similar scope of services. A negotiated rate does not mean much on its own. It matters next to what comparable organizations are getting from that same carrier for comparable care. Claims data adds another layer here, showing how often peers are billing a given code and what they are getting paid for it, a fuller picture than the rate alone.

2 Map service-line-level underpayment

A contract that looks fine in aggregate can hide underpayment in specific service lines. Layer claims volume against the peer rates from step one to see which service lines drive revenue, and whether they are priced above, at, or below market.

- Medicare benchmarking still has a place here. It should not carry the whole analysis now that real peer dollar amounts are public, but it remains a useful reference point, especially when a carrier opens with a Medicare comparison of its own.

3 Create a clear, consistent, and backable narrative of the market

Know where rates stand across the market for the services that matter most, and build that into a narrative the team can stand behind every time it comes up. The strength of that narrative comes from three things: it stays clear enough that anyone on the team can explain it, consistent enough that it does not shift depending on who is in the room, and backed by real data so it holds up under scrutiny. That combination is what builds confidence, both for the team bringing it and for the carrier sitting across the table.

4 Use volume to anchor the conversation

A below-market rate on a code billed a thousand times a year matters far more than an above-market rate on one billed twice. Weighted underpayment, volume times rate gap, translates rate position into dollars that finance leaders and carriers both understand. Claims data can extend that comparison to peers too, showing whether an organization is billing a given service more or less often than similar providers in the market, which adds another layer of context to the conversation.

5 Weigh rate against the full payer scorecard

Rate is one input. Denials, delayed payments, and other friction in how dollars move into the provider's bank account matter just as much as what the contract says on paper. A complete view of a carrier relationship looks at rate alongside performance across the full payer scorecard.

REAL STORY

The playbook under real-time negotiating pressure

Two case studies shared by a national healthcare consulting firm at the 2026 HFMA Provider and Payer Symposium illustrate how the playbook functions in practice. Both were presented during a session on price transparency and contract strategy in Chicago on February 26, 2026.[12]

CASE ONE · DEFENDING THE RATE

15% → **~2%**

PAYER'S CLAIM — ACTUAL GAP

A payer came into a renewal claiming a 15 percent overpayment and pushing for a 6 percent rate decrease across the aggregate contract. The consulting team ran the analysis across payers and service lines and found the actual gap was closer to 2 percent. Rather than accepting the payer's framing, the hospital negotiated toward a budget-neutral outcome and **avoided the cut entirely**.

CASE TWO · WINNING THE INCREASE

35% below

MARKET ON A GROWTH SERVICE LINE

A health system identified through service-line benchmarking that one of its growth service lines was reimbursed 35 percent below market. The payer had cited its own transparency data in the renewal letter to push for a decrease. The health system came back with a data-supported proposal anchored on the same transparency data and **secured a meaningful improvement** it would not have had the evidence to request before.

The common thread isn't just that the hospital had data. It's that the hospital had done the work before the payer arrived. The analysis framed the conversation rather than responding to it.

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03

SECTION THREE

Gaps, fixes, and what can change in the next 24 months

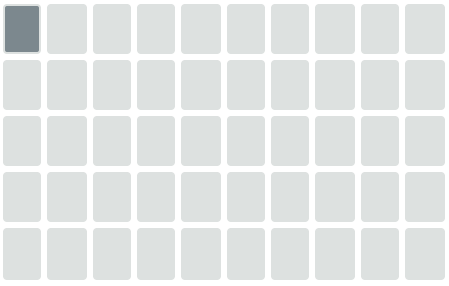
2026 brought the biggest structural improvements to price transparency data since its inception. Here's what's still ahead.

Schema 2.0 went live February 2, 2026. Hospital MRF changes took effect April 1, 2026. The journey to make healthcare pricing fully transparent is ongoing, but there are a few focal points over the next one to two years that will help shape the movement.

TiC Schema 3.0: The next round of improvements

The December 2025 proposed rule, known as Schema 3.0 (officially CMS-9882-P), further addresses content and accuracy challenges. If finalized, it would restructure how payer files are organized and add three new contextual files that do not currently exist anywhere in the transparency data corpus.

THE MOST SIGNIFICANT STRUCTURAL CHANGE



50 files

A carrier offering fifty plans that share the same network and negotiated rates currently publishes fifty separate rate files with **identical content**.

→

1 file

Under the proposed rule, the shift is to **one rate file per provider network** — a substantial reduction in redundancy.

That reduction in redundancy would make the data far more accessible to organizations that lack enterprise-scale retrieval infrastructure, lowering the barrier to entry for everyone working with the files.

Each closes a gap practitioners have worked around for years

The three new contextual files each address a specific analytical gap that practitioners have been working around since the files went live, none of which exists anywhere in the transparency data today.

PHANTOM RATE RESPONSE

The Utilization File

Would identify every provider that submitted and received reimbursement for at least one claim over the prior 12 months. Instead of inferring which rates are active through taxonomy filtering and volume analysis, it would explicitly identify which providers are actually operating under their contracts.

PHANTOM RATE FIX AT THE SOURCE

The Taxonomy File

Would publish each payer's internal provider taxonomy mapping (the same mapping payers already use to deny out-of-scope claims.) If a payer's systems know a podiatrist does not perform cardiac surgery, this file makes that visible in the data rather than requiring external filtering to remove the rate.

TRACK RATE MOVEMENT

The Change-log File

Would track what changed between reporting periods, letting analysts identify rate shifts over time without a full comparison of multi-gigabyte files. For managed care teams tracking payer rate movements across renewal cycles, this is a meaningful efficiency gain.[8,13]

On the timeline

The implementation timeline for the proposed rule remains uncertain. Practitioners and advocates, including Payerset in its formal CMS commentary, have called for finalization in **2027**.[8]

The 2028 drug data horizon

The Consolidated Appropriations Act (CAA) of 2026, signed in February 2026, included landmark PBM transparency reforms covering 100% rebate pass-through and comprehensive compensation disclosures to plan sponsors. Those provisions take full commercial market effect for plan years beginning on or after August 3, 2028 (January 1, 2029 for calendar-year plans).[14] Separately, CMS has issued a request for information on a prescription drug MRF requirement under the Transparency in Coverage rule, with implementation repeatedly delayed.[15] There is hope that implementation will begin later this year or in 2027.

2022

MEDICAL CLAIMS DATA

Transparency in Coverage rates went public, and a wave of ERISA fiduciary litigation followed for the employers who had the data and didn't act.

2026

CAA SIGNED · FEBRUARY

PBM transparency reforms become law: 100% rebate pass-through and full compensation disclosure to plan sponsors.

2028

COMMERCIAL EFFECT

Standardized drug pricing data arrives for plan years on or after Aug 3, 2028. For calendar-year plans it's Jan 1, 2029.

At the **Midwest Business Group on Health** conference in May 2026, **James Gelfand**, President and CEO of the ERISA Industry Committee, warned that the coming wave of standardized prescription drug data, expected around 2028, will raise the bar for what a prudent fiduciary is expected to know and act on.

He argued that, just as earlier transparency rules around medical claims data made it harder for plan sponsors to claim ignorance about overpayments, the same dynamic will apply to pharmacy.

Employers and advisors who build the capability to analyze and respond to that data now, **before the plaintiffs' bar fully mobilizes around it**, will be in a stronger position when the next round of litigation arrives.

What the practitioner community is asking CMS for next

The regulatory process for price transparency is ongoing, and the organizations that work with this data daily are engaged in shaping its next phase. The recommendations below reflect input submitted to CMS through formal public comment.[8]

Accuracy over volume

The ability to retrieve and normalize transparency data at scale is no longer the bottleneck. What the market needs most is continued confidence that the underlying data is correct, that negotiated rates reflect actual contract terms, that provider-rate associations are current, and that network identifiers are consistent.

A centralized payer file registry

Hospitals post to a known location and attest to the accuracy of what they post; payers have no equivalent accountability mechanism. A centralized CMS-managed registry, with attestation requirements parallel to what now exists for hospitals, would bring the payer framework into alignment with the accountability model that has proven effective on the provider side.

Accelerated timeline for the proposed rule

The December 2025 proposed rule would introduce utilization files, taxonomy files, and network-level reporting on top of Schema 2.0. The 12-month implementation window following finalization likely overstates what is required. The market demonstrated it can move quickly when requirements are clear.

Embed utilization data in the files

The current framework captures what was contracted; the next meaningful step is capturing what was actually used. Requiring payers to include utilization data alongside negotiated rates would let researchers, employers, and providers distinguish active contracts from dormant ones and weight rate analyses by real-world volume rather than theoretical coverage.

The 24-month horizon is unusually compressed, and not all hospitals face the same planning problem. Those operating in cap-state markets are navigating a different set of constraints than those elsewhere. All hospitals face the attestation regime, and managed care teams across the board should be preparing for **utilization data integration**, the next substantial analytical inflection in how this data gets used.

CLOSING

A measurable trend with a visible horizon

Five years ago, price transparency was a regulatory aspiration with full compliance below 30 percent. CMS's early-2021 assessment found just 27 percent of hospitals fully compliant, and the data that was posted was so inconsistent researchers described it as messy and confusing. In 2026, nearly every hospital in the country has published a machine-readable file with rates a named executive has attested are true, accurate, and complete. The compliance problem has not been fully solved, but it has been substantially reduced.

The market is separating into operators who have built the infrastructure to use this data as market intelligence and those who have not. Those who have already built the capability will capture more value as data quality continues to improve, and the distance between them and those still working from incomplete analytical foundations will grow. A healthcare market where price is visible and increasingly used as an input to contracting and benefit design is no longer a future state. The data infrastructure to support it is more developed than it has ever been.

27% → **~Every**

COMPLIANT IN 2021 — HOSPITAL POSTING IN 2026

1.7M

CARE-DELIVERY NPIS NOW COVERED BY PAYER FILES[5,17]

payerset

Healthcare pricing intelligence built on the premise that price transparency data is only valuable when it is accurate, accessible, and actionable.

Accurate
Formats normalized, provider identifiers resolved, implausible rates filtered.

Accessible
Delivered through a self-service analytics platform and enterprise data integration.

Actionable
A comprehensive historical archive covering every major payer and compliant hospital.

Payerset aggregates machine-readable files from commercial health plans and hospitals across the United States. The team has been working in price transparency since the early enforcement years and has built relationships across the policy, provider, payer, and employer communities that inform how the platform is designed. They've collaborated with CMS and ecosystem partners to advise on data standards and enforcement.

The platform serves health systems using rate benchmarking and underpayment detection to prepare for contract negotiations, managed care organizations auditing network adequacy and competitor pricing, and employers and benefits advisors using the data to evaluate carrier performance and support direct contracting strategies.

payerset.com

Thought leaders & practitioners

The following individuals represent a cross-section of the people advancing price transparency research, policy, advocacy, and practice. This is a representative list, not a complete one.

Cynthia Fisher

FOUNDER & CHAIR, PATIENTRIGHTSADVOCATE.ORG

A leading national voice for hospital price transparency compliance, publishing semi-annual MRF compliance reports widely cited in policy and enforcement discussions.

Marilyn Bartlett

FORMER CIO, MONTANA STATE EMPLOYEE BENEFITS PLAN

Led Montana's reference-based pricing initiative, one of the earliest and most documented examples of a public employer using price benchmarks to drive hospital rate reform.

Shawn Gremminger

PRESIDENT & CEO, NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS

Focuses on purchaser-led market reform and employer data rights.

Stacey Richter

HOST, RELENTLESS HEALTH VALUE PODCAST

Widely followed voice on employer-driven healthcare reform and price transparency strategy.

Brian Cotter

FOUNDER, BRIGHT SPOT INSIGHTS

Works deep in the technical side of price transparency — parsing MRF files, benchmarking tools, running original rate analyses, and building community among practitioners.

Mark Cuban

CO-FOUNDER, COST PLUS DRUGS

Brought transparent drug pricing to public attention and demonstrated the viability of cost-plus pharmaceutical pricing.

James Gelfand

PRESIDENT & CEO, ERISA INDUSTRY COMMITTEE

Leads employer advocacy on health plan transparency, fiduciary duty, and PBM reform.

Elizabeth Mitchell

PRESIDENT & CEO, PACIFIC BUSINESS GROUP ON HEALTH

Led the PBGH Health Care Data Demonstration Project, the most comprehensive employer-funded rate and quality analysis to date.

Keith Smith, MD

CO-FOUNDER, SURGERY CENTER OF OKLAHOMA

Pioneer of transparent all-inclusive pricing for surgical care and a reference point for the free-market transparency movement.

Dr. Eric Bricker

AHEALTHCAREZ

Physician educator and commentator on healthcare finance, widely followed for accessible explanations of commercial payment dynamics.

References

1. *American Hospital Association, et al. v. Azar*, No. 20-5193 (D.C. Cir. Dec. 29, 2020). The D.C. Circuit upheld the CMS Hospital Price Transparency Rule, affirming that the ACA's "standard charges" disclosure requirement permits CMS to require public posting of negotiated rates. law.justia.com/cases/federal/appellate-courts/cadc/20-5193
2. Departments of HHS, Labor & Treasury. "Transparency in Coverage; Final Rule." 85 Fed. Reg. 72158. Nov 12, 2020. Effective Jan 11, 2021. Requires plans and issuers to publish MRFs; plan-sponsor name and EIN required from inception. Payer MRF enforcement began July 1, 2022. federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage
3. Whaley, Christopher M., et al. *Prices Paid to Hospitals by Private Health Plans: Round 5.1.* RAND Corporation, RRA1144-2-v2. Dec 2024. In 2022, employers and private insurers paid an average of 254% of Medicare across inpatient and outpatient settings. rand.org/pubs/research_reports/RRA1144-2-v2.html
4. CMS. CY 2024 Hospital OPPS Policy Changes: Hospital Price Transparency (CMS-1786-FC). Nov 2, 2023. Finalized standardization requirements for hospital MRFs, including required data elements, affirmation statement, and increased civil monetary penalty structure. cms.gov/newsroom/fact-sheets/hospital-price-transparency-fact-sheet
5. Little, Jacob (Co-Founder, Payerset) and DiMaso, Gerald (CEO, Payerset). Payerset platform documentation. Approximately 1.7 million care-delivery NPIs in commercial contracting. payerset.com
6. American Hospital Association. *Fast Facts on U.S. Hospitals, 2026.* Data from the 2024 AHA Annual Survey (~6,100 registered hospitals). aha.org/statistics/fast-facts-us-hospitals
7. CMS. CY 2026 OPPS/ASC Final Rule. 45 CFR Part 180. Effective Jan 1, 2026; enforcement April 1, 2026. Eliminates the '999999999' placeholder; requires median, 10th and 90th percentile allowed amounts from 835 remittance data; adds CEO/senior official attestation; requires organizational Type 2 NPI for all hospital MRF filers. cms.gov/newsroom/fact-sheets/cy-2026-opps-ambulatory-surgical-center-final-rule-hospital-price-transparency-policy-changes
8. DiMaso, Gerald (CEO, Payerset, Inc.). Formal Commentary, Proposed Rule CMS-9882-P (RIN 0938-AV58). Comment ID CMS-2025-0058-0034. Submitted to CMS, CCIIO, HHS. Feb 22, 2026. regulations.gov/comment/CMS-2025-0058-0034
9. Payerset. "A Practical Look at Reimbursement Benchmarking with Price Transparency Data." Payerset Blog. payerset.com/post/a-practical-look-at-reimbursement-benchmarking-with-price-transparency-data
10. Payerset. Company observation. Large regional hospital system physician-retention analysis using Transparency in Coverage data, 2025. Client anonymized. payerset.com
11. Phillips, Matt (Customer Experience, Payerset). Direct client observation. Large New York metro area hospital system maternity and OB/GYN rate benchmarking engagement, 2025. Client anonymized. payerset.com
12. Little, Jacob (Co-Founder, Payerset). Direct observation. "Price Transparency and Contract Strategy" session, HFMA Provider and Payer Symposium, Chicago. Feb 26, 2026. Case studies presented during the session illustrate negotiation outcomes using price transparency data analysis. payerset.com
13. Federal Register. Transparency in Coverage Proposed Rule CMS-9882-P. Dec 2025. Introduces the Utilization File, Taxonomy File, Change-log File, network-level reporting, and network-based file consolidation. federalregister.gov/public-inspection/2025-23693/transparency-in-coverage
14. H.R. 7148, Consolidated Appropriations Act, 2026. Pub. L. 119-75. Signed Feb 3, 2026. PBM transparency reforms: 100% rebate and remuneration pass-through to ERISA group health plans; mandatory semiannual reporting of drug pricing, rebate, and compensation data. Effective for plan years on or after Aug 3, 2028 (Jan 1, 2029 for calendar-year plans). congress.gov/bill/119th-congress/house-bill/7148/text
15. Departments of HHS, Labor & Treasury. Request for Information on Prescription Drug Machine-Readable File Requirements under the Transparency in Coverage Final Rule. June 2, 2025. federalregister.gov/documents/2025/06/02/2025-09858/request-for-information-regarding-the-prescription-drug-machine-readable-file-requirement-in-the
16. Gelfand, James (President & CEO, ERISA Industry Committee). Remarks at the Midwest Business Group on Health Annual Conference, Chicago. May 5, 2026. On 2028 drug data release and fiduciary duty expectations. Direct observation: Andrew Gordon, attendee. eric.org
17. Seshamani, Meena and Jacobs, Douglas. "Hospital Price Transparency: Progress and Commitment to Achieving Its Potential." Health Affairs Forefront. Feb 14, 2023. CMS assessment: 27% of hospitals fully compliant with both MRF and shoppable services requirements in Feb 2021; 70% by Nov 2022. healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential

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