A FREE INDUSTRY RESOURCE
FROM THE TEAM AT
payerset

2027 Price Transparency Field Guide

FOR MARKET ACCESS



Price transparency data for medical device and diagnostics companies

What the data includes and the key market access decisions it drives, from the contract you have in front of you to the product you haven't built yet.

01

SECTION 01

Where Visibility Is Limited

Pricing, targeting, customer education, pipeline and payer coverage decisions still run on precedent and hearsay. This section maps the five market access motions where the payer's black box has cost device and diagnostics teams the most, and why the data to change that finally exists.

Medical device and diagnostics companies make some of their highest-stakes decisions on precedent or anecdote: what to charge, what discounts to extend and to which customers, where to send a sales team, what to build next, whether a customer is being paid correctly.

This presents a clear visibility problem. Until recently, the data that would ground these decisions in fact rather than hearsay was locked inside individual contracts, only known to the payer. The data needed to enable new strategies has reached an inflection point: the publishing of negotiated rates has finally opened the payer's black box. Below are the five market access business motions where visibility has been the most limited:

1 Pricing & Contracting

Without a clear picture of negotiated rates and coverage across a market, pricing and discounting decisions tend to be made on assumptions or hearsay. Every point of margin given away in a negotiation is a point that doesn't come back.

2 Commercial & Sales Targeting

Field capacity is finite. Placing a rep or an instrument in a territory where no plan covers the procedure and no payer has a payment policy in place is a resourcing mistake that was preventable.

3 Customer Education

High-value billing codes sit unused when a customer defaults to a general or component code instead of the specific code that actually applies. Neither side may notice until it surfaces as weaker-than-expected sales or a hard renewal. A customer who isn't collecting what they should on every claim carries a quiet revenue-leakage problem of its own, one that eventually becomes the manufacturer's problem too.

4 Pipeline Strategy & Product Development

Product or panel design is a multi-year, high-dollar bet, and it's hard to know the difference between building a product or test that pays and adding another fast-follower test competing for the same reimbursement dollar.

5 Payer Coverage & Value Story

A device or test can be clinically sound and still stall at the payer medical policy committee if nobody has built the economic case in the payer's own terms.

Until recently, the data that would ground these decisions in fact rather than hearsay was locked inside individual contracts, only known to the payer.

02

SECTION 02

A New Line of Sight

Health insurers now publish the negotiated rate for every provider and every code. Here’s what those machine-readable files actually contain, how granular they get, and the 15 years of mandates and lawsuits it took to open them up.

Price transparency data comes from the machine-readable files health insurers publish under the Transparency in Coverage rule. They show the negotiated rates they've agreed to pay for every provider and every code. These are not modeled estimates or averages, but the real number filed as the negotiated rate, sourced directly from the payer's own files.

For market access, this means:

Every rate-relevant code

Not just DRGs: CPT, HCPCS, and PLA codes, alongside the facility fees and professional fees that get billed around them.

Every payer and plan type

Including commercial, ACA/exchange, and self-funded employer plans (increasingly relevant for device and diagnostics companies pursuing direct-to-employer strategies), which the files reveal as a distinct category with contracted rates that can differ materially from a payer's standard commercial book.

Every site of service

From hospital inpatient and outpatient to ambulatory surgery centers, physician offices, and the full range of lab settings, hospital, reference, and public health labs: critical for understanding how the same test, procedure, or device gets reimbursed differently depending on where it's performed.

Provider-level granularity

Filed at the organizational and individual NPI levels, revealing that specific physicians or facilities command materially different rates than their peers.

This took around 15 years of mandates, lawsuits, and schema upgrades to become a dataset that a market access team can leverage:

Regulatory Timeline, Price Transparency Data

YEAR	MILESTONE
2010	ACA Section 2718, the first transparency mandate. Largely toothless for a decade; chargemasters posted in obscure corners of hospital websites.
2019	Hospital Price Transparency Rule finalized: negotiated rates required in machine-readable files, effective January 1, 2021. Hospital groups sued; the D.C. Circuit rejected the challenge.
2022	Payer machine-readable files go live: Transparency in Coverage enforcement begins July 1, producing the most comprehensive rate dataset in U.S. healthcare history.
2024	Data quality upgrade: CMS adds required fields and standardizes formats. The data becomes good enough for analytical use, not just disclosure.
2026	Current state: TiC Schema 2.0 (February 2) tightens payer file quality further. The field moves from basic compliance to strategic advantage.

03

SECTION 03

Where It Comes Into Focus

This section runs through five key business motions in market access: pricing and contracting, commercial and sales targeting, customer education, pipeline strategy, and payer coverage. For each one, it shows how price transparency data sharpens the team's focus and where it can put new revenue on the table, with an example built on real negotiated rates data.

3.1

Pricing & Contracting

Every negotiation starts from somewhere, and too often that starting point is guesswork: what was agreed to last cycle, or what a competitor is rumored to be charging. The rates already filed by the payers in this market draw a much sharper line between where there's room to hold firm and where a concession actually makes sense.

What price transparency data unlocks

Real, posted negotiated rates, filed state by state and payer by payer, turn guesses into a defensible floor and ceiling for a negotiating position. The same principle extends upstream: anchoring go-to-market and budget-impact models in actual contracted rates rather than list prices produces a cost-effectiveness case built on what payers actually pay.

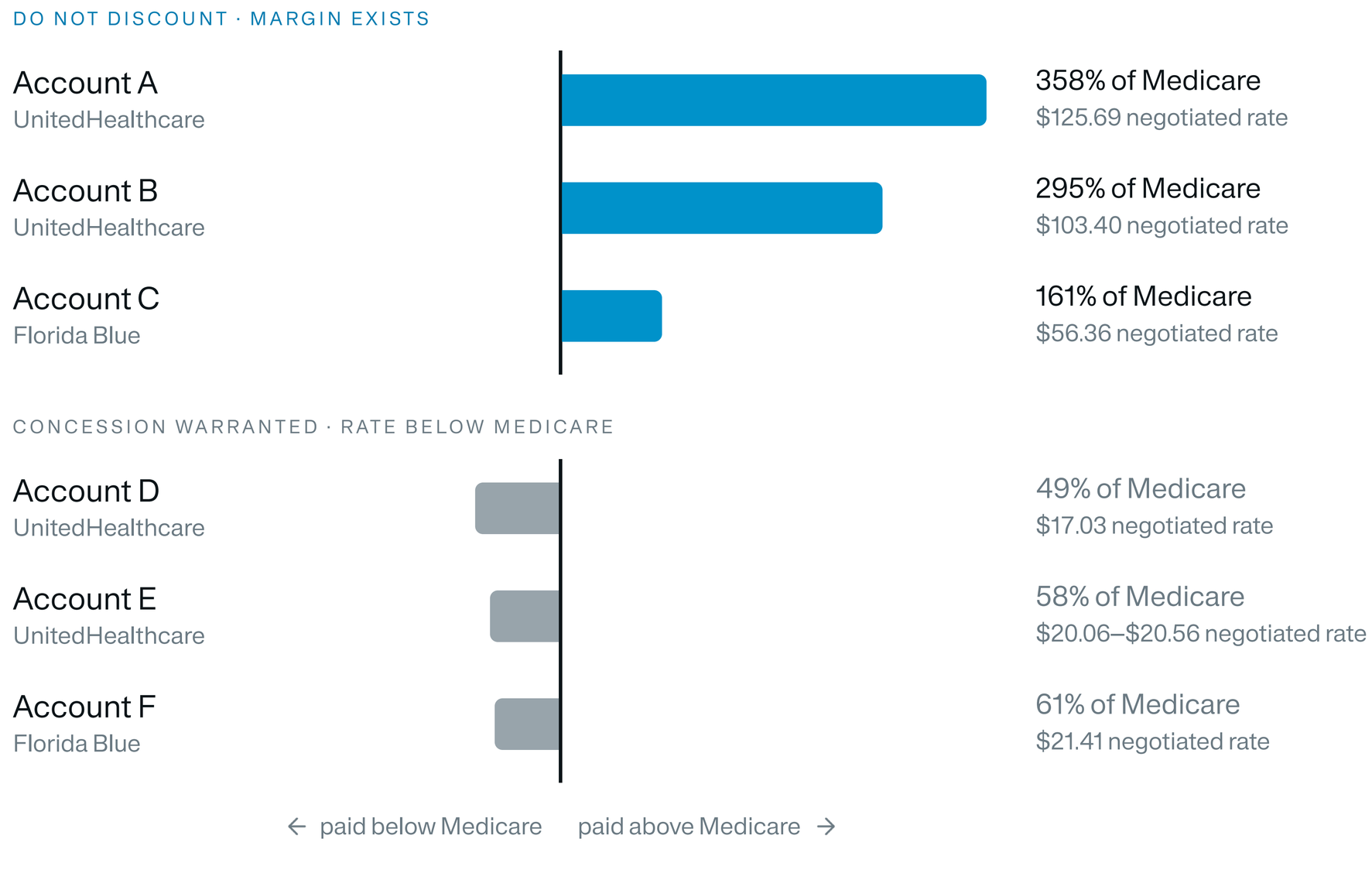
The data in action

Pulling negotiated-rate data for a single procedure code across the accounts in one market shows just how wide the spread already is: some accounts sitting well above Medicare with margin to give up in a negotiation, others already filed below parity with none to spare. A device or diagnostics company setting a discount floor has no reason to offer the same concession to both.

Every point of margin given away in a negotiation is a point that doesn't come back.

CPT 87624 · HIGH-RISK HPV · NEGOTIATED RATE VS MEDICARE

Discounts: Named Accounts



$17-$126

For the same code, in the same market

The rate is set by the account and the payer, not the market: a flat discount overpays the strong accounts and underserves the thin ones. The same provider can land on both sides on different payers.

3.2

Commercial & Sales Targeting

A territory plan built on tenure or a hunch sends reps to accounts that were never going to pay well in the first place. Filed rates turn that plan into a ranked list: which accounts in a market are already reimbursed well enough to be worth the call.

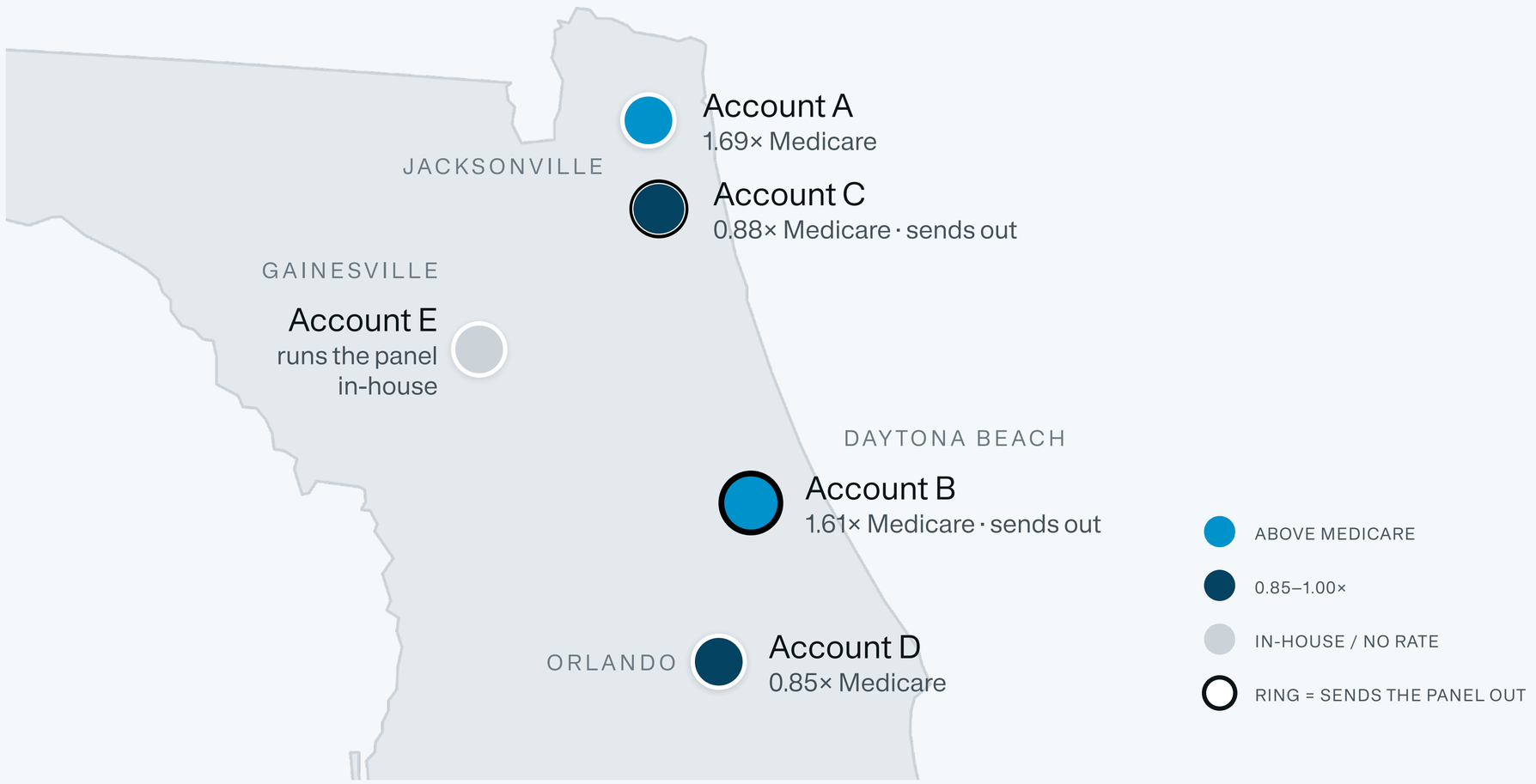
What price transparency data unlocks

Seeing coverage and payment strength by provider, payer, and geography before a territory plan is drawn means the field goes where reimbursement already exists and is strong. Getting the target list right the first time lets a fixed-size commercial organization grow revenue faster than headcount.

The data in action

A territory-prioritization output ranking health systems in a market by their best negotiated rate for the relevant code, relative to Medicare and to the reference-lab baseline, with a flag for which accounts already send the work out versus keep it in-house. Ranking on rate first (not headcount or historical priority) can put a mid-size account above a larger one the team has always assumed was the priority.

Top Accounts in the Market



1 Account A — Jacksonville

HIGH VALUE

Aetna $77.18 · Fla. Blue $118.71

Best 1.69× Medicare · +$76 vs reference lab · reference-scale independent lab

Holds the single highest filed rate in the market. A partner-or-compete account, not a straight conversion.

2 Account B — Orlando & Daytona

SENDS OUT

UHC $113.30 · Aetna $73.85 · Fla. Blue $83.30

Best 1.61× Medicare · +$71 vs reference lab · singles in-house, panel out

The richest 87801 rate of any system here, and it does not bill the panel. Capability, volume and price all present.

3 Account C — Jacksonville

SENDS OUT

Aetna $62.00 · only payer with a filed rate

Best 0.88× Medicare · +$25 vs reference lab · whole molecular workup out

The cleanest whole-workup send-out in the market: a volume-capture play more than a margin play.

4 Account D — Orlando

IN-HOUSE

UHC $59.67 · Aetna $60.00

Best 0.85× Medicare · +$18 vs reference lab · mostly in-house, ~5% panel

Runs most STI singles in-house, bills the panel about one in twenty. Limited room on the rate.

3.3

Customer Education

A customer quietly billing the wrong code collects less than they should, and by the time it shows up as a weak renewal, nobody remembers why. Comparing what an account is actually billing against what a payer allows turns this silent shortfall into a data-driven conversation.

What price transparency data unlocks

With visibility into how a customer is actually billing relative to what's available and what policy allows, commercial and customer teams can turn a silent, ongoing margin loss into a specific, coachable conversation, often the single fastest-to-resolve use case here, because the fix is behavioral rather than structural.

The data in action

A diagnostics company holding a specific, proprietary code for its own assay often finds a customer billing the generic fallback code instead, collecting less than they should on every claim. The same gap shows up from the payer side: showing an account exactly where its own negotiated rate sits against the rest of the market is often what gets a stalled renewal talk moving. Customers who aren't getting optimal reimbursement on the product don't just under-collect quietly; they become a revenue leakage problem the account team finds out about only when the renewal is already at risk.

Talking points

ILLUSTRATIVE

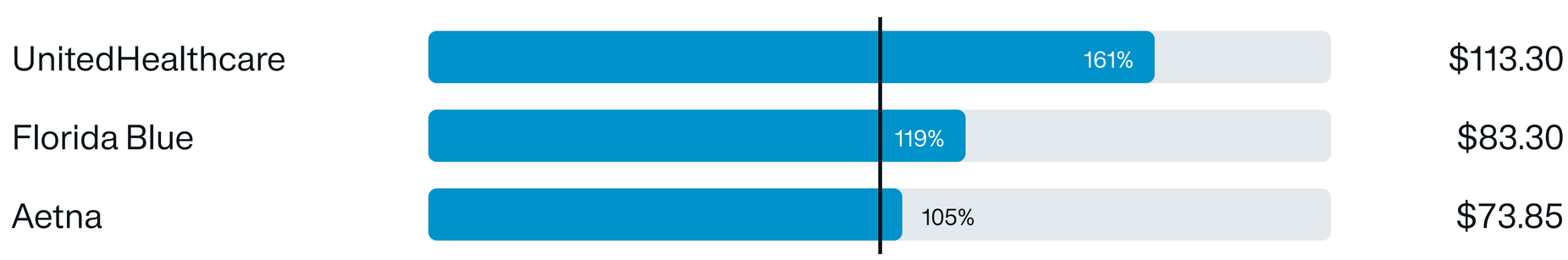
What you bill today	What the payer allows for our code	Gap per claim	Gap per year at your volume
$113.30	**$187.00**	**$73.70**	**$176,880**
87801 generic fallback	0XXXU assay-specific PLA		2,400 claims a year

THE FIX Bill the assay-specific code on every qualifying claim.

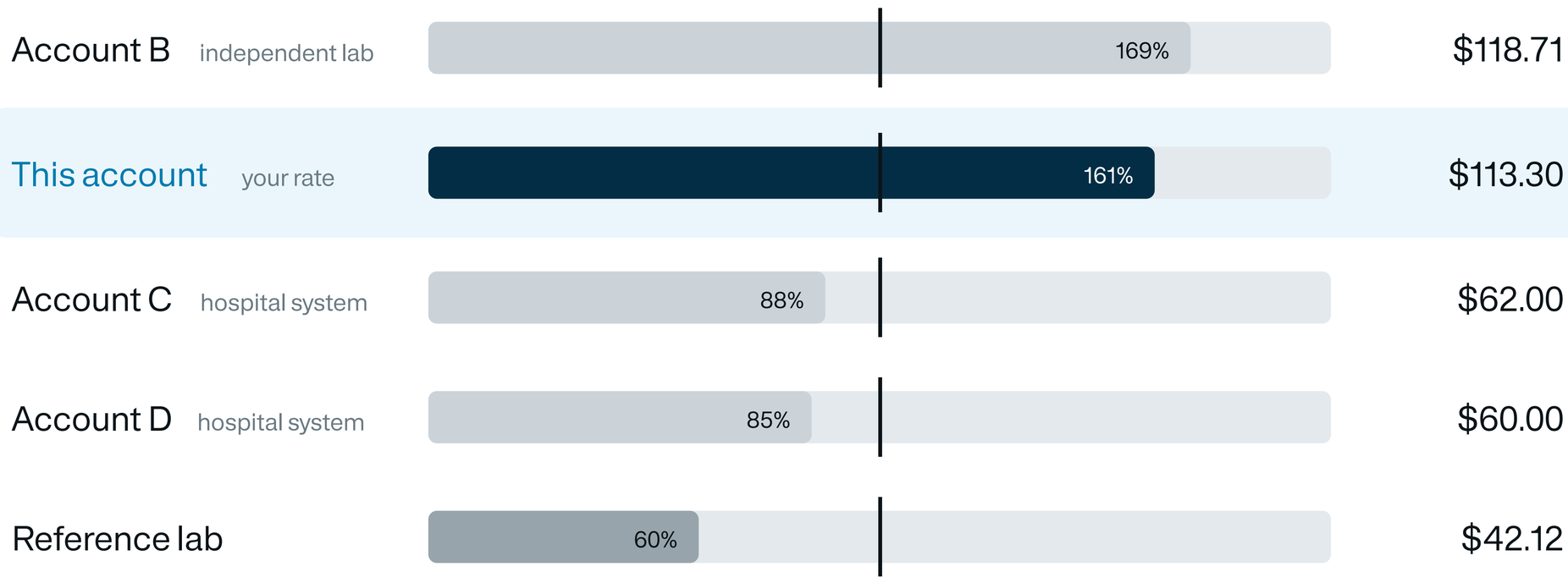
CPT 87801 · NEGOTIATED RATE PER TEST · SHARE OF MEDICARE

You vs. Your Market

THIS ACCOUNT · BY PAYER



THE MARKET · BEST FILED 87801 RATE



+$71

Per test vs. the reference lab

What UnitedHealthcare pays this account over the reference lab for the same panel. This account also clears Medicare on Florida Blue and Aetna; only Account B, an independent reference lab, files a higher rate.

3.4

Pipeline Strategy & Product Development

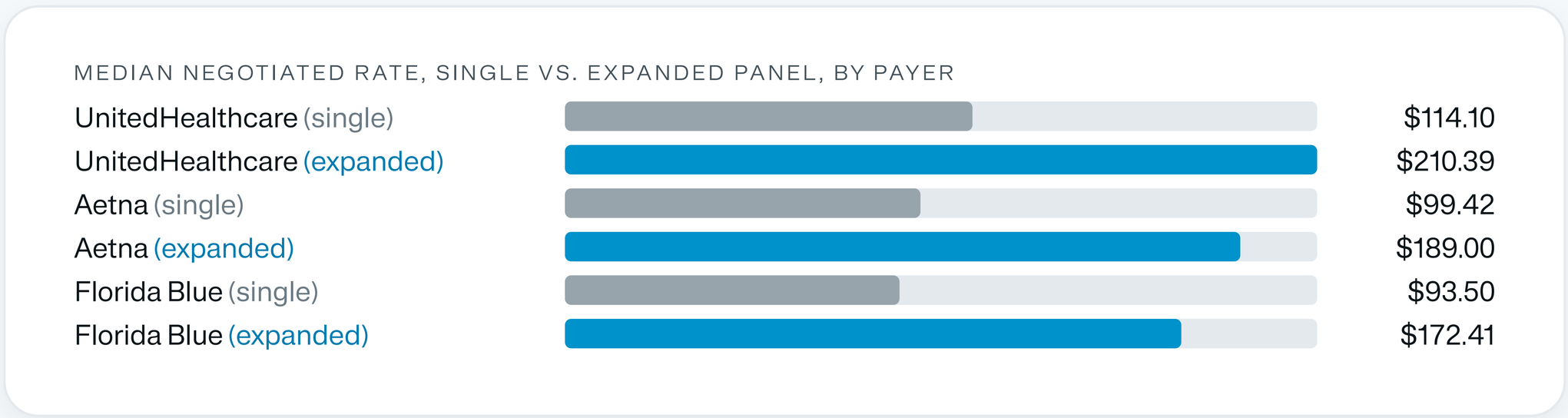
A new panel or device design commits years of development before its reimbursement is proven out. Checking how comparable products are paid today, before that investment is made, replaces a guess with a calculated read on the market.

What price transparency data unlocks

Before a multi-target panel or new device design is finalized, many questions are answerable in the data: how often are comparable panels or procedures actually billed? Does a two-target panel net meaningfully differently from a five-target one? Knowing reimbursement behavior beforehand can mean the difference between a product that pays for its own development and one that never catches up. The same evidence base supports the internal business case: a cost-effectiveness model built on real reimbursement data rather than assumptions.

The data in action

A side-by-side of the negotiated rate for a narrower panel against a version with added targets, by payer, showing whether the expansion is actually worth more per test or just adds cost with the reimbursement not following.



3.5

Payer Coverage & Value Story

By the time a product reaches a payer's medical policy committee, the clinical case is usually the easy part. What often stalls the process is a value argument that leans on projections instead of real numbers.

What price transparency data unlocks

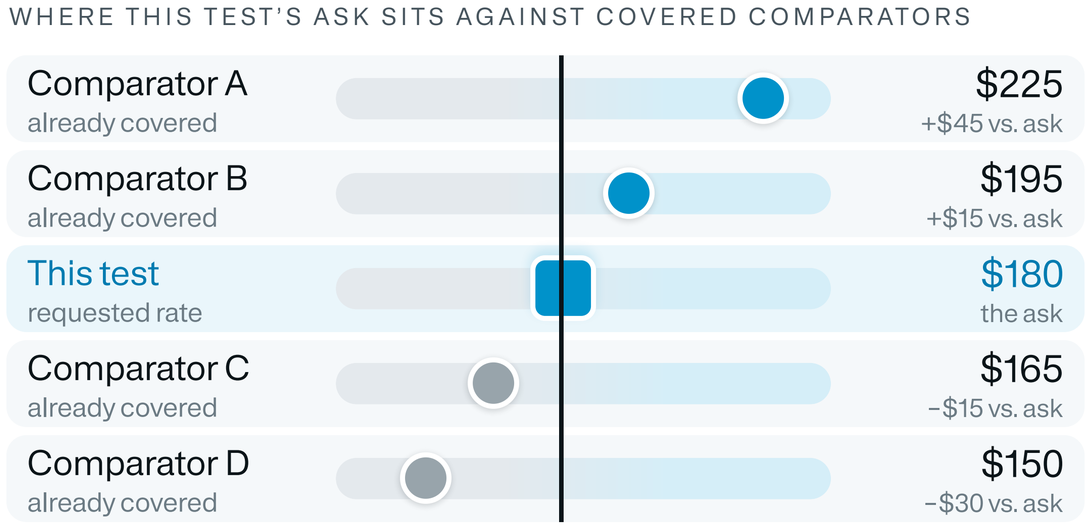
Quantifying that value with actual market rates turns a qualitative clinical pitch into a defensible dossier committees can act on. Because the same underlying rate and utilization data drives the pricing, targeting, and product-development lenses above, this dossier stays consistent with (and reinforced by) the numbers the rest of the organization is already using internally.

The data in action

Two ways this argument gets built, both drawn from the same filed rates driving 3.1 and 3.2: one dataset, multiple audiences.

PRECEDENT-BASED COVERAGE ASK

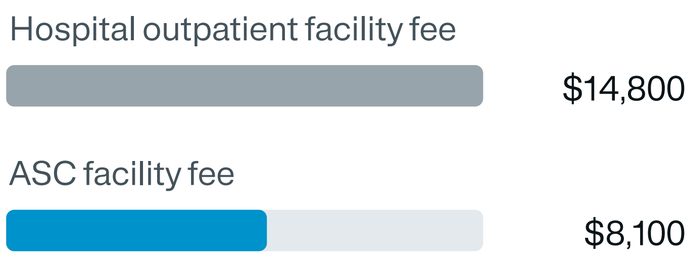
WHERE THIS TEST'S ASK SITS AGAINST COVERED COMPARATORS



Two of the four covered comparators are paid above the rate being requested here. The ask sits mid-pack, not at the edge of what the payer already accepts.

SITE-OF-CARE SHIFT ARGUMENT

SAME PROCEDURE, HOSPITAL OUTPATIENT VS. ASC



The payer's own contracted rates, not a national average, show what moving this procedure to a lower-cost setting is actually worth to them, while the device is reimbursed in both settings.

04

SECTION 04

What You Can Do Starting Today

You don’t need a new platform or a six-month project to get started. These are tactical first steps a market access team can take this week, each one a foundation for the strategies in Section 03.

Tactical first steps you can take now that can serve as a basis for your larger strategy.

01 Look inward first

Segment your own accounts by rate or by site of service and see where you already may be over- or underpriced.

02 Know your floor and ceiling

Pull your own negotiated rate for your top code across your three to five largest payers, rank it against Medicare, and flag the single biggest below-Medicare outlier for your next contract cycle.

03 Rank the accounts

Pick one market. Rank the accounts you don't yet serve there by filed rate. Your next call may be the account with the highest rates and no current relationship.

04 Flag the silent shortfall

Pull rate and billing-pattern data for your ten highest-volume existing accounts. Flag anyone billing a general or component code instead of yours, and set up one conversation.

05 Pressure-test the bet

Before your next product or panel design review, look up how a comparable configuration is reimbursed today across three payers. One data point on the table, not a full model.

The bigger shift sits upstream of any single one of these.

Once pricing, sales, customer success, product, and market access are all pulling from the same filed rates instead of five separate assumptions, the conversations between those teams change too: a negotiator isn't arguing against a guess a colleague heard secondhand, a territory plan isn't defended by tenure, and a coverage pitch isn't a separate spreadsheet from the one sales is already using.

Everyone is working from the same number.

05

SECTION 05

Questions to Expect

Bring negotiated-rate data into a pricing or coverage conversation and you will get pushback. Here are the objections you're most likely to hear, and how to answer each one with the data itself.

The pushback a market access team typically hears when they propose using this kind of data internally, and a straight answer to each.

01 **Is this real data, or another modeled estimate?**

Real. Every rate in this guide is a negotiated rate a health plan filed in its own machine-readable files under the Transparency in Coverage rule, not a survey, a benchmark, or an assumption. That's also the honest limit of it: it's what the payer agreed to pay, not proof of what was actually remitted on a specific claim.

02 **Don't we already track our own rates internally?**

Most teams track their own contracted rates closely. What this data adds is visibility into everyone else's rates: competitors, comparator accounts, the rest of the market, which is exactly what an internal contracts database was never built to hold.

03 **Why does this matter outside of pricing and contracting?**

Because the same filed rates behind a negotiating position also sit behind a territory plan, a customer conversation, a product decision, and a coverage dossier. Once every team is working from the same numbers instead of five separate guesses, the conversations between them change too, not just the numbers each team produces on its own.

04 **How current is it, and how much work is it to keep using?**

Payer files are refreshed on a regular cadence (every chart in this guide notes its data vintage), and pulling a rate for one code, one market, or one account is not a data engineering project. Section 4 is a starting point: each first step is scoped to an afternoon, not a quarter.

What The Data Is

- ✓ A filed negotiated rate
- ✓ From the payer's own file
- ✓ Broken out by code, payer, and provider

What The Data Isn't

- — A survey
- — A benchmark
- — A model
- — A record of what a claim actually paid

06

SECTION 06

The Horizon

Lab fee cuts, site-neutral payment, consolidation, bundled payment and Medicare Advantage are all reshaping how devices and diagnostics get paid. Five shifts to watch, and why tracking rates over time will matter more than any single snapshot.

Diagnostics reimbursement pressure isn't resolved, just postponed

Congress averted the next round of PAMA-mandated Medicare clinical lab fee schedule cuts for 2026 with short-term relief legislation, but that's a postponement, not a fix: labs reported new payment-rate data between May and July 2026, and cuts of up to 15% on roughly 800 lab services return to the table absent structural reform (the RESULTS Act being the leading proposal). Diagnostics companies that can show real-world reimbursement resilience will be better positioned than those relying on the status quo holding.

Site-of-service economics are being redrawn from the top down

Site-neutral payment policy is projected to move roughly $182 billion in Medicare spending over the next decade, and ASCs already receive only about 53–56% of comparable hospital outpatient reimbursement for similar procedures under current MedPAC data. For device companies whose products move between hospital outpatient and ASC settings, this isn't a background policy debate. It's a direct input into where procedure volume (and device revenue) will land.

Payer and provider consolidation is changing who's actually on the other side of the table

As payers and health systems roll up into the same enterprises, the rate-setting leverage shifts away from a straightforward payer-versus-provider negotiation. A filed rate that looks stable today may sit inside a very different balance of power by the next renewal cycle, which makes tracking the data over time, not just as a single snapshot, more important than it used to be.

Value-based and bundled payment is expanding past primary care

When the procedure a device supports, or the panel a diagnostic sits inside, gets pulled into a bundled payment, the product stops being reimbursed on its own line item and becomes one cost inside someone else's fixed payment. That changes who the value story is actually being told to, and what evidence they need to hear.

Medicare Advantage keeps growing, and its rates don't always follow Medicare's

MA plans increasingly set their own coverage and payment policies rather than defaulting to traditional Medicare's CLFS or physician fee schedule rates. Benchmarking a device or test only against traditional Medicare understates or overstates a growing share of the market with different reimbursement dynamics.

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The Healthcare **Price Transparency** Solution