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2026 MID-YEAR EDITION · DATA THROUGH JUNE 2026

The Vairate Price Transparency Trend Report

An actuarial analysis of commercial base rate and conversion factor trends extracted from monthly payer price transparency files.

20,000+	4	18
payer contract terms decoded	national PPO networks	months of observation

Based on 20,000+ payer contract terms across four national PPO networks, from files published from January 2025 through June 2026.

By Greg Mottet, FSA
Founder, Vairate

FIVE FINDINGS AT A GLANCE

Where reimbursement terms stand as of June 2026

01 Inpatient base rates rose 5.3%

+5.3%

Hospital MS-DRG base rates rose 5.3% over the 12 months ending June 2026.

02 Outpatient rose about 5%

+5.1%
APC conversion factors

+5.0%
Outpatient case rates

Both outpatient facility methodologies moved together: APC conversion factors +5.1%, outpatient case rates +5.0%.

03 Professional conversion factors rose 2.3%

+2.3%*

Professional (RBRVS) conversion factors rose 2.3%, well below the facility pace, which is a long-standing pattern.

04 Geography is where rates vary most

≈⅔

Where a hospital sits correlates with its inpatient base rate more strongly than anything else we measured. The highest-priced region runs roughly two-thirds above the lowest.

05 Networks are converging

20.1% → 19.6%

Avg. difference between two networks paying the same hospital, Jun 25 → Jun 26

Networks are converging on facility reimbursement terms. Two networks paying the same hospital differ by about 20% on the inpatient MS-DRG base rate, on average, and over the last 12 months that gap has started to narrow. Contracts are slowly being renegotiated.

* Read the professional figure with caution. This edition's professional conversion factors are drawn predominantly from a single national network, so the 2.3% result should not be taken as a market-wide rate of change. Subsequent editions will incorporate professional data from additional networks, and the figure is subject to change — potentially significantly, and in our view more likely upward — as that coverage expands.

Change is measured over the 12 months ending June 2026, read from the latest published files, with granularity down to the specific network, provider, and code.

WHAT CHANGED THIS EDITION

A timely, contract-level read the market has never had

This is the first edition of the Vairate Price Transparency Trend Report, which will be published on a semi-annual basis.

It exists because the market has never had a timely, contract-level read on where base rates and conversion factors sit or how they are moving. Survey-based trend studies capture market-level best estimates of aggregate trend without unit cost components. Studies based on market claims datasets measure what was actually allowed, which is the right lens for many questions, but these studies are often two to three years lagged, and deidentified data can't resolve to a specific network, provider, or contract term. Meanwhile, every payer now publishes its negotiated rates in machine-readable files — the raw material for exactly these types of measurements.

That is what this report does, and it compensates for two key deficiencies not addressed by existing resources. It is **more current**: we decode payer machine-readable files as the payers publish them, not on a lagged claims cycle. And it is **more granular**: because we extract the underlying reimbursement terms, the same data that produces this market view resolves all the way down to an individual provider, methodology, and code, network by network. We decode the files back into the base rates and conversion factors underneath them, and hold a consistent set of providers steady over time, so the movement we report is negotiated change in a fixed set of reimbursement terms — not a shift in the mix.

This edition covers January 2025 through June 2026 across four national PPO networks. It reports facility base rate and conversion factor trend (MS-DRG, APC), outpatient case rate trend, and professional conversion factor trend (RBRVS). Professional trend is currently based predominantly on one network, which is informative but short of a market-level read, and case-rate payment logic varies enough that an average level isn't directly comparable across contracts, so this edition publishes their **trends**, but withholds their **averages** and **distributions**. The roadmap on the final page shows what is next.

DATA WINDOW	VERSION	CADENCE
Jan 2025 – Jun 2026	2026 Mid-year	Semi-annual

EXECUTIVE SUMMARY

Four things this edition establishes about commercial base rates and conversion factors from January 2025 through June 2026

1 **Base rates and conversion factors are steadily increasing.** Over the trailing 12 months, inpatient (MS-DRG) base rates rose 5.3%, outpatient facility (APC) 5.1%, and outpatient case rates 5.0%, while professional (RBRVS) rose 2.3%. Facility running higher than professional is expected, and is generally attributed to facility negotiating leverage; what's new here is watching it month by month at the contract level, straight from publicly available data.

2 **Networks are converging on facility conversion factors.** The spread between the networks paying the same hospital narrowed over the year — early evidence that competitive pressure is compressing facility rates. Professional has not converged in what we can observe.

3 **Medicare-indexed pricing is highly prevalent.** Many commercial inpatient and professional contracts scale off Medicare weights or relative value units (RVUs), while outpatient leans toward case rates, percent-of-charge, and proprietary schedules. That prevalence is what makes a market-wide trend study possible: enough of the market is priced on a common Medicare yardstick to measure movement consistently, contract to contract. (Where these figures sit relative to Medicare, and why that multiple reads higher than claims-based benchmarks, are explained in Chapter 4.)

4 **Geography is the dimension along which conversion factors vary most.** The same inpatient methodology, at the same hospital size, ranges from the low 200s of the Medicare base rate in the lowest-priced regions to the high 300s in the highest. Hospital size is also associated with higher base rates, but its spread is consistently narrower than the regional one. These are descriptive associations, not causal claims — consolidation, market dynamics, and local labor cost all plausibly sit underneath.

> Methodology, scope, and limitations are in the final chapter.

We decoded 20,000+ headline reimbursement terms into their key components (base rates, conversion factors, schedules, years, etc.), and then held a consistent set steady to measure how they move.

Price transparency data is abundant and, taken raw, can be misleading. A machine-readable file contains rates, but it does not tell you which reimbursement methodology a rate belongs to, whether a number is based on a headline conversion factor or an incidental line item, or whether the same contract is even present from one month to the next. Answering those questions is the work, and it is what separates a claim you can defend from an analysis you quietly stop trusting.

We started from a universe of roughly **4,000 general acute care hospitals** and **30,000 medical groups** across four national PPO networks, and narrowed from there to what can be measured consistently.

THE STARTING UNIVERSE

≈4,000	≈30,000	4
general acute care hospitals	medical groups	national PPO networks

EXHIBIT 1

Decoded contract volume and the consistent-reporting cohort

Providers / contracts, from a universe of ~4,000 hospitals and ~30,000 medical groups across four national PPO networks

METHODOLOGY	BENCHMARKABLE TERM DECODED providers / contracts	CONSISTENTLY REPORTED providers / contracts
Inpatient · MS-DRG	**2,361** / 5,120	**2,201** / 4,295
Outpatient · APC	**770** / 895	**448** / 508
Outpatient · Case rate	**1,849** / 2,797	**1,715** / 2,265
Professional · RBRVS	**18,699** / 25,154	**15,789** / 17,569

Providers are hospitals (facility methodologies) or medical groups (professional); contracts are provider × payer. Professional (RBRVS) reflects three national networks this edition; see methodology.

VOLUME

The table shows two things. The first is **volume** — how many contracts we decode, by methodology, across the four networks. Inpatient MS-DRG base rates resolve for at least one network for 2,361 hospitals, outpatient case rates for 1,849, and professional RBRVS conversion factors for 18,699 medical groups. Outpatient APC is the outlier at 770: APC-based outpatient contracting is genuinely uncommon (Chapter 2). We do not decode every contract in the country and do not attempt to. But at this volume there is more than enough to benchmark a national market and to measure how it moves.

WHAT WE SET ASIDE

The second is **what we set aside**. A contract enters the study only if the provider reports it in every full quarter of the window; the right-hand column is what survives that test. The reduction is deliberate. Because the same contracts are present in every period, the cohort is fixed, so a change in the average cannot be due to the mix of which contracts were reported in any given month. It is movement in the negotiated term itself.

Contracts that fall out are not useless; they are just not usable *here*. A handful of observations across a year can still tell a negotiator roughly where a specific contract sits, or be pieced together into a workable read on one provider. That is a different bar from a national trend study, where an inconsistently reported series would fold mix and movement into the same number.

What we decode, then, is a deliberate subset: contracts priced off a Medicare-indexed methodology — MS-DRG base rates, APC and RBRVS conversion factors — plus outpatient case rates, which are **not** Medicare-indexed but are prevalent enough on the outpatient side to track. We work with these terms because they can be extracted consistently across providers and networks, which makes them the clearest available read on where the market is moving. That is not a claim that they are all that matters in a negotiation. A real contract includes additional claim-level logic, carve-outs, stop-loss provisions, and secondary schedules that sit outside this scope entirely. The study further excludes percent-of-charge and custom-weight MS-DRG contracts.

SIDEBAR · CONVERSION FACTORS VS. RATES

A conversion factor is the multiplier that scales a fee schedule: the MS-DRG base rate applied to DRG weights, the RBRVS dollar multiplier applied to relative value units, the APC multiplier applied to APC weights. It is the single number that moves the entire schedule, which is useful for benchmarking. It is a proxy for aggregate reimbursement, but it is **not** the final reimbursement: what a provider is actually paid also depends on provider charges, payment policy, carve-outs, stop-loss provisions, etc., none of which this report measures. When we say a base rate rose 5%, we do not mean reimbursement rose exactly 5%.

Chapter 2 HOW THESE NUMBERS ARE BUILT

Every figure in this report starts from a single contract term: a base rate, a conversion factor, or a weighted-average case rate.

The unit

Each contract in this study reduces to one number, and which number depends on the methodology:

Inpatient (MS-DRG)	the **base rate**, applied to Medicare's DRG weights
Outpatient facility (APC)	the **conversion factor**, applied to Medicare's APC weights
Professional (RBRVS)	the **conversion factor**, applied to relative value units
Outpatient case rate	the **weighted-average case rate** across the contract's case-rate schedule

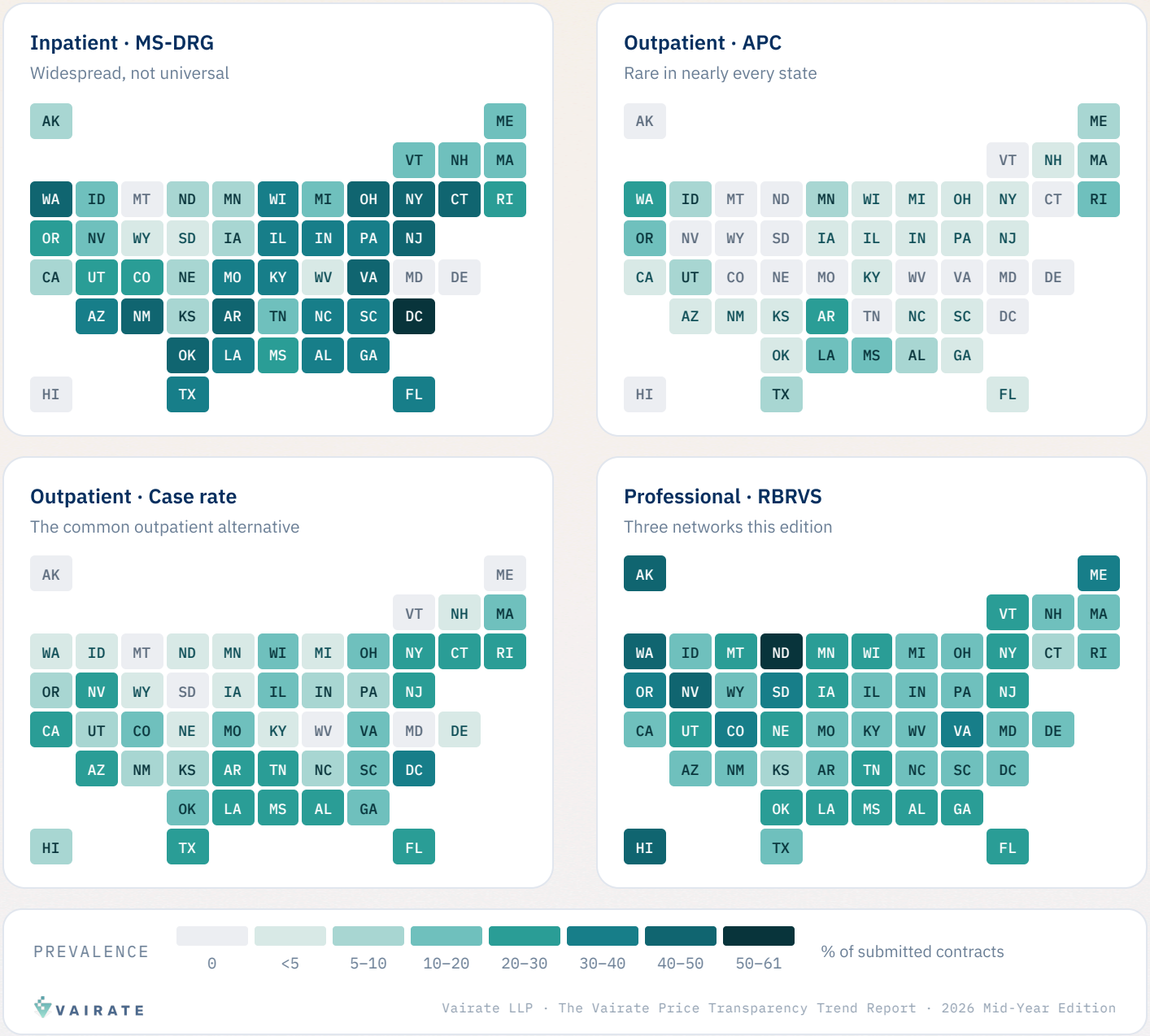
That single term is the foundation of everything that follows. Every trend, distribution, regional cut, and compression measure in this report is a way of aggregating or expressing it. Nothing here is a claim about realized reimbursement, which also depends on provider charges, payment policy, and other factors.

Methodologies vary by market

Reimbursement methodologies vary considerably by market. It is important to understand which methodologies are used in your market, and their prevalence, in order to interpret the results in this study correctly.

EXHIBIT 2 **Methodology prevalence by state**

Share of submitting providers in each state whose consistent contracts use the methodology. Conservative measure; true prevalence is higher. Identical scale across all four panels.



The three most important findings from these plots are:

Inpatient MS-DRG weights are widespread but not universal — heaviest in the Northeast, Atlantic, and parts of the South, West, and Midwest; lightest where custom non-Medicare DRG weights dominate (California most notably), which our conservative methodology excludes.

Outpatient APC is rare. In most states only a low single-digit share of outpatient contracts are APC-based. This is why the APC figures rest on a smaller cohort, and we flag them.

Case rates are the more common alternative to APCs for outpatient. That is why we track case-rate *trend* even without publishing a case-rate *benchmark*.

This is why the report keeps four separate series and never blends them into a single headline number: they are different price terms, applicable to different contracts, and they do not move together.

From a term to a trend

Trend is measured directly on those terms. We take the same contracts, hold them constant across the window (Chapter 1), and read each contract's term every month. Aggregating to a weighted average per methodology gives one monthly value per series; indexing each series to 100 at January 2025 gives the path; the endpoints give the percent change.

Two consequences worth noting. First, because the cohort is fixed, a change in the series is a change in the negotiated terms themselves, not a change in who is being measured. Second, the terms remain the underlying metric for measuring trend, so nothing in the next section affects the trend figures.

From a term to a comparable scale

We convert MS-DRG, APC, and RBRVS terms to a comparable scale by dividing by the Medicare base rate or conversion factor. While this does not produce a pure percent of Medicare, it enables a Medicare-like comparison across methodologies in addition to networks, providers, and regions.

That is a useful reference scale, but it is also the number in this report most easily misread. The box below is the rule for reading it.

READER'S GUIDE

How to read "percent of Medicare" in this report

What it is

We divide each negotiated base rate or conversion factor by **Medicare's own base rate or conversion factor** for the matching schedule and year. It compares one price term to another price term.

What it is not

It is **not** a percent of what Medicare actually pays. Medicare's base rate is only the starting point of a Medicare payment: indirect medical education (IME), disproportionate share (DSH), uncompensated care (UCC), outlier payments, quality/MIPS adjustments, and other factors also stack on top. These add-on payments (principally IME, DSH, UCC, and outlier payments) are approximately 22% of total Medicare IPPS payments nationally (Milliman 2025). None of them are in our denominator.

What that means when you read it

Treated as a strict percent-of-Medicare reimbursement, these figures will typically **overstate** where contracts sit — the denominator is smaller than all-in Medicare payment, so the ratio is larger. Read it as a common yardstick for comparing contracts to each other, not as a statement of how a commercial rate compares to a Medicare payment.

It does not apply everywhere

Case rates are not Medicare-indexed, so they never appear on this scale — we publish case-rate trend without a percent-of-Medicare figure. The term is what we measure; percent of Medicare is one optional way of expressing it.

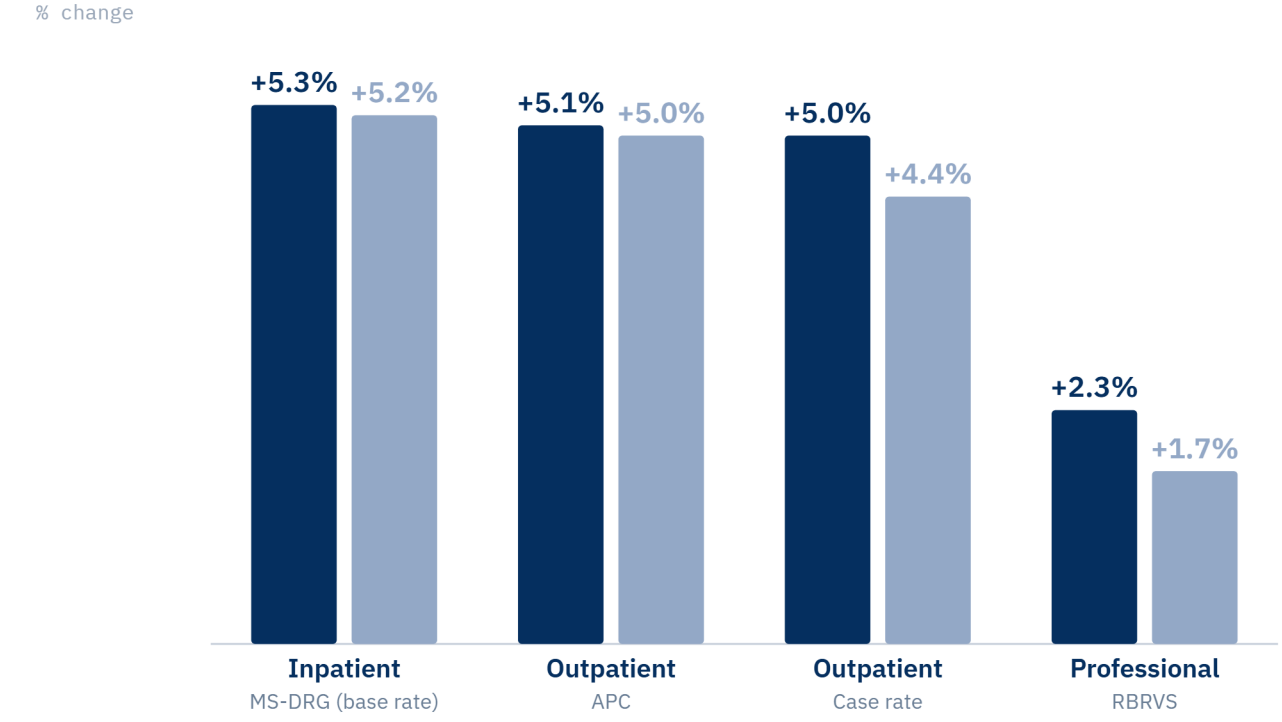
What this series covers next

This edition benchmarks the methodologies that support a directly comparable price term. It does not yet publish case-rate benchmarks, percent-of-charge contracts, or custom-weight DRG contracts — all prevalent, all on the roadmap (final page).

Commercial unit cost trend proxies measured straight from payer contract data, month by month.

The finding is easy to state: over the trailing 12 months, facility base rates and conversion factors rose about 5% and professional about 2%. Anyone who negotiates these contracts knows facilities tend to out-trend professional. What has never existed is a timely, contract-level measurement of *how much* — updated monthly, straight from published rates.

EXHIBIT 3 **Trend summary by methodology**



Professional (RBRVS): three networks; excludes one Aetna product for data quality; Premera professional excluded Jan–Feb 2025. Percent change only — no benchmark is shown on this exhibit.

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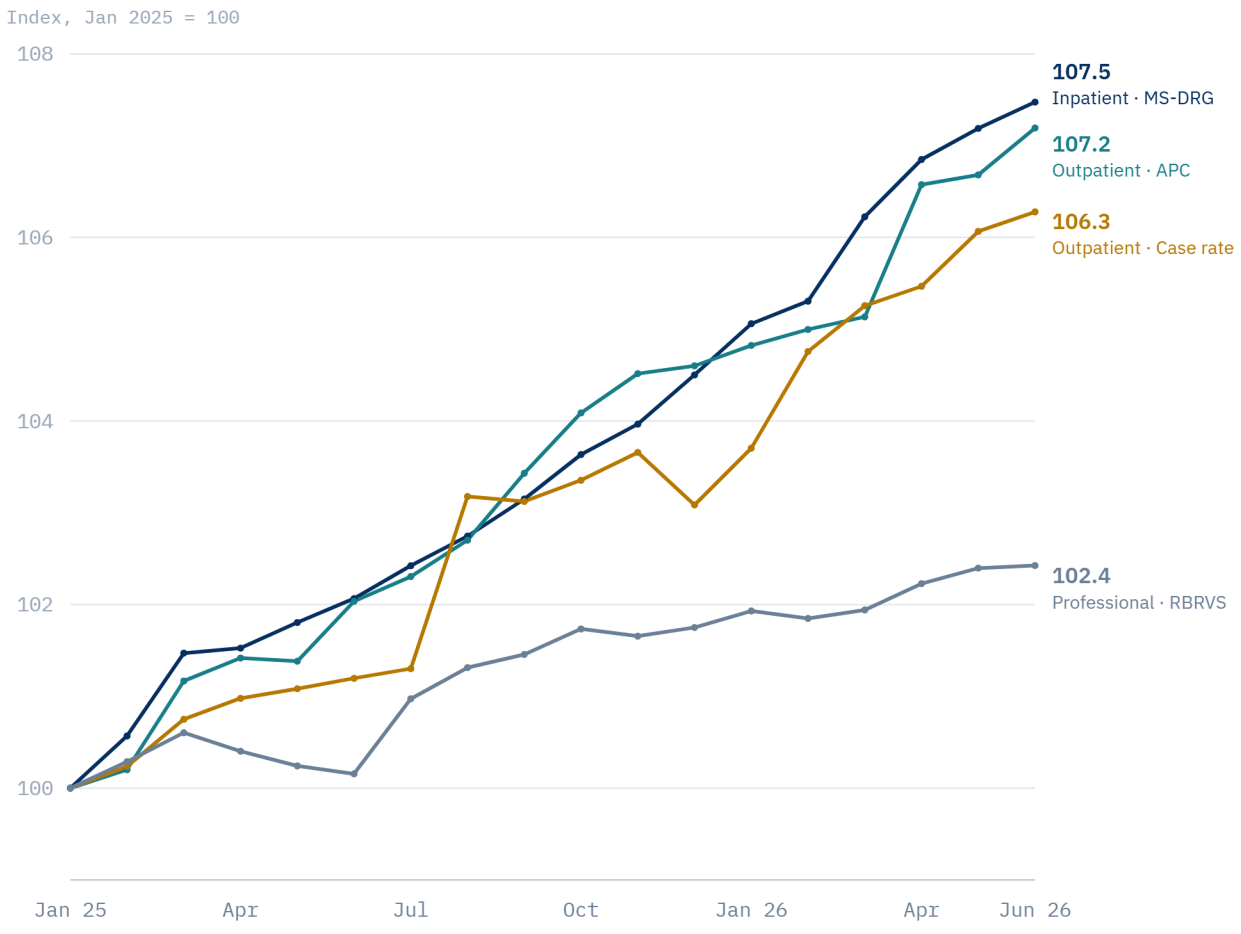
EXHIBIT 4

Monthly indexed trend, by setting and methodology

Each series indexed to 100 at January 2025 · monthly through June 2026 · every monthly observation plotted, no smoothing · quarter-consistent cohort



Professional (RBRVS): predominantly based on one network. Two networks were largely excluded due to provider mapping. One network was excluded for data quality.

Outpatient (Case Rates): monthly changes in reported codes introduce additional variation.

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Facility base rates climbed steadily from January 2025 (inpatient reaching an index of about 107 by June 2026, outpatient facility just behind); professional climbed far more gently, to about 102. This is negotiated change in reimbursement terms accumulating quietly and continuously, legible here in a way no annual survey can show. Further, any movement can be traced back to the facilities and networks behind it, providing the ability to view the market at a high level and drill down to the underlying drivers.

Professional (RBRVS) figures are directional.

This edition's professional coverage is concentrated in a single national network: we excluded a second carrier's professional records for data quality, and provider mapping for the remaining networks is still maturing. So the professional series is closer to one large carrier's book than to a balanced four-network read — one reason we publish professional *trend and position* but withhold a professional *benchmark*. Read +2.3% as directional. Note also that a measured conversion-factor trend can carry some effect from shifts in the underlying relative-value mix, so treat it as movement in the reimbursement term rather than a clean unit cost change.

There is a structural reason professional moves so gently: a large share of professional conversion factors are not individually negotiated at all. Many smaller physician groups are reimbursed on standardized fee schedules that carriers offer broadly, while groups with leverage negotiate their own rates and often trend higher. The blended professional trend is a mix of the two.

17,569

consistently reported professional contracts

15,789

medical groups in the cohort

3

networks, but concentrated in one

SIDEBAR · WHAT CURRENT DATA ENABLES

Every number here reflects rates published through June 2026 — read straight from price transparency files — avoiding both the aggregation of surveys and the two-to-three-year lag in market claims data. And because we extract the underlying contract terms, the measurements resolve down to specific networks, providers, and codes. Timeliness is only bounded by payers' own publication (see methodology), which is far more current than claims data.

Facility base rates span a wide band, indicating substantial variation across facilities and networks.

Scope note: benchmarks are shown for **facility methodologies (MS-DRG, APC) only**. Professional (RBRVS) absolute benchmarks are withheld this edition; professional appears as trend (Chapter 3) and competitive position (Chapter 6).

EXHIBIT 5 **Inpatient · MS-DRG distribution**

% of the Medicare base rate · June 2026 · discharge-weighted · n = 4,360 contracts

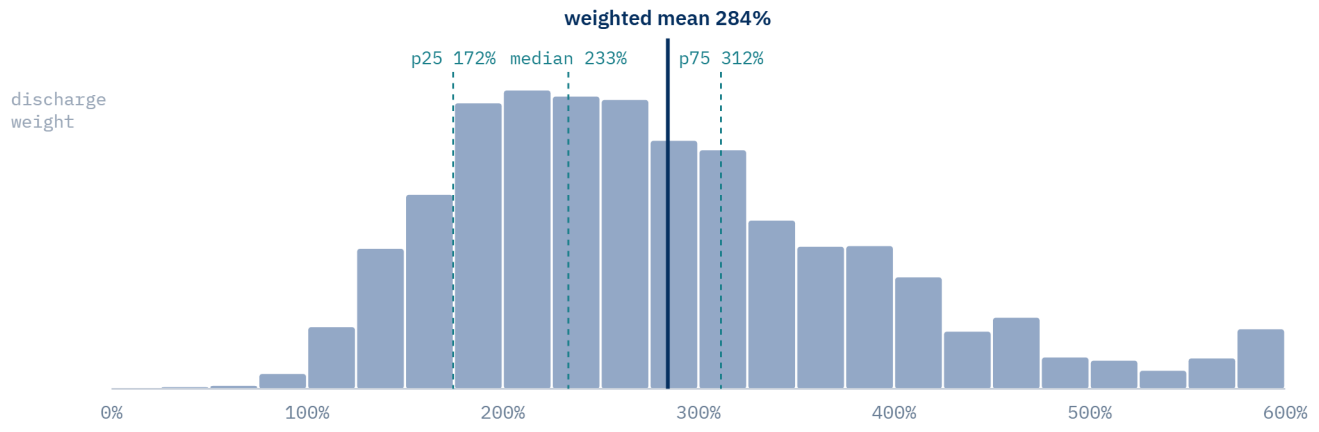

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EXHIBIT 6 **Outpatient · APC distribution**

△ thin data
n = 529 contracts

% of the Medicare (OPPS) conversion factor · June 2026

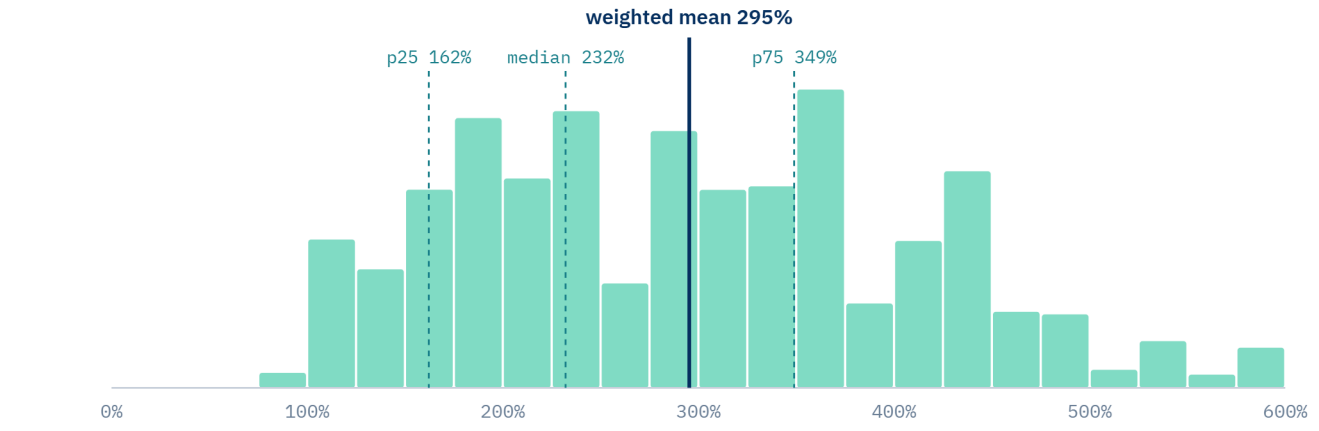

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TABLE A

Key numbers, facility

METHODOLOGY	WEIGHTED MEAN	P25	MEDIAN	P75	N (CONTRACTS)
Inpatient · MS-DRG	**284%**	172%	233%	312%	4,360
Outpatient · APC	**295%**	162%	232%	349%	529 △ thin

MS-DRG as % of the **Medicare base rate**; APC as % of the Medicare (OPPS) conversion factor. Discharge-weighted.

Half of the inpatient contracts measured fall between 172% and 312% of the Medicare base rate. Drilling down into specific regions (Chapter 5) shows that some of this variation is associated with regional differences. However, there are many drivers of hospital base rates, including consolidation, leverage, and labor costs, among other factors. The base rate is also not the only mechanism through which hospitals are reimbursed for inpatient care, so some of the variation could reasonably be explained by additional payment terms such as outlier reimbursement.

Reminder — what these percentages are measured against

Each figure compares a negotiated term to **Medicare's own base rate or conversion factor**, not to what Medicare actually pays. IME, DSH, UCC, outlier, quality adjustments, and sequestration are not in the denominator. Read as a strict percent of Medicare reimbursement, these numbers would typically overstate. See the reader's guide in Chapter 2.

How this reconciles with published commercial-to-Medicare benchmarks

244%
RAND inpatient (2022 data)

263%
RAND outpatient (2022 data)

Published studies — including RAND's 2020–2022 study, which puts inpatient at 244% of Medicare and outpatient at 263% (2022 data; RAND 2024) — measure incurred claims across the full provider mix. Ours isolates the negotiated reimbursement term and covers only the contracts from which such a term can be extracted, likely sitting above the whole-market average because percent-of-charge contracts — often associated with smaller facilities — are not included. Also, carriers with lower market penetration and presumably higher rates are given the same weight as larger carriers, creating a further bias toward higher percentages.

The two sources fall within an expected range after considering this difference in approach and two additional factors: four years of trend from 2022 to 2026, and Medicare IME, DSH, UCC, and outlier payments, which materially increase inpatient Medicare reimbursement (~22% nationally; Milliman 2025) and therefore lower RAND's reported inpatient percent of Medicare. In short, a higher number than RAND is expected — the result of trend, the absence of Medicare add-on payments in the denominator, and the selection and weighting of contracts leaning toward higher costs.

Sources: RAND (2024); Milliman (2025). Full citations in the references at the end of this report.

Hospital base rates vary considerably by region and bed count, with geography showing the wider spread of the two.

The market average is a single number laid over enormous variation. Two axes together provide a high-level understanding of the variation: region and hospital size. The matrix below is the core view of this chapter. It shows association, not cause — the drivers underneath (consolidation, market structure, local cost) are multiple and are not disentangled here.

EXHIBIT 7 **Region × hospital size — inpatient MS-DRG base rate**

Percent of the Medicare base rate (not all-in Medicare reimbursement — see Chapter 4) · June 2026 · MS-DRG only; APC is too thin for this grid · hospital-size bands by staffed bed count

	<100 beds	100–299 beds	300+ beds
Northeast	268%	291%	388%
Pacific Coast	305% △	347%	387% △
Southeast Atlantic	295%	287%	307%
Interior West	285%	281%	313% △
Heartland	217%	219%	243%
South	207%	209%	234%

% OF MEDICARE BASE RATE 200 390 △ thin support (30–49 providers)

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Two patterns read straight off the surface.

Geography is the dominant axis.

207% – 388%

Read down any column: the same size of hospital, using the same methodology, ranges from the low 200s of the Medicare base rate in the South and Heartland to the high 300s in the Northeast and on the Pacific Coast. Across the whole surface, base rates run from about 207% to about 388% — nearly a two-fold range — and most of that spread is geography.

Hospital size adds a secondary layer.

249% → 302%

Read across any row: within a region, larger hospitals generally carry higher base rates than smaller ones, with the largest step at the 300-plus-bed tier (most pronounced in the Northeast). The gradient is real but consistently narrower than the regional range, and in a few regions it is nearly flat between the two smaller size bands.

249%	259%	302%
<100 beds, national	100–299 beds, national	300+ beds, national

> The takeaway: where a hospital's base rate sits tracks most closely with the market it operates in; hospital size is a real but secondary consideration on top of that. Nationally, the same gradient holds — inpatient base rates run from about 249% of the Medicare base rate at hospitals under 100 beds to about 302% at 300-plus.

Regional trend

Benchmarks are one story; how fast each region is moving is another.

REGION	MS-DRG 12-MO TREND	RBRVS 12-MO TREND
Pacific Coast	**+6.4%**	+3.1%
Northeast	**+5.8%**	+2.5%
South	**+5.8%**	−0.1%
Southeast Atlantic	**+5.1%**	+2.6%
Heartland	**+4.6%**	+2.0%
Interior West	**+3.4%**	+1.0%

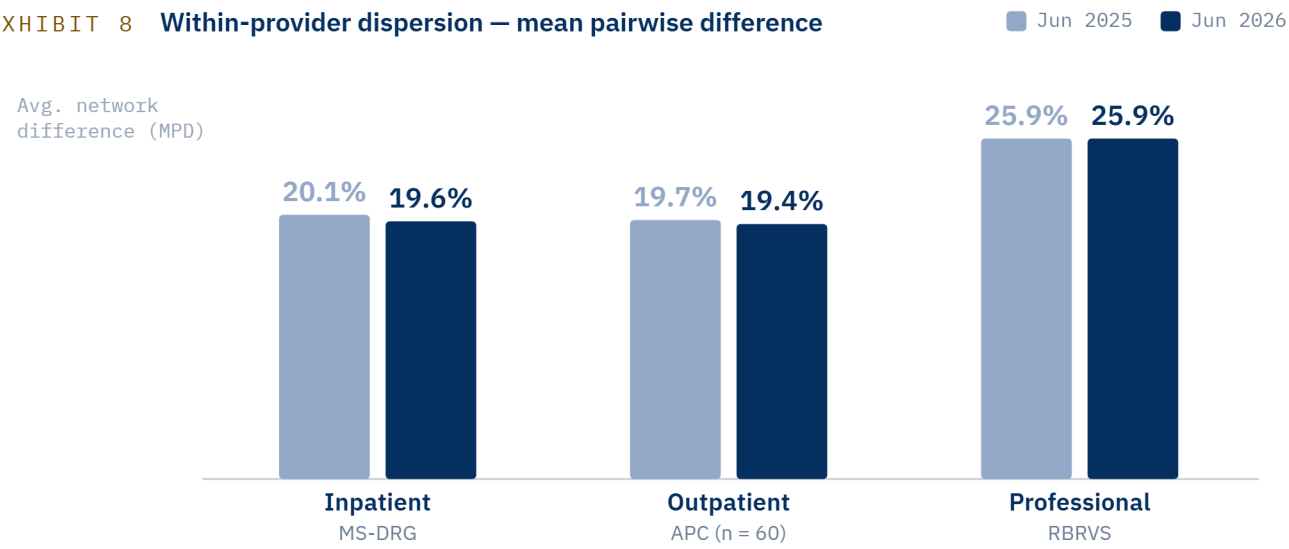
RBRVS shown as **trend only** — professional benchmarks withheld; professional coverage concentrated in one network (directional). APC and case-rate regional not shown.

The highest-priced regions are not always the fastest-rising — the South carries among the lowest inpatient base rates but among the fastest inpatient trend. On the professional side the regional picture is muted everywhere and essentially flat in the South (−0.1%), consistent with the standardized-pricing pattern noted in Chapter 3.

The networks paying the same provider are converging on facility conversion factors — and, in what we can observe, holding apart on professional.

If contracting is becoming more competitive, the different networks paying the same provider should be drifting closer together. To measure this, base rates and conversion factors can be used as a reasonable proxy. We measure convergence directly, provider by provider, two ways.

EXHIBIT 8 **Within-provider dispersion — mean pairwise difference**



METHODOLOGY	MPD JUN 25 → JUN 26	DISPERSION (CV)	PROVIDERS
Inpatient · MS-DRG	20.1% → 19.6% narrowing	0.120 → 0.116	1,329
Outpatient · APC	19.7% → 19.4% narrowing	0.109 → 0.105	60
Professional · RBRVS	25.9% → 25.9% flat	0.130 → 0.130	1,768

Measured over providers with at least two networks reporting the same methodology. These use the net-patient-revenue weighting; see methodology.

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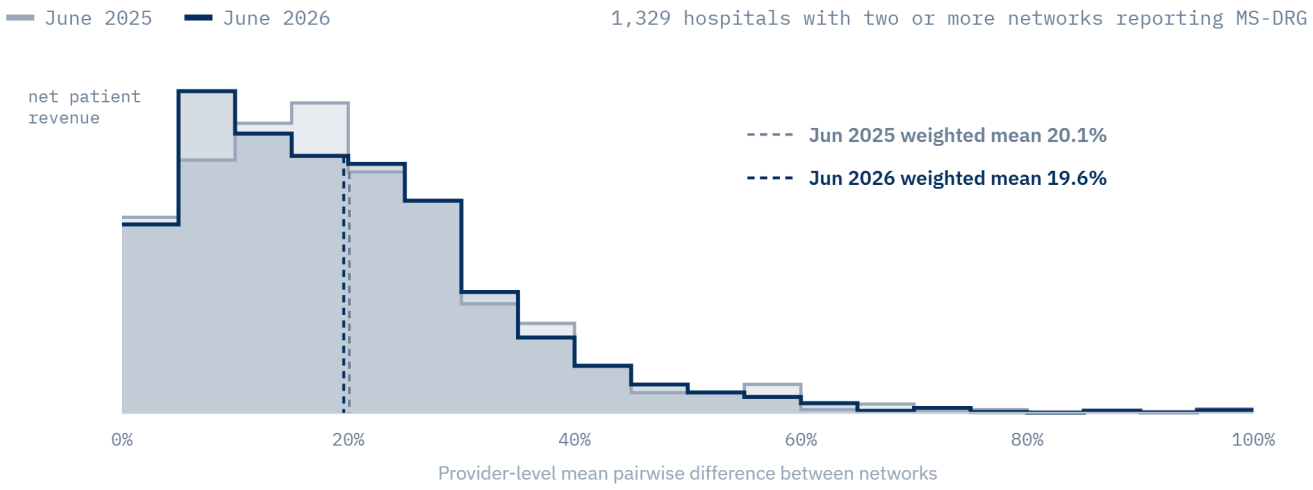
We report two measures for two different audiences. **Mean pairwise difference (MPD)** is the plain-language variant: an MPD of 20% means any two networks paying the same provider have conversion factors about 20% apart, on average. **Coefficient of variation (CV)** is the statistical companion — the standard deviation of a provider's network conversion factors relative to their mean. They tell the same story here, which is itself reassuring.

The story: on facility conversion factors, the networks paying a given hospital are converging. The average difference narrowed from 20.1% to 19.6% over the year, similar on outpatient facility (n = 60, directional but moving the same way). The distribution below makes the movement visible.

EXHIBIT 9 **MS-DRG within-provider dispersion, distribution of provider-level MPD**



Hospital net patient revenue by 5-point MPD bin, 0–100%. Weighted-mean MPD annotated for both periods so the leftward shift is legible where the curves overlap.

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The distribution shift is real but early: across roughly 1,300 hospitals, the spread of network conversion factors is starting to move toward zero — hospitals shifting left, toward less dispersion. This is the market beginning to compress, not a market that has already compressed.

Professional is different — and here we can only report what we can see.

On professional, the networks paying a given physician group still differ by about 26% on average, unchanged over the year and the widest of the three. But read that carefully: this cohort is roughly 1,750 groups where two or more networks report the same provider, a small slice of the ~30,000-group professional universe. Within what we can observe, there is **no evidence** that professional conversion factors are converging. That is not a finding that they aren't; it is that the data we can see today does not let us draw the conclusion. Facility is where competitive pressure is measurably showing up first.

Case-rate compression not published this edition; see roadmap.

The value is seeing where you stand, and seeing the market move before it moves past you.

This report is the market view. For teams responsible for network performance and contracting, three things follow from having access to the data underneath.

1 **The market is moving, and a moving market creates winners and losers.** Compression is the tell: in just 18 months — not the full data history back to 2022 — the spread between networks paying the same hospital has already begun to narrow. Contracts are being actively renegotiated and networks are converging, which means relative position is being reordered right now. Standing still isn't neutral; if your competitors are working their position and you aren't, your relative position erodes on its own. The teams that treat this as a core competitive discipline will pull ahead of the ones that wait.

2 **Identify shifts in the market, then drill down to the drivers underneath it.** The market number is the starting point, not the destination. Beneath it, you can put your network next to a specific competitor at a specific provider and see, as soon as it posts in the transparency files: **when** they renegotiated a contract, **how large** the move was, and **which terms** actually changed. That's the shift from *believing* you're competitive to *watching* your position and your competitors' moves in near-real time, at the contract level. No other source shows you that.

3 **Set negotiation targets based on contract-level intelligence.** Geography is where the largest differences sit — in where base rates start, and in how fast they are moving. Inpatient trend ranged from +3.4% in the Interior West to +6.4% on the Pacific Coast against a national 5.3%, and regional base rates span the low 200s to the high 300s of the Medicare base rate. However, digging deeper shows that each negotiation can be supported by much more localized and relevant information. The same data that produces the national number resolves to the region and to the individual provider. It's also usable in both directions: looking back, whether the moves you just made landed ahead of or behind your market; and looking forward, where that market is moving now — in time to act on it, rather than reading about it a year from now.

+3.4%	+5.3%	+6.4%
Interior West, slowest	National inpatient	Pacific Coast, fastest

How competitive intelligence matures

Most health plan competitive intelligence is maturing along the same path, and three things separate the leaders: **how actionable the intelligence is**, **how much of your book the intelligence covers**, and **how long it takes you to find out a competitor moved.**

EXHIBIT 10 **The price transparency maturity curve**

	1 · Ad hoc	2 · At scale	3 · Market-level
WHAT IT COVERS	The handful of high-stakes negotiations you have time to analyze	Every negotiation, on a standard competitive read	Every negotiation, plus market-level views
WHAT YOU SEE	Competitor terms for that provider, in that negotiation	Competitor terms for all negotiations	Competitor moves as they post — when, how large, which terms
WHEN YOU LEARN IT	During the negotiation (select providers only)	During the negotiation	The month it publishes
BLIND SPOT	Everything you didn't have time to look at	Where the market is heading next	—

Many teams are still operating in stage 1, and that is not a failure — it is where everyone started, and it helps move the needle in real negotiations. It becomes a problem only if it is where you stay. A stage 1 team is looking at a small share of its spend, and only for the negotiations where bandwidth is allocated, which is not necessarily the negotiations with the largest competitive gaps. A stage 2 team knows where it stands broadly but is still reacting contract by contract. Only at stage 3 do you see a competitor's move while there is still time to plan a response to it.

That last step is the one worth building toward deliberately, and it is the one this report is made of: the same decoded data, read continuously at the market level. What you are holding is that view of the national market; the same measurement resolves to your regions, your providers, and the specific networks you compete with. Competitive position becomes something a team can set corporate goals against and measure.

And Chapter 6 is the reason not to wait. Spreads are narrowing now, which suggests positions are being reordered now. The plans that move up this curve fastest will be the ones setting the pace; the ones that stay where they are will find a moving market has repriced around them. Keep up, and lead the pack.

> Spreads are narrowing now, which suggests positions are being reordered now.

General market commentary, not advice for any specific negotiation. See scope and reliance, final chapter.

About this report. The Vairate Price Transparency Trend Report is a descriptive benchmark of commercial *base rates and conversion factors* — the reimbursement terms that scale rates, not realized reimbursement — decoded from payer machine-readable files. It is intended for health plan network-management, provider-contracting, and healthcare-economics professionals, and for provider-side contracting and finance teams. It is not prepared for, and should not be used in, any specific negotiation, transaction, rate filing, or valuation. It presents descriptive market observations; it is not a statement of actuarial opinion with respect to any specific entity, contract, or transaction, and should not be relied upon as such.

Author and qualification. Greg Mottet is a Fellow of the Society of Actuaries and is qualified to render the actuarial findings in this report on the basis of his education and experience in healthcare actuarial practice. This report has been prepared in accordance with applicable Actuarial Standards of Practice.

Conflict of interest. Vairate has a direct commercial interest in this report. It is produced from the same decoded price-transparency data that Vairate offers commercially through DecipherPro, and it is distributed as marketing. The findings are presented as measured; readers should weigh them with that interest in mind.

What we measured — conversion factors, not rates. A conversion factor is the multiplier that scales a fee schedule (the MS-DRG base rate, the RBRVS dollar multiplier, the APC multiplier). Realized reimbursement additionally depends on payment policy, billed charges, coding, and other factors, which this report does not measure. Reported trends are movements in the base rate or conversion factor and may include some effect from shifts in the underlying service mix, particularly for professional services.

Benchmark — percent of the corresponding Medicare rate. Facility benchmarks are a percent of Medicare's own base rate (inpatient) or conversion factor (outpatient) for the matching schedule and year. They **exclude** the Medicare payment adjustments that convert a base rate into a paid claim — IME, DSH, UCC, outlier payments, quality/MIPS adjustments, and sequestration (add-on payments, principally IME, DSH, UCC, and outlier payments, are approximately 22% of total Medicare IPPS payments nationally; Milliman 2025). Reported figures are therefore higher than all-in commercial-to-Medicare benchmarks by construction; Chapter 4 explains the reconciliation. Professional absolute benchmarks are withheld this edition.

Timeliness. Figures reflect rates published as of June 2026, read directly from payer files. Timeliness is bounded by payers' own file publication, which can trail a contract's effective date and varies by payer — materially shorter than the lag in claims-based benchmarks, but not instantaneous.

Weighting. Base rate and conversion factor benchmarks and trend are weighted by a **non-dollar volume proxy** — annual discharges for hospitals and physician count for groups — so the benchmark is not skewed toward highly reimbursed hospitals. (Hospitals lacking a discharge count are dropped from these tables.) The dispersion measures (CV, MPD) in Chapter 6 use a **net patient revenue** weight, because dispersion is about where the dollars at stake differ. Both choices are deliberate and disclosed so the difference is not mistaken for inconsistency.

Selection and scope. This report measures negotiated, Medicare-indexed contracts — those from which a headline base rate or conversion factor can be extracted. It excludes percent-of-charge arrangements, custom-weight contracts, and providers (notably solo and small independent practitioners) on standardized non-negotiated schedules. Because those excluded contracts tend to sit below the negotiated-contract average, reported benchmarks are biased upward relative to the whole market. This is a property of the scope, and the scope is intentional: negotiated Medicare-indexed contracts are the relevant comparison set for competitive positioning.

Data and reliance. Findings rely on payer-published machine-readable files disclosed under the federal Transparency in Coverage rule; on CMS reference data for Medicare weights, relative value units, base rates, and conversion factors; and on standard hospital reference data for hospital characteristics used in the analysis (region, bed size, and the discharge volume used for weighting). Vairate does not assume responsibility for the accuracy of payer-published source files. Benchmark comparison uses RAND (2024), based on 2020–2022 commercial claims, and Milliman (2025) for the magnitude of Medicare inpatient add-on payments. Information date: data as of June 2026; report prepared August 2026. No subsequent events are known. This PDF constitutes the complete actuarial report.

Scope and cohort. Four national PPO networks: United, Aetna, Cigna, and BlueCard. No comparisons among networks are presented anywhere; all results pool across networks. Scope is limited to general acute care hospitals and affiliated professional entities. Trend is measured on a quarter-consistent cohort: a provider qualifies for a methodology only if it reports that methodology in every full calendar quarter of the window. Regional and hospital-size cuts use a fixed reference vintage of hospital characteristics, held constant across the series so a provider's grouping cannot change mid-window and register as movement.

Professional (RBRVS) coverage this edition. Professional coverage is concentrated in a single national network: one carrier's professional data was excluded for data quality, two months of a regional carrier's professional data were excluded for misreporting, and provider-to-group mapping for the remaining networks is still maturing. Professional is reported as **trend and competitive position only**; professional absolute benchmarks are withheld. Facility methodologies (MS-DRG, APC) reflect all four networks.

Not covered this edition (see roadmap): professional conversion factor *benchmarks* (trend shown); outpatient case-rate *benchmarks* (trend shown); percent-of-charge contracts; MS-DRG contracts using custom, non-Medicare weights; carve-outs (burns, trauma, behavioral health, maternity, newborn); stop-loss / outlier terms, typically 5–20% of facility reimbursement and occasionally higher, whose exclusion means reported figures understate total contracted reimbursement; and secondary professional fee schedules (drugs/ASP, DME, laboratory, ambulance, anesthesia).

Known limitations under active refinement. Base rate and conversion factor extraction is under continuing development; material changes will be disclosed in the edition in which they take effect. Professional provider mapping and single-network concentration are the principal limitations this edition. Case-rate and professional benchmark extraction are not yet at publication grade. The DecipherPro extraction pipeline is a model within the meaning of applicable actuarial standards; its intended purpose and known material limitations are as described here.

Suppression. Cells with 30 to 49 providers carry a thin-data marker; cells with fewer than 30 providers are suppressed.

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EXHIBIT 11

Coverage roadmap

What this edition publishes, by term type. A green check means shown this edition; an orange circle means it is on the roadmap; a red ✕ means not applicable for this term type.

TERM TYPE	AVAILABLE	BENCHMARK VS. MEDICARE	TREND
Inpatient · MS-DRG (base rate)	✓	✓	✓
Outpatient · APC	✓	✓	✓
Professional · RBRVS	✓	○	✓
Outpatient · Case rate	✓	✕	✓
Percent-of-charge	○	○	○
Custom-weight MS-DRG	○	○	○

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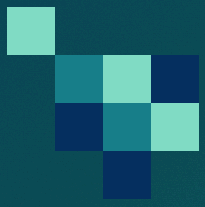

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2026 Mid-Year Edition

Prepared August 2026