trek health

2026 State of Payer Negotiations

How providers use data to prepare, negotiate, and protect reimbursement

July 2026

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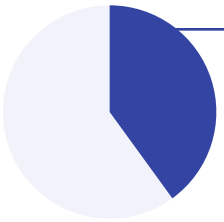
Executive summary

This report presents findings from a national survey conducted by Trek Health to better understand how provider organizations are using Transparency in Coverage (TiC) data to support commercial payer contract strategy. The research explores current adoption, implementation challenges, and the role of reimbursement data in benchmarking, payer negotiations, and broader financial decision-making.

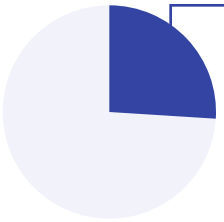
The results paint a clear picture: TiC data exists, but its integration into negotiation workflows, financial modeling, and competitive intelligence is incomplete across most of the industry. The organizations best positioned in payer negotiations are not necessarily those with the most data. Instead, they are those with the most structured processes for converting data into strategy.

Key findings

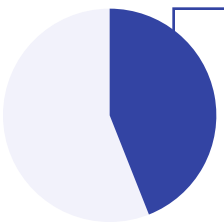
Payer policy changes not reflected in contracts is the most commonly cited source of revenue leakage.



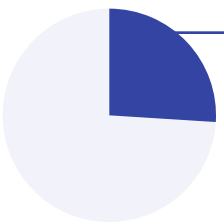
Nearly 40% of organizations report limited or no meaningful use of TiC data in negotiation preparation



Only 26% proactively model the financial impact of payer policy changes before reimbursement is affected



44% cite limited time and resources as the biggest barrier to turning transparency data into negotiation leverage



More than 60% say forecasting reimbursement shifts is often or always challenging

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The research behind this report

Price transparency regulations gave provider organizations access to payer-negotiated reimbursement rates through Transparency in Coverage (TiC) machine-readable files (MRFs), creating an unprecedented opportunity to benchmark reimbursement and strengthen payer negotiations. However, access to data alone does not translate into better financial outcomes. Converting raw MRFs into actionable negotiation intelligence requires specialized data infrastructure, analytics, and operational workflows that many organizations have yet to implement.

To better understand how provider organizations are using Transparency in Coverage data in practice, Trek Health surveyed 161 healthcare leaders across hospitals, health systems, and provider organizations. Respondents were asked to describe their organization's current approach to Transparency in Coverage data, payer negotiations, and reimbursement strategy, providing insight into organizational practices rather than individual perspectives.

This report benchmarks the current state of Transparency in Coverage adoption, highlights common barriers to data utilization, and identifies opportunities for provider organizations to improve payer performance through better use of reimbursement data. The findings provide a practical view of where the industry stands today and where organizations can create competitive advantage through more informed payer strategy.

Trek Health developed this research as part of its mission to help provider organizations transform fragmented payer information into actionable financial intelligence. By bringing together validated Transparency in Coverage data, payer contracts, payer policies, market benchmarks, and AI-powered workflows in a single platform, Trek helps organizations benchmark reimbursement, identify negotiation opportunities, monitor payer activity, and make more informed financial decisions that improve payer performance.

The TiC data utilization gap

Nearly 40% of respondents are operating with limited or no TiC-informed negotiation preparation, entering contract discussions without the market rate intelligence that regulations specifically created to make available.

How does your organization use Transparency in Coverage (TiC) data to prepare for payer negotiations?

Review TiC data for general awareness, but it rarely informs preparation	7%
To benchmark rates during pre-negotiation analysis	23%
Incorporate into financial modeling and negotiation planning	19%
Defines rate targets, prioritization, and negotiation strategy before discussions begin	18%
Do not use in negotiation preparation	11%
Not sure/Don't know	23%

Rate benchmarking remains the most common use case for TiC data, though it accounts for just under a quarter of respondents. Financial modeling and negotiation strategy development follow. Combined, these use cases suggest that roughly 60% of organizations are incorporating TiC data into some aspect of payer negotiation preparation. The more telling figure is the 23% who do not know how their organization uses TiC data at all. This is not a data maturity problem. It is an organizational knowledge fragmentation problem. In larger health systems, TiC analysis may be siloed within analytics teams or external vendors, with results failing to reach the contract managers, managed care leaders, and finance staff who are actually at the negotiating table. An additional 11% report not using TiC data in negotiation preparation at all, and 7% use it only for general awareness.

The underutilization extends beyond the negotiating table. Nearly a third of respondents do not use TiC data outside of active contract cycles, leaving its value as a continuous monitoring and strategic planning tool largely untapped.

Which of the following activities does your organization currently use Transparency in Coverage (TiC) data, outside of active payer negotiations?

We do not currently use TiC data outside of payer negotiations	31%
Market expansion or new market entry analysis	30%
Monitoring payer rate changes over time	30%
Service line performance analysis and optimization	29%
Financial forecasting and budget planning	26%
Identifying underpayments or reimbursement leakage	23%
Contract compliance and validation	18%
Physician recruitment and retention planning	10%
Supporting executive reporting or board-level insights	9%
Regulatory, audit, or compliance analysis	9%

Among organizations that have extended TiC utilization beyond contract cycles, market expansion analysis, payer rate monitoring, and service line optimization each represent meaningful use cases. These organizations remain a minority of the overall sample.

Barriers to translating transparency data into leverage

44% of respondents cite limited time and analytic resources as their primary barrier to operationalizing TiC data — the most common response by a significant margin.

What limits your organization's ability to translate transparency data into negotiation leverage today? (Please select all that apply)

Limited time or analytic resources	44%
Data exists but is difficult to normalize and/or trust	39%
Insights are not tied to contracts and/or financial modeling	17%
Teams operate in silos with disconnected tools	18%
Don't know/Not sure	11%
Other	9%
No significant limitations	8%

Organizations are not failing to use TiC data because they lack access to it. They are failing because they lack the capacity to process it. TiC machine-readable files are among the largest structured data artifacts in healthcare, and normalizing them into comparable, actionable rate benchmarks requires engineering infrastructure and analytic expertise that most provider organizations have not built internally.

Data quality and normalization challenges compound the capacity problem. Even where analytic resources exist, trust in the data is low. TiC files are inconsistently formatted, variably complete, and difficult to cross-reference across payers without standardized NPI-TIN matching, plan-type classification, and rate normalization logic. Organizations that have invested in TiC analysis frequently encounter data that is technically compliant with MRF requirements but practically difficult to use.

Beyond capacity and data quality, structural integration failures limit impact further. When TiC analysis does produce reliable benchmarks, the findings often do not flow into the contract management systems, financial planning models, or negotiation preparation workflows where they would have the greatest effect. Only 8% of respondents report no significant limitations, confirming that underutilization is a multilayer challenge across capacity, data quality, and organizational integration simultaneously.

Negotiation readiness: Effectiveness, confidence, and capability gaps

Most organizations cannot consistently apply data-informed approaches across payers, service lines, and contract cycles — and a meaningful share are absorbing preventable financial exposure as a result.

How effective is your organization when using market, contract, and payer behavior data during active payer negotiations to defend and justify rate targets?

Never effective	2%
Rarely effective	12%
Occasionally effective	39%
Often effective	**37%**
Very effective	**9%**

How confident are you that your payer negotiation strategy reflects current market realities across rates, competitors, and payer behavior?

Never confident	3%
Rarely confident	16%
Occasionally confident	34%
Often confident	**35%**
Very confident	**11%**

The 39% in the "occasionally effective" category represent organizations with some data-informed negotiation capacity but without the process consistency to apply it reliably across payers, service lines, and contract cycles. The 14% who are rarely or never effective are likely entering negotiations with a structural informational disadvantage, relying on historical precedent or consultant snapshots rather than current market intelligence.

How does your organization anticipate the financial impact of payer policy updates before they affect reimbursement?

Model impact for select payers or service lines	32%
Proactively track and model policy changes across major payers	26%
Identify risk reactively but struggle to quantify financial exposure	19%
Typically identifies impact after revenue is affected	14%
Not sure/Don't know	7%
Other	2%

Only 26% of respondents proactively track and model payer policy changes before those changes affect reimbursement. An additional 32% model impact selectively, by payer or service line, leaving meaningful exposure unquantified. The reactive cohort is substantial: 19% can identify risk but cannot quantify it financially, and 14% typically learn about reimbursement impact only after revenue has already been affected. Together, roughly a third of respondents are systematically absorbing preventable financial exposure. By the time they identify and respond to a payer policy change, the revenue impact has already materialized.

The revenue leakage problem

More than 60% of respondents say forecasting reimbursement shifts driven by payer rate changes, policy updates, or methodology changes is often or always challenging. Only 9% find it rarely or never so.

Which areas pose the greatest risk of revenue leakage for your organization today? (Please select all that apply)

Payer policy changes not reflected in contracts	**68%**
Inconsistent payment practices across payers	64%
Methodology or payment logic changes by payers	42%
Below-market contracted rates	30%
Limited competitive rate visibility	25%
Not sure/Don't know	9%
Other	7%

The dominant revenue leakage risks identified in the survey are contract management and compliance problems, not rate problems. Payer policy changes not reflected in contracts and inconsistent payment practices across payers ranked as the top two leakage sources, and both reflect the same underlying failure: the gap between what payers are contractually obligated to do and what they are actually doing is not being systematically monitored. Rate optimization has historically been the primary focus of payer negotiation strategy, but the survey data suggests the more immediate revenue protection opportunity lies elsewhere — ensuring existing contracts are being honored, identifying policy changes before they affect reimbursement, and catching methodology shifts that reduce effective reimbursement gradually without surfacing as an explicit denial.

Below-market contracted rates and limited competitive rate visibility ranked lower, not because they are unimportant, but because most organizations already recognize them as problems. The leakage risks at the top of the list are less visible and therefore more likely to go unaddressed.

What is the most significant financial or strategic risk your organization accepts today when entering payer negotiations?

Payer non-compliance, denials, underpayments, and non-payment	19%
Payer policy changes & independent rulemaking	19%
Administrative burden & access barriers	13%
Medicaid/medicare dependence & rate pressure	12%
Market dynamics, service mix & redirection risk	10%
Cost structure/modeling	8%
Internal knowledge gaps	6%

The near-equal distribution between payer non-compliance risk and payer policy change risk reflects a bifurcation in how organizations conceptualize their negotiation vulnerabilities. Organizations facing high non-compliance and underpayment risk are dealing with a contract enforcement problem. Those primarily concerned with policy change risk are dealing with a market intelligence and monitoring problem. The 6% identifying internal knowledge gaps as their primary risk is likely an undercount — internal knowledge fragmentation surfaced as a recurring theme across the survey, and in each instance the underlying driver is the same: organizational processes that do not consistently move available intelligence to the people responsible for acting on it.

Competitive intelligence: How provider organizations assess their market position

Understanding where rates sit relative to other providers in the same market is a foundational input to payer negotiation strategy. The survey asked how organizations currently assess their competitive position.

How does your organization currently assess its competitive position relative to other providers in your markets? (Please select all that apply)

Consultant-led market or benchmarking studies	44%
Publicly available market benchmarks or industry reports	43%
Transparency in Coverage (TiC) data analysis	34%
Side-by-side comparisons of competitor reimbursement for similar services	31%
Historical rate change or trend analysis across payers	23%
Informal payer feedback or anecdotal market intelligence	27%
Service line or specialty-level competitive analysis	21%
We do not have a consistent or repeatable approach today	16%
Internal contract and reimbursement data only	11%

Consultant-led studies and industry reports remain the dominant approaches, while TiC data analysis has emerged as a meaningful but not yet dominant method for competitive positioning. A notable share of respondents report no consistent or repeatable approach at all, entering negotiations without systematic market rate context.

Reliance on consultant-led benchmarking creates a structural problem given the current pace of payer policy change.

When a payer adjusts its reimbursement methodology, issues a new payment bulletin, or modifies its payment practices, the impact flows through remittances immediately. A benchmarking study conducted months prior may not capture those shifts, meaning organizations building rate targets on consultant outputs are often negotiating from a market picture that no longer reflects current conditions. TiC data is updated on a defined regulatory schedule and covers the full scope of in-network negotiated rates rather than a curated sample. The barrier is not data availability. It is the normalization and analytical infrastructure required to convert raw machine-readable files into clean, comparable benchmarks.
Transparency in Coverage regulations have created a more level informational playing field in theory. In practice, the gap between the rate intelligence provider organizations have access to and what they are deploying at the negotiating table remains large. The barriers are organizational: analytic capacity, internal knowledge sharing, workflow integration, and the decision to treat TiC data as a continuous operational input rather than a periodic contract preparation task. The organizations that have addressed those constraints are already visible in this data, and the gap between where they operate and where most of the industry operates is measurable. Closing it is the challenge the industry is working through now.

Organizations at the frontier have integrated multiple methods into a continuous intelligence workflow, combining real-time TiC benchmarks, historical trend analysis, and service-line-level competitor comparisons to enter negotiations with current numbers rather than lagged estimates. That approach remains the exception rather than the norm.

Strategic implications and recommendations

The underutilization of Transparency in Coverage data is no longer a data availability problem. It is an operational challenge. While reimbursement data is widely available, many provider organizations still lack the infrastructure to convert raw machine-readable files into trusted intelligence that supports payer strategy.

The first step is establishing a trusted data foundation. Raw TiC files must be continuously ingested, normalized, and validated before the data can support reliable benchmarking and financial decision-making. This aligns with the 39% of survey respondents who identified data normalization and trust as a primary barrier. Once organizations can trust the data, they can use it with confidence across the payer lifecycle.

From there, reimbursement intelligence should be connected with payer contracts and financial performance to create a complete view of payer relationships. Bringing these data sources together enables organizations to identify negotiation opportunities, prioritize high-value contracts, quantify financial impact, and make more informed contracting decisions.

The same connected approach should extend to payer policy monitoring. With only 26% of organizations proactively monitoring policy changes, many continue to discover reimbursement risk only after revenue has been affected. Continuous monitoring allows organizations to anticipate financial impact, adjust operations, and strengthen contract strategies before issues reach the claims process.

Ultimately, provider organizations need a connected payer intelligence infrastructure that unifies reimbursement data, payer contracts, and payer policies. Organizations that establish this foundation will be better positioned to reduce revenue leakage, prioritize negotiation opportunities, and improve payer performance over time.

Conclusion

Transparency in Coverage regulations have created a more level informational playing field in theory. In practice, the gap between the rate intelligence provider organizations have access to and what they are deploying at the negotiating table remains large. The barriers are organizational: analytic capacity, internal knowledge sharing, workflow integration, and the decision to treat TiC data as a continuous operational input rather than a periodic contract preparation task. The organizations that have addressed those constraints are already visible in this data, and the gap between where they operate and where most of the industry operates is measurable. Closing it is the challenge the industry is working through now.

Ready to put these insights into action?

The findings in this report highlight a growing opportunity for provider organizations to strengthen payer performance through better use of reimbursement data. Trek Health helps organizations benchmark reimbursement, strengthen payer negotiations, and proactively monitor payer activity using validated Transparency in Coverage data, payer contracts, payer policies, and AI-powered workflows.

Schedule a personalized demo to see how Trek Health can help your organization improve payer performance.

Schedule a demo →

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