Episode Introduction and Focus

This episode isn't about patient shopping tools or consumer price estimates. This is a conversation for physicians, administrators, and revenue leaders who live in the real world of payer contracts, underpayments, denials, an annual budget pressure.

It's about what the price transparency laws actually unlocked on the payer side, what data is now available because of them, why payers released it so reluctantly, and why a whole new category of software has emerged almost overnight to turn that raw data into something you can actually use.

And most importantly, it's about why renewing insurance contracts every single year is no longer optional best practice, but essential financial governance.

Welcome to Medical Money Matters, the podcast where you can find experts, answers, and resources so that you achieve mastery over the financial and business aspects of your practice.

Hello everyone, I'm your host, Chillerina. I began my career in accounting and finance and I have more than 30 years of experience running medical groups.

I own and operate a national healthcare consulting and revenue cycle company and am the author of Physician Heal Thy Financial Self. In 2020, I co-founded the Physicians Leadership Project and in 2025, released Physicians Edge, the first of its kind CME accredited online business education for physicians.

Host Introduction and Background

My passion is to increase financial and business literacy for physicians. Negotiated payer rates are public. For decades, some of the most important numbers in healthcare lived behind locked doors.

The actual negotiated rates between payers and providers, the numbers that determine whether a practice thrives, survives, or quietly bleeds margin, were treated like trade secrets.

You were expected to negotiate them, manage against them and forecast your future with only partial visibility, which may also be referred to as guessing.

And now, suddenly, those rates are posted online, publicly available, downloadable by anyone. often buried inside massive machine-readable files that can be tens or even hundreds of gigabytes in size, split across dozens of links, and structured in ways that make them nearly impossible to interpret without specialized tools.

So yes, the data is public. But that doesn't mean it's usable. And that gap between availability and usability is where the real story begins. This episode isn't about patient shopping tools or consumer price estimates.

How Transparency Laws Exposed Negotiated Rates

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And, most importantly, it's about why renewing insurance contracts every single year is no longer optional best practice, but essential financial governance.

At the center of all of this is the Transparency and Coverage Rule. In plain language, this rule requires most health plans and insurers to publicly post machine-readable files that include three major categories of information.

First, in-network negotiated rates for covered services. Second, out-of- network allowed amounts and billed charges. And third, prescription drug pricing files, which have had a more complicated rollout but are still part of the broader framework.

The key thing to understand is that this isn't summary data. This isn' averages. These files contain the actual negotiated rates tied to billing codes, associated with providers or provider groupings, and connected to specific plans.

This is the first time, at scale, that the market has been able to see what payers are actually paying, or more specifically agreeing to pay, for specific services in specific geographies.

When the rule was finalized, regulators explicitly acknowledged that these files would be massive and complex and that third parties would almost certainly need to compile, normalize, and analyze the data to make it useful.

That's not an accident. It's an admission that transparency alone doesn't create insight. Infrastructure does. Inside these payer machine-readable files, the most valuable data, especially for physician groups and health systems, is the in-network negotiated rate data.

Conceptually, this data ties a specific service code to a negotiated dollar amount under a specifically plan, along with metadata about the provider arrangement.

Sometimes that's an individual NPI. Sometimes it's a tax ID grouping.

What the Transparency and Coverage Rule Reveals

Sometimes, it is a network entity that requires additional mapping to fully understand. But at its core, this data answers a question that used to be almost impossible to answer at scale.

What does this payer actually pay for this service in this market? The out-of-network files add another layer of insight. They show allowed amounts and billed charges for services delivered outside the network.

While not as directly actionable for most in- network providers, this data can still be revealing. It shows payer behavior, pricing boundaries, and variability across services and geographies.

It can also inform out-of-network strategy, dispute posture, and broader understanding of how payers value certain services when contracts aren't in place.

But let's be honest about the experience of actually trying to use this data directly. Even regulators and policy analysts have acknowledged the barriers.

Files are huge. Links are sometimes broken or poorly indexed. Schemas vary across payers. Provider identifiers aren't always consistent. Duplicate records are common.

and there's almost no context explaining why a particular rate exists, whether it's tied to quality incentives, volume thresholds, legacy contracts, or other factors layered on top of the base fee schedule.

This is what people mean when they talk about reluctant compliance. Payers technically complied with the rule, but in a way that makes it very difficult for an average practice or health system to extract value without help.

The data is there, But it's raw, fragmented and overwhelming. It's not a spreadsheet you can open and scan. it is more like a data lake that requires engineering, normalization and analytics before it becomes useful.

And that's exactly why we've seen an explosion of new software platforms focused on price transparency and negotiated rate intelligence. These tools exist because the problem isn't access anymore.

Why Payer Data Is Hard to Use

The problem is interpretation. At a minimum, modern transparency-driven tools need to ingest payer machine-readable files on a regular basis, manage updates and versioning, deduplicate records, and normalize codes and identifiers.

They need map NPIs, tax IDs, groups, locations in a way that reflects how contracts actually operate in the real world. They need to make rates searchable by code, payer, geography and specialty.

And most importantly, they need turn raw rates into defensible benchmarks, percentiles, distributions and comparisons that stand up in negotiation conversations.

This is where the idea of contract intelligence really comes into focus. These tools aren't just data warehouses. They're designed to answer practical questions.

Are we underpaid relative to the market for our highest volume codes? Which payer represents the biggest gap between our current rates and local benchmarks?

Where should we focus our next negotiation effort to get the greatest financial impact? Several companies have emerged as leaders in this space, each with a slightly different angle, but a shared goal, turning payer transparency data into leverage.

Here's a list. You're listening to Medical Money Matters, a weekly podcast brought to you by Healthy Practices, A healthcare consulting and revenue cycle company dedicated to keeping our clients independent.

Please reach out if we can do anything at all to support your practice. You can find more information online at healtheps.com. That's www.healtheps dot com.

Please follow or subscribe to get all future episodes downloaded as soon as they're released. Hex IQ, for example, has positioned itself around fast, practical access to negotiated rates.

The emphasis is on making payer data searchable and usable without requiring a data science team. This idea is simple but powerful. If you want to know what a payer is paying for a specific code in your market, you should be able to find that answer quickly.

Software Platforms Turning Raw Data Into Insight

That speed matters when you're preparing for negotiations or trying to sanity check your own contract performance. Rivet Health approaches the problem from an operational and accountability perspective.

Benchmarking is a core component, but it's tightly connected to real-world workflows around underpayments, denials, and payer behavior. The value proposition isn't just knowing where your rates sit in the market, it is understanding how those rates actually play out in practice and where payer performance diverges from contractual expectations.

Clearcut Health leans into the idea of validated standardized data sets. Rather than focusing only on front-end dashboards, ClearCut emphasizes turning raw transparency files into clean, structured data that can be consumed in multiple ways, through dash boards, APIs, or direct downloads.

This appeals to organizations that want flexibility, the ability to integrate transparency data into their own analytic, environment, and financial models.

And then there's Turquoise Health. Turques emphasizes data quality, traceability, and defensibility. The focus is on clean rates and clear methodology, being able to show not just what the benchmark is, but how it was derived.

That matters when negotiations get contentious and payers push back. Transparency data is only as powerful as your ability to explain and defend it. What all of these platforms have in common is that they exist because transparency alone isn't enough.

Insight requires structure. Leverage requires context. And action requires tools that fit into the way contracting and revenue cycle teams actually work.

So what can physician groups and health systems actually do with this data today? The most immediate and common use case is contract benchmarking. Instead of negotiating based on anecdotes or outdated surveys, groups can now look at their top 25 or 50 codes by volume and margin and compare their current allowed amounts to market distributions.

You can see where you sit relative to your peers, where your meaningfully below market, and where may already be competitive.

Benchmarking and Revenue Cycle Applications

That feeds directly into negotiation strategy. Rather than asking for across-the-board increases, you can build targeted, data-driven asks. You can say, for these specific codes, we are in the bottom quartile of the market, despite high volume and strong outcomes.

That's a very different conversation than a generic rate increase request. There are also meaningful revenue cycle applications. If transparency-derived benchmarks suggest that your expected allowed amounts should be higher than what you're consistently being paid, that's a signal worth investigating.

It can help prioritize audits, appeals, and pay your follow-up. You can also inform how you triage denials, focusing attention where the gap between expected and actual reimbursement is largest.

Over time, this data can even inform strategic decisions. Service line expansion, site of service planning, and payer mix strategy all benefit from a clearer understanding of reimbursement reality.

Transparency data doesn't replace your contract, but it does shine a light on where your contact is strong and where it's weak. All of this leads to a bigger, more fundamental point.

Renewing insurance contracts matters to every group, and doing it annually is no longer optional. Healthcare costs rise every year. Labor, supplies, rent, technology, compliance, it all gets more expensive.

At the same time, payers are constantly changing their behavior. Payment policies evolve. Edits are added. Bundling logic shifts. Prior authorization expands.

If your contracts don't keep pace with those changes, margin erosion is almost guaranteed. Markets also move. If your competitors renegotiate and you don't, you fall behind.

Not because you're inefficient, but because your anchor to outdated economics. And many contracts are evergreen, quietly renewing year after year without meaningful review.

That silence is expensive. Annual renewal creates cadence and leverage. It turns contracting into a predictable governance process instead of a reactive scramble.

Why Annual Contract Renewal Matters

it aligns negotiations with budgeting and planning cycles. t prevents contract debt, where multiple years of issues

pile up and become too large to fix in a single negotiation.

And it keeps exhibits and fee schedules current, reducing the risk of discovering months of underpayment after the fact. Importantly, renewal doesn't always mean massive rate increases.

Sometimes it means getting a smaller increase but tightening up language or clarifying definitions. Maybe you're elongating timely filing windows or reducing the prior authorization burden.

You can improve dispute resolution terms and maybe even clean up offsets and recoupments. These details matter and they're much easier to address incrementally than after years of neglect.

A simple annual operating system makes this manageable. Start by identifying your highest impact codes by volume, margin, and denial frequency. Benchmark them using transparency-derived tools.

Identify gaps and prioritize payers. Build a clear narrative that is supported by data. negotiate updates and document them carefully. Then monitor performance quarterly so surprises don't compound.

Use of a tool like Contract Visualizer from Healthy Practices can show you the impact of the new contract rate given your group's individual coding pattern and CPT code mix.

And it can tell you exactly what the financial impact will be. The plans know exactly what they're offering you. Do you know what exactly you're getting?

RVUs are shifting pretty dramatically for 2026, so don't get caught in the dark. Please reach out if we can assist you with renewing your contracts or just updating your contracting strategy in general.

The transparency era belongs to the organized. The data is out there, the tools exist to make it useful. the groups that win will be the ones that treat contracting as an ongoing discipline, not a once every few years event.

Negotiated rates may be public now, but advantage still belongs those who know how to use them. Until next time. Thanks for tuning in to the Medical Money Matters podcast.

If you're tired of struggling to make sense of your payer contracts, it's time to level up with Contract Visualizer.

Contract Visualizer and Closing Remarks

Contract visualizer simplifies the complexity of payer agreements, giving you clear insights, actionable data, and the power to negotiate better terms.

Don't let hidden details cost your practice. Take control of you contracts today. Using the simple upload tool, you can add your practice-specific data to get a clear picture of the dollar impact of what the insurers are offering you in a new contract.

Level the playing field and negotiate from a place of knowledge and power. Visit healtheps.com slash contract dash visualizer to learn more and unlock the clarity your practice deserves.

Until next time, let's keep driving smarter, more profitable decisions. See you on the next episode of Medical Money Matters.