Trends



Statistics and Strategies for Health Plan Sponsors

Fourth Quarter 2026

Statistics

The cost of health services can vary dramatically within a geographic region, as illustrated by the sample comparison below of selected health services provided by four carriers in one city. Moreover, the insurer with the lowest and highest costs varies by service.

Median Rates for Eight Services in Houston as of October 2026

Services	Carrier A	Carrier B	Carrier C	Carrier D
Metabolic Panel	$14	$6	$18	$9
Evaluation Management Office Visit	$131	$144	$146	$162
Doppler Echocardiogram	$402	$766	$503	$735
Lower-Joint MRI	$686	$985	$1,153	$1,115
Colonoscopy	$832	$988	$593	$3,339
C-Section	$12,543	$12,107	$10,661	$13,315
Knee Surgery	$17,018	$16,441	$13,951	$17,248
Pulmonary Edema	$16,229	$19,155	$22,477	$17,575

Note: The colors represent relative cost, with orange indicating higher-cost services and teal indicating lower-cost services.

Source: Segal's Analysis of Medical Provider Pricing (AMPP), powered by Green Light.

Leveraging healthcare price transparency data

Health plan sponsors continue to face mounting pressure from rising healthcare costs. Medical trends are approaching historic highs, driven by provider price inflation, hospital consolidation, increased utilization and growing reimbursement complexity. Provider networks are constantly evolving as health systems acquire competitors, expand into new markets, recruit providers and renegotiate contracts. In some markets, favorable out-of-network reimbursement and independent dispute resolution (IDR) outcomes have created incentives for providers to leave network arrangements and pursue higher reimbursement outside of contracted rates. As a result, a network that delivered competitive value just a few years ago may no longer represent the most cost-effective option today.

The federal Transparency in Coverage (TiC) rule has fundamentally changed healthcare pricing analysis by providing unprecedented visibility into negotiated provider reimbursement rates. Previously, confidentiality restrictions and the opaque nature of provider contracting limited plan sponsors' ability to evaluate and benchmark network pricing. Today, plan sponsors and their advisors can compare network pricing across competing offerings, identify variation in reimbursement rates for the same services, assess provider contract competitiveness and validate whether a network is delivering the value expected.

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Best practices for getting the most out of TiC data

While multiple factors influence carrier selection and performance evaluations, including service quality, administration and clinical support, provider reimbursement levels typically have the greatest impact on overall healthcare costs. Consequently, validating network competitiveness has become both a prudent fiduciary practice and an increasingly important component of a comprehensive cost-management strategy.

Currently, TiC data does not contain claims utilization data. Segal's Analysis of Medical Provider Pricing (AMPP), developed in partnership with Green Light, helps plan sponsors efficiently combine TiC data with a plan's claims experience and Medicare benchmarking.

These analytics can support the following initiatives:

- **Network price market check.** AMPP is a cost-effective way to assess the market without conducting a full RFP. It can support due diligence to validate that the incumbent network remains a highly competitive option or identify potential savings opportunities that may justify a broader procurement process.
- **Enhanced RFPs.** An AMPP analysis unlocks more data to complement and validate other discount methodologies. It can check the accuracy of vendors' repricing. It can also support more targeted vendor questions and provide benchmarking data for prospective performance guarantees on fees. For more information on setting prospective performance guarantees, see our November 1, 2024 article, "Effective Methods for Evaluating Competing Medical Networks."
- **Post-implementation evaluations.** After a new network is implemented, AMPP data can help assess whether the pricing assumptions used during procurement continue to hold up and whether performance guarantees or pricing commitments are being met.
- **Network optimization and steerage.** By comparing reimbursement rates among in-network providers offering the same services, plan sponsors can identify steerage opportunities that direct participants toward high-quality, lower-cost providers and care. AMPP can also identify high-cost network providers that have excessive procedure pricing which can be removed if ample choice and access to similar quality providers exist.
- **Direct contracting and network impact modeling.** AMPP analysis can identify direct contracting opportunities, evaluate alternative network configurations and quantify potential savings, while preserving provider access and high-quality outcomes.
- **Benchmarking.** Use Medicare reference pricing, transparency data and market comparisons to evaluate provider reimbursement levels, identify pricing outliers and validate network competitiveness.

Caveats and the need for expertise

TiC data offers significant insight into provider pricing, but it is not without limitations. The data may contain duplicate records, "ghost rates" for services that are rarely performed and contract-specific pricing arrangements that can distort comparisons. Meaningful interpretation requires actuarial judgment and contracting expertise to account for utilization, provider mix, geographic variation and contract nuances.

A powerful new tool

When combined with claims analytics, Medicare benchmarking and experienced interpretation, TiC data can provide plan sponsors with a powerful tool to evaluate network value, strengthen fiduciary oversight and make more informed healthcare purchasing decisions.

TiC final rule

The Departments of Labor, Health and Human Services, and the Treasury recently finalized updates to the TiC regulations designed to improve the accuracy, accessibility and usability of healthcare pricing data. Key changes include revised machine-readable file requirements, quarterly rather than monthly reporting, formal attestations regarding data accuracy and completeness, expanded consumer access to cost information by phone and future prescription drug transparency reporting.

For plan sponsors, these enhancements can provide more reliable data to evaluate network competitiveness, benchmark provider reimbursement, strengthen fiduciary oversight and identify cost-management opportunities. Beginning in 2027, as the new requirements are phased in plan sponsors should work with their insurers, third-party administrators and advisors need to understand compliance obligations and explore how enhanced transparency data can support network, procurement and healthcare purchasing strategies. To learn more about the final rule, see our October 19, 2026 insight, "Final Rule on Healthcare Transparency in Coverage."

To discuss the implications for your plan of anything covered here, contact your Segal consultant or get in touch via our website, segalco.com.

This *Trends* was published in November 2026. For previous issues of *Trends* or other Segal publications, visit the insights page of our website, segalco.com.

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