

The Infusion Reimbursement Index

A quarterly benchmark of what health insurers contract to pay for infused (J-code) drugs. Its headline finding: **commercial contracted rates are squeezing the buy-and-bill margin** — drugs carrying 85% of Part B drug spend have a median contracted rate below the typical cost of acquiring the drug.

By **CareCost Research** · Reviewed by **Erin Rose** · 2026-08-12 · [the metric](#) · [how we verified it](#) · [methods](#)

958	61	51	830K
DRUGS	INSURERS	STATES + DC	CHECKED PRICES

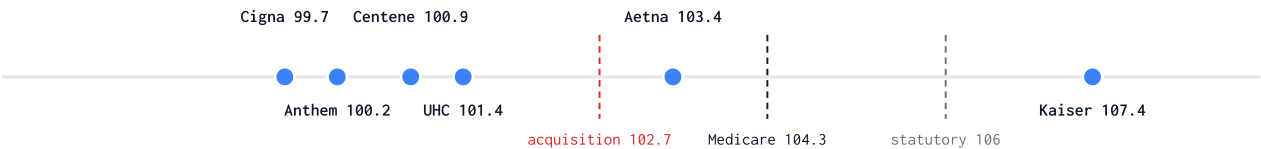
Every insurer filing reconciled to its own published benchmark at **100.0% exact** · contracted rates, not amounts paid
· CC BY 4.0 — reuse with attribution · [full method](#) · [raw data](#)

The findings, in short

Commercial contracted rates are squeezing the buy-and-bill margin. Drugs carrying **85.0% of Part B drug spend** have a median commercial contracted rate below CMS’s typical non-340B acquisition benchmark. On a scale where ASP = 100: the commercial median is **101.5**, typical acquisition is **102.7**, Medicare pays **104.3** after sequestration (106 by statute). The typical commercial contract sits **below what Medicare pays** — and below what the drug typically costs to acquire.

Five of the six national carriers contract at or below actual Medicare (104.3 after sequestration); Kaiser is the exception at 107.4. The higher figures in the payer table belong to smaller regional plans, not to the carriers holding most commercial volume.

NATIONAL CARRIER	× ASP	VS MEDICARE
Cigna	0.997×	-5.9%
Anthem	1.002×	-5.5%
Centene	1.009×	-4.8%
UnitedHealthcare	1.014×	-4.3%
Aetna	1.034×	-2.5%
Kaiser	1.074×	+1.3%



The National Carrier Scorecard: spend-weighted contracted-rate index (ASP = 100), with the acquisition and Medicare benchmarks drawn through it.

Insurers disagree with each other more than they disagree with Medicare. For the same drug in the same state, the Same-Drug Spread is **1.16×** (95% CI 1.156–1.164, 9,183 markets, insurers ranked high-to-low rather than max-over-min).

What this means in dollars — a modeled example. Infliximab (Remicade / biosimilars): at 244 billing units per patient-year and a modeled 30-point rate gap, the difference is about **\$2,304 per patient per year** — roughly **\$69,128** across a 30-patient panel. Illustrative scenario, not a measured payment.

Contracted rates published in insurers' own machine-readable files — not amounts paid on a claim. Vintage 2026-Q2. 829,646 publishable cells of 3,953,447. Full method: [METHODOLOGY.md](#).
Data: [report_data.json](#).

Data integrity — Version 2.0, August 12, 2026. We identified an error in the original analysis, rebuilt the dataset from all 37 insurer filings, corrected the affected findings, and published exactly what changed — including one withdrawn payer figure. [Every change is documented here.](#)

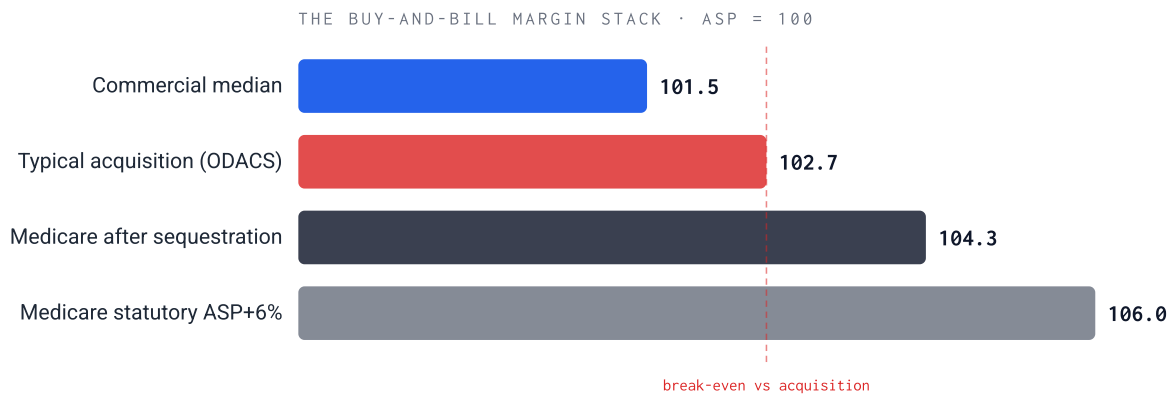
These are the prices in insurers' public files — the contracted rates, not the amounts actually paid on a claim. Every number uses only data that passed our quality check.

THE BUY-AND-BILL SQUEEZE · Q2 2026

85%

of Part B drug spend is on drugs whose median contracted rate is below the typical acquisition benchmark

On a scale where
ASP = 100:
the median commercial contracted rate is **1.015× ASP**. Typical non-340B acquisition is **102.7** (CMS ODACS). Medicare pays **104.3** after sequestration — **106** by statute. The commercial median sits below all three.



Finding two: **your contract matters**. For the same drug in the same state, the 90th-percentile insurer contracts **1.16×** the 10th-percentile rate, across 9,183 drug-state markets (17% of markets are 1.5× or wider). That is the **Same-Drug Spread** — the part of the squeeze that depends on which contract you hold.

Middle pay 1.01× ASP · Weighted 1.01× · Biggest single insurer = 12.7% of prices · All-drug spread 1.26×

95% CI: spread 1.16-1.16× (9,183 markets) · Index 100.1-103.0 (resampling whole insurers)

You buy an infused drug for roughly its ASP. Medicare then pays you ASP + 6%. Most commercial insurers pay you **less than that** — so the contract that looks like your best business is often paying you below what the government does for the identical drug.

You usually buy the drug for about the Medicare price, called ASP. So comparing what you are paid to ASP is a fast way to see your margin. Paid 1.05× ASP is thin. Paid under 1.0× and you may be losing money on the drug itself. This holds when you buy near ASP; it changes under 340B pricing or some biosimilar deals, which we flag.

The Same-Drug Spread — how we measure it

For one drug in one state, line the insurers up by their middle contracted rate. The Same-Drug Spread compares an insurer near the top (the 90th percentile) with one near the bottom (the 10th), then takes the middle of that ratio across every drug-and-state market with enough insurers. It shows how far apart insurers are for the identical drug — without letting one outlier set the number.

DEFINITION OF RECORD

Same-Drug Spread = median across markets of (90th-percentile insurer rate ÷ 10th-percentile insurer rate), for each drug × state with at least 6 publishable insurers. Reported on brand infusion drugs, professional billing, excluding skin substitutes and biosimilars. (The all-drug figure uses markets with at least 8 insurers.) Current value: **1.16×** (all-drug 1.26×). We report percentiles rather than the highest-over-lowest ratio because $\text{max} \div \text{min}$ rises with the number of insurers filing and so partly measures coverage rather than disagreement — the size of that effect is published in the methods below.

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FINDING TWO

1.16×

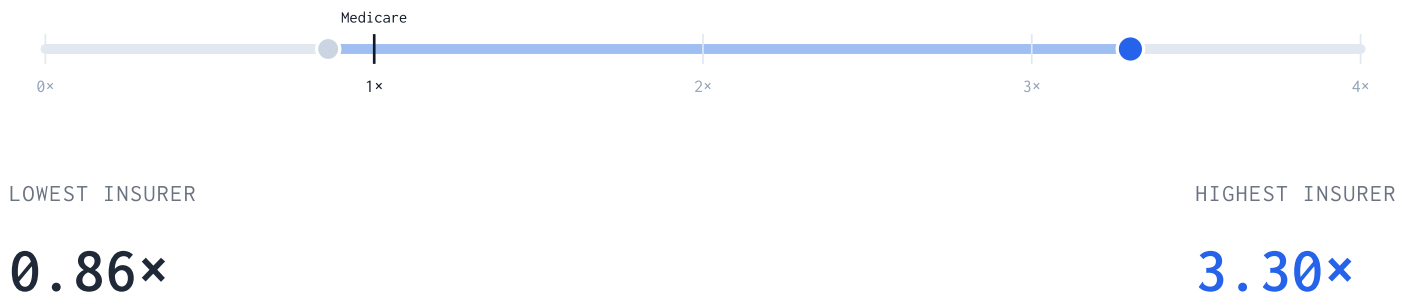
Same drug. Same state.
Your contract decides.

01 – HOW FAR APART ARE INSURERS?

The same drug, different pay

Start with one drug. **Rituxan (rituximab)**, billed in **TX**. Here is what the highest- and lowest-paying insurers pay for it, next to Medicare (1.0×).

Rituxan (rituximab) – TX

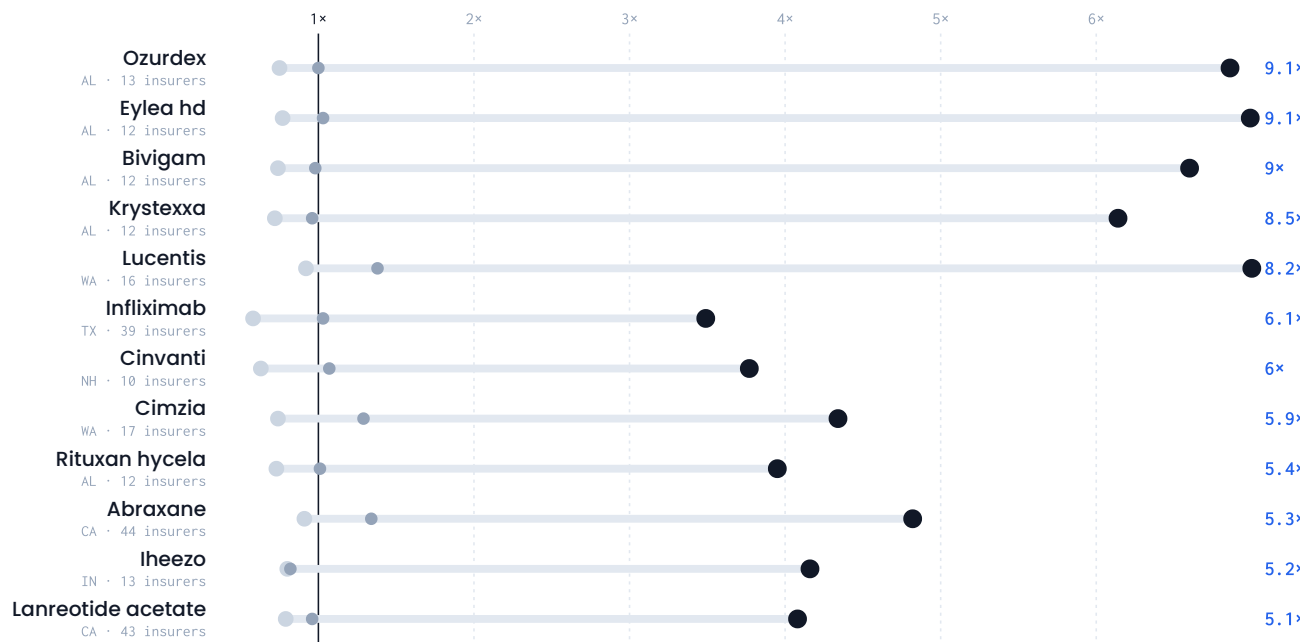


At the extremes, the highest insurer contracts **3.8×** the lowest — same drug, same state. (These are the extremes, not the typical spread: the headline figure is p90/p10.)

That is not a fluke. Below are the drugs with the widest gaps between insurers. Each line runs from the lowest-paying insurer to the highest. The dot is the middle. These are brand infusion drugs, the drugs most practices bill.

Insurer pay gap, by drug (× Medicare ASP)

EXHIBIT 1



n=12 brand drugs · ≥10 insurers · lowest insurer (light) · middle · highest (dark) · contracted, not paid

Does one big insurer drive this? No. Drop the largest insurer (aetna) completely and the numbers barely move: the Index goes 101.5 → 101.3, and the Same-Drug Spread 1.16x → 1.14x.

WHAT TO DO

List your top 5 drugs by spend. Find your pay on each, next to ASP. If you are below the middle insurer on a drug you use a lot, that gap is money you lose every month.

02 – WHICH DRUGS ARE RISKY?

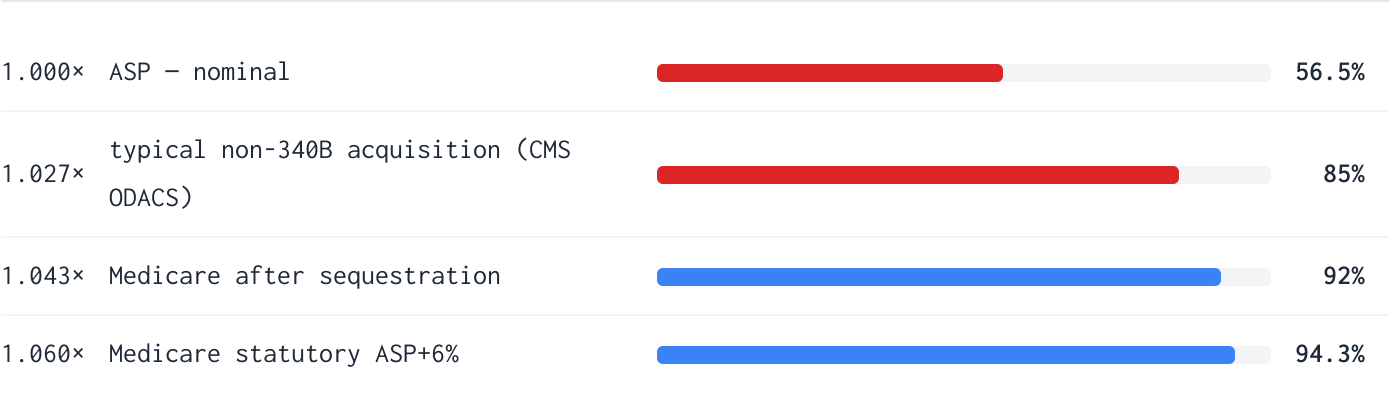
Rates below the typical acquisition benchmark

Break-even is not 1.0x. You rarely buy a drug at exactly its ASP, and Medicare does not pay 1.0x either. Measured against what a non-340B practice typically pays to acquire the drug — **1.027x ASP**, per

CMS's own ODACS survey — **85%** of all Part B infusion spend is contracted below acquisition cost.

Share of Part B infusion spend contracted below each line

EXHIBIT 2A



Skin substitutes are excluded here, as everywhere this report draws a conclusion: their prices are administratively set rather than ASP-anchored. Including them, the share below acquisition would read 87.1% of \$53.4B – the exclusion makes the headline smaller, not larger. Underwater is defined against typical acquisition (102.7), not bare ASP, because a practice rarely buys at exactly ASP. 477 drugs – \$35.8B of \$42B – sit below acquisition.

The measured-margin check

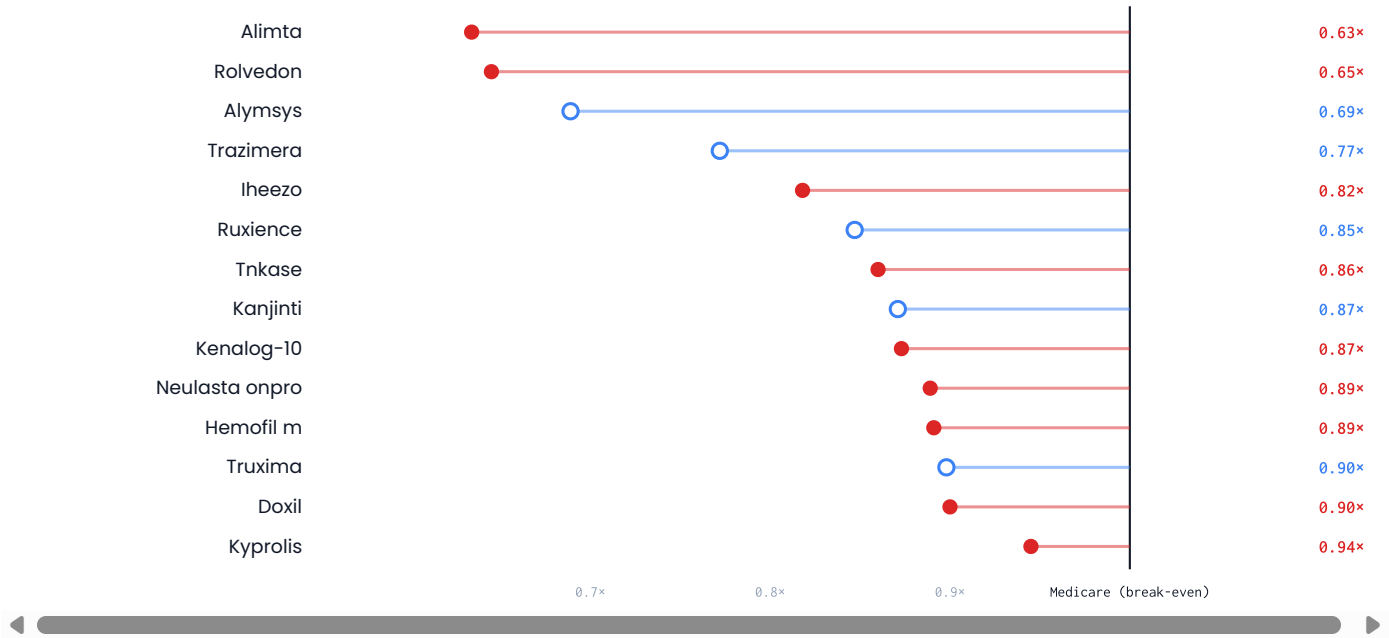
The 102.7 benchmark is a survey average, and a fair question is whether real invoices agree. For **77 drugs** where acquisition cost is directly measured (NADAC), the median measured acquisition index is **97.7** – this subset skews toward multi-source drugs, which are bought below ASP, so it does not contradict the brand-heavy survey line. The finding that survives either benchmark: **44%** of measured drugs have a median contracted rate **below their own measured acquisition cost**.

DRUG	CODE	CONTRACTED	MEASURED ACQ.	MARGIN (PTS)	PART B SPEND
Retacrit	Q5106	98.5	-39.4	\$29M	
Octreotide Acetate Er	J2353	96.6	-28.4	\$343M	
Budesonide	J7626	100.7	-13.6	\$27M	

Darzalex	J9145	97.8	-2.1	\$86M
Hemlibra	J7170	97.3	-1.7	\$181M
Darzalex Faspro	J9144	98.6	7.4	\$2,311M
Elahere	J9063	98.9	8.2	\$168M
Polivy	J9309	95.6	11.4	\$188M

Measured acquisition from NADAC, monthly refresh; margin = median contracted index minus measured acquisition index, in ASP points.
Your invoice governs.

How far below break-even (× Medicare ASP) EXHIBIT 2



Sorted by distance below Medicare · solid red = brand/single-source (real risk) · hollow blue = biosimilar (check your purchase price)

► Drugs whose median contracted rate sits below the acquisition benchmark (102.7) (data table)

Two kinds of risk. For **brand and single-source drugs** (red), you buy near ASP, so a median below the acquisition benchmark ($\approx 1.03\times$) means the contracted rate likely does not cover the drug. For **biosimilars** (blue), you often buy well below ASP, so a low rate can still work — but check your real purchase price.

Alimta (pemetrexed disodium)	J9305	0.63	53	BRAND RISK
Rolvedon (eflapegrastim-xnst)	J1449	0.65	55	BRAND RISK
Alymsys (bevacizumab-maly)	Q5126	0.69	56	BIOSIMILAR
Trazimera (trastuzumab-qyyp)	Q5116	0.77	54	BIOSIMILAR
Iheezo (chloroprocaine hcl)	J2403	0.82	56	BRAND RISK
Ruxience (rituximab-pvvr)	Q5119	0.85	58	BIOSIMILAR
Tnkase (tenecteplase)	J3101	0.86	56	BRAND RISK
Kanjinti (trastuzumab-anns)	Q5117	0.87	57	BIOSIMILAR
Kenalog-10 (triamcinolone acetonide)	J3301	0.87	59	BRAND RISK
Neulasta onpro (pegfilgrastim)	J2506	0.89	54	BRAND RISK
Hemofil m (antihemophilic factor, human)	J7190	0.89	54	BRAND RISK
Truxima (rituximab-abbs)	Q5115	0.90	57	BIOSIMILAR
Doxil (doxorubicin hcl peg-liposomal)	Q2050	0.90	57	BRAND RISK
Kyprolis (carfilzomib)	J9047	0.94	57	BRAND RISK

WHAT TO DO

For each red (brand) drug you give, check that your pay covers what you paid plus your time. For biosimilars, check that your purchase price is below the pay.

02B – THE RANKING

The CareCost Buy-and-Bill Risk List

The 25 drugs with the greatest reimbursement exposure, scored 0–100 on Part B spend, the deficit against the acquisition benchmark, and how far apart payers sit. “Gap / \$100k” is the modeled margin

exposure per \$100,000 of acquisition-benchmark drug cost — benchmark exposure, not your practice’s actual acquisition price.

#	DRUG	RISK SCORE	INDEX	GAP / \$100K	PART B SPEND	PAYER SPREAD	ASP TREND	MEASURED MARGI
1	Enhertu J9358	83	95.2	-\$7,291	\$552M	1.14×	27.1%	
2	Octreotide Acetate Er J2353	82	96.6	-\$5,925	\$343M	1.22×	-8.8%	-28.4 pt
3	Orencia J0129	82	97.6	-\$4,941	\$718M	1.20×	0.4%	
4	Lanreotide Acetate J1930	80	95.4	-\$7,072	\$237M	1.27×	-46.0%	
5	Syfovre J2781	80	96.2	-\$6,345	\$339M	1.16×	-3.7%	
6	Evenity J3111	79	95.7	-\$6,774	\$651M	1.11×	30.6%	
7	Imfinzi J9173	77	98.1	-\$4,489	\$823M	1.16×	12.1%	
8	Ocrevus J2350	75	97.8	-\$4,817	\$475M	1.15×	1.2%	
9	Prolia J0897	75	98.0	-\$4,541	\$1,976M	1.13×	39.2%	18.7 pt
10	Xolair J2357	75	97.7	-\$4,903	\$316M	1.22×	11.5%	
11	Nplate J2802	74	95.6	-\$6,879	\$316M	1.13×	5.3%	
12	Opdivo J9299	74	98.2	-\$4,342	\$1,514M	1.14×	15.0%	
13	Kyprolis J9047	73	94.5	-\$7,944	\$291M	1.13×	36.8%	

14	Entyvio J3380	72	98.8	-\$3,764	\$574M	1.21×	-1.5%	
15	Krystexxa J2507	70	97.3	-\$5,226	\$241M	1.16×	28.8%	
16	Polivy J9309	70	95.6	-\$6,955	\$188M	1.14×	20.8%	11.4 pt
17	Gammagard Liquid J1569	69	99.5	-\$3,069	\$570M	1.23×	5.2%	
18	Reblozyl J0896	69	98.3	-\$4,294	\$727M	1.13×	14.3%	
19	Darzalex Faspro J9144	69	98.6	-\$3,988	\$2,311M	1.13×	22.2%	7.4 pt
20	Tecentriq J9022	68	98.2	-\$4,345	\$459M	1.14×	18.1%	
21	Truxima Q5115	68	89.8	-\$12,526	\$98M	1.48×	-45.5%	
22	Adcetris J9042	68	96.2	-\$6,283	\$142M	1.16×	36.7%	
23	Yervoy J9228	68	98.3	-\$4,297	\$422M	1.15×	16.5%	
24	Hizentra J1559	67	97.7	-\$4,873	\$247M	1.15×	23.2%	
25	Privigen J1459	67	99.1	-\$3,538	\$360M	1.21×	10.1%	

CareCost Risk Score 0-100: rank-weighted blend of Part B spend (45%), reimbursement deficit vs the 102.7 acquisition benchmark (40%), and between-payer dispersion (15%). Drugs under \$50M spend or under 15 payers excluded, along with skin substitutes, whose prices are administratively set rather than ASP-anchored and which this report scopes out throughout.

ASP trend and measured margin are context columns – they do not enter the frozen Risk Score. Trend = payment-limit change 2022-2026; measured margin only where NADAC-measured acquisition exists.

The national market is squeezed. Is yours?

Pick your state, your dominant payer, and up to five drugs you buy and bill. We benchmark them against this corpus — in your browser, nothing leaves the page.

Your state... ▼

Your dominant payer... ▼

Drug or J-code...

Drug or J-code...

Drug or J-code...

Drug or J-code...

Drug or J-code...

The 2026 Payer Reimbursement Scorecard

Insurer parent groups, ranked by what they pay (weighted by Medicare spend, so bigger drugs count more).

PAYER	GRADE	INDEX	VS ACQUISITION	BRAND	BIOSIMILAR	VARIABILITY	DRUGS	STATES
BlueCross BlueShield of Illinois†	A	166.1	+61.7%	166.0	170.7	High	713	8
Anthem Colorado†	A	132.5	+29.0%	131.6	154.8	Medium	890	8
BlueCross BlueShield of Wyoming†	A	132.3	+28.8%	130.8	210.1	Low	911	7
BlueCross BlueShield of South Carolina†	A	124.7	+21.5%	124.1	196.1	Low	869	6
HMSA (BCBS Hawaii)†	A	124.1	+20.8%	123.3	141.9	Low	874	5
Regence Idaho†	A	118.4	+15.3%	118.5	118.2	Low	714	6

Premera Blue Cross†	A	114.9	+11.9%	114.0	156.4	Low	897	9
BlueCross BlueShield of Nebraska†	A	113.2	+10.2%	113.2	121.8	Low	932	7
BlueCross BlueShield of Texas†	A	113.2	+10.2%	113.2	132.2	Low	781	28
BlueCross BlueShield of Oklahoma†	A	112.4	+9.4%	112.1	167.0	High	630	3
Regence Utah†	A	109.7	+6.8%	109.7	111.8	Low	710	5
Blue KC (Kansas City)†	A	109.6	+6.7%	109.6	109.9	Medium	758	2
BlueCross BlueShield of Arkansas	A	108.5	+5.6%	108.5	133.4	Low	917	21
Blue Shield of California†	A	108.1	+5.3%	107.7	114.4	Medium	850	4
BlueCross BlueShield of Kansas†	A	108.1	+5.3%	108.1	117.4	Low	847	6
BCBS North Dakota†	A	107.3	+4.4%	107.3	107.0	High	909	3
Blue Cross of Idaho†	A	107.1	+4.3%	106.9	113.7	Medium	928	6
BlueCross BlueShield of Louisiana†	A	107.0	+4.2%	107.0	109.5	Low	900	7
Blue Cross NC	A	105.7	+2.9%	105.6	121.8	Medium	844	52
Kaiser Permanente	A	105.4	+2.7%	105.0	117.3	High	937	8
Regence BlueCross BlueShield	A	105.0	+2.2%	104.9	105.7	Medium	718	15
Excellus BCBS†	B+	103.7	+1.0%	103.6	122.2	Low	915	1
Aetna	B	103.2	+0.4%	103.0	112.8	Medium	920	51
Anthem Massachusetts	B	102.9	+0.2%	102.9	103.8	Low	851	25
Anthem Wisconsin†	B	102.8	+0.1%	102.6	109.3	Medium	884	14
Capital Blue Cross	B	102.7	-0.0%	102.7	103.6	Low	924	35

Regence Washington†	C+	101.5	-1.2%	101.4	106.9	Low	699	5
BlueCross BlueShield of Vermont†	C+	101.1	-1.6%	101.3	97.3	Low	158	1
Anthem California†	C+	100.6	-2.0%	100.5	113.6	Medium	927	5
Anthem New Hampshire†	C	100.2	-2.5%	100.1	107.8	Low	852	14
Centene†	C	100.1	-2.6%	100.1	101.4	Medium	333	41
Anthem Indiana	C	100.1	-2.6%	100.0	109.3	Medium	942	29
Anthem Missouri†	C	100.0	-2.6%	100.0	102.6	Medium	871	16
Horizon BCBS of New Jersey†	C	100.0	-2.6%	100.0	102.6	Medium	936	6
Wellmark BCBS (Iowa/South Dakota)	C	100.0	-2.6%	100.0	113.6	Low	908	10
Cigna	C	100.0	-2.6%	100.0	107.8	Medium	945	52
Anthem Kentucky†	C	100.0	-2.6%	100.0	100.0	Medium	929	17
UnitedHealthcare	C	100.0	-2.6%	100.0	104.3	High	945	52
Anthem New York	C	100.0	-2.6%	100.0	102.5	Low	927	15
Anthem Ohio	C	100.0	-2.6%	100.0	102.5	Medium	940	19
BlueCross BlueShield of Tennessee†	C	100.0	-2.6%	100.0	108.5	Low	869	10
Harvard Pilgrim Health Care†	C	100.0	-2.6%	100.0	100.3	Low	917	10
BlueCross BlueShield of Alabama†	C	99.9	-2.7%	99.9	102.5	Low	742	6
Anthem Georgia	C	99.9	-2.8%	99.9	100.9	Medium	923	20
CareFirst BlueCross BlueShield	C	99.9	-2.8%	99.8	104.2	Low	880	19
Regence Oregon†	C	99.9	-2.8%	99.8	102.5	Low	705	7

BlueCross BlueShield of Minnesota†	C	99.8	-2.8%	99.8	100.3	High	925	9
Anthem Virginia	C	99.7	-2.9%	99.7	101.4	Low	922	22
Florida Blue†	C	99.7	-2.9%	99.6	101.7	Low	839	5
Anthem Connecticut†	C	99.7	-3.0%	99.6	104.3	Low	924	5
Anthem Nevada†	C	99.7	-3.0%	99.6	101.7	Low	860	4
BlueCross BlueShield of Massachusetts†	D	99.5	-3.1%	99.6	96.9	High	795	13
BlueCross BlueShield of Rhode Island†	D	99.1	-3.5%	99.0	101.7	Low	778	3
Anthem Maine†	D	98.4	-4.2%	98.3	102.7	Medium	824	13
BlueCross BlueShield of Mississippi†	D	96.2	-6.3%	96.2	108.4	Low	773	4
BlueCross BlueShield of Michigan†	D	95.3	-7.2%	95.2	101.1	Medium	644	17
BlueCross BlueShield of Arizona	D	83.0	-19.2%	83.0	84.2	Medium	883	19

† thin book (under 10,000 publishable rates) – treat the grade as indicative, not comparable.

This issue includes the national carriers (UnitedHealthcare, Aetna, Anthem, Cigna, Centene, Kaiser) alongside the Blue Cross plans.

INSURER GROUP	DRUGS	PAY (× ASP)	
bcbs_sc	746	1.34×	
bcbs_wy	777	1.24×	
bcbs_ne	793	1.18×	
premera	780	1.13×	
bcbs_hcsc	779	1.13×	
hmsa	746	1.13×	

bcbs_id	787	1.10×	
bcbs_nc	719	1.10×	
bcbs_kc	661	1.09×	
bcbs_ar	783	1.08×	

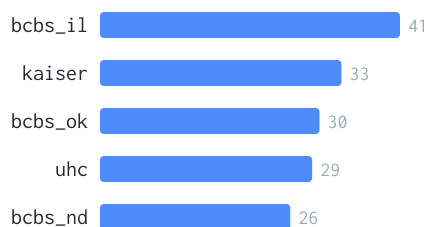
► Show all 37 insurer groups

Two ways insurers set rates

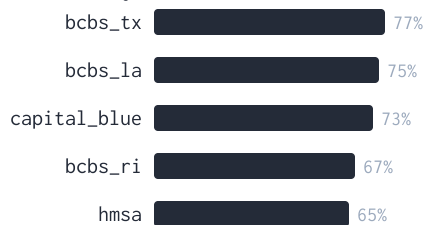
EXHIBIT 3

Some insurers set a different price for each practice (many prices). Others post one price for everyone (one price).

MANY PRICES (per practice)



ONE PRICE (for everyone)



WHAT TO DO

If your insurer posts one price for everyone, you cannot really negotiate the price — your options are site of care and drug mix. If it sets a price per practice, bring these numbers as your comparison.

Some states look expensive — Wyoming’s median runs well above the national line. But hold the insurer constant and the geography disappears: within any single carrier operating in 20+ states, no state’s median differs from that carrier’s national median by more than 1.3% (most are within 0.1%). Fee schedules are effectively national. A “high-paying state” is a state whose local carrier pays high — which contract, not which map pin.

What to do with this: benchmark yourself against your payer’s national line, not your state’s median. A “cheap state” excuse or an “expensive state” comfort are both reading the wrong number — the carrier sets one book nationwide.

Middle pay by state (× Medicare ASP)

EXHIBIT 4



► Contracted-rate index by state (ASP = 100) (data table)

The hospital "premium" is largely a billing-form artifact

People say hospitals get paid ~30% more than offices for the same drug. That is not really true. Office and hospital claims use different billing forms, so it is not a fair match. When you compare the same billing form at both places, the gap is about **1.06×**, not **1.32×**. (based on 1,099 matched cases). The bigger as-billed gap is real, but it comes from the billing form, not a higher drug price.

05 – FIND YOUR AREA

Your drugs, by specialty

Each drug is grouped by the specialty that gives it most. Cancer, eye, and rheumatology drugs are paid closest to Medicare. A wide gap between the middle and the top means the insurer you are on matters a lot.

SPECIALTY	DRUGS	MIDDLE × ASP	TOP 10% PAY
Pain Management FEW	4	1.29×	2.40×
Nephrology FEW	1	1.16×	1.52×
Osteopathic Manipulative Medicine FEW	1	1.11×	1.37×
Diagnostic Radiology	5	1.11×	1.69×
Interventional Pain Management FEW	2	1.08×	1.36×
Pulmonary Disease	9	1.08×	1.36×

Ambulatory Surgical Center	9	1.07×	1.61×
Physician Assistant FEW	3	1.07×	1.33×
Orthopedic Surgery	21	1.07×	1.59×
Medical Oncology	8	1.05×	1.49×
Allergy/ Immunology	5	1.05×	1.49×
Otolaryngology FEW	1	1.04×	1.75×

► Show all 40 specialties

Rows with fewer than 5 drugs are marked "few" – do not read too much into a small group.

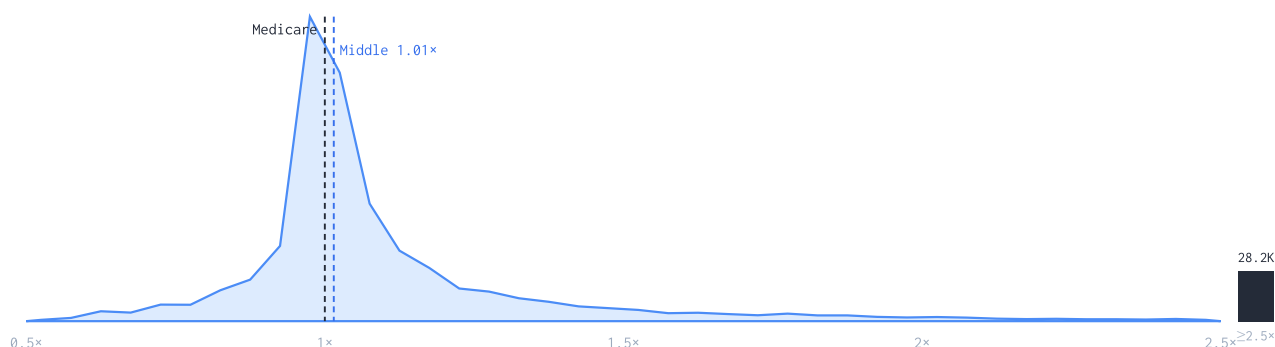
The pattern is scrutiny. The specialties where the money is – oncology, ophthalmology, rheumatology – are priced tightest to ASP, because payers watch their biggest lines hardest. The variable bands sit in smaller specialties. If yours is one of them, your contract is less likely to match the market default, in either direction – which makes checking it worth more, not less.

06 – THE BIG PICTURE

Most drugs sit near Medicare. A few don't.

How pay is spread out (× Medicare ASP)

EXHIBIT 5



Checked prices · far-right bar = the 28.2K prices at 2.5× or more

How much of the gap can you actually negotiate? Between carriers – which contract you are on – the 90th-to-10th percentile spread is **1.202×**, and no amount of negotiating changes it. Inside a single carrier the picture is different: only **11.5%** of carrier-markets hold one price for everyone, and the

median carrier holds **9** distinct prices for the same drug in the same state. That is the part that is winnable at the table. (44,184 markets.)

Inside the fee schedules: how all 37 filings actually price

The Same-Drug Spread exists because payers run three different pricing machines. Of 37 filings, thirty run a **card system** — about three rates per drug per state, 90%+ of practices on the standard one — or an outright **posted price** (Premera holds literally one rate in half its markets). Seven run a **dispersed book**: Blue Shield of California holds hundreds of rates per market (3.2× practice-to-practice spread), UnitedHealthcare ~47 (30% of practices off-card), with BCBS Arizona, Kaiser and the BCBS Federal Employee Program in between.

PAYER	HOW IT PRICES	DISTINCT RATES / MARKET	PRACTICES ON THE STANDARD RATE	PRACTICE-TO-PRAI
Blue Shield of California	Negotiated book	328	31%	
BlueCross BlueShield of Arizona	Negotiated book	9	31%	
Kaiser Permanente	Negotiated book	14	38%	
BCBS Federal Employee Program	Negotiated book	41	69%	
Centene	Negotiated book	7	69%	
UnitedHealthcare	Negotiated book	47	70%	
Excellus BCBS	Negotiated book	3	74%	
Aetna	Card system	24	88%	

Elevance Health (Anthem)	Card system	3	90%
BlueCross BlueShield of Tennessee	Card system	4	92%
Capital Blue Cross	Card system	3	92%
Highmark	Card system	3	92%

Showing the 12 least-uniform filings; the remaining 25 are card systems with 90-100% of practices on the standard rate. Full data for all 37 is in report_data.json.

Across all 37 filings, exactly one payer pays scale a premium. At UnitedHealthcare, top-quartile practices by footprint contract about **9% higher** than bottom-quartile ones, winning in 89% of markets. One payer runs the opposite model: at BCBS Arizona, the largest practices contract about **7% lower** — a volume-discount book. At the other 35, the ratio is 1.00: everyone is on the card, and size buys nothing. Even Blue Shield of California, whose rates disperse enormously, does not price by practice size. The practical read: with a card payer, your leverage is network participation, not rate negotiation; at a dispersed-book payer, the tier you are on is worth asking about.

All 37 filings, professional billing, cells with 25+ practices. 'Modal share' is the share of practice rows on the single most common rate (row grain includes modifiers, so approximate). Practice size is a within-payer footprint proxy; size effects are correlation, not causation.

Does this match an outside source? Yes. Medicare's own drug pay is ASP + 6% (about 1.06× ASP). Our middle insurer pay is 1.01× ASP — right around it. So "insurers pay about Medicare" is not just our math.

About 90% of Medicare drug dollars go to drugs paid 0.95–1.1× ASP. The big-money drugs are paid near Medicare. The high markups are on smaller drugs and on skin substitutes — a separate group we set aside because their prices are administratively set rather than ASP-anchored (91 skin-substitute codes: middle 1× ASP but top 1.78× and highest 9.2×).

PAY BAND	DRUGS	MEDICARE \$B	% OF \$
below Medicare (<0.95x)	92	\$1	1.8%

at Medicare (0.95-1.1x)	568	\$51	95.4%
premium (1.1-1.5x)	121	\$1.3	2.4%
high (>=1.5x)	34	\$0.2	0.3%

07 – NEXT QUARTER

What we'll track next quarter

The denominator itself is moving. Every ASP-tied contract inherits the drug’s own price path with a roughly two-quarter lag. Spend-weighted, Medicare payment limits rose **9.0%** across this window — but **28.9% of Part B spend sits on drugs whose payment limit is falling**, dragging every contracted rate tied to them down automatically.



The double squeeze

143 drugs — \$6.5B of Part B spend — are below the acquisition benchmark *and* on a falling payment limit. For these, doing nothing means the squeeze deepens on its own. The steepest declines:

DRUG	CODE	PAYMENT-LIMIT CHANGE	CONTRACTED INDEX	PART B SPEND
RUXIENCE	Q5119	-75.7%	84.7	\$75M
RIABNI	Q5123	-68.5%	112.8	\$51M
FULPHILA	Q5108	-61.1%	147.7	\$68M

ABRAXANE	J9264	-57.1%	124.2	\$215M
VEGZELMA	Q5129	-50.3%	161.4	\$96M
LANREOTIDE ACETATE	J1930	-46.0%	95.4	\$237M
TRUXIMA	Q5115	-45.5%	89.8	\$98M
MVASI	Q5107	-40.3%	97.2	\$107M
CIMZIA	J0717	-39.6%	113.5	\$274M
OGIVRI	Q5114	-35.8%	118.0	\$63M

CMS quarterly ASP files, 2022-2026; preliminary quarters excluded. Refreshes every quarter with the CMS file.

Issue 02 publishes November 2026, on Q3 2026 filings. Each quarter the Index, the Risk List, the Payer Scorecard and the denominator trend are recomputed under the frozen definitions above, so movement means the market moved – not the method.

SPECIAL ANALYSES

Deeper cuts that stand on their own: policy friction, the pharmacy channel, and the negotiation baseline. The core findings above do not depend on them. Each is also published as a standalone research note: [The Four Levers of Reimbursement](#) · [Medicare Negotiation: The Before-Picture](#) · [Site-of-Care Economics](#).

What an insurer pays is half the question. The other half is what it makes you do first, whether it is trying to move the infusion out of your office, and whether the pharmacy channel pays better. For 36 drugs we hold all four.

Denosumab • J0897

DOSSIER

WHAT YOU ARE PAID

0.98×

median insurer rate, as a multiple of ASP. Medicare pays 1.06×

PRIOR AUTHORIZATION

83%

19 of 23 insurers require it before you may treat.

SITE-OF-CARE STEERING

26%

6 of 23 run a program to move the infusion out of your office.

PHARMACY CHANNEL

0.99×

what white-bagging pays against the medical rate. Parity is 1.00×

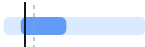
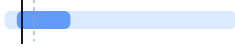
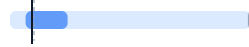


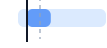
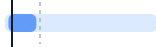
Middle 80% of insurers, 0.96× to 1.14×. Median 0.98×, about \$29.51 per billing unit. 59 insurers priced; 23 with a published policy.

Read it as one sentence. The middle insurer pays 0.98× ASP — below what many practices pay to buy the drug — while 83% make you get approval first, 26% are working to move the infusion elsewhere, and the pharmacy channel sits at parity, 0.99×.

Every drug where we hold both

DRUG	MEDICARE \$	INSURER RATES (× ASP)	MIDDLE	PRIOR AUTH	STEERING	PHARMACY
Denosumab J0897	\$1.98B		0.98×	83%	26%	0.99×
Faricimab J2777	\$1.77B		1.02×	75%	10%	1.17×

Aflibercept J0178	\$1.23B		1.04×	78%	17%	1.26×
Abatacept J0129	\$718M		0.98×	90%	30%	3.02×
Romosozumab J3111	\$651M		0.96×	79%	21%	1.02×
Vedolizumab J3380	\$574M		0.99×	94%	39%	1.52×
Ravulizumab J1303	\$535M		0.99×	92%	32%	0.97×
Ocrelizumab J2350	\$475M		0.98×	92%	24%	1.17×
Tocilizumab J3262	\$348M		1.04×	89%	37%	1.14×
Efgartigimod alfa-fcab (Vyvgart) J9332	\$337M		1.00×	88%	35%	0.95×
Rituximab J9312	\$327M		1.05×	76%	24%	1.18×
Omalizumab J2357	\$316M		0.98×	93%	30%	1.04×
Infliximab J1745	\$260M		1.03×	86%	34%	2.40×
Pegloticase J2507	\$241M		0.97×	77%	41%	0.98×
Golimumab (Simponi Aria) J1602	\$232M		1.05×	92%	35%	3.23×
Mepolizumab J2182	\$210M		0.99×	96%	24%	1.09×
Benralizumab J0517	\$188M		0.99×	96%	25%	1.13×

Teprotumumab (Tepezza) J3241	\$164M		0.97×	82%	18%	1.01×
Lecanemab-irmb (Leqembi) J0174	\$139M		1.00×	100%	13%	0.93×
Eculizumab J1299	\$138M		1.01×	93%	33%	0.92×
Secukinumab (Cosentyx IV) J3247	\$127M		0.99×	88%	28%	0.92×
Natalizumab J2323	\$115M		1.00×	84%	24%	1.16×
Belimumab J0490	\$104M		0.98×	96%	26%	0.93×
Risankizumab (Skyrizi IV) J2327	\$103M		1.03×	96%	11%	1.16×
Ferric Carboxymaltose (Injectafer) J1439	\$91M		0.99×	75%	17%	1.94×
Eptinezumab J3032	\$77M		0.97×	79%	38%	0.91×
Donanemab-azbt (Kisunla) J0175	\$74M		1.00×	80%	13%	0.99×
Inebilizumab (Uplizna) J1823	\$64M		0.97×	90%	29%	0.94×
Anifrolumab (Saphnelo) J0491	\$63M		0.99×	85%	25%	0.96×
Ranibizumab J2778	\$37M		1.33×	91%	18%	5.74×

Ublituximab J2329	\$34M		0.97×	86%	33%	1.10×
Guselkumab (Tremfya IV) J1628	\$19M		1.09×	89%	11%	1.02×
Reslizumab J2786	\$6M		0.98×	92%	40%	0.95×
Ustekinumab J3358	\$5M		1.10×	93%	23%	1.26×
Zoledronic acid J3489	\$3M		1.57×	73%	9%	1.51×
Edaravone (Radicava) J1301 check denominator	\$1M		2.70×	95%	33%	0.18×

Prior auth and steering are the share of insurers whose published policy requires them. Pharmacy is what the white-bag channel pays as a multiple of the medical rate – 1.00× is parity. "med" marks a medium-confidence channel figure that should not be quoted.

Infliximab: what each insurer prefers, and what it pays

Infliximab is the one drug here with real biosimilar competition, so it is the only place we can watch an insurer steer. A filled dot is the product the insurer prefers; a hollow ring is reachable only through step therapy.

bcbs_ar		bcbs_ks	
● Inflectra	1.68×	● Inflectra	1.36×
● Remicade	1.12×	● Avsola	1.23×
● Avsola	1.04×	○ Q5104	1.13×
○ Renflexis	1.33×	○ J1745	1.06×
bcbs_ma		bcbs_ne	
● Inflectra	0.94×	● Renflexis	1.18×
● Avsola	0.91×	● Inflectra	0.99×

☐ Q5104	1.04×	☒ Avsola	0.87×
☐ J1745	1.03×	☐ Remicade	1.17×
bcbs_sc		bcbs_tn	
☒ Renflexis	1.01×	☐ Q5104	1.00×
☒ Inflectra	0.94×	☐ J1745	0.99×
☐ J1745	0.99×	☐ Q5103	0.71×
☐ Q5121	0.91×	☐ Q5121	0.65×
blueshield_ca		capital_blue	
☒ Inflectra	1.02×	☒ Remicade	1.07×
☒ Avsola	0.89×	☒ Inflectra	0.89×
☐ Renflexis	1.13×	☐ Q5104	1.06×
☐ Remicade	1.11×	☐ Q5121	0.79×
excellus		hmsa	
☒ Inflectra	1.46×	☒ Inflectra	1.28×
☒ Avsola	1.20×	☒ Avsola	1.13×
☐ Renflexis	1.01×	☐ J1745	3.49×
☐ Remicade	0.99×	☐ Q5104	1.52×
premera		regence	
☒ Inflectra	1.07×	☒ Inflectra	0.99×
☒ Avsola	1.02×	☒ Avsola	0.95×
☐ Renflexis	1.42×	☐ Renflexis	1.06×
☐ Remicade	1.17×	☐ Remicade	1.03×
uhc		wellmark	
☒ Inflectra	1.45×	☒ Inflectra	1.46×
☒ Avsola	1.13×	☒ Avsola	1.16×
☐ Renflexis	1.04×	☐ Q5104	1.01×
☐ Remicade	1.03×	☐ J1745	0.99×

bcbs_la		bcbs_ms	
○ Q5104	1.08×	● Remicade	1.09×
○ Q5121	0.71×	● Inflectra	0.73×

kaiser

○ J1745	1.44×
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Across **19** insurer-drug policies that name both a preferred and a non-preferred product, the preferred product's median rate is 1.07× ASP against 1.12× for the non-preferred one. With only 19 policies this difference is not statistically distinguishable from chance, and it reverses when computed unpaired — so we publish the grid and draw no directional conclusion from it yet.

Where the policy data stops

Policy covers **84.6%** of publishable rate cells, measured at parent-carrier level (31 carriers, 36 drugs, as of 2026-08-02). These carriers are priced but ungated:

CARRIER	RATE CELLS	SHARE OF PRICES
bcbs_nc	43,198	6.08%
bcbs_az	17,394	2.45%
bcbs_carefirst	17,203	2.42%
harvard_pilgrim	9,170	1.29%
bcbs_id	5,660	0.8%
bcbs_al	4,711	0.66%
bcbs_wy	4,606	0.65%
bcbs_nd	3,269	0.46%
bcbs_ri	2,334	0.33%
bcbs_kc	1,609	0.23%
bcbs_vt	158	0.02%

Policy is a point-in-time snapshot; rates are the quarterly filing. A carrier missing here is priced but ungated – we know what it pays, not what it requires.

09 – THE BEFORE-PICTURE FOR DRUG PRICE NEGOTIATION

The first Part B drugs Medicare will ever negotiate

In January 2026 CMS selected the first physician-administered drugs for price negotiation. From January 2028 their benchmark stops being ASP+6% and becomes the negotiated Maximum Fair Price – and CMS will publish only 106% of MFP for them. This table is what commercial insurers pay for those drugs **before** that happens. There will be no other public before-picture.

DRUG	PART B SPEND	INSURERS	MIDDLE (× ASP)	P10	P90	\$/UNIT
Orencia (abatacept) J0129	\$718M	58	0.976×	0.96×	1.21×	\$44.77
Entyvio (vedolizumab) J3380	\$574M	59	0.988×	0.97×	1.22×	\$21.37
Xolair (omalizumab) J2357	\$316M	58	0.977×	0.90×	1.10×	\$45.5
Botox (onabotulinumtoxinA) J0585	\$395M	59	1.001×	0.96×	1.20×	\$6.51
Cimzia (certolizumab pegol) J0717	\$274M	57	1.135×	1.10×	2.20×	\$3.91
Cosentyx (secukinumab) J3247	\$127M	50	0.991×	0.98×	1.12×	\$18.07

Selected 2026-01-27; MFP effective 2028-01-01. The first Part B drugs ever selected for Medicare price negotiation. From 2028 their benchmark becomes the negotiated Maximum Fair Price, not ASP+6% – CMS will publish only 106% of MFP for them. This table is the commercial baseline before that happens. Cosentyx has notable but not majority Part B spending.

Cite it, embed it, take the data

Everything here is CC BY 4.0 — reuse with attribution. Tables as CSV for your own analysis; the two headline graphics as embeds or a downloadable pack; the full dataset and method open.

Data (CSV)

[Risk List](#) · [Payer Scorecard](#) · [Below acquisition](#) · [All drugs](#) · [Fee schedules](#)

Graphics

[Chart pack \(zip\)](#) · [Embed: Margin Stack](#) · [Embed: Carrier Scorecard](#)

For press

[Press page & quotable findings](#) · [Methodology](#) · [Full dataset](#) · [Checksums](#)

Contact

press@carecostestimate.com
corrections@carecostestimate.com

Check your own drugs and state

Type a drug or pick your state. This runs in your browser — nothing is sent anywhere.

Data, methods, and how to cite this

Cite as: CareCost Estimate Infusion Reimbursement Index, Issue 01 (Q2 2026), v2.0. CC-BY 4.0. Licensed CC-BY 4.0 — reuse with credit. [Download the PDF edition](#) for filing or attachment.

The full drug table and the dataset download are in the lookup tool above (free with a work email). The methods below are open to everyone.

Words we use

ASP

Average Sales Price. The public Medicare drug price. Medicare pays ASP plus 6%.

$\times$ ASP

An insurer's contracted rate divided by ASP, on a scale where ASP = 1.00 (or 100 as an index). Typical acquisition is about 1.027; Medicare pays 1.043 after sequestration, 1.06 by statute. A quick margin check — not a claims payment.

BUY-AND-BILL

You buy the drug, give it, then bill the insurer. Your margin is the pay minus what you paid.

THE SAME-DRUG SPREAD

The 90th-percentile insurer's contracted rate divided by the 10th-percentile insurer's, for the same drug in the same state. We do not use highest-over-lowest: it grows mechanically with the number of insurers filing.

PUBLISHABLE

Data that passed our quality check (enough separate practices, tied to ASP). Only this is used in the numbers.

WHERE THE DATA COMES FROM

Insurers' public price files (Transparency in Coverage), from Q2 2026. We mined 712 million provider-level prices across 69 insurers, then grouped them. These are contracted prices, not the amounts paid on a claim.

WHAT WE COUNTED

69 insurers mined → 61 with publishable prices → 39 parent groups. 958 drugs, 51 states + DC. 830K publishable prices; 509K weaker (not used in headlines); 2615K set aside.

WHAT THIS DATA CAN'T TELL YOU

The biggest single insurer is 12.7% of the prices. If an insurer, state, or drug is missing, that means no data — not zero. This issue includes the national carriers (UnitedHealthcare, Aetna, Anthem, Cigna, Centene, Kaiser) alongside the Blue Cross plans.

USING × ASP AS MARGIN

× ASP works as a margin check because you usually buy near ASP. It looks better than reality under 340B (you buy well below ASP) and worse during shortages (you may pay above ASP). Treat it as a direction, not your exact books.

THE SAME-DRUG SPREAD – WHAT'S CONTROLLED

Same drug code + same state + publishable only. It does not hold billing form constant, and it runs wider for skin substitutes and biosimilars (unsettled prices). So we report the clean number — brand infusion drugs, one billing form, no skin substitutes or biosimilars: 1.16× — next to the all-drug 1.26×.

WE CHECKED IT TWO WAYS

Drop the largest insurer and the numbers barely move (Index 101.5→101.3; Spread 1.16×→1.14×). And our middle pay (1.01× ASP) lines up with Medicare's own ASP+6% — an outside check.

HOW WE VERIFIED THIS

Reconciled to source, exactly

Every one of the 37 insurer filings was re-aggregated from row level and compared against that filing's own published benchmark: 37/37 reconciled at 100.0% exact across ~21 million cells. A filing that failed would have stopped the build.

Quality tiers, disclosed

Only 829,646 of 3.95M cells clear the publishable bar (provider counts, anchor quality, plausibility band). The 66% we suppressed is stated, not hidden, and the tier rules are published in the methods.

Corrections in public

This version restated the prior release, named the withdrawn payer figure, and documented every

Gates that can fail

The build runs 13 acceptance checks — retired-number scan, banned-phrase scan of the full document including metadata, claim-to-page verification — each shipped with a positive control proving the gate fires on an injected error.

Uncertainty, quantified

Headline figures carry 95% bootstrap confidence intervals — resampling whole insurers for the Index, whole markets for the Spread — not sampling-error theater.

Auditable end to end

The full dataset (report_data.json), methodology, per-file checksums (sha256sums.txt) and archived

change in the version history. Errata are machine-readable (errata.json).

source URLs are public under CC BY 4.0. Every printed figure traces to the corpus.

DEFINITIONS OF RECORD – FROZEN

Frozen as of Issue 01 v2.0 and held constant across issues; any future change ships as a versioned methods note, never silently. **Same-Drug Spread** = median across drug×state markets of the 90th-percentile insurer rate ÷ the 10th-percentile rate, markets with ≥6 publishable insurers. **Index** = median contracted rate ×100 on a scale where ASP = 100. **Acquisition benchmark** = 102.7 (CMS ODACS non-340B). **Risk Score** = rank-weighted blend: Part B spend 45%, deficit vs acquisition 40%, between-payer dispersion 15%.

WHY CLAIMS-BASED STUDIES REPORT 2-3× ASP AND THIS REPORT SAYS 1.015×

WHAT IS CHANGING TO THE BENCHMARK ITSELF

WHAT WE TESTED AND DROPPED

An apparent 'shared pricing engine across nominally independent insurers' signal did not survive removing the drug x state main effect. It did not hold up, so we do not report it.

HOW TO CITE

CareCost Estimate Infusion Reimbursement Index, Issue 01 (Q2 2026), v2.0. CC-BY 4.0. A permanent page per drug is planned for the next issue.

VERSION HISTORY & CORRECTIONS

v2.0 – restated. Rebuilt on all 37 insurer filings, which adds UnitedHealthcare and Aetna: the corpus goes from 972,300 to 3,953,447 cells and from 52 to 61 publishable insurers. **Numbers changed, and some materially.** The Index moves 102.6 to 101.5. Blue Shield of California, published in v1.4 as the highest-paying insurer at 1.683x spend-weighted, is 1.047x on the rebuilt corpus with essentially unchanged drug coverage (733 to 728 drugs) – the earlier figure was wrong, not merely narrower. Treat any v1.4 citation of that value as withdrawn. **Corrected a filter defect.** The biosimilar flag matched any hyphen in a generic name, which is the FDA four-letter suffix carried by newly licensed originators – so 117 brand biologics (\$13.4B of Part B spend, including Darzalex Faspro,

Vabysmo, Enhertu and Padcev) were wrongly excluded from the headline universe. They are restored; the Same-Drug Spread is recomputed on the corrected universe. Two drug labels were also wrong at source and are overridden: J0585 named the cosmetic product rather than the therapeutic one, and J0129 named the self-administered autoinjector rather than the IV code.