

Rhode Island Office of the Health Insurance Commissioner's Report

*Pursuant to Rhode Island General Law
§ 27-18-33.3(c)*

February 26, 2026

*This report presents the legislatively mandated
evaluation of the payment for clinician-
administered drugs.*



STATE OF RHODE ISLAND

Office of The Health Insurance Commissioner

Department of Business Regulation

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Executive Summary

On June 24, 2024, Governor McKee signed into law Rhode Island House and Senate Bills 7365 SUB A¹ and S086. These bills covered multiple topics related to clinician-administered drugs (CADs) in Rhode Island, including the addition of R.I.G.L §27-18-33.3(c), which directs the Office of the Health Insurance Commissioner (OHIC) to conduct an analysis of the payment for clinician-administered drugs. This report is in response to R.I.G.L §27-18-33.3(c).

This report presents a summary of the analysis of the payment for clinician-administered drugs based on insurer reporting. More detailed examination through a formal market conduct exam will be necessary in the future.

A Summary of the findings of this report include:

- Based on available information all carriers subject to R.I.G.L §27-18-33.3(b) are complying with requirement to not refuse to authorize, approve, or pay a provider for a covered clinician-administered drug that was administered by any in-network hospital or clinic.
- Carriers report various methodologies for determining reimbursement rates for CADs; reimbursement rates are most commonly determined through contract negotiations and not through a set formula.
- As of February 26, 2026, OHIC has received no complaints regarding potentially inaccurate payments.
- OHIC staff recently met with hospital representatives regarding insurer compliance with R.I.G.L §27-18-33.3(b). Additional information on insurer conduct may be forthcoming. If a formal complaint is submitted by the hospital(s) OHIC will investigate and update this report with any relevant findings.

Background

Prior to the effective date of R.I.G.L §27-18-33.3, it was common practice for insurers in the State of Rhode Island to refuse to authorize, approve, or pay for a covered clinician administer drug that was administered by an in-network hospital or clinic. Payers would instead insist that the CAD be obtained through a “preferred pharmacy” whose contract with the carrier often made CADs less expensive. These medications would then be transported to the hospital, clinic, or other site of service where they would be administered by a clinician. This is a widespread practice in the United States known as “White Bagging”.

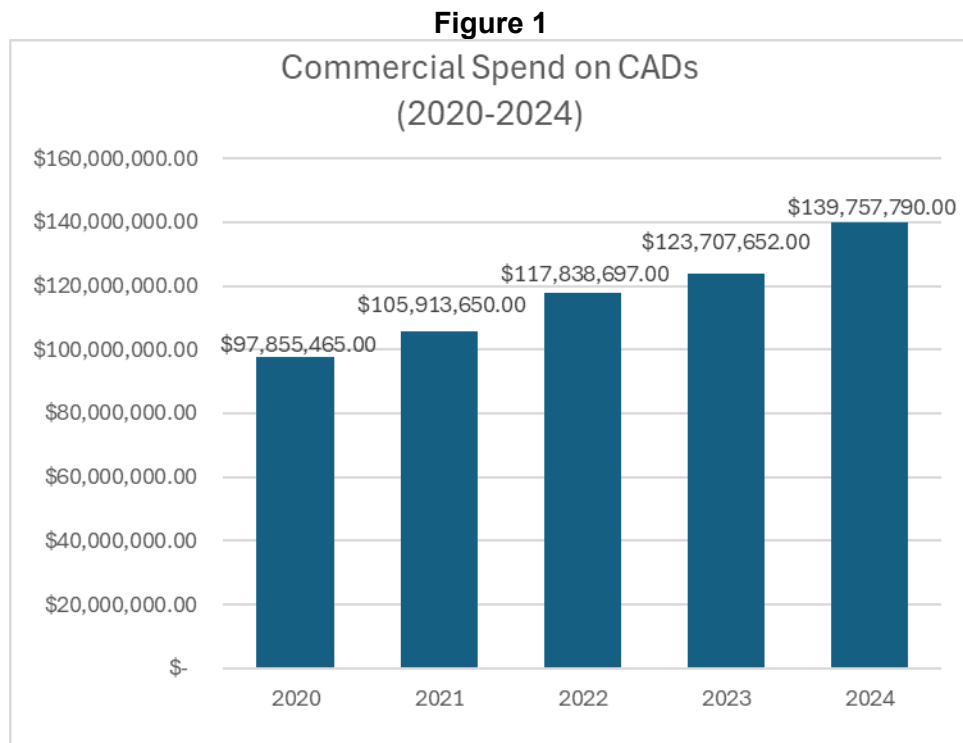
Providers have long criticized the practice of White Bagging as a threat to patient’s timely access to appropriate care.² Meanwhile carriers often characterize the practice as a cost-saving measure meant to direct patients away from – often expensive – hospital and clinic pharmacies to cheaper, “preferred pharmacies”.

R.I.G.L §27-18-33.3 restricted the practice of White Bagging while requiring that reimbursement rates to the provider shall be at a rate equal to the payments between the insurer and a preferred pharmacy, thereby mitigating potential cost growth impacts.

¹ <https://webserver.rilegislature.gov/BillText/BillText25/HouseText25/H5494A.pdf>

² <https://www.ama-assn.org/system/files/issue-brief-asco-patient-access-to-medication-safety.pdf>

CADs represent a significant and increasing amount of drug spending. Figure 1 shows the total commercial spend on CADs from 2020 to 2024. Data on 2025 – the first year R.I.G.L §27-18-33.3 was in effect, will be available in fall 2026.



Sources

The Office of the Health Insurance Commissioner requested that each carrier submit a narrative detailing how reimbursements to providers for clinician-administered drugs (CADs) are calculated. Carriers were directed to include in their narrative:

- General methodology for reimbursing providers for CADs
- Any standardized formulas used to develop reimbursement rates for CADs
- Any variations in methodology and/or reimbursement by provider, provider type, or site of care
- Methodology for determining reimbursement rates for CADs when there are multiple preferred pharmacies for that CAD
- Processes put in place to identify and rectify incorrect payments
- Steps taken to comply with R.I.G.L §27-18-33.3

All carriers submitted responses. OHIC followed up with insurers when additional clarification was needed.

To gather data from providers on potentially inaccurate payments, OHIC is reliant on the submission of complaints by providers. OHIC maintains close contact with providers operating in the State of Rhode

Island and has solicited feedback regarding potentially inaccurate payments. As of February 26, 2026, OHIC has not received any complaints regarding potentially inaccurate payments.

Survey Responses

All carriers report that they are in full compliance with R.I.G.L §27-18-33.3.

All carriers reported that reimbursement for CADs is determined during contract negotiations and is not developed through a fixed or standardized formula across contracts. The methodology varies across contracts but can include:

- Percentage of Medicare fee schedule
- A specifically negotiated rate
- Average Sale Price plus an additional; percentage
- A percentage of Average Wholesale Price (AWP) or Wholesale Acquisition Cost (WAC)
- Local competitive reimbursement rates

One carrier reported that they have developed a drug fee schedule that includes maximum allowable payments. This fee schedule is regularly updated based on AWP and Average Sales Price (ASP).

Carriers reported that reimbursement can fluctuate depending on provider type due to the providers' ability to negotiate more favorable acquisition prices. No carriers reported differing reimbursement for site of care.

Two carriers reported that they do not have any preferred pharmacy arrangements in Rhode Island. As a result, the language in the statute that directs carriers to reimburse providers "at a rate equal to payments between the insurer and a preferred pharmacy." does not apply.

To rectify incorrect payments all carriers reported that providers have access to the standard appeals process. One provider reported a regular audit to identify potentially inaccurate payments under R.I.G.L §27-18-33.3.

Provider Complaints

As of February 26, 2026, OHIC has received no formal complaints. OHIC was recently contacted by the hospital representatives regarding an allegation that some payers are not complying with R.I.G.L §27-18-33.3 (b).

Hospital representatives reported that they intend to file a formal complaint with OHIC; at the time this report was submitted OHIC has not received the complaint but will investigate these accusations thoroughly once they are reported in detail.

Limitations and Recommendations

Although as noted above, OHIC has received no complaints regarding potentially inaccurate payments to providers, providers have limited visibility into the accuracy of payments. An inaccurate payment as it pertains to R.I.G.L §27-18-33.3(c)(iii) would be any payment for a clinician administered drug not equal to the payment for the same drug that would be made to a preferred pharmacy.

Providers are generally not privy to the contract terms between insurers and preferred pharmacies and would have no way of knowing if the payment they received for a CAD was potentially inaccurate. Furthermore, reimbursement rates to preferred pharmacies are not static and can fluctuate frequently because of changes in acquisition costs, introducing variables that could result in inaccurate payments

that are outside of the view of providers. To fully assess compliance with the payment provisions of the statute, OHIC will need to perform a target market conduct examination. OHIC plans to add this to the examination schedule.

As noted above OHIC may receive a complaint regarding payer noncompliance with R.I.G.L §27-18-33.3(b). As OHIC does not currently know the full details of the alleged conduct we are unable to make any recommendations at this time – though it may be necessary to add language to address payer conduct that does not comply with the clear intentions of R.I.G.L §27-18-33.3.

Given the need for further claims runout and potential examination of insurer market conduct to assess the full impact of R.I.G.L §27-18-33.3 the Office of the Health Insurance Commissioner has no recommended changes at this time.