

2026 Annual Specialty Drug Survey Report

A Data-Driven Look at Specialty Drug Costs in 2025

PUBLIC SECTOR HEALTHCARE ROUNDTABLE

NATIONAL INSTITUTE FOR PUBLIC EMPLOYEE HEALTH CARE POLICY

Executive Summary

Public sector health care purchasers, who provide health coverage to America's teachers, firefighters, law enforcement officers, and other essential government workers, are experiencing significant challenges as they try to balance the costs of innovative prescription drugs with robust, competitive health insurance benefits and access to life-sustaining medications.

This report presents findings from the 2026 Specialty Drug Survey, conducted by the National Institute for Public Employee Health Care Policy and Public Sector HealthCare Roundtable. This year, 19 public sector plan sponsors representing 15 states responded to the annual survey, collectively covering nearly 3.8 million beneficiaries. Together they spent $22.9 billion on commercial health care in their 2025 reporting year (calendar 2025 for most, fiscal 2024-25 for some), more than a quarter of it ($6.1 billion) on pharmacy benefits, plus $5.9 billion on Medicare pharmacy benefits.



About the National Institute for Public Employee Health Care Policy

The National Institute for Public Employee Health Care Policy (the Institute) is a nonprofit 501(c)(3), nonpartisan policy organization dedicated to educating the public and health policy community about the unique challenges facing public sector health care purchasers and the employees, retirees, and dependents they serve. Through research, issue briefs, and events, the Institute works to ensure that the needs of public sector plan sponsors are represented in national health policy conversations.

About the Public Sector HealthCare Roundtable

The Roundtable is a non-profit, non-partisan coalition of public sector purchasers from across the United States, including states, counties, and municipalities. The Roundtable works to amplify the voices of tens of millions of public sector employees, retirees, and their dependents. Over 15% of the American workforce is employed by public sector entities and collectively they carry $749 billion in other post-employment benefits (OPEB) liabilities,[1] including health care services and prescription drugs. These current and former public servants are foundational to their communities and rely on stable, affordable retiree health coverage.

Public sector employers collectively serve tens of millions of Americans who have served in critical public service roles in state agencies, public universities, municipal governments, school districts, and retirement systems. These employers have a fiduciary duty to the state and beneficiaries to provide high-quality, comprehensive health benefits at an affordable cost. Comprehensive, affordable health care benefits are essential tools for states, cities, and municipalities competing with private employers to attract and retain high-quality employees.

[1] The Pew Charitable Trusts. (May 1, 2023). *Do states have enough saved for retiree health care benefits?* https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2023/05/do-states-have-enough-saved-for-retiree-health-care-benefits

Key Findings at a Glance

In plan year 2025, public sector purchasers responding to the Specialty Drug Survey:

Covered almost
2.6M members
in commercial plans & nearly
1.2M members
in Medicare plans.

Spent
$22.9 billion on total **commercial** health care,
$6.1 billion of which was on pharmacy benefits.
and spent
$5.9 billion on total **Medicare** pharmacy benefits,
$2.6 billion of which was on specialty drugs.

Spent nearly half of all pharmacy benefit dollars on specialty drugs: **48.8%** in commercial plans and **45.6%** in Medicare plans.

Processed **47.8 million** commercial and **38.1 million** Medicare pharmacy claims.

Public sector purchasers used an average of
5.6 utilization management strategies per commercial plan
and
2.7 utilization management strategies per Medicare plan
to manage specialty drug costs.

In plan year 2025:

- All respondents used at least one targeted strategy to manage specialty drug costs in their commercial plans.
- **88.2%** of public sector purchaser respondents managed specialty drug costs in their Medicare plans with one or more targeted strategies.
- To address rising specialty drug costs, **88.2% of** public sector purchaser respondents **modified their commercial** pharmacy benefit design and **64.7% modified their Medicare** pharmacy benefit design within the last five years.
- All respondents covered glucagon-like peptide-1 medications (GLP-1s) in their commercial plans and **88.2%** covered GLP-1s in their Medicare plans, though coverage for weight management was limited to **41.2%** of responding commercial plan sponsors.

The data make clear that public sector plan sponsors are doing everything within their power to manage costs; however, plan-level tools are insufficient to offset the market-wide rising costs of specialty drugs.

Policy Options At a Glance

The Roundtable encourages policymakers to consider the following policy options:

1. Extend **competitive Medicare negotiated drug prices** to public sector commercial plans.
2. Accelerate **generic and biosimilar** market entry and uptake.
3. Unleash innovation by **reforming drug patent practices**.
4. Deploy **artificial intelligence and advanced analytics** with appropriate guardrails.
5. Support **value-based and outcomes-based contracting** frameworks.
6. Provide public sector plan sponsors with adequate **lead time to implement regulatory changes**.
7. Require CMS to **separately analyze and publish** individual and EGWP Parts C and D plan data
8. Require **drug pricing transparency** from manufacturers.
9. Reform **pharmacy benefit manager (PBM)** standards.
10. Support public sector purchasers' participation in **CMS Innovation Center models**.
11. Advance responsible integration of **pharmacogenomics and precision medicine**.
12. Safeguard public sector purchasers from the compounding costs of the **No Surprises Act (NSA).**

Purpose of the Survey

This report presents findings from the 2026 Specialty Drug Survey, which includes data for the 2025 plan year. For a decade, the survey has documented public sector purchasers' health care and pharmacy costs, spending trends, and strategies they deploy to manage cost pressures, particularly those driven by specialty drug spending.

Public sector employers are frequently overlooked in surveys that otherwise capture the broad landscape of employer-sponsored health benefits and public health care programs, leaving a critical gap in the data available to policymakers. Public sector purchasers occupy a unique position in the health care landscape. Unlike private employers, public sector purchasers' premium contributions draw directly from state and local government budgets. Unlike public health programs, their benefits serve a defined population of employees, retirees, and their dependents, not the general public. This annual survey is one of the few public sources of longitudinal, multi-organization data focused solely on public sector health plans.



The Public Sector Landscape

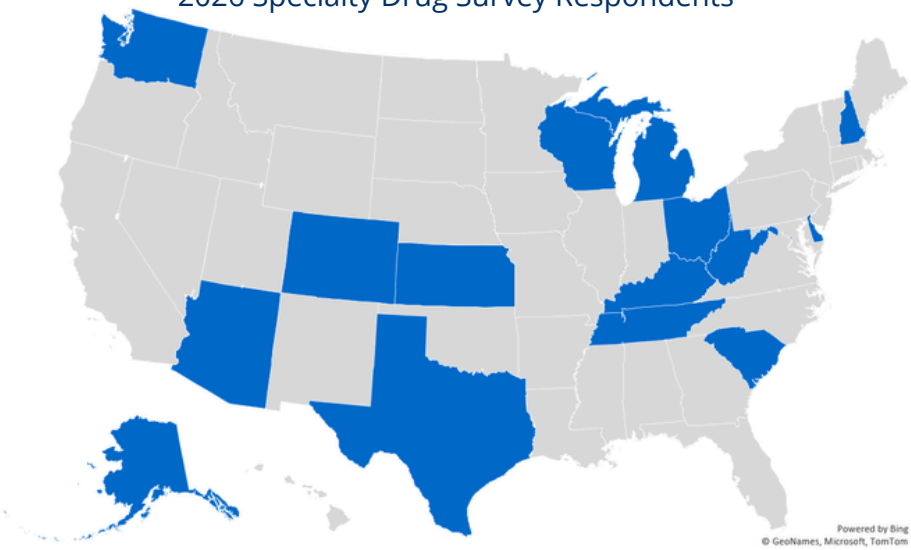
Profile of Responding Organizations

Public sector health care purchasers are a diverse group. They include large state employee benefit programs, county purchasing pools, university systems, statewide retirement systems, and other smaller plans. These plans can serve anywhere from a few hundred to over a million employees, retirees, and their dependents.

Public sector purchasers that responded to this survey represent a broad cross-section of public sector plan types, including state employee benefit programs and health plans, teacher and school employee retirement systems, public university systems, statewide county pools, and state-level retirement systems managing health benefits for active and retired members.

Nineteen plan respondents represented 15 states spanning all major geographic regions of the country. This geographic diversity strengthens the survey's value, capturing variation in regulatory domains, labor market conditions, cultural environments, and political contexts that shape how public sector purchasers design and manage benefits. This variation also reflects the diverse communities these plans serve and the associated differences in provider market dynamics.

2026 Specialty Drug Survey Respondents



AK - State of Alaska, Division of Retirement and Benefits
AZ - Arizona State Retirement System
CO - Colorado Public Employees' Retirement Association
DE - Delaware State Employee Benefits Committee
KS - Kansas State Employee Health Plan
KY - Teachers' Retirement System of Kentucky
KY - University of Kentucky
MI - Michigan Public School Employees' Retirement System
NH - New Hampshire HealthTrust
OH - School Employees Retirement System of Ohio
OH - State Teachers Retirement System of Ohio
SC - South Carolina Public Employee Benefit Authority
TN - Tennessee Department of Finance and Administration, Division of Benefits Administration
TX - Employees Retirement System of Texas
TX - Teacher Retirement System of Texas
TX - Texas Association of Counties Health and Employee Benefits Pool
WA - Washington State Health Care Authority
WV - West Virginia Public Employees Insurance Agency
WI - Wisconsin Department of Employee Trust Funds

Responding organizations collectively offer a broad range of health benefit programs. All of the respondents offered at least one Medicare plan serving retirees 65 years old and older and their dependents while 17 of the 19 respondents offer commercial plans covering active employees, retirees under 65, and their dependents. Most responding organizations offer both, reflecting that many public employers cover beneficiaries throughout the full life cycle.

Public sector purchasers responding to the 2026 Specialty Drug Survey covered almost 2.6 million members through commercial plans and nearly 1.2 million beneficiaries through Medicare plans. Across all plan types, respondents provided health care benefits to nearly 3.8 million employees, retirees, and their dependents. These beneficiaries' health benefits depend on the ability of state and local governments to sustain comprehensive, affordable health care benefits.

Aggregated across all public sector employers nationally, the population relying on public sector purchasers for health insurance encompasses tens of millions of Americans. The scale of this coverage and magnitude of the spending required to sustain it underscore why the cost trends documented in this report carry consequences that extend far beyond any individual plan, reaching into state budgets, municipal finances, and the long-term fiscal commitments governments have made to the people who serve their communities through their roles as public employees.

The Uniqueness of Public Sector Purchasers

While public sector purchasers provide employer-sponsored health insurance much like their private-sector counterparts, they operate under a distinct set of considerations and constraints. Public sector plans' benefit design decisions are shaped by collective bargaining agreements, procurement rules that limit contracting flexibility, exposure to legal challenges, and accountability to elected and appointed officials. Because their budgets are taxpayer-funded, public sector purchasers face heightened scrutiny over how funds are spent and many carry a fiduciary responsibility to both the state and their beneficiaries.



Public sector purchasers also have a distinctive relationship with their workforce. Historically, state and local governments have offset lower wages with more comprehensive benefit packages including offering more generous health care benefits, covering a higher portion of the health care insurance premium, and/or providing lower health care insurance premium plan options. Additionally, public employees and retirees maintain coverage through their public employer for life. Consequently, public sector purchasers can invest in services that yield long-term savings and quality-of-life improvements that their private-sector counterparts may not project to be financially advantageous.

To provide health insurance benefits to public sector employees and retirees 65 years old and older, some public sector purchasers provide their members the option to enroll in an MA Employer Group Waiver Plan (EGWP). As defined by the Centers for Medicare and Medicaid Services (CMS), "EGWPs are employer-only Medicare Advantage (MA) and/or Part D plans" and "may take advantage of CMS waivers to provide Part C and/or Part D benefits to Medicare beneficiaries" based on their employment.[2] Unlike individual MA plans, public sector purchasers negotiate with third-party administrators and PBMs on behalf of their membership as a whole. This allows public sector purchasers to tailor MA plans to their beneficiaries rather than having beneficiaries sort through individual MA offerings in their community to find the best fit for them. Additionally, many public sector purchasers who offer EGWPs model their benefits off of their commercial plans, smoothing employees' and retirees' experiences through transitions between insurance plans.

Within this landscape, public sector purchasers have developed innovative approaches to deliver comprehensive benefits at affordable, sustainable costs. Even so, this innovation cannot counteract broad market forces. This report seeks to highlight both the successes and challenges public sector purchasers face and to ensure their perspectives are represented in broader conversations about health care and prescription drug affordability.

Commercial Plans – Membership, Spend, and Cost

The data in this section reflect commercial plan spending and utilization across the 17 responding organizations that reported offering at least one commercial plan for the 2025 calendar, plan, or fiscal year.



Commercial Plan Membership

Across the 17 responding organizations that offer commercial health plans, enrollment totaled **2.6 million covered** employees, retirees under age 65, and their dependents across 14 states. The mean enrollment per organization is approximately 153,000 members, and the median is approximately 67,000 members, reflecting the wide variation in plan membership sizes across respondents.

2025 Snapshot

Public sector purchasers responding to the Specialty Drug Survey covered almost 2.6 million members through commercial plans.

[2] Centers for Medicare and Medicaid Services. (July 2024). Employer Group Plans https://www.cms.gov/files/document/slides-employer-group-plans-july-2024.pdf.

Commercial Health Care Spending

Responding organizations spent a combined **$22.9 billion** on commercial health care benefits for their respective 2025 calendar, plan, or fiscal year. The mean total commercial spend per organization was approximately $1.3 billion, and the median was approximately $704 million, reflecting the significant variation in plan membership and budget size among respondents. Across all organizations, per capita total health care spending was $8,850 per beneficiary, higher than per capita spending recorded in the 2025 Annual Specialty Drug Survey Report of $7,060.[3]



Public sector purchasers responding to the Specialty Drug Survey spent $22.9 billion in total commercial health care.

Commercial Pharmacy Claims

Responding organizations processed a combined **47.8 million commercial pharmacy claims** in the previous calendar, plan, or fiscal year. The mean number of pharmacy claims processed was 3.2 million, whereas the median number of claims processed was 500,000. Across all reporting organizations, public sector purchasers processed 19.7 pharmacy claims per member and spent $120 per claim. Last year's Annual Report found that in 2024, public sector purchasers processed 11.4 claims per member and spent $160 per claim. However, the 2024 and 2025 respondent groups differ, so the change in claims per member and spend per claim likely reflects who responded rather than a true increase in claim volume or decrease in cost per claim.



Public sector purchaser respondents processed over 47.8 million commercial pharmacy claims or 19.7 pharmacy claims per member.

Commercial Pharmacy Benefit Spending

Responding organizations spent a combined **$6.1 billion** on pharmacy benefits in the 2025 calendar, plan, or fiscal year. Pharmacy benefit spending in 2025 represents approximately **26.6% of total commercial health care spending** among organizations that reported both figures, the same share of total health care spending as in 2024.[4] In the 2025 calendar, plan, or fiscal year, public sector purchasers spent $2,360 per capita on pharmacy benefits.



Public sector purchasers responding to the Specialty Drug Survey spent $6.1 billion on commercial pharmacy benefits.

Sixteen organizations reported $2.8 billion in commercial pharmacy rebates. Among the 11 that reported pharmacy spending before rebates, rebates equaled about 40 cents of every dollar spent on pharmacy benefits.

[3,4] National Institute for Public Employee Health Care Policy & Public Sector HealthCare Roundtable. (March 20, 2026). 2025 Annual Specialty Drug Survey Report: A data-driven look at specialty drug costs in 2024.
http://healthcarepolicy-institute.org/2025-annual-specialty-drug-survey-report-a-data-driven-look-at-specialty-drug-costs-in-2024/

Commercial Specialty Drug Spending

Of the $6.1 billion in commercial pharmacy benefit spending, **$2.8 billion was attributable to specialty drugs** (48.8%) in the 2025 calendar, plan, or fiscal year. This is similar to last year's Annual Report findings that in 2024, 50.2% of all commercial pharmacy spending was spent by public sector purchasers on specialty drugs. Respondents spent $1,140 per capita on commercial specialty drugs, compared to $920 per capita in 2024.

2025 Snapshot

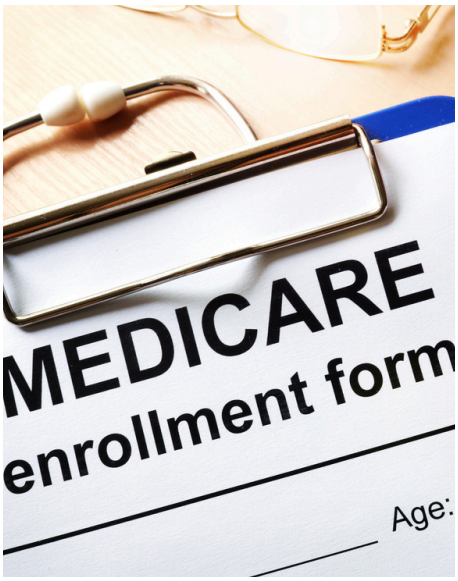
Public sector purchasers responding to the survey spent $2.8 billion on specialty drugs in commercial plans.

Medicare – Membership, Spend, and Cost

All public sector purchaser respondents offered Medicare plans and 17 reported data on Medicare plan spending and utilization for the 2025 calendar, plan, or fiscal year. The number of organizations reporting each individual measure varies.

Medicare Plan Membership

Of the 19 public sector purchasers responding to the Specialty Drug Survey, all offer Medicare plans that cover a combined 1.2 million members. These are the group retiree plans each organization sponsors for Medicare-eligible retirees, which include Part C and Part D EGWPs, Medicare supplement plans, and a few self-funded or secondary plans for medical coverage. The most common Medicare plan type offered by respondents was standalone Part D EGWPs. These plans represent a significant share of public sector retiree health coverage nationally, serving retired teachers, firefighters, law enforcement officers, and other public servants who have become eligible for Medicare after their time in the public workforce.



2025 Snapshot

Public sector purchasers responding to the Specialty Drug Survey covered 1.2 million members enrolled in a Medicare plan.

Medicare Health Care Spending

Eleven of the 19 responding organizations reported Medicare medical spending for their respective 2025 calendar, plan, or fiscal year. Because organizations fund and administer their Medicare plans differently, they reported this figure on different bases, and the results are presented by plan funding arrangement rather than as a single total.

Five self-funded organizations reported the medical claims their plans paid directly, including three that reported claims for Medicare supplement plans, for a combined $2.8 billion.

2025 Snapshot

Self-funded public sector purchasers responding to the Specialty Drug Survey paid a combined $2.8 billion in Medicare medical claims.

Among the remaining organizations, one fully-insured organization reported $672 million in claims its insurance carrier paid, one reported $497 million in allowed amounts, and two provided estimates totaling $2.1 billion. These differences reflect the variety of ways public sector purchasers deliver Medicare coverage to their retirees, and future survey cycles will seek more consistent reporting of Medicare medical spending.

Medicare Pharmacy Claims

Responding organizations processed a combined **38.1 million Medicare pharmacy claims** in the previous calendar, plan, or fiscal year. The mean number of pharmacy claims processed was 3.2 million, whereas the median number of claims processed was 2.4 million. Across all reporting organizations, public sector purchasers processed an average of 38.8 pharmacy claims per member and spent an average of $150 per claim.

2025 Snapshot

Public sector purchaser respondents processed over 38.1 million Medicare pharmacy claims or 38.8 pharmacy claims per member.



Medicare Pharmacy Benefit Spending

Responding organizations spent a combined **$5.9 billion** on pharmacy benefits in the 2025 calendar, plan, or fiscal year. In the 2025 calendar, plan, or fiscal year, public sector purchasers spent $5,850 per capita on Medicare pharmacy benefits.



Twelve public sector purchasers with Medicare plans reported almost $1.9 billion in rebates. Among the eight that reported Medicare pharmacy spending before rebates, rebates equaled about 31 cents of every dollar spent on Medicare pharmacy benefits.

Medicare Specialty Drug Spending

Of the $5.9 billion in Medicare pharmacy benefit spending, **$2.6 billion was attributable to specialty drugs** (45.6%) in the 2025 calendar, plan, or fiscal year. Respondents spent $2,640 per capita on Medicare specialty drugs.



Commercial and Medicare Plan Comparisons

This section compares five pharmacy benefit measures across respondents' commercial and Medicare plans. Together, these measures show how pharmacy costs and utilization differ between the two plan types and where specialty drugs drive the largest share of spending. The set of organizations reporting commercial data differs from the set reporting Medicare data. For this reason, the figures in this section are best used to understand the relative scale of pharmacy and specialty drug costs in each plan type.

Pharmacy Spending Per Member

In 2025, public sector purchasers spent $2,360 per member on pharmacy benefits in their commercial plans and $5,850 per member in their Medicare plans. Medicare pharmacy spending per member was nearly two and a half times that of commercial plans.

Pharmacy Claims Per Member

Public sector purchasers processed 19.7 pharmacy claims per commercial member and 38.8 pharmacy claims per Medicare member. Medicare plans processed about twice as many claims per member as commercial plans.

Pharmacy Spending Per Claim

Commercial plans spent $120 per claim, while Medicare plans spent $150 per claim. Medicare pharmacy spending per claim was 25.0% higher than commercial spending per claim.

Specialty Drug Spending Per Member

Commercial plans spent $1,140 per member on specialty drugs, while Medicare plans spent $2,640 per member. Medicare specialty drug spending per member was more than double that of commercial plans.

Rebates as a Share of Drug Spending

For every dollar spent on prescription drugs, commercial plans received about 40 cents in rebates, while Medicare plans received about 31 cents. Commercial plans received about 9 cents more in rebates per dollar of drug spending than Medicare plans.

What These Differences May Represent

These comparisons reflect real differences in the populations each plan serves and the benefit structures under which each operates. Medicare members are older and more likely to manage multiple chronic conditions, which generally means more prescriptions per person and greater use of high-cost therapies. Medicare plans also operate under federal Part D rules, including the out-of-pocket cap, manufacturer discount obligations, and federal subsidies.

Taken together, these measures suggest that the higher cost of Medicare pharmacy benefits is driven more by how many prescriptions members fill than by how much each prescription costs. Medicare members filled about twice as many prescriptions per person as commercial members, while spending per claim was only about 25.0% higher. This pattern is consistent with an older population that is more likely to manage several chronic conditions at once.

Specialty drug spending follows a similar pattern: it is more than twice as high per member in Medicare plans, but specialty drugs make up a comparable share of total pharmacy spending in both plan types. This suggests specialty costs rise with overall pharmacy use rather than making up a disproportionate share of Medicare spending.



Key Finding

Medicare pharmacy spending per member was nearly two and a half times that of commercial plans. The gap reflects an older population that fills about twice as many prescriptions.

The lower rebate return in Medicare plans may reflect the federal rules that shape Part D, such as protected-class coverage requirements and other limits on formulary exclusions. These rules reduce administrators' leverage to negotiate rebates with manufacturers, and the rebate arrangements available in different Medicare products also differ.

For public sector purchasers, the result is that each Medicare retiree costs substantially more to cover than a commercial member. At the same time, purchasers have fewer tools to manage those costs, since many commercial strategies such as copay accumulators and broad formulary exclusions are restricted or unavailable in Medicare.

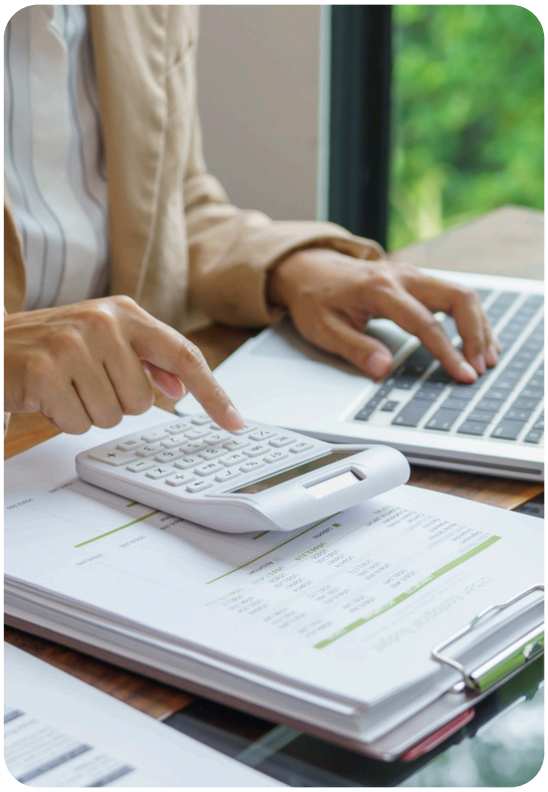
Responding to Rising Specialty Drug Costs

The data points in this report quantify the budget pressures Specialty Drug Survey respondents are facing. This section presents survey findings on how respondents are managing rising health care costs, especially specialty drug costs, through two primary levers: utilization management and benefit design. Utilization management strategies can promote appropriate and cost-effective prescribing but cannot change the underlying price of a drug. Benefit design changes can shift costs; however, they raise affordability and accessibility concerns. The strategies documented here represent a sector doing everything within its means to manage costs amidst market-wide cost growth.

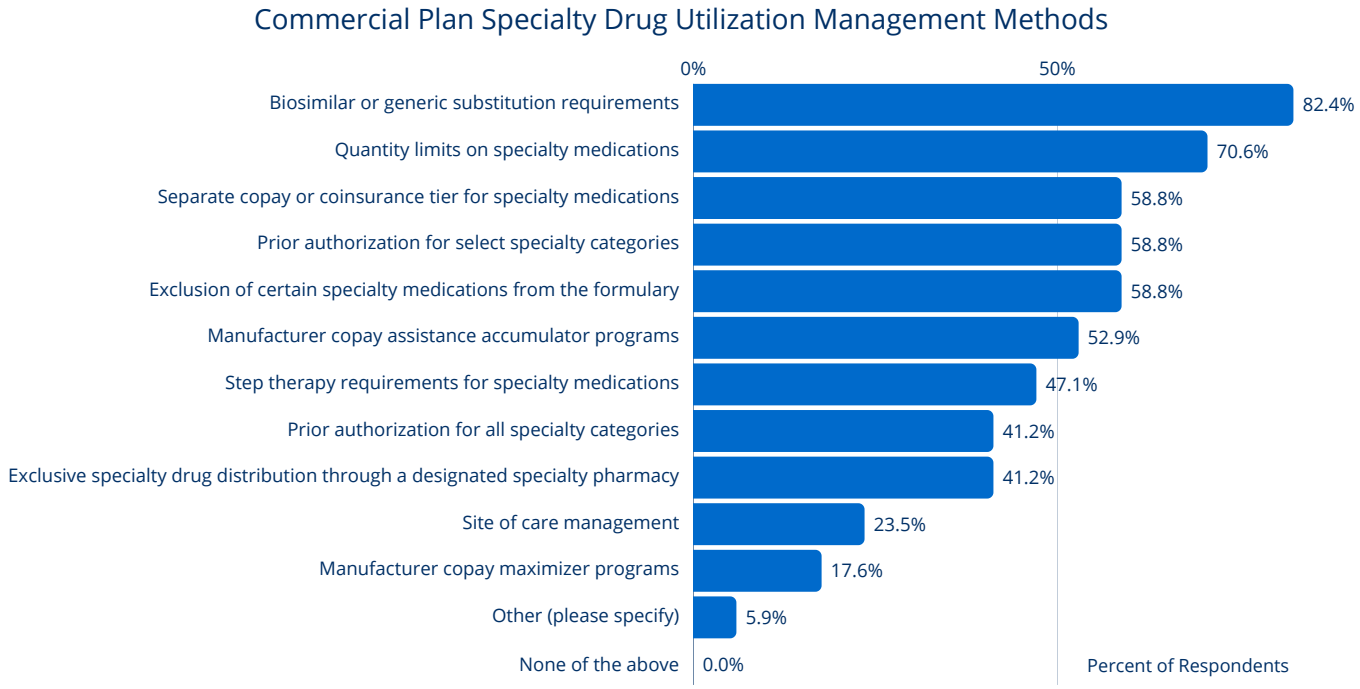
Utilization Management Strategies

Commercial Cost Containment Strategies

Every one of the 17 responding organizations reported they deployed at least one targeted strategy to manage specialty drug costs in 2025. Biosimilar or generic substitution requirements are the most common (82.4% adoption) followed by quantity limits on specialty medications (70.6%). A majority of respondents deployed separate copay or coinsurance tiers for specialty medications (58.8%), prior authorization for select specialty categories (58.8%), exclusion of certain specialty medications from the formulary (58.8%), and/or manufacturer copay accumulator programs (52.9%). Only one organization reported another utilization management method: filling patient medications through a health system's internal pharmacy and transporting that medication to the location of the drug's administration (also called clear bagging)[5] for some specialty drugs administered through the medical benefit, allowing the drug to be paid for through the pharmacy benefit.



[5] Melazzo, T. (2022). What color bag? Three emerging practices pharmacists should know. Pharmacy Today, 28(2), 36–37.



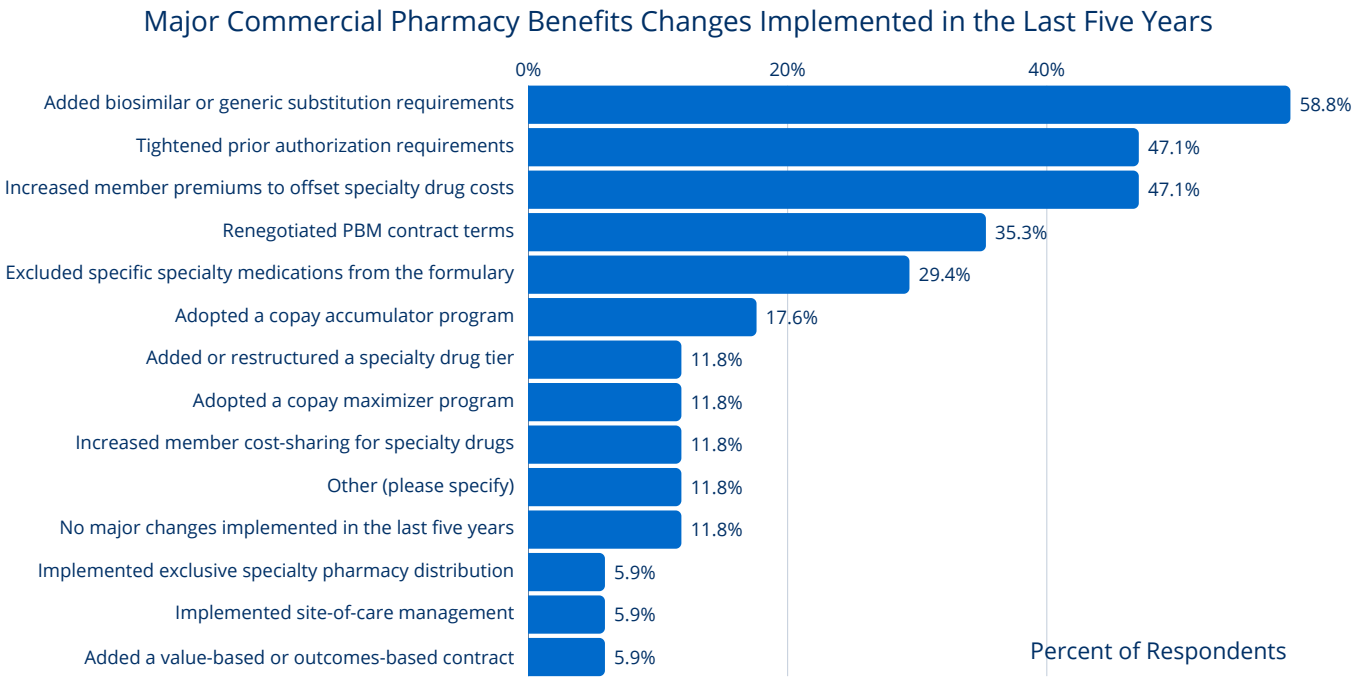
2025 Snapshot

In plan year 2025, all responding public sector purchasers used at least one targeted strategy to manage specialty drug costs for commercial plans, with an average of 5.6 utilization management methods per organization.

Commercial Pharmacy Benefit Changes

Over the past five years, 88.2% of public sector purchaser respondents modified their commercial plan benefit design in response to rising specialty drug costs. On average, public sector purchaser respondents implemented 3.1 strategies in response to rising specialty drug costs in the last five years. The five most common changes were: adding a biosimilar or generic substitution requirement (58.8%), increasing member premiums to offset specialty drug costs (47.1%), tightening prior authorization requirements (47.1%), renegotiating PBM contract terms (35.3%), and excluding specific specialty medications from the formulary (29.4%). The other changes implemented include a clear bagging program and a specialty maximum out-of-pocket.





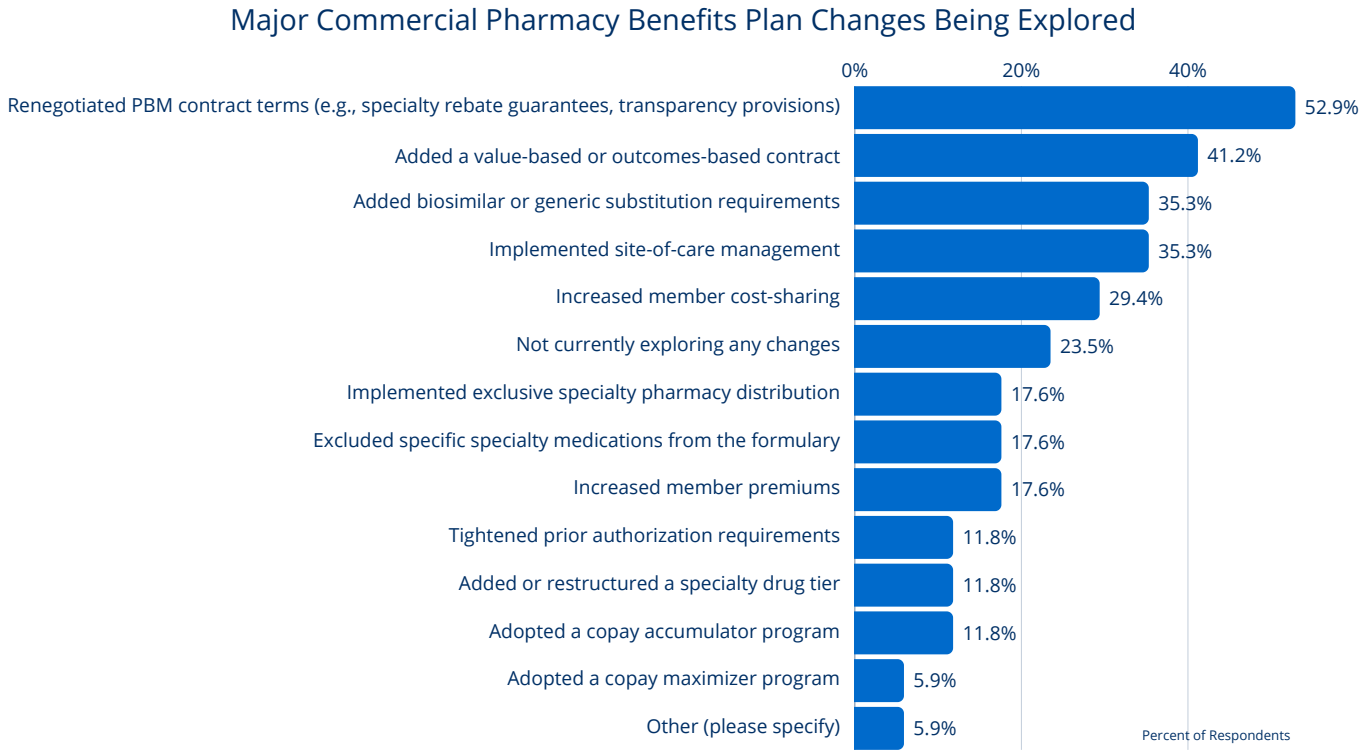
The range of benefit changes reported indicates public sector purchasers are exploring a wide array of benefit options. Additionally, the higher adoption frequency of added substitution requirements, tightened prior authorization requirements, and increased member premiums may indicate these options are the most effective, accessible, and/or politically feasible specialty drug cost-containment strategies for commercial plans.

The reported changes generally fall into three categories: limiting benefits (e.g., excluding certain specialty medications or classes), adjusting member costs (e.g., increasing member premiums), and managing utilization and delivery (e.g., enhanced utilization management). While not captured in the survey, plans could also pursue additional appropriations from legislators or financial leaders to help offset rising costs, though this option is often politically difficult as it typically requires reallocating funds from other programs or raising taxes. Additionally, these approaches may not be available to all plans depending on their funding structure.

Key Finding

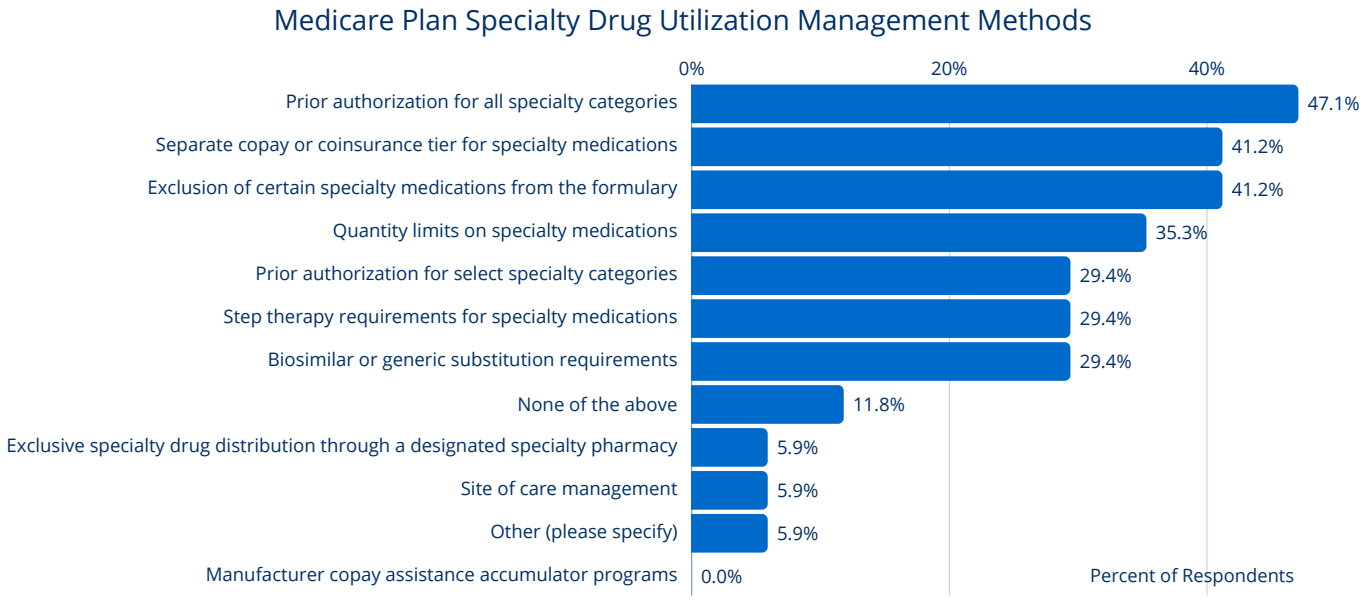
Almost all public sector purchaser respondents modified their commercial pharmacy benefit design between 2021 and 2025 to address rising specialty drug costs.

In addition to changes implemented in the past five years, public sector purchaser respondents reported continued interest in exploring additional benefit changes to contain costs. Renegotiating PBM contract terms, such as specialty rebate guarantees or transparency provisions, drew interest from a majority of respondents (52.9%). Nearly a quarter of respondents reported they are not exploring any benefit changes.



Medicare Cost Containment Strategies

In plan year 2025, 88.2% of respondents used at least one targeted strategy to manage specialty drug costs in their Medicare plans, deploying an average of 2.7 utilization management methods. Almost half of respondents (47.1%) utilized prior authorization for all specialty drug categories and no respondents reported using a manufacturer copay assistance accumulator program. One respondent noted they are fully-insured and do not have independent control over their plans' utilization management strategies.



As opposed to commercial plans, public sector purchasers' Medicare plans clearly disfavor three utilization management methods. Manufacturer copay assistance programs are not allowed for Medicare claims, thus no adoption for copay accumulator programs is to be expected.[6] Limited adoption of exclusive specialty drug distribution through a designated specialty pharmacy and site of care management may indicate these strategies are less effective, inaccessible, politically infeasible, and/or against current federal or state statute for specialty drug cost-containment in Medicare plans.

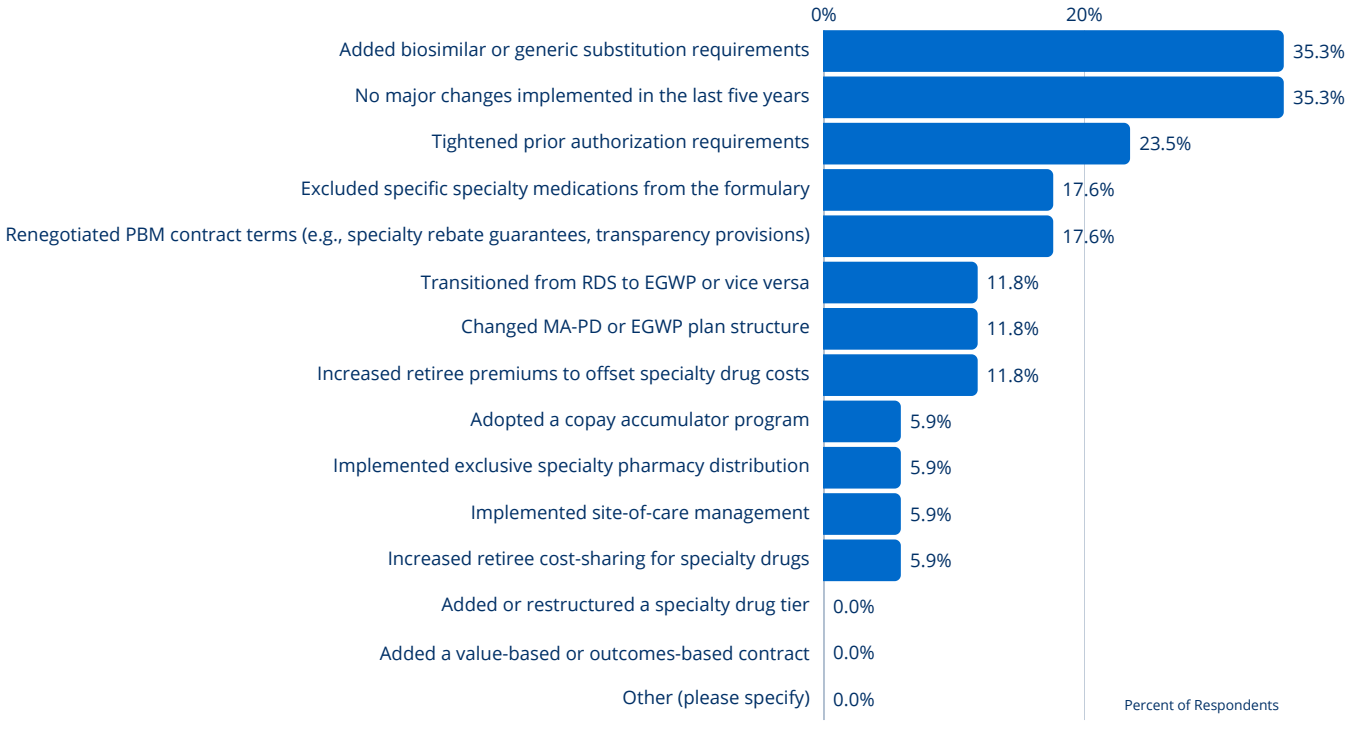
2025 Snapshot

In plan year 2025, 88.2% of responding public sector purchasers used at least one targeted strategy to manage specialty drug costs for Medicare plans, with an average of 2.7 utilization management methods per organization.

Medicare Pharmacy Benefit Changes

Over the past five years, 64.7% of public sector purchaser respondents modified their Medicare plan benefit design in response to rising specialty drug costs. On average, public sector purchaser respondents implemented 1.5 strategies in response to rising specialty drug costs in the last five years. The most commonly implemented Medicare benefit changes were adding a biosimilar or generic substitution requirement (35.3%) and tightening prior authorization requirements (23.5%). Over a third of respondents (35.3%) did not implement a new Medicare utilization management strategy in the last five years.

Major Medicare Pharmacy Benefits Changes Implemented in the Last Five Years



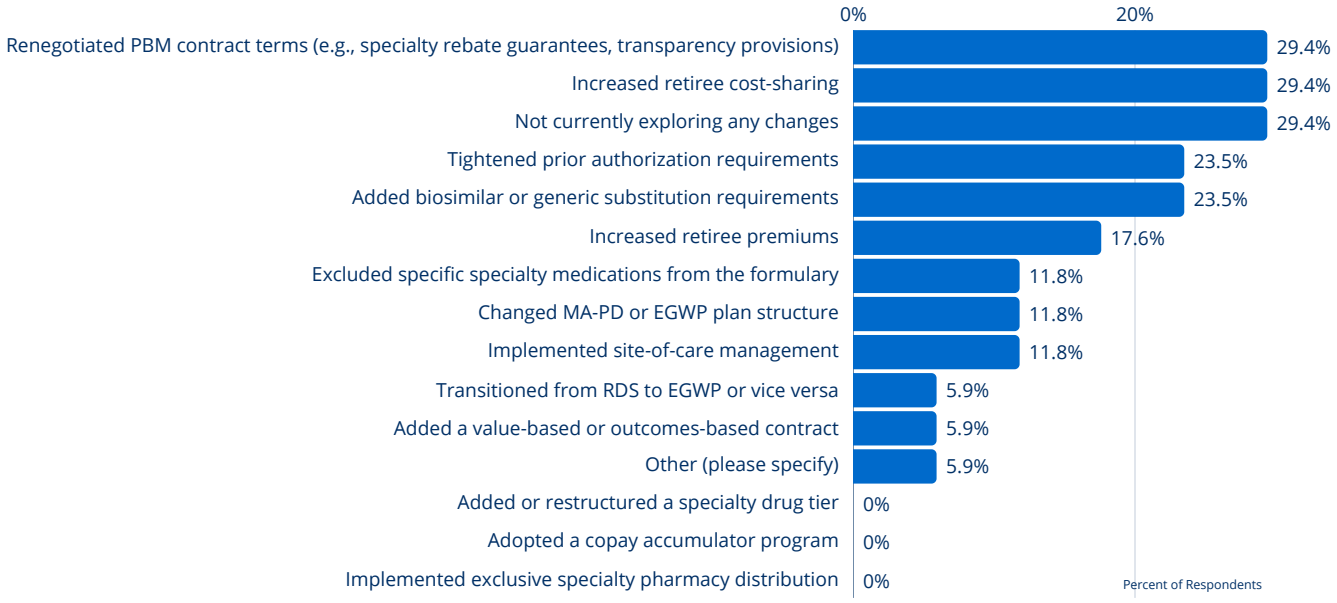
[6] Social Security Act §1128B(b), 42 U.S.C. § 1320a-7b(b)

Key Finding

Over a third of public sector purchaser respondents did not modify their Medicare pharmacy benefit design between 2021 and 2025.

Public sector purchasers also indicated they are currently exploring or interested in learning more about a variety of pharmacy cost containment strategies for their Medicare plans including renegotiating PBM contract terms (29.4%), increasing retiree cost-sharing (29.4%), adding biosimilar or generic substitution requirements (23.5%), and tightening prior authorization requirements (23.5%).

Major Medicare Pharmacy Benefits Plan Changes Being Explored



Comparing Commercial and Medicare Pharmacy Benefit Cost Containment Strategies

Most public sector purchaser respondents offered both commercial and Medicare pharmacy benefits to their employees and retirees, fifteen of whom answered utilization management questions for both plan types. Among those who offer both types of pharmacy benefits, the strategies they use to manage specialty drug costs diverge by plan type. Two-thirds of respondents had at least some overlap between their commercial and Medicare utilization management methods. The pattern was similar for changes made in the last five years: a plurality (46.7%) reported partial overlap and one in five reported identical changes. Changes being considered for the future were the most polarized. A plurality (40.0%) had no overlap between the two plans, while a third of respondents were considering identical changes. On average, respondents' current methods overlapped by 36.0%, changes made in the last five years by 47.8%, and changes being considered by 46.7%.

Overlap Between Commercial and Medicare Specialty Drug Utilization Management Methods

Similarity Between Utilization Management Methods	Current Methods	Methods Implemented in the Last Five Years	Methods Being Considered
Identical	6.7%	20.0%	33.3%
Partial Overlap	60.0%	46.7%	26.7%
No Overlap	33.3%	33.3%	40.0%
Mean Overlap	36.0%	47.8%	46.7%

Respondents generally reported fewer utilization management techniques being applied or considered for Medicare plans. On average, public sector purchasers reported 5.6 utilization management methods applied to their commercial plans while applying an average 2.7 methods to their Medicare plans. Additionally, when respondents applied a pharmacy benefit cost containment strategy to one plan type, it was almost always implemented in the commercial plan. This likely occurs due to the policies governing Medicare plan coverage. For example, over half of public sector purchasers' commercial plans utilize a manufacturer copay accumulator program while none apply to Medicare plans. This trend fits the policy landscape because federal law bars Medicare enrollees from using manufacturer copay assistance[7], making an accumulator program unnecessary. Other prominent Medicare pharmacy benefit legislation requires certain drugs to be covered[8], allows CMS to review plan formularies[9], and establishes an out-of-pocket cap under the redesigned Part D benefit.[10]

Additionally, many public sector purchasers provide Medicare drug coverage through an EGWP run by a carrier or PBM. When plans are fully-insured, public sector purchasers may have little direct control over the utilization management practices deployed.

Shared patterns also tend to emerge among low-friction tools that work in both types of plans. These strategies lower unit costs or confirm a medication is appropriate for the patient without shifting costs onto plan enrollees and include biosimilar or generic substitution requirements, prior authorization, and PBM contract renegotiation.

Overall, public sector purchasers appear to tailor their commercial and Medicare benefits to the different populations and to the different rules and contracts each benefit operates under. They also seem to rely on a small core set of strategies that work in both settings. The averages also mask a split: in each comparison, a sizable share of plans had either no overlap (33.3% to 40.0%) or identical strategies (6.7% to 33.3%), so the averages should be read alongside the distribution in the table above.



Key Finding

Public sector purchasers tailor specialty drug management to each benefit's population, regulations, and contracts, while relying on a small set of shared strategies.

[7] Social Security Act §1128B(b), 42 U.S.C. § 1320a-7b(b)
[8] Social Security Act § 1860D-4(b)(3)(G), 42 U.S.C. § 1395w-104(b)(3)(G)
[9] Social Security Act § 1860D-11(e)(2)(D), 42 U.S.C. § 1395w-111(e)(2)(D)
[10] Social Security Act § 1860D-2(b)(4), 42 U.S.C. § 1395w-102(b)(4)

Spotlight on GLP-1s — Promise, Cost, and the Public Sector Calculus

The GLP-1 Drug Class and Its Significance for Plan Sponsors

GLP-1s represent one of the most significant developments in pharmaceutical therapeutics in decades. Originally developed for the management of type 2 diabetes, GLP-1 medications have been used to treat sleep apnea, cardiovascular disease, and other conditions associated with obesity. As a result, demand for GLP-1 drugs has grown dramatically, and coverage for these medications has already become a substantial topic of discussion among public sector purchasers, state and local legislators, state and local fiscal leaders, employee and retiree unions, and employees, retirees, and their dependents.

GLP-1s present a particularly difficult challenge for public sector purchasers. GLP-1 medications have demonstrated meaningful, sustained weight loss in a portion of the population. Yet evidence on their short- and long-term cost savings demonstrates increased health savings and higher net health care costs.[11] Meanwhile, per-member treatment costs are high, the eligible population is potentially vast, and budget constraints limit public sector purchasers' ability to offer coverage.

Prevalence of GLP-1 Coverage Among Respondents

Coverage of GLP-1 medications is nearly universal among survey respondents. All commercial health plans covered GLP-1 medications, and a majority (88.2%) of Medicare plans covered GLP-1s in 2025.



GLP-1 Covered Indications and Utilization Management

While GLP-1 coverage is near-universal, the scope of that coverage varies significantly by indication. Among public sector purchasers, 41.2% reported that weight management, one of the most frequently discussed indications for GLP-1 medications, were covered under their commercial plans. No responding public sector purchasers covered GLP-1s for weight management in their Medicare plans, consistent with the federal exclusion of weight-loss drugs from Medicare Part D.[12]

2025 Snapshot

All responding purchasers covered GLP-1s in their commercial plans and 88.2% covered GLP-1s in their Medicare plans, but coverage for weight management was limited to commercial plans at 41.2% of purchasers.

[11] Hwang, J. H., Laiteerapong, N., Huang, E. S., Mozaffarian, D., Fendrick, A. M., & Kim, D. D. (2025). Fiscal Impact of Expanded Medicare Coverage for GLP-1 Receptor Agonists to Treat Obesity. JAMA health forum, 6(4), e250905. https://doi.org/10.1001/jamahealthforum.2025.0905

[12] Social Security Act § 1860D-2(e)(2)(A), 42 U.S.C. § 1395w-102(e)(2)(A)

Anticipated GLP-1 Cost, Coverage, and Policy Changes

GLP-1 medications are widely reported to be a significant driver of specialty drug spending nationally.[13] While the list prices for GLP-1s are falling, net plan costs for public sector purchasers may not be lower if rebates shrink in parallel. Demand for GLP-1s is also expected to keep growing as oral formulations become more widely available and the Food and Drug Administration approves additional indications. Some public sector purchasers are already responding to state and local rules on covered indications. Many have also said tight state budgets are forcing them to contain costs, and some have restricted GLP-1 access as a result, including dropping coverage for weight loss, expanding prior authorization requirements, and narrowing formulary coverage.

Coverage of GLP-1s for weight management differs between commercial and Medicare plans because federal law excludes drugs used for weight loss from Medicare Part D coverage.[14] Public sector purchasers rely on state, local, and municipal policies and budgets to determine coverage of GLP-1s for weight management in commercial plans, whereas they also have to consider federal restrictions when crafting Medicare plan policies.

Although federal law prohibits Medicare Part D from covering medications for weight management, CMS announced a new Innovation Center demonstration and model that would allow Medicare beneficiaries to access GLP-1 medications for weight management. The Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model is a voluntary program where the federal government negotiates directly with manufacturers for lower-cost GLP-1 medications on behalf of Medicare Part D plan sponsors, including Part C and Part D EGWPs, and state Medicaid agencies.[15] To improve health outcomes for Medicare beneficiaries, the BALANCE Model also pairs the medications with non-pharmaceutical healthy lifestyle interventions. The BALANCE Model was originally planned to be implemented for Medicare Part D on January 1, 2027, but has been indefinitely postponed due to insufficient participation by individual market Medicare Part D plan sponsors who cited concerns about lack of utilization estimates, uncertain financial risk, and market instability.

In the meantime, CMS created the Medicare GLP-1 Bridge demonstration program to give Medicare enrollees access to GLP-1 medications for weight loss for a $50 monthly copayment.[16] The Bridge demonstration is available to all Medicare Part D enrollees, including public sector retirees and their dependents, who could also obtain coverage in the BALANCE Model if their former employer chooses to participate.[17] As a result, public sector retirees and their dependents enrolled in their former employers' Medicare plans may have had access to low-cost GLP-1 medications for weight loss since July 1, 2026, when the Bridge Demonstration began. CMS has indicated that the Bridge demonstration will help prepare for a potential launch of the BALANCE Model in Medicare Part D after the Bridge demonstration ends on December 31, 2027. Even if BALANCE launches, participation is voluntary, so retirees would gain access only if the public sector purchaser elects to take part. If BALANCE does not launch or their plan does not participate, these retirees are likely to turn to their former employers for GLP-1 coverage for weight loss.

[13] Sclafani, P., & Appezzato, S. (2026, June 18). How GLP-1 growth and specialty drugs are driving cost pressure. Pharmaceutical Commerce. www.pharmaceuticalcommerce.com/view/how-glp1-growth-and-specialty-drugs-are-driving-cost-pressure
[14] Social Security Act § 1860D-2(e)(2)(A), 42 U.S.C. § 1395w-102(e)(2)(A)
[15] Centers for Medicare & Medicaid Services. (2026, September 29). BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth) Model. www.cms.gov/priorities/innovation/innovation-models/balance
[16] Centers for Medicare & Medicaid Services. (2026, July 13). Medicare GLP-1 Bridge. www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge
[17] Centers for Medicare & Medicaid Services. (2026, September 29). BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth) Model. www.cms.gov/priorities/innovation/innovation-models/balance

GLP-1 medications leave public sector purchasers with competing obligations they cannot fully meet. Clinical evidence and member demand are pushing toward broader access because the drugs produce meaningful weight loss and are approved for a growing list of obesity-related conditions. At the same time, employees, retirees, unions, and legislators are watching GLP-1 coverage decisions closely. Budget constraints pull in the opposite direction, since per-member costs are high, the potentially eligible population is large, and evidence of long-term cost savings remains inconclusive. Coverage is also funded from state and local budgets that are already under strain. Most respondents have tried to balance these pressures by covering GLP-1s broadly while limiting weight-management coverage and tightening utilization management, but changes in federal policy are likely to challenge that approach. If no federal option meets the demand created by the GLP-1 Bridge Demonstration, public sector purchasers may face pressure from their retirees to fill the gap without additional funding and without the evidence they would need to justify the cost. How purchasers respond will depend on better evidence of long-term value, stronger pricing leverage with manufacturers and PBMs, and clearer federal direction on Medicare coverage after 2027.

Key Finding

Shifting federal policy is reshaping the landscape for public sector purchasers' coverage of GLP-1s for weight management. Temporary access through the Medicare GLP-1 Bridge Demonstration combined with the delayed BALANCE Model could leave retirees without weight-management coverage after 2027, causing them to turn to their former employers to fill the gap.



Policy Recommendations

The Public Sector HealthCare Roundtable urges policymakers to consider policies that address drug prices directly, expand access to lower-cost alternatives, and extend the benefits of federal drug pricing reform to the public sector employer market.

Extend competitive Medicare negotiated drug prices to public sector commercial plans

The *Inflation Reduction Act* created a mechanism for Medicare to negotiate prices for certain high-cost drugs in the Part D program including those provided through EGWPs. These negotiated prices have been extended to employer-sponsored coverage for Medicare-eligible retirees. However, public sector retirees who are not yet eligible for Medicare due to their age do not have access to the same affordable drug products as older retirees. Additionally, many Americans, including public sector employees, are working past age 65. These Medicare-eligible, active public sector employees may not have access to Medicare Part D negotiated drug costs because they are enrolled in their public sector commercial plan for pharmacy coverage. Public sector active employees and retirees deserve access to affordable prescription drug products, regardless of their Medicare eligibility and enrollment status. Congress should explore pathways to extend Medicare negotiated drug prices to public sector employees and retirees with employer-sponsored commercial insurance.

Accelerate generic and biosimilar market entry and uptake

Generic drugs and biosimilars represent an effective mechanism for introducing price competition into the pharmaceutical marketplace, yet barriers to market entry and adoption continue to delay savings for patients and plan sponsors. Congress should pass the *Biosimilar Red Tape Elimination Act*[18] to improve the accessibility of generic drugs and biosimilars, reduce the backlog of generic applications, close patent thicket loopholes that delay competition, and streamline biosimilar interchangeability pathways. Policymakers should also encourage prescribing and substitution policies that make lower-cost generic and biosimilar products the default option where clinically appropriate, ensuring that public sector purchasers and their members can fully benefit from pharmaceutical competition.

Unleash innovation by reforming drug patent practices

Pharmaceutical patent protections serve a legitimate purpose, but manufacturers are increasingly exploiting these systems to delay generic and biosimilar competition and preserve high drug prices long after the original innovation has been fully rewarded. Public sector purchasers and their millions of beneficiaries cannot afford the continued price growth of older products while covering the costs of new, innovative therapeutic modalities. Congress should pass the *Medication Affordability and Patent Integrity Act*[19] and the *Affordable Prescriptions for Patients Act*[20] to strengthen patent review processes, limit patent thickets, close existing loopholes, and unleash innovation.

[18] Biosimilar Red Tape Elimination Act. S.1954. 119th Cong. (2025). congress.gov/bill/119th-congress/senate-bill/1954
[19] Medication Affordability and Patent Integrity Act. S.2658. 119th Cong. (2025). congress.gov/bill/119th-congress/senate-bill/2658
[20] Affordable Prescriptions for Patients Act. S. 1041. 119th Cong. (2025). www.congress.gov/bill/119th-congress/senate-bill/1041

Policy Recommendations (cont.)

Deploy artificial intelligence and advanced analytics with appropriate guardrails

Artificial intelligence and advanced analytics-enabled tools can improve clinical decision-making, administrative efficiency, care coordination, and value-based care. However, regulatory guardrails are necessary to promote accountability through increased transparency and ensure patient safety and data privacy.

Support value-based and outcomes-based contracting frameworks

As gene therapies and other potentially curative but extremely high-cost treatments enter the market, public sector purchasers need flexible contracting tools that tie reimbursement to demonstrated clinical outcomes. Congress should establish regulatory safe harbors and model contract frameworks that facilitate outcomes-based pricing and should align Medicaid best-price rules so they do not inadvertently discourage manufacturers from entering value-based arrangements with public sector purchasers.

Provide public sector plan sponsors adequate lead time to implement regulatory changes

Unlike private employers, public sector purchasers typically operate under multi-year contracts with health plans, PBMs, and other vendors that cannot be modified on short notice without significant legal, financial, and administrative consequences. Regulatory changes that require immediate or near-term contract modifications place a disproportionate burden on public sector plans. Congress and CMS should establish a standard practice of providing public sector plan sponsors with sufficient advance notice and, where necessary, explicit regulatory safe harbors to renegotiate or amend existing contracts in an orderly and compliant manner before new requirements take effect.

Require CMS to separately analyze and publish individual and EGWP Parts C and D plan data

Compared to EGWPs, individual MA and standalone Part D plans serve fundamentally different populations, operate under distinct contractual and benefit design structures, and respond differently to payment and policy changes. CMS currently collects Parts C and D plan data and has the ability to disaggregate individual and EGWP plans for data analysis, public reporting, and informing policy making. CMS's current practice of analyzing and reporting these populations together obscures the distinct experience of public sector retirees and allows EGWP data to improperly influence individual Parts C and D market analyses. Disaggregating these populations would improve the accuracy of Parts C and D market assessments, enable more targeted policy design, and give public sector plan sponsors and policymakers the information they need to evaluate how policies affect public sector employees, retirees, and their dependents.

Policy Recommendations (cont.)

Require drug pricing transparency from manufacturers

Public sector purchasers cannot effectively manage costs they cannot see. Federal legislation should require pharmaceutical manufacturers to publicly disclose list prices, net prices after rebates, and production and research costs for high-cost drugs, particularly those subject to significant year-over-year price increases.



Reform Pharmacy Benefit Manager (PBM) standards

The Roundtable supports efforts to increase PBM accountability for containing annual changes in drug costs (i.e., pharmacy trend) and delivering lower net effective drug costs. Public sector purchasers already work to hold their PBMs accountable through plan design and contract oversight. The California Public Employees' Retirement System (CalPERS), a Roundtable board member, has already implemented this type of accountability mechanism, requiring its PBM to put a multi-million-dollar lump sum at risk if annual pharmacy trend exceeds 6.5 percent.[21] This kind of arrangement illustrates the leadership public sector purchasers are already providing on this issue and could serve as a model for broader PBM accountability standards in Part D. At the same time, public sector purchasers are not uniform, and no single accountability model will fit every plan. The Roundtable encourages Congress to consult with public sector purchasers directly as it develops policy in this area. The Roundtable broadly supports efforts to increase transparency and accountability across the health care system but encourages Congress to recognize and accommodate the oversight structures public sector purchasers already have in place as it considers new policies in this area. The Roundtable recommends Congress pass into law the *PBM Price Transparency and Accountability Act*.[22]

The Roundtable also supports establishing appropriate guardrails on PBMs' ability to limit direct contracting between manufacturers, health plans, and other entities. Specifically, policies should promote transparency and accountability while preserving purchasers' ability to evaluate innovative approaches to managing prescription drug costs. In the context of GLP-1 medications, some public sector purchasers have explored direct contracting with manufacturers and encountered challenges within existing PBM relationships. Establishing clear guardrails could improve transparency in contracting arrangements and help ensure purchasers have the ability to pursue cost-effective options that best serve their beneficiaries.

[21] CalPERS. CalPERS Announces New Pharmacy Benefits Contract with CVS Caremark to Foster Affordability and Improve Quality. (July 15, 2025). https://www.calpers.ca.gov/newsroom/calpers-news/2025/calpers-announces-new-pharmacy-benefits-contract-with-cvs-caremark-to-foster-affordability-and-improve-quality

[22] PBM Price Transparency and Accountability Act. S.3345. 119th Cong. (2025). congress.gov/bill/119th-congress/senate-bill/3345

Support public sector purchasers' participation in CMS Innovation Center models

The CMS Innovation Center plays a critical role in testing and evaluating new payment and delivery system models designed to improve quality while reducing costs. Thus, public sector purchasers must be able to participate in these innovative models to identify policies that save costs for federal, state, and municipal budgets. The Roundtable appreciates that CMS included EGWPs in the BALANCE Model and encourages CMS to keep EGWPs eligible to participate in innovative payment models like the Global Benchmark for Efficient Drug Pricing (GLOBE), Guarding U.S. Medicare Against Rising Drug Costs (GUARD), and Cell and Gene Therapy Access (CGT) Models.

Advance responsible integration of pharmacogenomics and precision medicine

When applied responsibly, pharmacogenomics and precision medicine, including genetic and biomarker-informed prescribing, can improve treatment effectiveness, reduce adverse drug events, and eliminate unnecessary or ineffective utilization of services, especially for high-cost therapies. The Roundtable recognizes the value of preventative health care and urges Congress and the Administration to explore options that promote public sector purchasers' ability to fully reimburse the practical application of pharmacogenomics and other preventative precision medicine interventions.



Safeguard public sector purchasers from the compounding costs of the *No Surprises Act* (NSA)

Public sector purchasers are managing sustained growth in prescription drug spending while also absorbing unanticipated, unpredictable costs from the NSA, including physician-administered medications. The NSA Independent Dispute Resolution (IDR) process has accumulated administrative fees and produced arbitration awards that far exceed congressional expectations, totaling $22.4 billion from 2022 through 2025.[23] These costs are being absorbed by public sector purchasers and beneficiaries in the form of higher premiums. The University of Texas System, one of the Roundtable's members, shared that their premiums will rise by 9% in 2027, with 2.9 percentage points directly attributable to IDR award costs.[24] Because public sector plans are financed through state and local general revenue and member contributions, the increases fall on taxpayers and active employees, retired public servants, and their dependents. The Roundtable recommends Congress pass the Lower Premiums, Faster Payments Act.[25] The Roundtable encourages Congress and the Administration to examine the impact of IDR awards on state and local government budgets and work with public sector purchasers to develop solutions that prevent abuse of the IDR process. Addressing IDR cost pressures alongside high drug prices is essential to keeping comprehensive coverage affordable for public sector purchasers and the millions of beneficiaries they serve.

[23] CHIR Faculty. Spending on IDR process pushes no surprises act costs to more than $22.4 billion over just four years. Georgetown University Center on Health Insurance Reforms. (August 28, 2026). https://chir.georgetown.edu/spending-on-idr-process-pushes-no-surprises-act-costs-to-more-than-22-4-billion-over-just-four-years/

[24] Public Sector HealthCare Roundtable. Letter to Speaker Johnson, Leader Jeffries, Leader Thune, and Leader Schumer. (September 21, 2026).

[25] Lower Premiums, Faster Payments Act. H.R.10788. 119TH Cong. (2026). www.congress.gov/bill/119th-congress/house-bill/10788?hl=hr10788&s=1&r=1

Conclusion

The public sector purchasers represented in this report are among the most consequential health care buyers in the United States. Together, they covered nearly 3.8 million teachers, firefighters, law enforcement officers, public workers, and their families. With $749 billion in OPEB liabilities on public sector balance sheets nationwide, the financial stakes of pharmacy benefits policy extend well beyond any individual plan — they reach into state budgets, municipal finances, and the long-term fiscal health of governments across the country.

The data in this report clarify the challenges facing public sector purchasers, especially related to specialty drug costs and spend. As the specialty drug pipeline continues to expand by bringing new therapies to market and broadening the indications for existing ones, the cost pressures public sector purchasers are experiencing will intensify. Every public sector purchaser that responded to the survey deployed targeted strategies to manage specialty drug costs within the structural and political constraints that govern public sector benefits administration.

The cost-management tools available to public sector purchasers are necessary but insufficient. These strategies can slow the rate at which cost growth translates into premium increases, benefit reductions, or higher taxes, but they cannot reverse underlying market inflationary trends. Therefore, the Roundtable encourages state and federal policymakers to engage with public sector purchasers in conversations about drug pricing reform.

At the center of this report are people including firefighters living with chronic obstructive pulmonary disease, teachers living with an autoimmune disease, and police officers with a child living with type 2 diabetes. Public sector employers and purchasers, federal and state policymakers, and the broader health care system share an obligation to ensure that comprehensive, affordable health coverage remains available to the people who earned it through public service.



Appendix A

The 2026 Specialty Drug Survey collected responses from 19 public sector plan sponsors across 15 states. Seventeen respondents offered commercial health plans and all respondents offered Medicare plans. Results reflect self-reported data for the 2025 calendar, plan, or fiscal year. Per-member and per-claim figures are calculated among organizations that reported both numbers, so these figures will not match the ratio of reported totals. Survey respondents reporting 2024 and 2025 data do not match, so differences in figures reflect who responded for each year as well as changes in spending, costs, membership, and claims volume.

Survey data are self-reported by plan sponsors and has not been independently audited. Response counts vary by metric due to differences in data availability across organizations. The findings reflect the experience of these survey respondents and should not be extrapolated to the broader public sector market.

Respondent Overview

Nineteen organizations responded to the 2026 Specialty Drug Survey, representing 15 states. Seventeen organizations offer a commercial health plan and all 19 respondents offer Medicare plans.

Responding organizations include:

- Arizona State Retirement System
- Colorado Public Employees' Retirement Association
- Delaware State Employee Benefits Committee
- Employees Retirement System of Texas
- Kansas State Employee Health Plan
- Michigan Public School Employees' Retirement System
- New Hampshire HealthTrust
- School Employees Retirement System of Ohio
- South Carolina Public Employee Benefit Authority
- State of Alaska, Division of Retirement and Benefits
- State Teachers Retirement System of Ohio
- Teacher Retirement System of Texas
- Teachers' Retirement System of Kentucky
- Tennessee Department of Finance and Administration, Division of Benefits Administration
- Texas Association of Counties Health and Employee Benefits Pool
- University of Kentucky
- Washington State Health Care Authority
- West Virginia Public Employees Insurance Agency
- Wisconsin Department of Employee Trust Funds

The states represented include:

- Alaska
- Arizona
- Colorado
- Delaware
- Kansas
- Kentucky
- Michigan
- New Hampshire
- Ohio
- South Carolina
- Tennessee
- Texas
- Washington
- West Virginia
- Wisconsin

Appendix A

Partial Visibility Into Plan Offerings

The survey does not capture a complete picture of every plan offering, beneficiary, and cost for each responding organization. Some respondents have visibility into only some, not all, of the plans they sponsor. In many cases, this reflects how a plan is funded: organizations generally have access to detailed claims and enrollment data for self-funded plans. For fully-insured plans, the insurance carrier pays claims and may share only limited information with the public sector plan sponsor. As a result, response counts vary by measure and the figures reported for an individual organization may reflect only part of its plan offerings, membership, or spending. This is most evident in Medicare medical spending, which 11 of the 19 respondents reported, on different bases. The findings in this report therefore describe the plans for which respondents were able to report data and may understate total enrollment and spending across all the plans these organizations offer.

Reporting Period

Respondents reported data for their most recently complete twelve-month reporting period, which this report refers to as the 2025 plan year. Because public sector purchasers operate on different budget and benefit cycles, the reporting period varies by organization: most respondents reported data for calendar year 2025, while some reported data for a plan or fiscal year (e.g., fiscal year 2024-25). As a result, figures for different organizations may cover periods that do not fully overlap. References to 2024 figures from the 2025 Annual Specialty Drug Survey Report reflect respondents' reporting periods for that survey, and because the 2024 and 2025 respondent groups differ, those comparisons reflect who responded as well as any change in spending.

Pharmacy Spending and Rebates

Respondents reported pharmacy benefit spending on different bases. Some reported spending before manufacturer rebates were applied, while others reported spending net of rebates. Sixteen organizations reported $2.8 billion in commercial pharmacy rebates, and 12 reported almost $1.9 billion in Medicare pharmacy rebates. Because rebates as a share of spending can only be calculated against spending before rebates, the rebate rates in this report (about 40 cents per dollar for commercial plans and about 31 cents per dollar for Medicare plans) are based on the 11 commercial and eight Medicare organizations that reported pharmacy spending before rebates. Pharmacy spending totals combine figures reported before and after rebates, so they are not directly comparable across organizations and may understate spending before rebates.

Defining Specialty Drugs

There is no single, standardized definition of a specialty drug across public sector purchasers. Respondents defined specialty medications according to their own plan criteria, PBM classifications, or cost thresholds. This variation may affect the comparability of specialty drug spending and claims percentage figures across organizations. Metrics such as the percentage of pharmacy claims attributable to specialty drugs showed wide dispersion across respondents, reflecting these definitional differences.

Rounding Standards

Figures in this report are rounded once from unrounded source data using the standards below. Ratios, percentage differences, and other comparisons are calculated from unrounded values before rounding. Values are rounded half up (e.g., 46.65% rounds to 46.7%). Because of rounding, percentages may not sum to exactly 100% and totals may not equal the sum of their parts. Qualifiers indicate where the unrounded value falls: "almost" and "nearly" mean the unrounded value is below the rounded figure, while "over" and "more than" mean it is above.

Rounding Standards Used in This Report

Type of figure	Rounding standard	Example
Dollar totals of $1 billion or more	One decimal, in billions	$22.9 billion
Dollar totals under $1 billion	Three significant figures, in millions	$704 million
Counts of 1 million or more	One decimal, in millions	47.8 million claims
Counts under 1 million	Nearest thousand	153,000 members
Per-member and per-claim spending	Nearest $10	$2,360 per member; $120 per claim
Rates and averages	One decimal	19.7 claims per member; 5.6 methods
Percentages	One decimal	48.8%
Rebates per dollar of spending	Whole cents	40 cents
Survey counts	Exact; spelled out under 10 and at the start of a sentence	Five self-funded organizations; 17 respondents

Causal Conclusions Not Supported

The survey captures spending and utilization but does not isolate the drivers of spending. The survey data alone cannot quantify the relative contributions of factors such as drug price inflation, shifts in the mix of drugs prescribed, changes in plan design, or population health changes. Additional research would be required to establish causal relationships.





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