2025 Annual Specialty Drug Survey Report

A Data-Driven Look at Specialty Drug Costs in 2024

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. The data in this report tell a clear and urgent story: the costs of specialty drugs continue to outpace all other health care spending and are a primary driver of rising health care costs.

This report presents findings from the 2025 Specialty Drug Survey, conducted by the National Institute for Public Employee Health Care Policy and Public Sector HealthCare Roundtable. Twenty-three public sector plan sponsors representing 17 states responded, collectively covering approximately over 5.5 million beneficiaries. Together they spent nearly $30 billion in 2024 on commercial health care, nearly $8 billion of which was spent on pharmacy benefits alone.

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 spend $749 billion annually in other post-employment benefits (OPEB) liability,[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. (2023, May 1). *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 2024, public sector purchasers responding to the Specialty Drug Survey reported:

Covering **over**
4.2M members
in commerical plans and **over**
1.45M members
in Medicare plans.

Spending almost
$30 billion in total commercial health care,
$8 billion of which was on pharmacy benefits

Processing over **48.3 million** commercial pharmacy claims.

While pharmacy claim volume and claims per member declined, ***pharmacy benefit spend per claim grew.***

Over 50%
of all pharmacy benefit spending on specialty drugs, *driven by a small number of high-cost medications*

Compared to commercial care spending,

Pharmacy benefit spending grew
1.8 times faster
Specialty drug spending grew
2.4 times faster
from plan year 2021 to 2024

In plan year 2024, all responding public sector purchasers:

- **Used at least one targeted strategy** to manage specialty drug costs.
- **Modified their health plan benefit design** to address rising specialty drug costs within the last five years.
- **Covered GLP-1s**, though coverage for weight management indications was limited.

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 rising costs of specialty drugs.

Policy Options At a Glance

The Roundtable encourages policymakers to consider the following policy options:

1. Extend **Medicare drug price negotiation** to the employer market.
2. Accelerate **generic and biosimilar** market entry and uptake.
3. Advance responsible integration of **pharmacogenomics and precision medicine**.
4. Deploy **artificial intelligence and advanced analytics** with appropriate guardrails.
5. Unleash innovation by **reforming drug patent practices**.
6. Strengthen the **health care workforce** supporting prescription drug management and patient care.
7. Support **value-based and outcomes-based contracting** frameworks.
8. Provide public sector plan sponsors with adequate **lead time to implement regulatory changes**.
9. Require CMS to **separately analyze** individual and group Medicare Advantage data.
10. Require **drug pricing transparency** from manufacturers.
11. Reform **pharmaceutical benefits manager** standards.
12. Support public sector purchasers' participation in **CMS Innovation Center models**.

Purpose of the Survey

This report presents findings from the 2025 Specialty Drug Survey, which includes data for the 2024 plan year. For almost 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 government budgets. Unlike public health programs, their benefits serve a defined population of employees, retirees, and their dependents, not the general public. Yet data on their experience is rarely collected and reported at scale. This annual survey is the only public source of longitudinal, multi-organization data focused solely on public sector health plans.

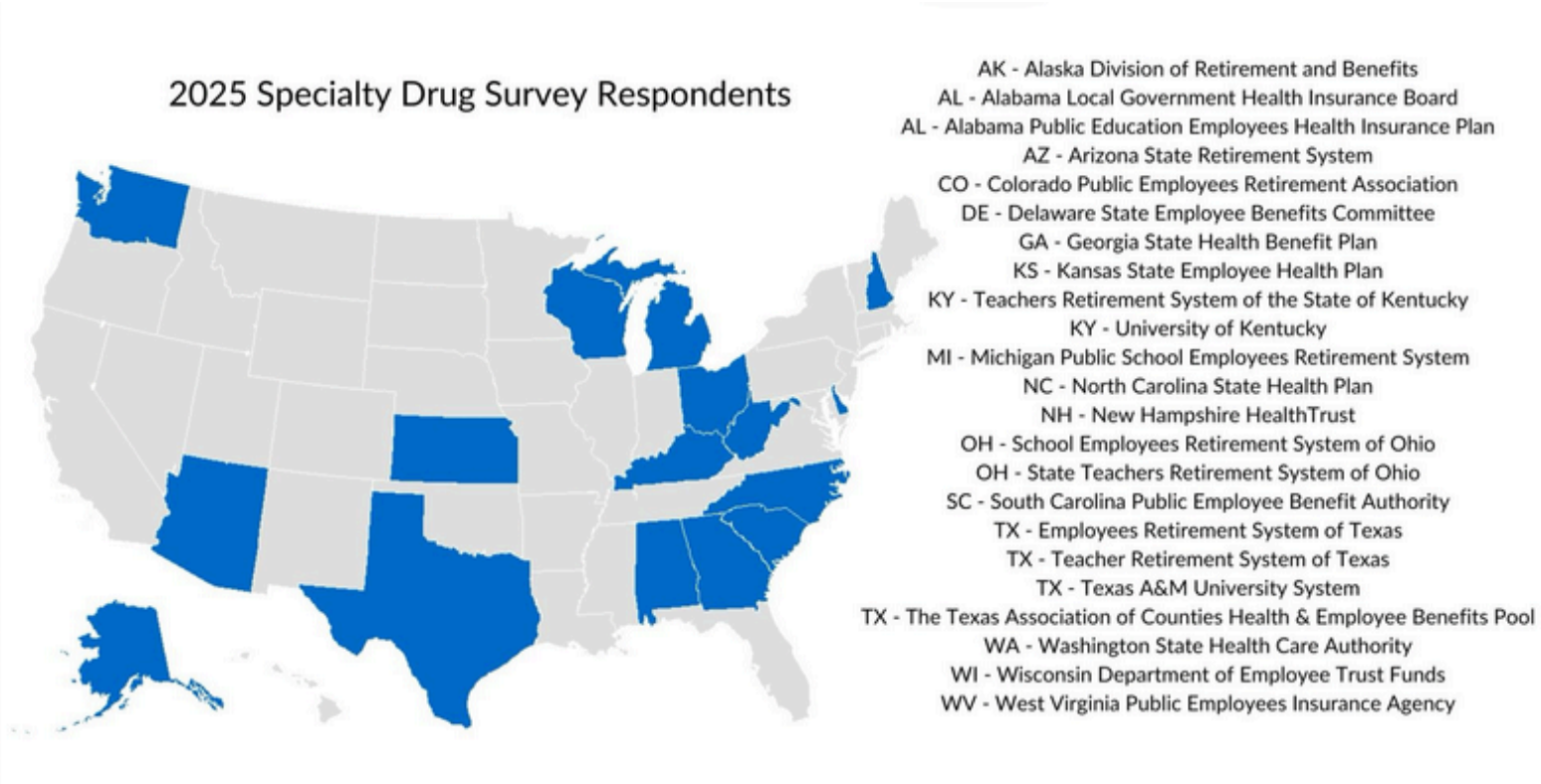
The Public Sector Landscape

Profile of Responding Organizations

Public sector health care purchasers are a diverse group. They range from large state employee benefit programs to university systems, statewide retirement systems, county purchasing pools, and other smaller plans. These plans can serve anywhere from hundreds to hundreds of millions of 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.

23 respondents represented 17 states spanning all major 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. The variation also reflects the diverse communities these plans serve — from urban centers to rural areas — and the differences in provider market dynamics that come with each.



Responding organizations collectively offer a broad range of health benefit programs. 22 of the 23 respondents offer at least one commercial health plan covering active employees, retirees under age 65, and their dependents, while 21 offer at least one Medicare plan serving retirees 65 years old and older. Most responding organizations offer both, reflecting that many public employers cover beneficiaries throughout the full life cycle.

Public sector purchasers responding to the 2025 Specialty Drug Survey covered over 4.2 million members through commercial plans and more than 1.45 million beneficiaries through Medicare plans. Across all plans, respondents provided health care benefits to nearly 5.7 million employees, retirees, and 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 underscores 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 them.

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. 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 benefits packages, covering a greater share of premium costs than most private employers. 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.

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, Spending, and Costs

The data in this section reflect commercial plan spending and utilization across all responding organizations for the 2024 plan year. Snapshot totals include all responding organizations. Year-over-year and cumulative growth rates are based on organizations that were able to provide consistent, verifiable historical data.

Commercial Plan Membership

Snapshot on the 2024 Plan Year Commercial Plan Membership

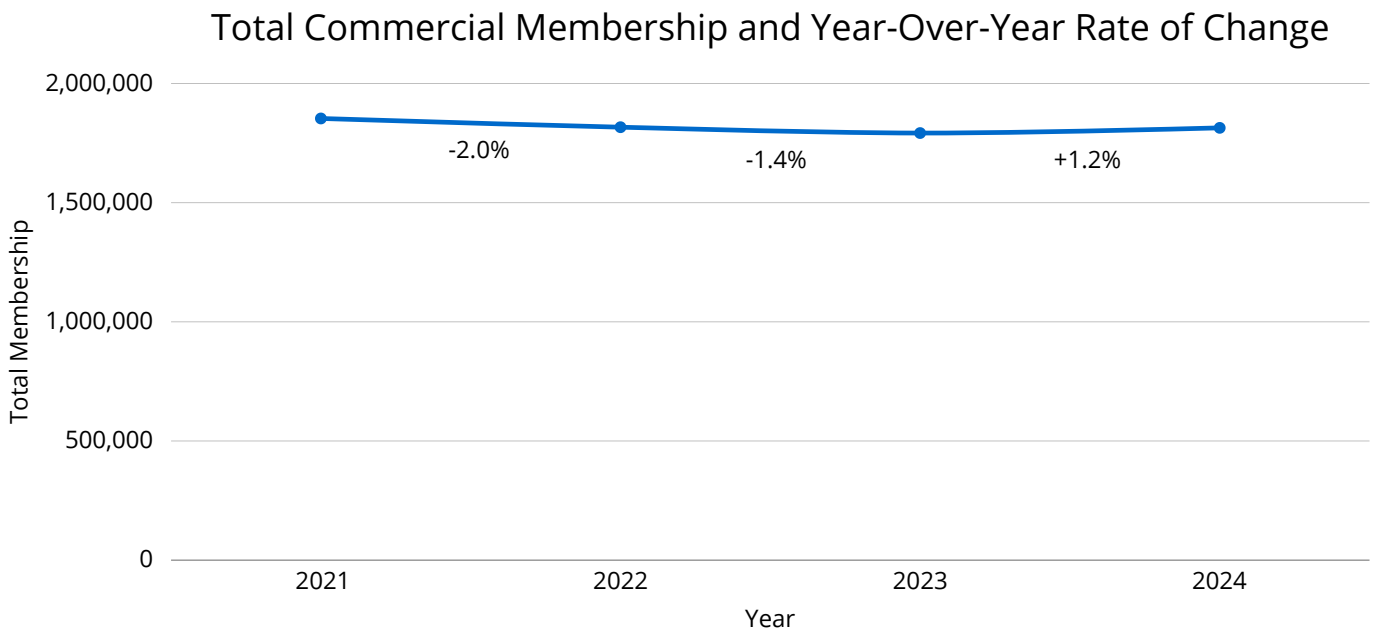
Across all 22 responding organizations that offer commercial health plans, enrollment totaled 4,240,889 covered employees, retirees under age 65, and their dependents. The mean enrollment per organization is approximately 192,800 members, and the median is approximately 84,300, reflecting the wide variation in plan membership sizes across respondents.

2024 Snapshot

Public sector purchasers responding to the Specialty Drug Survey covered over 4.2 million members through commercial plans

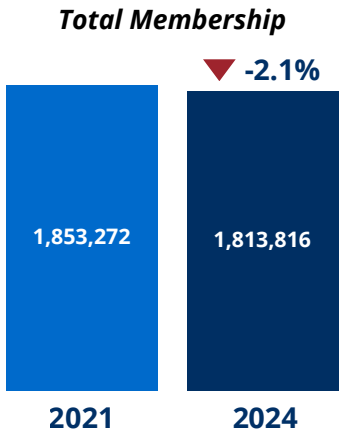
Year-Over-Year Change in Membership

From 2023 to 2024, membership among the cohort grew by 1.2%, reversing two consecutive years of decline. The prior declines may reflect a range of factors unrelated to health care — including state and local budget pressures that reduced workforce size, retirements outpacing new hires, or compositional characteristics of the cohort itself, which tends to include larger and longer-tenured organizations whose membership trends may not be representative of the entire public sector market. The 2023–2024 recovery suggests some stabilization, though a single year of growth is insufficient to establish a trend.



Cumulative Decline in Membership

Over the four-year period, cumulative membership among the cohort declined from 1.85 million to 1.81 million, a decrease of 2.1%. This decline warrants careful interpretation, it may reflect genuine workforce contraction driven by state and local budget pressures, an aging workforce in which retirements are outpacing new hires, or factors specific to the cohort's composition which tends to skew toward larger, longer-tenured organizations whose membership dynamics may not be representative of all public sector employers. The Institute and Roundtable will continue monitoring these trends and provide additional information in the following Annual Specialty Drug Survey Reports.



Commercial Health Care Spending

Snapshot on the 2024 Plan Year Commercial Health Care Spending

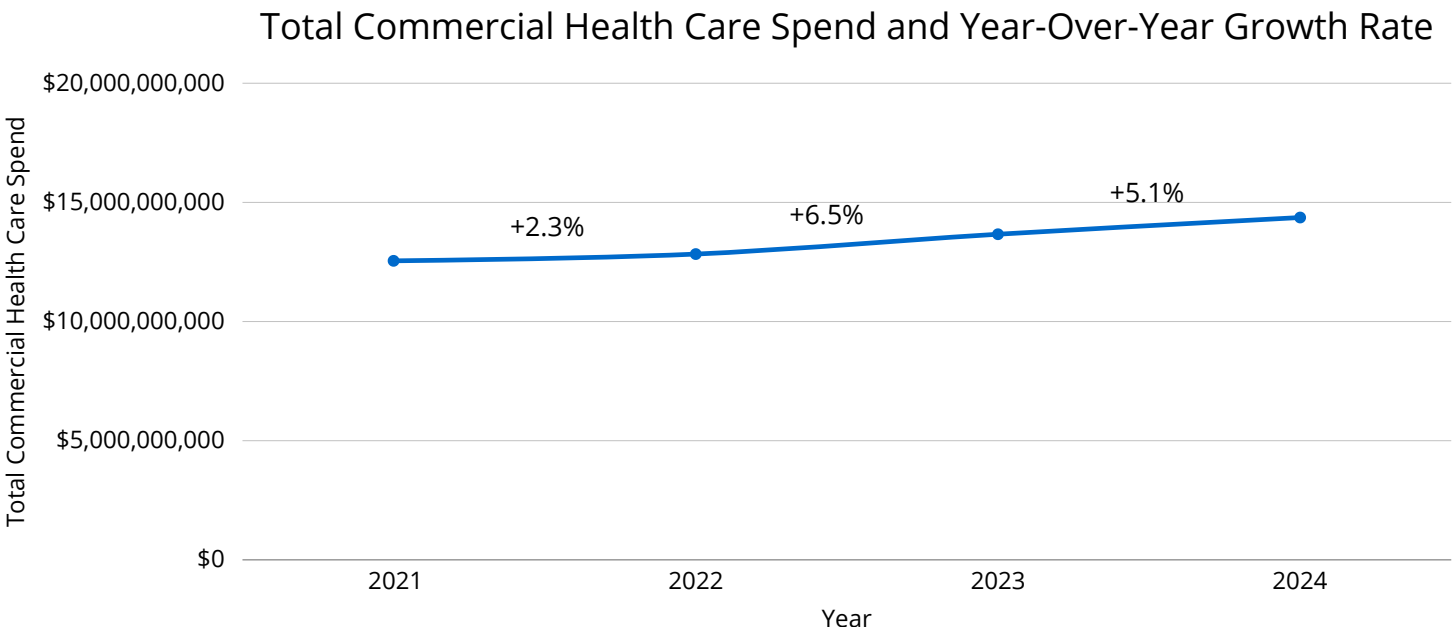
Responding organizations spent a combined $29,930,522,152 on commercial health care benefits in 2024 across most of the responding organizations. The mean spending per organization was approximately $1.5 billion and the median was approximately $660 million, reflecting the significant variation in plan membership and budget size among respondents. Across all organizations, per capita total health care spending was $7,060 per beneficiary.

2024 Snapshot

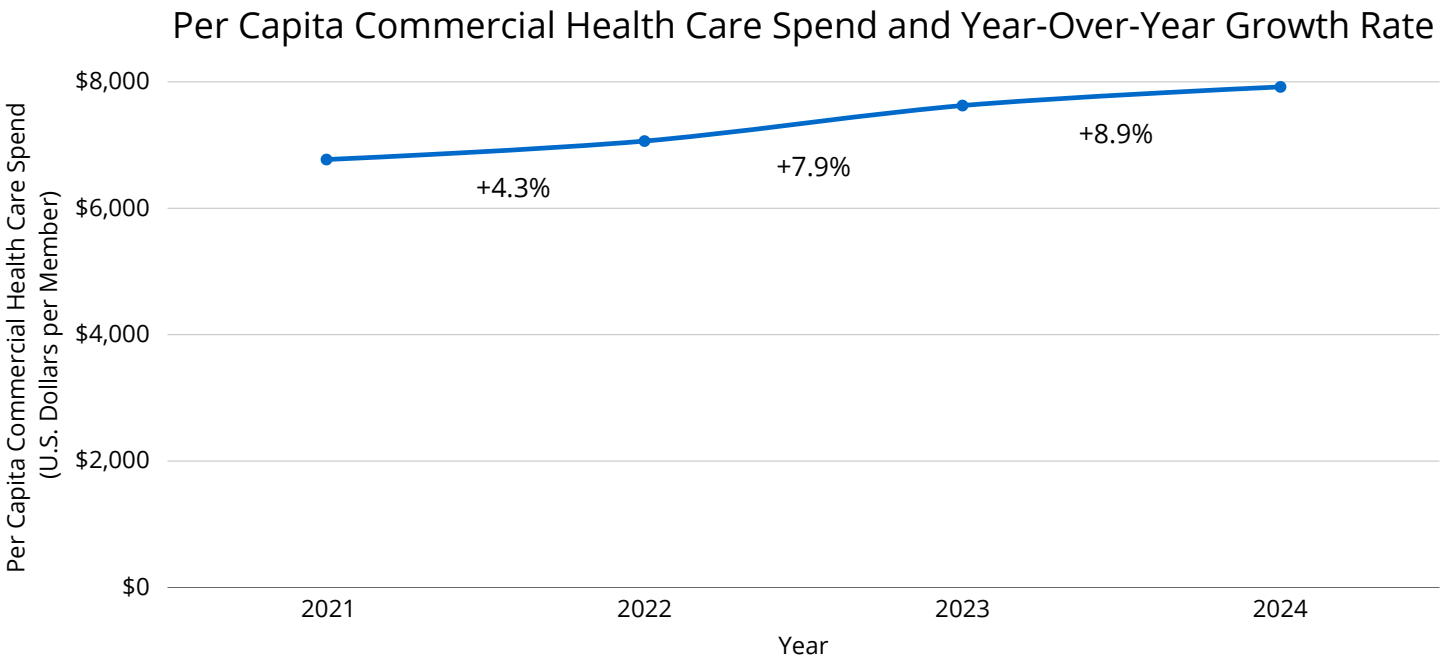
Public sector purchasers responding to the Specialty Drug Survey spent almost $30 billion in total commercial health care.

Year-Over-Year Growth in Total Commercial Health Care Spending

Among the cohort, total commercial health care spending grew 5.1% from 2023 to 2024. This follows spending growth of 6.5% from 2022 to 2023 and 2.3% from 2021 to 2022.

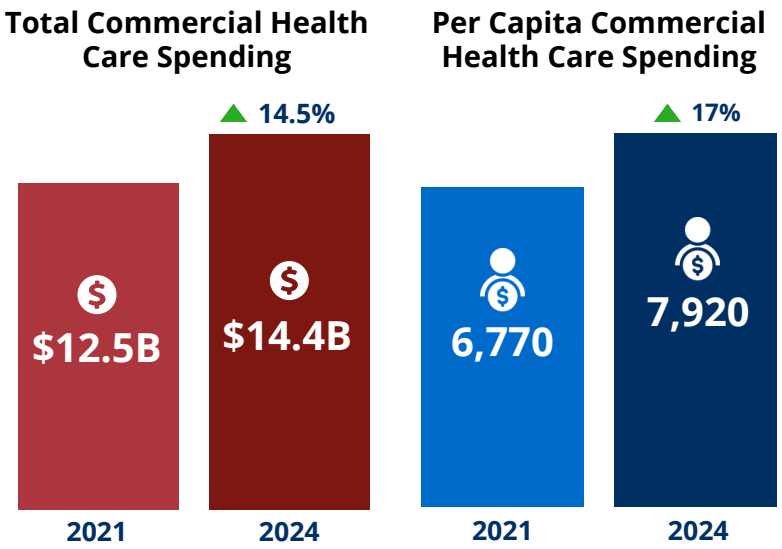


On a per capita basis, commercial health care spending grew 4.3% from 2021 to 2022, accelerated to 7.9% from 2022 to 2023, and moderated to 3.9% from 2023 to 2024. The spike in per capita spending growth between 2022 and 2023 is significantly higher than the adjacent years.



Cumulative Growth in Total Commercial Health Care Spending

Among the cohort, total commercial health care spending grew 14.5% from 2021 to 2024, rising from $12.5 billion to $14.4 billion over three years. On a per capita basis, commercial health care spending among the cohort grew 17.0% from 2021 to 2024. In 2021, total per capita spending was $6,770 which grew to $7,920 in 2024.



Key Finding

Total commercial health care spending grew by 14.5% while per capita spending increased by 17.0%

Key Drivers and Context

Total health care cost growth, while significant, tells only part of the story. Per capita spending growth outpaced total spending growth in the cohort over the same period, indicating that costs are rising for each individual member covered. These trends reinforce a consistent finding across survey years: the cost of providing health care benefits to public sector employees, retirees, and their dependents is rising in ways that demand deeper examination of what is driving the growth.

Commercial Pharmacy Claims

Key Drivers and Context

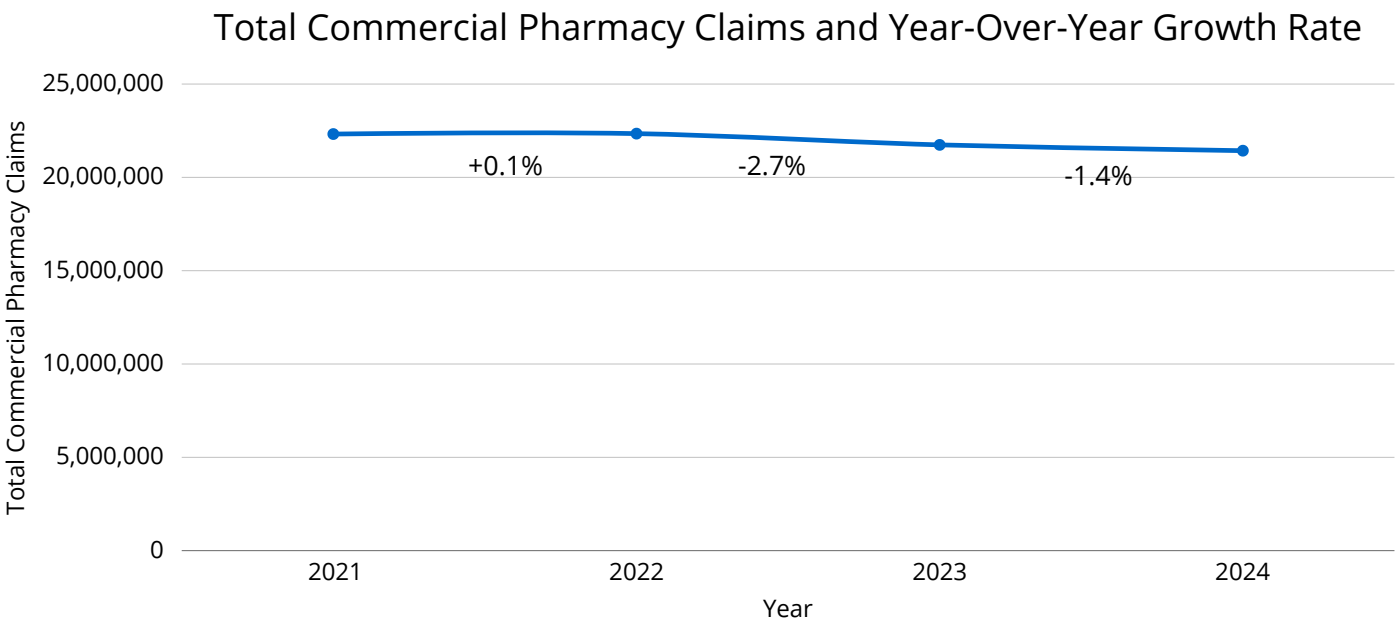
Responding organizations processed a combined 48,342,341 commercial pharmacy claims in 2024. The mean number of pharmacy claims processed was 2,417,000 whereas the median number of claims processed was 838,000. The average respondent processed 11.4 pharmacy claims per member and $165 spent per claim.

2024 Snapshot

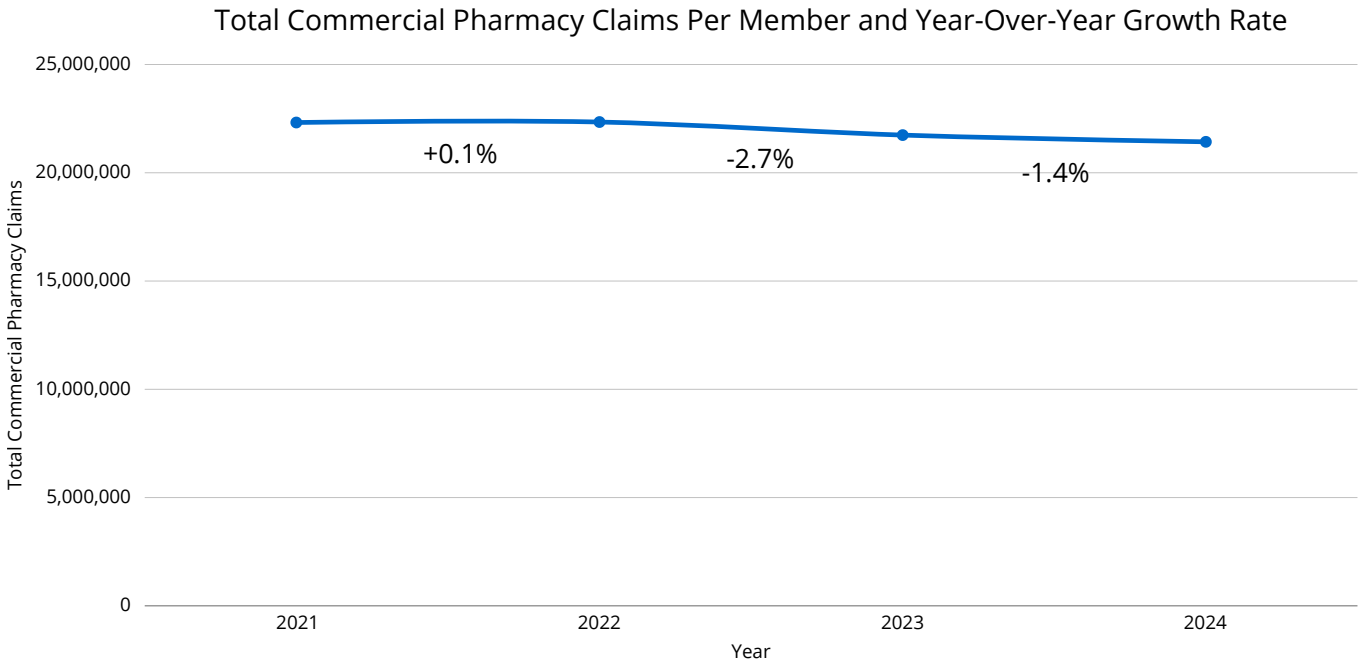
Public sector purchaser respondents processed over 48.3 million commercial pharmacy claims or 11.4 pharmacy claims per member in 2024.

Year-Over-Year Decline in Pharmacy Claim Volume

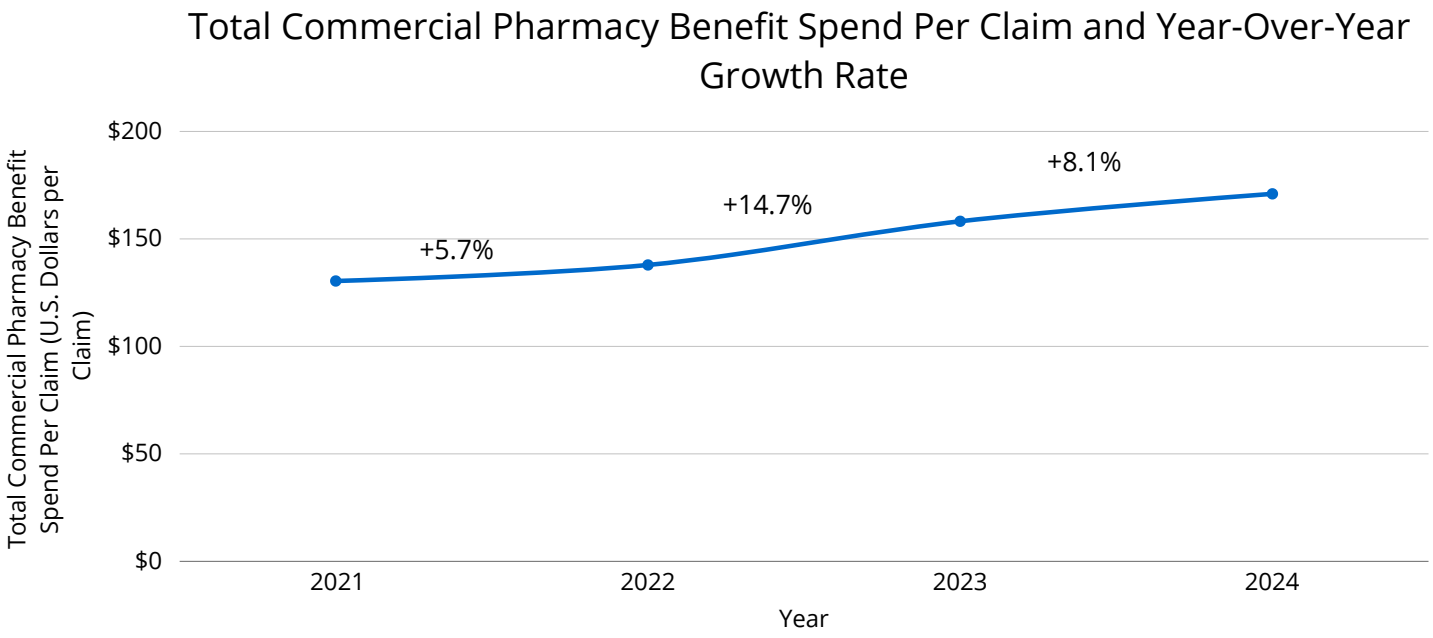
Among the cohort, pharmacy claim volume grew slightly from 2021 to 2022 and declined ever since. The largest decline occurred from 2022-2023.



The decline in total commercial pharmacy claims per member mirrors the total commercial pharmacy claims trend.

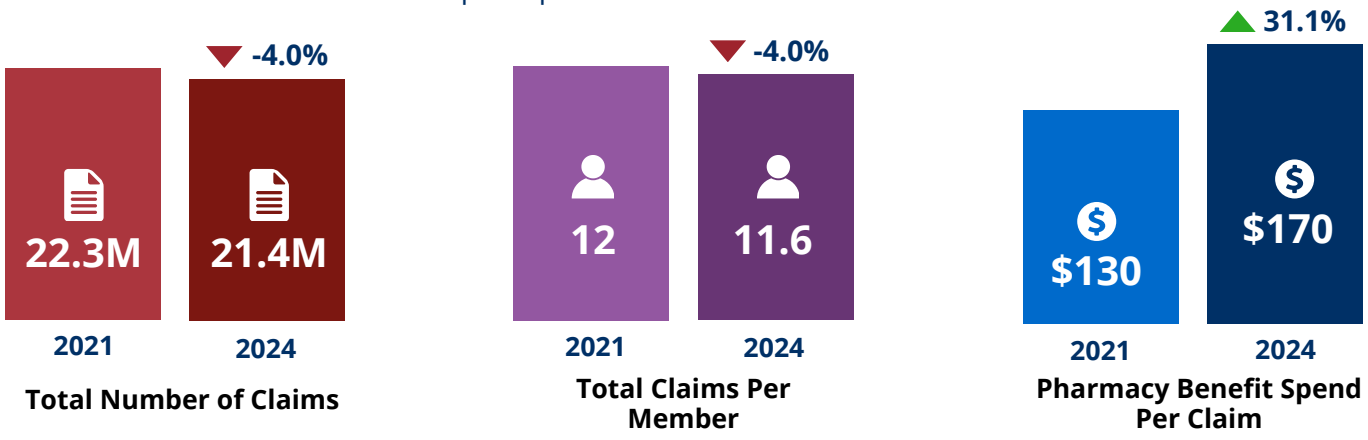


Pharmacy benefit spend per pharmacy claim among the cohort grew consistently across all three reporting periods, rising 5.7% from 2021 to 2022, accelerating sharply to 14.7% from 2022 to 2023, and remaining elevated at 8.1% from 2023 to 2024. The 2022 to 2023 spike — in which the cost of the average pharmacy claim grew at more than twice the prior year's rate — reflects the same period of intense specialty drug cost pressure visible elsewhere in this report.



Cumulative Decline in Pharmacy Claim Volume

Cumulatively, total claim volume among the cohort fell 4.0% from 2021 to 2024, falling from 22.3 million claims to 21.4 million. Over the same period of time, total claims per member declined by 0.4 claims. When combined with rising health care costs, the pharmacy claim volume decline is associated with a $40 increase in spend per claim.



Key Finding

While total pharmacy claim volume and claims per member declined, pharmacy benefit spend per claim grew.

Commercial Pharmacy Benefit Spending

Snapshot on the 2024 Plan Year Commercial Pharmacy Benefit Spending

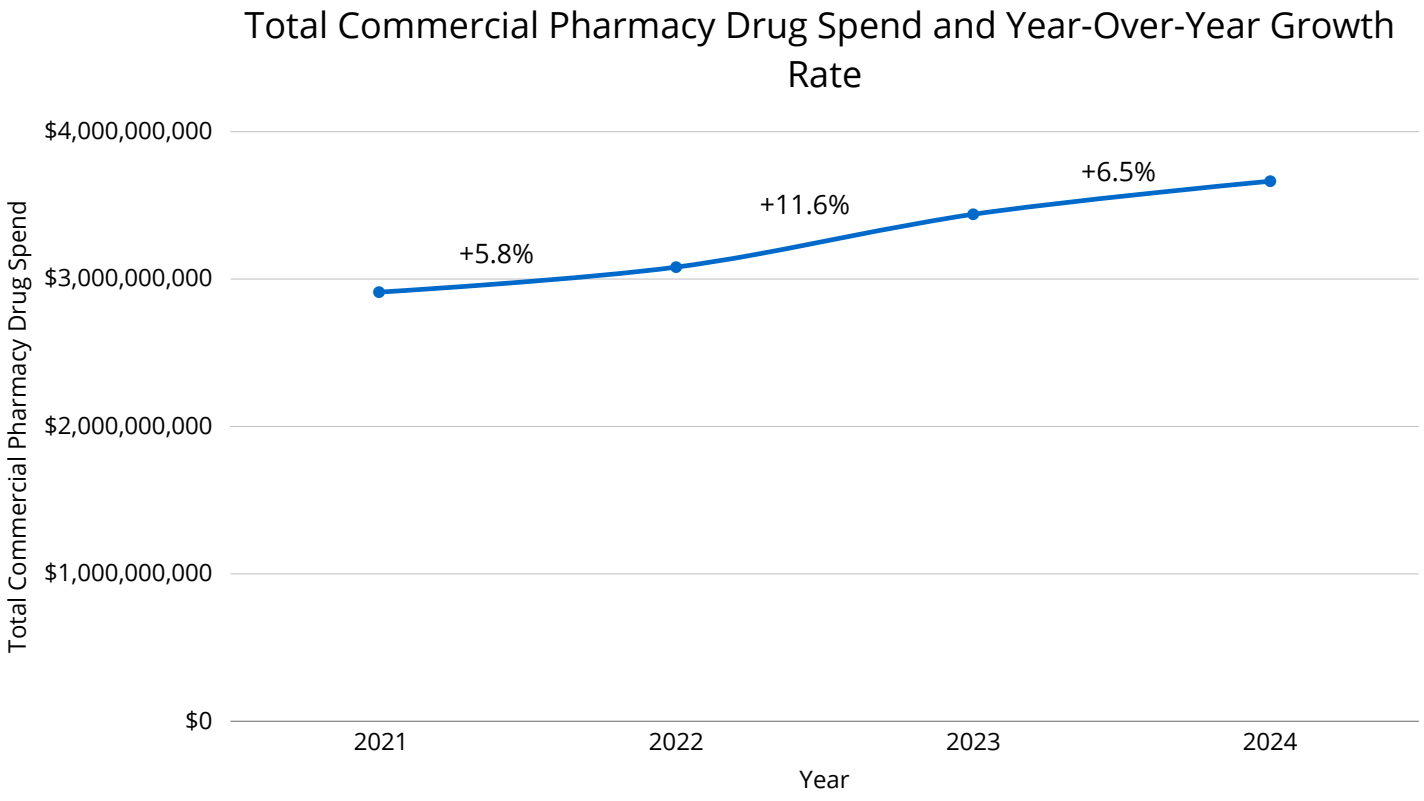
Responding organizations spent a combined $7,949,358,247 on pharmacy benefits in 2024, representing approximately 26.6% of total commercial health care spending among organizations that reported both figures. In 2024, public sector purchasers spent $1,875 per capita on pharmacy benefits.

2024 Snapshot

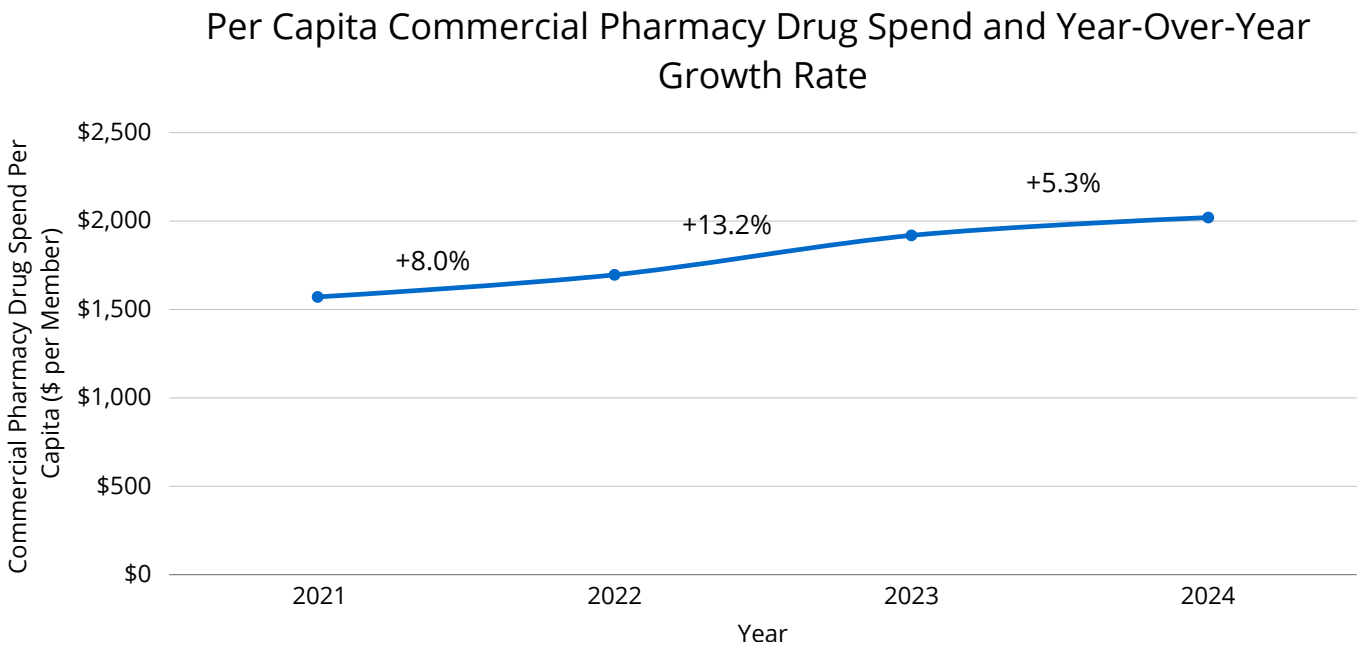
Public sector purchasers responding to the Specialty Drug Survey spent $7.9 billion on total commercial pharmacy benefits.

Year-Over-Year Growth in Commerical Prescription Drug Spending

Among the cohort, pharmacy benefit spending grew 6.5% from 2023 to 2024 — faster than the 5.1% growth in total health care spending from 2023 to 2024. As seen in other portions of the report, commercial pharmacy drug spending rose significantly from 2022 to 2023, double the growth of the prior year.

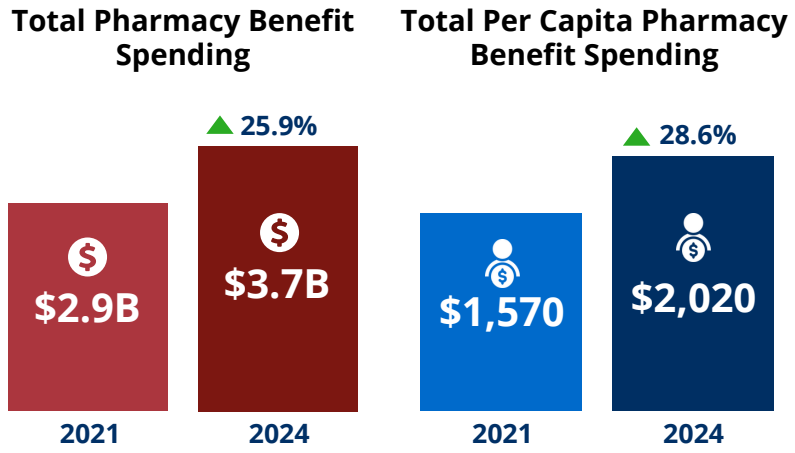


Per capita commercial prescription drug spending grew 8.0% from 2021 to 2022, accelerated sharply to 13.2% from 2022 to 2023, and moderated to 5.3% from 2023 to 2024.



Cumulative Growth in Commercial Prescription Drug Spending

Over the full three-year period, the cohort's pharmacy spending grew 25.9%, from $2.9 billion to $3.7 billion. Per capita pharmacy spending grew 28.6% over the three-year period, rising from $1,570 per member in 2021 to $2,020 in 2024.



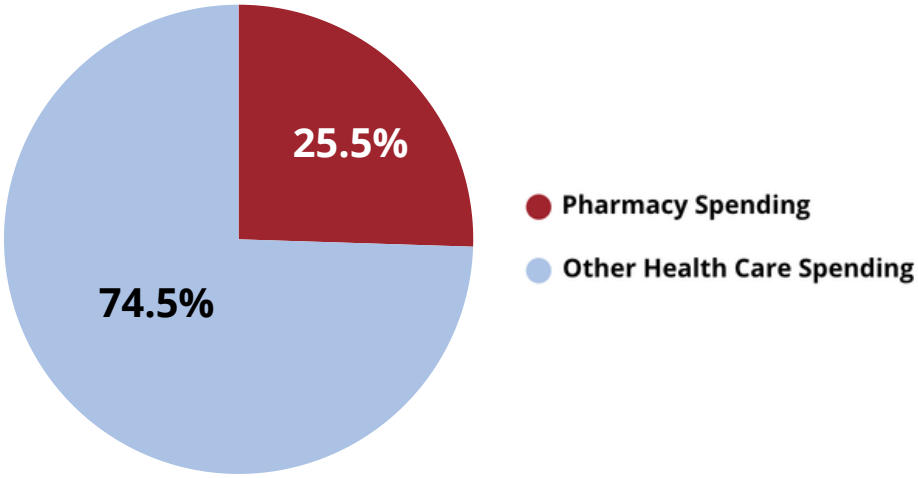
Key Finding

Public sector purchasers that responded to the survey experienced 25.9% growth in pharmacy spending overall and 28.6% growth in pharmacy spending per capita from 2021 to 2024.

Pharmacy Spend as a Share of Total Health Care Spending

Among the cohort, pharmacy benefit spending represents 25.5% of total commercial health care spending. Pharmacy spending grew 1.8 times faster than total health care spending from 2021 to 2024 (25.9% vs. 14.5%).

Total Commercial Health Care Spending in 2024



Key Finding

Public sector purchaser respondents are experiencing pharmacy benefit spending growth that is 1.8 times faster than total commercial health care spending.

Commercial Specialty Drug Spending

Snapshot on the 2024 Plan Year Commercial Specialty Drug Spending

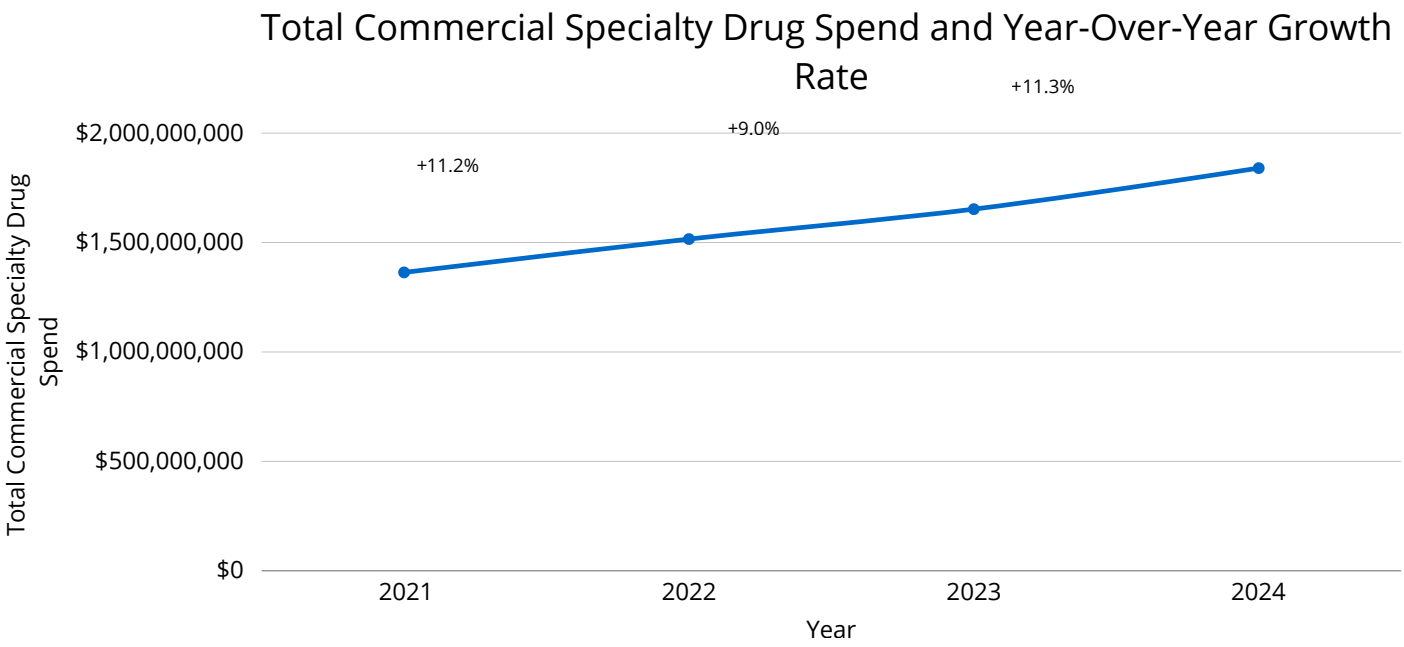
Of the $7.9 billion in total pharmacy benefit spending, $3,898,321,252 was attributable to specialty drugs in 2024. Respondents spent $920 per capita on commercial specialty drugs.

2024 Snapshot

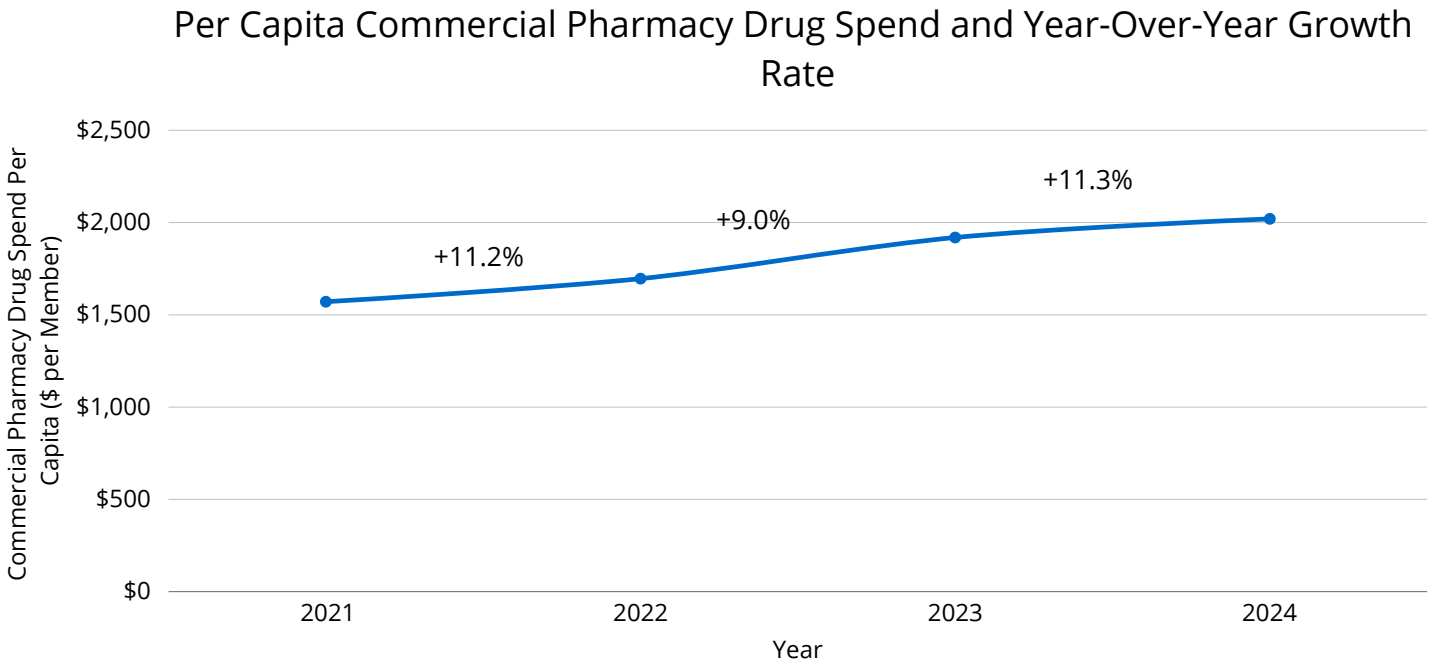
Public sector purchasers responding to the survey spent nearly $3.9 billion on specialty drugs in commercial plans.

Year-Over-Year Growth in Commercial Specialty Drug Spending

Commercial specialty drug spending grew 11.2% from 2021 to 2022, moderated slightly to 9.0% from 2022 to 2023, and reaccelerated to 11.3% from 2023 to 2024. Unlike total pharmacy spending, which saw a sharp spike in 2022 to 2023 before moderating, specialty drug spending has maintained consistently high growth across all three periods.

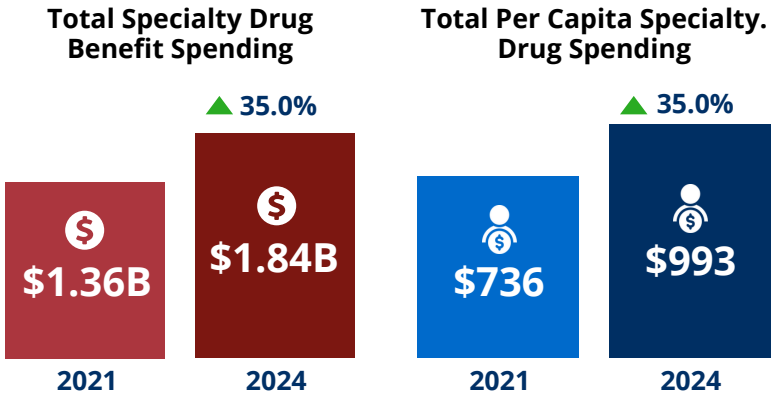


Total per capita specialty drug spending echoes the growth rate of the total specialty drug spending.



Cumulative Growth in Commercial Specialty Drug Spending

From 2021 to 2024, total specialty drug spending and per capita specialty drug spending among the cohort grew 35.0%.



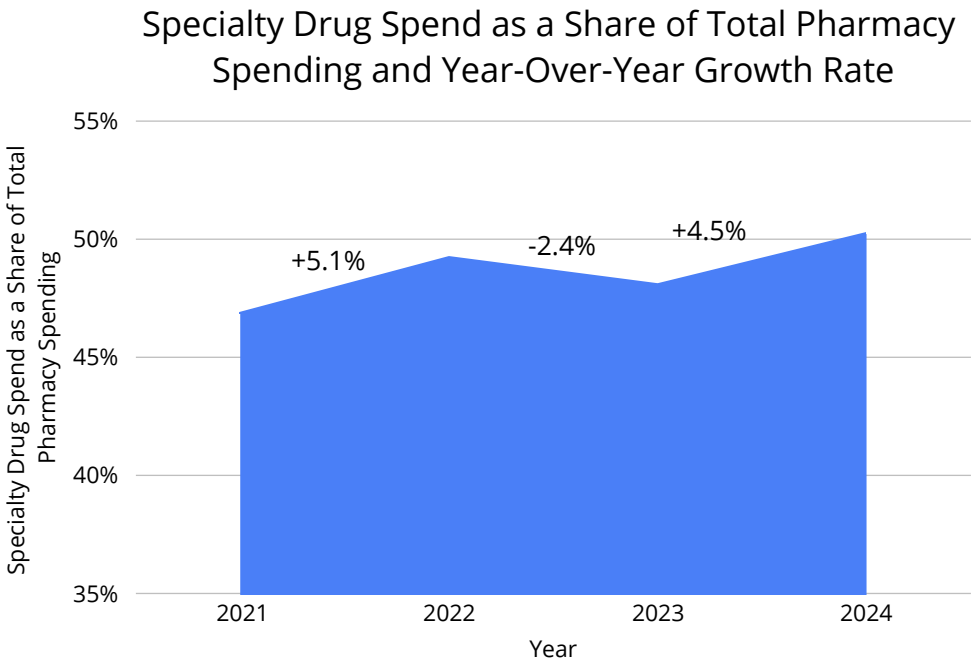
Specialty drug spending grew 2.4 times faster than total health care spending (35.0% vs. 14.5%) and outpaced total pharmacy spending growth by nearly 10 percentage points (35.0% vs. 25.9%) over the same period.

Key Finding

From 2021 to 2024, specialty drug spending grew 2.4 times faster than total health care spending growth.

Specialty Drug Spending as a Share of Total Commercial Pharmacy Spending

Among the cohort, specialty drugs now account for 50.2% of all pharmacy benefit spending, rising 7.2% since 2021. Despite representing a small fraction of total prescription claims volume, spending on specialty drugs accounts for more than half of every pharmacy dollar spent.



Notable Trends and High-Cost Therapeutic Categories

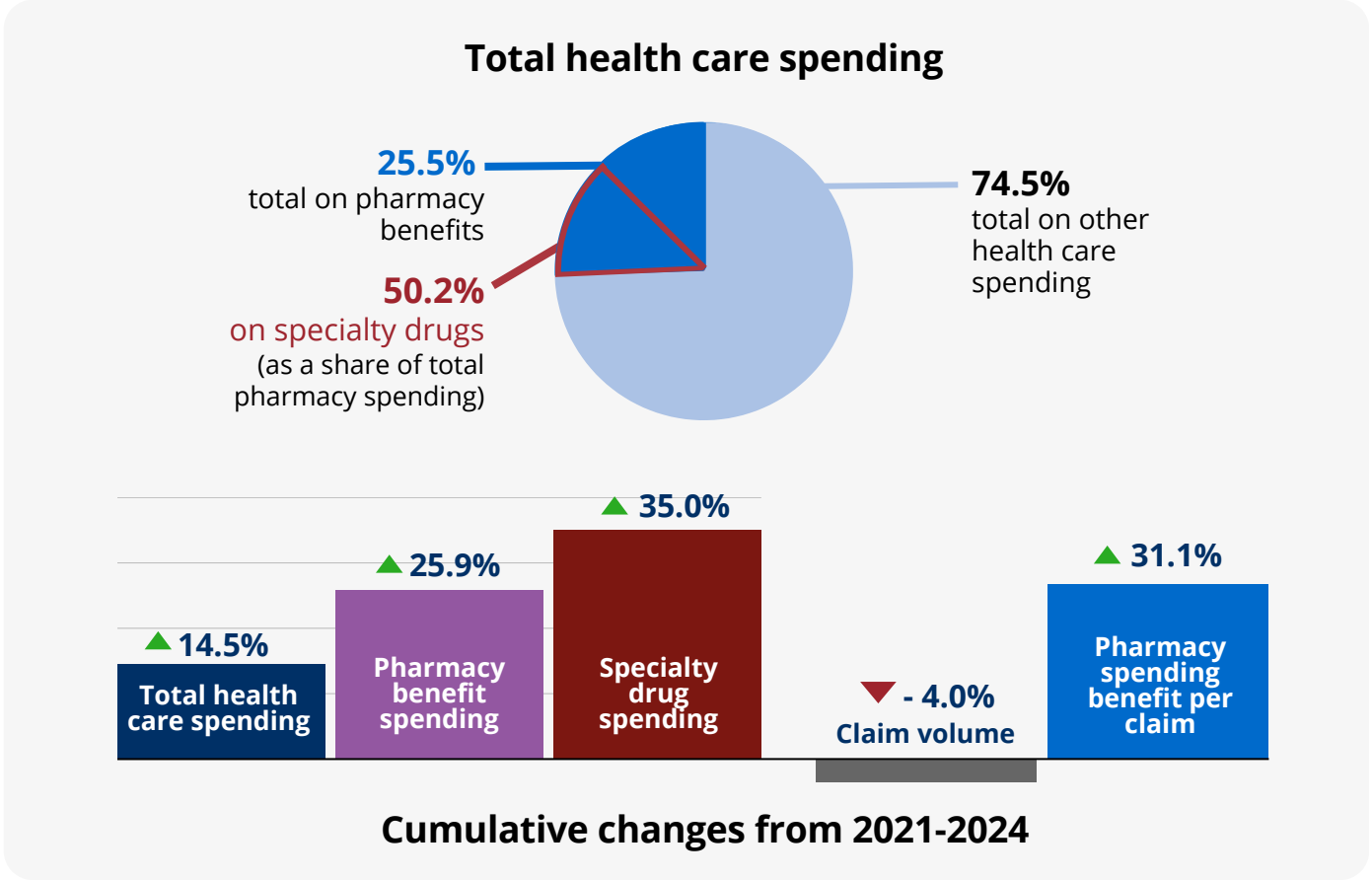
Specialty drug spending growth is being driven by a combination of price inflation for existing therapies, expanded indications for established specialty drugs, and the ongoing introduction of new high-cost therapies for complex and rare conditions. One of the most publicized drivers of specialty drug cost growth are glucagon-like peptide-1 receptor agonists (GLP-1s), which is highlighted later in the report as a case study. The pipeline of specialty drugs in development, including cell and gene therapies and new biologics for autoimmune and oncologic conditions, suggests that this cost pressure will intensify in the years ahead.

Key Finding

Specialty drugs account for more than half of all pharmacy benefit spending, driven by a small number of very high-cost medications

Key Commercial Plan Results: Rising Prices Is Driving Cost Growth

The most consequential finding in this year's data is the relationship between claims volume and spending. From 2021 to 2024 among the cohort:



The most consequential finding in this year's data is the relationship between claims volume and spending. Total health care spending increased significantly over the four-year period but pharmacy benefit spending grew almost twice as fast and specialty drug spending grew even faster. At the same time, the number of pharmacy claims filed declined. As such, plans are covering fewer prescriptions, paying more for each one, and directing an ever-larger share of every pharmacy dollar toward a small number of high-cost specialty medications. The data indicate that rising drug prices and increased utilization of high-cost specialty therapies — not growth in prescription volume or plan membership — are driving the cost crisis facing public sector health plans.

Key Finding

The growth in public sector purchasers' spending on specialty medications is primarily driven by higher medication prices and increased utilization of high-cost specialty medications.

Medicare Plans — Membership

Medicare Plan Membership

Of the public sector purchasers responding to the specialty drug survey, 91% offer Medicare plans covering 1,450,723 million beneficiaries across all 17 states. 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.

2024 Snapshot

Public sector purchasers responding to the specialty drug survey provided Medicare plans to over 1.45 million beneficiaries in

Additional Medicare Plan Information

Unfortunately, the 2025 report is unable to include more detailed data on Medicare plans due to insufficient response rates among survey participants. This is a recognized gap, and improving Medicare data collection will be a priority heading into future survey cycles. More comprehensive Medicare reporting is anticipated in upcoming editions of the report.

Responding to Rising Specialty Drug Costs

The cost trends captured in this report are not simply data points — they represent real and immediate budget pressures. This section presents survey findings on how respondents are managing rising specialty drug costs through two primary levers: utilization management and benefit design.

Both levers have limits. Utilization management strategies can promote appropriate and cost-effective prescribing, but they 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 respond to market-wide challenges.

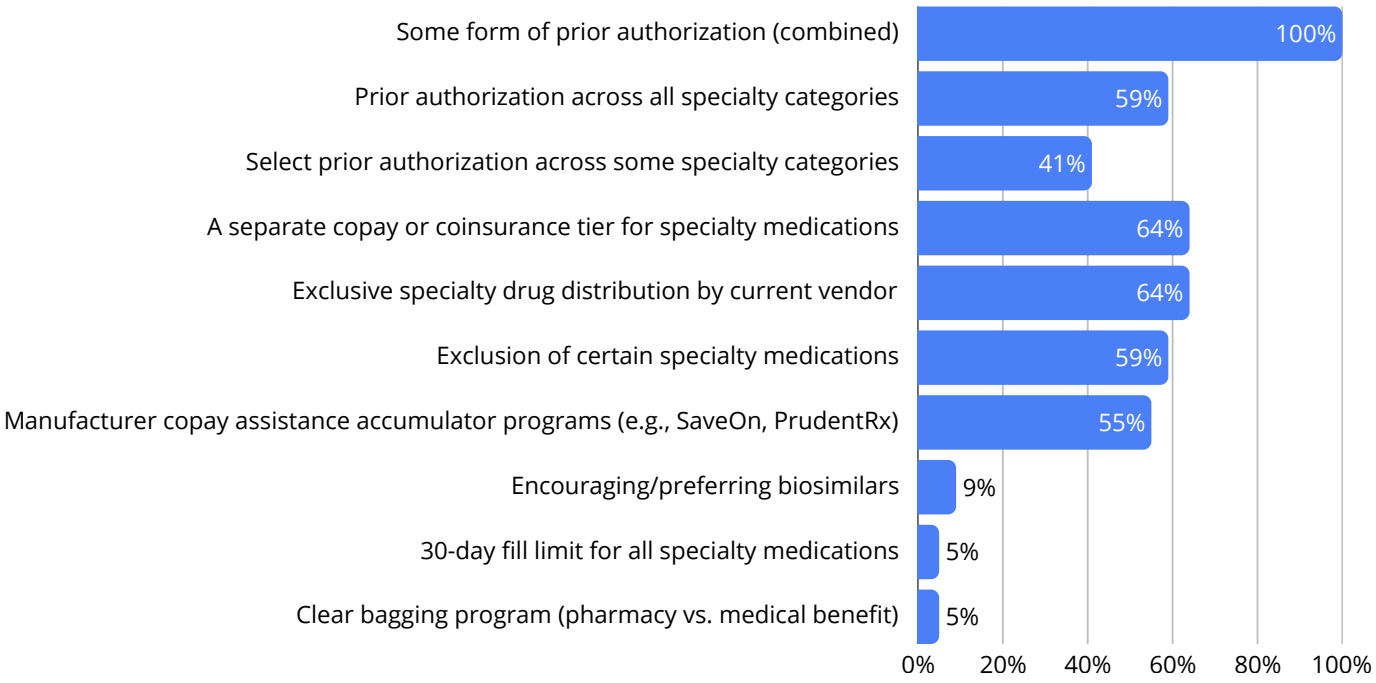
2024 Snapshot

Public sector purchasers responding to the specialty drug survey provided Medicare plans to over 1.45 million beneficiaries in

Commercial Utilization Management Strategies

Every one of the 23 responding organizations reported they deployed at least one targeted strategy to manage specialty drug costs in 2024. Prior authorization is universal, with 100% of respondents applying some form of prior authorization across specialty drug categories in their commercial plans. Nearly two-thirds of respondents use a separate copay or coinsurance tier for specialty medications (64%) or require exclusive distribution of specialty drugs through a designated vendor (64%). Additionally, a majority of respondents excluded certain specialty medications or classes from coverage altogether (59%), and more than half implemented manufacturer copay assistance accumulator programs (55%).

Commercial Specialty Drug Utilization Management Strategies



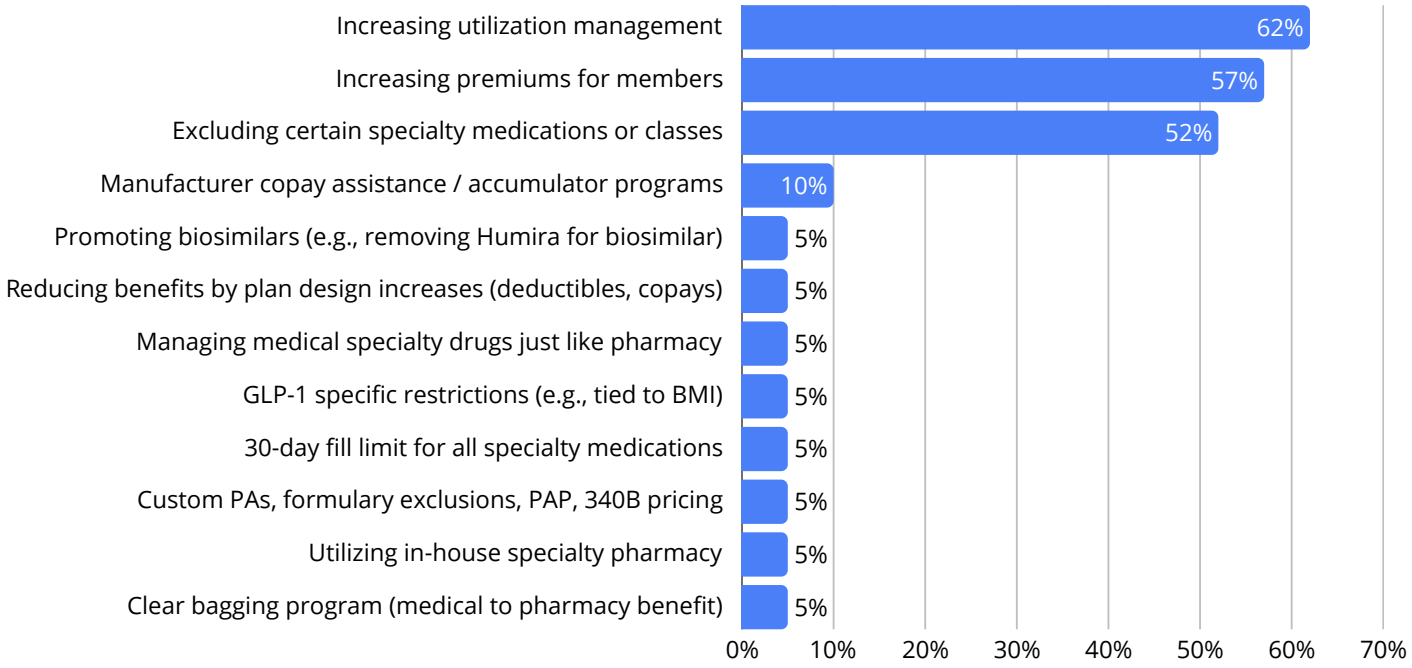
The universal adoption of prior authorization and widespread use of tiering, exclusions, and accumulator programs reflect a community that is actively deploying every available tool to manage costs while preserving employee, retiree, and their dependents' access to necessary medications. This variation highlights that public sector purchasers are deliberately calibrating their utilization management strategies to meet the unique needs of their beneficiaries.

Key Finding

In plan year 2024, all responding public sector purchasers used at least one targeted strategy to manage specialty drug costs.

Over the past five years, nearly all public sector purchaser respondents modified their plan benefit design in the last five years in response to rising specialty drug costs. The reported changes generally fall into three categories: limiting benefits (e.g., excluding certain specialty medications or classes), managing 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.

Plan Benefit Design Modifications within the Last Five Years Due to Rising Specialty Drug Costs



The sharp drop-off in adoption after the top three strategies reveals where plans are focusing their cost-containment efforts: utilization management (62%), increased member premiums (57%), and exclusion of certain specialty medications or drug classes (52%). While plans have a broad array of cost-containment tools available, most are concentrating their efforts on a relatively narrow set of strategies. This suggests that these approaches may be most effective, accessible, and/or politically feasible cost-containment options.

Key Finding

Every responding public sector purchaser modified their health plan benefit design between 2019 and 2024 in order to address rising specialty drug costs.

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 (T2D), 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 remains inconclusive. Meanwhile, per-member treatment costs are high, the eligible population is potentially vast, and budget constraints limit public sector purchasers' ability to offer coverage.

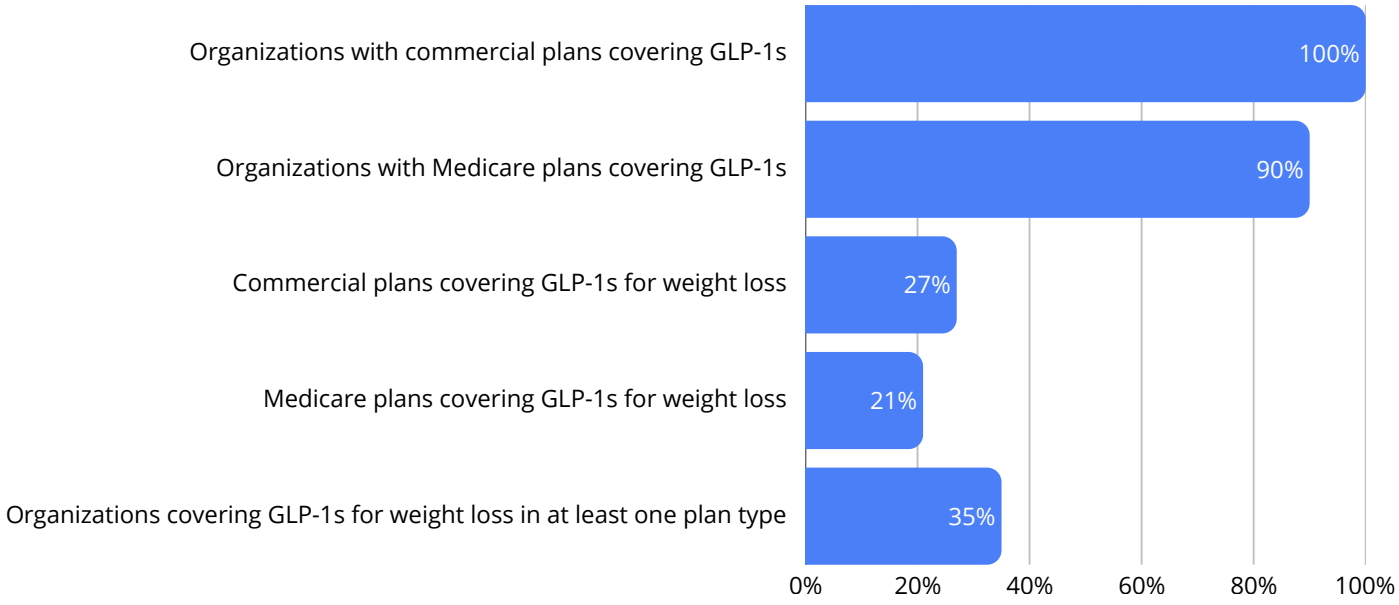
Prevalence of GLP-1 Coverage Among Respondents

Coverage of GLP-1 medications is essentially universal among survey respondents. All organizations offering commercial health plans covered GLP-1 medications, and a vast majority of organizations with Medicare plans covered GLP-1s in 2024.

GLP-1 Covered Indications and Utilization Management

While GLP-1 coverage is near-universal, the scope of that coverage varies significantly by indication. Almost every organization covered GLP-1s for a documented Type 2 diabetes diagnosis. On the other hand, only 27% of respondents covered GLP-1s for weight loss under their commercial plans, and 21% did so under their Medicare plans. Among those that covered GLP-1s for weight management, coverage was typically conditioned using prior authorization to confirm documentation of eligibility based on body mass index (BMI) thresholds, specific comorbidities, prior weight loss attempts, and/or enrollment in healthy lifestyle programs.

Prevalence and Type of GLP-1 Coverage



Key Finding

In 2024, all responding public sector purchasers covered GLP-1s for Type 2 Diabetes management, though coverage for weight management indications were limited.

Anticipated GLP-1 Cost, Coverage, and Policy Changes

GLP-1 medications are already a significant contributor to specialty drug spending among respondents. The 35.0% cumulative growth in specialty drug spending reflects, in part, the expanding utilization of GLP-1s alongside continued price inflation for specialty therapies. In the coming years, demand for GLP-1 medications is expected to continue growing as oral formulations become more widely available and the Food and Drug Administration approves additional treatment indications. In fact, some public sector purchasers are already responding to state and local regulations governing covered indications. The expected growth trajectory of GLP-1s will heighten public sector purchasers' discussions on the value and tradeoffs of covering these high-profile medications.

At the same time, the cost implications of covering GLP-1 medications remain a significant constraint for public sector purchasers. Plan sponsors reported that they are concerned coverage expectations will continue to outpace the policy and market mechanisms that would make these medications affordable.

Key Finding

Public sector purchasers are navigating a rapidly shifting clinical and policy landscape with limited tools to manage the rising costs of GLP-1 medication coverage.

Policy Recommendations

The data in this report point toward a clear and urgent set of policy priorities. The fundamental finding — that pharmacy claims are falling while pharmacy costs are rising sharply — makes clear that the problem is drug pricing, specifically specialty drugs.

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.

1. Extend Medicare drug price negotiation to the employer market

The Inflation Reduction Act created a mechanism for Medicare to negotiate prices for high-cost drugs, but those negotiated prices do not automatically extend to Medicare Advantage (MA) employer group waiver plans (EGWPs). Legislation that makes negotiated prices available to EGWPs, which include public sector purchasers, would directly reduce the cost of the highest-spend drugs for the 1.45 million Medicare plan members represented in this survey and many millions more nationwide.

2. Accelerate generic and biosimilar market entry and uptake

Generic drugs and biosimilars represent the most effective mechanisms 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 to improve the accessibility of generic drugs and biosimilars,[2,3] 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.

3. 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 importance of getting the right drug to the right patient at the right time to improve patient outcomes and manage plan spending. The Roundtable encourages Congress to pass the Right Drug Dose Now Act of 2025 to improve public sector purchasers' access to pharmacogenomics and precision medicine.[4]

[2] Biosimilar Red Tape Elimination Act. S.1954, 119th Cong. (2025). congress.gov/bill/119th-congress/senate-bill/1954
[3] Biosimilar Red Tape Elimination Act. H.R.5526. 119th Cong. (2025). congress.gov/bill/119th-congress/house-bill/5526
[4] Right Drug Dose Now Act of 2025. H.R.2471. 119th Cong. (2025) congress.gov/bill/119th-congress/house-bill/2471

4. 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.

5. 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[5] to strengthen patent review processes, close existing loopholes, and unleash innovation.

6. Strengthen the health care workforce supporting prescription drug management and patient care

Effective prescription drug management depends on a robust and well-supported health care workforce, including pharmacists, physicians, nurses, and other clinical professionals responsible for prescribing, dispensing, and monitoring medications. Federal policymakers should support policies that expand workforce capacity and training in medication management, pharmacogenomics, and precision medicine, particularly as complex specialty therapies and gene-based treatments become more common. Strengthening the clinical workforce will improve patient safety, promote appropriate medication use, and help public sector purchasers manage the growing complexity and cost of prescription drug therapies.

7. 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.

[5] Medication Affordability and Patent Integrity Act. S.2658. 119th Cong. (2025). congress.gov/bill/119th-congress/senate-bill/2658

8. 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, pharmacy benefit managers, 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 the Centers for Medicare and Medicaid Services 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.

9. Require CMS to separately analyze individual and group Medicare Advantage data

Individual MA plans and EGWPs serve fundamentally different populations, operate under distinct contractual and benefit design structures, and respond differently to payment and policy changes. Analyzing and reporting these populations together obscures the distinct experience of public sector retirees and allows EGWP data to improperly influence individual MA market analysis. Disaggregating these populations would improve the accuracy of MA market assessments, enable more targeted policy design, and give public sector plan sponsors and policymakers the information they need to evaluate how MA policies affect public sector employees, retirees, and their dependents.

10. 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.

11. Reform pharmacy benefit manager standards

While pharmacy benefit managers (PBMs) play a central role in how public sector plans manage drug spending, reforms are necessary to improve transparency across the prescription drug supply chain, realign incentives toward clinical value and total cost of care, and ensure that savings flow to public sector plans and their members. PBM reforms should include fiduciary standards, robust audit authority, and protections for pharmacy access with particular attention to Medicare Part D and MA plans serving public sector retirees through EGWPs, where PBM practices have an outsized impact on retiree out-of-pocket costs and plan sponsor budgets. As such, Congress should pass into law the PBM Price Transparency and Accountability Act.[6]

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

12. Support public sector purchasers' participation in CMS Innovation Center models

The Centers for Medicare and Medicaid Innovation (CMMI) 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 Better Approaches to Lifestyle and Nutrition for Comprehensive Health (BALANCE) Model and looks forward to further partnership opportunities.

Conclusion

The public sector purchasers represented in this report are among the most consequential health care buyers in the United States. Together, they cover more than 5.65 million teachers, firefighters, law enforcement officers, public workers, and their families. With $749 billion in other post-employment benefit liabilities on public sector balance sheets nationwide, the financial stakes of correctly approaching drug 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 make the challenge facing these purchasers impossible to ignore. Specialty drug spending among the survey cohort grew 35.0% from 2021 to 2024, more than twice the rate of total health care spending growth over the same period. Specialty drugs consume more than half of every pharmacy benefit dollar, despite representing a fraction of total prescription claims. 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. The growth in public sector purchasers' specialty drug spending is being driven by rising prices for existing medications and growing utilization of some of the highest-cost therapies.

Every public sector purchaser that responded to the survey deployed targeted strategies to manage specialty drug costs including utilization management strategies, benefit design changes, specialty pharmaceutical distribution arrangements, and manufacturer copay assistance accumulators. Within the structural and political constraints that define public sector benefits administration, these purchasers have demonstrated remarkable resourcefulness.

The cost-management tools available to public sector purchasers are necessary but not sufficient. They can slow the rate at which cost growth translates into premium increases, benefit reductions, or higher taxes, but they cannot reverse the underlying trend. The gap between what plan-level management can accomplish and what the market demands of plan sponsors widens with every newly approved specialty drug. Therefore, state and federal policymakers must 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 2025 Specialty Drug Survey collected responses from 23 public sector plan sponsors across 17 states. 22 respondents offer commercial health plans and 21 respondents offer Medicare plans. Results reflect self-reported data for the 2024 plan year, with historical data provided for prior years where available.

Survey data is 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

23 organizations responded to the 2025 survey, representing 17 states. Twenty-two of the 23 organizations offer a commercial health plan. Responding organizations include:

- Alabama Local Government Health Insurance Board
- Alabama Public Education Employees Health Insurance Plan
- Alaska Division of Retirement and Benefits
- Arizona State Retirement System
- Colorado Public Employees Retirement Association
- Delaware State Employee Benefits Committee
- Employees Retirement System of Texas
- Georgia State Health Benefit Plan
- Kansas State Employee Health Plan
- Michigan Public School Employees Retirement System
- New Hampshire HealthTrust
- North Carolina State Health Plan
- School Employees Retirement System of Ohio
- Carolina Public Employee Benefit Authority
- State Teachers Retirement System of Ohio
- Teacher Retirement System of Texas
- Teachers Retirement System of the State of Kentucky
- Texas A&M University System
- The Texas Association of Counties Health & 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: Alabama, Alaska, Arizona, Colorado, Delaware, Georgia, Kansas, Kentucky, Michigan, New Hampshire, North Carolina, Ohio, South Carolina, Texas, Washington, West Virginia, and Wisconsin.

Snapshot Tools

Aggregate dollar figures labeled as "2024 Snapshot" represent the sum across all responding organizations for the 2024 plan year. These totals should not be directly compared with the cohort-based growth rate figures, which are limited to the subset of organizations with complete longitudinal data.

Growth Rate Methodology

Year-over-year and cumulative growth rates throughout this report are calculated using a consistent cohort of organizations that reported reviewed, verified data for all years from 2021 through 2024. Due to variability in year-over-year survey responses, the cohort consists of a subset of all survey respondents. This cohort-based approach ensures that reported growth rates reflect actual changes in spending rather than fluctuations caused by changes in the composition of survey respondents across years.

The cohort of respondents tend to be larger and longer-tenured survey participants. Their experience may not reflect the trends at smaller or newer responding organizations. The cohort-based approach was chosen to ensure analytical rigor, but readers should be aware that the growth rates apply specifically to these plans.

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, pharmacy benefits manager classifications, or cost thresholds (e.g. Medicare defines specialty drugs as medications costing $670 or more per month). 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.

Causal Conclusions Not Supported

The survey captures spending and utilization trends but does not isolate the drivers of those trends. The observed divergence between declining claim volume and rising costs is consistent with the interpretation that price increases, rather than utilization growth, are the primary driver of spending growth. However, 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.