The Pharmacy Lever

What you can and cannot do about pharmacy costs right now, and what changes when your funding structure does

Table of Contents

Pharmacy Is Now Your Fastest-Growing Cost Line. It Is Also the One You Can See Least Clearly

Pharmacy spend has crossed 24% of total healthcare costs[1] and is rising 10% to 12% annually, faster than medical costs, which are themselves rising 7% to 9%.[2] Specialty medications alone now account for more than half of everything your plan spends on drugs.

And yet a fully insured arrangement gives you less visibility into pharmacy than into almost any other cost in your business. The carrier holds the detail: what your plan spends by drug, by employee and by condition; what rebates the drugs your employees use generate and who keeps them; what it pays its pharmacy benefit manager and the difference between what the pharmacy benefits manager (PBM) pays for drugs; and what passes through to your plan. You pay all of it, but you do not benefit from transparency in pricing or rebates. You see none of the savings.

This guide maps exactly what you can act on right now, what the carrier controls that you do not and what opens up when your funding structure changes. The picture is not complicated. The problem is structural.

[1] Business Group on Health, "2026 Employer Health Care Strategy Survey: Executive Summary," August 19, 2025.

[2] HUB International, "2026 Benefits Cost Trends Report," August 12, 2025.

Lane 1: What You Can Act on Now

In a fully insured arrangement, the carrier controls the formulary and what is covered. What is available to you is a set of pre-built plan choices the carrier has already designed and filed. These are not custom levers. They are choices from a menu. Here is what is on it.

Plan design structure

You can adjust member cost-sharing within the carrier's approved plan options, including deductible levels, co-pay tiers and coinsurance structure. Changing these can shift a portion of cost from the plan to employees, and can influence utilization behavior at the margin, such as steering members toward generics over branded drugs.

The realistic limit: cost shifts to employees do not reduce total pharmacy spend. They redistribute it. The underlying drug pricing, rebate flow and PBM contract terms remain entirely with the carrier regardless of how you structure member cost-sharing.

Formulary adjustments

You can request different formulary positioning, subject to carrier approval. Options typically include movement between broad and narrow formulary tiers, closed formulary options, mandatory generics and mandatory mail order. Where the carrier offers them, more aggressive prior authorization, step therapy and clinical management programs may also be available.

The realistic limit: Since the carrier controls the formulary, your choices are limited to exception options within what the carrier has already designed and filed. You can influence which drugs your employees use. You cannot influence how those drugs are contracted or priced.

Anti-obesity medication exclusion

Some carriers offer employers the option to exclude anti-obesity medications as a benefit category, typically structured as a rider or plan design option rather than a drug-level exclusion. Availability varies by carrier and state. State mandate laws in some jurisdictions require coverage regardless of how you want to structure the benefit.

For an employer where anti-obesity medication utilization is present and the carrier offers this option, the exclusion can reduce pharmacy spend. The exclusion applies to medications prescribed specifically for weight management, not to GLP-1 drugs prescribed for type 2 diabetes, which remain covered.

The practical limit on this lever is true of every fully insured lever — your own pharmacy claims data stays with the carrier. Whether anti-obesity medication utilization is even present in your group, how material it is and whether excluding it would change your costs at all are questions you cannot answer from where you sit. Every plan design decision you make, you make without the information that would tell you whether it is the right one.

Lane 2: What the Carrier Controls That You Do Not

A fully insured arrangement trades visibility and control for pricing stability. That is the deal every carrier offers, and for years it was the rational choice. The carrier takes on the financial risk of your plan. In exchange, the carrier keeps the spread on prescription drug pricing, keeps the rebates and controls the formulary.

Two specific revenue streams are worth understanding.

Drug rebates

In a fully insured arrangement, the carrier retains the rebates that pharmaceutical manufacturers pay to have their drugs preferred on the formulary. The same applies to rebates on drugs flowing through the medical plan as administered medications, such as specialty biologics given in a clinical setting. You have no visibility into either revenue stream. You pay for the drugs. The rebate goes to the carrier.

This creates a structural conflict of interest. The carrier has a financial incentive to design the formulary to maximize rebate revenue, not to minimize your drug spend. A higher-rebate drug may cost your plan more in net terms than a lower-rebate alternative, but the carrier captures the difference. You absorb the cost without seeing the calculation behind it.

PBM contract spread

The carrier holds the contract with the pharmacy benefit manager, not you. The spread between what the carrier negotiates with the PBM and what flows through to your claims is not disclosed to you. This is distinct from rebates; spread is the difference between the ingredient cost the carrier negotiates and the rate passed through to your plan. Both revenue streams, rebates and spread, are embedded in the carrier's economics. Both are reflected in your premium over time.

Can your broker negotiate on either of these at renewal? Yes, and the issue should be raised. But the negotiation is constrained by the same non-transparency. You are negotiating about revenue streams you cannot see, on a contract you are not party to, with an entity whose room to move is limited by the same information asymmetry.

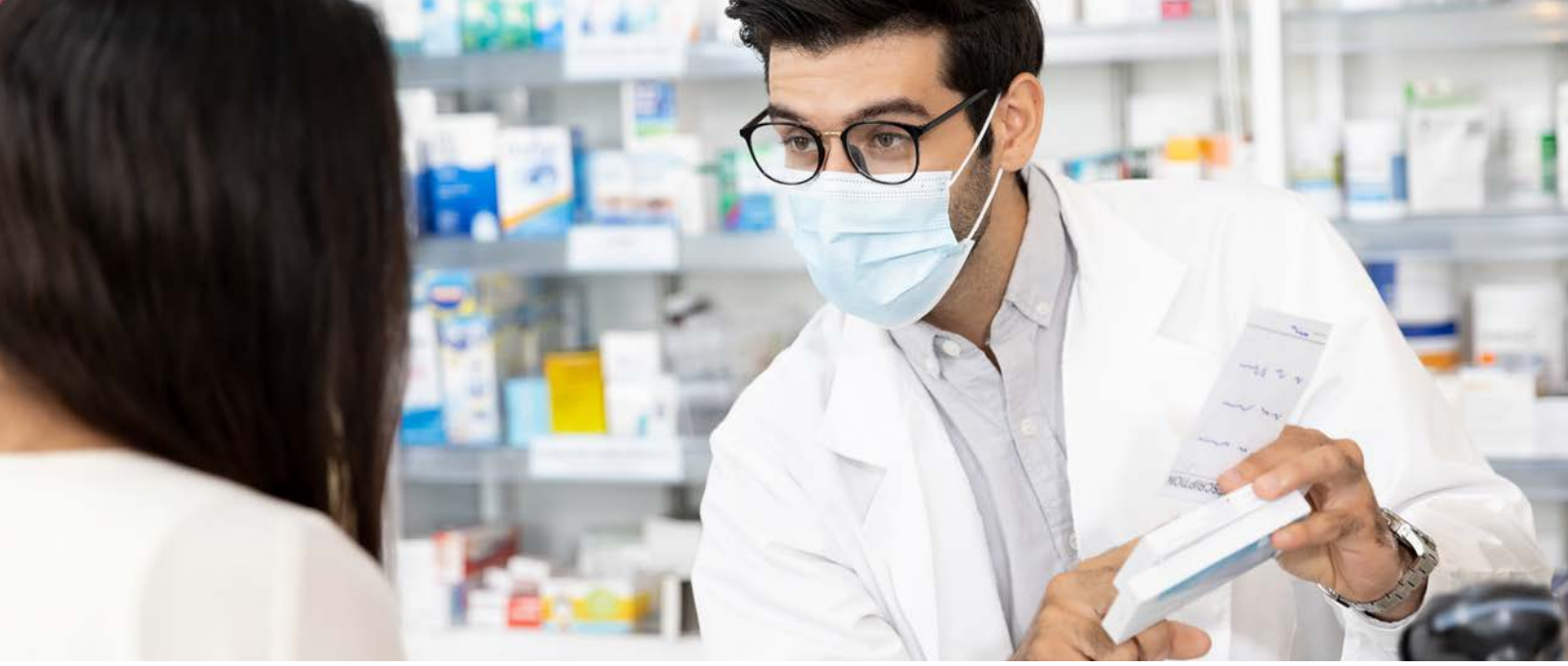
Forty-one percent of employers are changing PBMs or conducting pharmacy benefit RFPs in 2026.[3] However, this option is primarily available to those outside a fully insured plan and in many cases becomes the catalyst for middle market employers to evaluate their current funding arrangement.

Lane 3: What Changes When Your Funding Structure Does

If you have looked at self-funding before, you may have reasons it did not fit. Maybe the timing was wrong, the group felt too small or an earlier attempt was structured in a way that carried more risk than you wanted. Those experiences are real, and they reflect the moment and the structure you evaluated. What follows is not a claim that self-funding is right for every employer. It is a description of what the employer changes and what a Funding Strategy Assessment is built to test against your own group rather than assert in the abstract.

When your funding structure changes, so does what you own.

[3] Business Group on Health, "2026 Employer Health Care Strategy Survey: Executive Summary," August 19, 2025.



The PBM contract becomes yours to negotiate and rebates flow to your plan. You can see your claims, see your pharmacy utilization and make decisions based on your population rather than the carrier's pooled assumptions. The levers in Lane 1 are replaced by strategies designed around your data.

Here is what that means specifically.

PBM contract control

In a self-funded arrangement, you can negotiate or bid the PBM contract directly. This includes transparent pricing rather than traditional PBM pricing, maximum rebate guarantees that are not dependent on overutilization of high-cost branded drugs, clearly defined contract terms and the ability to run active market checks. PBM contract renegotiation by expert consultants can improve ingredient cost savings 5% to 15% without any member-facing plan changes. Results depend on group-specific claims experience, industry, geography and plan design.

Ownership also changes what your advisor can catch on your behalf. In one example, a HUB pharmacy consultant reviewing a self-funded client's PBM contract identified two overlapping guarantee stipulations under which missing one guarantee would offset the other. HUB and the client adjusted the contract terms so that both had to be covered independently. When one of the guarantees was subsequently missed, the client received a $750,000 financial guarantee payout. That outcome is contract vigilance rather than a reduction in pharmacy spend, but it is only available to an employer that holds the contract.

Rebate transparency

Rebates flow directly to your self-funded plan rather than to the carrier. For drugs flowing through the medical plan, the same applies. You can see what rebates are being generated and hold the PBM accountable to performance guarantees on rebate targets.

Specialty drug management

In a self-funded arrangement, targeted drug exclusions, preferred specialty pharmacy networks, site-of-care programs and aggressive prior authorization structures can be custom-designed for your specific population and claims experience. These are not pre-built carrier choices. They are strategies built around your data.

GLP-1 cost management with data

Consider what data access changes for a decision like GLP-1 coverage. An employer with access to their own pharmacy data can review GLP-1 utilization by indication, assess whether prior authorization processes are functioning as intended, estimate rebate offsets and explore formulary options based on their actual population. Without data, every GLP-1 drug decision is made blind.

GLP-1 medications for obesity carry an annual gross cost of $16,000 to $17,000 per covered employee. At that cost per member, knowing whether the utilization is present and appropriate in your group becomes a critical reason to own your own data.

What ownership asks in return

Ownership cuts both ways. When you self-fund, you take on the month-to-month variability of claims, which means a high-cost year lands on you rather than on the carrier. Stop-loss insurance exists to cap that exposure, and how it is structured determines how much risk you carry. There is also more to administer and more financial responsibility to hold. None of this makes self-funding wrong. It makes it a decision to size rather than assume and sizing it is what the assessment does.

A funding change also adds to certain fiduciary responsibilities onto the plan sponsor. Self-funded plans operate differently from fully insured ones, and your obligations around plan administration and oversight increase with them. This is manageable and it is defensible when the structure is set up with those obligations in view. A structured assessment and broker support map those responsibilities before you take them on, which is the answer your board and counsel will want to see.

A note on smaller groups

One qualifier: The degree of PBM flexibility available in a self-funded arrangement depends on how that arrangement is structured. Smaller groups moving to self-funding may still follow some standardization if they use a carved-in PBM arrangement. Whether the full range of Lane 3 levers is available to your group at your size is exactly what a Funding Strategy Assessment is designed to tell you as the answer will be specific to your unique situation.

What This Means for Your Next Renewal Conversation

Pharmacy costs are rising whether you act or not. What determines whether you have any real options is not your vendor relationships or your plan design choices. It is what you own.

In a fully insured arrangement, what you own is a choice from a menu the carrier designed. The carrier owns the PBM contract, the rebates and the data. That is the trade every carrier offers in exchange for premium predictability and for years it was the rational one. Examining it now is not a reversal of that decision; it is the same financial discipline applied with information you can finally see, and with a structure your board and counsel can stand behind.

The question for your next renewal is whether that trade still makes sense for a company your size, with your pharmacy utilization patterns, in 2026 and 2027.

Request Your Funding Strategy Assessment

Pharmacy is the fastest-growing line in your health spend and the one where your current arrangement gives you the fewest options. The Funding Strategy Assessment shows you which alternatives are realistic for an employer your size, what your current cost structure actually contains, and what changes when the arrangement does. Thirty minutes. No materials required to get started.

Request your funding strategy assessment

Contact a HUB Advisor at hubinternational.com