

Express Scripts® Pharmacy Benefit Services

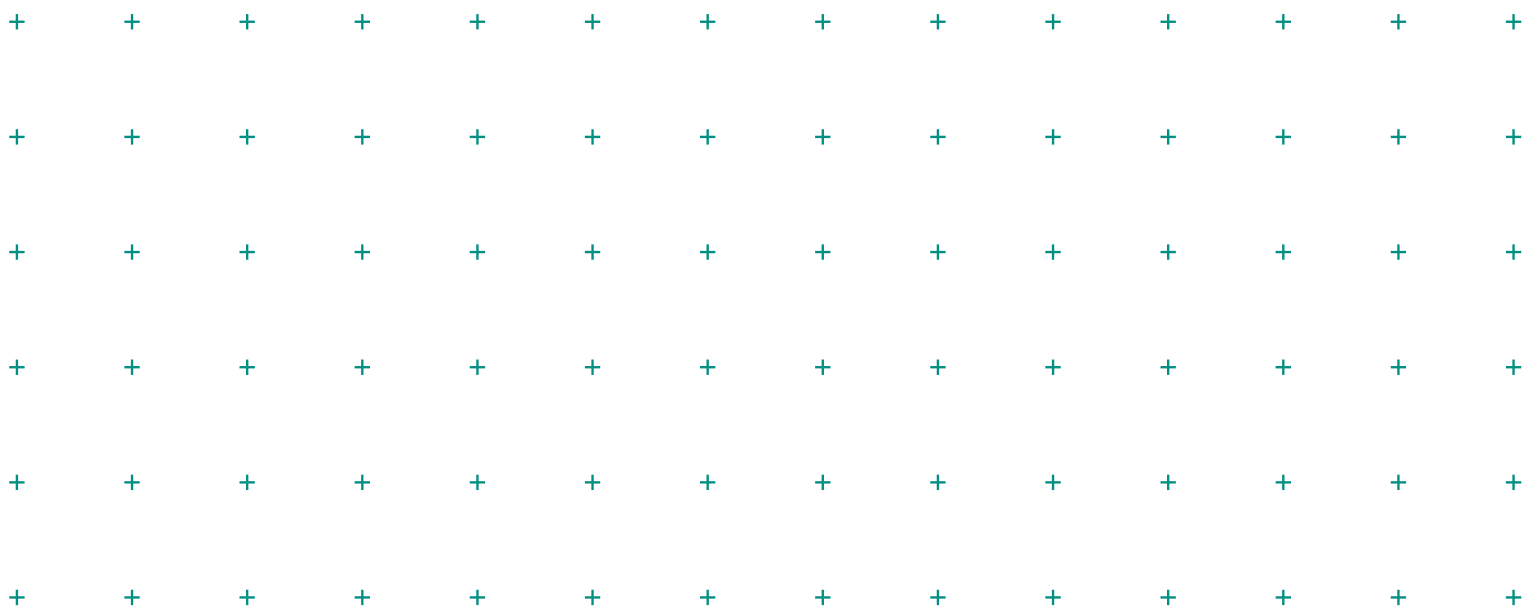
The future of pharmacy benefits

Key signals from buyers and members on where
pharmacy benefits are headed next



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What we heard

500

HR decision makers

88

Health plan leaders

101

Consultants

3,000

Americans

Every year, pharmacy benefits grow more complex—and more consequential. In our most recent Annual Buyer Insights research, we set out to understand how the people who help build pharmacy benefit strategy and the people who live with it, are experiencing that complexity right now.

Listen to both groups at once and the picture sharpens. We heard from 500 HR decision makers, 88 health plan leaders and 101 benefits consultants—the people who shape pharmacy benefit strategy every day. And we heard from 3,000 Americans who count on that strategy for their own health and their families’.

Three consistent themes rose to the top of the list—the needs top of mind for consumers and the priorities plan sponsors are most focused on.



The need for relief

Affordability isn’t just a talking point—it’s a daily reality. Costs keep climbing, and both plan sponsors and members feel the pressure to act.



The need for ease

Benefits keep multiplying and the people who use them need more help finding their way through.



The need for proof

Buyers want partners who show their work. Proof of demonstrated outcomes and transparency is simply the baseline in benefit strategy.



Why it matters

These themes are more than data points. They map where pharmacy benefits need to go next—and they hand plan sponsors, health plans and consultants a clear read on where to strengthen strategy, close gaps in care and improve the member experience. Read on to explore how these findings can be applied to your own pharmacy benefit strategy.

Relieving cost pressures

In pharmacy and beyond, affordability is the pressure point every stakeholder feels—just in different ways.

For the clients you support, that concern can lead to real trade-offs¹:

35% can't afford a medication their doctor prescribed, up from 32%

24% have used discounts or coupons to close the gap

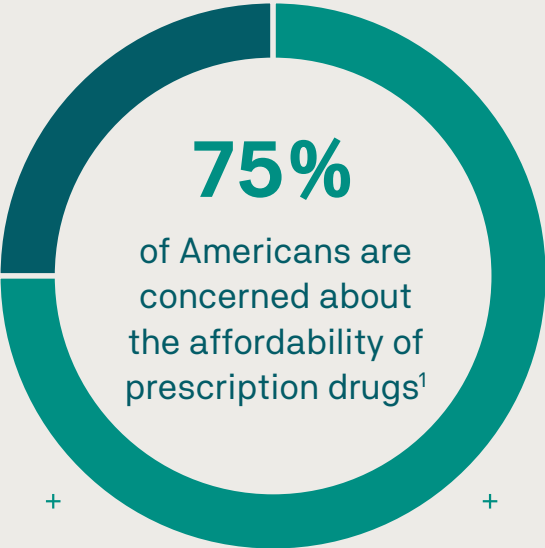
18% have researched a medication's cost to determine whether they could afford it, up from 16%

11% have rationed or skipped doses

10% have stopped filling a prescription altogether



Member concerns are at the top of your clients' list



Affordability trade-off ladder



CAUTION

These trade-offs add up

When cost pushes members to ration, skip or stop filling a prescription, adherence suffers—and poor adherence can lead to worse health outcomes, more complications and greater downstream costs.

Ensuring medical and drug affordability is employers' #1 future benefit-investment priority—ahead of every other area.² Health plan leaders feel it too, with 22% naming affordability a top future priority. Employers are pairing that focus with new approaches for managing high-cost conditions, and consultants are training their attention on two categories in particular: GLP-1 medications and the cost of rare disease and gene therapies.

Clients are leaning into wellness and prevention to bend the cost curve over time, paired with formulary management—guiding members toward clinically appropriate, lower-cost alternatives—to control cost without sacrificing access. Health plans, for their part, optimize networks and channel strategies and lean on utilization management to keep therapy and dosing appropriate.



Ensuring affordability is an employer's #1 future investment priority for members.

Wellness, prevention and formulary management are among the most direct levers for bending the cost curve without cutting access.²



GLP-1s: Not a one-size-fits-all approach

Few therapy categories illustrate the tension between affordability and access more clearly than GLP-1s.

Most recent Annual Buyer Insights research:

44%

of employers reported covering GLP-1s, while 45% said they were considering future coverage²

63%

of health plans and consultants report GLP-1s account for more than 15% of total pharmacy spend²

At the same time, things are changing rapidly in this category. Coverage has been decreasing as organizations face growing questions about long-term affordability, appropriate use and sustained outcomes.

As a result, many employers are taking a more deliberate approach to evaluating where, when and how GLP-1 coverage fits within their broader benefits strategy.

Members, for their part, are largely satisfied:

87% of GLP-1 users report satisfaction with the medication. But satisfaction doesn't end the conversation. They still worry about side effects (49%), long-term safety (42%) and cost (40%). About a third want more help with nutrition, lifestyle changes and managing side effects. And 9 in 10 say they'd take on at least one added step—regular monitoring, an exercise program, ongoing blood work—if it meant their GLP-1 stayed covered. That willingness is an opening, not an obstacle.¹

87%

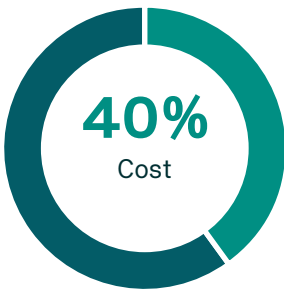
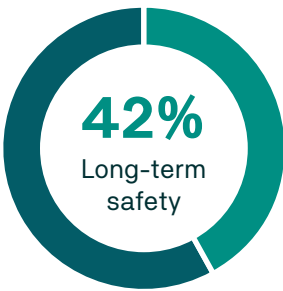
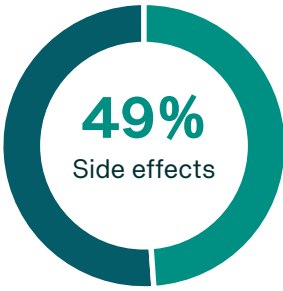
of GLP-1 users are satisfied¹

9 in 10

would take on an added step to keep coverage¹



GLP-1 member satisfaction vs. top concerns



There is no one-size-fits-all approach to GLP-1 coverage.

Instead, clients are seeking solutions that help them determine where coverage makes the most sense, establish appropriate clinical criteria and support members throughout their treatment journey. Striking that balance can help improve outcomes, manage costs and create greater confidence in long-term benefit strategy.



THE EVERNORTH CONNECTION

An intentional approach to GLP-1s

At Express Scripts Pharmacy Benefit Services, we serve as an expert partner, helping plans navigate GLP-1 coverage decisions and offering a range of solutions tailored to their unique goals and priorities.



Easing the health care experience

The navigation gap: perception vs. reality



Even well-designed benefits fall short if people can't find their way through them.

Nearly 9 in 10 clients believe their members know where to go for information and when to use the benefits available to them.²



Members tell a different story:

64% find it hard to know when to use which benefit or solution, 61% aren't confident they know everything available to them and half struggle just to navigate the online portals meant to make things simpler. Optimizing coverage at enrollment feels daunting to a majority and 52% feel overwhelmed by the sheer volume of plan information.¹

That gap matters because it quietly erodes value.

Organizations may be paying for benefits members aren't using—or aren't using well—simply because they can't find their way to them. And the timing compounds the problem: compared with last year, nearly 2/3 of Americans worry their coverage will be scaled back, including pharmacy and prescription drug benefits (63%, up from 60%).¹

Here's the twist. Many employers aren't cutting benefits at all—they're investing more. The disconnect isn't a lack of offering something. It's whether members know it exists, understand how to use it and feel confident doing so. That's a navigation problem, not an investment problem—and it calls for a navigation answer.



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Perception gap

~9 in 10

clients believe their members know where to go for information and when to use the benefits available to them.

vs.

MEMBER REALITY

Find it hard to know when to use which benefit or solution

64%

Aren't confident they know everything their employer offers

61%

Feel overwhelmed by the sheer volume of plan information

52%



WEEKLY COORDINATION TIME

Average hours
per week spent
coordinating vendors

13hrs

Employers²

19hrs

Health plans²

18hrs

Consultants²

When more vendors mean more complexity

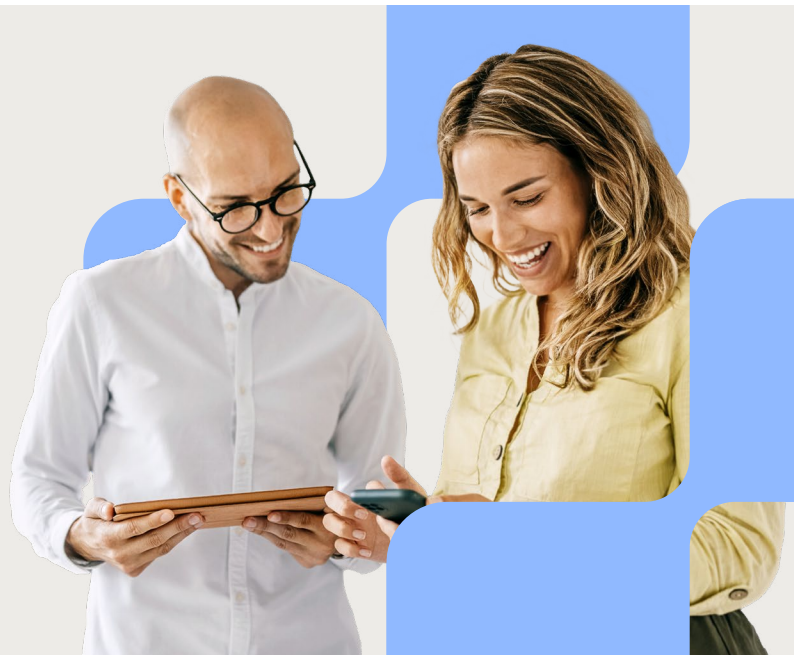
Complexity is mounting behind the scenes, too. Employers spend roughly 13 hours a week managing vendors—time that could go toward strategy instead of spreadsheets—and every new vendor arrives with its own ROI story to evaluate separately. Health plan leaders feel it even more acutely: nearly half (47%) now work with 10 or more vendors, with consultants close behind (38%).²

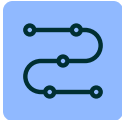
The growing number of vendors is increasing complexity and administrative burden for clients.



You're supporting clients who may be investing more in benefits than members realize.

Before adding something new, discuss what tools are available to help members find and use what's already there—often the faster path to value.





The path forward starts with a simple reframe

Before adding new benefits, ensure clients and members can find, understand and use the ones already in place. And when new solutions are worth adding, the right foundation makes them easy to connect—**so their existing ecosystem plugs in rather than getting boxed in.**



THE EVERNORTH CONNECTION

Simplifying the vendor landscape through digital innovation

Health Connect 360® and the Evernorth Digital Health Formulary® bring pharmacy, medical and clinical data together in one place—reducing vendor complexity and giving members a clearer, more connected path to care.

With the Digital Health Formulary’s breadth of vetted point-solution vendors and digital connections already integrated across plans and partners, your existing benefits ecosystem plugs in easily—so you get the clinical depth and flexible technical integrations to keep everything connected, not limited.



Proving value of investments

Buyers have always wanted evidence their solutions work. What's new is the skepticism—and the insistence on seeing what truly drives value.

From promises to proof

Clients have always wanted proof. What's changed is a sharper skepticism about what actually drives value—and a growing expectation that a partner will fulfill its commitments, not just pitch solutions. As investments grow and cost pressure holds, plan sponsors are looking for evidence that a pharmacy benefit is improving health, not just holding down a line item.

Increasingly, that evidence means clinical outcomes. Improving outcomes like medication adherence is a top future investment strategy for 13% of employers and 22% of health plan leaders. Identifying at-risk members for targeted intervention is a priority for 10% of employers and 15% of health plan leaders. And 28% of employers and 35% of health plan leaders are focused on utilization management to ensure appropriate therapy and dosing.²

The through-line: Clients want partners who help members get and stay well—on the right therapy, supported and out of the hospital—not just a partner who reports a number at year-end.

13% of employers and 22% of health plan leaders name improving clinical outcomes, like medication adherence, a top future investment.²

Data and reporting matter here—but as part of the proof, not the whole story. Clients already report high satisfaction with reporting; what they're really asking for is someone who turns that data into action and owns the results alongside them: clear visibility into how the benefit is performing and consultation on what to do next.



Our mutual clients increasingly want proof of clinical value, not just cost savings.

Stakeholders who pair reporting with consultation—and own outcomes with you—make that value easier to demonstrate.





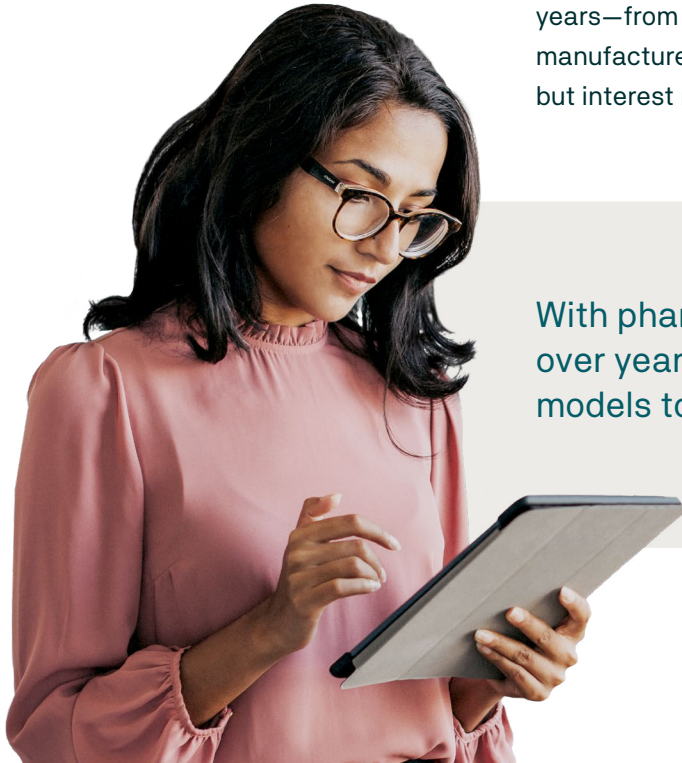
75%

of consumers remain concerned about the lack of transparency in the prescription drug system.¹

Transparency you can verify

Members feel the transparency gap too. 75% remain concerned about the lack of transparency across the health care and prescription drug system—including how rebates and pricing agreements work—and they want clearer answers on what medications cost, how coverage decisions get made and how their benefits actually work¹

Clients are answering by looking beyond their current arrangements. More than 8 in 10 employers, health plans and consultants are actively considering or planning to evaluate alternative PBM models in the coming years—from rebate-free structures to pass-through pricing to direct manufacturer contracting. Health plans and consultants lead the shift, but interest reaches every stakeholder group we spoke with.²



With pharmacy spend rising as much as 30% year over year, employers are exploring alternative models to manage costs.



THE EVERNORTH CONNECTION

A model built for transparency

Evernorth SignatureSM pharmacy benefit services offers plan sponsors a transparent, pass-through approach to pharmacy benefits—giving buyers clearer visibility into pricing and performance and the proof points they need to evaluate value with confidence.



Turning insight into action

Clients and their members alike are expressing the need for relief from cost pressures, an easier way to interact with care and proven results. These needs are connected—someone squeezed by cost also struggles to navigate what’s available, and the clients managing that complexity are the same ones asking for evidence their strategy works. Solve for one alone and the others keep pulling at the seams.

The organizations making real progress start by listening closely to what their members are living through, and by choosing a partner who brings more than a product—one who helps manage cost responsibly, makes benefits easier to find and use and stands behind the outcomes. Do all three together, and the whole system starts to feel less like a maze and more like a map.



That’s the role Express Scripts Pharmacy Benefit Services aims to play: a source of insight you can act on and a steady hand helping you stay ahead of what’s next in pharmacy benefits.

Ready to talk through what these findings mean for your client’s pharmacy benefits strategy?

Please reach out to your Evernorth representative or [connect with our team](#)



MORE INSIGHTS
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*Consumer respondents were adults with health insurance and prescription drug coverage through an employer or union, government or military employment or the VA.

1. Evernorth Health Services, Annual Buyer Insights: Consumer Report (Wave 6, December 2025/January 2026)
2. Evernorth Health Services, Annual Buyer Insights: B2B Report (Wave 6, December 2025/January 2026)

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