EMPLOYER HEALTH BENEFITS

2025 Annual Survey

Summary of Findings

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Employer-sponsored insurance covers 154 million people under the age of 65[1]. To provide a current snapshot of employer-sponsored health benefits, KFF conducts an annual survey of private and non-federal public employers with ten or more workers. This is the 27th Employer Health Benefits Survey (EHBS) and reflects employer-sponsored health benefits in 2025.

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

The average annual premiums for employer-sponsored health insurance in 2025 are $9,325 for single coverage and $26,993 for family coverage. Over the last year, the average single premium increased by 5% and the average family premium increased by 6%. Comparatively, there was an increase of 4% in workers' wages and inflation of 2.7%[2] [3]. Over the last five years, the average premium for family coverage has increased by 26%, compared to a 28.6% increase in workers' wages and inflation of 23.5% [Figure A, Figure B].

The average premium for firms with 10 to 199 workers is comparable to the average premium at larger firms for covered workers with single coverage ($9,211 and $9,361) but lower for family coverage ($26,054 vs. $27,280). The average premiums for covered workers in high-deductible health plans with a savings option (HDHP/SO) are lower than the overall average premiums for both single coverage ($8,620) and family coverage ($25,379). In contrast, average premiums for covered workers enrolled in PPOs are higher than the overall average premiums for both single ($9,818) and family coverage ($28,272).

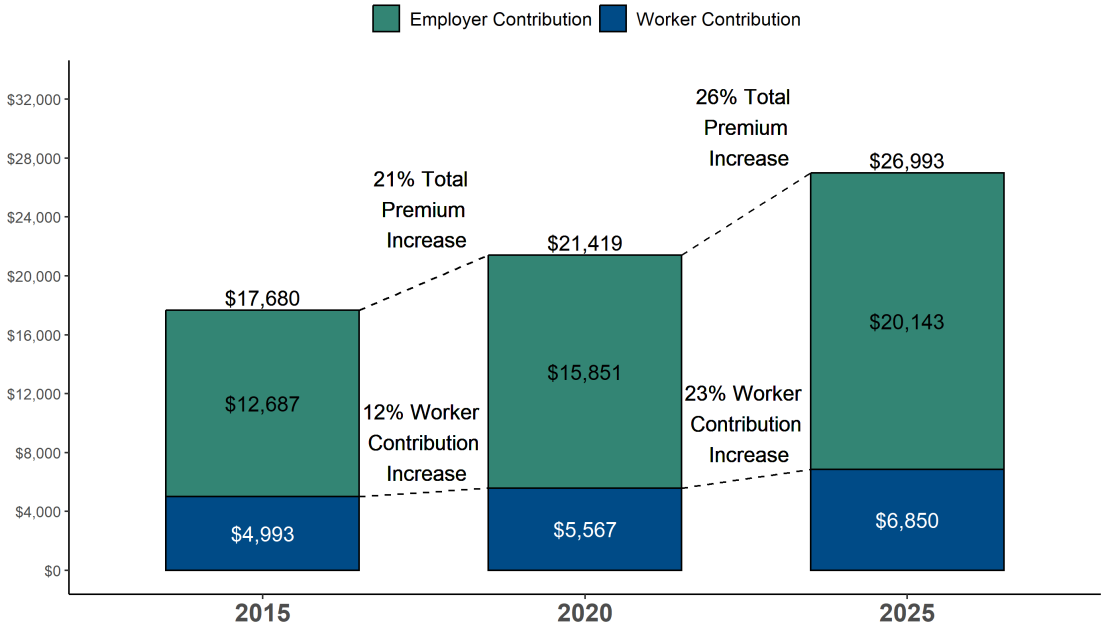
Premiums also differ with firm characteristics. The average premiums for both single and family coverage are relatively low for covered workers at private for-profit firms and relatively high for covered workers in private not-for-profit firms. The average premiums for covered workers at firms with larger shares of older workers (where at least 35% of the workers are age 50 or older) are higher than the average premiums for covered workers at firms with smaller shares of older workers for both single ($9,599 vs. $9,068) and family ($27,699 vs. $26,332) coverage. The average premiums for covered workers at firms with relatively large shares of higher-wage workers (where at least 35% of workers earn $80,000 a year or more) are higher than the average premiums for covered workers at firms with smaller shares of higher-wage workers for both single ($9,600 vs. $9,133) and family ($27,957 vs. $26,313) coverage [Figure C].

[1] KFF's analysis of data from the 2023 American Community Survey. See KFF. Health insurance coverage of the population ages 0–64 [Internet]. San Francisco (CA): KFF; [cited 2025 Sep 15]. [Time frame: 2023]. Available from: https://www.kff.org/state-health-policy-data/stateindicator/health-insurancecoverage-population-0-64/

[2] Bureau of Labor Statistics, Mid-Atlantic Information Office. Consumer Price Index historical tables for U.S. city average (1967=100), Consumer Price Index for All Urban Consumers (CPI-U) (not seasonally adjusted) [Internet]. Philadelphia (PA): BLS, Mid-Atlantic Information Office; [cited 2025 Sep 15]. Available from: https://www.bls.gov/regions/mid-atlantic/data/consumerprice indexhistorical1967base_us_table.htm

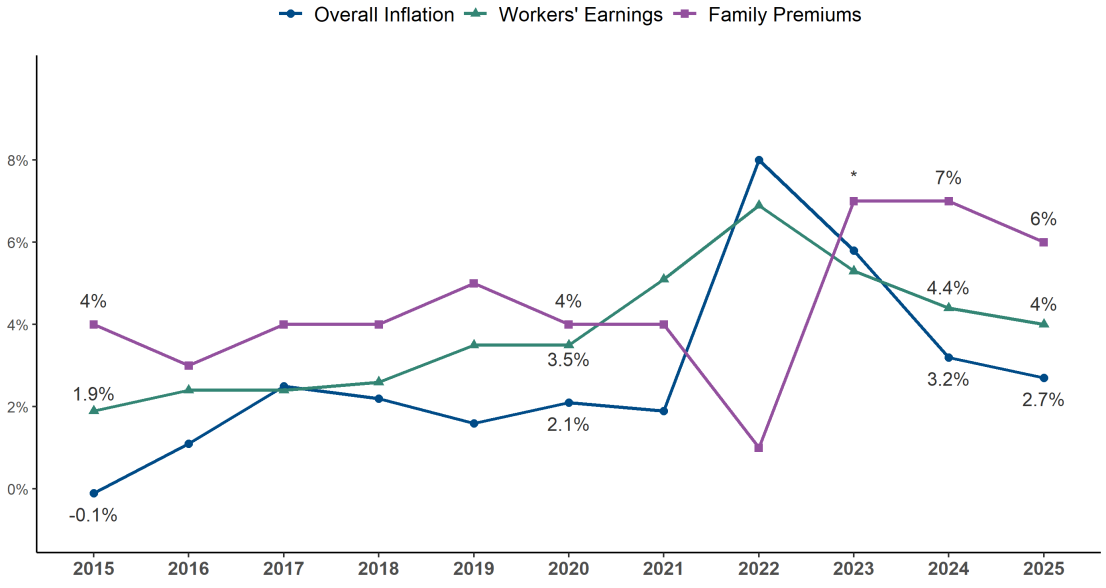
[3] Average hourly earnings of production and nonsupervisory employees (seasonally adjusted) from the Current Employment Statistics survey. See Bureau of Labor Statistics. Current Employment Statistics—CES (national) [Internet]. Washington (DC): BLS; [cited 2025 Sep 15]. Available from: https://www.bls.gov/ces/data/

Figure A
Average Annual Worker and Employer Premium Contributions for Family Coverage, 2015, 2020, and 2025



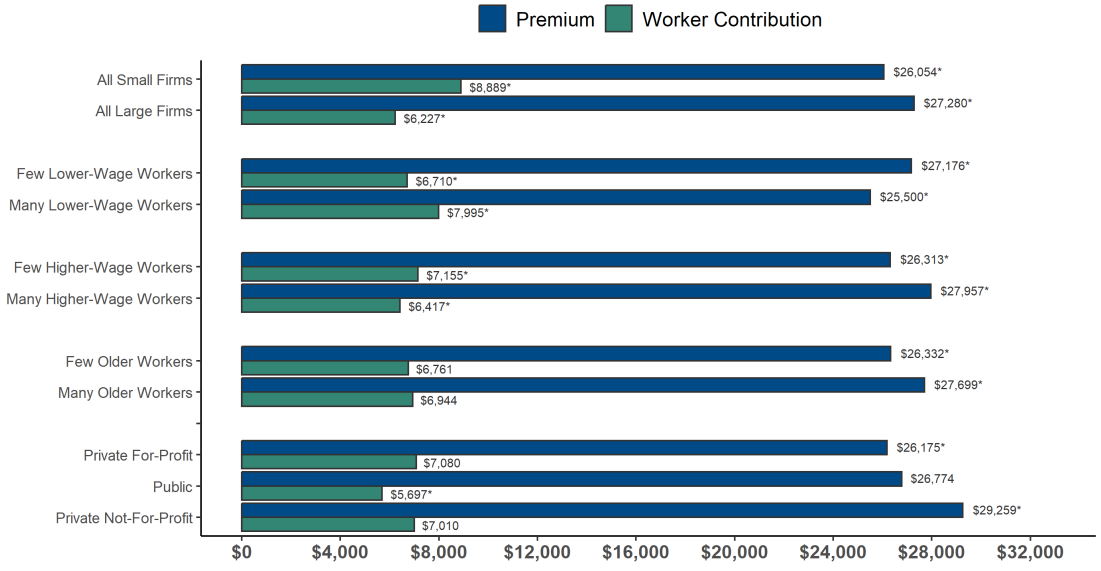
SOURCE: KFF Employer Health Benefits Survey, 2020 and 2025; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

Figure B
Average Annual Increases in Premiums for Family Coverage Compared to Other Indicators, 2015-2025



* Family Premiums Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2025; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2015-2025; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2015-2025.

Figure C
Average Annual Premiums and Worker Contributions for Family Coverage, by Firm Characteristics, 2025



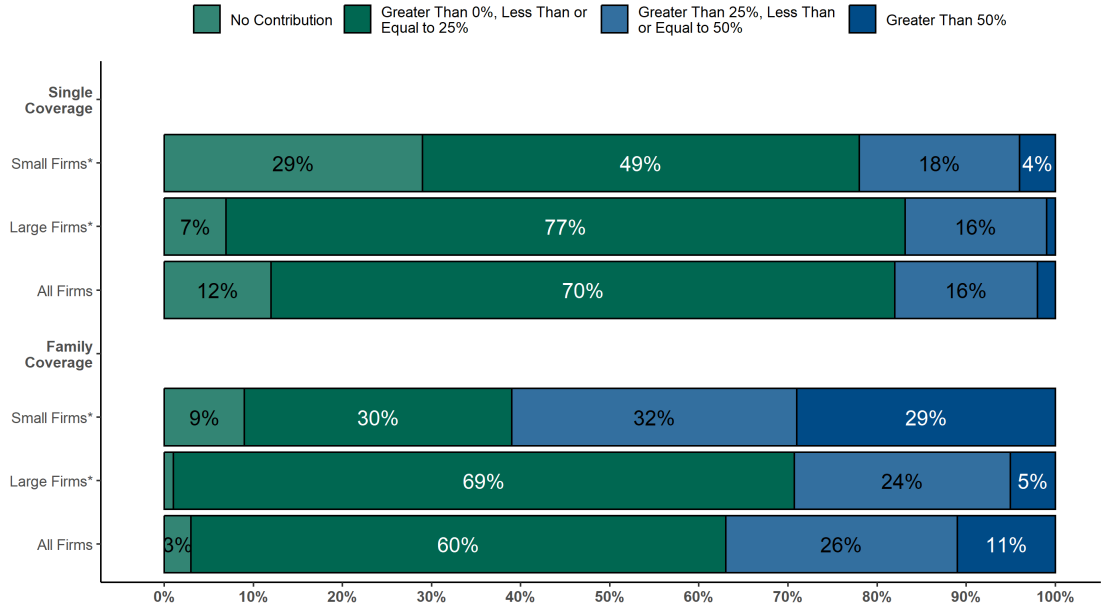
* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Firms with many lower-wage workers are those where at least 35% earn at or below the 25th percentile of national earnings ($37,000 in 2025). Firms with many higher-wage workers are those where at least 35% earn at or above the 75th percentile of national earnings ($80,000 in 2025). Firms with many older workers are those where at least 35% of workers are age 50 or older.
SOURCE: KFF Employer Health Benefits Survey, 2025

Most covered workers contribute to the cost of the premium directly. On average, covered workers contribute 16% of the premium for single coverage and 26% of the premium for family coverage, similar to the percentages contributed in 2024. The average contribution rates for single coverage are the same for covered workers in firms with 10 to 199 workers and in larger firms (16%) but the average contribution rate for family coverage is higher for covered workers in firms with 10 to 199 workers than for those in larger firms (36% vs. 23%). On average, covered workers at private, for-profit firms have relatively high premium contribution rates and covered workers in public firms have relatively low contribution rates for both single coverage and family coverage.

Twenty-nine percent of covered workers at firms with 10 to 199 workers are enrolled in a plan where the employer pays the entire premium for single coverage, compared with only 7% of covered workers at larger firms. In contrast, 29% of covered workers at firms with 10 to 199 workers are in a plan where they must contribute more than half of the premium for family coverage, compared to 5% of covered workers at larger firms [Figure D].

The average annual contribution amounts for covered workers are $1,440 for single coverage, similar to the amount last year, and $6,850 for family coverage, higher than the amount last year. The average contribution amount for family coverage for covered workers at firms with 10 to 199 workers ($8,889) is higher than the amount for covered workers at larger firms ($6,227) [Figure C]. Eleven percent of covered workers, including 28% of covered workers at firms with 10 to 199 workers, are in a plan with a worker contribution of $12,000 or more for family coverage.

Figure D
Distribution of Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2025

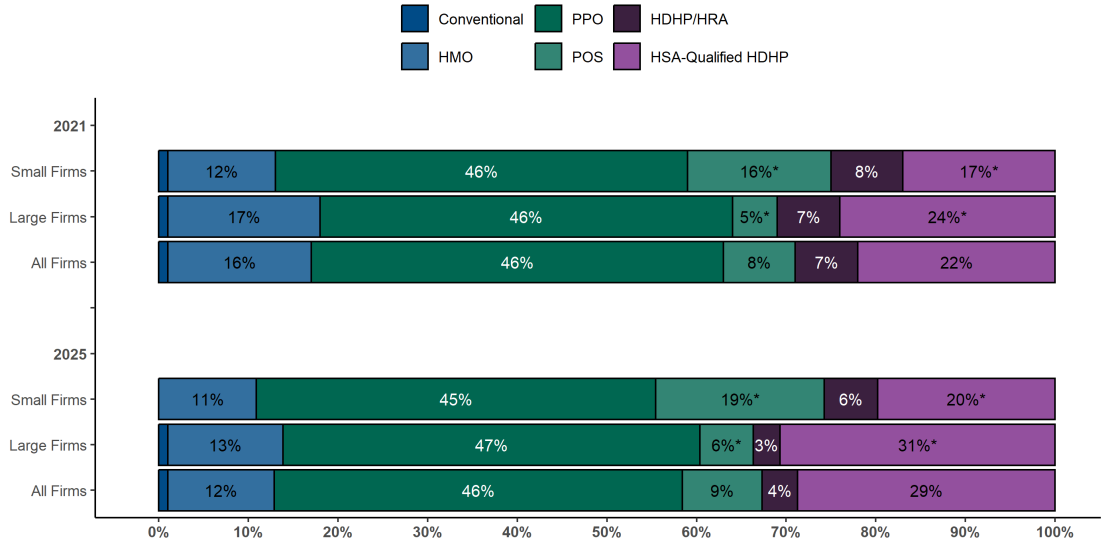


* Distributions are statistically different between Small Firms and Large Firms within coverage type ($p < 0.05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2025

PLAN ENROLLMENT

PPOs continue to be the most common plan type in 2025. Forty-six percent of covered workers are enrolled in a PPO, 33% are enrolled in a high-deductible plan with a savings option (HDHP/SO), 12% are enrolled in an HMO, 9% are enrolled in a POS plan, and less than one percent are enrolled in a conventional (also known as an indemnity) plan [Figure E].

Figure E
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type and Firm Size, 2021 and 2025



* Enrollment in plan type is statistically different between All Small Firms and All Large Firms within year ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan. HDHP/SO is high-deductible health plan with a savings option, such as a health reimbursement arrangement (HRA) or health savings account (HSA). In total, 33% of covered workers are enrolled in an HDHP/SO, incluidng 26% of covered workers at small firms and 35% at large firms.
SOURCE: KFF Employer Health Benefits Survey, 2021-2025;

SELF FUNDING

Many firms - particularly larger firms - have self-funded health plans, which means that they pay for the health services of enrollees directly from their own funds rather than through the purchase of health insurance. Sixty-seven percent of covered workers, including 27% of covered workers at firms with 10 to 199 workers and 80% at larger firms, are enrolled in plans that are self-funded.

Thirty-seven percent of covered workers in firms with 10 to 199 workers are covered by a level-funded plan, similar to the percentage in 2024. Level-funded arrangements combine a relatively small self-funded component with stop-loss insurance, which limits the employer's liability and transfers a substantial share of risk to insurers. These plans have the potential to meaningfully affect competition in the small group market because, unlike insured plans, they use health status in rating and underwriting, and are not required to provide all of the essential health benefits that are mandatory for insured plans.

EMPLOYEE COST SHARING

Eighty-eight percent of workers with single coverage have a general annual deductible that must be met before most services are paid for by the plan, the same percentage last year (88%).

The average deductible amount in 2025 for workers with single coverage and a general annual deductible is $1,886, similar to last year. The average deductible for covered workers at firms with 10 to 199 workers ($2,631) is higher than the average deductible at larger firms ($1,670). For covered workers with an annual deductible, the average deductible for single coverage has increased 17% over the last five years and 43% over the last 10 years.

Thirty-four percent of covered workers in 2025 are in a plan with a general annual deductible of $2,000 or more for single coverage, similar to the percentage (32%) last year. Over half (53%) of covered workers in firms with 10 to 199 workers are in such a plan, compared with 28% of covered workers in larger firms. The share of covered workers in a plan with a general annual deductible of $2,000 or more for single coverage has increased 32% over the last five years and 77% over the last ten years [Figure F].

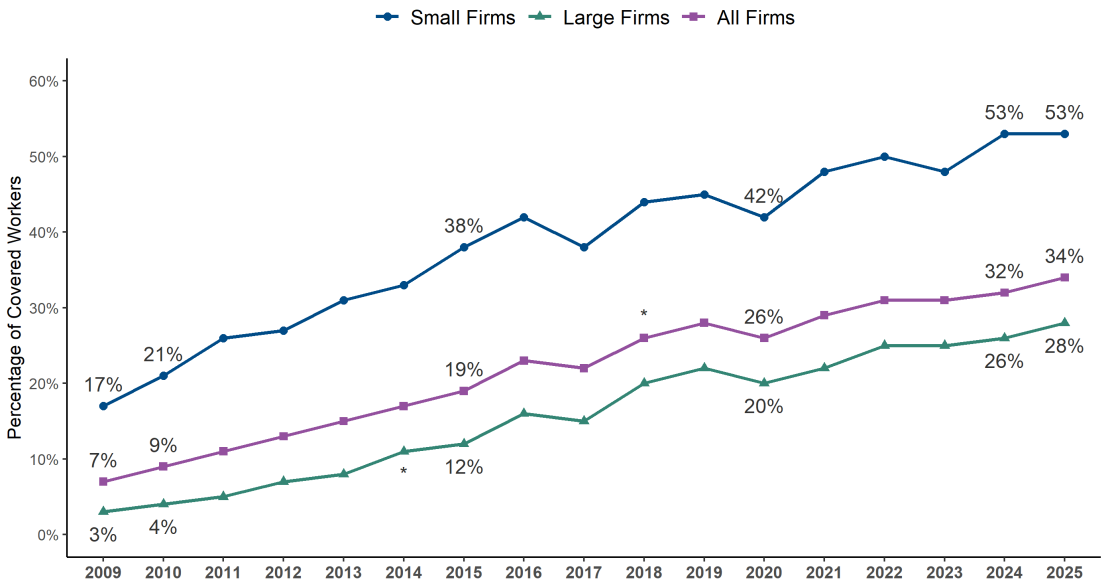
Some workers in health plans with high deductibles also receive contributions to savings accounts from their employers. These contributions can be used to reduce cost sharing amounts. Thirty-three percent of covered workers in an HDHP with a Health Reimbursement Arrangement (HRA), and 3% of covered workers in a Health Savings Account (HSA)-qualified HDHP receive an account contribution for single coverage that is greater than or equal to their deductible amount. Additionally, 19% of covered workers in an HDHP with an HRA and 10% of covered workers in an HSA-qualified HDHP receive account contributions that, if applied to their deductible, would reduce their personal annual liability to less than $1,000.

In addition to any general annual deductible they may have, most covered workers also pay a portion of the cost of care when they use health care services, typically a copayment (a fixed dollar amount) or coinsurance (a percentage of the covered amount). For physician office visits, the average copayment for a primary care visit is $27, similar to the amount last year, and the average copayment for a visit to a specialist is $45, higher than the amount last year. The average coinsurance rate is 19% for both primary care and specialist visits, similar to the percentages last year.

When admitted to the hospital, 65% of covered workers have coinsurance requirements, 11% have a copayment, and 8% have both a copayment and coinsurance requirement. The average coinsurance rate for a hospital admission is 20% and the average copayment amount is $313. The cost sharing requirements for outpatient surgery follow a similar pattern to those for hospital admissions, although the average copayment amount for outpatient surgery is lower ($186).

Virtually all covered workers are in plans with an annual limit on in-network cost sharing (called an out-of-pocket maximum) for single coverage, although these limits vary significantly. Among covered workers in plans with an out-of-pocket maximum for single coverage, 12% are in a plan with an out-of-pocket limit of $2,000 or less, while 21% are in a plan with a limit above $6,000.

Figure F
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size, 2009-2025



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2025; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE

Sixty-one percent of firms with 10 or more workers offer health benefits to at least some of their workers, similar to the percentage last year (65%). As explained in the Methods, the 2025 survey sample was limited to firms with 10 or more employees, resulting in a higher overall offer rate than previously published estimates. Firms with 200 or more workers are much more likely than smaller firms to offer health benefits (97% vs. 59%).

Because most firms are small, the overall offer rate can fluctuate over time, as estimates for smaller firms tend to vary considerably from year to year. Most workers, however, work for larger firms, where offer rates are higher and much more stable. Among firms with 200 or more workers, 96% of firms with 200 to 999 workers, and over 99% of firms with 1,000 or more workers, offer health benefits to at least some of their workers. Overall, 91% of workers are employed by a firm that offers health benefits to at least some of its workers. This percentage is similar to the percentages five years ago (92%).

Even in firms offering health benefits, many workers are not covered by health benefits provided by the firm. Some are not eligible to enroll (due to factors such as waiting periods or part-time or temporary work status), while others who are eligible choose not to enroll (they may feel the coverage is too expensive, or they may be covered through another source). Additionally, some firms provide incentives for workers or spouses of workers not to enroll in their plans, or to enroll in a spouses' plan. On average, at firms that offer coverage, 80% of workers are eligible. Among eligible workers, 76% take up the firm's offer. Overall, 61% of workers at firms that offer health benefits are enrolled in that coverage.

The coverage rate varies with workforce characteristics. Among workers at firms offering health benefits, those working for firms with a relatively large share of younger workers are less likely to be covered by their own firm than workers in firms with a smaller share of younger workers (39% vs. 64%) and those working at firms with a relatively large share of lower-wage workers are less likely to be covered by their own firm than

workers at firms with a smaller share of lower-wage workers (43% vs. 64%)[4] The share of workers employed at public organizations covered by their own employer (72%) is higher than the shares of workers covered that are employed at private for-profit firms (59%), or private non-for-profit firms (60%).

Across firms that offer health benefits and firms that do not, 55% of workers are covered by a health plan offered by their employer, similar to the percentage last year (57%).

HEALTH PROMOTION AND WELLNESS PROGRAMS

Many firms sponsor programs to help workers identify health issues and manage chronic conditions. These programs include health risk assessments, biometric screenings, and health promotion programs.

Health Risk Assessments. Among firms offering health benefits, 35% of firms with 10 to 199 workers and 53% of larger firms provide workers the opportunity to complete a health risk assessment. Among large firms that offer a health risk assessment, 53% use incentives or penalties to encourage workers to complete the assessment, similar to the percentage last year.

Biometric Screenings. Among firms offering health benefits, 22% of firms with 10 to 199 workers and 43% of larger firms provide workers the opportunity to complete a biometric screening. Among large firms with a biometric screening program, 62% use incentives or penalties to encourage workers to complete the assessment, similar to the percentage last year.

Health and Wellness Promotion Programs. Many firms offering health benefits offer programs to help workers identify and address health risks and unhealthy behaviors. Fifty-six percent of firms with 10 to 199 workers and 83% of larger firms offer a program in at least one of these areas: smoking cessation, weight management, and behavioral or lifestyle coaching. The percentage of both smaller firms and larger firms offering one of these programs are similar to the percentages last year (61% and 79%, respectively).

GLP-1 DRUG COVERAGE FOR WEIGHT LOSS

GLP-1 (Glucagon-like peptide-1) agonists, used to help control blood sugar levels in people with type 2 diabetes and certain other conditions, have also been shown to be an effective drug to help people lose weight. The high cost of these drugs, however, combined with the large number of people who could benefit and the potential for long-term usage, has raised concerns about the costs of covering them as a weight-loss treatment.

Among firms that offer health benefits with 200 or more workers, 16% of firms with 200 to 999 workers, 30% of firms with 1,000 to 4,999 workers, and 43% of firms with 5,000 or more workers cover GLP-1 agonists when used primarily for weight loss in 2025. The percentage of firms with 5,000 or more workers covering GLP-1 agonists for weight loss is higher than the percentage last year (43% vs. 28%) [Figure G]. Thirty-four percent of firms covering these drugs for weight loss require enrollees to meet with a dietitian, case manager, or therapist, or participate in a lifestyle program in order to receive the coverage.

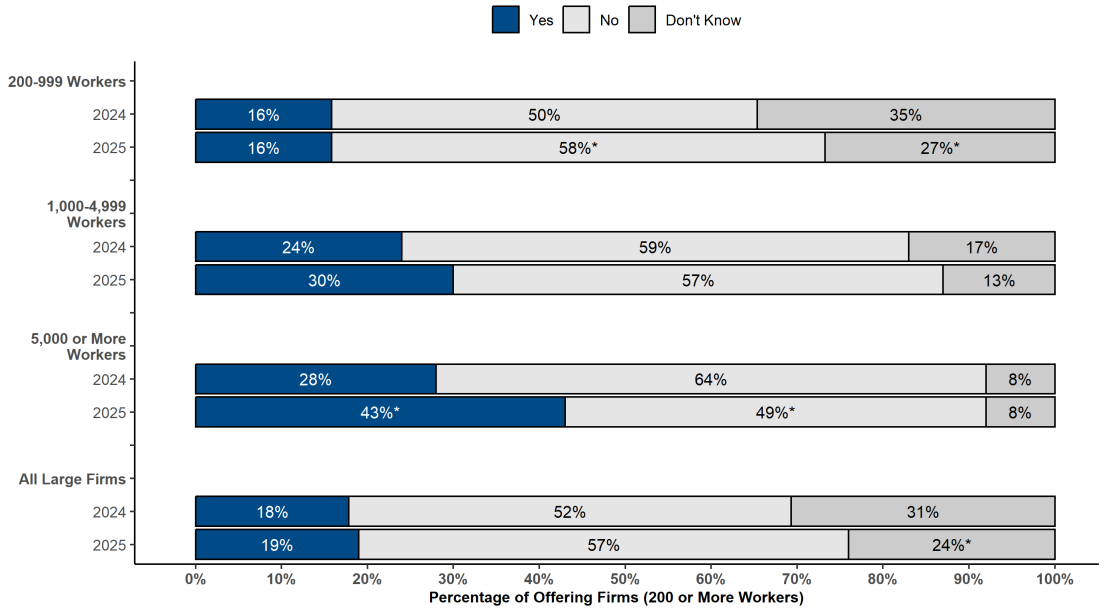
Firms covering GLP-1 agonists primarily for weight loss were asked how the use of the drug compared to expectations and about the impact on the firm's spending for prescription drugs. Forty-four percent of these firms with 1,000 to 4,999 workers, and 59% of these firms with 5,000 or more workers, say that the use of these medications for weight loss was higher than expected. Forty-three percent of these firms with 1,000 to 4,999 workers, and 66% of these firms with 5,000 or more workers say that covering GLP-1 agonists for weight loss had a "significant" impact on the health plan's prescription drug spending [Figure H].

Among firms with 200 or more workers that offer health benefits and do not cover GLP-1 agonists for weight loss, only 1% say that they are "very likely" to begin covering GLP-1 agonists for weight loss within the next 12 months,

[4]This threshold is based on the twenty-fifth percentile of workers' earnings ($37,000 in 2025). Seasonally adjusted data from the Current Employment Statistics Survey. Bureau of Labor Statistics. Current Employment Statistics—CES (national) [Internet]. Washington (DC): BLS. Available from: https://www.bls.gov/ces/publications/highlights/highlights-archive.htm

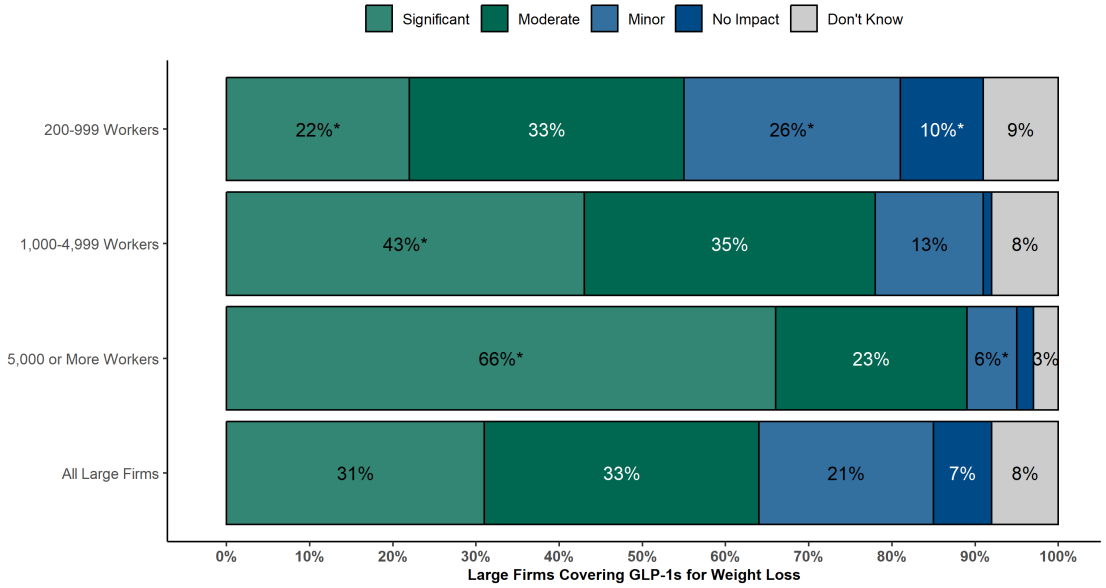
24% say that they were “somewhat likely,” 67% say that they were “not likely,” and 8% do not know the answer to the question.

Figure G
Percentage of Firms Whose Largest Plan Includes Coverage For GLP-1 Agonists When Used Primarily For Weight Loss, by Firm Size, 2024-2025



* Estimate is statistically different from estimate for the previous year shown with size and response categories ($p < .05$).
NOTE: Large Firms have 200 or more workers. Firms with multiple plans were asked about their plan with the largest enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2024-2025;

Figure H
Firms View on How Much Of An Impact GLP-1 Agonists Will Have on Prescription Drug Spending, by Firm Size, 2025



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Firms with multiple plans were asked about their plan with the largest enrollment. Among firms with 200 or more workers that offer health benefits, 19% reported that their largest plan included coverage for any GLP-1 antagonists when used primarily for weight loss.
SOURCE: KFF Employer Health Benefits Survey, 2025

EMPLOYEE CONCERNS WITH PLAN AND UTILIZATION MANAGEMENT

Consumer concerns about health plan management—such as prior authorization requirements—have received growing public attention in recent years. Firms offering health benefits were asked to assess how concerned they believe their employees are about various aspects of health plan management. Among large firms (200 or more workers):

Affordability of Cost Sharing. Twenty percent believe that their employees level of concern over the affordability of cost sharing is "high," 27% believe the level of concern is "moderate," 33% believe the level of concern is "low," 12% believe the level of concern is "none," and 7% do not know the level of concern [Figure I]. Firms with 10 to 199 workers are more likely than larger employers to believe their employees have no concern about the affordability of cost sharing (21%).

Scheduling Timely Appointments With Providers. Seventeen percent believe that their employees level of concern over their ability to schedule timely appoints is "high," 26% believe the level of concern is "moderate," 29% believe the level of concern is "low," 20% believe the level of concern is "none," and 8% do not know the level of concern [Figure I]. Firms with 200 or more workers are more likely than smaller firms to believe that employees have a "high" or "moderate" level of concern about their ability to schedule timely appointments with providers (29%).

Complexity of Prior Authorization Requirements. Twelve percent believe that their employees level of concern over the complexity of prior authorization requirements is "high," 32% believe the level of concern is "moderate," 31% believe the level of concern is "low," 16% believe the level of concern is "none," and 9% do not know the level of concern [Figure I].

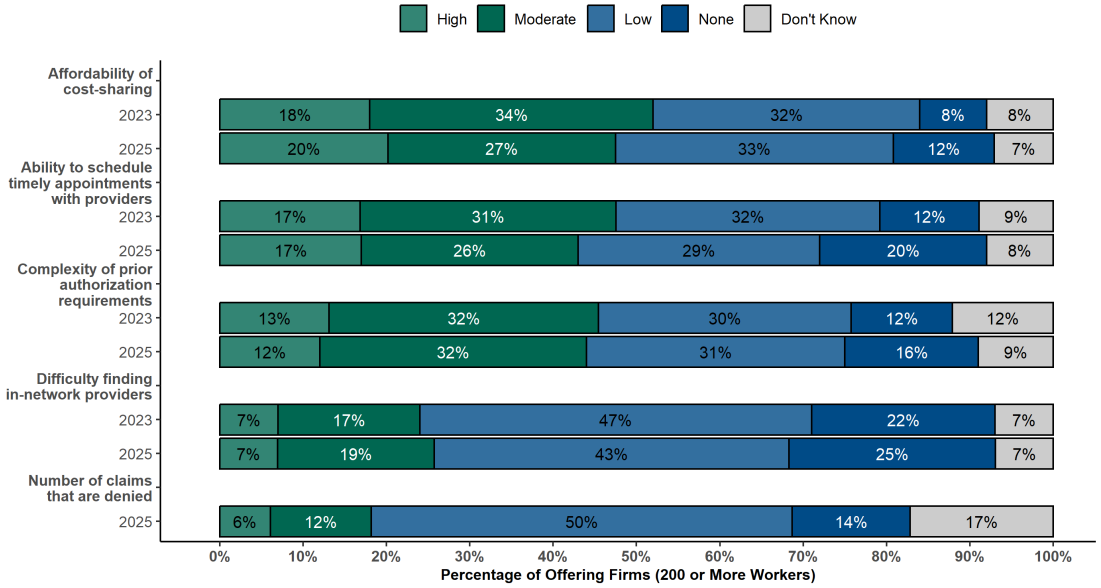
Finding In-Network Providers. Seven percent believe that their employees level of concern over the difficulty of finding in-network providers is "high," 19% believe the level of concern is "moderate," 43% believe the level of

concern is “low,” 25% believe the level of concern is “none,” and 7% do not know the level of concern [Figure I]. Firms with 10 to 199 workers are more likely than larger employers to believe their employees have no concern about their ability to find in-network providers (29%).

Number of Denied Claims. Six percent believe that their employees level of concern about the number of denied claims is “high,” 12% believe the level of concern is “moderate,” 50% believe the level of concern is “low,” 14% believe the level of concern is “none,” and 17% do not know the level of concern [Figure I].

Figure I

Among Large Firms Offering Health Benefits, How Much Concern Do Employers Have With Various Elements of the Firm's Plans, 2023-2025



NOTE: Large Firms have 200 or more workers. Cost-sharing may include copays, coinsurances and deductibles. The 'Number of claims that are denied' was not asked in 2023.
SOURCE: KFF Employer Health Benefits Survey, 2023-2025;

SUFFICIENCY OF PROVIDER NETWORKS

Firms offering health benefits were asked whether they believed the provider network for their health plan with the largest enrollment included a sufficient number of providers to ensure timely access to primary care, specialty care, and mental health services. Ninety-two percent of these firms believe their largest health plan provides timely access to **primary care** services, 89% believe it provides timely access to **specialty care**, and 70% believe it provides timely access to **mental health** services. These percentages are similar among small and large firms.

HEALTH PLAN PROVIDER NETWORKS

Tiered and Narrow Networks. Health plans structure their networks of providers to provide access to care and to encourage enrollees to use providers that are lower cost, or that provide better care. One option to accomplish these goals are high-performance or tiered network plans, which use cost-sharing or other incentives

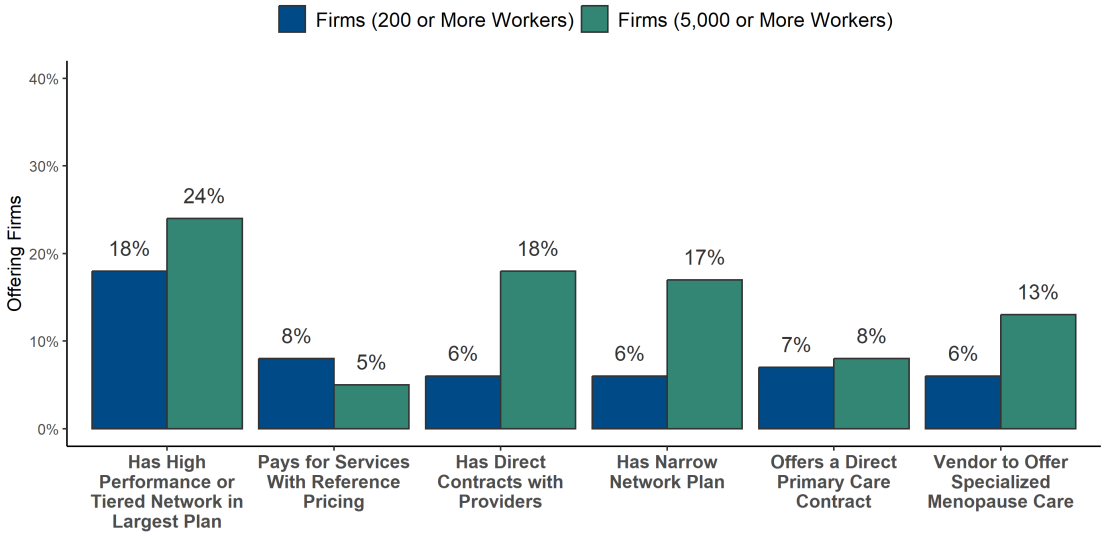
to encourage enrollees to certain in-network providers. Another option are narrow network plans, which significantly restrict the number of participating providers in order to reduce costs.

Among firms with 50 or more employees that offer health benefits, 15% have a high-performance network or tiered network as part of their health plan with the largest enrollment in 2025. Firms with 5,000 or more employees are more likely to include a high-performance or tiered network in their largest health plan than smaller employers (24% vs. 15%). Eight percent of firms with 50 or more employees that offer health benefits offer a health plan that can be considered a narrow network in 2025, similar to the percentage last year (8%). Firms with 5,000 or more employees are more likely to offer a narrow network plan than employers with fewer employees (17% vs. 8%) [Figure J].

MENOPAUSE SUPPORT BENEFITS

Some employers contract with a vendor to offer specialized care or a virtual care benefit to provide support for enrollees during menopause. These services may include education, access to specialty care, and mental health support. Among employers with 200 or more workers that offer health benefits, 4% of firms with 200 to 999 workers, 10% of firms with 1,000 to 4,999 workers, and 13% of firms with 5,000 or more workers have vendor contracts to provide support for workers or their dependents during menopause [Figure J].

Figure J
Percentage of Large Firms With Various Network Strategies, 2025



NOTE: Firms with multiple plans were asked about their plan with the largest enrollment. A high-performance network groups providers within the network based on quality, cost, and/or the efficiency of care they deliver. Direct contract involves employers contracting directly with facilities, independent of the plan's third-party administrator or insurer. Some plans partner with vendors to replace deductibles with copays that vary by provider cost. Enrollees who choose lower-cost providers pay less, and vendors like Surest and Coupe Health support these models with app-based copay comparison tools. In reference pricing, the plan covers a set amount, and enrollees pay any charges above it. Firms were asked if they use third-party vendors, such as Maven Clinic or Carrot, to provide menopause benefits like digital resources and virtual visits.
SOURCE: KFF Employer Health Benefits Survey, 2025

APPROACHES TO PRIMARY CARE

Some employers are using alternative approaches to provide primary care options for their workers. These include approaches using virtual care and direct contracts with networks of primary care providers. Among firms

with 50 or more workers that offer health benefits, 30% have a contract to provide virtual primary care services, including telehealth primary care options, that go beyond the services provided to workers in their health plan networks. Firms with 1,000 or more workers are more likely than smaller firms to have a contract for virtual primary care services (45% vs. 29%).

Seven percent of firms with 50 or more workers that offer health benefits contract directly with an organization to provide primary care services to their workers in addition to the primary care providers offered through their health plan networks. The percentage is similar for smaller and larger firms [Figure J].

ICHRA AND ASSISTING EMPLOYEES WITH PURCHASING COVERAGE IN THE NON-GROUP MARKET

Some employers provide funds to some or all of their employees to help them purchase coverage in the individual ("non-group") market. Employers that do not otherwise offer health benefits may offer these funds as an alternative to offering a group plan. Additionally, employers that offer a group plan to some employees may use this approach for other types or classes of workers, such as those working part time or remotely. One way an employer can provide tax-preferred assistance for employees to purchase non-group coverage is through an Individual Coverage Health Reimbursement Arrangement, or ICHRA. In 2025, 4% of firms that offer health benefits and 9% of firms that do not offer health benefits offered funds to one or more of their employees to purchase non-group coverage.

Modest shares of employers not currently offering an ICHRA option are considering doing so in the near future. Among firms with 10 or more workers that offer health benefits, 2% say they are "very likely" and an additional 6% are "somewhat likely" to offer an ICHRA to at least some employees in the next two years. Among firms with 10 to 199 workers that do not offer health benefits, 2% say they are "very likely" and an additional 16% say they are "somewhat likely" to offer an ICHRA to at least some employees in the next two years.

DISCUSSION

Average annual premiums increased by 5% for single coverage and 6% for family coverage in 2025, similar to the rate of growth over the past two years. Over the last five years, average family premiums have risen 26%, roughly in line with the cumulative increase in inflation (23.5%) and wage growth (28.6%) over the same period.

Early reports suggest that cost trends will be higher for 2026, potentially leading to higher premium increases unless employers and plans find ways to offset higher costs through changes to benefits, cost sharing, or plan design. One place where this story is playing out is coverage of GLP-1 agonists for weight loss. The share of the largest firms covering these medications for weight loss increased significantly in 2025, but many of these firms also reported higher than expected use, as well as a significant impact on prescription costs. Discussions with individual employers suggest that some have stopped covering these medications for weight loss, with a few even tightening up coverage for those with diabetes. While concerns over the negative health impacts of obesity remain, they are now in competition with concerns about the high cost and proper use of GLP-1 agonist medications, particularly at a time when other cost pressures may be growing. Whether and how to provide coverage for GLP-1 agonists will continue to be an important topic for employers and workers over the next few years.

Another potential strategy for managing rising costs is to increase employee cost sharing. While key measures such as the average deductible have grown more modestly in recent years, continued premium growth could prompt employers to raise out-of-pocket amounts for workers. Yet many may feel constrained in doing so; nearly half of large employers report that their employees have "high" or "moderate" concern about current cost-sharing levels. Many covered workers already face substantial cost-sharing, for example more than one-third of covered workers are enrolled in a plan with a deductible of $2,000 or more for single coverage.

METHODOLOGY

The KFF 2025 Employer Health Benefits Survey reports findings from a survey of 1,862 randomly selected non-federal public and private employers with ten or more workers. Davis Research, LLC conducted the field work between January and July 2025. The overall response rate is 13%, which includes firms that offer and do not offer health benefits. Unless otherwise noted, differences referred to in the text and figures use the 0.05 confidence level as the threshold for significance. Small firms have 10-199 workers unless otherwise noted. Values below 3% are not shown on graphs to improve readability. Some distributions may not sum due to rounding. For more information about survey methodology, see the Survey Design and Methods section at http://ehbs.kff.org/.

Filling the need for trusted information on national health issues, KFF is a nonprofit organization based in San Francisco, California.
