KFF

Employer Health Benefits

2026 SUMMARY OF FINDINGS

Employer-sponsored insurance covers almost 157 million people under age 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 28th Employer Health Benefits Survey (EHBS), reflecting employer-sponsored health benefits in 2026.

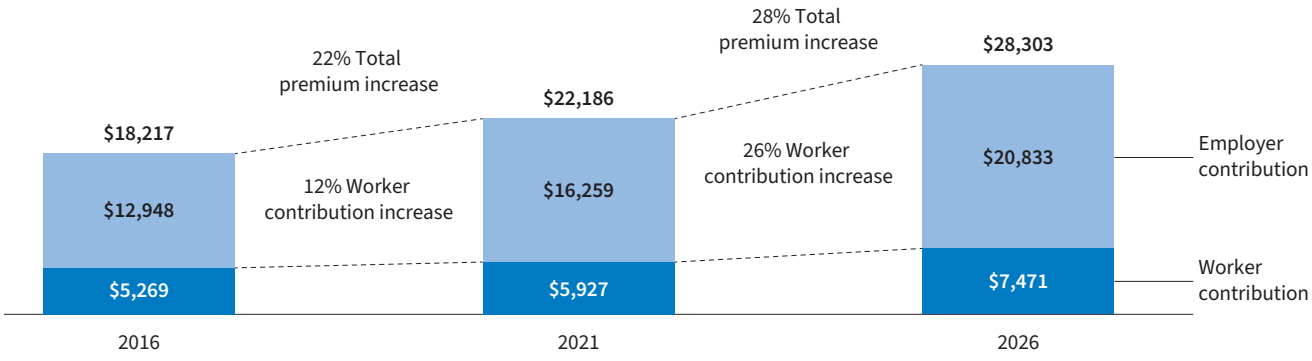
Health Insurance Premiums and Worker Contributions

The average annual premiums for employer-sponsored health insurance in 2026 are $9,804 for single coverage and $28,303 for family coverage. Over the last year, the average single premium increased by 5%, and the average family premium increased by 5%. By comparison, workers' wages increased by 3.7%, while inflation was 2.7%.[2,3] Over the last five years, the average premium for family coverage has increased by 28%, compared with a 26.9% increase in workers' wages and inflation of 24.4% [Figure A, Figure B].

The average premium for smaller firms (firms with 10 to 199 workers) is similar to the average premium at larger firms for covered workers with single coverage ($9,593 and $9,865) but lower for covered workers with family coverage ($27,288 vs. $28,592) [Figure C]. The average premiums for covered workers in HSA-qualified plans are lower than the overall average premiums for both single coverage ($8,989) and family coverage ($26,450). The average premiums for covered workers enrolled in PPOs are higher than the overall average premiums for both single ($10,272) and family coverage ($29,522).

Figure A

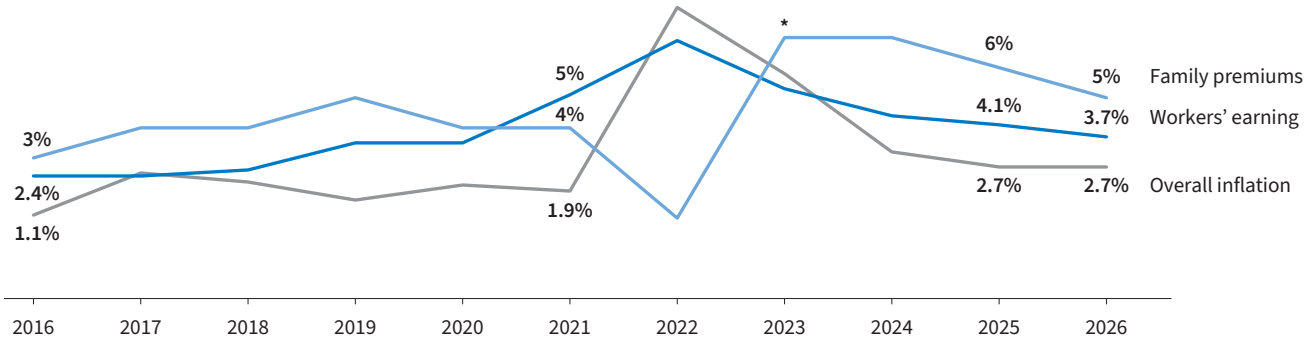
Average Annual Worker and Employer Premium Contributions for Family Coverage, 2016, 2021, and 2026



Source: KFF Employer Health Benefits Survey, 2021 and 2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016.

Figure B

Average Annual Increases in Premiums for Family Coverage Compared to Other Indicators, 2016–2026



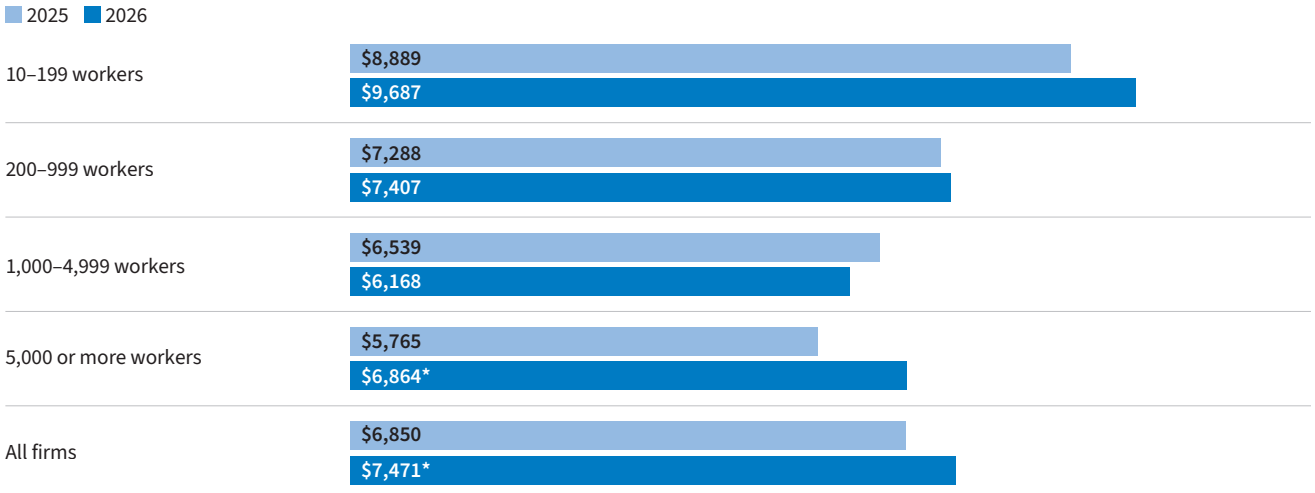
Note: * Family Premiums Estimate is statistically different from estimate for the previous year shown ($p < .05$).
Source: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2016-2026; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2016–2026.

Premiums also vary with firm characteristics. Average premiums for covered workers are relatively high in the Northeast for both single coverage ($10,806) and for family coverage ($31,378) and are relatively low in the South for both single coverage ($9,272) and for family coverage ($26,702). The average premiums for covered workers at firms with relatively large shares of higher-wage workers (where at least 35% of workers earn $82,000 a year or more) are higher than the average premiums for covered workers at firms with smaller shares of higher-wage workers for family ($29,139 vs. $27,664) coverage. The average premium for family coverage for covered workers at firms with a relatively large share of older workers (where at least 35% of the workers are age 50 or older) is higher than the average premium for covered workers at firms with a smaller share of older workers ($28,689 vs. $27,889). The average premium for single coverage for covered workers in private, for-profit firms is relatively low ($9,291); the average premiums for covered workers in private, not-for-profit firms are relatively high for both single ($10,927) and family ($30,783) coverage [Figure C].

Most covered workers contribute to the cost of the premium directly. On average, covered workers contribute 18% of the premium for single coverage and 27% of the premium for family coverage, similar to the percentages contributed in 2025. The average contribution rates for single coverage are similar for covered workers in smaller firms and larger firms (16% vs. 18%) but the average contribution rate for family coverage is much higher for covered workers in smaller firms than for those in larger firms (37% vs. 25%). On average, covered workers at private, for-profit firms have a relatively high premium contribution rate for single coverage (20%). The average contribution rate for family coverage is higher for covered workers in firms with relatively large shares of lower-wage workers (where at least 35% earn $38,000 or less annually) than those in firms with smaller shares of lower-wage workers (31% vs. 27%).

Figure C

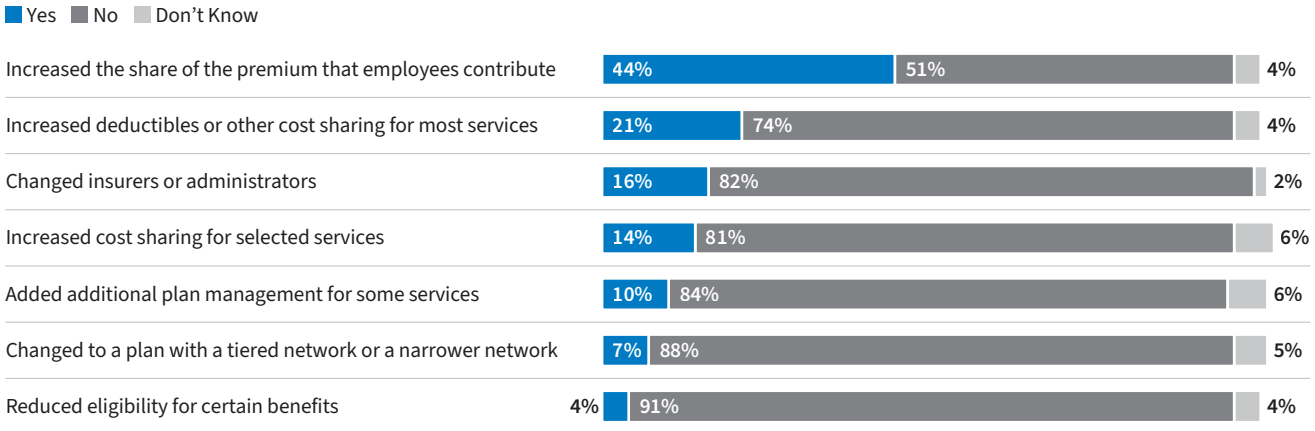
Average Annual Worker Contributions for Family Coverage, by Firm Size, 2025–2026



Note: * Estimate is statistically different from estimate for the previous year shown ($p < .05$).
Source: KFF Employer Health Benefits Survey, 2026

Figure D

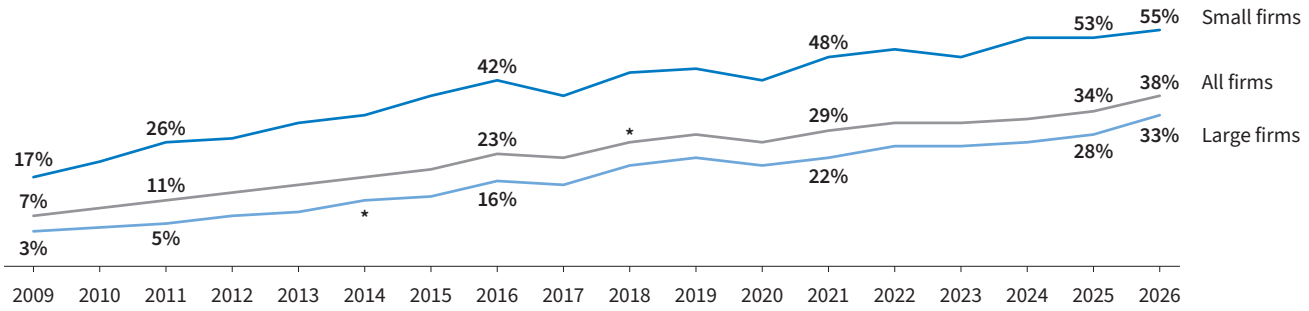
Among Large Firms Offering Health Benefits, Firm Responses to Higher Projected Health Plan Costs, 2026



Note: Large firms have 200 or more workers. Additional plan management includes prior authorization.
Source: KFF Employer Health Benefits Survey, 2026

Figure E

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size, 2009–2026



Note: * Estimate is statistically different from estimate for the previous year shown ($p < .05$). 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, 2018–2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009–2017

Twenty-nine percent of covered workers at smaller firms are enrolled in a plan where the employer pays the entire premium for single coverage, compared with only 5% of covered workers at larger firms. In contrast, 32% of covered workers at smaller firms are in a plan where they must contribute more than half of the premium for family coverage, compared to 6% of covered workers at larger firms [Figure D].

The average annual contribution amounts for covered workers are $1,672 for single coverage and $7,471 for family coverage, both higher than last year. The average contribution amount for family coverage for covered workers at smaller firms ($9,687) is higher than the amount for covered workers at larger firms ($6,840) [Figure C]. Thirteen percent of covered workers, including 31% of covered workers at smaller firms, are in a plan with a worker contribution of $12,000 or more for family coverage. The average contribution amount for family coverage for covered workers enrolled in HSA-qualified plans is lower than the overall average contribution amount for covered workers ($6,211 vs. $7,471).

Reactions To Higher Projected Costs

Employers have multiple avenues by which they can respond to higher health care costs. These include increasing the amount of the premium that workers pay for coverage, changing provider networks, or modifying benefits. The cost of health benefits was projected to increase substantially in 2026, and early projections for 2027 point to further cost growth. Firms offering health benefits were asked whether they took certain actions in response to projected cost increases for their plan with the largest enrollment.

The most commonly reported employer action by large firms was increasing the share of the premium that workers contribute toward their coverage (44%). Other actions by large firms included increasing deductibles or other cost sharing for most services (21%), changing insurers or plan administrators (16%), increasing cost sharing for specific services (14%), adding utilization management requirements, such as prior authorization, for some services (10%), switching to a plan with a tiered or narrower provider network (7%), and reducing or tightening eligibility for certain benefits (4%) [Figure D].

Large firms offering health benefits were generally more likely to report taking actions in response to projected cost increases compared to firms overall. Among all firms, 18% increased the share of premiums paid by workers, and 4% increased deductibles or other cost sharing for most services.

Plan Enrollment

Health plans are often categorized into plan types based on their coverage of out-of-network services and whether they require primary care referrals. This survey classifies plans into five plan types. Beginning in 2026, this survey changed how it classifies high-deductible health plans associated with a Health Reimbursement Arrangement (HRA). In previous years, these plans were grouped with HSA-qualified plans in a broader HDHP/SO (high-deductible health plan with a savings option) category. HRA plans are now classified as PPOs, POS plans, or HMOs based on their plan characteristics. HSA-qualified plans are now reported as a separate plan type.

PPOs continue to be the most common plan type in 2026. Fifty percent of covered workers are enrolled in a PPO, 29% are enrolled in an HSA-qualified plan, 12% are enrolled in an HMO, 8% are enrolled in a POS plan, and less than one percent are enrolled in a conventional (also known as an indemnity) plan.

Self-Funding

Many firms, particularly larger firms, have self-funded health plans, which means that they pay for health services for enrollees directly from their own funds, rather than through the purchase of health insurance. Seventy-one percent of covered workers, including 25% of covered workers at smaller firms and 85% at larger firms, are enrolled in plans that are self-funded.

Thirty-eight percent of covered workers in smaller firms are covered by a level-funded plan, similar to the percentage in 2025. 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 may use health status in rating and underwriting. Level-funded plans are also 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 as the percentage last year (88%).

Among covered workers in a plan with a general annual deductible in 2026, the average deductible amount is $1,955, similar to the amount last year. The average deductible for covered workers at smaller firms ($2,624) is higher than the average deductible at larger

firms ($1,772). For covered workers in a plan with a general annual deductible, the average deductible for single coverage has increased 18% over the last five years and 34% over the last 10 years.

Thirty-eight percent of covered workers in 2026 are in a plan with a general annual deductible of $2,000 or more for single coverage, similar to the percentage (34%) last year. Over half (55%) of covered workers in smaller firms are in such a plan, compared with 33% of covered workers in larger firms [Figure E]. The share of covered workers in a plan with a general annual deductible of $2,000 or more for single coverage has increased 31% over the last five years and 63% over the last ten years.

Some workers in health plans with high deductibles also receive contributions to savings accounts from their employers, which can be used to reduce cost sharing liability. Among covered workers in an HSA-qualified health plan, 3% receive an account contribution for single coverage that is greater than or equal to their deductible amount, and an additional 10% of covered workers in an HSA-qualified plan receive account contributions that, if applied to their deductible, would reduce their personal annual liability to less than $1,000. Some workers also have access to funds in health reimbursement arrangements (HRAs) established by their employers, which can often be used for cost sharing. As of 2026, this survey no longer collects the amounts contributed to HRAs, so the impacts of these contributions on worker cost sharing cannot be calculated. In 2026, 8% of covered workers are in a plan that is offered along with a health reimbursement arrangement. Among these covered workers, 61% are in a plan where the HRA contribution can be used to reduce plan cost sharing liability.

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 and the average copayment for a visit to a specialist is $46. Each of these amounts is similar to the amount last year. The average coinsurance rate is 20% for both primary care and specialist visits, similar to the percentages last year.

When admitted to the hospital, 60% of covered workers have a coinsurance requirement, 11% have a copayment, and 10% have both. The average coinsurance rate for a hospital admission is 20% and the average copayment amount is $317. 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 ($205).

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, 14% are in a plan with an out-of-pocket limit of $2,000 or less, while 24% are in a plan with a limit above $6,000.

Availability of Employer-Sponsored Coverage

In 2026, 67% of firms with 10 or more workers offer health benefits, higher than the percentage last year (61%) but similar to the percentage two years ago (65%) and lower than the percentage (73%) five years ago.

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, 98% 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, 92% of workers are employed by a firm that offers health benefits to at least some of its workers, lower than the percentage (94%) five years ago.

Inducements Not to Enroll. Among firms with ten or more employees that offer health benefits, 8% provide additional compensation or benefits to employees if they enroll in a spouse's plan, and 7% provide additional compensation or benefits to employees if they do not participate in the firm's health benefits.

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/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 spouse's plan. On average, at firms that offer coverage, 80% of workers are eligible. Among eligible workers, 74% take up the firm's offer.

Overall, 59% of workers at firms that offer health benefits are enrolled in that coverage. All of these percentages are similar to the percentages in 2025.

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 (44% vs. 62%) 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 (47% vs. 61%).[4] Workers at public organizations are more likely to be covered by their own employer (72%) than workers at private for-profit firms (57%), or private not-for-profit firms (57%).

Across firms that offer health benefits and firms that do not, 55% of workers are covered by a health plan offered by their employer, the same percentage as last year.

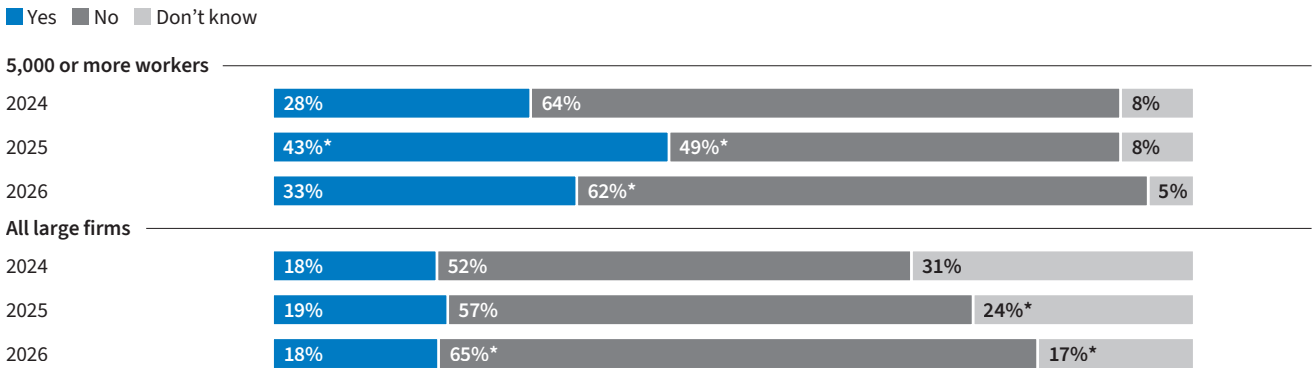
GLP-1 Drug Coverage for Weight Loss

GLP-1 (glucagon-like peptide-1) agonists, used to help control blood sugar levels in people with type 2 diabetes, have also been shown to be effective at helping people lose weight. Health plans generally have covered these medications when prescribed for people with diabetes, but there is now widespread interest in their use for people who have a clinical need to lose weight. Although the cost of these drugs has been decreasing, the large number of people who may benefit from them, combined with the potential of long-term maintenance usage, has raised questions about their impact on plan costs. The increasing availability of direct-to-consumer programs for these medications, often at relatively low costs, has also provided options for employers to potentially fund access to these medications through account contributions.

Among firms that offer health benefits with 200 or more workers, 16% of firms with 200 to 999 workers, 29% of firms with 1,000 to 4,999 workers, and 33% of firms with 5,000 or more workers cover GLP-1 agonists when used primarily for weight loss in 2026. The overall percentage of firms with 200 or more workers that cover GLP-1 agonists for weight loss (18%) is similar to the percentage last year (19%) and two years ago [Figure F]. Forty percent of firms that cover these medications for weight loss, including 59% of firms with 5,000 or more workers, require enrollees to meet with a dietitian, case manager, or therapist, or participate in a lifestyle program

Figure F

Percentage of Large Firms Whose Largest Plan Includes Coverage For GLP-1 Agonists When Used Primarily For Weight Loss, by Firm Size, 2024–2026



* Estimate is statistically different from estimate for the previous year shown with size and response categories ($p < .05$).

Note: * Estimate is statistically different from estimate for the previous year shown with size and response categories ($p < .05$). 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, 2024–2026

in order for the drug to be covered, similar to the percentage (34%) last year.

Among firms with 200 or more workers that cover GLP-1 agonists for weight loss in their plan with the largest enrollment, 29% say that covering these medications has had a "significant" impact on their plan's prescription drug spending, 27% say that the impact on spending has been "moderate", 23% say that the impact on spending has been "minor", 10% say that there has been no impact on spending, and 11% say they do not know. The share of these firms saying that covering GLP-1 agonists for weight loss has had a significant impact on prescription drug spending increases with firm size, ranging from 21% of firms with 200 to 999 workers to 61% of firms with 5,000 or more workers.

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, 13% say that they are "somewhat likely," 79% say that they are "not likely," and 7% do not know the answer to the question. Twelve percent of these firms say that they have stopped covering these medications for weight loss within the last 12 months

Prescription Drug Policy

Some employers are pursuing strategies outside of their health plan or pharmacy benefit manager (PBM) to help workers obtain lower-cost prescription drugs. Firms with 50 or more workers offering prescription drug coverage were asked about several of these approaches. Thirty-three percent of these employers offer enrollees access to lower-cost mail-order generic drugs through a third-party vendor, such as Mark Cuban Cost Plus, SingleCare, or GoodRx.

Eleven percent of these employers limit coverage for certain prescriptions exclusively to mail-order pharmacies. In these cases, the plan does not pay for those prescriptions if an enrollee uses an in-person pharmacy.

A smaller share of employers participate in an international prescription drug purchasing service, such as ScriptSourcing or CanaRx, which provides access to discounted maintenance medications purchased outside the United States (9%).

In Vitro Fertilization

Improving affordable access to in vitro fertilization (IVF) and other assisted reproductive services has been a topic of public debate in recent years, particularly after President Trump campaigned on the idea of providing access to these services at no cost. Among firms with 200 or more workers, 24% of firms with 200 to 999 workers, 38% of firms with 1,000 to 4,999 workers, and 47% of firms with 5,000 or more workers provide coverage for IVF services in their plan with largest enrollment, either through their plan or through a third-party vendor. Firms with 200 to 999 workers are more likely than larger firms to say that they do not know (27% vs. 9%).

Prior Authorization of Services

Health plan management practices, particularly prior authorization, have received considerable recent attention. Firms with 200 or more workers offering health benefits were asked about recent changes in the use of prior authorization in their plan with the largest enrollment. Seven percent of these firms say that the number of services subject to prior authorization is "higher" than it was last year, 2% say that it is "lower" than last year, 70% say that it is "about the same" as last year, and 21% say they do not know. Firms with 1,000 or more workers are more likely than firms with 200 to 999 workers to say that the number of services subject to prior authorization is "higher" than it was last year (12% vs. 6%). Among firms that say that the number of services subject to prior authorization is "higher" than it was last year, 48% say that prior authorization was added to additional services to help control overall cost growth in the plan.

Ability of Employers To Obtain Information About the Cost and Use of Services

Firms that offer health benefits with 200 or more workers were asked about their ability to obtain information about the cost and use of medical services (other than prescription drugs) in their plan with the largest enrollment. This information might include summary information from an insurer or plan administrator or more specific data reports. Specifically, firms were asked how strongly they agree or disagree that they are able to obtain enough information to understand each of these areas [Figure G]:

- **Service use by type of medical provider.** Sixteen percent of these firms "strongly agree" that they are able to get sufficient information to understand the service use of plan enrollees by type of medical

provider, 54% of the firms "agree" that they are able to get this information, 12% "disagree" that they are able to get this information, 3% "strongly disagree" that they are able to get this information, and 16% say that they do not know. Firms with 1,000 or more workers are more likely than firms with 200 to 999 workers to say that they "strongly agree" that they are able to get sufficient information to understand the service use of plan enrollees by type of medical provider (25% vs. 14%).

- **The medical conditions of plan enrollees, including those that contribute the most to plan cost.** Twenty percent of these firms "strongly agree" that they are able to get sufficient information to understand the medical conditions of plan enrollees, including those that contribute the most to plan cost, 52% of the firms "agree" that they are able to get this information, 11% "disagree" that they are able to get this information, 4% "strongly disagree" that they are able to get this information, and 14% say they do not know. Firms with 1,000 or more workers are more likely than firms with 200 to 999 workers to say that they "strongly agree" that they are able to get sufficient information to understand the medical conditions of plan enrollees (28% vs. 18%).
- **The prevalence of chronic conditions among plan enrollees**. Eighteen percent of these firms "strongly agree" that they are able to get sufficient information to understand the prevalence of chronic conditions among plan enrollees, 52% of the firms "agree" that they are able to get this information, 12% "disagree" that they were able to get this information, 2% "strongly disagree" that they are able to get this information, and 15% say they do not know. Firms with 1,000 or more workers are more likely than firms with 200 to 999 workers to say that they "strongly agree" that they are able to get sufficient information to understand the prevalence of chronic conditions among plan enrollees (27% vs. 16%).
- **The prices the plan pays to in-network providers, and how those prices compare to other providers.** Fourteen percent of these firms "strongly agree" that they are able to get sufficient information to understand the prices the plan pays to in-network providers and how those prices compare to other providers, 46% of the firms "agree" that they are able to get this information, 19% "disagree" that they are able to get this information, 4% "strongly disagree" that they are able to get this information, and 17% say they do not know.
- **Areas where enrollees may have unmet needs or gaps in care.** Ten percent of these firms "strongly agree" that are able to get sufficient information to understand areas of unmet needs or gaps in care, 45% of the firms "agree" that they are able to get this information, 20% "disagree" that they are able to get this information, 5% "strongly disagree" that they are able to get this information, and 19% say they do not know.

Provider Networks

Employers that offer health benefits were asked to characterize the breadth of the provider network in their plan with the largest enrollment, for all providers as well as specifically for services for mental health and substance use conditions.

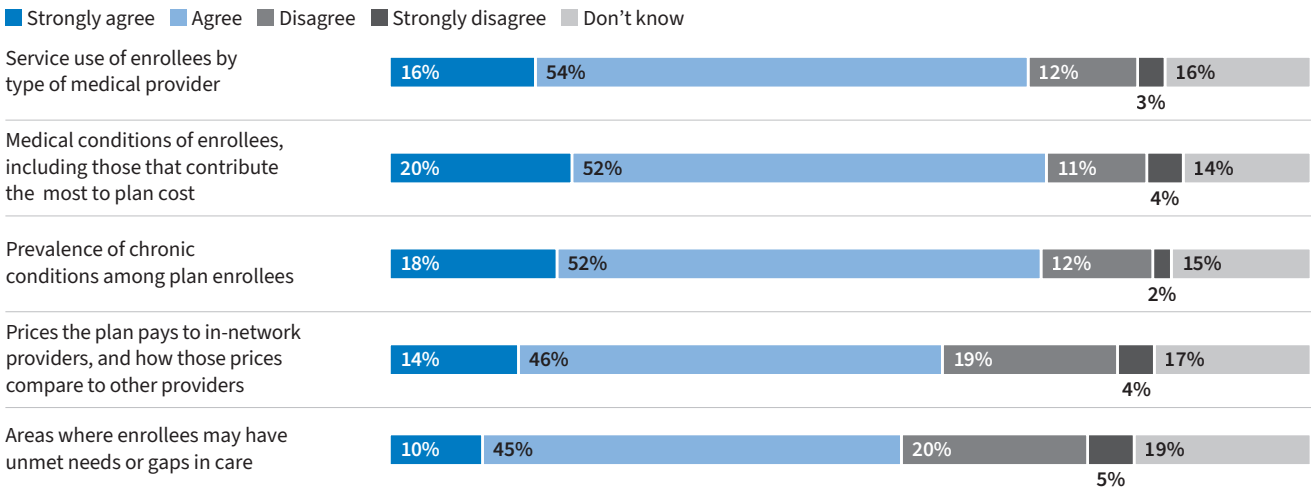
Fifty-one percent of firms characterize the network in their plan with the largest enrollment as "very broad," 38% say it is "somewhat broad," and 7% say it is "somewhat narrow" or "very narrow." Firms with 200 or more employees are more likely than smaller firms to characterize the provider network in their plan with the largest enrollment as "very broad" (64% vs. 50%).

Twenty-two percent of firms characterize the network in their plan with the largest enrollment as "very broad" for mental health and substance use condition services, 42% say it is "somewhat broad" for these services, and 15% say it is "somewhat narrow" or "very narrow". Firms with 200 or more employees are more likely than smaller firms to characterize the provider network in their plan with the largest enrollment as "very broad" for mental health and substance use condition services (32% vs. 21%).

Employers that offer health benefits are less likely to characterize the network in their plan with the largest enrollment as "very broad" for mental health and substance use condition services than for medical services overall. This is true for small firms (10 to 199 employees) (21% vs. 50%) and larger firms (32% vs. 64%).

Figure G

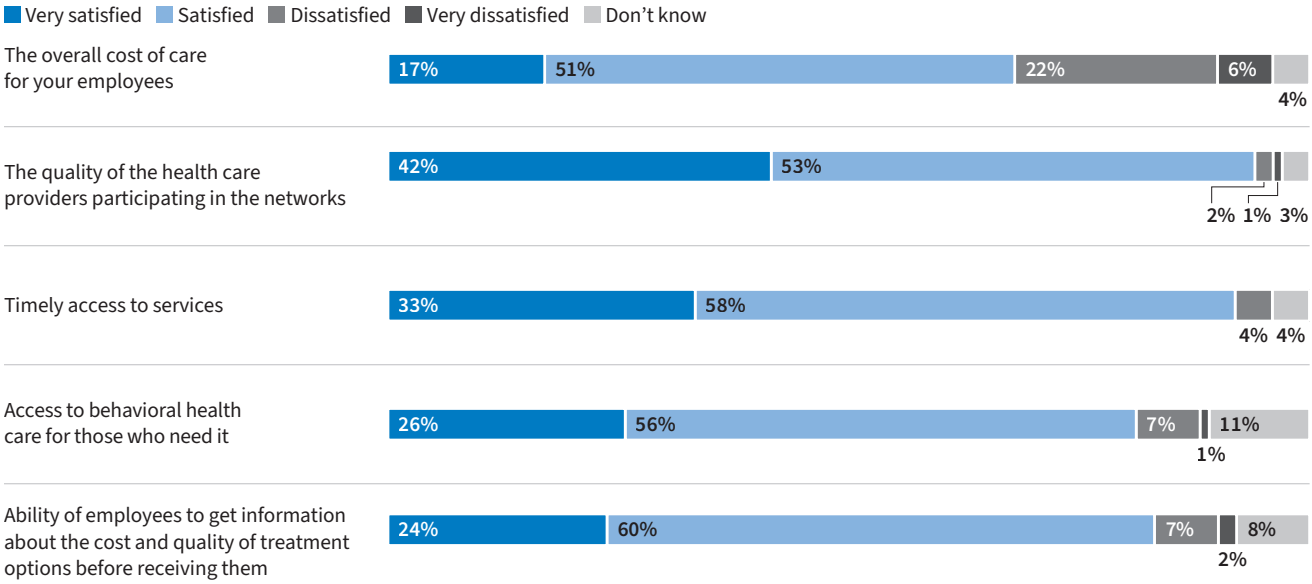
Percentage of Large Firms That Agree They Can Obtain Information On the Cost and Use of Various Medical Services, 2026



Note: Large firms have 200 or more workers.
Source: KFF Employer Health Benefits Survey, 2026

Figure H

Firms' Level of Satisfaction With Aspects of Their Health Plans, 2026



Source: KFF Employer Health Benefits Survey, 2026

Treatment Options for Substance Use Conditions

Firms with 200 or more workers offering health benefits were asked whether they had made efforts in the last two years to expand the availability of services to treat substance use conditions. Among these firms, 34% say that they have added new virtual providers within the last two years, and 20% say that they have added new providers or facilities for in-person care.

Employer Satisfaction With Health Plans

Firms that offer health benefits were asked about their satisfaction with several aspects of the health plans they offer [Figure H]:

- **Cost of care:** Employers have low levels of satisfaction with the overall cost of care for their workers. Only 17% of firms say they are "very satisfied" with the overall cost of care, while 51% say they are "satisfied." In contrast, 29% say they are "dissatisfied" or "very dissatisfied".
- **Quality of network providers:** Firms report higher levels of satisfaction with the quality of providers participating in their plan networks. Forty-two percent of firms say they are "very satisfied", and 53% say they are "satisfied." Only 2% say they are "dissatisfied" or "very dissatisfied" with the quality of network providers.
- **Timely access to services**: Thirty-three percent of firms say they are "very satisfied" with timely access to services in the health plans they offer, and 58% say they are "satisfied." Only 5% say they are "dissatisfied" or "very dissatisfied."
- **Access to behavioral health care:** Twenty-six percent of firms say they are "very satisfied" with access to behavioral health care in the health plans they offer, and 56% say they are "satisfied." Only 7% say they are "dissatisfied" or "very dissatisfied."
- **Employee access to information about the cost and quality of treatment options:** Twenty-four percent of firms say they are "very satisfied" with workers' ability to obtain information about the cost and quality of treatment options before receiving care, and 60% say they are "satisfied." 8% say they are "dissatisfied" or "very dissatisfied."

Discussion

Despite early projections pointing toward higher costs in 2026, average premiums increased at a relatively modest pace. Over the last five years, family health insurance premiums have grown at about the same rate as general inflation and workers' wages (28% vs 24.4% and 26.9%).

Heading into 2027, forecasts are again projecting premium increases approaching double digits. How and when higher projected health care spending translates into higher premiums remains to be seen, but employers may face increasing pressure to maintain the affordability of their plans if steep increases materialize. In 2026, 18% of employers, including 66% of employers with 5,000 or more employees, said they increased the share of premiums paid by workers in response to anticipated premium increases. After decades in which the average share of the premium paid by workers has remained relatively stable, a shift toward higher worker contributions could raise new affordability concerns.

Much of the policy response to rising health care costs has focused on increasing price transparency, strengthening employers' negotiating position with providers, and giving purchasers more information to design efficient provider networks. Many employers agree or strongly agree that they have the data they need to understand key elements of their health plans, and most employers that have sought access to their claims data reported receiving it. How greater access to data will change employers' role as health care purchasers will be an important policy topic over the next several years, particularly because many employers continue to place a high value on broad provider networks. Eighty-nine percent of employers described the provider network in their largest plan as "very broad" or "somewhat broad." Mental health and substance use disorder services are one notable exception: only 64% described those networks as broad or very broad. Some large employers are addressing accessibility challenges for these conditions by adding virtual and in-person providers.

While rising costs remain a significant challenge for employer plans going forward, employers reported high levels of satisfaction with several key elements of their plans. Prescription drug costs remain an important area of focus for managing plan costs. Meaningful shares of large employers continue to cover GLP-1 drugs when prescribed primarily for weight loss, but lower prices available through direct-to-consumer arrangements, together with the significant cost of these drugs, may lead employers to continue adapting their coverage. Small shares of employers are also exploring alternative approaches to purchasing some prescription drugs, including international sourcing and alternative mail-order pharmacy arrangements.

Methodology

The KFF 2026 Employer Health Benefits Survey reports findings from a survey of 1,937 randomly selected non-federal public and private employers with ten or more workers. Davis Research, LLC conducted the fieldwork between January and July 2026. The overall response rate is 11%, 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 to 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.

Endnotes

[1] KFF's analysis of data from the 2024 American Community Survey. See KFF. Health insurance coverage of the population ages 0–64 [Internet]. San Francisco (CA): KFF; [cited 2026 Aug 19]. [Time frame: 2024]. Available from: https://www.kff.org/state-health-policy-data/stateindicator/health-insurance-coverage-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. 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;. Available from: https://www.bls.gov/ces/data/

[4] This threshold is based on the twenty-fifth percentile of workers' earnings ($38,000 in 2026). 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

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