Employer Health Benefits

Annual Survey
2026

KFF

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2026 Employer Health Benefits Survey

KFF

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Table of Contents

Introduction **5**

Summary of Findings **8**

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS 8

PLAN ENROLLMENT 11

SELF-FUNDING 12

EMPLOYEE COST SHARING 12

AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE 14

GLP-1 DRUG COVERAGE FOR WEIGHT LOSS 14

IN VITRO FERTILIZATION 16

PRIOR AUTHORIZATION OF SERVICES 16

ABILITY OF EMPLOYERS TO OBTAIN INFORMATION ABOUT THE COST AND USE OF SERVICES 16

PROVIDER NETWORKS 18

DISCUSSION 19

METHODOLOGY 20

Survey Design and Methods **22**

SURVEY TOPICS 22

SAMPLE DESIGN 22

RESPONSE RATE 23

FIRM SIZES AND KEY DEFINITIONS 24

ROUNDING AND IMPUTATION 27

WEIGHTING 30

STATISTICAL SIGNIFICANCE AND LIMITATIONS 30

DATA COLLECTION AND SURVEY MODE 30

EMPLOYER SURVEY LANDSCAPE 31

PREFERRED REPORTING ITEMS FOR COMPLEX SAMPLE SURVEY ANALYSIS (PRICSSA) 31

2026 SURVEY 32

OTHER RESOURCES 32

1 Cost of Health Insurance **35**

PREMIUMS FOR SINGLE AND FAMILY COVERAGE 35

PREMIUM DISTRIBUTION 41

PREMIUM CHANGES OVER TIME 44

2 Health Benefits Offer Rates **48**

FIRM OFFER RATES 48

OFFERS TO SPOUSES AND DEPENDENTS 52

PROVISIONS TO ENCOURAGE ENROLLMENT IN OTHER COVERAGE 53

SPOUSAL ELIGIBILITY AND SURCHARGES 53

PART-TIME WORKERS 56

CHOICE/ICHRA AND ASSISTING EMPLOYEES WITH PURCHASING COVERAGE IN THE NON-GROUP MARKET 57

FIRMS NOT OFFERING HEALTH BENEFITS 60

3 Employee Coverage, Eligibility, and Participation **65**

ELIGIBILITY 65

TAKE-UP RATE 70

COVERAGE 71

COVERAGE AMONG ALL FIRMS 73

4 Types of Plans Offered **76**

NUMBER OF PLAN TYPES OFFERED 76

PERCENTAGE OF FIRMS OFFERING HSA-QUALIFIED PLANS 79

5 Market Shares of Health Plans **83**

COVERAGE IN HSA-QUALIFIED PLANS 85

6 Worker and Employer Contributions for Premiums **88**

DISTRIBUTIONS OF WORKER CONTRIBUTIONS TO THE PREMIUM 93

DIFFERENCES BY FIRM CHARACTERISTICS 97

DIFFERENCES BY REGION AND INDUSTRY 101

CHANGES OVER TIME 102

7 Employee Cost-Sharing **107**

GENERAL ANNUAL DEDUCTIBLES FOR WORKERS IN PLANS WITH DEDUCTIBLES 107

GENERAL ANNUAL DEDUCTIBLES AMONG ALL COVERED WORKERS 113

GENERAL ANNUAL DEDUCTIBLES AND ACCOUNT CONTRIBUTIONS 116

GENERAL ANNUAL DEDUCTIBLES FOR WORKERS ENROLLED IN FAMILY COVERAGE 119

COVERAGE OF SERVICES AND PRODUCTS BEFORE MEETING THE GENERAL ANNUAL DEDUCTIBLE 124

HOSPITAL ADMISSIONS AND OUTPATIENT SURGERY 125

COST-SHARING FOR PHYSICIAN OFFICE VISITS 130

OUT-OF-POCKET MAXIMUMS 135

8 Health Plans with Savings Accounts 139

AVAILABILITY OF AND ENROLLMENT IN HSA-QUALIFIED PLANS 139

EMPLOYER CONTRIBUTIONS TO HSA ACCOUNTS 139

WORKER AND EMPLOYER CONTRIBUTIONS TO HSA-QUALIFIED PLAN PREMIUMS 142

COST-SHARING 145

HEALTH REIMBURSEMENT ARRANGEMENTS 147

9 Prescription Drug Benefits 151

TIERS NOT EXCLUSIVELY FOR SPECIALTY DRUGS 152

COINSURANCE MAXIMUMS 156

SEPARATE TIERS FOR SPECIALTY DRUGS 157

10 Plan Funding 164

SELF-FUNDED PLANS 164

LEVEL-FUNDED PLANS 168

STOPLOSS COVERAGE 170

11 Retiree Health Benefits 173

EMPLOYER RETIREE BENEFITS 173

BENEFIT ELIGIBILITY 176

MEDICARE ADVANTAGE 178

12 Employer Opinions and Practices: Satisfaction with Health Plans, Provider Networks, Coverage for GLP-1s, and Access to Data 182

EMPLOYER SATISFACTION WITH HEALTH PLANS 182

HEALTH PLAN NETWORKS 184

REACTIONS TO HIGHER PROJECTED COSTS 190

GLP-1 DRUG COVERAGE FOR WEIGHT LOSS 191

PRIOR AUTHORIZATION OF SERVICES 195

IN VITRO FERTILIZATION 197

EMPLOYER ACCESS TO INFORMATION ABOUT THE COST AND USE OF MEDICAL SERVICES BY PLAN ENROLLEES 197

EMPLOYER ACCESS TO INFORMATION ABOUT THE COST AND USE OF PRESCRIPTION DRUGS 202

Introduction

Employer-sponsored insurance covers 157 million people under age 65. To provide a current snapshot of employer-sponsored health benefits, KFF conducts an annual survey of private and non-federal public employers with 10 or more workers. This is the 28th Employer Health Benefits Survey (EHBS) and reflects employer-sponsored health benefits in 2026. As in years past, the survey examines trends in employer coverage, including premiums, employee contributions, cost sharing, offer rates, and employer practices. This year, we asked employers detailed questions about satisfaction with their health plans; coverage of GLP-1 agonists and IVF; actions taken in response to projected cost increases; and firms' ability to obtain information about health care costs and utilization. The 2026 survey includes 1,937 interviews with non-federal public and private firms. The survey was fielded from December 2025 through July 2026.

Key Findings

- **Family premiums reach $28,000.** The average annual premium for family coverage reached $28,303 this year, 5 percent higher than last year. Over the last five years, family premiums grew 28%, compared with inflation of 24.4% and wage growth of 26.9%.
- **Coverage rates remain stable.** Among workers in all firms, including those that offer and those that do not offer health benefits, 55% are covered by health benefits offered by their employer, similar to the percentage last year (55%). Sixty-six percent of small firms and 98% of large firms offer health benefits to at least some workers, with an overall offer rate of 67%.
- **Some large firms responded to projected cost increases by increasing workers' premium contributions or cost sharing.** Among large firms offering health benefits, 44% increased the share of premiums paid by workers, and 21% increased deductibles or other cost sharing for most services. In 2026, covered workers contribute an average of 18% of the premium for single coverage and 27% for family coverage.
- **Average deductible nears $2,000.** Among workers who face an annual deductible for single coverage, the average this year stands at $1,955, compared to $1,886 in 2025. Covered workers at small firms face much larger average deductibles than workers at larger firms ($2,624 vs. $1,772).
- **Coverage of GLP-1 drugs for weight loss has remained relatively stable.** Among firms with 200 or more workers, the share covering GLP-1 agonists for weight loss is similar to the previous two years. Among firms with 200 or more workers that cover GLP-1 agonists for weight loss, 29% say that covering these medications has had a significant impact on their plan's prescription drug spending, including 61% of firms with 5,000 or more workers.
- **In-vitro fertilization coverage.** About a quarter (27%) of large firms provide coverage for in-vitro fertilization services, unchanged from 2024.
- **Mail-order prescription drug alternatives.** A third (33%) of employers with at least 50 workers offer enrollees access to lower-cost mail-order generic drugs through venders such as GoodRx, Single-Care, or Mark Cuban Cost Plus. In addition, 9% participate in an international prescription drug purchasing service, such as ScriptSourcing or CanaRx, to access discounted maintenance medications from outside the U.S.
- **On-site and near-site clinics.** A quarter (24%) of offering employers with at least 50 workers provide health services by contracting with clinics either on site or near their site. These clinics treat both work-related and non-work-related conditions.

- **Firms report narrower networks for mental health and substance use services than for providers overall.** Among firms offering health benefits, 15% characterize the network for mental health and substance use services as "somewhat narrow" or "very narrow," compared with 7% for providers overall. Three in ten large firms added new virtual providers for substance use services in the past two years.

Survey results are released in several formats, including a full report with downloadable tables and a summary of findings. Additional resources, including an interactive graphic of premium trends and a de-identified public-use dataset, are available at ehbs.kff.org.

Summary of Findings



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).

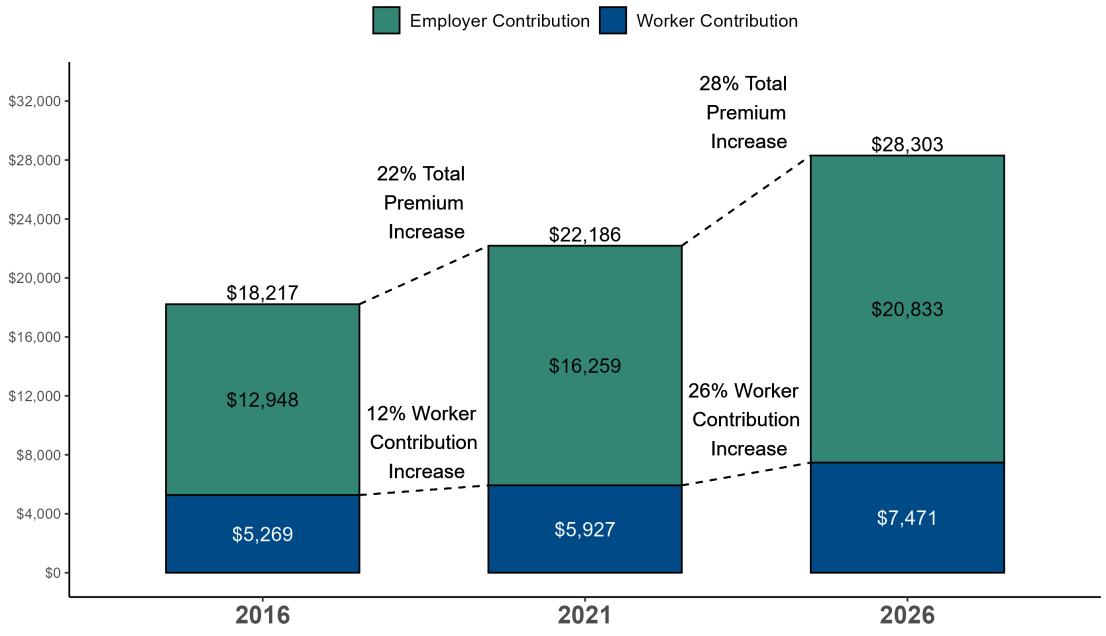
Premiums also vary with firm characteristics. Average premiums for covered workers are relatively high in the Northeast for both single coverage ($10,806) and for family coverage ($31,378) and are relatively low in the South for both single coverage ($9,272) and for family coverage ($26,702). The average 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].

[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/state-indicator/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

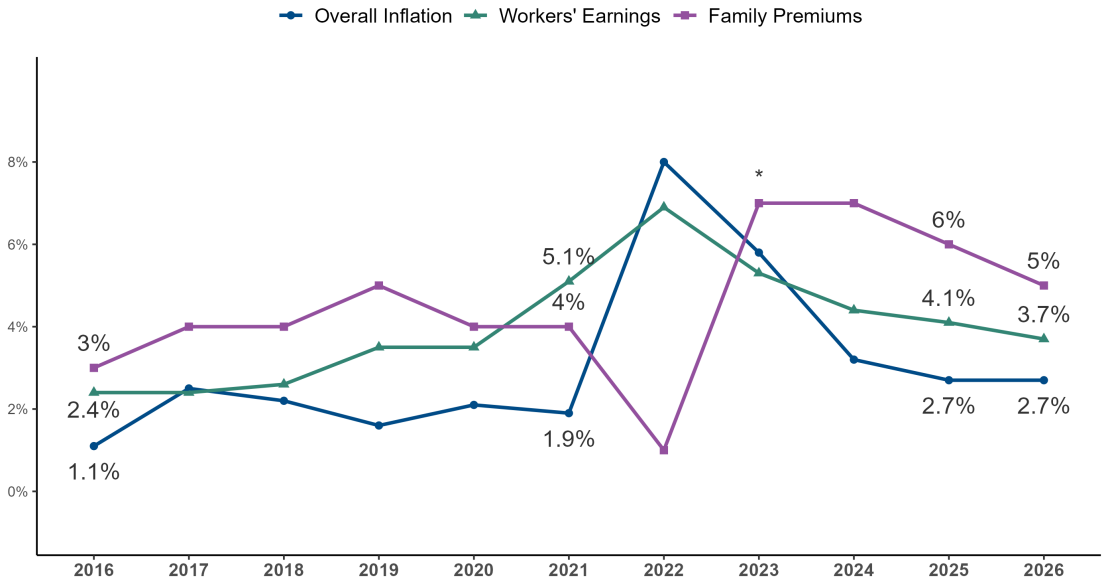
[3] Average hourly earnings of production and nonsupervisory employees (seasonally adjusted) from the Current Employment Statistics survey. See Bureau of Labor Statistics. Current Employment Statistics—CES (national) [Internet]. Washington (DC): BLS;. Available from: https://www.bls.gov/ces/data/

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



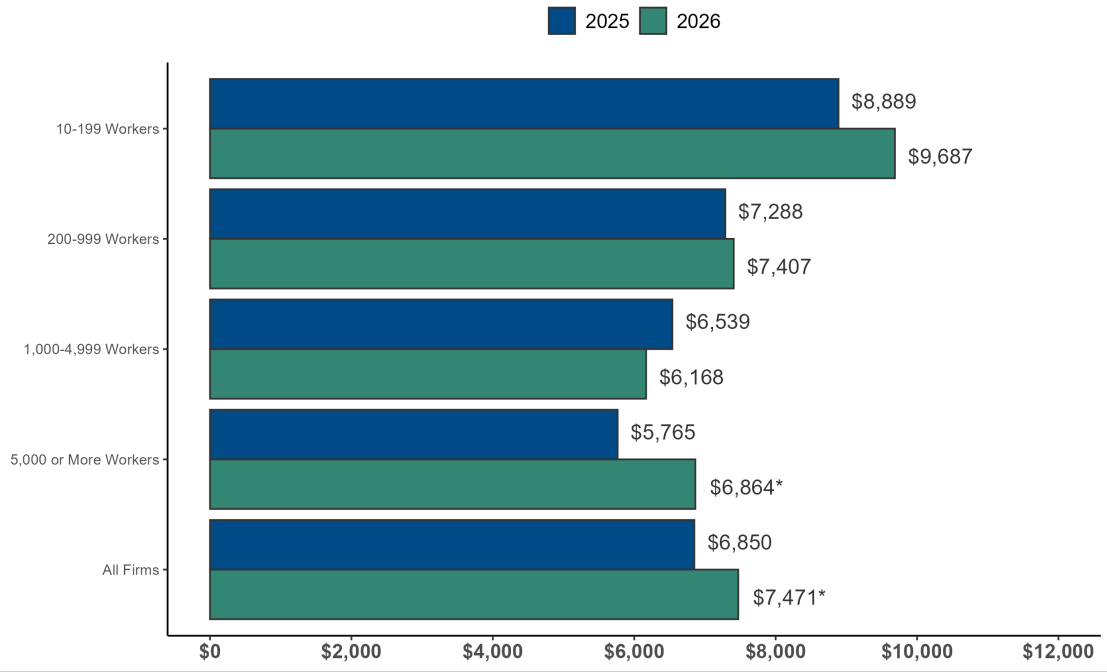
SOURCE: KFF Employer Health Benefits Survey, 2021 and 2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016.

Figure B
Average Annual Increases in Premiums for Family Coverage Compared to Other Indicators, 2016-2026



* The estimated increase in family premiums is statistically different from the 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.

Figure C
Average Annual Worker Contributions for Family Coverage, by Firm Size, 2025-2026



* Estimate is statistically different from estimate for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2025-2026;

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%).

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

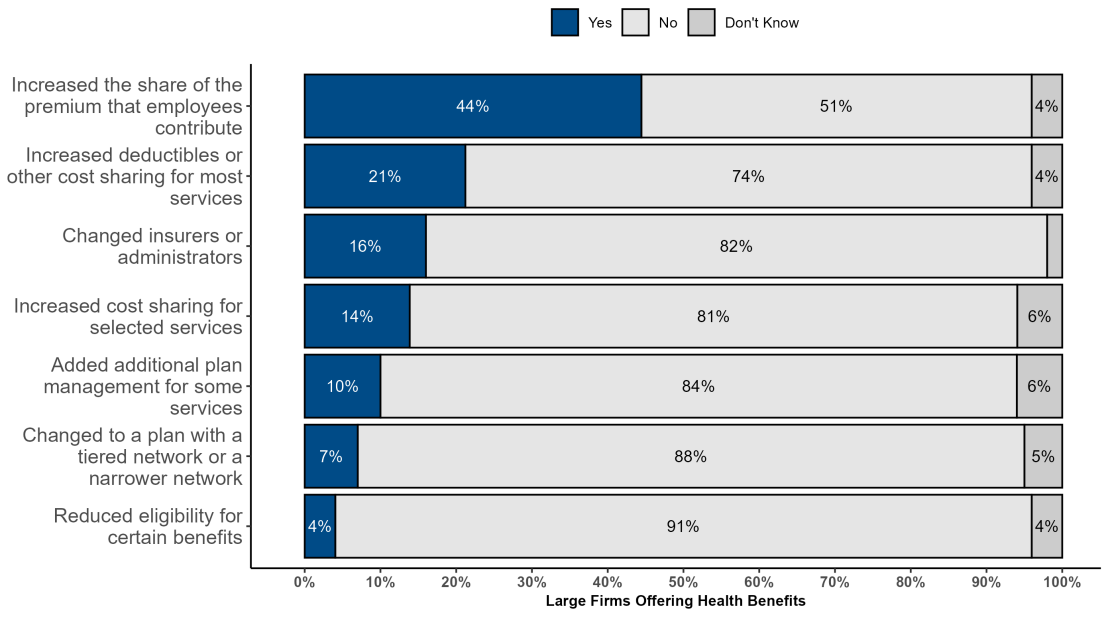
Employers have multiple avenues by which they can respond to higher health care costs. These include increasing the amount of the premium that workers pay for coverage, changing provider networks, or modifying

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.

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

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.

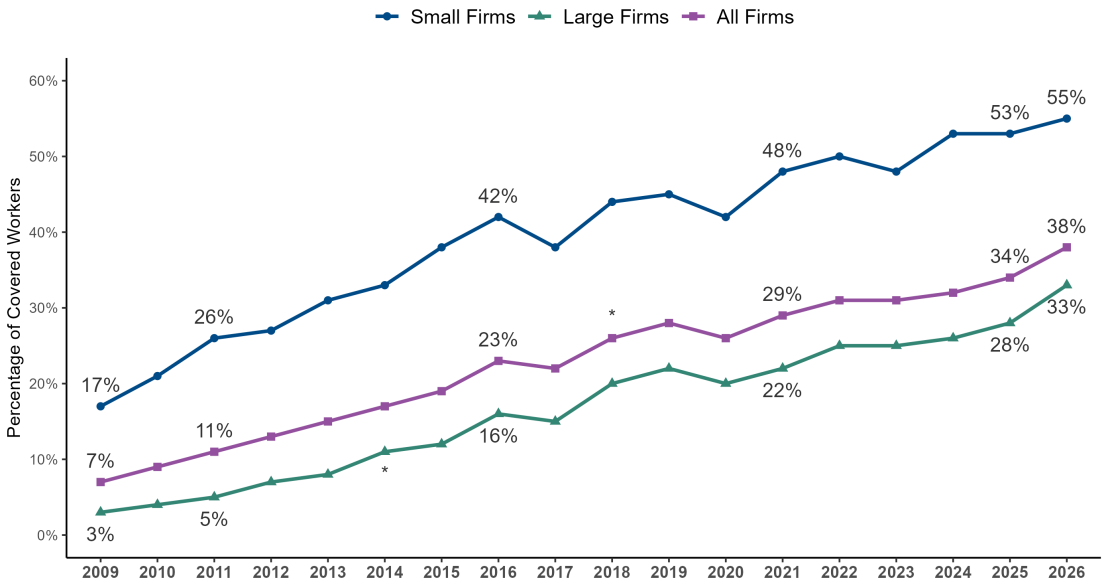
EMPLOYEE COST SHARING

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.

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



* 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 HSA-Qualified plans and other plan types. 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

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,

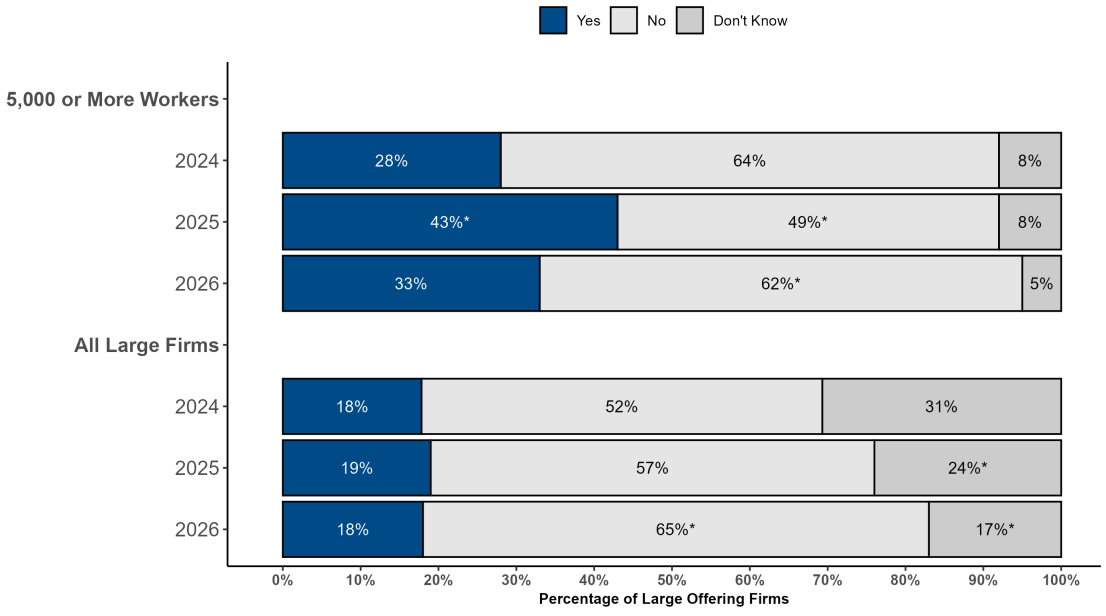
[4]This threshold is based on the twenty-fifth percentile of workers' earnings ($38,000 in 2026). Seasonally adjusted data from the Current Employment Statistics Survey. Bureau of Labor Statistics. Current Employment Statistics—CES (national) [Internet]. Washington (DC): BLS. Available from: https://www.bls.gov/ces/publications/highlights/highlights-archive.htm

require enrollees to meet with a dietitian, case manager, or therapist, or participate in a lifestyle program 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.

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 within the same 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, 2024-2026;

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

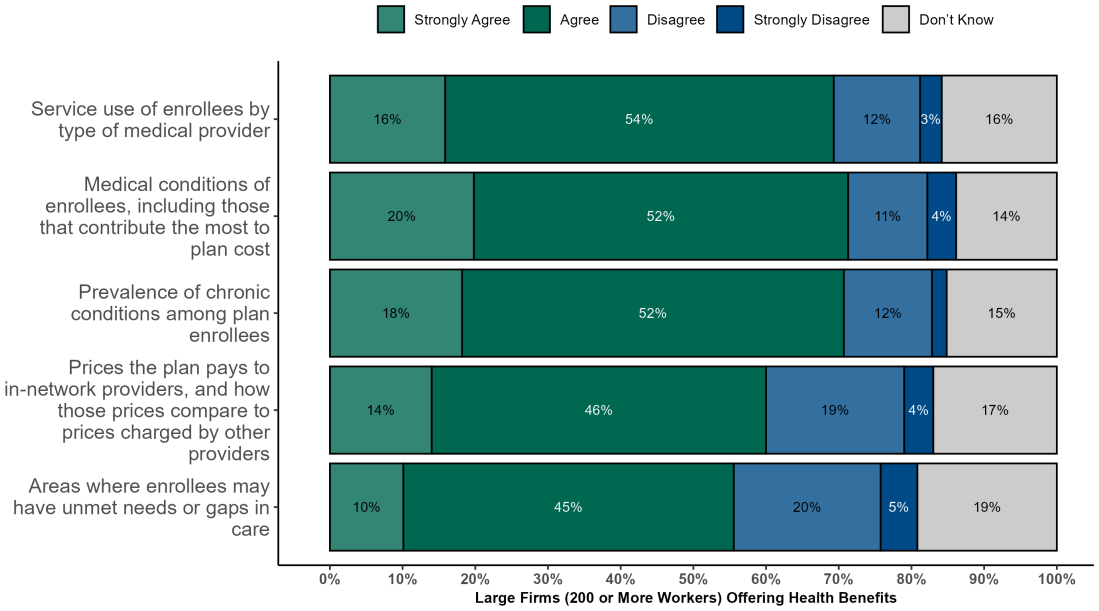
Firms that offer health benefits with 200 or more workers were asked about their ability to obtain information about the cost and use of medical services (other than prescription drugs) in their plan with the largest enrollment. This information might include summary information from an insurer or plan 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.

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

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%).

TREATMENT OPTIONS FOR SUBSTANCE USE CONDITIONS

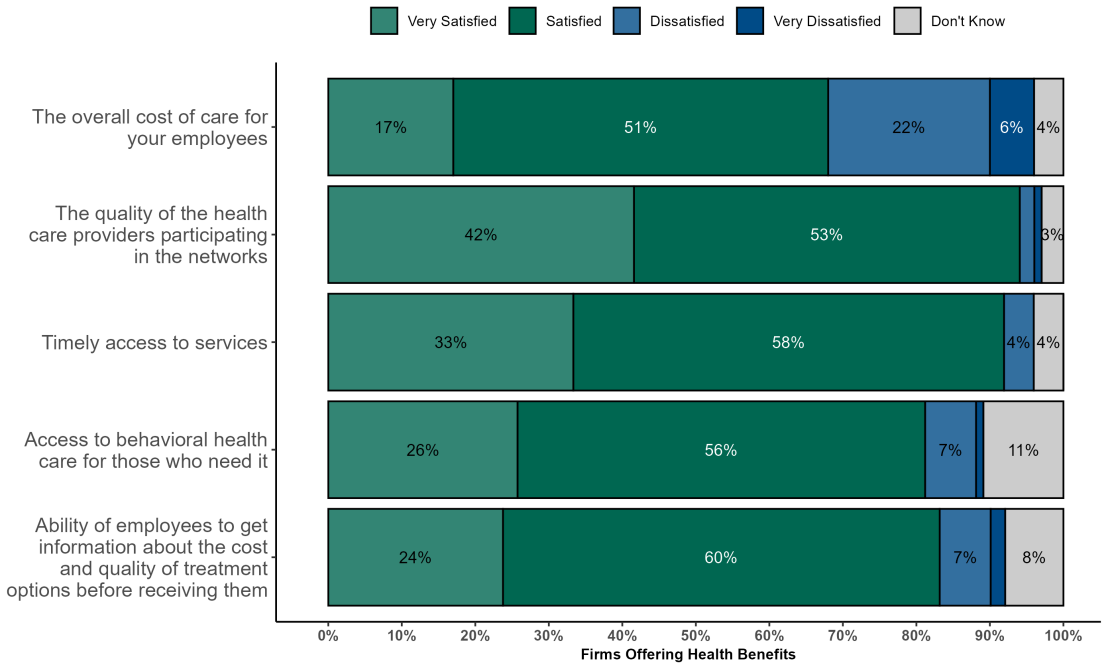
Firms with 200 or more workers offering health benefits were asked whether they had made efforts in the last two years to expand the availability of services to treat substance use conditions. Among these firms, 34% say that they have added new virtual providers within the last two years, and 20% say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

Figure H
Firms' Level of Satisfaction With Aspects of their Health Plans, 2026



SOURCE: KFF Employer Health Benefits Survey, 2026

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 health care spending projections 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/.

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

Survey Design and Methods



Survey Design and Methods

KFF has conducted this annual survey of employer-sponsored health benefits since 1999. Since 2020, KFF has employed Davis Research LLC (Davis) to field the survey. From January to July 2026, Davis interviewed business owners as well as human resource and benefits managers at 1,937 firms.

SURVEY TOPICS

The survey includes questions on the cost of health insurance, offer rates, coverage, eligibility, plan type enrollment, premium contributions, employee cost sharing, prescription drug coverage, retiree health benefits, and wellness programs.

Firms that offer health benefits are asked about the attributes of their largest HMO, PPO, POS and HSA plans. Exclusive provider organizations (EPOs) are grouped with HMOs, and conventional (or indemnity) plans are grouped with PPOs.

Plan Definitions:

- HMO (Health Maintenance Organization): A plan that does not cover non-emergency services provided out of network.
- PPO (Preferred Provider Organization): A plan that allows use of both in-network and out-of-network providers, with lower cost sharing for in-network services and no requirement for a primary care referral.
- POS (Point-of-Service Plan): A plan with lower cost sharing for in-network services, but that requires a primary care gatekeeper for specialist or hospital visits.
- HSA (Health Savings Account): A plan with a deductible of at least $1,650 for single coverage or $3,300 for family coverage, paired with a health savings account. (See the introduction to Section 8 for more detail on HSAs and other high deductible health plans with savings options.)

To reduce respondent burden, questions on cost sharing for office visits, hospitalization, outpatient surgery, and prescription drugs are limited to the firm's largest plan. Firms offering multiple plan types report premium contributions and deductibles for their two largest plans. Within each plan type, respondents are asked about the plan with the highest enrollment.

Firms report attributes of their current plans as of the time of the interview. While the survey fielding begins in January, many firms have plan years that do not align with the calendar year. In some cases, firms may report data based on the prior year's plan. As a result, some reported attributes-such as HSA deductible thresholds-may not align with current regulatory requirements. Additionally, plan decisions may have been made months prior to the interview.

SAMPLE DESIGN

The sample for the annual KFF Employer Health Benefits Survey includes private firms and nonfederal government employers with ten or more employees. The universe is defined by the U.S. Census' 2021 *Statistics of U.S. Businesses* (SUSB) for private firms and the 2022 *Census of Governments* (COG) for non-federal public employers. At the time of sample design (December 2025), this data represented the most current information on the number of public and private firms. The sample size is determined based on the number of firms needed to achieve a target number of completes across five firm-size categories and whether the firm was located in California.

We attempted to re-interview prior survey respondents who participated in either the 2024 or 2025 survey, or both. In total,
* 207 firms participated in 2024, * 307 firms participated in 2025, and * 729 firms participated in both years.

Non-panel firms were randomly selected within size and industry groups.

Since 2010, the sample has been drawn from a Dynata list (based on a census compiled by Dun & Bradstreet) of the nation's private employers, and from the COG for public employers. Starting in 2025, we included an augmented sample of 50 firms from the *Forbes America's Largest Private Companies* list. This list includes U.S.-based firms with annual revenue of $2 billion or more and is intended to complement the Dynata sample frame.

To increase precision, the sample is stratified by ten industry categories and six size categories. Education is treated as a separate category for sampling but included in the "Service" category for weighting.

For more information on changes to sampling methods over time, please consult the extended methods (http://ehbs.kff.org) which describes changes made in each year's survey.

RESPONSE RATE

Response rates are calculated using a CASRO method, which accounts for firm eligibility in the study. The rate is computed by dividing the number of completes by the sum of refusals and the estimated number of eligible firms among those with unknown eligibility. The overall response rate is 11% [Figure M.1]. As in prior years, the response rate for panel firms is higher than for non-panel firms.

Similar to other employer and household surveys, response rates have declined over time. Since 2017, we have attempted to increase the number of completes by expanding the number of non-panel firms in the sample. While this strategy improves the precision of estimates-particularly for subgroups-it tends to reduce the overall response rate.

Most survey questions are asked only of firms that offer health benefits. A total of 1,668 of the 1,937 firms responding to the full survey indicated that they offer health benefits.

We asked one question of all firms we contacted by phone, even if they declined to complete the full survey: **"Does your company offer a health insurance program as a benefit to any of your employees?"** A total of 3,653 firms responded to this question, including 1,937 full survey respondents and 1,716 firms who responded to this question only.

These responses are included in the estimates of the percentage of firms offering health benefits presented in Chapter 2. The response rate for this question is 20.4% [Figure M.1].

Figure M.1

Response Rates for Various Subsets of the Sample, 2026

Firm Type	Response Rate for Full Survey	Response Rate for Firms Answering A6
Small Firms (10-24 Workers)	9%	23%
Small Firms (10-199 Workers)	11%	24%
Large Firms (200 or More Workers)	11%	18%
Panel Firms (Completed Survey in at Least One of the Past Two Years)	53%	58%
Non Panel Firms	5%	16%
ALL FIRMS	**11%**	**20%**

SOURCE: KFF Employer Health Benefits Survey, 2026

While response rates have decreased, elements of the survey design limit the potential impact of a response bias. Most major statistics are weighted by the number of covered workers at a firm. Collectively, 3,300,000 of the 70,400,000 workers covered by their own employer's health benefits nationwide were employed at firms that completed the survey. The most important statistic weighted by the number of employers is the offer rate. Firms that do not complete the full survey are still asked whether they offer health benefits, ensuring a larger sample. As in previous years, most responding firms are very small. As a result, fluctuations in the offer rate for these small firms significantly influence the overall offer rate.

FIRM SIZES AND KEY DEFINITIONS

Throughout the report, we present data by firm size, region, and industry; [Figure M.2] displays selected characteristics of the sample. Unless otherwise noted, firm size is defined as follows: small firms have 10-199 workers, and large firms have 200 or more workers.

A firm's primary industry classification is based on Dynata's designation, which in turn is derived from the U.S. Census Bureau's North American Industry Classification System (NAICS) [Figure M.3]. Firm ownership type, average wage level, and workforce age are based on respondents' self-reported information.

While there is considerable overlap between firms categorized as "State/Local Government" in the industry classification and those identified as publicly owned, the two categories are not identical. For example, public school districts are included in the "Service" industry category, even though they are publicly owned.

Family coverage is defined as health insurance coverage for a family of four.

Figure M.2

Selected Characteristics of Firms in the Survey Sample, 2026

	Sample Size	Sample Distribution After Weighting	Percentage of Total for Weighted Sample
FIRM SIZE			
10-24 Workers	249	755,029	55.5%
25-49 Workers	213	286,442	21.0%
50-199 Workers	386	249,006	18.3%
200-999 Workers	499	59,645	4.4%
1,000-4,999 Workers	400	8,911	0.7%
5,000 or More Workers	190	2,401	0.2%
REGION			
Northeast	246	178,145	13.1%
Midwest	515	384,783	28.3%
South	547	451,446	33.2%
West	629	347,060	25.5%
INDUSTRY			
Agriculture/Mining/Construction	134	139,723	10.3%
Manufacturing	189	94,823	7.0%
Transportation/Communications/Utilities	106	60,424	4.4%
Wholesale	89	66,687	4.9%
Retail	123	123,827	9.1%
Finance	95	55,706	4.1%
Service	736	601,272	44.2%
State/Local Government	232	28,975	2.1%
Health Care	233	189,998	14.0%
ALL FIRMS	**1,937**	**1,361,434**	**100.0%**

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure M.3
Industries by NAICS code

Industry	SIC Code Range	NAICS Sector	NAICS Description
Agriculture/Mining/Construction	0100-1799	11	Agriculture Support, Forestry, Fishing, and Hunting
		21	Mining
		23	Construction
Manufacturing	2000-3999	31	Manufacturing
Transportation/Communications /Utilities	4000-4299 & 4400-4999	22	Utilities
		48	Transportation and Warehousing
		51	Information
Wholesale	5000-5199	42	Wholesale Trade
Retail	5200-5999	44	Retail Trade
Finance	6000-6799	52	Finance and Insurance
		53	Real Estate and Rental & Leasing
Service	7000-7999 & 8100-8199 & 8300-8999	54	Professional, Scientific, and Technical Services
		55	Management of Companies and Enterprises
		56	Administrative & Support and Waste Management & Remediation Services
		71	Arts, Entertainment, and Recreation
		72	Accommodation and Food Services
		81	Other Services (except Public Administration)
State/Local Government	9000-9999	NA	
Education	8200-8299	61	Educational Services
Health Care	8000-8099	62	Health Care and Social Assistance

[Figure M.4] shows the categorization of states into regions, based on the U.S. Census Bureau's regional definitions. State-level data are not reported due to limited sample sizes in many states and because the survey collects information only on a firm's primary location-not where employees may be based. Some mid-size and large employers operate in multiple states, so the location of a firm's headquarters may not correspond to the location of the health plan for which premium information was collected.

Figure M.4
States by Region, 2025

Northeast	Midwest	South	West
Connecticut	Illinois	Alabama	Alaska
Maine	Indiana	Arkansas	Arizona
Massachusetts	Iowa	Delaware	California
New Hampshire	Kansas	District of Columbia	Colorado
New Jersey	Michigan	Florida	Hawaii
New York	Minnesota	Georgia	Idaho
Pennsylvania	Missouri	Kentucky	Montana
Rhode Island	Nebraska	Louisiana	Nevada
Vermont	North Dakota	Maryland	New Mexico
	Ohio	Mississippi	Oregon
	South Dakota	North Carolina	Utah
	Wisconsin	Oklahoma	Washington
		South Carolina	Wyoming
		Tennessee	
		Texas	
		Virginia	
		West Virginia	

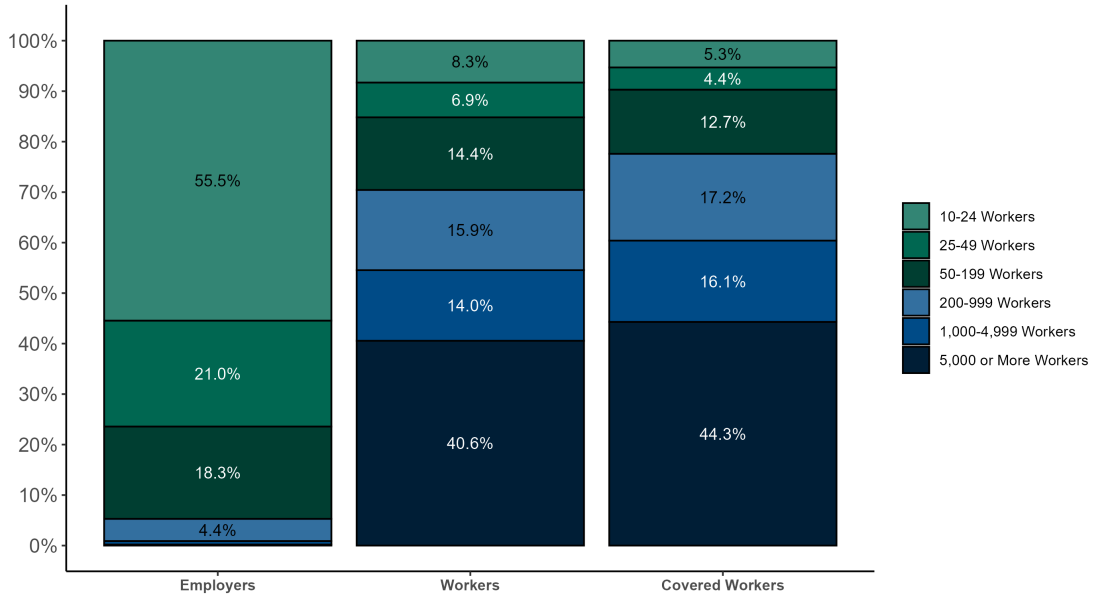
Source: KFF Employer Health Benefits Survey, 2026. From U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, available at http://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf

[Figure M.5] displays the distribution of the nation's firms, workers, and covered workers (employees receiving health coverage from their employer). Beginning in 2025, firms with fewer than 10 employees were excluded from the survey universe. Although most firms in the United States are small, most workers covered by health benefits are employed at large firms: 78% of the covered worker weight is controlled by firms with 200 or more employees. Conversely, firms with 10-199 employees represent 95% percent of the employer weight.

Because small firms make up the vast majority of all firms, they heavily influence statistics weighted by the number of employers. For this reason, most firm-level statistics are reported by firm size. In contrast, large firms-especially those with 1,000 or more workers-have the greatest influence on statistics related to covered workers. Even with the large firm category (those with 200 or more workers), 84% of the employer weight is driven by firms with 200-999 employees.

Statistics for small firms and employer-weighted measures tend to exhibit greater variability.

Figure M.5
Distribution of Employers, Workers, and Workers Covered by Health Benefits, by Firm Size, 2026



NOTE: Private-sector data are based on the U.S. Census Bureau's Statistics of U.S. Businesses, while state and local government data are from the Census Bureau's Census of Governments..
SOURCE: KFF Employer Health Benefits Survey, 2026

The survey asks firms what percentage of their employees earn more or less than a specified amount in order to identify the portion of the workforce that has relatively lower or higher wages. This year, the income threshold is $38,000 or less per year for lower-wage workers and $82,000 or more for higher-wage workers. These thresholds are based on the 25th and 75th percentile of workers' earnings as reported by the Bureau of Labor Statistics using data from the Occupational Employment Statistics (OES) (2024).[5] The cutoffs were inflation-adjusted and rounded to the nearest thousand.

Annual inflation estimates are calculated as an average of the first three months of the year. The 12 month percentage change for this period was 2.7%.[6] Data presented is nominal unless indicated specifically otherwise.

ROUNDING AND IMPUTATION

Some figures may not sum to totals due to rounding. While overall totals and totals by firm size and industry are statistically valid, some breakdowns are not reported due to limited sample sizes or high relative standard errors. Where the unweighted sample size is fewer than 30 observations, figures are labeled "NSD" (Not Sufficient Data). Estimates with high relative standard errors are reviewed and, in some cases, suppressed. Many subset estimates may have large standard errors, meaning that even large differences between groups may not be statistically significant.

[5] May 2024 Data from the Occupational Employment and Wage Statistics (OEWS) Survey. Bureau of Labor Statistics. Occupational Employment and Wage Statistics (OEWS) Tables [Internet]. Washington (DC): BLS; [cited 2026 Sep 24]. Available from: https://www.bls.gov/oes/tables.htm

[6] Bureau of Labor Statistics, Mid-Atlantic Information Office. Consumer Price Index historical tables for, U.S. City Average (1967 = 100) of Annual Inflation [Internet]. Washington (DC): BLS; [cited 2026 Sep 24]. Available from: https://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexhistorical1967base_us_table.htm

To improve readability, values below 3% are not shown in graphical figures. The underlying data for all estimates presented in graphs are available in Excel files accompanying each section at http://ehbs.kff.org.

To control for item nonresponse bias, we impute missing values for most variables. On average, 10% of observations are imputed. All variables-except single coverage premiums-are imputed using a hotdeck method, which replaces missing values with observed values from a similar firm (based on size and industry).

When both single and family coverage premiums are missing for a firm, the single coverage premium is first predicted using a random forest algorithm based on other known plan and firm characteristics. This predicted value is then used to impute related variables, such as family premiums and worker contributions, using the hotdeck approach. Some variables are hotdecked based on their relationship to another variable. For example, if a firm reports a family worker contribution but not a family premium, we impute a ratio between the two and then calculate the missing premium.

In 2026, there were thirty-two variables where the imputation rate exceeded 20%, most of which were related to plan-level statistics. When constructing aggregate estimates across all plans, the imputation rate is typically much lower. A few variables are not imputed-these are usually cases where a “don’t know” response is considered valid.

To ensure data quality, we conduct multiple reviews of outliers and illogical responses. Each year, several hundred firms are recontacted to verify or correct their responses. In some cases, responses are edited based on open-ended comments or established logic rules.

Figure M.6

Imputation Rates of Premiums, Worker Contributions, and Deductibles, by Plan Type, 2022-2026

	2022	2023	2024	2025	2026
HMO					
Single Premium	10.2%	7.8%	9.1%	9.2%	9.6%
Single Contribution	6.9	4.4	5	5.4	7.1
Single Deductible	8.9	4.8	4.4	4.1	5.7
Family Premium	12.8	13.1	11.4	10.9	14.9
Family Contribution	9.7	10	9.5	9.3	12.6
Family Deductible	8.5	5.5	7	5.8	7.1
PPO					
Single Premium	8%	7.9%	7.3%	7.1%	6%
Single Contribution	4.7	4.9	3.3	3.7	2.9
Single Deductible	4.5	2.7*	2.5	2.6	2.6
Family Premium	9.1	10.2	7.8	8.9	7.9
Family Contribution	7.3	7.3	5.4	6.3	5.6
Family Deductible	5.5	4.3	5	4.4	4.5
POS					
Single Premium	15.5%	16.4%	19.8%	19.4%	12.7%*
Single Contribution	6.9	11.9	8.8	7.7	6.3
Single Deductible	10.6	11.6	9.5	8.9	6.3
Family Premium	20.6	20	26.5	23.5	19.3
Family Contribution	13.4	17.3	20.9	14*	13.3
Family Deductible	14.7	11.5	14.2	9.9	11.4
HSA-Qualified					
Single Premium	7.1%	6.1%	7.3%	6.4%	6.9%
Single Contribution	3.1	3.8	3.5	1.7*	4.2*
Single Deductible	4.3	2.4*	2.3	2	2.8
Family Premium	7.4	6.9	8	7.5	8.6
Family Contribution	4.3	5.7	4.2	3.6	5.8
Family Deductible	4.9	5.3	4.5	3.3	3.8

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2022-2026

WEIGHTING

Because we select firms randomly, it is possible through the use of weights to extrapolate results to national (as well as firm size, regional, and industry) averages. These weights allow us to present findings based on the number of workers covered by health plans, the number of workers, and the number of firms. In general, findings in dollar amounts (such as premiums, worker contributions, and cost sharing) are weighted by covered workers. Other estimates, such as the offer rate, are weighted by firms.

The employer weight was determined by calculating the firm's probability of selection. This weight was trimmed of overly influential weights and calibrated to U.S. Census Bureau's 2022 Statistics of U.S. Businesses for firms in the private sector, and the 2022 Census of Governments totals. The worker weight was calculated by multiplying the employer weight by the number of workers at the firm and then following the same weight adjustment process described above. The covered-worker weight and the plan-specific weights were calculated by multiplying the percentage of workers enrolled in each of the plan types by the firm's worker weight. These weights allow analyses of workers covered by health benefits and of workers in a particular type of health plan.

The trimming procedure follows the following steps: First, we grouped firms into size and offer categories of observations. Within each strata, we calculated the trimming cut point as the median plus six times the interquartile range (M + [6 * IQR]). Weight values larger than this cut point are trimmed. In all instances, very few weight values were trimmed.

To account for design effects, the statistical computing package R version 4.6.1 (2026-06-24 ucrt) and the library "survey" version 4.5 were used to calculate standard errors.

STATISTICAL SIGNIFICANCE AND LIMITATIONS

All statistical tests are performed at the 0.05 confidence level. For figures spanning multiple years, comparisons are made between each year and the previous year shown, unless otherwise noted. No statistical tests are conducted for years prior to 1999.

Subgroup comparisons are made against all other firm sizes not included in the specified group. For example, firms in the Northeast are compared to an aggregate of firms in the Midwest, South, and West. For plan type comparisons (e.g., average premiums in PPOs), results are tested against the "All Plans" estimate. In some cases, plan-specific estimates are also compared to similar estimates for other plan types (e.g., single and family premiums in HSAs vs. HMO, PPO, and POS plans); such comparisons are noted in the text.

Two statistical tests are used: the t-test and the Wald test. A small number of observations for certain variables can result in large variability around point estimates. Readers should be cautious of these when interpreting year-to-year changes, as large shifts may not be statistically significant. Standard errors for selected estimates are available in a technical supplement at http://ehbs.kff.org.

Due to the complexity of many employer health benefit programs, the survey may not capture all elements of any given plan. For instance, employers may offer intricate and varying prescription drug benefits, premium contributions, or wellness incentives. Interviews were conducted with the individual most knowledgeable about the firm's health benefits, though some respondents may not have complete information on all aspects of the plan. While the survey collects data on the number of workers enrolled in coverage, it does not capture the characteristics of those offered or enrolled in specific plans.

DATA COLLECTION AND SURVEY MODE

Starting in 2022, we expanded the use of computer assisted web interview (CAWI), offering most respondents the opportunity to complete the survey using an online questionnaire rather a telephone interview. In 2026, fifty-five percent of survey responses were completed via telephone interview, and the remainder were completed online.

Previous analysis has found that survey mode had little impact on major statistics such as annual premiums, contributions, and deductibles.

EMPLOYER SURVEY LANDSCAPE

Given the complexity of the private health insurance system, estimating changes in health insurance costs is challenging and depends on both what is being measured and how it is measured. The KFF Employer Health Benefits Survey provides a comprehensive snapshot of current-year premiums and uses methods designed to produce estimates representative of workers and employers with 10 or more workers.

Actuarial and consulting firms often produce prospective estimates of employer health benefit cost growth. These forecasts often include assumptions about changes in health care prices, utilization, and the mix of services. Prospective estimates of cost growth may be higher than the premium increases ultimately observed, in part because employers can mitigate anticipated cost increases by changing plan designs, provider networks, vendors, or other aspects of their plans.

By contrast, the KFF Employer Health Benefits Survey measures observed health insurance premiums or premium equivalents, that is the cost of the plans actually offered to workers in the current year. Other annual employer surveys, including AHRQ's MEPS-Insurance Component and Mercer's National Survey of Employer-Sponsored Health Plans, use probability samples to measure employer health benefit costs. While these surveys use different methods and cover somewhat different populations, over time they have documented a similar rate of premium growth.

PREFERRED REPORTING ITEMS FOR COMPLEX SAMPLE SURVEY ANALYSIS (PRICSSA)

In their Journal of Survey Statistics and Methodology article, Seidenberg, Moser, and West (2023) propose a checklist for survey administrators and sponsoring organizations to help external researchers quickly understand the methods used to create a complex sample dataset.[7] The Preferred Reporting Items for Complex Sample Survey Analysis (PRICSSA) recommends a standard format to enumerate data collection and analysis techniques across a variety of different surveys. KFF has adopted this checklist to increase transparency for our readership and also to promote reproducibility among external researchers granted access to our public use files.

- 1.1 Data collection dates: January 05, 2026-July 13, 2026.
- 1.2 Data collection mode(s): fifty-five percent computer-assisted telephone interviewing (CATI), and the remainder completed with computer assisted web interview (CAWI).
- 1.3 Target population: Private firms as well as state and local government employers with ten or more employees in 50 US states and Washington DC.
- 1.4 Sample design: A sample stratified by ten industry categories and six size categories drawn from a Dynata list (based on a census assembled by Dun and Bradstreet) of the nation's private employers and the Census of Governments for public employers.
- 1.5 Full Survey response rate: 11 percent (CASRO method).
- 2.1 Missingness rates: On average, 10% of observations are imputed.
- 2.2 Observation deletion: Observations found to be duplicated firms, out of business, or no longer exisiting in the sample universe.

[7] Seidenberg, Andrew B, Richard P Moser, and Brady T West. 2023. "Preferred Reporting Items for Complex Sample Survey Analysis (PRICSSA)." Journal of Survey Statistics and Methodology 11 (4): 743-57. https://doi.org/10.1093/jssam/smac040.

- 2.3 Sample sizes: 1,937 firms completed the entire survey, 3,653 completed at least the offer question, out of 35,781 initially sampled firms, generalizing to a total of about one million firms.
- 2.4 Confidence intervals / standard errors: All statistical tests are performed at the .05 confidence level.
- 2.5 Weighting: `empwt` (firms), `empwt_a6` (firms, including those answering only the offer question), `wkrwt` (workers), `covwt` (policyholders), `hmowt`, `ppowt`, `poswt`, and `hsawt` (plan weights)
- 2.6 Variance estimation: Taylor Series Linearization with `newcell` used as the stratum variable but no PSU variable.
- 2.7 Subpopulation analysis: The R `survey` package toolkit such as `svyby` and a complex sample design's `subset` method allowed for most analysis of subdomains.
- 2.8 Suppression rules: Where the unweighted sample size is fewer than 30 observations, figures include the notation "NSD" (Not Sufficient Data). Estimates with high relative standard errors are reviewed and in some cases not published.
- 2.9 Software and code: All design-based analyses were performed using R version 4.6.1 (2026-06-24 ucrt) and `survey` library version 4.5.

2026 SURVEY

The 2026 survey includes new questions on substance use disorder services, transparency, and prior authorization, among other topics. As in previous years, modifications were also made to existing questions to improve clarity and reflect changes in the health care marketplace.

Previous surveys combined high deductible plans paired with HSAs or HRAs into a single plan type referred to as high deductible health plans with savings options ("HDHP/SOs"). Over time, the prevalence of HSA-qualified plans has grown while that of high deductible plans paired with HRAs has waned. The different types and uses of HRAs also has made it more difficult to make generalizations about these plans. So, beginning this year, the survey no longer tracks the HDHP/SOs as a plan type and instead focuses on HSA-qualified plans as a plan type. The survey will continue to ask employers whether they offer HRAs and what the HRA funds may be used for, but will no longer ask about the amounts made available in these arrangements.

Due to data availability changes starting with the 2022 SUSB, we revised the firm size categories used for weighting. Prior surveys calibrated nationwide totals based on each firm's employment using the categories 10-24, 25-49, 50-199, 200-999, 1,000-4,999, and 5,000+. For this year's survey, firm sizes were grouped into 10-19, 20-99, 100-499, 500-999, 1,000-4,999, and 5,000+ employment categories. When analyzing the impact with the 2021 SUSB, the most recent year with both categorizations available, we did not find any changes to our main findings weighted separately based on the two distinct sets of firm sizes. We also adjusted how our weighting accounts for California. Statistics of US Businesses (SUSB) public tables include nationwide counts for firms with 500 or more and 5,000 or more employees, and these tables also contain California statewide counts for firms with 500 or more employees, but not for California firms with 5,000 or more employees. From special tabulations received from the US Census Bureau, we know the distribution of the largest firms in California to be stable over time. Among California firms with at least 500 employees in both the 2016 and 2021 SUSB, the share of firms with 500-999 employees was 34%, the share of firms with 1,000-4,999 employees was 44%, and the remaining share of firms with 5,000+ employees was 22%. We retained this distribution to estimate the weighting cell for firms with 5,000+ employees with any presence in California based on the 2022 count of firms with 500+ employees.

OTHER RESOURCES

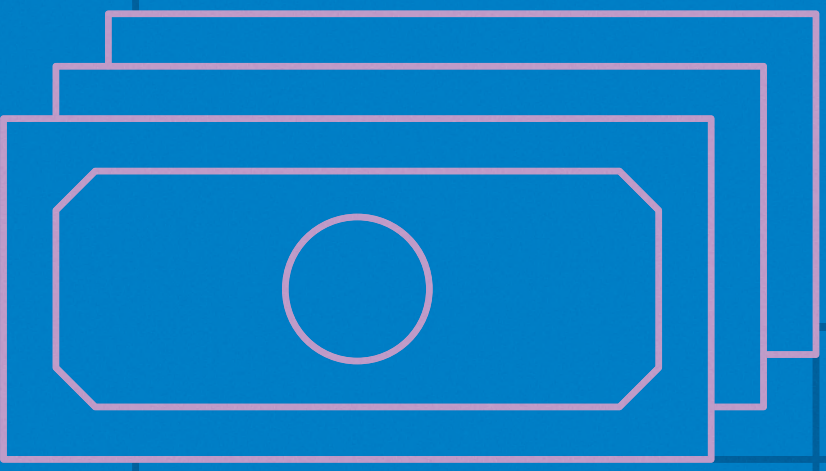
Additional information about the Employer Health Benefits Survey is available at http://ehbs.kff.org, including an interactive graphic and historical reports. Researchers may also request access to a public use dataset at https://www.kff.org/contact-us/.

The Survey Design and Methods section on our website includes an extended methodology document that is not available in the PDF or printed versions of this report. Readers interested in more detailed information on survey methods should consult the online edition.

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SECTION 1

Cost of Health Insurance



Section 1

Cost of Health Insurance

The average annual health insurance premiums in 2026 are $9,804 for single coverage and $28,303 for family coverage. The average single coverage premium increased 5% in 2026, the same as the average family premium increased (5%). The average family premium has increased 28% since 2021 and 55% since 2016.

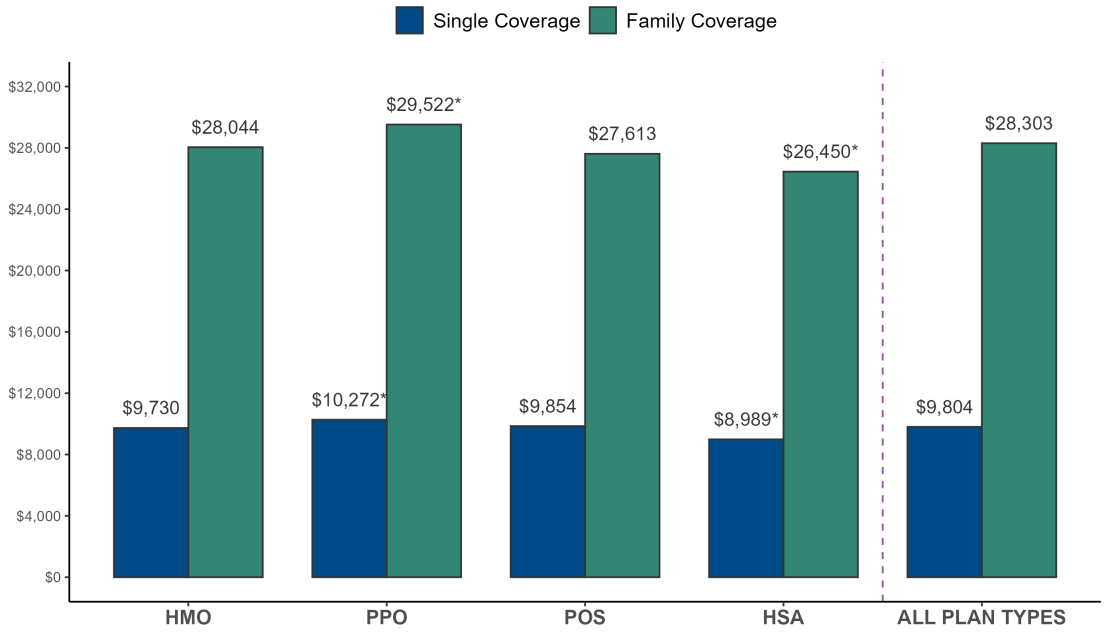
As part of this report, KFF publishes an online tool which allows users to look at changes in premiums and worker contributions for covered workers at different types of firms over time: https://www.kff.org/interactive/premiums-and-worker-contributions/

PREMIUMS FOR SINGLE AND FAMILY COVERAGE

The average premium for single coverage in 2026 is $9,804 per year. The average premium for family coverage is $28,303 per year [Figure 1.1].

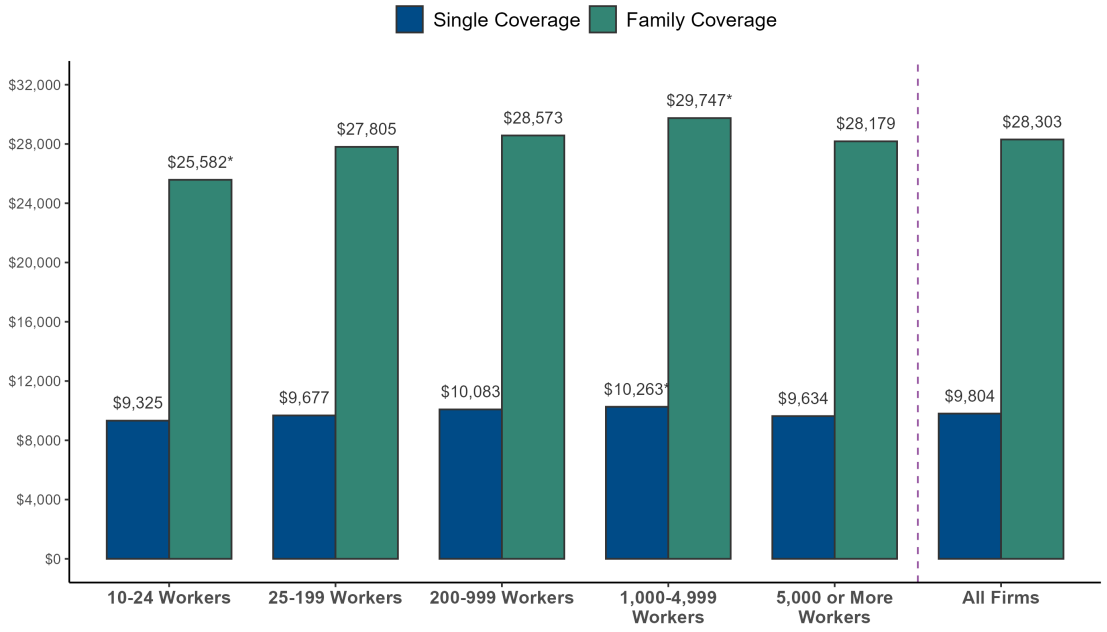
- The average annual premiums for single coverage are similar for covered workers at firms with 10 to 199 workers ($9,593) and at larger firms ($9,865) [Figure 1.3].
- The average annual premiums for family coverage are lower for covered workers at firms with 10 to 199 workers ($27,288) than for those at larger firms ($28,592) [Figure 1.3].
- The average annual premiums for covered workers in HSA-qualified plans are lower than the average premiums for coverage overall for both single coverage ($8,989 vs. $9,804) and family coverage ($26,450 vs. $28,303). The average premiums for covered workers in PPOs are higher than the overall average premiums for both single coverage ($10,272 vs. $9,804) and family coverage ($29,522 vs. $28,303) [Figure 1.1].
- The average premium for covered workers with both single and family coverage is higher in the Northeast and lower in the South [Figure 1.4].
- The average premium for family coverage for covered workers at firms with relatively large shares of lower-wage workers (where at least 35% of workers earn $38,000 a year or less) is lower than the average premium for covered workers at firms with smaller shares of lower-wage workers ($26,533 vs. $28,524). The average premium 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) is higher than the average premium for covered workers at firms with smaller shares of higher-wage workers for family coverage ($29,139 vs. $27,664) [Figure 1.6] and [Figure 1.7].
- The average premium for family coverage for covered workers at firms with relatively large shares of older workers (firms where at least 35% of the workers are age 50 or older) is similar to the average premium for covered workers at firms with smaller shares of older workers ($28,689 and $27,889) [Figure 1.7].
- The average premiums for single coverage and family coverage are relatively lower for covered workers at private for-profit firms and relatively higher for covered workers at private not-for-profit firms [Figure 1.6] and [Figure 1.7].
- The average premiums for single coverage are relatively higher for covered workers at firms with at least some union workers than firms without any union workers [Figure 1.6].

Figure 1.1
Average Annual Premiums for Covered Workers, Single and Family Coverage, by Plan Type, 2026



* Estimate is statistically different from All Plans estimate ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 1.2
Average Annual Premiums for Covered Workers, Single and Family Coverage, by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 1.3

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Firm Size, 2026

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
All Small Firms	$793	$2,246	$9,519	$26,949
All Large Firms	815	2,361	9,785	28,329
ALL FIRM SIZES	**$811**	**$2,337**	**$9,730**	**$28,044**
PPO				
All Small Firms	$837	$2,371	$10,040	$28,452
All Large Firms	861	2,482	10,331	29,789
ALL FIRM SIZES	**$856**	**$2,460**	**$10,272**	**$29,522**
POS				
All Small Firms	$773*	$2,175	$9,275*	$26,105
All Large Firms	859*	2,398	10,307*	28,771
ALL FIRM SIZES	**$821**	**$2,301**	**$9,854**	**$27,613**
HSA-Qualified Plans				
All Small Firms	$753	$2,178	$9,037	$26,137
All Large Firms	748	2,211	8,977	26,531
ALL FIRM SIZES	**$749**	**$2,204**	**$8,989**	**$26,450**
ALL PLANS				
All Small Firms	$799	$2,274*	$9,593	$27,288*
All Large Firms	822	2,383*	9,865	28,592*
ALL FIRM SIZES	**$817**	**$2,359**	**$9,804**	**$28,303**

NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.

* Estimates are statistically different within plan and coverage types between All Small Firms and All Large Firms ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 1.4

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Region, 2026

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
Northeast	$975*	$2,777*	$11,701*	$33,320*
Midwest	935*	2,718*	11,221*	32,619*
South	718*	2,038*	8,614*	24,457*
West	812	2,365	9,742	28,381
ALL REGIONS	**$811**	**$2,337**	**$9,730**	**$28,044**
PPO				
Northeast	$940*	$2,762*	$11,275*	$33,140*
Midwest	870	2,486	10,445	29,828
South	807*	2,319*	9,679*	27,832*
West	861	2,430	10,330	29,166
ALL REGIONS	**$856**	**$2,460**	**$10,272**	**$29,522**
POS				
Northeast	$885	$2,451	$10,615	$29,407
Midwest	828	2,412	9,938	28,944
South	792	2,148	9,501	25,772
West	815	2,290	9,785	27,474
ALL REGIONS	**$821**	**$2,301**	**$9,854**	**$27,613**
HSA-Qualified Plans				
Northeast	$808*	$2,322	$9,691*	$27,862
Midwest	761	2,232	9,136	26,786
South	707*	2,092*	8,482*	25,109*
West	734	2,206	8,806	26,468
ALL REGIONS	**$749**	**$2,204**	**$8,989**	**$26,450**
ALL PLANS				
Northeast	$901*	$2,615*	$10,806*	$31,378*
Midwest	826	2,388	9,914	28,653
South	773*	2,225*	9,272*	26,702*
West	812	2,340	9,749	28,082
ALL REGIONS	**$817**	**$2,359**	**$9,804**	**$28,303**

* Estimates are statistically different within plan and coverage types from estimate for all firms not in the indicated region ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 1.5

Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Industry, 2026

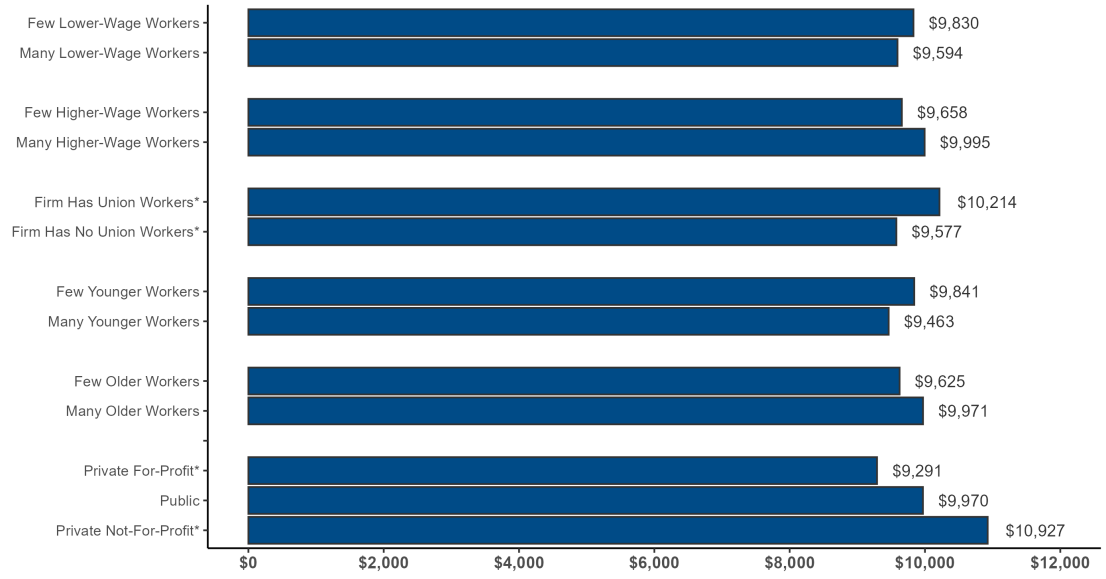
	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
PPO				
Agriculture/Mining/Construction	$763*	$2,197*	$9,155*	$26,369*
Manufacturing	855	2,391	10,256	28,687
Transportation/Communications/Utilities	766*	2,333	9,193*	27,991
Wholesale	834	2,555	10,013	30,660
Retail	757*	2,339	9,087*	28,071
Finance	946*	2,787*	11,349*	33,446*
Service	866	2,437	10,388	29,240
State/Local Government	845	2,344	10,142	28,128
Health Care	952*	2,683*	11,424*	32,192*
ALL INDUSTRIES	**$856**	**$2,460**	**$10,272**	**$29,522**
HSA-Qualified Plans				
Agriculture/Mining/Construction	$715	$2,210	$8,583	$26,524
Manufacturing	761	2,205	9,128	26,457
Transportation/Communications/Utilities	737	2,109	8,843	25,303
Wholesale	761	2,337	9,134	28,050
Retail	643*	1,981*	7,719*	23,778*
Finance	761	2,285	9,126	27,420
Service	737	2,154	8,847	25,845
State/Local Government	790	2,268	9,481	27,219
Health Care	829*	2,382	9,945*	28,582
ALL INDUSTRIES	**$749**	**$2,204**	**$8,989**	**$26,450**
ALL PLANS				
Agriculture/Mining/Construction	$749*	$2,222	$8,990*	$26,661
Manufacturing	804	2,303	9,643	27,630
Transportation/Communications/Utilities	774	2,338	9,286	28,055
Wholesale	793	2,410	9,517	28,925
Retail	716*	2,222*	8,589*	26,668*
Finance	838	2,478	10,053	29,733
Service	819	2,301	9,827	27,616
State/Local Government	848	2,356	10,174	28,272
Health Care	902*	2,565*	10,821*	30,778*
ALL INDUSTRIES	**$817**	**$2,359**	**$9,804**	**$28,303**

NOTE: HMO and POS premiums are included in the All Plans average. In most cases, there is an insufficient number of firms to report these averages by industry.

* Estimate is statistically different within plan type from estimate for all firms not in the indicated industry ($p < .05$).

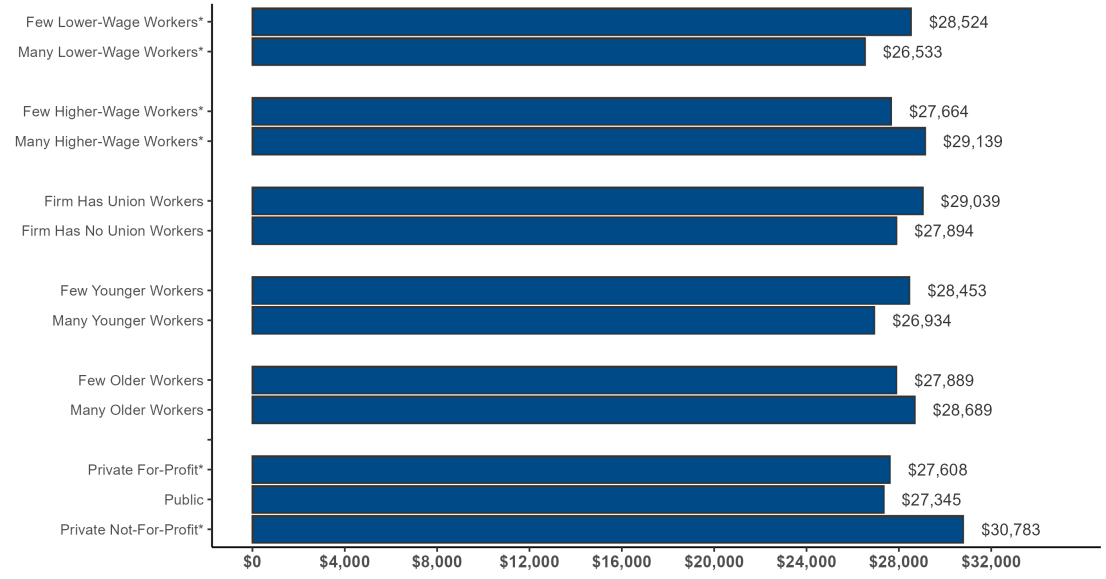
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 1.6
Average Annual Premiums for Covered Workers with Single Coverage, by Firm Characteristics, 2026



* Estimates are statistically different from each other within category (p < .05).
NOTE: Firms with many lower-wage workers have >35% of their workforces earning <$38,000 (25th percentile of national earnings, 2026). Higher-wage firms have >=35% earning >$82,000 (75th percentile). Firms with many older workers have ≥35% age 50+, and those with many younger workers have >=35% age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 1.7
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Characteristics, 2026



* Estimates are statistically different from each other within category (p < .05).
NOTE: Firms with many lower-wage workers have >35% of their workforces earning <$38,000 (25th percentile of national earnings, 2026). Higher-wage firms have >=35% earning >$82,000 (75th percentile). Firms with many older workers have ≥35% age 50+, and those with many younger workers have >=35% age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 1.8

Average Annual Premiums for Covered Workers, by Firm Characteristics and Firm Size, 2026

	Single Coverage		Family Coverage	
	All Small Firms	All Large Firms	All Small Firms	All Large Firms
LOWER WAGE LEVEL				
Few Lower-Wage Workers	$9,567	$9,907	$27,276	$28,884*
Many Lower-Wage Workers	$9,831	$9,533	$27,395	$26,316*
HIGHER WAGE LEVEL				
Few Higher-Wage Workers	$9,695	$9,646	$27,103	$27,857*
Many Higher-Wage Workers	$9,397	$10,123	$27,639	$29,460*
UNIONS				
Firm Has Union Workers	$10,394*	$10,204*	$29,628*	$29,008
Firm Has No Union Workers	$9,525*	$9,601*	$27,085*	$28,270
YOUNGER WORKERS				
Few Younger Workers	$9,621	$9,907	$27,364	$28,772
Many Younger Workers	$9,278	$9,504	$26,407	$27,048
OLDER WORKERS				
Few Older Workers	$9,245*	$9,759	$26,651	$28,322
Many Older Workers	$10,046*	$9,954	$28,115	$28,821
FUNDING ARRANGEMENT				
Fully Insured	$9,563	$10,241	$27,125	$29,079
Self-Funded	$9,686	$9,797	$27,781	$28,505
FIRM OWNERSHIP				
Private For-Profit	$9,215*	$9,316*	$26,529	$27,967
Public	$10,659*	$9,887	$29,409	$27,100
Private Not-For-Profit	$10,168	$11,177*	$28,418	$31,560*
ALL FIRMS	**$9,593**	**$9,865**	**$27,288**	**$28,592**

NOTE: Firms with many lower-wage workers are those where at least 35% earn at or below the 25th percentile of national earnings ($38,000 in 2026). Firms with many higher-wage workers are those where at least 35% earn at or above the 75th percentile of national earnings ($82,000 in 2026). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger. Small Firms have 10-199 workers and Large Firms have 200 or more workers.

* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

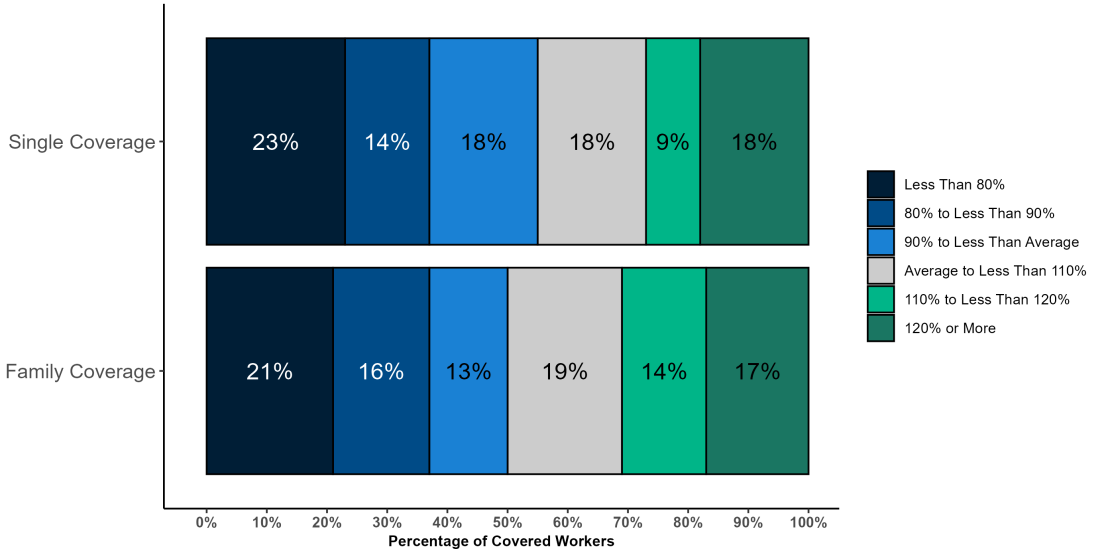
PREMIUM DISTRIBUTION

There is considerable variation in premiums for both single and family coverage.

- Eighteen percent of covered workers are employed at firms where the single premium is at least 20% higher than the average single premium, while 23% of covered workers are at firms with a single premium less than 80% of the average single premium [Figure 1.9].

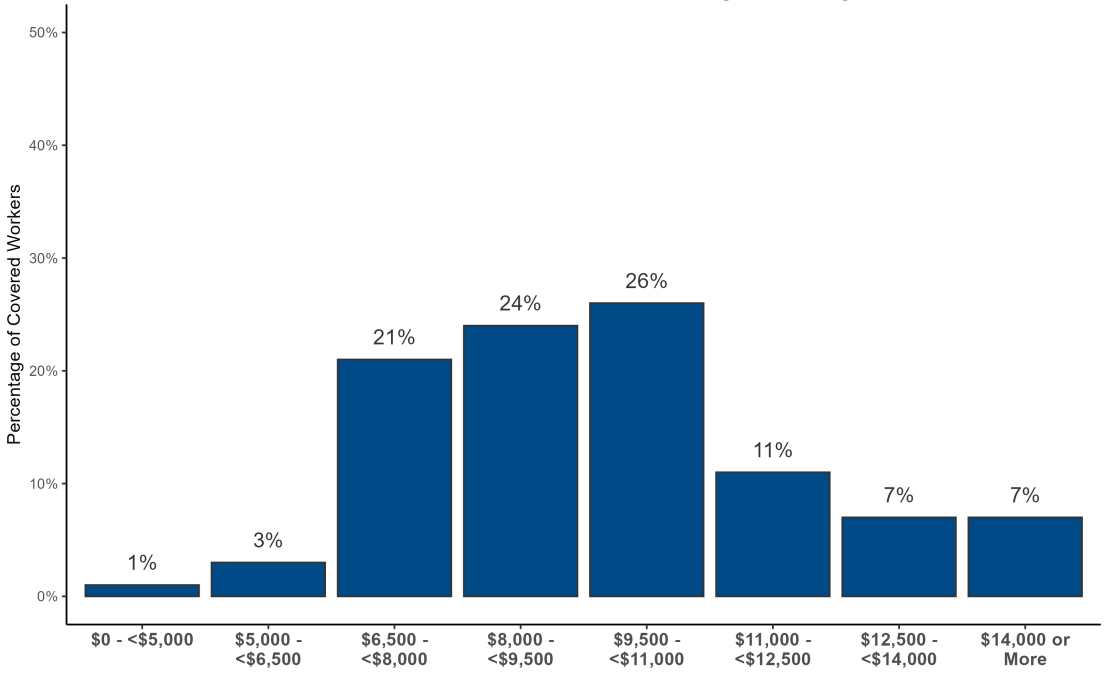
- For family coverage, 17% of covered workers are employed at a firm with a family premium at least 20% higher than the average family premium, while 21% of covered workers are at firms with a family premium less than 80% of the average family premium [Figure 1.9].
- Thirteen percent of covered workers are employed at a firm with an average annual premium of at least $12,500 for single coverage [Figure 1.10]. Twenty-one percent of covered workers are employed at a firm with an average annual premium of at least $33,000 for family coverage [Figure 1.11].

Figure 1.9
Distribution of Annual Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2026



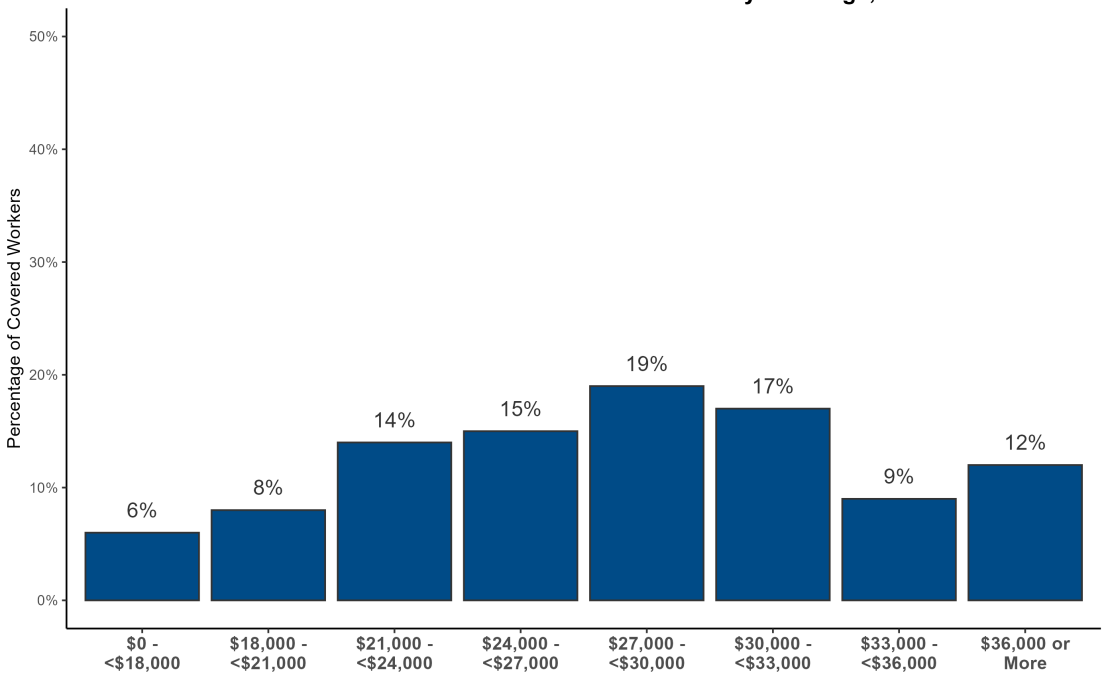
NOTE: The average annual premium is $9,804 for single coverage and $28,303 for family coverage. The premium distribution is relative to the average single or family premium. For example, $7,843 is 80% of the average single premium, $8,823 is 90% of the average single premium, $10,784 is 110% of the average single premium, and $11,765 is 120% of the average single premium. The same brea points relative to the average are used for the distribution for family coverage.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 1.10
Distribution of Annual Premiums for Covered Workers with Single Coverage, 2026



SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 1.11
Distribution of Annual Premiums for Covered Workers with Family Coverage, 2026



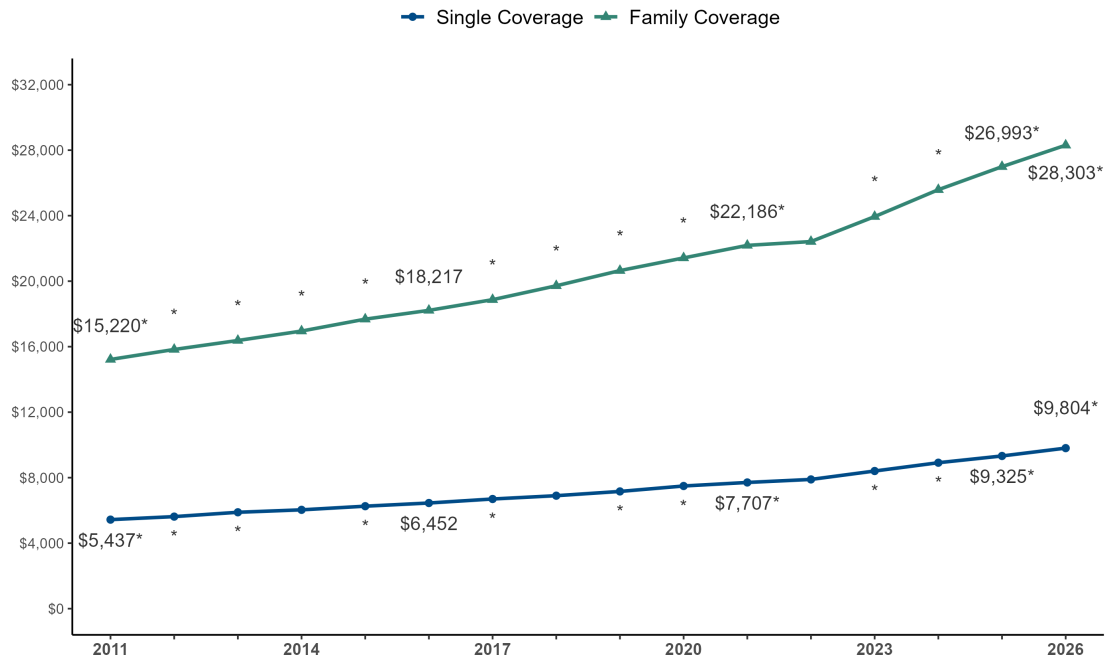
SOURCE: KFF Employer Health Benefits Survey, 2026

PREMIUM CHANGES OVER TIME

The average premiums for covered workers for both single and family coverage increased 5% from last year [Figure 1.12].

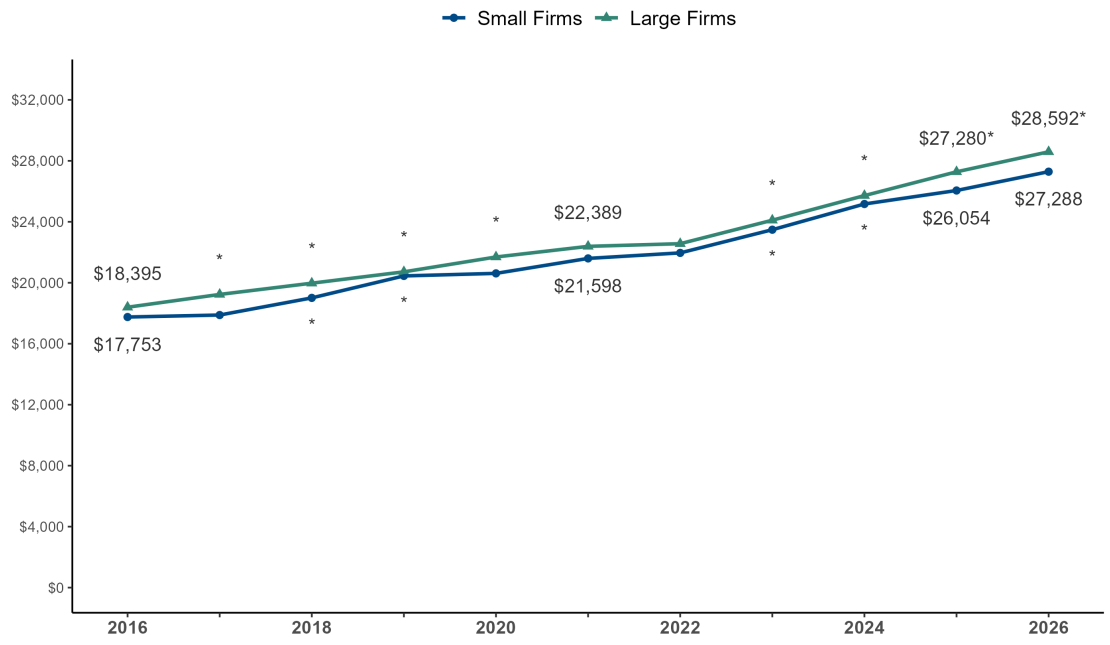
- The average premium for single coverage grew 27% over the past five years.
- The $28,303 average family premium in 2026 is 28% higher than the average family premium in 2021 and 55% higher than the average family premium in 2016. [Figure 1.15].
- The average family premiums for covered workers at smaller firms (firms with 10 to 199 workers) and at larger firms have grown at similar rates since 2021 (26% at smaller firms and 28% at larger firms). For smaller firms, the average family premium rose from $21,598 in 2021 to $27,288 in 2026. For larger firms, the average family premium rose from $22,389 in 2021 to $28,592 in 2026 [Figure 1.14].
- The average family premiums for covered workers at smaller firms (firms with 10 to 199 workers) and at larger firms have grown at similar rates since 2016 (54% at smaller firms and 55% at larger firms). For smaller firms, the average family premium rose from $17,753 in 2016 to $27,288 in 2026. For larger firms, the average family premium rose from $18,395 in 2016 to $28,592 in 2026 [Figure 1.13].
- Over the past five years, the average family premium for covered workers at large firms that are fully insured has grown at a similar rate to the average family premium for covered workers in fully or partially self-funded plans (33% for fully-insured plans and 27% for self-funded plans) [Figure 1.14].
- The average family premium grew 5% in 2026 while inflation was 2.7%. Over the last 5 years, family premiums grew 28%, while inflation during this period was 24.4%. Over the last ten years, the growth in the average premium for family coverage far outpaced inflation (55% vs. 37.9%) [Figure 1.15].
- The average family premium grew 5% in 2026 while wages grew 3.7%. Over the last 5 years, family premiums grew 28%, similar to the 26.9% growth in wages. Over the last ten years, the average family premium and average wages grew at roughly comparable rates (55% vs. 50.1%) [Figure 1.15].

Figure 1.12
Average Annual Premiums for Single and Family Coverage, 2011-2026



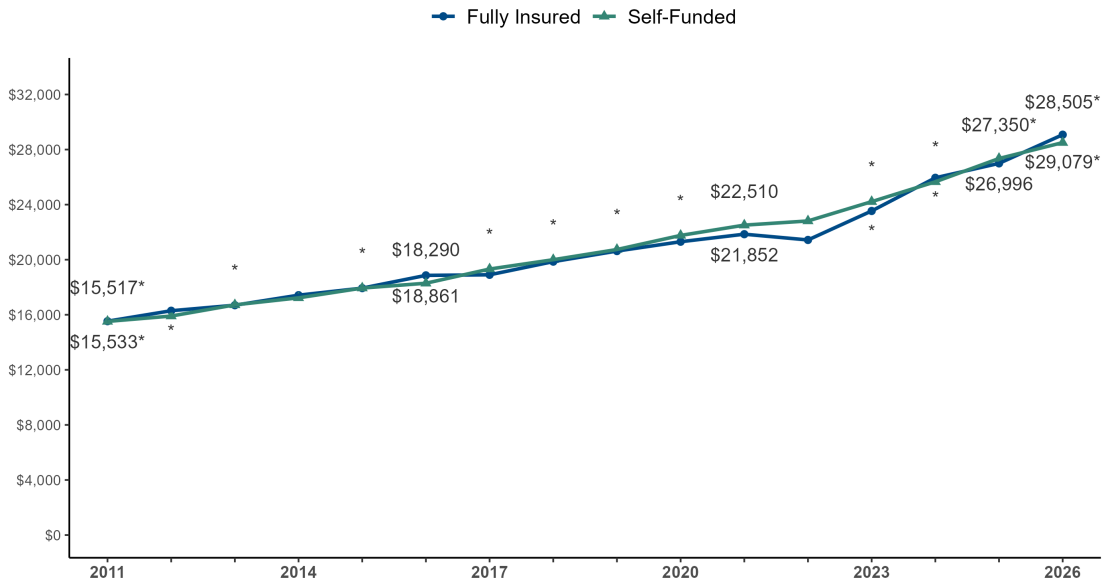
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.13
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 2016-2026



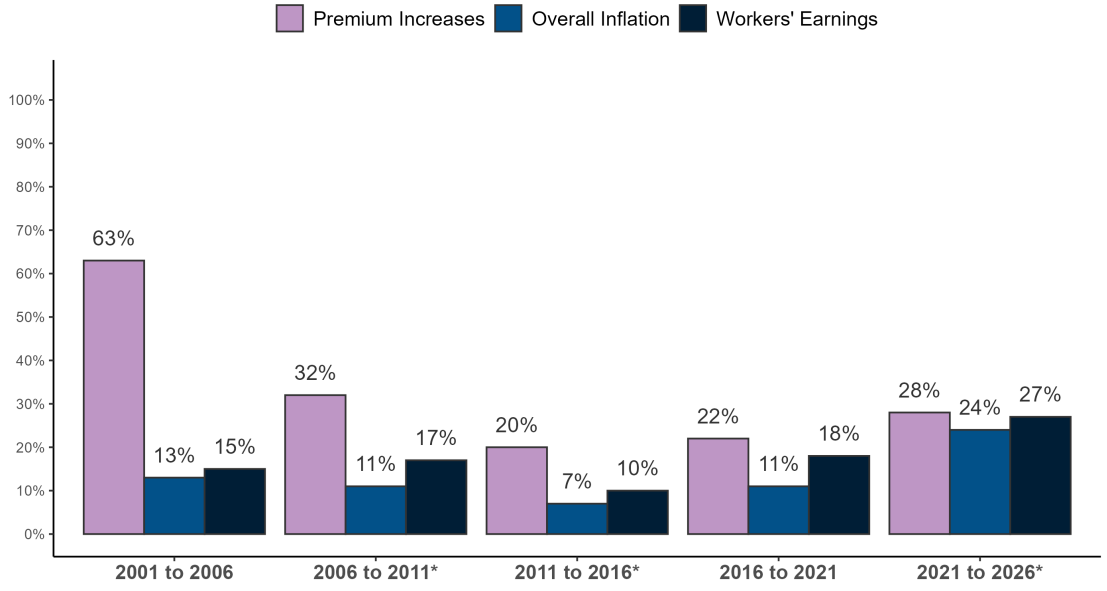
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.14
Among Workers in Large Firms, Average Annual Premiums for Family Coverage, by Funding Arrangement, 2011-2026



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Large Firms have 200 or more workers. For definitions of Self-Funded and Fully Insured Plans, see Section 10. Self-Funded includes plans that purchase stoploss coverage.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

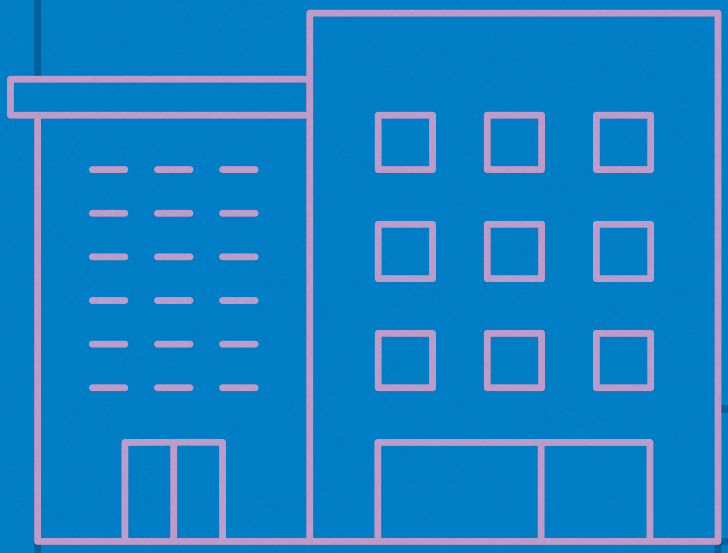
Figure 1.15
Cumulative Premium Increases, Inflation, and Earnings for Covered Workers with Family Coverage, 2001-2026



* Percentage change in family premium is statistically different from previous five year period shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2001-2026; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2001-2026.

SECTION 2

Health Benefits Offer Rates



Section 2

Health Benefits Offer Rates

Nearly all (98%) firms with 200 or more workers offer health benefits to at least some workers, while two in three (66%) smaller firms do. Ninety-five percent of firms that offer health benefits offer both single and family coverage, similar to the percentage last year.

Firms with fewer than 200 workers that do not offer health benefits say the most important reason they do not offer coverage is that the "cost of insurance is too high."

Beginning with the 2025 survey, the sample frame changed from firms with 3 or more employees to firms with 10 or more employees. Because firms with 3 to 9 employees historically have lower offer rates, excluding them increases overall offer rates and affects estimates for firms that do not offer coverage. Historical offer-rate tables have been adjusted to reflect this change. For more information, see the Methods section.

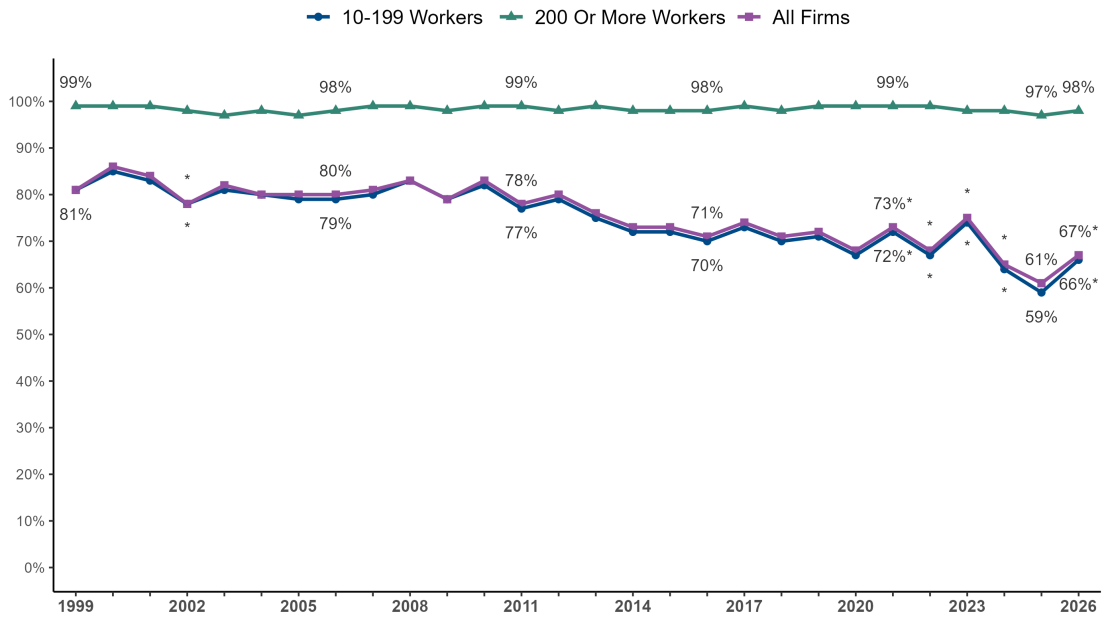
FIRM OFFER RATES

- 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 five years ago (73%) [Figure 2.1].
  - Among smaller firms (10 to 199 workers), the likelihood of offering health benefits increases with firm size: 59% of firms with 10 to 24 workers, 66% of firms with 25 to 49 workers, and 87% of firms with 50 to 199 workers offer health benefits to at least some of their workers [Figure 2.2].
  - The percentage of smaller firms that offer health benefits (66%) is higher than the percentage last year (59%) but lower than the percentage (72%) five years ago [Figure 2.1].
- A large majority of firms are small, and the survey sees considerable year-to-year variation in the offer rates for these firms, which results in fluctuations in the overall offer rate. Most workers, however, work for larger firms, where offer rates are much higher.

  + Eighty-nine percent of firms with 50 or more workers offer health benefits in 2026; this percenta

  - Among larger firms, 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. These percentages are similar to those last year.
- Because most workers are employed by larger firms, most workers work at a firm that offers health benefits to at least some of its employees. In 2026, 92% of all workers are employed by a firm that offers health benefits to at least some of its workers. This percentage is similar to the percentage last year (91%) but lower than the percentage five years ago (94%) [Figure 2.4].

Figure 2.1
Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2026



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Estimates include firms that completed the survey and those that answered only whether they offer health benefits (see Methods). Firm size is based on total number of employees (full- and part-time).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 2.2

Percentage of Firms Offering Health Benefits, by Firm Size, Region, and Industry, 2026

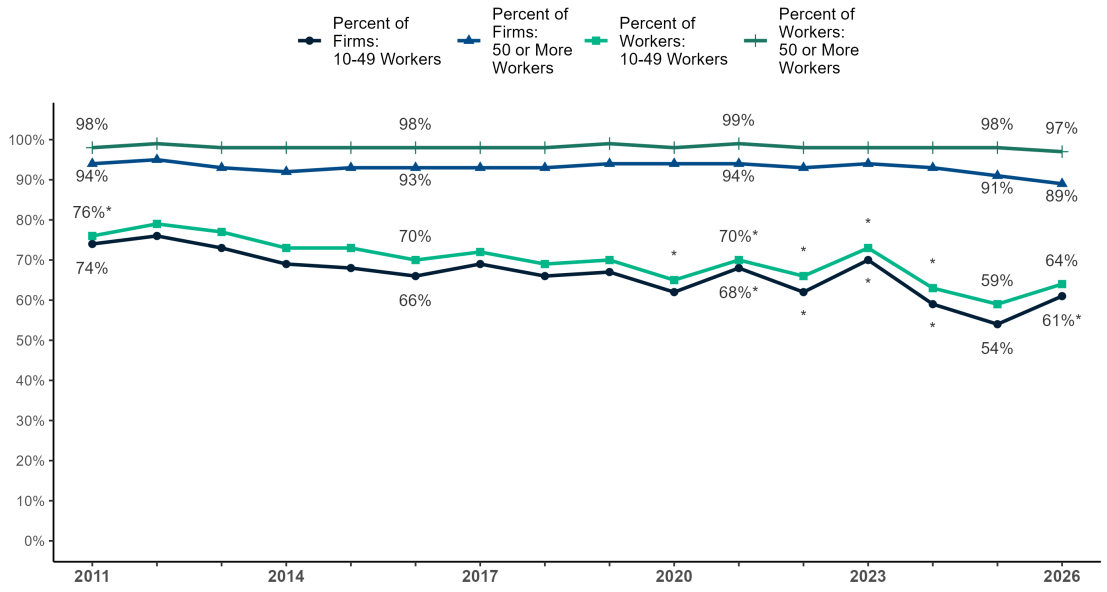
	Percentage of Firms Offering Health Benefits
FIRM SIZE	
10-24 Workers	59%*
25-49 Workers	66
50-199 Workers	87*
200-999 Workers	98*
1,000-4,999 Workers	99*
5,000 or More Workers	100*
All Small Firms (10-199 Workers)	**66%***
All Large Firms (200 or More Workers)	**98%***
REGION	
Northeast	70%
Midwest	66
South	65
West	70
INDUSTRY	
Agriculture/Mining/Construction	67%
Manufacturing	79*
Transportation/Communications/Utilities	77
Wholesale	84*
Retail	55*
Finance	73
Service	64
State/Local Government	97*
Health Care	65
ALL FIRMS	**67%**

NOTE: Estimates include firms that completed the survey and those that answered only whether they offer health benefits (see Methods). Firm size categories are determined by the number of workers at a firm, which may include full-time and part-time workers.

* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category ($p < .05$).

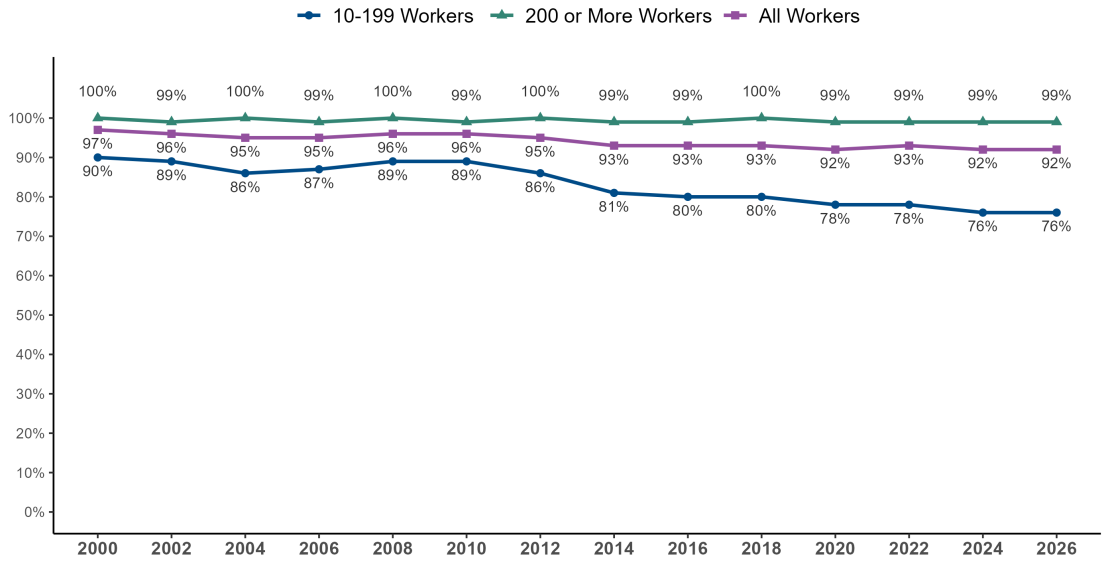
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 2.3
Percentage of Firms and Workers at Firms Offering Health Benefits, by Firm Size, 2011-2026



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Estimates include firms that completed the survey and those that answered only whether they offer health benefits (see Methods).Not all workers at a firm offering benefits are eligible or enrolled in their firm's health benefits.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 2.4
Percentage of Workers at Firms That Offer Health Benefits to at Least Some Workers, by Firm Size, 1999-2026

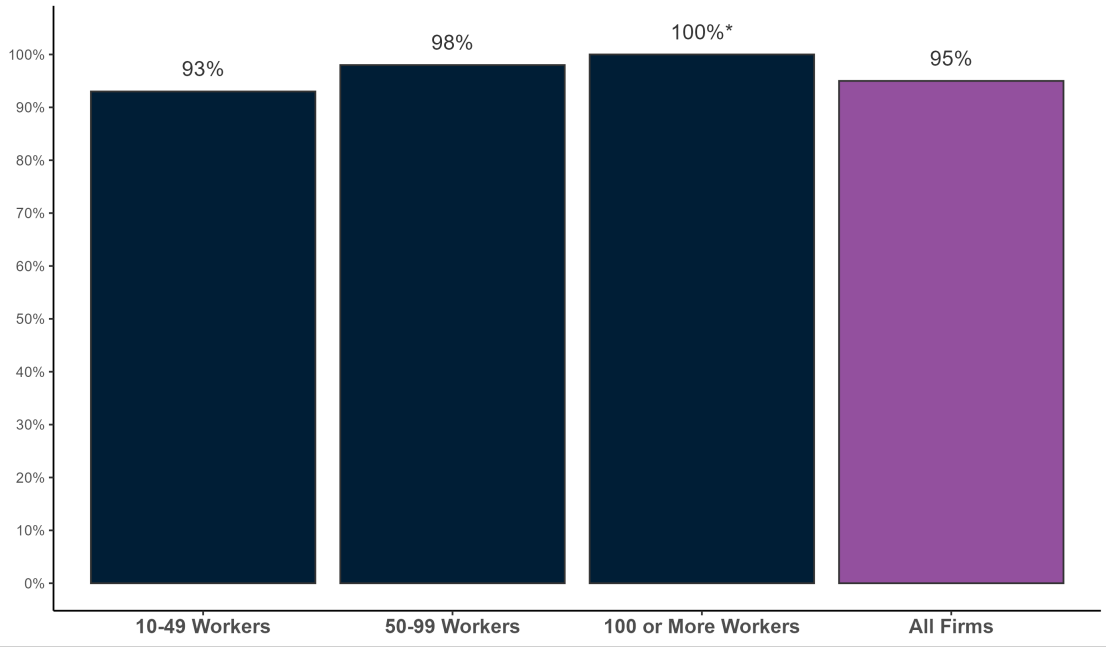


NOTE: Estimates include firms that completed the survey and those that answered only whether they offer health benefits (see Methods). Not all workers at a firm offering benefits are eligible or enrolled in their firm's health benefits.Not all years of data are displayed. Differences between consecutive years may be statistically significant. For full data tables and statistical testing, see the downloadable tables on the EHBS website.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

OFFERS TO SPOUSES AND DEPENDENTS

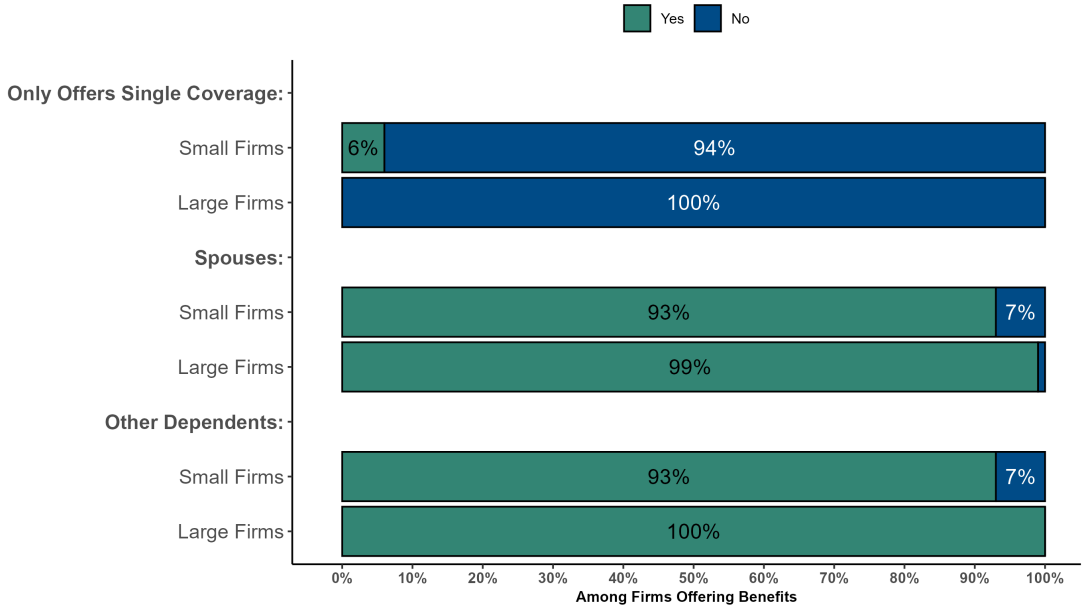
- Almost all firms that offer health benefits offer family coverage. In 2026, nearly all firms with 200 or more workers and 94% of smaller firms that offer health benefits offer family coverage to their workers [Figure 2.5].
- The vast majority of firms with 10 or more workers that offer health benefits offer them to spouses and dependents, such as children. Ninety-four percent of smaller firms and virtually all larger firms that offer health benefits offer coverage to spouses. These percentages are similar to the percentages in 2025 [Figure 2.6].
  - Ninety-three percent of smaller firms and virtually all larger firms that offer health benefits offer coverage to dependents other than spouses, such as children. These percentages are similar to the percentages in 2025 [Figure 2.6].
  - Seven percent of firms with 10 to 49 workers offering health benefits offer only single coverage to their workers, similar to the percentage last year.

Figure 2.5
Percentage of Firms Offering Health Benefits Which Offer Family Coverage, by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 2.6
Among Firms Offering Health Benefits, Availability of Coverage for Spouses and Other Dependents, by Firm Size, 2026



NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

PROVISIONS TO ENCOURAGE ENROLLMENT IN OTHER COVERAGE

Some firms have provisions to encourage workers or their spouses to forgo enrolling in coverage, or to choose other sources of coverage when available.

- Among firms with 10 or more workers offering coverage, 7% provide additional compensation or benefits to workers if they choose not to enroll in the firm's health plan and 8% provide additional compensation or benefits to workers who choose to enroll in a spouses health plan [Figure 2.7].

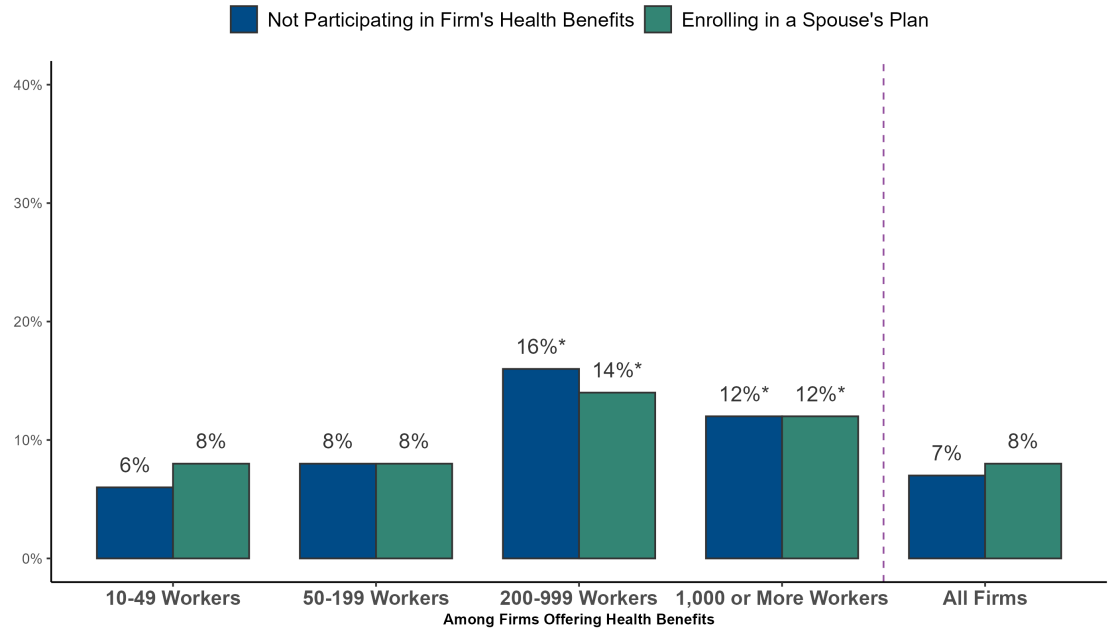
SPOUSAL ELIGIBILITY AND SURCHARGES

Some employers place conditions on the ability of dependent spouses to enroll in a health plan if the spouse is offered health insurance from another source, such as the spouse's own employer.

- Among firms offering health benefits to spouses, 81% say that an employee's spouse is able to enroll in the employee's health plan even if the spouse is offered coverage from another source, 6% say the spouse can enroll subject to some conditions (for example, the type of coverage offered), and 13% say that the spouse is not eligible to enroll if they have access to another source of coverage [Figure 2.8].
  - Firms with 1,000 or more workers are more likely than smaller firms to allow these spouses to enroll with conditions (17% vs. 6%).

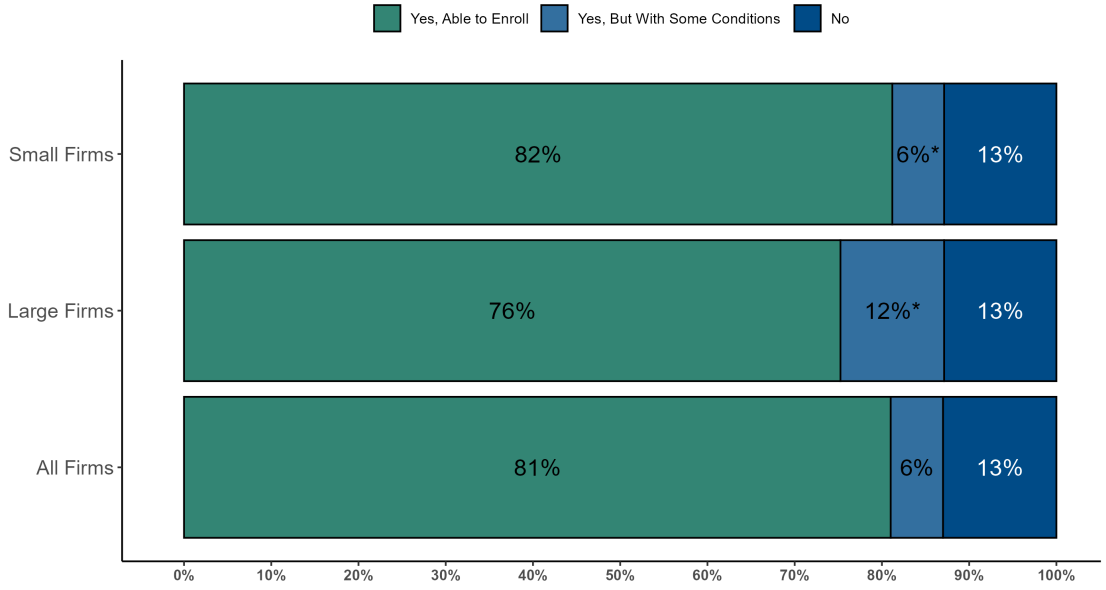
- Among firms offering coverage (with or without conditions) to spouses with access to other coverage, 8% require the spouses to pay more than spouses without access to other coverage if they decide to enroll. This may be implemented through higher premium contributions or higher cost sharing. Firms with 1,000 or more workers are more likely than smaller firms to have restrictions or assess higher costs to spouses with access to other coverage (17% vs. 8%).
- Overall, 24% of firms offering spousal coverage restrict eligibility or require a surcharge for spouses who have an offer of coverage from another source. Among large firms (200 or more workers) offering spousal coverage, this share is 29%, up from 22% in 2022 [Figure 2.9].

Figure 2.7
Percentage of Firms That Provide Workers Additional Incentives For Various Enrollment Decisions, by Firm Size, 2026



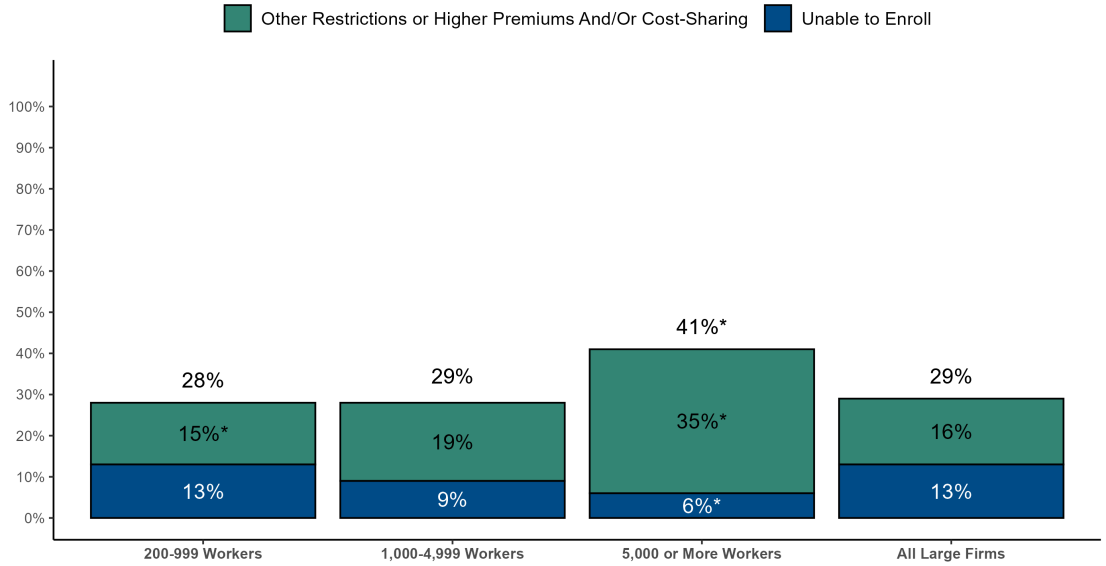
* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 2.8
Among Firms Offering Spousal Coverage, Spouses' Eligibility If They Have an Offer From Another Source, by Firm Size, 2026



* Estimates are statistically different between Small Firm and Large Firm estimates within category (p < .05).
NOTE: Some conditions may include requirements on the spouse's work status, a spousal premium surcharge, or the type of coverage the spouse has access to. Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 2.9
Among Large Firms that Offer Spousal Coverage, Spouses' Eligibility if They Have an Offer from Another Source, by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Some conditions may include requirements on the spouse's work status, a spousal premium surcharge, or the type of coverage the spouse has access to. Among firms with 200 or more workers offering coverage to spouses, 8% require a surcharge for spouses who are offered coverage from another source. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

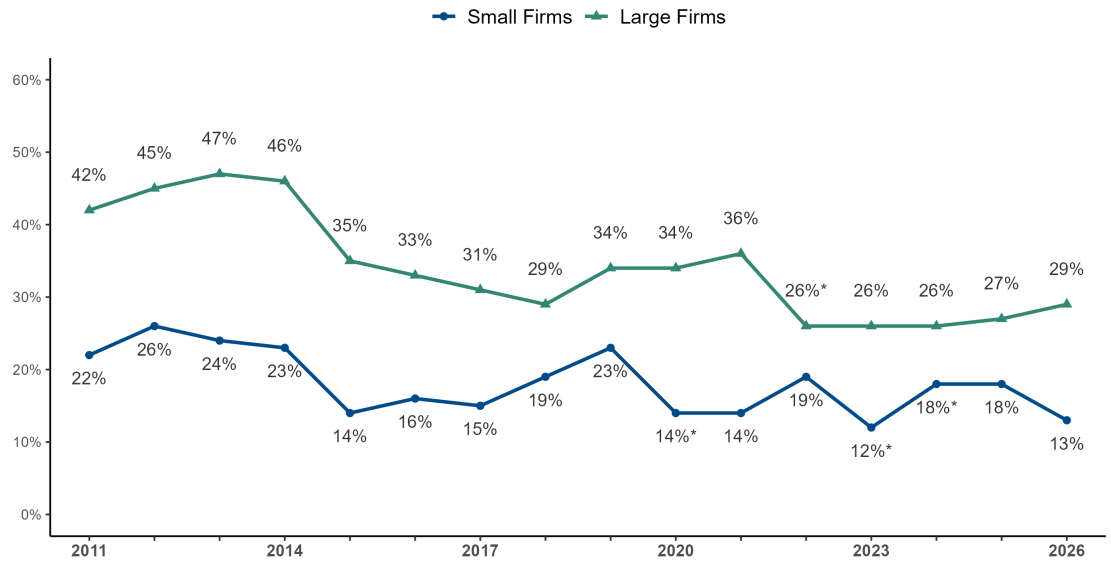
PART-TIME WORKERS

Among firms that offer health benefits, relatively few offer benefits to part-time workers.

The Affordable Care Act (ACA) defines "full-time" workers as those who work an average of at least 30 hours per week, and "part-time" workers as those who work fewer than 30 hours. The employer shared responsibility provision of the ACA requires that firms with at least 50 full-time equivalent employees offer most of their full-time employees coverage that meets minimum standards or be assessed a penalty.[1]

- Twenty-nine percent of firms with 200 or more workers that offer health benefits in 2026 offer health benefits to part-time workers, similar to the percentage (27%) that did so in 2025. Firms with 200 or more workers are more likely than smaller firms to offer health benefits to part-time workers [Figure 2.11].

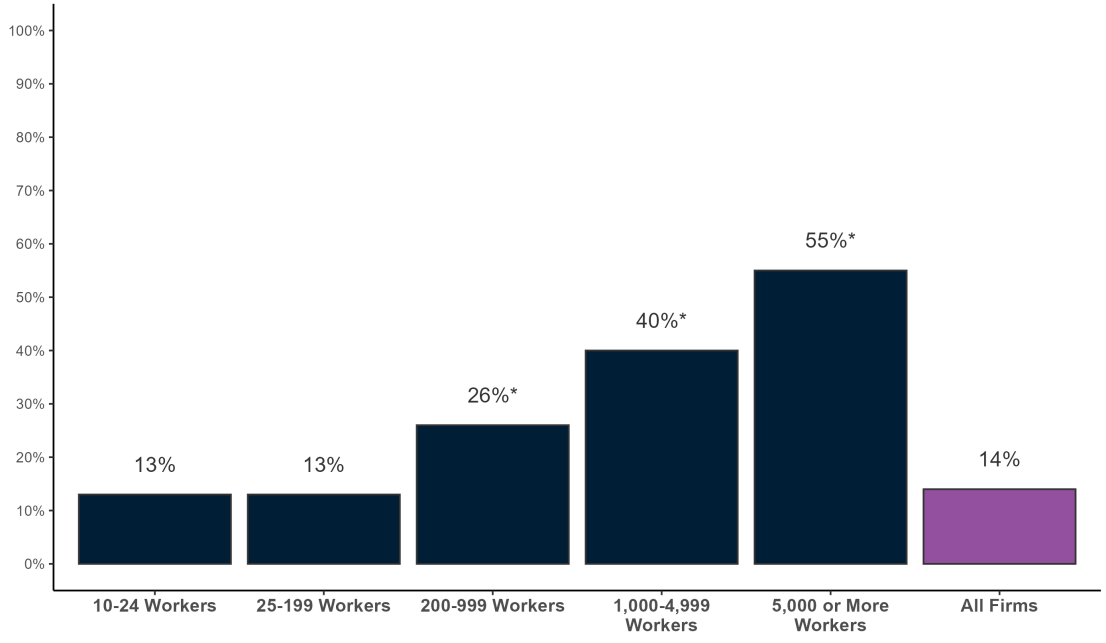
Figure 2.10
Among Firms Offering Health Benefits, Percentage That Offer to Part-Time Workers, by Firm Size, 2011-2026



* 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. Prior to 2015, each respondent defined part-time according to their firm's policies; starting in 2015, respondents were asked whether employees working fewer than 30 hours per week were eligible for benefits. There was no statistical testing between 2014 and 2015.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

[1] Employer Responsibility Under the Affordable Care Act. KFF. https://www.kff.org/infographic/employer-responsibility-under-the-affordable-care-act/.

Figure 2.11
Among Firms Offering Health Benefits, Percentage That Offer to Part-Time Workers, by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2026

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

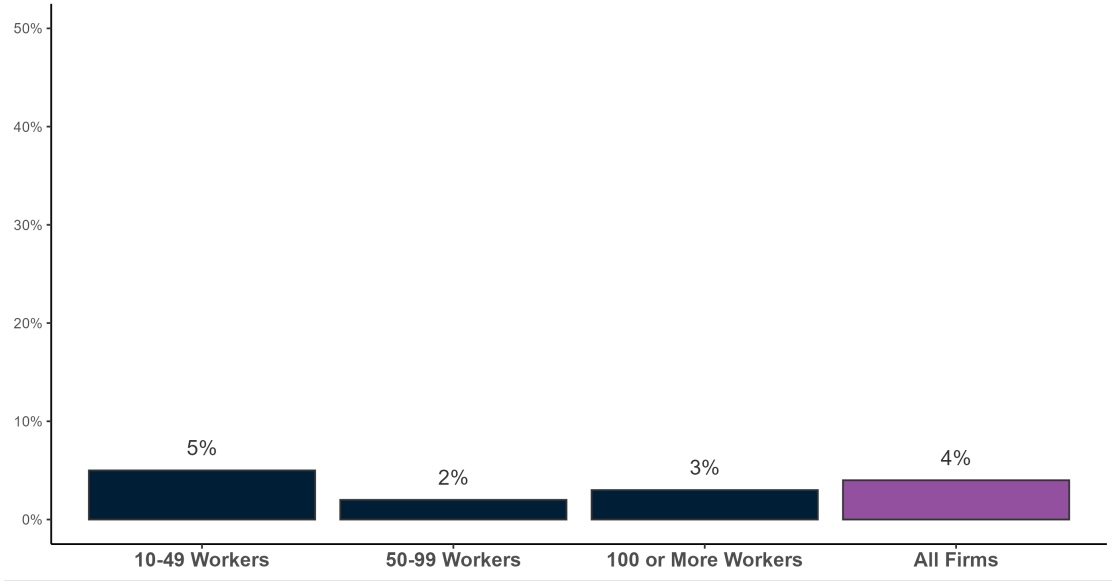
Some employers provide funds to some or all of their employees to help them purchase coverage in the individual ("non-group") market. Employers that do not otherwise offer health benefits may provide these funds as an alternative to offering a group plan. Employers that offer a group plan to some employees may also use this approach for other types or classes of workers, such as those working part-time or remotely.

One way employers can provide tax-preferred assistance for employees to purchase non-group coverage is through a Custom Health Option and Individual Care Expense Arrangement (CHOICE). Prior to 2026, these arrangements were called Individual Coverage Health Reimbursement Arrangements (ICHRAs). Small employers may also contribute toward employees' health coverage through a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA). Both employers that offer health benefits and those that do not were asked whether they provide funds to any employees to purchase non-group coverage.

- Four percent of firms that offer health benefits and 11% of firms that do not offer health benefits provided funds to one or more of their employees to purchase non-group coverage in 2026 [Figure 2.12].
- Among firms with 10 to 199 workers that do not offer health benefits, 11% offer funds to one or more of their employees to purchase non-group coverage, a similar percentage as last year (9%) [Figure 2.14].
- Firms that do not offer funds to any employees to purchase non-group coverage in 2026 were asked if they were likely to do so in the next two years.
  - Among firms with 10 or more workers that offer health benefits, 6% say they are "somewhat likely" to offer a CHOICE/ICHRA to at least some employees in the next two years [Figure 2.13].

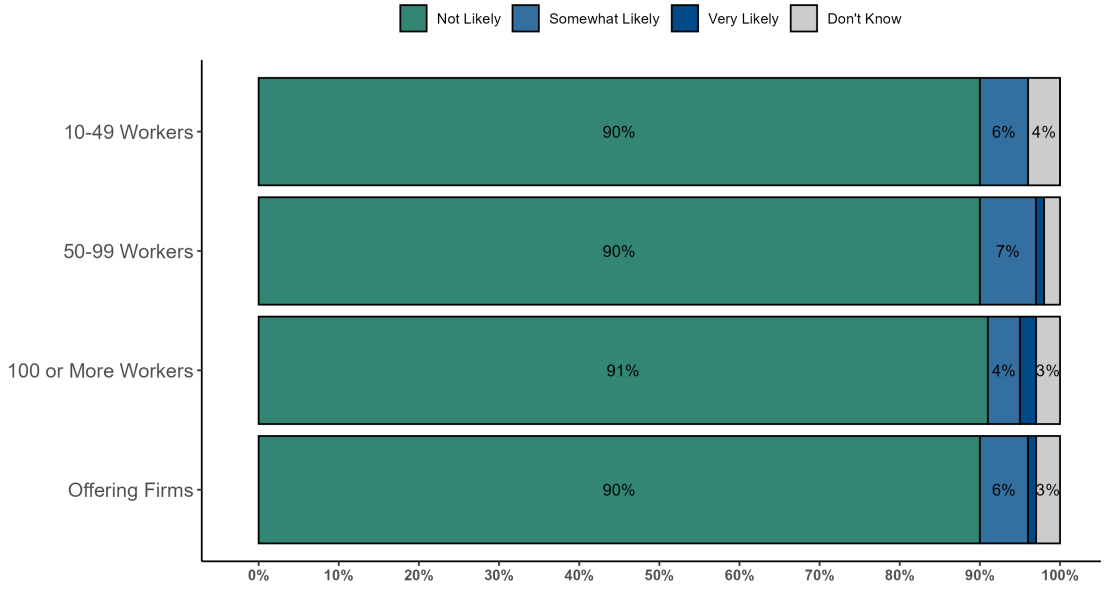
- Among firms with 10 to 199 workers that do not offer health benefits, 2% say they are “very likely” and an additional 13% say they are “somewhat likely” to offer a CHOICE/ICHRA to at least some employees in the next two years [Figure 2.15].

Figure 2.12
Among Firms Offering Health Benefits, Percentage of Firms That Provide Workers Funds to Purchase Non-Group Insurance, Such as Through an ICHRA, by Firm Size, 2026



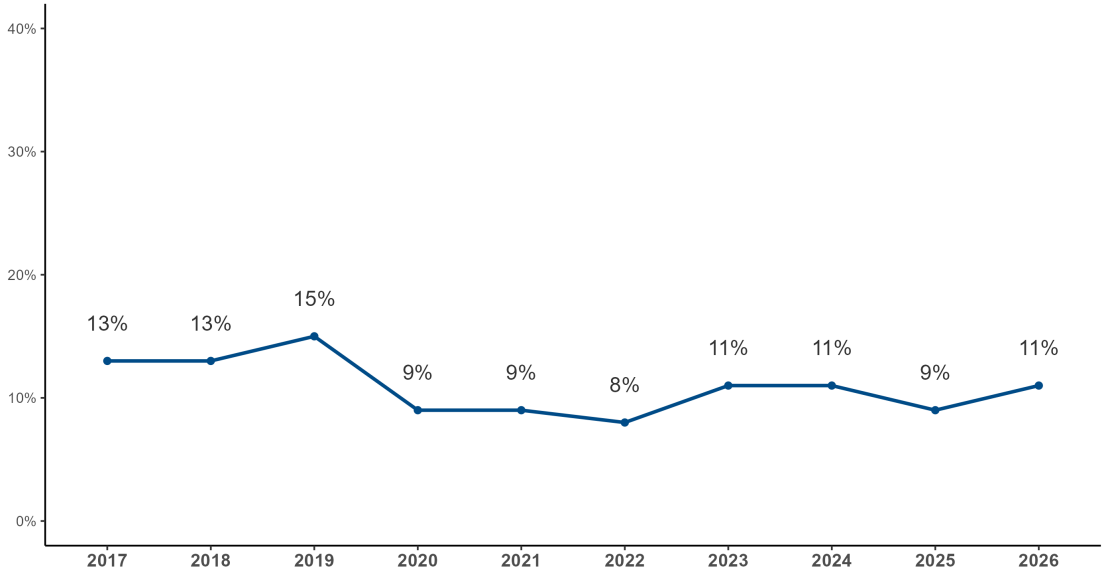
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Funds may be provided through an ICHRA or through an arrangement for smaller employers, such as a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA). An Individual Coverage Health Reimbursement Arrangement (ICHRA) allows employers to reimburse their employees tax-free for premiums, cost-sharing as well as some other health services and equipment.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 2.13
Likelihood of Offering an ICHRA in the Next Two Years Among Firms That Offer Health Benefits but Do Not Currently Offer an ICHRA, by Firm Size, 2026



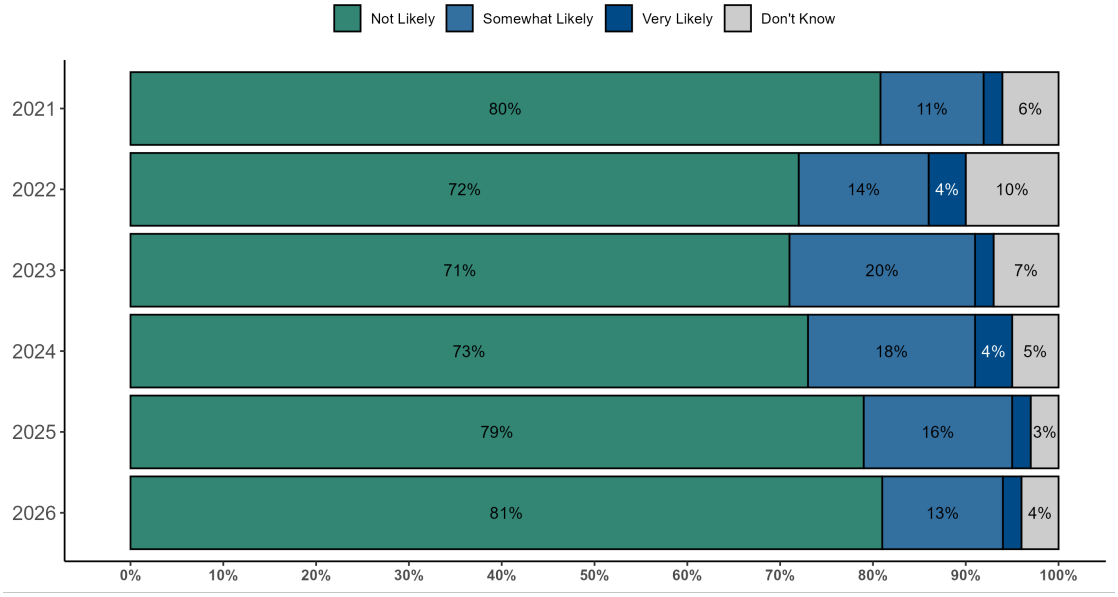
* Estimates are statistically different from each other within category ($p < .05$).
NOTE: An Individual Coverage Health Reimbursement Arrangement (ICHRA) allows employers to reimburse their employees tax-free for premiums, cost-sharing as well as some other health services and equipment.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 2.14
Among Small Firms Not Offering Health Benefits, Percentage Providing Funds for Employees to Purchase Non-Group Insurance, 2016-2026



Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 10-199 workers. Funds may be provided through an ICHRA or QSEHRA. Question wording has changed over time to reflect the inclusion of these options. An Individual Coverage Health Reimbursement Arrangement (ICHRA) allows employers to reimburse their employees tax-free for premiums, cost-sharing as well as some other health services and equipment.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012-2017

Figure 2.15
Likelihood of Offering an ICHRA in the Next Two Years Among Small Firms Not Offering Health Benefits, 2021-2026



NOTE: Small Firms have 10-199 workers. An Individual Coverage Health Reimbursement Arrangement (ICHRA) allows employers to reimburse their employees tax-free for premiums, cost-sharing as well as some other health services and equipment.
SOURCE: KFF Employer Health Benefits Survey, 2021-2026;

FIRMS NOT OFFERING HEALTH BENEFITS

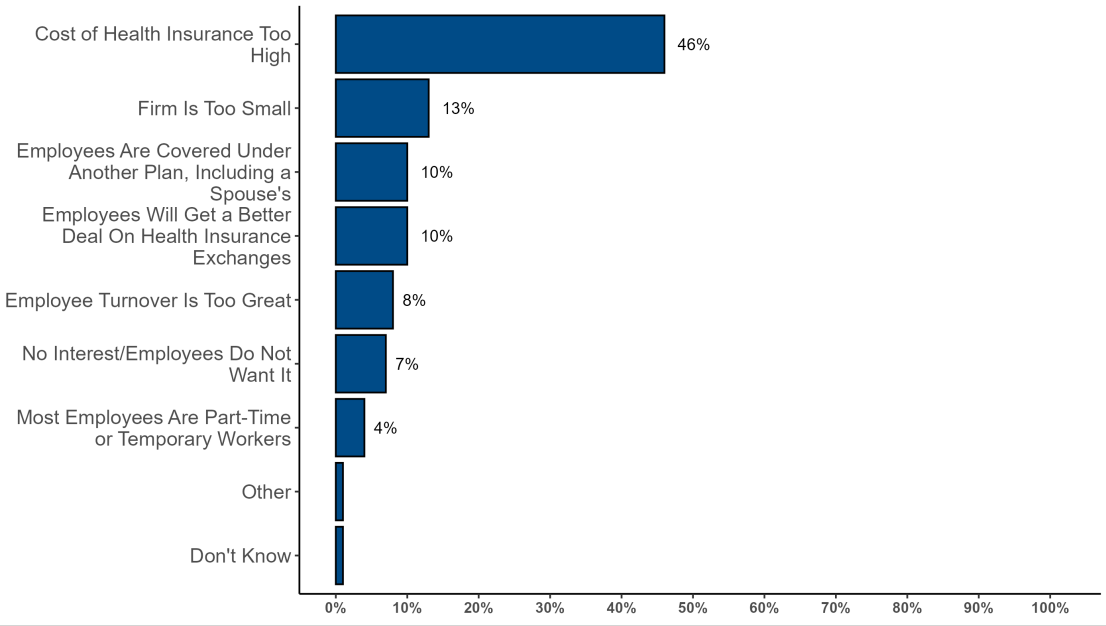
Firms that do not offer health benefits were asked several questions, including whether they have offered insurance or shopped for insurance in the recent past, what their most important reasons for not offering coverage are, and their opinion on whether their employees would prefer an increase in wages or health insurance if additional funds were available to increase their compensation. Because very few larger firms report not offering health benefits, we present responses only for firms with 10 to 199 workers.

- The "cost of insurance is too high" is the most common reason these firms cite for not offering health benefits. When firms were asked the most important reason for not offering coverage, 46% say the "cost of insurance is too high," 13% say the "firm is too small," 10% say that their "employees are covered under another plan, including coverage on a spouse's plan," 7% say that "their employees will get a better deal on the health insurance exchanges," 10% say that "most employees are part-time or temporary workers", and 8% say their "employees are not interested." [Figure 2.16]
- Some firms not offering health benefits have either offered health insurance in the past five years or shopped for health insurance in the past year [Figure 2.17].
  - Sixteen percent of firms not offering health benefits have offered health benefits in the past five years [Figure 2.17]. Among these firms, 10% stopped offering coverage within the past year.
  - Among firms that stopped offering coverage within the past five years, 31% say the firm stopped offering health insurance coverage after receiving a high renewal quote following high claims from a small number of enrollees.

  - Among firms that stopped offering coverage within the past five years, 34% say the cost of coverage was too high, 3% say premium increases were unpredictable or unsustainable, 28% say too few employees wanted to enroll, and 12% say employees obtained coverage elsewhere. Other reasons include transitioning to a stipend or other benefit instead of group coverage (9%), and downsizing, merging, or changing ownership (5%) [Figure 2.19].
  - Seventeen percent of firms not offering health benefits have shopped for coverage in the past year, similar to the percentage last year (16%) [Figure 2.17].

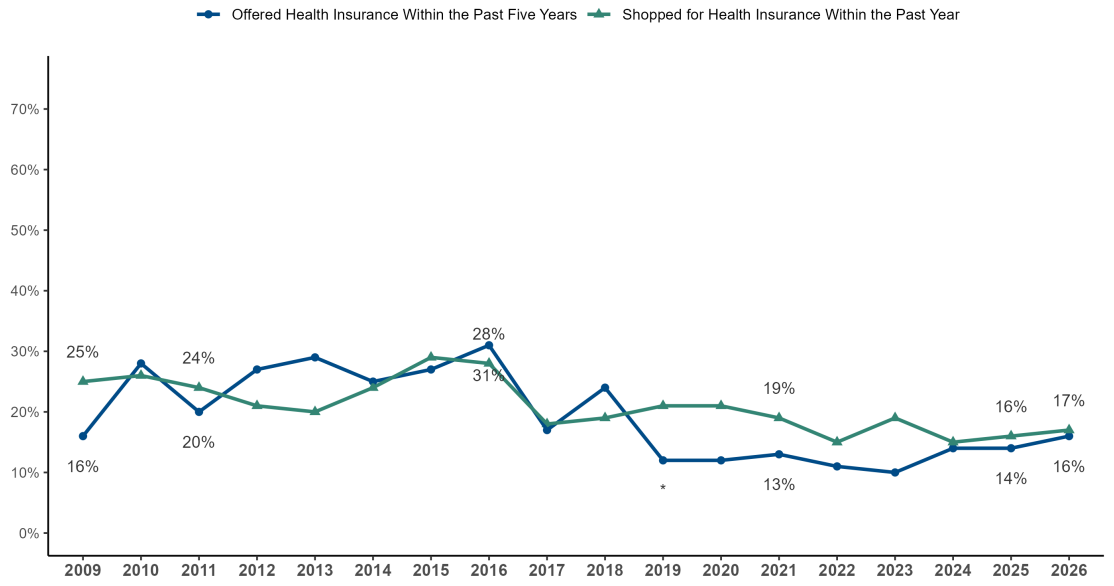
- Eighty-one percent of firms not offering health benefits agreed with the statement that their employees would prefer a two-dollar-per-hour increase. increase in wages rather than health insurance [Figure 2.18].

Figure 2.16
Among Small Firms Not Offering Health Benefits, Most Important Reason for Not Offering, 2026



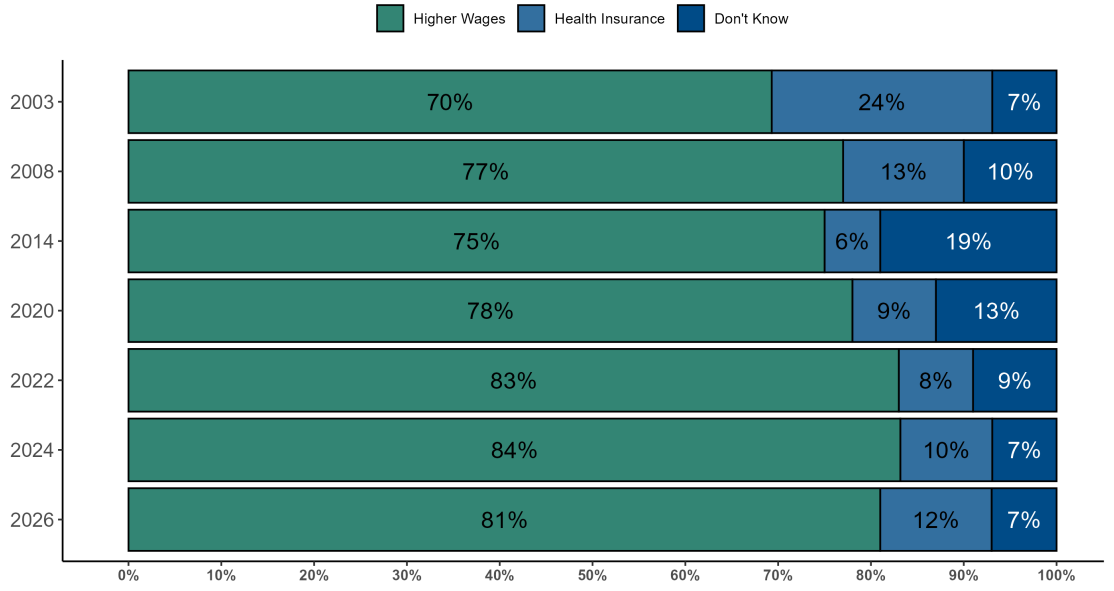
NOTE: Small Firms have 10-199 workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 2.17
Among Small Firms Not Offering Health Benefits, Percentage of Firms That Report the Following Actions, 2009-2026



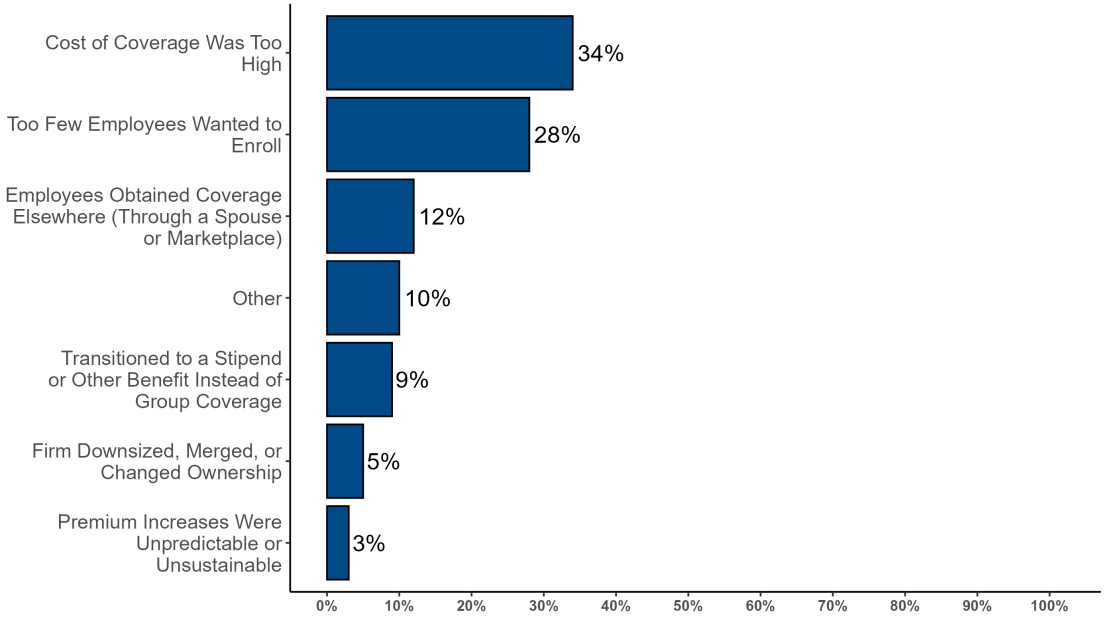
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 10-199 workers. 10% of small non-offering firms that indicated they had offered health insurance in the past five years said they stopped offering health benefits in the past 12 months.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 2.18
Among Small Firms Not Offering Health Benefits, Firms' View of Employees' Preference for Higher Wages or Health Insurance Benefits, 2008-2026



NOTE: Small Firms have 10-199 workers. The question asks firms whether they believe employees would rather receive an additional $2 per hour in the form of higher wages or health insurance.
SOURCE: KFF Employer Health Benefits Survey, 2020-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003-2014

Figure 2.19
Main Reasons Small Firms That Previously Offered Health Benefits Stopped Offering Coverage in the Past Five Years, 2026



NOTE: Small Firms have 10-199 workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

SECTION 3

Employee Coverage, Eligibility, and Participation



Section 3

Employee Coverage, Eligibility, and Participation

Employers are the principal source of health insurance in the United States, providing health benefits for 157 million nonelderly people.[1] Most workers are offered health coverage at work, and most of the workers who are offered coverage take it. Workers may not be covered by their own employer for several reasons: their employer may not offer coverage, they may not be eligible for the benefits offered by their firm, they may elect to receive coverage from another source (such as through their spouse's employer), or they may decline the offer from their firm. In 2026, 59% of workers in firms offering health benefits are covered by their own firm, similar to the percentages last year, five years ago, and ten years ago.

ELIGIBILITY

- Some workers employed at firms that offer health benefits may not be eligible to participate. Many firms, for example, do not offer coverage to part-time or temporary workers. Among workers in firms offering health benefits in 2026, 80% are eligible to enroll in the benefits offered by their firm, similar to the percentages last year, five years ago, and ten years ago [Figure 3.1].
  - Eligibility varies considerably with firm wage level. Workers in firms with a relatively large share of lower-wage workers (where at least 35% of workers earn $38,000 a year or less) have a lower average eligibility rate than workers in firms with a smaller share of lower-wage workers (73% vs. 81%) [Figure 3.6].
  - Workers in firms with a relatively large share of higher-wage workers (where at least 35% earn $82,000 or more annually) have a higher average eligibility rate than workers in firms with a smaller share of higher-wage workers (86% vs. 77%) [Figure 3.6].
  - Eligibility also varies by the age of the workforce within firms. Workers in firms with a relatively small share of younger workers (where fewer than 35% of the workers are age 26 or younger) have a higher average eligibility rate than those in firms with a larger share of younger workers (82% vs. 70%) [Figure 3.6].
  - Eligibility rates vary considerably for workers in different industries. The average eligibility rate remains particularly low for workers in retail firms (61%) [Figure 3.3].

[1] KFF. Health Insurance Coverage of the Non elderly [Internet]. San Francisco (CA): KFF; 2024 [cited 2026 Aug 5. Available from: https://www.kff.org/other/state-indicator/nonelderly-0-64/.

Figure 3.1

Eligibility, Take-Up, and Coverage Rates for Workers in Firms Offering Health Benefits, by Firm Size, 1999-2026

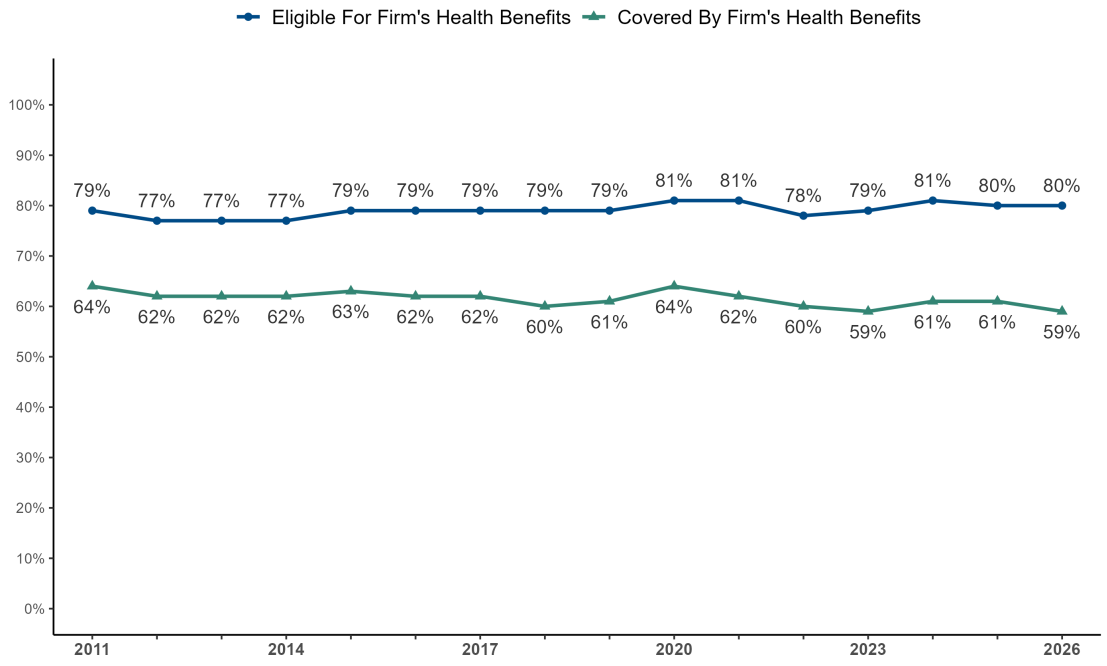
	Percentage Eligible			Percentage of Eligible That Take			Percentage Covered		
	Small Firms	Large Firms	All Firms	Small Firms	Large Firms	All Firms	Small Firms	Large Firms	All Firms
1999	80%	78%	79%	83%	86%	85%	67%	66%	66%
2000	81%	80%	81%	83%	84%	84%	68%	67%	67%
2001	86%*	82%	83%*	83%	85%	84%	71%	69%	70%
2002	81%*	80%	80%*	83%	86%	85%	67%*	69%	68%
2003	84%	80%	81%	81%	85%	84%	67%	68%	68%
2004	79%*	81%	80%	80%	84%	83%	63%*	68%	66%
2005	81%	79%	80%	81%	85%	83%	66%	67%	66%
2006	82%	76%	78%	82%	84%	83%	67%	63%	64%
2007	79%	78%	78%	79%	84%	82%	63%*	65%	64%
2008	81%	79%	79%	80%	84%	82%	64%	66%	65%
2009	80%	79%	79%	79%	82%	81%	63%	65%	64%
2010	81%	77%	78%	77%	82%	81%	63%	63%	63%
2011	82%	78%	79%	77%	83%	81%	63%	65%	64%
2012	78%*	76%	77%	79%	82%	81%	61%	62%	62%
2013	80%	76%	77%	79%	81%	80%	63%	62%	62%
2014	79%	76%	77%	78%	81%	80%	62%	62%	62%
2015	81%	79%	79%	75%	81%	79%	61%	63%	63%
2016	82%	78%	79%	77%	79%	79%	64%	62%	62%
2017	82%	78%	79%	74%	79%	78%	61%	62%	62%
2018	81%	77%	79%	73%	78%	77%	60%	60%	60%
2019	81%	79%	79%	73%	78%	76%	60%	61%	61%
2020	83%	81%	81%	74%	80%	78%	61%	65%	64%
2021	82%	81%	81%	74%	78%	77%	60%	63%	62%
2022	78%*	78%	78%	73%	78%	77%	57%	61%	60%
2023	82%*	78%	79%	71%	76%	75%	58%	60%	59%
2024	83%	80%	81%	72%	77%	76%	59%	62%	61%
2025	82%	80%	80%	72%	77%	76%	59%	61%	61%
2026	82%	80%	80%	70%	75%	74%	57%	60%	59%

NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.

* 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, 1999-2017

Figure 3.2
Eligibility and Coverage Rates for Workers in Firms Offering Health Benefits, 2011-2026



Tests found no statistical difference 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, 1999-2017

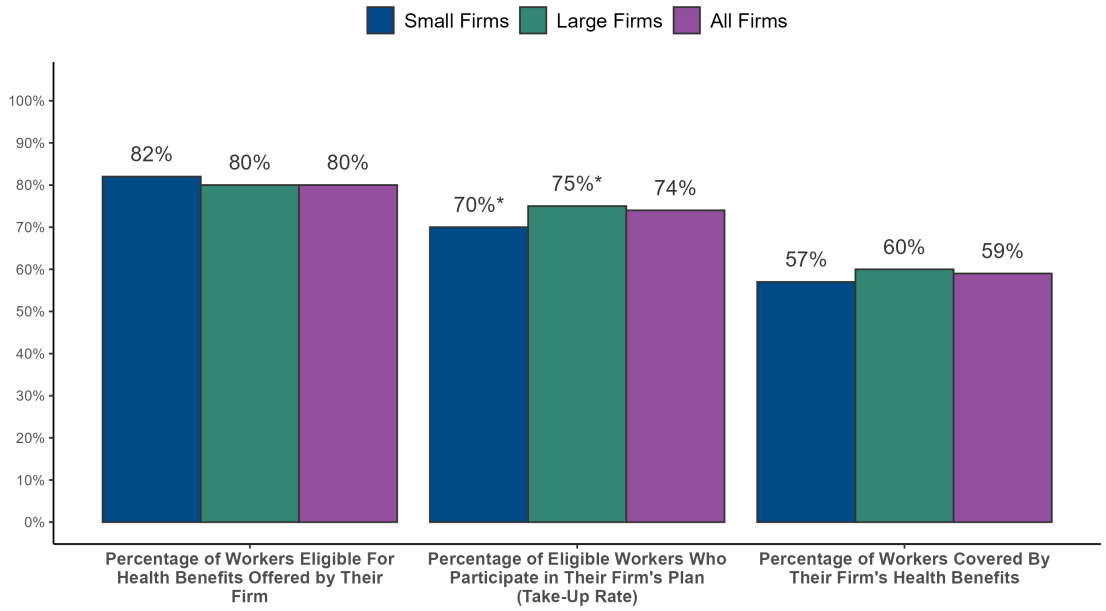
Figure 3.3
Eligibility, Take-Up, and Coverage Rates in Firms Offering Health Benefits, by Firm Size, Region, and Industry, 2026

	Percentage of Workers Eligible for Health Benefits Offered by Their Firm	Percentage of Eligible Workers Who Participate in Their Firm's Plan (Take-Up Rate)	Percentage of Workers Covered by Their Firm's Health Benefits
FIRM SIZE			
10-24 Workers	84%	72%	61%
25-49 Workers	81	72	58
50-199 Workers	81	68*	55
200-999 Workers	81	74	60
1,000-4,999 Workers	82	76	63
5,000 or More Workers	78	76	59
All Small Firms (10-199 Workers)	**82%**	**70%***	**57%**
All Large Firms (200 or More Workers)	**80%**	**75%***	**60%**
REGION			
Northeast	79%	70%*	55%
Midwest	79	72	57
South	85*	76	64*
West	76	77	59
INDUSTRY			
Agriculture/Mining/Construction	82%	68%	56%
Manufacturing	94*	77	73*
Transportation/Communications/Utilities	92*	83*	76*
Wholesale	92*	76	70*
Retail	61*	53*	32*
Finance	93*	80*	74*
Service	76	73	56
State/Local Government	86*	87*	74*
Health Care	76*	73	55
ALL FIRMS	**80%**	**74%**	**59%**

* Estimate for eligibility, take-up, or coverage rate is statistically different from the estimate for all other firms not in the indicated size, region, or industry category ($p < .05$).

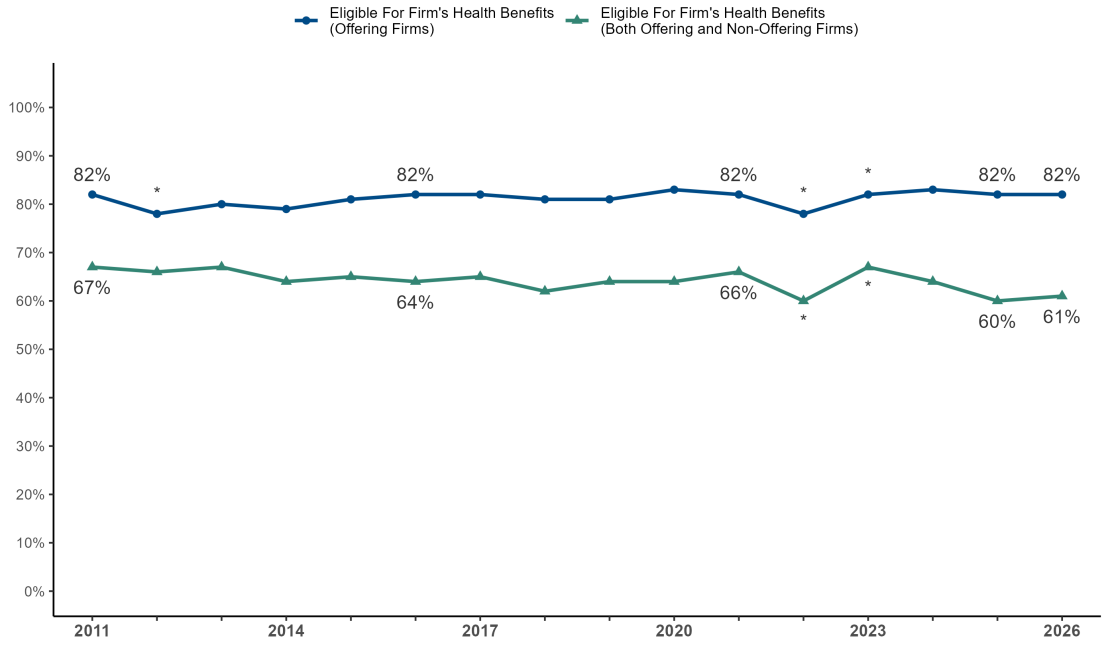
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 3.4
Eligibility, Take-Up, and Coverage Rates in Firms Offering Health Benefits, by Firm Size, 2026



* Estimate for eligibility, take-up, or coverage rate is statistically different between large and small firms ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 3.5
Among Workers at Small Firms, Eligibility for Workers At Their Own Firms, 2011-2026

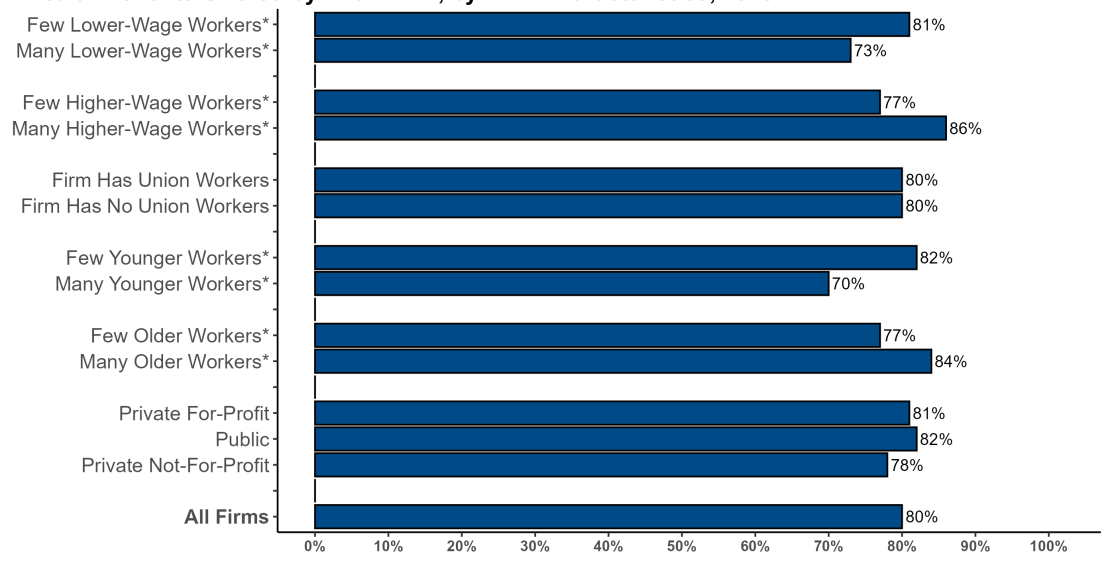


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: By definition, no workers at non-offering firms are eligible for health benefits. Small Firms have 10-199 workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

TAKE-UP RATE

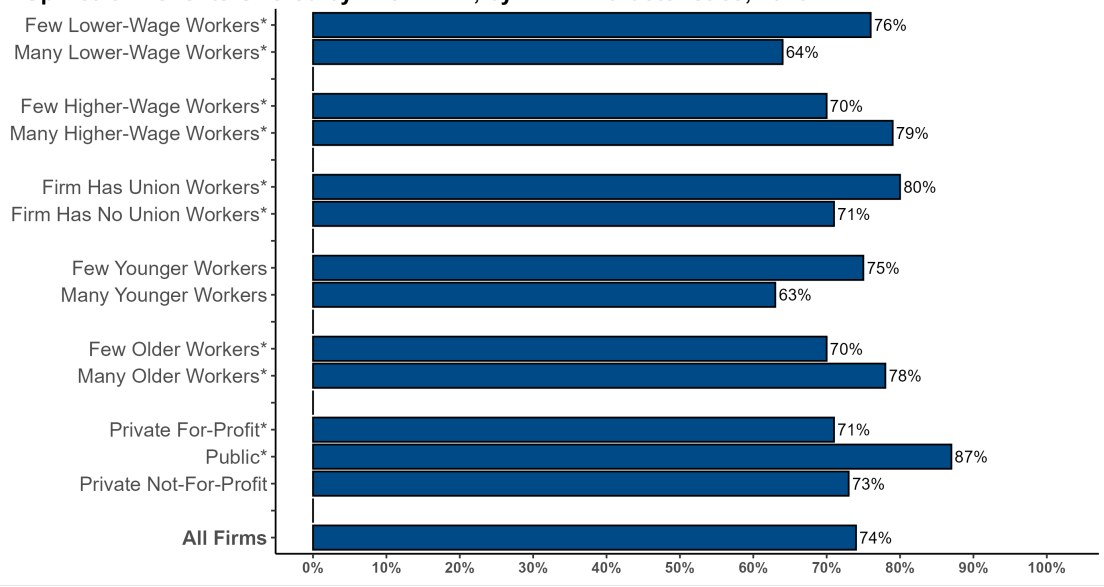
- On average, 74% of eligible workers take up coverage when it is offered to them, the similar to the percentage last year.
  - Eligible workers in firms with 10 to 199 workers have a lower average take-up rate than those in larger firms (70% vs. 75%) [Figure 3.8].
    - Eligible workers in firms with a relatively large share of lower-wage workers have a lower average take-up rate than those in firms with a smaller share of lower-wage workers (64% vs. 76%) [Figure 3.7].
  - Eligible workers in firms with a relatively large share of higher-wage workers have a higher average take-up rate than those in firms with a smaller share of higher-wage workers (79% vs. 70%) [Figure 3.7].
  - Eligible workers in private, for-profit firms have a lower average take-up rate (71%) and eligible workers in public firms have a higher average take-up rate (87%) than workers in other firm types [Figure 3.7].
  - Eligible workers in firms with some union workers have a higher average take-up rate (80%) than eligible workers in firms with no union workers (71%) [Figure 3.7].
- The average percentages of eligible workers taking up benefits in offering firms also vary across industries [Figure 3.3].
- The share of eligible workers taking up benefits in offering firms (74%) is similar to the share in 2021 (77%) but lower than the share in 2016 (79%) [Figure 3.1].

Figure 3.6
Among Workers in Firms Offering Health Benefits, Percentage of Workers Eligible for Health Benefits Offered by Their Firm, by Firm Characteristics, 2026



* 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 ($38,000 in 2026). Firms with many higher-wage workers are those where at least 35% earn at or above the 75th percentile of national earnings ($82,000 in 2026). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 3.7
Among Workers in Firms Offering Health Benefits, Percentage of Eligible Workers Who Take Up Health Benefits Offered by Their Firm, by Firm Characteristics, 2026



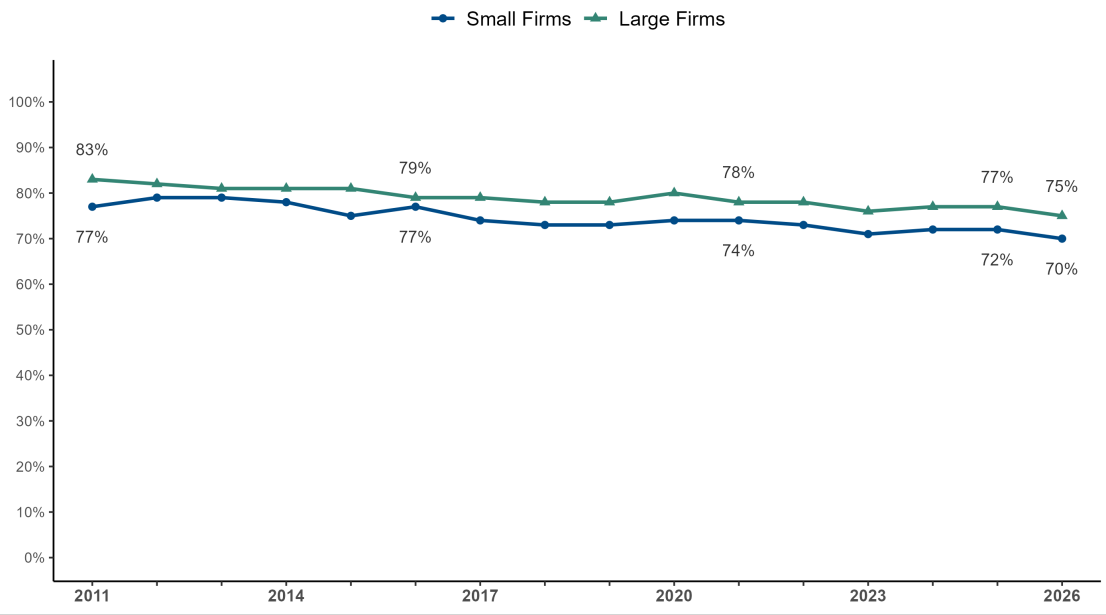
* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Firms with many lower-wage workers have >35% of their workforces earning <$38,000 (25th percentile of national earnings, 2026). Higher-wage firms have >=35% earning >$82,000 (75th percentile). Firms with many older workers have ≥35% age 50+, and those with many younger workers have >=35% age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2026

COVERAGE

- In 2026, the percentage of workers at firms offering health benefits covered by their firm's health plan is 59%, the same as last year [Figure 3.10].
  - The coverage rate at firms offering health benefits is similar for smaller firms (10 to 199 workers) and larger firms in 2026. Rates for both groups are similar to last year. [Figure 3.1].
- There is significant variation by industry in the coverage rate among workers in firms offering health benefits. The average coverage rate is particularly low in the retail industry (32%) [Figure 3.3].
- The coverage rate also varies with firm wage levels. Among workers in firms offering health benefits, those in firms with a relatively large share of lower-wage workers are less likely to be covered by their own firm than workers in firms with a smaller share of lower-wage workers (47% vs. 61%). A similar pattern exists in firms with a relatively large share of higher-wage workers, with workers in higher-wage firms being more likely to be covered by their employer's health benefits than those in firms with a smaller share of higher-wage workers (68% vs. 54%) [Figure 3.9].
- The age distribution of workers is also related to variation in coverage rates. Among workers in firms offering health benefits, those in firms with a relatively small share of younger workers are more likely to be covered by their own firm than those in firms with a larger share of younger workers (62% vs. 44%). Similarly, workers in offering firms with a relatively large share of older workers are more likely to be covered by their own firm than those in firms with a smaller share of older workers (65% vs. 54%) [Figure 3.9].
- Among workers in firms offering health benefits, those working in firms with some union workers are more likely than workers in firms with no union workers to be covered by their own firm [Figure 3.9].

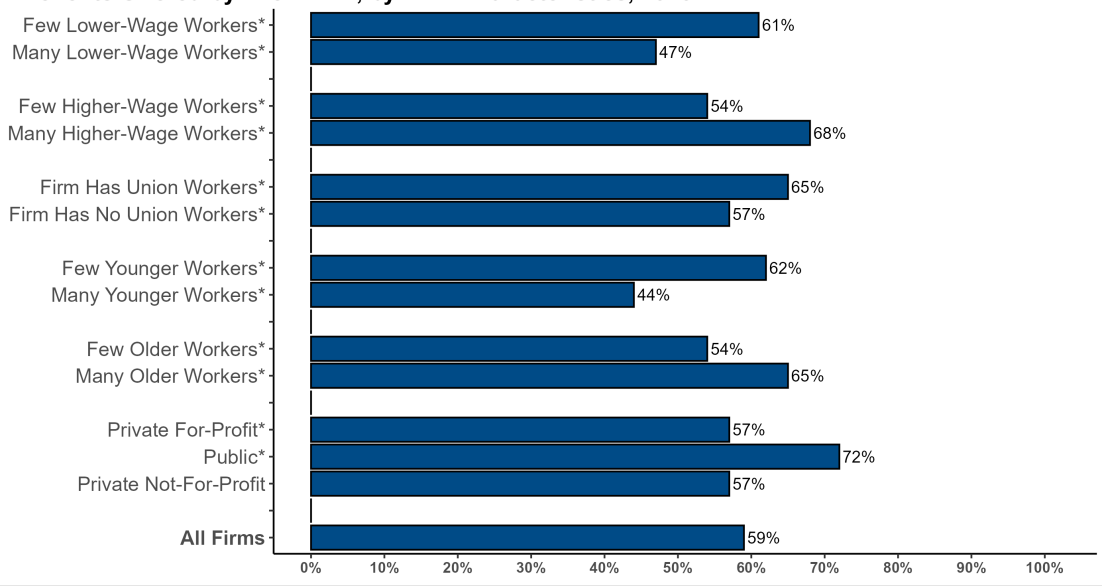
- Among workers in firms offering health benefits, those working in public firms are more likely than workers in other firm types to be covered by their own firm [Figure 3.9].

Figure 3.8
Among Workers in Firms Offering Health Benefits, Percentage of Eligible Workers Who Take Up Health Benefits Offered by Their Firm, by Firm Size, 2011-2026



Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 3.9
Among Workers in Firms Offering Health Benefits, Percentage of Workers Covered by Health Benefits Offered by Their Firm, by Firm Characteristics, 2026

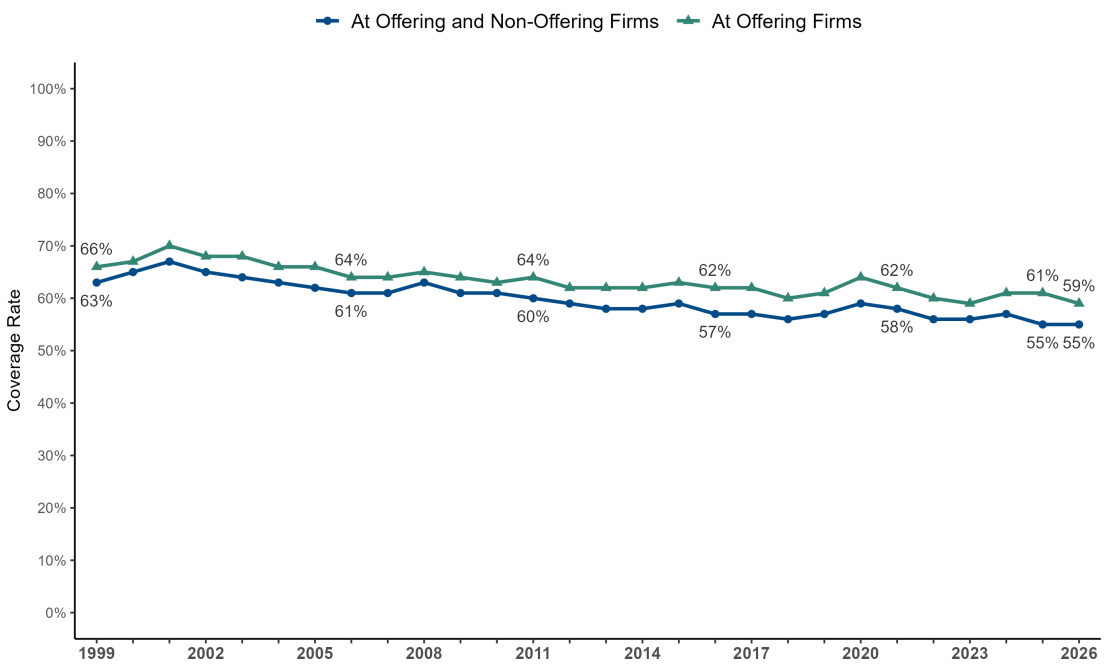


* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Firms with many lower-wage workers have >35% of their workforces earning <$38,000 (25th percentile of national earnings, 2026). Higher-wage firms have >=35% earning >$82,000 (75th percentile). Firms with many older workers have ≥35% age 50+, and those with many younger workers have >=35% age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2026

COVERAGE AMONG ALL FIRMS

- Among workers in all firms, including those that offer and those that do not offer health benefits, 55% are covered by health benefits offered by their employer, similar to the percentages last year (55%) and ten years ago (57%) but lower than five years ago (58%) [Figure 3.10].

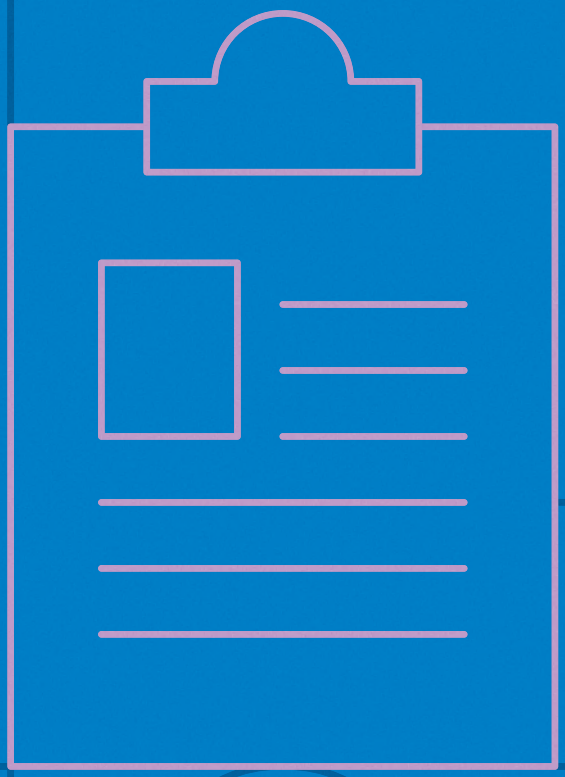
Figure 3.10
Percentage of Workers Covered by Their Firm's Health Benefits, 1999-2026



Tests found no statistical difference 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, 1999-2017

SECTION 4

Types of Plans Offered



Section 4

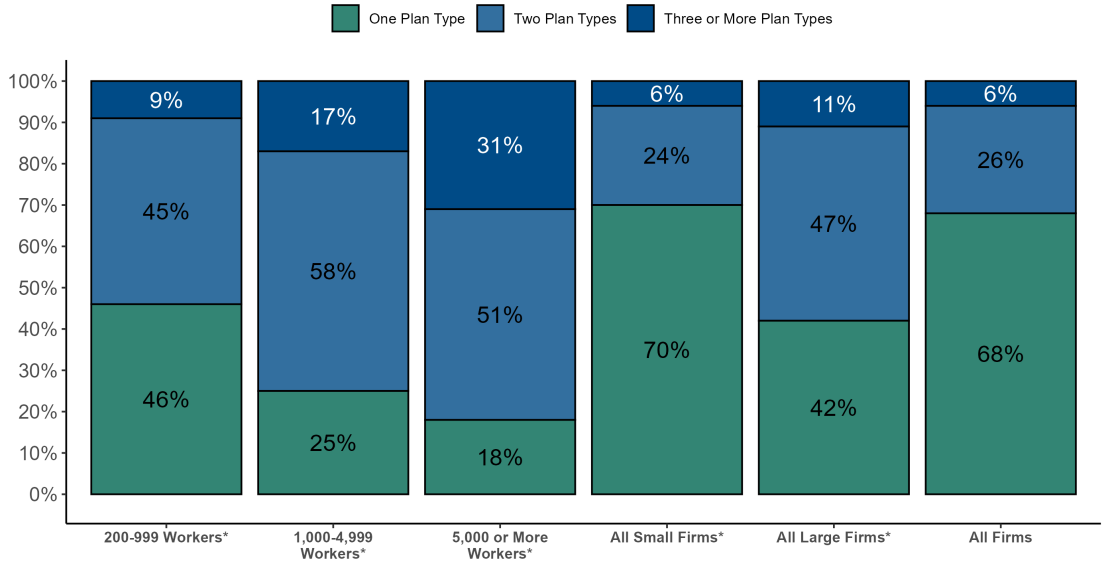
Types of Plans Offered

Most firms (68%) that offer health benefits offer only one type of health plan. Firms with 200 or more workers are more likely than smaller firms to offer more than one plan type.

NUMBER OF PLAN TYPES OFFERED

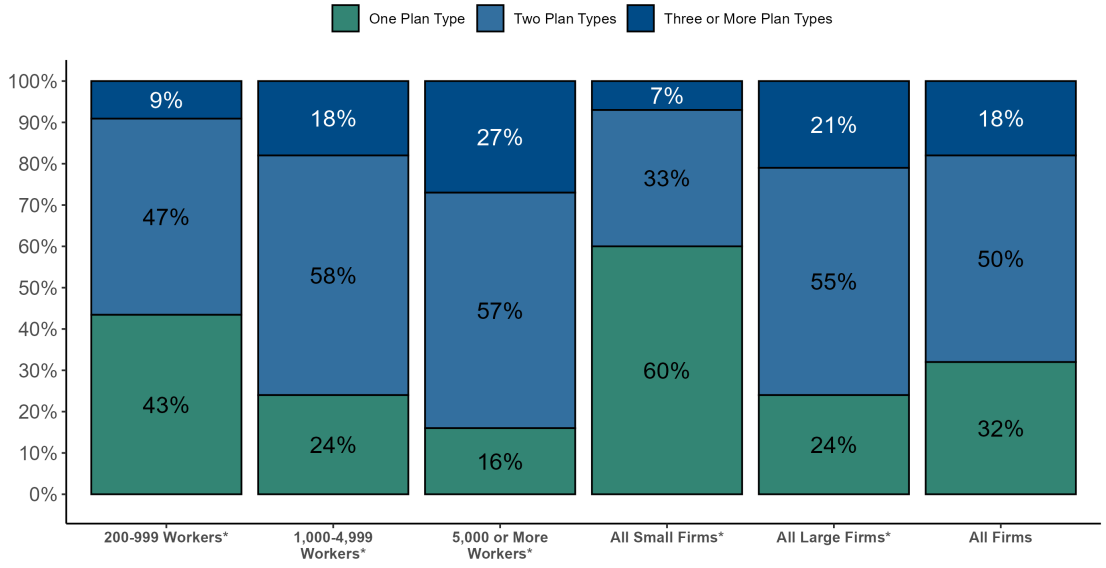
- Among firms that offer health benefits, 68% offer only one type of health plan in 2026. Firms with 200 or more workers are more likely than smaller firms to offer more than one plan type (58% vs. 30%) [Figure 4.1].
- While most firms are small, most workers are employed by larger firms, which are more likely to offer more than one type of health plan. Sixty-eight percent of covered workers in 2026 are employed in a firm that offers more than one type of health plan. Seventy-six percent of covered workers in firms with 200 or more workers are employed by a firm that offers more than one plan type, compared to 40% of covered workers in smaller firms [Figure 4.2].
- Seventy-five percent of covered workers in firms that offer health benefits work in firms that offer a PPO, 56% work in firms that offer an HSA-qualified plan, 19% work in firms that offer an HMO, 11% work in firms that offer a POS plan, and 1% work in firms that offer one or more conventional plans [Figure 4.4].
- Among covered workers in firms offering only one type of health plan, 60% are in firms that offer only PPOs and 19% are in firms that offer only HSA-qualified plans [Figure 4.5].

Figure 4.1
Among Firms Offering Health Benefits, Percentage of Firms That Offer One, Two, or Three or More Plan Types, by Firm Size, 2026



* Distribution is statistically different from distribution for all other firms not in the indicated size category (p < .05).
NOTE: The survey identifies whether firms offer conventional, HMO, PPO, POS, and HSA-qualified plans and collects information on the plan with the largest enrollment within each type. The number of plan types offered does not indicate the total number of plans, because firms may offer multiple plans within each type and different plans to different workers. Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 4.2
Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms Offering One, Two, or Three or More Plan Types, by Firm Size, 2026



* Distribution is statistically different from distribution for all other firms not in the indicated size category (p < .05).
NOTE: The survey identifies whether firms offer conventional, HMO, PPO, POS, and HSA-qualified plans and collects information on the plan with the largest enrollment within each type. The number of plan types offered does not indicate the total number of plans, because firms may offer multiple plans within each type and different plans to different workers. Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 4.3

Among Firms Offering Health Benefits, Percentage of Firms That Offer the Following Plan Types, by Firm Size, 2026

	Conventional	HMO	PPO	POS	HSA-Qualified
FIRM SIZE					
10-24 Workers	1%	8%*	44%	23%	23%
25-199 Workers	2	14	42	20	31
200-999 Workers	1	16	66*	20	41*
1,000-4,999 Workers	1	23*	78*	12*	61*
5,000 or More Workers	2	24*	80*	10*	68*
All Small Firms (10-199 Workers)	**1%**	**11%***	**43%***	**21%**	**27%***
All Large Firms (200 or More Workers)	**1%**	**17%***	**68%***	**19%**	**44%***
ALL FIRMS	**1%**	**11%**	**45%**	**21%**	**28%**

NOTE: The survey identifies whether firms offer conventional, HMO, PPO, POS, and HSA-qualified plans and collects information on the plan with the largest enrollment within each type. The number of plan types offered does not indicate the total number of plans, because firms may offer multiple plans within each type and different plans to different workers.

* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 4.4

Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms That Offer the Following Plan Types, by Firm Size, 2026

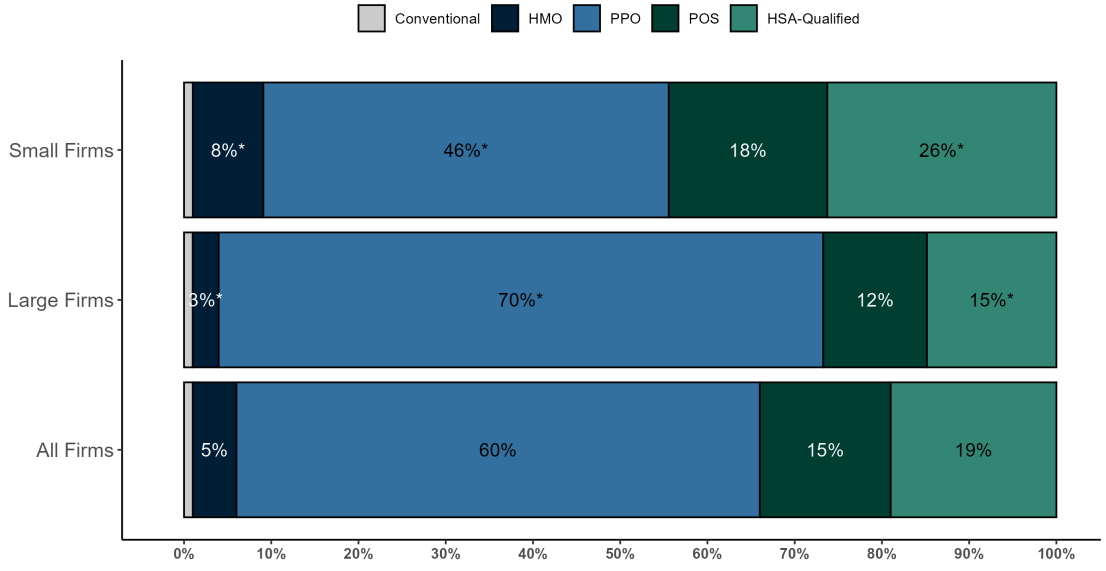
	Conventional	HMO	PPO	POS	HSA-Qualified
FIRM SIZE					
200-999 Workers	1%	14%	75%	15%	48%*
1,000-4,999 Workers	1	19	81*	8	66*
5,000 or More Workers	2	24	86*	7*	67*
All Small Firms (10-199 Workers)	**2%**	**13%***	**51%***	**18%***	**33%***
All Large Firms (200 or More Workers)	**1%**	**21%***	**82%***	**9%***	**62%***
ALL FIRMS	**1%**	**19%**	**75%**	**11%**	**56%**

NOTE: The survey identifies whether firms offer conventional, HMO, PPO, POS, and HSA-qualified plans and collects information on the plan with the largest enrollment within each type. The number of plan types offered does not indicate the total number of plans, because firms may offer multiple plans within each type and different plans to different workers.

* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 4.5
Among Firms Offering Only One Type of Health Plan, Percentage of Covered Workers in Firms That Offer Each Plan Type, by Firm Size, 2026



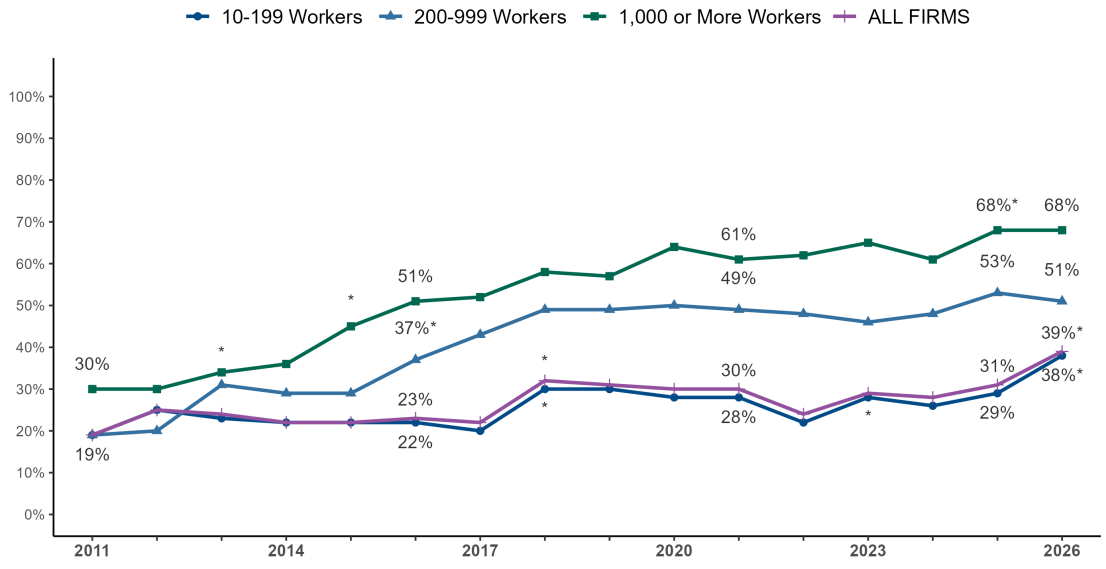
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. The survey identifies whether firms offer conventional, HMO, PPO, POS, and HSA-qualified plans and collects information on the plan with the largest enrollment within each type. The number of plan types offered does not indicate the total number of plans, because firms may offer multiple plans within each type and different plans to different workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

PERCENTAGE OF FIRMS OFFERING HSA-QUALIFIED PLANS

Thirty-nine percent of firms with 10 or more workers offering health benefits offer an HSA-qualified plan [Figure 4.6]. This percentage is more than last year (31%) and five years ago (31%).

- Firms with 200 or more workers are more likely than smaller firms to offer an HSA-qualified plan to at least some workers (54% vs. 38%). The percentage of larger firms offering an HSA-qualified plan is similar to five years ago. Among smaller firms, the percentage offering an HSA-qualified plan increased from 29% to 38% over the last five years.

Figure 4.6
Among Firms Offering Health Benefits, Percentage That Offer an HSA-Qualified Plan, by Firm Size, 2011-2026



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: The survey identifies whether firms offer conventional, HMO, PPO, POS, and HSA-qualified plans and collects information on the plan with the largest enrollment within each type. The number of plan types offered does not indicate the total number of plans, because firms may offer multiple plans within each type and different plans to different workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2017

The survey collects information on the plan with the largest enrollment for each plan type a firm offers. While we know the number of plan types a firm offers, we do not know the total number of plans. In addition, firms may offer different types of plans to different workers. For example, workers at one location may be offered one type of plan, while workers at another location are offered a different type.

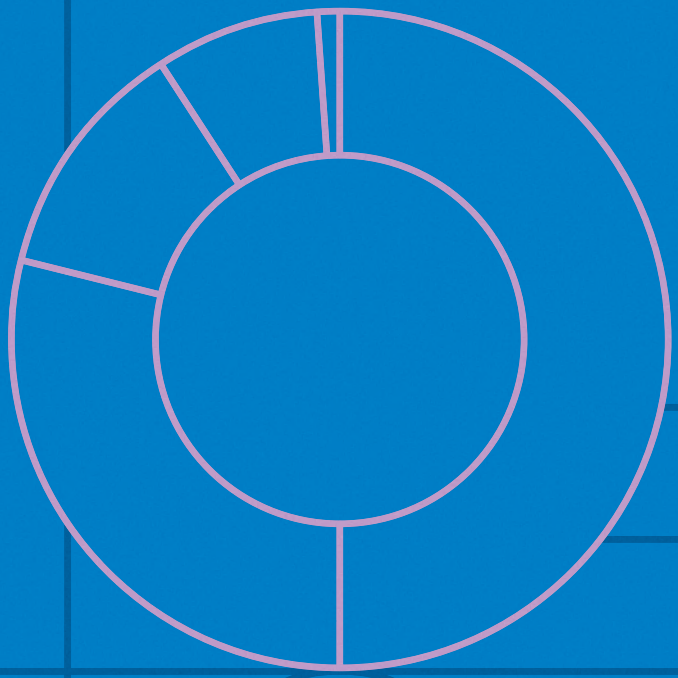
Health plans are often categorized into plan types based on their coverage of out-of-network services and whether they require primary care referrals. This survey classifies plans into five plan types:

- **Conventional/Indemnity:** A plan with no preferred provider network and the same cost sharing regardless of physician or hospital.
- **HMO (Health Maintenance Organization):** A plan that does not cover non-emergency services provided by out-of-network providers.
- **PPO (Preferred Provider Organization):** A plan that covers services from both in-network and out-of-network providers, generally with lower cost sharing for in-network services, and does not require a primary care referral for specialist care.
- **POS (Point-of-Service):** A plan that covers services from both in-network and out-of-network providers, generally with lower cost sharing for in-network services, but requires a primary care referral for specialist care.
- **HSA-qualified plan:** A high-deductible health plan that meets federal requirements allowing an enrollee to contribute to a Health Savings Account (HSA). In 2026, an HSA-qualified plan must have a deductible of at least $1,650 for single coverage and $3,300 for family coverage.

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 category. HRA plans are now classified as conventional, PPOs, POS plans, or HMOs based on their plan characteristics. HSA-qualified plans are now reported as a separate plan type.

SECTION 5

Market Shares of Health Plans



Section 5

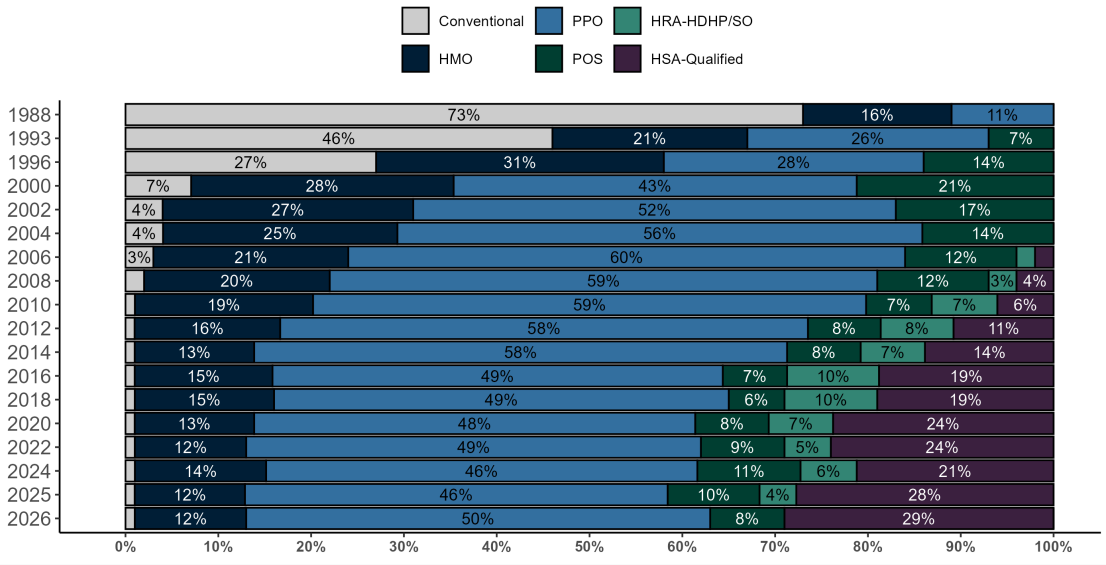
Market Shares of Health Plans

Health plans are often characterized into plan types based on their coverage of out-of-network services and their use of primary care gatekeeping. In 2026, PPOs remain the most common plan type.

As described previously, high-deductible health plans (HDHPs) associated with a health reimbursement arrangement (HRA) are no longer classified as an HDHP/SO plan type. As a result, covered workers who were classified as enrolled in an HDHP/HRA in previous versions of this survey are now included in the HMO, PPO, POS, or conventional plan categories. In 2025, 4% of covered workers were enrolled in an HDHP/HRA, compared with 7% in 2021. Historical comparisons should be interpreted in light of this change in methods.

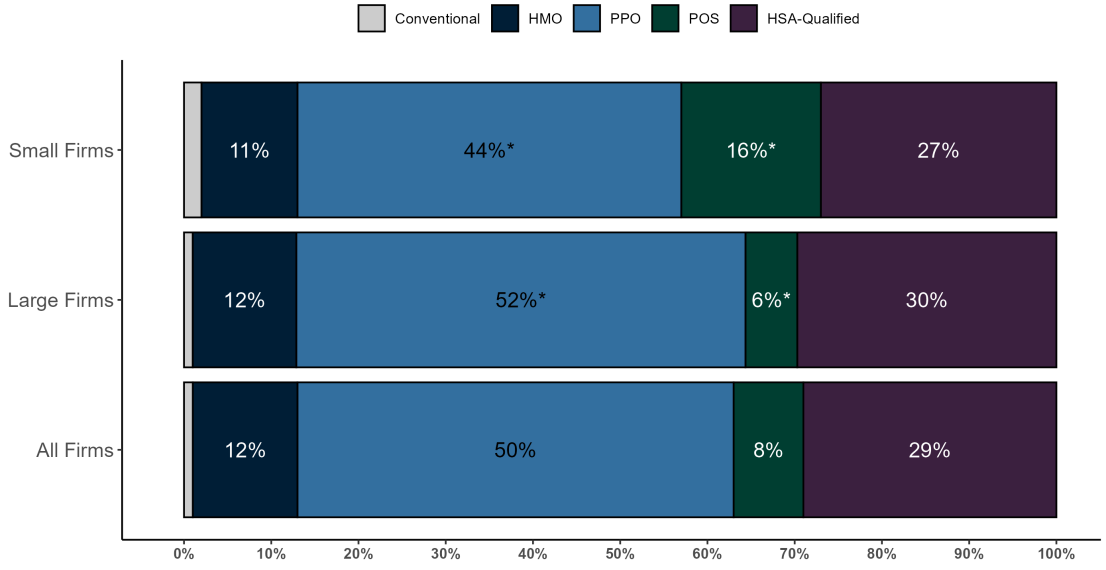
- Fifty percent of covered workers are enrolled in PPOs in 2026, followed by HSA-qualified plans (29%), HMOs (12%), POS plans (8%), and conventional plans (less than one percent). All of these percentages are similar to the enrollment percentages in 2025 [Figure 5.1].
- The percentage of covered workers enrolled in HSA-qualified plans is similar to the percentage last year (29%), but higher than the percentages five years ago (22%) and 10 years ago (19%) [Figure 5.1].
- The percentage of covered workers enrolled in HMOs (12%) is the same percentage as last year and similar to the percentage five years ago (16%) [Figure 5.1].
- A larger share of covered workers are enrolled in HSA-qualified plans than in HMOs in both smaller firms (10 to 199 workers) and larger firms (200 or more workers) [Figure 5.2].
- Plan enrollment patterns differ between firms with 10 to 199 workers and larger firms.
  - The share of covered workers enrolled in a PPO is larger in larger firms than in smaller firms (52% vs. 44%) [Figure 5.2]. This is different than last year and may reflect the change in methods around classifying plans associated with a health reimbursement arrangement.
  - The share of covered workers enrolled in a POS plan is larger in smaller firms than in larger firms (16% vs. 6%) [Figure 5.2].
  - The shares of covered workers enrolled in an HSA-qualified plan are similar in smaller firms (27%) and in larger firms (30%). The shares of covered workers enrolled in an HMO are similar in firms with 10 to 199 workers (11%) and in larger firms (12%) [Figure 5.2].
- Plan enrollment patterns also differ across regions.
  - Covered workers in the West are more likely (23%) to be enrolled in an HMO than workers in other regions, while covered workers in the Midwest are less likely (5%) to be enrolled in an HMO [Figure 5.3].
  - Covered workers in the Midwest are more likely (41%) to be enrolled in an HSA-qualified plan than workers in other regions, while covered workers in the South and West are less likely to be enrolled in an HSA-qualified plan (24%) [Figure 5.3].
  - Covered workers in the West are less likely (37%) to be enrolled in a PPO than workers in other regions [Figure 5.3].

Figure 5.1
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2026



NOTE: Information was not collected for POS plans in 1988 or for HDHP-HRA and HDHP-HSA plans before 2006. Beginning in 2026, HDHP-HRA plans are no longer classified as a separate plan type. Instead, plans with deductibles of at least $1,000 for single coverage and $2,000 for family coverage that are offered with an HRA are classified as another plan type. See the Survey Design and Methods section for a discussion of weighting changes over time.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017; KPMG Survey of Employer-Sponsored Health Benefits, 1993 and 1996; The Health Insurance Association of America (HIAA), 1988.

Figure 5.2
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type and Firm Size, 2026



* Enrollment in plan type is statistically different between All Small Firms and All Large Firms ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. HMO stands for health maintenance organization; PPO, preferred provider organization; and POS, point-of-service plan. HSA-qualified plans are health plans that meet the requirements for enrollees to contribute to a health savings account.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 5.3

Distribution of Health Plan Enrollment for Covered Workers, by Firm Size, Region, and Industry, 2026

	Conventional	HMO	PPO	POS	HSA-Qualified
FIRM SIZE					
10-24 Workers	1%	11%	48%	20%*	20%*
25-49 Workers	<1	11	41	19*	29
50-199 Workers	2	11	43*	13*	30
200-999 Workers	<1	8*	54	11	26
1,000-4,999 Workers	<1*	12	53	5*	31
5,000 or More Workers	<1*	14	51	4*	31
All Small Firms (10-199 Workers)	**2%***	**11%**	**44%***	**16%***	**27%**
All Large Firms (200 or More Workers)	**<1%***	**12%**	**52%***	**6%***	**30%**
REGION					
Northeast	<1%*	8%	56%	7%	29%
Midwest	1	5*	47	6	41*
South	<1	12	58*	6*	24*
West	1	23*	37*	15*	24
INDUSTRY					
Agriculture/Mining/Construction	1%	5%*	48%	10%	36%
Manufacturing	<1*	10	47	7	35
Transportation/Communications/Utilities	0*	15	53	4*	28
Wholesale	1	4*	60	12	23
Retail	1	16	51	4*	28
Finance	<1*	6*	35*	4*	56*
Service	<1	14	49	9	28
State/Local Government	<1	11	61*	9	19*
Health Care	1	15	53	12	19*
ALL FIRMS	**<1%**	**12%**	**50%**	**8%**	**29%**

NOTE: HMO stands for health maintenance organization; PPO, preferred provider organization; and POS, point-of-service plan. HSA-qualified plans are health plans that meet the requirements for enrollees to contribute to a health savings account.

* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category ($p < .05$).

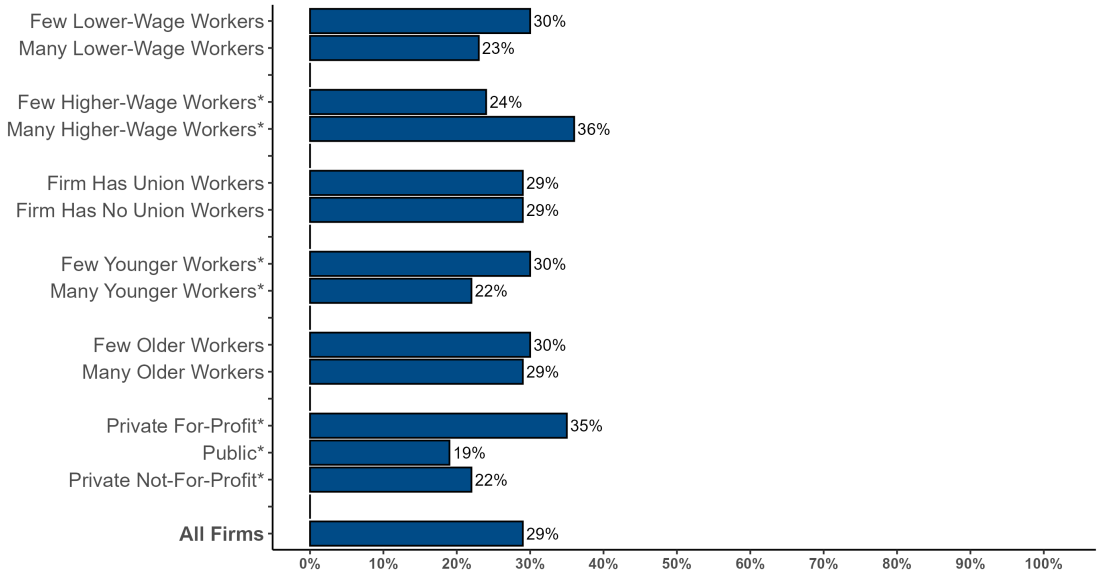
SOURCE: KFF Employer Health Benefits Survey, 2026

COVERAGE IN HSA-QUALIFIED PLANS

The share of covered workers enrolled in HSA-qualified plans varies with firm characteristics.

- Covered workers in firms with a relatively large share of younger workers (firms where at least 35% of the workers are age 26 or younger) are less likely to be enrolled in an HSA-qualified plan than covered workers in firms with smaller shares of younger workers (22% vs. 30%) [Figure 5.4].
- Covered workers in firms with a relatively large share of higher-wage workers (firms where at least 35% of workers earn $82,000 a year or more) are more likely to be enrolled in an HSA-qualified plan than covered workers in firms with smaller shares of higher-wage workers (36% vs. 24%) [Figure 5.4].
- Covered workers in private, for-profit firms are more likely (35%) to be enrolled in an HSA-qualified plan than covered workers in public firms (19%) or in private, not-for-profit firms (22%). [Figure 5.4].

Figure 5.4
Percentage of Covered Workers Enrolled in HSA-Qualified Plans, by Firm Characteristics, 2026



* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Firms with many lower-wage workers have >35% of their workforces earning <$38,000 (25th percentile of national earnings, 2026). Higher-wage firms have >=35% earning >$82,000 (75th percentile). Firms with many older workers have ≥35% age 50+, and those with many younger workers have >=35% age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2026

SECTION 6

Worker and Employer Contributions for Premiums

Section 6

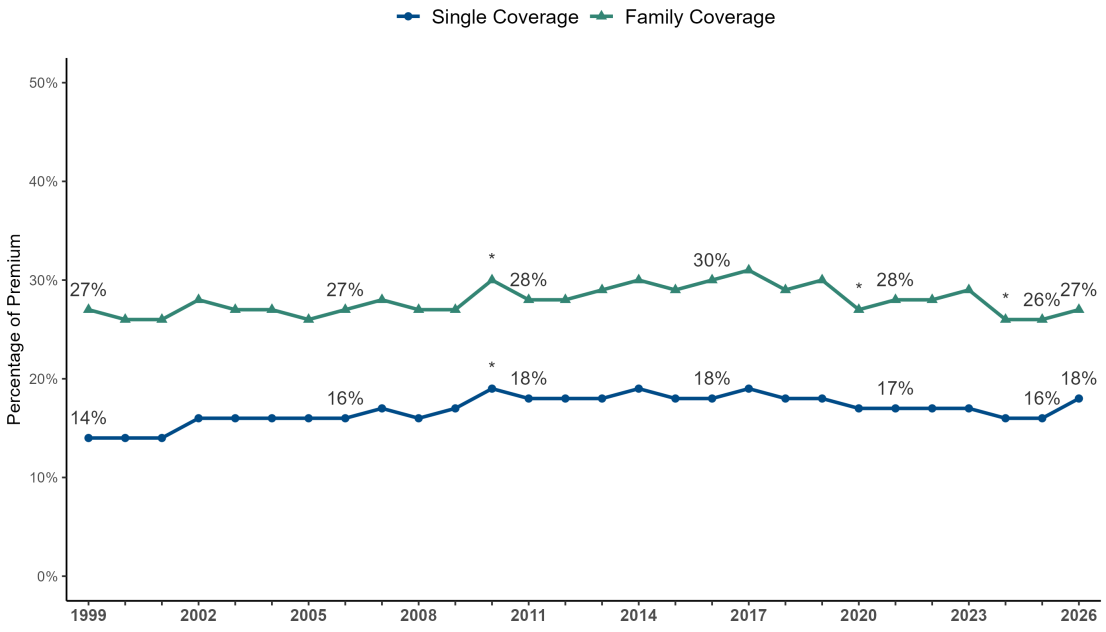
Worker and Employer Contributions for Premiums

The vast majority of covered workers make contributions toward the cost of their coverage.

- In 2026, the average contribution percentages for covered workers are 18% of the premium for single coverage and 27% of the premium for family coverage, similar to the levels last year [Figure 6.1].[1]
  - The average contribution percentage for single coverage is similar for covered workers in smaller firms (firms with 10 to 199 workers) and for those in larger firms [Figure 6.2].
    - Covered workers in smaller firms contribute, on average, a much higher percentage of the premium for family coverage than covered workers in larger firms (37% vs. 25%) [Figure 6.2].
- The average contribution amount for covered workers for single coverage is $139 per month ($1,672 annually), higher than last year ($1,440) [Figure 6.3]. The average contribution amount for covered workers for family coverage is $623 per month ($7,471 annually), higher than the amount ($6,850 annually) last year [Figure 6.3].
  - The average contribution amount for covered workers for single coverage in smaller firms is lower than the average contribution amount for covered workers in larger firms ($1,451 vs. $1,736) [Figure 6.7].
  - The average contribution amount for covered workers for family coverage in smaller firms is higher than the average contribution amount for covered workers in larger firms ($9,687 vs. $6,840) [Figure 6.7].
    - The average contribution amount for family coverage among workers enrolled in HSA-qualified plans is lower than the overall average contribution amount for covered workers ($6,211 vs. $7,471) [Figure 6.6].

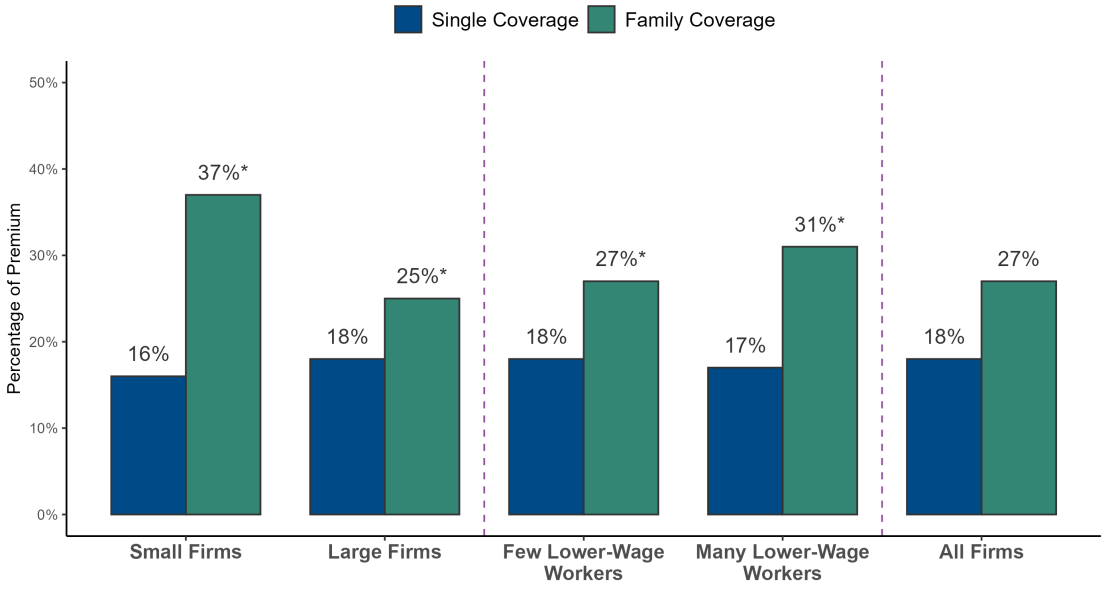
[1] The average percentage contribution is calculated as a weighted average of all a firm's plan types and may not necessarily equal the average worker contribution divided by the average premium.

Figure 6.1
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999-2026



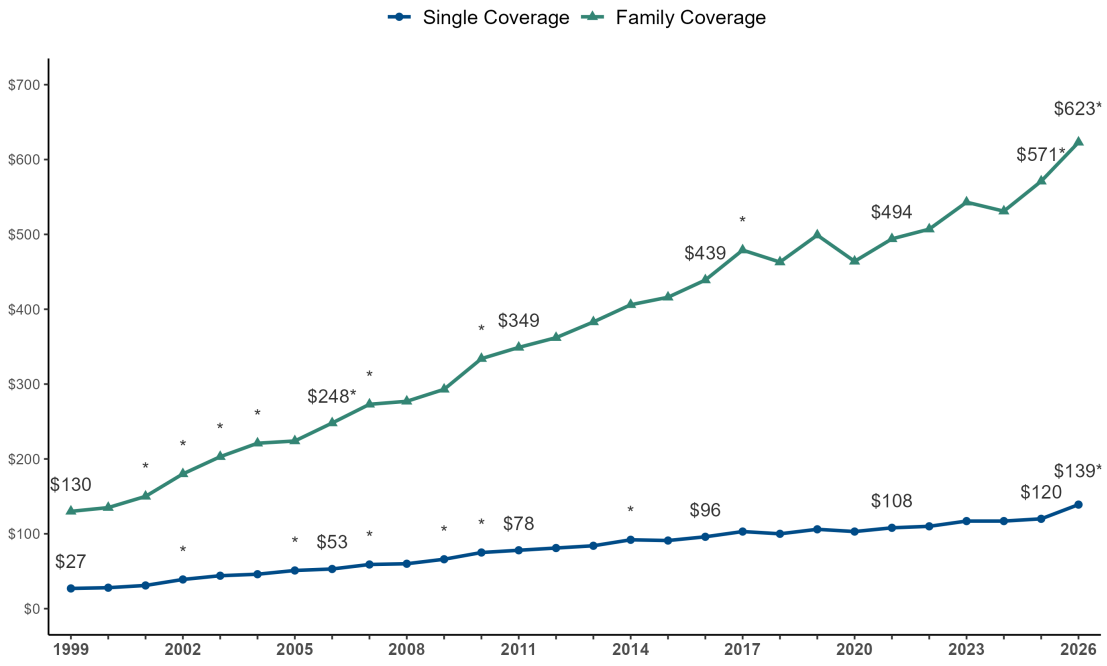
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.2
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Characteristics, 2026



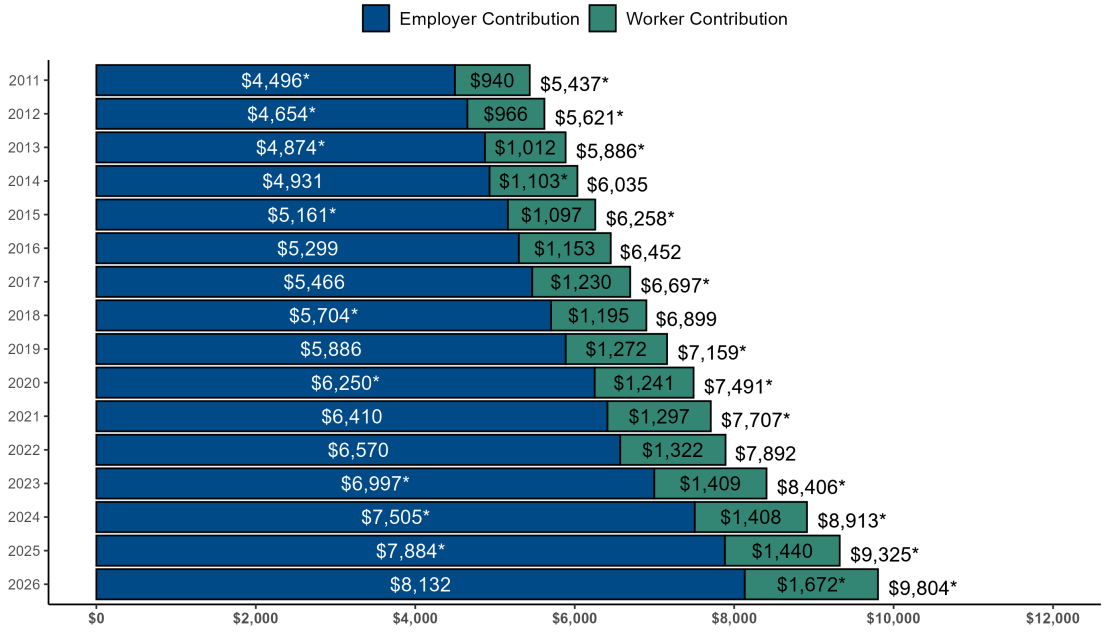
* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn at or below the 25th percentile of national earnings ($38,000 in 2026).
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 6.3
Average Monthly Worker Premium Contributions for Single and Family Coverage, 1999-2026



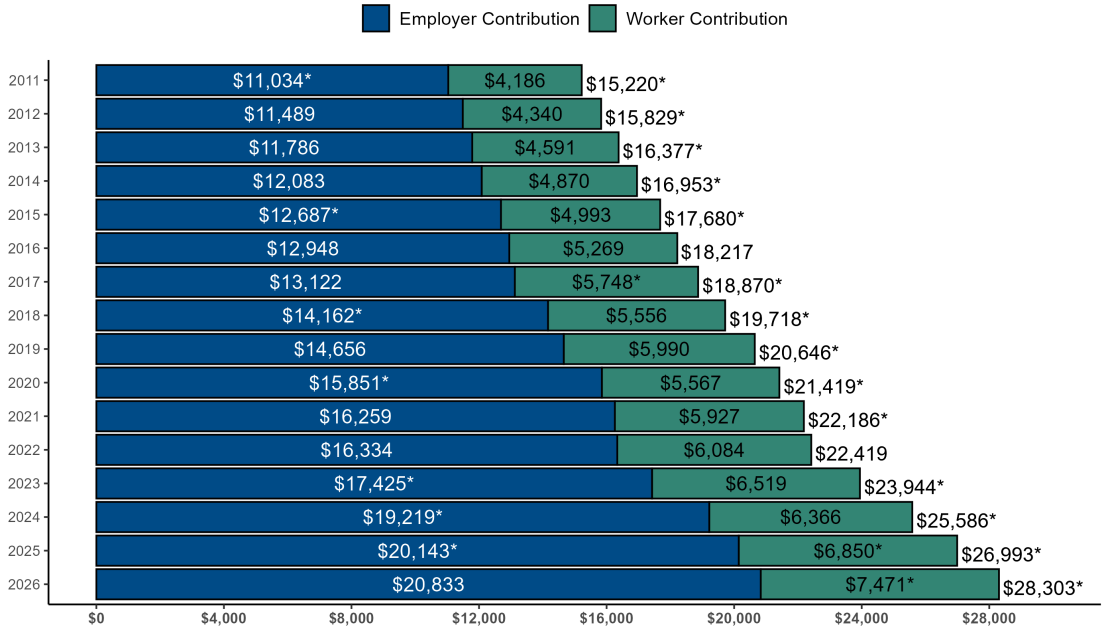
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.4
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single Coverage, 2011-2026



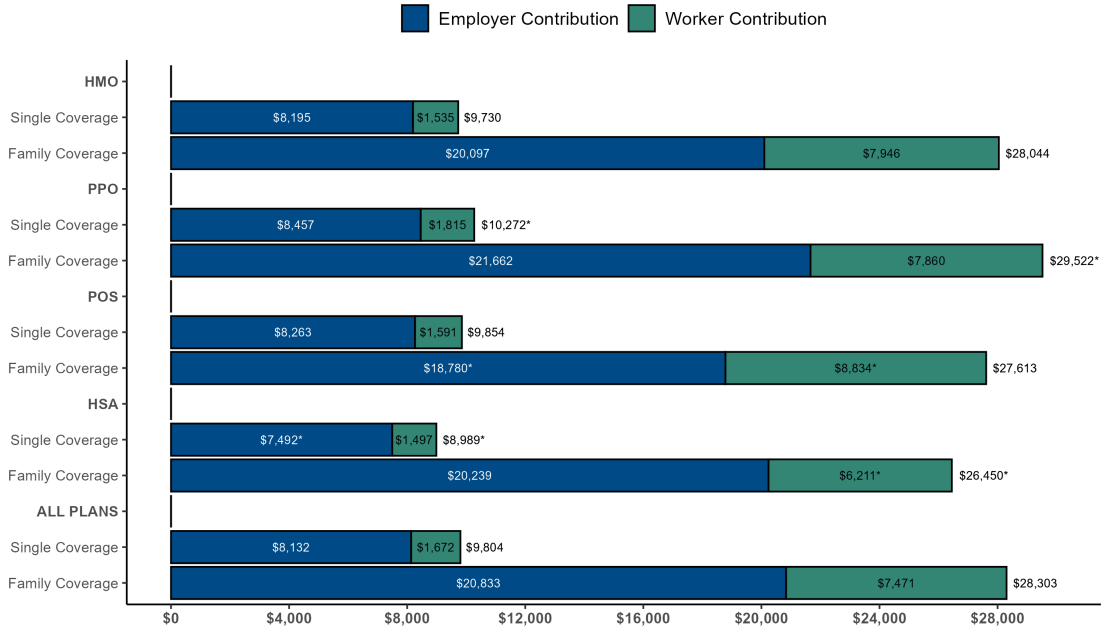
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.5
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 2011-2026



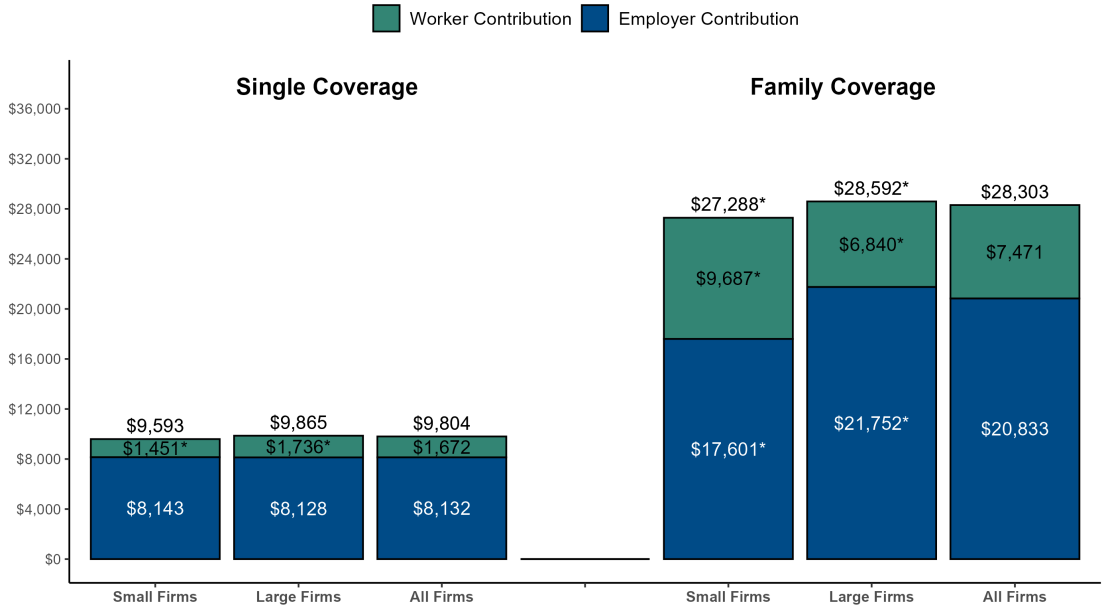
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.6
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Plan Type, 2026



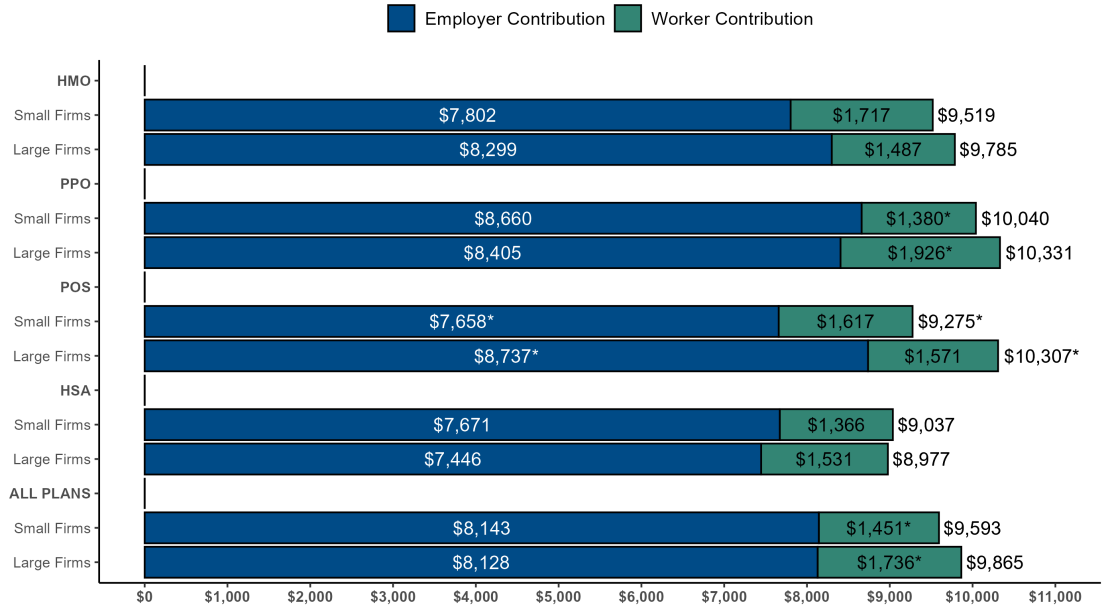
* Estimate is statistically different from All Plans estimate within coverage type ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 6.7
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Firm Size, 2026



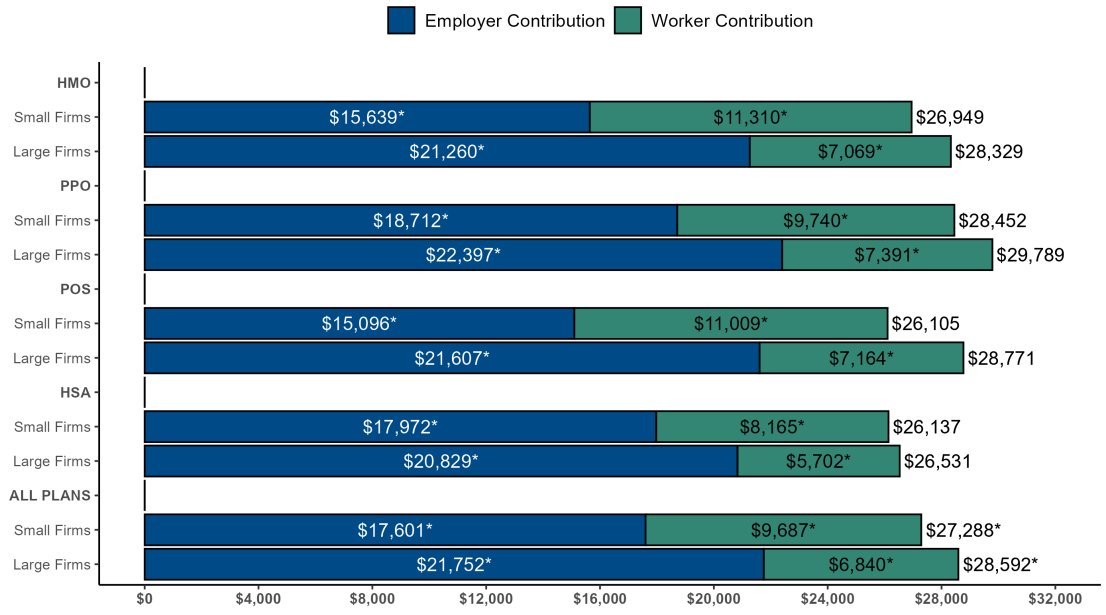
Estimates are statistically different between small and large firms within coverage type ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 6.8
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single Coverage, by Plan Type and Firm Size, 2026



* Estimates are statistically different within plan type between All Small Firms and All Large Firms ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 6.9
Average Annual Employer and Worker Premium Contributions and Total Premiums for Family Coverage, by Plan Type and Firm Size, 2026



* Estimates are statistically different within plan type between All Small Firms and All Large Firms ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

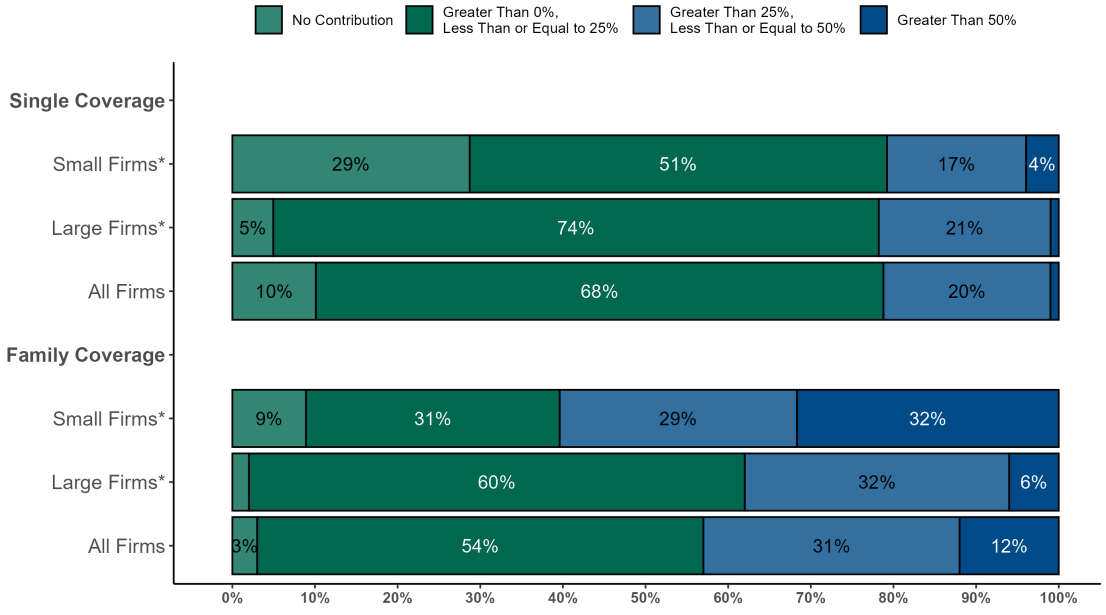
DISTRIBUTIONS OF WORKER CONTRIBUTIONS TO THE PREMIUM

Almost nine in ten covered workers (88%) are in a plan where the employer contributes at least half of the premium for both single and family coverage [Figure 6.10].

- Ten percent of covered workers are in a plan where the employer pays the entire premium for single coverage, while only 3% of covered workers are in a plan where the employer pays the entire premium for family coverage [Figure 6.10].
- Covered workers in smaller firms (firms with 10 to 199 workers) are much more likely than covered workers in larger firms to be in a plan where the employer pays the entire premium for single coverage.
  - Twenty-nine percent of covered workers in smaller firms are in a firm where their employer pays the full premium for single coverage, compared to 5% of covered workers in larger firms [Figure 6.10].
  - For family coverage, 9% of covered workers in smaller firms have an employer that pays the full premium, compared to 2% of covered workers in larger firms [Figure 6.10].
- Twelve percent of covered workers are in a plan where the worker contributes more than half of the premium for family coverage [Figure 6.10].
  - This percentage differs significantly by firm size. Thirty-two percent of covered workers in smaller firms are in a plan where the worker contribution for family coverage is more than half of the premium, compared to 6% of covered workers in larger firms [Figure 6.10].
  - Small shares of covered workers in smaller firms (4%) or in larger firms (1%) are in a plan where the worker must contribute more than 50% of the premium for single coverage [Figure 6.10].

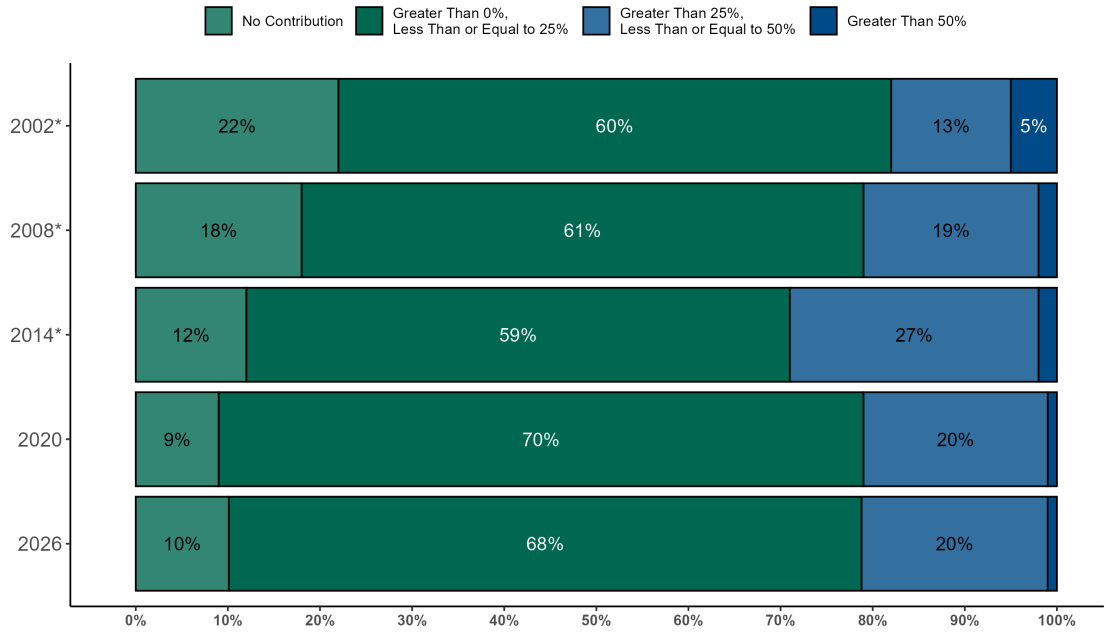
- There is substantial variation in the dollar amounts that covered workers must contribute toward health coverage.
  - Among covered workers in firms with 10 to 199 workers, 34% have a contribution for single coverage of less than $500 a year, while 29% have a contribution of $2,000 or more [Figure 6.13]. For family coverage, 16% have a contribution of less than $3,000, while 37% have a contribution of $10,500 or more [Figure 6.14].
  - Among covered workers in firms with 200 or more workers, 9% contribute less than $500 a year for single coverage, while 31% have a contribution of $2,000 or more [Figure 6.13]. For family coverage, only 11% contribute less than $3,000 a year, while 11% have a contribution of $10,500 or more [Figure 6.14].

Figure 6.10
Distribution of Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2026



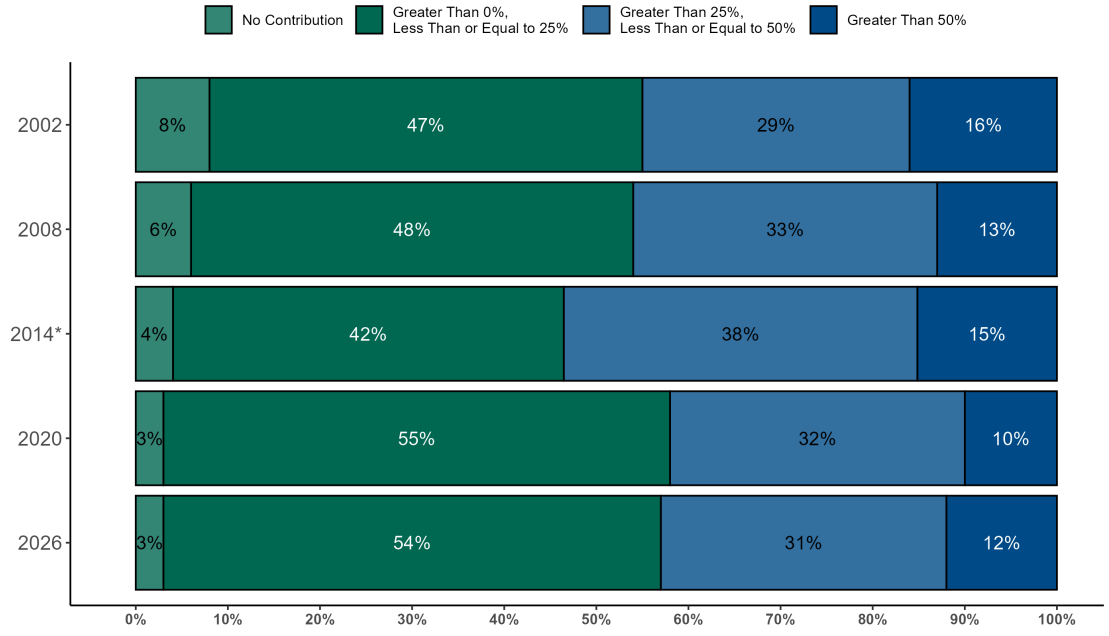
* Distributions are statistically different between All Small Firms and All Large Firms within coverage type ($p < 0.05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 6.11
Distribution of Percentage of Premium Paid by Covered Workers for Single Coverage, 2002-2026



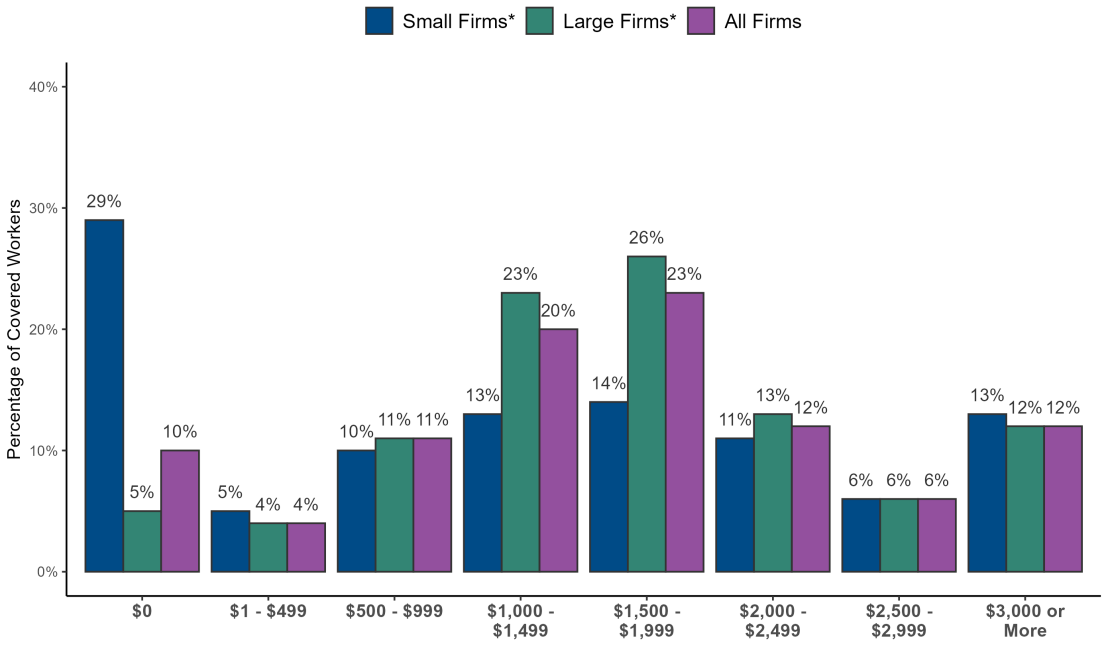
* Distribution is statistically different from distribution for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

Figure 6.12
Distribution of Percentage of Premium Paid by Covered Workers for Family Coverage, 2002-2026



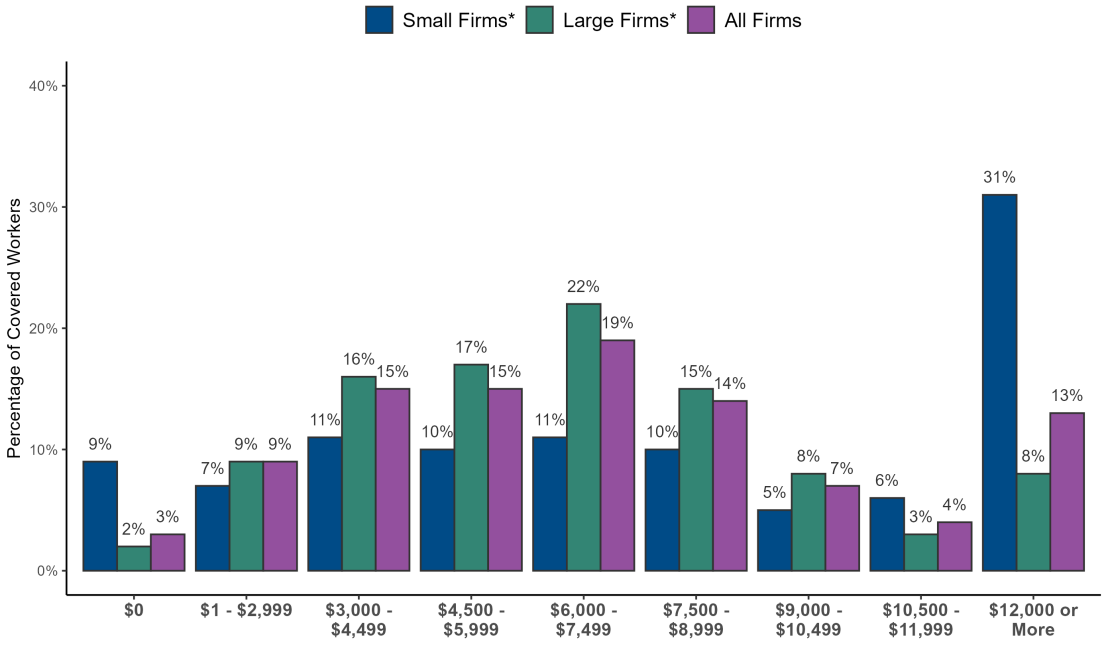
* Distribution is statistically different from distribution for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

Figure 6.13
Distribution of Worker Contributions for Single Coverage, by Firm Size, 2026



* Distribution is statistically different from distribution for all other firms not in the indicated size category (p < .05).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 6.14
Distribution of Worker Contributions for Family Coverage, by Firm Size, 2026



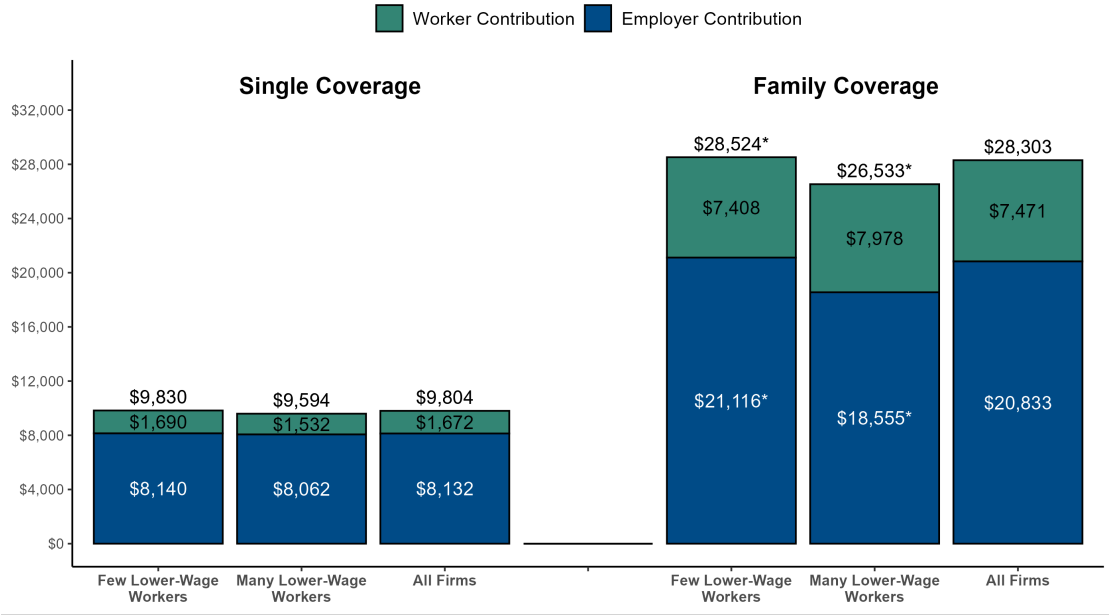
* Distribution is statistically different from distribution for all other firms not in the indicated size category (p < .05).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

DIFFERENCES BY FIRM CHARACTERISTICS

The average share of the premium paid by covered workers varies with firm characteristics.

- For single coverage, covered workers in private, for-profit firms have a relatively high average contribution rate (20%) while, those in private, not-for-profit firms have a relatively low average contribution rate (20%).
- The average contribution rate for family coverage is higher for covered workers at firms with few older workers (where at least 35% are 50 years or older) than those in firms with many older workers (29% vs. 26%) [Figure 6.17].
- 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 6.17].
- The average contribution rate for family coverage is lower for covered workers in firms with relatively large shares of higher-wage workers (where at least 35% earn $82,000 or more annually) than those in firms with smaller shares of higher-wage workers (25% vs. 29%) [Figure 6.17].
- Covered workers in firms that have at least some union workers have a lower average contribution rate for family coverage than those in firms without any union workers (22% vs. 31%) [Figure 6.17].
- Covered workers in large firms that are fully insured have a higher average contribution rate for family coverage than those in firms with self-funded plans (28% vs. 24%) [Figure 6.17].

Figure 6.15
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single and Family Coverage, By Firm Wage Level, 2026



* Estimate is statistically different between firm wage level categories (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 ($38,000 in 2026).
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 6.16

Average Annual Premium Contributions Paid by Covered Workers for Single and Family Coverage, by Firm Characteristics, 2026

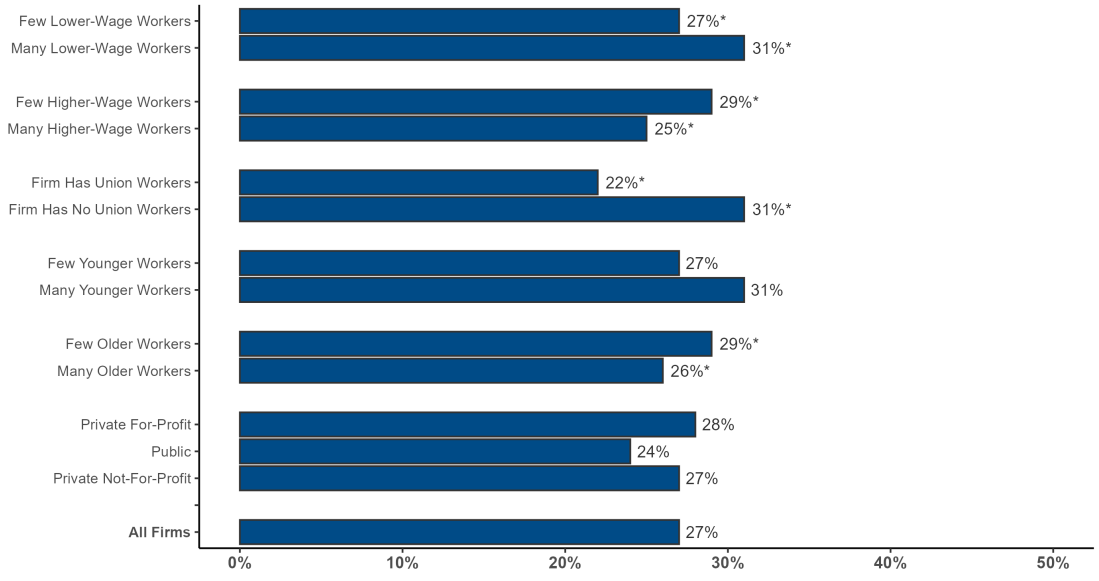
	Single Coverage		Family Coverage	
	Worker Contribution	Percent Contribution	Worker Contribution	Percent Contribution
LOWER WAGE LEVEL				
Few Lower-Wage Workers	$1,690	18%	$7,408	27%*
Many Lower-Wage Workers	$1,532	17%	$7,978	31%*
HIGHER WAGE LEVEL				
Few Higher-Wage Workers	$1,663	18%	$7,858	29%*
Many Higher-Wage Workers	$1,684	18%	$6,964	25%*
UNIONS				
Firm Has Union Workers	$1,574	16%*	$6,127*	22%*
Firm Has No Union Workers	$1,727	19%*	$8,218*	31%*
YOUNGER WORKERS				
Few Younger Workers	$1,663	18%	$7,419	27%
Many Younger Workers	$1,757	20%	$7,943	31%
OLDER WORKERS				
Few Older Workers	$1,645	18%	$7,791	29%*
Many Older Workers	$1,697	18%	$7,172	26%*
FUNDING ARRANGEMENT				
Fully Insured	$1,517*	16%	$9,348*	35%*
Self-Funded	$1,734*	18%	$6,726*	24%*
FIRM OWNERSHIP				
Private For-Profit	$1,843*	20%*	$7,606	28%
Public	$1,417	15%	$6,588	24%
Private Not-For-Profit	$1,461*	14%*	$7,861	27%
ALL FIRMS	**$1,672**	**18%**	**$7,471**	**27%**

NOTE: Firms with many lower-wage workers are those where at least 35% earn at or below the 25th percentile of national earnings ($38,000 in 2026). Firms with many higher-wage workers are those where at least 35% earn at or above the 75th percentile of national earnings ($82,000 in 2026). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

* Estimates are statistically different from each other within firm characteristic ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 6.17
Average Percentage of Family Premium Paid by Covered Workers, by Firm Characteristics, 2026



* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Firms with many lower-wage workers have >35% of their workforces earning <$38,000 (25th percentile of national earnings, 2026). Higher-wage firms have >=35% earning >$82,000 (75th percentile). Firms with many older workers have ≥35% age 50+, and those with many younger workers have >=35% age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 6.18

Average Percentage of Premium Paid by Covered Workers, by Firm Characteristics and Size, 2026

	Single Coverage			Family Coverage		
	Small Firms	Large Firms	All Firms	Small Firms	Large Firms	All Firms
LOWER WAGE LEVEL						
Few Lower-Wage Workers	15%	19%	18%	36%*	24%	27%*
Many Lower-Wage Workers	20%	16%	17%	45%*	28%	31%*
HIGHER WAGE LEVEL						
Few Higher-Wage Workers	16%	18%	18%	41%*	25%	29%*
Many Higher-Wage Workers	15%	18%	18%	30%*	24%	25%*
UNIONS						
Firm Has Union Workers	14%	16%*	16%*	28%	21%*	22%*
Firm Has No Union Workers	16%	20%*	19%*	38%	27%*	31%*
YOUNGER WORKERS						
Few Younger Workers	16%	18%	18%	37%	24%	27%
Many Younger Workers	14%	21%	20%	42%	29%	31%
OLDER WORKERS						
Few Older Workers	15%	19%	18%	40%*	25%	29%*
Many Older Workers	17%	18%	18%	33%*	24%	26%*
FUNDING ARRANGEMENT						
Fully Insured	16%	16%	16%	39%*	28%*	35%*
Self-Funded	15%	19%	18%	30%*	24%*	24%*
FIRM OWNERSHIP						
Private For-Profit	19%*	21%*	20%*	36%	26%	28%
Public	7%*	16%	15%	31%	23%	24%
Private Not-For-Profit	12%*	14%*	14%*	41%	23%	27%
ALL FIRMS	**16%**	**18%**	**18%**	**37%**	**25%**	**27%**

NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn at or below the 25th percentile of national earnings ($38,000 in 2026). Firms with many higher-wage workers are those where at least 35% earn at or above the 75th percentile of national earnings ($82,000 in 2026). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 6.19

Average Annual Premium Paid by Covered Workers for Single and Family Coverage, by Plan Type and Region, 2026

	Single Coverage		Family Coverage	
	Percent Contribution	Worker Contribution	Percent Contribution	Worker Contribution
HMO				
Northeast	24%*	$2,760*	30%	$9,538
Midwest	17	1,865*	25	8,123
South	18	1,530	30	8,048
West	13	1,175*	28	7,455
ALL REGIONS	**16%**	**$1,535**	**29%**	**$7,946**
PPO				
Northeast	19%	$2,117*	25%*	$7,800
Midwest	18	1,784	26	7,569
South	19	1,783	30	8,020
West	17	1,611	28	7,985
ALL REGIONS	**19%**	**$1,815**	**28%**	**$7,860**
POS				
Northeast	20%	$2,013	34%	$9,847
Midwest	19	1,815	25*	6,765*
South	20	1,837	42*	10,438
West	13*	1,215*	32	8,612
ALL REGIONS	**17%**	**$1,591**	**33%**	**$8,834**
HSA-Qualified Plans				
Northeast	18%	$1,669	20%*	$5,483
Midwest	18	1,622	24	6,340
South	17	1,409	28	6,629
West	15	1,217	23	5,982
ALL REGIONS	**17%**	**$1,497**	**24%**	**$6,211**
ALL PLANS				
Northeast	19%	$2,030*	24%*	$7,390
Midwest	18	1,724	25	7,041
South	19	1,671	30*	7,844
West	15*	1,356*	27	7,477
ALL REGIONS	**18%**	**$1,672**	**27%**	**$7,471**

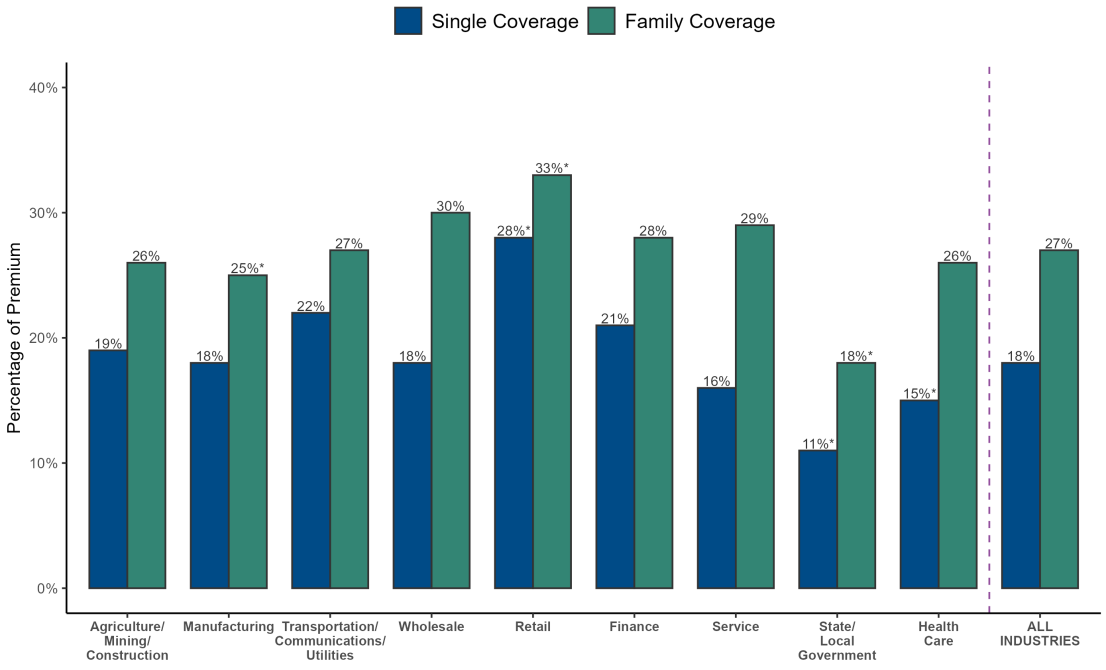
* Estimate is statistically different within plan and coverage type from estimate for all other firms not in the indicated region ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

DIFFERENCES BY REGION AND INDUSTRY

- The average worker contribution rate for single coverage is relatively low in the West (15%) [Figure 6.19].
- The average worker contribution rate for family coverage is relatively low in the Northeast (24%) and the Midwest (25%) and relatively high in the South (30%) [Figure 6.19].
- Average worker contribution rates vary significantly across industries for single and family coverage [Figure 6.20].

Figure 6.20
Average Percentage of Premium Paid by Covered Workers, by Industry, 2026



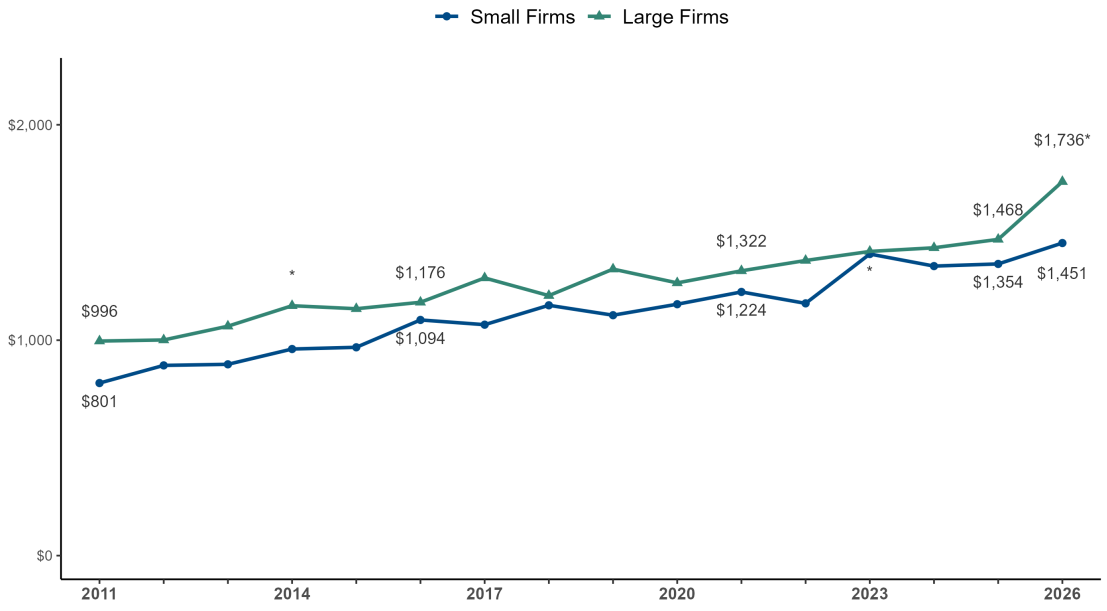
* Estimate is statistically different within coverage type from estimate for all other firms not in the indicated industry category ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2026

CHANGES OVER TIME

The average worker contribution amounts in 2026 are higher than the amounts last year for single coverage ($1,672 vs. $1,440) and for family coverage ($7,471 vs. $6,850) [Figure 6.21].

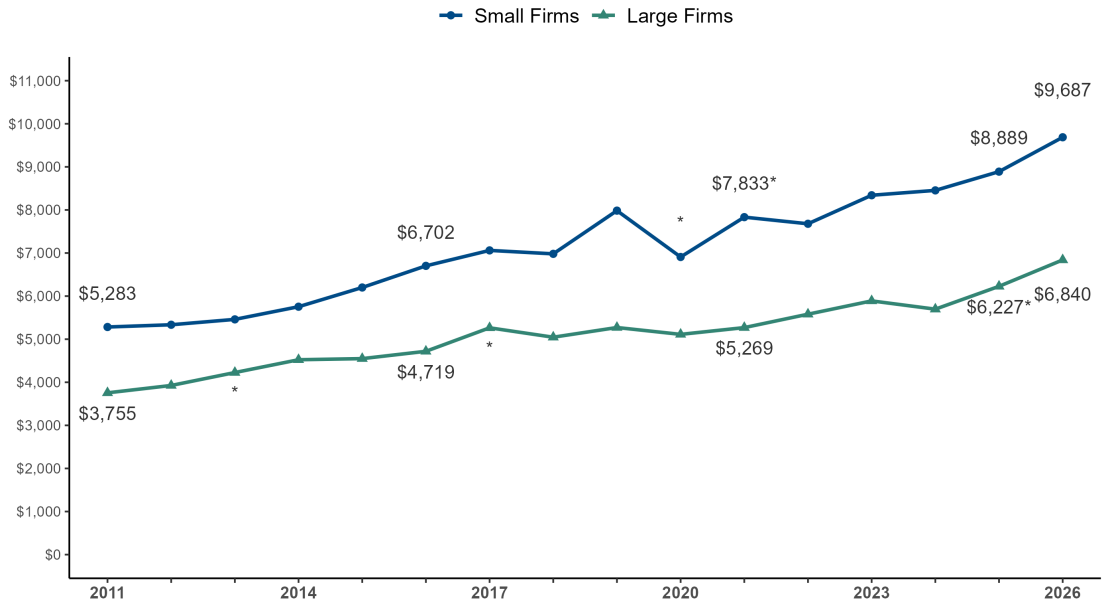
- Over the last five years, the average worker contribution amount for single coverage has increased 29% and the average worker contribution for family coverage increased 26%. For comparison, during the same period inflation increased 24.4% and workers' wages increased 26.9%.
- Over the last 10 years, the average worker contribution amount for single coverage has increased 45% and the average worker contribution amount for family coverage has increased 42% [Figure 6.4] and [Figure 6.5].
- The average worker contribution amount for family coverage increased 42% at private for-profit firms, 46% at public firms and 41% at private not-for-profit firms over the last ten years.

Figure 6.21
Average Annual Worker Contributions for Covered Workers with Single Coverage, by Firm Size, 2011-2026



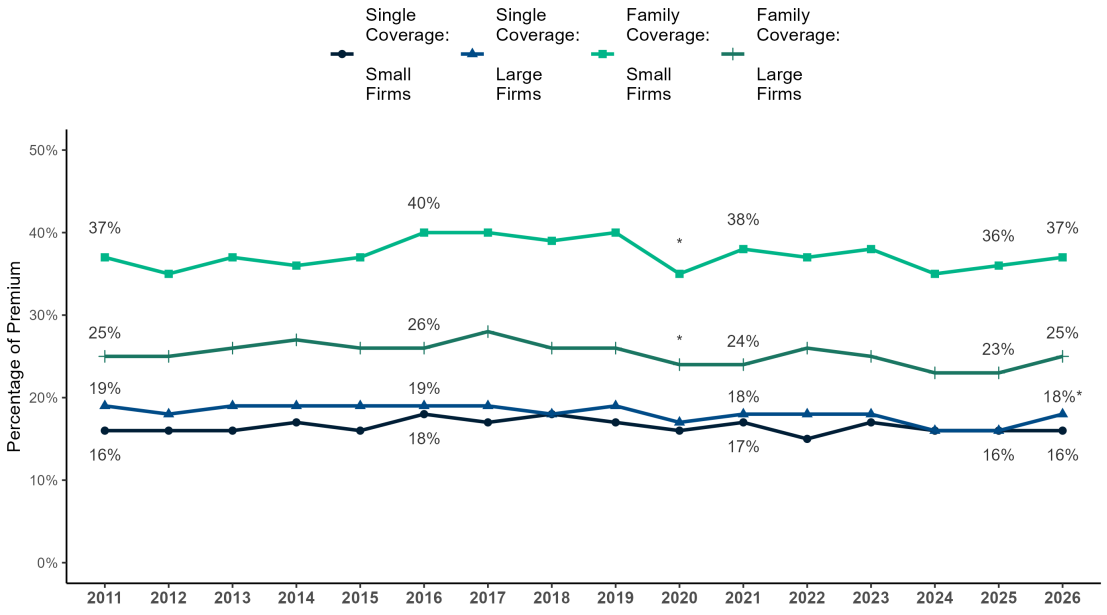
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.22
Average Annual Worker Contributions for Covered Workers with Family Coverage, by Firm Size, 2011-2026



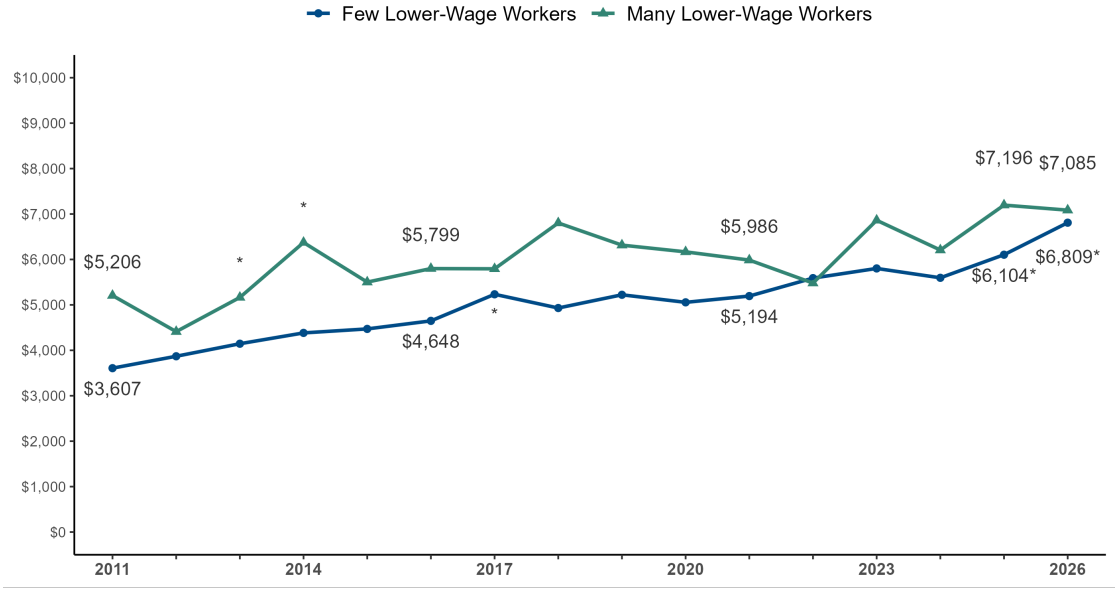
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.23
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2011-2026



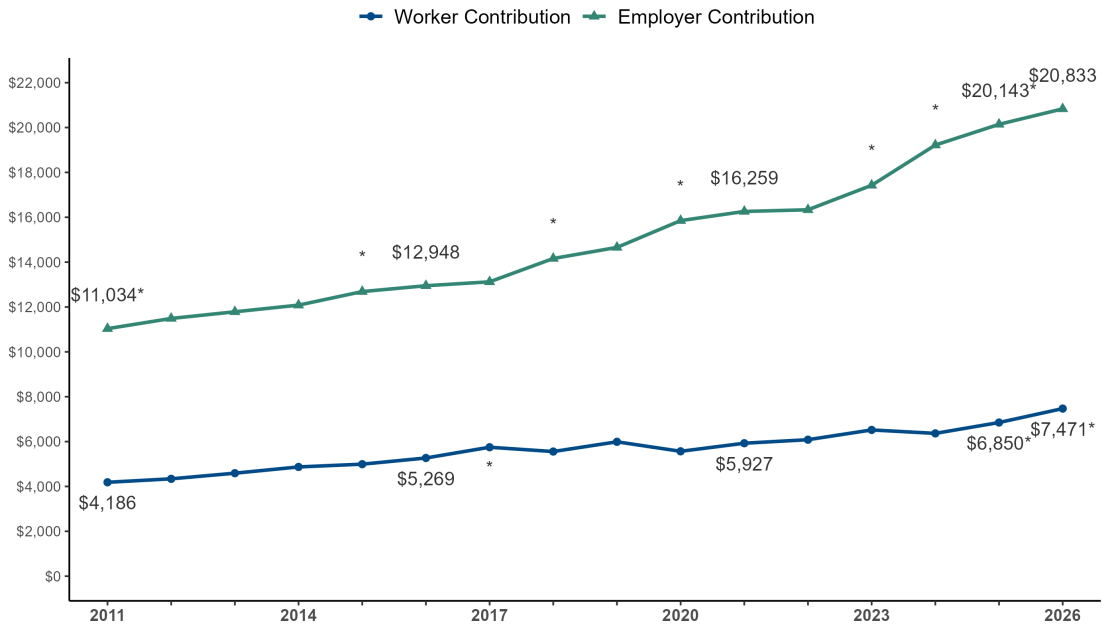
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.24
Among Large Firms, Average Annual Worker Contributions for Covered Workers with Family Coverage, by Firm Wage Level, 2011-2026



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn at or below the 25th percentile of national earnings ($38,000 in 2026).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

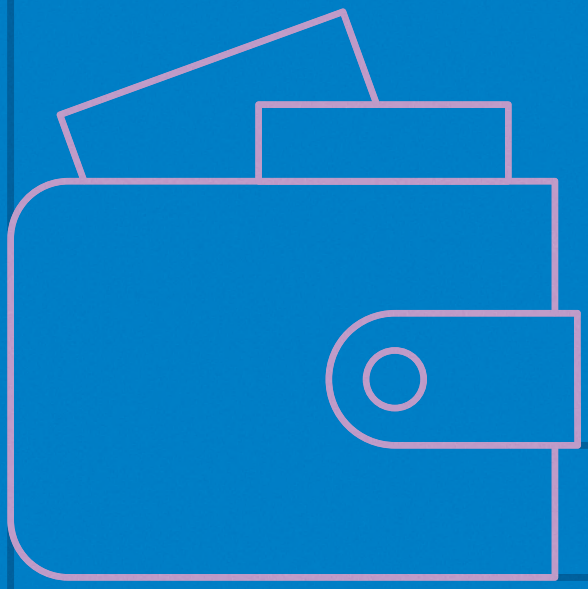
Figure 6.25
Average Annual Worker and Employer Contributions to Premiums for Family Coverage, 2011-2026



* 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, 1999-2017

SECTION 7

Employee Cost Sharing



Section 7

Employee Cost-Sharing

In addition to any required premium contributions, most covered workers must pay a share of the cost for the medical services they use. The most common forms of cost-sharing are deductibles (an amount that must be paid before most services are covered by the plan), copayments (fixed dollar amounts), and coinsurance (a percentage of the charge for services). Some plans combine forms of cost-sharing, such as requiring coinsurance for a service up to a maximum amount, or assessing either coinsurance or a copayment for a service, whichever results in the higher payment. The type and level of cost-sharing may vary by the type of plan in which the worker is enrolled. Cost-sharing may also vary by the type of service, with with different requirements for office visits, hospitalizations, and prescription drugs.

The cost-sharing amounts reported here are for covered workers using in-network services. Plan enrollees receiving services from out-of-network providers often face higher cost-sharing and may be responsible for charges that exceed the plan's allowable amounts. This survey does not allow us to capture all of the complex cost-sharing requirements in modern plans, including ancillary services (such as durable medical equipment or physical therapy) or cost-sharing arrangements that vary across different settings (such as tiered networks). Therefore, we do not collect information on all plan provisions and limits that affect the out-of-pocket liability of plan enrollees.

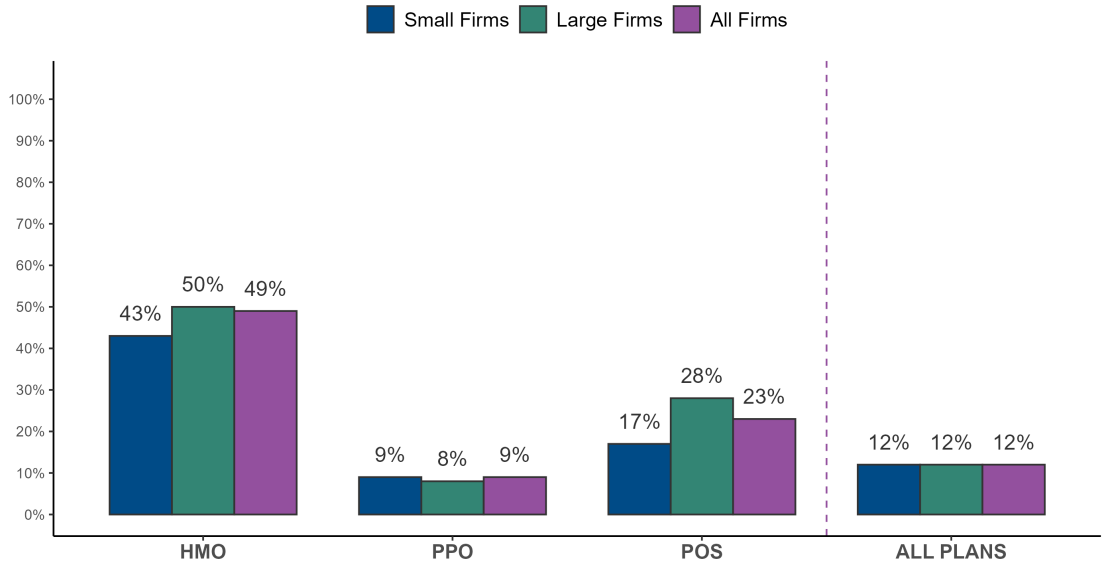
GENERAL ANNUAL DEDUCTIBLES FOR WORKERS IN PLANS WITH DEDUCTIBLES

We consider a general annual deductible to be an amount that must be paid by enrollees before most services are covered by their health plan. Non-grandfathered health plans are required to cover some services, such as preventive care, without cost-sharing. Some plans require enrollees to meet a specific deductible for certain services, such as prescription drugs or hospital admissions, in lieu of or in addition to a general annual deductible. As discussed below, some plans with a general annual deductible for most services exclude specified classes of care from the deductible, such as prescriptions or physician office visits.

- Eighty-eight percent of covered workers in 2026 are enrolled in a plan with a general annual deductible for single coverage, the same percentage as last year and similar to the percentage five years ago (85%), but higher than the percentage ten years ago (83%) [Figure 7.2].
- The percentage of covered workers enrolled in a plan with a general annual deductible for single coverage is similar for covered workers in smaller firms (firms with 10 to 199 workers) (88%) and for those in larger firms (88%) [Figure 7.5].
- The likelihood of a plan having a general annual deductible varies by plan type. Forty-nine percent of covered workers in HMOs do not have a general annual deductible for single coverage, compared to 23% of workers in POS plans and 9% of workers in PPOs [Figure 7.1].
- For workers with single coverage in a plan with a general annual deductible, the average annual deductible is $1,955, similar to the average deductible last year ($1,886) [Figure 7.3] and [Figure 7.8].
- For covered workers in plans with a general annual deductible, the average deductibles for single coverage are $1,562 in HMOs, $1,446 in PPOs, $1,902 in POS plans, and $2,912 in HSA-qualified plans [Figure 7.5].

- Among covered workers in plans with a general annual deductible, average deductibles for single coverage are higher at smaller firms (firms with 10 to 199 workers) than at larger firms across plan types. For covered workers in PPOs, the most common plan type, the average deductibles for single coverage are $2,097 in smaller firms and $1,282 in firms with 200 or more workers [Figure 7.5]. Overall, for covered workers in plans with a general annual deductible, the average deductible for single coverage at smaller firms ($2,624) is higher than the average deductible at larger firms ($1,772) [Figure 7.3].
- The average general annual deductible for single coverage ($1,955) for workers in plans with a deductible is higher than five years ago ($1,658) and ten years ago ($1,464) [Figure 7.9].

Figure 7.1
Percentage of Covered Workers with No General Annual Deductible for Single Coverage, by Plan Type and Firm Size, 2026



Tests found no statistical difference between All Small Firms and All Large Firms estimate within plan type ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. General annual deductibles are for in-network providers. HSA-qualified plans are excluded because all enrollees face a minimum deductible. Within each plan type, similar shares of covered workers have no general annual deductible for single and family coverage.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.2

Percentage of Covered Workers in a Plan That Includes a General Annual Deductible for Single Coverage, by Plan Type and Firm Size, 2006-2026

	HMO			PPO			POS			ALL PLANS		
	Small Firms	Large Firms	All Firms	Small Firms	Large Firms	All Firms	Small Firms	Large Firms	All Firms	Small Firms	Large Firms	All Firms
2006	17%	10%	12%	73%	69%	70%	34%	28%	31%	57%	54%	55%
2007	16%	20%*	19%	70%	71%	70%	50%*	41%	46%*	60%	59%	59%
2008	23%	18%	20%	71%	66%	67%	56%	41%	48%	64%	56%	59%
2009	26%	12%	15%	73%	74%	74%	63%	58%	61%*	68%	61%	63%
2010	29%	25%*	26%*	79%	76%	77%	70%	70%	70%	73%	68%*	70%*
2011	37%	27%	29%	77%	83%	81%	70%	71%	70%	75%	74%	74%
2012	34%	29%	30%	76%	77%	77%	61%	63%	62%	73%	73%	73%
2013	46%	40%	42%	76%	82%	81%	77%	49%	65%	77%	78%	78%*
2014	60%	28%	36%	85%	85%	85%	69%	72%*	70%	83%	80%	81%
2015	48%	40%	43%	85%	84%	84%	77%	61%	70%	82%	81%	81%
2016	45%	47%	46%	86%	84%	85%	79%	66%	73%	82%	83%	83%
2017	45%	37%	39%	79%	88%	86%	70%	58%	64%	78%	83%	81%
2018	67%	53%	56%*	85%	89%	88%	88%*	63%	77%	87%*	85%	86%*
2019	62%	43%	48%	85%	84%	84%	81%	76%	79%	84%	81%	82%
2020	50%	49%	49%	78%	84%	83%	77%	79%	78%	80%	84%	83%
2021	75%*	52%	57%	82%	87%	86%	83%	83%	83%	86%	85%	85%
2022	67%	58%	60%	89%	88%	88%	82%	84%	83%	88%	88%	88%
2023	67%	67%	67%	84%	92%	90%	89%	83%	86%	88%	90%	90%
2024	60%	53%	54%	85%	92%	91%	78%*	95%	87%	84%	89%	88%
2025	70%	49%	53%	85%	89%	88%	88%	83%	86%	88%	88%	88%
2026	57%	50%	51%	91%	92%	91%	83%	72%	77%	88%	88%	88%

NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. General annual deductibles are for in-network providers. HSA-qualified plans are excluded because all enrollees face a minimum deductible.

* 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, 2006-2017

Figure 7.3

Percentage of Covered Workers in a Plan That Includes a General Annual Deductible and Average Deductible for Single Coverage, by Firm Size and Region, 2026

	Percentage of Covered Workers in a Plan With a General Annual Deductible	Among Covered Workers With a General Annual Deductible for Single Coverage, Average Deductible
FIRM SIZE		
10-49 Workers	88%	$2,658*
50-199 Workers	88	2,598*
200-999 Workers	88	2,311*
1,000-4,999 Workers	89	1,873
5,000 or More Workers	87	1,523*
All Small Firms (10-199 Workers)	**88%**	**$2,624***
All Large Firms (200 or More Workers)	**88%**	**$1,772***
REGION		
Northeast	93%*	$1,772
Midwest	96*	2,120*
South	84	1,991
West	81*	1,827
ALL FIRMS	**88%**	**$1,955**

* Estimate is statistically different from estimate for all other firms not in the indicated size or region category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.4

Percentage of Covered Workers in a Plan That Includes a General Annual Deductible and Average Deductibles for Single Coverage, by Firm Characteristics, 2026

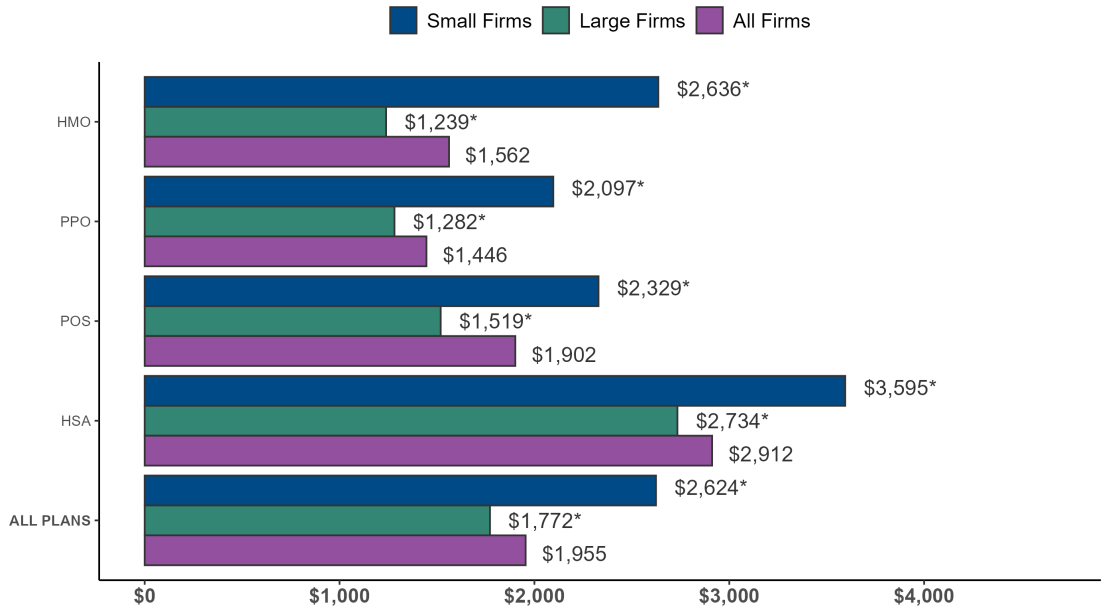
	Percentage of Covered Workers in a Plan With a General Annual Deductible	Among Covered Workers With a General Annual Deductible for Single Coverage, Average Deductible
LOWER WAGE LEVEL		
Few Lower-Wage Workers	88%	$1,926
Many Lower-Wage Workers	90%	$2,181
HIGHER WAGE LEVEL		
Few Higher-Wage Workers	87%	$2,049
Many Higher-Wage Workers	89%	$1,835
UNIONS		
Firm Has Union Workers	85%	$1,522*
Firm Has No Union Workers	90%	$2,193*
YOUNGER WORKERS		
Few Younger Workers	88%	$1,934
Many Younger Workers	90%	$2,145
OLDER WORKERS		
Few Older Workers	89%	$2,101*
Many Older Workers	87%	$1,811*
FIRM OWNERSHIP		
Private For-Profit	94%*	$2,114*
Public	76%	$1,343*
Private Not-For-Profit	83%	$2,020
ALL FIRMS	**88%**	**$1,955**

NOTE: Firms with many lower-wage workers are those where at least 35% earn at or below the 25th percentile of national earnings ($38,000 in 2026). Firms with many higher-wage workers are those where at least 35% earn at or above the 75th percentile of national earnings ($82,000 in 2026). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

* Estimates are statistically different from each other within firm characteristic ($p < .05$).

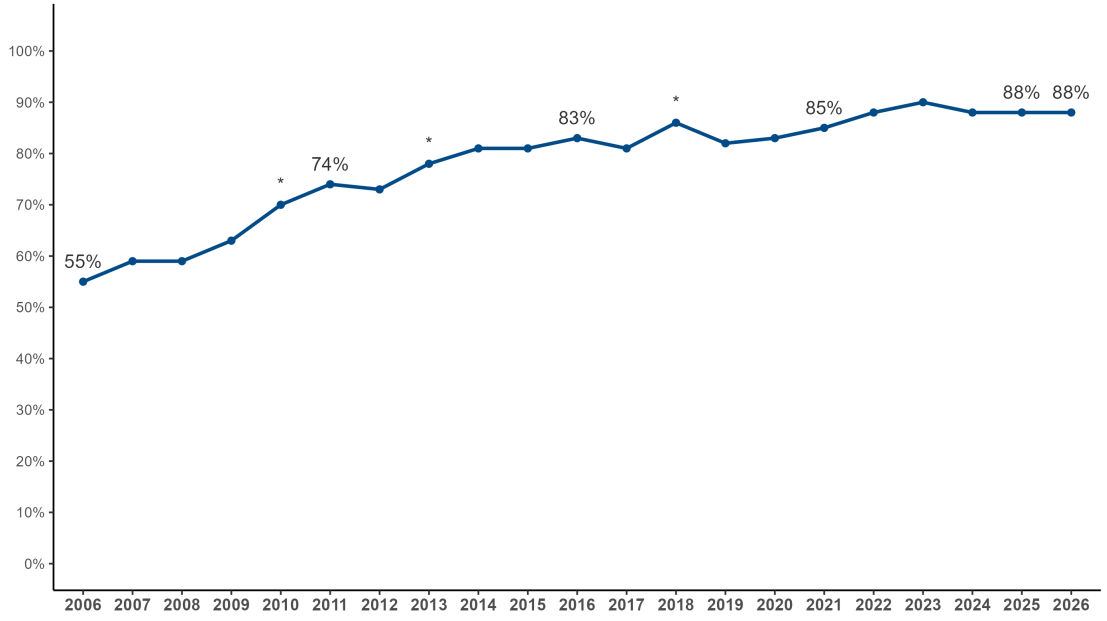
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.5
Among Covered Workers with a General Annual Deductible for Single Coverage, Average Deductible, by Plan Type and Firm Size, 2026



* Estimate is statistically different between All Small Firms and All Large Firms estimate within plan type (p < .05).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. General annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.6
Percentage of Covered Workers with a General Annual Deductible for Single Coverage, 2006-2026



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: General annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.7

Among Covered Workers With a General Annual Deductible, Average Single and Family Coverage Deductible, by Plan Type, 2006-2026

	Family Coverage Deductible With Aggregate Structure			Family Coverage Deductible With Separate Per-Person Structure			Single Coverage			
	HMO	PPO	POS	HMO	PPO	POS	HMO	PPO	POS	All Plans
2006	$752	$1,026	$1,227	NSD	$708	NSD	$340	$464	$576	$567
2007	$764	$1,058	$1,349	NSD	$492*	$723	$403	$467	$625	$617
2008	$1,137	$1,247*	$1,615	NSD	$488	$870	$524	$525*	$713	$715*
2009	$1,522	$1,470*	$1,959	$686	$591	$1,129	$692	$609*	$990	$806*
2010	$1,292	$1,501	$2,208	$449	$583	$1,186	$573	$656	$1,025	$897*
2011	$1,479	$1,409	$1,840	$798	$622	$817	$878	$628	$917	$955
2012	$1,322	$1,728*	$2,157	$568	$626	$1,146	$615	$710	$1,031	$1,067*
2013	$1,726	$1,826	$2,859	$609	$770*	$895	$723	$775	$1,268	$1,119
2014	$2,088	$1,914	$2,306	$870	$811	NSD	$948	$822	$1,162	$1,186
2015	$2,776	$2,025	$2,466	$718	$930	$1,153	$1,011	$958*	$1,257	$1,320*
2016	$2,253	$2,140	$3,995*	$632	$1,052	$1,269	$852	$1,026	$1,778	$1,464*
2017	$2,626	$2,482*	$2,618*	$1,045	$913	$1,293	$1,140	$1,034	$1,356	$1,492
2018	$2,267	$2,924*	$3,566	$687	$1,007	$1,864	$854	$1,182*	$1,621	$1,558
2019	$2,878	$2,815	$4,518	$811	$1,067	$1,809	$1,166	$1,153	$1,919	$1,632
2020	$3,035	$2,621	$3,886	NSD	$1,085	NSD	$1,201	$1,157	$1,703	$1,617
2021	$3,098	$2,954	$4,009	$1,190	$1,126	$1,197	$1,190	$1,237	$1,802	$1,658
2022	$3,125	$2,882	$4,082	$1,600	$1,446*	$2,257*	$1,447	$1,290	$1,966	$1,747
2023	$2,916	$2,950	$3,931	$1,835	$1,430	$3,399	$1,180	$1,261	$1,866	$1,729
2024	$3,680	$2,754	$4,156	$1,548	$1,642	$3,651	$1,457	$1,246	$2,146	$1,773
2025	$3,285	$3,118	$4,842	$2,413	$1,361	$1,811	$1,649	$1,337	$2,122	$1,886
2026	$3,207	$3,320	$3,875	$2,127	$1,693	$2,397	$1,562	$1,446	$1,902	$1,955

NOTE: General annual deductibles are for in-network providers. The survey distinguishes between aggregate deductibles, which combine all family members' out-of-pocket expenses, and separate per-person deductibles, typically capped at a specified number of family members.
NSD: Not Sufficient Data

* 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, 2006-2017

Figure 7.8

Prevalence and Value of General Annual Deductibles for Single Coverage, by Firm Size, 2006-2026

	Average General Annual Deductible Among Covered Workers Who Face A Deductible For Single			Percentage Of Covered Workers With A General Annual Deductible For Single Coverage			Average General Annual Deductible For Single Coverage Among All Covered Workers		
	Small Firms	Large Firms	All Firms	Small Firms	Large Firms	All Firms	Small Firms	Large Firms	All Firms
2006	$737	$496	$567	57%	54%	55%	$425	$234	$295
2007	$895*	$519	$617	60%	59%	59%	$516	$269	$342*
2008	$1,112*	$553	$715*	64%	56%	59%	$713*	$284	$416*
2009	$1,241	$640*	$806*	68%	61%	63%	$850	$376*	$517*
2010	$1,403	$686	$897*	73%	68%*	70%*	$1,020*	$456*	$630*
2011	$1,488	$757	$955	75%	74%	74%	$1,145	$546*	$717
2012	$1,555	$875*	$1,067*	73%	73%	73%	$1,148	$629*	$782
2013	$1,732	$884	$1,119	77%	78%	78%*	$1,340	$670	$869
2014	$1,750	$971	$1,186	83%	80%	81%	$1,473	$765*	$965*
2015	$1,920	$1,105*	$1,320*	82%	81%	81%	$1,575	$890*	$1,078*
2016	$2,083	$1,238	$1,464*	82%	83%	83%	$1,682	$1,026	$1,210*
2017	$2,129	$1,276	$1,492	78%	83%	81%	$1,661	$1,049	$1,215
2018	$2,131	$1,355	$1,558	87%*	85%	86%*	$1,867	$1,159	$1,346*
2019	$2,267	$1,412	$1,632	84%	81%	82%	$1,927	$1,184	$1,383
2020	$2,262	$1,418	$1,617	80%	84%	83%	$1,828	$1,187	$1,350
2021	$2,442	$1,397	$1,658	86%	85%	85%	$2,094*	$1,201	$1,431
2022	$2,583	$1,493	$1,747	88%	88%	88%	$2,267	$1,320	$1,550
2023	$2,501	$1,478	$1,729	88%	90%	90%	$2,193	$1,341	$1,564
2024	$2,590	$1,538	$1,773	84%	89%	88%	$2,186	$1,374	$1,573
2025	$2,631	$1,670	$1,886	88%	88%	88%	$2,309	$1,461	$1,663
2026	$2,624	$1,772	$1,955	88%	88%	88%	$2,312	$1,565	$1,733

NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. General annual deductibles are for in-network providers. Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

* 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, 2006-2017

GENERAL ANNUAL DEDUCTIBLES AMONG ALL COVERED WORKERS

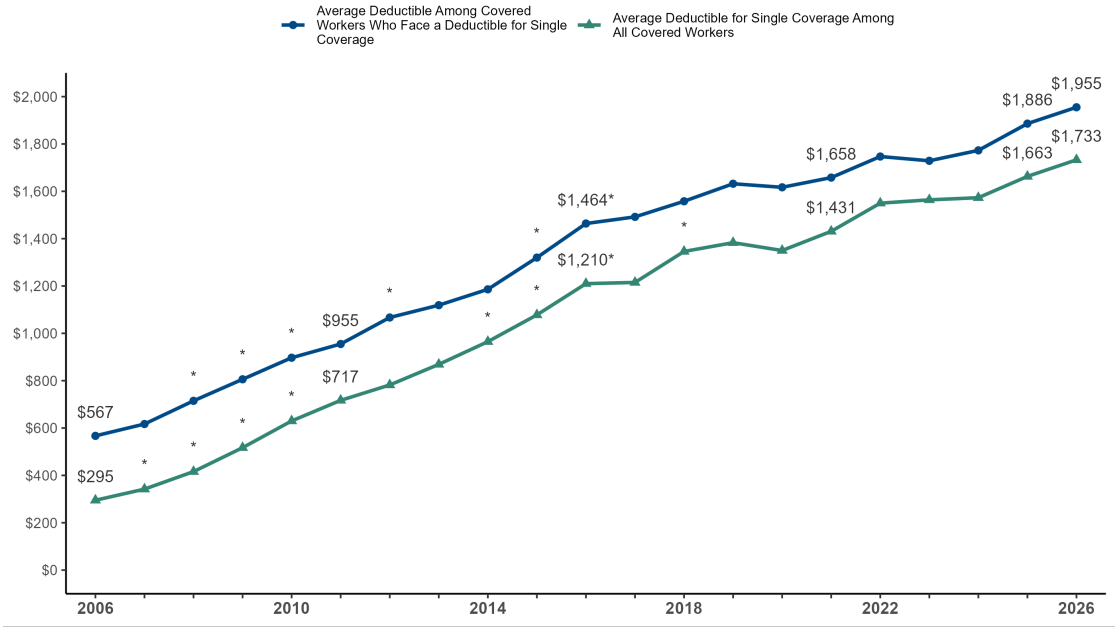
As discussed above, the share of covered workers in plans with a general annual deductible has increased over time, from 83% in 2016 to 88% this year [Figure 7.6]. The average deductible amount for covered workers in plans with a deductible has also increased over the same period, from $1,464 in 2016 to $1,955 in 2026 [Figure 7.9]. Neither trend by itself, however, captures the full impact that changes in deductibles have had on all covered workers. We can look at the average impact of both trends together by assigning a zero deductible to covered workers in plans with no deductible and examining how the resulting average changes over time. These averages are lower than the averages among only workers in plans with deductibles, but the changes over time reflect both workers facing higher monetary deductible amounts and a greater number of workers facing deductibles.

- Using this approach, the average general annual deductible for all covered workers with single coverage

(with or without a deductible) in 2026 is $1,733, similar to the amount last year ($1,663) [Figure 7.9].

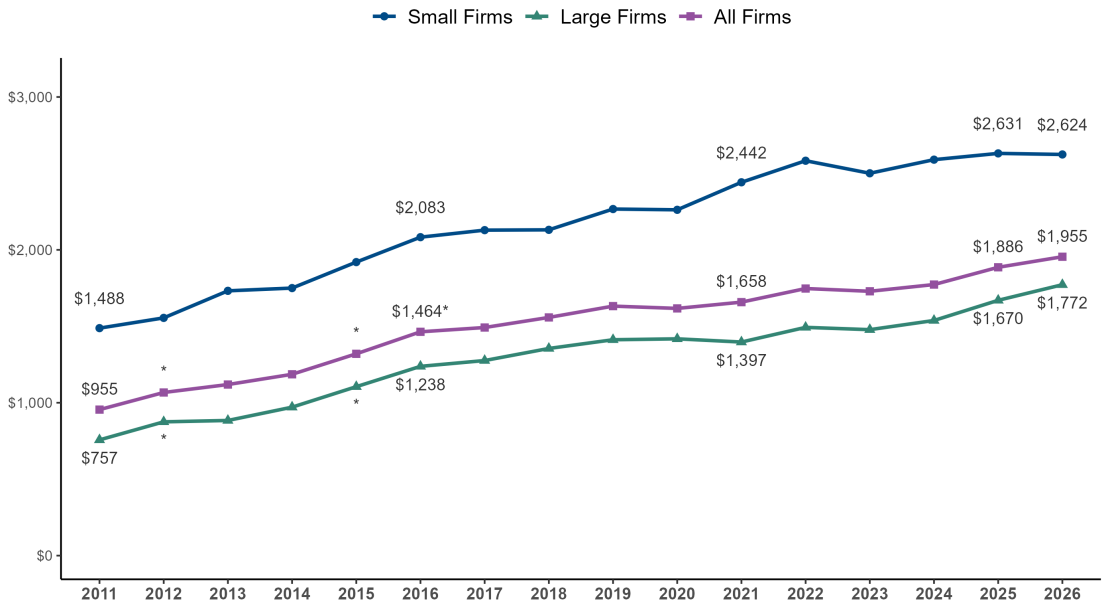
- The 2026 value is 21% higher than the average general annual deductible in 2021 ($1,431) and 43% higher than in 2016 ($1,210) [Figure 7.9].
- Another way to assess deductibles on covered workers is to look at the percent of all covered workers who are in a plan with a deductible that exceeds a certain amount. Thirty-eight percent of covered workers are in plans with a general annual deductible of $2,000 or more for single coverage, similar to the percentage last year (34%) but higher than the percentage five years ago (29%) [Figure 7.12].
  - Workers at smaller firms are more likely to have a general annual deductible of $2,000 or more for single coverage than workers at larger firms (55% vs. 33%) [Figure 7.11].

Figure 7.9
Average General Annual Deductibles for Single Coverage, 2006-2026



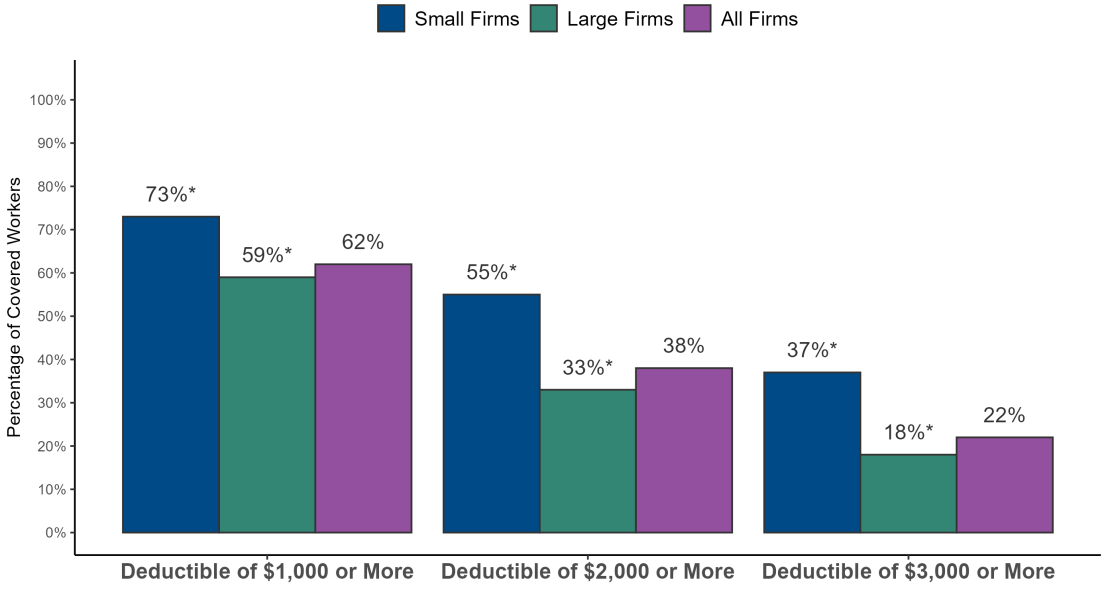
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.10
Among Covered Workers Who Face a Deductible for Single Coverage, Average General Annual Deductible for Single Coverage, by Firm Size, 2011-2026



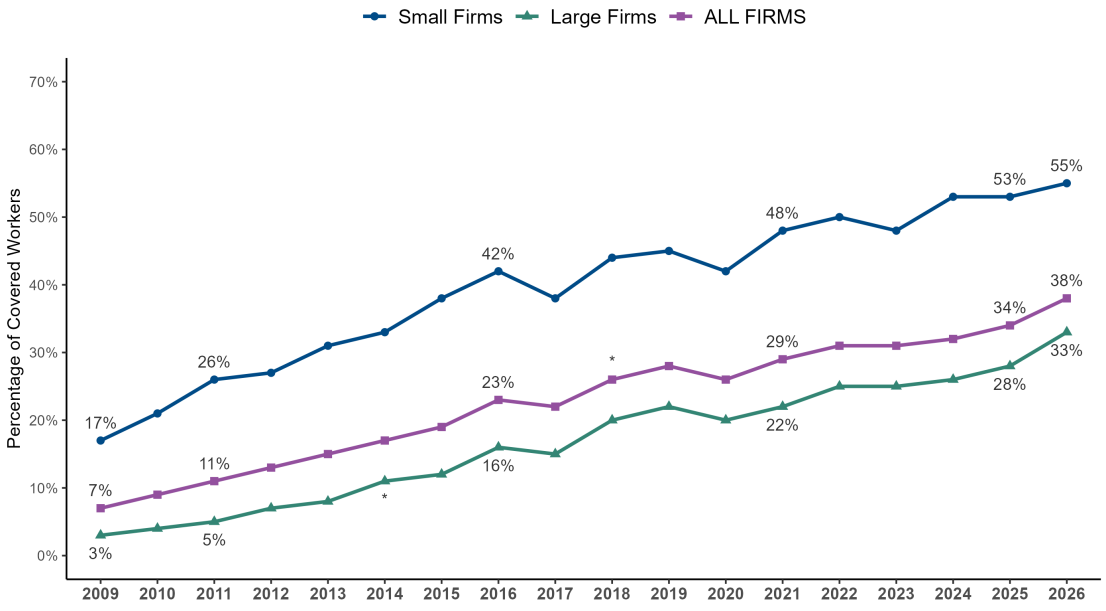
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. General annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.11
Percentage of Covered Workers Enrolled in a Plan with a High General Annual Deductible for Single Coverage, by Firm Size, 2026



* Estimate is statistically different between All Small Firms and All Large Firms estimate (p < .05).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HSA-qualified plans and other plan types. Average general annual health plan deductibles are for in-network services.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.12
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



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: These estimates include all covered workers, including those in HSA-qualified plans. 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

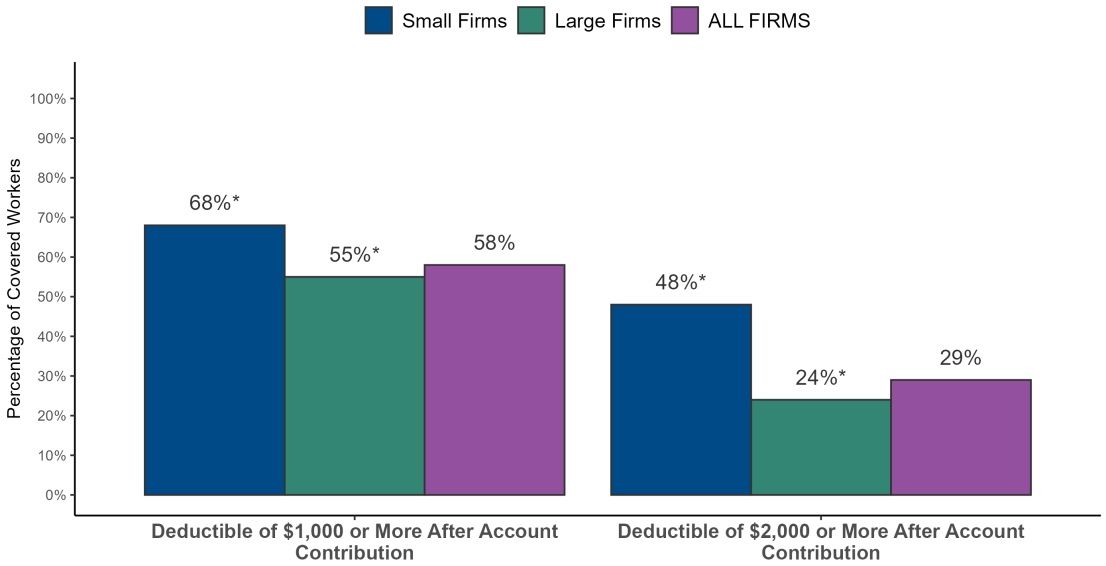
GENERAL ANNUAL DEDUCTIBLES AND ACCOUNT CONTRIBUTIONS

HSA-qualified plans are subject to a minimum deductible, have an important impact on the average deductible amounts across the market. The higher deductibles in these plans, however, are often paired with employer contributions to an HSA, offsetting some or all of the higher cost-sharing.

- Among covered workers enrolled in an HSA-qualified plan, 3% receive an employer HSA contribution for single coverage that is at least equal to their deductible, and another 10% receive a contribution that would reduce their deductible to $1,000 or less. [Figure 7.14].
- If employer HSA contributions are subtracted from general annual deductibles, the percentage of covered workers with a deductible of $2,000 or more would be reduced from 38% to 29% [Figure 7.13].

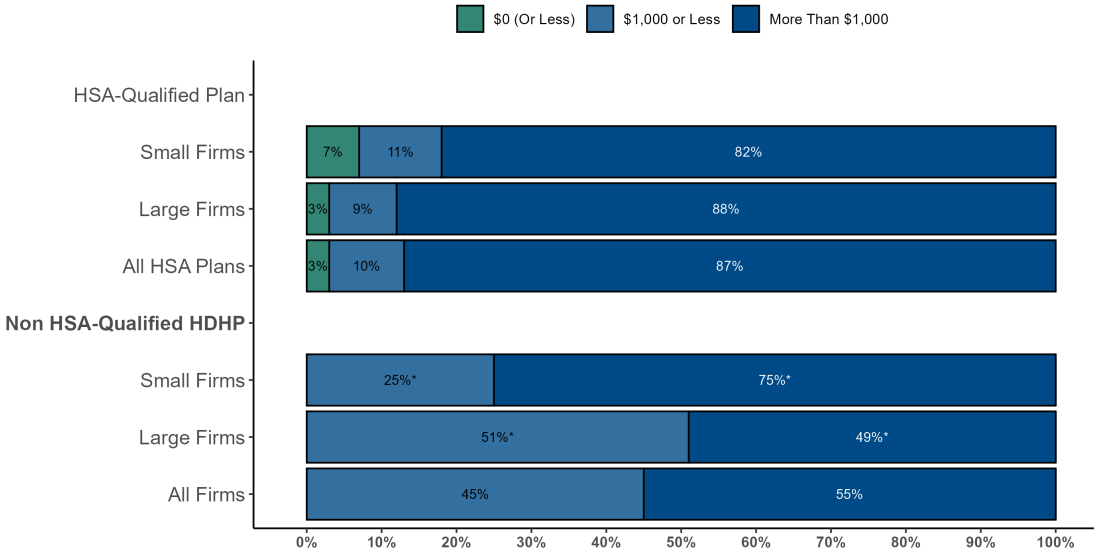
Some employers also make funds available to employees through health reimbursement arrangements (HRAs), which in many cases can also be used by employees to reduce their cost-sharing liability. The survey this year did not collect information on the amounts that employers make available in HRAs, so we cannot estimate their potential impact on cost-sharing liability. Additional information on the ways that workers can use funds made available by employers in HRAs is provided in Chapter 8.

Figure 7.13
Percentage of Covered Workers Enrolled in a Plan with a High General Annual Deductible for Single Coverage, Reduced by Any HSA Contributions, by Firm Size, 2026



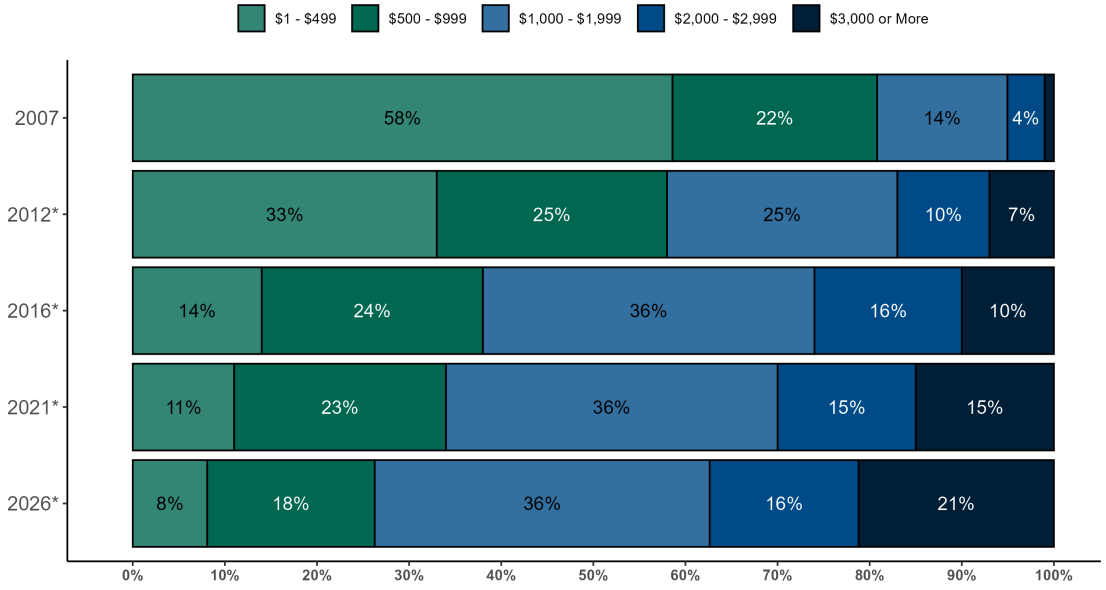
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: These estimates include workers enrolled in HSA-qualified plans and other plan types. Average general annual health plan deductibles are for in-network services. The net liability for covered workers enrolled in an HSA-qualified plan is calculated by subtracting the account contribution from the single coverage deductible. Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.14
Among Covered Workers with a General Annual Deductible, Distribution of General Annual Deductibles for Single Coverage, Reduced by Any HSA Contributions, by Plan Type and Firm Size, 2026



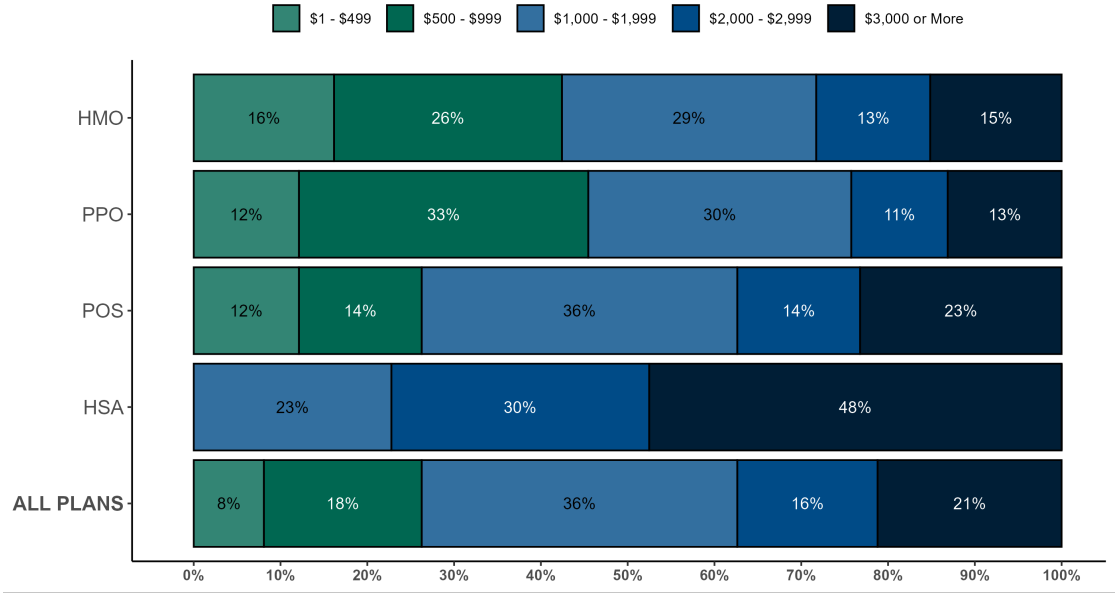
* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: The net liability for covered workers enrolled in an HSA-qualified plan is calculated by subtracting the account contribution from the single coverage deductible.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.15
Among Covered Workers with a General Annual Deductible, Distribution of General Annual Deductible for Single Coverage, 2007-2026



* Distribution is statistically different from distribution for the previous year shown (p < .05).
NOTE: General annual deductibles are for in-network providers. In 2026, 88% of covered workers are enrolled in a plan with a general annual deductible.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 7.16
Among Covered Workers with a General Annual Deductible, Distribution of General Annual Deductibles for Single Coverage, by Plan Type, 2026



NOTE: General annual deductibles are for in-network providers. In 2026, 88% of covered workers are enrolled in a plan with a general annual deductible.
SOURCE: KFF Employer Health Benefits Survey, 2026

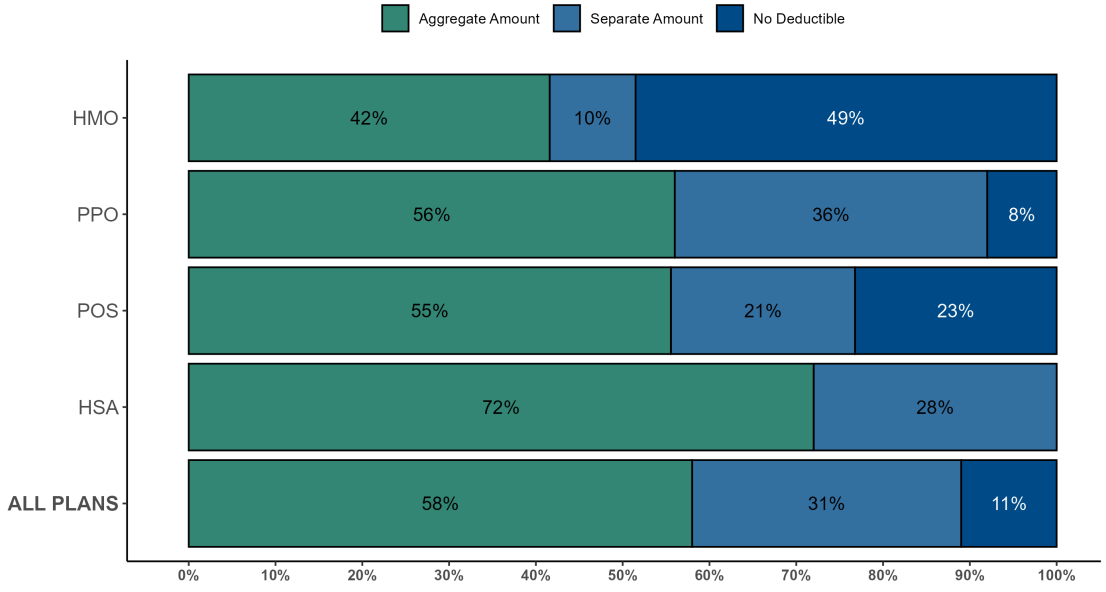
GENERAL ANNUAL DEDUCTIBLES FOR WORKERS ENROLLED IN FAMILY COVERAGE

General annual deductibles for family coverage are structured in two primary ways: (1) an aggregate family deductible, where the out-of-pocket expenses of all family members count against a specified family deductible amount and where the deductible is considered met when the combined family expenses exceed the deductible amount, or (2) a separate per-person family deductible, where each family member is subject to a specified deductible amount before the plan covers expenses for that member. Many plans with a per-person deductible, however, consider the deductible for all family members met once a certain number of family members (such as two or three) meet their specified deductible amount.[1]

- Forty-nine percent of covered workers in HMOs are in plans without a general annual deductible for family coverage, much higher than the percentage of covered workers in plans without a family deductible in PPOs (8%) and POS plans (23%). As defined, all covered workers in HSA-qualified plans have a general annual deductible for family coverage [Figure 7.17].
- Among covered workers enrolled in family coverage, 42% of those in HMOs have an aggregate general annual deductible, compared with 56% of those in PPOs, 55% of those in POS plans, and 72% of those in HSA-qualified plans [Figure 7.17].
  - The average deductible for covered workers in plans with an aggregate annual deductible for family coverage are $3,207 for HMOs, $3,320 for PPOs, $3,875 for POS plans, and $5,380 for HSA-qualified plans [Figure 7.18]. The average deductible for HSA-qualified plans is higher than last year ($4,936). The average deductible amounts for the other plan types are similar to the amounts last year.
- For covered workers in HMOs, PPOs, and HSA-qualified plans with an aggregate deductible for family coverage, average annual deductibles are higher at firms with 10 to 199 workers than at larger firms [Figure 7.21].
- Among covered workers enrolled in family coverage, 10% of those in HMOs have a separate per-person annual deductible, compared with 36% of those in PPOs, 21% of those in POS plans, and 28% of those in HSA-qualified plans.
  - The average deductible amounts for covered workers in plans with separate per-person annual deductibles for family coverage are $1,693 for PPOs, and $4,614 for HSA-qualified plans [Figure 7.18].
- Twenty-eight percent of covered workers in plans with a separate per-person annual deductible for family coverage have a limit on the number of family members required to meet separate deductible amounts [Figure 7.21]. Among these covered workers, the most common number of family members required to meet the separate per-person deductible is two [Figure 7.22].

[1] Some workers with separate per-person deductibles or out-of-pocket maximums for family coverage do not have a specific number of family members that are required to meet the deductible amount and instead have another type of limit, such as a per-person amount with a total dollar amount limit. These responses are included in the averages and distributions for separate family deductibles and out-of-pocket maximums.

Figure 7.17
Distribution of Type of General Annual Deductible for Covered Workers with Family Coverage, by Plan Type, 2026



NOTE: The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.18

Among Covered Workers With a General Annual Deductible, Average Deductibles for Family Coverage, by Deductible Type, Plan Type, and Firm Size, 2026

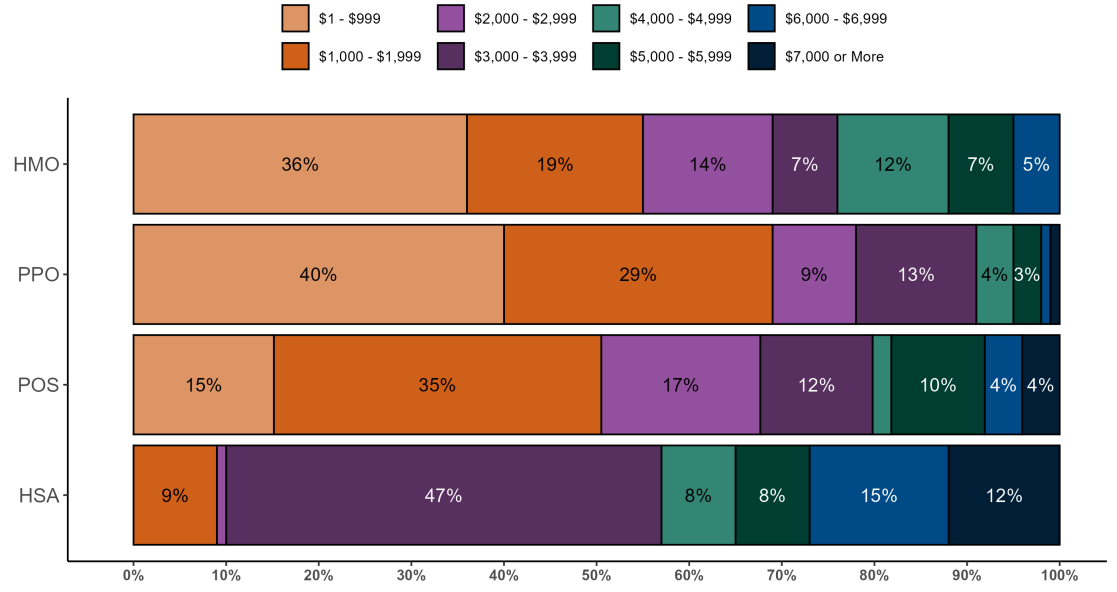
	Aggregate Amount	Separate Per-Person Amount
HMO		
All Small Firms (10-199 Workers)	$5,605*	NSD
All Large Firms (200 or More Workers)	$2,606*	$2,038
ALL FIRM SIZES	**$3,207**	**$2,127**
PPO		
All Small Firms (10-199 Workers)	$4,719*	$1,910
All Large Firms (200 or More Workers)	$2,851*	$1,665
ALL FIRM SIZES	**$3,320**	**$1,693**
POS		
All Small Firms (10-199 Workers)	$4,658	NSD
All Large Firms (200 or More Workers)	$3,220	NSD
ALL FIRM SIZES	**$3,875**	**$2,397**
HSA-Qualified Plans		
All Small Firms (10-199 Workers)	$6,508*	$4,826
All Large Firms (200 or More Workers)	$5,077*	$4,563
ALL FIRM SIZES	**$5,380**	**$4,614**

NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. General annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
NSD: Not Sufficient Data

* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).

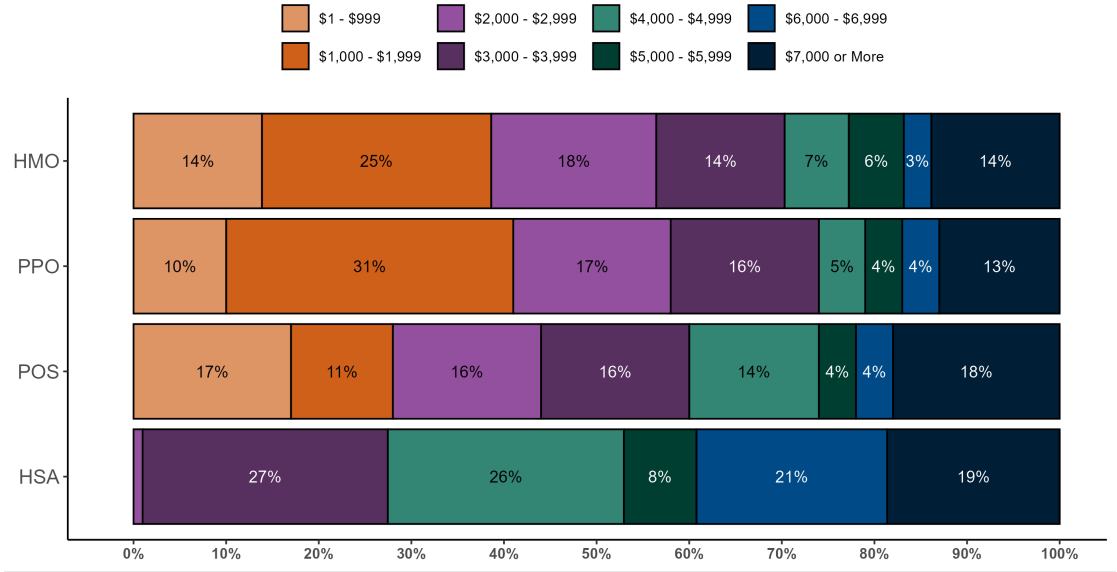
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.19
Among Covered Workers with a Separate Per-Person General Annual Deductible for Family Coverage, Distribution of Deductibles, by Plan Type, 2026



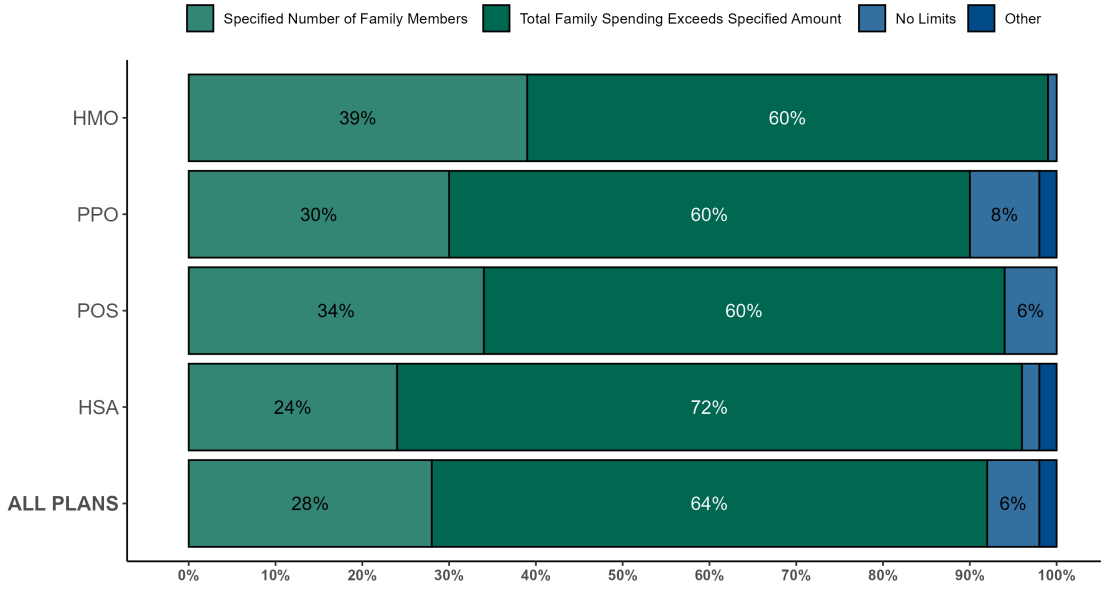
NOTE: General annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.20
Among Covered Workers with an Aggregate General Annual Deductible for Family Coverage, Distribution of Deductibles, by Plan Type, 2026



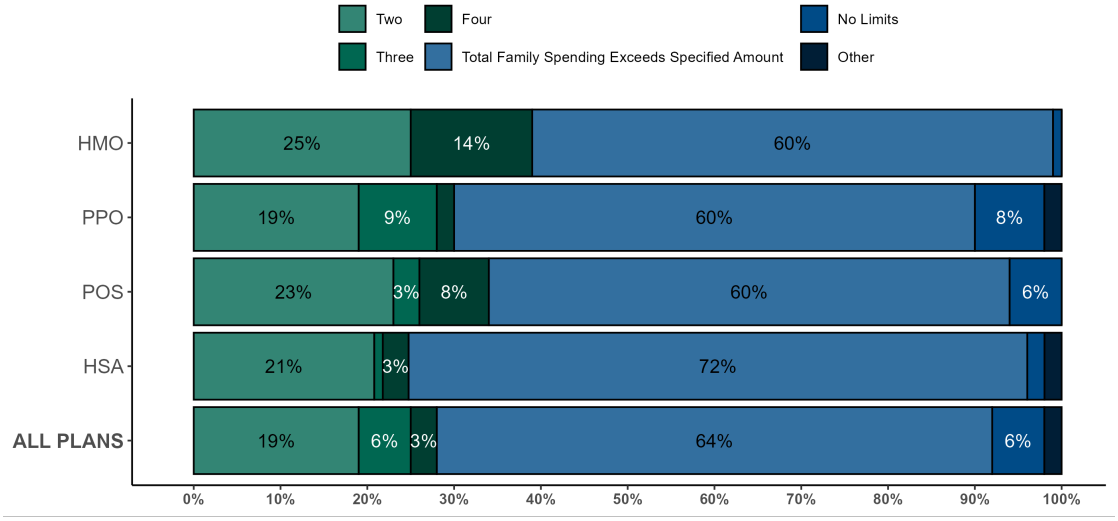
NOTE: By definition, covered workers in an HSA-Qualified plan have a family deductible of $3,300 or more. General annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.21
Among Covered Workers With a Separate Per-Person General Annual Deductible for Family Coverage, Structure of Deductible Limits, by Plan Type, 2026



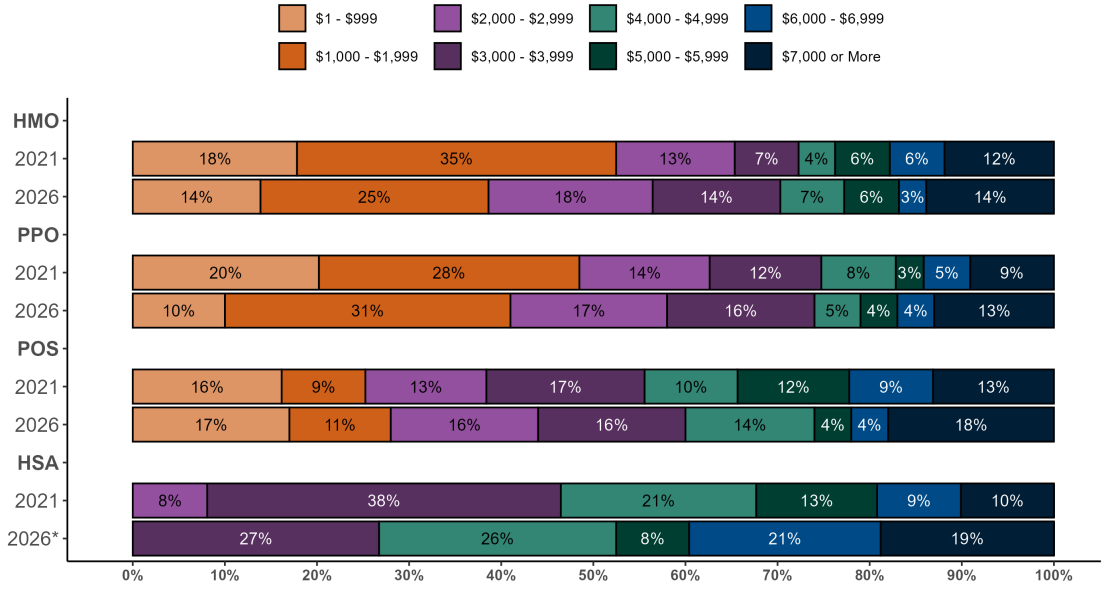
NOTE: General annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.22
Among Covered Workers With a Separate Per-Person General Annual Deductible for Family Coverage and a Per-Person Limit, Distribution of Maximum Number of Family Members Required to Meet the Deductible, by Plan Type, 2026



NOTE: General annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount. Firms with a separate family deductible were asked if they had a combined limit or if the limit was met when a specified number of family members reached their per-person limit. 'Other' category may include per-person limits with a total family dollar limit.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.23
Among Covered Workers With an Aggregate General Annual Deductible for Family Coverage, Distribution of Aggregate Deductibles, by Plan Type, 2021 and 2026



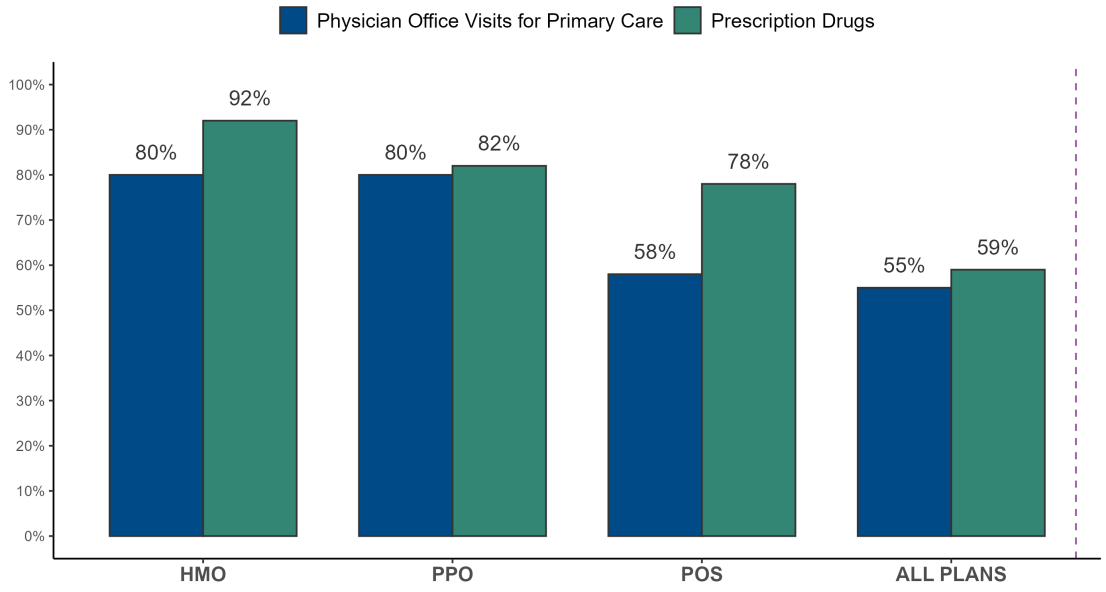
* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
NOTE: General annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
SOURCE: KFF Employer Health Benefits Survey, 2021-2026;

COVERAGE OF SERVICES AND PRODUCTS BEFORE MEETING THE GENERAL ANNUAL DEDUCTIBLE

A majority of covered workers with a general annual deductible are enrolled in plans in which the deductible does not have to be met before certain services, such as physician office visits or prescription drugs, are covered. Covered workers in HSA-qualified plans are not included in these estimates, because different deductible requirements apply to HSA-qualified plans.

- Among covered workers enrolled in a plan with a general annual deductible, 80% in HMOs, 80% in PPOs, and 58% in POS plans are enrolled in plans where the deductible does not have to be met before primary care office visits are covered [Figure 7.24].
- Similarly, among covered workers enrolled in a plan with a general annual deductible, 92% in HMOs, 82% in PPOs, and 78% in POS plans are enrolled in plans where the deductible does not have to be met before prescription drugs are covered [Figure 7.24].

Figure 7.24
Among Covered Workers with a General Annual Deductible, Percentage with Coverage for the Following Services Without Having to First Meet the Deductible, by Plan Type, 2026



NOTE: These questions are asked of firms with a deductible. HSA-qualified plans are required by law to apply the deductible to most services, therefore they are excluded from this figure.
SOURCE: KFF Employer Health Benefits Survey, 2026

HOSPITAL ADMISSIONS AND OUTPATIENT SURGERY

Whether or not a covered worker is in a plan with a general annual deductible, most covered workers face additional types of cost-sharing (such as a copayment, coinsurance, or a per diem charge) when admitted to a hospital or undergoing outpatient surgery. The distribution of workers with cost-sharing for hospital admissions or outpatient surgery does not equal 100%, as workers may face a complex combination of types of cost-sharing. For this reason, the average copayment and coinsurance rates include workers who may have a combination of these cost-sharing methods. Coinsurance, in particular, may include minimums or maximums which affect the liability of enrollees. We report the distribution of cost-sharing for covered workers enrolled in a plan which covers hospital admissions and outpatient surgery, respectively. A small share of firms indicate that they have some “other” type of cost-sharing arrangement.

- In addition to any general annual deductible that may apply, 60% of covered workers have coinsurance and 11% have a copayment that apply to an inpatient hospital admission. A lower percentage of covered workers have per-day (per diem) payments (4%), a separate hospital deductible (3%), or both a copayment and coinsurance (10%). Seventeen percent of covered workers have no additional cost-sharing for hospital admissions after any general annual deductible has been met [Figure 7.27]. Covered workers with both a copay and coinsurance may be required to pay both, or to pay the greater or lesser amount.
  - Covered workers in HMOs are more likely than workers in other plan types to have a copayment for hospital admissions, while those in PPOs and HSA-qualified plans are less likely to have a copayment [Figure 7.28].
  - Covered workers in PPOs are more likely and those in HMOs and POS plans are less likely than those in other plan types to have a coinsurance requirement for hospital admissions [Figure 7.28].

- In 2026, the average coinsurance rate for a hospital admission is 20%, the average copayment is $317, and the average per diem charge is $337 [Figure 7.31]. Eighty percent of workers enrolled in a plan with a per diem for hospital admissions have a limit on the number of days for which the per diem charge applies [Figure 7.32].

- The cost-sharing provisions for outpatient surgery are similar to those for hospital admissions, as most workers have coinsurance or copayments. In 2026, 12% of covered workers have a copayment and 64% have a coinsurance requirement for outpatient surgery. In addition, 5% have both a copayment and a coinsurance requirement, while 19% have no additional cost-sharing after any general annual deductible has been met [Figure 7.29] and [Figure 7.30].

  - For covered workers with cost-sharing for outpatient surgery, the average coinsurance rate is 20% and the average copayment is $205 [Figure 7.31].

Figure 7.25

Distribution of Covered Workers' Cost Sharing for Hospital Admissions, by Plan Type, 2026

Plan Type	Separate Annual Deductible for Hospital Admissions	Copayment	Coinsurance	Both Copayment and Coinsurance	Charge Per Day	None After Any General Annual Deductible Is Met
HMO	8%	34%*	27%*	12%	11%*	24%
PPO	2	7*	69*	14	3	8*
POS	3	22*	40*	12	9*	24
HSA	<1*	5*	63	1*	<1*	31*
ALL PLANS	**3%**	**11%**	**60%**	**10%**	**4%**	**17%**

NOTE: Based on the cost-sharing in addition to any general annual plan deductible. The distribution may not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers have an 'Other' type of cost sharing. 'Both Copayment and Coinsurance' includes the requirements to pay the higher amount of a copayment or coinsurance under the plan. Less than one percent of covered workers are enrolled in a plan that does not cover hospital admissions. These workers are excluded from the distribution.

* Estimate is statistically different from All Plans estimate ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.26

Distribution of Covered Workers' Cost Sharing for Outpatient Surgery, by Plan Type, 2026

Plan Type	Separate Annual Deductible for Outpatient Surgery	Copayment	Coinsurance	Both Copayment and Coinsurance	None After Any General Annual Deductible Is Met
HMO	<1%	33%*	30%*	4%	33%
PPO	<1	7*	75*	8	9*
POS	2	36*	41*	6	18
HSA	<1*	3*	66	1*	30*
ALL PLANS	**<1%**	**12%**	**64%**	**5%**	**19%**

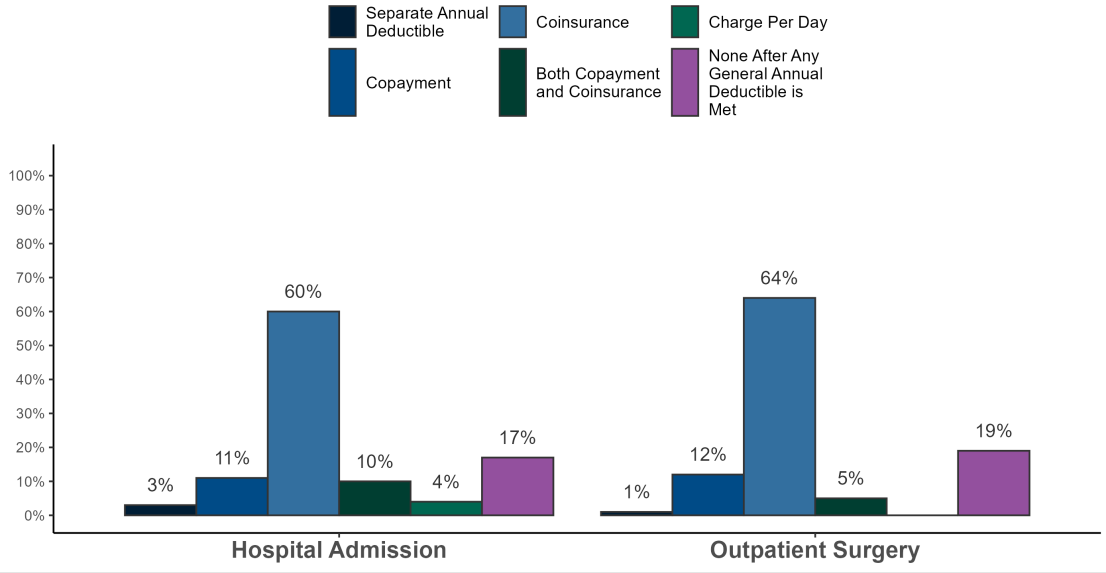
NOTE: Based on the cost-sharing in addition to any general annual plan deductible. The distribution may not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers have an 'Other' type of cost sharing. 'Both Copayment and Coinsurance' includes the requirements to pay the higher amount of a copayment or coinsurance under the plan. Less than one percent of covered workers are enrolled in a plan that does not cover outpatient surgery. These workers are excluded from the distribution.

* Estimate is statistically different from All Plans estimate ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.27

Percentage of Covered Workers with the Following Types of Cost Sharing for Hospital Admissions and Outpatient Surgery, in Addition to Any General Annual Deductible, 2026



NOTE: Based on the cost-sharing in addition to any general annual plan deductible. The distribution may not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers have an 'Other' type of cost sharing. 'Both Copayment and Coinsurance' includes the requirements to pay the higher amount of a copayment or coinsurance under the plan.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.28

Among Covered Workers With Separate Cost Sharing for Hospital Admissions or Outpatient Surgery, Average Cost Sharing, by Type, 2026

	Charge Per Day	Coinsurance	Copayment
Outpatient Surgery	N/A	20%	$205
Hospital Admission	$337	20%	$317

NOTE: Estimates represent cost sharing in addition to any general annual deductible. The average amounts include workers who may have a combination of types of cost sharing. Cost sharing amounts are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.29

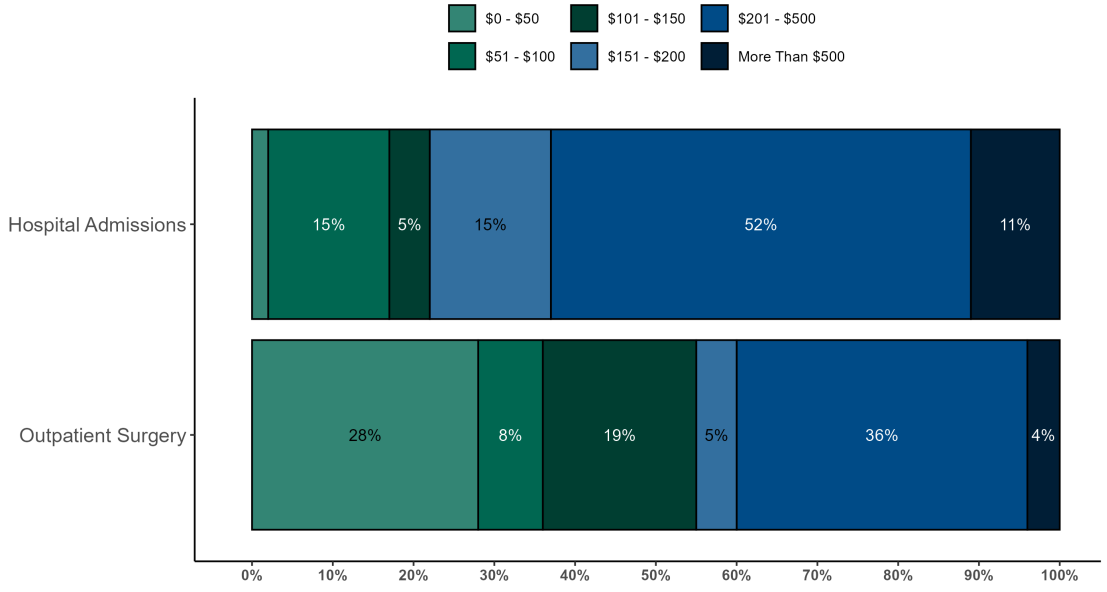
Among Covered Workers With a Charge Per Day for Hospital Admissions, Average Cost Sharing Features, 2026

	Among Covered Workers With a Charge Per Day for Hospital Admissions
Average Charge Per Day	$337
Percentage of Covered Workers With a Limit On the Number of Days a Worker Must Pay the Per-Day Amount	80%

NOTE: Estimates represent cost sharing in addition to any general annual deductible. Average amounts include workers who may have a combination of types of cost sharing. Amounts are for in-network services.

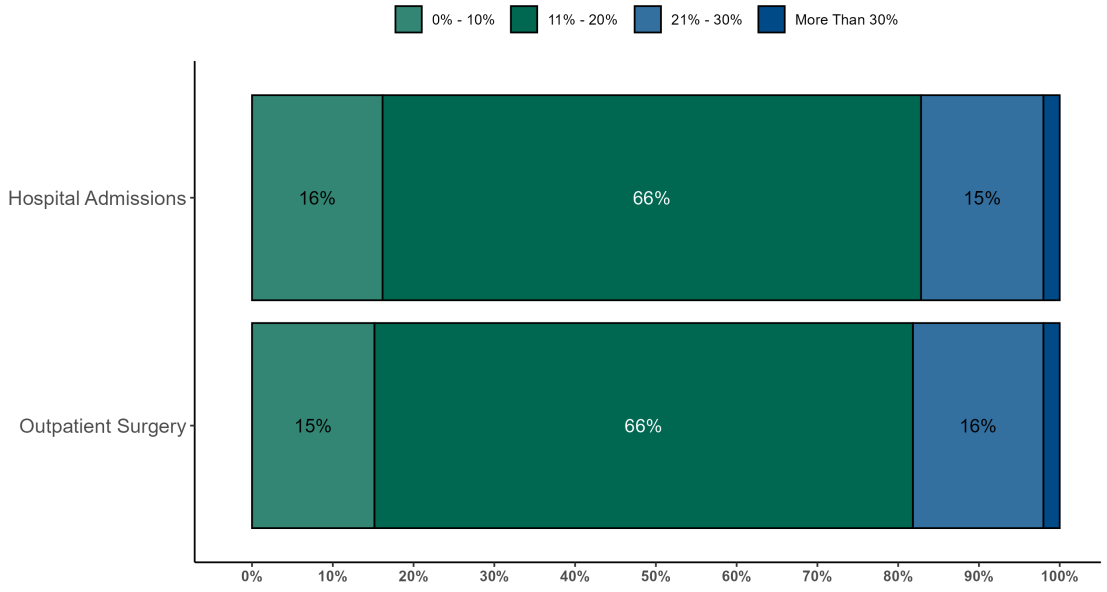
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.30
Among Covered Workers with a Copayment for Hospital Admissions or Outpatient Surgery, Distribution of Copayments, 2026



NOTE: Estimates represent cost sharing in addition to any general annual deductible. Distribution includes workers who may have a combination of types of cost sharing. Cost sharing amounts are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.31
Among Covered Workers with Coinsurance for Hospital Admissions or Outpatient Surgery, Distribution of Coinsurance Rates, 2026



NOTE: Estimates represent cost sharing in addition to any general annual deductible. Distribution includes workers who may have a combination of types of cost sharing. Cost sharing amounts are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2026

COST-SHARING FOR PHYSICIAN OFFICE VISITS

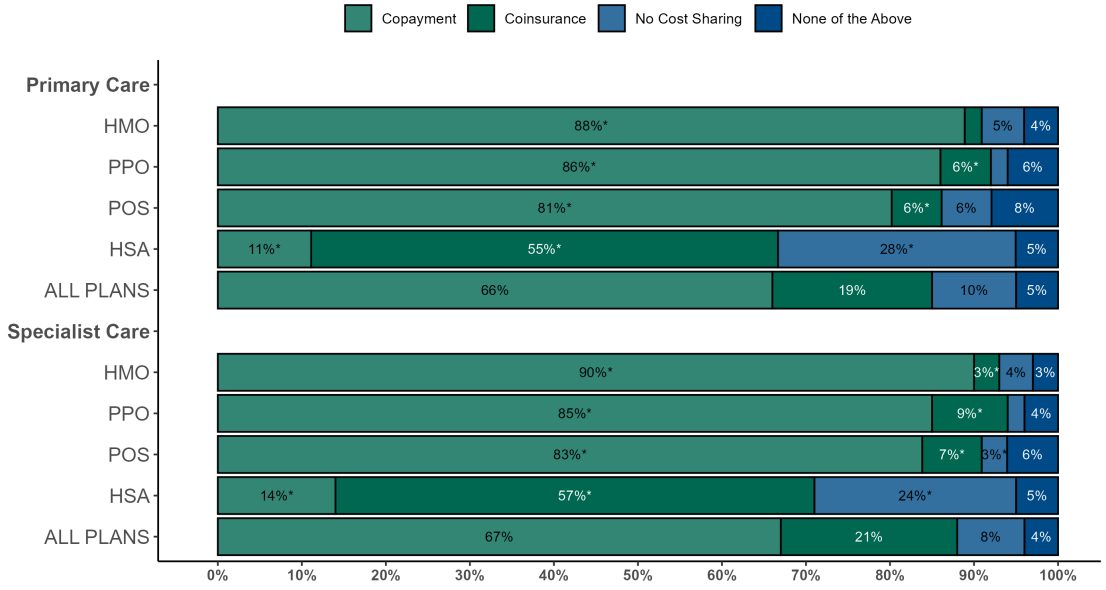
The majority of covered workers are enrolled in health plans that require cost-sharing for an in-network physician office visit, in addition to any general annual deductible.[2] The amounts shown below are for visits to in-network providers.

- The most common form of cost-sharing for a physician office visit is a copayment. Sixty-six percent of covered workers have a copayment for a primary care office visit and 19% have coinsurance. For specialist office visit, 67% of covered workers have a copayment and 21% have coinsurance [Figure 7.32].
  - Covered workers at firms with 10 to 199 workers are less likely to have coinsurance than workers at larger firms for a primary care office visit (8% vs. 22%) or an office visit with a specialist. (9% vs. 24%) [Figure 7.37].
  - Covered workers in HSA-qualified plans are less likely to have a copayment for a primary care office visit than workers in other plan types. For covered workers in HSA-qualified plans, 11% have a copayment for a primary care office visit, 55% have coinsurance, and 28% have no cost-sharing after the general annual deductible is met [Figure 7.35].
  - Covered workers in HSA-qualified plans also are less likely to have a copayment for office visits to specialists than workers in other plan types. For covered workers in HSA-qualified plans, 14% have a copayment for an office visit to a specialist, 57% have coinsurance, and 24% have no cost-sharing after the general annual plan deductible is met [Figure 7.35].
- Among covered workers with a copayment for physician office visits, the average copayments are $27 for a primary care office visit and $46 for a specialist. Both amounts are similar to last year. [Figure 7.36].
- Among covered workers with coinsurance for physician office visits, the average coinsurance rates are 20% for a primary care office visit and 21% for a specialist. Each of these is similar to the rates last year [Figure 7.36].

[2] Starting in 2010, the survey asked about the prevalence and cost of physician office visits separately for primary care and specialty care. Prior to the 2010 survey, if the respondent indicated the plan had a copayment for office visits, we assumed the plan had a copayment for both primary and specialty care visits. The survey did not allow for a respondent to report that a plan had a copayment for primary care visits and coinsurance for visits with a specialist physician. The changes made in 2010 allow for variations in the type of cost-sharing for primary care and specialty care visits. The survey includes cost-sharing for in-network services only.

Figure 7.32

Percentage of Covered Workers with the Following Types of Cost Sharing for Physician Office Visits, by Plan Type, 2026



* Estimate is statistically different from All Plans estimate ($p < .05$).
NOTE: Figure represents cost sharing in addition to any general annual deductible. The survey includes questions on cost sharing for in-network services only.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.33

Among Covered Workers With Copayments And/Or Coinsurance for Physician Office Visits, Average Copayments and Coinsurance, by Plan Type, 2026

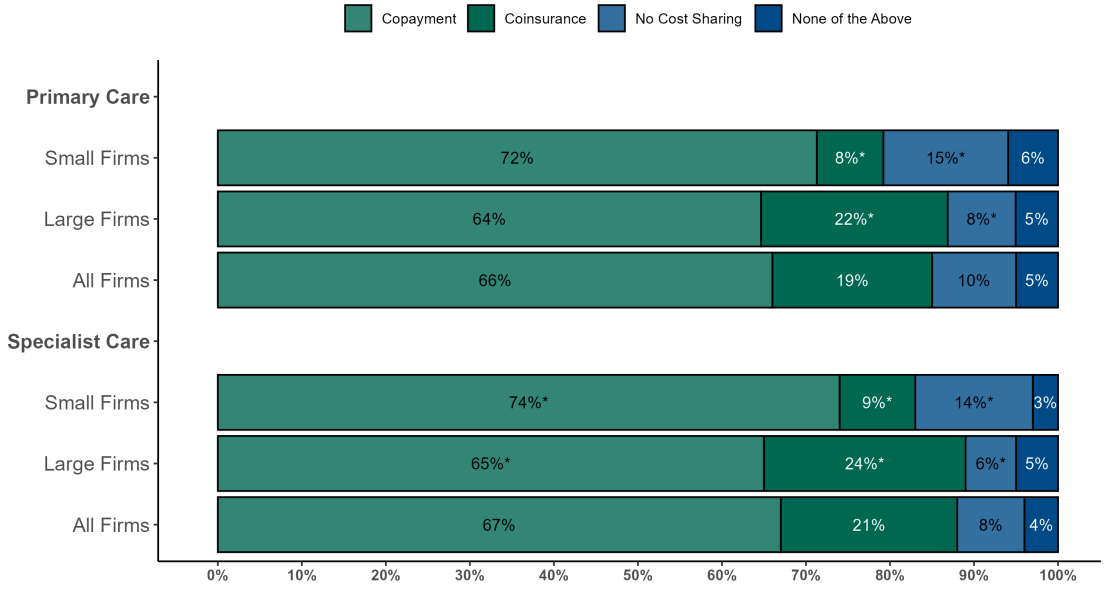
	HMO	PPO	POS	HSA	All Plans
Primary Care Office Visit					
Average Copayment ($)	$25	$28	$28	$30	**$27**
Average Coinsurance (%)	NSD	24%*	NSD	20%	**20%**
Specialty Care Office Visit					
Average Copayment ($)	$42	$47	$44	$49	**$46**
Average Coinsurance (%)	NSD	24%*	NSD	20%	**21%**

NOTE: Cost-sharing averages are for in-network visits.
NSD: Not Sufficient Data

* Estimate is statistically different from All Plans estimate ($p < .05$).

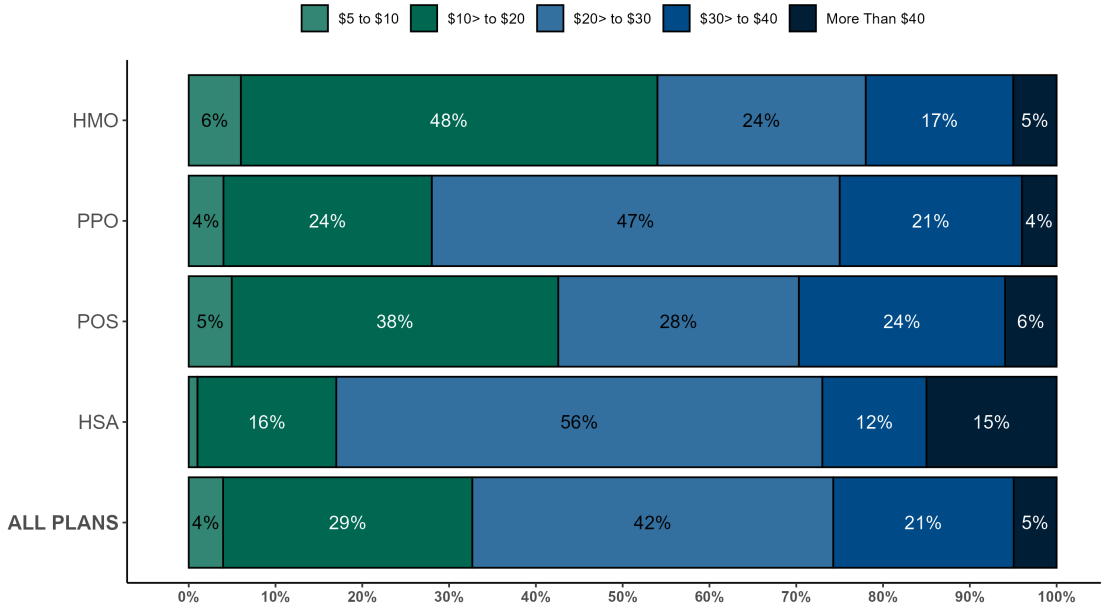
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.34
Percentage of Covered Workers with the Following Types of Cost Sharing for Physician Office Visits, by Firm Size, 2026



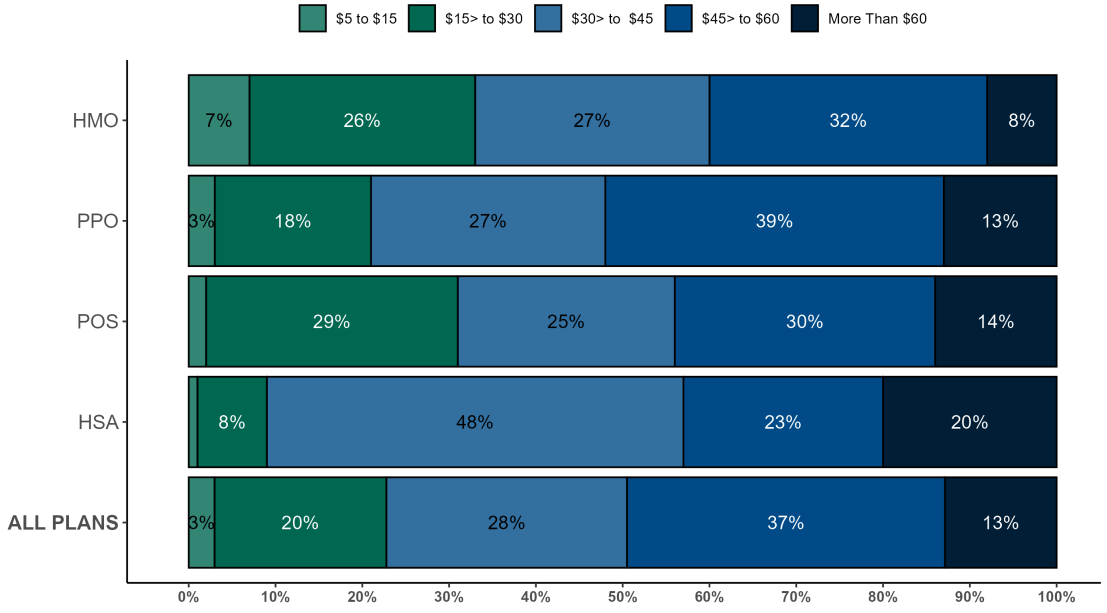
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Figure represents cost sharing in addition to any general annual deductible. The survey includes questions on cost sharing for in-network services only.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.35
Among Covered Workers with a Copayment for a Primary Care Physician Office Visit, Distribution of Copayments, by Plan Type, 2026



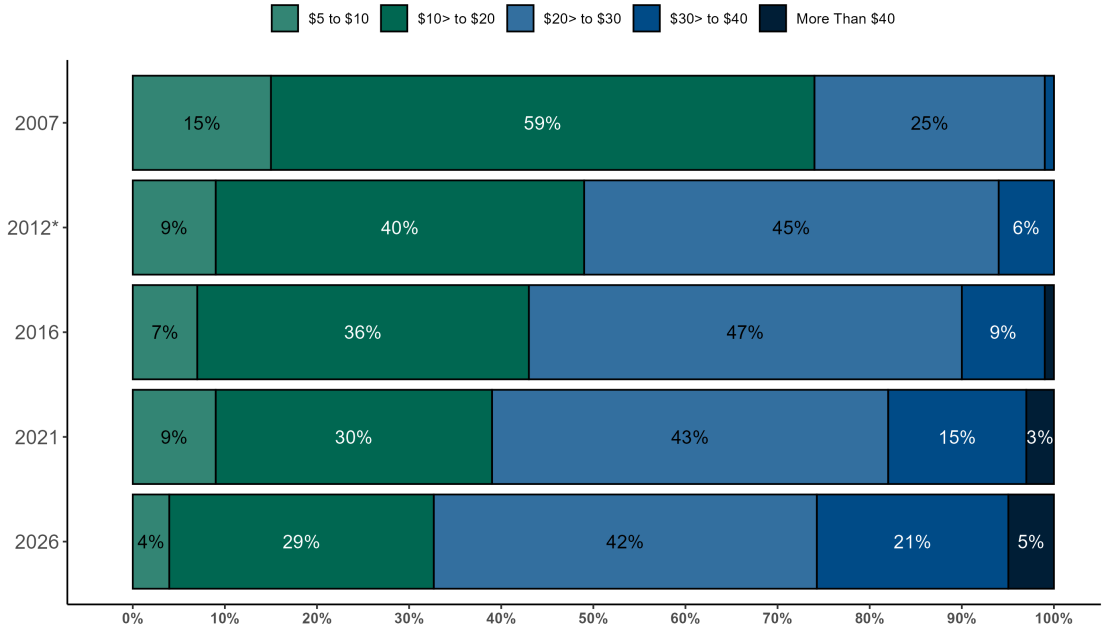
NOTE: Copayments are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.36
Among Covered Workers with a Copayment for a Specialist Physician Office Visit, Distribution of Copayments, by Plan Type, 2026



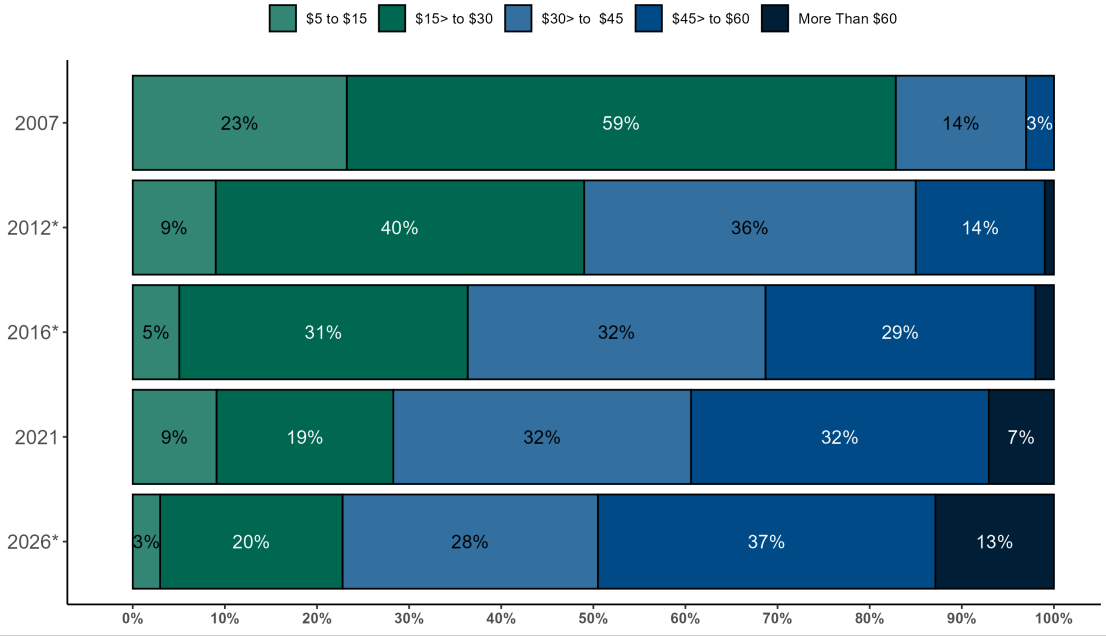
NOTE: Copayments are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 7.37
Among Covered Workers with a Copayment for a Primary Care Physician Office Visit, Distribution of Copayments, 2007-2026



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 7.38
Among Covered Workers with a Copayment for a Specialist Physician Office Visit, Distribution of Copayments, 2007-2026



* Distribution is statistically different from distribution for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 7.39

Among Covered Workers With a Copayment And/Or Coinsurance for Physician Office Visits, Average Copayment and Coinsurance, 2006-2026

	Primary Care		Specialist Care	
	Copayment	Coinsurance	Copayment	Coinsurance
2006	$18		$23	
2007	$19*	17%	$25*	
2008	$19	18%	$26	
2009	$20*	18%	$28*	
2010	$22*	18%	$31*	18%
2011	$22	18%	$32	18%
2012	$23	18%	$33	19%
2013	$23	18%	$35	19%
2014	$24	18%	$36	19%
2015	$24	18%	$37	19%
2016	$24	18%	$38	19%
2017	$25	19%	$38	19%
2018	$25	18%	$40	18%
2019	$25	18%	$40	19%
2020	$25	18%	$41	19%
2021	$25	18%	$42	20%
2022	$26	19%	$44	20%
2023	$26	19%	$44	20%
2024	$26	20%	$42	20%
2025	$27	19%	$45*	19%
2026	$27	20%	$46	21%

NOTE: Cost-sharing averages are for in-network visits.

* 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, 2006-2017

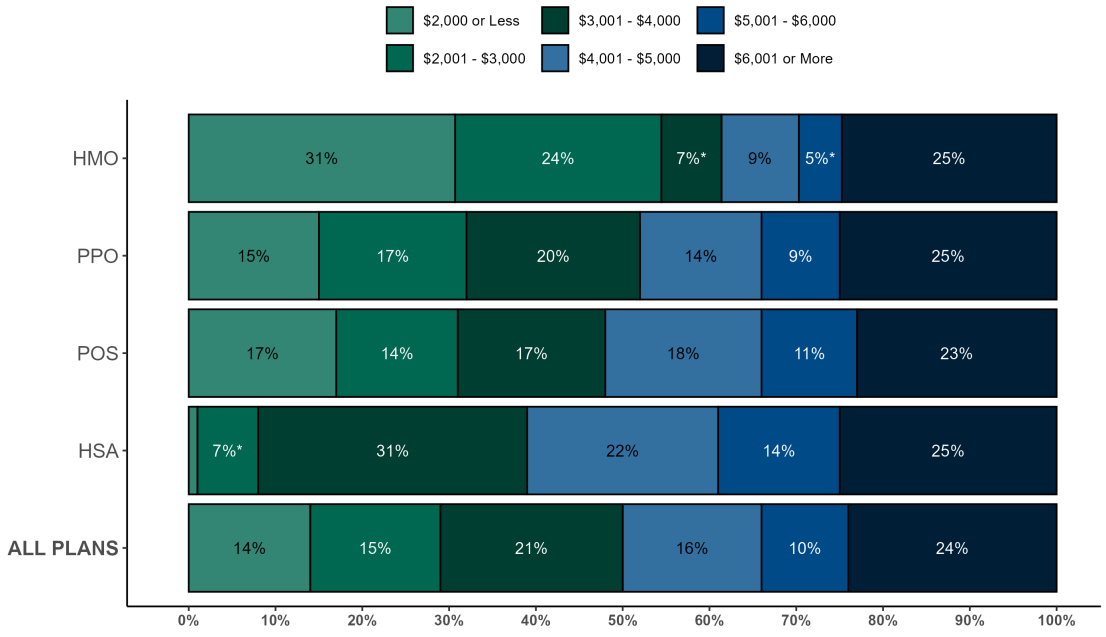
OUT-OF-POCKET MAXIMUMS

Virtually all covered workers are in a plan that either partially or fully limits the amount of cost-sharing that enrollees must pay in a year. This limit is generally referred to as an out-of-pocket maximum. The Affordable Care

Act (ACA) requires requires non-grandfathered health plans to have an annual out-of-pocket maximum of no more than $10,600 for single coverage and $21,200 for family coverage in 2026. HSA-qualified plans are subject to lower out-of-pocket limits.[3] Many plans have complex out-of-pocket cost-sharing structures, which makes it difficult to accurately collect information on this element of plan design.

- In 2026, more than 99% of covered workers are in a plan with an out-of-pocket maximum for single coverage [Figure 7.40].
- Among covered workers in plans with an out-of-pocket maximum for single coverage, 14% have a maximum of $2,000 or less, while 24% have a maximum above $6,000 [Figure 7.41].

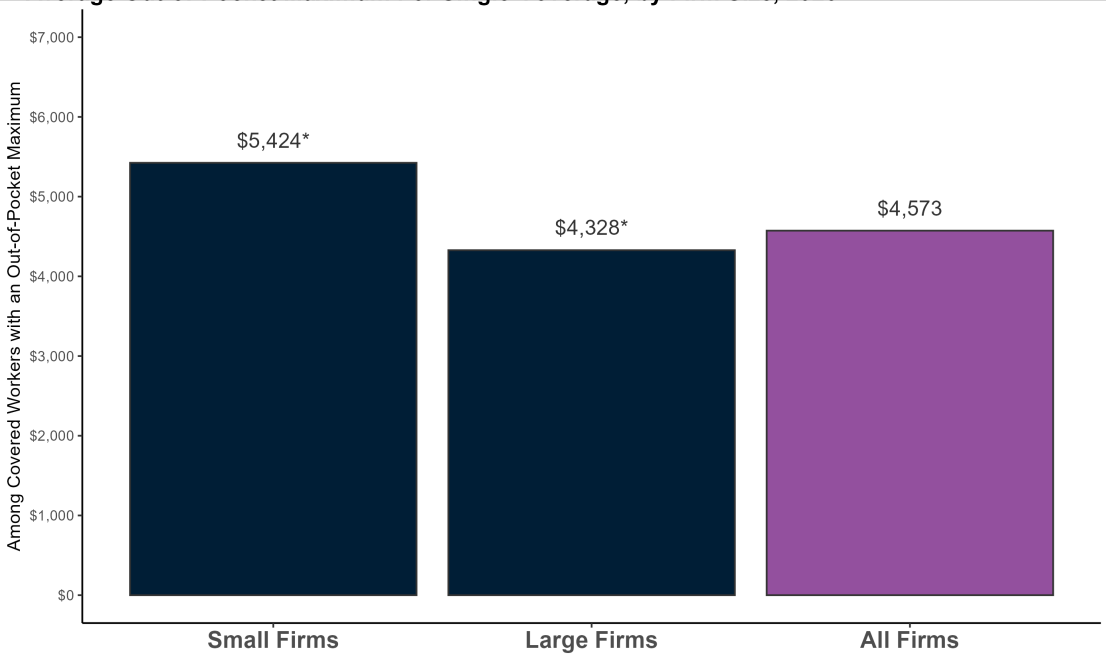
Figure 7.40
Among Covered Workers with an Out-of-Pocket Maximum for Single Coverage, Distribution of Out-of-Pocket Maximums, by Plan Type, 2026



* Estimate is statistically different from All Plans estimate within plan type (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2026

[3] For those enrolled in an HDHP/HSA, the out-of-pocket maximum may be no more than $8,500 for an individual plan and $17,000 for a family plan in 2026.

Figure 7.41
Average Out-of-Pocket Maximum For Single Coverage, by Firm Size, 2026



* Estimate is statistically different between All Small Firms and All Large Firms estimate (p < .05).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

SECTION 8

HSA–Qualified Plans



Section 8

Health Plans with Savings Accounts

Health plans can be paired with account options that workers can use to help pay for expenses not covered by the plan. The two most common account options are health savings accounts (HSAs) and health reimbursement arrangements (HRAs). HSAs and HRAs both allow workers to pay for health care expenses on a tax-preferred basis. Workers enrolled in an HSA-qualified plan can establish an HSA, into which employers and workers may make pre-tax contributions up to specified limits. Employer contributions to HSAs belong to workers once they are made, and workers may use their HSA funds to pay for health care expenses permitted by law.

In contrast, HRAs are employer-funded arrangements, and employers can determine how the funds may be used. For example, an employer could establish an HRA that workers could use only for a specific service, such as in-vitro fertilization, or it could establish an HRA that could be used for a broader range of services, or for plan cost-sharing. HRAs are nominal accounts, meaning that the employer promises to provide funds if an employee has eligible expenses, but the funds remain with the employer if the employee does not use them.

These savings arrangements are often (or, in the case of HSAs, always) paired with health plans with high deductibles. Since 2004, the survey has combined high deductible plans paired with HSAs or HRAs into a single plan type referred to as high deductible health plans with savings options ("HDHP/SOs"). Since that time, the prevalence of HSA-qualified plans has grown while that of high deductible plans paired with HRAs has waned. The different types and uses of HRAs has also made it more difficult to make generalizations about these plans. So, beginning this year, the survey will no longer track the HDHP/SOs as a plan type and instead focus on HSA-qualified plans as a plan type. The survey will continue to ask employers whether they offer HRAs and what the HRA funds may be used for, but will no longer ask about the amounts made available in these arrangements.

AVAILABILITY OF AND ENROLLMENT IN HSA-QUALIFIED PLANS

- Among firms with 10 or more workers offering health benefits, 39% offer an HSA-qualified plan to at least some of their workers, higher than the percentages last year (31%) and two years ago (28%).
- Firms with 200 or more workers are more likely than smaller firms to offer an HSA-qualified plan to at least some workers (54% vs. 38%) [Figure 4.6].
- As discussed in Section 5, 29% of covered workers are enrolled in an HSA-qualified plan in 2026, similar to the percentage last year (29%), but higher than the percentages five years ago (22%) and 10 years ago (19%) [Figure 5.1].

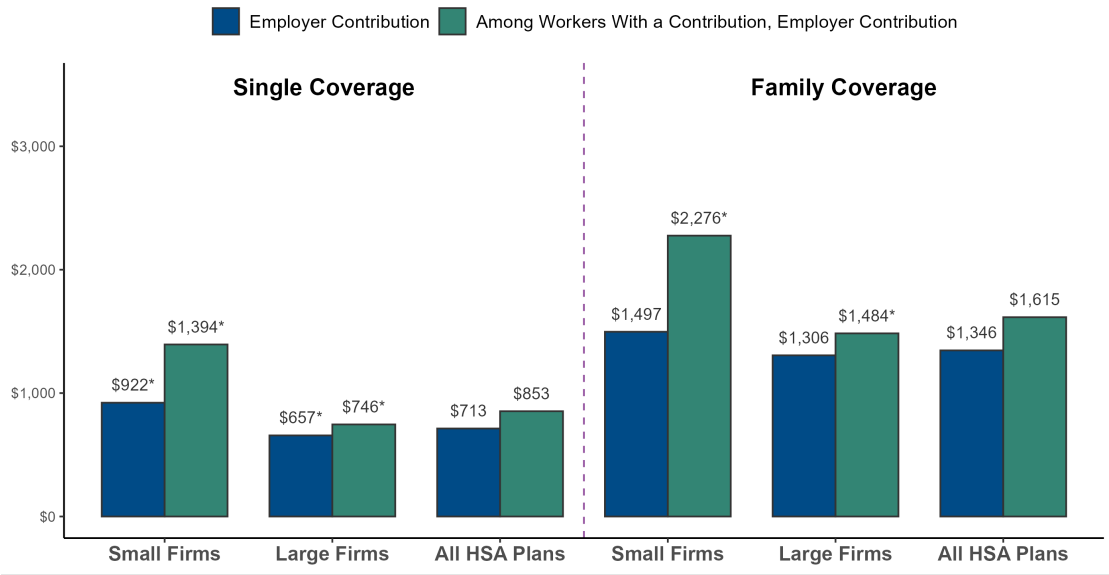
EMPLOYER CONTRIBUTIONS TO HSA ACCOUNTS

Employers may, but are not required to, make contributions to the HSAs of employees enrolled in HSA-qualified plans.

- Covered workers enrolled in HSA-qualified plans in 2026 receive an average annual employer HSA contribution of $713 for single coverage and $1,346 for family coverage [Figure 8.1].

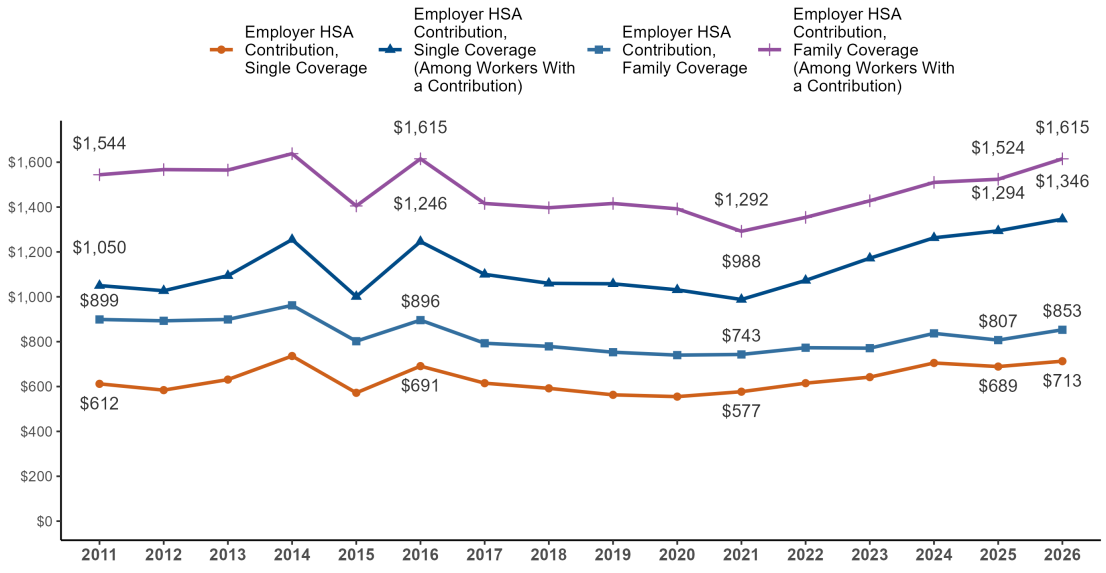
- In many cases, employers that sponsor HSA-qualified plans do not make any contributions to HSAs established by their employees. Thirty-nine percent of employers offering single coverage and 40% of employers offering family coverage through HSA-qualified plans do not make HSA contributions. Among covered workers enrolled in HSA-qualified plans, 16% with single coverage and 16% with family coverage do not receive an employer HSA contribution, similar to the percentages last year [Figure 8.1] and [Figure 8.2].
- The average HSA contributions number reported above include covered workers whose employer contribution is zero. Excluding workers with no employer contribution, the average employer HSA contribution is $853 for single coverage and $1,615 for family coverage.
- The amounts that employers contribute to HSAs can vary considerably. Twenty-seven percent of covered workers in an HSA-qualified plan receive an annual employer HSA contribution of less than $400 for single coverage, including 16% who receive no employer contribution [Figure 8.3]. In contrast, 16% receive an annual employer HSA contribution of $1,200 or more. Two percent of covered workers have an employer that matches worker HSA contributions for single coverage.

Figure 8.1
Average Annual Employer Contributions to HSA Accounts for Covered Workers Enrolled in HSA-Qualified Plans, 2026



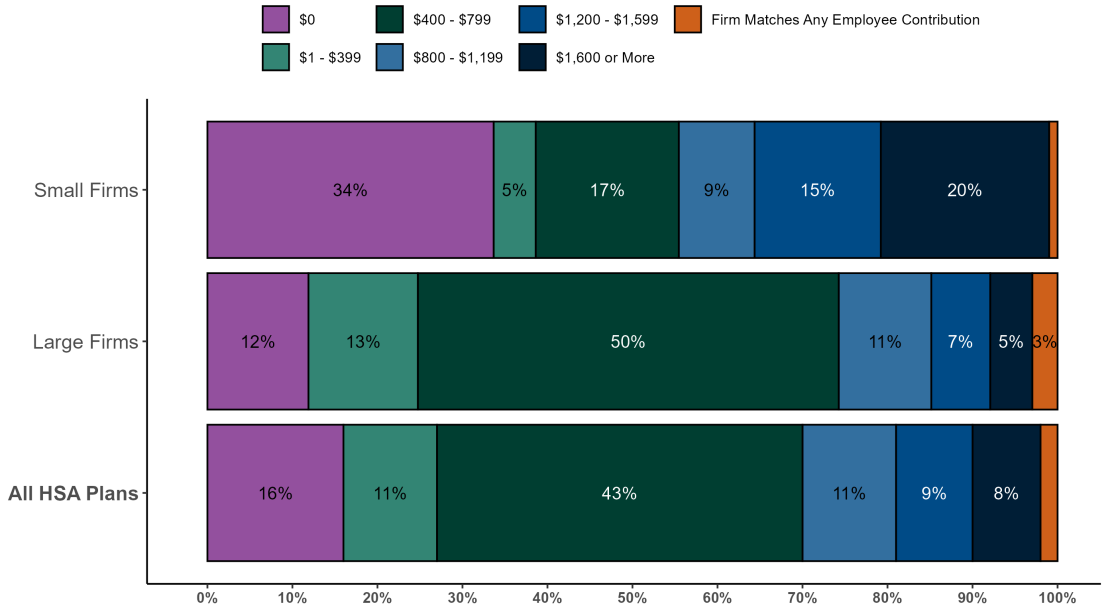
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. In 2026, 39% of workers in an HSA-qualified single coverage plan and 40% of workers in an HSA-qualified family coverage plan were enrolled in a plan without an employer contribution to the HSA account. Workers in plans where employers match HSA contributions are excluded from the average (two percent for single coverage and two percent for family coverage).
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 8.2
Average Annual Employer Contributions to HSA Accounts for Covered Workers Enrolled in HSA-Qualified Plans, 2011-2026



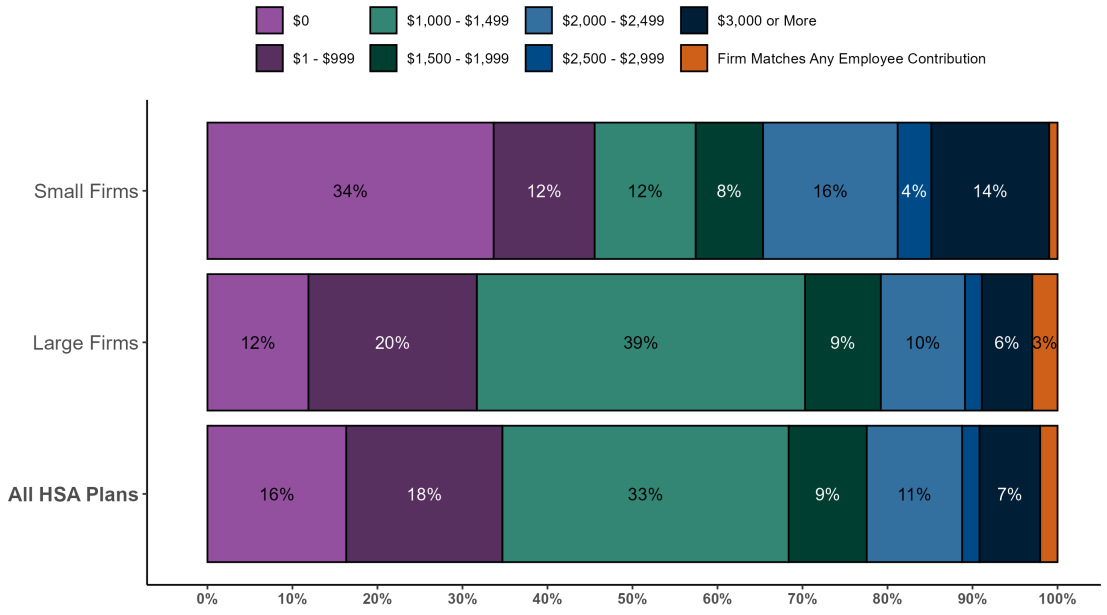
Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. In 2026, 39% of workers in HSA-Qualified single coverage plan and 40% of workers in an HSA-Qualified family coverage plan were enrolled in a plan without an employer contribution to the HSA account. Workers in plans where employers match HSA contributions are excluded from the average (two percent for single coverage and two percent for family coverage).
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 8.3
Distribution of Covered Workers with the Following Annual Employer Contributions to Their HSA Accounts, for Single Coverage, 2026



NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 8.4
Distribution of Covered Workers with the Following Annual Employer Contributions to Their HSA Accounts, for Family Coverage, 2026



NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

WORKER AND EMPLOYER CONTRIBUTIONS TO HSA-QUALIFIED PLAN PREMIUMS

- The average worker premium contribution for covered workers enrolled in HSA-qualified plans are $1,497 for single coverage and $6,211 for family coverage, similar to the amounts last year [Figure 8.6].
- The average worker premium contribution for covered workers enrolled in HSA-qualified plans is similar to the average for covered workers overall for single coverage ($1,497 and $1,672), but lower for family coverage ($6,211 vs. $7,471).

Employers contribute to HSA-qualified plans in two ways: through contributions toward the cost of the health plan premiums and through contributions, if any, to workers' HSAs.

- The average annual employer contributions toward premiums for covered workers in HSA-qualified plans are $7,492 for single coverage and $20,239 for family coverage. These amounts are similar to last year [Figure 8.7].
- For single coverage, the average employer contribution toward premiums for covered workers in HSA-qualified plans ($7,492) is lower than the average employer contribution for workers in plans that are not HSA-qualified ($8,392) [Figure 8.7].

Employer contributions toward premiums for HSA-qualified plans can be combined with employer contributions, if any, to workers' HSAs to calculate the total employer contribution for workers enrolled in these plans.

- The average total annual employer contribution for covered workers enrolled in HSA-qualified plans is $8,242 for single coverage and $21,742 for family coverage.

These amounts are similar to the average employer contributions for single and family coverage in plans that are not HSA-qualified [Figure 8.7].

Figure 8.5

Average Annual Premiums and Account Contributions for Covered Workers in HSA-Qualified Plans, Compared to Other Plan Types, 2026

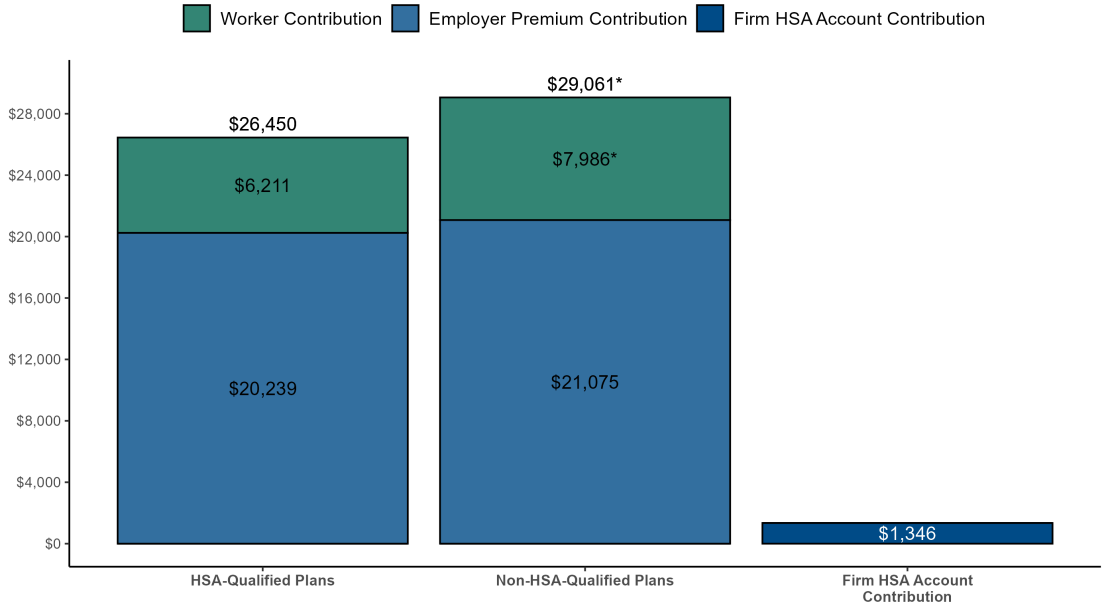
	Single Coverage		Family Coverage	
	HSA-Qualified Plans	Non-HSA-Qualified Plans	HSA-Qualified Plans	Non-HSA-Qualified Plans
Annual Premium	$8,989*	$10,135	$26,450*	$29,061
Worker Premium Contribution	$1,497	$1,744	$6,211*	$7,986
Firm Premium Contribution	$7,492*	$8,392	$20,239	$21,075
Annual Firm Contribution to HSA	$713	Not Applicable	$1,346	Not Applicable
Total Annual Firm Contribution (Firm Share of Premium and Firm HSA Contribution)	$8,242	$8,392	$21,742	$21,075
Total Annual Cost (Total Premium and Firm HSA Contribution)	**$9,729***	**$10,135**	**$27,874***	**$29,061**

NOTE: Values may not sum to totals. Averages are calculated at the firm level and then averaged, rather than by summing components.

* Estimate is statistically different from estimate from other plan types ($p < .05$).

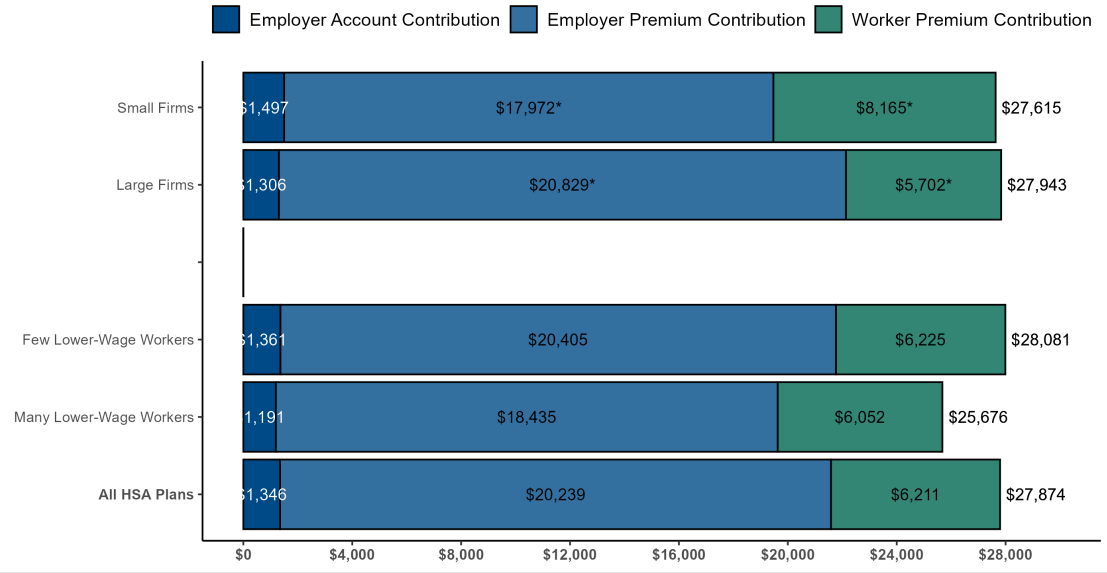
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 8.6
Average Annual Premiums and Contributions for Covered Workers in HSA-Qualified Plans and Other Plan Types, for Family Coverage, 2026



* Estimate is statistically different from estimate from other plan types ($p < .05$).
NOTE: Values may not sum to totals. Averages are calculated at the firm level and then averaged, rather than by summing components.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 8.7
Total Annual Costs (Premiums and Account Contributions) for Covered Workers in HSA-Qualified Plans, for Family Coverage, by Firm Characteristics, 2026



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. Values may not sum to totals. Averages are calculated at the firm level and then averaged, rather than by summing components. Firms with many lower-wage workers are those where at least 35% earn at or below the 25th percentile of national earnings ($38,000 in 2026).
SOURCE: KFF Employer Health Benefits Survey, 2026

COST-SHARING

For covered workers in HSA-qualified plans the the average deductibles for single coverage is $3,595 at small firms and $2,734 at large firms. Overall, the average deductible for single coverage is $2,912 [Figure 8.9].

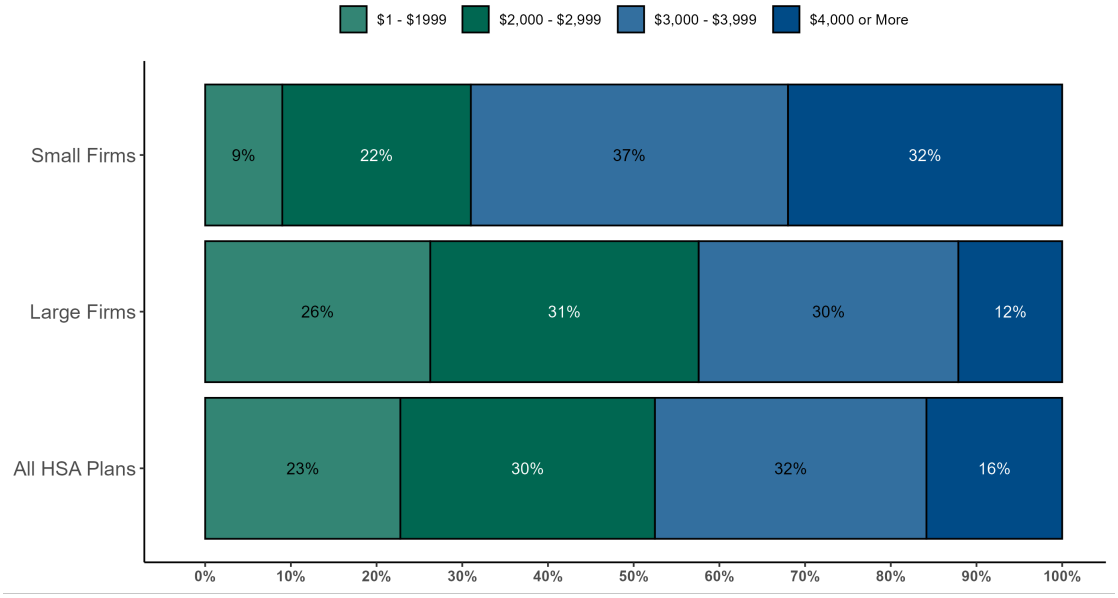
- Forty-eight percent of covered workers in HSA-qualified plans have a deductible of $3,000 or more for single coverage.

While HSA-qualified plans often have higher deductibles, they are often paired with employer account contributions, which can offset some costs. If employer HSA contributions are subtracted from general annual deductibles, the average deductible for single coverage is $2,222.

Among covered workers enrolled in family coverage, 72% of those in HSA-qualified plans have an aggregate general annual deductible. The average deductible for covered workers in HSA-qualified plans with an aggregate annual deductible for family coverage is $5,380 for HSA-qualified plans.

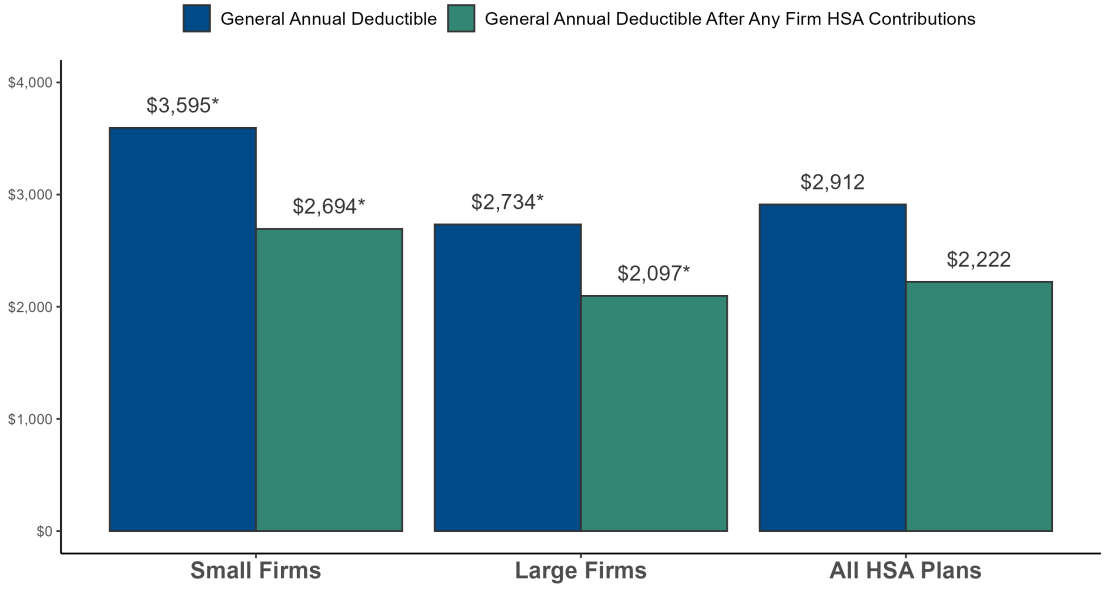
- Nineteen percent of covered workers in HSA-qualified plans with an aggregate annual deductible for family coverage have a deductible of $7,000 or more.

Figure 8.8
Distribution of Covered Workers in HSA-Qualified Plans with the Following General Annual Deductibles for Single Coverage, by Firm Size, 2026



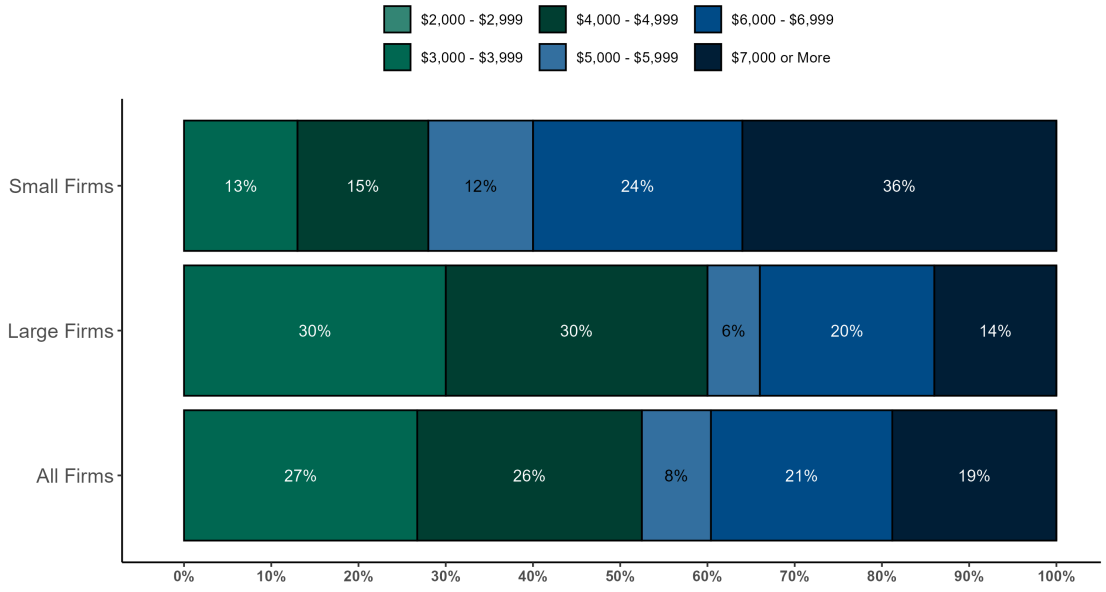
NOTE: For HSA-qualified plans, the legal minimum deductible for 2026 is $1,700 for single coverage and $3,400 for family coverage. Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 8.9
General Annual Deductible for Workers in HSA-Qualified Plans After Any Employer Account Contributions for Single Coverage, by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. The net liability for covered workers enrolled in an HSA-qualified plan is calculated by subtracting the employer's HSA contribution from the single coverage deductible.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 8.10
Distribution of Covered Workers in HSA-Qualified Plans with the Following Aggregate Family Deductibles, 2026



NOTE: For HSA-qualified plans, the legal minimum deductible for 2026 is $1,700 for single coverage and $3,400 for family coverage. Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 8.11

Distribution of Covered Workers in HSA-Qualified Plans and Other Plan Types With the Following Types of Cost Sharing in Addition to the General Annual Deductible, 2026

	HSA-Qualified Plans	PPO	HMO	POS
Separate Cost Sharing for Primary Care Physician Office Visits				
Copayment	11%	86%*	88%*	81%*
Coinsurance	55%	6%*	2%*	6%*
None	28%	2%*	5%*	6%*
Other	5%	6%	4%	8%
Separate Cost Sharing for Specialty Care Physician Office Visits				
Copayment	14%	85%*	90%*	83%*
Coinsurance	57%	9%*	3%*	7%*
None	24%	2%*	4%*	3%*
Other	5%	4%	3%	6%

* Estimates are statistically different between the plan type and HSA-Qualified Plans ($p < .05$).

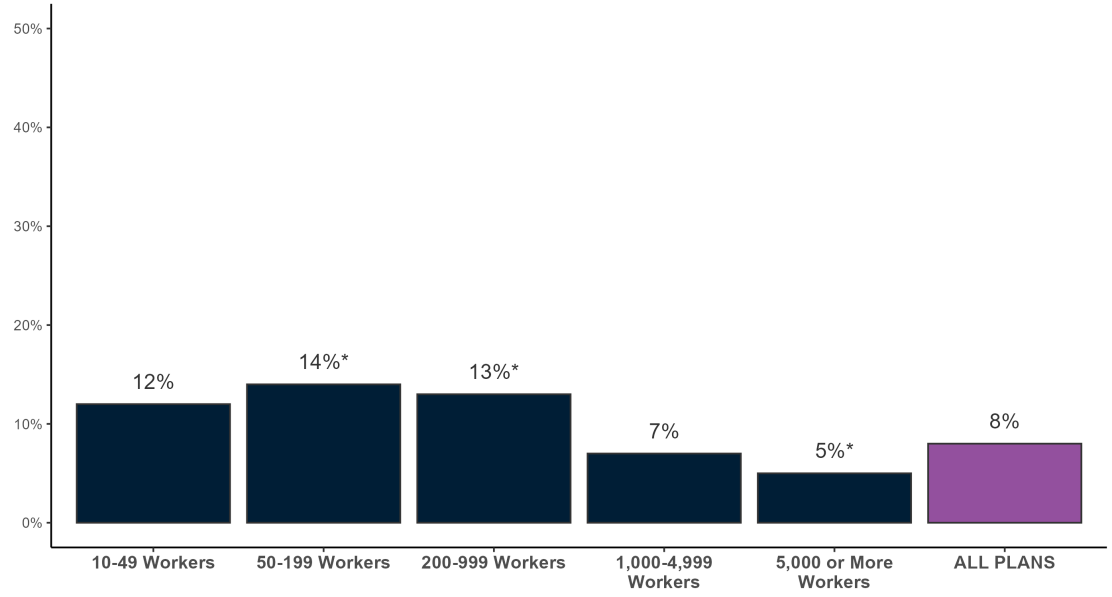
SOURCE: KFF Employer Health Benefits Survey, 2026

HEALTH REIMBURSEMENT ARRANGEMENTS

Some employers offering health benefits make funds available to covered workers through an HRA.

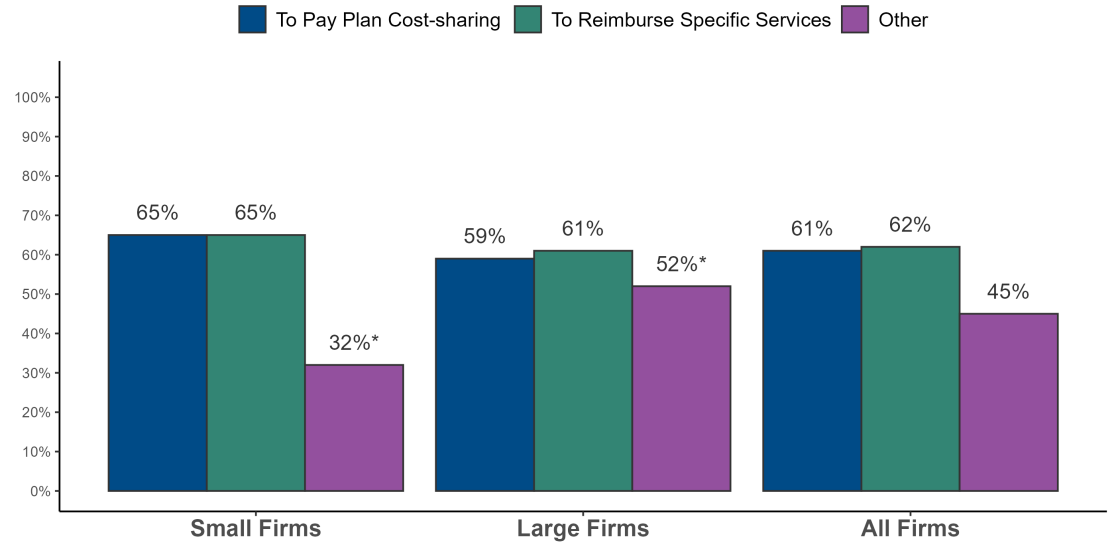
- In 2026, 8% of covered workers are in a plan that is offered along with a health reimbursement arrangement [Figure 8.12].
- Among covered workers in a plan offered with an HRA, 61% are in a plan where HRA funds can be used to offset workers' cost-sharing expenses [Figure 9.13].

Figure 8.12
Among Firms Offering Health Benefits, Percentage of Covered Workers Enrolled in a Plan That is Paired with an HRA, by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: A health reimbursement arrangement HRA is funded only by the employer and is a way in which an employer can make pre-tax money available for some types of medical care.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 8.13
Among Covered Workers in a Plan Paired with an HRA, Function of the HSA, by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: In 2026, 8% of covered workers are enrolled in a plan paired with a health reimbursement arrangement (HRA). Specific services include benefits beyond those covered by the plan (for example, prescription drugs, mental health visits, dental care, or fertility care). An HRA is funded solely by the employer and reimburses workers for eligible medical expenses on a tax-free basis. Small Firms have 10-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Health Reimbursement Arrangements (HRAs) are employer-funded arrangements that reimburse employees for eligible health care expenses. Employers may make a specified amount of money available through an HRA for premiums and medical expenses incurred by employees or their dependents. HRAs are accounting devices, and employers are not required to expend funds until an employee incurs an expense that is eligible for reimbursement. Unspent HRA funds can usually be carried over to the next year, sometimes subject to a limit. Employees generally cannot take their HRA balances with them if they leave their job, although an employer can choose to make the remaining balance available to former employees to pay for health care. HRAs are often offered along with health plans with high deductibles. In such cases, employees may use HRA funds to pay eligible health care expenses and then pay out of pocket until the health plan deductible is met. Certain preventive services or other services, such as prescription drugs, may be covered by the plan before the employee meets the deductible.

Health Savings Accounts (HSAs) are savings accounts established by individuals to pay for health care expenses. An individual may establish an HSA if they are covered by an HSA-qualified plan that meets federal requirements, including a minimum deductible of $1,650 for single coverage and $3,300 for family coverage in 2026, compared with $1,600 and $3,200, respectively, in 2025. Employers can facilitate employees' access to HSAs by offering an HSA-qualified plan and may also assist employees by identifying HSA options, facilitating applications, or negotiating favorable fees from HSA vendors.

Both employers and employees can contribute to an HSA, up to the statutory contribution limit of $4,400 for single coverage and $8,650 for family coverage in 2026. Employee contributions to an HSA may be made on a pre-tax basis, and some employers arrange for employees to fund their HSAs through payroll deductions. Employers are not required to contribute to HSAs established by their employees, but employer contributions are not taxable to the employee. Interest and other earnings on amounts in an HSA are not taxable, and withdrawals used to pay for qualified medical expenses are not taxed. The account is owned by the individual, so employees retain their HSA balances if they leave their job.

SECTION 9

Prescription Drug Benefits

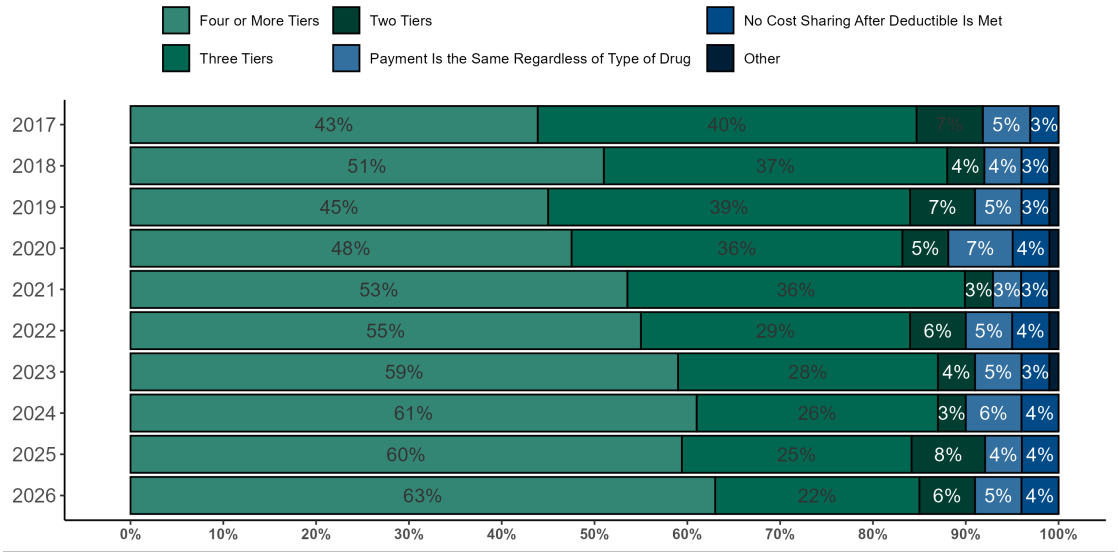


Section 9

Prescription Drug Benefits

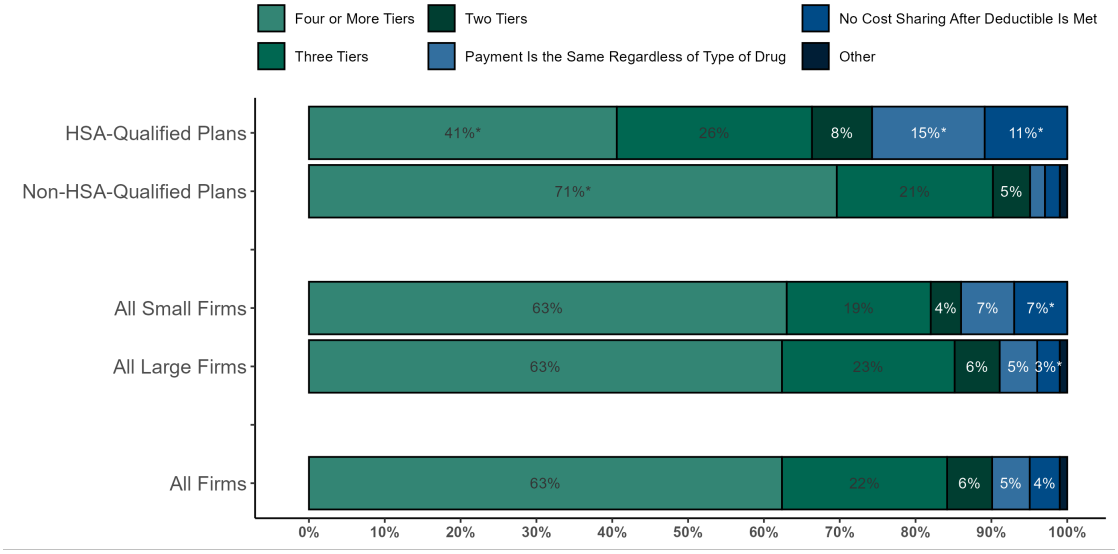
Nearly all (98%) covered workers are in a firm that provides prescription drug coverage to enrollees in its largest health plan. Over time, employer plans have incorporated more complex prescription drug benefit designs as employers and insurers have expanded the use of formularies with multiple cost-sharing tiers and other management approaches. To reduce the burden on respondents, we ask firms offering health benefits about the attributes of prescription drug coverage only for their largest health plan. We collect information on cost-sharing in up to four tiers, and, if applicable, a separate tier exclusively for specialty drugs. Some plans may have more than one tier for specialty drugs, or other variations in their formularies that are not captured by the survey.

Figure 9.1
Distribution of Covered Workers Facing Different Cost-Sharing Formulas for Prescription Drug Benefits, 2017-2026



Tests found no statistical difference from distribution for the previous year shown ($p < .05$).
NOTE: The number of tiers includes any tiers specifically for specialty drugs. Excluding tiers specifically for specialty drugs, 24% of covered workers with prescription drug coverage are enrolled in a plan with four or more tiers, 58% have three tiers, 6% have two tiers, 6% have the same cost sharing regardless of the drug, and 6% have no cost sharing after the deductible is met. For more information on the definition of specialty drugs and how this survey defines drug formulary tiers, see Section 9.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

Figure 9.2
Distribution of Covered Workers Facing Different Cost-Sharing Formulas for Prescription Drug Benefits, by Plan Type and Firm Size, 2026



* Distribution is statistically different between HSA-QualifiedPlan and Non-HSA-Qualified distributions or between Large and Small Firms ($p < .05$).
NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. Number of tiers include any tiers specifically for specialty drugs. Excluding tiers specifically for specialty drugs, 24% of covered workers with prescription drug coverage are enrolled in a plan with four or more tiers, 58% have three tiers, 6% have two tiers, 6% have the same cost sharing regardless of the drug, and 6% have no cost sharing after the deductible is met. For more information on the definition of specialty drugs and how this survey defines drug formulary tiers, see Section 9.
SOURCE: KFF Employer Health Benefits Survey, 2026

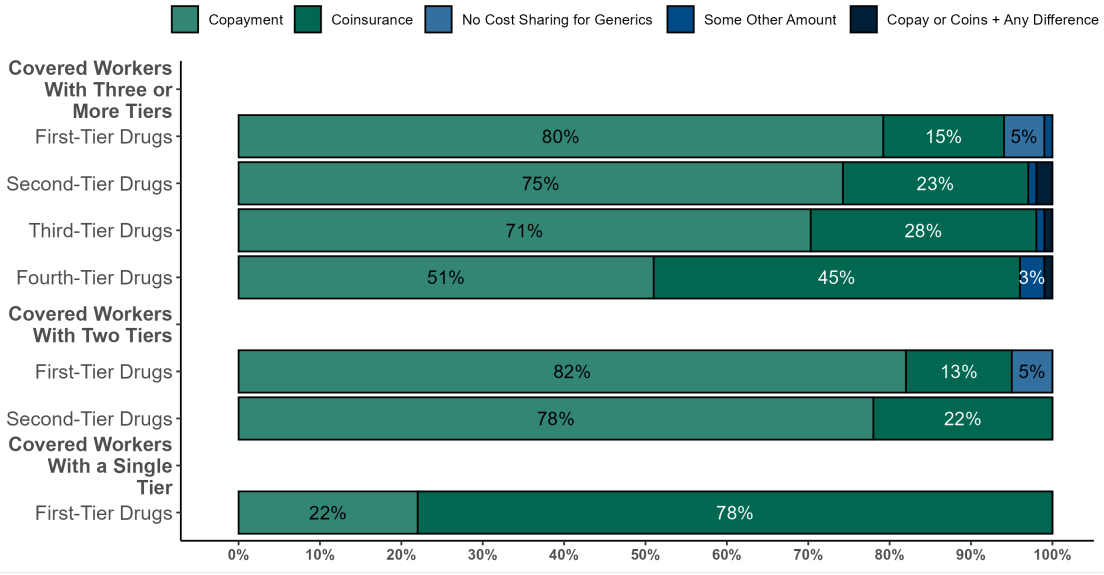
TIERS NOT EXCLUSIVELY FOR SPECIALTY DRUGS

Excluding formulary tiers that cover only specialty drugs, a large share (82%) of covered workers are in a plan with three or more tiers of cost sharing for prescription drugs. The cost-sharing statistics presented in this section do not include tiers that cover only specialty drugs. When specialty drugs are covered on a tier with other drugs, those drugs are included in these averages. Cost-sharing statistics for tiers covering only specialty drugs are presented separately below.

- For covered workers in a plan with three or more tiers of cost-sharing for prescription drugs, copayments are the most common form of cost-sharing in the first three tiers, and coinsurance is the second-most common [Figure 9.3].
  - Among covered workers in plans with three or more tiers of cost-sharing for prescription drugs, the average copayment is $12 for first-tier drugs, $36 for second-tier drugs, $66 for third-tier drugs, and $136 for fourth-tier drugs [Figure 9.6].
  - Among covered workers in plans with three or more tiers of cost-sharing for prescription drugs, the average coinsurance rate is 21% for first-tier drugs, 26% for second-tier drugs, 35% for third-tier drugs, and 30% for fourth-tier drugs [Figure 9.6].
- Six percent of covered workers are in a plan with two tiers of prescription drug cost-sharing, excluding tiers that cover only specialty drugs.
  - For these workers, copayments are more common than coinsurance in both tiers [Figure 9.3]. The average copayment is $13 for the first tier and $37 for the second tier. The average coinsurance rate is 19% for the first tier and 27% for the second tier [Figure 9.6].

- Six percent of covered workers are in a plan with the same cost-sharing for all prescription drugs, excluding tiers that cover only specialty drugs [Figure 9.2].
  - Among these workers, 22% have copayments and 78% have coinsurance [Figure 9.3].

Figure 9.3
Among Covered Workers with Prescription Drug Coverage, Distribution with the Following Types of Cost Sharing for Prescription Drugs, 2026



NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs. 'Copayment or Coinsurance Plus Any Difference' category includes workers who pay a copayment or coinsurance plus the difference between the cost of the prescription and the cost of a comparable generic drug. Coins is an abbreviation of coinsurance.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 9.4

Among Covered Workers With Three or More Tiers of Prescription Drug Cost Sharing, Distribution With the Following Types of Cost Sharing, by Firm Size, 2026

	Copayment	Coinsurance	No Cost Sharing for Generics	Some Other Amount
First-Tier Drugs, Often Called Generics				
All Small Firms (10-199 Workers)	92%*	3%*	5%	<1%
All Large Firms (200 or More Workers)	76*	19*	5	<1
ALL FIRMS	**80%**	**15%**	**5%**	**<1%**
Second-Tier Drugs, Often Called Preferred Drugs			**Copayment or Coinsurance Plus Any Difference**	
All Small Firms (10-199 Workers)	93%*	6%*	1%	<1%
All Large Firms (200 or More Workers)	71*	27*	2	<1
ALL FIRMS	**75%**	**23%**	**2%**	**<1%**
Third-Tier Drugs, Often Called Non-Preferred Drugs				
All Small Firms (10-199 Workers)	89%*	10%*	1%	<1%
All Large Firms (200 or More Workers)	66*	33*	1	<1
ALL FIRMS	**71%**	**28%**	**1%**	**<1%**
Fourth-Tier Drugs				
All Small Firms (10-199 Workers)	74%*	23%*	2%	1%
All Large Firms (200 or More Workers)	41*	54*	1	3
ALL FIRMS	**51%**	**45%**	**1%**	**3%**

NOTE: Small Firms have 10-199 workers and Large Firms have 200 or more workers. Number of tiers refers to the number of tiers excluding those specifically for specialty drugs. 'Copayment or Coinsurance Plus Any Difference' category includes workers who pay a copayment or coinsurance plus the difference between the cost of the prescription and the cost of a comparable generic drug.

* Estimates are statistically different between Small Firm and Large Firm estimates within category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 9.5

Among Covered Workers With Three or More Tiers of Prescription Drug Cost Sharing, Distribution With the Following Types of Cost Sharing, by Plan Type, 2026

	Copayment	Coinsurance	No Cost Sharing for Generics	Some Other Amount
First-Tier Drugs, Often Called Generics				
HSA-Qualified Plans	61%*	35%*	4%	<1%
Non-HSA-Qualified Plans	85%*	10%*	5%	<1%
ALL PLANS	**80%**	**15%**	**5%**	**<1%**
Second-Tier Drugs, Often Called Preferred Drugs			**Copayment or Coinsurance Plus Any Difference**	
HSA-Qualified Plans	47%*	52%*	<1%	<1%
Non-HSA-Qualified Plans	83%*	15%*	2%	<1%
ALL PLANS	**75%**	**23%**	**2%**	**<1%**
Third-Tier Drugs, Often Called Non-Preferred Drugs				
HSA-Qualified Plans	49%*	51%*	<1%	<1%
Non-HSA-Qualified Plans	77%*	21%*	1%	<1%
ALL PLANS	**71%**	**28%**	**1%**	**<1%**
Fourth-Tier Drugs				
HSA-Qualified Plans	33%*	65%*	0%*	3%
Non-HSA-Qualified Plans	55%*	40%*	2%*	3%
ALL PLANS	**51%**	**45%**	**1%**	**3%**

NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs. 'Copayment or Coinsurance Plus Any Difference' category includes workers who pay a copayment or coinsurance plus the difference between the cost of the prescription and the cost of a comparable generic drug.

* Estimates are statistically different between plan type estimates within category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 9.6

Among Covered Workers With Prescription Drug Coverage, Average Copayments and Coinsurance, 2026

	Average Copayment	Average Coinsurance
Plans With Three or More Tiers		
First Tier	$12	21%
Second Tier	$36	26%
Third Tier	$66	35%
Fourth Tier	$136	30%
Plans With Two Tiers		
First Tier	$13	NSD
Second Tier	$37	NSD
Plans With the Same Cost Sharing For All Covered Drugs		
First Tier	$12	21%

NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs.
NSD: Not Sufficient Data

SOURCE: KFF Employer Health Benefits Survey, 2026

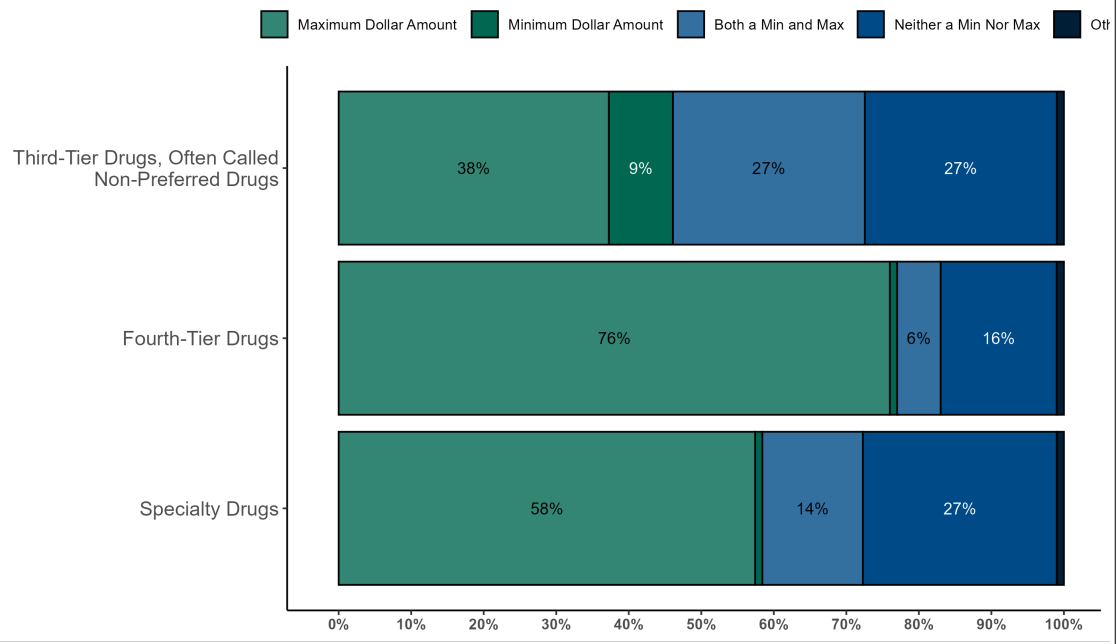
COINSURANCE MAXIMUMS

Coinsurance rates for prescription drugs often include maximum and/or minimum dollar amounts. Depending on the plan design, coinsurance maximums can significantly limit the amount an enrollee must spend out-of-pocket for higher-cost drugs. Even in plans without explicit coinsurance maximum amounts, the overall plan out-of-pocket maximum limits enrollee cost-sharing on covered services, including prescription drugs.

Coinsurance minimum and maximum amounts vary across tiers and plan designs.

- For example, among covered workers in a plan with coinsurance for the third cost-sharing tier, 38% have only a maximum dollar amount attached to the coinsurance rate, 9% have only a minimum dollar amount, 27% have both a minimum and maximum dollar amount, and 27% have neither.
- For those in a plan with coinsurance for the fourth cost-sharing tier, 76% have only a maximum dollar amount attached to the coinsurance rate, <1% have only a minimum dollar amount, 6% have both a minimum and maximum dollar amount, and 16% have neither [Figure 9.7].

Figure 9.7
Distribution of Coinsurance Structures for Covered Workers Facing Coinsurance for Prescription Drugs, 2026



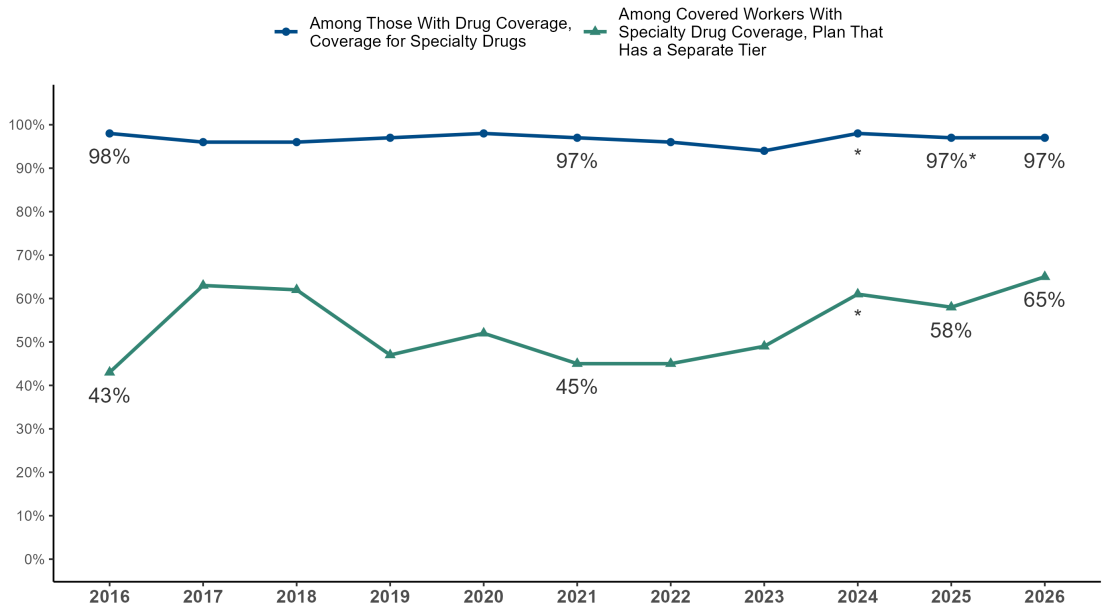
SOURCE: KFF Employer Health Benefits Survey, 2026

SEPARATE TIERS FOR SPECIALTY DRUGS

Specialty drugs are generally high-cost medications used to treat complex or chronic conditions, such as cancer, rheumatoid arthritis, or multiple sclerosis. They may be biologics or other drugs and often require special handling, administration, or monitoring. Given the high cost of these drugs, we ask separately about formulary tiers that cover only specialty drugs.

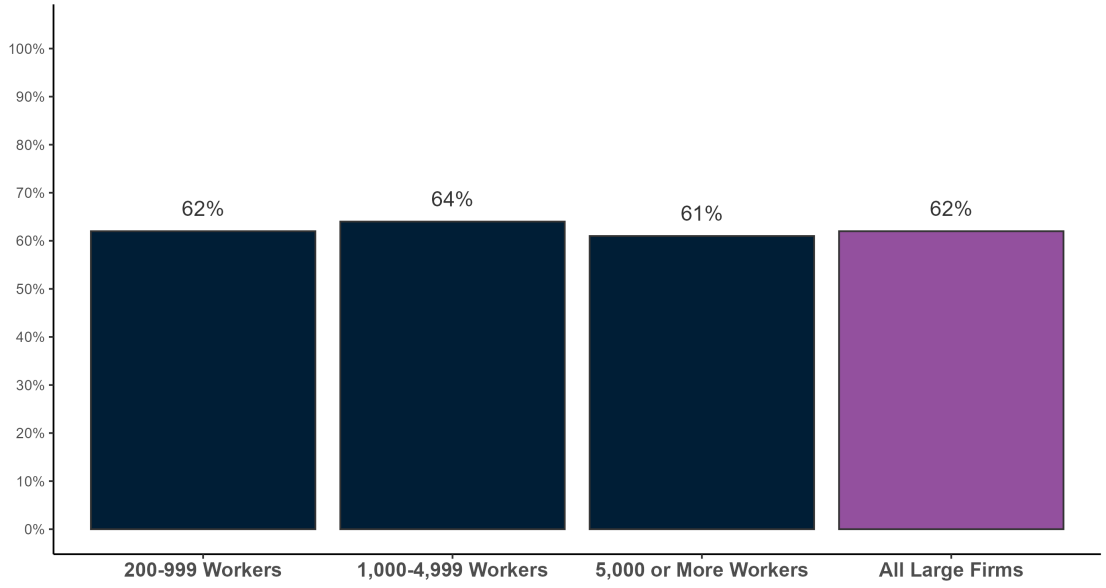
- In 2026, 89% of covered workers at firms with 10 or more workers are in a plan with coverage for specialty drugs, similar to the percentage as last year.
  - Covered workers in larger firms (firms with 200 or more workers) are more likely than workers in smaller firms to be in a plan with coverage for specialty drugs (93% vs. 76%).
  - Covered workers in smaller firms are more likely than workers in larger firms to work for a firm that did not know whether its largest plan covers specialty drugs (17% vs. 3%).
- Among covered workers in larger firms in a plan with coverage for specialty drugs, 62% are in a plan with at least one cost-sharing tier exclusively for specialty drugs [Figure 9.8].
  - Among covered workers in larger firms whose plan has at least one separate tier for specialty drugs, 41% have a copayment for specialty drugs and 54% have coinsurance [Figure 9.10]. The average copayment is $110 and the average coinsurance rate is 27% [Figure 9.11]. Seventy percent of those with coinsurance have a maximum dollar limit on the amount of coinsurance they must pay.

Figure 9.8
Among Large Firms with Prescription Drug Coverage, Percentage of Workers With Coverage for Specialty Drugs, 2016-2026



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Large Firms have 200 or more workers. Ninety-nine percent of firms offering health benefits offer prescription drug coverage.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016-2017

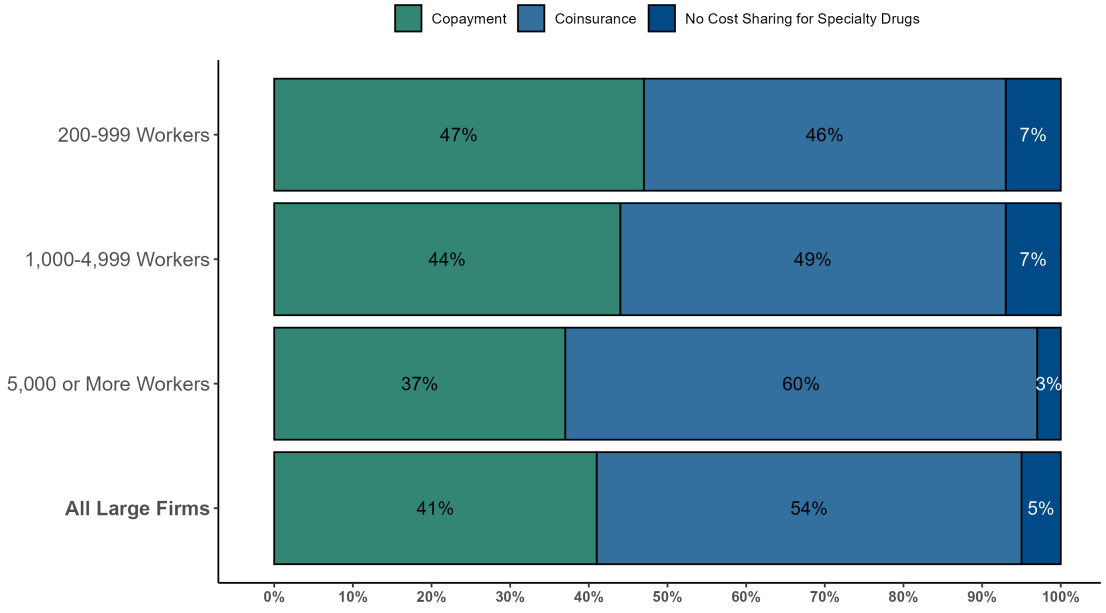
Figure 9.9
Among Large Firms Whose Prescription Drug Coverage Includes Specialty Drugs, Percentage of Covered Workers Enrolled in a Plan That Has a Separate Tier for Specialty Drugs, by Firm Size, 2026



Tests found no statistical difference from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 9.10

Among Covered Workers at Large Firms Enrolled in a Plan with a Separate Tier for Specialty Drugs, Distribution of the Following Types of Cost Sharing, by Firm Size, 2026



Tests found no statistical difference from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 9.11

Among Covered Workers at Large Firms Enrolled in a Plan With a Separate Tier for Specialty Drugs, Average Copayments and Coinsurance, by Firm Size, 2017 and 2026

	2017		2026	
	Average Copayment ($)	Average Coinsurance (%)	Average Copayment ($)	Average Coinsurance (%)
FIRM SIZE				
200-999 Workers	$90	24%	$115	27%
1,000-4,999 Workers	89	27	119	25
5,000 or More Workers	111*	28	104	28
All Large Firms (200 or More Workers)	**$101**	**27%**	**$110**	**27%**

* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

PRESCRIPTION DRUG POLICY

Firms with 50 or more workers offering prescription drug coverage were asked about several strategies to reduce prescription drug costs.

- Thirty-three percent of these firms offer enrollees access to lower-cost mail-order generic drugs through a third-party vendor, such as Mark Cuban Cost Plus, SingleCare, or GoodRx. Firms with 50 to 199 workers

are less likely than larger firms to offer access to lower-cost mail-order generic drugs through a third-party vendor (31% vs. 40%) [Figure 9.12].

  - The share of firms with 200 or more workers offering access to lower-cost mail-order generic drugs through a third-party vendor increased from 32% in 2024 to 40% in 2026.

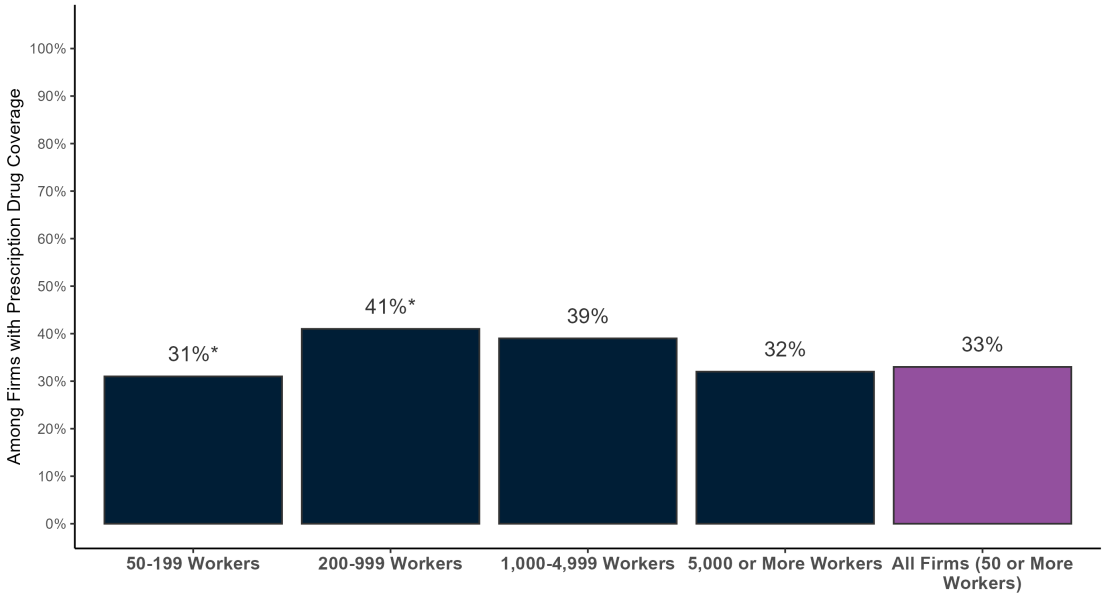
- Eleven percent of firms limit coverage for certain prescription drugs exclusively to mail-order pharmacies. In these cases, the plan does not pay for those prescriptions if an enrollee uses an in-person pharmacy.

  - Firms with 5,000 or more workers are more likely than smaller firms to limit coverage for certain prescription drugs exclusively to mail-order pharmacies (20%) [Figure 9.13].

- Nine percent of firms 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 [Figure 9.14].

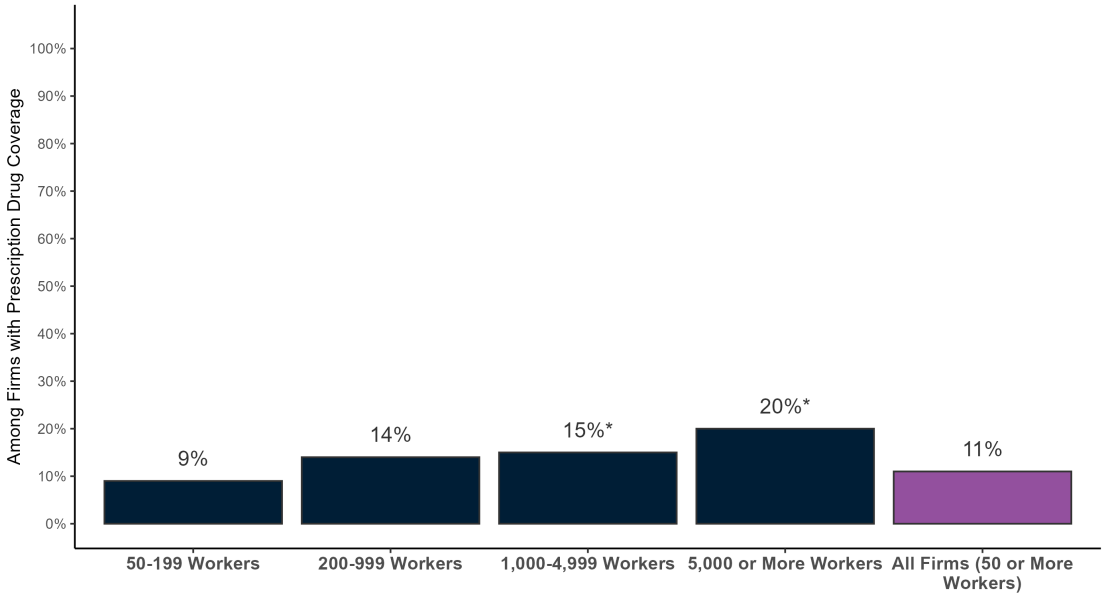
  - Firms with 5,000 or more workers are less likely than smaller firms to participate in an international prescription drug purchasing service (1%).

Figure 9.12
Percentage of Firms That Offer Coverage for Lower-Cost Mail-Order Generics, by Firm Size, 2026



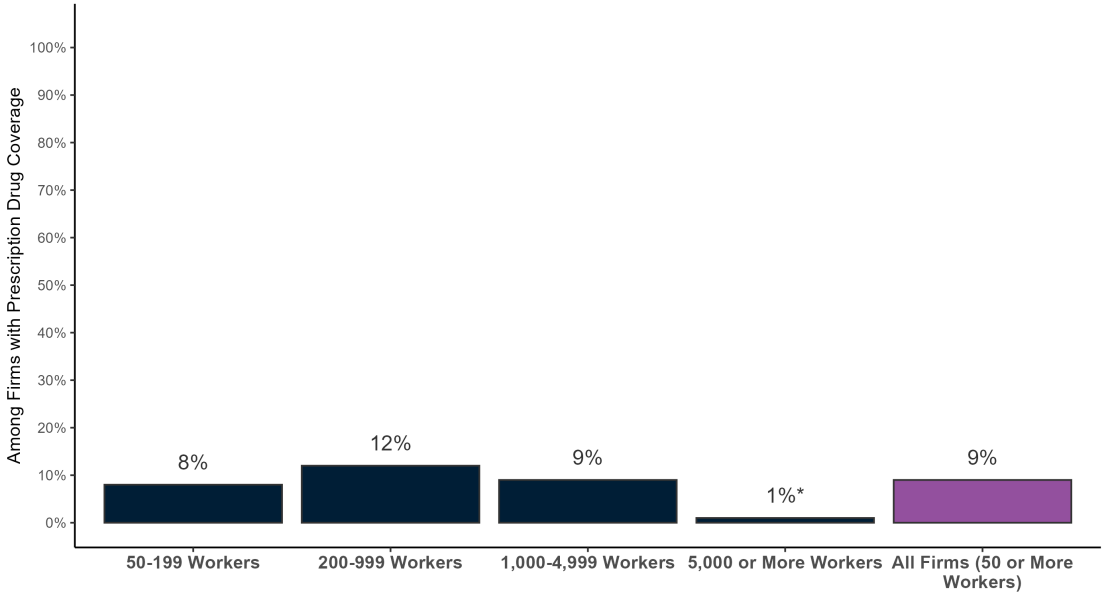
* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Lower cost-mail order generics may include coverage from either the plan or through a third-party vendor of products from companies such as 'Mark Cuban Cost Plus' or 'GoodRx'. Firms were asked about their plan with the largest enrollment, within their plan type with the most enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 9.13
Percentage of Firms That Cover Some Drugs Only Through Mail-Order Pharmacies, by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Plans with mail-order-only coverage generally do not cover certain prescriptions filled at a retail pharmacy. Firms were asked about the plan with the largest enrollment within their largest plan type.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 9.14
Percentage of Firms That Buy Prescription Drugs from Outside the USA through International Sourcing, by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: This may include vendors such as ScriptSourcing or CanaRx, which offer discounted maintenance medications through an international prescription service.
SOURCE: KFF Employer Health Benefits Survey, 2026

Generic drugs

- Drugs that are no longer protected by a patent and may be produced or distributed by multiple drug companies.

Preferred drugs

- Drugs included on a formulary or preferred drug list; for example, a brand-name drug without a generic substitute.

Non-preferred drugs

- Drugs not included on a formulary or preferred drug list; for example, a brand-name drug for which a generic substitute is available.

Fourth-tier drugs

- Drugs placed on an additional cost-sharing tier that typically requires higher copayments or coinsurance than the first three tiers. This tier may include specialty or other high-cost drugs.

Specialty drugs

- Generally high-cost medications used to treat complex or chronic conditions, such as cancer, rheumatoid arthritis, or multiple sclerosis. They may be biologic or other drugs and often require special handling, administration, or monitoring.

SECTION 10

Plan Funding



Section 10

Plan Funding

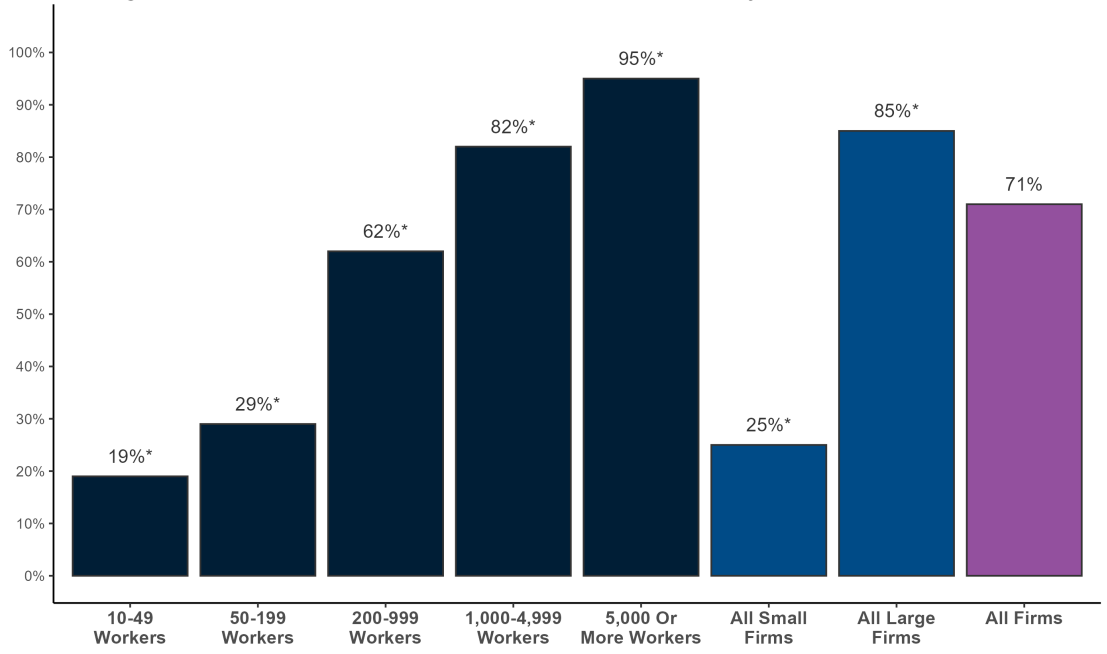
Many firms, particularly larger firms, choose to pay for some or all of the health services of their workers directly from their own funds rather than by purchasing health insurance to cover them. This is called self-funding. Both public and private employers can use self-funding to provide health benefits. Federal law (the Employee Retirement Income Security Act of 1974, or ERISA) exempts self-funded plans established by private employers (but not public employers) from most state insurance laws, including reserve requirements, mandated benefits, premium taxes, and some consumer protection regulations. In 2026, 71% of covered workers are in a self-funded health plan. Some employers who sponsor self-funded plans purchase stoploss coverage to limit their liabilities.

In recent years, a complex funding option, often called level-funding, has become more widely available to small employers. Level-funded arrangements are nominally self-funded options that package together a self-funded plan with extensive stoploss coverage that significantly reduces the risk retained by the employer. Thirty-eight percent of covered workers in firms with 10 to 199 workers are in a level-funded plan in 2026.

SELF-FUNDED PLANS

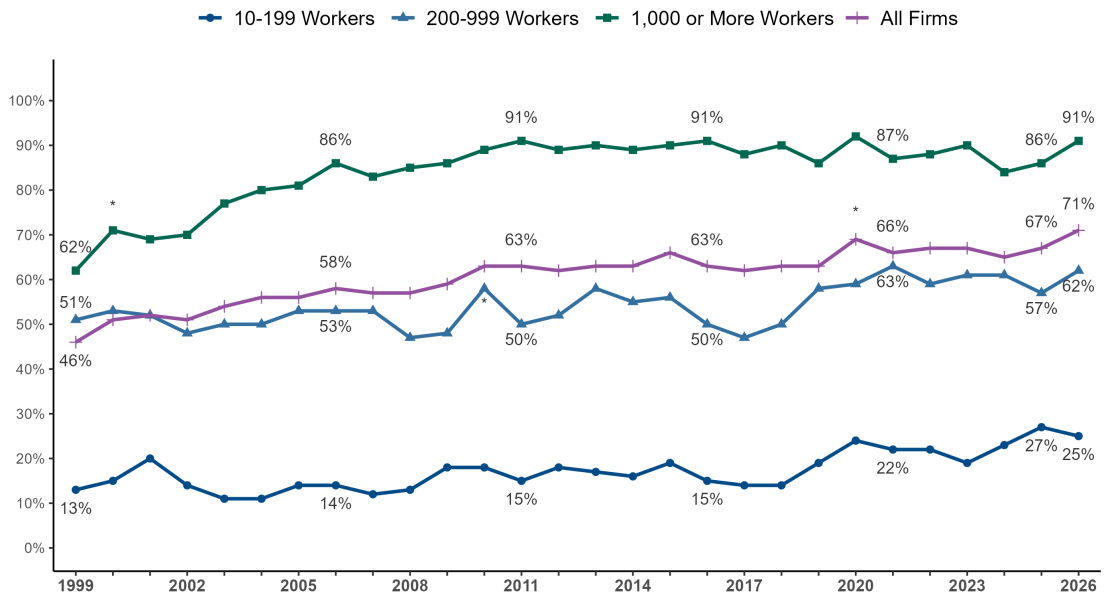
- Seventy-one percent of covered workers are in a plan that is self-funded, similar to the percentage (67%) last year [Figure 10.2].
  - The percentage of covered workers enrolled in self-funded plans is higher than the percentages two years ago (65%), five years ago (66%) and ten years ago (63%) [Figure 10.2].
  - Covered workers in firms with 200 or more workers are significantly more likely to be in a self-funded plan than covered workers in smaller firms (85% vs. 25%) [Figure 10.1] and [Figure 10.1].

Figure 10.1
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 10.2
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 1999-2026



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. Overall, 71% of covered workers are in a self-funded plan in 2026. Funding status for conventional plans was not asked in 2006 and is excluded from that year's averages.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 10.3

Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, Region, and Industry, 2026

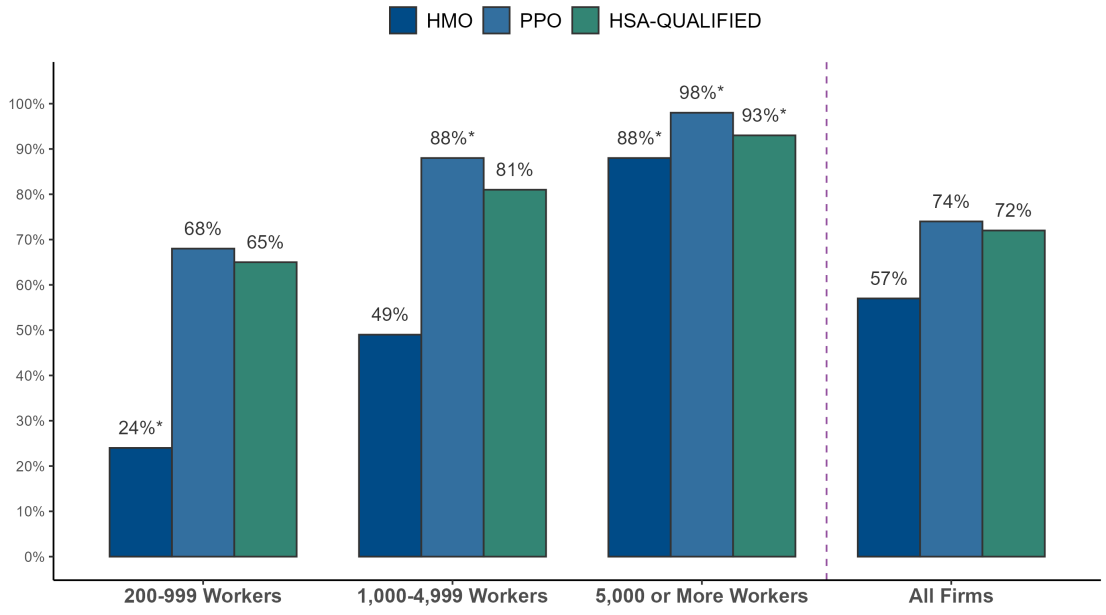
	Covered Workers in a Self-Funded Plan
FIRM SIZE	
200-999 Workers	62%*
1,000-4,999 Workers	82*
5,000 or More Workers	95*
All Small Firms (10-199 Workers)	**25%***
All Large Firms (200 or More Workers)	**85%***
REGION	
Northeast	78%
Midwest	78*
South	71
West	59*
INDUSTRY	
Agriculture/Mining/Construction	64%
Manufacturing	73
Transportation/Communications/Utilities	77
Wholesale	69
Retail	85*
Finance	77
Service	61*
State/Local Government	78
Health Care	82*
ALL FIRMS	**71%**

NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.

* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category ($p < .05$).

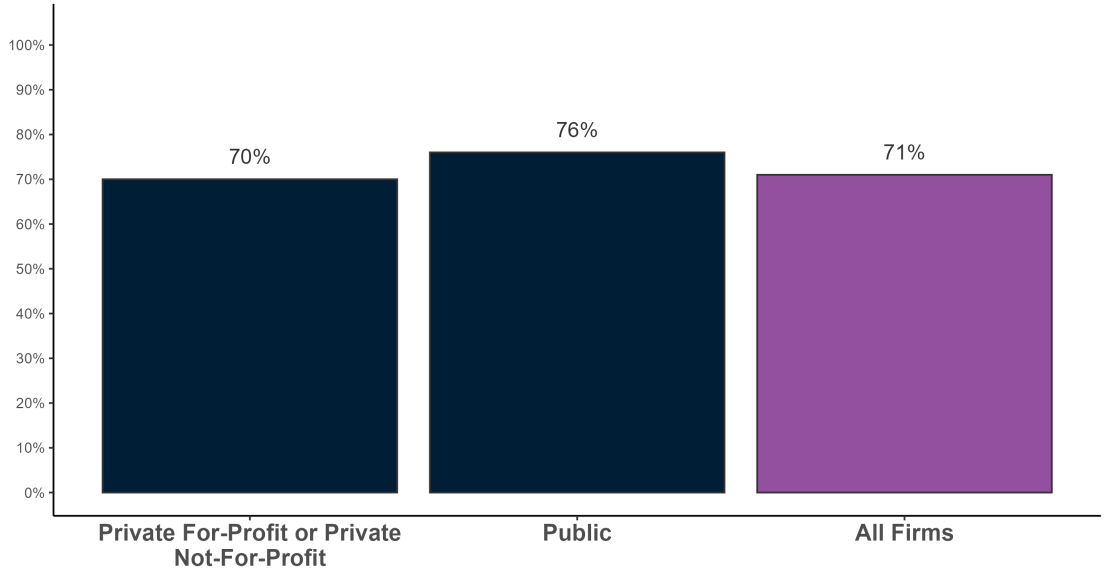
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 10.4
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Plan Type and Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category within plan type ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 10.5
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Ownership Type, 2026



Tests found no statistical difference between firm ownership types ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. Private firms include both private for-profit and private not-for-profit. Seventy-three percent of covered workers in private for-profits and 64% of workers enrolled at private not-for-profits are self-funded
SOURCE: KFF Employer Health Benefits Survey, 2026

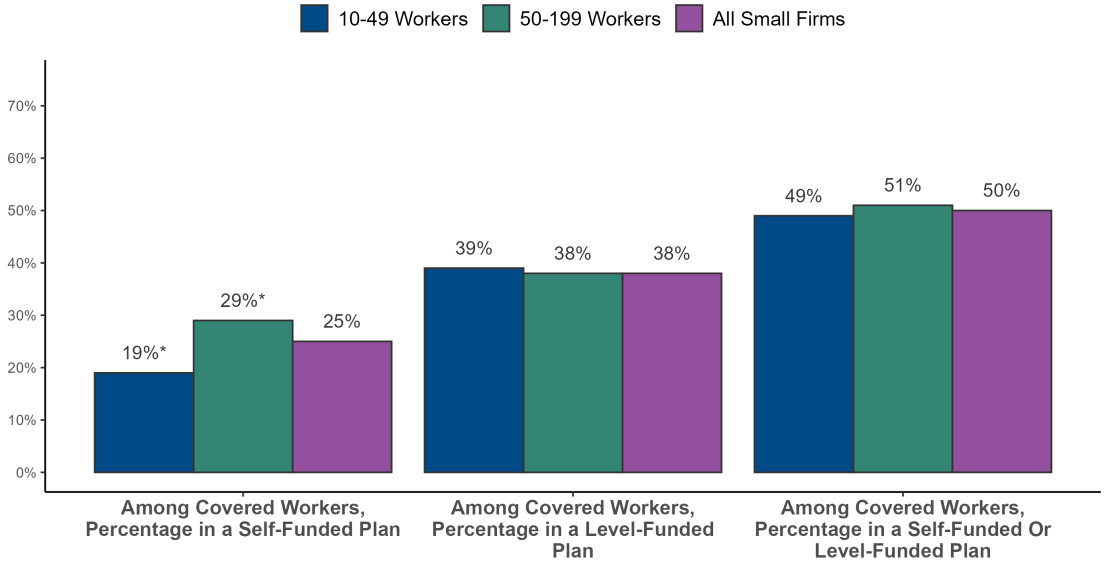
LEVEL-FUNDED PLANS

In recent years, insurers have been offering health plans that provide a nominally self-funded option for small and mid-sized employers that incorporates stoploss insurance with relatively low attachment points. In these arrangements, the insurer calculates an expected monthly expense for the employer, which includes a share of estimated annual claims costs, premiums for the stoploss protection, and an administrative fee. The employer pays this "level premium" amount, with the possibility of reconciliation between the employer and insurer at the end of the year, although small employers are often protected from any meaningful additional liability. These policies are sold as self-funded plans, so they generally are not subject to state requirements for insured plans and, for those sold to employers with fewer than 50 employees, are not subject to the rating and benefit standards in the ACA for small firms.

Due to the complexity of the funding (and regulatory status) of these plans, and because employers often pay a monthly amount that resembles a premium, respondents may be confused as to whether or not their health plan is self-funded or insured. There also may be confusion because different plan administrators (generally insurers) use different labels to refer to these arrangements. We asked employers with fewer than 200 workers whether or not they have a level-funded plan.

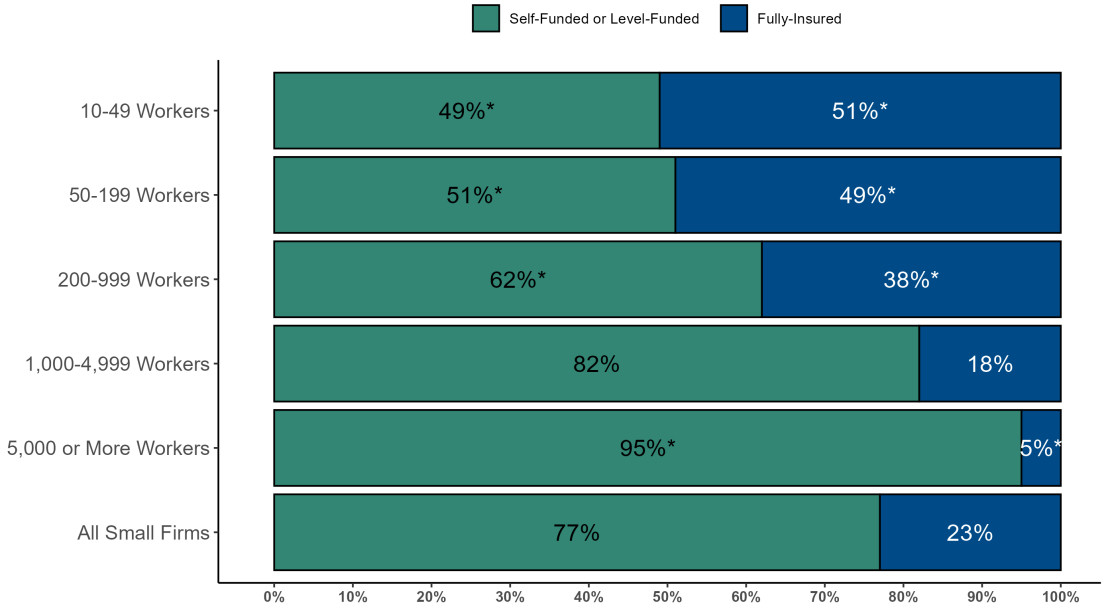
- Thirty-seven percent of firms with 10 to 199 workers that offer health benefits offer a level-funded plan in 2026, the same percentage as last year [Figure 10.8].
- Thirty-eight percent of covered workers in firms with 10 to 199 workers are enrolled in a level-funded plan in 2026, similar to the percentage last year [Figure 10.6] . Fifty percent of covered workers in firms with 10 to 199 workers are enrolled in either a level-funded plan or a self-insured plan, similar to the percentage last year [Figure 10.7] and [Figure 10.8].

Figure 10.6
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Funded Plan, by Firm Size, 2026



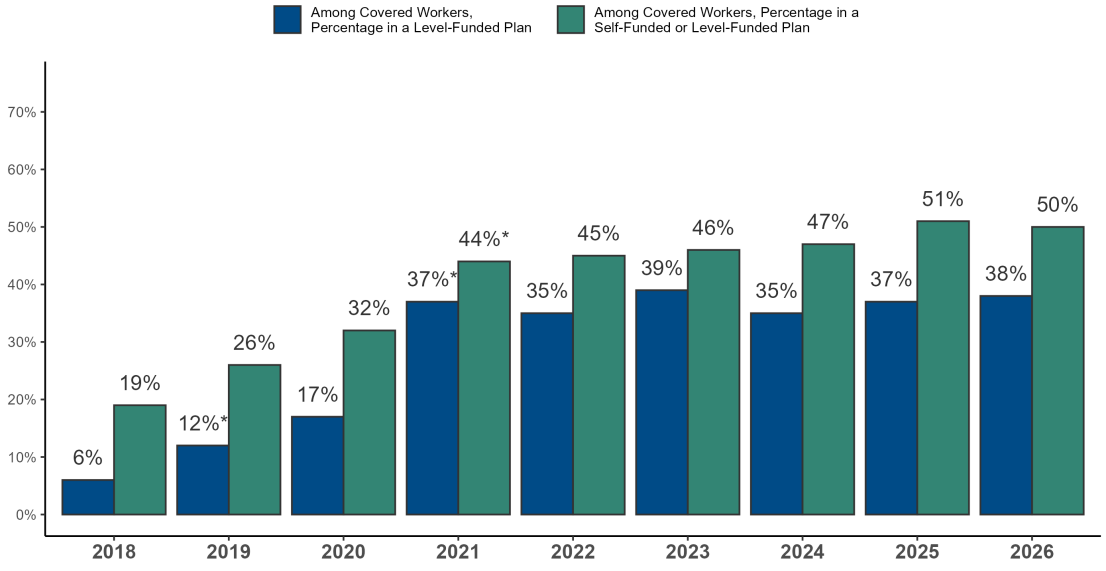
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Small Firms have 10-199 workers. This figure shows the percentage of covered workers; In 2026, 37% of small firms reported that they had a level-funded plan. This includes respondents who indicated both that their plan was level-funded and fully insured.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 10.7
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Insured Plan, by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Small Firms have 10-199 workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 10.8
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Funded Plan, 2018-2026



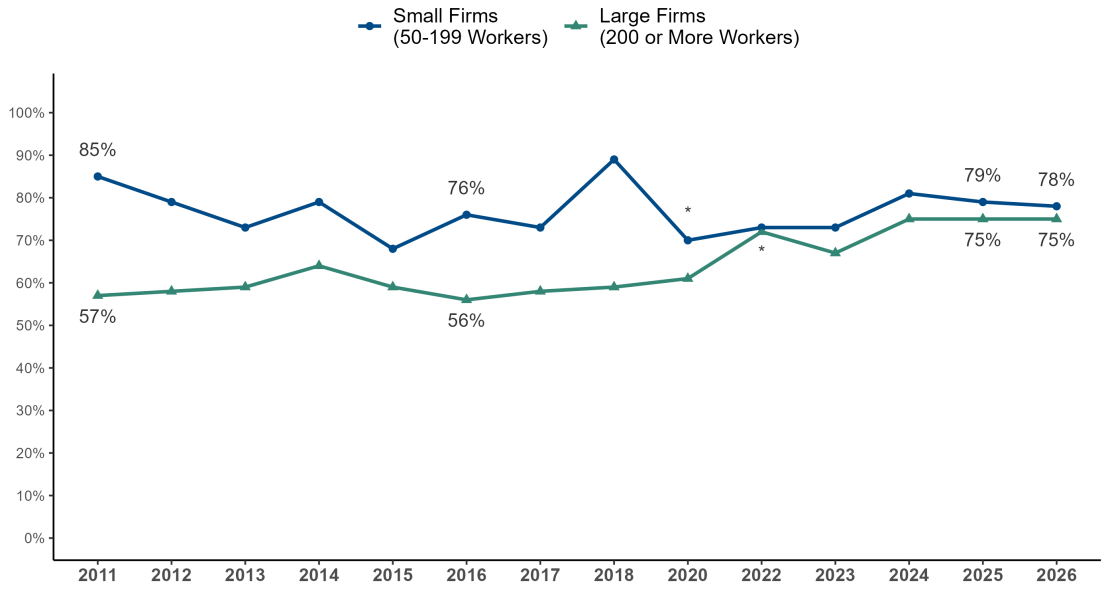
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Small Firms have 10-199 workers. This figure shows the percentage of covered workers; In 2026, 37% of small firms reported that they had a level-funded plan. This includes respondents who indicated both that their plan was level-funded and fully insured.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026;

STOPLOSS COVERAGE

Employers purchase insurance, often referred to as “stoploss” coverage, to protect themselves from unexpected losses for claims incurred by a self-funded plan. There are different types of stoploss coverage. For example, a policy may cover any amount that the plan sponsor must pay over a specified amount for each worker or enrollee (referred to as specific stoploss coverage) or it may limit the total amount the plan sponsor must pay for all claims in the plan over the plan year (referred to as aggregate stoploss coverage). Stoploss coverage may also be focused on particular types of claims (e.g., organ transplants). A firm may have more than one type of stoploss coverage.

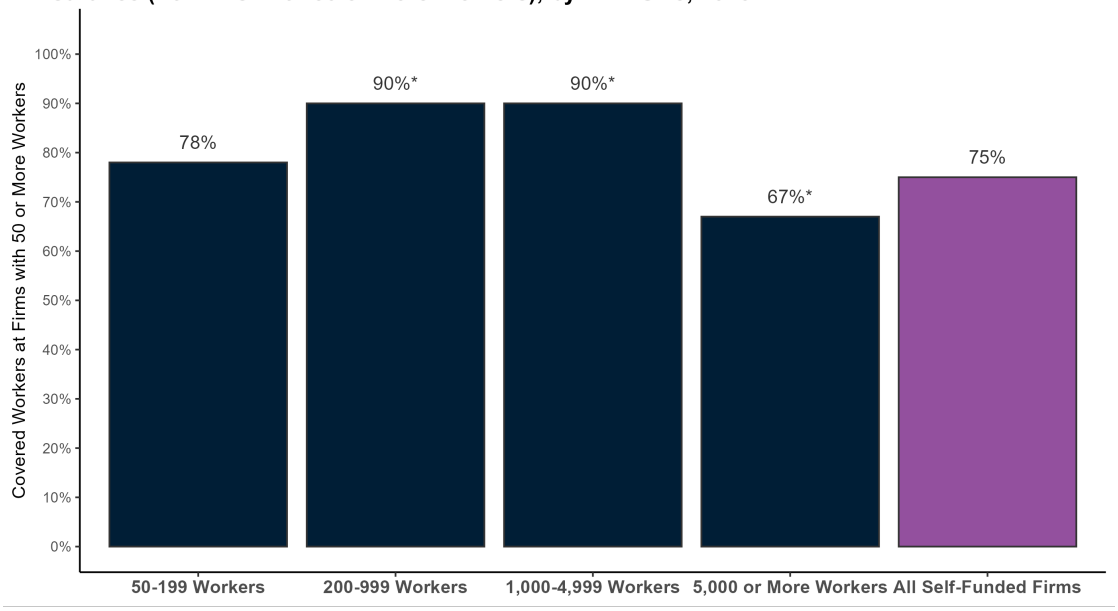
- Among covered workers in self-funded plans at firms with 200 or more workers, 75% of covered workers are in plans that have stoploss insurance, similar to the percentage last year (75%) [Figure 10.9]. Covered workers in firms with 5,000 or more workers are less likely than covered workers in smaller firms to be in a plan with stoploss insurance [Figure 10.10].

Figure 10.9
Among Covered Workers Enrolled in a Self-Funded Plan, Percentage Covered by Stoploss Insurance (At Firms with 50 or More Workers), by Firm Size, 2011-2026



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. We did not ask about stoploss coverage in 2019 or for small firms in 2021.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011-2017

Figure 10.10
Among Covered Workers Enrolled in a Self-Funded Plan, Percentage Covered by Stoploss Insurance (At Firms With 50 or More Workers), by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
SOURCE: KFF Employer Health Benefits Survey, 2026

Self-Funded Plan An insurance arrangement in which the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employers sponsoring self-funded plans typically contract with a third-party administrator or insurer to provide administrative services for the self-funded plan. In some cases, the employer may buy stoploss coverage from an insurer to protect the employer against very large claims.

Fully-Insured Plan An insurance arrangement in which the employer contracts with a health plan that assumes financial responsibility for the costs of enrollees' medical claims.

Level-Funded Plan An insurance arrangement in which the employer makes a set payment each month to an insurer or third-party administrator which funds a reserve account for claims, administrative costs, and premiums for stoploss coverage. When claims are lower than expected, surplus funds may be refunded at the end of the contract.

Stoploss Coverage Stoploss coverage limits the amount that a plan sponsor has to pay in claims. Stoploss coverage may limit the amount of claims that must be paid for each employee or may limit the total amount the plan sponsor must pay for all claims over the plan year.

Attachment Point Attachment points refer to the amount at which the insurer begins to pay its obligations for stoploss coverage, either because plan, individual or claim spending exceeds a designated amount.

SECTION 11

Retiree Health Benefits



Section 11

Retiree Health Benefits

Retiree health benefits are an important consideration for older workers making decisions about retirement, and can be a crucial source of coverage for people retiring before they are eligible for Medicare. For retirees with Medicare coverage, retiree health benefits can provide important supplementary coverage by helping them pay for cost sharing and benefits that Medicare does not cover.

Twenty-five percent of large firms offering health benefits offer retiree health benefits in 2026, similar to the percentage in 2025 (27%).

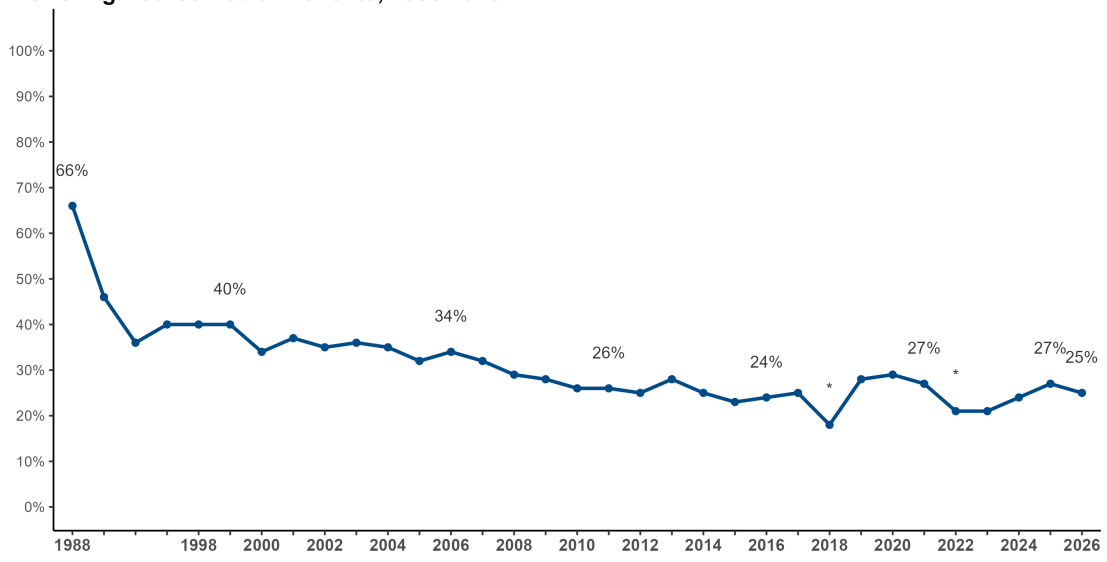
This survey asks questions about retiree health benefits only of firms with 200 or more workers that offer health benefits.

EMPLOYER RETIREE BENEFITS

In 2026, 25% of firms with 200 or more workers that offer health benefits offer retiree health benefits for at least some current workers or retirees [Figure 11.1]. Starting in 2019, we instructed firms to respond “yes” if they were providing coverage to retirees but were not offering these benefits to current employees, or if they were planning to provide retiree health benefits to current employees in the future.

- Retiree health benefit offer rates vary with firm characteristics.
- Firms with 5,000 or more workers are more likely than smaller firms to offer retiree health benefits (35% vs. 24%) [Figure 11.2].
- The share of firms that offer retiree health benefits varies considerably by industry [Figure 11.2].
- Public employers are far more likely than other types of firms to offer retiree health benefits (61% vs. 11%) [Figure 11.3].
- Firms that have at least some union workers are more likely to offer retiree health benefits than firms without any union workers (48% vs. 15%) [Figure 11.3].

Figure 11.1
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, 1988-2026



* Estimate is statistically different from estimate for the previous year shown ($p < .05$). No statistical tests are conducted for years prior to 1999.
NOTE: Large Firms have 200 or more workers. In 2019, this question was reworded. As a result, no statistical testing was conducted that year. For more information, see the 2019 Methods section.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017; KPMG Survey of Employer-Sponsored Health Benefits, 1991, 1993, 1995, 1998; The Health Insurance Association of America (HIAA), 1988.

Figure 11.2

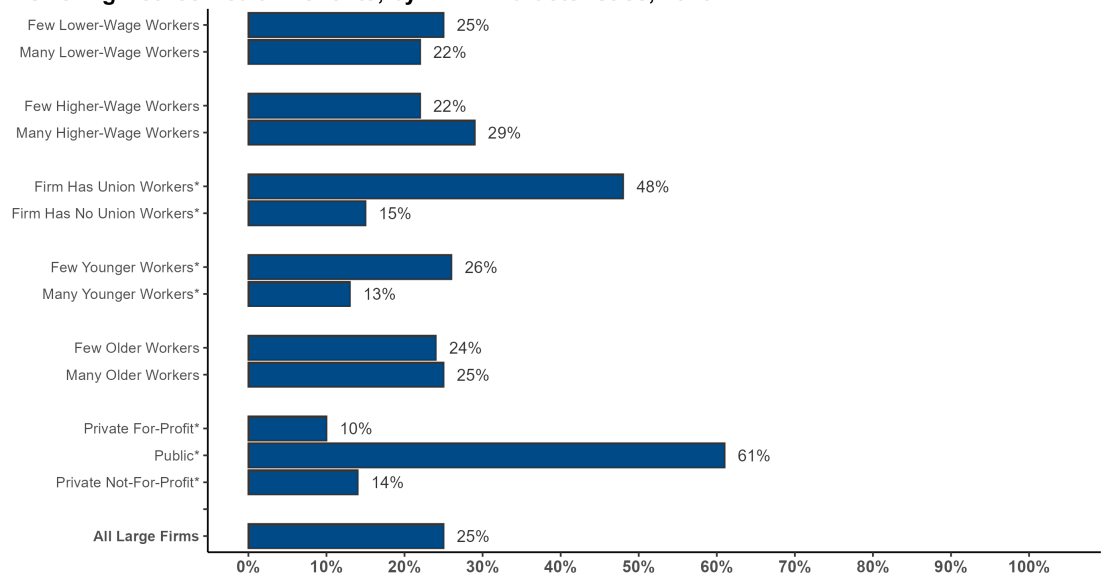
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, by Firm Size, Region, and Industry, 2026

	Large Firms Offering Retiree Health Benefits
FIRM SIZE	
200-999 Workers	23%*
1,000-4,999 Workers	34*
5,000 or More Workers	35*
REGION	
Northeast	26%
Midwest	23
South	24
West	26
INDUSTRY	
Agriculture/Mining/Construction	7%*
Manufacturing	11*
Transportation/Communications/Utilities	50*
Wholesale	3*
Retail	5*
Finance	26
Service	30
State/Local Government	65*
Health Care	11*
All Large Firms (200 or More Workers)	**25%**

* Estimate is statistically different from estimate for all other Large Firms not in the indicated size, region, or industry category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 11.3
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, by Firm Characteristics, 2026



* Estimates are statistically different from each other within category ($p < .05$).
NOTE: Large Firms have 200 or more workers. Firms with many lower-wage workers have >35% of their workforces earning <$38,000 (25th percentile of national earnings, 2026). Higher-wage firms have >=35% earning >$82,000 (75th percentile). Firms with many older workers have ≥35% age 50+, and those with many younger workers have >=35% age 26 or younger.
SOURCE: KFF Employer Health Benefits Survey, 2026

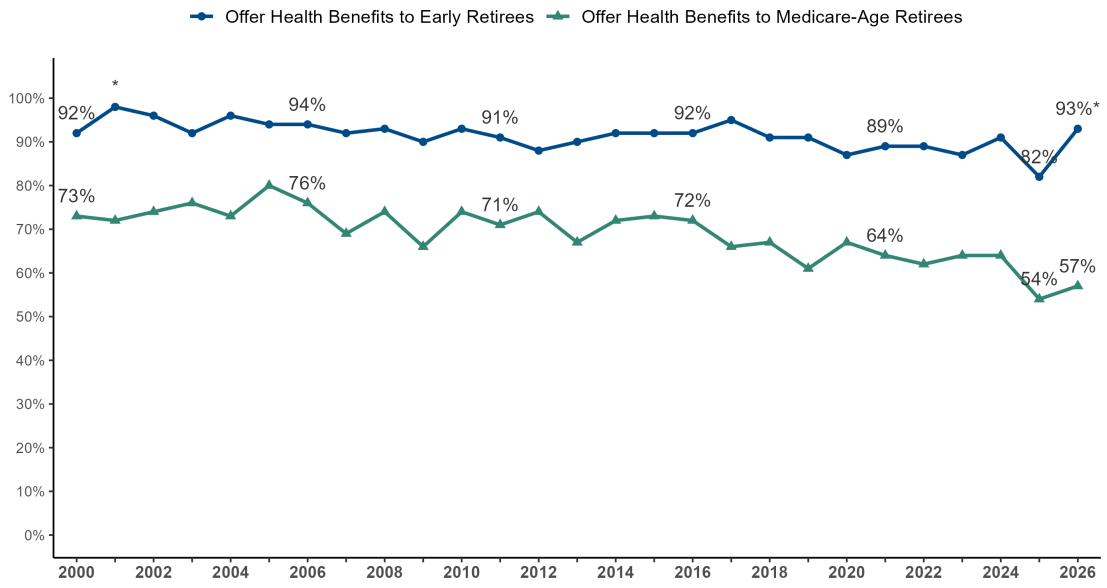
BENEFIT ELIGIBILITY

Among firms with 200 or more workers that offer retiree health benefits:

- Ninety-three percent offer benefits to early retirees under age 65 [Figure 11.4].
- Fifty-seven percent offer benefits to Medicare-age retirees [Figure 11.4].
- Fifty-one percent offer benefits to both early and Medicare-age retirees.

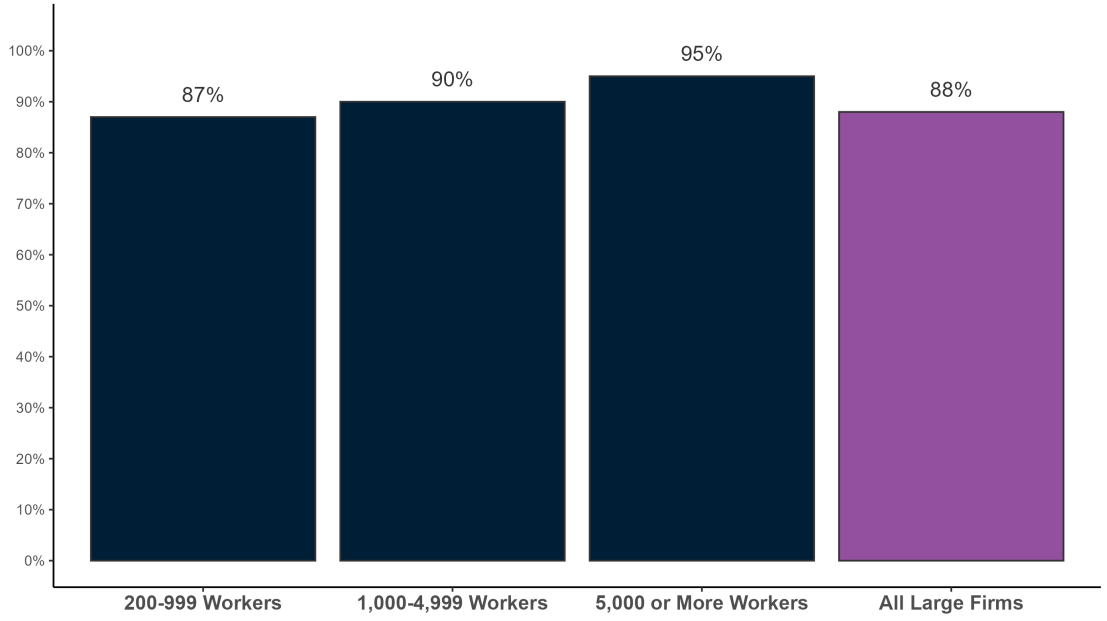
Among firms that offer retiree health benefits, three in four (88%) offer health benefits to retirees' spouses [Figure 11.5].

Figure 11.4
Among Large Firms Offering Health Benefits to Active Workers and Retirees, Percentage of Firms Offering Health Benefits to Early and Medicare-Age Retirees, 2000-2026



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Among Large Firms offering health benefits to active workers and offering retiree coverage, 51% offer health benefits to both early and Medicare-age retirees. Large Firms have 200 or more workers. Early retirees are those who retire before the age of 65.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2017

Figure 11.5
Among Large Firms Offering Health Benefits to Active Workers and Retirees, Percentage of Firms Offering Health Benefits to Retirees' Spouses, by Firm Size, 2026



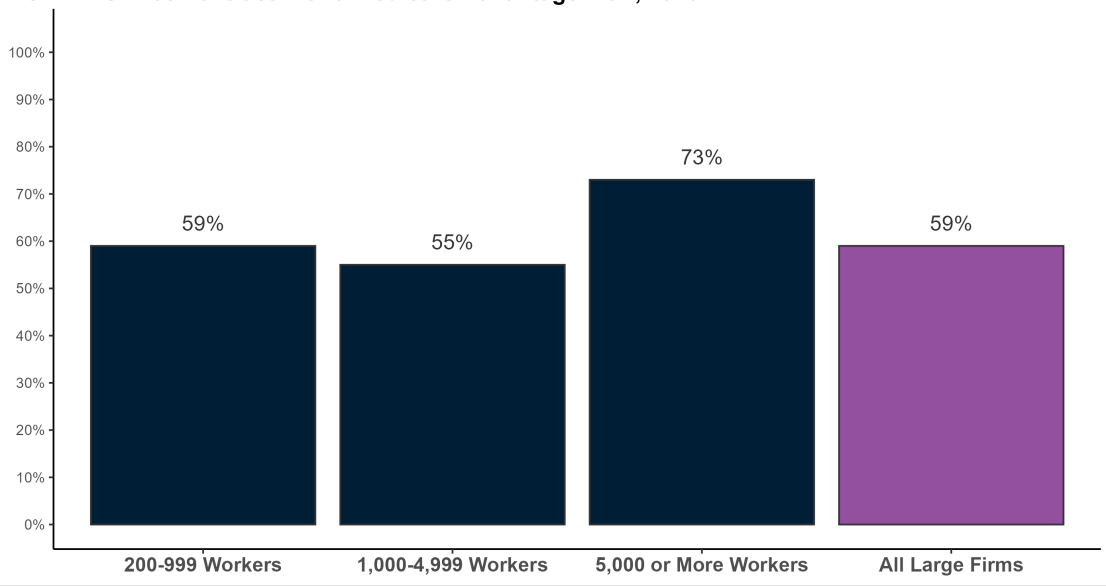
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

MEDICARE ADVANTAGE

Fifty-nine percent of firms that offer retiree health benefits to Medicare-age retirees offer coverage to at least some Medicare-age retirees through a contract with a Medicare Advantage plan, similar to the share last year (47%) [Figure 11.7].

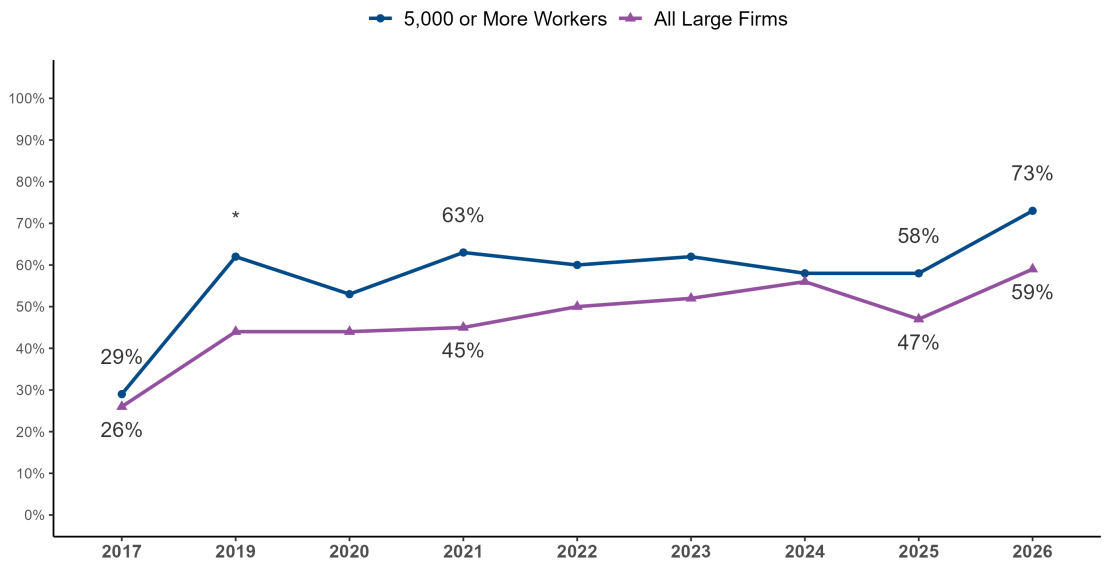
- Among firms that offer retiree health benefits through a Medicare Advantage plan:
  - Sixty-one percent offer retiree health benefits only through Medicare Advantage plans, while 39% offer a choice of Medicare Advantage and other types of plans for retiree health benefits [Figure 11.8]. Both shares are similar to last year.
  - Sixty-one percent say, to the best of their knowledge, that the shift to offering Medicare Advantage plans lowered their per-retiree costs; 16% say the shift did not lower their per-retiree costs; and 23% say they do not know [Figure 11.9].
- Among firms that offer retiree health benefits but do not offer benefits through a Medicare Advantage plan in 2026, 5% are somewhat likely to do so in the next two years [Figure 11.10].

Figure 11.6
Among Large Firms That Offer Retiree Health Benefits to Medicare-Age Retirees, Percentage of Firms That Contract with a Medicare Advantage Plan, 2026



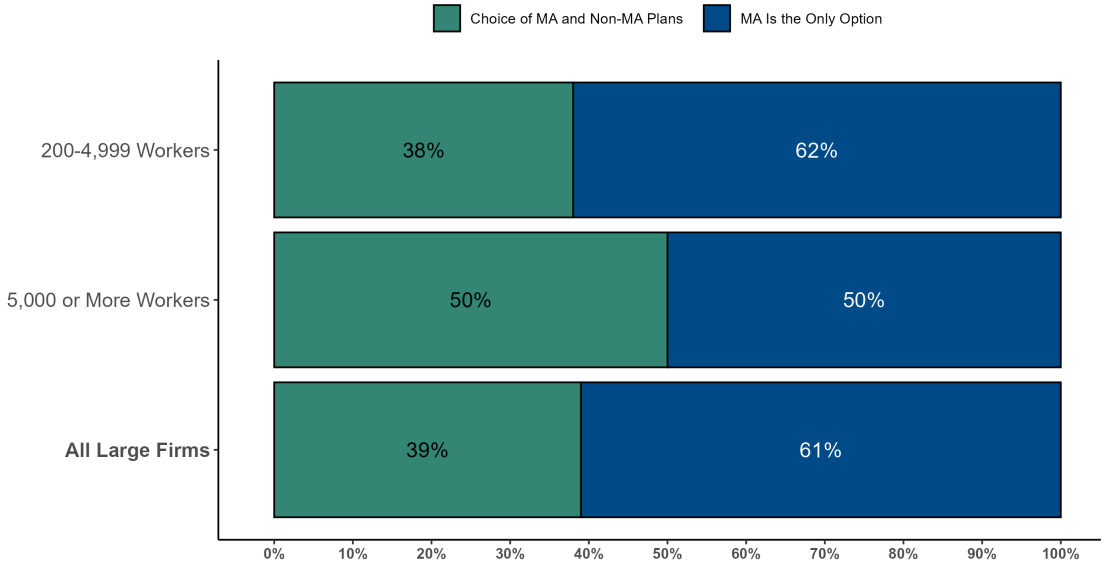
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: MA refers to Medicare Advantage, an arrangement where private health plans receive capitated payments to provide all Medicare-covered services to enrollees. Fifty-seven percent of large firms offering retiree health benefits offer retiree health benefits to Medicare-age retirees. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 11.7
Among Large Firms That Offer Retiree Health Benefits to Medicare-Age Retirees, Percentage of Firms That Contract with a Medicare Advantage Plan, 2017-2026



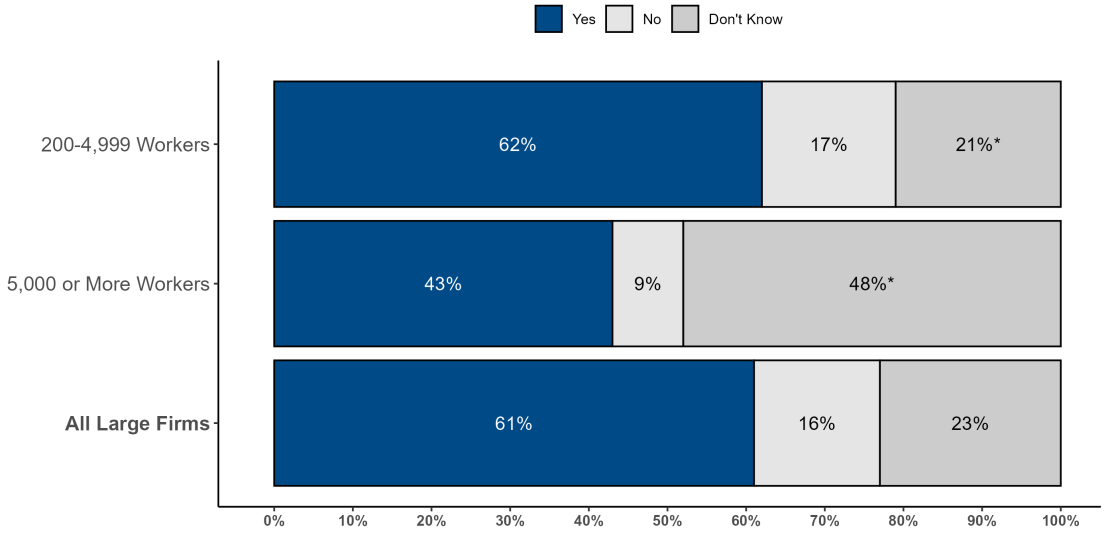
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Large Firms have 200 or more workers. MA refers to Medicare Advantage, an arrangement where private health plans receive capitated payments to provide all Medicare-covered services to enrollees. In 2026 fifty-seven percent of large firms offering retiree health benefits offer retiree health benefits to Medicare-age retirees.
SOURCE: KFF Employer Health Benefits Survey, 2019-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

Figure 11.8
Among Large Firms Offering Retiree Benefits Through A Contract with a Medicare Advantage Plan, Percentage of Firms Which Offer Retirees a Choice, 2026



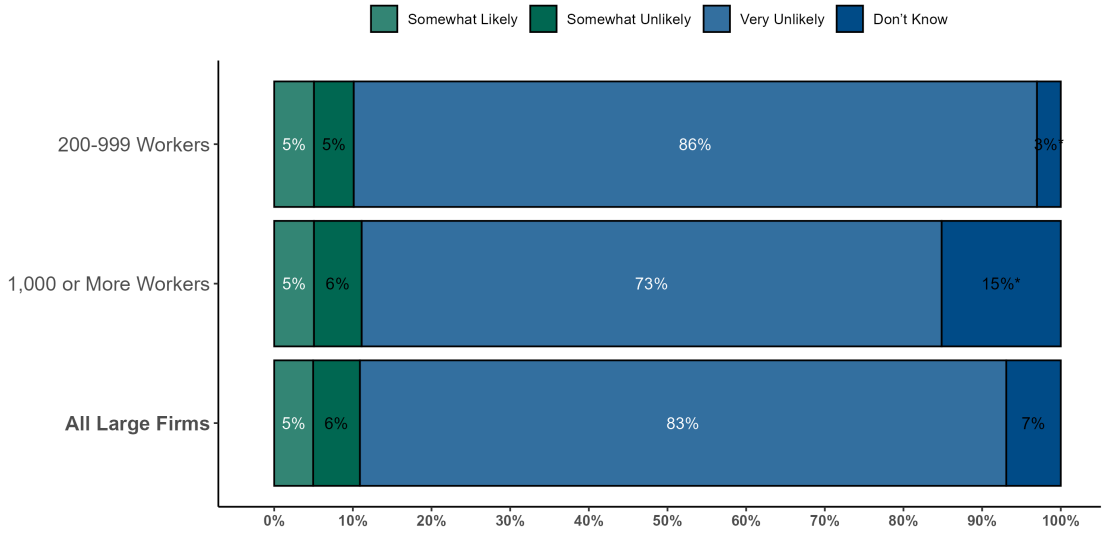
NOTE: MA refers to Medicare Advantage, an arrangement where private health plans receive capitated payments to provide all Medicare-covered services to enrollees. Thirty-four percent of large firms offering retiree health benefits contract with a Medicare Advantage (MA) plan. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 11.9
Among Large Firms Offering Retiree Benefits Through A Contract with a Medicare Advantage (MA) Plan, Percentage of Firms Which Believe The Shift to MA Lowered The Cost Per Retiree, 2026



NOTE: MA refers to Medicare Advantage, an arrangement where private health plans receive capitated payments to provide all Medicare-covered services to enrollees. Thirty-four percent of large firms offering retiree health benefits contract with a Medicare Advantage (MA) plan. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 11.10
Among Large Firms Offering Retiree Benefits But Not Currently Contracting with a Medicare Advantage (MA) plan, Percentage of Firms Which Plan to Start Offering Health Benefits Through an MA Plan in the Next Two Years, 2026



NOTE: In 2026, no firms said they were 'Very Likely' to start offering this type of plan. Large Firms have 200 or more workers. MA refers to Medicare Advantage, an arrangement where private health plans receive capitated payments to provide all Medicare-covered services to enrollees. Thirty-four percent of large firms offering retiree health benefits contract with a Medicare Advantage (MA) plan.
SOURCE: KFF Employer Health Benefits Survey, 2026

SECTION 12

Employer Opinions and Practices: Satisfaction with Health Plans, Provider Networks, Coverage for GLP-1s, and Access to Data

Section 12

Employer Opinions and Practices: Satisfaction with Health Plans, Provider Networks, Coverage for GLP-1s, and Access to Data

Employers frequently review and modify their health plans to incorporate new options or adapt to changing circumstances. Topics covered this year include employer satisfaction with their health plans, the structure and breadth of provider networks, employer responses to higher costs, coverage of GLP-1 agonists for weight loss, prior authorization practices, and employer access to information on prices and utilization.

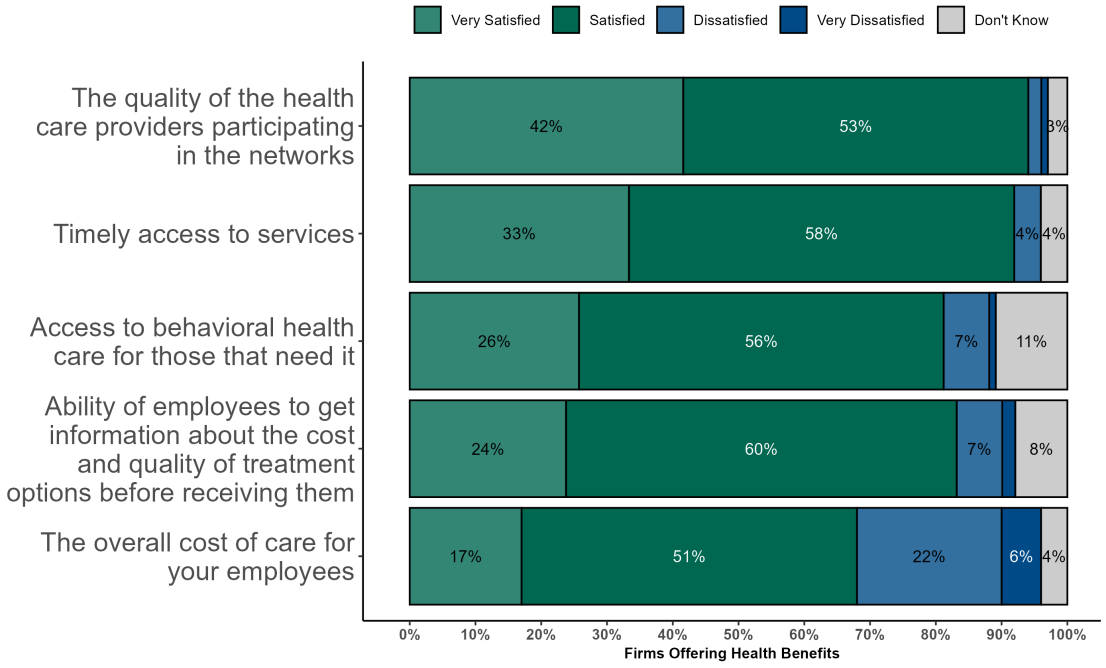
EMPLOYER SATISFACTION WITH HEALTH PLANS

Firms that offer health benefits were asked about their satisfaction with several aspects of the health plans offered to their employees.

- **Cost of care.** Only 17% of firms say that they are "very satisfied" with the overall cost of care for employees, 51% say that they are "satisfied", 29% say that they are "dissatisfied" or "very dissatisfied", and 4% say that they do not know [Figure 12.1]. Firms with fewer than 200 workers are less likely than larger firms to say that they are "very satisfied" with the overall cost of care for employees (16% vs. 23%).
- **Quality of network providers.** Forty-two percent of firms say that they are "very satisfied" and 53% say that they are "satisfied" with the quality of providers in plan networks. Only 2% say that they are "dissatisfied" or "very dissatisfied" with the quality of network providers, and 3% say that they do not know. [Figure 12.1].
- **Timely access to services.** Thirty-three percent of firms say that they are "very satisfied" and 58% say that they are "satisfied" with the timely access to services in the health plans that they offer. Only 5% say that they are "dissatisfied" or "very dissatisfied" with timely access to services in their health plans, and 4% say that they do not know [Figure 12.1].
- **Access to behavioral health care.** Twenty-six percent of firms say that they are "very satisfied" and 56% say that they are "satisfied" with access to behavioral health care in the health plans that they offer. Only 7% say that they are "dissatisfied" or "very dissatisfied" with access to behavioral health care in their health plans, and 11% say that they do not know [Figure 12.1]. The share of firms offering health benefits that report being "very satisfied" with access to behavioral health care in their health plan has increased since 2022, the last time firms were asked about plan satisfaction (26% vs. 16%).
- **Employee access to information about the cost and quality of treatment options.** Twenty-four percent of firms say that they are "very satisfied" with employees' ability to obtain information about the cost and quality of treatment options before receiving care, while 60% say that they are "satisfied." Seven percent say that they are "dissatisfied," 2% say that they are "very dissatisfied," and 8% say that they do not know

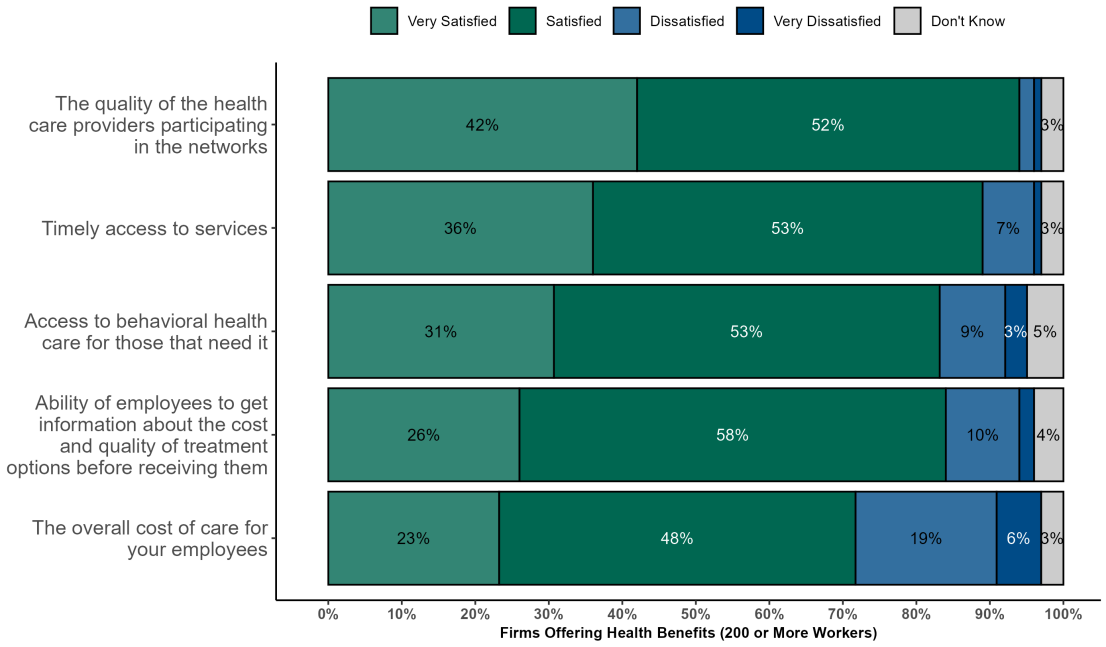
[Figure 12.1]. Firms with 1,000 or more workers are more likely than smaller firms to say that they are "dissatisfied" or "very dissatisfied" with employees' access to this information (15% vs. 8%).

Figure 12.1
Firms' Level of Satisfaction With Aspects of their Health Plans, 2026



SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.2
Large Firms' Level of Satisfaction With Aspects of their Health Plans, 2026



NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

HEALTH PLAN NETWORKS

Firms and health plans structure their provider networks to ensure access to care while also encouraging enrollees to use providers who are lower cost or provide better care. Firms were asked about several aspects of their provider networks, including network breadth, virtual care options, and access to on-site clinics.

BREADTH OF NETWORKS

Some firms offer their employees health plans with relatively small, or narrow, networks of providers. Narrow network plans limit the number of participating providers, which may help reduce costs and are generally more restrictive than standard HMO networks.

- Among firms that offer health benefits, 8% offer a narrow network plan in 2026, similar to the percentage last year (9%). Firms with 1,000 to 4,999 workers (13%) and 5,000 or more workers (20%) are more likely than smaller firms to offer a narrow network plan [Figure 12.3].

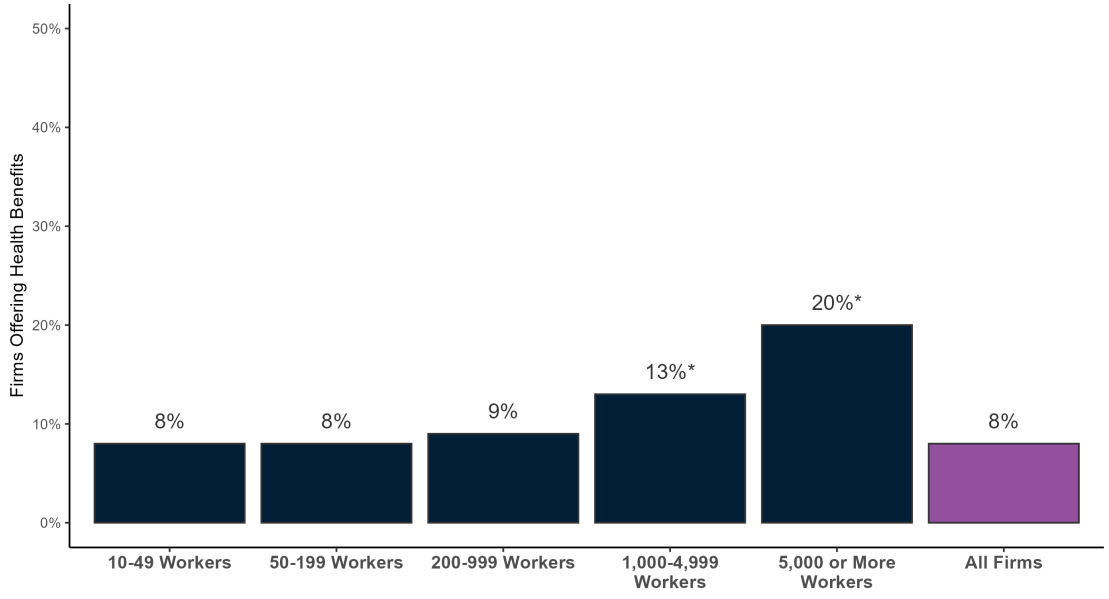
Firms offering health benefits were asked about the breadth of the provider network of their plan with the largest enrollment. A broad network includes most local doctors and hospitals; a narrow network has a limited number of providers.

- Among these firms, 51% say that the network is “very broad,” 38% say that it is “somewhat broad,” 5% say that it is “somewhat narrow,” 3% say that it is “very narrow,” and 4% say that they do not know [Figure 12.5]. Firms with 200 or more workers are more likely than smaller firms to characterize the network of their health plan with the largest enrollment as “very broad” (64% vs. 50%) [Figure 12.5].

Firms offering health benefits were also asked about the breadth of the provider network of their plan with the largest enrollment for mental health and substance use conditions.

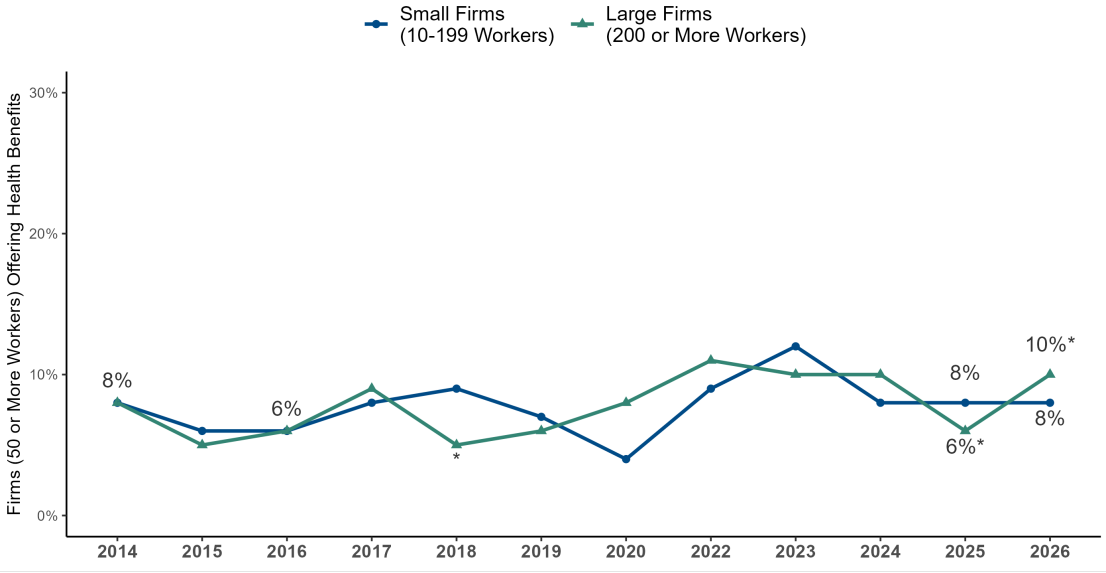
- Among these firms, 22% say that the network for mental health and substance use conditions is “very broad,” 42% say that it is “somewhat broad,” 12% say that it is “somewhat narrow,” 3% say that it is “very narrow,” and 20% say that they do not know [Figure 12.5]. Firms with 200 or more workers are more likely than smaller firms to characterize the network for these services as “very broad” (32% vs. 21%), while firms with fewer than 200 workers are more likely to say that they do not know (21% vs. 10%) [Figure 12.5].

Figure 12.3
Among Firms Offering Health Benefits, Percentage That Offer a Narrow Network Plan, by Firm Size, 2026



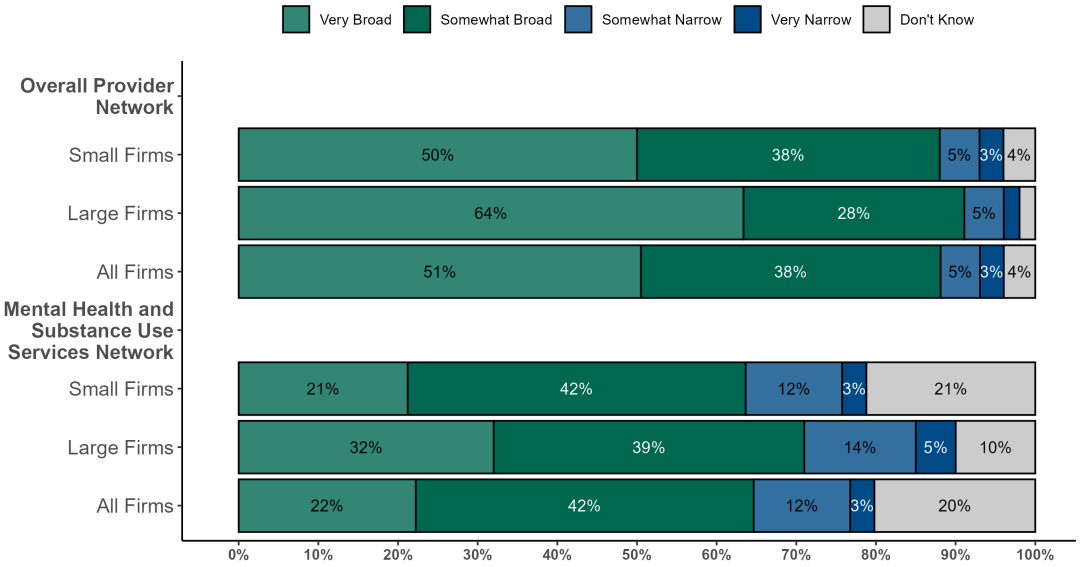
* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
NOTE: Narrow network plans limit the number of providers that can participate in order to reduce costs and generally are more restrictive than standard HMO networks.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.4
Among Firms Offering Health Benefits, Percentage of Firms That Offer a Narrow Network Plan, by Firm Size, 2014-2026



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Asked of firms with 50+ workers in 2014 and all offering firms thereafter. In 2026, 8% of offering firms offered a narrow network plan. Narrow network plans limit the number of providers that can participate in order to reduce costs and generally are more restrictive than standard HMO networks. Not asked in 2021.
SOURCE: KFF Employer Health Benefits Survey, 2018-2026; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014-2017

Figure 12.5
Among Firms Offering Health Benefits, How Broad the Firm Considers Its Largest Plan's Network, by Firm Size, 2026



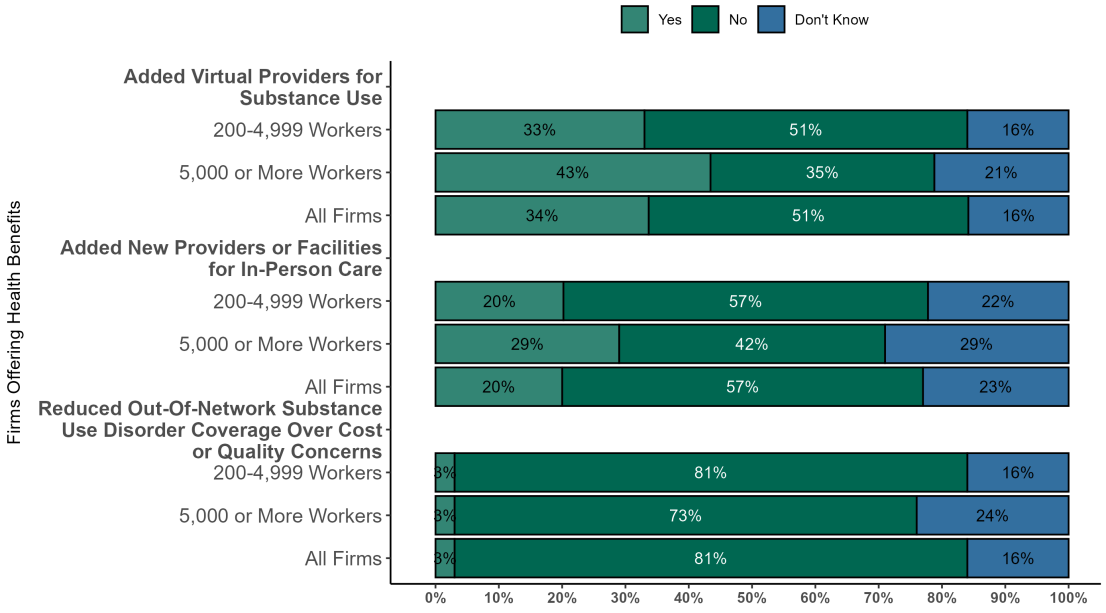
NOTE: A broad network includes most doctors and hospitals in the area. A narrow network is one which is limited to a small number of providers. Small Firms have 10-199 workers and Large Firms have 200 or more workers. Firms with multiple plans were asked about their plan with the largest enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2026

TREATMENT OPTIONS FOR SUBSTANCE USE CONDTIONS

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. Firms also were asked whether they had taken actions to reduce out-of-network coverage for these services due to concerns about cost or quality.

- 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 [Figure 12.6].
- Three percent of these firms say that they have taken actions to reduce out-of-network coverage for substance use services due to concerns about cost or quality [Figure 12.6].

Figure 12.6
Percentage of Large Firms that Changed Networks For Substance Use Providers in the Past 2 Years, 2026



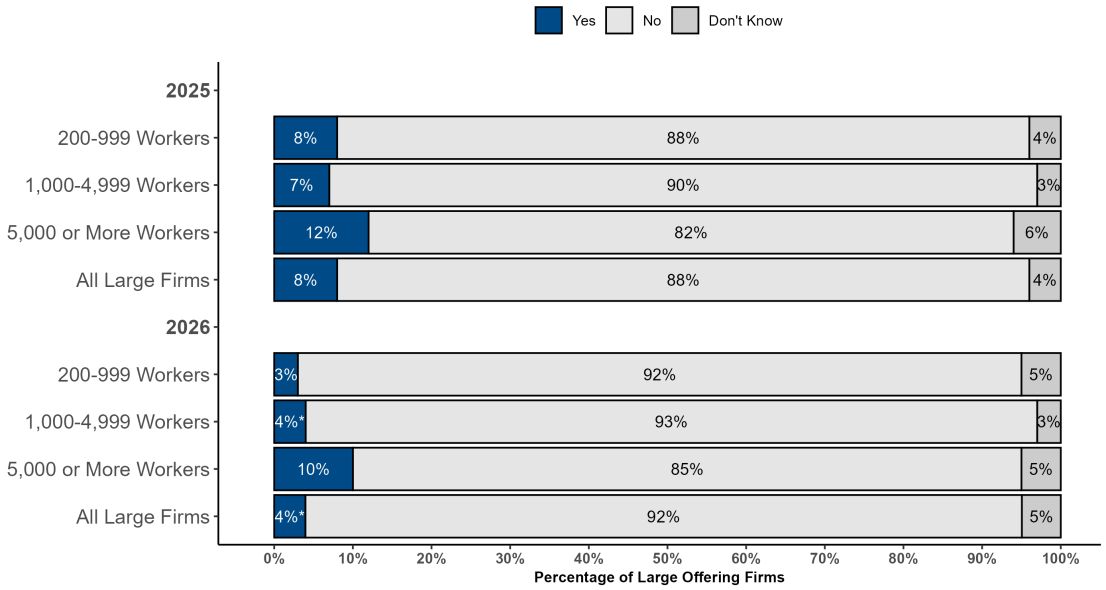
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

VARIABLE COPAY PLANS

Some firms offer plans, such as those from Surest and Coupe Health, that replace deductibles with copayments that vary based on the provider chosen by the enrollee. Enrollees who choose more efficient providers generally face lower copayments.

- Among firms with 200 or more workers that offer health benefits, 4% offer a plan to at least some employees that uses this variable copayment approach. Firms with 5,000 or more workers are more likely than firms with 200 to 4,999 workers to offer such a plan (10% vs. 4%) [Figure 12.7].

Figure 12.7
Percentage of Large Firms That Vary Copays Based on Provider Costs, by Firm Size, 2025-2026



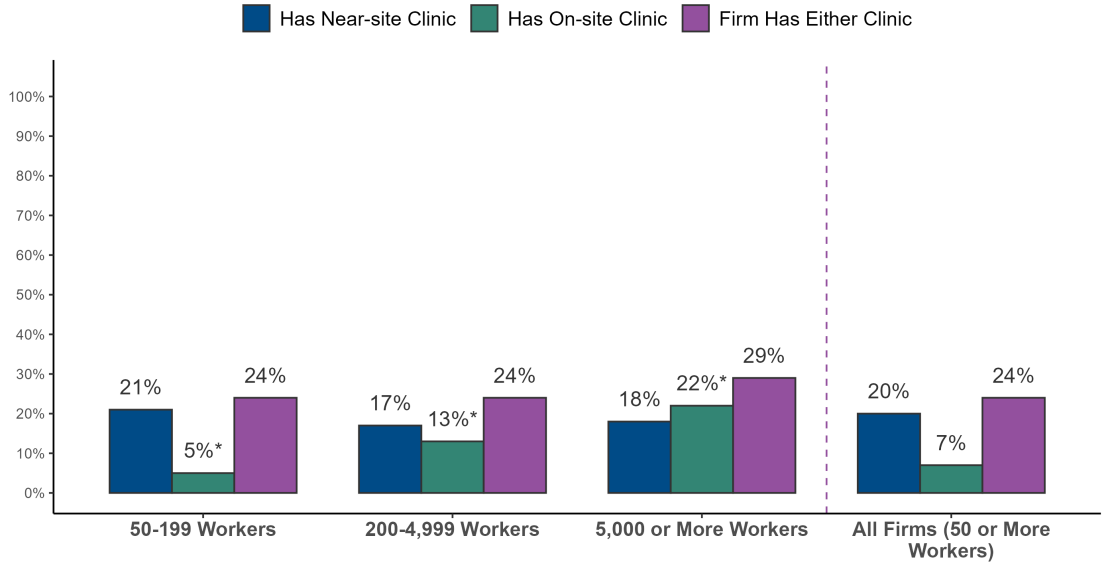
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Large Firms have 200 or more workers. Some plans partner with vendors to replace deductibles with copays that vary by provider cost. Enrollees who choose lower-cost providers pay less, and vendors like Surest and Coupe Health support these models with app-based copay comparison tools.
SOURCE: KFF Employer Health Benefits Survey, 2025-2026;

ON-SITE AND NEAR-SITE CLINICS

Some firms provide health care services through clinics located at or near their workplaces. These clinics are staffed by health professionals and may treat work-related or non-work-related conditions.

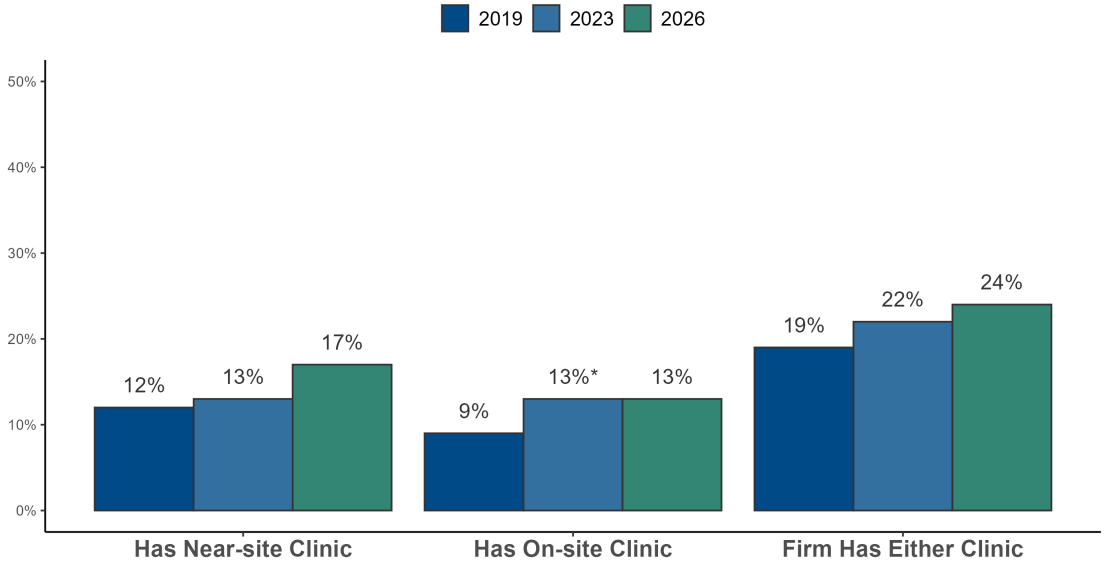
- Among firms with 50 or more workers that offer health benefits, 24% have an on-site or near-site clinic at at least one of their major locations. Seven percent have an on-site clinic and 20% have a near-site clinic [Figure 12.8].
- Among firms with 200 or more workers that offer health benefits, 24% have an on-site or near-site clinic [Figure 12.9]. Among firms with 200 or more workers that have this type of clinic, 28% have a near-site clinic, 46% have an on-site clinic, and 25% have both an on-site and a near-site clinic. Overall, 13% of large firms have an on-site clinic and 17% have a near-site clinic [Figure 12.9].

Figure 12.8
Among Firms Offering Health Benefits, Percentage of Firms with an On-Site Health Clinic, by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: An on-site health clinic is a workplace clinic staffed by health professionals that provides care for work-related and non-work-related illnesses. A near-site clinic is a health care facility located near the workplace that contracts to provide services to employees and may serve multiple employers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.9
Among Large Firms Offering Health Benefits, Percentage with an On-Site Health Clinic, by Firm Size, 2019, 2023, and 2026



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: An on-site health clinic is a workplace clinic staffed by health professionals where employees can receive health care for either work-related or non-work-related illnesses. Near-site clinics are health care facilities conveniently located near a work-site, that contract to deliver services to employees. Multiple employers can contract with the same near-site clinic.
SOURCE: KFF Employer Health Benefits Survey, 2019-2026;

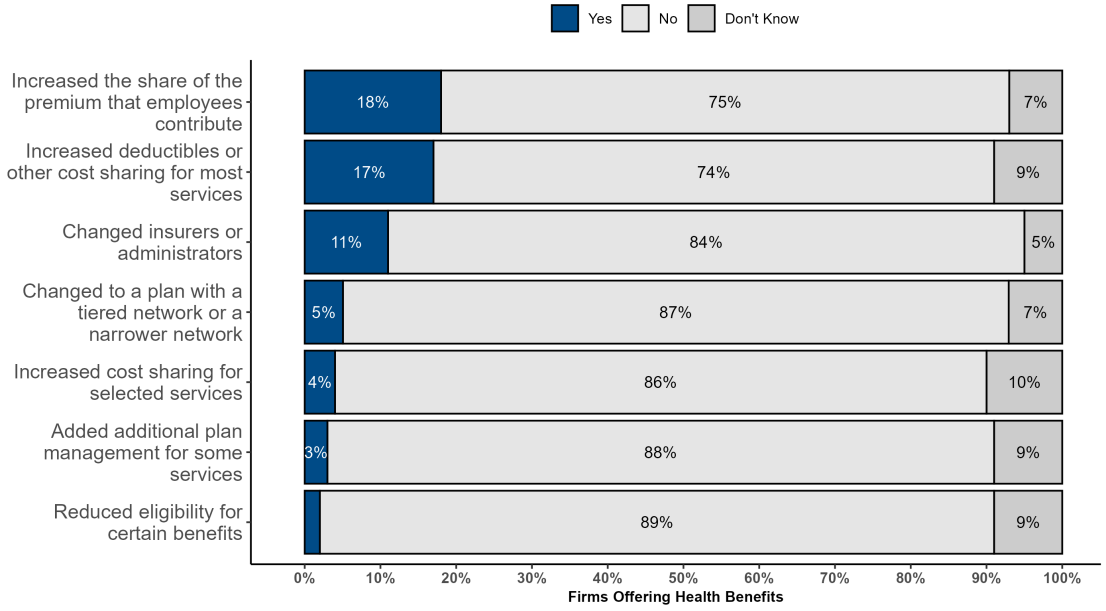
REACTIONS TO HIGHER PROJECTED COSTS

Health insurance costs were projected to increase relatively rapidly in 2026. Firms offering health benefits were asked whether they took certain actions in response to projected cost increases for their plan with the largest enrollment.

Among these firms:

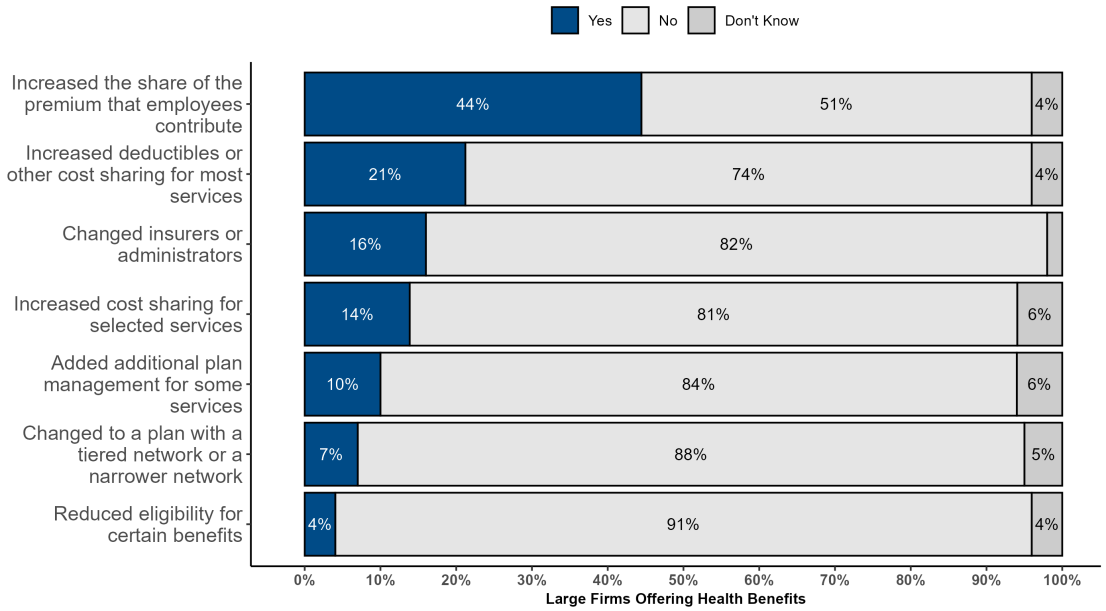
- Seventeen percent increased deductibles or other cost sharing for most services [Figure 12.10]. Firms with 1,000 or more workers are more likely than smaller firms to have taken this action (33% vs. 16%).
- Four percent increased cost sharing for selected services [Figure 12.10]. Firms with 1,000 or more workers are more likely than smaller firms to have taken this action (20% vs. 4%).
- Two percent reduced or tightened eligibility for certain benefits [Figure 12.10]. Firms with 1,000 or more workers are more likely than smaller firms to have taken this action (10% vs. 2%).
- Three percent added additional management requirements, such as prior authorization, for some services [Figure 12.10]. The likelihood of taking this action increased with firm size, ranging from 3% of firms with 10 to 199 workers to 21% of firms with 5,000 or more workers.
- Eighteen percent increased the share of the premium paid by employees [Figure 12.10]. The likelihood of taking this action increased with firm size, ranging from 16% of firms with 10 to 199 workers to 66% of firms with 5,000 or more workers.
- Eleven percent changed insurers or administrators.
- Five percent switched to a plan with a tiered or narrower provider network.

Figure 12.10
Among Firms Offering Health Benefits, Firm Responses to Higher Projected Health Plan Costs, 2026



NOTE: Additional plan management includes prior authorization.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.11
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

GLP-1 DRUG COVERAGE FOR WEIGHT LOSS

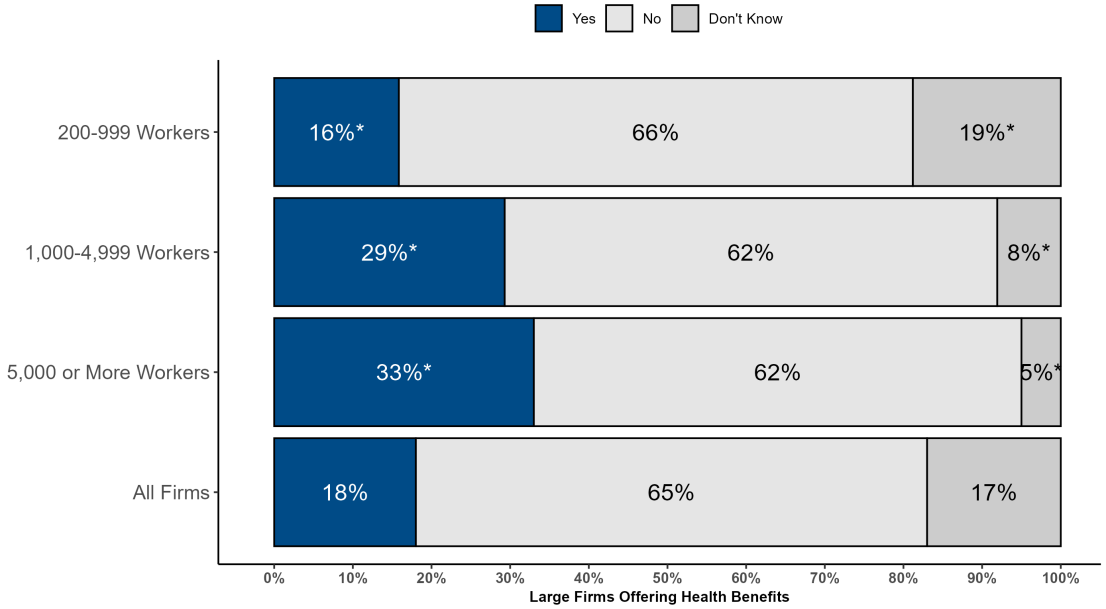
GLP-1 (glucagon-like peptide-1) agonists are used to help control blood sugar levels in people with type 2 diabetes, and have also been shown to be effective treatments for obesity. Common brand names include Wegovy, Saxenda, and Zepbound. Health plans generally have covered GLP-1 drugs when prescribed to treat diabetes, but there is widespread interest in their use for people who have a clinical need to lose weight. Although the costs of these drugs have been declining, the large number of people who may benefit from them, combined with the potential for long-term use, has raised questions about their impact on plan spending. The increasing availability of direct-to-consumer programs for these medications, often at relatively low costs, have also provided options for employers to potentially fund access through alternate methods, such as account contributions.

Firms with 200 or more workers that offer health benefits were asked about coverage of GLP-1 agonists when used primarily for weight loss in their plan with the largest enrollment.

- Among these firms, 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 [Figure 12.12].
  - Firms with 200 to 999 workers are more likely than larger firms to say that they do not know whether their plan covers GLP-1 agonists for weight loss (19% vs. 8%).
  - 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 (18%) [Figure 12.13].
  - The percentage of firms with 5,000 or more workers that cover GLP-1 agonists for weight loss is similar to the percentage last year (33% vs. 43%) [Figure 12.13].

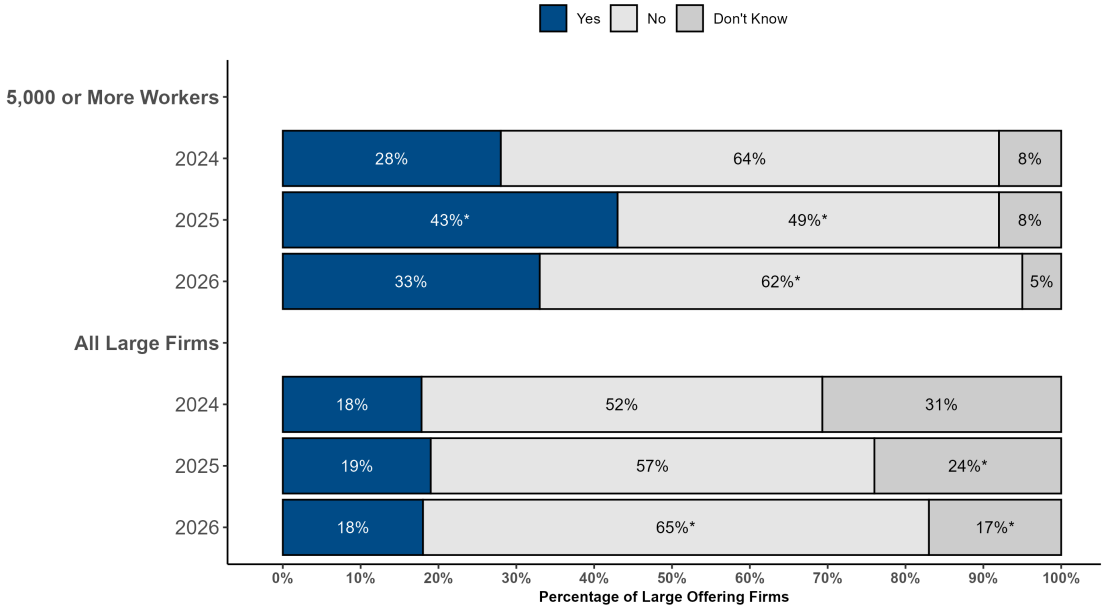
- Among firms that cover GLP-1 agonists for weight loss, 40% require enrollees to meet with a clinical professional (such as a dietitian, case manager, or therapist) or participate in a lifestyle program in order for the drug to be covered, similar to the percentage last year (34%) [Figure 12.14].
  - Firms with 200 to 999 workers are less likely (35%) and firms with 5,000 or more workers are more likely (59%) to have such a requirement [Figure 12.14].
- Among firms that cover GLP-1 agonists for weight loss, 29% say that covering these medications has had a significant impact on their plan's prescription drug spending, 27% say that the impact has been moderate, 23% say that the impact has been minor, 10% say that there has been no impact, and 11% say that they do not know [Figure 12.15].
  - 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 [Figure 12.16].
  - Firms with 200 to 999 workers are more likely than larger firms to say that covering these medications for weight loss has had only a minor impact on prescription drug spending (30% vs. 5%) [Figure 12.15].
- Among firms with 200 or more workers that do not cover GLP-1 agonists for weight loss in their plan with the largest enrollment, 12% say that they stopped covering these medications for weight loss within the last 12 months [Figure 12.17].
- Among firms with 200 or more workers that do not cover GLP-1 agonists for weight loss in their plan with the largest enrollment, only 1% say that they are very likely to begin covering GLP-1 agonists for weight loss within the next 12 months, while 13% say that they are somewhat likely to do so, 79% say that they are not likely to do so, and 7% say that they do not know [Figure 12.16].

Figure 12.12
Percentage of Large Firms Whose Largest Plan Includes Coverage For GLP-1 Agonists When Used Primarily For Weight Loss, by Firm Size, 2026



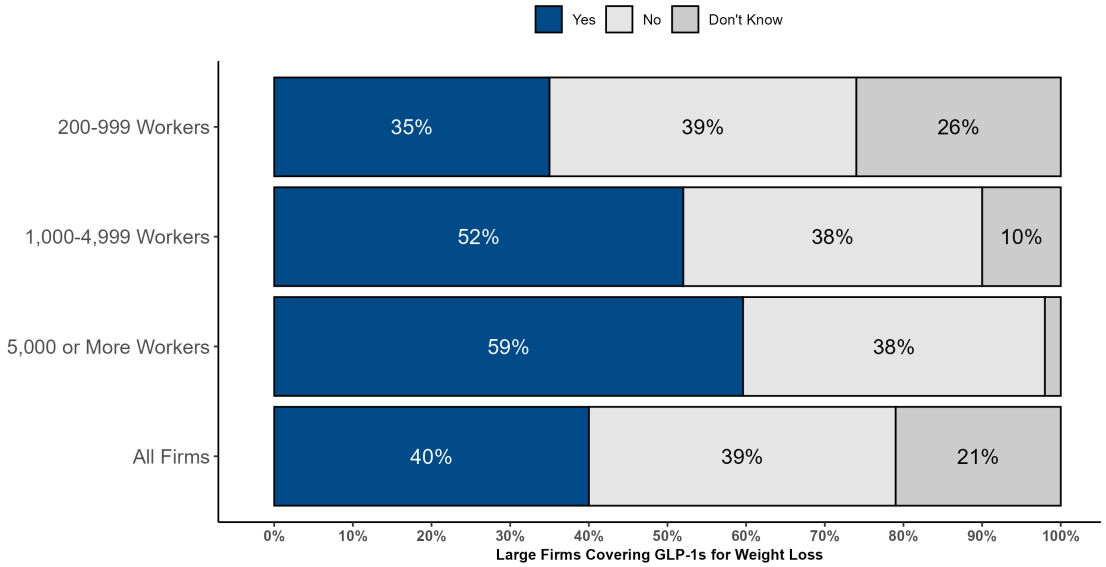
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Large Firms have 200 or more workers. Firms with multiple plans were asked about their plan with the largest enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.13
Percentage of Large Firms Whose Largest Plan Includes Coverage For GLP-1 Agonists When Used Primarily For Weight Loss, by Firm Size, 2024-2026



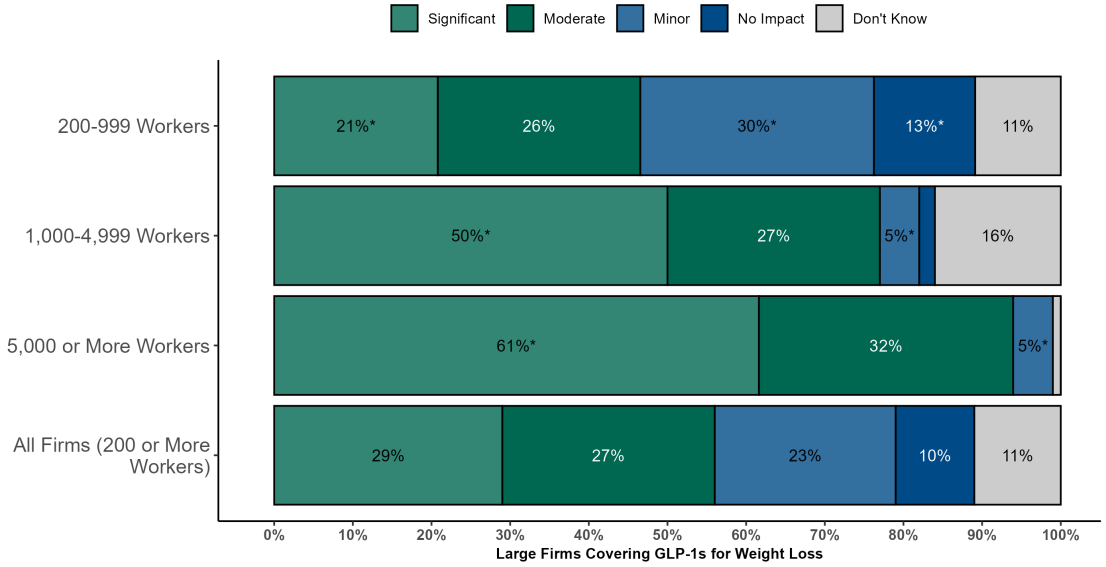
* Estimate is statistically different from estimate for the previous year shown within the same size and response categories ($p < .05$).
NOTE: Large Firms have 200 or more workers. Firms with multiple plans were asked about their plan with the largest enrollment.
SOURCE: KFF Employer Health Benefits Survey, 2024-2026;

Figure 12.14
Among Large Firms Covering GLP-1s for Weight Loss, Share Requiring Lifestyle or Clinical Support, by Firm Size, 2026



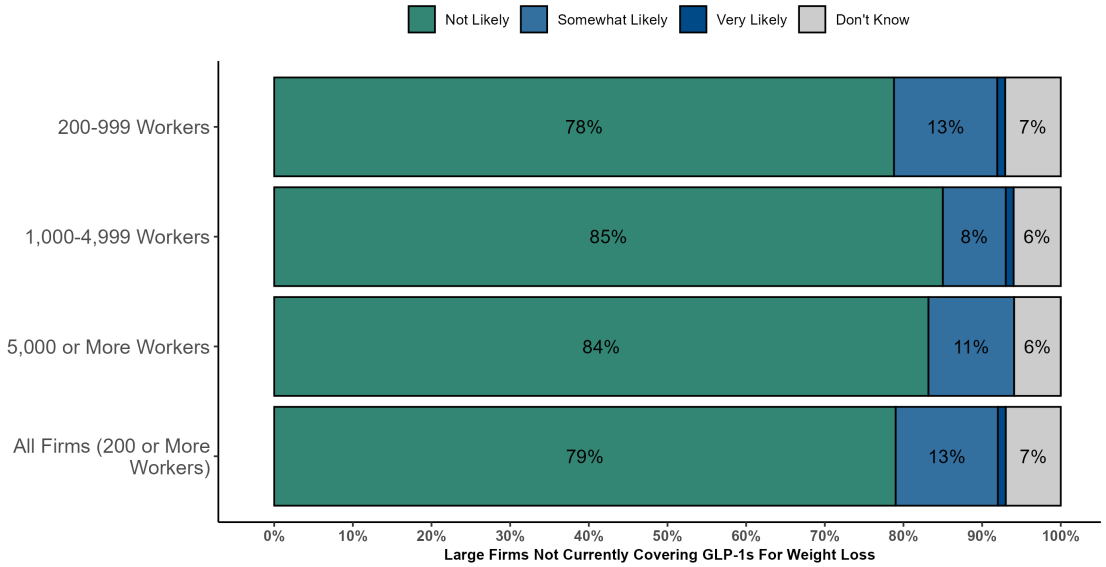
NOTE: Firms with multiple plans were asked about their plan with the largest enrollment. Among firms with 200 or more workers that offer health benefits, 18% reported that their largest plan included coverage for any GLP-1 agonist drugs when used primarily for weight loss. Clinical support includes meeting with a dietitian, case manager, therapist, or participating in a lifestyle program. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.15
Large Firms' Views on the Impact of GLP-1 Coverage for Weight Loss on Prescription Drug Spending, by Firm Size, 2026



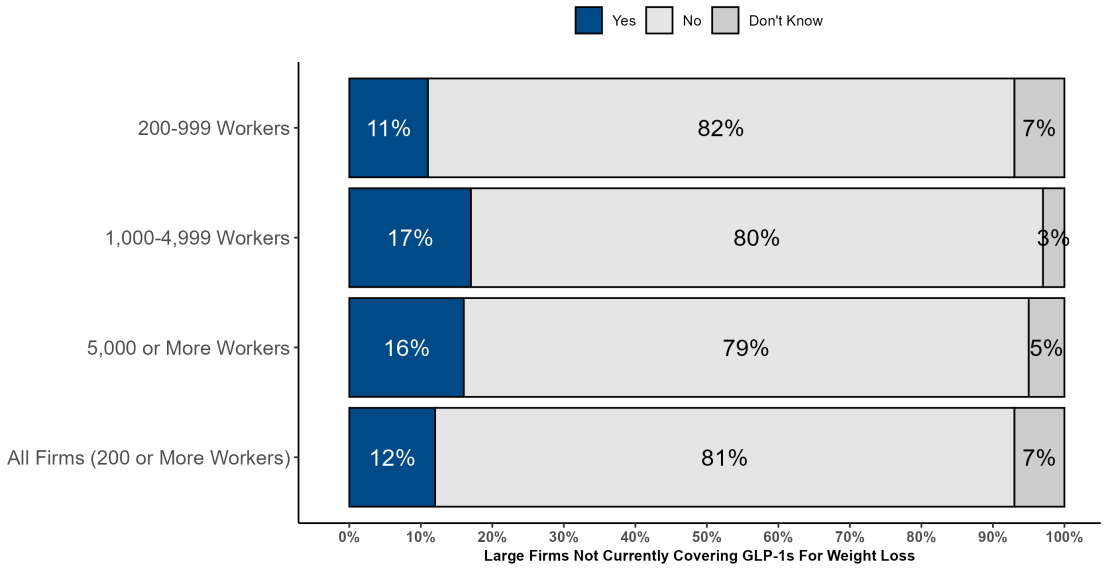
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size (p < .05).
NOTE: Firms with multiple plans were asked about their plan with the largest enrollment. Among firms with 200 or more workers that offer health benefits, 18% reported that their largest plan included coverage for any GLP-1 agonist drugs when used primarily for weight loss. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.16
Among Large Firms Not Covering GLP-1 Agonists for Weight Loss, Views on the Likelihood of Adding Coverage in the Next 12 Months, by Firm Size, 2026



Tests found no statistical difference 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, 65% reported that their largest plan did not include coverage for GLP-1 agonist drugs when used primarily for weight loss. Firms that were unsure were not asked whether they were likely to add coverage. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.17
Among Large Firms Not Covering GLP-1 Agonists for Weight Loss, Percentage That Dropped Coverage Over the Last 12 Months, by Firm Size, 2026



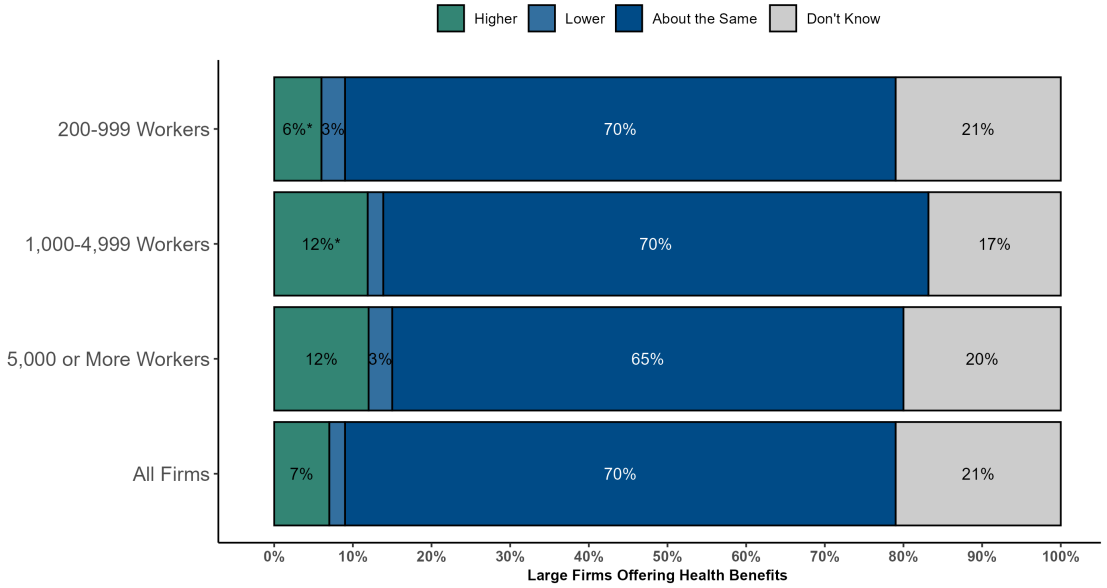
Tests found no statistical difference from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Firms with multiple plans were asked about their plan with the largest enrollment. Among firms with 200 or more workers that offer health benefits, 65% reported that their largest plan did not include coverage for GLP-1 agonist drugs when used primarily for weight loss. Firms that were unsure were not asked whether they were likely to add coverage. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

PRIOR AUTHORIZATION OF SERVICES

Certain health plan management practices, particularly prior authorization, have received considerable attention in recent years. Firms with 200 or more workers that offer health benefits were asked about recent changes in the usage of prior authorization in their plan with the largest enrollment.

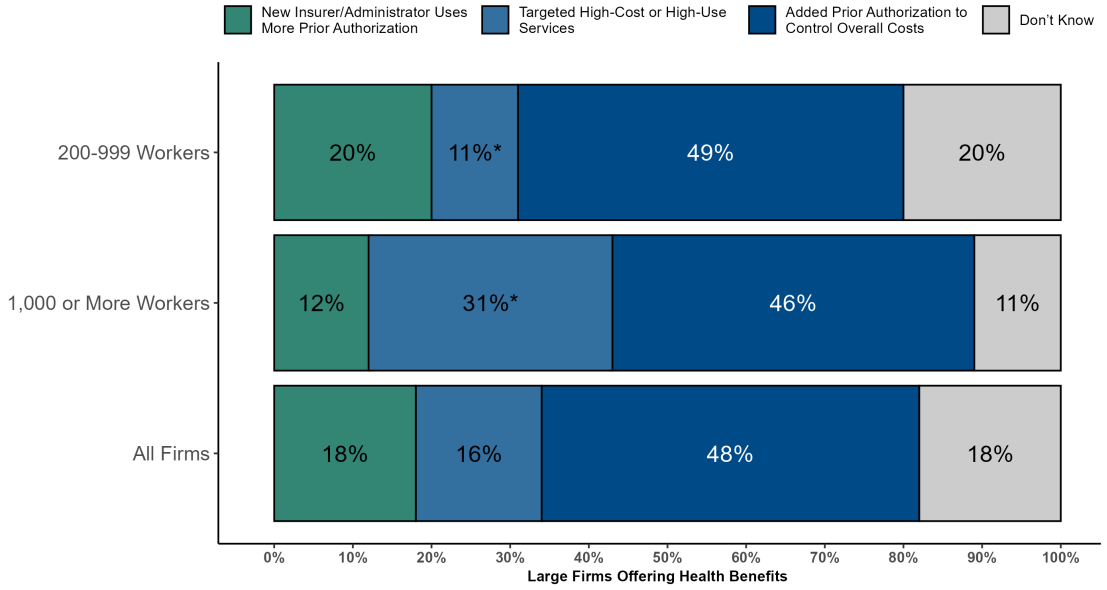
- Seven percent of these firms say that the number of services subject to prior authorization is higher than it was last year, 2% say that it is lower, 70% say that it is about the same, and 21% say that they do not know [Figure 12.18].
  - Firms with 1,000 or more workers are more likely than firms 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%) [Figure 12.18].
  - Among firms that say that the number of services subject to prior authorization is higher than it was last year, 18% say that the primary reason is that the plan has a new insurer or administrator that makes greater use of prior authorization, while 16% say that new services were made subject to prior authorization to target specific areas where use or costs were higher than expected or seemed unreasonable, 48% say that prior authorization was added to additional services to help control overall cost growth in the plan, and 18% say that they do not know [Figure 12.19].

Figure 12.18
Among Large Firms that Offer Health Benefits, Number of Services Subject to Prior Authorization Compared to the Previous Year, 2026



* 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. Large Firms have 200 or more workers. Firms were asked if the number of services subject to prior authorization was higher, lower, or about the same as the previous year.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.19
Among Large Firms that Increased the Number of Services Subject to Prior Authorization, Primary Reason for this Change, 2026



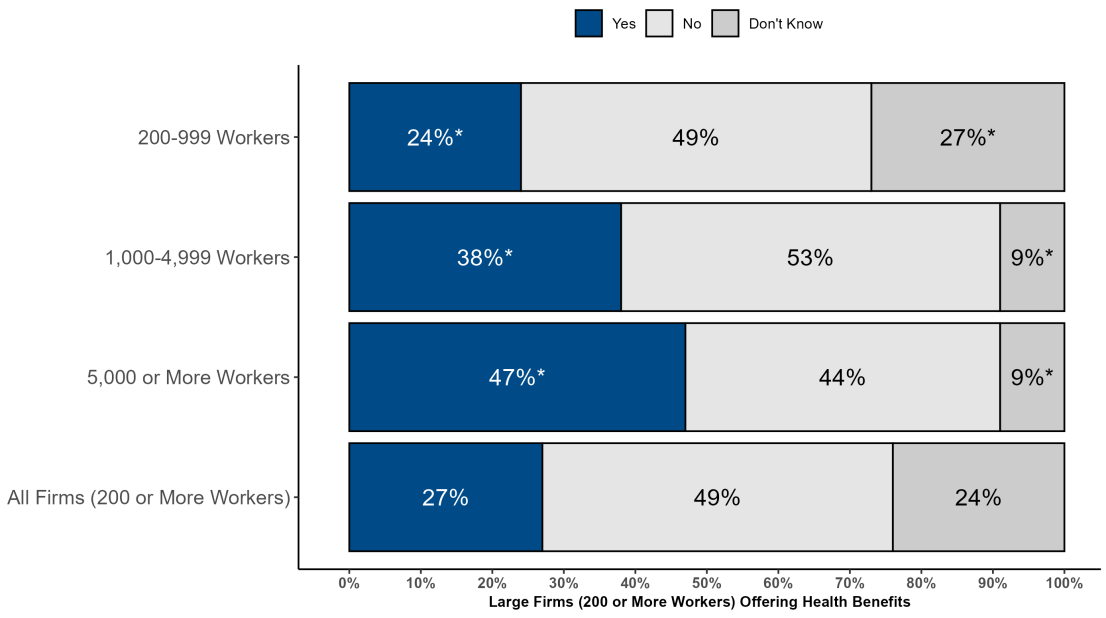
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Firms with multiple plans were asked about their plan with the largest enrollment. Large Firms have 200 or more workers. Firms were asked if the number of services subject to prior authorization was higher, lower, or about the same as the previous year.
SOURCE: KFF Employer Health Benefits Survey, 2026

IN VITRO FERTILIZATION

Improving affordable access to in vitro fertilization (IVF) and other assisted reproductive services has received considerable public attention in recent years. During the 2024 presidential campaign, President Trump proposed making IVF services free for patients, and in 2025, he signed an executive order directing the development of recommendations to expand access to IVF and reduce its cost. Firms with 200 or more workers that offer health benefits were asked whether their plan with the largest enrollment covers IVF services, either through the plan or through a third-party vendor.

- Among these firms, 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. Firms with 200 to 999 workers are more likely than larger firms to say that they do not know whether their plan covers IVF services (27% vs. 9%) [Figure 12.20].
- The percentage of large firms offering health benefits that cover IVF services in 2026 (27%) is the same as the percentage in 2024 (27%).

Figure 12.20
Percentage of Large Firms that Provide Coverage for In Vitro Fertilization (IVF), by Firm Size, 2026



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

EMPLOYER ACCESS TO INFORMATION ABOUT THE COST AND USE OF MEDICAL SERVICES BY PLAN ENROLLEES

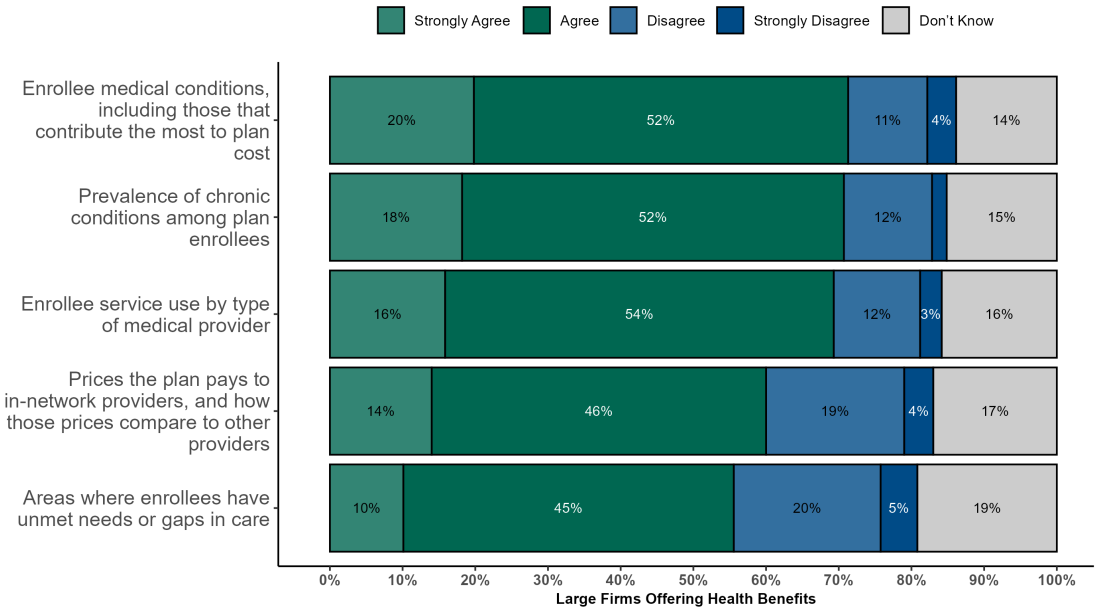
Providing employers with greater transparency into the cost and use of health care services within the plans they sponsor has become an important priority for policymakers and plan sponsors. Firms were asked a series of questions about the cost and utilization information available to them, including whether they have access to claims data for their plan enrollees.

ABILITY OF EMPLOYERS TO OBTAIN INFORMATION ABOUT THE COST AND USE OF SERVICES

Firms with 200 or more workers that offer health benefits were asked about their ability to obtain information about the cost and use of medical services (apart from prescription drugs) in their plan with the largest enrollment. This information may include summary information from an insurer or plan administrator, or more detailed data reports. Specifically, firms were asked how strongly they agreed or disagreed that they have enough information to understand each of the following areas:

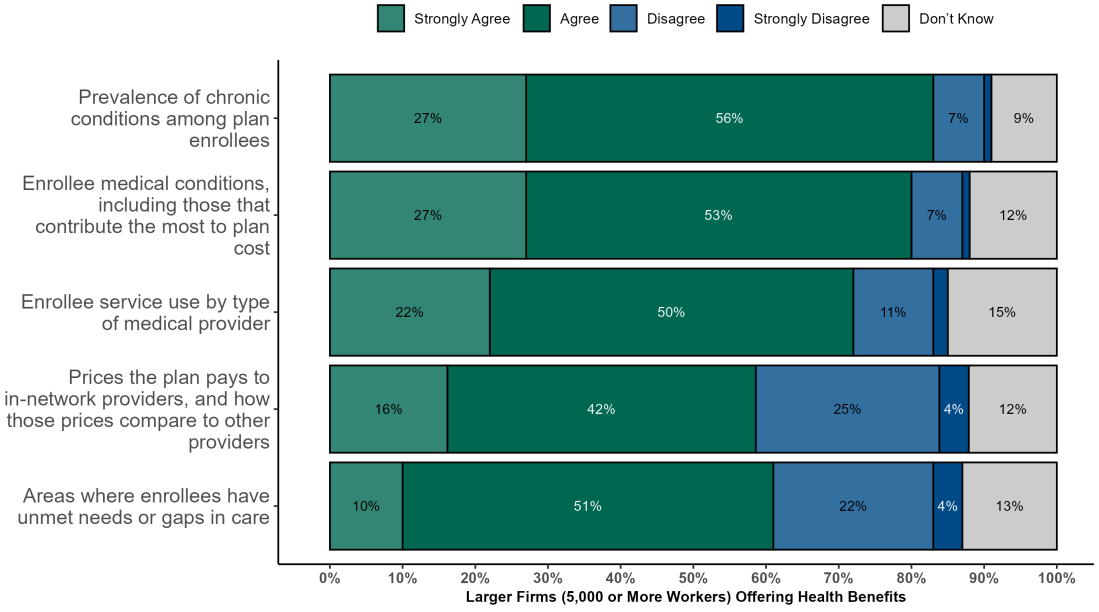
- **Service use by type of medical provider.** Sixteen percent of these firms "strongly agree" that they are able to get sufficient information to understand the service use of plan enrollees by type of medical provider, 54% "agree," 12% "disagree," 3% "strongly disagree," and 16% say that they do not know [Figure 12.21]. 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 service use 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% "agree," 11% "disagree," 4% "strongly disagree," and 14% say that they do not know [Figure 12.21]. 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% "agree," 12% "disagree," 2% "strongly disagree," and 15% say that they do not know [Figure 12.21]. 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% "agree," 19% "disagree," 4% "strongly disagree," and 17% say that they do not know [Figure 12.21].
- **Areas where enrollees may have unmet needs or gaps in care.** Ten percent of these firms "strongly agree" that they are able to get sufficient information to understand areas where enrollees may have unmet needs or gaps in care, 45% "agree," 20% "disagree," 5% "strongly disagree," and 19% say that they do not know [Figure 12.21].

Figure 12.21
Percentage of Large Firms That Agree That They are Able to Get 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 12.22
Percentage of Large Firms (5,000 or More Workers) That Agree That They are Able to Get Information on the Cost and Use of Various Medical Services, 2026



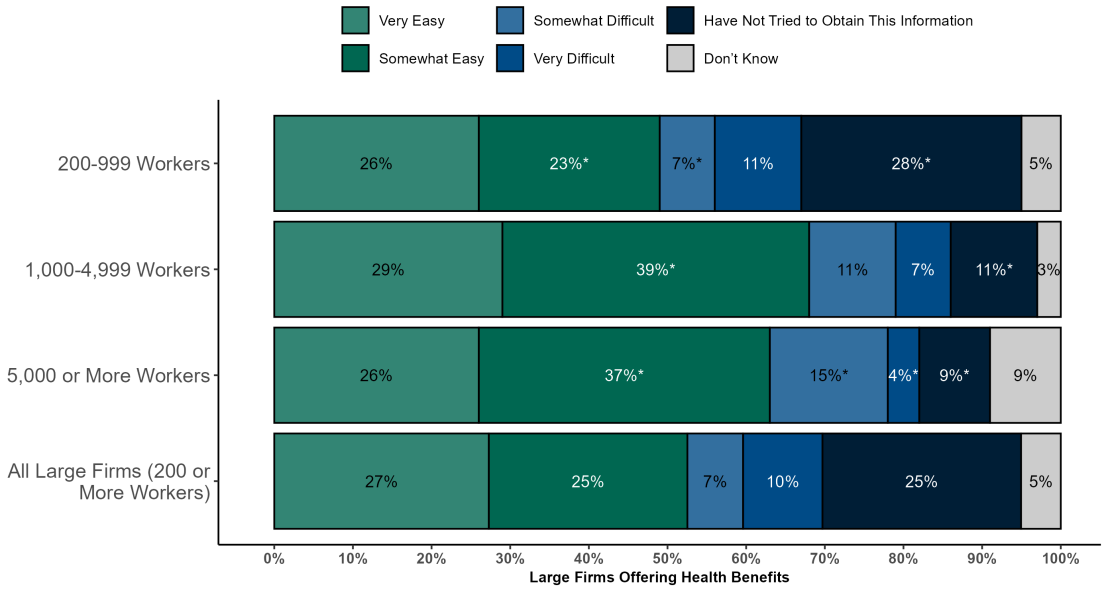
NOTE: Larger firms have 5,000 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

ACCESS TO CLAIMS DATA OF ENROLLEES

Firms with 200 or more workers that offer health benefits were asked about their access to claims data for plan enrollees. Claims data is defined as detailed information about the services used by plan enrollees, which may have personal identifiers removed, and the amounts paid to providers for each service.

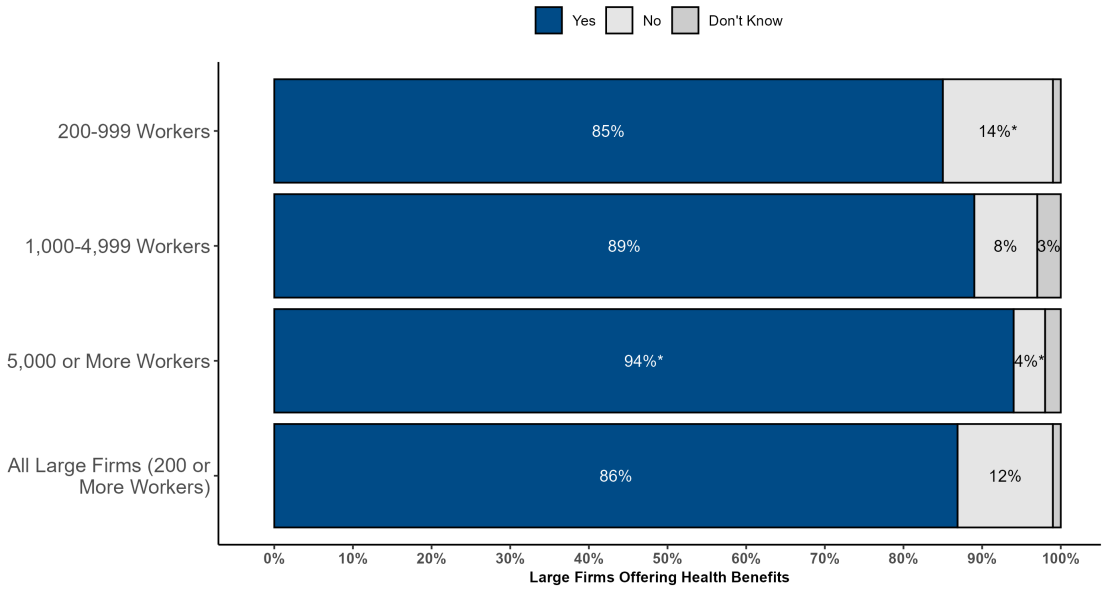
- Among these firms, 27% say that it is “very easy” to access claims data from their plan administrator or vendors, 25% say that it is “somewhat easy,” 7% say that it is “somewhat difficult,” 10% say that it is “very difficult,” 25% say that they have not tried to access claims data, and 5% say that they do not know [Figure 12.24].
- Firms that have been able to access claims data for their enrollees were asked how helpful the data has been in making decisions about health benefits. Sixty-six percent of these firms say that their claims data has been “a great deal” of help, 29% say that it has been “somewhat” helpful, 4% say that it has provided “very little” help, and 1% say that it has been “not at all” helpful [Figure 12.25].

Figure 12.23
Percentage of Large Firms That Can Easily Access Claims Data From Plan Administrators or Vendors, by Firm Size, 2026



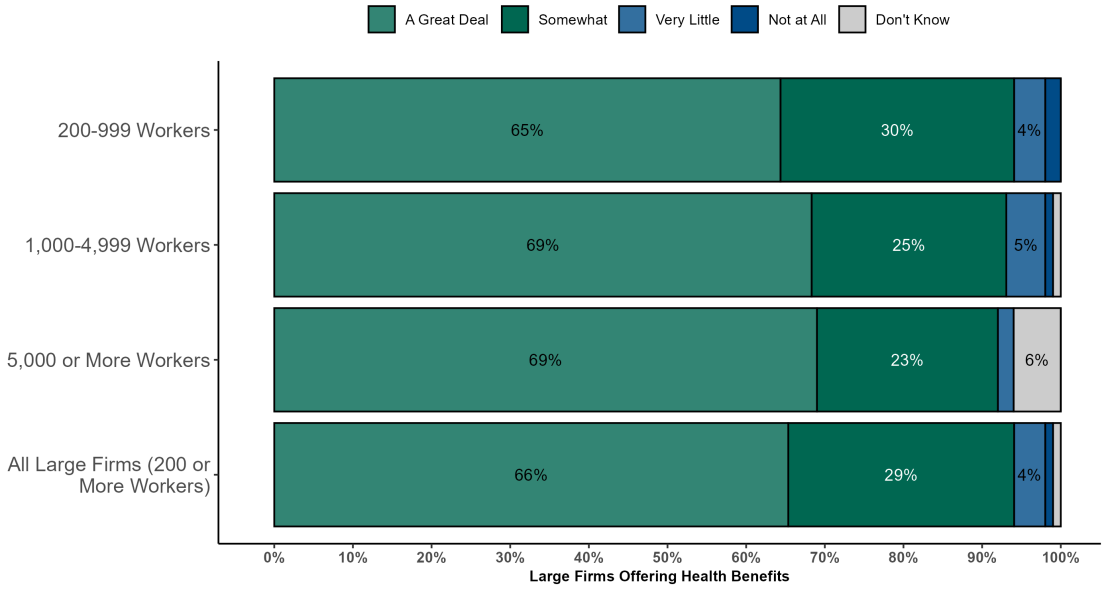
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Claims data is a detailed record of health care services used by plan enrollees and payments to providers. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.24
Among Large Firms That Tried to Obtain Claims, Percentage That Were Able to Obtain Data From Their Insurer or Plan Administrator, by Firm Size, 2026



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: This question was asked among the 70% of large firms offering health benefits that tried to obtain claims data. Claims data provide detailed records of health care services used by plan enrollees and payments to providers. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.25
Among Large Firms That Have Obtained Claims Data, Usefulness of Data in Making Health Benefit Decisions, by Firm Size, 2026



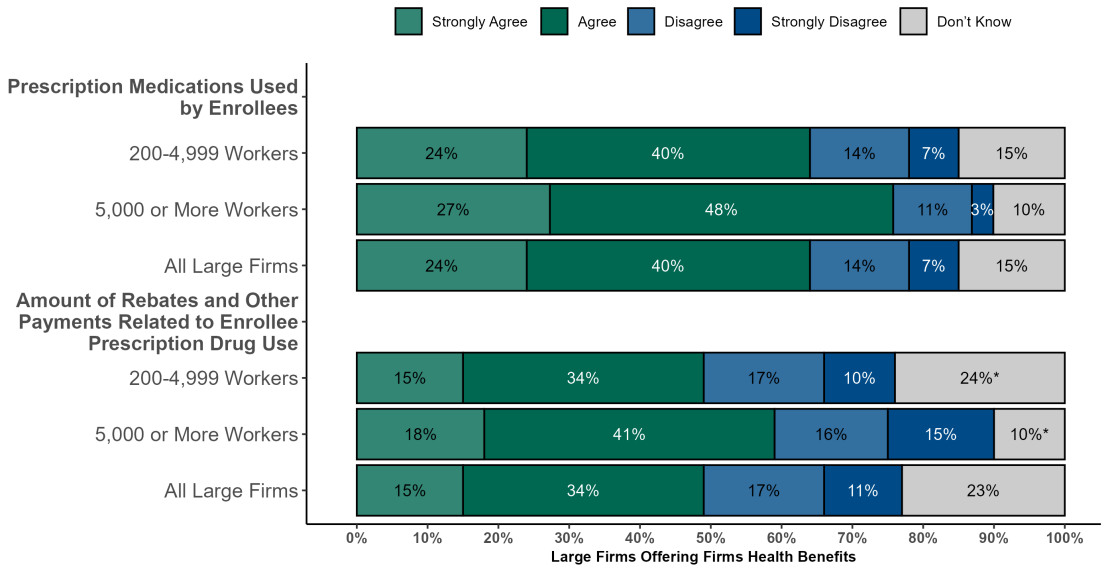
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: This question was asked of the 60% of large firms that obtained claims data. Claims data provide detailed records of health care services used by plan enrollees and payments to providers. Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2026

EMPLOYER ACCESS TO INFORMATION ABOUT THE COST AND USE OF PRESCRIPTION DRUGS

Firms with 200 or more workers that offer health benefits were asked about their ability to obtain information about the cost and use of prescription drugs in their plan with the largest enrollment. Specifically, firms were asked how strongly they agreed or disagreed with statements about their ability to obtain sufficient information about the following:

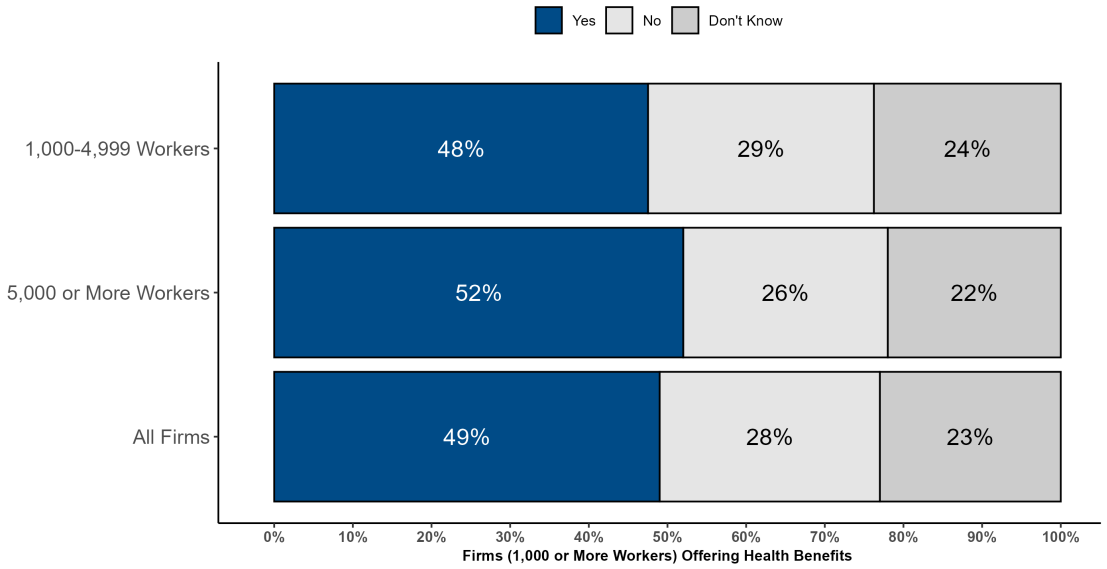
- **Prescription medications used by plan enrollees.** Twenty-four percent of these firms "strongly agree" that they are able to get sufficient information about the prescription medications used by plan enrollees, 40% "agree," 14% "disagree," 7% "strongly disagree," and 15% say they do not know [Figure 12.26].
- **Rebates and other manufacturer payments related to prescription drug use by plan enrollees.** Fifteen percent of these firms "strongly agree" that they are able to get sufficient information about rebates and other payments, such as administrative fees and incentives, that drug manufacturers pay to the insurer, administrator, or PBM related to prescription drug use by plan enrollees, 34% "agree," 17% "disagree," 11% "strongly disagree," and 23% say they do not know [Figure 12.26].

Figure 12.26
Percentage of Large Firms Able to Obtain Sufficient Information About Management of Prescription Drug Benefits, by Firm Size, 2026



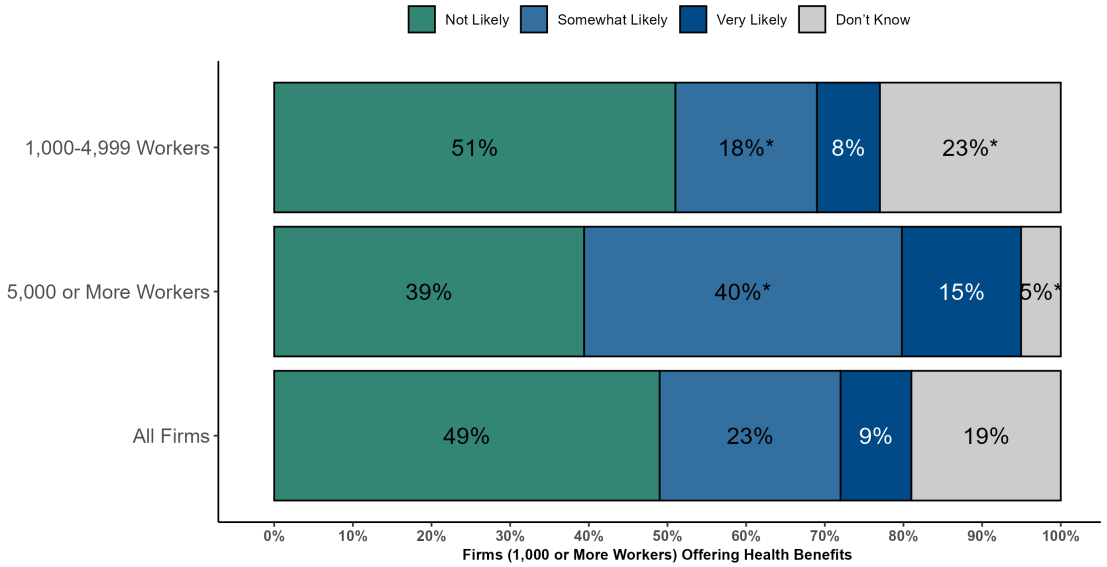
* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
NOTE: Firms with multiple plans were asked about their plan with the largest enrollment. Large Firms have 200 or more workers. Managers of prescription drug benefits can include insurers, administrators, or PBMs. Other payments include administrative fees and incentives paid by drug manufacturers to the prescription drug benefit manager.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.27
Percentage of Larger Firms That Use a Transparent or "Pass-Through" PBM, by Firm Size, 2026



Tests found no statistical difference 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. Firms have 1,000 or More Workers. This type of PBM is paid an explicit administrative fee and promises to pass through any rebates, discounts, or other types of compensation from drug manufacturers to the plan sponsor.
SOURCE: KFF Employer Health Benefits Survey, 2026

Figure 12.28
Among Larger Firms That Do Not Use a Transparent PBM, Likelihood They Will in the Next 2 Years, 2026



* 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. Firms have 1,000 or More Workers. This type of PBM is paid an explicit administrative fee and promises to pass through any rebates, discounts, or other types of compensation from drug manufacturers to the plan sponsor.
SOURCE: KFF Employer Health Benefits Survey, 2026

KFF

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