Weekly Checkup

Health Insurance Premiums Keep Rising

MICHAEL BAKER | OCTOBER 30, 2026

Surveys show the cost of employer sponsored health insurance is once again moving in the wrong direction. According to KFF's 2026 Employer Health Benefits Survey, annual premiums for family coverage reached $28,303, an increase of 5 percent from last year. Workers contributed an average of $7,471 toward those premiums, 9 percent more than in 2025, while wages grew 3.7 percent. Marsh projects that employers' health benefit costs per worker will increase 8.2 percent in 2027, even after planned cost-control measures. **The surveys measure different things – one reports current premiums, the other forecasts employers' future costs – but both reflect a persistent problem: The bill for health coverage keeps growing, and relief is not obviously imminent.**

Understanding the continuing increase requires acknowledging the difference between the cost of insurance and the cost of care. Premiums finance expected medical claims, along with administration and other expenses. Those claims are shaped by negotiated prices, how frequently patients use services, and the treatments they receive. The cost of care, however, is the sum of the inputs to the care itself, such as supplies (e.g., a hospital, drug, implant) and labor (e.g., the nurse, doctor, receptionist). Many affordability proposals target how costs are divided among employers, workers, insurers, and taxpayers without necessarily changing the underlying expense itself. If the cost of care continues to rise, lowering the amount paid by one party simply leaves another with a larger bill. It does little to contain the pressures driving premiums higher.

A recent *Health Affairs* study helps illustrate why shifting the payment for care isn't a solution to cost containment. Researchers examining Blue Cross Blue Shield of Massachusetts found that commercial health spending per member grew 11.8 percent in the fiscal year ending June 2025. Inflation-adjusted prices for medical services increased just 1.3 percent, while utilization increased 4.8 percent. Retail prescription drug spending rose

21.7 percent in nominal terms, fueled partly by rapidly growing use of GLP-1 medications. These findings describe one insurer, not the national population, but they caution against assuming high prices alone can explain every spending increase.

Increasing utilization also pushes up the cost of insurance. A recent Phoenix Center analysis examined the relationship between medical claims and premium revenue at five large insurers. It found a 1-percent increase in claims was associated with an approximately 1-percent increase in premium revenue over time. The findings do not isolate the effects of utilization or establish how premiums change for any particular insurance plan, but they underscore an obvious economic relationship: When greater utilization or higher prices increase insurers' claims expenses without corresponding savings elsewhere, those costs must eventually be financed through higher premiums or absorbed through lower margins.

As utilization continues to drive health care spending, policymakers tend to mistake shifting costs between payers for reducing them. Employers can increase workers' premium contributions or deductibles, lowering the amount the company pays without necessarily influencing the cost of treatment. Or they can cap a patient's copayment, which may assuage an immediate financial burden but transfer some expenses to the broader insurance pool. Such arrangements can provide valuable financial protection, but they do not make the underlying medical services cheaper to arrest long-term growth.

An October report from the Department of Health and Human Services relies on this cost-shifting theory and estimates an association between state hospital provider tax adoption and higher commercial insurance premiums. Comparing premium trends in states that adopted hospital provider taxes with trends in other states, researchers estimate that adoption was associated with a 1.5–1.7 percent increase in premiums for employer-sponsored single coverage. It subsequently projects that restrictions targeting this provider tax enacted in the One Big Beautiful Bill Act could lower employer-sponsored premiums by 2.2–2.5 percent by 2032. Though potentially promising, the projection warrants caution. It extrapolates from historical tax adoptions to future tax reductions, amid other changes in state Medicaid policy that complicate causal interpretation. Even if the savings materialize, they are measured against what premiums otherwise would have been, not against what people pay today.

Reducing distortions that elevate premiums – such as the provider tax – can be worthwhile even without reversing the larger trend. Insurance design, provider payment policies, and market competition all influence spending in different ways. Correcting inefficiencies in one area may leave other pressures intact. But savings relative to a projected baseline do not necessarily translate into a lower bill. If a future premium would otherwise reach $30,000, a reform that reduces it by 2.5 percent would bring it to

$29,250. That is real savings, but it could still be higher than the prior year's average family premium. Any estimate of premium relief should therefore be considered alongside the other forces shaping health care spending.

A credible affordability agenda must look beyond which actor in the system receives the invoice. Greater provider competition, practical price transparency, incentives for efficient sites of care, and competition from generics and biosimilars can discipline spending without treating reduced access as the measure of success. Insurance design should also help patients obtain high-value care rather than simply discourage use. **With premium growth outpacing wages, distinguishing genuine reductions in medical spending from a rearrangement of who pays is more than an accounting exercise. It is the difference between temporary budget relief and lasting affordability.**