2026 SURVEY FINDINGS

PULSE OF THE PURCHASER

Bringing employer healthcare insights into focus



National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

Pulse of the Purchaser Research Institute

Introduction

Every year, the Pulse of the Purchaser survey offers insider views into how employers are navigating healthcare challenges. This year's survey, our largest response ever, comes as employers continue to face relentless cost growth despite sustained efforts to improve value, transparency, and accountability. Employers project costs will rise an average of 7.7% before plan design changes next year, with many expecting increases well above that level.

A key finding is that cost pressure alone does not drive action. Employers with the highest cost increases are not necessarily adopting more strategies to manage them. The stronger predictor is access to data. Employers with complete access to medical claims data report using significantly more purchasing strategies than those without it.

Across the country, employers cite similar concerns — drug prices, hospital prices, and high-cost claims — but those with usable claims data are better positioned to move from concern to action and manage costs more deliberately.

This year, we also asked employers where the healthcare dollar goes. Their estimates show where purchasers believe costs are concentrated and where improvement may be possible. Together, the findings show how employers are navigating today's healthcare marketplace, including:

- Purchasing strategies and data access
- PBM contracting and hospital purchasing
- Benefit design
- Policy changes that could support a better-functioning healthcare marketplace

Employers are increasingly frustrated that they are expected to pay the bill but often lack the information, leverage, or contractual rights to influence outcomes. That dissatisfaction is driving stronger support for PBM reform, hospital price transparency, hospital rate regulation, and closer oversight of healthcare markets. More employers are also engaging directly in policymaking, especially when they have the data and resources to understand how the system affects their organizations.

The encouraging message is that engagement matters. Employers that invest in understanding their data, evaluating vendors, working with local coalitions, and implementing high-value purchasing strategies show that progress is possible. No single strategy will solve system-wide dysfunction, but thoughtful action, supported by transparency and accountability expectations, can make a difference.

We hope these findings help employers, policymakers, healthcare organizations, coalitions, and other partners identify practical opportunities to improve affordability, value, and outcomes.

Thank you to our coalition members and the hundreds of employers who contributed. Their insights can help employers, coalitions, and partners turn findings into action to improve affordability, accountability, and value.

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About this report

Pulse of the Purchaser, a national survey of employers and other healthcare purchasers, was conducted with National Alliance member coalitions in May and June 2026. The survey had 408 responses – our largest sample to date – from private and public employers across the country.

The survey gauged current employer/purchaser perspectives, concerns, and insights related to the workforce environment; healthcare affordability; benefit design approaches; and health and wellbeing strategies.

What this year's data says

Executive Summary

Healthcare costs continue to rise, but the 2026 Pulse of the Purchaser survey shows that pressure alone does not drive action. Employers expect an average 7.7% cost increase before plan design changes, and one in three of those who gave an estimate expect increases of 9% or more. Yet, employers facing the highest increases are not significantly more likely to have purchasing strategies in place.

A new question this year provides greater visibility into the drivers of healthcare spending. Employers identify hospital and facility costs as the largest share of healthcare expenditures, followed by prescription drugs and professional fees—highlighting where affordability pressures are most concentrated.

The strongest predictor of action is access to data. Employers with full claim-level access use more purchasing strategies, have greater confidence in vendor oversight, and are more likely to engage in policy initiatives. In fact, they report currently using nearly four more strategies on average than employers with limited or no access. Data access is what moves employers from concern to capability.

Across the report, employers are signaling frustration but also inspiration to influence change. Support for policy intervention has grown significantly since 2023, with strong majorities saying PBM reform, hospital price transparency, and hospital rate regulation will help address affordability challenges. At the same time, the survey identifies a set of high-value purchasing strategies that employers are adopting or considering to improve value and manage costs.

The opportunity now is to convert purchaser intent into action by giving employers the data, leverage, transparency, and policy environment needed to manage healthcare more effectively. The findings suggest that when employers can see their data, exercise their purchasing power, and engage in reform efforts, they are far better positioned to influence both costs and outcomes.

Base: 408 responses, fielded May-June 2026; bases vary by question; each page carries its own base.

Employer Demographics

37 coalitions had employer members participate

Organization size

Number of employees



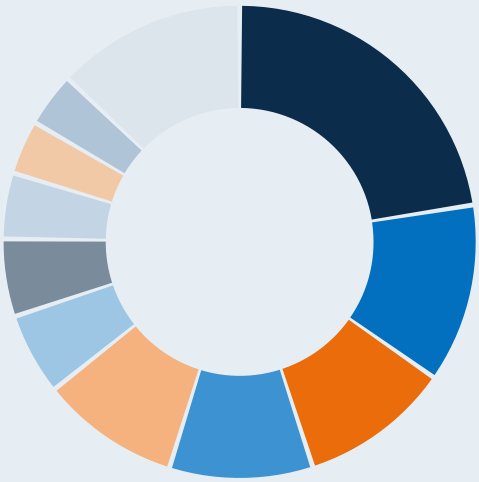
Top 10 coalitions with highest employer member participation

- Business Health Care Group (WI)
- California Health Care Coalition
- Dallas/Fort Worth Business Group on Health
- Economic Alliance for Michigan
- Florida Alliance for Healthcare Value
- HealthCareTN
- Houston Business Coalition on Health
- Lehigh Valley Business Coalition on Healthcare
- Midwest Business Group on Health
- Washington Health Alliance

Respondents span all sizes

- Small (under 1,000) 38%
- Mid (1,000–9,999) 38%
- Large (10,000+) 25%

Industry type

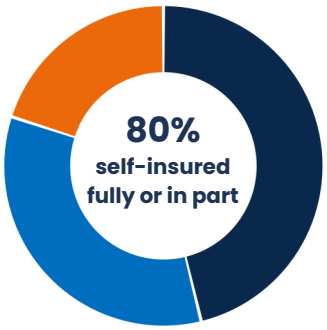


Healthcare & Social Assistance	22.5%
Manufacturing	12.2%
Educational Services	10.3%
Finance & Insurance	9.8%
Federal, State, or Local Government	9.5%
Information Technology	5.6%
Retail/Wholesale Trade	5.3%
Accommodation & Food Services	4.5%
Construction	3.7%
Professional & Technical Services	3.7%
All other industries	12.9%

Base: 386 gave coalition, 368 gave employer size, 378 industry; percentages may not total 100% due to rounding

Employer Demographics

Funding arrangement



Self-insured	46.2%
Both fully & self-insured	33.8%
Fully insured	20%

Organization type

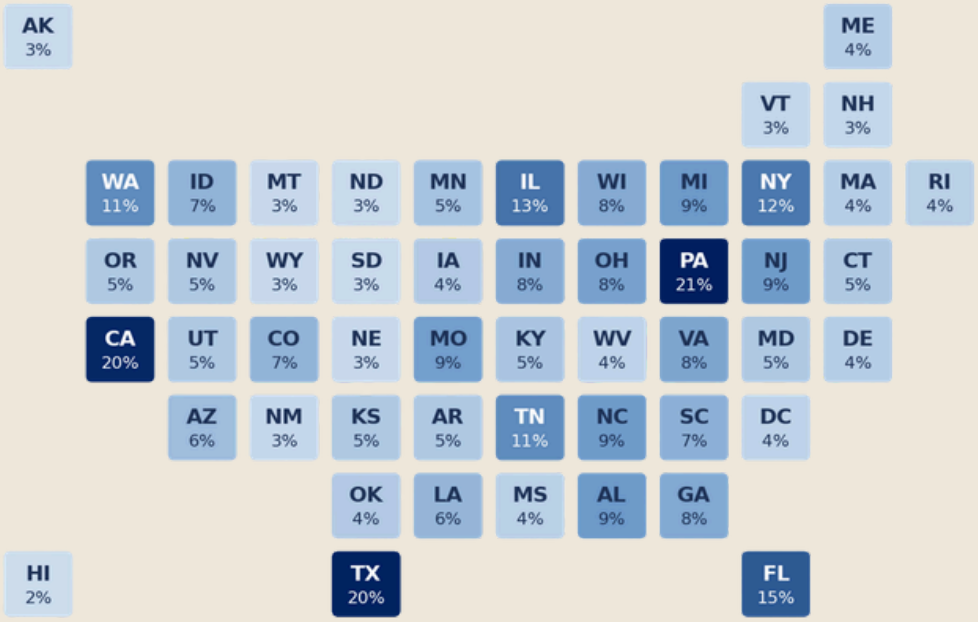
Three in five respondents are private employers and one in four is a public purchaser



- **61 %** Private business
- **11%** Local government (city, county, municipality)
- **9%** State government or agency
- **7 %** Federal government or agency
- **2%** Union
- **11%** None of the above

Distribution by State

Where the 2026 respondents operate



Most-represented states: PA 21% TX 20% CA 20% FL 15% IL 13%

269 employers (75%) operate in a single state.



National reach, local roots

- All 50 states and DC are represented
- Three in four respondents operate in a single state
- 37 coalitions had employer members respond
  - 14 of them with 10 or more respondents

Base: 355 employers; 6 answering 'don't know' or 'other' are excluded, 374 organization type, 357 state(s)

WHO ANSWERED

The people who sign the contracts

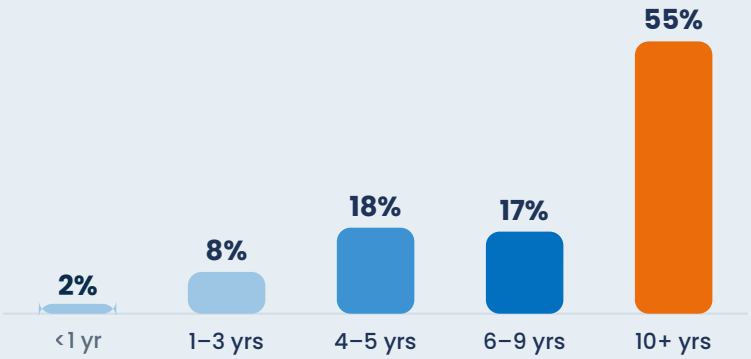
89% of respondents are middle or senior management or above and 72% have six or more years in benefits.

89%
in middle management or above

72%
with six or more years in benefits

55%
with a decade or more of tenure

Years of experience in benefits



Role level



3.7 million
covered lives



Represented in survey as self-reported by employer respondents and summed

Base: 354 role and experience, 357 state, multi-state employers counted in each state, 385 coalition, 356 covered lives

01 SECTION

What Employers Expect to Pay

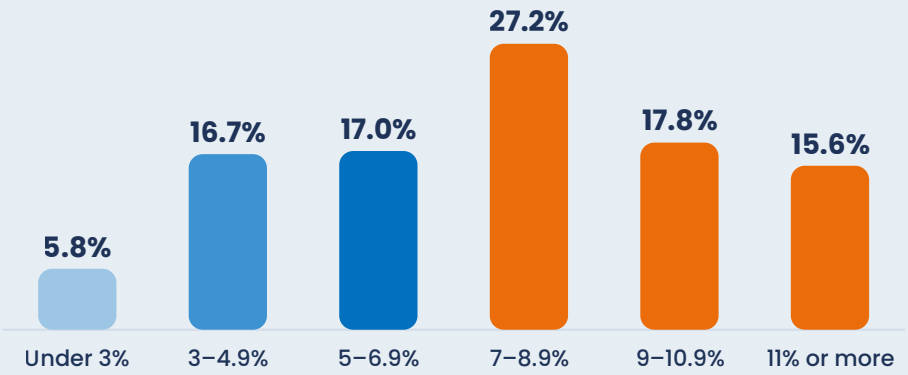
For the first time we asked employers to put a number on next year.

- Expected cost increase for the next plan year
- How total healthcare spend is allocated
- Affordability threats



Employers forecast cost increases

Expected cost increase for the next plan year, before any plan design changes



7.7%

average expected increase, before any plan design changes

> *Our costs continue rising steadily, especially for specialty care and prescription drugs. We're balancing affordability, competitive benefits, and long-term sustainability.*
>
> — Survey respondent

One in three at 9% or more

- 33% of employers with an estimate expect an increase of 9% or more
- One in seven could not say what their trend will be

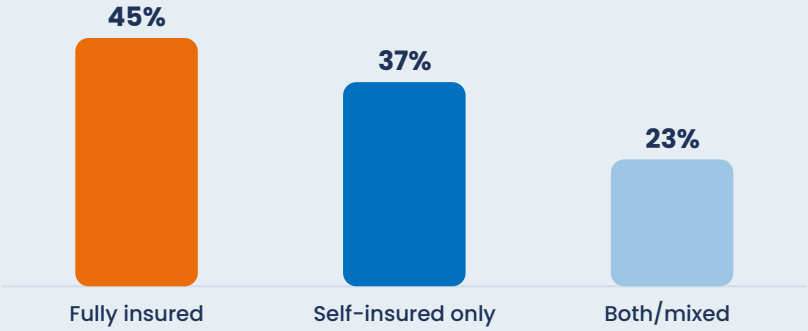
+22 pts

gap between fully-insured and mixed-funding employers on expecting 9% or more

Fewest levers, steepest slope

Fully insured employers report the highest expected increases — and they are also the group with the least access to claim-level data.

Share expecting an increase of 9% or more, by funding arrangement

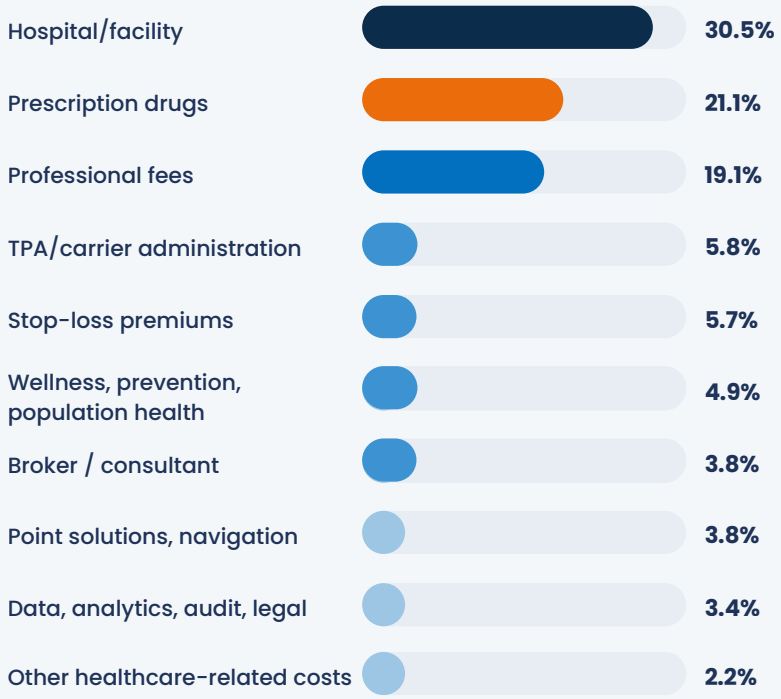


Base: 276 employers who gave an estimate, of 319 answering; 43 answered "don't know" and are excluded; The average uses band midpoints, with 12.5% assumed for the '11% or more' band

Base: 53 fully insured / 128 self-insured only / 93 mixed funding (p=0.004); cost-expectation base 319 answering, 276 with an estimate

Where is employer healthcare spending going?

Employer best estimates of total healthcare spend



Includes only respondents whose allocations sum to 90–110% (n=166). These are best estimates, not audited financials.

Hospital and facility care drives the largest share of costs

Employers' direct estimate for hospital/facility costs is 30.5%. When hospital-affiliated professional fees and physician-administered drugs billed through hospital systems are included, the National Alliance estimates hospital services approach half of every dollar employers spend on healthcare (*Setting the Record Straight: A Challenge to Align Hospital Prices with Value, National Alliance, 2026*). The survey did not ask employers to make this split.

How premiums stack up against the national benchmark



> *We managed to keep our premium below the national average by shifting to a self-funded model three years ago. That transition, combined with aggressive network management, made the difference.*
>
> — Survey respondent

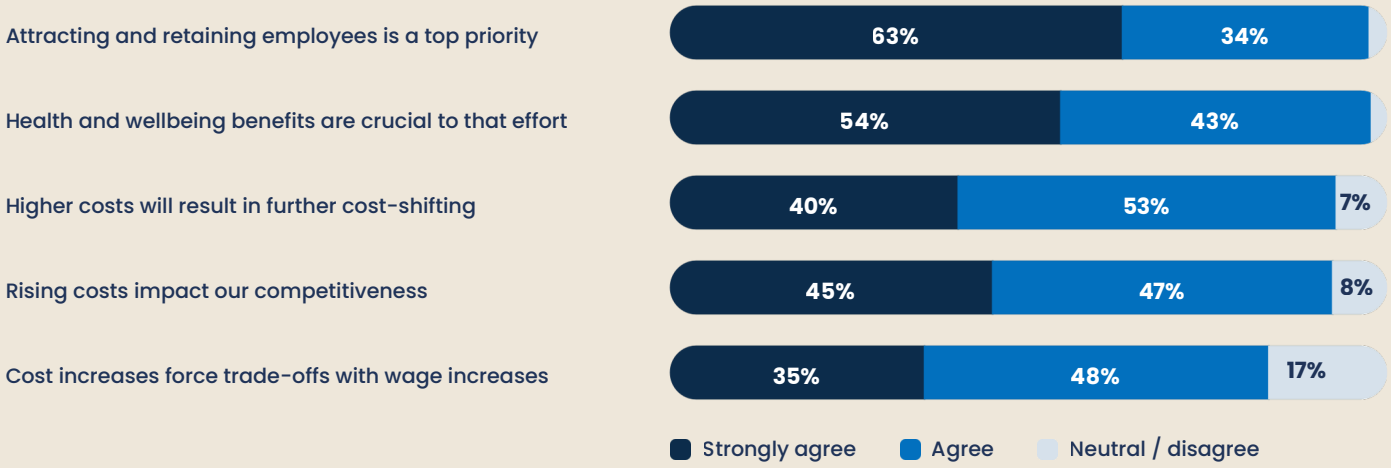
Employers paying higher premiums expect sharper increases

Employers already paying above-average premiums also expect the sharpest increases: 48% expect a rise of 9% or more, against 26% of everyone else, and their average expected increase is 8.7% versus 7.1%.

Base: premium comparison base 316; Premium position by expected increase: 88 higher-premium employers with an estimate vs 183 others; $p<0.001$ on both the 9%+ share and the mean.

Employers continue to feel strong cost pressures

Employers are weighing benefits, wages, and pricing against rising healthcare costs

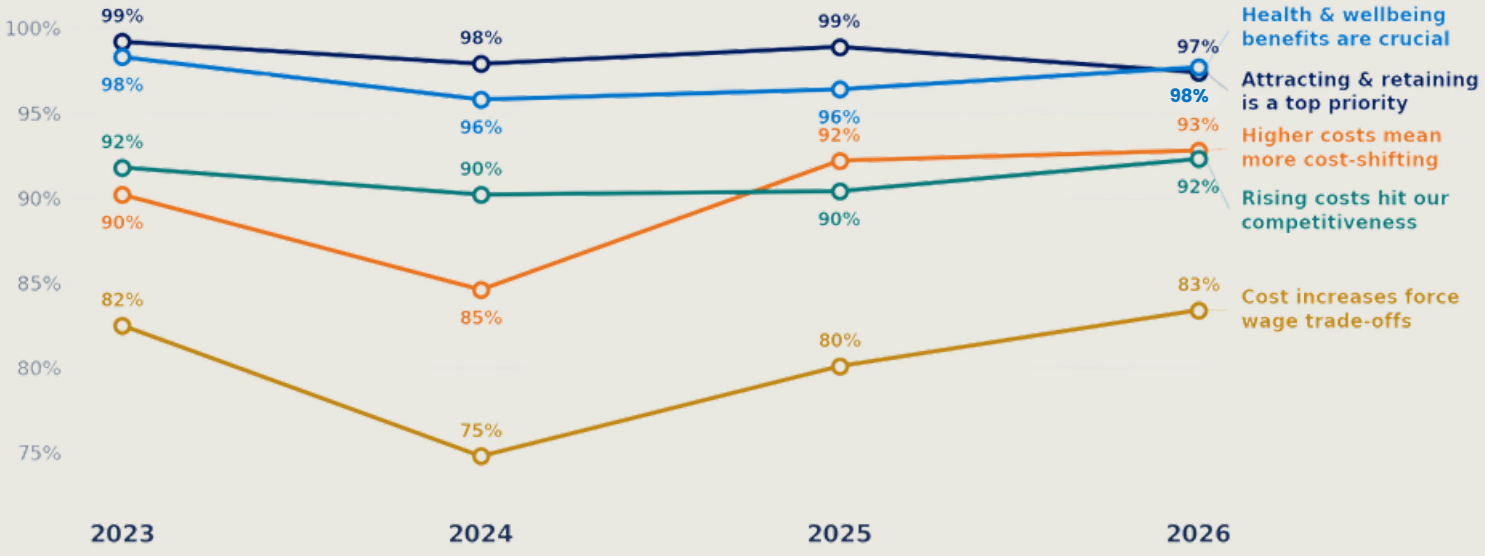


Employer workforce concern remains strong

Employer views have remained steady since 2023, with no meaningful changes across any of the five statements. Concern about rising healthcare costs is widespread and is pushing many employers from frustration toward action.

Workforce attitudes have not moved in four years

Percent who agree or strongly agree, 2023 to 2026



Base: employers answering each statement — 120–122 in 2023, 142–143 in 2024, 280–281 in 2025, 349–350 in 2026
2024 has the smallest base of the four years (142–143), and a similar dip appears across other question sets that year

02 SECTION

Data Access Is the Dividing Line

The strongest predictor of whether an employer acts is access to data. Consideration is shared across employers but not all have the capacity.

- What employers with claims data actually do differently
- Access on paper against barriers in practice
- How the uses of data changes with employer size



Employers with better data access take more action

What this chart shows — and why it matters

Across all 26 hospital and high-cost claim strategies, employers with complete medical claims data were more likely to be taking action. The largest gaps appear in strategies that require employers to compare prices, evaluate providers, negotiate contracts, or challenge vendor performance.

The chart compares 11 hospital purchasing strategies and 15 high-cost claim strategies employers are "currently doing" by whether employers report complete access to medical claims data.

Strategy	WITH complete medical claims access	WITHOUT	Strategy	WITH complete medical claims access	WITHOUT
Enhanced screening or early detection	70%	58%	Negotiating or auditing hospital prices	47%	29%
Navigator, advocacy or case management	67%	60%	Site-of-care strategies (hospital)	45%	30%
Stop-loss, captive or financial protection	66%	62%	Advanced primary care	45%	22%
Disease-specific vendors or programs	65%	51%	Reviewing hospital price transparency data	43%	24%
Reviewing pharmacy claims billed as medical	63%	46%	Tiered networks	42%	28%
Requesting claims data and audits	58%	42%	Direct contracting (hospital)	39%	17%
Steering members to higher-value sites	56%	36%	Non-traditional pharmacy procurement	39%	24%
Centers of excellence or bundled payments (hospital)	55%	39%	Direct contracting with providers (high-cost claims)	38%	17%
Centers of excellence (high-cost claims)	53%	40%	Carving out prior authorization	35%	21%
Site-of-care management (infusion, specialty) (high-cost claims)	52%	36%	Negotiating limits on outlier facility prices	32%	10%
Expert medical opinion for complex cases	51%	36%	Reference-based pricing	31%	10%
Evaluating networks on price and quality	49%	27%	Gene and cell therapy protection	30%	13%
Coalition or consultant finds high-priced sites	47%	28%	Precision medicine or biomarker testing	29%	21%

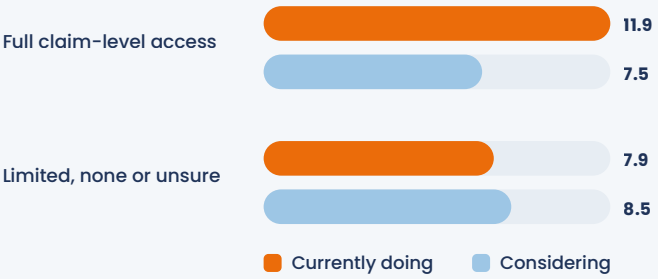
Base: 153–163 employers with complete claim-level access to medical claims data and 80–84 without, depending on the item; "without" combines employers who said no and those who were not sure; two-proportion tests; these are associations, not cause and effect — employers with claims access may act more because they can see more, or may have insisted on access because they were already acting; data access is self-reported and was not verified

What separates employers who act is not what they pay – it is what they can see

Employers are not short of intent. They are short of actionable information.

Purchasing strategies in use, by data access

Mean count of the 26 hospital and high-cost-claim strategies



Data access drives action

Employers with full claim-level access employ an average of 11.9 high value strategies vs. just 7.9 for those with limited or no access to claims. While both cohorts express interest, real access to claims is the difference between consideration and action.

+4.0
more strategies in use with full claims access

-1.0
difference on considering — not significant

> *Even if I did have access to our data, I don't know that I have the capacity to review and make decisions.*
> — *Survey respondent*

Employers facing the steepest increases are not doing more, nor are those who are facing higher premiums.

How to read this graph:

Every orange dot sits to the right of zero. Employers who can see their claims run more of every strategy listed. Navy and grey scatter around zero. What an employer expects to pay tells you almost nothing about what strategies they enact.

What each dot represents

- Has complete claim-level data access
- Expects a 9% or higher cost increase
- Pays premiums above the national average

(Hollow circles are not significant)

26 of 26
- point the same way
- 21 are significant

10 of 26
- point the same way
- none are significant

15 of 26
- point the same way
- one is significant

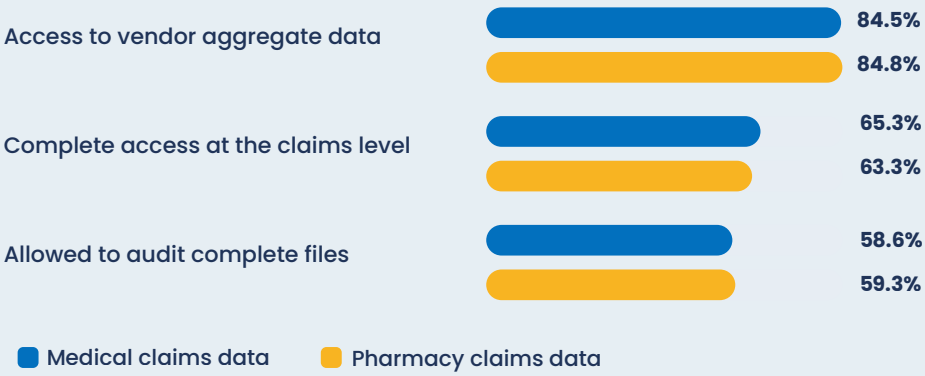


Base: 166 employers with full medical claim-level access and 86 with limited, none or unsure — those answering the access question and at least one of the 26 strategy items

Access on paper, but barriers in practice

Roughly one in three employers report they do not have complete claim-level access and only about three in five are confident they can audit their own complete files.

Medical and pharmacy claims data, asked separately for the first time



"Verification requires data. Contracts that restrict access to claims, eligibility, or rebate data limit the plan sponsor's ability to confirm that disclosures match operational reality."

— Nautilus Health Institute, Contract X-Ray: CAA 2026 Readiness Report

"Our major medical carriers place contractual restrictions on extracting complete, unredacted claim-level financial fields."
— Survey respondent

"While we technically have full access to our claim level and aggregate data and hold audit rights on paper, navigating vendor contract terms and technical silos remains a challenge."

— Survey respondent

Three quarters of employers keep their claims data with the health plan or TPA. That group is the least likely to have complete access to their data (59.2%).

Only one in four names an independent data warehouse, but 84.1% of those employers report complete pharmacy claim-level access — the highest of any storage arrangement.

Medical claims look the same: 85.9% versus 61.7%.

Where the data lives predicts whether you can access it



For reference: complete claim-level access across all employers is 63.3%

Base: 248–259 employers; medical and pharmacy asked separately for the first time in 2026
Base: 258 employers answered Q98; access rates are of the 41–191 in each group who also answered Q123. Q98 is check all that apply, so the groups overlap and shares sum to more than 100% — 38 of the 64 employers with an independent data warehouse also store data with their health plan or TPA; three selected "Other" and are not charted; association only: storage and data-access rights are usually negotiated together

How are employers using their data?

Nearly everyone uses claims data for cost analysis. The gap widens sharply for the uses that require leverage.

What employers use their health data for, by size



Roughly double, small to large

- Financial integrity 32% to 69%,
- Benchmarking 41% to 78%,
- Vendor accountability 35% to 67%

From tracking costs to managing performance

Cost analysis is common among employers of every size. Larger employers are much more likely to use their data to examine the financial integrity of the plan and hold vendors accountable.

Two different markets, two different needs

Small employers use data to see what happened. Large employers use it to hold vendors to account. Small employers may receive claims reports but still lack the staff time, tools, or support to turn them into decisions. As organizations grow, data use shifts from basic cost tracking toward financial oversight and vendor accountability.

> *"Improving access to healthcare claims data through more user-friendly reports, faster updates, and clearer explanations would make it easier for us to analyze the information and apply it effectively in our decision-making."*
>
> *— Survey respondent*

Base: 84 / 107 / 64 employers by size band; The gaps between the smallest and largest employers are significant at p<0.001 for benchmarking, financial integrity and vendor performance management

03 SECTION

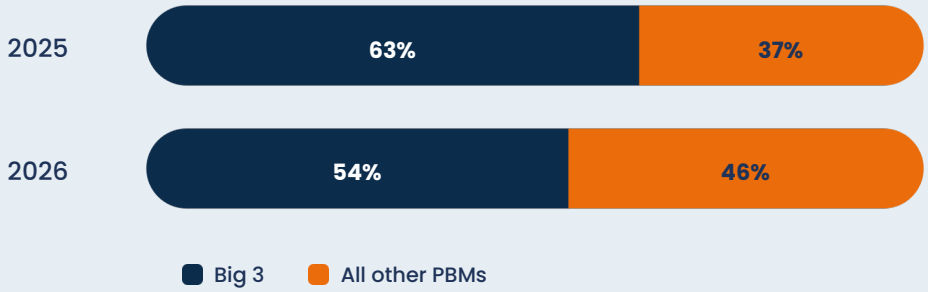
The PBM Market Is Moving

- Where the market shift is actually happening
- Switching intent, and how it widens with size
- Contract terms and fiduciary concern



PBM market movement

Big Three share of named PBMs fell from 63.4% in 2025 to 54.3% in 2026. Both years are classified by the PBM employers named.



-9.1 pts

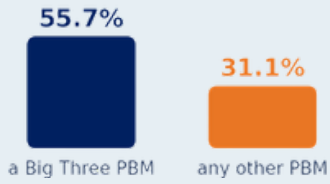
Big Three share of named PBMs 2025 to 2026

Who has switched in the past year?

Already moved
Changed PBM in the last year
% of employers who now use...



About to move
Considering a change in 1-3 years
% of employers who now use...



Employers are looking beyond the Big Three

Of the 27 employers who changed PBMs in the last year, 20 now use a non-Big Three PBM and 7 use one of the Big Three.

Looking forward, the pressure sits with the Big Three: 56% of their clients are considering a change, against 31% of others.

Big Three still lead the market, but their share declined as employers continued to test alternatives in search of greater transparency, control, and value.

Employers currently using another PBM were more than twice as likely to report changing PBMs in the past year — 24.4%, compared with 11.3% of current Big Three users. This *could* point to a shift from a Big Three PBM to any other PBM, but cannot be confirmed as the results only show where employers are now, not which PBM they left. Looking ahead, however, more than half of Big Three users are considering a change, creating the potential for continued market movement.

> *"Lack of transparency, lack of trust, misaligned incentives — where there is mystery there is margin."*
>
> — Survey respondent

Big Three users more likely to report higher premiums

Big Three users were 11 percentage points more likely to report higher-than-average premiums than users of other PBMs.



Use as directional; the 2025 PBM name was an optional write-in with lower response; 2026 used a pick-list; Big Three and all-other-PBM groups are classified by the PBM entity named; see appendix for classification rules.

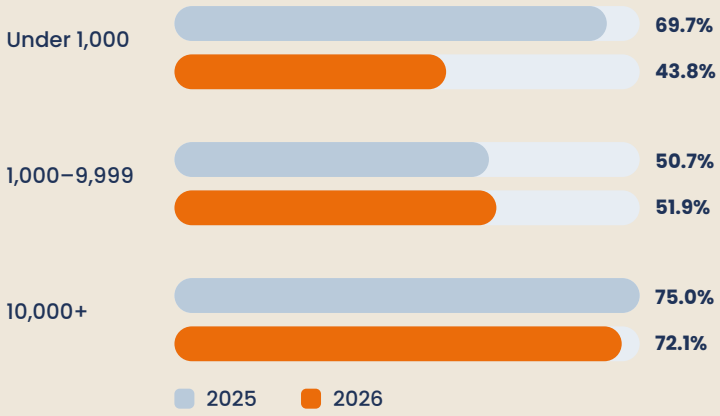
Base: 164 (2025) / 265 (2026) named a PBM, p=0.064; switching base 82 vs 62, p=0.046; premium base 143 vs 120, p=0.061

Base: 144 employers who named a PBM and answered "Have you changed your PBM in the last year?" (62 Big Three, 82 other); 259 who named a PBM and answered "Are you considering changing your PBM in the next 1–3 years?" (140 Big Three, 119 other); two-proportion tests; association only

Zooming in on the shift: A focus on small employers

The market shift away from the Big Three sits almost entirely with employers under 1,000. The mid-size band was flat and the largest employers barely moved.

Share of employers naming a Big Three PBM, by size



-26 pts

Big Three share among employers under 1,000, 2025 to 2026

The first shift came from small employers. The next may come from larger ones.

Small employers drove nearly all of the decline in Big Three market share. Among employers still using a Big Three PBM, interest in changing rises with size — from 47% of employers under 1,000 to 60% of employers with 10,000 or more employees. This suggests the next wave of market movement could come from larger purchasers.

Big Three clients are shopping

Considering a PBM change in the next one to three years — and the gap widens with employer size.

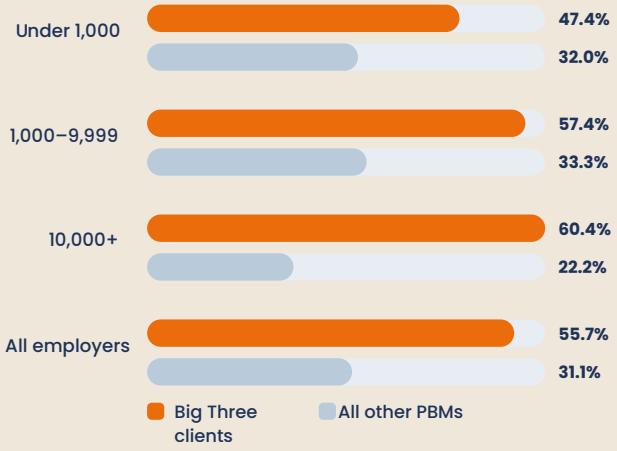
56% vs 31%

of Big Three clients are considering a change, against everyone else

The gap widens with size

- +15 points among the smallest
- +24 among mid-size
- +38 among the largest.

Considering a PBM change, by size and PBM type



Large employers are interested — but change takes time

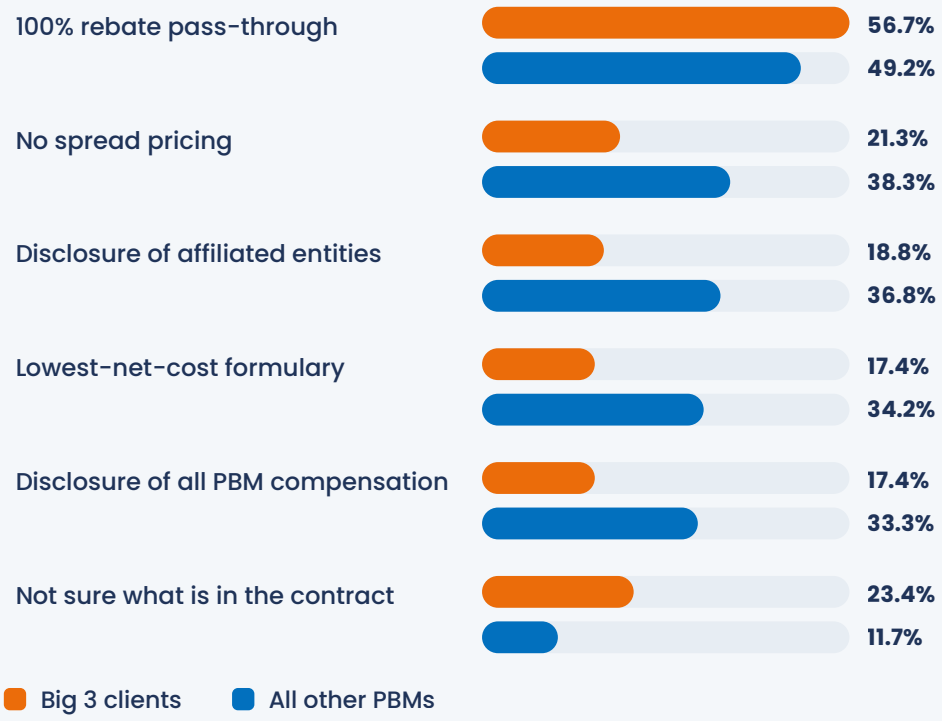
Large employers show the strongest interest in changing PBMs, but they have moved the least so far. That gap may reflect the scale of the decision: Larger organizations often use formal procurement cycles and need more time to evaluate pricing, operations, and member impact before making a change.

"We competitively procure PBM services every three years. The result of our next procurement may or may not result in a change in our PBM."
— Survey respondent, employer with 50,000+ employees

Base 2026: 89 / 108 / 68 employers naming a PBM; chi-square p=0.0016 (2026), p=0.011 (2025); year-over-year mix is directional
Base: 140 Big 3 / 119 all other PBMs; overall p<0.001; by size ns / p=0.013 / p=0.006; the 10,000+ other-PBM cell is n=18

What employers say is in their PBM contracts

Share reporting each protection, Big Three against all other PBMs.
Self-reported.



Beyond rebates, the contract gap is consistent

- Rebate pass-through is the only protection where Big Three clients report equal or better terms.
- On every other contract term shown, employers using non-Big Three PBMs report stronger protection.
- This includes no spread pricing, disclosure of affiliated entities and compensation, and lowest-net-cost formulary design.
- The gaps range roughly 16 to 18 percentage points.

Nearly 1 in 4 of Big Three clients (23%) answered "not sure" to what is in their contracts; twice as likely as those using other PBMS (12%)



> *"The main motivation is to reduce overall pharmacy spend while improving transparency, access to claims data, and alignment of incentives around lowest net cost."*
> *— Survey respondent*

Federal law will require PBMs to pass through 100% of rebates and other remuneration beginning with plan years starting 30 months after February 3, 2026—August 3, 2028; for calendar-year plans, this would generally begin January 1, 2029. (Consolidated Appropriations Act, 2026, H.R. 7148, 119th Cong., enacted Feb. 3, 2026)

Base: 141 Big 3 / 119 all other PBMs; self-reported; association only — many non-Big Three employers moved to obtain these terms

04 SECTION

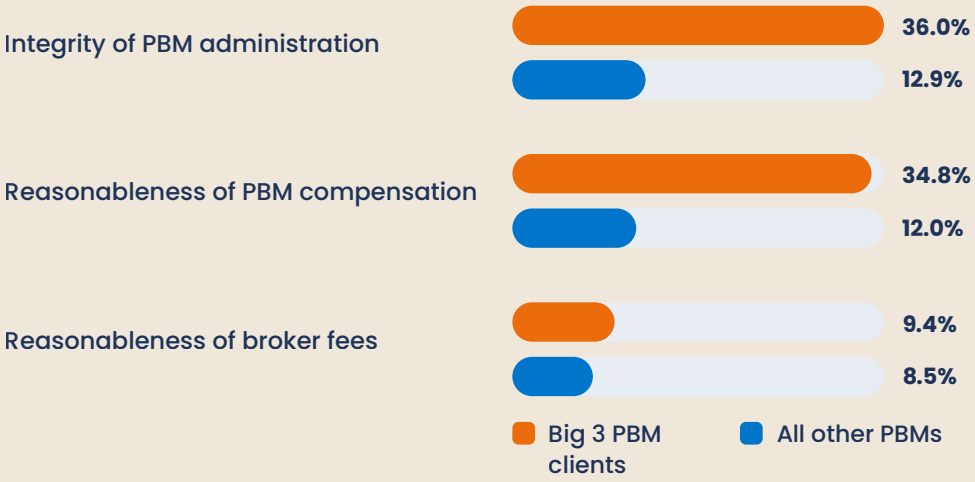
Fiduciary Confidence

- Where concern concentrates
- How data access and concern travel together
- Four years of fiduciary concern, 2023 to 2026



Fiduciary concern is highest around PBM oversight

Share somewhat concerned or concerned, 2026



Nearly three times the concern

Big Three clients are nearly three times as likely to question the integrity of PBM administration — 36% compared with 13% — and the reasonableness of PBM compensation — 35% compared with 12%.

By contrast, concern about broker fees differs little between the two groups.

> *"According to Indiana state code, PBMs are supposed to act in a fiduciary capacity. Our PBM has told us they were not going to do that because, technically, our organization is not under ERISA."*
>
> *— Survey respondent*

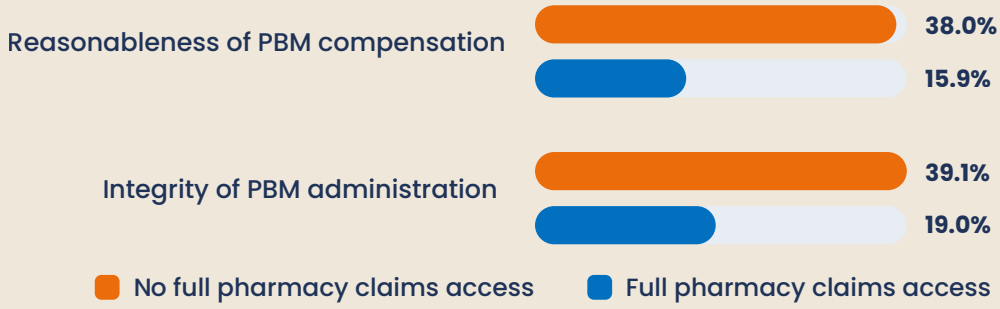
Less access, less confidence

Employers without claims access are more than twice as likely to be concerned about PBM compensation (+22.1 pts) and integrity (+20.1 pts). Data access predicts confidence as reliably as it predicts action.

The finding does not prove that limited access causes distrust, but it shows that employers feel less confident when they cannot independently review how their pharmacy benefit is operating.

Opacity and distrust travel together

Concern level by whether the employer has full pharmacy claims access



Base by PBM type: approximately 139 Big 3 / 116 all other PBMs; both pharmacy items p<0.001, broker item not significant

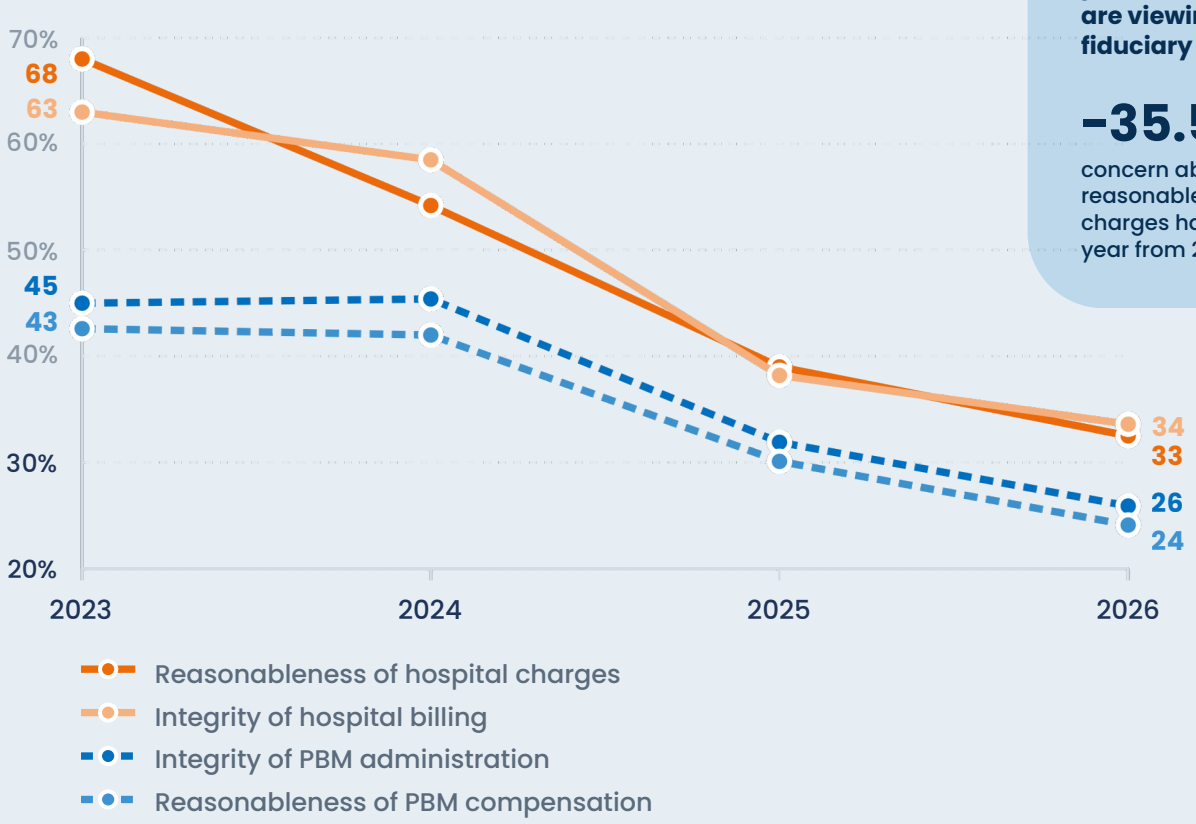
Fiduciary concern about hospital and PBM charges continues to fall

Despite continued concern about hospital and pharmacy costs, employers are viewing them less as fiduciary issues.

-35.5 pts

concern about the reasonableness of hospital charges has dropped year over year from 2023 to 2026

Share of somewhat concerned or concerned, 2023 to 2026



32.5%
concerned about hospital charge reasonableness, from 68.0%

33.6%
concerned about hospital billing integrity, from 63.0%

24.1%
concerned about PBM compensation, from 42.6%

What could be driving the decline?

Three potential hypotheses:

1. Genuine improvement
2. High prices becoming normalized
3. Attention shifting to other pressures

Base: 100 (2023) to 265 (2026); p<0.001; 2023 asked these items in a single grid, so the trend is rated General rather than Direct

05 SECTION

Hospital Purchasing

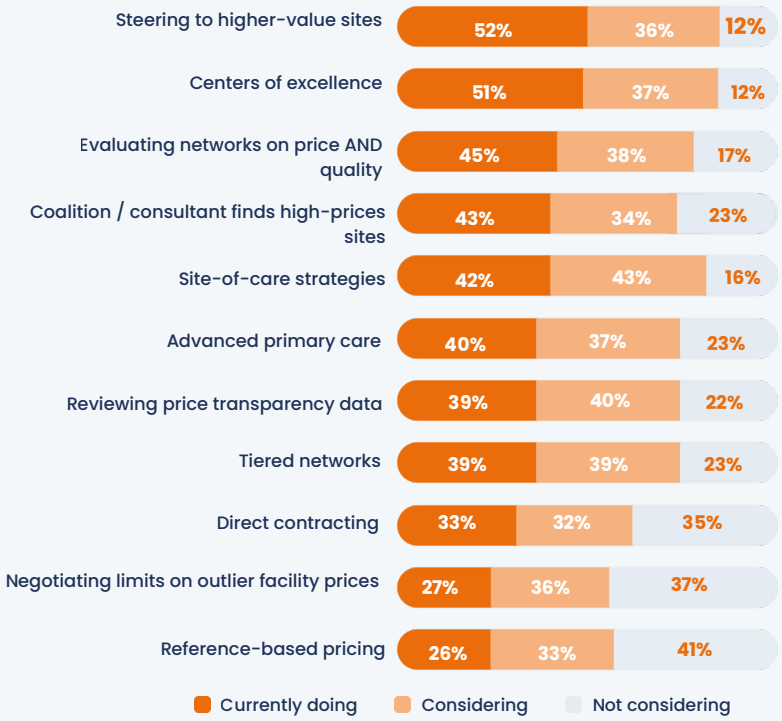
Where employers are steering care, what they are considering next, and what is stopping them from using the price information already available.

- Current adoption and the consideration pipeline
- Use of hospital price and quality information
- The single biggest barrier to action



Employer approaches to hospital purchasing

Employers are most likely to address hospital costs through member steering, centers of excellence, and network evaluation. Strategies that require direct negotiation or broader network disruption remain less common.



Action starts where employers have more control

Half of employers are already steering members to higher-value sites or using centers of excellence. These approaches can lower costs and improve quality without requiring employers to renegotiate hospital prices or substantially redesign their networks.

Stronger purchasing levers are still emerging

Direct contracting, reference-based pricing, and limits on outlier facility prices remain among the least widely used strategies. Still, roughly 3 in 10 employers are considering each—showing meaningful interest despite the greater complexity and potential for employee disruption.

Use of hospital price and quality information



Biggest single barrier to using it



The challenge is turning information into action

Only 30% of employers regularly use hospital price and quality information to guide purchasing decisions. Limited staff capacity is the most commonly reported barrier, followed by the disconnect between price and quality data, difficulty accessing information, and limited influence over carrier or TPA contracting.

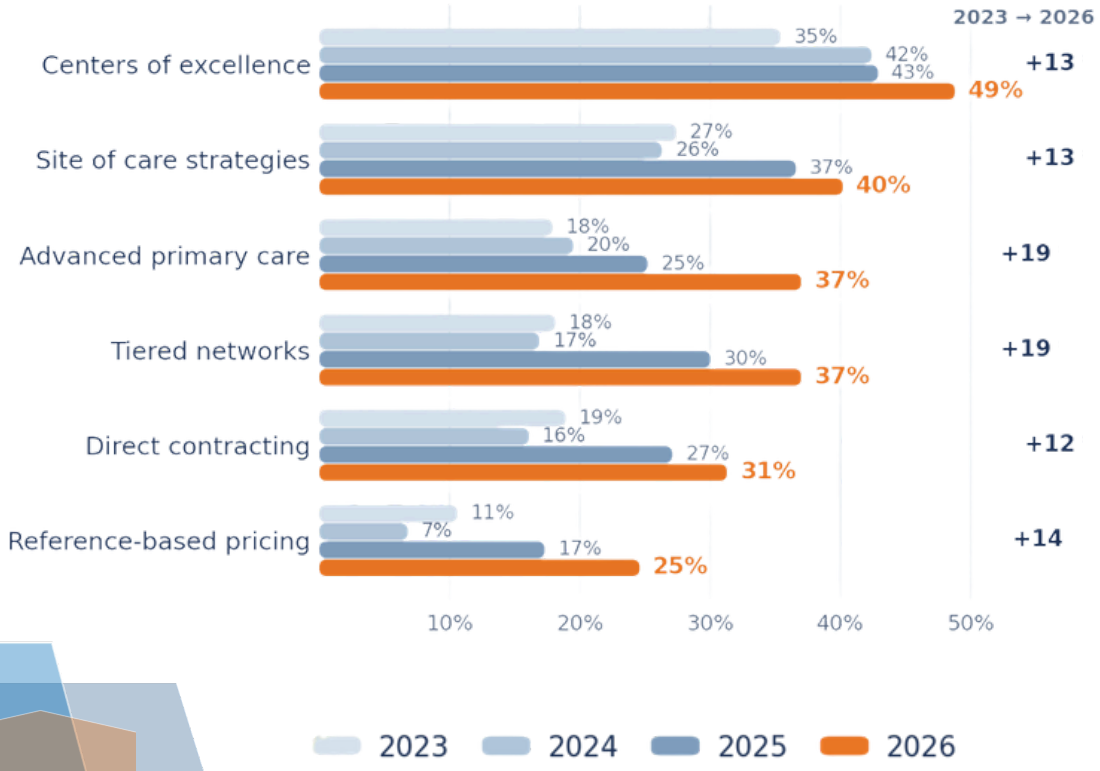
> *"It's a classic 'data rich, insight poor' problem. We can pull hospital price files and quality ratings, but they're not linked."*
>
> — Survey respondent

Base: 241–248 employers per strategy; 263 for information use; 249 for barriers; the barriers question was written as select-all but fielded as single-select; reported as biggest single barrier

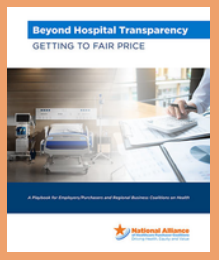
More employers are acting on hospital prices every year

> *We currently implement center-of-excellence programs, tiered networks, enhanced primary care, and member guidance to high-value providers. Over the next 1–3 years, we plan to expand into direct contracting, reference pricing, and site-of-care strategies to further address hospital pricing.*
>
> — Survey respondent

Share of employers currently doing each strategy. The six hospital-pricing strategies asked identically in all four years.



National Alliance Hospital Transparency Resources





Momentum is broadening

Every hospital strategy shown is being used by more employers than in 2023. The largest gains are in advanced primary care and tiered networks, both up 19 percentage points, while centers of excellence remains the most widely used approach.

Base: 94-96 employers in 2023, 118 in 2024, 225-227 in 2025 and 243-248 in 2026. Significance is on the change in "currently doing" between 2023 and 2026 (two-proportion test). This trend keeps 'need more information' respondents in the base for all years; the adoption chart on the previous page excludes them. Five further hospital pricing strategies were added to the survey in 2026 and have no prior-year comparison.
2024 has the smallest base of the four years, so we describe the change from 2023 to 2026 rather than year by year.

06 SECTION

Affordability Threats and Policy

Employer threats and support for regulation. Frustration hardening into specific asks.

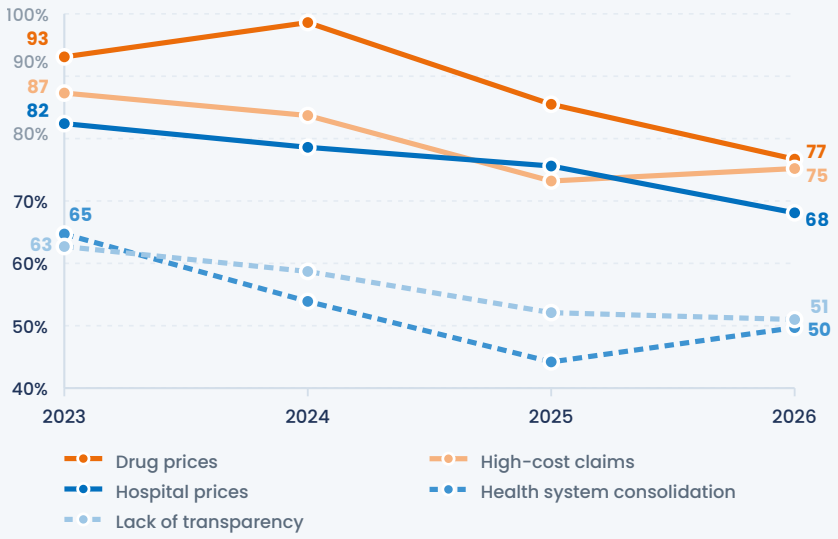
- What employers rate as a significant threat
- Four years of threat ratings against policy support
- Which reforms employers say would help their plan



The same top three threats rise to the top again

Drug prices, high-cost claims, and hospital prices lead for a sixth year. But employers are rating those threats as less severe than they did in previous years.

Trend of top three affordability concerns for employers by "significant threat"



Rank holds for a sixth year

- Drug prices 76.7%;
- High-cost claims 75.2%;
- Hospital prices 68.1%.;

The same top three we have reported every year.

Every line is falling

Hospital prices 82.4% to 68.1% since 2023, drug prices 93.1% to 76.7%, and health system consolidation 64.7% to 49.7%.

But why?

Employers' frustrations led them to search for outside help in policy regulation.

Falling threat ratings and rising demand for regulation are moving in opposite directions at the same time. Taken together they suggest employer alarm and frustration hardening into specific, targeted asks, not that employers have stopped worrying.

"Hospital prices, drug prices & high-cost claims are what keep us up at night." - Survey Respondent

Less alarm, and more demand for regulation

Two things moving in opposite directions since 2023. Threat ratings fell across the board and support for regulation rose sharply.

Alarm down

Drug prices as a significant threat fell from its 2024 peak of 98.6% to 76.7% in 2026. Hospital prices fell from its peak in 2023 of 82.4% to 68.1%.

Demand up

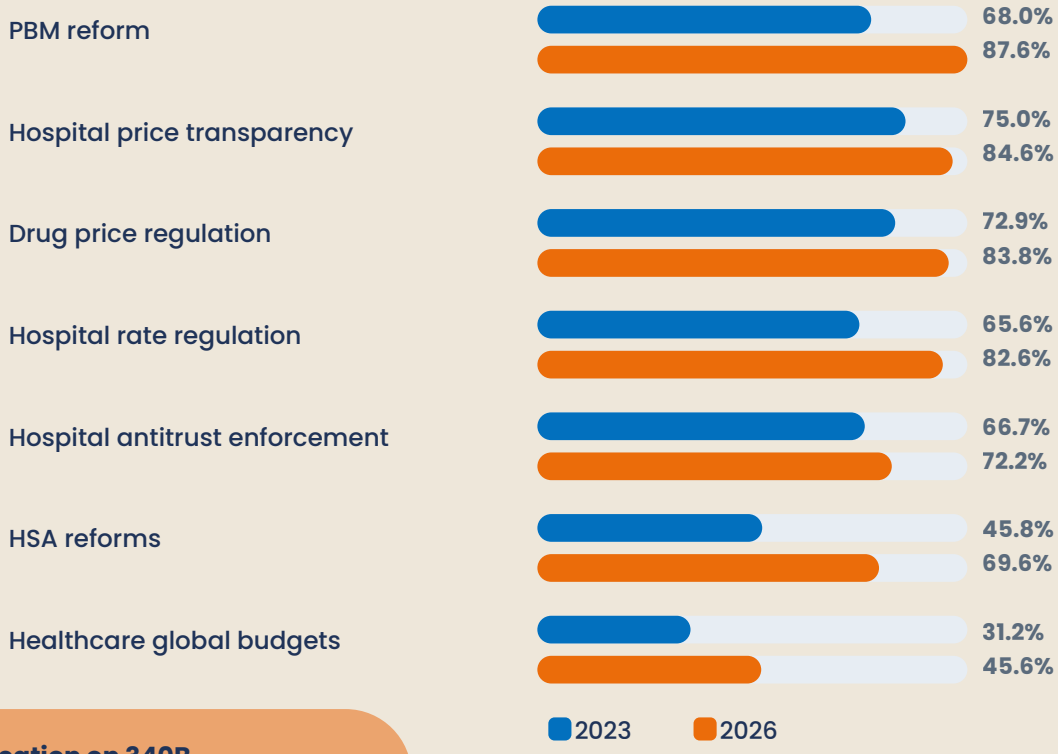
Over the same period support for PBM reform rose +20 points and for hospital rate regulation +17.



Base: 102 (2023) to 304 (2026); significant at p<0.01 to p<0.001; holds after standardizing to the 2025 employer-size mix
Includes employers who stated PBM and hospital reform would be very or somewhat helpful, 2023 against 2026

Employers see growing value in policy reform

Share saying each reform would be very or somewhat helpful, 2023 compared with 2026



Support rose across every reform,

significantly so on all but hospital antitrust enforcement

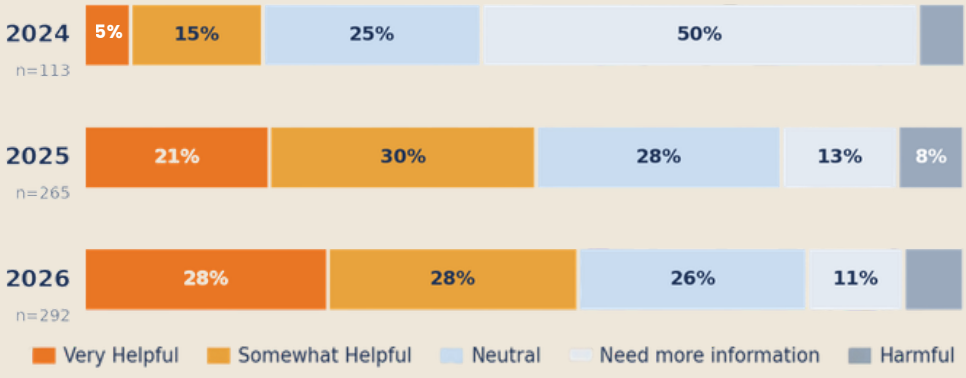
PBM reform remained the most widely supported, rising nearly 20 percentage points. HSA reform saw the largest increase at 23.8 points, while support for hospital rate regulation rose 17 points.

Education on 340B has turned into support

In 2024, half of employers said they did not know enough to have a view. Two years later, 56% say shrinking the size of the 340B Drug Pricing Program would be helpful (+36 points from 2024).

More employers now support changes to 340B

Would shrinking the size of the 340B Drug Pricing Program be helpful to your plan?



The 340B Program's impact on employers

Visit the National Alliance website to access our resources on understanding the impact of 340B on employers.

Base: 96 (2023) to 304 (2026); trends hold after standardizing to the 2025 employer-size mix
Base 340B: employers answering the item - 113 (2024), 265 (2025), 292 (2026); added in 2024;
"Harmful" combines somewhat and very harmful; 2024 and 2025 used "hurtful"; 2026 uses "harmful"; rows may not sum to 100%

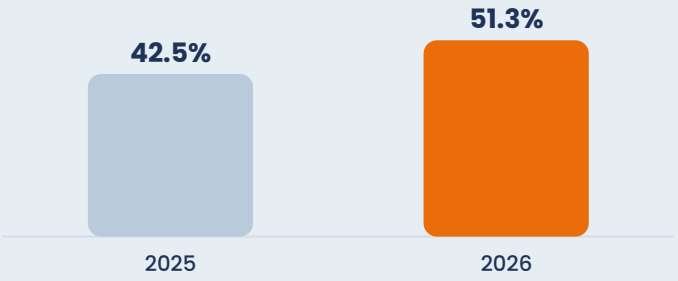
POLICY

Policy engagement is rising

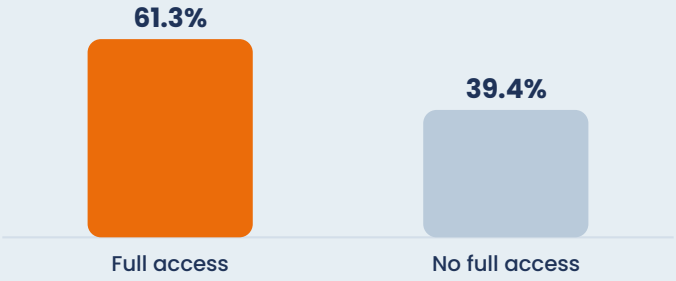
Data access marks a clear divide

More than half of employers now engage in federal or state health policy, an increase of nearly nine percentage points in one year.

Engaged in federal or state health legislation



Engagement by pharmacy claims access, 2026



+8.8 pts
Increase in employer engagement since 2025

+21.9 pts
Higher engagement among employers with full pharmacy claims access

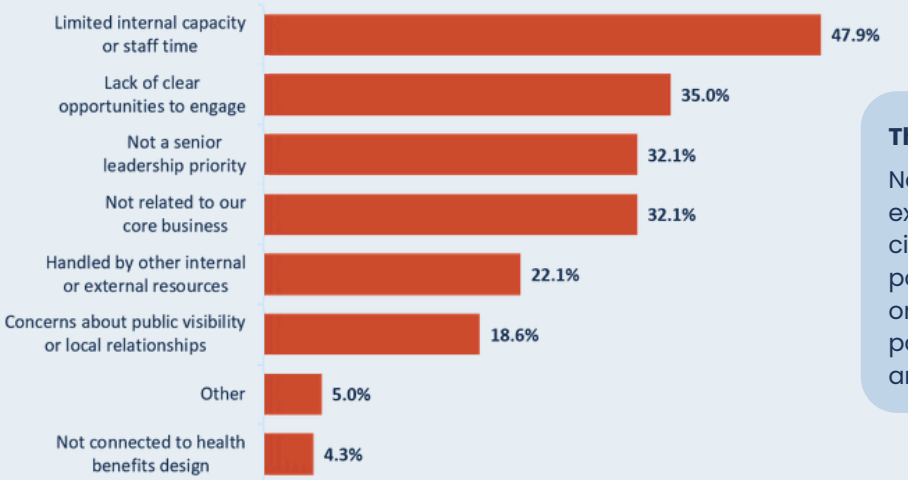
47.9%
Cite limited staff capacity as a barrier

Data access and policy engagement move together

Employers with full pharmacy claims access are nearly 22 percentage points more likely to engage in federal or state health policy. Access may give employers stronger evidence to identify problems, communicate their experience, and participate in policy discussions — although the survey does not prove that data access causes engagement.

The barrier is time, not disagreement

Why employers have not engaged in federal or state healthcare legislative efforts



The biggest barrier is capacity

Nearly half of the employers who explained why they have not engaged cite limited staff capacity (48%). Far fewer point to a lack of interest, relevant issues, or opportunities, suggesting that participation is often limited more by time and resources than by willingness.

Base: 266 (2025) / 300 (2026), p<0.05; by data access p<0.001. Barrier base 300; 140 employers who said they have not engaged and gave a reason, of 146 answering no to "Has your organization engaged in federal or state healthcare legislation efforts?" (300 answered; 51.3% said yes); select all that apply, so percentages sum to more than 100

07 SECTION

Benefit Design and Health Advancement Strategies

High-cost claims, obesity management, women's health, mental health

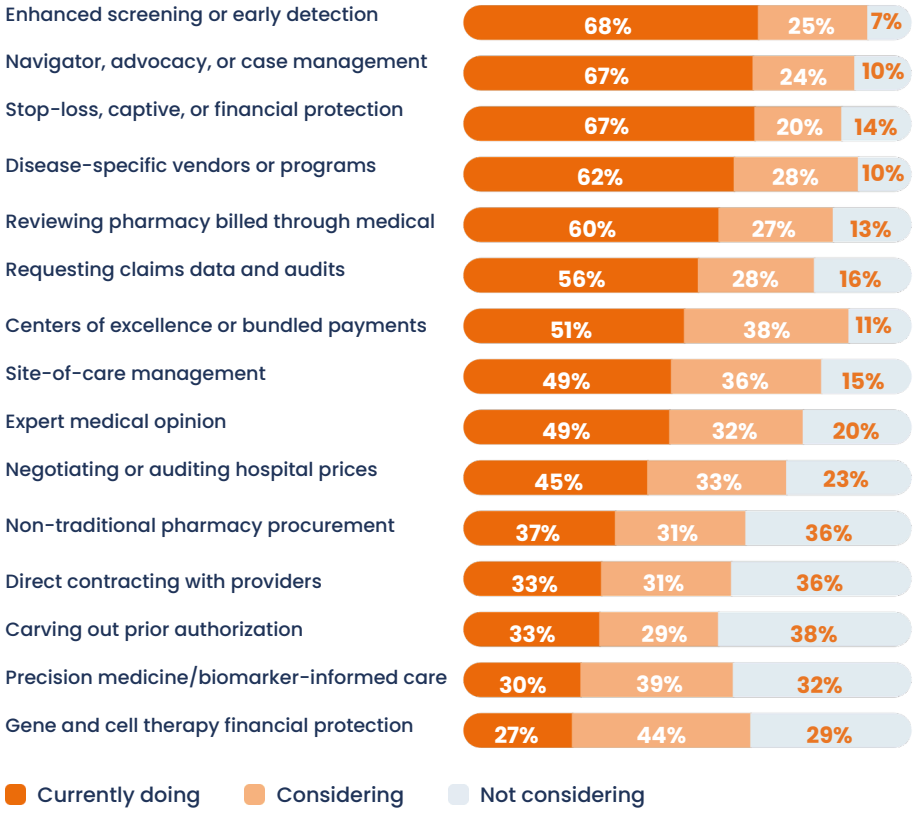
Equity and prior authorization — what employers are doing and what they are considering next.

- Adoption and pipeline for every strategy tracked
- Where interest is durable and movement is not
- The measures that moved most since 2023



Employers lead with early intervention and coordinated care

Employers are most likely to manage high-cost claims through early detection, financial protection, navigation, and disease-specific programs. Across ten of the 15 strategies, at least three in four employers are either using the approach or considering it.



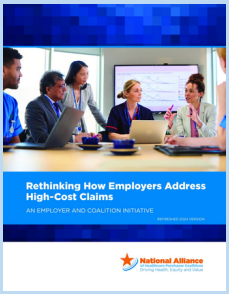
The clearest unmet need

Only about one in four employers currently have financial protection or outcomes-based arrangements for gene and cell therapies. Another 44% are considering these approaches — the largest planning pipeline among the strategies measured.

Financial protection remains a core strategy

Nearly two-thirds of employers use stop-loss, captive reinsurance, or another form of financial protection for high-cost claims. An additional 20% are considering it, making financial protection one of the most established strategies on the page.

> "Our organization focuses on early detection, care navigation, and expert opinion for complex cases now, while exploring specialized disease programs and high-value provider arrangements to better manage high-cost claims in the near future."
>
> — Survey respondent





Explore National Alliance resources on high-cost claims for practical strategies, employer insights, and tools to help organizations better understand and manage their highest-cost cases.

Base: 234–242 employers per strategy; gene and cell therapy protection is new in 2026

Employers see value in prior authorization — but want less burden

Most employers believe prior authorization helps control costs and prevent unnecessary care. At the same time, many say the process creates too much burden for patients, plan members, and providers.



Necessary does not mean working well

Employers largely support the purpose of prior authorization, but many question how it is carried out. The findings point toward targeted reform — removing low-value requirements, reducing delays, and improving the experience for patients and providers.

85%
say it is necessary to mitigate cost

51%
say it burdens plan members too heavily

55%
are considering at least one change to their approach

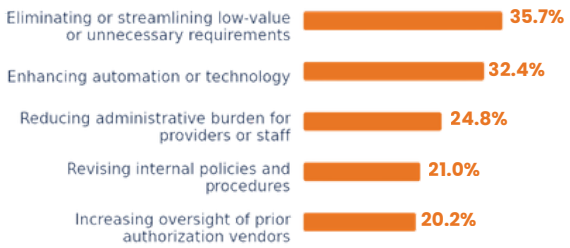
More than half are considering changes

55%
considering at least one change



45%
considering no changes at all

Employers are targeting unnecessary friction



Some employers are taking greater control

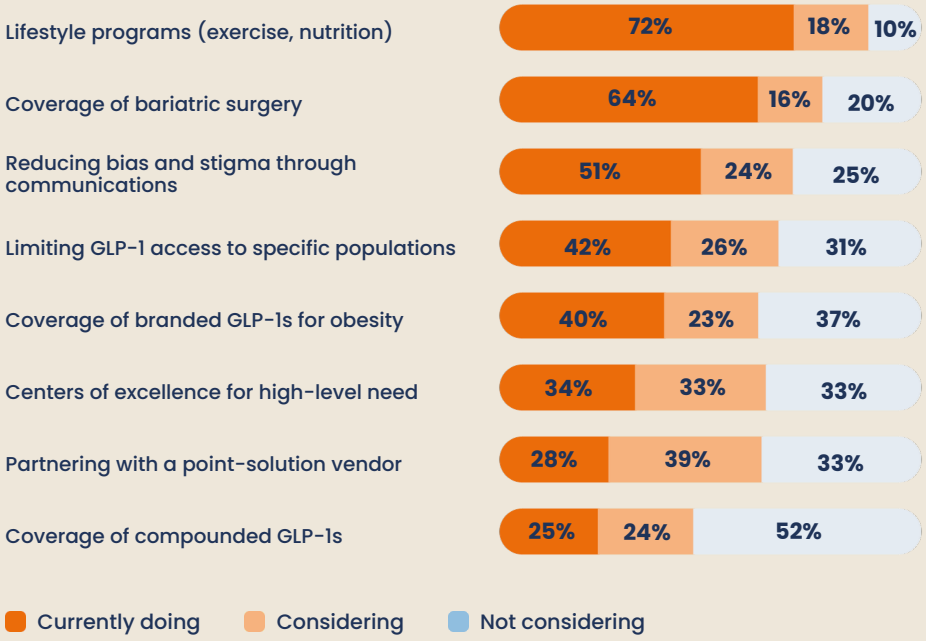
Nearly one-third of employers currently carve out or independently manage prior authorization, and another 26.5% are considering doing so. This may reflect growing interest in stronger oversight, faster decisions, and a more consistent member experience.

> "We are continuously refining our utilization management and prior authorization workflows to mitigate plan spend and eliminate waste, while closely auditing our vendors to minimize unnecessary administrative delays or disruptions for our members."
>
> — Survey respondent

Base: 241–242 for views; 238 for changes; 234 for carve-out; views shown as % agree or strongly agree

Obesity strategies extend beyond GLP-1 coverage

Employers are combining lifestyle support, bariatric surgery, targeted GLP-1 coverage, and specialized management. Branded GLP-1 coverage remains important, but employers are increasingly focused on how the benefit is managed and who qualifies.



Vendor management is the pipeline

More than one-third of employers are considering a point-solution partner — the largest pipeline of any strategy shown. This suggests employers are looking for additional support with eligibility, navigation, prescribing oversight, and ongoing care.

Compounded GLP-1 coverage remains limited

One in four employers currently cover compounded GLP-1s, while more than half are not considering coverage. Among the strategies measured, compounded products have the lowest overall employer interest.

63%
cover or are considering branded GLP-1s for obesity

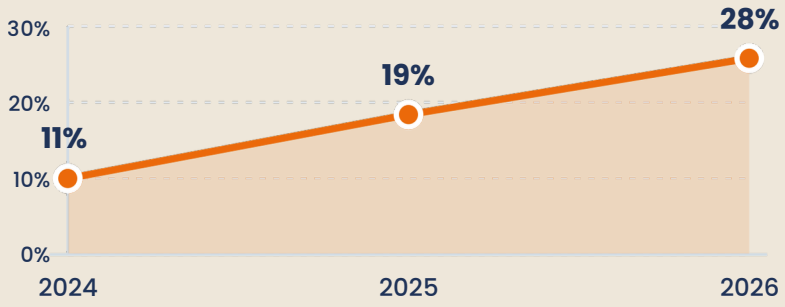
68%
limit or are considering limiting GLP-1 access to specific populations

90%
offer or are considering lifestyle programs

Coverage has plateaued; management is where the movement is

Coverage is steady; management is expanding

- The share of employers using a point-solution vendor to manage GLP-1 access rose from 11% in 2024 to 28% in 2026.
- Over the same period, interest in branded GLP-1 coverage remained relatively stable.
- Employers appear to be adding more structure around the benefit rather than simply expanding access.
- Employers covering or considering branded GLP-1s are more likely to use or consider point-solution management (83% vs. 29%).



Use of a point-solution vendor to manage GLP-1 access

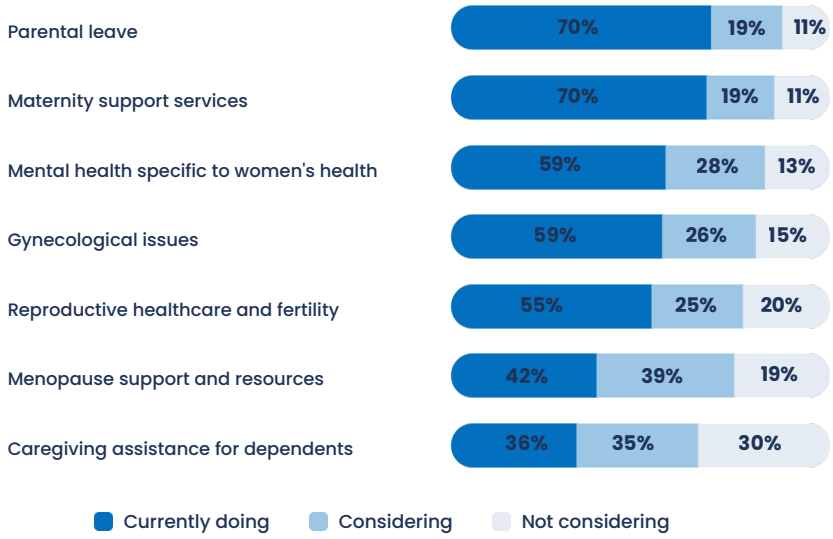
Base: 266–271 employers per strategy; Partnering with a point-solution vendor rose significantly against 2024 (p<0.001). No other item in this set changed significantly

Women's health benefits are expanding beyond maternity care

Employers are broadening women's health benefits to include mental health, menopause, gynecological care, fertility, and caregiving support. Women's mental health recorded the largest increase among the benefit areas tracked.

Women's mental health saw the largest gain

The share of employers **offering mental health support specific to women rose from 43% in 2024 to 59% in 2026, a gain of +16 points.** More than eight in 10 employers now offer or are considering this support.



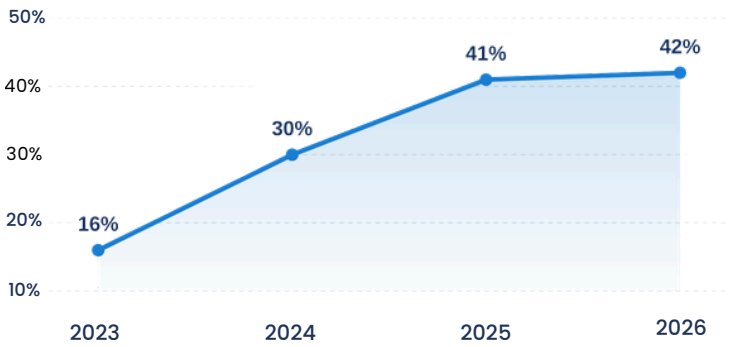
> "Overall, women's mental health (postpartum, perimenopause) is an under-addressed gap, we're adding a digital tool this year to help."
>
> — Survey respondent

87%
offer or are considering women's mental health support

81%
offer or are considering menopause support

+16 pt
Rise in women's mental health support against 2024

Menopause support has grown rapidly



Currently offering menopause support and resources

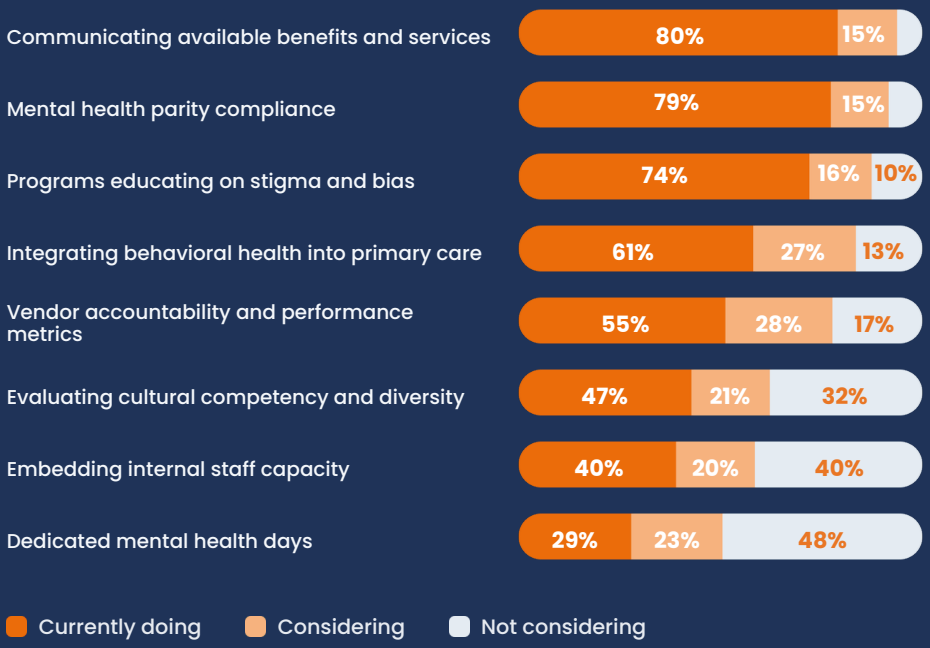
Adoption of menopause support has nearly tripled (16% to 42%) in three years

The share of employers offering menopause support increased from 16% in 2023 to 42% in 2026 — a gain of +26 percentage points. With another 39% considering it, menopause is moving quickly from an emerging benefit to a more common part of women's health strategy.

Base: 287–291 employers per benefit; women's mental health p<0.001, the 2023 item asked about mental health support generally and is not comparable;

Mental health foundations are strong and accountability is next

These foundations were already in place in 2023 and many have not changed since. Most employers already communicate available mental health benefits, address stigma, and monitor parity compliance. The next opportunity is strengthening vendor accountability, integration with primary care, and support for a diverse workforce.



Core practices are widespread

Communication, parity compliance, and stigma education are now common parts of employer mental health strategies. These efforts form the foundation; the next step is making sure programs are accessible, effective, and delivering measurable results.

Cultural competency needs renewed attention

The share of employers considering an evaluation of cultural competency and diversity has fallen 17 points since 2023, from 38% to 21%, while the share already doing it has not changed. Employers have stopped adding to this work rather than abandoning it.

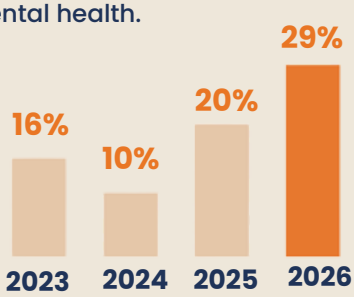
88%
integrate or are considering integrating into primary care

83%
have or are considering vendor accountability measures

52%
offer or are considering dedicated mental health days

Dedicated mental health days are gaining traction

The share of employers offering dedicated mental health days doubled from 16% in 2023 to 29% in 2026. At the same time, the share not considering them fell from 66% to 48%, showing a gradual shift toward more visible, organization-wide support for mental health.



Share currently offering dedicated mental health days

2023 to 2026 Comparison

66% → 48% are not considering it

18% → 23% are considering it

16% → 29% currently offer it

Base: 282–286 employers per strategy; employers considering an evaluation of cultural competency and diversity has fallen 17 points since 2023, from 38% to 21% (p<0.01), while the share already doing it has not changed. Mental Health Days 119 employers in 2023, 129 in 2024, 243 in 2025, 283 in 2026. The 2025 to 2026 rise alone is also significant (19.3% to 27.9%, p=0.022). Adoption is even across employer size.

Health equity activity holds as analytics interest declines

Employers continue to use a range of health equity strategies, but fewer are considering analyzing claims by race, ethnicity, income, geography, or gender than in 2024.



Interest in subgroup analysis is falling

- Fewer employers are considering analyzing claims by race and ethnicity. The share fell 17 percentage points, while "not considering" is now the most common response.
- The survey did not test why this shift occurred, but current national and local political dynamics may be influencing employer decisions about collecting, analyzing, or reporting demographic data.

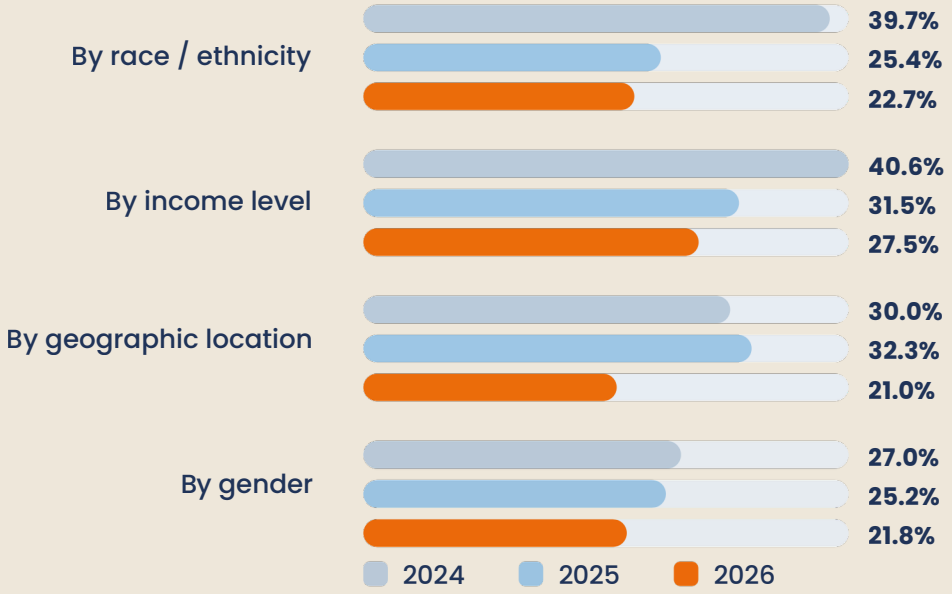
Employee surveys are the exception

Stratifying employee survey results by population group remains the most common equity-analysis strategy under consideration. Employers may feel more comfortable beginning with employee-reported information than with medical claims data.

Fewer employers are considering subgroup claims analysis

Share considering analyzing claims by race and ethnicity, income level, geographic location, or gender, 2024 to 2026

> *"We're early on health equity, started with geographic and gender claims analysis because we suspected rural access issues (we were right). Cross-department meetings (HR, D&I, benefits) have been eye-opening. Surveying employees showed satisfaction gaps, but we haven't stratified by race/income yet, data quality and sample size are barriers. Focus groups are on our radar but we need vendor support."*
>
> *— Survey respondent*



Base: 287–291 per strategy; 288–289 per analytic dimension; race/ethnicity $p<0.001$; income and geography $p<0.05$

Five actions employers can take

1

Treat data access as a strategic imperative

Employers with full claims data access consistently reported greater implementation of purchasing and cost-management strategies than employers without access. Access to complete medical and pharmacy claims data should be viewed not merely as a reporting requirement, but as a foundational business asset that enables informed decision-making, vendor accountability, and effective benefit management.

2

Focus on high-value purchasing, not cost shifting

Rising costs alone do not lead employers to adopt more strategies. Instead, successful purchasers are using targeted approaches such as site-of-care management, centers of excellence, navigation support, direct contracting, and claims audits to improve value. Employers need to prioritize initiatives that influence the cost and quality of care rather than relying primarily on shifting costs to employees.

3

Strengthen oversight of pharmacy benefit management

Rapid movement in the PBM marketplace, growing interest in changing PBMs, and increasing support for PBM reform reflect employers' desire for greater transparency and accountability. Employers need to regularly evaluate contract provisions, compensation disclosures, formulary management practices, and access to pharmacy claims data to ensure alignment with fiduciary responsibilities and organizational goals.

4

Use policy engagement as a business strategy

Support for healthcare pricing and transparency reforms continues to rise, and employer participation in healthcare policy discussions has increased substantially. Employers should work through coalitions and industry partners to advocate for transparency, fair pricing, and policies that improve healthcare market accountability. Collective purchaser voices can help address affordability challenges that employers cannot solve independently.

5

Invest in long-term workforce health and affordability

Employers continue expanding efforts in areas such as women's health, mental health, obesity management, and protection against high-cost claims. These investments should be integrated into a broader strategy that balances affordability, employee wellbeing, and workforce productivity. Sustainable healthcare value comes from addressing both the drivers of cost and the health needs of employees and their families.

APPENDIX

Methodology

The online questionnaire was administered via Qualtrics in May and June 2026. Participation was voluntary; responses were collected and analyzed anonymously and are reported in aggregate only. The study uses a non-probability sample recruited through National Alliance member coalitions.

We received 408 records and 247 completed the whole instrument. Every percentage uses all valid responses to that question. Blanks were excluded and skipped questions were never treated as a no. Bases therefore vary by question and are printed on every page.

How to read this report

1. Every cross-group difference in this report is an association. We are not assuming causation.
2. The PBM comparisons carry selection effects: Employers on a non-Big Three PBM are more than twice as likely to have switched recently, and they moved to obtain the terms they now report.
3. Trends carry a comparability rating — direct, general, directional or new in 2026. Some trends may reflect changes in wording between surveys.
4. We replaced the PBM contract-terms instrument in 2026 and dropped the hospital-attitudes question matrix, so neither is trended.

Statistical testing

Pearson chi-square for categorical comparisons, with Fisher exact on 2x2 tables where an expected cell falls below 5. Welch t-test for means. Wilson intervals for proportions. We did not correct for multiple comparisons. Where a page reports many tests at once, we state how many were significant rather than highlighting individual items.

Covered lives

356 employers reported the covered lives in their plans, totalling 3.7 million (median 2,344, excluding zero entries). Applying the employer-size midpoint method used in prior years to all 368 who gave a size band estimates roughly 6.2 million across the full sample. We lead with the reported figure.

Comparability ratings for trends

Direct — same wording, options, and format in every year compared; read differences at face value. Most trends in this report are direct.
General — same substance, but the format or context changed (the 2023 fiduciary items were asked in a single grid). Direction and rough size are meaningful; exact point-to-point comparisons are not.
Directional — the instrument changed between years (the PBM name was a write-in in 2025 and a pick-list in 2026); read as direction only.
New in 2026 — asked for the first time; no trend.

Where wording changed enough to break comparability, we start the trend at the first comparable year rather than rate it — the women's mental health trend begins in 2024 for this reason.

PBM Classification

In 2025, employers wrote in the name of their primary PBM (optional, 164 classifiable responses); in 2026, employers selected from a list of PBMs, with write-in options for coalition-purchased and other arrangements (265 classifiable responses). The higher 2026 response and the change in question format mean the year-over-year comparison should be read as directional; the 2026 within-year comparisons by employer size are unaffected.

Responses in both years were classified by the corporate entity that administers the pharmacy benefit, regardless of purchasing channel or rented network:

- **Big Three** — CVS Caremark (including Aetna, whose pharmacy benefit is administered by Caremark, and Caremark purchased through a pharmacy coalition), Express Scripts/Evernorth (including Cigna), and OptumRx (including coalition-purchased Optum).
- **All other PBMs** — every other named PBM, including insurer-owned PBMs outside the Big Three (such as CarelonRx/Elevance and Prime Therapeutics) and PBMs that rent a Big Three pharmacy network but administer the benefit themselves.
- **Excluded** — respondents answering "not sure" or "various," and responses naming only a carrier where no PBM could be identified. Percentages are of classifiable responses.

Quotes from respondents were cited verbatim

Sample composition

The 2026 sample skews smaller than 2025: employers under 1,000 rose from 27% to 38% of respondents. To confirm this shift does not drive the year-over-year findings, we recomputed the twelve headline 2025–2026 comparisons after re-weighting the 2026 responses to the 2025 employer-size mix: the Big Three share of named PBMs; policy engagement; currently doing each of the six hospital-pricing strategies (advanced primary care, tiered networks, reference-based pricing, direct contracting, centers of excellence, and site-of-care strategies); dedicated mental health days; use of a GLP-1 point-solution vendor; and drug prices and hospital prices rated a significant threat. In every case the size-adjusted change kept the same direction and stayed within about one percentage point of the reported change.

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PULSE OF THE PURCHASER

About the National Alliance of Healthcare Purchaser Coalitions

For more than 30 years, the National Alliance has brought together business coalitions and their employer and purchaser members to drive high-quality healthcare that enhances patient experience, promotes health equity, and improves outcomes while lowering costs. Its members represent public and private sectors, nonprofits and labor unions providing health benefits to over 90 million Americans — more than half of the employer-sponsored insurance market — spending over $850 billion annually.

About the Pulse of the Purchaser Research Institute

PPRI is an employer/purchaser panel convened by the National Alliance that invites employers to confidentially share perspectives to inform research and policy work. Participation helps the National Alliance and local coalitions understand purchaser priorities while providing financial support to these organizations.

To join, learn more, or get involved, click here.

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