

2026 Milliman Medical Index

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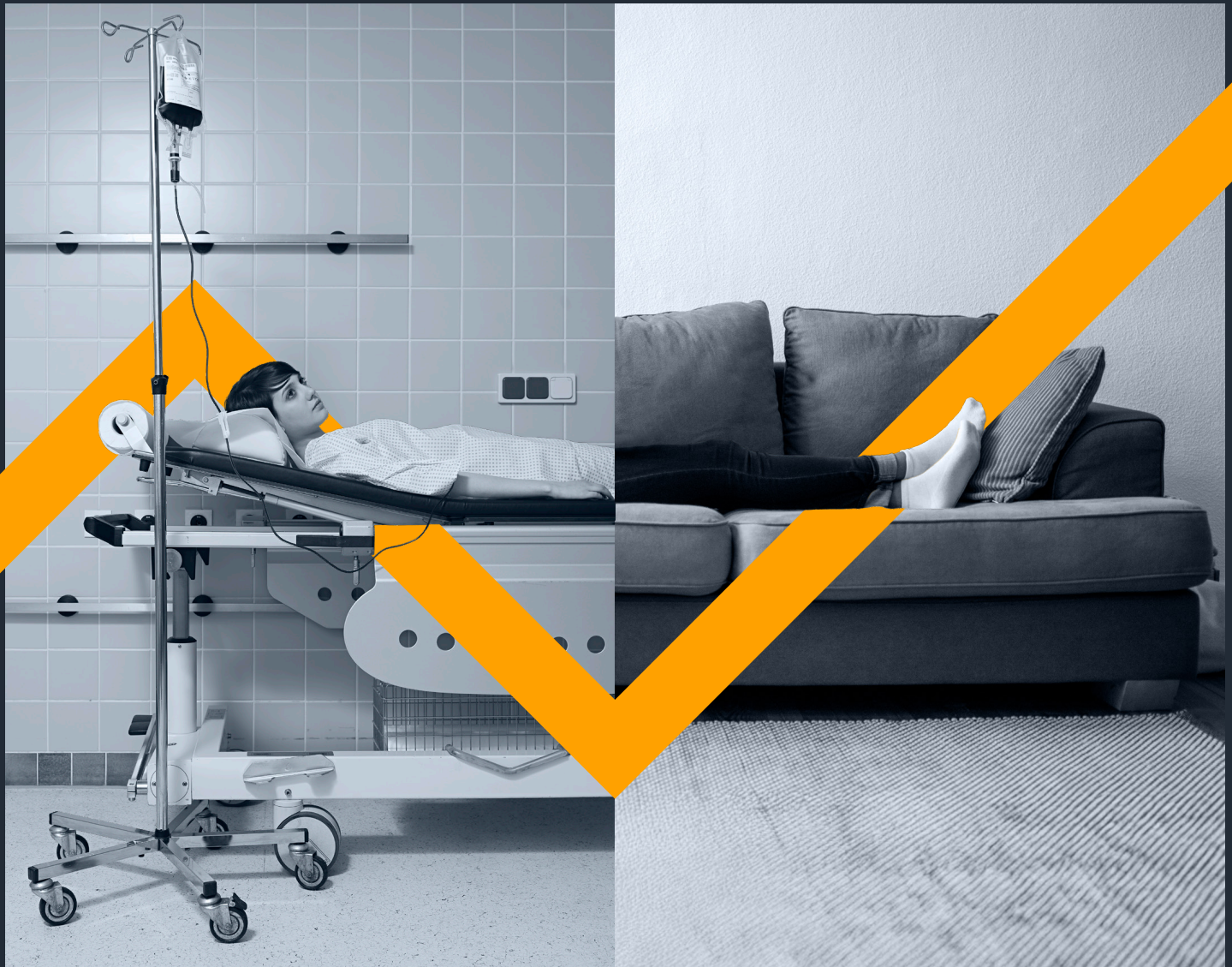
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Executive summary

In 2026, the cost of healthcare for a hypothetical American family of four covered by an average employer-sponsored health plan is \$37,824, according to the Milliman Medical Index (MMI).¹

\$37,824

for a family of four

\$8,460

for an average person

The MMI segments healthcare costs into five healthcare service categories: inpatient facility care, outpatient facility care, professional services, pharmacy, and other services.

Compared to the 2025 MMI, healthcare costs for the average person increased 7.9%, from \$7,838² to \$8,460. This is the highest increase for the MMI in more than a decade, excluding the fluctuations experienced as a result of the COVID-19 pandemic. Outpatient facility care and pharmacy services continue to be the primary categories driving cost increases, with outpatient facility costs rising 7.5% and pharmacy costs rising 14.8% over last year. These two categories alone contributed 69% of the year-over-year increase in the MMI for the average person.

What the MMI represents

The MMI quantifies the cost of employer-sponsored healthcare for a defined family of four. For nearly two decades, the MMI family has remained constant: a male age 47, a female age 37, a child age 4, and a child under age 1. The MMI family was “mathematically average” when it was created in 2005, with the family’s healthcare costs four times that of an individual. However, this is no longer the case—both the composition of a “typical” family unit and the distribution of healthcare costs among family members have changed significantly over the past two decades.

While the original MMI family no longer reflects how healthcare costs are distributed across a “typical” family today, we continue to publish the index based on its original design to support comparison with prior years. We encourage users to explore our interactive tool to model costs using their own family composition and see how expenses vary by healthcare service category.³

Components of cost

The MMI segments employer-sponsored healthcare costs into five categories: inpatient facility care, outpatient facility care, professional services, pharmacy, and other services. Professional services cover all professional fees from physicians and other healthcare professionals, regardless of the setting in which care is received. Other services include home healthcare, ambulance services, durable medical equipment, and prosthetics.

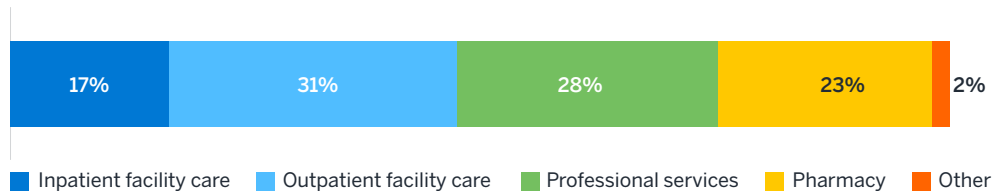
As shown in Figure 1, outpatient facility care and professional services are the two largest components, each representing approximately 30% of total cost. Pharmacy net of rebates has grown to approximately 23% of total healthcare costs, reflecting continued specialty drug and glucagon-like peptide-1 (GLP-1) cost pressure. Inpatient facility care accounts for roughly 17%, a share that has edged downward as care continues to migrate to outpatient settings. Other services remain at 2%.

1 The MMI value (\$37,824) represents annual healthcare costs for a specially defined family of four, gross of pharmacy rebates, covered by employer-sponsored insurance. The average person cost (\$8,460) and all other costs in this paper are net of pharmacy rebates unless otherwise noted.

2 Past MMI values have been restated to reflect information collected since last year’s publication. The restated 2025 value for the MMI family of four is \$35,281, which has increased by 7.2% between 2025 and 2026.

3 See 2026 Milliman Medical Index interactive tool at www.milliman.com/en/insight/2026-milliman-medical-index.

FIGURE 1: PERCENTAGE COST, BY MMI SERVICE CATEGORY, FOR AN AVERAGE PERSON



Numbers may not add to 100% due to rounding.

INPATIENT FACILITY CARE

Inpatient facility care, which covers hospital stays, surgeries, and other services requiring an overnight admission, accounts for approximately 17% of total healthcare costs in 2026, continuing a long-term decline from roughly 30% of total costs when the MMI was first published in 2005. This shift largely reflects procedures migrating to outpatient settings over time, reducing inpatient volume even as the cost per admission continues to rise. In 2026, inpatient costs grew by 4% year-over-year, driven by higher unit costs. It is worth noting that the relatively modest and declining inpatient share of total spending reflects this structural care-setting shift; on a per-admission basis, costs continue to trend upward.

OUTPATIENT FACILITY CARE

Outpatient facility care is the largest single component of MMI healthcare costs in 2026, representing approximately 31% of total spending. In 2026, outpatient costs grew 7.5% year-over-year, and these costs have increased by more than 300% for a family of four since the MMI was first published in 2005. Three structural forces are driving this sustained growth: 1) the continued acquisition of physician practices by hospital systems, which steers ancillary services like imaging and diagnostics into higher-cost facility settings; 2) the expansion of high-cost specialty drugs administered in outpatient settings, which generates both a drug cost and a separate facility fee; and 3) the ongoing shift of services from inpatient to outpatient settings as care delivery continues to evolve. We discuss these forces in more detail in the “What to watch” section of the report.

PROFESSIONAL SERVICES

Professional services represent approximately 28% of total MMI healthcare costs in 2026, growing 6% year-over-year for an average person. These expenses cover all professional fees, including those from physicians and other healthcare professionals, which are incurred when a patient uses a hospital, clinic, surgical center, standalone lab or imaging center, or a physician office. Higher physician service allowed cost trend in 2026 may be driven by a combination of increased unit cost inflation, including provider contracting pressure (e.g., provider group consolidations), reimbursement updates, and shifts toward higher-intensity coding or service mix. Additional pressure may come from elevated utilization, increased incentive payments, continued migration of services to higher-cost settings, and greater demand for specialty and behavioral health physician services.

PHARMACY

Pharmacy is the fastest-growing cost component in 2026, rising 14.8% year-over-year for an average person to represent approximately 23% of total MMI healthcare costs net of rebates. Utilization of GLP-1 drugs and other high-cost pharmacological therapies is the primary driver of cost increases in this category, though that growth is also facing some downward pressure from pharmacy benefit manager (PBM) reform legislation, which could provide cost relief in the years ahead. We explore these dynamics further in the “What to watch” section. Figure 2 summarizes how healthcare costs are segmented for our MMI average person and the change year-over-year.

FIGURE 2: COMPONENTS OF 2026 COMMERCIAL HEALTHCARE COSTS FOR AN AVERAGE PERSON

CATEGORY	2026 COST (AVG PERSON)	YEAR-OVER-YEAR CHANGE
Inpatient facility care	\$1,459	+4.0%
Outpatient facility care	\$2,590	+7.5%
Professional services	\$2,340	+6.0%
Pharmacy (net of rebates)	\$1,907	+14.8%
Other	\$164	+4.5%
Total	\$8,460	+7.9%

Source: 2026 Milliman Medical Index

EMPLOYEE COSTS

In the employer group insurance market, the total cost of healthcare is shared by employers and employees in three categories.

- **Employer contribution:** Employers that sponsor health plans subsidize the cost of healthcare for their employees by allocating dollars to pay a large share of the cost. The portion paid by the employer can vary according to the benefit plan option the employee selects.
- **Employee contribution:** Employees who choose to participate in the employer’s health benefit plan typically also pay a share of the premiums, usually through payroll deduction.
- **Employee out-of-pocket (OOP) cost:** When employees receive care, they often pay for a portion of these services through health plan deductibles and point-of-service copayments or coinsurance. These payments are capped by OOP maximums, but the costs can still be substantial.

The balance between these three categories has shifted gradually and consistently over time. Employers still pay most of the bill, but their share has declined from 61% in 2005 to 58% in 2026. Employee premium contributions have risen from 21% to 27% over the same period. Employee OOP spending, by contrast, declined from 18% to 15%, reflecting a pattern in which higher payroll deductions have accompanied lower point-of-care cost sharing. The cost shift, in other words, has operated primarily through the paycheck rather than through the doctor’s office visit.

That pattern continues. Recent employer surveys⁴ indicate that a growing share of employers plan to make cost-sharing changes to their health plans in 2026, suggesting the gradual shift in who bears premium cost is accelerating, alongside the highest trend environment in more than a decade.

FIGURE 3: HEALTHCARE COST BY SOURCE OF PAYMENT FOR AN AVERAGE PERSON

	AVERAGE PERSON	2026 SHARE
Employer contribution	\$4,899	58%
Employee contribution	\$2,295	27%
Employee out-of-pocket	\$1,266	15%
Total	\$8,460	100%

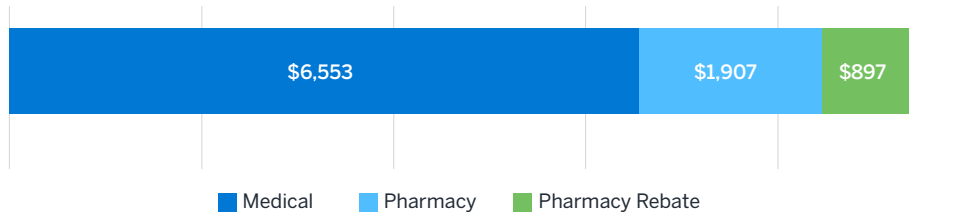
4 Mayer, K. (May 11, 2026). Soaring health costs push employers to shift more costs to workers. Society for Human Resource Management. Retrieved May 15, 2026, from <https://www.shrm.org/topics-tools/news/benefits-compensation/soaring-health-costs-push-employers-shift-costs-employees>.

Impact of prescription drug rebates

Pharmacy rebates are discounts negotiated between drug manufacturers and payers, including PBMs, in exchange for preferred placement on a plan's formulary, among other factors. These agreements are treated as proprietary, making it difficult to assemble a complete picture of their scope. Health insurers report rebate figures for fully insured businesses in statutory financial statements, but rebates for self-insured employers are not publicly available. If they share rebates with employers, PBMs typically remit the funds to employers 90 to 180 days after claims are paid.

In most employer-sponsored preferred provider organization (PPO) plans, rebates do not affect an employee's OOP costs but could reduce employee premium contributions. We project rebates in 2026 to be approximately 31% to 33% of allowed drug costs for an average person for the commercial large group market. Figure 4 illustrates the impact of rebates on the 2026 MMI value for the average person. If employers were not receiving the rebates, the MMI average person cost would have been \$897 (or 10.6%) higher.

FIGURE 4: ILLUSTRATIVE IMPACT OF PHARMACY REBATES ON THE MMI FOR AN AVERAGE PERSON



What to watch: Emerging forces shaping future healthcare costs

While the MMI measures what commercial healthcare costs are today, several developments on the horizon warrant attention from employers and plan sponsors planning for the future. The following sections examine three forces—GLP-1 drug coverage, PBM reform legislation, and billing enabled by artificial intelligence (AI)—that are either newly arrived or still evolving and whose full cost impact has yet to be reflected in the trend data.

GLP-1 drugs and employer coverage

GLP-1 receptor agonists, including Ozempic, Wegovy, Mounjaro, and Zepbound, remain a significant driver of prescription drug spending, and current market dynamics suggest they will continue to contribute materially to employer pharmacy costs in 2026.

GLP-1 therapies work by improving blood sugar control, slowing digestion, and reducing appetite. They are used primarily for Type 2 diabetes and, depending on the product, are also indicated for chronic weight management in adults and adolescents with obesity or related comorbidities. Some are additionally approved for other conditions like reducing cardiovascular risk in eligible patients.

From a cost perspective, GLP-1 therapies have become a meaningful and growing component of pharmacy spend. For example, Milliman analysis of a commercially insured population found that among patients using GLP-1s for weight loss, total pharmaceutical costs per patient per year grew substantially with longer adherence, reaching over \$18,000 before rebates for 24-month adherent patients by 2023, compared to under \$8,000 for nonadherent patients.⁵ Looking ahead, oral GLP-1 products, entering the market in 2026, may sustain near-term pharmacy cost pressure if broader access and improved adherence expand utilization further.

⁵ Craff, M., Ren, K., Hemmila, D., Ulin, I., & Ally, A. J. (August 18, 2025). Measuring how GLP-1 medications impact the total cost of care. Milliman. Retrieved May 15, 2026, from <https://www.milliman.com/en/insight/measuring-glp-1-impact-total-cost-of-care>.

Evidence on medical utilization offsets is emerging, but near-term findings remain mixed. In Milliman's analysis, cohorts using GLP-1 therapies for weight loss showed lower acute utilization over four years, including 4% fewer emergency department visits and fewer inpatient admissions. At the same time, total medical and pharmacy per member per month (PMPM) costs increased for this cohort, suggesting that near-term utilization improvements are unlikely to fully offset the pharmacy cost impact.⁶

Employer coverage strategy is also still evolving, with broader support for diabetes indications and more selective coverage for obesity treatment. According to a recent International Foundation of Employee Benefit Plans (IFEBC) survey, 91% of plan sponsors covered GLP-1s for diabetes, while only 34% covered them both for diabetes and weight loss.⁷ These findings suggest GLP-1 coverage is not binary; coverage policy details, such as indication criteria, eligibility rules, and clinical documentation requirements, are likely to remain central drivers of who receives treatment, treatment duration, and employer cost outcomes.

PBM reform and rebate pass-through legislation

PBM reform and rebate pass-through legislation at federal and state levels are expected to affect pharmacy costs in 2026 and beyond. The cumulative effect of federal mandates and state-level regulatory activity is reshaping how rebates, dispensing fees, and other manufacturer payments flow through employer-sponsored plans and ultimately reach employees.

At the federal level, the Consolidated Appropriations Act of 2026 (CAA 2026), enacted in February 2026, represents the most significant federal PBM reform affecting employer-sponsored plans to date. Effective August 3, 2028, the legislation requires that 100% of rebates, fees, and other manufacturer payments be passed through to both self-insured and fully insured employer plans, including payments to PBM-affiliated group purchasing organizations (GPOs), with exceptions only for bona fide service fees.⁸ The CAA 2026 establishes new transparency and reporting obligations, requiring drug-level reporting on spread pricing, margins, rebates, and net costs to plan sponsors and regulators.

Under traditional PBM models, rebates were often retained by PBMs, giving plan sponsors limited visibility into actual pharmacy economics. The CAA's 100% pass-through mandate, combined with drug-level transparency reporting, intends to meaningfully increase that visibility going forward.

At the state level, states continue to implement varied PBM reform requirements that affect employer pharmacy costs. Common approaches include transparency mandates on rebate retention and spread pricing, restrictions or outright bans on spread pricing, mandated fee structures, and rebate pass-through provisions. Because these state mandates may not apply uniformly to self-insured Employee Retirement Income Security Act of 1974 (ERISA) plans, employers operating across multiple states face varying compliance requirements depending on market and plan structure.

The combined effect of CAA 2026 and state-level reforms is expected to change how pharmacy costs flow to plan sponsors in 2026 and beyond—though the net impact on employer costs will depend significantly on how PBMs repricer their fee structures in response to the new pass-through requirements.

6 Kuester, M., Urick, C., Naber, J., & Barker, C. (December 23, 2025). Healthcare utilization and costs associated with obesity treatment in a commercial self-insured population. Milliman. Retrieved May 15, 2026, from <https://www.milliman.com/en/insight/healthcare-utilization-obesity-commercial-self-insured>.

7 International Foundation of Employee Benefit Plans. (June 13, 2024). Employer coverage of GLP-1 drugs on the rise. Retrieved May 15, 2026, from <https://www.ifebp.org/detail-pages/news/2024/06/13/employer-coverage-of-glp-1-drugs-on-the-rise>.

8 See the full text of the act at <https://www.congress.gov/bill/119th-congress/house-bill/7148/text>.

Outpatient facility cost growth

Over the past two decades, outpatient facility cost trend has outpaced every other service category. For a family of four, costs have quadrupled since the MMI was first published in 2005, and over the most recent five years alone, outpatient facility costs have grown 37%. Three core drivers underlie this sustained trend.

Physician practice consolidation – The shift of physician practices from private ownership to hospital employment continues at a notable pace. At least 47% of U.S. physicians were employed by or affiliated with hospital systems as of 2024, up from less than 30% in 2012.⁹ The share of hospital-owned practices grew from 23.4% to 34.5% over that period, while the share of private practices fell from 60.1% to 42.2%.¹⁰ Research indicates that these acquisitions are driving higher-intensity coding for office visits and increased use of hospital-based diagnostic services. While facility fees on office visits themselves have increased only modestly post-acquisition, the steering of ancillary services—imaging, diagnostics, infusion—into hospital-based settings is where the outpatient cost impact is most significant.¹¹

Outpatient administered drugs – Specialty drugs administered in outpatient settings represent a growing and increasingly higher-cost component of outpatient facility costs. When these drugs are administered in an outpatient facility, they generate both a drug cost and a separate facility fee, compounding the cost impact.

On the unit cost side, chimeric antigen receptor T-cell (CAR-T) cell therapies illustrate the scale of this pressure, with drug costs ranging from \$370,000 to \$530,000 at list price and total commercial insurance episode costs exceeding \$600,000 when facility charges and supportive care are included.¹²

On the utilization side, two trends are expanding the population receiving these high-cost therapies. Cancer prevalence is rising—an estimated 18.6 million Americans were living with a cancer history as of January 2025, a figure projected to exceed 22 million by 2035¹³, driven by both an aging population and improving survival rates that convert previously fatal diagnoses into ongoing treatment relationships. At the same time, newer therapies are being approved for earlier lines of treatment and broader patient populations, expanding eligibility well beyond the most severe cases where these drugs were initially indicated.

Site of care shifts – A third driver is the ongoing migration of services from inpatient to outpatient settings. From 2005 to 2024, hospital days decreased 5% while outpatient visits grew 44%.¹⁴ Data from 2025 show outpatient visits continue to rise, reflecting both higher overall demand and the continued shift away from inpatient care.¹⁵

Outpatient facility costs are unlikely to slow meaningfully in the near term. Physician consolidation with hospital systems continues to accelerate, specialty drug utilization and costs keep growing, and the shift of care to outpatient settings shows no signs of reversing as plans and health systems look for ways to manage costs. Together, these three forces make outpatient facility care one of the most important cost trends to watch in the years ahead.

9 Kane, C. K. (May 29, 2025). Policy research perspectives: Physician practice characteristics in 2024: Private practices account for less than half of physicians in most specialties. American Medical Association. Retrieved May 15, 2026, from <https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf>.

10 Government Accountability Office. (2025). Health care consolidation: Published estimates of the extent and effects of physician consolidation (GAO-25-107450). Retrieved May 15, 2026, from <https://files.gao.gov/reports/GAO-25-107450/index.html>.

11 Chang, J., Picher, C., Myers, M., & Gaeta, R. (April 2026). Effects of vertical integration on providers' billing and practice patterns in ESI (2018-2022). Health Care Cost Institute. Retrieved May 15, 2026, from https://healthcostinstitute.org/wp-content/uploads/2026/04/Vertical-Integration-ESI-Brief_20260410.pdf.

12 American Cancer Society. (July 7, 2025). CAR T-cell therapy and its side effects. Retrieved May 15, 2026, from <https://www.cancer.org/cancer/managing-cancer/treatment-types/immunotherapy/car-t-cell.html>.

13 Wagle, N.S., Nogueira, L., Devasia, T., et al. (May 30, 2025). Cancer treatment and survivorship statistics, 2025. Retrieved May 15, 2026, from <https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.70011>.

14 Godwin, J., Levinson, Z., & Neuman, T. (February 11, 2026). Hospital spending accounted for 40% of the growth in national health spending between 2022 and 2024. Kaiser Family Foundation. Retrieved May 15, 2026, from <https://www.kff.org/health-costs/hospital-spending-accounted-for-40-of-the-growth-in-national-health-spending-between-2022-and-2024/>.

15 American Hospital Association. (March 2026). Costs of caring: Challenges facing America's hospitals as they care for patients in 2026. Retrieved May 15, 2026, from <https://www.aha.org/costsofcaring>.

Hospital price inflation and AI-enabled billing optimization

Facility services continue to be material drivers of annual cost increases for employer-sponsored insurance. Many hospitals are responding to persistent staffing constraints, rising costs, and tighter payment scrutiny by investing in AI-enabled tools to strengthen revenue integrity and reduce uncaptured revenue. These tools are increasingly used in charge capture, coding support, and denials management, workflows where small changes in documentation completeness or coding intensity can meaningfully affect payment levels. Recent Healthcare Financial Management Association (HFMA) survey findings describe broad adoption of AI in these areas, with roughly half of organizations reporting that they have implemented AI-driven solutions in coding, denials management, and clinical documentation improvement.¹⁶ Notably, 90% of respondents believe automation and AI, paired with human oversight, will be moderately or extremely effective at improving financial performance, while only 9% report being “very confident” they currently capture all revenue to which they are entitled.¹⁷

AI-enabled billing optimization could influence observed hospital cost growth through several operational pathways, even if underlying utilization is unchanged. Charge capture tools can identify services that were performed but not billed. Documentation and coding tools can reduce undercoding and increase the likelihood that billed codes fully reflect documented complexity. Denial prediction and appeal automation can accelerate resubmissions and improve appeal success rates, raising the proportion of billed services that are ultimately paid.

AI is now being used on both sides of the payment system, from provider revenue-cycle workflows to payer activities such as claim and chart reviews.^{18,19} Oversight is also becoming more automated: The Centers for Medicare and Medicaid Services (CMS) launched its Crushing Fraud Chili Cook-Off initiative to evaluate whether explainable AI can detect anomalous billing patterns in Medicare fee for service claims while maintaining human interpretability.²⁰ For the 2026 MMI, the practical implication is to monitor AI-enabled billing optimization as a potential contributor to cost growth. As facility costs remain elevated, particularly in outpatient settings, it will be important to watch whether broader billing and payment dynamics move in tandem with facility cost growth, recognizing that AI adoption by both payers and providers could influence observed trends.

A deeper look at the MMI

HOW THE MMI IS CONSTRUCTED

The MMI represents the projected total cost of covered healthcare services for an average person, as well as for a hypothetical family of four (two adults and two children), covered under an average employer-sponsored PPO health benefit program during a full calendar year. The MMI reflects the following:

- Nationwide average provider fee levels negotiated by insurance companies and preferred provider networks
- Average PPO benefit levels offered under employer-sponsored health benefit programs
- Utilization levels representative of the average for people covered by large employer group health benefit plans in the United States

16 Healthcare Financial Management Association. (October 2, 2025). Healthcare leaders optimistic that automation and AI will improve revenue integrity. Retrieved May 15, 2026, from <https://www.hfma.org/technology/healthcare-leaders-optimistic-that-automation-and-ai-will-improve-revenue-integrity/>.

17 *ibid.*

18 Williams, J. (December 22, 2025). Battle of the bots: As payers use AI to drive denials higher, providers fight back. Healthcare Financial Management Association. Retrieved May 15, 2026, from <https://www.hfma.org/revenue-cycle/denials-management/health-systems-start-to-fight-back-against-ai-powered-robots-driving-denial-rates-higher/>.

19 Biniak, J. F., Sroczynski, N., & Neuman, T. (November 20, 2025). Chart reviews increase payments to Medicare Advantage insurers for 1 in 6 enrollees. Kaiser Family Foundation. Retrieved May 15, 2026, from <https://www.kff.org/medicare/chart-reviews-increase-payments-to-medicare-advantage-insurers-for-1-in-6-enrollees/>.

20 Centers for Medicare and Medicaid Services. (March 31, 2026). Crushing Fraud Chili Cook-Off Competition. Retrieved May 15, 2026, from <https://www.cms.gov/priorities/crushing-fraud-waste-abuse/overview/crushing-fraud-chili-cook-competition>.

The MMI plan pays approximately 86% of the total cost of care in 2026, meeting the minimum requirement of 60% for a large employer's health plan under the Affordable Care Act.

HOW THE MMI DIFFERS FROM OTHER INDICES

The MMI dollar amounts are the best estimates of annual healthcare costs grounded in actual health insurance administrative claims incurred over multiple years. The most recent year of data reflects approximately 47 million lives. We have projected it forward from 2024 to 2025 and 2026 using estimated trend rates (representing both cost and utilization trends) and restated past MMI values to reflect information collected since last year's publication.

The MMI reflects the most recent data from Milliman's ongoing research on healthcare costs. The MMI is derived from our flagship health cost research tool, [Milliman's Health Cost Guidelines™](#) and a variety of other Milliman and industry data sources, including [Milliman's Mid Market Survey](#), [Milliman MedInsight® Emerging Experience research database](#), and [Milliman Health Trend Guidelines™](#).

VARIABILITY IN COSTS

The MMI represents a useful benchmark, but any family or individual could have substantially different costs depending on a range of factors.

- **Age and gender.** Costs vary widely by age, with older individuals incurring higher average costs than younger ones. Gender differences also exist, driven primarily by maternity costs and differing patterns of healthcare utilization across genders.
- **Individual health status.** People with chronic or severe conditions typically have significantly higher healthcare costs than those without. This variation can be dramatic: A small share of any population accounts for a disproportionate share of total spending in any given year.
- **Geographic area.** Costs vary meaningfully by location due to differences in population density, provider practice patterns, access to care, and local price levels. Labor costs for clinical staff tend to be higher in high cost-of-living markets, and those costs flow through to the prices employers and employees pay.
- **Provider variation.** Even within the same city, costs for identical services can differ substantially from one provider to another. These differences reflect variation in billed charges, negotiated payment rates, and the payment methodologies in place, including capitation or case rates, which can influence utilization patterns and unit costs.
- **Site of care.** Where a service is performed now has a significant independent effect on cost, separate from who performs it. The same procedure billed in a hospital outpatient department typically carries a facility fee that does not apply in a physician office setting. As more physicians have become employed by or affiliated with hospital systems, a growing share of routine services are billed at facility rates, contributing to cost increases that have nothing to do with changes in the underlying service.
- **Insurance coverage and plan design.** The richness of a benefit plan affects both utilization and cost. Plans with lower cost-sharing requirements tend to generate higher utilization than those with higher deductibles and OOP requirements, all else equal.
- **Provider network.** Although the MMI assumes a PPO benefit program, health maintenance organization and narrow network plans may offer meaningful cost savings for employers willing to accept more constrained provider access, primarily through lower negotiated payment rates.
- **Pharmacy rebate arrangements.** Pharmaceutical manufacturers pay drug rebates to PBMs for preferred formulary placement. Historically, the share of rebates passed through to employer health plans has varied considerably, with smaller employers often at a disadvantage in negotiating favorable arrangements.

Acknowledgments

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