THE ALLIANCE
SIGNATURE
SEMINAR

INSIGHTS REPORT:

HEALTH INSURANCE POLICY

allhealthpolicy.org

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ALLIANCE
FOR HEALTH POLICY

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I. ACKNOWLEDGMENTS

Seminar Sponsors and Supporters

The Alliance for Health Policy recognizes and appreciates AHIP and the Blue Cross Blue Shield Association for their support of the Signature Seminar program, which makes this work possible.

II. SIGNATURE SEMINAR: HEALTH INSURANCE POLICY

Health insurance policy sits at the center of the U.S. health system. It determines how care is financed, who has access, and how costs are distributed, making it one of the most complex and consequential areas of health policy. Nearly every American is affected by this system, whether through Medicare, Medicaid, employer-sponsored coverage, or private insurance purchased in the marketplace. In 2024, 92% of Americans had some form of coverage, reflecting a patchwork of programs that require careful coordination and oversight.

The federal government plays a particularly influential role. Of the $4.5 trillion the nation spent on health care in 2022, the federal government financed about one-third, and its rules, especially for Medicare and Medicaid, shape practices across the private sector and state programs. More than 100 million people rely directly on federal coverage through Medicare, Medicaid, the Children's Health Insurance Program (CHIP), TRICARE, and the Veterans Health Administration. Federal policy not only provides coverage but also regulates markets, funds biomedical research, supports health workforce training, and sets standards that ripple throughout the health system in ways that have profound impacts on how health insurance works.

For Congress, understanding health insurance is essential. Members are responsible for lawmaking, oversight, budget decisions, and responding to constituent concerns, all of which require clarity on how coverage works, what tradeoffs policies involve, and how programs interact. Yet the mechanics of insurance—risk pooling, cost sharing, market stability—are often highly technical and difficult to compare across programs.

Federal agencies and the staff who run them establish minimum standards, implement coverage rules, coordinate funding across programs, set payment mechanisms, and oversee market stability for millions of Americans. Federal staff shape how public programs operate and influence employer coverage, marketplace offerings, state initiatives, and private sector practices.

At the same time, the Alliance gets consistent feedback from our policymaker community that health insurance is a confusing, complex, and intimidating area of health policy to learn and understand, and it is evolving every day. There is a widespread and demonstrated need for ongoing education on this topic.

For the broader policy community, understanding the intent behind coverage policies, the current architecture of insurance, and the scope and impacts of various programs is necessary to understand the broader landscape of health policy.

Given the central role of insurance in health policy and the ongoing challenges of understanding the subject, it is fitting that the Alliance for Health Policy Seminar focused on illuminating current top-of-mind issues, trends, structural and foundational questions, along with identifying areas of educational opportunity, to level-set where we are today, and bridge educational gaps in the future. By breaking down the building blocks of coverage, we aim to give policymakers and the greater policy community a shared foundation to interpret challenges, evaluate proposals, and engage in informed debate.

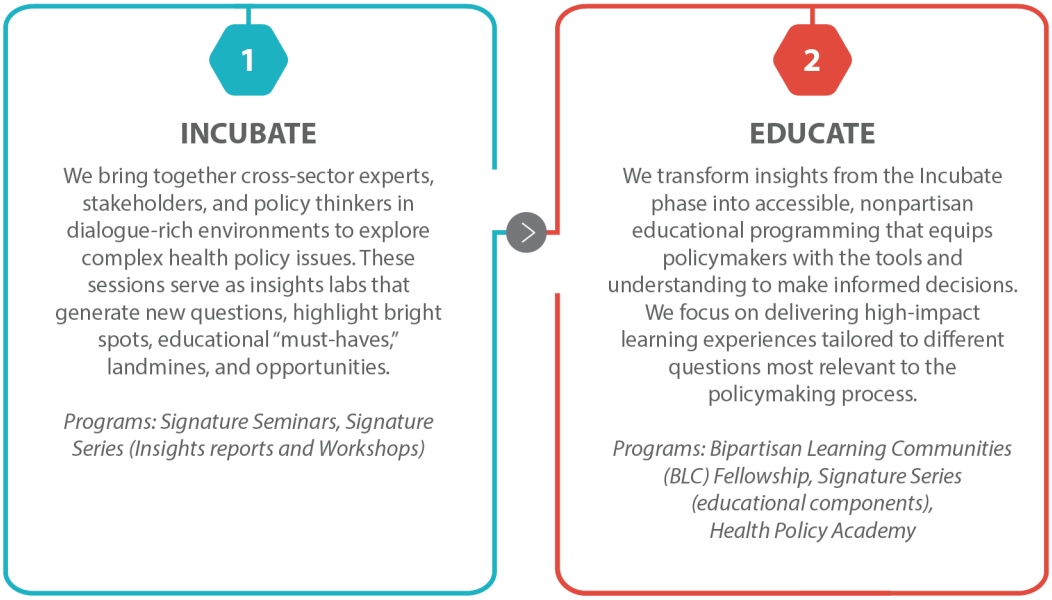
This insights report summarizes what was learned through the Alliance for Health Policy's 2025 listening process on health insurance, with a focus on interviews with experts from multiple perspectives. By capturing and distilling these points of view, the report highlights hot topics, ongoing trends, along with deeper-level concerns, giving Congress and other decision-makers a framework for understanding how today's concerns relate to fundamental questions whose answers drive one of the most consequential areas of domestic policy.

About the Alliance for Health Policy

The Alliance for Health Policy is a nonpartisan, nonprofit organization dedicated to helping policymakers and the public better understand health policy, the roots of the nation's health care issues, and the trade-offs posed by various proposals for change.

THE ALLIANCE'S INCUBATE TO EDUCATE MODEL

The Alliance applies a unique two-part "Incubate to Educate" model to its programming.



The Signature Seminars represent the first step of our program lifecycle, "Incubate." This involves gathering insights and bringing together experts to provide direction on key issues on the policy topic. This program gathers voices from across the health care policy community, including those currently serving in government roles, academics, patient voices, health care providers, payers, innovators, and technical experts.

These experts gather to join discussions and share recommendations for areas of focus that we'll apply to our second phase of programming, "Educate." In this phase, the Alliance develops and executes informed educational programming aimed at legislative staffers and the broader health policy community.

III. BACKGROUND

Listening Tour Summary

From May 2025 through July 2025, the Alliance for Health Policy conducted 12 in-depth interviews (IDIs) with leading experts in insurance policy to produce this report. This report presents an overview of the current health insurance policy landscape, reveals findings that highlight the most pressing gaps and priorities in health insurance policy, and identifies opportunities for future discussion.

Design and Methods

Participants represented patient advocacy, government, nonprofits, and the private sector. Selection criteria prioritized representation of bipartisan, multi-stakeholder perspectives, as well as policy and political expertise that reflect the breadth of the Alliance community. The 30-minute IDIs were conducted via Zoom and followed a semi-structured interview format. Findings are qualitative and provide directional insights.

Outcomes

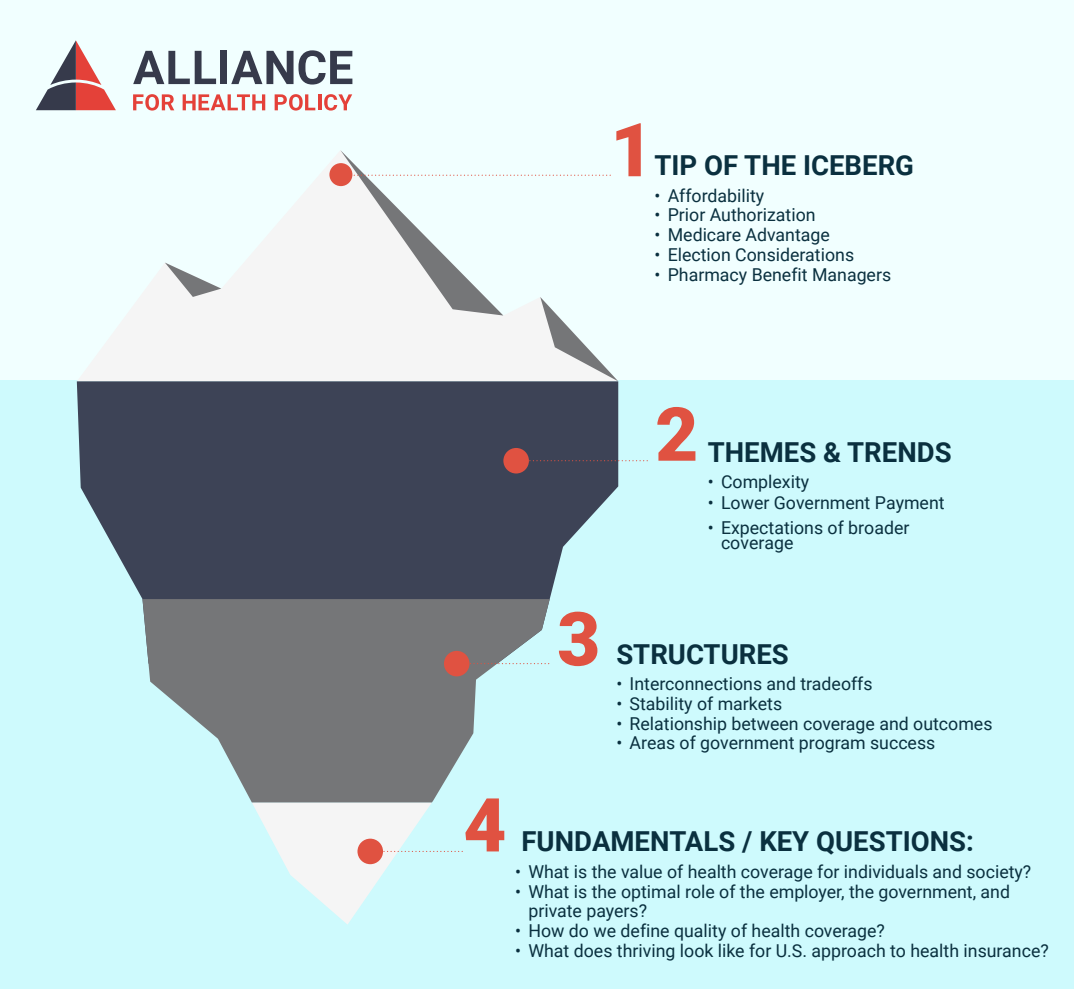
Findings from these IDIs were used to help inform the design of the Signature Seminar on Health Insurance, which gathered voices from across the broader health care policy community to focus on this core topic of community interest. The individuals who participated in the IDIs also helped identify relevant potential invitees and topics of discussion for the Seminar workshops.

The Alliance published a seminar report from these workshop sessions. The full report, including detailed examples and unattributed quotes, is available on the Alliance website. To view it, visit the site, click here, or scan the QR code.

See Seminar Report Here:

Scan using your mobile device to read the full report.

IV. THE ICEBERG MODEL: FROM TIMELY ISSUES TO SYSTEMIC AND FUNDAMENTAL INSIGHTS



The Alliance approach to analyzing these insights is informed by the "iceberg model" in systems thinking, first introduced by anthropologist Edward T. Hall to illustrate how much of culture and communication lies beneath the surface of what is visible. The iceberg model has been widely adopted for use in organizational strategy, business and management, and the public and private sectors. Systems thinking has the advantage of not only identifying areas within a structure, but also acknowledging the interactions and influence that one area has on another. In adapting this framework, our findings show that the most discussed issues, such as coverage debates or program costs, represent only the surface level of the conversation. Beneath the surface lie deeper structural dynamics, which often influence policy more than the visible discussions. By applying this model, the Alliance can categorize insights in a way that clarifies both the immediate topics that draw attention and the less visible but foundational forces that shape the health insurance policy.

Tier 1: At the tip of the iceberg, the most visible part, are the hot topics that dominate headlines and congressional debates, such as affordability, prior authorization, Medicare Advantage (MA), and pharmacy benefit managers (PBMs). These are the most talked-about topics for policy discussions, but they represent only a fraction of the forces shaping the system.

Tier 2: Beneath the surface lie medium-term trends that reflect the broader environment. These include the growing complexity of the policy environment for insurance, shrinking government payments, rising demands on insurers, and consolidation across markets.

Tier 3: Deeper still are the structural trends shaping the broader environment. These include interconnections and tradeoffs between policy choices, drivers of market stability, the relationship between coverage and health outcomes, and understanding which elements of government programs are working.

Tier 4: At the foundation of the pyramid are the fundamentals: questions about the value and intent of insurance, the definition of quality, the optimal role of government and private industry, and what a thriving approach to health care looks like. These building blocks are less frequently discussed, yet they are essential discussion points for achieving long-term solutions.

Throughout this process, the Alliance listens to experts while staying aware of the layers—capturing immediate concerns at the surface while also highlighting the deeper, timely, structural, and conceptual forces that shape health insurance policy and its future.

V. TIP OF THE ICEBERG: HOT TOPICS IN THE HEALTH INSURANCE LANDSCAPE

Affordability

Alliance community experts consistently identified affordability as the most urgent issue currently at the tip of the iceberg in the health insurance policy landscape. Rising premiums, out-of-pocket costs, and cost-sharing mechanisms were noted as placing pressure on consumers, employers, and government budgets alike. Participants emphasized that broader challenges in coverage, access, and stability will remain unresolved without meaningful solutions that address affordability.

> *"Health insurance policy always comes down to money…the cost of care, driving the cost to premiums, which then, in order to try to deal with…more cost to the individual through cost sharing through premiums…Cost is the driver, cost is the problem, and cost is something nobody's gotten a handle on yet."*
>
> – Director of Health Policy, Regulatory Organization

> *"Cost, obviously...I think premium costs are pretty high, and so folks are having a tough time with that…I think there's also an access challenge in terms of just providers that are out there, and so that makes their network smaller."*
>
> – Senior Vice President, Provider

> *"I think across the board on insurance, it's affordability. And that's either from a consumer perspective or an employer perspective. Or for ACA, it's from the taxpayer and consumer perspective."*
>
> – President & CEO, Health Care Consulting Firm

Prior Authorization

Experts identified prior authorization as a visible and bipartisan current concern. While intended to manage utilization, the process was described as burdensome for providers and disruptive to patients, often delaying access to needed care. Alliance community experts noted that these challenges have elevated prior authorization as a prominent flashpoint in policy debates, with frustration cutting across stakeholder groups. Respondents also pointed to recent movements aimed at addressing some of the challenges with the practice.

> *"What I think is interesting about prior authorization is that politically it's reaching a point where it seems like people are mad enough about it…So it's more political than policy."*
>
> – Director of Health Policy, Think Tank

> *"From a physician perspective…the complexity of paying for health care ...when you think about utilization management on its face, that's a great purpose. But how it's being executed in practice is actually reducing patients' access to care because it takes them longer to get the medications they need."*
>
> – Senior Vice President, Provider

> *"...Especially large hospital systems and large provider groups complaining about ... MA. The prior authorization, the time it requires to get prior authorization, the...an inability to contact people in the MA plan to get an answer. ...the prior authorization process has been a problem with some of the MA plans."*
>
> – Director of Health Policy, Regulatory Organization

> *"The commitments health plans made with the HHS Secretary — you could have seen that as plans and providers both making commitments for better patient care… there could be important steps forward now, but I think there's going to be more tensions between plans and providers, with the risk that patients get caught in the middle."*
>
> – Senior Scholar, University

Medicare Advantage (MA)

Experts identified the rapid growth of MA as a prominent topic of discussion, raising questions about payment accuracy, coding practices, and overall value to enrollees. While supplemental benefits such as vision and dental have made these plans attractive, concerns about spending and oversight have placed MA at the center of ongoing policy debates.

> *"I think more people are in an MA plan than are not in an MA plan in Medicare. But there are a lot, there's a lot of scrutiny about the payment and whether or not plans are being appropriately paid for, you know, conditions of the members that they have."*
>
> – CEO, Health Care Consulting Firm

> *"There's more and more data coming out like, is it actually better quality, or are they...just taking more money from the system, but then other people will say...people are then able to get vision and dental and other things...those flexibilities have created some really cool innovations, but there's probably a middle ground that we haven't struck yet."*
>
> – Insurance Specialist, Administration

> *"When it comes to upcoding, there are so many different [policy] options… there are these technical tweaks, and it's super doable. You could change this formula or go back two years on fee for service instead of one year…It's like there's just a million different things we could do…we need to do something in the short run."*
>
> – Director of Health Policy, Think Tank

Pharmacy Benefit Managers (PBMs)

Employers, providers, and policymakers increasingly raised concerns about the role of PBMs, particularly around transparency of rebate structures and pricing. While PBMs play a central role in negotiating formularies and managing drug costs, participants noted that their practices are often difficult to understand and evaluate. This lack of clarity has made PBMs a high-visibility issue in health insurance debates, with growing calls for greater accountability.

> *"We're seeing a lot more employers question the value of the PBM arrangement. PBM issues have kind of gotten more ingrained in the public consciousness. I think plan sponsors are starting to say, what is actually the value we're getting here?... Overarching both CEO and HR is, how are we getting a solid benefit at an affordable price, where we can attract and retain talent? And what are the strategies for that?"*
>
> – President & CEO, Health Care Consulting Firm

> *"The PBM issue, a lot of the rebates and all of that, a plan could never execute for its members, could never negotiate a formulary as a singular insurance company, effectively, unless you're one of the big ones and they have their own. So they're needed. PBMs serve a function because that is, they need someone else who is doing that. I think somewhere along the way, it became pretty obscured."*
>
> – Senior Vice President, Provider

Election-Year Pressures

Participants flagged election years as a period for heightened exposure for issues of health coverage, with political cycles influencing health insurance dynamics. The looming expiry of Affordable Care Act (ACA) premium subsidies, scheduled for late 2025, could drive premium spikes and enrollment losses unless Congress acts. Meanwhile, proposed legislation to extend these subsidies past the 2026 midterms underscores the heightened political sensitivity surrounding health care affordability during election cycles. As premiums, Medicaid funding, and access to coverage are political flashpoints, election-year pressures shape both policy discussions and practical outcomes at the surface of the health policy iceberg.

> *"At a policy level, people will roll off ACA and have to find coverage, or afford it, or go uninsured. ...those moderate senators... don't want to deal with either a premium increase or more uninsured folks going into an election year."*
>
> – CEO, Health Care Consulting Firm

VI. BELOW THE SURFACE: THEMES AND TRENDS

While public debate often centers on visible issues like the ones above, experts interviewed by the Alliance pointed to deeper trends shaping today's insurance landscape. These underlying dynamics cut across programs and markets, influencing costs, coverage, and competition in ways that are less immediately apparent. Recognizing these patterns is critical to understanding the structural pressures that drive today's policy tensions and shape the long-term stability of the health insurance landscape.

Complexity Across Systems

Experts engaged by the Alliance emphasized that overlapping programs and regulatory layers define the insurance landscape and create persistent confusion. Federal and state responsibilities intersect with Medicaid, the Children's Health Insurance Program, ACA marketplaces, the Employee Retirement Income Security Act (ERISA), and employer-sponsored insurance (ESI), leaving policymakers and consumers to navigate fragmented structures. According to these perspectives, the lack of alignment not only complicates policymaking but also reinforces administrative burdens for providers, plans, and beneficiaries who struggle to understand the rules governing their care.

> *"A huge, huge part of it is complexity…Like every state has two programs, that's not efficient, and then we have ESI [Employer-Sponsored Health Insurance] and ERISA [Employee Retirement Income Security Act] plans. And, you know, we have Medicare, and then we have duals. I mean, it's just the complexity is just absolutely mind-boggling."*
>
> – Director of Health Policy, Think Tank

> *"From the physician's perspective, the complexity of paying for health care is just that it's gotten out of hand…There's not a lot of transparency about how or why those decisions are made. So that's a huge challenge."*
>
> – Senior Vice President, Provider

> *"There are so many different iterations, so many different players. I don't think anybody's got a full handle on it yet."*
>
> –Director of Health Policy, Regulatory Organization

Market Consolidation

Experts noted that consolidation among insurers, hospitals, and physician groups continues to reshape the insurance landscape. Interviewees observed that while larger entities may achieve efficiencies, this dynamic can limit competition, strain smaller players, and raise concerns about affordability and consumer choice.

> *"So hospitals are acquiring hospitals and hospitals are buying up doctor practices and doctor practices are merging. ...everyone's getting more leverage because there's less competition. But employers aren't getting any bigger. ...they're losing ground."*
>
> – Director of Health Benefits Research, Nonprofit

> *"There's far more consolidation in the market. There are fewer plans offering services. ...The smaller players have a harder time competing with the national players. That's due to policy. ...I think that is the policy question, whether it is a good thing or a bad thing."*
>
> – Senior Scholar, University

Shrinking Government Payments

Experts underscored that declining government contributions are straining public programs' state budgets, and will have an impact on the private system as well. As demand for costly services grows, stagnant or reduced payments create gaps that often shift costs to providers and patients. Experts explained that these pressures can destabilize coverage, increase uncompensated care, and leave state systems facing difficult tradeoffs to maintain access.

> *"Right now, I think the bill [One Big Beautiful Bill Act] that just passed… that would be devastating to Medicaid. It's already an under-resourced program that is already tapping lots of other sources for funding, so this is just pulling back [$1 trillion], per the Congressional Budget Office] on a lot of that. So you are going to see disruptions to coverage. You are going to see a lack of access, and you're going to see people falling through the cracks. And that doesn't mean that they're not going to be getting care. They're going to show up in emergency rooms. They're going to need care, and there's not going to be a way to pay for that. And so states whose state budgets are already strapped are going to be even worse off."*
>
> – Senior Vice President, Provider

> *"I don't know … if [Medicaid changes] will put larger strains on the plans that have dual eligible, but … to the extent that it affects state budgets … maybe that somehow plays into how much plans are paying, how much states are paying on the duals, and maybe that somehow trickles down to plans. I'm not really sure exactly how that's going to play out."*
>
> – CEO, Health Care Consulting Firm

Increasing Demand for Care

Experts observed that expectations of what insurance should cover have steadily expanded, with growing calls for benefits that go beyond traditional medical services. They emphasized that this widening scope of responsibility places greater pressure on insurers, especially when paired with constrained public funding.

> *"Policy is clearly asking health plans to provide or build a network for more expanded services. Policymakers, payers, taxpayers, etc., want the health system to be more comprehensive...There's more responsibility being put on insurers.*
>
> – Senior Scholar, University

> *"...We're at this moment where people really are seeing lower and lower value in their coverage the more and more it—oddly enough—covers more benefits."*
>
> – President & CEO, Health Care Consulting Firm

VII. A BIT DEEPER: STRUCTURES THAT IMPACT THE POLICY ENVIRONMENT

Beyond the visible trends shaping the insurance landscape are the underlying structures that influence how the system operates. These include the relationship between coverage and outcomes, the factors that contribute to market stability, and the interactions among major public and private programs. Understanding these connections provides a clearer view of the policy environment and the elements that shape its performance over time.

Coverage and Outcomes: What is the relationship?

Experts emphasized that clarifying the link between coverage and outcomes is a fundamental question, with long-held assumptions being challenged. They noted that while coverage reduces financial barriers and enables access to care, recent discussions question whether it automatically translates into better health. Several pointed out that outcomes can vary widely depending on program design and population needs, underscoring the importance of understanding how insurance structure influences both access and long-term health, but generally, they believed there is a positive relationship between the two. This theme highlights the opportunity for deeper exploration and discussion of what coverage is expected to achieve beyond enrollment numbers and further study.

> *"There was a lot of discussion about how health insurance doesn't necessarily lead to better health."*
>
> – Director of Health Policy, Think Tank

> *"The more uninsured you have, the worse the health. A person who's uninsured will have worse health outcomes than someone who's insured, because they have access to medical care. And yes, you can go to the emergency room, but that's not the same as preventive care, prescription medicines, all those things."*
>
> – CEO, Health Care Consulting Firm

Market Stability: What makes a stable market? What are the benefits?

Experts pointed to market stability as a core aspect of health insurance. They observed that stability depends on factors such as competition, payment structures, and regulatory guardrails, yet these dynamics are not always well understood in policy discussions. Participants emphasized that congressional education on the mechanics of market stability is essential for shaping durable reforms that balance affordability, access, and long-term system performance.

> *"I'm spending a lot of [time] on things related to regulatory and legislative changes on the individual market and really zoning in on market stability. Thinking about what you need for market stability, what can help market stability, and what could worsen stability. And also the interconnectedness of different markets……I think it's really ripe for discussion because people often think about these markets separately, but the reality is that what happens in one affects the others."*
>
> – Senior Health Fellow, Nonprofit

Tradeoffs and Interconnections Across Programs

Experts underscored that every policy choice in health insurance involves tradeoffs, and actions in one area often ripple across others. They noted that the system's complexity—spanning Medicare, Medicaid, ESI, ERISA, and the ACA marketplaces—means that changes rarely occur in isolation. A policy aimed at reducing costs, for example, may affect access or quality in unintended ways. Experts emphasized that congressional education on these interconnections is critical, ensuring that reforms are evaluated not only by immediate outcomes but also by their downstream effects across programs.

> *"Maybe it all comes back down to…what's working… that helps frame things. It's not like good or bad, it's just the tradeoffs… Here are the different tradeoffs that exist. And here's how to date as an American system, we have decided to proceed…now we are at a crossroads where we want to reassess those tradeoffs and make a different decision."*
>
> – Insurance Specialist, Administration

Which elements of government programs are working?

Experts noted that evaluating government programs for areas of strength, as well as improvement, was an under-explored policy topic. Focusing on which elements are functioning as intended and why can help frame discussions in Congress, ensuring that areas of success are included in discussions of how to shape future policy alongside judgments about program challenges.

> *"Medicaid is a cost-effective program. Medicare does a pretty decent job of controlling costs…overall, it does a pretty good job of measuring costs…what I would love for people to walk out of the room thinking is: why are we doing all this stuff to try to control health care costs nationwide through this janky, layered system?… Of all of these different things that we're talking about, Medicare is the one with the most adequate margins that is responsible."*
>
> – Director of Health Policy, Think Tank

> *"…we're on a collision course right now where the system is not able to support it…what policymakers need is to be open to just reality, to understand the implications of what's working and what's not, and have educated conversations about those fundamentals."*
>
> – Senior Vice President, Provider

VIII. FUNDAMENTALS / KEY QUESTIONS: OPPORTUNITIES FOR GREATER EXPLORATION AND UNDERSTANDING

At the base of the iceberg are core policy questions that rarely take center stage but shape the entire health insurance system. These include how to define the value and goal of insurance, how quality is defined and measured, and the optimal role of the federal government, employers, and private payers. While less visible than hot topics or trends, these fundamentals provide the context for understanding how insurance works.

Value and Goal of Insurance: How do we define it? What is the value to consumers? To society?

Respondents raised questions about how the value of insurance should be defined and for whom. They observed that coverage is often treated as an end in itself, but the intent and utility of insurance differ for consumers, payers, and society at large. For some, value lies in financial protection, while for others it reflects access to broader benefits or stability in the system. Experts suggested that clearer articulation of these differing perspectives on value could lead to more constructive and transparent policy design.

> *"The public policy question is whether insurance should primarily deliver protection against catastrophic medical costs, or expand into ever more generous non-medical benefits — and what that means for market stability."*
>
> – Senior Scholar, University

> *"Cost has increased significantly faster than wages and inflation…people feel like insurance has gotten less valuable."*
>
> – President & CEO, Health Care Consulting Firm

> *"Would I want to be uninsured for my family? No. Nobody wants to have no insurance... we're working hard because we believe that health insurance improves people's health. And that gives people a better quality of life."*
>
> – Director of Health Policy Studies, Think Tank

Quality of Insurance Coverage: How do we define it? Measure it?

Experts highlighted that quality in insurance is difficult to define and often poorly communicated, creating confusion for both consumers and policymakers. While rising premiums receive significant attention, the adequacy of what coverage delivers is equally critical to how people experience the system. Several noted that misalignment between expectations and actual benefits fuels public frustration and complicates oversight. This gap underscores the importance of congressional education on how quality is defined, measured, and communicated across programs, so that policy discussions move beyond costs alone.

> *"Everybody focuses on excessive and rising health insurance premiums across the board…Certainly, when it comes to employer-sponsored insurance and Obamacare, we see that as well. But what concerns me even more, and I think concerns the public even more, is the quality of health insurance."*
>
> – Director of Health Policy, Think Tank

What is the optimal role of the government, employers, and private payers?

Interviewees noted that the responsibilities of government, employers, and private payers are complex and often overlap in shaping the health insurance system. Public programs such as Medicare and Medicaid play a central role for specific populations, while employers remain the most common source of coverage for working families. Private payers are increasingly expected to manage a broader range of services, reflecting shifting views of what health insurance encompasses. These dynamics point to the importance of congressional education on how roles and responsibilities are defined and interact across the system, so that discussions are grounded in a clear understanding of where different levers of influence exist.

> *"On the public insurance side, one thing I would always want people to think about is, who has power to control costs? … when you start looking at all of that, I think you just start to understand things a lot better, understand why things are complicated and why there's so many like levers that are hard to pull … the limits on federal decision making … are just limited outside of Medicare and Medicaid. … Medicare and Medicaid are driving our federal budget … if you want our budget to be on a sustainable path, you're going to have to grapple with Medicare and Medicaid."*
>
> – Director of Health Policy Studies, Think Tank

> *"Public payers, Medicare, Medicaid, and to some degree the exchanges are putting more responsibility on private payers. That includes covering services that haven't been covered traditionally, things like housing, transportation, more of the social benefits. … Policymakers, payers, taxpayers, etc. want the health system to be more comprehensive. Because there's really no other place in the health plan to kind of organize that — the health plan being asked to do more."*
>
> – Senior Scholar, University

What does thriving look like for the U.S. approach to health care?

Observers emphasized that defining what it means for the U.S. health care system to thrive is challenging, as perspectives vary across programs, payers, and patients. For some, thriving reflects affordability and financial stability, while for others it means broader access, improved outcomes, or a system responsive to community needs. These differing expectations shape how success is measured and where priorities are set. Clarifying what thriving entails is an important step for congressional education, enabling policy discussions to move beyond short-term concerns and toward a shared understanding of long-term goals.

> *"I think that's a really, really important topic because it centers the conversation. You know, like, why are we doing all this?"*
>
> – Director of Health Policy, Think Tank

IX. CONCLUSION

Health insurance is a wide-ranging policy topic, and even the most sophisticated, in-the-know experts find it complex and challenging. The Alliance for Health Policy's research revealed that while there is ample discussion at the "tip of the iceberg" on immediate issues, a deeper look highlights opportunities to examine the trends, systems, and fundamentals that impact and shape the broader landscape today.

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