

Health Insurance Fundamentals: How the U.S. System Really Works

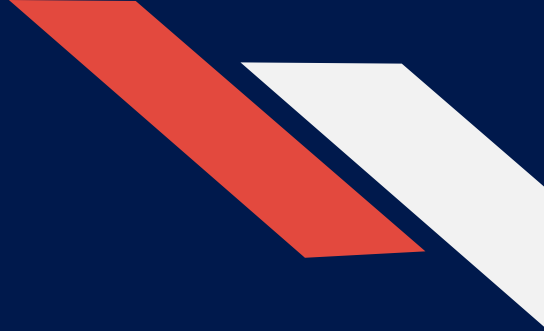
Wednesday, August 12, 2026

Welcome Remarks



Alison Jones, MPH

Director of Program Strategy &
Management
Alliance for Health Policy

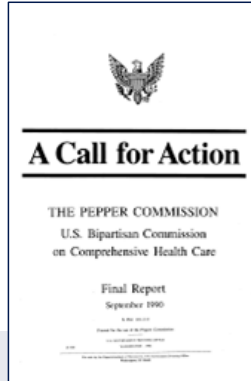


OUR VISION

To improve health and health care by
fostering a balanced exchange of evidence,
experience, and multiple perspectives.

About the Alliance for Health Policy

Educating and Advancing Health Policy



1990

Bipartisan Commission on Comprehensive Health Care (The Pepper Commission) Chair Senator Jay Rockefeller IV, acknowledges the need for continued, productive bipartisan dialogues at the conclusion of the commission.

Senator Rockefeller (D-WV), joined by Senator John "Jack" Danforth (R-MO), launch the Alliance for Health Reform.

1991



1992

The Alliance for Health Reform hosts its first congressional briefing quickly garnering the trust and attention of the policymaker and health policy community as a leading educational forum.

The organization announces the **Alliance for Health Policy** as the new name and future of the organization.

2017



2025

The Alliance welcomes its Inaugural class of fellows for the **Bipartisan Learning Communities Fellowship Program**, bringing together a cohort of 30, bipartisan, bicameral, staffers for a 10-month long fellowship program.



Incubate *to* Educate

1 INCUBATE

Generating insights and solutions



Expert Interviews and Insights Report

Deep-dive research and synthesis of expert perspectives



Workshops

Collaborative sessions to explore complex issues



Seminar/Series Report

Consolidated findings and recommendations from Signature Events



What does a good Congressional curriculum look like?

2 EDUCATE

Trusted, unbiased education that informs policy



Health Policy Academy

Core-concept grounding for policymakers



Webinars

Timely sessions on emerging issues



Congressional Briefings

Nonpartisan education on the Hill



Congressional Fellowship & Alumni Programming

Building a lasting, policy-literate network



The people making & shaping policy

Built up, informed, and ready to lead better health policy.

ZOOM POLL

**How would you describe your current familiarity with
how health insurance markets work?**

You may choose up to two.

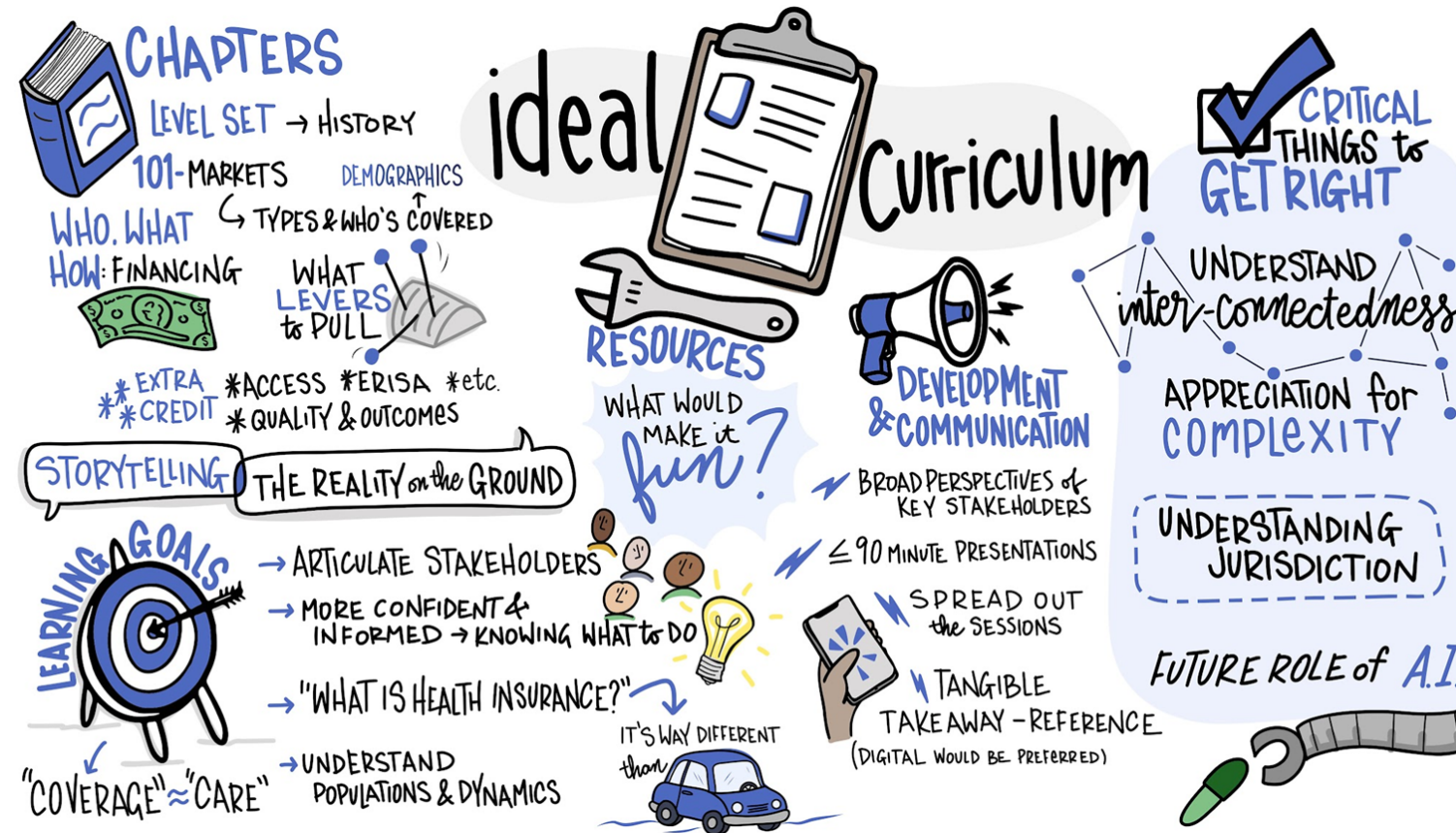
Built from a Listen-First Approach

Insights From The 2025 Insurance Seminar Informed Today's Focus On The Fundamentals

2025 SEMINAR REPORTS



GRAPHIC RECORDING: THE IDEAL CURRICULUM



WEBINAR: **HEALTH INSURANCE FUNDAMENTALS: HOW THE U.S. SYSTEM REALLY WORKS**

Wed, Aug 12, 2026 | 1:00 - 2:30 PM ET



Cynthia Cox, MPH

Senior Vice President and
Director of the Program on
the ACA and Director of the
Peterson-KFF Health
System Tracker, KFF
Moderator



**Frederick (Fritz)
Busch, FSA, MAAA**

Principal and
Consulting Actuary,
Milliman



Paul Fronstin, Ph.D.

Director, Health Benefits
Research, Employee
Benefit Research Institute



Mila Kofman, J.D.

Executive Director, DC
Health Benefit Exchange
Authority



Brian Webb, MPA

Director of Health Policy,
NAIC



ALLIANCE
FOR HEALTH POLICY

ZOOM POLL

**Which of these are you most hoping
we clear up today?**

You may choose up to two.

Congressional Fellowship

Now in its second year, the Fellowship invests in emerging health policy leaders on Capitol Hill — deepening policy knowledge, Hill-specific skills, and cross-party relationships.

30

Fellows in the 2026 class, across House and Senate

50 / 50

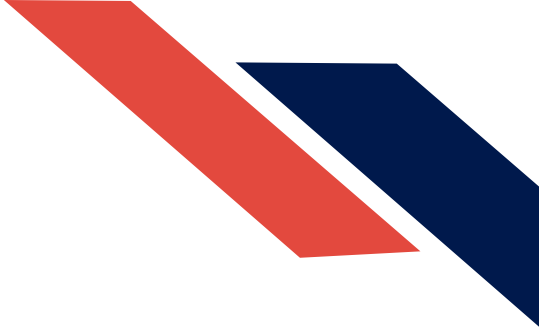
Bipartisan split across both parties

100%

Of 2025 Fellows surveyed would recommend it to other congressional staff

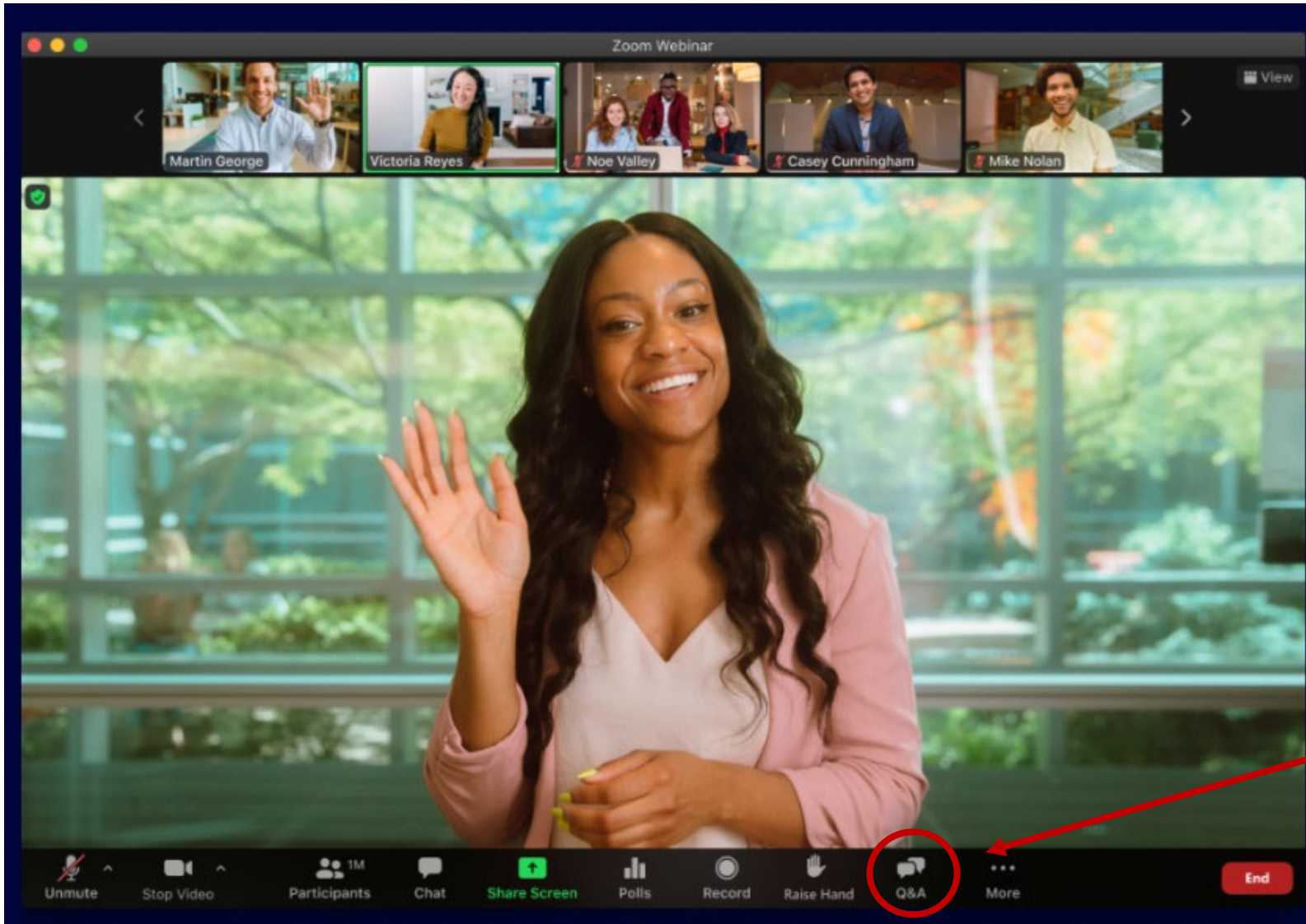
Applications for the 2027 class open this fall.
Nominate a rising health policy leader on the Hill.

Thank You to Our Sponsor!



**Elevance
Health**

Participating



To ask a question click the Q&A button and enter your text in the chat box.

Today's Moderator



Cynthia Cox, MPH (Moderator)

Senior Vice President and Director of the
Program on the ACA and Director of the
Peterson-KFF Health System Tracker

KFF

Panelists



Frederick (Fritz) Busch, FSA, MAAA
Principal and Consulting
Actuary
Milliman



Paul Fronstin, Ph.D.
Director, Health Benefits
Research
*Employee Benefit Research
Institute*



Mila Kofman, J.D.
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*DC Health Benefit
Exchange Authority*



Brian Webb, MPA
Director of Health Policy
NAIC



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Director of Health Policy
NAIC

Health Insurance Fundamentals: How the U.S. System Really Works



Brian Webb
Director of Health & Life Policy
National Association of Insurance Commissioners

What is Insurance?

Basic Definition: “A contract or risk-transfer mechanism where an insurer undertakes to indemnify another or pay a specified amount upon determinable contingencies.”

In Practice: Individual state laws legally classify products as “insurance” based on the presence of insurable risk, premium payments, and a distribution of loss

What Makes Health Insurance Different?

- Short-Term Risk (regular usage)
- Complexity (fractured; complicated)
- Churn
- Extensive Regulation
- Federal Regulation
 - McCarran-Ferguson (1945)
 - Employee Retirement Income Security Act (1974)
 - Health Insurance Portability & Accountability Act (1996)
 - Affordable Care Act (2010), etc.

Core Concepts of Health Insurance

- Licensure
- Solvency
- Cost-Sharing – Plan Design
- Rates (Premiums)
- Adverse Selection
- Network Adequacy
- Consumer Protections & Education

State Cooperation

- NAIC founded in 1871 to help coordinate state oversight
- Develops model laws/regulations; white papers; guidance; manuals. Also operates systems.
- Uses open meetings of working groups and committees to develop materials
 - Interested parties, including funded consumer reps
- Helps coordinate with federal agencies.

Conclusion

Any Questions?

Brian Webb

Director

Health & Life Policy

bwebb@naic.org

202-309-4845



**Frederick (Fritz) Busch,
FSA, MAAA**

Principal and Consulting
Actuary
Milliman

Coverage Tree For Alliance

August 2026

Fritz Busch, FSA MAAA



Sources of Health Coverage

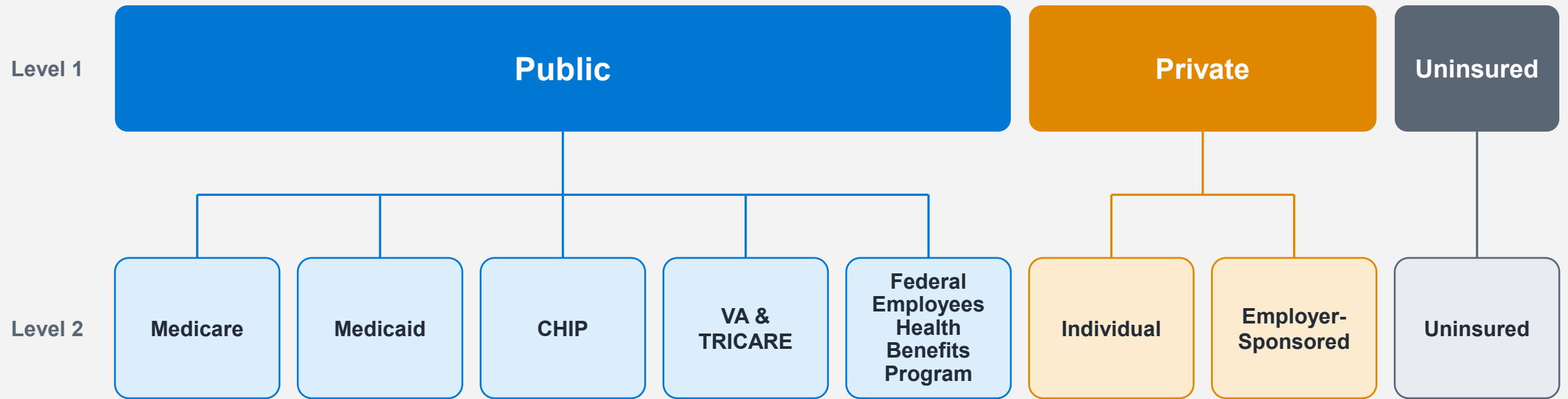
The US “Patchwork” system



Level 1 defines the coverage market; Level 2 identifies the sub-markets within each.

Sources of Health Coverage

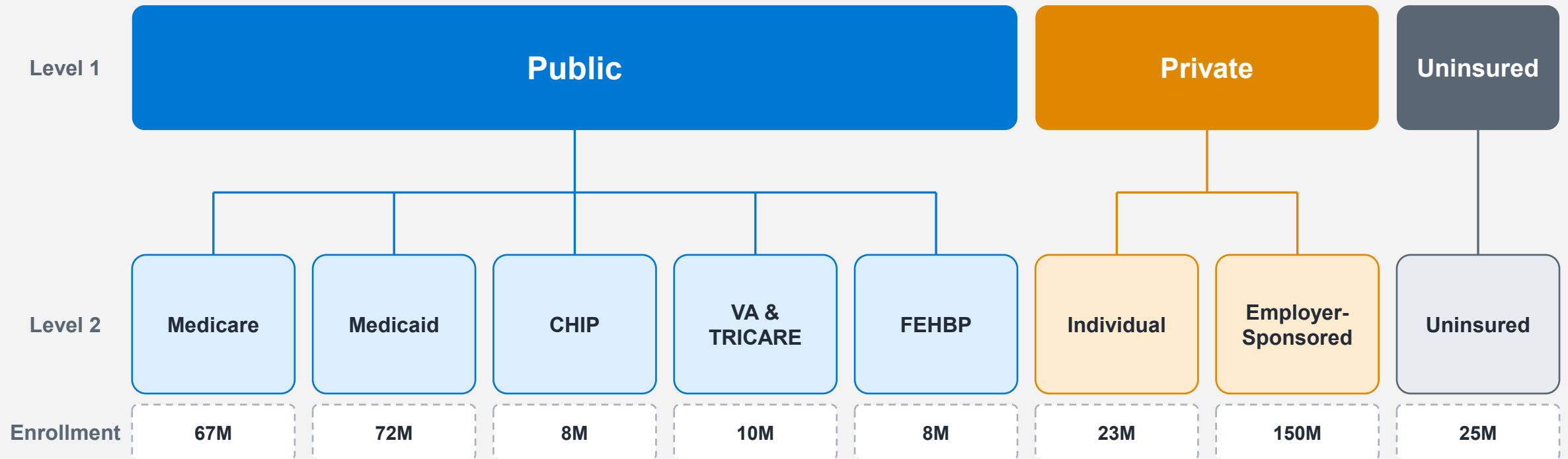
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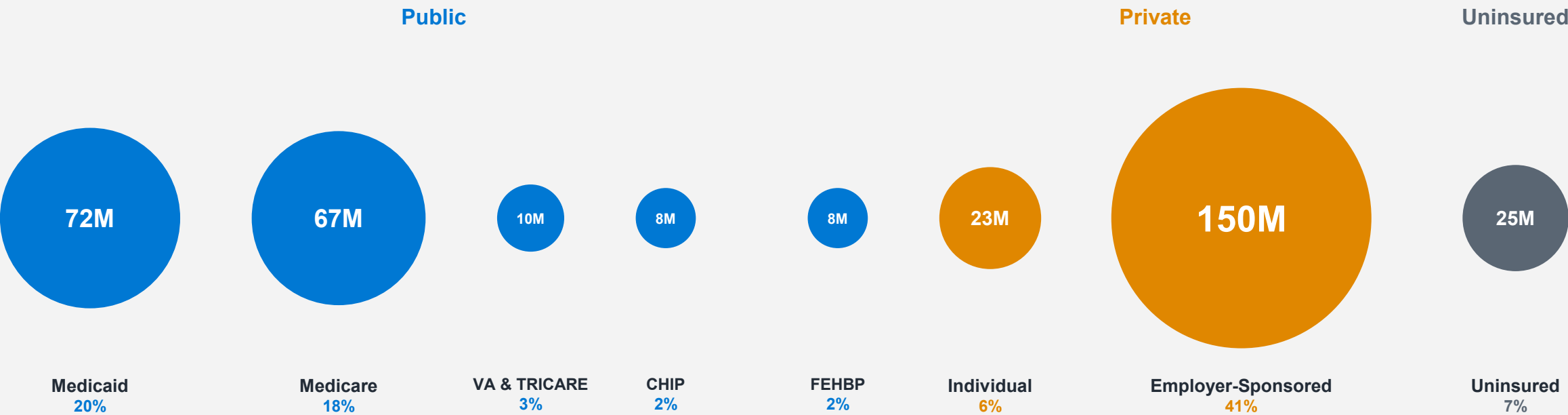
Sources of Health Coverage

The US “Patchwork” system



Sources of Health Coverage

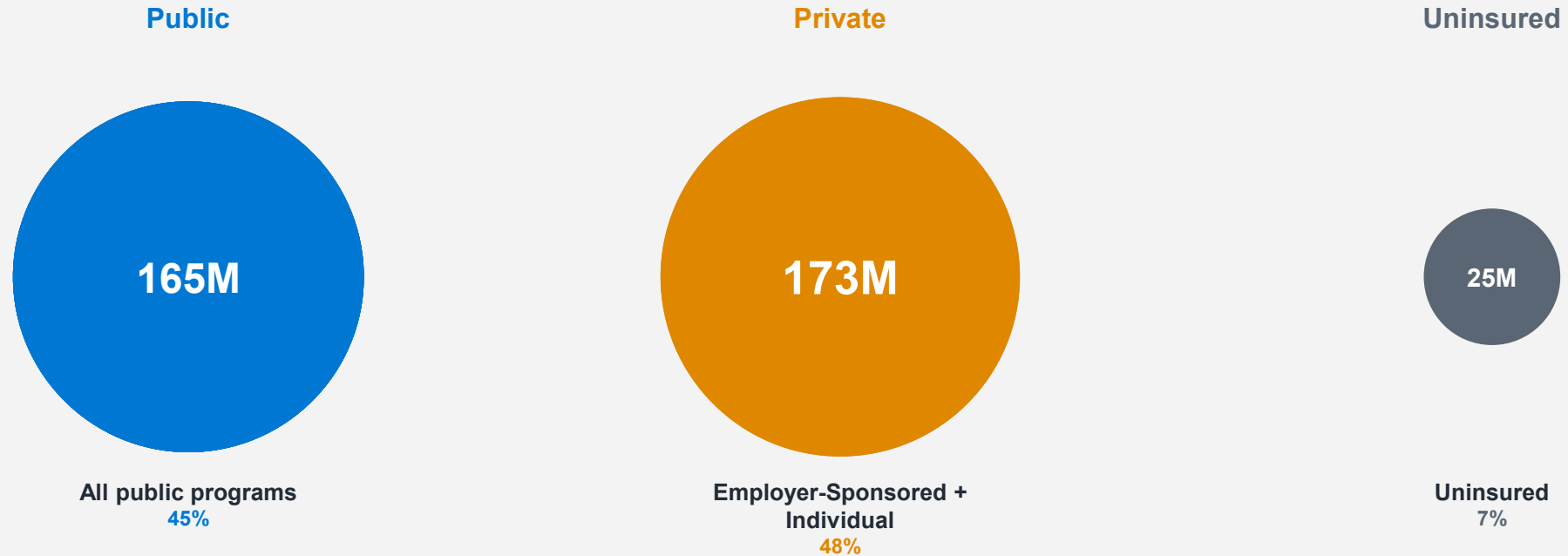
Enrollment by source, in millions of covered lives



Bubble area is proportional to enrollment; percentages show each source's share of the 363M total shown. Employer-sponsored coverage alone accounts for roughly as many lives as all public programs combined.

Sources of Health Coverage

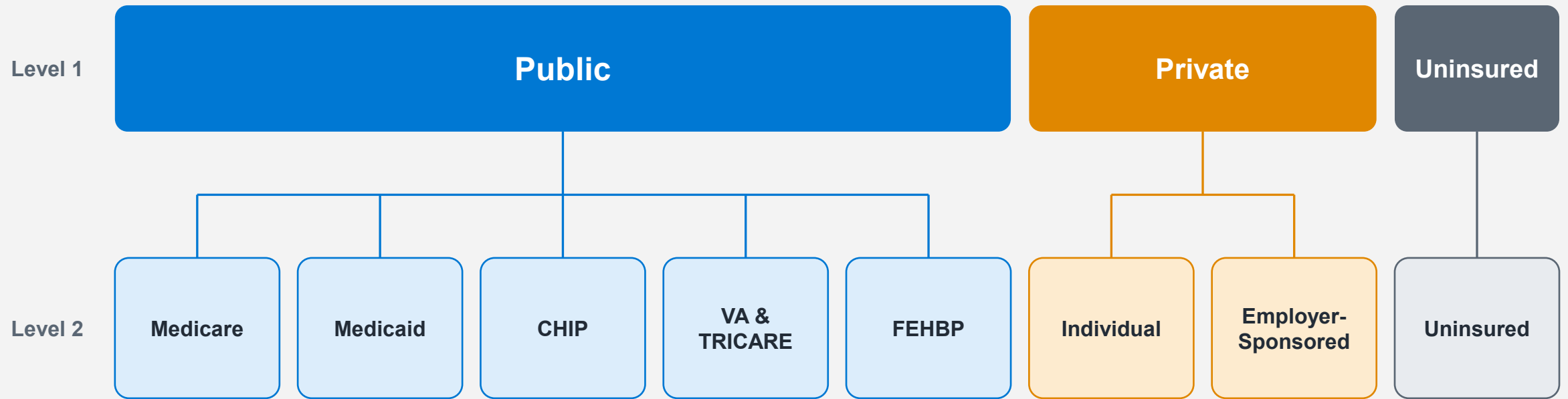
Enrollment by market, in millions of covered lives



- Bubble area is proportional to enrollment; percentages show each market's share of the 363M total shown. Rolled up, private coverage (173M) and public programs (165M) are close to equal in size.
- There is some double counting in Public due to 12M Dual eligibles

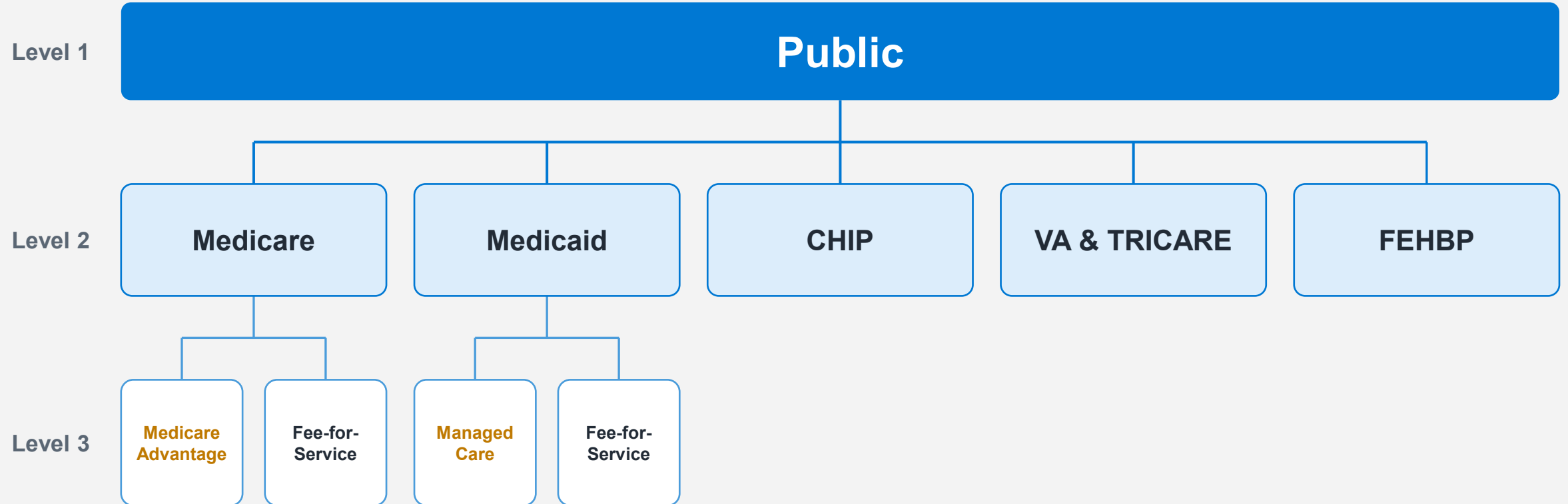
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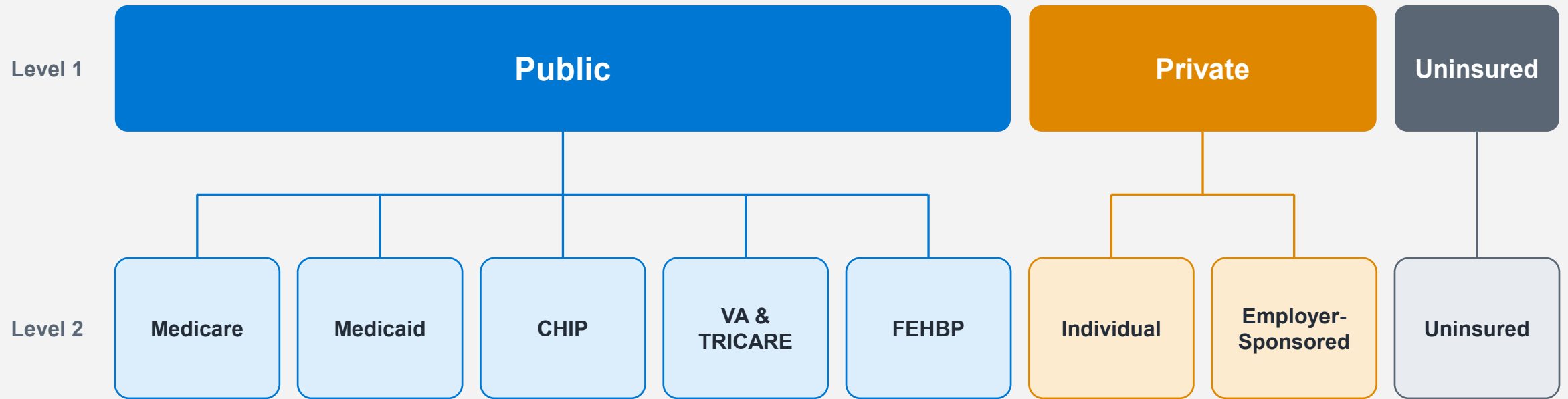
Sources of Public Health Program Coverage



Level 1 defines the coverage market; Level 2 identifies the sub-markets; Level 3 splits Medicare and Medicaid by how CMS pays.

Sources of Health Coverage

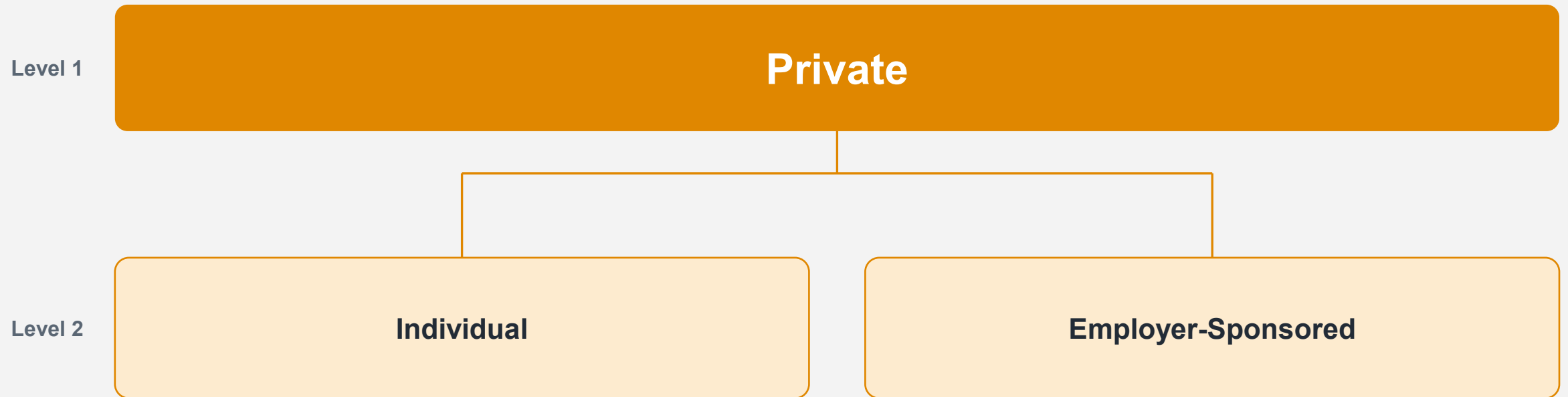
The US “Patchwork” system



Level 1 defines the coverage market; Level 2 identifies the sub-markets within each.

Sources of Health Coverage

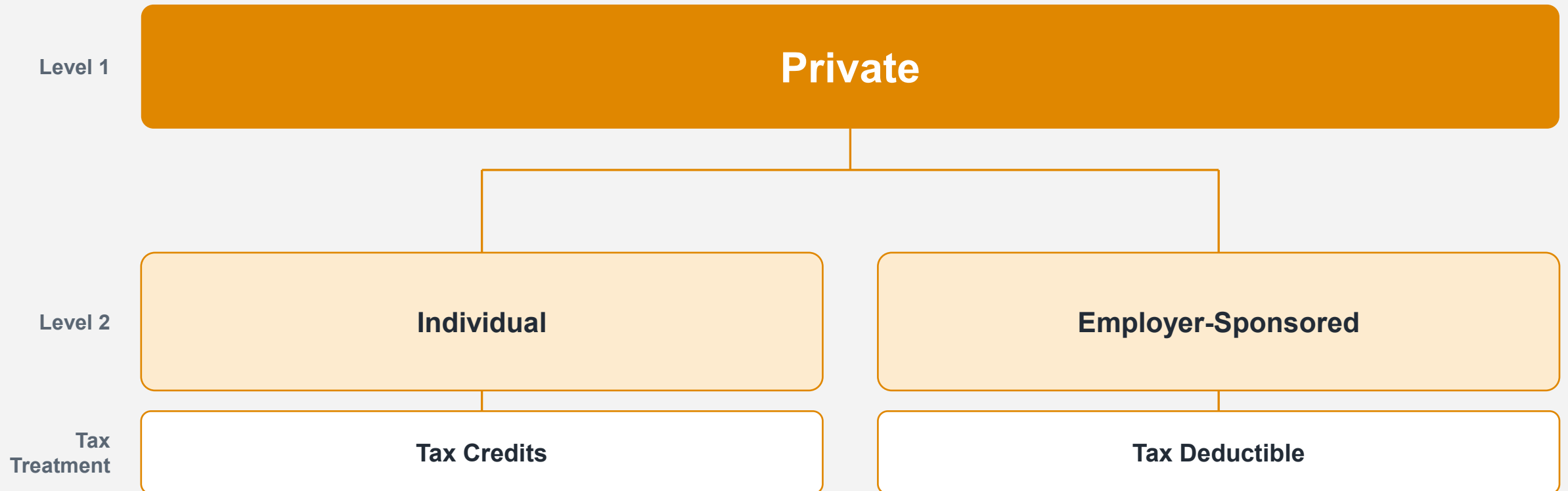
The US “Patchwork” system



Level 1 defines the coverage market; Level 2 identifies the sub-markets within each.

Sources of Health Coverage

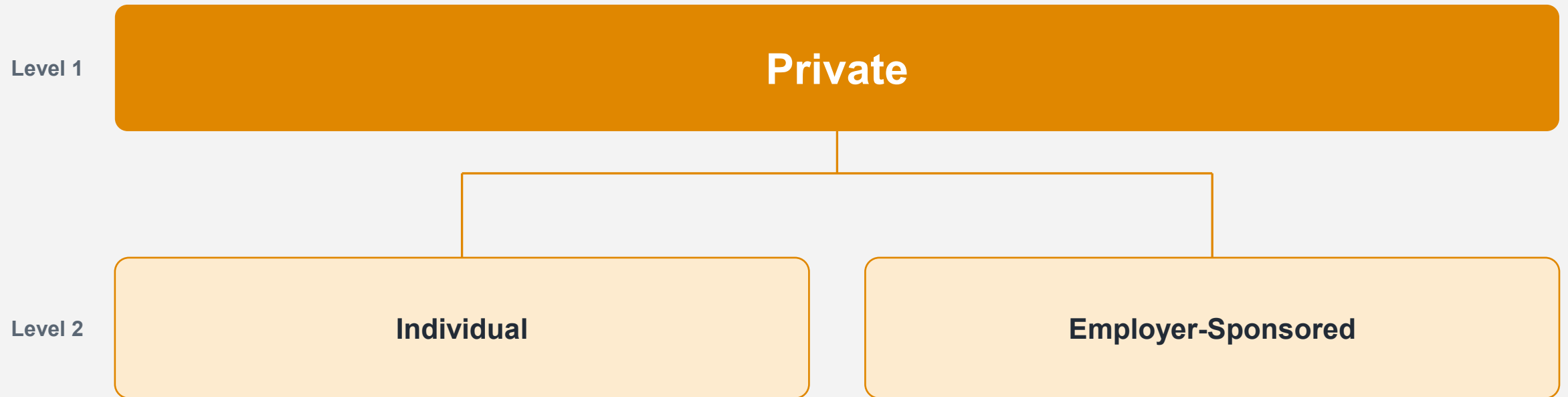
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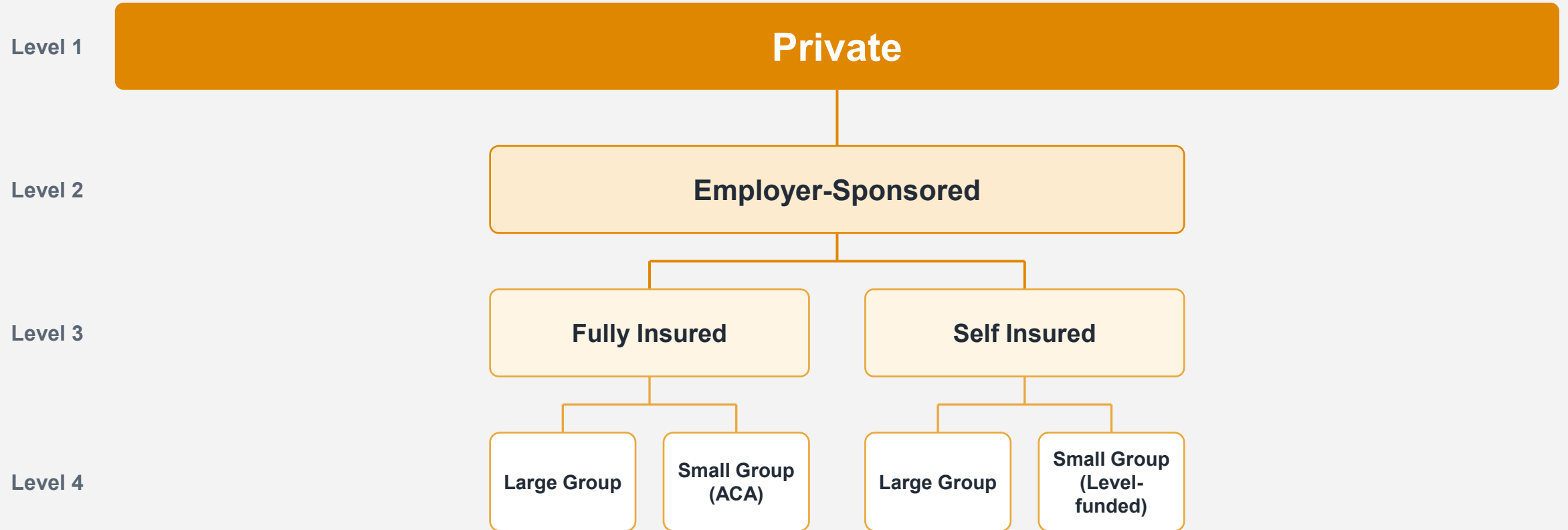
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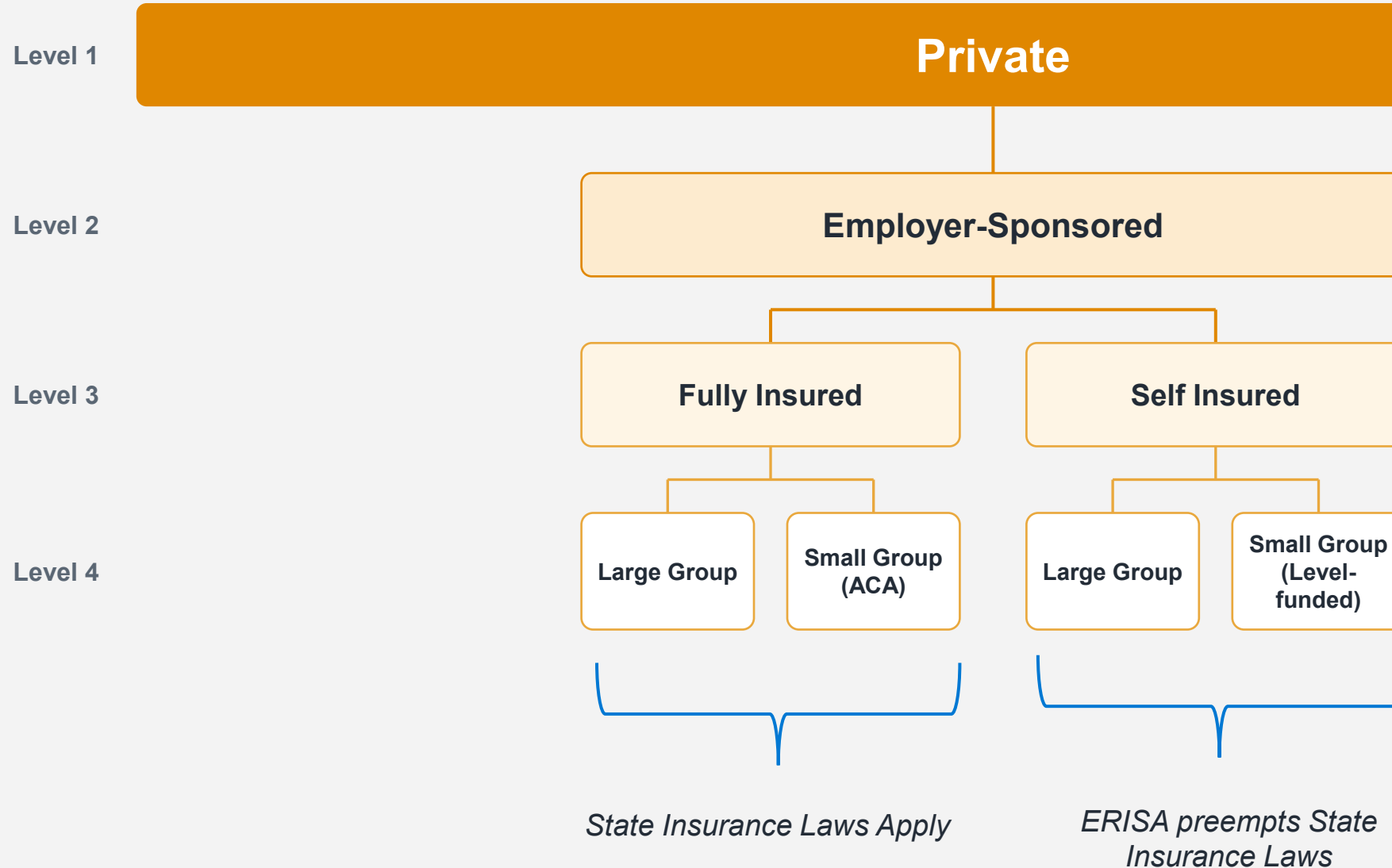
The US “Patchwork” system



Level 1 defines the coverage market; Level 2 identifies the sub-markets within each; Level 3 is employer funding method; Level 4 is groups size market.

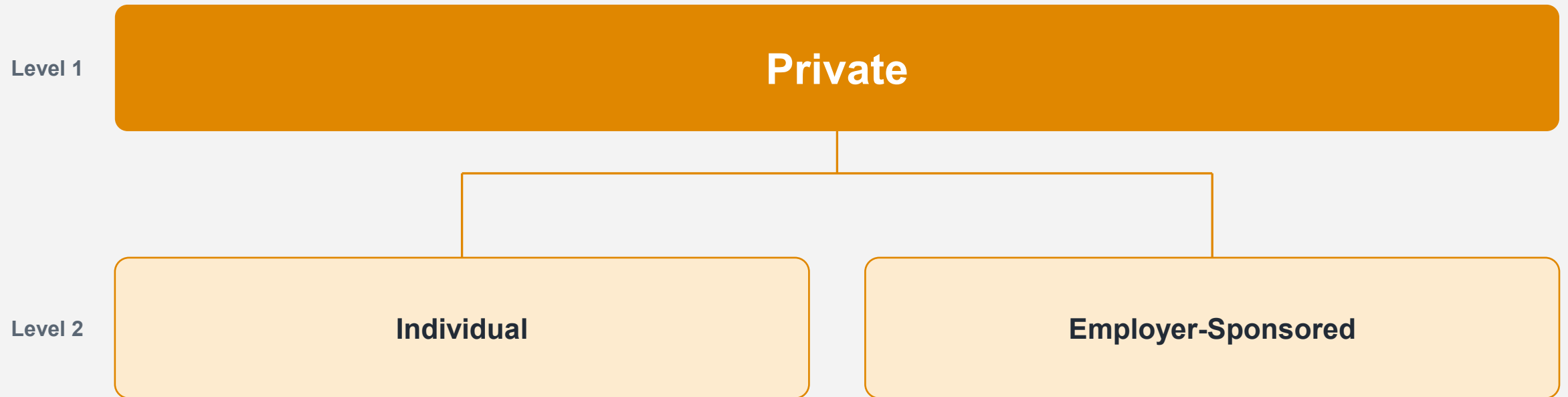
Sources of Health Coverage

The US “Patchwork” system



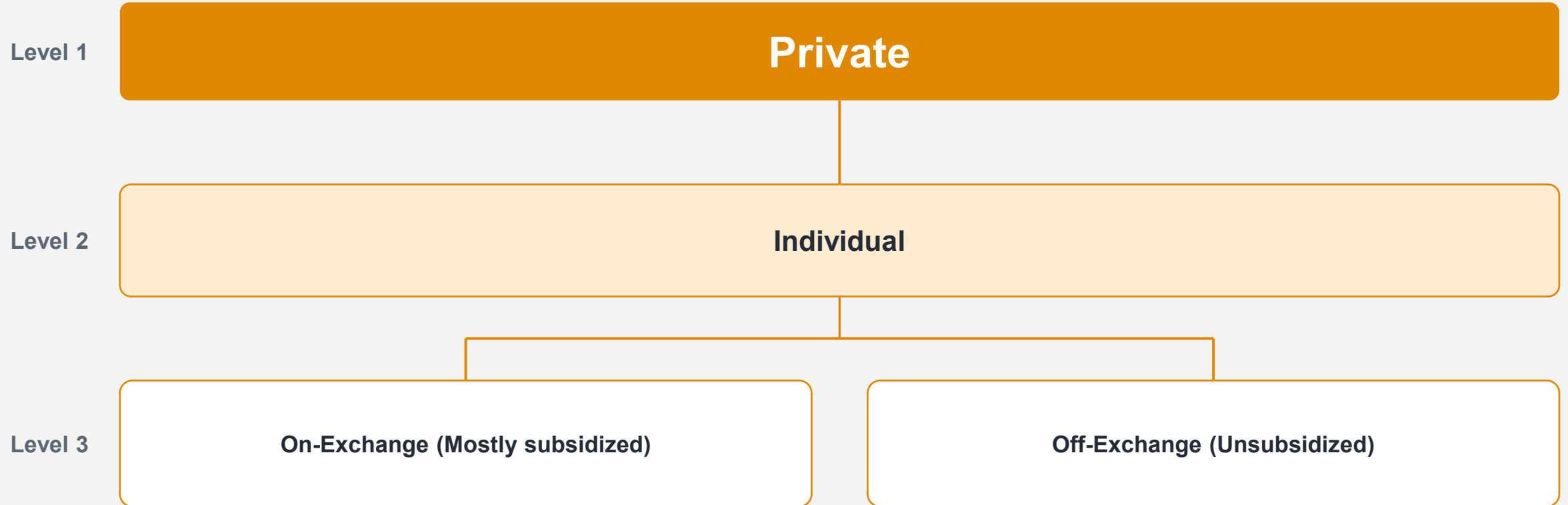
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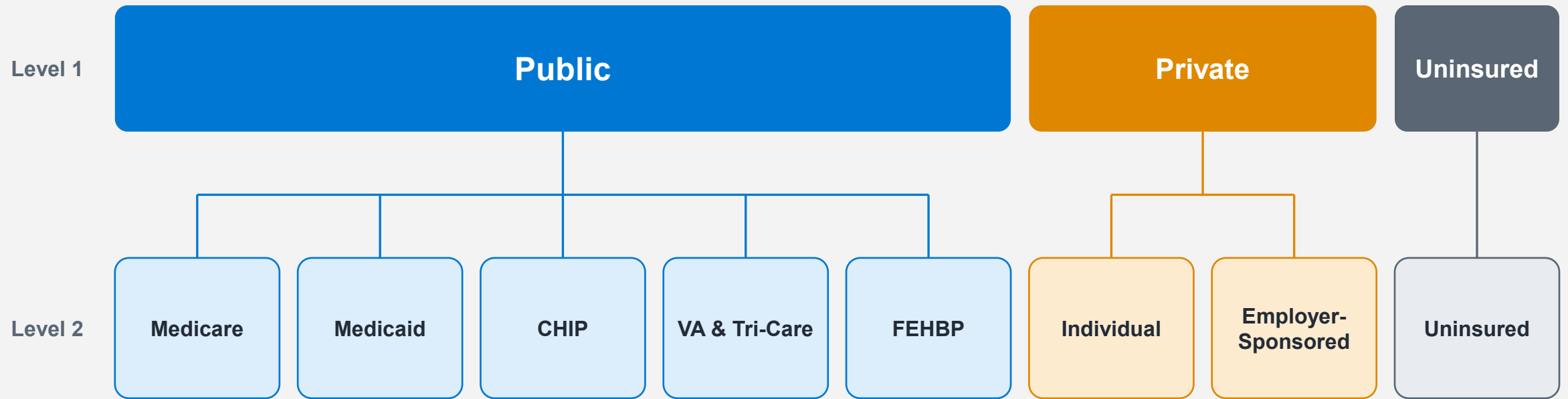
Market Segmentation: The Individual Market



Level 1 defines the coverage market; Level 2 identifies the sub-market; Level 3 splits the individual market by where coverage is purchased.

Sources of Health Coverage

The US “Patchwork” system



Level 1 defines the coverage market; Level 2 identifies the sub-markets within each.

Sources of Health Coverage

The US “Patchwork” system

Level 1

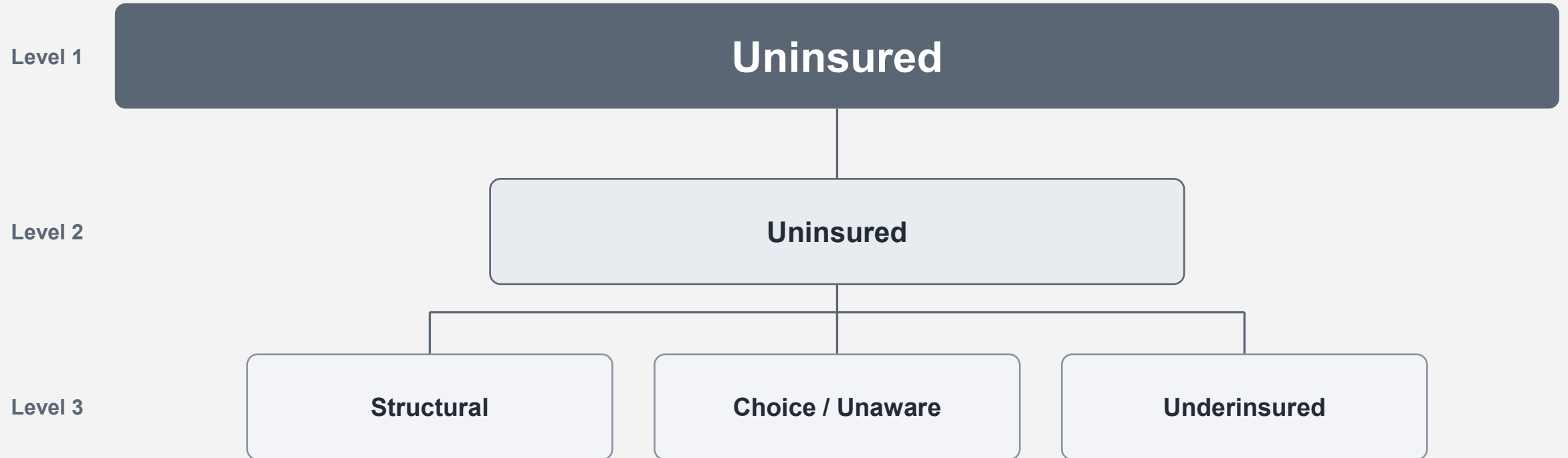
Uninsured

Level 2

Uninsured

Sources of Health Coverage

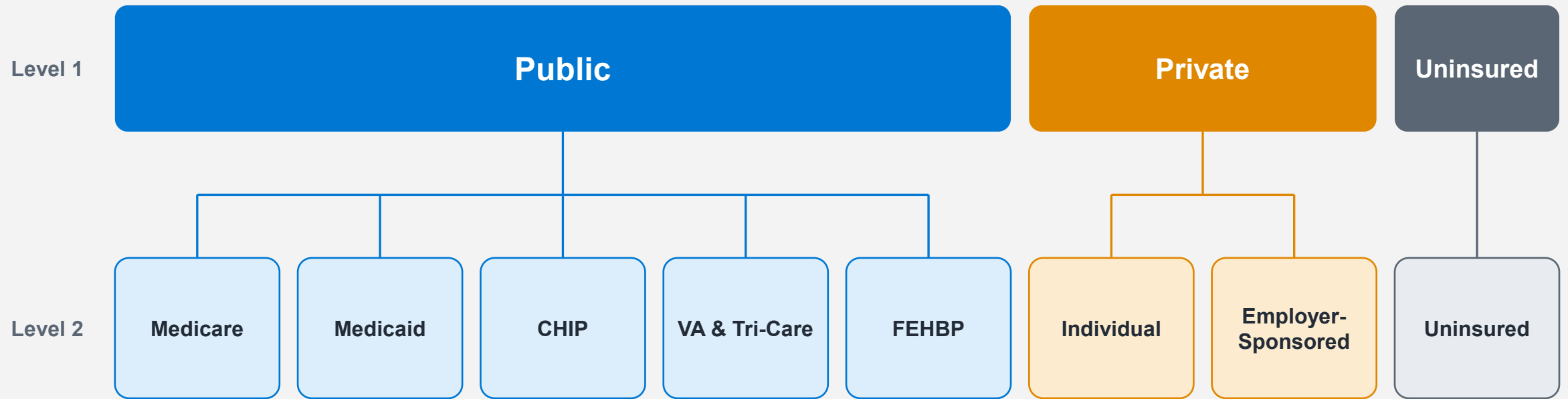
The US “Patchwork” system



Level 3 distinguishes why coverage is absent or insufficient: structural barriers, elective non-enrollment, and inadequate coverage.

Sources of Health Coverage

The US “Patchwork” system



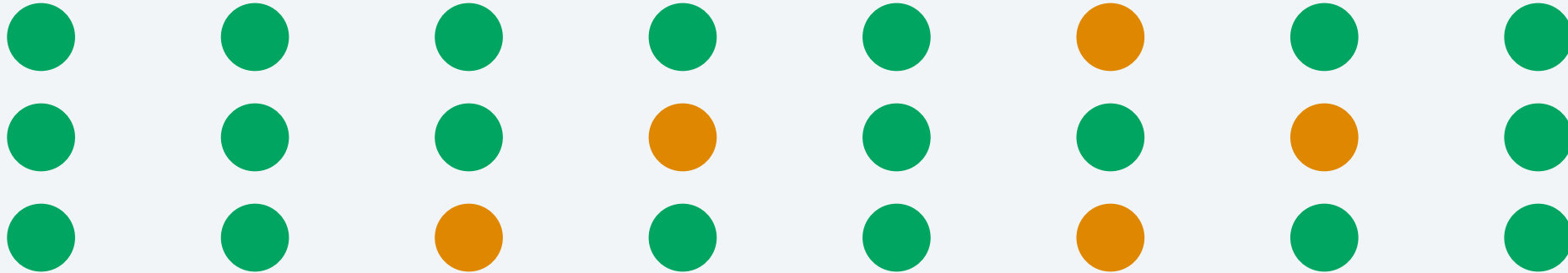
Level 1 defines the coverage market; Level 2 identifies the sub-markets within each.

Sources of Health Coverage

Risk Pooling: How Insurance Works — the many who are healthy today pay for the few who are not.

A balanced pool keeps cost stable

Many low-risk members fund the few who need care right now.



● **Low risk today**

Pays premiums, uses little care

● **High risk today**

Uses care the pool pays for

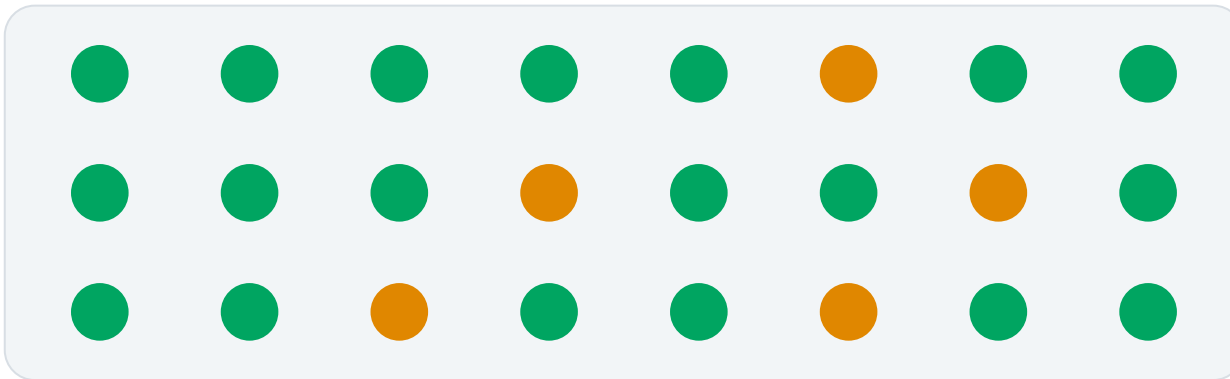
Over a lifetime, everyone switches sides. The healthy members paying in today are the ones drawing on the pool tomorrow, funded by whoever is healthy then. Pooling only works if both groups stay in.

Sources of Health Coverage

Risk Pooling: How Insurance Works — the many who are healthy today pay for the few who are not.

A balanced pool keeps cost stable

Many low-risk members fund the few who need care right now.



● Low risk today

Pays premiums, uses little care

● High risk today

Uses care the pool pays for

Too many high risks, cost rises

Fewer healthy members means less premium to spread.



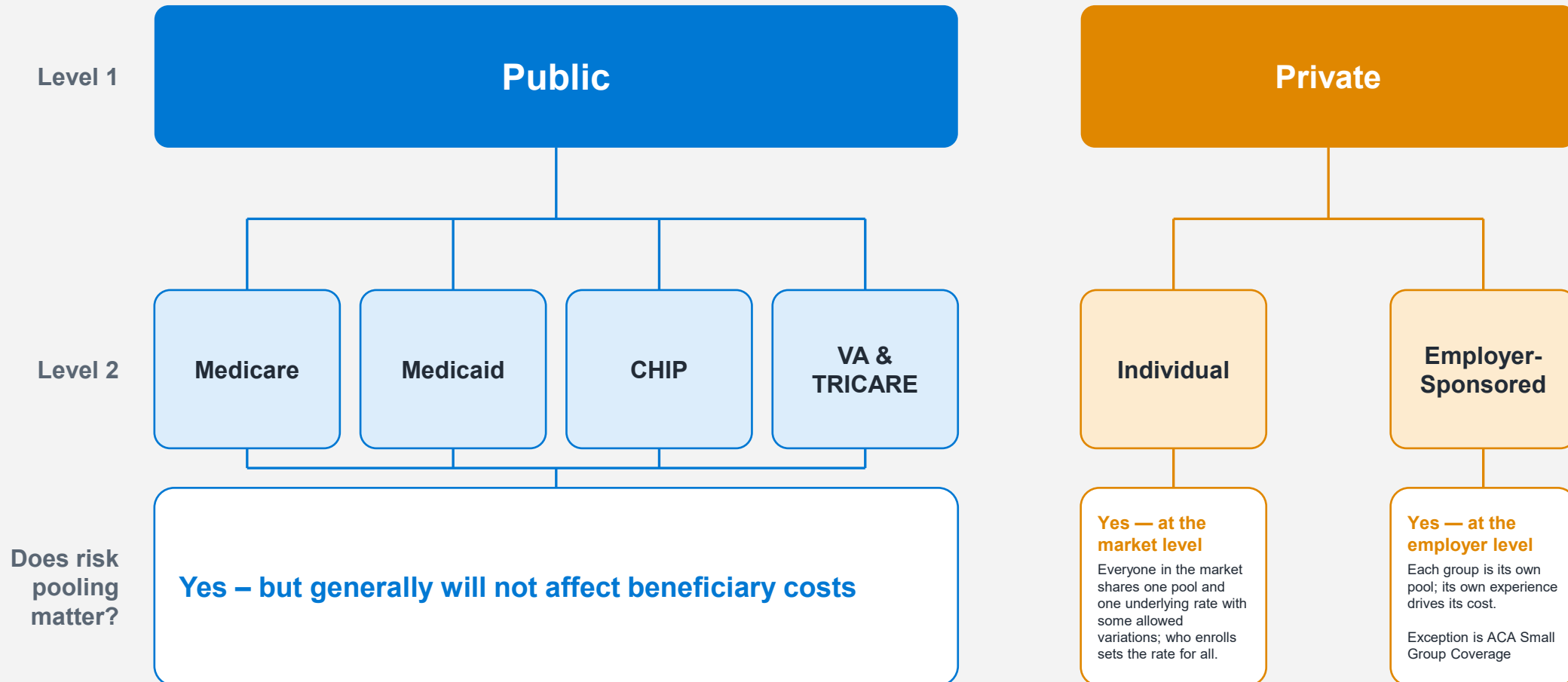
Premiums rise for everyone in the pool

and healthier members are more likely to drop out (death spiral)

Over a lifetime, everyone switches sides. The healthy members paying in today are the ones drawing on the pool tomorrow, funded by whoever is healthy then. Pooling only works if both groups stay in.

Sources of Health Coverage

Risk Pooling: Does it Really Matter? It depends on the program — and pooling level varies.



Sources of Health Coverage

Key Takeaways

1

A patchwork by “design”

No other developed country runs a system like it.

2

Segment sets the rules

Market determines your subsidy (if any), tax treatment, regulator, risk pool, politics and price.

3

Broad, but not universal

About 7% — some 25M people — remain uninsured, and more are underinsured. The gaps are structural, not just elective.

4

Hard to move

Every segment has entrenched interests — insurers, employers, providers, states.

Reform creates winners and losers, so change stays incremental.



Paul Fronstin, Ph.D.
Director, Health Benefits
Research
*Employee Benefit Research
Institute*



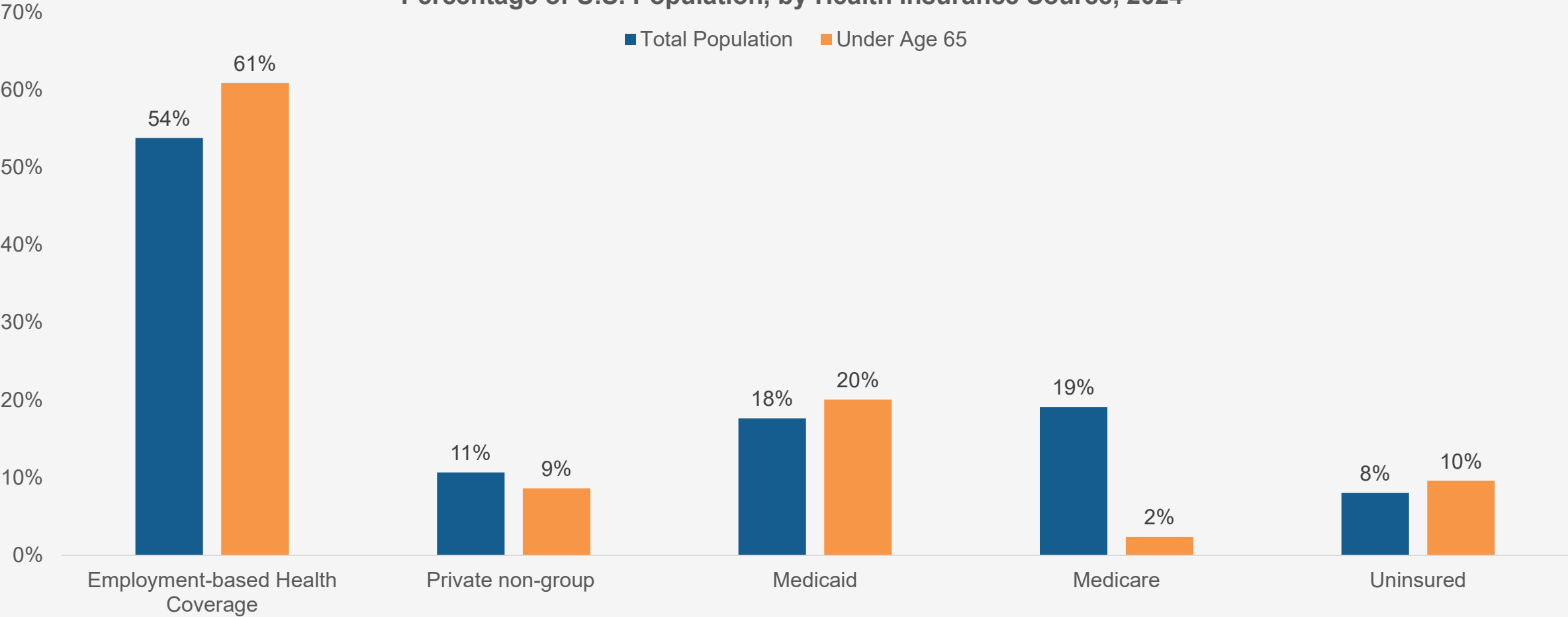
Health Insurance Fundamentals: How the U.S. System Really Works

Paul Fronstin, Ph.D.
Employee Benefit Research Institute
August 12, 2026

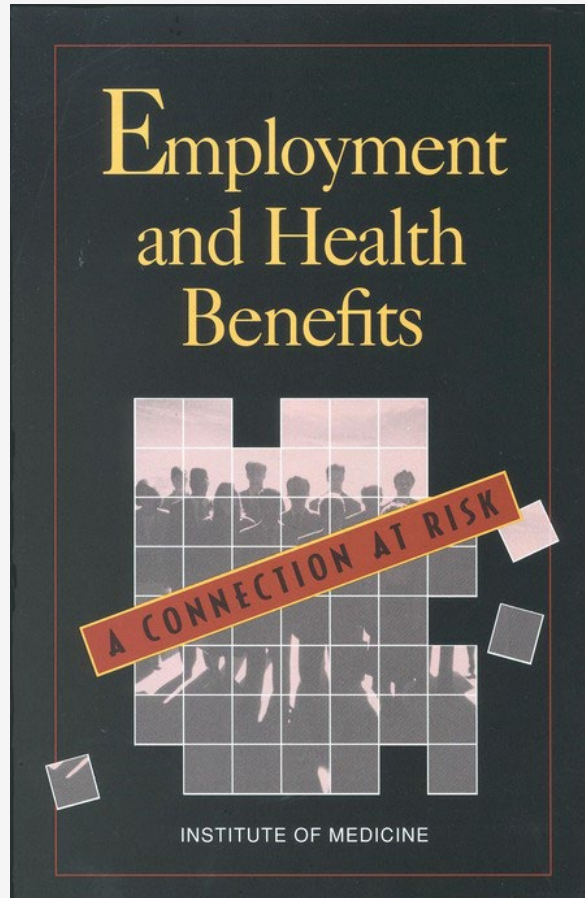
The U.S. Has Multiple Health Insurance Systems Serving Different Populations

Percentage of U.S. Population, by Health Insurance Source, 2024

■ Total Population ■ Under Age 65



How Employment-Based Health Insurance Evolved

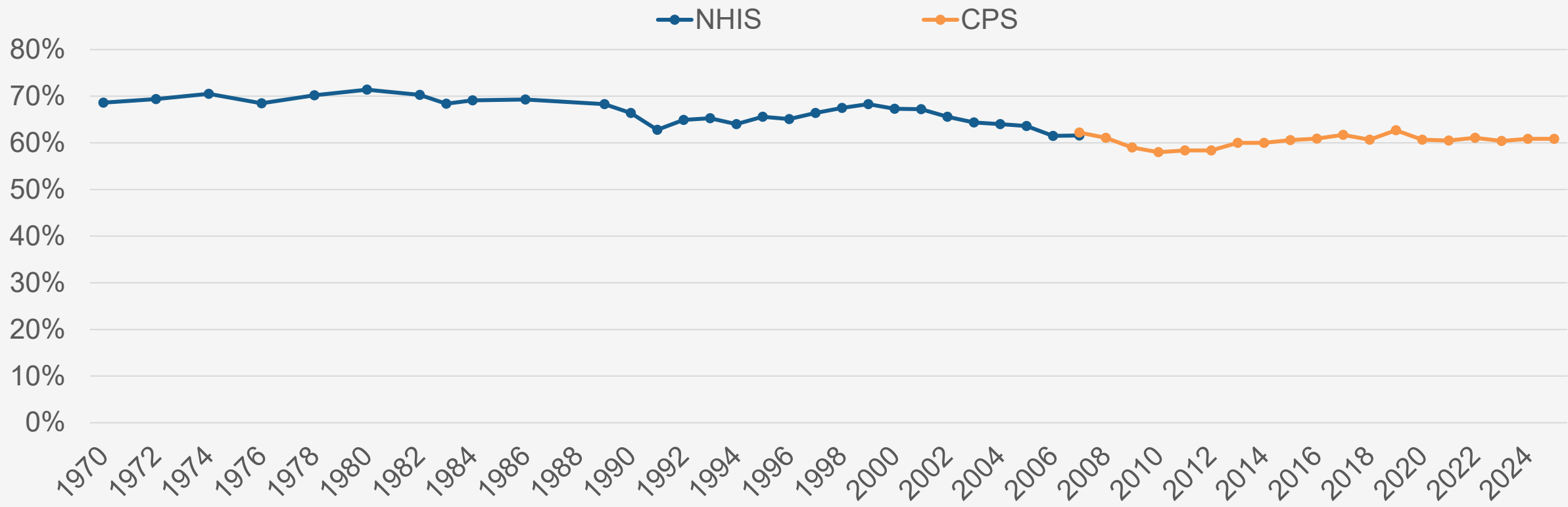


Employment-based health insurance is the product of history—not a deliberate design—which helps explain why the U.S. health insurance system looks so different from those of other countries.

- **It was not created by a single law or master plan.** Today's system evolved gradually through historical events, market forces, and public policy.
- **World War II accelerated employment-based coverage.** Wage controls led employers to compete for workers by offering health benefits instead of higher wages.
- **The tax exclusion made employer coverage financially attractive.** Employer-paid premiums were excluded from taxable income, encouraging both employers and employees to participate.
- **Medicare and Medicaid filled important gaps—not replaced employer coverage.** Public programs focused on older adults, people with disabilities, and some low-income populations, while employment-based coverage remained the primary source for working-age Americans.
- **ERISA established the modern framework.** The Employee Retirement Income Security Act (1974) gave employers broad flexibility to design and administer health benefit plans while preempting many state regulations.
- **Today,** employment-based coverage remains the foundation of health insurance for working Americans because it pools risk, offers economies of scale, and benefits from favorable tax treatment.

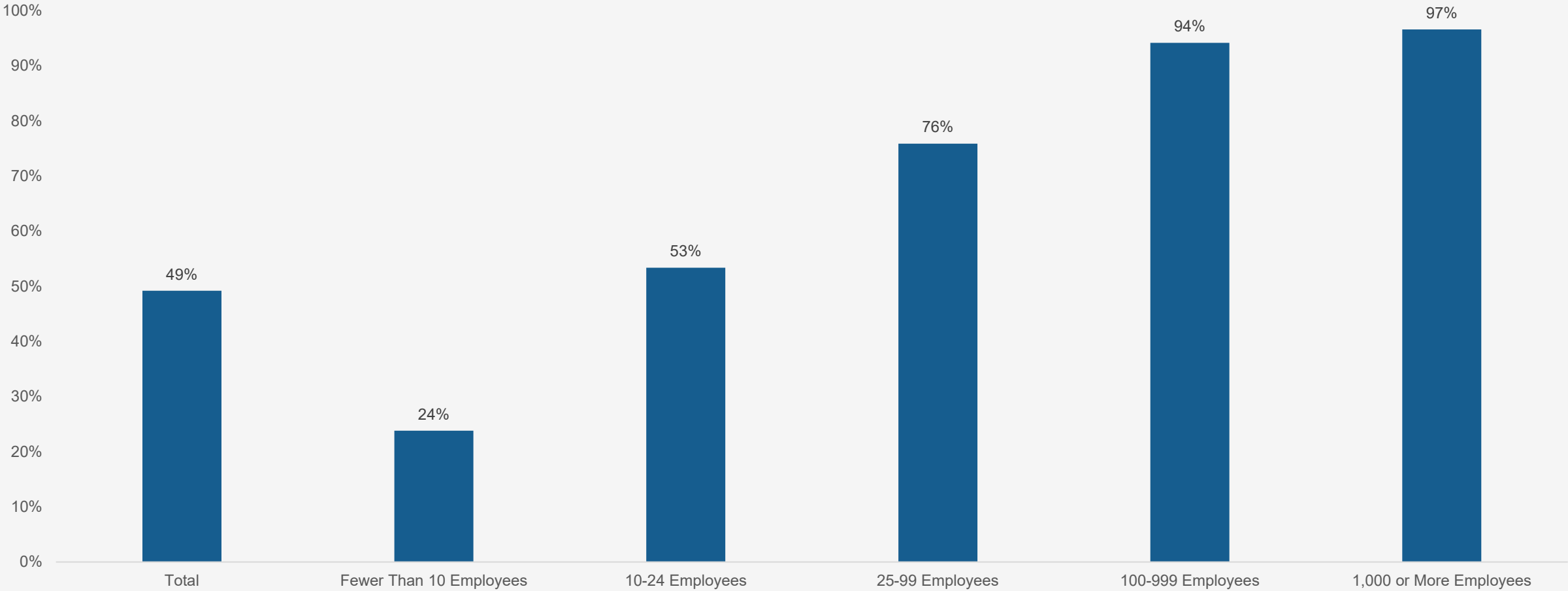
Employment-Based Health Benefits System Has Been Remarkably Stable

Percentage of Persons Under Age 65 With Employment-Based Health Coverage, 1970-2025



Multiple Health Insurance Systems Within Employment-Based Health Insurance System

Percentage of Private-Sector Employers That Offer Health Insurance, 2025



Multiple Health Insurance Systems Within Employment-Based Health Insurance System; Stable Since ACA Took Effect

Percentage of Private-Sector Employers That Offer Health Insurance, 2000-2025

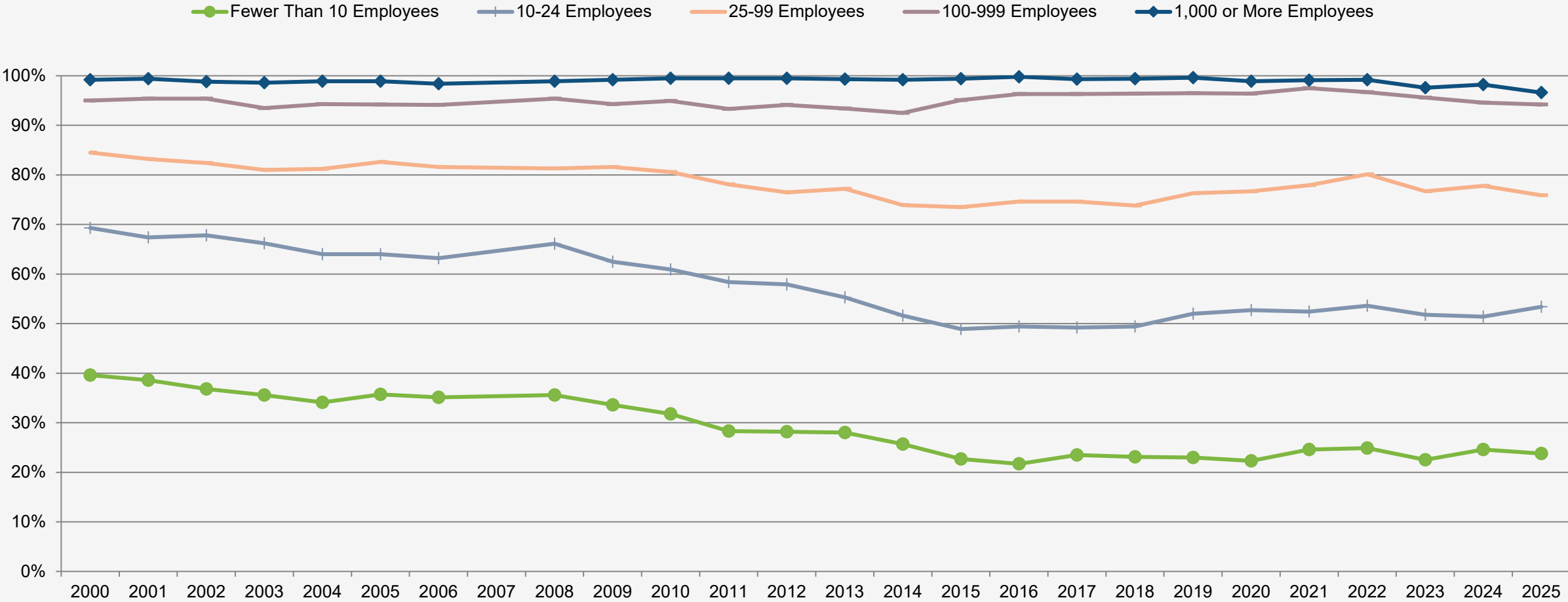
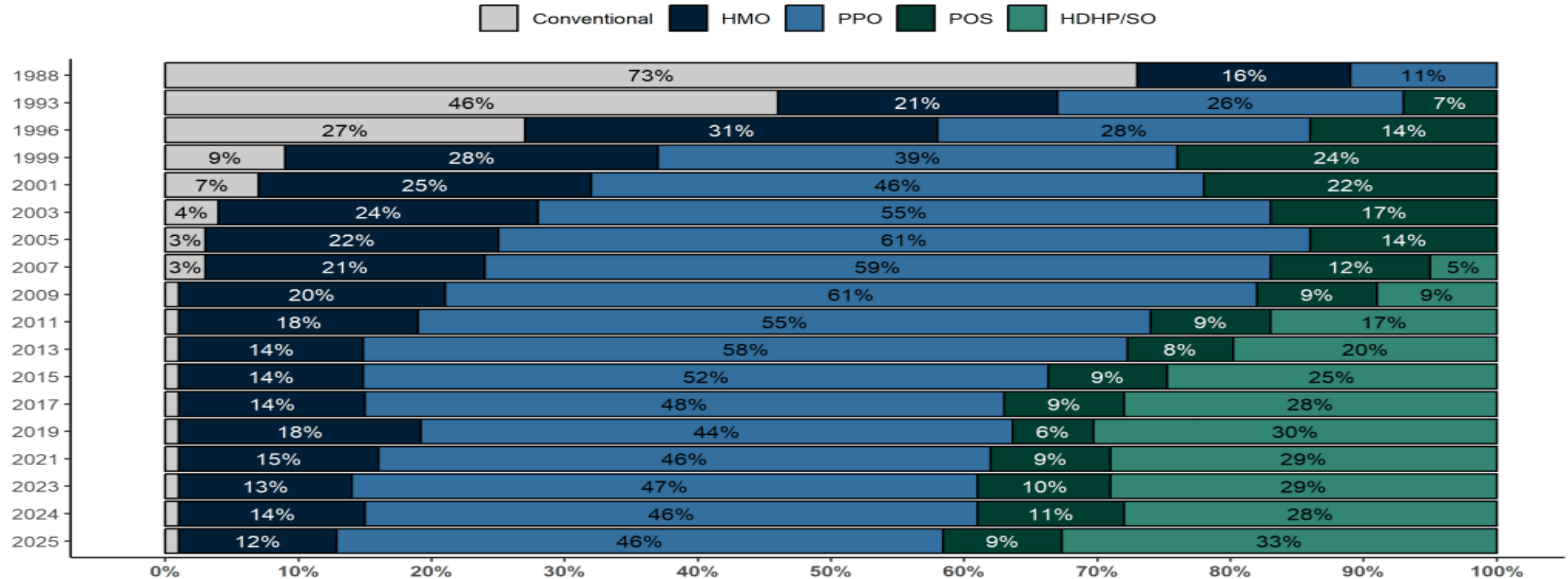


Figure 5.1

Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2025



NOTE: Information was not obtained for POS plans in 1988 or for HDHP/SO plans until 2006. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey and the 2021 KFF Survey for a discussion of weighting changes.

SOURCE: KFF Employer Health Benefits Survey, 2018-2025; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017; KPMG Survey of Employer-Sponsored Health Benefits, 1993 and 1996; The Health Insurance Association of America (HIAA), 1988.

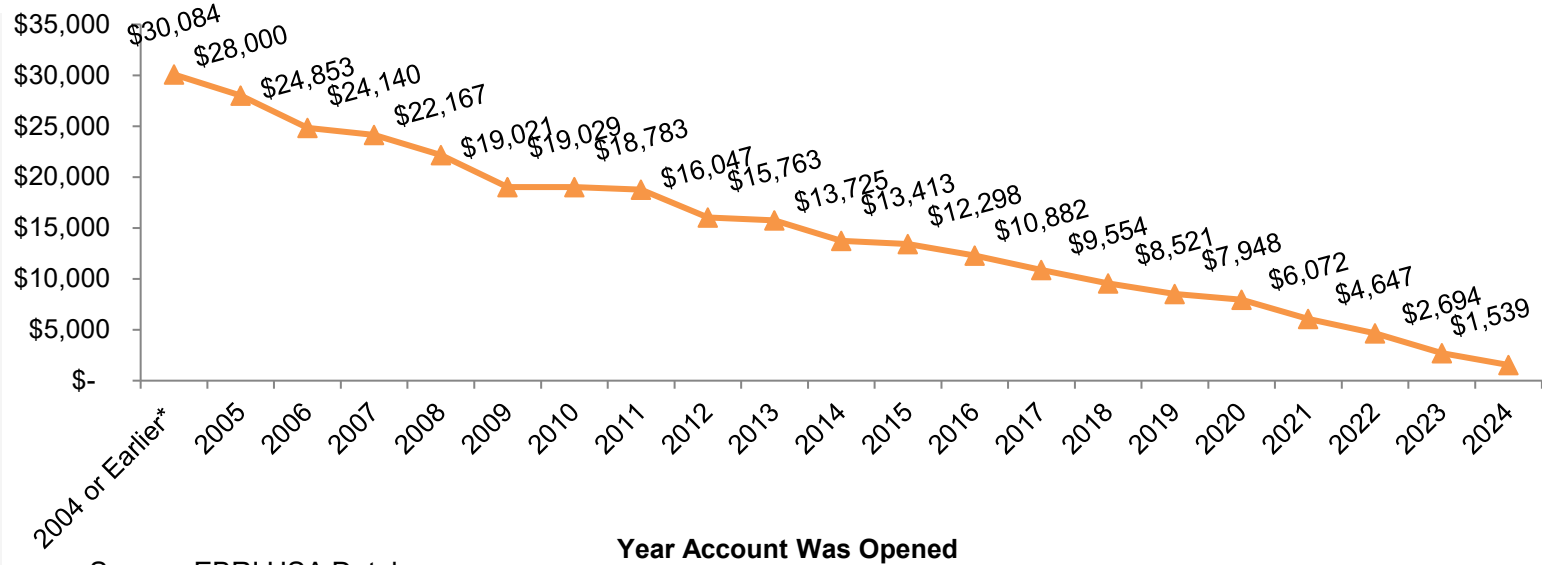
What is a Health Savings Account (HSA)?

- 2003 Medicare Modernization Act
- Must be paired with an HSA-eligible health plan (aka High-deductible health plan or HDHP) in order to contribute to HSA
 - Deductible of at least \$1,700 (self-only); \$3,400 (family) in 2026
 - Out-of-pocket maximum of no more than \$8,500 (self-only); \$17,000 (family) in 2026
 - All services must be subject to deductible, other than certain preventive services
- Contributions
 - Limited to no more than \$4,400 (self-only); \$8,750 (family)
 - \$1,000 catch-up contribution allowed for those ages 55+
- Triple tax advantage
 - Tax free contributions, accumulations, distributions for health care services, COBRA, LTCI premiums, retiree health premiums for Medicare-eligible retirees

Key HSA Stats

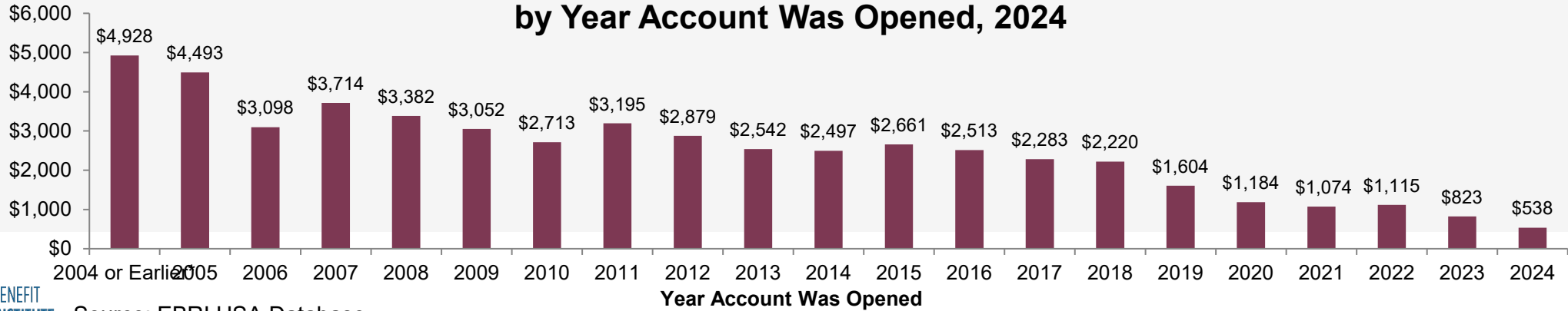
	2024
Balance	\$5,532
Employee Contributions	\$2,308
Employer Contributions	\$727
Distributions	\$1,870
Invested	18%

Average End-of-Year Account Balance, by Year Account Was Opened, 2024



Source: EBRI HSA Database.

Annual Average Individual Contributions to HSA, by Year Account Was Opened, 2024



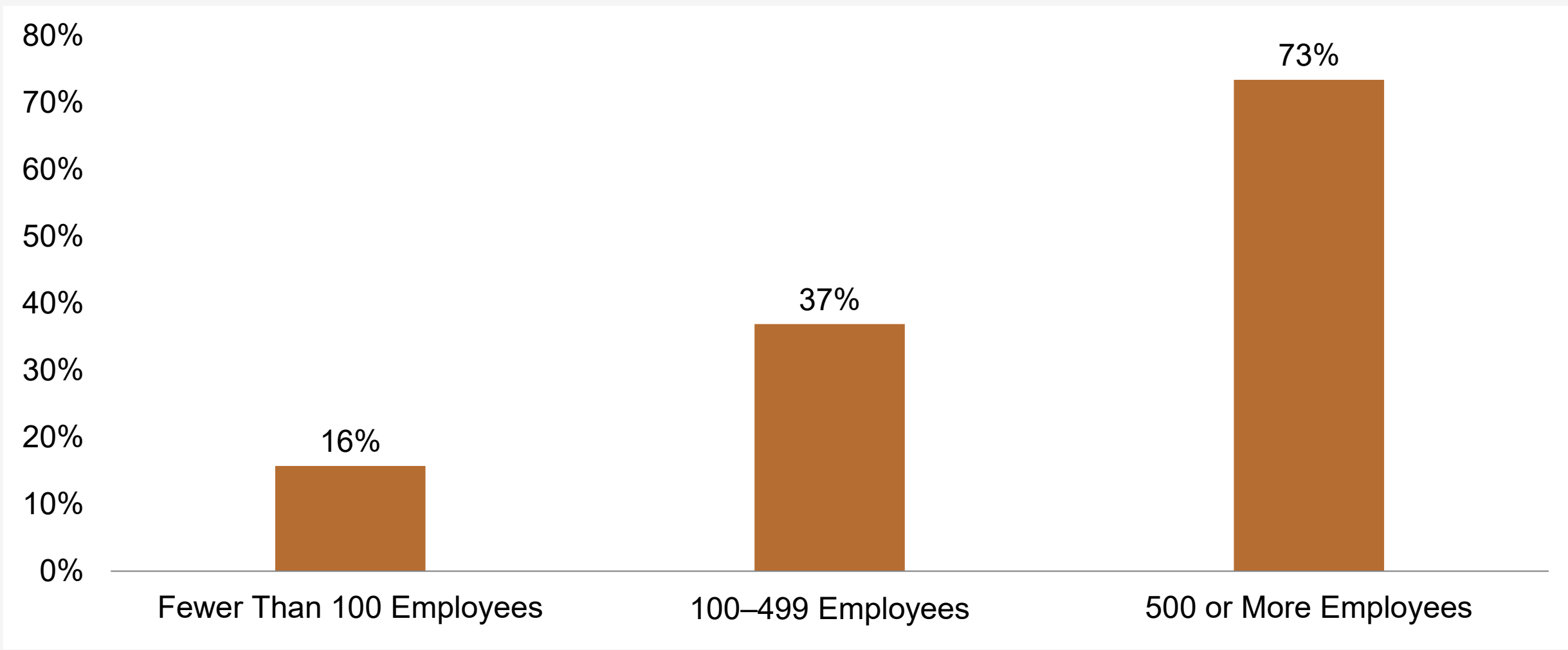
Source: EBRI HSA Database.

Networks Were Most Valued; Traditional Enrollees Valued Lower Cost Sharing, While HDHP Enrollees Valued Lower Premiums

How important were/would the following aspect of the health insurance plan (be) in your current choice of plan?
Top six shown

Traditional Plan	Very Important	High-Deductible Health Plan	Very Important
Good network of physicians and hospitals	80%	Good network of physicians and hospitals	76%
Low out-of-pocket costs when you see the doctor	75%	Lower cost of premium	72%
Prescription drug coverage	74%	Prescription drug coverage	70%
Lower cost of premium	72%	Low out-of-pocket costs when you see the doctor	68%
Simple to understand	69%	Simple to understand	63%
Specific coverage included in the plan	62%	Specific coverage included in the plan	59%

Percentage of Private-Sector Employers Offering Health Plans That Self-Insure at Least One Plan, by Firm Size, 2025



Source: Medical Expenditure Panel Survey - Insurance Component.

Employer Commitment to Health Benefits is Currently Strong

Employers often view themselves as paternalistic.

Employers wish to make it easier for their workers to get affordable health coverage.

Employers do not want to relinquish control over health coverage, viewing health benefits as a valuable recruitment and retention tool.

Benefits executives found it difficult to imagine future circumstances that would lead their companies to stop providing health coverage.

“We liked to have control. We can do a better job with design than the exchanges.”



Thank You!

Paul Fronstin, Ph.D.
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Mila Kofman, J.D.
Executive Director
*DC Health Benefit Exchange
Authority*



*DC Health Benefit
Exchange Authority*



Mila Kofman, J.D.
Executive Director
DC Health Benefit Exchange Authority

Who we are and our record of success

- A private-public partnership with a private Executive Board
- DC Health Link – DC’s Affordable Care Act (ACA) online health insurance marketplace.
 - ✓ Last state to start IT build, **1 of 4 state marketplaces to open for business on time** (& stay open) Oct 1, 2013
- ✓ NEAR UNIVERSAL COVERAGE: approx. 96% of DC residents covered
 - ✓ Cut uninsured rate by half since DC Health Link opened for business
- ✓ Cover approximately 115,000 people (private health insurance – individual and small group coverage)
- ✓ Cover 5,300+ District small businesses and non-profits (group coverage includes Members and designated Congressional staff on the Hill & District offices)
- ✓ Have 900+ DC Health Link brokers providing free help to customers
- ✓ Responsible for approximately \$800 million in annual premiums
- ✓ First in the Nation state-based marketplace Partnership with the Massachusetts Health Connector for Business (2017)



DC Health Benefit
Exchange Authority



DC Health Link -- a state-based marketplace (a.k.a. SBM)

- ✓ Transparent and competitive health insurance marketplace (also created a private market for individual dental plans)
- ✓ Reflect local conditions, priorities, and community needs (consensus stakeholder process for policy decisions)
- ✓ Use coverage design to make health care more affordable: essential plans with no deductibles for primary care, specialists, urgent care and generic Rx making medical care more affordable
- ✓ Advocate for lowest possible premiums for residents and small businesses
- ✓ Have the purchasing power of 115,000
- ✓ Enable small businesses to compete with large firms (all products with one bill; nationwide networks)
- ✓ Administer local affordability initiatives and the federal health insurance tax credit



DC Health Benefit
Exchange Authority



Our record of success cont.

- HealthCare4ChildCare – DC’s locally funded health coverage program (June 2022 law changed, opened for enrollment October 2022, coverage effective January 1, 2023). *State-based marketplaces (SBMs) implement local health coverage affordability initiatives.*
- **NEW 2026** Healthy DC Plan – DC’s Basic Health Plan under section 1331 of the ACA (announced May 2025, opened Nov 1, 2025 for enrollment, coverage started January 1, 2026)



NOW SMALL BUSINESSES CAN HAVE THE SAME PURCHASING POWER AS BIG COMPANIES.

Find affordable health coverage for your small business through DC Health Link. Compare plans side by side from private insurance companies competing for your business. Find your plan today.

DCHealthLink.com or call **855-532-LINK**



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BACKGROUND AND ADDITIONAL INFORMATION



DC Health Benefit
Exchange Authority



Highlights of Major Federal Laws Expanding Access to Health Insurance

1965:	MEDICARE (age 65 and over) & MEDICAID (no/low income)
1974:	ERISA (job-based coverage with restriction/preemption of state insurance regulation)
1985:	COBRA (continuation of job-based health coverage)
1996:	HIPAA (federal standards for job-based coverage and individual coverage) (<i>Happy 30th!</i>)
1998:	SCHIP (children)
1996-8:	MHPA, NMHPA, WHCRA
2003:	MEDICARE PART D (Rx added to Medicare)
2003:	Health Savings Accounts (HSAs)
2008:	MHPA – full; GINA
2010:	Affordable Care Act (ACA)
2021:	American Rescue Plan (ACA+)
2022:	Inflation Reduction Act (ACA+)
2025:	HR1 (Reconciliation Act): impacts on Medicaid and ACA marketplaces, and expansion of HSAs (bronze and catastrophic coverage)

Pre-ACA Private Health Insurance Market

- Consumers denied health insurance because of their past or present medical needs (a.k.a. no “guaranteed issue”, “medical underwriting” allowed)
- Consumers charged higher rates based on their health status and claims experience, gender, age (no restrictions on how much higher), industry/occupation, duration of coverage, tobacco, and group size for small businesses
- Existing medical needs not covered forever or for a period of time (a.k.a. pre-existing condition exclusions”)
- Annual and lifetime limits allowed, e.g., \$100,000/per year for a hospital procedure or a \$1m limit for all claims/year and then no more insurance coverage.
- Typical exclusions from individual coverage: maternity care



DC Health Benefit
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ACA: Consumer Protections

ACA: no one is denied coverage and ACA health insurance plans have to meet minimum standards.

- ✓ All health insurance sold to individuals, families, and small businesses must cover essential health benefits: primary and specialty care, hospital stays, lab work, preventive care (with no cost sharing), maternity care, mental health and substance use treatment.
- ✓ Consumers cannot be denied coverage or charged more because they had a medical condition in the past or currently.
- ✓ Pre-existing medical conditions cannot be excluded from coverage.
- ✓ No rate ups allowed except for age (1:3 limits). Women are no longer charged higher rates than men. No tobacco rating in DC.
- ✓ Annual and lifetime limits on coverage are prohibited.
- ✓ ACA made premiums more affordable with the federal health insurance tax credit (a.k.a. Premium Tax Credit, Advanced Premium Tax Credit lowering monthly premiums)

ACA Marketplaces & Federal Health Insurance Tax Credit

Background: The American Rescue Plan Act/Inflation Reduction Act (ARPA/IRA) lowered premiums and for the first time made middle class families eligible for lower premiums. Many sole proprietors & small business owners who buy their own coverage had lower premiums.

Who qualified for lower premiums:

- ✓ In 2025, 7 in 10 people with lower premiums in DC were sole proprietors or small business owners who buy coverage on their own (DC Health Link Individual & Family Marketplace).
- ✓ In 2025, residents **saved on average \$724/month** in lower premiums. Residents 55 and older saved on average \$1,135/month on their health insurance premium.

The expanded federal health insurance tax credit expired Dec 31, 2025. Current federal health insurance tax credit to lower monthly premiums is not available for individuals with an income above 4 times poverty level, e.g., family of 2 with income above \$88,000.

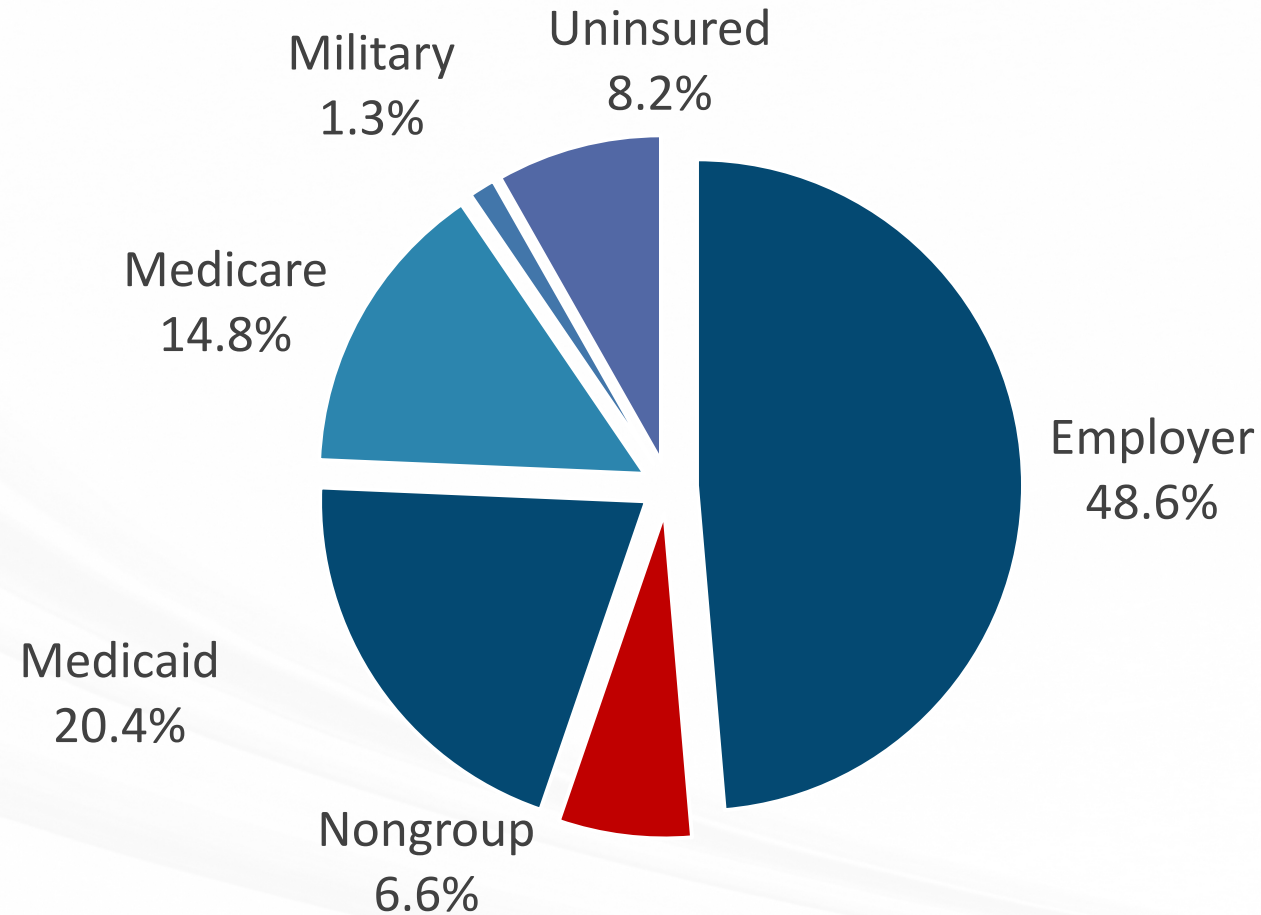


DC Health Benefit
Exchange Authority



Health Insurance Coverage, 2024

(Source: KFF)





DC Health Benefit
Exchange Authority



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**Poll 3: Now that you've heard from all four speakers,
what would you most like us to dig into?**

Choose up to two.

Moderated Q&A

Closing Remarks



Aharisi Bonner, MPH

Senior Insights Program
Manager

Alliance for Health Policy

Take Our Survey!

Please fill out the evaluation survey by using the QR code, link in the chat or via email this afternoon!



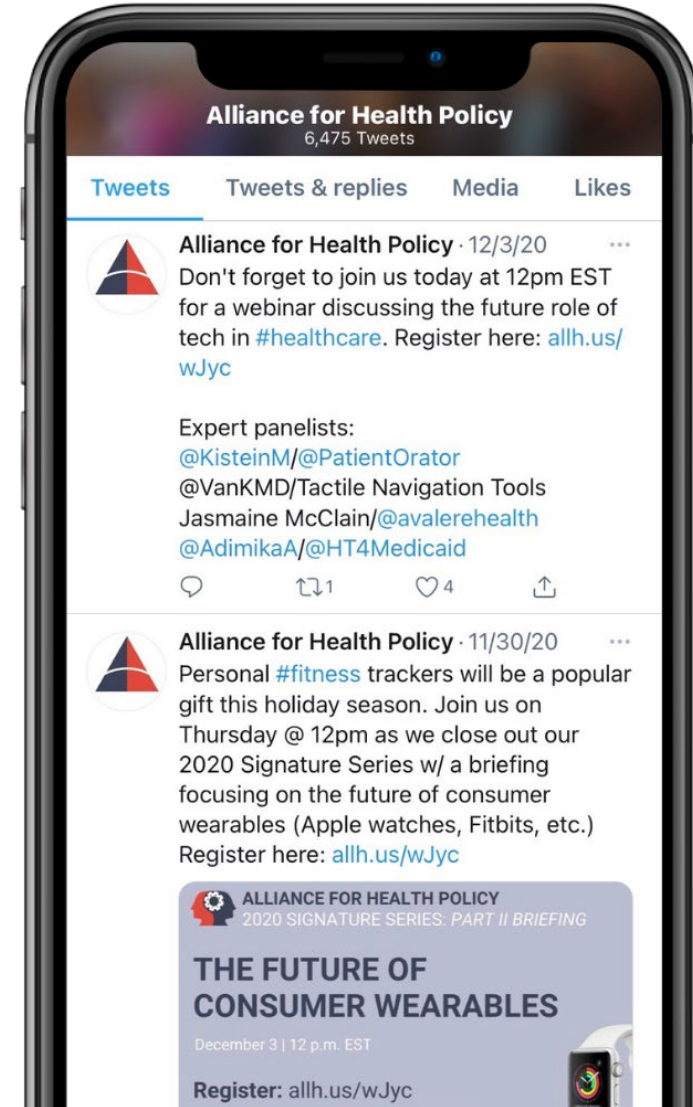
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Up Next: Signature Series Congressional Briefing

MACRA: What the 2015 Reform Got Right and Wrong, and Why It Matters Today

Building on the Alliance for Health Policy's broader exploration of health care payment, this congressional briefing will take a deeper look at how Medicare physician payment has evolved and the key issues shaping today's policy discussions.

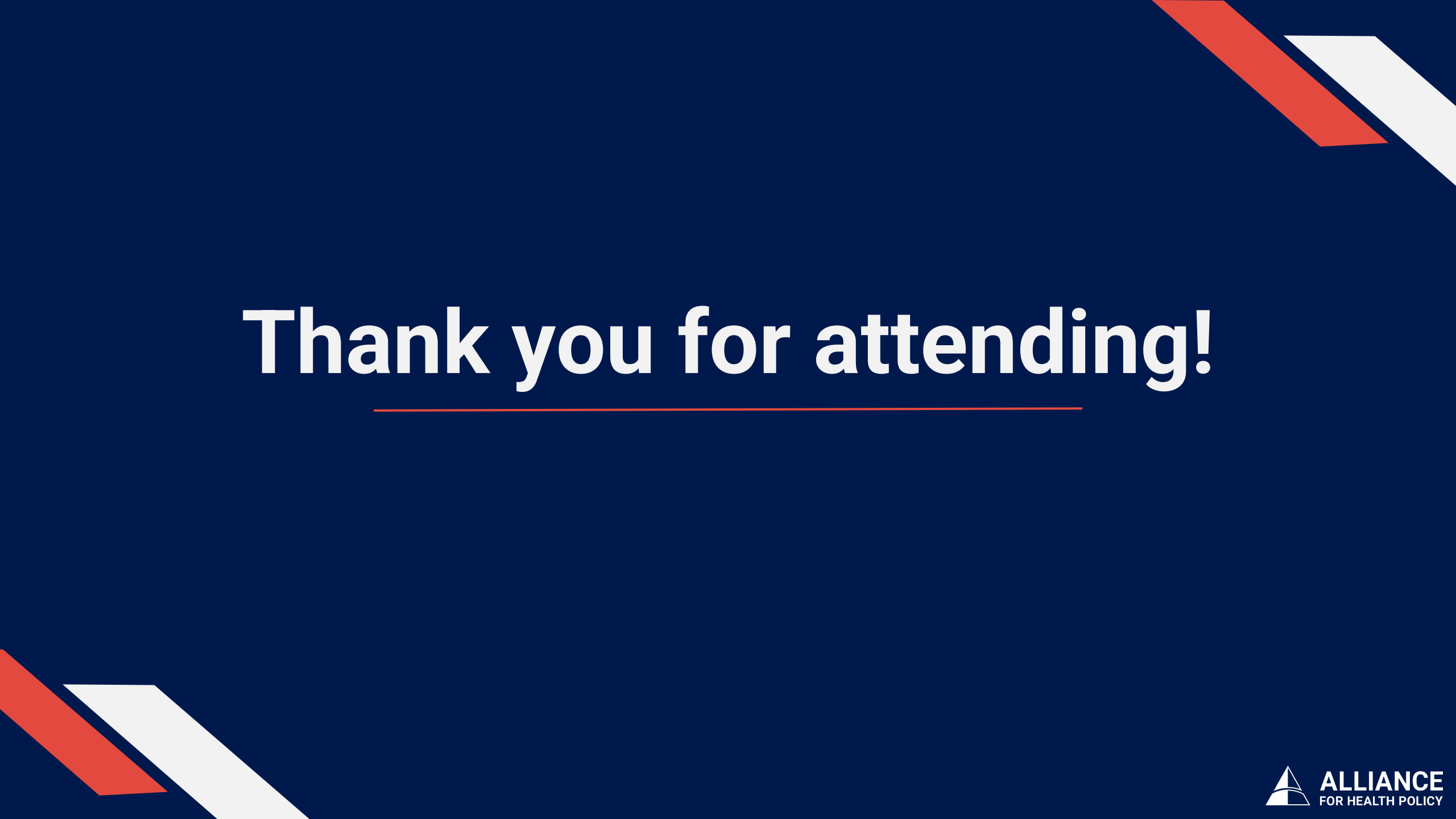
Speakers

- **Michael Baker**, MS, MA, Director, Health Care Policy, American Action Forum (*moderator*)
- **Brett Baker**, Partner, The Nickles Group
- **Michael Chernew**, Ph.D., Harvard Medical School, Leonard D. Schaeffer Professor of Health Care Policy
- **Kristen O'Brien**, JD, Principal, McDermott+

Other speakers to be announced!



[Register here today!](#)



Thank you for attending!
