EconoFact Chats: The State of Health Insurance in America
Mark Shepard, Harvard Kennedy School of Government
Published: 23rd February 2025

Michael Klein
I'm Michael Klein, executive editor of EconoFact, a nonpartisan, web-based publication of The Fletcher School at Tufts University. At EconoFact, we bring key facts and incisive analysis to the national debate on economic and social policies, publishing work from leading economists across the country. You can learn more about us and see our work at www.econofact.org.

Michael Klein
Mark Shepard, a professor at Harvard University's Kennedy School of Government, begins an article he co-authored by stating "the United States is an outlier in health insurance coverage. Almost all other high-income countries have near-universal coverage, while almost 10% of the non-elderly US population is uninsured." Mark goes on to show that this 10% rate is an improvement of the situation before the Affordable Care Act, also known as Obamacare, when the uninsured rate was about half again as large, but the reduction in the proportion of people lacking health insurance has stalled. A lack of health insurance threatens not only people's physical well-being, but their financial health as well, since a costly hospital visit can bankrupt a person who does not have health insurance. Mark's research and writings not only identify this problem but also suggest ways to address it. Mark, welcome to EconoFact Chats.

Mark Shepard
Thanks, Michael.

Michael Klein
Let's start out with how health insurance evolved in the United States. About half of Americans have health insurance through their job. And this is not the way health insurance works in other countries, right? How did this come to be in the United States?

Mark Shepard
You're right that health insurance in America looks a lot different from that in other high-income countries. The first thing to know about the US health insurance system is that we really don't have a coherent system. You might call it our health insurance non-system. We actually have a patchwork of many different ways that people get health insurance, without a central authority or organizing principle making sure that it all works and that everyone gets covered. And as you said, the largest patch within that patchwork is employer-sponsored insurance, where about 158 million Americans get their health insurance, and no other country puts job-based coverage so much at the center of their system. It's actually interesting how it came about. It's partly because of historical accidents, but also partly deliberate policy choices that we've made over the years.

Michael Klein
So what are the historical accidents and the policy choices, Mark, that led to this?

Mark Shepard
So the biggest historical accident—for that, you have to go back to World War Two. Because of the war mobilization, America was facing labor shortages. Wages and prices were rising, and so President Franklin Roosevelt tried to do something about it. He tried to tamp down on inflation by imposing wage and price controls. Now obviously that's not great economic policy as we would understand it today, but it's what they did, and it led to a big unintended consequence. So while wages were under control, they were capped, there was an exception for employee benefits—things like pensions and insurance—and firms realized that they could compete for workers by offering generous health insurance coverage. So at that point in history, most people didn't have health insurance. It was just starting to emerge as a product. Health care costs were low because medical science was pretty basic, and as health care costs were rising, people faced larger risks of medical bills. And suddenly, employers started to be major providers of health insurance in America. And that persisted even after the war, when wage controls were lifted.

Michael Klein
Was there any explicit government policy involved as well that promoted this type of system?

Mark Shepard
Well, yes, there were also some deliberate policy choices that caused that initial emergence of employer health insurance to persist. Probably the biggest one occurred starting in 1943, when the IRS decided that employer-provided health insurance would be tax-exempt, something that Congress later codified and that persists today. As my old economics Professor Martin Feldstein liked to point out, this created a massive tax incentive for firms to provide generous health insurance, even at the expense of lower wages for their workers. So for instance, if a firm gives its workers $1 of wages, they pay taxes on it, so only something like 65 to 75 cents actually reaches the worker. But if they contribute $1 to health insurance benefits, it all flows through tax-free, and that's a big tax subsidy for employer-sponsored health insurance, even beyond what might be economically optimal. So that's the first policy. A second policy choice that's led employer health insurance to persist is that the US has never adopted national health insurance, unlike most other high-income nations. That has been a repeated failure of policy pushes for national health insurance, starting with President Truman in the 1940s, whose push for national health insurance failed in the face of opposition from the American Medical Association, who labeled it as part of socialized medicine. They painted it as part of the Cold War—something that has been pointed out in recent work by my colleague, Marcella Allison, and her colleagues. But that failure to enact national health insurance has persisted over multiple presidents, Democrat and Republican. And I think the basic problem here is that politicians are really afraid to disrupt

the status quo of employer-based health insurance. And to be fair, job-based health insurance works pretty well for those who have it and for those who are in stable jobs. It creates a way to provide health insurance without big government programs, and that's something that many Americans are ideologically opposed to. And most people who have employer insurance are pretty satisfied with it. So in other words, it's pretty popular.

Michael Klein
Mark, you identify one of the problems associated with this employer-based health care is what you call 'job lock.' What do you mean by that?

Mark Shepard
Yeah, so centering health insurance around jobs creates a problem. If you lose your job, you lose your health insurance, and if you need to switch jobs, you may need to switch your health insurance and incur a lot of disruption—new doctors, new plans, new forms, all of those things. And so that's really a fundamental paradox of American health insurance system. Health insurance is supposed to protect you from risk, but health insurance itself under our employer-based system is uncertain and unstable. And so that brings us to the problem that you mentioned, of job lock. If you know that when you switch jobs or lose your job, you're going to lose your health insurance, people might get locked into jobs that may not be the best match for them, simply because they're afraid to lose their health insurance coverage. So while it's true that you can buy something called continuing coverage, or COBRA, if you leave your job, that tends to be expensive and temporary. So in practice, there's this lock-in effect, something that economists have studied and pointed out for decades, going back to classic work by Brigitte Madrian and John Gruber.

Michael Klein
So what are the economic implications of job lock more broadly for the economy?

Mark Shepard
So if people are locked into jobs that aren't the best match, it makes our system less dynamic. Workers are less willing to change jobs when they might find something better. Firms might be less willing to hire away new workers because of the need to switch their health insurance. It may also deter people from creating their own businesses or joining small firms who are less likely to offer coverage because it's so expensive. And finally, because insurance is such a large cost relative to wages, many firms have tried to find a way to avoid paying those costs, especially for their lower-income workers. This has led to something called segmented labor markets, in which it creates incentives for firms to contract out their lower-wage jobs—things like maintenance or security, rather than employing those people in-house. Because if you segment out those workers, you don't necessarily have to offer the same health insurance package that you would to your higher-income workforce and the rest of the firm.

Michael Klein
So, Mark, you said that about 158 million Americans get their health insurance through their employer. But there's also government-provided health insurance. When did the federal government start to get involved in the provision of health care?

Mark Shepard
Yeah, so while the US never enacted national health insurance for all Americans, the federal government is quite involved in the system today. It's not a purely private system. So the large role for federal health insurance started with Medicare and Medicaid, which were enacted in 1965 as part of President Lyndon Johnson's Great Society programs. So, by that point, job-based health insurance covered most Americans, but there were a couple groups who were clearly left out of the system. First, the elderly, who were often retired and didn't have jobs. Second, the poor, whose jobs typically didn't offer health insurance. So Medicare and Medicaid were new government programs that sought to cover those two groups. Medicare covered the elderly, those age 65 plus, and later expanded to people with disabilities, and Medicaid covered poor families with state-specific rules about what exactly "poor" meant. Over time, both programs have expanded in scope so that now they cover about 117 million Americans, in total, about 36% of the population. And importantly, neither of these programs is universal coverage. Instead, you can think of them as two more patches within our patchwork system trying to fill in gaps that were left by job-based health insurance.

Michael Klein
Were there other gaps even after employer-based health insurance and Medicare and Medicaid?

Mark Shepard
Yes, there are still major holes in the system, even after Medicare and Medicaid were enacted and even to the present today. So go back to 1965—Medicare and Medicaid come in, still, there was a growing what you might call "missing middle" within the system. There were people who were too young to qualify for Medicare but they were too high income to qualify for Medicaid, and their jobs didn't offer health insurance. This was especially true of lower and lower-middle-income jobs. These people in the missing middle for health insurance, in theory, were supposed to go out and buy health insurance on private markets directly from insurance companies. But these private markets had some major flaws, and these arose from market failures like adverse selection, that economists have been studying and writing about for decades. The basic challenge is that when insurance is voluntary and offered on private markets, it tends to be that the sick sign up for health insurance first, and that pushes up the overall cost of the insurance risk pool, makes it more expensive, and often leads firms to do things to try to avoid the sick, like denying coverage for pre-existing conditions. And so that's exactly what you saw in these private markets leading up to Obamacare. Private market coverage was expensive, it often didn't cover pre-existing conditions—like if you had cancer, that would be excluded from the

policy. And so many people didn't buy the coverage. And those people who don't buy any health insurance are the uninsured. About 15% of Americans were uninsured just after Medicare and Medicaid passed, and several decades later, leading up to Obamacare, in the early 2010s, the uninsurance rate was still around the same level—17% or 45 million Americans.

Michael Klein
So the Affordable Care Act, Obamacare, was passed in 2010. How many previously uninsured people obtained health insurance through Obamacare?

Mark Shepard
Yeah, so the ACA, or Obamacare, led to a clear reduction in uninsurance. It's not a mystery why—the ACA both expanded eligibility for Medicaid to more low-income Americans, and it also gave subsidies to buy private health insurance to lower-middle-income Americans. And so as a result, more people got coverage. So what you saw was between 2014, when the law took effect, and 2016—so in those two years—about 18 million Americans gained coverage, and the non-elderly uninsured rate fell from about 17% to about 10% within two years. So looked at one way, that's a pretty big success. It was the largest and fastest fall in uninsurance since Medicare and Medicaid came in, in the 1960s. But maybe looked at another way, it's a bit of a disappointment. Only about four-tenths of the uninsured—less than half of them—actually gained coverage. The other six-tenths, about 26 million people, still didn't have coverage, even after the ACA took effect. And since 2016, uninsurance has barely budged. It did rise by a few million people during the first Trump administration, as the administration was hostile to the ACA and tried to repeal it. It then fell by a few million during the pandemic and the Biden years, as subsidies for Obamacare coverage were made more generous. But overall, since 2016, we've been in a period of stasis. The non-elderly uninsured rate has been pretty much stuck around 10 to 11% or about 25 to 30 million people who still lack coverage, even today.

Michael Klein
Who are these 25 to 30 million people, Mark?

Mark Shepard
Yeah, so the first thing to note is that uninsurance is highest among the poor. Lower-income Americans, and other disadvantaged groups, especially actually Hispanic Americans, among whom almost a fourth of the population lack basic health insurance. Some of this is because of citizenship, because non-citizens are not eligible for subsidies under Medicaid or Obamacare coverage. A second thing to note is that uninsurance rates are also a lot higher in states that haven't expanded Medicaid yet, something that was made optional under the law by a 2012 Supreme Court decision. So for instance, in my home state of Texas, where I'm from, 16% of people still lack health insurance today, and that compares to only 2.6% uninsured in my current state of Massachusetts. That's about a sixfold difference in coverage rates.

Michael Klein
States that refused Obamacare expansion of Medicaid didn't do so because of the cost to the state government, though. The cost would have been covered by the federal government, right?

Mark Shepard
Yes, that's mostly right. About 90% of the costs would be covered by the federal government in steady state. That's a much higher matching rate, or federal share of spending, for the expansion groups compared to regular Medicaid. I think the opposition wasn't mainly about costs, although certainly that was relevant for some states. I think the main opposition was political. President Obama was an unpopular president on the right, and Obamacare bore his name—it has his name right there in the title. Obamacare was also a major expansion of the government's role in health care that was passed on a pure party-line vote, and so as a result, for at least a decade after the law took effect, Republicans found Obamacare to be politically toxic, something that would be hard to get on board with for their state.

Michael Klein
Who dubbed it Obamacare? It wasn't the Democrats, it was the Republicans, right?

Mark Shepard
It's interesting—originally, Republicans called it Obamacare as a pejorative. They wanted to associate it with the law, but eventually, President Obama claimed ownership of that name and said, "I'll take the credit, and I'll take the blame." And now it's his law. It's Obamacare.

Michael Klein
So it seems like these states that didn't accept the federal government's offer are, in a way, cutting off their nose to spite their face, or cutting off the poor people's nose to spite the face of their government.

Mark Shepard
Well, I think it's true that they would have to spend more money to enact Medicaid expansion. So that's one reason, and there are certainly arguments for not expanding Medicaid. There's a hope that people might buy private health insurance, but I think it's pretty clear in the data that when you don't expand Medicaid, the number of people without health insurance is much, much higher.

Michael Klein
So why do you think it's still the case that there is this lack of coverage?

Mark Shepard
Yeah, I think we're still living with the political reality of Obamacare being unpopular on the right, but I do see that opposition softening a bit in recent years. So it's worth noting that more and more states have adopted the Medicaid expansion in the years since the ACA took effect. Originally, there were 25 states that didn't expand Medicaid right at the start of the law, but over the past decade, that's fallen, and now it's only 10 states that haven't expanded Medicaid, and no state having expanded Medicaid has ever gone in the reverse direction and un-expanded it. So finally, I see some different change in tones from President Trump during the 2024 presidential campaign, when he argued that he actually helped to save Obamacare during his first term, when the program was facing turmoil and maybe even collapsing. Now, whether or not that's fully true that President Trump saved Obamacare, it is a major shift in political tone, and I think it bodes well for the politics of health insurance going forward. Interestingly, there are ways that President Trump can make it more politically viable for the remaining states, which are mostly red states, to expand Medicaid. He can do things like approve Medicaid expansions that include waivers or special provisions like work requirements, or healthy behavior incentives. Sometimes those are popular, and they can make it politically feasible to expand Medicaid and provide this important benefit for poor citizens.

Michael Klein
Is this sort of like a Nixon-goes-to-China moment—Trump, who tried to destroy Obamacare, might now embrace it, perhaps to increase his own popularity?

Mark Shepard
Yeah, it's popular. It's always tough to tell with President Trump which way things will go, but it's worth noting that originally, the ACA was supposed to be a bipartisan compromise. It was supposed to be universal coverage, something that was a key goal on the left, but done through private insurance markets, which was something that conservatives appreciate. In fact, the ACA originally was modeled on Republican Governor Mitt Romney's health insurance reform here in Massachusetts. And so while the bipartisan politics of the ACA certainly did not work out over the last 15 years, I've always wondered whether there might not be a chance to turn a corner, and maybe that's right now.

Michael Klein
So why don't people have health insurance? Is it because it's costly and it's not being picked up by the federal government?

Mark Shepard
Yeah, this is a great question, and it's a place where I think the conventional wisdom kind of has it wrong on this. So when you ask people, in general, or specifically when you survey the uninsured Americans, the number one answer they give for why they don't have coverage is cost.

They say it's too expensive. And in the policy debate, there's been tremendous focus on either the affordability question—how do we make insurance cheaper for families—or on lack of eligibility for Medicaid…those 10 states that haven't expanded Medicaid. So you might think that was the majority of the uninsured problem, but when you look in the data, it doesn't bear that out. People who've done careful analyses of the remaining uninsured find that about 80% of them—about eight in ten—look like they qualify for some form of affordable health insurance, which they simply haven't gotten enrolled in. So, in fact, almost half of the uninsured, it looks like, probably qualify for some form of completely free health insurance, either from Medicaid or from a fully subsidized health plan in one of the Obamacare private markets. And if it's free, it can't be unaffordable.

Michael Klein
Well, that's a deep economic view—that if something's free, it can't be unaffordable. You mentioned in Texas, 16% of the people lack health insurance, and in Massachusetts, it's only 2.6%. So that doesn't have to do with the affordability?

Mark Shepard
Yeah, it's a complex set of factors. It's partly about the lack of Medicaid expansion—that's a piece of it. It's partly about demographics—Texas has a much more low-income population, more Hispanics, who are excluded from support under the law. But it's also just a different set of political attitudes towards the law. There's been some evidence from recent work showing that Republicans are less likely to take up Obamacare health insurance if they're healthy. And so there may be a variety of reasons. But I think the key thing is to know that Obamacare creates a framework by which people are eligible for affordable coverage, or at least almost everyone. And what we're seeing now is that there's a major barrier of lack of take-up, where people aren't getting enrolled in the affordable coverage that they already seem to be eligible for. And so I think that's the number one challenge that I think policy makers need to focus on. Why aren't people taking up the coverage, that's pretty low cost, that they're already eligible for? And when I look at that problem, Michael, I see that it seems like the problem is that our system is really complicated. It's confusing to know what you're eligible for. The rules are very complicated. And even if you do know what you're eligible for—say, Medicaid or an Obamacare private market plan—it's confusing and complex to sign up for coverage. You have to fill out paperwork. There's administrative burden. There's something that economists call ordeals to sign up. And so even if you do get signed up for health insurance, your eligibility can then change. So maybe you're enrolled in Medicaid, but your income goes up, and now you no longer qualify for Medicaid. Maybe you're in a job, but you lose that job, and you now need to sign up for something new. In the current system, we ask people to figure it out on their own, to navigate the system on their own, but there's no organized system or automatic processes to make sure that everyone gets enrolled in the health insurance that they qualify for and that ultimately, they really need.

Michael Klein
So going back to Texas versus Massachusetts again, the rate of uninsured is five times higher in Texas than in Massachusetts, and surely the poverty rate isn't five times higher in Texas versus Massachusetts. So as you're alluding to, it must be a range of other factors. Could one of these be, as Tara Watson points out—who's now at Brookings— that in Hispanic households, sometimes there's one person who's undocumented, and nobody in the household then wants to take on any social safety net benefits because they're afraid of what the consequences could be if people start poking around in their households? Is that a possibility?

Mark Shepard
It's definitely a possibility. There's some evidence that fear of the immigration system leads to less take-up of social benefits. So I think uninsurance is a complex reality. And when I look at the system, I see a lot of need. I see a lot of complexity. And I see the government basically setting up programs and saying, "Please come sign up, and trust us that it'll work out," instead of creating a system that's simpler for people to automatically get the health insurance they need.

Michael Klein
I imagine that some of the complexity is not just for the sake of complexity. In fact, I think probably none of it is. But it's not a simple thing, right? Health insurance?

Mark Shepard
Well, at one level, that's right. But at another level, giving everyone a basic level of health insurance is something that every high-income nation around the world—except America—has managed to achieve. It's not that complicated to get people a basic form of health insurance. What you need is a coherent system to do so. And again, the reason we have such a complex system in America—or non-system, as I've called it—is because it emerged gradually. It emerged via a series of reforms that were all built to avoid disrupting the existing system and organizing it and to just add on patches to the patchwork. And so, what you get is what we have. And that creates a problem. That's a place where there's potential for improvements by simplifying and streamlining the system we have or perhaps doing more fundamental reforms.

Michael Klein
So we're talking about not having health insurance. What are actually the consequences of not having health insurance for people?

Mark Shepard
Yeah, Michael, this is an area where our knowledge has really expanded a lot among economists in the past 15 years. There's a growing body of causal evidence about how much not having health insurance really means for people's lives and for the economy more broadly. Let me point to three sets of findings. The first consequence of being uninsured is financial risk. Lack of

health insurance exposes people to greater financial costs if they get sick and need to use medical care. To larger medical bills, more medical debt, to bankruptcies. This has been something that has been known for a long time, but it's been really strongly documented in recent evidence. The second consequence of being uninsured is health. For a long time, there was a debate about whether health insurance really improved health, and the evidence from the well-known Oregon Health Insurance Experiment…that were pretty mixed on this question. What we've seen in the past 10 years, though, is a range of studies come out that show that health insurance does appear to save lives, especially for poor families who gain coverage. So we've seen evidence from the adoption of the ACA itself that it saved lives, and from a randomized study that encouraged many uninsured people under the ACA to sign up for coverage in a randomized way. They also found that that saved lives—and did so at a pretty cost-effective rate. So health insurance improves financial risk and saves lives. A third finding, though, is pretty surprising. The entity that benefits most from giving people health insurance is often not the individuals themselves. It's often the healthcare providers who were serving them if they had been uninsured. These are often safety-net hospitals or public clinics. They'll often deliver a lot of care to the uninsured that never gets paid for—something that's called uncompensated care. And estimates suggest that perhaps about two-thirds of the cost of health insurance is actually a financial transfer that's just covering the cost of care that was already being incurred on the uninsured, and that benefit flows through to the hospitals and safety-net providers, as opposed to necessarily the individual who was already receiving that care at low cost.

Michael Klein
Mark, I had Amy Finkelstein on the podcast some time ago, and she has a book where she calls for a baseline level of basic care for everyone. Do you think that that should be available, and if so, what do you think the baseline would involve?

Mark Shepard
Yeah, ideally we would. Ideally, the simplest way to make our system more organized and simpler would be what you might call universal basic insurance. Everyone has something automatically that they get, regardless of their income level or job status or anything else. And I think it's important to note that we actually do have something like this in America called EMTALA. It's a universal right to use emergency rooms when you get sick. It's a type of universal basic care, but it's pretty lousy. It's not what we would ideally design if we were thinking about getting people access to primary care and preventive care that would actually make them healthier in the long run. So if it were up to me, I would want to upgrade this to some type of universal basic insurance to make sure everyone has it—that would cover medically necessary care. Now, in terms of what that basic insurance looks like, I think there's a trade-off. If we wanted to prioritize lower cost to taxpayers, it might look like the Medicaid system, which is relatively low-cost to the government because it pays doctors and hospitals very little. If we wanted to spend more and provide better access to care, that basic coverage might look more like

Medicare, with an option to purchase private insurance through Medicare Advantage. That might be popular. If we wanted a more market-based system, it could be Obamacare markets. But I think while there are real trade-offs between the different ways of doing it, what's important is that there needs to be a way to ensure that everyone has access to basic health insurance in America. And while the details of what health insurance looks like can be complicated, that basic fact is something that we're not achieving that basically all other high-income countries are achieving right now.

Michael Klein
Do you think there's a moral dimension to this, Mark? In a country as wealthy as the United States, do we owe it to our fellow citizens that basic health care should be available?

Mark Shepard
Yeah, this is a great question. And of course, as economists, we're not the final arbiters of the morality of health care. But I think what's interesting—and was pointed out in the book by Amy Finkelstein and Liran Einav—is that the moral intuition that people deserve a basic level of healthcare seems to be so strong that even when people don't have health insurance, we give them a lot of healthcare anyway. That's the basic care, the care through emergency rooms and public clinics that I mentioned earlier. And so if you're already giving people basic care, and you're spending a good deal of money on it, why not organize that basic system to be something more like what doctors and health economists and other experts would say is the best bundle of care that people could get? So it would cover their primary care and their medications, not just care in an emergency room setting.

Michael Klein
So obviously today, we're living in a very deeply polarized society, and that idea of caring not just for your friends and neighbors but for everybody in the country may be more difficult these days. What do you see as the political viability of moving forward with having greater coverage?

Mark Shepard
Yeah, I think realistically, we're pretty far away from it being politically viable to do fundamental health insurance reform. I'm very much swayed by the economic arguments of Liran Einav and Amy Finkelstein that it would be optimal. But politically, incremental reforms are still the most likely to occur in coming years. And if I were encouraging policymakers to focus on one area, I would focus on reducing the complexity of our system by streamlining and organizing the existing patchwork to make it more system-like. So that would include filling in the remaining holes in the coverage of Medicaid in the 10 states that haven't yet expanded it. But it might also encourage better data systems and tracking of coverage, so that we know who the uninsured are, and we can track when people lose one form of health insurance, and set up a way that they might get quickly enrolled—maybe even automatically enrolled—in something new, in

a different form of health insurance that they newly qualify for. Remember that statistic that most of the uninsured actually already are eligible for some form of affordable health insurance. We're just not connecting it with them already. And so there might be other creative ways to simplify the system, but that's where I would focus. And the reason I think it might be politically feasible, Michael, is that this could be done in a way that improves the efficiency of the overall system without necessarily increasing government spending by a lot. So because of the chaos of our current system, because people are eligible for many different things, and their eligibility changes over time, it's often the case that people are duplicatively enrolled in both private and government-subsidized health insurance at the same time even, and that's a type of over-enrollment in which you actually raise public spending. Meanwhile, there's others who are falling through the cracks, who are not insured and they are not getting the coverage that they need. So if we could better organize the system, find ways to make sure that people are connected with just the health insurance they need, and no more, we might be actually able to increase health insurance coverage without dramatically raising federal spending.

Michael Klein
Mark, you're saying, "if policymakers asked you" I certainly hope they do, because you have a deep understanding of this, and a rational way to think about it, and it is not only an economic but, as we were suggesting, perhaps a moral problem as well. Thanks very much for speaking with me today, Mark, and for helping me and our listeners understand this complex issue better.

Mark Shepard
It was my pleasure, Michael. Thanks.

Michael Klein
This has been EconoFact Chats. To learn more about EconoFact and to see the work on our site, you can log into www.econofact.org. EconoFact is a publication of The Fletcher School at Tufts University. Thanks for listening.