



Health Care Coverage: Where we are, where we've been, where we might go

Dan Sacks

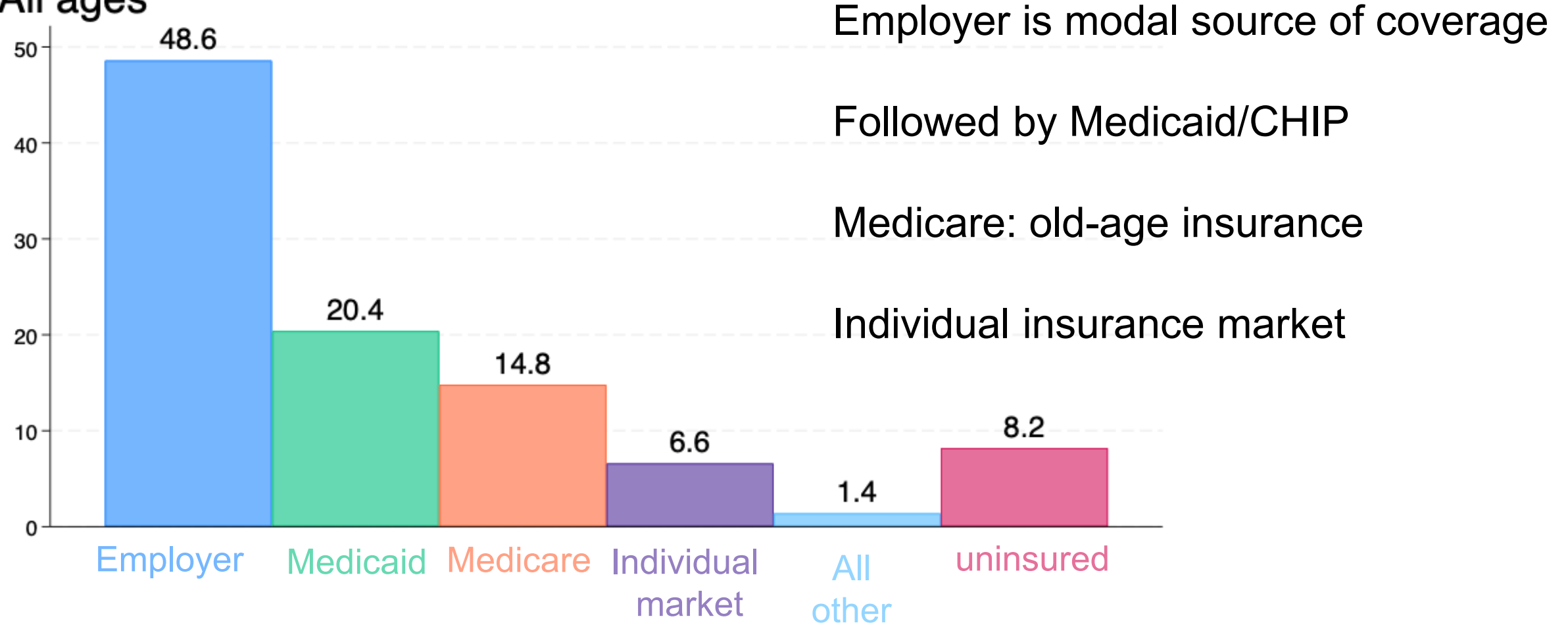
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Department of Risk and Insurance

University of Wisconsin-Madison

The landscape of health insurance coverage

All ages

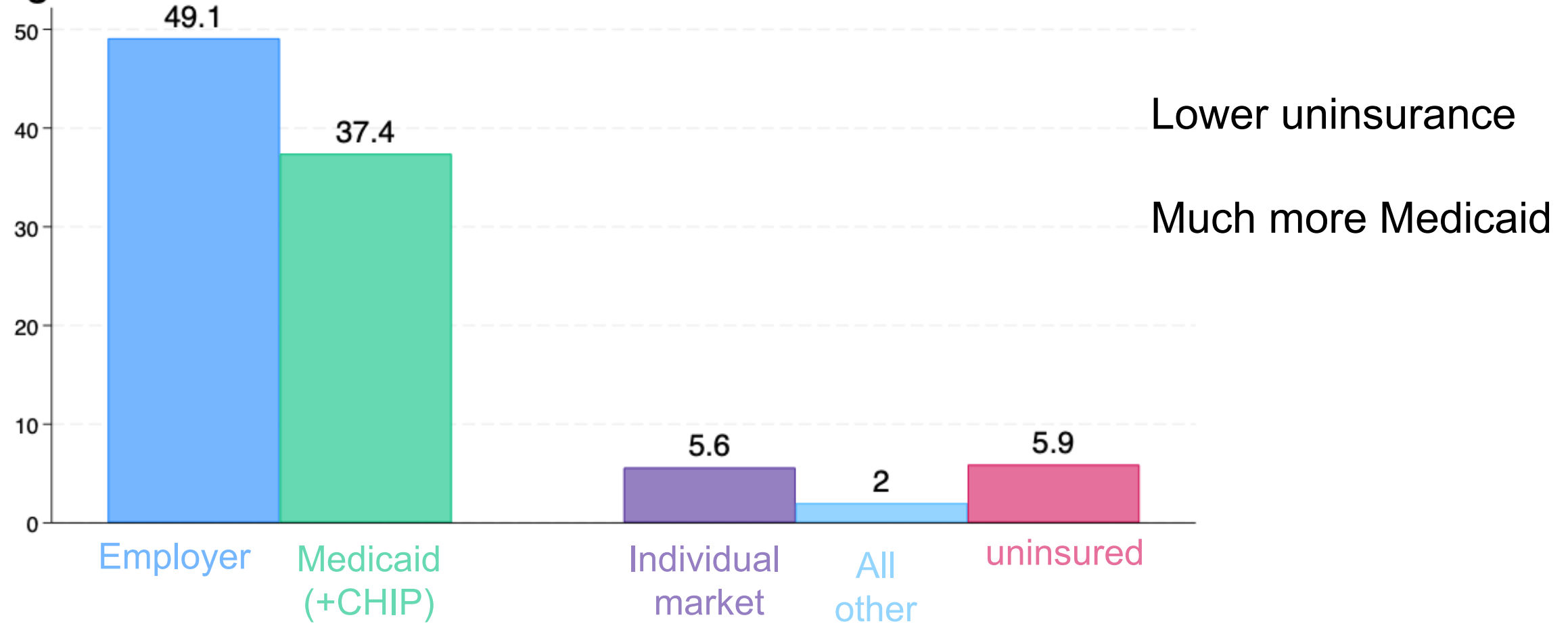


Source: Kaiser Family Foundation. 2024 coverage rates.



Health insurance coverage for children

Age 0-18

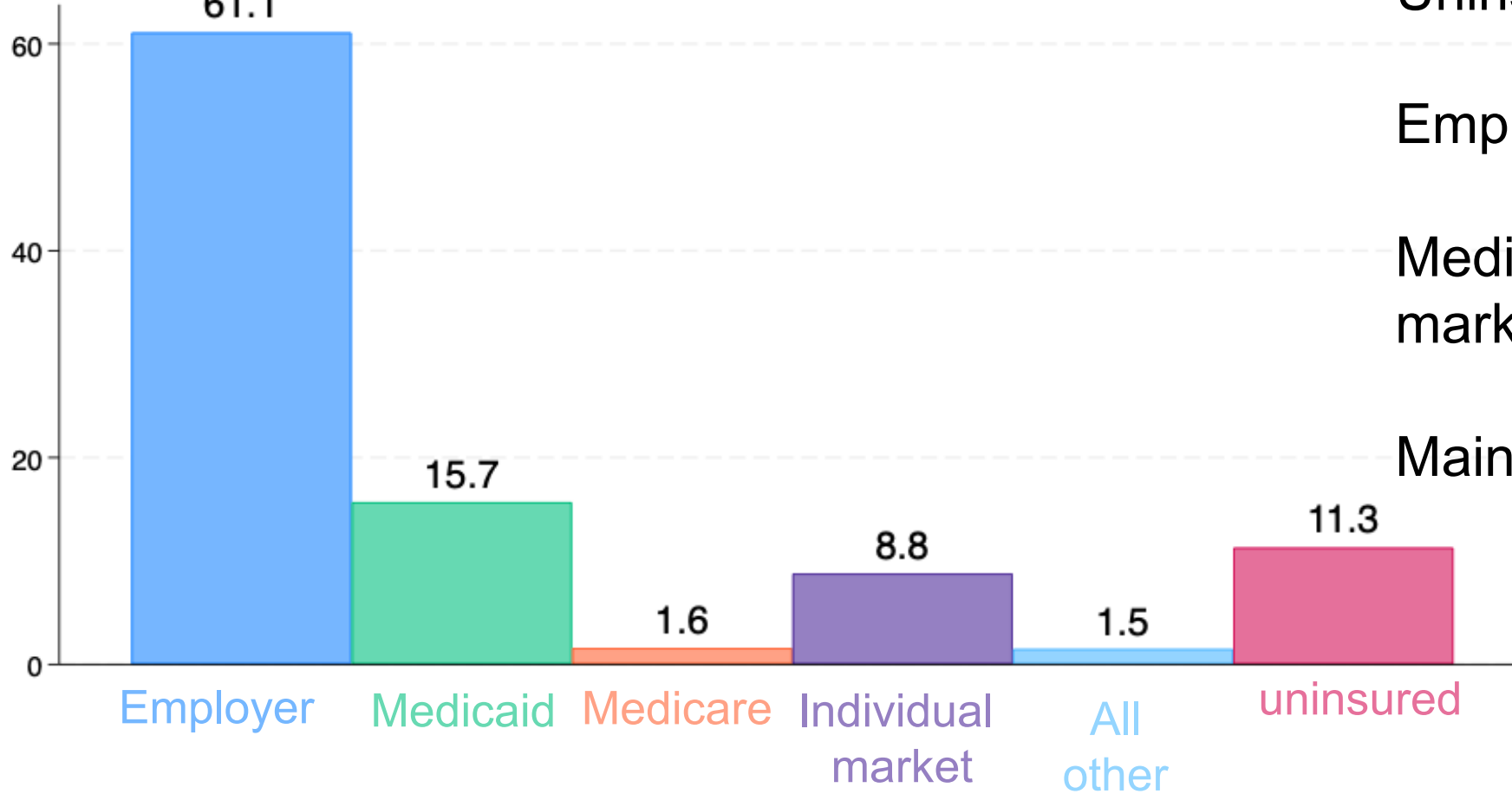


Source: Kaiser Family Foundation. 2024 coverage rates.



Health insurance coverage for non-elderly adults

Age 19-64
61.1



Uninsurance ~11%

Employer-provided dominant

Medicaid and individual market also important

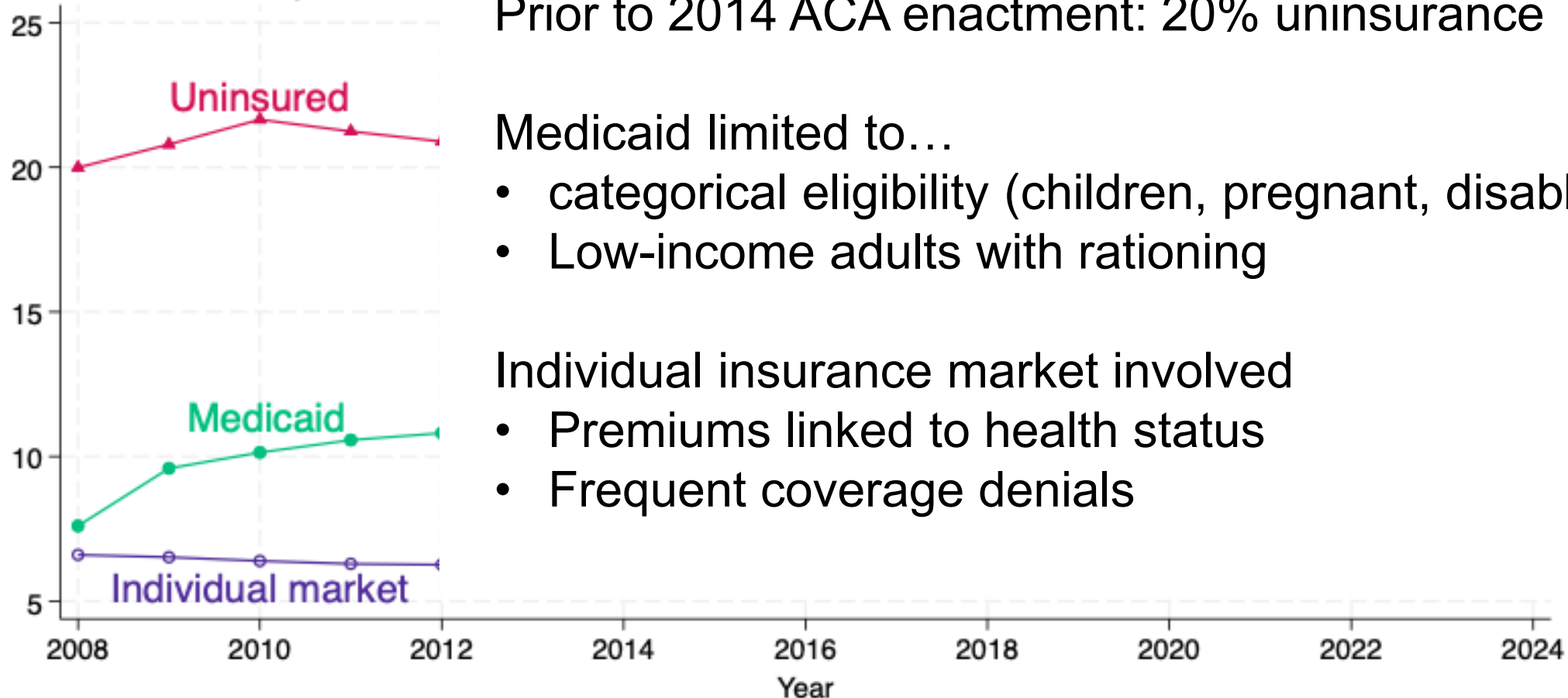
Main area of policy interest

Source: Kaiser Family Foundation. 2024 coverage rates.



The evolution of insurance coverage since the Affordable Care Act

Percent of 19-64 year-olds



Prior to 2014 ACA enactment: 20% uninsurance

Medicaid limited to...

- categorical eligibility (children, pregnant, disabled)
- Low-income adults with rationing

Individual insurance market involved

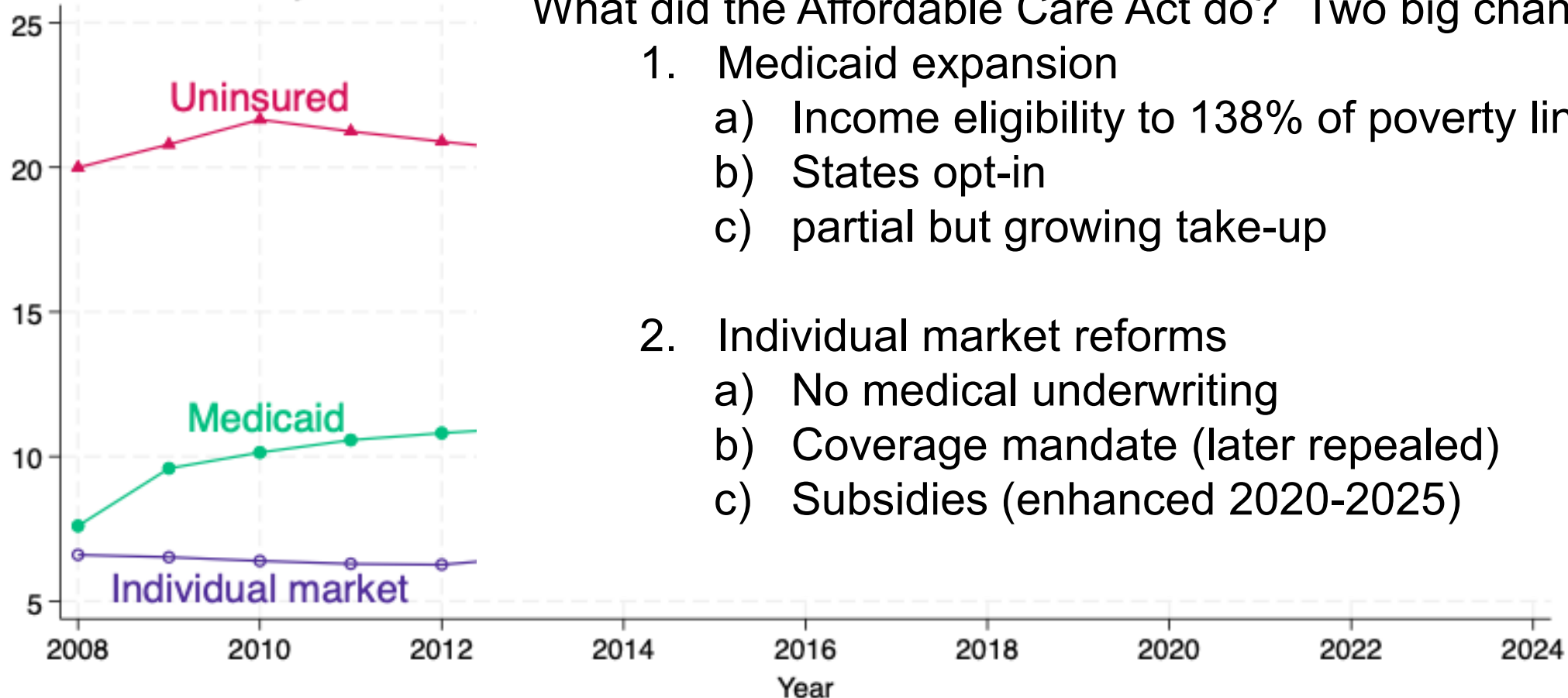
- Premiums linked to health status
- Frequent coverage denials

Source: Kaiser Family Foundation. 2024 coverage rates.



The evolution of insurance coverage since the Affordable Care Act

Percent of 19-64 year-olds



What did the Affordable Care Act do? Two big changes:

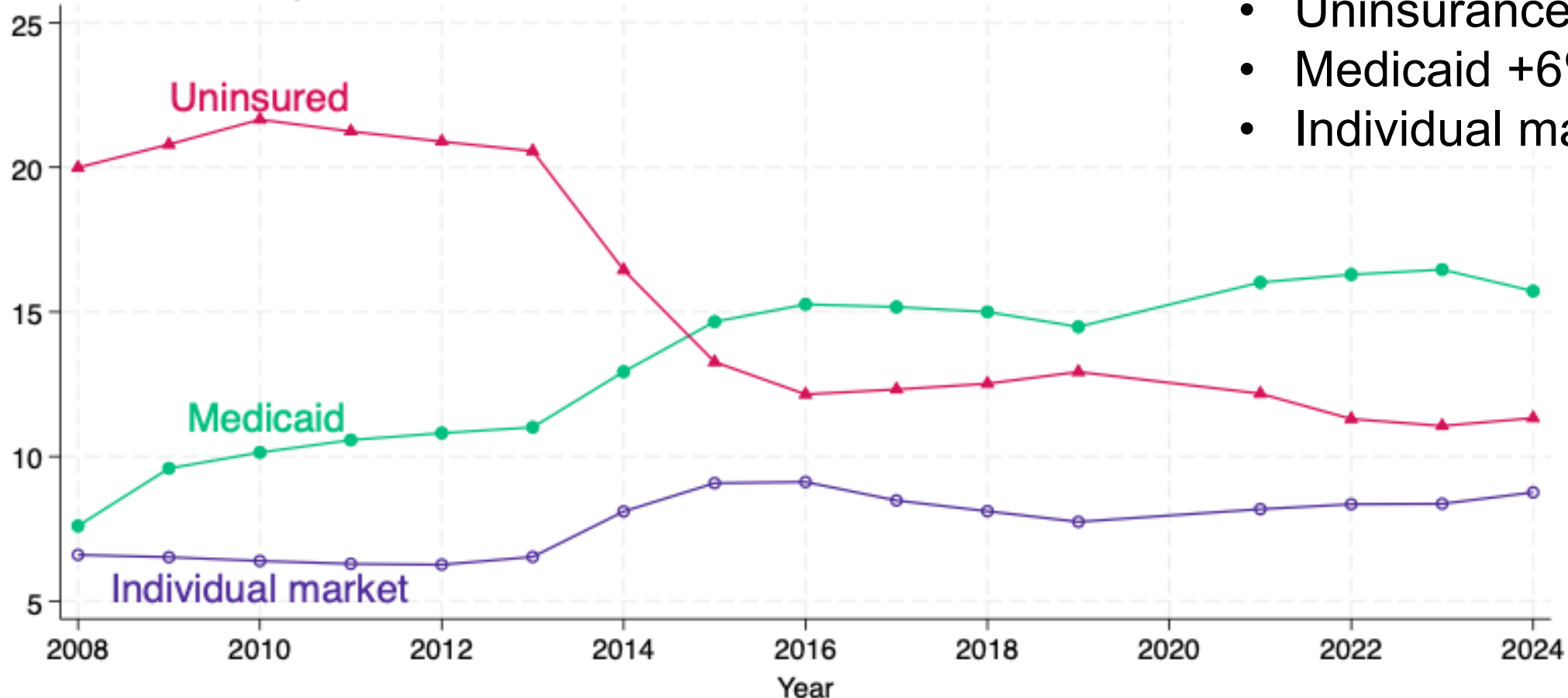
1. Medicaid expansion
 - a) Income eligibility to 138% of poverty line
 - b) States opt-in
 - c) partial but growing take-up
2. Individual market reforms
 - a) No medical underwriting
 - b) Coverage mandate (later repealed)
 - c) Subsidies (enhanced 2020-2025)

Source: Kaiser Family Foundation. 2024 coverage rates.



The evolution of insurance coverage since the Affordable Care Act

Percent of 19-64 year-olds



10 years post-ACA...

- Uninsurance -9%
- Medicaid +6%
- Individual market +3%

Source: Kaiser Family Foundation. 2024 coverage rates.



Recent policy actions focus on Medicaid and Individual Market, two areas with biggest post-ACA coverage growth

Expansions during COVID and under Biden administration

- Medicaid continuous coverage

- Medicaid post partum coverage

- Enhanced premium subsidies (temporary)

Policy actions during the Trump administration

- Expiration of enhanced premium subsidies

- Increased Medicaid work requirements and more frequent recertification

What lessons can prior state experiments provide for current policy decisions?



Lessons so far

1. Policy can increase health insurance coverage
 - Uninsurance fell following Romneycare , Medicaid expansion



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 - Uninsurance fell following Romneycare , Medicaid expansion
2. Policy choices matter and policy is hard, especially in insurance markets
 - Policy debate often focuses on unhealthy Americans, hard-hit with bills
 - Would like healthy people to get coverage --> bring down premiums for everyone
 - Small premiums, paperwork hassles may be especially likely to drive the healthiest out



Lessons so far

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2. Policy choices matter and policy is hard, especially in insurance markets
 - Policy debate often focuses on unhealthy Americans, hard-hit with bills
 - Would like healthy people to get coverage --> bring down premiums for everyone
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3. Health insurance coverage improves health
 - Medicaid reduced mortality by 20% ; expansion saved 22,000 lives
 - Mortality benefits *alone* imply cost-effectiveness in line with common interventions
 - Coverage also improves financial health, increases utilization, helps providers



Two Decades of Massachusetts Health Reform: Successes, Challenges, and Lessons

Mark Shepard

Harvard Kennedy School and NBER

University of Wisconsin

Institute for Research on Poverty

July 22, 2026

Introduction



Gov. Mitt Romney signs Mass. health reform law
(April 12, 2006)

- **Mass. health reform law turns 20 this year**
 - Enacted in 2006 under Gov. Mitt Romney, known as “Romneycare”
- **Leading state effort to expand health coverage to the uninsured**
 - Key model for the ACA (“Obamacare”) passed four years later in 2010
- **This talk: What have we learned?**
 - And what are the key lessons for health and social policy today?

Outline

1. **Policy Background:** How the Massachusetts (and ACA) Reforms Work
2. **Lessons Learned:** What are the key take-aways from two decades of reform?
3. **Concluding thoughts**

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Background: The Challenge of Health Coverage

1. **Challenge:** Persistent gaps in health insurance coverage

- Roughly 6-8% of residents lacked coverage pre-reform (*400-500k people of 6.4 million*)

2. **Uninsurance creates significant life problems**

- **Access:** People forgo needed medical care b/c of costs
- **Financial:** Large medical bills, medical debt if you get sick
- **Health:** Strong evidence that uninsurance raises mortality, harms mental health

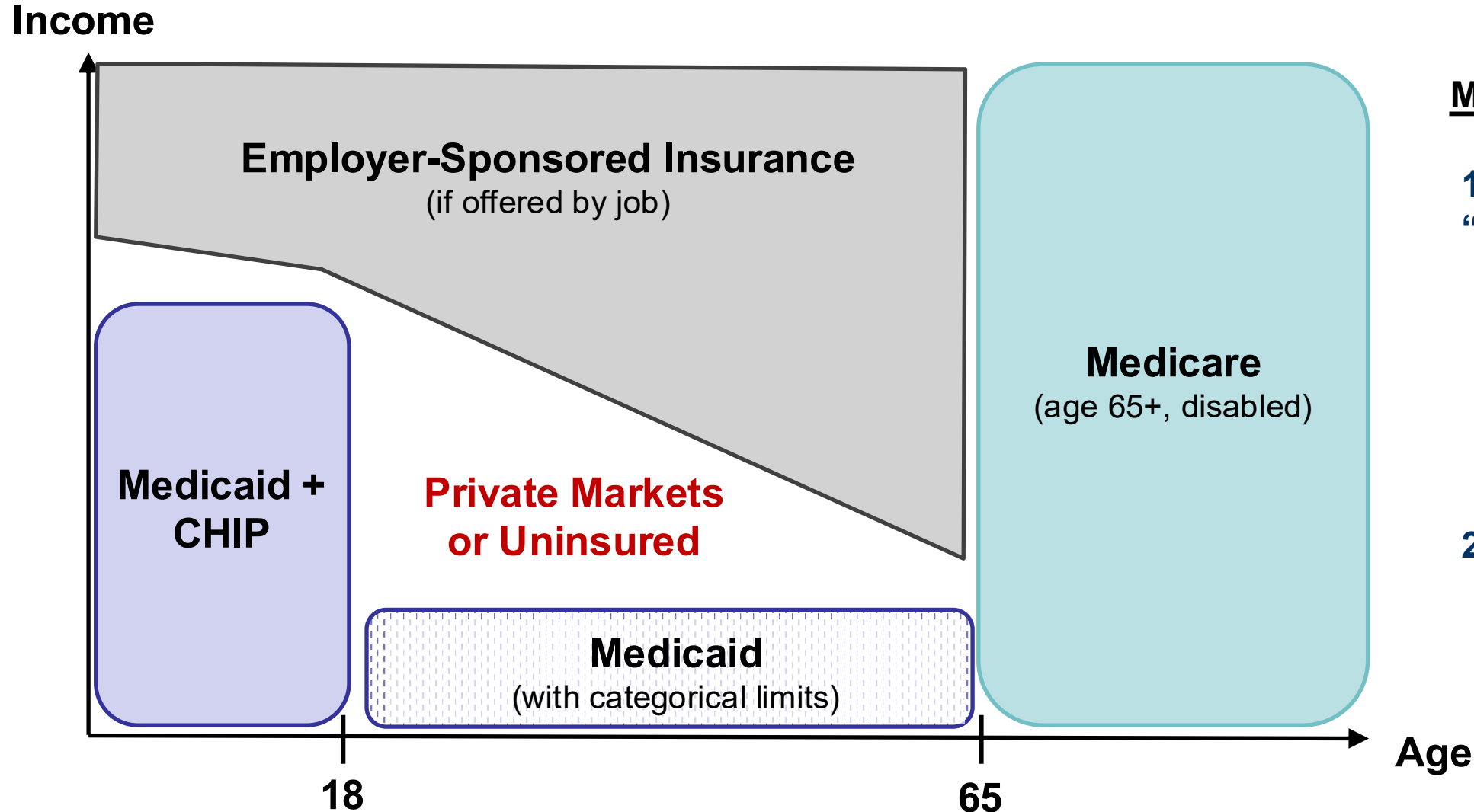
3. **Uninsurance is a systemic challenge**

- Driven by a broken health insurance *system*, not just individual choices

➤ **MA reform: Sought to expand coverage by filling in gaps in the existing system**

- But without radical system overhaul (*as in “Medicare for All” proposals*)

Patchwork Health Insurance System (pre-reform)



Mass. & ACA Strategy:

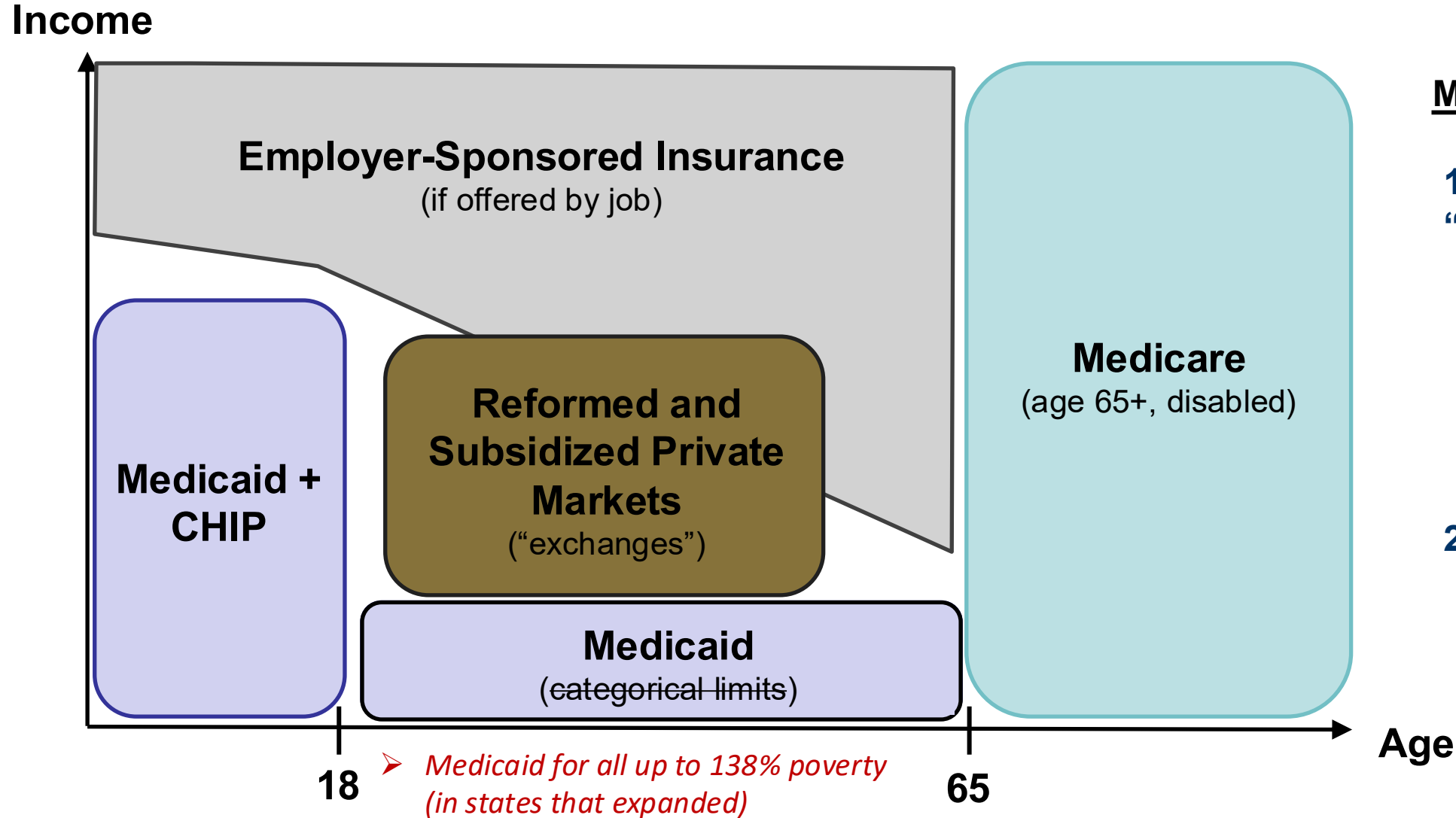
1. Fill in the gaps via “three-legged stool”

- 1) Market regulation
- 2) Affordability subsidies
- 3) Coverage “mandate”
(weakly enforced)

2. Don’t disrupt the existing system

- Retained complex & fragmented structure

Reform Approach of the ACA (Obamacare)



Mass. & ACA Strategy:

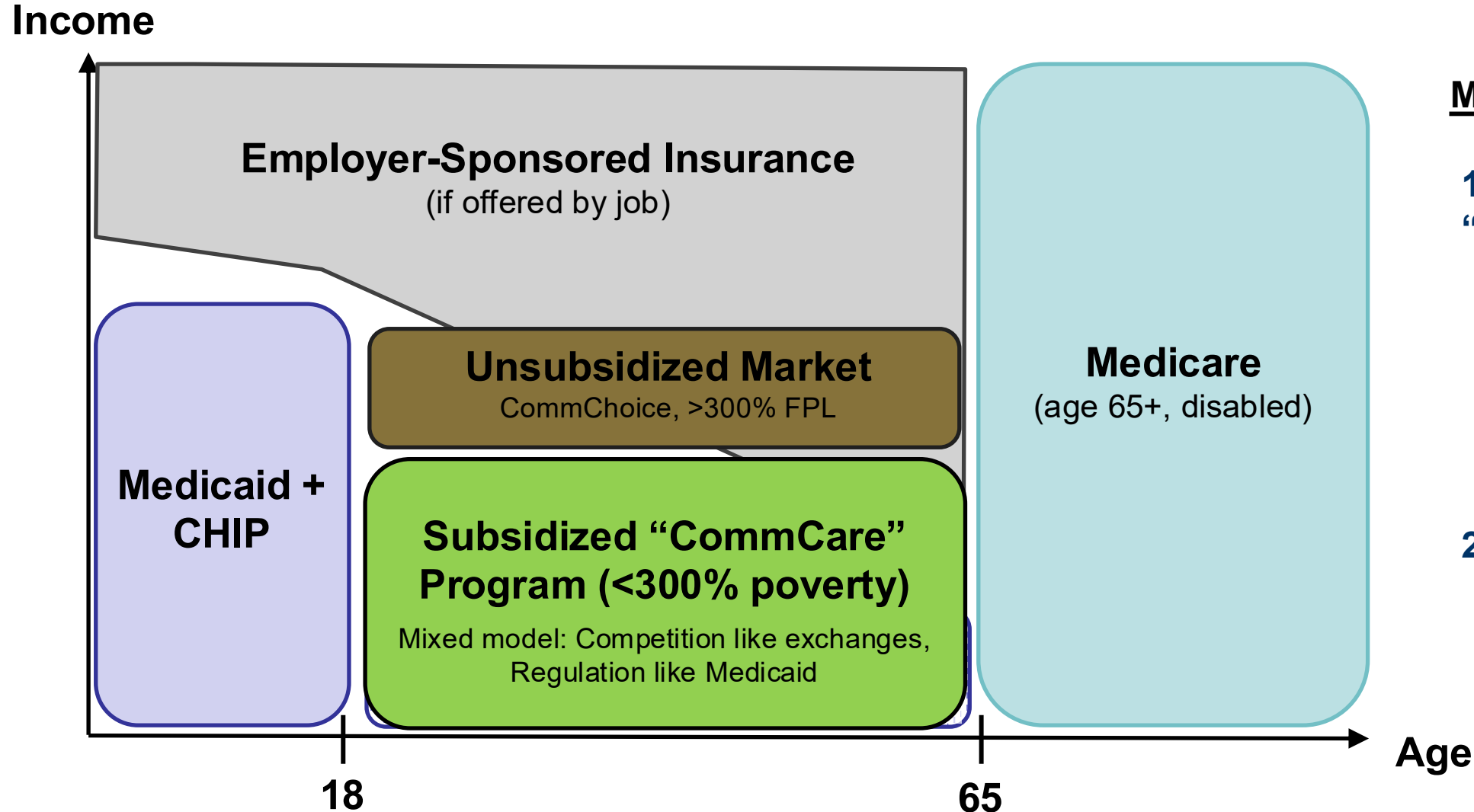
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Reform Approach in Massachusetts (Romneycare)



Mass. & ACA Strategy:

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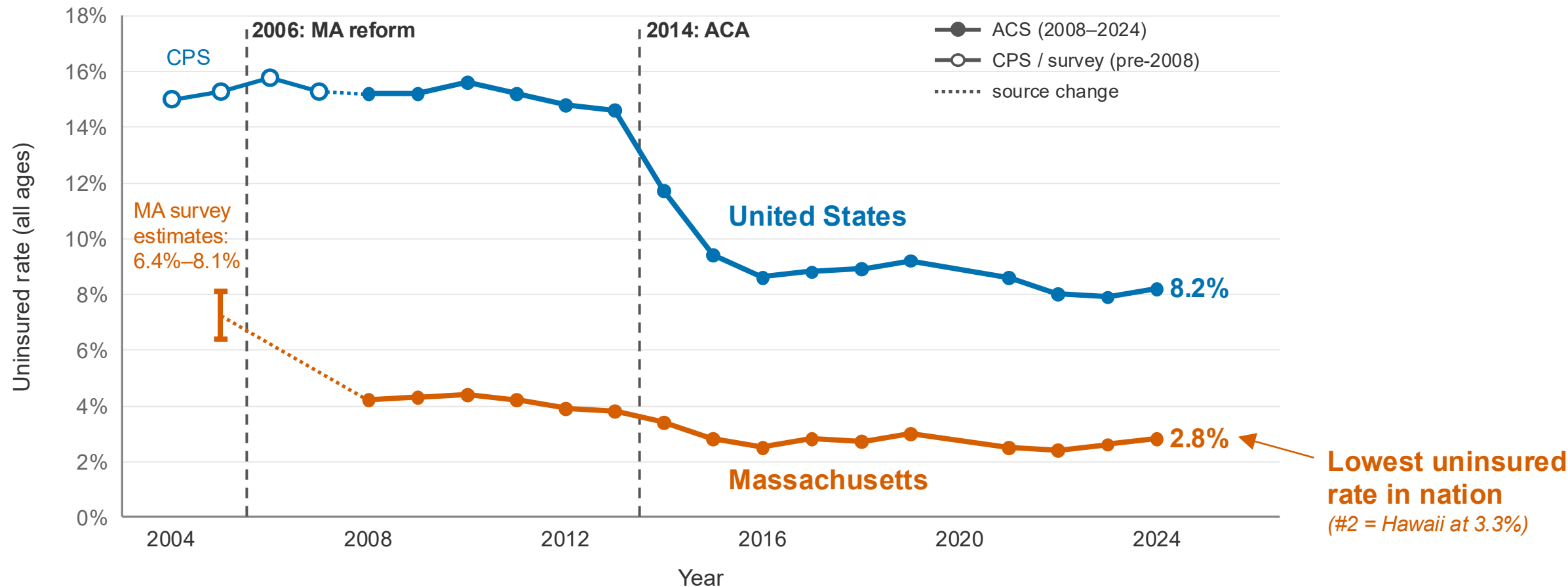
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Lesson #1: The Massachusetts model works (for coverage)

Massachusetts vs. U.S. uninsured rate, 2004–2024

Massachusetts has had the nation's lowest uninsured rate since its 2006 reform



Sources: 2008-2014 data from ACS (via KFF); 2004-07 US data from CPS; MA pre-reform estimates from MHIS and Urban Institute estimate from CPS data.

What explains Massachusetts' coverage success?

1. Natural advantages

- Strong economy, resilient employer coverage, robust health and social services sector
→ *MA had low uninsurance even pre-2006 reform*

2. Bipartisan reform consensus

- 2006 reform was collaboration b/n Republican governor + Democratic legislature
- Coverage (and the ACA) are less politicized in Massachusetts

3. State policy choices:

- **Subsidy generosity:** MA subsidies are more generous than ACA's → sustained via MA's add-on subsidies after 2014 (*"ConnectorCare" program*)
- **Individual Mandate:** Retained in MA (with tax penalty), even after ACA penalty repeal

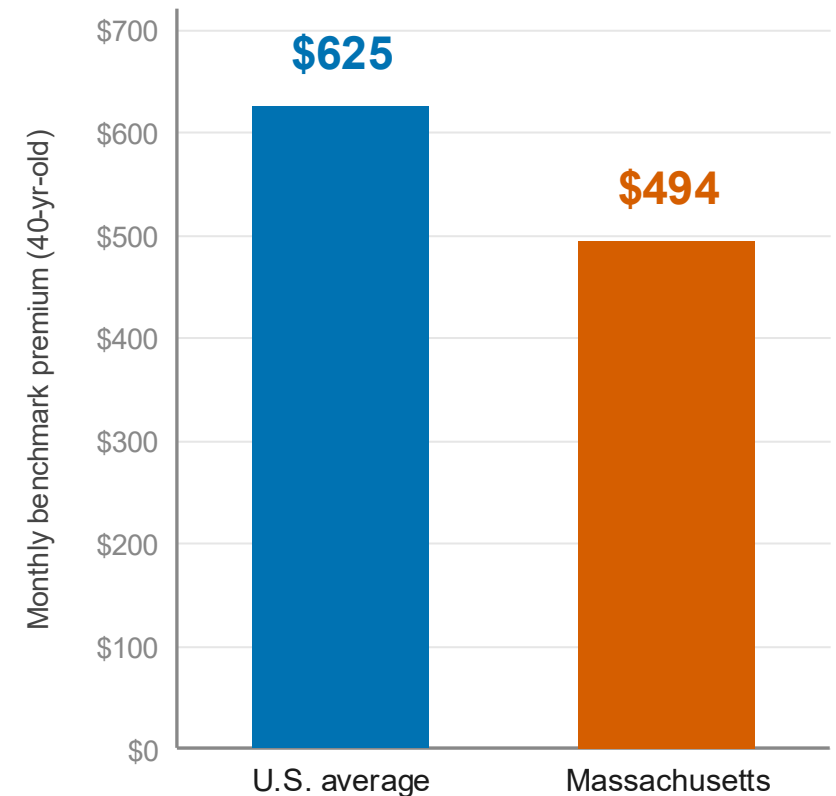
Lesson #2: Costs are Harder than Coverage

- **Romneycare reform was designed to cover the uninsured, not to lower costs**
- **Later 2012 MA reform law targeted cost growth**
 - Set state cost growth target of 3.1-3.6% per year
 - **Mixed success:** Target met in 4 of first 6 years (2013-18), but exceeded in almost all years since 2019
- **But MA's insurance marketplace is low-cost**
 - Benchmark premiums are 21% below national average in 2026 (*7th lowest state*)
 - Likely drivers: Generous subsidies (→ retain young & healthy), stronger competition, more active regulation

Massachusetts ACA benchmark premium vs. U.S. average, 2026

21% below the U.S. average

7th-lowest of 50 states + DC



Benchmark = 2nd-lowest-cost silver plan (SLCSP), 40-year-old, weighted by county enrollment. Source: KFF, 2026.

Lesson #3: Small Coverage Barriers Matter

American Economic Review 2019, 109(4): 1530–1567
<https://doi.org/10.1257/aer.20171455>

Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts[†]

By AMY FINKELSTEIN, NATHANIEL HENDREN, AND MARK SHEPARD*

How much are low-income individuals willing to pay for health insurance, and what are the implications for insurance markets? Using administrative data from Massachusetts' subsidized insurance exchange, we exploit discontinuities in the subsidy schedule to estimate willingness to pay and costs of insurance among low-income adults. As subsidies decline, insurance take-up falls rapidly, dropping about 25 percent for each \$40 increase in monthly enrollee premiums. Marginal enrollees tend to be lower-cost, indicating adverse selection into insurance. But across the entire distribution we can observe (approximately the bottom 70 percent of the willingness to pay distribution) enrollees' willingness to pay is always less than half of their own expected costs that they impose on the insurer. As a result, we estimate that take-up will be highly incomplete even with generous subsidies. If enrollee premiums were 25 percent of insurers' average costs, at most half of potential enrollees would buy

- **Key research finding:** Even small barriers lead to large declines in insurance coverage

1. Financial premiums (*affordability*)

- +\$40 / month premiums → 25% fall in enrollment
- *Young & healthy most likely to drop out (adverse selection)*

2. Administrative Burden (*frictions*)

- Small frictions → 33% lower take-up, 14% lower retention
- Outreach, simplification → ↑10% take-up (Ericson et al 2025)
- *Young and healthy most likely to drop out*



Relevance to recent insurance policy changes

➤ Looming issue: The “Big Beautiful Bill” (plus associated changes)

➤ Three sources of lower coverage:

1. Eligibility limits (*immigrants*) [-1.4 million]
2. Affordability (*expiring subsidies*) [-4.2 million]
3. Frictions (*paperwork, work req.*) [-10.4 million]
 - Total = 16 million fewer insured

● Effectively takes lessons from MA health reform and **turns them on their head**

- Higher premiums and frictions to reduce enrollment and save taxpayers money

What will Trump's 'big, beautiful bill' do to Medicaid and SNAP?

11 million could lose health coverage as GOP roots out “waste, fraud and abuse.”

By [Jay O'Brien](#), [Lauren Peller](#), and [Mariam Khan](#)

June 5, 2025, 12:24 PM



Source: [ABCNews](#)

Source: [KFF Analysis of CBO projections](#)

Outline

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Concluding thoughts

- **Two decades of experience with MA health insurance reform show its strengths and limits**
- **Strength:** Very effective at covering the uninsured
 - >97% of population covered
 - Associated benefits to people's lives: Better care access, financial protection, improved health and saved lives
- **Limits:** Less effective at controlling costs, fundamental system reform
- **Open question:** Will reform survive looming challenges of OBBBA and associated policies?
 - And what can states and other health system stakeholders do to address these looming challenges?

Evidence on Effects of ACA Medicaid Expansions on Public Health

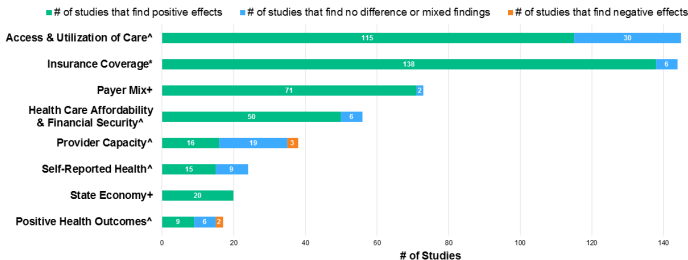
Angela Wyse
Assistant Professor of Economics at Dartmouth College

IRP Webinar on Health Insurance Expansions
July 22, 2026

Rich evidence of Medicaid's effects on access, utilization, and financial security...

Figure 1

Studies generally find positive effects of the ACA Medicaid expansion on different outcomes.



NOTES: This brief groups outcomes into 3 categories, indicated as such: [^]Coverage outcomes, ⁺Access outcomes, ⁺Economic outcomes. Studies may have findings on multiple outcomes and be counted in multiple bars. [^]Insurance Coverage includes coverage rates generally and for Medicaid.
SOURCE: KFF analysis of 404 studies of the impact of state Medicaid expansion published between January 2014 and January 2020.

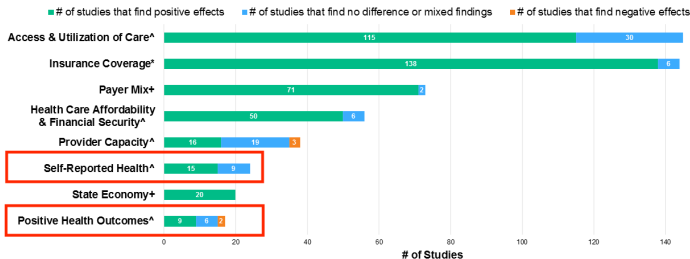


Figure 1: Source: Guth, Garfield, and Rudowitz (2020)

...but far less evidence about effects on health outcomes

Figure 1

Studies generally find positive effects of the ACA Medicaid expansion on different outcomes.



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Figure 2: Source: Guth, Garfield, and Rudowitz (2020)

Why is it difficult to learn about the health effects of Medicaid expansions?

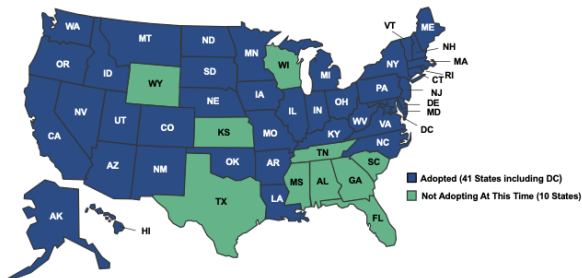
- Analyses - especially those using aggregate (e.g. county-level) data - often lack statistical power to detect effects
 - Need very large samples to find effects on major health events like mortality, which are rare on short time horizons
 - Ability to detect effect also depends on size of impact - may be important but too small to pick up with available samples
- Measured outcomes (e.g. increases in diagnoses or treatment initiation) may reflect more contact with the healthcare system (more screening, more testing) rather than ultimate effects on health
- Studies often track people for a few years, but effects on conditions like cardiovascular disease or cancer may develop over years or decades

Why is it difficult to learn about the health effects of Medicaid expansions?

But “no evidence of effects” $\neq$ “evidence of no effects”!

The natural experiment of ACA Medicaid expansions to low-income adults

Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KFF tracking and analysis of state activity. See link below for additional state-specific notes.
SOURCE: "Status of State Medicaid Expansion Decisions: Interactive Map," <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

KFF

New evidence about Medicaid's effect on mortality from large-scale administrative data

- A growing body work using large samples and administrative data finds that ACA expansions reduced mortality
 - Miller, Johnson, and Wherry (2021) and Goldin, Lurie, and McCubbin (2021) identify mortality reductions, but confidence intervals are very wide - essentially 0-100% reduction in mortality
- In Wyse and Meyer (2025), we examine the causal effect of Medicaid on mortality using the 37-million-person universe of low-income adults
- We link the 2010 Census to tax record to identify low-income adults and link them to administrative data on Medicaid enrollment and all-cause mortality data from SSA records
- Our study setting has sufficient statistical power to detect effects and offers much tighter confidence intervals than previous work

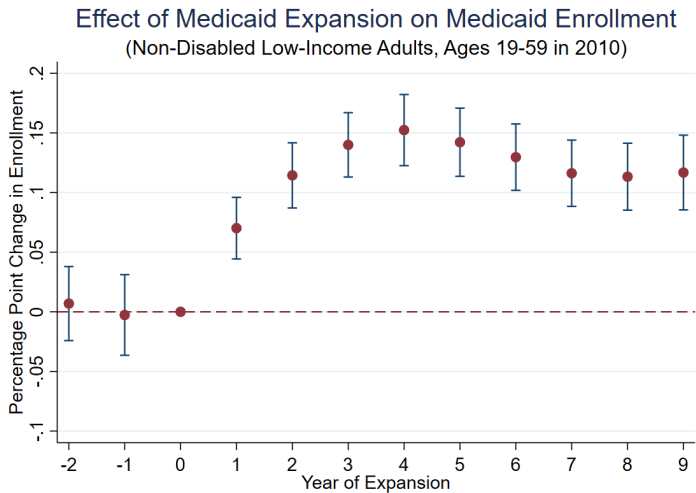


Table 1: Difference-in-Differences Estimates of Effect of Medicaid Expansion on Medicaid Enrollment (Ever Enrolled in Year)

Sample:	Non-Disabled (Main Sample)	All (Including Disabled)
Post x expansion	0.117*** (0.017)	0.106*** (0.016)
N (People x years, millions)	441.2	489.3
N (People, millions)	37.5	41.9
Mean Medicaid Enrollment		
Expansion states (pre-period)	0.24	0.3
Non-expansion states	0.2	0.25
Demographic controls	Yes	Yes
Fixed effects	State, Year	State, Year
SE clustering	State	State

Note: Sample includes adults with 2009 income < 1.38x the Federal Poverty Level (FPL) according to administrative tax data who were ages 19-59 in 2010.

Effect of Medicaid Expansion on Mortality Hazard

(Non-Disabled Low-Income Adults, Ages 19-59 in 2010)

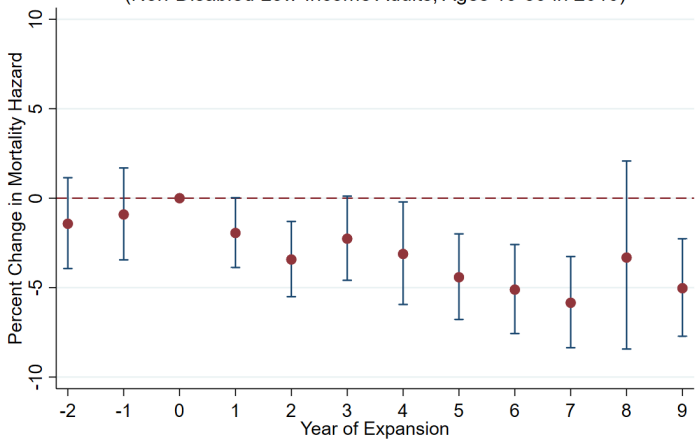


Table 2: Effect of Medicaid Expansion on Mortality Hazard (Proportional Change in the Mortality Hazard) - Population-Level Effect

	Non-Disabled (Main Sample)	All (Including Disabled)
Post x expansion	-2.46%**	-1.27%*
95% CI	(-4.52%, -0.40%)	(-2.73%, 2.15%)
N (People x years, millions)	441.2	489.3
N (People, millions)	37.5	41.9
Demographic controls	Yes	Yes
Fixed effects	State, Year	State, Year
SE clustering	State	State

Note: Sample includes adults with 2009 income < 1.38x the Federal Poverty Level (FPL) according to administrative tax data who were ages 19-59 in 2010.

Table 3: Effect of Medicaid Expansion on Mortality - Individual-Level Effect

Sample:	Non-Disabled (Main Sample)	All (Including Disabled)
ToT Estimate	-21.02%	-12.00%
95% CI - Upper bound	-3.68%	2.72%
95% CI - Lower bound	-38.00%	-25.77%

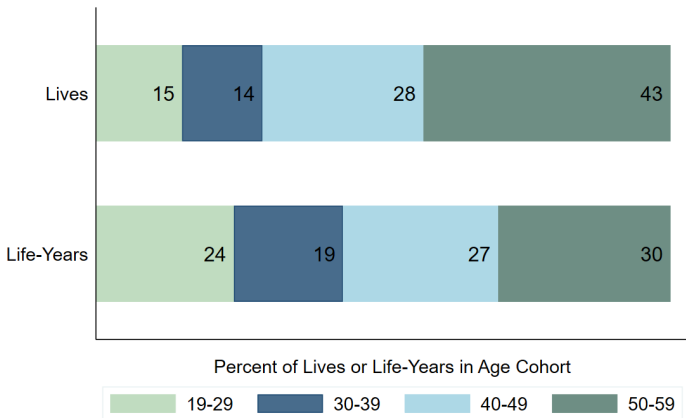
Note: Treatment on treated estimate assumes no spillovers, i.e. no effect of Medicaid expansion on the mortality hazard of people not induced to enroll.

spillovers

Our estimates suggest:

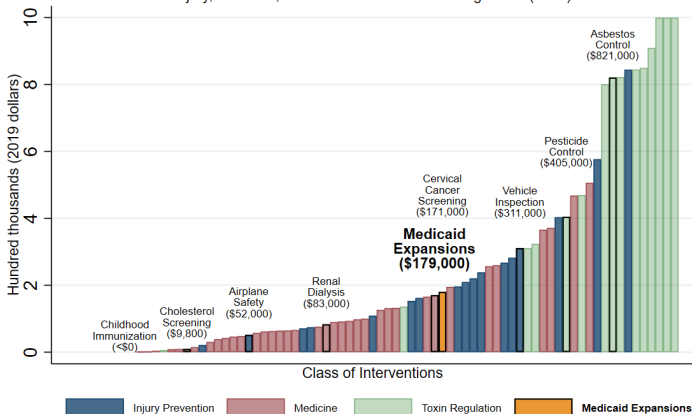
- **27,400 lives** saved by Medicaid expansions in 2010-2022
 - **3,200 avoided deaths per post-expansion year**, close to the annual non-elderly adult deaths from leukemia
- An additional **12,800 deaths** would have been avoided if non-expansion states had adopted expansion in 2014
- The **cost per life saved** was about **\$5.4 million**
 - Well below the \$10-11 million value of a statistical life used in federal government cost-benefit analyses
- The **cost per life-year saved** was about **\$179,000**
 - Well below estimates of societal willingness-to-pay for additional life years from Braithwaite et al. (2008)

Distribution of Lives and Life-Years Saved by Medicaid Expansions Across 2010 Age Cohort



Cost-Effectiveness of Medicaid Expansions and Other Life-Saving Interventions: Average Cost Per Life-Year Saved

Injury, Medicine, and Toxin estimates from Tengs et al. (1995)



Summary: Medicaid expansions' causal effect on enrollment and mortality

- Our estimates suggest a 21 percent reduction in the mortality hazard of new Medicaid enrollees, with a 95% confidence interval (3.7-38%) that excludes large mortality point estimates from key prior studies
- Proportional treatment-on-the-treated estimates are similar across sub-groups defined by age, race, gender, family status, income, and employment, but not significant in all cases
- We estimate that Medicaid expansions saved the lives of 27,400 people at a cost of \$5.4 million per life and \$179,000 per life-year; younger adults accounted for nearly half of all life-years saved