

**Statement of**

**Robert A. Book, Ph.D.\***

**Senior Research Director, Health Systems Innovation Network, LLC**

**Outside Healthcare and Economics Expert, American Action Forum**

**Before the**

**Committee on the Budget**

**United States House of Representatives**

**Tuesday, January 24, 2017**

**“Failures of the Affordable Care Act and How to Reverse Them”**

\*The views expressed here are my own and not those of either the Health Systems Innovation Network, LLC, or the American Action Forum.

Chairman Black, Ranking Member Yarmouth, and Members of the Committee:

Thank you for the opportunity to share my research on the failures of the Affordable Care Act to achieve its goals, the harmful – presumably unintended – effects it has caused, and some reforms that can be enacted to make health care truly affordable to all Americans who seek it.

Proponents of the Affordable Care Act, both in Congress and outside, promised that it would bring about lower health insurance premiums, better access to health care, lower health care costs for patients, lower total national health care expenditures in part due to savings on administrative costs and non-profit CO-OP health insurance, and – most of all – fewer Americans foregoing health care because they can't afford to pay for it.

In fact, the opposite has happened. Health insurance premiums have increased at record rates, especially for those who pay for their own coverage instead of getting it at work. More health plans than ever have narrow networks of providers, limiting access to care in the name of saving money. Copayments and deductibles are at all-time highs, and according to Gallup, more Americans than ever say they have avoided or delayed obtaining health care because they cannot afford the cost. Clearly, having health *coverage* does not mean that one can obtain health *care*. In addition to paying record-high premiums, families earning as little as \$41,000 per year may have to spend as much as \$14,300 out of pocket before obtaining *any* coverage for treatment of diseases or injuries<sup>1</sup> – and even that coverage may be restricted to a very small set of in-network providers.

Despite all these factors making it more difficult for patients to access health care, total national spending on health care has continued to increase every year, both in dollars and as a percent of GDP. Administrative costs have increased as well, as the cost of establishing and operating the government-run exchanges vastly exceeded the savings to insurers by marketing through those exchanges. Most of the CO-OPs have shut down, taking their taxpayer-financed start-up loans with them.

One of the reasons the ACA was passed was that we were paying too much for health care and not getting enough in return. Clearly, we are paying even more, and getting even less, than ever before. The problems that plagued the health care system before the ACA are still with us, and a new layer of problems has been added.

Another reason the ACA was passed was to save lives. Proponents said that thousands of people were dying due to a lack of health coverage. If that were true, mortality rates should have decreased when the full provisions of the ACA came into effect. However, that has not happened. The Centers for Disease Control and Prevention recently reported that U.S. life expectancy dropped in 2015<sup>2</sup> – for the first time since 1993. While this decrease might not be the fault of the ACA, there is certainly no increase in life expectancy for which the ACA might take credit.

---

1 Centers for Medicare and Medicaid Services, “Out-of-pocket maximum/limit,” at <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit>.

2 Jiaquan Xu, Sherry L. Murphy, Kenneth D. Kochanek, and Elizabeth Arias, “Mortality in the United States, 2015,” NCHS Data Brief No. 267, December 2016, at <http://www.cdc.gov/nchs/products/databriefs/db267.htm>.

Medicare beneficiaries have a separate set of new problems. The ACA mandated that the federal government implement a program whose express purpose is to pay doctors and hospitals bonuses for reducing the amount of health care delivered to seniors and the disabled. The canard hurled at health insurance companies for decades has now become the official policy of the federal government towards its beneficiaries.

In addition, the promise of health coverage for all has still not been achieved. On September 9, 2009, then-President Obama told a joint session of Congress that, “There are now more than 30 million American citizens who cannot get coverage.” The latest figures from the Census Bureau, indicate that in 2015, there were still 29 million uninsured. Due to a change in definitions, these numbers might not be directly comparable, but it is clear that the ACA proponents’ goal of covering everyone is far from being achieved.

Last week, the Congressional Budget Office (CBO) released an alarmist report on a possible ACA repeal, predicting that 18 million people would lose coverage and premiums would increase by 20 to 25 percent if, as the report put it, “portions” of the ACA would be repealed. They chose to assume that all the ACA provisions that make coverage expensive would remain in place, but that subsidies to pay for insurance, and the individual mandate, would be repealed. This is a “straw person” argument, because that is not anyone’s idea of how to reform health care. The implementation of the ACA dismantled substantial portions of the pre-ACA health coverage system, particularly as related to the individual market, and it is well understood that simply repealing the ACA will not bring that system back. Furthermore, the old system had its problems as well. There is no alternative but to replace the ACA with an improved system that allows all Americans to access health care at reasonable and truly affordable prices.

In order to make health care accessible and health coverage affordable, it is necessary to eliminate those factors that artificially increase prices without improving care or benefitting patients. It is imperative to repeal provisions requiring people to purchase health plans that include costly coverage for services they do not want, will not need, or will not use. People should be permitted to purchase comprehensive coverage if they so choose, or basic or catastrophic coverage if they so choose. People’s choices should not be limited merely to different “actuarial values,” but to different collections of covered services as well.

Furthermore, if subsidies are to be given, they should be structured in such a way as to encourage health insurers to provide coverage for individuals with pre-existing conditions or adverse health status without requiring them to raise premiums for everyone. This is possible if subsidies are based on the health status of an insurer’s client base, rather than merely on income.

### **Premiums and Deductibles Have Increased, Not Decreased**

In 2008, then-candidate Obama promised that health insurance premiums would cost \$2,500 less per year per family as a result of his health care plan.<sup>3</sup> In 2010, after the health reform law had

---

3 Thomas B. Edsall, “Obama’s Long List Of Promises To Keep, Obligations To Meet,” January 4, 2009; updated May 25, 2011, at [http://www.huffingtonpost.com/2008/12/04/obamas-long-list-of-promi\\_n\\_148598.html](http://www.huffingtonpost.com/2008/12/04/obamas-long-list-of-promi_n_148598.html).

passed the Senate and shortly before it passed the House, then-President Obama stated the savings for employer-sponsored covered “could be as much as \$3,000” per year, per employee.<sup>4</sup> Instead of decreasing, annual premiums for employer-sponsored coverage have increased by an average of \$4,300 by 2016,<sup>5</sup> and individual premiums increased 50 percent in the first year (2014) and continued to increase thereafter.<sup>6,7,8,9</sup>

It used to be that annual deductibles were typically \$1,000 or less; consumers had to be motivated with the tax benefits of health savings accounts to enroll in “high deductible” plans with deductibles of \$2,400 per family. That seems almost quaint now; the average deductible for a family silver plan in 2017 is \$7,474<sup>10</sup> – a level unheard-of before the ACA marketplace reforms came into effect in 2014. Deductibles for employer-sponsored plans have increases as well, from an average of \$978 in 2010 to \$1,478 in 2016.<sup>11</sup>

### **Administrative Costs Have Increased, Not Decreased**

During the debate leading up to the passage of the ACA, proponents argued that one of the benefits of establishing government-run health insurance exchanges would be the reduction in administrative costs associated with private health insurance. These arguments were based partly on assertions of superior efficiency of government operations over those of the private sector,<sup>12,13</sup> but primarily on the claim that having an exchange would eliminate the need for insurance companies to spend money on marketing. In addition, it was claimed that<sup>14</sup> requiring a minimum

- 
- 4 Barack H. Obama, “Remarks by the President on Health Insurance Reform in Fairfax, Virginia,” March 19, 2010, as of accessed on 1/19/2017 at <https://www.whitehouse.gov/the-press-office/remarks-president-health-insurance-reform-fairfax-virginia>.
  - 5 Kaiser Family Foundation, *2016 Employer Health Benefits Survey*, September 14, 2016, at <http://kff.org/report-section/ehbs-2016-summary-of-findings>
  - 6 Douglas Holtz-Eakin, “The Affordable Care Act After Five Years: Wasted Money And Broken Promises,” Testimony before the Senate Finance Committee, March 19, 2015, at <https://www.americanactionforum.org/testimony/the-affordable-care-act-after-five-years-wasted-money-and-broken-promi>.
  - 7 Patrick J. Egan, “Obamacare’s premiums are going up — at the same rate as everyone else’s,” *The Washington Post*, November 17, 2014, at <https://www.washingtonpost.com/news/monkey-cage/wp/2014/11/17/obamacares-premiums-are-going-up-at-the-same-rate-as-everyone-elses>.
  - 8 Brian Blase, “Overwhelming Evidence that Obamacare Caused Premiums to Increase Substantially,” *Forbes.com*, July 28, 2016, at <http://www.forbes.com/sites/theapothecary/2016/07/28/overwhelming-evidence-that-obamacare-caused-premiums-to-increase-substantially>.
  - 9 “Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace,” ASPE Research Brief, October 2016, at <https://aspe.hhs.gov/sites/default/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf>.
  - 10 “Aging Consumers without Subsidies Hit Hardest by 2017 Obamacare Premium & Deductible Spikes,” *HealthPocket*, October 26, 2015, at <https://www.healthpocket.com/healthcare-research/infostat/2017-obamacare-premiums-deductibles>.
  - 11 Kaiser Family Foundation, *2016 Employer Health Benefits Survey*, 14 September 2016, Exhibit 7.7, at <http://kff.org/report-section/ehbs-2016-section-one-cost-of-health-insurance>.
  - 12 Paul Krugman, “The Health Care Racket,” *The New York Times*, February 16, 2007.
  - 13 Steffie Woolhandler, Terry Campbell, and David U. Himmelstein, “Costs of Health Care Administration in the United States and Canada,” *New England Journal of Medicine*, August 2003; 349:768-775, at <http://www.nejm.org/doi/full/10.1056/NEJMsa022033#t=article>.

Medical Loss Ratio (MLR) and reduction of executive pay<sup>15</sup> through limits on the deductibility of compensation (Section 9014) would limit the unrestrained pursuit of profit<sup>16</sup>. The predicted impact was that reducing administrative costs would lead to lower premiums and lower national spending on health care without having to reduce the quantity or quality of actual health care delivered.

That is not what has occurred. Instead, total administrative costs increased. While insurers indeed appear to have spent less on administrative costs, both on a per-covered-person basis and as a percentage of total premiums since the law went into effect, government spending necessary to set up and operate the exchanges vastly exceeded the amount saved by private-sector insurers, leading to an increase in total administrative costs. In fact, just the federal government's expenditures in establishing and operating the ACA exchanges – a function devoted solely to enrollment – vastly exceeds the *total* administrative costs, both for enrollment and operations – of private-sector insurers prior to the implementation of the exchanges.

In 2013, the year before the exchange provisions took effect, administrative costs averaged \$414 per covered person per year in the individual market. In 2014, the first year in which exchanges operated, average costs for the entire individual market increased to an average of \$893 per covered person-year. However, this obscures the full effect of the administrative cost of operating the exchanges, because these figures include both those covered in exchanges and those covered by Qualified Health Plans (QHPs) through off-exchange enrollment. For those covered in the exchange, just the federal government's administrative costs amounted to \$1,539 per effectuated exchange enrollee, not including administrative costs incurred by insurers. Because insurers were instructed to report their costs for the entire individual market (both on-exchange and off-exchange) together, it is impossible to determine with certainty the relative administrative costs for both groups. Depending on what assumptions one makes, total administrative costs (both government costs and insurer costs) for exchange enrollees could range from \$1,562 to \$1,804 and costs for off-exchange enrollees could range from \$265 to \$414.<sup>17</sup>

## **Consumer Operated and Oriented Plans: A costly failure**

---

14 Jacob S. Hacker, "The Case for Public Plan Choice in National Health Reform," Institute for America's Future (undated but apparently completed in December 2008), p.6.  
[http://institute.ourfuture.org/files/Jacob\\_Hacker\\_Public\\_Plan\\_Choice.pdf](http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf)

15 Frank Clemente, "A Public Health Insurance Plan: Reducing Costs and Improving Quality," Institute for America's Future, February 5, 2009, p. 6, at  
[http://www.ourfuture.org/files/IAF\\_A\\_Public\\_Health\\_Insurance\\_Plan\\_FINAL.pdf](http://www.ourfuture.org/files/IAF_A_Public_Health_Insurance_Plan_FINAL.pdf).

16 Edward M. Kennedy, "A Democratic Blueprint for America's Future," Address at the National Press Club, January 12, 2005. <http://www.commondreams.org/views05/0112-37.htm>; Pete Stark, "Medicare for All," *The Nation*, February 6, 2006. <http://www.thenation.com/doc/20060206/stark>; Max Baucus, "Call to Action Health Reform 2009," November 12, 2008, p. 77 <http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf>; Hacker (2008), p. 6-8; Clemente (2009), p. 15.

17 Robert A. Book, "The ACA Exchanges Increased Administrative Costs of Health Insurance," American Action Forum, December 21, 2016, at <https://www.americanactionforum.org/wp-content/uploads/2016/12/2016-12-21-ACA-Admin-Costs.pdf>

The ACA called for the establishment of non-profit “Consumer Operated and Oriented Plans” (CO-OPs) to offer health insurance at lower prices and with patient, rather than corporate, interests at heart. These plans were supposed to be an alternative to private for-profit or ordinary not-for-profit health insurers. They were supposed to take the profit motive out of health insurance, and put the interests of patients (members/owners) ahead of the interests of solvency.

To further protect CO-OPs from the supposedly evil influence of insurance past, employees and former employees of “pre-existing insurers” – that is, those in existence prior to the ACA – would not be allowed to serve on a CO-OP board of directors. And, CO-OPs would get a lot of taxpayer money (in the form of “loans”) to get started and make it work.

It turns out that giving large amounts of taxpayer money to people to run a business in which they by law must have no experience was not a recipe for success, either for patients or taxpayers.<sup>18</sup> Twenty-three CO-OPs were established, and in less than three years, 17 of the 23 failed, either going bankrupt, shut down by state regulators for failing to maintain reserves sufficient to pay claims, or otherwise running out of money, after taking \$2 billion in taxpayer financing that will never be paid back.<sup>19</sup> An 18th CO-OP, in Maryland, has converted to a for-profit insurance company,<sup>20</sup> under regulations promulgated by the Obama administration<sup>21</sup> but not authorized by any statute passed by Congress.<sup>22</sup>

### **Federal Government Paying Bonuses for Denying Care to Medicare Beneficiaries**

One of the clearly stated goals of ACA proponents was to prevent patients from being denied health care so that others could increase their profits. As then-candidate Obama put it, one of his goals was “making sure that they are limited in the ability to extract profits and deny coverage.”<sup>23</sup>

Now, one of the lesser-known provisions of the ACA calls for the federal government to pay physicians and hospitals bonuses if they deny health care to seniors and the disabled – and even encourages them to form local monopolies to make it harder for them to find alternative sources of care. And most patients won't even know that's the reason they are being denied care.<sup>24</sup>

---

18 Robert A. Book, “What We Should Learn From the Health CO-OP Failures,” *Forbes.com*, October 30, 2015, at <http://www.forbes.com/sites/theapothecary/2015/10/30/what-we-should-learn-from-the-health-co-op-failures>.

19 Tara O'Neill Hayes, “17 Co-ops Have Failed After Receiving Nearly \$2 Billion in Taxpayer Financing,” American Action Forum, September 16, 2016, at <http://www.americanactionforum.org/weekly-checkup/17-co-ops-failed-receiving-nearly-2-billion-taxpayer-financing>.

20 “Health Insurance Purchasing Cooperatives: State and Federal Roles,” National Conference of State Legislatures, September 1, 2016, at <http://www.ncsl.org/research/health/purchasing-coops-and-alliances-for-health.aspx>.

21 Department of Health and Human Services, “Patient Protection and Affordable Care Act; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program,” 18 FR 29146–29156, at <https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0070-0002&disposition=attachment&contentType=pdf>.

22 Robert A. Book, “The CO-OP Dream Is Over,” *Forbes.com*, May 27, 2016, at <http://www.forbes.com/sites/theapothecary/2016/05/27/the-co-op-dream-is-over>.

23 Barack H. Obama, Remarks during the Democrats’ Second 2008 Presidential Debate, June 3, 2007, transcript at [http://www.nytimes.com/2007/06/03/us/politics/03demsdebate\\_transcript.html?\\_r=0](http://www.nytimes.com/2007/06/03/us/politics/03demsdebate_transcript.html?_r=0).

24 Robert A. Book, “ACA 'Savings': Paying Doctors And Hospitals Bonuses To Deny Care To Patients,” *Forbes.com*, February 21, 2016, at <http://www.forbes.com/sites/theapothecary/2016/02/21/aca-savings-paying->

Section 3022 of the ACA establishes the Medicare Shared Savings Program (MSSP). The MSSP establishes the notion of Accountable Care Organizations (ACOs). These are groups of health care providers (hospitals, physicians, other providers) who join together for purposes of obtaining bonus payments based on their participation in the MSSP and Medicare fee-for-service incentive program.

ACOs are paid bonuses to “reduce costs” for treating their patients. Because this is part of “fee for service” Medicare, reducing costs is equivalent to reducing services delivered. Thus, the physicians and hospitals who are members of ACOs benefit from devising procedures that reduce access to care for their Medicare patients.<sup>25</sup> In the first year of the program, ACOs generated \$128 million in “savings.”<sup>26</sup>

Furthermore, patients have little say in the matter, and derive essentially no benefit from the program. If insurers reduce costs, patients might benefit from reduced premiums. Medicare patients have no such opportunity to derive benefit from the ACO program. Furthermore, patients don't even “enroll” in an ACO – they are assigned to an ACO ex post based on the preponderance of their utilization. That is, at the end of the year, if a patient happens to have had a plurality of care (measured by either service counts or dollars of Medicare claims), from physicians who are members of a particular ACO, then that patient is assigned to that ACO according to a methodology developed by CMS.<sup>27</sup> Not only do patients not enroll in ACOs; they might not even be aware of them, as assignments may take place after the fact.

ACA proponents began by accusing insurance companies of denying patients care to save money; they ended up passing a law under which the federal government enlists doctors and hospitals to do the same thing on behalf of the federal government.

## **Millions of Americans Still Uninsured**

According to numerous opponents of further health care reform, 20 million people have gained health coverage due to the ACA.<sup>28</sup> According to a report by the Office of the Assistant Secretary of HHS for Planning and Evaluation, this consists of 2.3 million people between the ages of 19 and 25 covered under a parent's employer-based health plan, and 17.7 million people between the ages of 18 and 64 who enrolled in either Medicaid or Marketplace plans. This last figure nets

---

[doctors-and-hospitals-bonuses-to-deny-care-to-patients.](#)

25 Robert A. Book, “Why Are Hospitals Buying Physician Practices and Forming Insurance Companies?” American Action Forum, February 11, 2016, at <http://www.americanactionforum.org/research/why-are-hospitals-buying-physician-practices-and-forming-insurance-companies>.

26 Tara O'Neill Hayes and Brittany La Couture, “HHS Takes Wrong Steps in the Right Direction,” American Action Forum, January 27, 2015, at <http://www.americanactionforum.org/insight/hhs-takes-wrong-steps-in-the-right-direction>.

27 “Medicare Shared Savings Program Shared Savings and Losses and Assignment Methodology Specifications,” Centers For Medicare and Medicaid Services, December 2015, at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V4.pdf>.

28 HHS Press Office, “20 million people have gained health insurance coverage because of the Affordable Care Act, new estimates show,” March 3, 2016, at <https://www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates>.

out people who moved from employer-sponsored coverage to Medicaid or Marketplace plans. However, it does not seem to net out people who were covered in the individual market prior to 2014. That is estimated by CMS at 12.8 million in 2013, some of whom, no doubt, switched to Medicaid or Marketplace plans – especially if their pre-2014 plan was cancelled for not meeting ACA requirements.

RAND has estimated a net increase of 16.9 million covered, consisting of 22.8 million newly insured, minus 5.9 million who had coverage before but became uninsured. Of the 22.8 million newly insured, approximately 1.5 million gained coverage through Medicare, military coverage, or other plans that were available prior to the ACA.<sup>29</sup> This leaves a net increase of 15.5 million more people covered, including 6.5 million newly enrolled in Medicaid.

For many years, the accepted metric for measuring changes in the level of health coverage was the Census Bureau's Current Population Survey Annual Social and Economic Supplement. While this measure, like all measures, was imperfect, for some reason the Census Bureau chose the year 2014 to implement changes in the method of data collection and the definition of "coverage," thus making it difficult to compare pre- and post-ACA coverage numbers. In 2015, at the direction of Congress, the Census Bureau conducted the survey both ways. The "old method" produced an estimate of the percent uninsured that is 0.7 percentage points higher,<sup>30</sup> corresponding to an additional 2.2 million people being uninsured in 2014.

The Census Bureau's estimate for the number of uninsured in 2015 is 29.0 million, which would be approximately 31.2 million under the "old" method. When addressing a joint session of Congress on September 9, 2009, then-President Obama used a figure of "30 million American citizens." It is unclear where he got that figure, since the latest Census figure available at that time would have been for 2008, when the Census estimate was 46.3 million.<sup>31</sup> It is possible that he meant "citizens" literally; that is, to exclude uninsured noncitizen immigrants from the figure.

Many of the newly insured are enrolled in Medicaid. Some of these are newly eligible, in states that expanded Medicaid eligibility due to the higher federal subsidies provided in the ACA for able-bodied adults with income below the poverty line. Others, however, were eligible before the ACA was passed, but for some reason did not sign up. It could be that some were unaware of their eligibility, and became aware as a result of the publicity and outreach efforts surrounding the ACA and enrolled. This is known as the "woodwork effect." It is also possible that some particular eligible individuals had no need for health care during a particular period of time (this is common), and thus had no reason to enroll – until the ACA was enacted along with an individual mandate penalty that could be avoided by simply enrolling.

---

29 Katherine Grace Carman, Christine Eibner, and Susan M. Paddock, "Trends in Health Insurance Enrollment, 2013-15," *Health Affairs*, June 2015, **34**:69(1044-1048), abstract at [http://www.rand.org/pubs/external\\_publications/EP50692.html](http://www.rand.org/pubs/external_publications/EP50692.html).

30 Carla Medalia, Brett O'Hara, and Jessica C. Smith, "How did the questionnaire change in the CPS ASEC affect health insurance estimates?" How did the questionnaire change in the CPS ASEC affect health insurance estimates, U.S. Census Bureau, March 16, 2016, at <http://www.census.gov/content/dam/Census/library/working-papers/2016/demo/SEHSD-WP2016-03.pdf>.

31 Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2008," Census Bureau, September 2009, at <https://www.census.gov/prod/2009pubs/p60-236.pdf>.

For this latter group, it's useful to note that in some sense, people eligible for Medicaid but not actually enrolled are *de facto* insured. Unlike private insurance, Medicaid coverage is retroactive. A Medicaid-eligible individual – or a health care provider treating one – can file claims for Medicaid payment for services provided up to 90 days prior to that individual's enrollment in Medicaid (provided that the individual was Medicaid-eligible at the time of service). This means that, in effect, unenrolled Medicaid-eligible individuals are covered in case they need treatment, even without being enrolled. (Hospitals are very good at getting Medicaid-eligible patients enrolled, so they can be reimbursed for services.) Therefore, those who were previously eligible for Medicaid and signed up to avoid the penalty for being uninsured, or as a result of widespread publicity, are “newly insured” only in a narrow technical sense, and should not really be considered covered due to the ACA.

### **How Can Health Coverage Be Fixed?**

First, provisions that serve primarily to increase premiums and deductibles should be repealed. This includes broad coverage mandates for services not every patient wants, nor should every patient pay for.

Second, the ACA includes a number of taxes that merely feed back into higher premiums. Such taxes should be repealed. These include the health insurance “annual fee” tax, the medical device tax, and others.

Third, and most importantly, the problem of adverse selection, whereby healthy individuals remain uninsured, increasing premiums for those who seek to become insured, should be solved. The way to solve this without losing protection for those with pre-existing conditions is to restructure the premium subsidies to take into account health status, not just income. That is, insurance companies should be incentivized to cover “sick” people by a subsidy structure that makes them just as attractive customers as “healthy” people. The key insight, which may be learned from the Medicare Advantage Risk Adjustment algorithm, is to tie subsidy adjustments to enrollees' health relative to the pool of *eligible* potential enrollees, not to the pool of people who actually enroll.

These reforms could contribute to making health care truly affordable to all who seek it.