

INDEPENDENCE INSTITUTE ISSUE BACKGROUNDER

How the Gruber Model Failed in Colorado

BY LINDA GORMAN, HEALTH CARE POLICY CENTER DIRECTOR • IB-A-2015 • FEBRUARY 2015

MIT professor Jonathan Gruber made millions predicting the effect of Obamacare. Given that people who make unkind remarks can do good work, it is important to assess how well the Gruber predictive model has performed. In Colorado, its poor predictions will likely end up costing taxpayers billions of dollars.

In 2011, Connect for Health Colorado, the state's Obamacare health benefits exchange, hired Gruber and Associates to forecast the effects of Obamacare. Gruber and Associates predicted that Colorado's non-disabled under age 65 Medicaid enrollment would be 710,000 by 2016. As of August 2014, total Colorado Medicaid enrollment exceeded 1.1 million people, with an estimated 985,504 people in the non-disabled under age 65 category.¹

Since Medicaid enrollment already is 40 percent higher than predicted, taxpayers are in for a shock. Assuming that the federal government matches Colorado's estimated per capita expenditure, \$2,601 for FY 2013-14 for the least expensive group of Medicaid adults, Gruber's incorrect forecast could cost state and federal taxpayers more than \$1 billion a year.²

Even as Gruber and Associates underestimated the demand for Medicaid, they overestimated the demand for subsidized

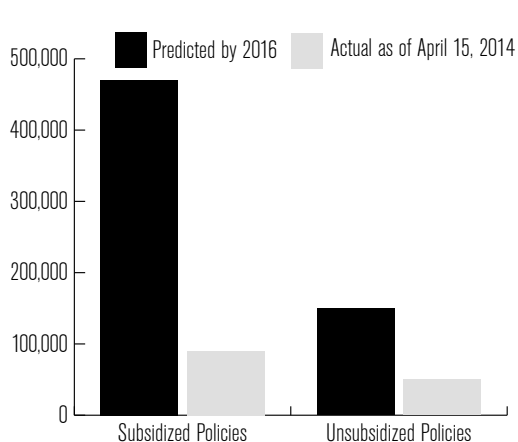
health insurance policies. At the end of enrollment for 2014, the purchase of subsidized exchange policies was only one-sixth of what the Gruber and Associates had predicted by 2016: 470,000 subsidized policies.

The purchase of unsubsidized policies through the exchange has also been far below predictions. Enrollment in 2014 was about one-third of the 150,000 policies predicted for 2016. The enrollment so far is only one-third of the 150,000 predicted for 2016.

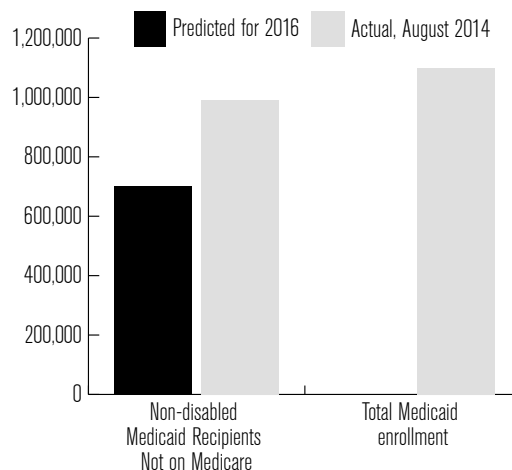
Finally, Gruber and Associates estimated that premiums in Colorado's individual market would rise by about 19 percent and that insurance would become "about 11 percent more generous on average, partly due to the mandates described above, and partly due to individuals choosing richer insurance with their tax credits." Taking tax credits into account, "premium costs paid by consumers in the individual market [would] fall considerably, by 27% on average."³

At the end of 2010, almost 167,000 individual major medical policies covered about 280,000 Colorado lives. Roughly 28 percent of the number were covered by plans that were not employer self-funded major medical coverage.⁴ Without Obamacare, Gruber and Associates estimated that

Private insurance Sign-ups Underestimated, Especially for Subsidized Policies



Medicaid Enrollment is Already Far Beyond Predictions



the individual market would grow to 360,000 by 2016.

With Obamacare the market was projected to fall to 70,000 people, primarily “those who are ‘grandfathered’ into their old individual plans.” Gruber and Associates predicted that “those who remain in the grandfathered market see no change in their premiums.” That was an odd prediction for Gruber to make, given that Obamacare increased taxes on health insurers and on the things that health insurance premiums purchase, specifically medical devices and pharmaceuticals.

Again, Gruber’s prediction was wrong. The costs of old individual plans did not remain flat. The cost of a grandfathered plan for an 18 year old purchased in 2011 for \$144.28 a month had increased by 37 percent to \$197.39 a month by early 2014.

When 470,000 people are predicted to receive subsidized policies, more than twice the number of people purchasing pre-reform unsubsidized policies, simple arithmetic dictates that the average premium cost *directly paid by consumers* will fall unless premium costs rise at unprecedented rates. The rest of the premium cost, of course, is paid by federal taxpayers. Gruber and Associates’ prediction that Colorado individual market premiums would rise by 19 percent is proof of an understanding that substituting tax subsidies for direct payment does not affect the cost of health insurance.

Before and after premium cost comparisons are difficult because Obamacare-compliant individual policies differ substantially from the policies that individuals chose to purchase prior to Obamacare. It is clear, however, that at least some people who owned individual policies at the time Obamacare took effect experienced price hikes far in excess of 19 percent. For example, one younger man with a standard policy from a major insurer saw his premiums nearly double from \$158.30 a month to \$304.47 a month. To add insult to injury, the higher premium was coupled with an increase of \$1,300 in the cap on out-of-pocket costs.

Another way to begin to assess the increase in premiums resulting from Obamacare is to compare premiums in the Colorado exchange to premiums in the state’s high-risk pool. Unlike almost all of the narrow network plans in Colorado’s health exchange, the CoverColorado high-risk pool network included any willing provider in the state. In its last year of operation, CoverColorado premiums were set at 137 percent of the “industry average.” The industry average was a weighted average of Colorado’s five largest individual health insurance carriers’ premiums adjusted for benefit differences.

In 2013, Rebecca Ryan paid \$375 a month to be insured by CoverColorado. She went to the state exchange when the

state canceled the CoverColorado plan. The least expensive option was a Kaiser-Permanente HMO that cost about \$360 a month. The Kaiser premium was roughly 4 percent less than the CoverColorado premium. This example suggests that the least expensive exchange plan was more than 30 percent more expensive than the average individual plan. Ms. Ryan said that though the two plans were roughly comparable in their limits on total out-of-pocket costs, Kaiser had a narrow network that did not include her physician. The only exchange plan that did let her keep her doctor cost \$526 per month, an increase of 40 percent for a premium that was already 37 percent higher than the market average for individual policies.

Gruber and Associates may wax rhapsodic about the effect of the subsidies on consumer costs. However, these anecdotes seem to indicate that people would have been better off if insurance markets had been left alone and Obamacare subsidies had been applied to the much lower premiums that existed before Professor Gruber and his associates helped impose the Obamacare train wreck on United States health insurance markets.

¹ This estimate relies on state estimates of the number of disabled enrollees and those over 65 for the 2014-15 budget year that were published in [February 2014](#) for the 2014-2015 fiscal year. It subtracts those people from the total Medicaid enrollment as of August 30, 2014. FY 2014-15 enrollees 65 and older were projected to be 43,419. 10,537 disabled adults 60 to 64 were projected. 67,137 disabled people were projected to be included in the group 59 and younger. As the Gruber estimates did not include people who were on Medicare, the assumption used here is that all disabled people on Medicaid were also eligible for SSI and Medicare coverage. The August 30, 2014 Medicaid caseload was 1,106,597. 1,106,597 minus the sum of disabled people and those 65 or older (121,093) is 985,504. The Gruber and Associates estimate of those on public insurance was 710,000 by 2016. 985,504 minus 710,000 is 275,504, an error slightly under 40 percent. (38.8 to be precise).

² For FY 2013-14 Colorado [estimated](#) that expansion adults from 60+ to 133% of the federal poverty level cost the state \$2,601. [Budget documents](#) suggest that the state expects the federal government to pay 58 percent of its Medicaid costs. Assuming a conservative matching rate of 50 percent for non-disabled adults and rounding down, the state and federal per capita cost to taxpayers would be 2 times \$2,601 or roughly \$5,200 per person. Therefore, the error in the forecast as of mid-2014 could cost to taxpayers 275,000 times \$5,200 or something in the neighborhood of \$1.4 billion.

³ Jonathan Gruber. January 2012. Report on RFP COHIEX #0001 for an Independent Consulting Firm to Conduct Background Research to Support the Development of the Colorado Health Benefit Exchange, pps 14-15.

⁴ Colorado Department of Regulatory Agencies, Division of Insurance. [Colorado Health Insurance Cost Information Summary—Aggregated Company Data, 2012](#). See totals at the bottom of the page titled “Comprehensive Major Medical.” Note that these totals are only for plans licensed to be sold in the state under state law. They do not include lives covered by large employer ERISA plans which are governed by federal statute.