

A Public Choice Analysis of the Affordable Care Act's Interim Final Rules

Christopher J. Conover
Research Scholar
Center for Health Policy and Inequalities Research
Duke University
Box 90392
Durham, NC 27705
conoverc@duke.edu

Jerry Ellig
Senior Research Fellow
Mercatus Center at George Mason University
3351 N. Fairfax Dr., 4th Floor
Arlington, VA 22201
jellig@gmu.edu

October 28, 2011

THIS IS A DRAFT WORKING PAPER THAT IS NOT YET READY TO BE POSTED ON
THE WEB – PLEASE DO NOT CITE OR QUOTE

Abstract

Federal agencies issued eight major “interim final regulations” in 2010 to quickly implement major provisions of the Affordable Care Act. Previous research found that the Regulatory Impact Analyses (RIAs) for these regulations were seriously incomplete, often omitting significant benefits, costs, or regulatory alternatives. Analysis of equity was cursory at best. For these regulations, the quality and use of regulatory analysis fell well below the standards set by other federal agencies and by HHS itself. This paper demonstrates that the low-quality analysis was a predictable result of the way that the administration and Congress chose to manage the regulatory process. Presidential and congressional decisions, in turn, reflected the political incentives both actors faced in 2010. This suggests that institutional rather than personal factors explain the poor quality of analysis and decisions that occur when agencies implement important presidential priorities in the face of tight legislative deadlines. To promote transparency and informed decisionmaking, additional checks and balances in the regulatory process are needed to prevent politics from short-circuiting analysis.

The authors would like to thank Mark Adams and Corey Carpenter for research assistance and Robin Bowen, Jason Fichtner, Richard Williams, and three anonymous external peer reviewers for helpful comments.

For decades, executive orders have required federal agencies to analyze the benefits and costs of proposed regulations and alternative approaches. The Office of Information and Regulatory Affairs (OIRA) reviews regulations and the accompanying analysis, and it can return regulations to agencies if either is deficient. Nevertheless, politics sometimes trumps analysis in regulatory policy. As Donald Arbuckle, a former deputy administrator of the Office of Information and Regulatory Affairs (OIRA)¹ during the Clinton and Bush administrations, notes, “[I]n a battle between analysis and politics, politics will win handily” (Arbuckle 2011).

Political priorities may affect not just the quality of regulatory decisions, but also the quality of regulatory analysis that is supposed to inform those decisions. If a president or high-ranking White House officials have already made major decisions about favored regulations, then OIRA cannot credibly threaten to return regulations. With major decisions already made, agency economists have little incentive to produce high-quality analysis and likely face pressure to produce analysis that supports prior decisions.

Congressional politics can also discourage agencies from conducting or using thorough regulatory analysis. Congress may put deadlines in legislation to ensure that agencies implement programs or regulations before the next election or before a new Congress takes office. But tight deadlines can prevent agencies from conducting high-quality analysis before they issue regulations. Several researchers have found that statutory deadlines generally reduce public participation in the regulatory process, limit the information available to agencies, and lead to rushed decisionmaking (Gersen and O’Connell 2008; Abbott 1987a, 1987b; Asimow 1999).

The Patient Protection and Affordable Care Act (ACA) provides a unique opportunity to explore the effects of presidential and congressional politics on the quality of regulatory analysis and decisions.² The law required agencies to put significant programs or requirements in place on very short deadlines – often within six months of the legislation’s enactment. The most cogent examples are eight major regulations issued as “interim final rules” in 2010. These eight rules provided the only opportunity for the administration and Congress to demonstrate the law’s tangible benefits prior to the 2010 and 2012 elections. The White House drove executive branch regulatory policy, continuing a form of presidential administration that initiates regulations rather than just checking agency proposals.

Reviews of HHS’ Regulatory Impact Analyses (RIAs) for these regulations found that the RIAs were seriously incomplete, often omitting significant benefits, costs, or regulatory alternatives. Analysis of equity was cursory at best (Conover and Ellig 2011). For these regulations, the quality and use of regulatory analysis fell well below the standards set by other federal agencies and by HHS itself. The quality of analysis was comparable to that which accompanied a series of interim final homeland security regulations issued by the Bush administration following 9/11 (Ellig and Conover 2011).

¹ The deputy administrator is the career civil servant who manages OIRA; OIRA’s administrator is a political appointee subject to Senate confirmation.

² The new health reform law consists of the Patient Protection and Affordable Care Act (PPACA) enacted on March 23, 2010 [Pub. L. No. 111-148, 124 Stat. 119 (2010)] and the Health Care and Education Reconciliation Act of 2010 [Pub.L. 111-152, 124 Stat. 1029]. Throughout this paper, the combination of these laws will be referred to simply as the Affordable Care Act (ACA).

This similarity to the Bush homeland security regulations, which also reflected legacy presidential priorities and were issued under tight deadlines, suggests that institutional rather than personal factors explain why the analysis was of such low quality. This paper provides that explanation and suggests reforms to the regulatory process that could help restore important checks and balances in situations where politics is especially likely to impinge on the quality of regulatory analysis and decisions.

1. The Regulations³

All eight of the regulations we examined were “economically significant” under Executive Order 12866, which governs regulatory analysis by executive branch agencies; that is, they had costs, benefits, or other economic effects exceeding \$100 million annually. Table 1 lists and summarizes them.

Six of these regulations are “prescriptive” regulations; they affect the terms of contracts between health insurers, insured people, and/or medical care providers. They do what most people imagine when they think of “regulation.” The regulations tell private parties what they must, may and cannot do.

Two of the regulations (shown in italics) outline the terms of spending programs authorized in the health care law. This is not unusual. Many federal agencies issue regulations to implement spending or revenue collection programs. The Department of Health and Human Services (HHS), for example, annually issues numerous regulations that recalculate the rates Medicare and Medicaid will pay doctors, hospitals, skilled nursing facilities, and other health care providers. These are known as “transfer” or “budget” regulations.

³ For the convenience of the reader, we repeat this section summarizing the regulations in our Part A, Part B, and Part C papers in this series.

Table 1: Summaries of economically significant interim final health care regulations issued in 2010

Regulation	HHS RIN	Agencies	Principal Purpose
<i>Early Retiree Reinsurance Program</i>	<i>0991-AB64</i>	<i>HHS</i>	Establishes a \$5 billion program to subsidize health insurance for early retirees between 2010 and 2014.
Dependent Coverage for Children up to Age 26	0991-AB66	HHS, Labor, Treasury	Requires group health plans and health insurers to allow children under the age of 26 to continue on their parents' health insurance plans.
Grandfathered Health Plans	0991-AB68	HHS, Labor, Treasury	Defines the extent of changes group health plans and health insurers can make without forfeiting their right to be considered "grandfathered" health plans exempt from some provisions of the Patient Protection and Affordable Care Act.
Preexisting Condition Exclusions, Limits, et. al.	0991-AB69	HHS, Labor, Treasury	Rules for group health plans and health insurers that implement various patient protections such as limiting or eliminating preexisting condition exclusions, placing dollar limits on benefits, and prohibiting rescissions of insurance coverage.
Coverage of Preventive Services	0938-AQ07	HHS	Requires group health plans and health insurers to cover costs of preventive care.
Claims Appeals and External Review Processes	0991-AB70	HHS, Labor, Treasury	Requires group health plans and health insurers to establish certain internal and external review processes for patients' claims and appeals.
<i>Preexisting Condition Insurance Plan</i>	<i>0991-AB71</i>	<i>HHS</i>	<i>Establishes a high risk health insurance pool program to provide subsidized insurance to people with preexisting conditions until 2014.</i>
Medical Loss Ratio Requirements	0950-AA06	HHS	Requires health insurance issuers to expend a designated percentage of their revenues on medical care or quality-enhancing activities.

Note: rules in italics are budget regulations.

An interim final rule is a regulation that takes effect without being issued first as a proposal for public comment. The Administrative Procedure Act normally requires agencies to publish proposed rules in the *Federal Register*, provide the public with an opportunity to comment on the proposal, and then issue a final rule that takes the public comments into account. For an interim final rule, the agency writes the rule, announces when it will take effect, and may go back and change it later in response to public comment. An agency can issue an interim final rule if it

determines that regular notice-and-comment rulemaking is “impractical, unnecessary, or contrary to the public interest.” (APA 5 USC Sec. 553(b)) Previous research finds that agencies are 50 percent more likely to issue an interim final rule when faced with a legislative deadline than when there is no deadline (Gersen and O’Connell 2008, 943). For these eight economically significant health care regulations, the agencies cited the legislative deadlines to argue that it was impractical to issue proposed rules.

Each of the Affordable Care Act’s interim final rules involved provisions of the law that took effect three, six, or nine months after enactment on March 23, 2010. In most cases, the law established deadlines when various provisions took effect, but did not explicitly require agencies to issue regulations. The agencies chose to issue regulations rather than carrying out the law via other means, such as guidance or policy documents. Copeland (Copeland 2010, 4-5) notes that “the agencies’ use of rulemaking to accomplish the underlying statutory objectives does not appear to be either improper or unusual.”

Regulatory agencies met or exceeded almost all deadlines. In only one instance did an economically significant rule become effective after a legislatively-imposed deadline (five weeks later). In three other instances, a rule took force within less than a week of the deadline. In all remaining instances, rules were implemented weeks or months before the target date set by Congress. In those cases, the agencies argued that health insurers needed clear rules before fall so they could renegotiate contracts that would take effect on January 1, 2011.

Interim final regulations often take effect before the agency receives public comments. The public comment period for half of the regulations ended well after they took effect. For half of the health care rules, the end of the comment period came 30 to 63 days past the date the rule took effect. For two of these rules, the effective date occurred at least two months prior to the congressionally-imposed deadline for having a particular program or statutory provision in effect (which arguably was necessary to ensure employer health plan contracts could be renegotiated in time to become effective on the January 1 start date typically used for such plans). In three cases, the 60-day comment period ended on the day the rule became effective. In one other case, the pre-effective-date comment period lasted 57 days.

2. Quality and Use of Regulatory Analysis

Prior research finds that the quality and use of analysis in these health care regulations was significantly incomplete, below federal agencies’ usual standards, and comparable to the quality of analysis for a group of interim final homeland security regulations issued by the Bush administration after 9/11.

One paper (Conover and Ellig 2011) found that the health care RIAs presented no monetary estimates of benefits, often over-estimated the number of people who would benefit, and usually under-estimated costs – often by hundreds of millions or billions of dollars:

- For example, the regulation establishing subsidies for early retiree health insurance failed to consider the possibility of “crowd out,” which would mean a substantial portion of the subsidies would be given to employers who were going to continue health insurance for

early retirees anyway. This omission means the analysis substantially overstates the number of people who would retain coverage as a result of the regulation.

- None of the regulations consider “moral hazard” – the risk that individuals will engage in wasteful health care spending or unhealthy activities because the insurance company is paying most of the cost. Moral hazard is a very real cost documented in health economics literature; reductions in moral hazard are a benefit.

For at least three and possibly five of the eight rules, more accurate estimates of benefits and costs would likely have reversed the conclusion that benefits outweighed costs.

In numerous cases, the agencies neglected to analyze alternatives that would have been obvious to researchers familiar with the health policy literature:

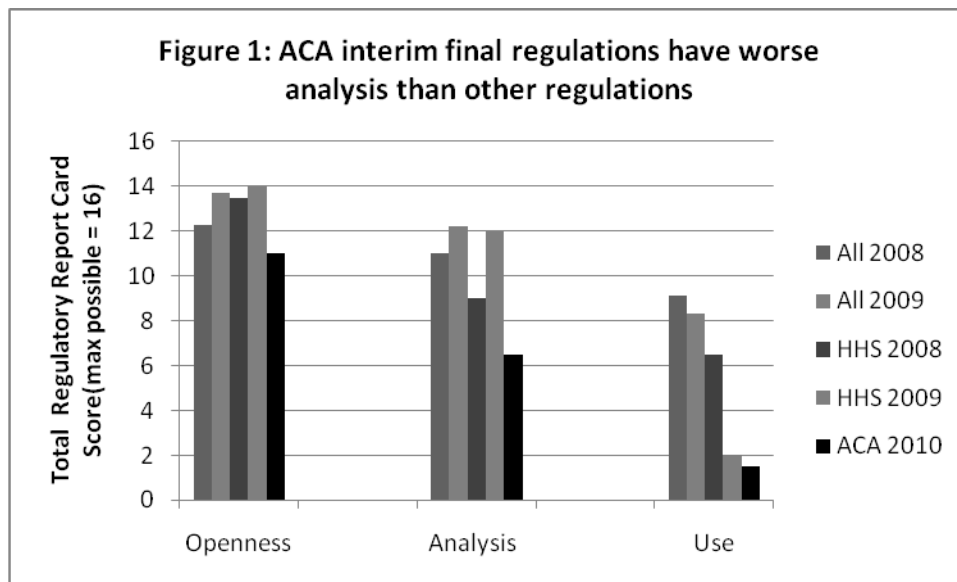
- For the regulation extending health insurance coverage to adult dependent children below the age of 26, the analysis did not even consider the effects of using the established Internal Revenue Service definition of “dependent,” even though that arguably would have made compliance much simpler. Instead, the regulation involved a whole new definition.
- The analysis of the regulation mandating coverage of preventive services did not consider alternative criteria for covered services, such as services that produce net cost savings or produce results at some specified cost per outcome. In addition, this analysis selectively cited literature that conveyed the impression that most preventive services “pay for themselves” by reducing the need for future health care expenditures, when in reality only a minority of such services do so.
- The analysis of claims appeals and external review processes considered no alternatives at all, even though the departments issuing this regulation are surely aware of at least three alternatives: state laws more restrictive than the proposed federal regulation, state laws less restrictive than the proposed federal regulation, and the appeals and review processes mandated by the Labor Department for employer plans covered under the Employee Retirement and Income Security Act.

Despite the importance of fairness and equity in health care debates, the analysis of equity was even less complete than the economic analysis. Most of the RIAs mentioned the transfers the regulations create, sometimes mis-identifying them as benefits or costs. But analysis of equity also requires a coherent ethical theory that defines fairness and explains how one would know whether a regulation improves or reduces fairness. Unfortunately, the equity analysis in these RIAs usually consists of mere assertions that some result represents an improvement in equity, with no definition of equity provided.

Another paper (Ellig and Conover 2011) employed the grading scale from the Mercatus Center’s Regulatory Report Card to assess the relative quality of the health care RIAs. The Regulatory Report Card offers a common grading scale that allows us to compare the quality and use of regulatory analysis based on criteria derived from Executive Order 12866 and OMB guidance.

Report Card criteria fall into three categories: Openness (How accessible, clear, and well-documented is the analysis?), Analysis (How well does the analysis identify the desired outcomes, systemic problem, alternatives, costs, and benefits), and Use (To what extent did the agency claim to use the analysis or make provisions for retrospective analysis of the regulation?) (Ellig and McLaughlin 2012)

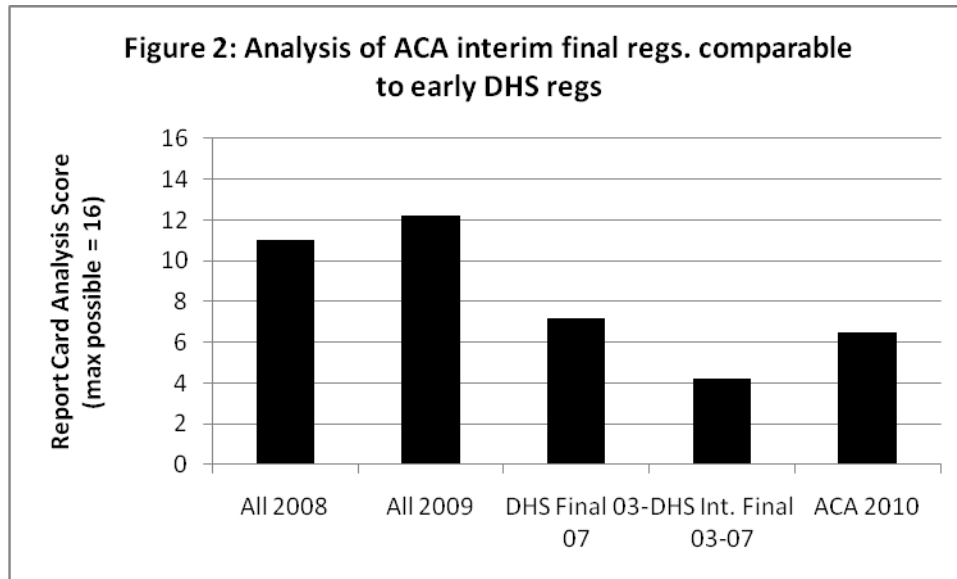
Figure 1 compares the quality and use of analysis for the prescriptive, interim final ACA regulations with that for all prescriptive, economically significant regulations proposed by executive branch agencies and by HHS in 2008 and 2009.⁴ The analysis of the ACA interim final rules does not just fail to live up to ideal standards promulgated by OMB. Quality also falls far short of federal agencies' normal practice, even though the quality and use of analysis in 2008 and 2009 was not particularly high. The highest-scoring regulation in 2008 earned 43 out of 60 possible points, equivalent to a grade of C. The highest-scoring regulation in 2009 earned 48 out of 60 possible points, equivalent to a B-.



The quality of analysis for the health care regulations is roughly comparable to that which accompanied a cluster of interim final homeland security regulations the Bush administration issued in the years following 9/11. The Bush administration's early homeland security regulations rarely identified the systemic problem the regulation was supposed to fix or evaluated alternatives to the proposed regulation. Nor did they explain why federal action was necessary to safeguard facilities and assets where the private sector had substantial investments at stake (Belcore and Ellig 2008).

⁴ "Prescriptive" regulations do what most people think of when they think of "regulation;" they specify what individuals, firms, or other levels of government can and cannot do. Budget regulations implement spending or revenue collection programs. Some of the interim final ACA and DHS regulations were budget regulations and are not included in these charts.

For the DHS regulations, Report Card scores are available only for the Analysis criteria. Figure 2 compares the Analysis scores for the prescriptive ACA regulations, prescriptive regulations issued by DHS during its first few years, and prescriptive regulations issued by all executive branch agencies in 2008 and 2009. Both the homeland security and ACA regulations have much lower quality of analysis than other regulations had in 2008 and 2009.



This result suggests that the relatively low quality of analysis for these regulations reflecting presidential priorities is not due to the peculiarities of any particular administration. Indeed, both the Bush and the Obama administrations pledged to improve the quality of regulatory analysis. Both appointed noted regulatory scholars as OIRA administrators – John Graham and Susan Dudley in the Bush administration, Cass Sunstein in the Obama administration. The Bush administration published an updated, extensive, peer-reviewed guidance for regulatory analysis (Circular A-4) and sought to rein in “midnight regulations.” The Obama administration issued a memorandum urging departments to respect scientific integrity, sought public comments on revising Executive Order 12866, and ultimately reaffirmed it with Executive Order 13563. Deficiencies in the quality and use of analysis occurred despite these good intentions. Political and institutional factors explain why.

3. Presidential Politics

Enactment of health reform was an enormous gamble by the Obama administration because failure was not viewed as an option (Feder 2011). Objectively, the conditions were ripe for passage of comprehensive health reform (Peterson 2011; Hacker 2010), and neither the president nor Congress wanted to risk having to wait years or decades for this opportunity to reappear. Moreover, failure on such a momentous issue—in which the president arguably had invested more political capital than anything else in his first year as president—was seen as significantly jeopardizing his ability to make progress on any of the other major initiatives on his ambitious agenda, such as immigration reform and energy policy.

As a practical matter, it has long been recognized that "[t]he relationship between analysis and politics is an uneasy one. Political imperatives always threaten the thoughtful application of risk or benefit-cost analysis" (Arbuckle 2011). But politics can do more than override analysts' recommendations. Politics can also diminish the incentive and opportunity for agencies to produce high-quality analysis of their regulatory proposals.

Sometimes a regulation or set of regulations implement a priority that already received extensive thought and discussion at high levels of the administration before the agency economists even conducted the regulatory analysis. Of course, OIRA intervention to ensure that regulations reflect presidential policies is nothing new (McGarity 1991; Cooper and West 1988; West 2005). President Clinton's Executive Order 12866 explicitly states that OIRA review is supposed to ensure that regulations are consistent with the president's priorities (EO 12866, Sec. 2(b)). But Elena Kagan's classic article on "Presidential Administration" describes new methods by which Clinton went well beyond regulatory review to exercise control over executive branch regulatory agencies:

A self-conscious and central object of the White House was to devise, direct, and/or finally announce administrative actions - regulations, guidance, enforcement strategies, and reports - to showcase and advance presidential policies. In executing this strategy, the White House in large measure set the administrative agenda for key agencies, heavily influencing what they would (or would not) spend time on and what they would (or would not) generate as regulatory product (Kagan 2001, 2248).

Clinton issued "formal directives (generally styled as memoranda to the heads of departments) instructing one or more agencies to propose a rule or perform some other administrative action within a set period of time." (Kagan 2001, 2285) Directives were often very detailed, specifying particular regulatory or enforcement strategies. White House staff initiated and guided high-priority regulatory initiatives. The president took ownership of the resulting regulations, rather than presenting them merely as decisions of the issuing agencies. Even at the Environmental Protection Agency (EPA), which rarely received these presidential directives, top political officials noted that White House staff intervened to shape regulations that had significant political impact (Bressman and Vandenberg 2006).

Kagan predicted that future presidents would continue to initiate and direct high-priority regulatory actions rather than just review those proposed by agencies. Evidence suggests she was right. John Graham, OIRA administration under President G.W. Bush, describes several instances in which the president directed OIRA or agencies to initiate actions (Graham 2008). Graham himself pioneered the "prompt letter," which publicly requested that agencies initiate or expedite regulatory action or research relevant to regulatory decisions. President Obama continued to employ the "administrative presidency" model (Shapiro and Wright 2011).

At least for some presidential priorities, many key decisions are already made before the regulatory analysis is done. In this type of case, the quality of regulatory analysis would likely be lower, for three reasons.

First, high-level White House involvement before the agency develops the regulation short-circuits the normal enforcement mechanism in Executive Order 12866 that is supposed to promote high-quality analysis. Executive Order 12866 empowers OIRA to review significant federal regulations and the accompanying regulatory analysis, and OIRA can normally require changes or even return regulations to agencies for further analysis. OIRA's "return letters" may include very blunt criticism of the quality of the analysis, and their public availability on the agency's website helps serve a "name and shame" function (Jacobs 2006). But this quality control function cannot work very well if OIRA cannot credibly threaten to return regulations.

If a regulation implements a significant administration priority and most key decisions have already been made, then it is unlikely that OIRA could return the regulation. As one former federal economist noted, after senior managers altered his cost and benefit estimates on a regulation, "Those in OMB who thought the benefits and costs were poorly estimated were told by the White House to back off" (Williams 2008, 9). This is consistent with Bressman and Vandenberg's finding that White House offices tend to have more influence than OIRA on high-profile regulations (Bressman and Vandenberg 2006, 49). With the principal enforcement mechanism emasculated, we should expect to see lower-quality analysis.

Second, agency economists who conduct regulatory impact analysis often take a "value of information" approach when deciding how to focus their efforts. That is, they devote more effort to analysis when Congress has not mandated a specific regulatory approach, and they put the most effort into parts of the analysis that might actually affect decisions (Williams 2008, 14). Research on the effects of economic analysis most frequently finds that analysis affects regulatory decisions on the margins (Hahn and Tetlock 2008; Morgenstern and Landy 1997). Analysis has the most effect when it precedes decisions. (See case studies in Morgenstern 1997.) If most decisions are already made before the analysis is even done, the agency economists are less likely to make a significant effort to produce high-quality analysis.

Third, when decisions precede analysis, analysts face pressure to write the analysis so that it justifies the decisions. The resulting analysis may be less objective and hence lower quality. Interviews with agency economists confirm that decision makers often view the economic analysis as nothing more than a document written to support their decisions and convince OIRA to approve the regulation (Williams 2008, 4). Agency economists often face pressure to doctor the analysis so that it supports decisions already made (Williams 2008, 8-9). Even some recent, highly sophisticated regulatory impact analyses offer limited discussion of alternatives and have been characterized as "litigation support documents" or analysis of decisions already made for other reasons (Harrington, Heinzerling, and Morgenstern 2009, 221).

For these reasons, regulations implementing high-priority presidential initiatives might be expected to have lower-quality regulatory analysis.

Health care regulations from the ACA provide an ideal case study of the effects of presidential administration on regulatory analysis. From the beginning, the Obama administration directed the health care reform campaign from the highest levels. Both the White House Office of Health Reform and HHS Office of Health Reform were created by executive order on April 8, 2009 (Secretary 2011). The head of the White House health reform office became popularly known as

the “health care czar.” In the words of one scholar of the relationship between White House staff and executive agencies,

A czar’s appointment conventionally suggests a President determined to accomplish something difficult, important, and substantive. Therefore the President tasks a powerful, purposeful, and at least somewhat autocratically-minded agent with access to himself, to accomplish that agenda and ensure that it does not fall prey to interagency squabbling, wandering agendas, or bureaucratic inertia ... It seems clear that at least some of Obama’s czars were tasked to bring about particular and significant policy change, and to do so from the White House Office rather than from the agencies or even the Executive Office (Saiger 2011, 2582-2583).

Indeed, the newly elected president was so intent on achieving a major health reform plan that his original strategy was to make former senator Thomas A. Daschle “the first Cabinet secretary in decades to have an office in the West Wing” by simultaneously appointing him head of HHS and director of the newly created White House Office of Health Reform (Shear and Connolly 2009). When Daschle’s tax troubles precluded this plan from playing out, the president appointed a trio of individuals who worked together effectively to promote reform:

- Kathleen Sebelius, a two-term governor of Kansas who also previously had served eight years as its commissioner of insurance (during which time she denied a proposal to allow the state’s Blue Cross/Blue Shield plan to convert to for-profit status), was appointed secretary of HHS in March 2009;
- Nancy-Ann DeParle was appointed White House health care “czar” the same day as Sebelius was named to head HHS; in addition to her public sector experience just cited, DeParle was strongly criticized by both conservatives (Neubauer 2009) and progressives for her deep ties to the health industry through various boards on which she served (Schulte 2009)
- Jeanne Lambrew, a protégé of former Senate Majority Leader Tom Daschle who had previous experience as a program associate director at the Office of Management and Budget, originally was appointed as deputy director of the White House Office of Health Reform in December 2008. In May 2009 she was appointed the director of the HHS Office of Health Reform; in March 2011 she became deputy assistant to the president for health policy (Washington Post 2011).

There is little indication that the HHS secretary and White House health czar appreciably differed in their visions for health reform and the rules needed to make it work. Quite the contrary, the evidence suggests that from the beginning, they worked extremely well in securing the enactment of reform (Wolf 2009) and have continued this teamwork to the present, effectively coordinating DeParle’s current role in playing the “inside game” of making top-level strategic decisions about the implementation of health reform while Sebelius handles the “outside game” of dealing with various stakeholder groups (Vekshin and Armstrong 2011).

Moreover, especially in light of the fractious political battle required to push the plan through Congress, these principals were well aware of the critical importance of the regulations needed to implement the law. As two experts sympathetic to the administration's efforts put it just one day after the ACA was signed into law: "The legislation tasks federal or state officials with writing regulations, making appointments, and giving precise meaning to many terms. Many of these actions will provoke controversy.... Far from having ended, the war to make health care reform an enduring success has just begun. Winning that war will require administrative determination and imagination and as much political resolve as was needed to pass the legislation" (Aaron and Reischauer 2010).

Other political appointees with extensive industry or health policy experience did not arrive until weeks after the bill had been signed into law. They generally reflected the very skeptical attitude of Secretary Sebelius and others in the administration regarding private health insurers generally and for-profit health insurers particularly:

- Jay Angoff in April 2010 was appointed director of the newly created Office of Consumer Information and Insurance Oversight in HHS. He previously had served five years as Missouri's insurance commissioner, spent 1999-2000 as director of private insurance within what became the Centers for Medicare and Medicaid Services and then spent a decade as "a class-action litigator who specialized in making big insurers pay out" (Washington Post 2011).
- Steve Larsen was named in June 2010 to become deputy director for oversight within OCIIO. He previously had served as Maryland's commissioner of insurance. In that capacity he had denied a plan to let Carefirst (a Blue Cross/Blue Shield plan that was the state's largest insurer) convert to for-profit status on grounds it would be bad for consumers (Washington Post 2011). As the Washington Post put it, "Larsen's appointment, along with insurance watchdogs Karen Pollitz and Richard Popper, was widely considered to portend a new era of tough scrutiny of insurers" (Appleby 2010).
- Karen Pollitz likewise arrived at OCIIO in June 2010 as deputy director for consumer support. Although she arrived after a 13-year academic career, prior to that she had served as deputy assistant secretary for health legislation at HHS for the four years of the Clinton administration (Washington Post 2011); thus, she had both extensive bureaucratic experience and familiarity with the myriad of issues surrounding health care reform.
- Richard Popper was the fourth OCIIO principal to arrive in June 2010, as deputy director for Insurance Programs. He previously had served for eight years as the executive director for Maryland's high risk pool; this well suited his responsibility to oversee the Pre-existing Condition Insurance Plan (Washington Post 2011).
- Peter Lee, the former CEO and current health policy director of the Pacific Business Group on Health—a business coalition which represents many of the West Coast's largest private and public employers—became director of delivery system reform, in the HHS Office of Health Reform, on June 1, 2010 (Raubert 2010).

This group of individuals had formal authority over all the rules reviewed in this paper at three levels: the Office of Consumer Information and Insurance Oversight (OCIIO), Office of the Secretary (OS) at HHS, and the White House.⁵ These individuals were subject to the oversight of only three higher level policy officials: the president, vice president and the White House chief of staff. It is not unreasonable to expect that every major rule received close scrutiny by some or all of these individuals, especially given the unusually high degree of personal involvement by the secretary of HHS in the rule-making process.

Two incidents illustrate the latter point. First, shortly after passage of the ACA, a dispute arose over how to interpret the pre-existing condition exclusion as it applied to children under 19, which was to become effective September 23, 2010. As written, the law merely required insurers to cover pre-existing conditions if a child was given health insurance, but this theoretically permitted insurers to deny coverage to such children. The requirement that all individuals (children and adults) with pre-existing conditions be offered coverage (a so-called “guaranteed issue” requirement) was not to become effective until 2014 (Tapper 2010). On March 29, 2010 (less than a week after the ACA became law), Secretary Sebelius wrote a letter to Karen Ignagni, the head of America’s Health Insurance Plans (the major health insurance industry trade group) stating that “I am preparing to issue regulations in the weeks ahead ensuring that the term “pre-existing condition exclusion” applies to both a child’s access to a plan and to his or her benefits once he or she is in the plan. These regulations will further confirm that beginning in September 2010: children with pre-existing conditions may not be denied access to their parents’ health insurance plan” (Sebelius 2010). Accompanying the letter was a statement from the chairmen of the three House committees responsible for health policy stating, “We have been assured by the Department of Health and Human Services that any possible ambiguity in the underlying bill can be addressed by the Secretary with regulation.” In short, the secretary unilaterally imposed a guaranteed issue requirement on insurers effective in 2010 even though the law did not explicitly provide for this until 2014. The rule writers did not consider an alternative approach that would have adhered to the letter of the law as enacted. Instead, the letter written by Secretary Sebelius two months before the rule’s release appears to have foreclosed any further analysis inconsistent with how the administration’s political appointees wanted the law to be interpreted.

Second, “Although the health care bill signed into law in March did not mention end-of-life planning, the topic was included in a huge Medicare regulation setting payment rates for thousands of physician services. The final regulation was published in the Federal Register in late November. The proposed rule, published for public comment in July, did not include advance care planning” (Pear 2011). It was later determined that Secretary Sebelius had been responsible for adding this provision to the final rule even though it had not undergone any sort of public comment; this culminated in a strongly-worded expression of concern issued by leaders of the House Energy and Commerce Committee (Upton et al. 2011).

This aggressive use of executive authority to reach beyond the letter of the law is by no means unique to the ACA. For example, Secretary of Education Arne Duncan recently “announced that

⁵ The OS was responsible for rules related to a) dependent coverage for children; b) the Early Retiree Insurance Program and c) medical loss ratio requirements. OCIIO was responsible for rules related to a) preventive health services; b) grandfathered health plans; c) pre-existing condition exclusions etc.; d) the Pre-existing Condition Insurance Plan; and e) claims appeals and external review processes;

he will unilaterally override the centerpiece requirement of the No Child Left Behind school accountability law, that 100 percent of students be proficient in math and reading by 2014” by offering waivers to states that in his view are making sufficient progress (Dillon 2011). Similarly, the Department of Homeland Security recently issued rules allowing illegal immigrants who were facing deportation to be allowed to stay in the country and apply for a work permit so long as they do not have criminal records; this amounts to selective enforcement of existing immigration statutes (Caldwell 2011).

4. Congressional Politics

Health care reform was a lodestar for the congressional leadership as well as the president. It became an article of faith that failure to pass health care reform would jeopardize the electoral prospects for Democrats in Congress both in 2010 and 2012. Thus, even though congressional leaders recognized that selected Democrats became more vulnerable if they voted for the health care bill, House Speaker Nancy Pelosi and Senate Majority Leader Harry Reid persuaded them to place loyalty to the president above personal political concerns (Stolberg, Zeleny, and Hulse 2010).

Congress could not, however, simply declare victory once the legislation was passed. Implementing the ACA would require a significant number of major new regulations, and so Congress faced the challenge of ensuring that the regulators faithfully carried out its wishes. In delegating rulemaking responsibility to agencies, Congress faces a classic principal-agent problem. Absent direction from Congress, the agency may have different priorities than Congress. In such instances, Congress may not get the regulation it would have written if its members were privy to the agency’s expert knowledge. (McCubbins 1985; Abbott 1987a, 180)

The principal-agent problem may have a temporal dimension, termed “coalitional drift” or “legislative drift” (Epstein and O’Halloran 1994; Gersen and O’Connell 2008). Congress affects agency decisions via oversight, budgeting, and approval or disapproval of presidential nominees (Wood and Waterman 1991; Moe 1985; McCubbins 1985; Calvert, Matthew D. McCubbins, and Barry R. Weingast 1989). If the next election puts the other party in charge of Congress, then the agency will likely have different political incentives after the election than it has during the current Congress. A new congressional majority could prompt the agency to deviate from the past majority’s intent. The new Congress could also exercise an ex post veto by invalidating new regulations (interim or final) under the Congressional Review Act--an approach that was attempted for one of the rules analyzed in this paper (Providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule relating to status as a grandfathered health plan under the Patient Protection and Affordable Care Act 2010).

Even if the same party retains control of Congress after the election, large shifts in the makeup of Congress could lead to significant changes in chairmanships and majorities on the relevant oversight committees. Changes in legislation or appropriations that affect regulatory agencies must first pass through the relevant committees, and committees have a great deal of power to block changes (Weingast and Marshall 1998; Weingast 1981). Empirical research demonstrates that agencies respond to their oversight committees (Moe 1985; Weingast and Moran 1983; Weingast 1984).

The threat of divided government in the future may accentuate current lawmakers' concerns about legislative drift. Divided government tends to reduce production of regulations because "agencies are less able to reliably determine which discretionary regulatory activities will be acceptable to all relevant political principals, who themselves may be deeply divided on the desirability of certain potential regulatory initiatives" (Yackee and Yackee 2009, 130). If a possible change in control of Congress would also lead to divided government, current lawmakers would be even more eager to see regulations issued quickly.

Finally, some empirical research demonstrates that agencies make different decisions depending on the political salience of the regulations they are considering (Shapiro and Morrall 2011). This has occurred even in cases where Congress and committees appear to exercise little influence (Carpenter 2002). A shift in political salience, or a shift in the nature of the interest groups concerned about the regulation, could thus create a phenomenon similar to legislative drift even in the absence of electoral changes that alter the composition of committees.

Statutory deadlines provide a mechanism to mitigate legislative drift. If an upcoming election might change the agency's political incentives, then a deadline before the new Congress takes office ensures that the agency writes the regulation under the watchful oversight of the same Congress that enacted the law (Gersen and O'Connell 2008, 936). In a study of regulatory deadlines between 1987 and 2003, Gerson and O'Connell (945-6) found that deadlines shorten the average duration of rulemakings – especially HHS rulemakings.

The potential for legislative drift seems highly relevant to circumstances surrounding passage of the Affordable Care Act. The legislation passed in March 2010, with the off-year congressional election just seven months away. As Congress voted on the final legislation, protestors outside sang, "We'll remember, in November, Hey He-ey, Good-Bye!" (<http://www.youtube.com/watch?v=4OoQXQ6mLUA>) Regardless of one's views on the merits of the legislation, it's hard to deny that the threat of a new congressional majority hostile to the ACA was very real at the time Congress wrote and voted on the legislation. After all, the law had been enacted in the face of majority public opposition; according to nearly 140 polls monitored by RealClearPolitics.com between July, 2009 and passage of the bill, a mere 10 polls showed majority support for the health plan (RealClearPolitics.com 2011). Likewise, between passage of the bill and August 10, 2011, only one of 87 polls tracked by RCP opposed repeal of the law; in many cases, support for repeal exceeded opposition to repeal by double-digit amounts, sometimes exceeding 30 percentage points (RealClearPolitics.com 2011).

Admittedly, many Democrats believed that once voters actually experienced some of the benefits of the law, public opposition to the law would fade away and ideally become an issue that might contribute to rather than threaten electoral support for Democrat candidates in the fall (Klein 2010). Likewise, many thought (or hoped) that the principal components of ACA would become politically impregnable once the public became accustomed to them (Cohn 2010; Pollack 2011). Medicare, for example, had surmounted enormous political obstacles to enactment to eventually become a third rail of politics (Brown 1996; Oberlander 2003). This provided a strong incentive to "front-load" the legislation with various insurance reforms that would take effect quickly,

before the November elections. As Drew Altman, president of the Kaiser Family Foundation, explained:

The major benefits of the law -- the coverage expansions, subsidies, and insurance market reforms -- do not kick in until 2014. To compensate for that, the architects of the legislation built in a long list of early deliverables so the public would see tangible and understandable benefits right away -- from allowing dependent children to stay on family policies until age 26, to beginning to eliminate the prescription drug doughnut hole for seniors (Altman 2010).

Put more directly by another scholar of health politics, “front-loaded benefits boost the ACA’s appeal and could help forestall mounting repeal efforts” (Kersh 2011, 615). One indication that haste arose from politics trumping good policy can be seen in the original bill that passed the House on November 7, 2009. That bill made January 1, 2010 the effective date for the pre-existing condition insurance plan, medical loss ratio requirements, coverage of young adults up to age 26 and the prohibition on pre-existing condition exclusions and related health insurance reforms (Kaiser Family Foundation 2011). While House members may not have known it would take the Senate until December 24 to pass its version of a bill, most impartial observers likely would agree that a January 1 start date for these various provisions would have produced chaos even had a bill been signed into law by mid-November. Regulators could not have been expected to produce responsible regulations related to each provision within such a tight time frame. And there was no reason except politics for these new policies not to be rolled out in a more orderly fashion.

As Congress debated the health care reform bill, a raucous crowd personified the intertemporal principal-agent problem. Control of Congress was up for grabs, and a shift from Democratic to Republican control would lead to divided government. Regardless of the anticipated effect on the 2010 elections, the somewhat surprisingly virulent opposition likely signaled a shift in political salience. Ambitious statutory deadlines for regulations and programs created by the Affordable Care Act were thus a rational congressional strategy either to avoid legislative drift or forestall an adverse electoral outcome in the first place.

All eight regulations in this study had deadlines prior to January 2, 2011; as a practical matter, the agencies’ reliance on interim final rules was understandable. Based on the normal amount of time required to write a regulation, conduct a thorough RIA, have it vetted by OIRA, obtain public comments, revise the rule and have it vetted by OIRA one last time, nine months arguably was not a long enough period of time following the law’s enactment to issue any of these as final rules. That this did not happen can be attributed to Congress’s having established ambitious statutory timelines for various provisions of the law to become effective.

Were the deadlines set in the ACA too ambitious? Within a month of passage, Nancy-Ann DeParle, then-director of the White House Office of Health Reform—an experienced bureaucrat who previously had run Tennessee’s Medicaid program, had served under President Clinton from 1997-2000 as an administrator for what later became the Centers for Medicare and Medicaid Services (CMS), and who subsequently became deputy chief of staff to President Obama (Executive Office of the President 2011)--reported being “confident” the administration

could move quickly in putting the many needed regulations in place (Serafini 2010). However, Mark McClellan—another former CMS administrator under President George W. Bush, who had gained extensive experience in implementing a major Medicare reform (the prescription drug benefit) and who directs the Engelberg Center for Health Care Reform at the Brookings Institution—was much more dubious. In his experience, it had taken six to nine months just to get his key staff on board despite accelerated hiring procedures that no longer were available to HHS in 2010 (Serafini 2010).

Scholarly literature recognizes that tight deadlines can curtail the quality of regulatory analysis and decisions. In a seminal article on regulatory deadlines, Abbott (1987a, 172) noted that these deadlines can “induce agencies to act hastily and promulgate cost-inefficient or ill-advised rules.”⁶ He cites multiple instances where deadlines forced agencies to issue costly regulations that generated little benefit, or make key decisions about regulations before risk assessments or regulatory impact analyses were completed. In other cases, deadlines discouraged agencies from ensuring that their decisions were based on high-quality scientific evidence, in one case leading to regulations less stringent than the evidence may have justified. Deadlines also prevented agencies from regulating efficiently by addressing the biggest problems first (Abbott 1987a, 1987b).

Gersen and O’Connell (2008, 933) likewise argue that deadlines can reduce the quality of agency analysis or decisions: “A straightforward potential result is to decrease the quality of agency deliberations and decisions. If a task that normally takes six hours to finish must be completed in one hour, a natural inference is that the quality of the output will be sacrificed.” Their primary empirical evidence of lower quality, however, is that regulations issued under deadlines are more likely to be interim final rules and have fewer opportunities for public comment (943-945). But measuring process is not the same thing as directly measuring the quality of the agency’s analysis.

Scholars also suggest that interim final rules can reduce regulatory quality and accountability to the public. More often than not, interim final rules have public comment periods that did not end until after the interim final rule became effective. This is potentially problematic since experts on Congress generally have found that interim final rules are less likely to be changed by post-effective-date comments than by comments filed before the rule becomes final. Potential commenters are also more likely to comment if the rule has not yet gone into effect (Copeland 2010, 11). Indeed, the Administrative Conference of the United States has said as much (Administrative Conference of the United States 1995). Public input into rules serves a critical function: it provides a surrogate political process that ensures accountability. As one scholar has noted, “rules adopted with public participation are likely to be more effective and less costly to administer than rules written without such participation. They contain fewer mistakes” (Asimow 1999, 707-708). As well, prevailing judicial doctrine holds that post-adoption approach to

⁶ Abbott (1987a, 1987b) also notes that statutory deadlines affect agency resource allocation. They can divert agency attention from working on more important regulations that do not have deadlines. Agencies subject to statutory deadlines also find that they have to divert resources to defending themselves from litigation when they miss deadlines. We do not address these costs in this study of health care regulations. We do not know what regulations federal agencies did not work on because they were working on the interim final health care regulations, and they faced no litigation over the deadlines associated with these regulations.

obtaining public input is inferior to pre-adoption procedure and this defect is not viewed as harmless error (Asimow 1999).⁷

Of the eight economically significant interim final rules issued under the ACA analyzed in the present study, five had comment periods that ended after the effective date of the rule -- in some cases fully 60 days after the implementation date (Copeland 2010). Moreover, one of the inherent risks of interim final rules is that there is no particular incentive for agencies to move on to the step of finalizing these rules; some analyses have found that between two-fifths and half of interim final rules had not yet been finalized three years after adoption (Asimow 1999, 737). If an interim final rule receives comments and the agencies do not finalize the rule, then the public has zero influence on the rule, contrary to the goals of the APA.

The last time an administration issued a series of interim final rules reflecting significant executive branch priorities in the face of tight legislative deadlines was in the years following 9/11, when DHS issued a series of interim final rules. Belcore and Ellig (2009) found that the quality of regulatory analysis associated with these rules was consistently lower than the quality of regulatory analysis that accompanied other rules the department proposed. Moreover, there is evidence that these rules reflected the same pattern of over-estimating benefits and underestimating costs that we found for the ACA regulations (Mueller and Stewart 2011). All of these interim final rules involved either legislative deadlines or legislative language urging the department to act expeditiously.

Hastily crafted regulations pose a potential risk to the public under any circumstances. But they should especially be avoided in instances in which Congress itself may have acted too hastily (or at least without sufficient transparency and deliberation). In such cases, executive agencies can serve as a fail-safe mechanism by analyzing options that Congress may not have considered.

The entire premise of regulatory impact analysis is to ensure a regulatory system “that protects and improves their health, safety, environment, and well-being and improves the performance of the economy without imposing unacceptable or unreasonable costs on society.” (Executive Office of the President 1993) The most recent OMB report on the benefits and costs of federal regulation puts it even more rigorously: “Careful consideration of costs and benefits is best understood as a way of ensuring that regulations will improve social welfare, above all by informing design and development of various options so as to identify opportunities for both minimizing the costs of achieving social goals (cost-effectiveness) and maximizing net social benefits (efficiency).” (Office of Information and Regulatory Affairs: Office of Management and Budget 2011, 3)

Analytical requirements for economically significant regulations are especially intensive, to ensure that agencies and others have the best possible information about the likely effects of various decision options for rules that will have a large impact on the economy. Executive Order 12866 (Sec. 6(a)(3)(C)) requires agencies to identify, and quantify where possible, the costs and benefits of proposed regulations, along with “the costs and benefits of potentially effective and reasonably feasible alternatives to the planned regulation, identified by the agencies or the public ... and an explanation of why the planned regulatory action is preferable to the identified potential alternatives.” To perform this task well unquestionably takes time, so statutory

⁷ A “harmless error” is one that is sufficiently small that it would not justify a rule’s modification or repeal.

deadlines may preclude an agency from being able to seriously analyze regulatory alternatives to the specific programmatic design embedded by Congress in a statute. In such cases, the executive order instructs agencies to perform the analysis “to the extent practicable.” Failure to do a thorough analysis, however, seriously undercuts one of the important purposes of the entire regulatory process that has been established over decades.

5. Abbreviated Regulatory Process

For all of these regulations, the issuing agencies waived the normal “notice and comment” process on the grounds that the regulations had to be implemented quickly to meet legislative deadlines. In some cases, the deadlines were explicit, such as the requirement that HHS establish the Early Retiree Reinsurance Program and Preexisting Condition Insurance Plan within 90 days of the date the legislation took effect. Many provisions of the legislation took effect on September 23, 2010 (six months from the date of enactment). Agencies knew that employers and insurance companies faced impossible deadlines in designing insurance provisions for plan years beginning on January 1 (the standard start date for employer-based health plans) unless rules were in place providing real-world guidance far in advance of that date, and even before September 23.⁸ The same reasoning applied to the Medical Loss Ratio regulation, though the legislative deadline was later. In light of the statutory deadlines facing these agencies, the justifications offered for earlier release of various rules appear sound.⁹

However, as one illustration of what would have been possible with more “relaxed” deadlines, the law specifies that regulations regarding health care choice compacts (to permit the offering of health plans in more than one state) be issued no later than July 1, 2013, but that no such compact can take effect before January 1, 2016. It is reasonable to expect that within such generous constraints, there will be no need to issue regulations as interim final rules and there will be ample time to modify such rules in light of public comments prior to their becoming effective. Likewise, allowing various insurance reform provisions to become effective on September 23, 2011 rather than 2010 would have permitted a much more orderly process of issuing the regulations required to implement them. Had the agencies been given that additional time, it seems unlikely that the quality of the regulatory impact analyses would have been as low as we observed.

⁸ Most employers have their open enrollment periods in October or November so that employees have ample time to ponder whatever health plan choices they have and plans have time to update their eligibility files and distribute information to plan members prior to the January 1 start date. This in turn requires employers to have negotiated benefits and prices with health plans in the late summer or early fall.

⁹ It is beyond the scope of this analysis to assess the incremental benefits of issuing regulations quickly, e.g., to reduce market uncertainty, versus waiting until the last possible moment. Our focus is on the quality of regulations issued under such tight statutory deadlines. Absent such deadlines, there would have been ample opportunity both for public comment and to conduct more rigorous regulatory impact analyses.

Table 2: Data on economically significant interim final health care regulations issued in 2010

Regulation	Date Published/ Effective	Deadline for Public Comments	Legislative Deadline	Days Effective Before Deadline	Days at OIRA
<i>Early Retiree Reinsurance Program</i>	<i>5/5/2010 6/1/2010</i>	<i>6/4/2010 (30 days)</i>	<i>6/21/2010</i>	<i>20</i>	<i>4</i>
Dependent Coverage for Children up to Age 26	5/13/2010 7/12/2010	8/11/2010 (90 days)	9/23/2010	73	3
Grandfathered Health Plans	6/17/2010 6/14/2010	8/16/2010 (60 days)	9/23/2010	102	7
Preexisting Condition Exclusions, Limits, et. al.	6/28/2010 8/27/2010	8/27/2010 (60 days)	9/23/2010	27	5
Coverage of Preventive Services	7/19/2010 9/17/2010	9/17/2010 (60 days)	9/23/2010	6	13
Claims Appeals and External Review Processes	7/23/2010 9/21/2010	9/21/2010 (60 days)	9/23/2010	2	4
<i>Preexisting Condition Insurance Plan</i>	<i>7/30/2010 7/30/2010</i>	<i>9/28/2010 (60 days)</i>	<i>6/21/2010</i>	<i>-39</i>	<i>3</i>
Medical Loss Ratio Requirements	12/1/2010 1/1/2011	1/1/2011 (30 days)	1/1/2011	0	1

Note: Rules in italics are budget regulations.

Source: Copeland (2010), reginfo.gov, and *Federal Register* notices for each regulation.

Table 2 shows that in half the cases, rules were implemented weeks or months before the effective date set by Congress. In three other instances, a rule took force within less than a week of the deadline; in only one instance did an economically significant rule become effective after a legislatively-imposed deadline (in this case five weeks later). Perhaps this illustrates the administration's enthusiasm for the landmark health care reform law. Or perhaps it merely confirms the public choice hypothesis that agencies are quite responsive to the policy preferences of the current majorities on congressional committees (e.g., Weingast and Marshall 1998; Weingast and Moran 1983)

Agencies can elect to offer a post-effective date comment period; it is not required in cases where the "good cause" exemption has been invoked (Asimow 1999, 733). Four of the eight rules had a comment period that ended after the rule took effect. The amount of time allowed for post-effective comments ranged from 3 days (early retiree reinsurance program) to 63 days

(grandfathered health plans). Four had comment periods that ended on the date the rule took effect. Three of these provided for 60 days of public comment.

The fourth, medical loss ratio rules, provided for only 30 days. However, a Request for Information related to the medical loss ratio rule was issued on April 15, 2010 (Internal Revenue Service, Employee Benefits Security Administration, and Office of the Secretary 2010) Thus, the agencies implicitly had begun inviting public comment many months prior to the issuance of the rule. In this particular instance, the law required the National Association of Insurance Commissioners (NAIC) to develop the uniform definitions and standard methodologies for calculating the medical loss ratio. In the course of developing a model rule and recommendations to Secretary Sebelius, the NAIC itself sought input from dozens of consumer groups, regulators, health care organizations, members of Congress, state legislators, and industry trade groups and also provided a period for public comments. (National Association of Insurance Commissioners 2010) In short, there was a longer period of public input than might otherwise be suggested by the 30 days available for formal public comment.

Table 2 lists two additional pieces of data for each regulation. The “Pages” column lists the total number of pages in the *Federal Register* notice. The page count for the Medical Loss Ratio regulation includes a 24-page technical appendix to the Regulatory Impact Analysis referenced in the *Federal Register* notice. Aside from this appendix, none of the regulations had a separate Regulatory Impact Analysis document. The regulatory analysis was in its own section of the notice or included in the agency’s preamble justification for the regulation. Apparently agencies did attempt to comply with the Executive Order 12866 requirement that they perform the regulatory analysis “to the extent practicable.”

For interim final rules, an agency invoking the good cause exception technically is excused from having to prepare both: a) statements detailing the impact of the rule on small business; and b) cost-benefit analyses required by the Unfunded Mandates Reform Act (UMRA) for “major” regulatory actions. (Asimow 1999) All of the interim final rules reviewed here invoked the exception not to publish (a), but routinely added language to the effect: “nevertheless, the Departments carefully considered the likely impact of the regulations on small entities in connection with their assessment under Executive Order 12866” (Internal Revenue Service, Employee Benefits Security Administration, and Office of Consumer Information and Insurance Oversight 2010, 22). Each interim final rule likewise invoked the UMRA exemption to conducting a cost-benefit analysis, yet de facto at least made an effort at following the analytic requirements of UMRA, including a qualitative and quantitative assessment of the anticipated costs and benefits of the mandate and identification of regulatory alternatives and selection of the least burdensome alternative (or explanation for why the least burdensome alternative was not selected).

Due to their “emergency” nature, interim final rules may also receive less scrutiny from the Office of Information and Regulatory Affairs. The interim final health care regulations received rapid review at OIRA, averaging just five days; only a single rule spent more than a week under OIRA review. Most were at OIRA for five days or less. By comparison, OIRA took an average of 27 days to review proposed economically significant regulations in 2009 and 56 days to do so in 2008. While an abbreviated OIRA review may not have been unusual for a single rule, having

eight consecutive ACA-related rules in a row approved in such an accelerated fashion suggests this was not business as usual. Such rapid clearance of these rules may have reflected either earlier informal “under the table” clearance by OIRA staff (itself unusual) or instructions from higher-ups that the rules were to be cleared without serious review.

6. Conclusions

From a process perspective, it appears that the analysis and review associated with these regulations was less thorough than economically significant regulations typically receive. As we have documented in previous papers, the result was certainly subpar. (Conover and Ellig 2011; Ellig and Conover 2011)

The abbreviated regulatory process and low-quality analysis are predictable results of the incentives the regulatory agencies faced. A combination of top-down direction and tight deadlines eliminated the agencies’ ability and incentives to produce high-quality RIAs or use the results to make choices. Presidential and congressional decisions, in turn, flowed predictably from the political incentives President Obama and Congress faced in 2010.

OIRA regulatory review is supposed to check agency “tunnel vision” and ensure that regulations reflect the broader public interest by prompting agencies to conduct high-quality analysis of proposed regulations and their alternatives. (DeMuth and Ginsburg 1986; Dudley 2009) But when “presidential administration” of regulation includes initiation of legislative proposals and White House direction of regulatory agencies’ efforts to implement them, the presidential check on agencies’ analysis disappears. And when tight deadlines foreclose opportunities to conduct substantial regulatory impact analysis on an issue as important as health care reform, clearly some limits on the use of interim final regulations are needed. Alternative checks on the quality of analysis would help insulate it from presidential and congressional politics.

6.1 Alternative regulatory review authority

One check on the president’s ability to short-circuit regulatory analysis would be for Congress to designate an independent authority to review the analysis. From the standpoint of Congress, having the Congressional Budget Office or Government Accountability Office serve as an independent check on the quality of RIAs has the advantage of building upon an existing body of expertise already used in developing legislation. But it is equally plausible to imagine this role undertaken by some other entity that is viewed as having the requisite scientific expertise and independence to conduct such reviews impartially.

Independence from politics is a key criterion. A congressionally-designated regulatory review entity needs to have sufficient independence that it can review agency regulatory analysis according to widely-accepted scholarly standards. In the United Kingdom, for example, the National Audit Office is responsible for scrutinizing public spending on behalf of Parliament; this office has conducted four consecutive years of evaluations of a sample of RIAs and issued other reports aimed at improving the quality of RIAs (National Audit Office 2009, 2010, 2004, 2005, 2006, 2007). The comptroller and auditor general is an officer of the House of Commons who also serves as the head of the National Audit Office, which employs some 800 staff. Both

the comptroller and the National Audit Office are totally independent of the governing parliamentary party.

6.2 Mandatory peer review

External peer review of regulatory analysis could provide another check. In principle, external peer review already is required for original data and formal analytic models used by agencies in RIAs. However, RIA documents themselves are already reviewed through an interagency review process under E.O. 12866 that involves application of the principles and methods defined in OMB Circular A-4. Consequently, OIRA does not require peer review for RIAs, although “agencies are encouraged to have RIAs reviewed by peers within the government for adequacy and completeness” (Office of Management and Budget 2004, 33). Either Congress or OIRA could make such peer review mandatory – perhaps just for significant or economically significant regulations. Of course, peer review is only as good as the attention paid to it. Unless OIRA or Congress are prepared to monitor such peer reviews in some fashion (e.g., through GAO audits of a random sample of peer-reviewed RIAs), there may be little incentive for agency staff to incorporate the suggestions of peer reviewers, especially in cases where analysis is being used to support a politically-motivated regulatory scheme.

6.3 Eliminate government monopoly on RIAs

The ultimate check on political influence in RIAs would be to eliminate the federal government’s monopoly on the analysis. The health care RIAs read as if they were produced after key decisions had already been made – a problem not unique to these regulations. Under the current regulatory process, the timing effectively gives the federal government a monopoly on producing regulatory impact analyses and inhibits the public’s ability to affect the quality of the analysis when it might actually affect agency decisions.

Both problems could be mitigated if agencies were required to conduct and publish regulatory impact analyses (along with all underlying studies and data) for public comment before the proposed regulation is actually written. Agencies would have analysis of regulatory alternatives before they chose which alternative to pursue. In addition, the public would have the opportunity to replicate, improve, and comment upon the agency’s economic analysis before the agency uses the analysis to make decisions.

6.4 Constrain use of interim final rulemaking

Of course, administrations may attempt to use interim final rulemaking to evade any reformed analytical procedures. To prevent this, Congress would need to explicitly rein in interim final rulemaking, so that it is permitted only for relatively trivial administrative matters or for genuine emergencies that pose an immediate threat to public health and safety. Legislative deadlines should not, by themselves, count as “good cause” to allow agencies to issue interim final rules. Indeed, the need to conduct sound analysis for economically significant regulations should count as “good cause” for an agency to miss legislated deadlines. Finally, all interim final rules should have sunset provisions that automatically terminate the rule if the agency has not issued a final rule under the normal notice-and-comment process by a date certain.

It is beyond the scope of this paper to assess fully the merits of these major structural changes to the rule-making process. But each has the potential to mitigate political influence on the quality and use of regulatory analysis. Our review of the interim final health care regulations proposed in 2010 suggests that mitigation is long overdue.

References

- Aaron, Henry J., and Robert D. Reischauer. 2010. The War Isn't Over. *New England Journal of Medicine*.
- Abbott, Alden F. 1987a. The Case Against Federal Statutory and Judicial Deadlines: A Cost-Benefit Appraisal. *Administrative Law Review* 39:171-204.
- Abbott, Alden F. 1987b. Case Studies on the Costs of Federal Statutory and Judicial Deadlines. *Administrative Law Review* 39:467-87.
- Administrative Conference of the United States. 1995. Recommendation 95-4, Procedures for Noncontroversial and Expedited Rulemaking. In *Recommendations of the Administrative Conference of the United States*
- Altman, Drew. 2011. *Implementation Is Forever*. Kaiser Family Foundation, April 6, 2010 2010 [cited July 20 2011]. Available from http://www.kff.org/pullingittogether/040610_altman.cfm.
- Appleby, Julie. 2010. Appointments of federal watchdogs suggest more tough scrutiny for insurers. *Washington Post*, June 1, 2010.
- Arbuckle, Donald R. 2011. The Role of Analysis on the 17 Most Political Acres on the Face of the Earth. *Risk Analysis* 31 (6):884-892.
- Asimow, Michael. 1999. Interim Final Rules: Making Haste Slowly. *Administrative Law Review* 51 (Summer):703-755.
- Belcore, Jamie, and Jerry Ellig. 2009. Homeland Security and Regulatory Analysis: Are We Safe Yet? *Rutgers Law Journal*:1-96.
- Bressman, List Schultz, and Michael P. Vandenbergh. 2006. Inside the Administrative State: A Critical Look at the Practice of Presidential Control. *Michigan Law Review* 105 47-100.
- Bressman, List Schultz, and Michael P. Vandenbergh. 2006. Inside the Administrative State: A Critical Look at the Practice of Presidential Control. *Michigan Law Review* 105:47-100.
- Brown, Lawrence D. 1996. The Politics of Medicare and Health Reform, Then and Now. *Health Care Financing Review* 18 (2):163-168.
- Brown, Lawrence D. 2011. The Elements of Surprise: How Health Reform Happened. *Journal of Health Politics Policy and Law* 36 (3):419-427.
- Caldwell, Alicia A. 2011. US makes criminals priority for deportation *Associated Press*, August 19, 2011.
- Calvert, Randall J., Matthew D. McCubbins, and Barry R. Weingast. 1989. A Theory of Political Control and Agency Discretion. *American Journal of Political Science* 33 (3):588-611.
- Carpenter, Daniel P. . 2002. Groups, the Media, Agency Waiting Costs, and FDA Drug Approval. *American Journal of Political Science* 46 (3):490-505.
- Cohn, Jonathan 2010. You Thought Passing Health Reform Was Hard? Try Repealing It. *New Republic*.
- Conover, Christopher J., and Jerry Ellig. 2011. Beware the Rush to Presumption, Part A: Material Omissions in Regulatory Analyses for the Affordable Care Act's Interim Final Rules. Working Paper, Mercatus Center at George Mason University.
- Cooper, Joseph, and William F. West. 1988. Presidential Power and Republican Government: The Theory and Practice of OMB Review of Agency Rules. *Journal of Politics* 50 (4):864-95.
- Copeland, Curtis W. 2010. Initial Final Rules Implementing the Patient Protection and Affordable Care Act (P.L. 111-148). Washington, DC: Congressional Research Service.

- Copeland, Curtis W. 2010. Regulations Pursuant to the Patient Protection and Affordable Care Act (P.L. 111-148). Washington, DC: Congressional Research Service.
- Copeland, Curtis W., and Maeve P. Carey. 2011. Upcoming Rules Pursuant to the Patient Protection and Affordable Care Act (P.L. 111-148). Washington, DC: Congressional Research Service.
- DeMuth, Christopher C., and Douglas H. Ginsburg. 1986. White House Oversight of Agency Rulemaking. *Harvard Law Review* 99 (5):1075-1088.
- Dillon, Sam. 2011. Overriding a Key Education Law. *New York Times*, August 11, 2011.
- Dudley, Susan E. 2009. Lessons Learned, Challenges Ahead. *Regulation and Governance*:6-11.
- Ellig, Jerry, and Christopher J. Conover. 2011. Beware the Rush to Presumption, Part B: Sub-Standard Regulatory Analyses for the Affordable Care Act's Interim Final Rules. Working Paper, Mercatus Center at George Mason University.
- Ellig, Jerry, and Patrick McLaughlin. 2012. The Quality and Use of Regulatory Analysis in 2008. *Risk Analysis* (32).
- Ellig, Jerry, and John Morrall. 2010. Assessing the Quality of Regulatory Analysis: A New Evaluation and Data Set for Policy Research. Working Paper, Mercatus Center at George Mason University.
- Epstein, David, and Sharyn O'Halloran. 1994. Administrative Procedures, Information, and Agency Discretion. *American Journal of Political Science* 38 (3):697-722.
- Executive Office of the President. 1993. Executive Order 12866. *Federal Register* 58 (190):51735-44.
- Executive Office of the President. 2011. *Deputy Chief of Staff Nancy-Ann DeParle* 2011 [cited July 21 2011]. Available from <http://www.whitehouse.gov/administration/staff/nancy-ann-deparle>.
- Feder, Judith. 2011. Too Big to Fail: The Enactment of Health Care Reform. *Journal of Health Politics Policy and Law* 36 (3):413-416.
- Gersen, Jacob E., and Anne Joseph O'Connell. 2008. Deadlines in Administrative Law. *University of Pennsylvania Law Review* 156:839-922.
- Graham, John D. 2008. Saving Lives Through Administrative Law and Economics. *University of Pennsylvania Law Review* 157:395-540.
- Hacker, Jacob S. 2010. The Road to Somewhere: Why Health Reform Happened. *Perspectives on Politics* 8 (03):861-876.
- Hahn, Robert W., and Paul C. Tetlock. 2008. Has Economic Analysis Improved Regulatory Decisions? *Journal of Economic Perspectives* 22 (1):67-84.
- Harrington, Winston, Lisa Heinzerling, and Richard Morgenstern. 2009. *Reforming Regulatory Impact Analysis*: Resources for the Future Press.
- Internal Revenue Service, Department of the Treasury;, Department of Labor; Employee Benefits Security Administration, and Department of Health and Human Services; Office of Consumer Information and Insurance Oversight. 2010. Interim Final Rules for Group Health Plans and Health Insurers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act. edited by D. o. t. T. Internal Revenue Service, D. o. L. Employee Benefits Security Administration and D. o. H. a. H. S. Office of Consumer Information and Insurance Oversight. HealthCare.gov Implementation Center.
- Internal Revenue Service, Department of the Treasury;, Department of Labor; Employee Benefits Security Administration, and Department of Health and Human Services; Office

- of the Secretary. 2010. Medical Loss Ratios; Request for Comments Regarding Section 2718 of the Public Health Service Act. *Federal Register* 75 (71).
- Jacobs, Scott. 2006. Current Trends in Regulatory Impact Analysis: The Challenges of Mainstreaming RIA into Policy-making. Washington, D.C.: Jacobs and Associates.
- Kagan, Elena. 2001. Presidential Administration. *Harvard Law Review* 114:2246-2385.
- Kaiser Family Foundation. 2011. *Side-by-Side Comparison of Major Health Reform Proposals* 2011 [cited July 20 2011]. Available from <http://www.kff.org/healthreform/sidebyside.cfm>.
- Kersh, Rogan. 2011. Health Reform: The Politics of Implementation. *Journal of Health Politics Policy and Law* 36 (3):613-623.
- Klein, Ezra. 2010. Health care and the election. *Washington Post*.
- McCubbins, Mathew D. 1985. The Legislative Design of Regulatory Structure. *American Journal of Political Science* 29 (4):721-48.
- McGarity, Thomas. 1991. *Reinventing Rationality*. Cambridge: Cambridge University Press.
- Moe, Terry M. 1985. Control and Feedback in Economic Regulation: The Case of the NLRB. *American Political Science Review* 79 (4):1094-1116.
- Morgenstern, Richard. 1997. *Economic Analysis at EPA*. Washington, DC: Resources for the Future.
- Morgenstern, Richard D., and Marc K. Landy. 1997. Economic Analysis: Benefits, Costs, Implications. In *Economic Analyses at EPA: Assessing Regulatory Impact*, edited by R. D. Morgenstern. Washington, DC: Resources for the Future.
- Morone, James A. 2011. Big Ideas, Broken Institutions, and the Wrath at the Grass Roots. *Journal of Health Politics Policy and Law* 36 (3):375-385.
- Mueller, John, and Mark G. Stewart. 2011. Evaluating the Risks, Costs, and Benefits of Homeland Security Spending. In *APSA 2011 Annual Meeting*. Seattle, WA.
- National Association of Insurance Commissioners. 2011. *NAIC Committee Advances MLR Recommendations*, October 14, 2010 2010 [cited June 20, 2011 2011]. Available from http://www.naic.org/Releases/2010docs/naic_advances_mlr_recommendations.htm.
- National Audit Office. 2004. Evaluation of Regulatory Impact Assessments Compendium Report 2003-04.
- National Audit Office. 2005. Evaluation of Regulatory Impact Assessments Compendium Report 2004-05.
- National Audit Office. 2006. Evaluation of Regulatory Impact Assessments Compendium Report 2005-06.
- National Audit Office. 2007. Evaluation of Regulatory Impact Assessments Compendium Report 2006-07.
- National Audit Office. 2009. Delivering High Quality Impact Assessments.
- National Audit Office. 2010. Assessing the Impact of Proposed New Policies.
- Neubauer, Chuck. 2009. Obama health ‘czar’ worked at legally troubled health firms. *Washington Times*, December 8, 2009.
- Oberlander, Jonathan. 2003. *The Political Life of Medicare*. Chicago: University of Chicago Press.
- Office of Information and Regulatory Affairs: Office of Management and Budget. 2011. 2011 Report to Congress on the Benefits and Costs of Federal Regulations and Unfunded Mandates on States, Local, and Tribal Entities. Washington, DC.
- Office of Management and Budget. 2004. Final Information Quality Bulletin for Peer Review.

- Oversight, Center for Consumer Information & Insurance. 2011. *Regulations and Guidance*. Center for Consumer Information & Insurance Oversight, Department of Health and Human Services 2011 [cited August 8 2011]. Available from <http://cciio.cms.gov/resources/regulations/index.html#cya>.
- Pear, Robert. 2011. U.S. Alters Rule on Paying for End-of-Life Planning. *New York Times*, January 4, 2011.
- Peterson, Mark A. 2011. It Was a Different Time: Obama and the Unique Opportunity for Health Care Reform. *Journal of Health Politics Policy and Law* 36 (3):429-436.
- Pollack, Harold. 2011. Health Reform and Public Health: Will Good Policies but Bad Politics Combine to Produce Bad Policy? *University of Pennsylvania Law Review* 159:2061-2086.
- U.S. Senate. 2010. *Providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule relating to status as a grandfathered health plan under the Patient Protection and Affordable Care Act*. 111th Congress, S. J. RES. 39.
- Rauber, Chris. 2010. PBGH's Peter Lee to join Obama administration in reform role. *San Francisco Business Times*, May 20, 2010.
- RealClearPolitics.com. 2011. *Obama and Democrats' Health Care Plan* 2011 [cited May 14 2011]. Available from http://www.realclearpolitics.com/epolls/other/obama_and_democrats_health_care_plan-1130.html#polls.
- RealClearPolitics.com. 2011. *Repeal of Health Care Law: Favor/Oppose* 2011 [cited May 14 2011]. Available from http://www.realclearpolitics.com/epolls/other/obama_and_democrats_health_care_plan-1130.html#polls.
- Saiger, Aaron J. 2011. Obama's "Czars" for Domestic Policy and the Law of the White House Staff. *Fordham Law Review* 29:2577-2615.
- Schulte, Fred. 2011. *Obama health czar DeParle made millions from companies under federal investigation*. Greenchange, July 3, 2009 2009 [cited July 28 2011]. Available from <http://www.greenchange.org/article.php?id=4609>.
- Sebelius, Kathleen. 2011. *Letter to Karen Ignagni* [Letter], March 29, 2010 2010 [cited July 28 2011]. Available from http://abcnews.go.com/images/Politics/Letter_Sebelius_to_Ignagni_100330.pdf.
- Secretary, Department of Health and Human Services: Office of the. 2011. *Secretary Sebelius Announces HHS Office of Health Reform Personnel* 2011 [cited July 20 2011]. Available from <http://www.hhs.gov/news/press/2009pres/05/20090511a.html>.
- Serafini, Marilyn Werber. 2010. Writing The Rules For The Health Law. *National Journal*
- Shapiro, Sidney A., and Ronald F. Wright. 2011. The Future of the Administrative Presidency: Turning Administrative Law Inside-Out. Wake Forest University Legal Studies Paper No. 1738491.
- Shapiro, Stuart, and John Morrall. 2011. The Triumph of Regulatory Politics: BCA and Political Salience. Working Paper, Rutgers University.
- Shear, Michael D., and Ceci Connolly. 2009. Obama Assembles Powerful West Wing. *Washington Post*, January 8, 2009.
- Stolberg, Sheryl Gay, Jeff Zeleny, and Carl Hulse. 2010. The Long Road Back. *New York Times*, March 21, 2010.

- Tapper, Jake. 2011. *In Controversy Over Coverage for Kids With Pre-existing Conditions, Who's to Blame? The New Law or the Insurance Companies?* ABC News 2010 [cited July 28 2011]. Available from <http://blogs.abcnews.com/politicalpunch/2010/03/in-controversy-over-coverage-for-kids-with-preexisting-conditions-whos-to-blame-the-new-law-or-the-i.html>.
- Upton, Fred, Cliff Stearnes, Joseph R. Pitts, and Phil Gingrey. 2011. *Letter to Secretary Kathleen Sebelius*. House Committee on Energy and Commerce 2011 [cited July 28 2011].
- Vekshin, Alison, and Drew Armstrong. 2011. Sebelius and DeParle Keep Health Reform Going. *Bloomberg Businessweek*, March 3, 2011.
- Washington Post. 2011. *Jay Angoff* 2011 [cited July 20 2011]. Available from http://www.whorunsgov.com/Profiles/Jay_Angoff.
- Washington Post. 2011. *Jeanne Lambrew* 2011 [cited July 20 2011]. Available from http://www.whorunsgov.com/Profiles/Jeanne_Lambrew.
- Washington Post. 2011. *Karen Pollitz* 2011 [cited July 20 2011]. Available from http://www.whorunsgov.com/Profiles/Karen_Pollitz.
- Washington Post. 2011. *Richard Popper* 2011 [cited July 20 2011]. Available from http://www.whorunsgov.com/Profiles/Richard_Popper.
- Washington Post. 2011. *Steve Larsen* 2011 [cited July 20 2011]. Available from http://www.whorunsgov.com/Profiles/Steve_Larsen.
- Weingast, Barry R. 1981. Regulation, Reregulation, and Degulation. *Law and Contemporary Problems* 44 (1):147-77.
- Weingast, Barry R. 1984. The Congressional-Bureaucratic System: A Principal Agent Perspective (with Applications to the SEC). *Public Choice* 44:147-91.
- Weingast, Barry R., and William J. Marshall. 1998. The Industrial Organization of Congress, or, Why Legislatures, Like Firms, are Not Organized As Markets. *Journal of Political Economy* 96 (1):132-63.
- Weingast, Barry R., and Mark J. Moran. 1983. Bureaucratic Discretion or Congressional Control? Regulatory Policymaking by the Federal Trade Commission. *Journal of Political Economy* 91 (5):765-800.
- West, William F. 2005. The Institutionalization of Regulatory Review: Organizational Stability and Responsive Competence at OIRA. *Presidential Studies Quarterly* 35:76-93.
- Williams, Richard. 2008. The Influence of Regulatory Economists in Federal Health and Safety Agencies. Working Paper, Mercatus Center at George Mason University
- Wolf, Richard. 2009. Sebelius, DeParle ready to tackle health care overhaul *USA Today*, June 2, 2009.
- Wood, B. Dan, and Richard W. Waterman. 1991. The Dynamics of Political Control of the Bureaucracy. *American Political Science Review* 85 (3):801-28.
- Yackee, Jason Webb, and Susan Webb Yackee. 2009. Regulation and Divided Government,. *Regulation and Governance* 3:128-44.