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THE POOR QUALITY OF AFFORDABLE CARE ACT REGULATIONS

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WILL THE PATIENT Protection and Affordable Care Act (ACA) improve the performance of the U.S. health care system? The quality of the major interim final regulations issued under the ACA in 2010 gives three main reasons for pessimism on this score.

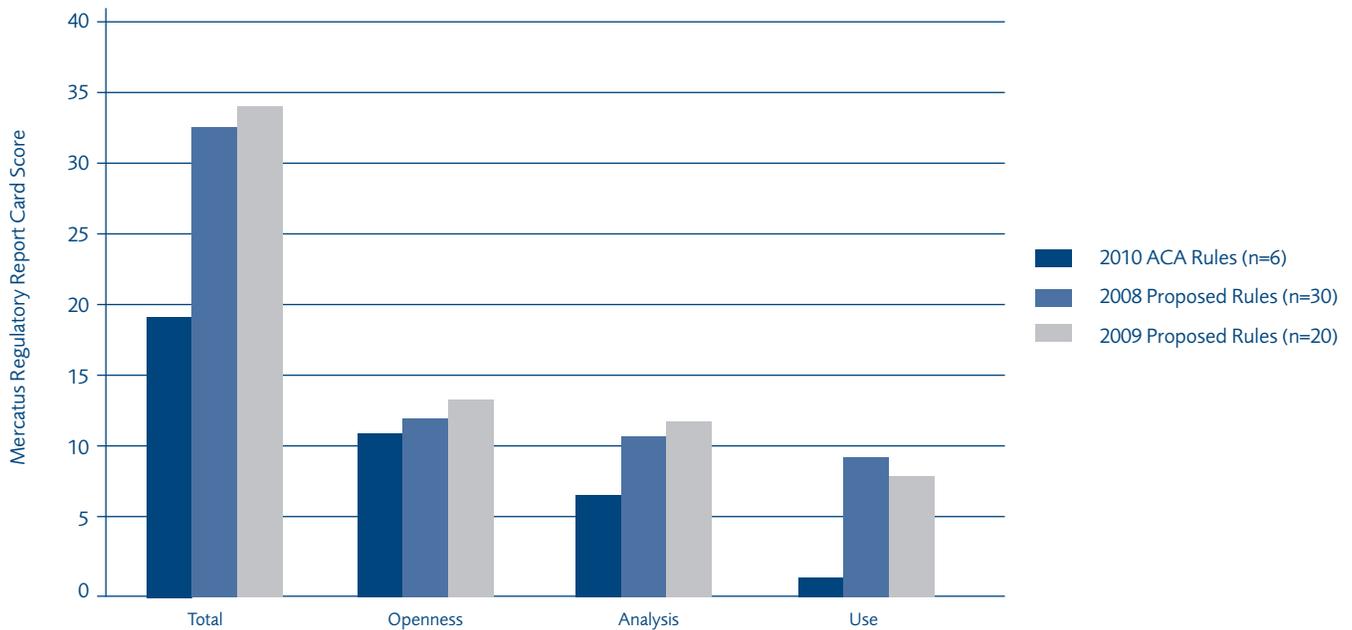
First, the quality of analysis for these regulations is measurably lower than for other major regulations proposed in 2008 and 2009. Second, the analyses supporting these regulations tended to overestimate the rules' benefits and underestimate their costs, in some cases by amounts exceeding billions of dollars. Third, the analyses often ignored more effective or less costly alternatives.

Had these regulations been accurately analyzed, it is likely that at least some would have failed a simple cost-benefit test. The challenge for Congress is to ensure that future ACA regulations yet to be issued do not repeat such flaws.

HOW THESE REGULATIONS WERE EVALUATED

WE USED THE Mercatus Center's Regulatory Report Card scoring system to compare the first eight major regulations issued under the ACA with all major proposed regulations issued in 2008 and 2009. 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,

FIGURE 1: REPORT CARD SCORES FOR PRESCRIPTIVE REGULATIONS



Source: Authors' calculations from data in Christopher J. Conover and Jerry Ellig, "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, Arlington, VA, 2012).

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?).¹

As Figure 1 shows, the quality and use of analysis for the ACA interim final regulations falls well below the standards set by other agencies and by the Department of Health and Human Services itself in conventional notice-and-comment rulemakings in previous years. However, the regulatory impact analyses for the eight ACA interim final rules is comparable to the analysis that accompanied a series of interim final homeland security regulations issued by the Bush administration following 9/11. This suggests that the institutions, not the people or party in power, explain the decline in quality of regulatory analysis when agencies implement significant presidential priorities on short deadlines.²

In general, the health regulations were less transparent than the major proposed rules issued by the Bush and Obama administrations in 2008 and 2009. This means it was difficult for the lay public or even experts to understand how the analysis calculated at least some of its estimates of benefits or costs. In some cases, the rules inadequately assessed the expected benefits or failed to demonstrate how the rule would achieve them. In other cases, the analysis failed to demonstrate that there was some market failure or other systematic problem that could be addressed only through federal government action. Some rules also failed to identify alternative, less expensive approaches to regulation or failed to adequately assess costs and compare these to benefits. In fact, not one of

these rules sought to monetize expected benefits, making it unclear why the agency concluded that the rule had benefits that exceeded its costs.

The lowest scores were for use of the analysis. Apparently, agencies used analysis as a post hoc justification of a regulatory approach already decided upon. The analyses did not always explain why the agency chose a particular option. Little thought was given to establishing measures, goals, or data sources that would permit the agency to evaluate the rule's future impact.

We examined in greater detail how well these regulations evaluated benefits, costs, equity, and regulatory alternatives. We found that the regulatory impact analyses were seriously incomplete or inaccurate, often omitting or mismeasuring significant benefits, costs, or regulatory alternatives. This resulted in a general pattern of exaggerated benefits and understated costs. Analysis of equity was cursory at best. In short, the regulatory analyses for these regulations were insufficient to guide decisions or inform the public.³

WHAT DIFFERENCE DOES IT MAKE?

ONE EXAMPLE ILLUSTRATES the kinds of problems we found in the ACA regulatory analyses. None of the eight rules mentions moral hazard, even though this is an inherent feature of health insurance. Moral hazard simply means that when someone else is paying the bill, people are less likely to avoid a

risk. In the context of health insurance, this means that people with insurance may be more likely to use medical care or less likely to care for their own health.

The size of this commonsense effect on behavior has been measured scientifically. The RAND Corporation performed a randomized, controlled trial of health insurance coverage. People randomly assigned to a plan that gave them completely free health care had medical expenses 50 percent higher than those randomly assigned to plans with modest cost sharing.⁴

Clearly, some of this additional care was of value to patients in the free care plan. But at least some of it was waste, meaning that the cost of the added care exceeded its worth to patients. RAND calculated that fully 30 percent of the total annual cost of medical spending for the free care group was wasted in this fashion. Yet for the average patient, this additional spending did not lead to any improvement in health status. The waste due to moral hazard ranges from 10 percent of spending for patients in plans with modest cost sharing to 28 percent for those on Medicare⁵ to 44 percent for the additional spending induced by the Medicare prescription drug plan.⁶ By ignoring an effect of this magnitude, the analyses understate the potential costs of various ACA regulations by double-digit percentages.

For at least three rules, the magnitude of such estimation errors is large enough that more accurate measurement of benefits and costs might well have reversed the presumption that benefits exceeded costs. These include the early retiree reinsurance program (where costs appear to have been understated by \$9–\$10 billion over four years), dependent coverage for children up to age 26 (where costs were underestimated by at least 20 percent) and the preexisting-condition insurance plan (where benefits appear to have been overestimated by at least \$1.5 billion and costs underestimated by at least \$6 billion).

This does not imply that these rules confer no benefits on the individuals whose health costs will be subsidized by taxpayers or policyholders. But reasonable people may conclude such transfers are not worthwhile if society bears an often hidden cost of \$1 or \$2 or \$3 for every dollar of health benefits delivered to patients.

KEY LESSONS

A COMBINATION OF top-down direction from the White House and tight deadlines imposed by Congress appears to have contributed to an abbreviated regulatory process that severely impaired the ability and willingness of agencies to produce high-quality regulatory impact analyses.

We have no way of determining whether the administration's process for developing these high-priority regulations was the sole reason for their poor quality or whether the tight dead-

lines imposed by Congress alone would have produced the same result. These rules spent much less time in the Office of Information and Regulatory Affairs (OIRA) review than rules typically do. But the involvement of both White House and high-ranking agency staff in the promulgation of these rules suggests that the administration likely got the rules it wanted written, in which case additional time for OIRA review would have made little or no difference in their quality.

POLICY RECOMMENDATIONS

THERE ARE SEVERAL steps Congress could take to help ensure that the final versions of these regulations—and subsequent regulations implementing other provisions of the ACA—reflect a more careful assessment of their consequences.

First, Congress could conduct more diligent oversight. This could be accomplished through oversight hearings or confirmation hearings for the heads of regulatory agencies; individual members of Congress also may meet with agency officials, write letters, or file public comments on rules.

Second, Congress could use the Congressional Review Act to overturn the final versions of these rules if it believes the analysis is insufficient. Senator Mike Enzi attempted this approach in the form of S.J. 39, introduced September 21, 2010, to disapprove the rule related to grandfathered health plans; the resolution was defeated by a vote of 40–59. This helps illustrate that such legislation is difficult to pass in a Congress divided along party lines. Moreover, since the president can veto the congressional resolution of disapproval, Congress is unlikely to overturn a rule issued by one of the president's own Cabinet departments. In the absence of more sweeping reforms—such as a requirement that Congress affirmatively approve major regulations—oversight is likely the more effective option.

Third, Congress can and often has used the text of appropriations bills either to direct or preclude the development of particular proposed rules, place restrictions on implementation or enforcement of certain provisions, or otherwise restrict certain types of regulatory activity. This same mechanism can be used to require the use of certain procedures before or after a rule is issued. Because of the urgency required in passing appropriations bills, such language can be used to steer the course of rulemaking even when the president is in the opposition party.⁷

CONCLUSION

POLICY MAKERS CANNOT eradicate politics from the regulatory process. But they can better ensure that politics does not trump good policy. This may require better congressional

checks and balances on the executive branch, a strategy the Founding Fathers would have understood well.

ENDNOTES

1. For a full explanation of the Report Card methodology and 2008 scoring results, see Jerry Ellig and Patrick McLaughlin, "The Quality and Use of Regulatory Analysis in 2008," *Risk Analysis* (forthcoming 2012). A prepublication version of this article is available at <http://mercatus.org/publication/quality-and-use-regulatory-analysis-2008>.
2. This section summarizes a much longer analysis in Christopher J. Conover and Jerry Ellig, "Beware the Rush to Presumption, Part C: A Public Choice Analysis of the Affordable Care Act's Interim Final Rules" (working paper, Mercatus Center at George Mason University, Arlington, VA, 2012).
3. Christopher J. Conover and Jerry Ellig, "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, Arlington, VA, 2012).
4. Emmett B. Keeler, Joan L. Buchanan, John E. Rolph, Janet M. Hanley, and David M. Reboussin, *The Demand for Episodes of Medical Treatment in the Health Insurance Experiment* (Santa Monica, CA: RAND Corporation, 1988).
5. Amy Finkelstein and Robin McKnight, "What Did Medicare Do (and Was It Worth It)?" (National Bureau of Economic Research Working Paper no. 11609, Cambridge, MA, 2005).
6. Mark V. Pauly, "Medicare Drug Coverage and Moral Hazard," *Health Affairs* 23, no. 1 (2004): 113–22.
7. Curtis W. Copeland, *Congressional Influence on Rulemaking and Regulation through Appropriations Restrictions* (Washington, DC: Congressional Research Service, 2008).

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