No. 12-02
January 2012

WORKING PAPER

BEWARE THE RUSH TO PRESUMPTION, PART B: Substandard Regulatory Analyses for the Affordable Care Act's Interim Final Rules

By Jerry Ellig and Christopher J. Conover

MERCATUS CENTER
George Mason University

Beware the Rush to Presumption, Part B:

Substandard Regulatory Analyses for the Affordable Care Act's Interim Final Rules

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

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

Abstract

Federal agencies issued eight major interim final regulations in 2010 to quickly implement major provisions of the Affordable Care Act (ACA). This paper employs the Mercatus Center's Regulatory Report Card scoring system to compare the quality and use of regulatory impact analyses (RIAs) for these regulations with the quality and use of RIAs for major proposed regulations in 2008 and 2009. The quality and use of analysis for the ACA interim final regulations falls well below the standards set by other agencies and even by the U.S. Department of Health and Human Services in conventional notice-and-comment rulemaking in previous years. The analysis in the eight ACA RIAs 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 institutional, rather than personal or partisan, factors explain why the quality of regulatory analysis declines when agencies implement significant presidential priorities on short deadlines.

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. We would especially like to acknowledge Mark Adams's tireless assistance in evaluating these regulations under the Mercatus Center's Regulatory Report Card scoring system.

1. Introduction

In 2010, the Obama administration rapidly issued eight major "interim final rules" to implement the Affordable Care Act (ACA).[1] These regulations cover a wide variety of topics, such as allowing parents to keep adult children on their health care policies until age 26, mandating coverage for preventive care services, and requiring insurance companies to spend a specified percentage of premium dollars on health care services. Two of the regulations provide federal subsidies for health insurance for early retirees and for individuals with costly preexisting conditions. These eight rules encompass nearly all the major components of the ACA scheduled to go into effect prior to 2014. Since issuing these rules, U.S. Department of Health and Human Services (HHS) officials have assured legislators that the benefits of the regulations justify their costs.[2]

Yet prior scholarship suggests that rules implementing signature presidential priorities under tight deadlines may be accompanied by seriously incomplete regulatory analysis. Interim final rules, which are issued prior to a public comment period, involve less public input and discussion.[3] Tight deadlines driven by congressional or presidential priorities can prompt analytical shortcuts, leading to lower-quality decisions.[4] In the Bush administration, for example, a series of interim final homeland security regulations issued in the years following 9/11 had less complete analysis than other homeland security rules.[5] Likewise, the Bush administration's "midnight regulations" issued between Election Day 2008 and Inauguration Day had lower-quality analysis than regulations proposed earlier in 2008.[6]

More recently, in Part A of this series, we found that the regulatory impact analyses (RIAs) for the interim final health care regulations issued in 2010 were seriously incomplete, often omitting significant benefits, costs, or regulatory alternatives. Analysis of equity was cursory at best. In short, the regulatory analysis for these regulations was insufficient to guide decisions or inform the public.[7]

---

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

[2] House Energy and Commerce Committee, *The Views of the Department of Health and Human Servies on Regulatory Reform: An Update*, video of testimony by Sherry Glied, 112th Cong., 1st sess., 2011.

[3] Michael Asimow, "Interim Final Rules: Making Haste Slowly," *Administrative Law Review* 51 (Summer 1999): 703–55.

[4] Jacob E. Gersen and Anne Joseph O'Connell, "Deadlines in Administrative Law," *University of Pennsylvania Law Review* 156 (2008): 839–922; Alden F. Abbott, "The Case against Federal Statutory and Judicial Deadlines: A Cost-Benefit Appraisal," *Administrative Law Review* 39 (1987): 171–204; and Alden F. Abbott, "Case Studies on the Costs of Federal Statutory and Judicial Deadlines," *Administrative Law Review* 51 (Summer 1987): 467–87.

[5] Jamie Belcore and Jerry Ellig, "Homeland Security and Regulatory Analysis: Are We Safe Yet?" *Rutgers Law Journal* (2009):1–96.

[6] Patrick McLaughlin and Jerry Ellig, "Does OIRA Review Improve the Quality of Regulatory Impact Analysis? Evidence from the Final Year of the Bush II Administration," *Administrative Law Review* (forthcoming 2011).

[7] 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), http://mercatus.org/publication/material-omissions-in-regulatory-analyses-for-the-affordable-care-acts-interim-final-rules.

A disinterested observer might ask whether our assessment in Part A is too harsh. Perhaps it is unreasonable to ask government health care analysts to be fully conversant with major categories of health reform benefits and costs identified in the scholarly health policy literature. Perhaps it is unreasonable to require (as Executive Order 12866 does) that agencies prepare evidence-based analyses of a wide variety of alternatives that might achieve regulatory objectives. Perhaps it is unreasonable to expect agencies to define and defend some specific concept of fairness when they claim their regulations promote fairness. In short, perhaps our Part A documents nothing more than a wide gap between the exacting standards of scholars with lots of time on their hands and the practical exigencies of actually governing.

This paper addresses that potential concern by comparing the quality of analysis for the eight interim final ACA regulations with the quality of analysis for other economically significant regulations proposed by federal agencies under the normal notice-and-comment process in 2008 and 2009. We evaluate each regulation according to the 12 criteria employed in the Mercatus Center's Regulatory Report Card, a project that assesses the quality and use of regulatory analysis by executive branch agencies. The 12 criteria are grouped into three categories: openness, analysis, and use. A regulation can earn up to 20 points on each group of criteria, for a maximum possible score of 60 points.

Scoring the interim final regulations according to the Report Card criteria allows us to compare their quality and use of analysis with the quality and use of analysis for several "control groups" of regulations: all economically significant regulations proposed in the two previous years, all economically significant regulations proposed by HHS in the two previous years, and a set of interim final regulations issued rapidly by the Department of Homeland Security (DHS) in the years following 9/11. If the quality or use of analysis in these health care regulations is superior to that in other regulations in prior years, that suggests the Obama administration's emphasis on evidence-based policymaking has elevated the quality of regulatory analysis and its use in decisions, even if the analysis of these regulations was not perfect. If the quality or use of analysis in these health care regulations is comparable to that in most other regulations in prior years, then there is nothing special about these regulations. The analytical deficiencies Part A identified are likely shared by other types of regulations as well.[8] Finally, if the quality or use of analysis for these health care regulations is inferior to that of other regulations (like the DHS interim final regulations), that suggests significant presidential priorities combined with tight deadlines tend to reduce the quality of analysis and decisions.

1.1 The Regulations[9]

The ACA required agencies to put significant programs or requirements in place on very short deadlines, often within six months of the legislation's enactment. The phrase "the Secretary shall"—designating items that require rules from the implementing agencies—appears 1,563 times in the final legislation, dwarfing the number of regulations needed for any prior health care

[8] Conover and Ellig, "Beware the Rush to Presumption: Part A: Material Omissions in Regulatory Analyses for the Affordable Care Act's Interim Final Rules."

[9] For the convenience of the reader, we repeat this summary of the regulations in our Part A, Part B, and Part C papers in this series.

reform.[10] This does not imply that more than 1,500 rules will be issued. More than 40 provisions in the ACA either required or permitted the issuance of implementing regulations.[11] By the end of 2010, at least 18 final rules (some interim) had been issued.[12] The Unified Regulatory Agenda issued in December 2010 lists 29 ACA-related actions in the proposed-rule stage along with an additional 24 long-term actions.[13] Half of these were final rules expected to be issued after taking into account comments related to previously issued interim final rules.[14] In addition to formal regulations, hundreds of guidance documents, frequently asked questions, forms, letters, and other sub-regulatory documents have been issued that further clarify and refine the rules issued.[15]

Our analysis focuses on the eight major regulations issued rapidly as interim final rules in 2010. These regulations implement the principal aspects of the ACA that alter health care plans before 2014. All of these regulations 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.[16]

Table 1 lists and summarizes these major regulations. Six of the eight are "prescriptive" regulations: they affect the terms of contracts between health insurers, insured people, 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. HHS, for example, annually issues numerous regulations that recalculate the rates Medicare and Medicaid pays doctors, hospitals, skilled nursing facilities, and other health care providers. These are known as transfer or budget regulations.

---

[10] James A. Morone, "Big Ideas, Broken Institutions, and the Wrath at the Grass Roots," *Journal of Health Politics, Policy and Law* 36, no. 3 (2011): 381.
[11] Curtis W. Copeland, *Initial Final Rules Implementing the Patient Protection and Affordable Care Act (P. L. 111-148)* (Washington, DC: Congressional Research Service, 2010), 2.
[12] Ibid.
[13] Curtis W. Copeland, *The Unified Agenda: Implications for Rulemaking Transparency and Participation* (Washington, DC: Congressional Research Service, 2009). Long-term actions refer to regulations under development that agencies do not expect to take action on in the next 12 months.
[14] Curtis W. Copeland and Maeve P. Carey, *Upcoming Rules Pursuant to the Patient Protection and Affordable Care Act (P. L. 111-148)* (Washington, DC: Congressional Research Service, 2011).
[15] For examples, see Center for Consumer Information and Insurance Oversight, *Regulations and Guidance*, U.S. Department of Health and Human Services (August 8, 2011), http://www.hhs.gov/news/press/2010pres/04/20100402b.html.
[16] Executive Order 12866, *Federal Register* 58, no. 190 (October 4, 1993): 51, 735–44.

Table 1: Summaries of Economically Significant Interim Final Health Care Regulations Issued in 2010

Regulation	HHS RIN*	Agencies	Principal Purpose
Early Retiree Reinsurance Program	*0991-AB64*	*HHS*	*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 up to age 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, and So Forth	0991-AB69	HHS, Labor, Treasury	Establishes 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.
Preexisting-condition Insurance Plan	*0991-AB71*	*HHS*	*Establishes a high-risk health insurance pool program to provide subsidized insurance to people with preexisting conditions until 2014.*
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.
*U.S. Department of Health and Human Services Regulation Identifier Number.
Source: Authors' notes based on the Notice of Proposed Rulemaking for each regulation. Each notice can be looked up by RIN at www.regulations.gov.

An interim final rule is a regulation that takes effect without first being issued 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 public comments into account.[17] For an interim final rule, the agency writes the rule and announces when it will take effect. The agency may go back and change the rule 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."[18] 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.[19] 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 ACA interim final rules involved provisions of the law that took effect three, six, or nine months after their 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. Curtis W. Copeland of the Congressional Research Service notes that "the agencies' use of rulemaking to accomplish the underlying statutory objectives does not appear to be either improper or unusual."[20]

1.2 Principal Findings

The analysis accompanying most of these regulations was seriously incomplete and rarely used. The highest-scoring interim final health care regulation earned 25 out of a possible 60 points (42 percent) on the Mercatus Center's Regulatory Report Card scoring system. The lowest-scoring interim final regulation received 13 points (22 percent). These regulations usually earned about half of the possible points on the openness criteria, less than half of the possible points on the analysis criteria, and virtually no points on the use criteria.

The quality and use of analysis for the 2010 interim final health care regulations was well below the standards set by other agencies in conventional notice-and-comment rulemaking. For prescriptive regulations, the 2010 interim final health care regulations scored 35–40 percent below the economically significant regulations proposed by executive branch agencies in 2008 and 2009. For budget regulations, the 2010 interim final health care regulations scored about the same as regulations proposed in 2008 and 2009 on the openness and analysis criteria, but lower on use.

The use of analysis for the 2010 interim final health care regulations was well below the standards set by HHS in conventional notice-and-comment rulemaking. The health care regulations score lower than HHS regulations issued in 2008 and 2009, mostly due to much lower scores on the use criteria.

The poor quality and use of analysis is comparable to that of interim final rules related to homeland security. We compared the health care regulations' scores with scores earned by interim final homeland security regulations issued rapidly after 9/11. The prescriptive interim

[17] Administrative Procedure Act (APA), Pub. L. No. 79-404, 60 Stat. 237 (June 11, 1946).
[18] Ibid., sec. 553(b).
[19] Gersen and O'Connell, "Deadlines in Administrative Law," 943.
[20] Copeland, *Initial Final Rules Implementing the Patient Protection and Affordable Care Act*, 4–5.

final health care regulations score better than the DHS interim final regulations on the accessibility (a measure under openness) and outcomes (a measure under analysis) criteria but about the same on the other analysis criteria. (The homeland security regulations were evaluated only on the accessibility criterion and the four analysis criteria.) One health care budget regulation scored somewhat better than the single homeland security budget regulation on the analysis criteria, and one scored slightly worse.

2. Report Card Evaluation Method

The Mercatus Center's Regulatory Report Card has assessed the quality and use of regulatory analysis for proposed, economically significant regulations issued by executive branch agencies since 2008. The Report Card methodology is a middle ground between checklist systems for scoring regulatory analysis and in-depth qualitative case studies.[21] The Report Card consists of 12 criteria grouped into three categories: openness, analysis, and use. Table 2 lists the 12 criteria. Appendix 1 provides additional detail on the kinds of questions considered under each criterion.

The Mercatus Center's Regulatory Report Card scoring system evaluates whether the RIA and preamble to the proposed rule make a reasonable effort at covering the major elements of regulatory analysis and present sufficient information for the reader to verify the underlying data, models, and results. The method does not, however, require the evaluators to replicate the analysis, verify the underlying data and models, or perform their own analysis. The developers of the Report Card acknowledge that an analysis that scores well may still have flaws and inaccuracies that are apparent only to a specialist well versed in the scholarly literature relevant to that particular regulation.[22]

For example, an RIA might accurately identify that a proposed rule will adversely affect minimum-wage workers in small firms, and therefore merit a high score on the criterion of whether it has identified all parties who would bear costs and the incidence of these costs. But if

---

[21] For checklist systems, see Government Accountability Office (GAO), *Air Pollution: Information Contained in EPA's Regulatory Impact Analyses Can Be Made Clearer* (Washington, DC: GAO, 1997); GAO, *Regulatory Reform: Agencies Could Improve Development, Documentation, and Clarity of Regulatory Economic Analyses* (Washington, DC: GAO, 1998); Robert W. Hahn et al., "Assessing Regulatory Impact Analyses: The Failure of Agencies to Comply with Executive Order 12,866," *Harvard Journal of Law and Public Policy* 23, no. 3 (2000): 859–71; Robert W. Hahn and Patrick Dudley, "How Well Does the Government Do Cost-Benefit Analysis?" *Review of Environmental Economics and Policy* 1, no. 2 (2007): 192–211; Robert W. Hahn and Robert Litan, "Counting Regulatory Benefits and Costs: Lessons for the U.S. and Europe," *Journal of International Economic Law* 8, no. 2 (2005): 473–508; Art Fraas and Randall Lutter, "The Challenge of Improving the Economic Analysis of Pending Regulation: The Experience of OMB Circular A-4" (discussion paper, Resources for the Future, 2010); and Stuart Shapiro and John Morrall, "The Triumph of Regulatory Politics: BCA and Political Salience" (working paper, n.p., 2011). For in-depth qualitative studies, see Thomas McGarity, *Reinventing Rationality* (Cambridge, UK: Cambridge University Press, 1991); Art Fraas, "The Role of Economic Analysis in Shaping Regulatory Policy," *Law and Contemporary Problems* 54, no. 4 (1991): 113–25; Richard Morgenstern, *Economic Analysis at EPA* (Washington, DC: Resources for the Future Press, 1997); Eric A. Posner, "Transfer Regulations and Cost-Effectiveness Analysis," *Duke Law Journal* 53, 2003:1,067–110; and Winston Harrington, Lisa Heinzerling, and Richard Morgenstern, *Reforming Regulatory Impact Analysis* (Washington, DC: Resources for the Future Press, 2009). For a more extensive explanation and justification of this evaluation method, see Jerry Ellig and Patrick McLaughlin, "The Quality and Use of Regulatory Analysis in 2008," *Risk Analysis* 32 (forthcoming 2012). A working paper version is available at http://mercatus.org/publication/quality-and-use-regulatory-analysis-2008.

[22] Ellig and McLaughlin, "The Quality and Use of Regulatory Analysis in 2008," 12.

the RIA's measure of the size of this impacted group is flawed, the RIA may nevertheless systematically understate or overstate the magnitude of such costs. The RIA might rely on an unrepresentative survey to determine the number of firms in a particular size class. It may use a flawed method for estimating the number of minimum-wage workers who work for firms in that size category. It may not have considered changes in incentives to employ such workers created by the new rule.

In short, the Report Card methodology does not evaluate RIAs in as much detail as our Part A paper did. Thus, it may fail to identify some of the kinds of deficiencies identified in that paper. The strength of the method is that it provides an established metric for comparing the quality of the ACA RIAs with the quality of a variety of other RIAs.

Table 2: Regulatory Analysis Assessment Criteria

Openness

1. **Accessibility:** How easily were the regulatory impact analysis, the proposed rule, and any supplementary materials found online?
2. **Data Documentation:** How verifiable are the data used in the analysis?
3. **Model Documentation:** How verifiable are the models and assumptions used in the analysis?
4. **Clarity:** Was the analysis comprehensible to an informed layperson?

Analysis

5. **Outcomes:** How well does the analysis identify the desired benefits or other outcomes and demonstrate that the regulation will achieve them?
6. **Systemic Problem:** How well does the analysis identify and demonstrate the existence of a market failure or other systemic problem the regulation is supposed to solve?
7. **Alternatives:** How well does the analysis assess the effectiveness of alternative approaches?
8. **Benefit-Cost Analysis:** How well does the analysis assess costs and compare them with benefits?

Use

9. **Some Use of Analysis:** Does the preamble to the proposed rule or the regulatory impact analysis present evidence that the agency used the analysis?
10. **Cognizance of Net Benefits:** Did the agency maximize net benefits or explain why it chose another option?
11. **Measures and Goals:** Does the proposed rule establish measures and goals that can be used to track the regulation's results in the future?
12. **Retrospective Data:** Did the agency indicate what data it will use to assess the regulation's performance in the future and establish provisions for doing so?

Ten of the twelve evaluation criteria listed in Table 2 closely parallel the RIA checklist released by the Office of Management and Budget (OMB) on November 3, 2010.[23] This is not surprising since both the administration's checklist and the Mercatus Center's evaluation criteria are based on Executive Order 12866 and OMB Circular A-4.[24] Appendix 2 presents a crosswalk chart comparing the OMB checklist with the 12 criteria used in the Regulatory Report Card.

The principal Regulatory Report Card evaluation criteria not mentioned in the OMB checklist are two criteria that assess whether the agency provided for retrospective analysis of a regulation's actual effects after it was adopted: criterion 11 (measures and goals) and criterion 12 (retrospective data). Although ex-post, retrospective analysis has not received as much attention as ex-ante analysis of proposed regulations, Section 5 of Executive Order 12866 states that agencies should conduct retrospective analysis.[25] In Executive Order 13563, President Obama directed agencies to develop plans for periodic retrospective reviews of regulations.[26] The Government Performance and Results Act (GPRA) Modernization Act of 2010 requires federal agencies to identify regulations that contribute to their high-priority goals and to assess quarterly whether the regulations are contributing to the goals as planned.[27] Since the RIA assesses prospective results of a proposed regulation and its alternatives, it seems logical to build upon that foundation when the regulation is proposed by indicating goals, measures, and data that could be used for retrospective review in the future.

For each criterion, the evaluators assigned a score ranging from 0 (no useful content) to 5 (comprehensive analysis with potential best practices). Thus, each analysis has the opportunity to earn between 0 and 60 points. In general, the research team used the guidelines in Table 3 for scoring. However, because the analysis criteria involve so many discrete aspects of regulatory analysis, each of the four analysis criteria has a series of subquestions that each receives a 0–5 score. These scores were then averaged to calculate the score for the individual criterion. To ensure scoring consistency, all eight evaluations were conducted by two individuals who have scored other regulations for the Report Card since 2008. Individual report cards showing all scores and scoring notes for each regulation are available online.[28]

---

[23] Office of Management and Budget (OMB), *Agency Checklist: Regulatory Impact Analysis* (Washington, DC: OMB, 2010).
[24] Executive Order 12866, *Federal Register* 58, no. 190 (October 4, 1993): 51,735–44; OMB, *Circular A-4* (Washington, DC: OMB, 2003).
[25] Executive Order 12866, section 5.
[26] Executive Order 13563, *Federal Register* 76, no 14 (January 21, 2011): 3,821–23.
[27] Government Performance and Results Modernization Act of 2010, Pub. L. No. 111-352, sec. 6(b)(3).
[28] For the individual report cards, see www.mercatus.org.

Table 3: What Do the Scores Mean?

5	**Complete analysis of all or almost all aspects, with one or more "best practices."**
4	**Reasonably thorough analysis of most aspects and/or shows at least one "best practice."**
3	**Reasonably thorough analysis of some aspects.**
2	**Some relevant discussion with some documentation of analysis.**
1	**Perfunctory statement with little explanation or documentation.**
0	**Little or no relevant content.**

The Regulatory Report Card assesses how well agencies do the things presidents have been telling them to do in executive orders governing regulation for more than three decades. Report Card scores are not assessments of whether a proposed rule is economically efficient, fair, or otherwise good public policy. Even the use criteria evaluate only the extent to which the agency claimed or appeared to have used information from the analysis, not whether the agency made the same decisions the evaluators would have made. If information about the regulation's likely outcomes, the systemic problem, alternatives, benefits, or costs appeared to affect the agency's decision, the agency received credit for using the analysis.

3. Quality and Use of Analysis for the Interim Final Health Care Regulations

Table 4 shows the scores for the interim final health care regulations issued in 2010. The regulation on insurance company coverage of preventive services received the highest score, 25 out of a maximum possible 60 points, or 42 percent of the possible points. Two regulations tied for the lowest score of 13 points. All of the regulations did better on the openness criteria, such as availability on the Internet and documentation of sources, than on the analysis or use criteria. Indeed, the low use scores indicate that the agencies offered little indication in the *Federal Register* notices that they used the analysis to make decisions about the regulations or that they plan to evaluate the regulations' results in the future.

Table 4: Report Card Scores for Interim Final Health Care Regulations in 2010

Regulation	HHS RIN*	Total Score (Max=60)	Openness (Max=20)	Analysis (Max=20)	Use (Max=20)
Coverage of Preventive Services	0938-AQ07	25	13	11	1
Preexisting-condition Insurance Plan	*0991-AB71*	*21*	*11*	*8*	*2*
Medical Loss Ratio Requirements	0950-AA06	21	13	7	1
Dependent Coverage for Children up to Age 26	0991-AB66	19	11	6	2
Grandfathered Health Plans	0991-AB68	19	10	7	2
Preexisting-condition Exclusions, Limits, et al.	0991-AB69	17	10	5	2
Early Retiree Reinsurance Program	*0991-AB64*	*13*	*8*	*4*	*1*
Claims Appeals and External Review Processes	0991-AB70	13	9	3	1

Note: The rules in italics are budgetary regulations; the other rules are prescriptive regulations.
* U.S. Department of Health and Human Services Regulation Identifier Number.

Table 5 shows the highest scores on each individual criterion and indicates which regulation(s) received that score. Four regulations earned the highest possible score of 5 on criterion 1, accessibility. This means the *Federal Register* notice and any accompanying regulatory analyses were easy to find on both regulations.gov and the agency's web page. The only other criteria on which any regulation received a reasonably good score of 4 were criterion 2 (data documentation) and criterion 5 (outcomes). On the other criteria related to quality of analysis, the best scores are poor to middling: 3 or below. Finally, the low scores on the use criteria (criteria 9–12) indicate only that the agencies acknowledged they were aware of the regulatory analysis, not that it was actually used.

Table 5: Highest Scores on Individual Criteria for Interim Final Health Care Regulations in 2010

Criterion	Highest Score (Max=5)	Regulation(s)
1. Accessibility	5	Medical Loss Ratio Grandfathered Health Plans Early Retiree Reinsurance Program Dependent Coverage for Children up to Age 26
2. Data Documentation	4	Medical Loss Ratio Coverage of Preventive Services
3. Model Documentation	3	Preexisting-condition Insurance Plan Coverage of Preventive Services
4. Clarity	2	All 8
5. Outcomes	4	Coverage of Preventive Services
6. Systemic Problem	3	Coverage of Preventive Services
7. Alternatives	3	Grandfathered Health Plans
8. Cost-benefit	2	Medical Loss Ratio Coverage of Preventive Services Dependent Coverage for Children up to Age 26
9. Any Use of Analysis	1	All 8
10. Cognizance of Net Benefits	0	All 8
11. Goals and Measures	0	All 8
12. Retrospective Data	1	Grandfathered Health Plans Preexisting-condition Insurance Plan Dependent Coverage for Children up to Age 26 Preexisting-condition Exclusions, Limits, et al.

4. Comparison with Prior Years' Proposed Regulations

To date, the Mercatus Center's Regulatory Report Card project has evaluated all proposed economically significant regulations in 2008 and 2009. We can assess the relative quality and use of analysis for the health care regulations by comparing their scores with the scores of regulations from 2008 and 2009.

To compare the health care regulations with other regulations, we need to separate budget regulations from prescriptive regulations to compare like with like. 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. HHS, for example, annually issues multiple regulations that recalculate Medicare payment rates to doctors, hospitals, and other health care providers. But because there are alternative ways to define eligibility, alternative processes by which to qualify for payment or funding, and alternative approaches to disbursement, regulatory impact analysis

still provides a way to ensure that such regulations are implemented using the most efficient, effective, and equitable approach.

The distinction between prescriptive and budget regulations matters because previous research has found that budget regulations usually receive much lower quality analysis than ordinary regulations. OMB observes that although budget regulations generate social costs via mandates, prohibitions, and price distortions, agencies do not usually estimate their social benefits and costs.[29] Posner concludes that agencies rarely perform analysis for these regulations and presents several case studies showing that the analysis has been inadequate when agencies do attempt it.[30] On the Mercatus Center's Regulatory Report Card, budget regulations received an average of only 17 points in 2008 and 20 points in 2009, compared to an average of 32–34 points for prescriptive regulations.[31] Statistical tests show that the scores of budget regulations are indeed different from the scores of prescriptive regulations.[32] Executive Order 12866 makes no distinction between prescriptive regulations and budget regulations, but OMB and agencies apparently treat budget regulations differently.[33]

4.1 Prescriptive Regulations

Table 6 compares the six prescriptive interim final health care regulations' scores with the scores prescriptive, economically significant proposed regulations received in 2008 and 2009. In general, the health care regulations score much lower than the economically significant proposed regulations in both years. The average total score for the health care regulations is about 40 percent below the average total scores of prescriptive proposed regulations in both 2008 and 2009. The differences are almost always large, and the t-statistics indicate that they are almost always highly statistically significant.[34]

The one exception occurs on the openness criteria. The health care regulations scored essentially the same on openness as regulations proposed in the last year of the Bush administration but not quite as well as those proposed in the first year of the Obama administration. For most criteria, the 2009 regulations score about the same as the 2008 regulations.[35] Thus, the lower scores for the health care regulations cannot be attributed to systematic differences in the quality of regulatory analysis in the two administrations.

---

[29] Office of Information and Regulatory Affairs (OIRA), *2008 Report to Congress on the Benefits and Costs of Federal Regulations and unfunded Mandates on States, Local, and Tribal Entities* (Washington, DC: OMB, 2008), 12–7.
[30] Posner, "Transfer Regulations and Cost-Effectiveness Analysis."
[31] Jerry Ellig and John Morrall, "Assessing the Quality of Regulatory Analysis: A New Evaluation and Data Set for Policy Research" (working paper, Mercatus Center at George Mason University, Arlington, VA, 2010), 4, http://mercatus.org/sites/default/files/publication/wp1075-assessing-the-quality-of-regulatory-analysis.pdf.
[32] McLaughlin and Ellig, "Does OIRA Review Improve the Quality of Regulatory Impact Analysis?"
[33] Executive Order 12866.
[34] In plain English, "statistically significant" means there is a very high likelihood that the average scores for the health care regulations really are different from the average scores of the other two groups of regulations; the difference is more than just random chance. "Statistically insignificant" means the scores for different sets of regulations are like sets of ping-pong balls pulled at random out of the same bucket: any difference in the averages appears to be due to random chance. A 95-percent confidence level means the chance that the differences denoted as "statistically significant" would have been as large as shown is 5 percent or less.
[35] Ellig and Morrall, "Assessing the Quality of Regulatory Analysis."

Table 6: Report Card Scores for Prescriptive Regulations—2010 Interim Final Health Care versus 2008–09 Proposed Regulations

	2010 Health Care (n=6)	2008 Proposed Regulations (n=30)	t-stat.	2009 Proposed Regulations (n=20)	t-stat.
Total	19.0	32.4	5.06***	34.2	5.34***
Categories of Criteria					
Openness	11.0	12.3	1.04	13.7	3.11***
Analysis	6.5	11.0	3.38***	12.2	4.02***
Use	1.5	9.1	6.75***	8.3	4.64***
All Categories Average	6.3	10.8	5.17***	11.4	4.90***
	(n=18)	(n=90)		(n=60)	
Individual Criteria					
1. Accessibility	4.5	3.3	1.85*	4.0	1.43
2. Data Documentation	2.7	2.6	0.07	3.0	0.90
3. Model Documentation	1.8	2.8	2.04**	3.3	3.37**
4. Clarity	2.0	3.5	4.03***	3.3	3.55***
5. Outcomes	2.2	3.1	2.17**	3.6	3.12***
6. Systemic Problem	1.3	2.4	1.79*	2.3	1.73*
7. Alternatives	1.5	2.9	2.98***	3.3	3.60***
8. Cost-benefit	1.5	2.6	3.51***	3.1	4.05***
9. Any Use of Analysis	1.0	2.6	2.82***	2.2	1.97*
10. Cognizance of Net Benefits	0.0	2.9	5.91***	2.7	4.27***
11. Goals and Measures	0.0	1.5	3.46***	1.6	3.96***
12. Retrospective Data	0.5	2.0	3.31***	1.9	3.03***
All Criteria Average	1.6	2.7	6.87***	2.8	7.22***
	(n=72)	(n=360)		(n=240)	

Note: t-test for difference in means; statistical significance:
***99-percent confidence level, **95-percent confidence level, *90-percent confidence level.

We can gain additional insight by breaking the scores down according to the 12 Report Card criteria. Table 6 shows that the prescriptive health care regulations score lower than 2008 and 2009 proposed regulations on all criteria but two.

On criterion 6, discussion of the systemic problem, the health care regulations score below the regulations proposed in 2008 and 2009, but the difference is only statistically significant at the 90-percent confidence level. This probably reflects the fact that scores on this criterion were consistently low in both 2008 and 2009. Figure 1 reproduces the scores and scoring notes for the

preventive services regulation, which earned the best score for analysis of the systemic problem. This regulation's analysis asserted three types of market failures, but it did not develop a coherent theory explaining why these market failures exist or present much evidence that usage of preventive services is suboptimal. The analysis also did not spend much time examining uncertainties about the existence or size of the problem. Yet this analysis scored best.

Figure 1: Scoring Notes for Analysis of the Systemic Problem in the Preventive Care Regulation

6. How well does the analysis identify and demonstrate the existence of a market failure or other systemic problem the regulation is supposed to solve?	3		
Does the analysis identify a market failure or other systemic problem?	5	6A	RIA states that preventive services are underutilized because (1) turnover prevents health plans from benefiting from cost reductions in the future, (2) individuals must pay now but receive savings later, and (3) some preventive care involves spillover benefits for society as a whole. All three are characterized as "market failures."
Does the analysis outline a coherent and testable theory that explains why the problem (associated with the outcome above) is systemic rather than anecdotal?	3	6B	Theories above are testable, but need to be spelled out in greater detail to be logically coherent. The departments need to make an asymmetric information argument to explain why frequent switching of insurance would lead individuals to not internalize the health benefits of preventative care. The departments also need to explain why individuals should be expected to excessively discount future health costs.
Does the analysis present credible empirical support for the theory?	2	6C	RIA cites evidence that people use more preventive services when the cost is lower. But nowhere does it define the "optimal" usage or show whether current usage is above or below this level. The size or relative importance of the three "market failures" is not estimated.
Does the analysis adequately assess uncertainty about the existence or size of the problem?	2	6D	See answer to 5E above. Uncertainty about the number of plans and people affected could be interpreted as uncertainty about the size of the problem.

Source: Mercatus Center at George Mason University, "Coverage of Preventive Services Interim Final Rule," Mercatus Center Regulatory Report Card, January 2012.

On most of the criteria, scores for regulations proposed in 2008 and 2009 average around 3 points. This indicates that the average analysis has reasonably thorough discussion of some but not all aspects of the criterion. Average scores for the health care regulations, on the other hand, usually fall between 1 and 2. For these regulations, the agencies merely offered assertions about possible effects or presented only fragments of relevant theory or evidence. Once again, for most criteria, the 2009 regulations score about the same as the 2008 regulations, so the subpar analysis for the health care regulations does not appear to be part of a larger pattern of differences across administrations.

Because we have a relatively small number of regulations, Table 7 and subsequent tables also conduct joint tests for differences in means for all categories of criteria and for all criteria. The results of these tests also suggest that the quality of analysis for the interim final health care regulations was significantly lower than for economically significant proposed regulations in 2008 and 2009.

4.2 Budget Regulations

Scores for the budget regulations tell a slightly different story. The quality and use of analysis for budget regulations from the health care bill are essentially the same as for budget regulations proposed in 2008 and 2009 (see Table 7). The averages for total score, openness, and analysis are equivalent, with no statistically significant differences. The health care regulations score lower on use.

On individual criteria, the score differences are rarely statistically significant. Almost all of the scores on individual criteria are quite low: usually below 2 points. With the exception of only a few criteria, the 2009 regulations again score about the same as the 2008 regulations, suggesting little change in the quality of analysis between administrations. When we increase the number of observations by testing for differences in means across all categories or all criteria, we still find no significant differences.

Table 7: Report Card Scores for Budget Regulations—2010 Interim Final Health Care versus 2008–09 Proposed Regulations

	2010 Health Care (n=2)	2008 Proposed Regulations (n=15)	t-stat.	2009 Proposed Regulations (n=22)	t-stat.
Total	17.0	17.1	0.02	20.5	0.76
Categories of Criteria					
Openness	9.5	8.6	0.46	10.5	0.50
Analysis	6.0	3.5	1.70	4.9	0.69
Use	1.5	4.9	1.87*	5.1	1.73*
All Categories Average	5.7	5.7	0.02	6.8	0.75
	(n=6)	(n=45)		(n=66)	
Individual Criteria					
1. Accessibility	4.5	4.0	1.01	4.1	0.59
2. Data Documentation	1.5	1.5	0.04	1.9	0.36
3. Model Documentation	1.5	1.3	0.20	2.0	0.58
4. Clarity	2.0	1.8	0.29	2.5	0.85
5. Outcomes	2.0	1.7	1.70	1.3	1.06
6. Systemic Problem	1.5	1.9	1.87*	1.0	0.98
7. Alternatives	1.5	0.8	0.79	1.2	0.43
8. Cost-benefit	1.0	1.1	0.16	1.4	0.87
9. Any Use of Analysis	1.0	2.1	1.33	2.3	1.38
10. Cognizance of Net Benefits	0.0	0.7	2.20**	0.6	1.21
11. Goals and Measures	0.0	1.0	1.63	1.1	1.53
12. Retrospective Data	0.5	1.1	1.02	1.2	0.97
All Criteria Average	1.4	1.4	0.02	1.7	1.06
	(n=24)	(n=180)		(n=264)	

Note: t-test for difference in means; statistical significance:
***99-percent confidence level, **95-percent confidence level, *90-percent confidence level.

5. Comparison with Other HHS Regulations

Federal regulations cover an incredibly wide range of topics, from airport congestion to mine safety to health care. Some topics may be inherently easier to analyze than others, and health care is a notoriously difficult and complex topic. Moreover, even if two topics are equally difficult or complex, it may be easier to conduct a good regulatory analysis on one topic if there is more preexisting scholarly literature to draw upon. Comparing the interim final health care

regulations with other HHS regulations, therefore, could suggest if they score low because they are interim final regulations or because they are HHS regulations.

Table 8: Report Card Scores for Prescriptive Regulations—2010 Interim Final Health Care versus 2008-09 HHS Proposed Regulations

	2010 Health Care (n=6)	**2008 Proposed Regulations (n=2)**	**t-stat**	**2009 Proposed Regulations (n=1)**	**t-stat**
Total	19.0	29.0	2.83**	26	NA
Categories of Criteria					
Openness	11.0	13.5	1.74	14.0	NA
Analysis	6.5	9.0	1.22	12.0	
Use	1.5	6.5	6.12***	2.0	
All Categories Average	6.3	9.7	1.69*	9.3	1.04
	(n=18)	(n=6)		(n=3)	
Individual Criteria					
1. Accessibility	4.5	3.0	2.40*	3	NA
2. Data Documentation	2.7	3.5	1.04	4	NA
3. Model Documentation	1.8	3.5	1.85	3	NA
4. Clarity	2.2	3.5	6.36***	4	NA
5. Outcomes	2.2	3.5	1.73	3	NA
6. Systemic Problem	1.3	1.0	0.55	3	NA
7. Alternatives	1.5	2.5	1.22	3	NA
8. Cost-benefit	1.5	2.0	1.22	3	NA
9. Any Use of Analysis	1.0	2.0	2.12*	1	NA
10. Cognizance of Net Benefits	0.0	1.5	6.36***	1	NA
11. Goals and Measures	0.0	1.0	NA	0	NA
12. Retrospective Data	0.5	2.0	3.68***	0	NA
All Criteria Average	1.6	2.4	2.71***	2.3	1.78*
	(n=72)	(n=24)		(n=12)	

Note: t-test for difference in means; statistical significance:
***99-percent confidence level, **95-percent confidence level, *90-percent confidence level.
Since HHS proposed only one ordinary economically significant regulation in 2009, it is not possible to calculate t-statistics when comparing the interim final regulations to the 2009 regulation.

5.1 Prescriptive Regulations

Table 8 compares the prescriptive interim final health care regulations' average scores with the average scores for the only three prescriptive, economically significant regulations HHS proposed in 2008 and 2009. The average total score for the 2010 interim final regulations is 7–10 points lower than the average score for regulations proposed in 2008 and 2009. On individual criteria, the interim final regulations outscore the proposed regulations only on criterion 1, accessibility. In all of the other cases where differences are statistically significant, the 2008 and 2009 HHS regulations have better quality or use of analysis than the interim final regulations from the health care bill.

5.2 Budget Regulations

Table 9 compares the scores of the 2010 interim final health care budget regulations with scores for budget regulations HHS proposed in 2008 and 2009. Average total scores are about the same. The interim final health care regulations score higher than proposed HHS regulations on only two criteria: accessibility and outcomes. The difference is statistically significant for 2008 but not 2009. The pattern is similar to the pattern observed when comparing the health care budget regulations with all budget regulations from 2008 and 2009; it shows similar scores for analysis accompanied by lower scores for use.

Table 9: Report Card Scores for Budget Regulations—2010 Interim Final Health Care versus 2008-09 HHS Regulations Proposed

	2010 Health Care (n=2)	2008 Proposed Regulations (n=9)	t-stat.	2009 Proposed Regulations (n=11)	t-stat.
Total	17.0	18.9	0.49	17.3	0.09
Categories of Criteria					
Openness	9.5	9.4	0.03	11.5	1.19
Analysis	6.0	4.1	1.23	5.7	0.15
Use	1.5	5.3	3.42***	5.9	3.93***
All Category Average	5.7	6.3	0.43	7.7	1.34
	(n=6)	(n=27)		(n=33)	
Individual Criteria					
1. Accessibility	4.5	4.0	2.71**	4.0	1.02
2. Data Documentation	1.5	1.9	0.41	2.8	1.27
3. Model Documentation	1.5	1.7	0.20	2.5	0.99
4. Clarity	2.0	1.9	0.14	2.3	0.79
5. Outcomes	2.0	0.8	1.99*	1.2	1.14
6. Systemic Problem	1.5	0.7	1.51	1.3	0.45
7. Alternatives	1.5	1.3	0.25	1.5	0.06
8. Cost-benefit	1.0	1.3	0.90	1.7	2.12*
9. Any Use of Analysis	1.0	2.4	2.22**	2.9	3.13***
10. Cognizance of Net Benefits	0.0	0.9	3.62***	0.6	1.07
11. Goals and Measures	0.0	1.0	1.57	1.2	2.67**
12. Retrospective Data	0.5	1.0	2.71**	1.2	1.45
All Criteria Average	1.4	1.6	0.59	1.9	1.87*
	(n=24)	(n=108)		(n=132)	

Notes: t-test for difference in means; statistical significance:
***99-percent confidence level, **95-percent confidence level, *90-percent confidence level.

6. Comparison with Homeland Security Interim Final Regulations

The health care regulations were issued as interim final regulations under tight legislative deadlines. They also reflect a significant policy priority of the Obama administration. The last time an administration issued a cluster of economically significant, interim final regulations that reflected one of its overriding policy priorities under tight deadlines occurred when DHS issued a series of interim final regulations in the wake of 9/11. In regard to one controversial program, a former DHS undersecretary for preparedness told *The Washington Post*, "You have management issues, political pressure, the complexity of what is arguably a very tough thing to do, all within

an unreasonable deadline and it's kind of the old adage—we can hurry up and do it fast, or we can take a little bit longer and do it right. . . . External pressures on DHS made this a hurry-up-and-do-it-fast."[36]

In a pilot study that preceded the Regulatory Report Card, Belcore and Ellig used the Report Card's accessibility criterion and four analysis criteria to assess the quality of analysis for regulations issued by DHS during its first five years of existence.[37] During this time, seven economically significant DHS regulations started out as interim or interim final rules. Table 10 lists these regulations and their scores on the criteria used in the pilot study. One of these was a budget regulation (shown in italics); the other six were prescriptive regulations.

Table 10: Scores for Homeland Security Interim Final Regulations

	1. Accessibility	Analysis* (Max=20)	5. Outcomes	6. Systemic Problem	7. Alternatives	8. Cost-benefit
Area Maritime Security (1625-AA42)	2	3	1	0	0	2
Vessel Security (1625-AA46)	2	3	1	0	0	2
Maritime Facility Security (1625-AA43)	2	3	1	0	0	2
U.S.-Visit Biometric Data (1650-AA00)	2	5	1	0	2	2
H1-B Visa Allocation (1615-AB32)	4	3	1	1	0	1
Community Disaster Loans (1660-AA44)	*4*	*2*	*1*	*0*	*0*	*1*
Chemical Facilities (1601-AA41)	4	8	2	2	2	2

Source: Data are from Jamie Belcore and Jerry Ellig, "Homeland Security and Regulatory Analysis: Are We Safe Yet?" *Rutgers Law Journal*, 2009:1–96. The Belcore-Ellig study included separate criteria and scores for cost analysis and comparison of costs with benefits. For this table, these were combined into a single criterion to be consistent with the scoring in the Mercatus Center's Regulatory Report Card.
*This is the sum of scores on criteria 5–8.
Note: The regulation in italics is a budget regulation.

[36] Spencer Hsu, "DHS Strains as Goals, Mandates Go Unmet," *The Washington Post*, March 6, 2008.
[37] Belcore and Ellig, "Homeland Security and Regulatory Analysis."

Table 11 compares average scores for the prescriptive, interim final health care regulations with the prescriptive, interim final homeland security regulations. The health care regulations clearly outscore the homeland security regulations on criterion 1, accessibility. The health care regulations also have a higher score on criterion 5, outcomes, and this difference is statistically significant at the 95-percent confidence level. Neither group of regulations, however, scores well on any of the four analysis criteria. A score of 1 indicates merely that the agency made assertions relevant to the criterion, with little coherent theory or analysis. A score of 2 means only that the agency offered some pieces of theory or evidence but far from a comprehensive analysis. Average scores for both groups of regulations are almost always below 2 on criteria 5–8, which suggests the average regulation from either group is accompanied by serious gaps in analysis and evidence.

Table 11: Report Card Scores for Interim Final Rules—Prescriptive Health Care versus Prescriptive Homeland Security Regulations

	2010 Health Care (n=6)	**Homeland Security (n=6)**	**t-stat**
Analysis	6.5	4.2	1.70
Individual Criteria			
1. Accessibility	4.5	2.7	3.84***
5. Outcomes	2.2	1.2	2.30**
6. Systemic Problem	1.3	0.5	1.75
7. Alternatives	1.5	0.7	1.39
8. Cost-benefit	1.5	1.8	1.20
All Criteria Average	2.2	1.4	2.54**
	(n=30)	(n=30)	

Note: t-test for difference in means; statistical significance:
***99-percent confidence level, **95-percent confidence level.

It is difficult to infer much from a comparison of the budget regulations because only one homeland security regulation was a budget regulation. Comparing scores in Table 12, the most we can say is that one health care regulation scored somewhat better on the analysis criteria than the DHS regulation and the other scored slightly better. But none of the scores are especially high.

Table 12: Report Card Scores for Three Interim Final Budget Regulations

	2005 DHS/FEMA Community Disaster Loan Program	2010 HHS Preexisting-condition Insurance Program	2010 HHS Early Retiree Reinsurance Program
Analysis	2	8	4
Individual Criteria			
1. Accessibility	4	4	5
5. Outcomes	1	3	1
6. Systemic Problem	0	2	1
7. Alternatives	0	2	1
8. Cost-benefit	1	1	1
All Criteria Average	Homeland Security (n=5)	2010 Health Care (n=10)	t-stat.
	1.2	2.1	1.09

Most of the homeland security regulations enjoyed somewhat longer reviews at the Office of Information and Regulatory Affairs (OIRA) than the health care regulations. OIRA reviewed the homeland security regulations for an average of 22 days, compared to 5 days for the health care regulations. Three of the DHS regulations received very rapid review: the U.S.-Visit Biometric Data regulation (12 days), the Chemical Facilities regulation (3 days), and the Community Disaster Loans regulation (0 days). The rest were all reviewed for at least 25 days. None of the health care regulations spent longer than 13 days in OIRA review.

Compared to the homeland security regulations, the interim final health care regulations and their accompanying analysis are easier to find online and have slightly better analysis of the outcomes the regulation is supposed to produce. However, neither group of regulations has especially high scores on the four analysis criteria. Their average scores are far below the averages for proposed, economically significant regulations in 2008 and 2009. This suggests that the incomplete analysis may be a systematic result of presidential priorities and tight deadlines, rather than a problem unique to the health care regulations.

7. Conclusions

The quality and use of analysis for the ACA interim final regulations falls well below the standards set by other agencies and by HHS itself in conventional notice-and-comment rulemaking in previous years. Federal agencies, including HHS, have clearly demonstrated that they are fully capable of performing much more thorough analysis and using it to make regulatory decisions. The critical findings in our Part A paper, therefore, result not from the excessively high standards of academic perfectionists, but from the failure of these health care

RIAs to satisfy the quality norms that are typical in federal regulatory analysis.[38]

The analysis in the eight ACA RIAs is comparable to the analysis that accompanied a series of interim final homeland security regulations issued by the Bush administration following 9/11, another set of regulations that reflected high-level administration priorities and time pressures. This suggests that subpar regulatory analysis cannot be blamed on one administration or political party, but rather reflects an institutional problem that persists under certain circumstances regardless of administration. We explore the institutional roots of this problem in our Part C paper.[39]

[38] Conover and Ellig, "Beware the Rush to Presumption: Part A: Material Omissions in Regulatory Analyses for the Affordable Care Act's Interim Final Rules."
[39] Conover and 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), http://mercatus.org/publication/a-public-choice-analysis-of-the-affordable-care-acts-interim-final- rules.

Appendix 1: Major Factors Considered under Each Criterion in the Mercatus Regulatory Report Card

Note: Regardless of how they are worded, all questions involve qualitative analysis of how well the RIA addresses the issue, rather than "yes/no" answers.

Openness

1. How easily were the RIA, the proposed rule, and any supplementary materials found online?

How easily can the proposed rule and RIA be found on the agency's website?
How easily can the proposed rule and RIA be found on regulations.gov?
Can the proposed rule and RIA be found without contacting the agency for assistance?

2. How verifiable are the data used in the analysis?

Is there evidence that the RIA used data?
Does the RIA provide sufficient information for the reader to verify the data?
How much of the data are sourced?
Does the RIA provide direct access to the data via links, URLs, or provision of data in appendices?
If data are confidential, how well does the RIA assure the reader that the data are valid?

3. How verifiable are the models and assumptions used in the analysis?

Are models and assumptions stated clearly?
How well does the RIA justify any models or assumptions used?
How easily can the reader verify the accuracy of models and assumptions?
Does the RIA provide citations to sources that justify the models or assumptions?
Does the RIA demonstrate that its models and assumptions are widely accepted by relevant experts?
How reliable are the sources? Are the sources peer-reviewed?

4. Was the Regulatory Impact Analysis comprehensible to an informed layperson?

How well can a non-specialist reader understand the results or conclusions?
How well can a non-specialist reader understand how the RIA reached the results?
How well can a specialist reader understand how the RIA reached the results?
Is the RIA written in "plain English" (i.e., light on technical jargon and acronyms, well-organized, grammatically correct, direct language used)?

Analysis

5. How well does the analysis identify the desired outcomes and demonstrate that the regulation will achieve them?

How well does the RIA clearly identify ultimate outcomes that affect citizens' quality of life?
How well does the RIA identify how these outcomes are to be measured?
Does the RIA provide a coherent and testable theory showing how the regulation will produce the desired outcomes?
Does the analysis present credible empirical support for the theory?
Does the analysis adequately assess uncertainty about the outcomes?

6. How well does the analysis identify and demonstrate the existence of a market failure or other systemic problem the regulation is supposed to solve?

Does the analysis identify a market failure or other systemic problem?
Does the analysis outline a coherent and testable theory that explains why the problem (associated with the outcome above) is systemic rather than anecdotal?
Does the analysis present credible empirical support for the theory?
Does the analysis adequately assess uncertainty about the existence and size of the problem?

7. How well does the analysis assess the effectiveness of alternative approaches?

Does the analysis enumerate other alternatives to address the problem?
Is the range of alternatives considered narrow or broad?
Does the analysis evaluate how alternative approaches would affect the amount of the outcome achieved?
Does the analysis adequately address the baseline—what the state of the world is likely to be in the absence of further federal action?

8. How well does the analysis assess costs and benefits?

Does the analysis identify and quantify the incremental costs of all alternatives considered?
Does the analysis identify all expenditures likely to arise as a result of the regulation?
Does the analysis identify how the regulation would likely affect the prices of goods and services?
Does the analysis examine costs that stem from changes in human behavior as consumers and producers respond to the regulation?
Does the analysis adequately address uncertainty about costs?
Does the analysis identify the approach that maximizes net benefits?
Does the analysis identify the cost-effectiveness of each alternative considered?
Does the analysis identify all parties who would bear costs and assess the incidence of costs?
Does the analysis identify all parties who would receive benefits and assess the incidence of benefits?

Use

9. Does the proposed rule or the RIA present evidence that the agency used the Regulatory Impact Analysis?

Does the proposed rule or the RIA assert that the RIA's results affected any decisions?
How many aspects of the proposed rule did the RIA affect?
How significant are the decisions the RIA affected?

10. Did the agency maximize net benefits or explain why it chose another option?

Did the RIA calculate net benefits of one or more options so that they could be compared?
Did the RIA calculate net benefits of all options considered?
Did the agency either choose the option that maximized net benefits or explain why it chose another option?
How broad a range of alternatives did the agency consider?

11. Does the proposed rule establish measures and goals that can be used to track the regulation's results in the future?

Does the RIA contain analysis or results that could be used to establish goals and measures to assess the results of the regulation in the future?
In the RIA or the proposed rule, does the agency commit to performing some type of retrospective analysis of the regulation's effects?
Does the agency explicitly articulate goals for major outcomes the rule is supposed to affect?
Does the agency establish measures for major outcomes the rule is supposed to affect?
Does the agency set targets for measures of major outcomes the rule is supposed to affect?

12. Did the agency indicate what data it will use to assess the regulation's performance in the future and establish provisions for doing so?

Does the RIA or proposed rule demonstrate that the agency has access to data that could be used to assess some aspects of the regulation's performance in the future?
Would comparing actual outcomes to outcomes predicted in the RIA generate a reasonably complete understanding of the regulation's effects?
Does the agency suggest it will evaluate future effects of the regulation using data it has access to or commits to gathering?
Does the agency explicitly enumerate data it will use to evaluate major outcomes the regulation is supposed to accomplish in the future?
Does the RIA demonstrate that the agency understands how to control for other factors that may affect outcomes in the future?

Appendix 2: Crosswalk of 2010 OMB Regulatory Impact Analysis Checklist with Mercatus Regulatory Report Card Evaluation Criteria

OMB Checklist	Mercatus Evaluation Criteria
Does the RIA include a reasonably detailed description of the need for the regulatory action?	Criterion 6: How well does the analysis demonstrate the existence of a market failure or other systemic problem the regulation is supposed to solve?
Does the RIA include an explanation of how the regulatory action will meet that need?	Criterion 5: How well does the analysis identify the desired outcomes and demonstrate that the regulation will achieve them?
Does the RIA use an appropriate baseline (i.e., best assessment of how the world would look in the absence of the proposed action)?	Criterion 7, Question D: Does the analysis adequately assess the baseline—what the state of the world is likely to be in the absence of further federal action?
Is the information in the RIA based on the best reasonably obtainable, scientific, technical, and economic information and is it presented in an accurate, clear, complete, and unbiased manner?	Criterion 2: How verifiable are the data used in the analysis? Criterion 3: How verifiable are the models or assumptions used in the analysis? Criterion 4: Was the analysis comprehensible to an informed layperson? *Criterion 3 includes an assessment of whether the models and assumptions are based on peer-reviewed or otherwise reliable publications. However, the Mercatus evaluation does not assess the quality of the underlying science.*
Are the data, sources, and methods used in the RIA provided to the public on the Internet so that a qualified person can reproduce the analysis?	Criterion 1 takes the first step by assessing how easily the RIA itself can be found on the Internet. Criteria 3 and 4 include an assessment of how easily the reader could find the underlying data, sources, and methods from information or links provided in the RIA or the *Federal Register*.
To the extent feasible, does the RIA quantify and monetize the anticipated benefits from the regulatory action?	Criterion 5, Question 2: How well does the analysis identify how the outcomes are to be measured?

To the extent feasible, does the RIA quantify and monetize the anticipated costs?	Multiple questions under Criterion 8 (Benefits and Costs) assess how well the analysis identifies, quantifies, and monetizes costs.
Does the RIA explain and support a reasoned determination that the benefits of the intended regulation justify its costs (recognizing that some benefits and costs are difficult to quantify)?	Criterion 8, Question F: Does the analysis identify the approach that maximizes net benefits? Criterion 8, Question G: Does the analysis identify the cost-effectiveness of each alternative considered?
Does the RIA assess the potentially effective and reasonably feasible alternatives?	Criterion 7: How well does the analysis assess the effectiveness of alternative approaches?
Does the preferred option have the highest net benefits (including potential economic, public health and safety, and other advantages; distributive impacts; and equity), unless a statute requires a different approach?	Criterion 10: Did the agency maximize net benefits or explain why it chose another option?
Does the RIA include an explanation of why the planned regulatory action is preferable to the identified potential alternatives?	Criterion 9: Does the proposed rule or RIA present evidence that the agency used the Regulatory Impact Analysis? Criterion 10: Did the agency maximize net benefits or explain why it chose another option?
Does the RIA use appropriate discount rates for the benefits and costs that are expected to occur in the future?	Criterion 5, Question 2: How well does the analysis identify how the outcomes are to be measured? Also, several questions about measurement and comparison of benefits and costs are measured under Criterion 8 (Benefits and Costs).
Does the RIA include, if and where relevant, an appropriate uncertainty analysis?	Criterion 5, Question E: Does the analysis adequately assess uncertainty about the outcomes? Criterion 6, Question D: Does the analysis adequately assess uncertainty about the existence and size of the problem? Criterion 8, Question E: Does the analysis adequately address uncertainty about costs?

Does the RIA include, if and where relevant, a separate description of the distributive impacts and equity (including transfer payments and effects on disadvantages or vulnerable populations)?	Criterion 8, Question H: Does the analysis identify all parties who would bear costs and assess the incidence of costs? Criterion 8, Question I: Does the analysis identify all parties who would receive benefits and assess the incidence of benefits?
Does the analysis include a clear, plain-language executive summary, including an accounting statement that summarizes the benefit and cost estimates for the regulatory action under consideration, including the qualitative and non-monetized benefits and costs?	Criterion 4: Was the analysis comprehensible to an informed layperson?
Does the analysis include a clear and transparent table presenting (to the extent feasible) anticipated benefits and costs (qualitative and quantitative)?	Criterion 4: Was the analysis comprehensible to an informed layperson?
Goals and measures to assess results of the regulation in the future—no content.	Criterion 11: Does the proposed rule establish measures and goals that can be used to track the regulation's results in the future?
Provisions for gathering data to assess results of the regulation in the future—no content.	Criterion 12: Did the agency indicate what data it will use to assess the regulation's performance in the future and establish provisions for doing so?