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Director's Perspective

Sound analysis essential to easing uncertainty about economy, policies

As the U.S. economy continues with a slow and at times questionable recovery, experts point to the role of uncertainty in holding back faster progress. Businesses are reluctant to move forward with investments and new commitments to permanent hires. Households shaken by the depths of the recession, as well as unusually high and persistent unemployment, likewise refrain from commitments to significant new purchases and debt obligations.

Prior to the passage of the Patient Protection and Affordable Care Act of 2010, a large element of the looming uncertainty for businesses and households was the unknown future of the health-care system, which President Obama remained resolute on reforming. Indeed, the outcomes of this major piece of legislation are still very uncertain, and

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U.S. Health-Care Reform: A Primer and an Assessment

By Robert Haveman and Barbara Wolfe

After efforts by five presidents and numerous senators and congressional representatives, a comprehensive health-care reform bill was passed by the U.S. Congress and signed into law by President Obama. The Patient Protection and Affordable Care Act of 2010 is long — 1,200 pages — complex, and comprehensive; no major part of the health-care system goes unchanged. Providers, consumers, and taxpayers will all be affected. While the act is now the law of the land, modifications to its provisions likely will be made; the administration, Congress, and the Supreme Court all have the opportunity to weigh in.

The pre-reform U.S. health-care system is a unique and awkward combination of arrangements that produces a huge volume of services — as of 2008, expenditures reached \$2.3 trillion or 16.2 percent of the nation's gross domestic product, \$7,700 per capita. These services are often distributed inefficiently and inequitably, and per-capita costs and total cost relative to gross domestic product exceed those of other developed nations.

Most non-elderly Americans — 162 million people, or 53.2 percent of the population — obtain health insurance through their own or a family member's employer. Under this arrangement, they then purchase health care largely from private providers (doctors, clinics, hospitals) under constraints imposed by their health-care plans. Some of these insurance plans are tied to various groupings of providers, known as preferred provider organizations or health maintenance organizations. People covered under the latter usually need to choose among providers that are members of a group organized by the plan; those under the former face financial incentives to choose member providers.

American families without a regular full-time worker (e.g., many families headed by single parents, older adults, or people with disabilities) are not offered employer-based insurance. Many employees of small firms also are not offered employer-based coverage and have to purchase insurance themselves, usually at much higher prices compared to employer-based insurance. Low-income families without job-related insurance rely largely on a federally sponsored, state-based insurance program: Medicaid. Each state has a somewhat different set of eligibility requirements and coverage arrangements under Medicaid, even though all states operate within federal government guidelines. Generally, benefits under Medicaid are comprehensive and generous, although compensation to providers is not. As a result, providers in some markets decline to serve Medicaid-covered patients. In 2010, more than 60 million Americans (one in four children) received insurance under this program. The government spent \$340 billion on the health care of Medicaid beneficiaries in 2008; the program accounts for nearly 16 percent of all personal health-care spending and

almost 45 percent of spending on nursing home care. Were it not for Medicaid, many of these lower-income families would be without health insurance.

Individuals 65 or older receive health-care coverage from Medicare, a public program that covers much but not all of the expenses of inpatient hospital stays. Nearly all former workers 65 and older have this coverage. Medicare also covers physician services and outpatient visits, but this insurance requires a monthly premium and relatively high cost-sharing. If people covered by Medicare join a participating managed care health plan, they can obtain additional services. Finally, Medicare has a voluntary subsidized prescription drug benefit, available since 2006, that requires premium and patient cost-sharing. Medicare expenditures are more than \$500 billion, 15 percent of the federal budget. The program is funded by a combination of general revenues (40 percent), payroll taxes (38 percent), beneficiary premiums (12 percent), and other sources. Many people with Medicare purchase supplementary insurance to cover the required patient cost-sharing; a combination of Medicare and Medicaid covers most low-income older adults.

Children in low- to moderate-income families who are not eligible for Medicaid may be covered by the newest public program, the Children's Health Insurance Program (CHIP), another joint state-federal program with income eligibility guidelines that differ by state. The federal government pays a higher share of the costs of this program than for Medicaid to encourage more generous eligibility standards, though federal allocations are capped annually. States can obtain waivers to cover parents under CHIP; however, states do not receive the higher federal matching support for parents. In 2009, 7.7 million people were enrolled in CHIP.

Finally, almost 18 percent of Americans younger than 65 in 2008 had no health insurance at all. Many families without a full-time worker at a large firm are not offered an employer-based policy. Self-employed people, including farmers and anyone who is not offered employer-based coverage, typically have to pay much more for insurance if they buy it on their own, compared to the per-person price for employer-group insurance. In addition, many low-income people do

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Eight Problems (among Many) with the Pre-Reform U.S. System

We outline eight problems that are among the many with the U.S. health-care system prior to reform.

1. The Uninsured Population

The large number of Americans without health-care coverage — more than 15 percent of the population — is an internationally embarrassing offshoot of the complex and costly nature of the American employer-based health insurance arrangement.

2. Constrained Access to Health Care

Many Americans forego health care, especially preventive care, because they lack health insurance altogether or their insurance requires that they pay high cost-sharing rates relative to their incomes.

3. Private Insurance Market Problems

The U.S. health insurance market is a private market — largely due to job-based health insurance — in which health insurance policies are bought and sold. As such, it is essential that many buyers and sellers participate in the market, and that both groups have full information.

4. Health-Care Costs

To many the primary problem with the U.S. health-care system is its overall cost — more than 16 percent of gross domestic product. With the share of the population older than age 65 projected to grow rapidly, many fear that this percentage can only rise.

5. Regressive and Inefficient Financing Arrangements

The arrangements to finance the U.S. health-care system contribute to its high costs. To assist families to purchase private health coverage offered by employers, U.S. federal tax policy allows individuals to pay for health insurance premiums using pre-tax dollars. This provision results in a very regressive financing arrangement.

6. Coverage beyond Traditionally Insurable Components

Largely as an offshoot of the regressive financing arrangement, U.S. health coverage has expanded to include items traditionally not insured, such as dental care (including braces) and eye care (including glasses). This expansion means that those with higher incomes receive the greatest public subsidies for services that are largely predictable.

7. The Problem of “Pre-Existing Conditions”

Because of the nature of the employer-provided health insurance arrangement, the available insurance options tend to be limited and very expensive for people with pre-existing conditions.

8. Underserved Areas

Across the nation, there are numerous “underserved areas” where access to care is limited. In most cases this is tied to low reimbursement by Medicaid, payment uncertainty if uninsured, or inflexible licensing laws that prevent the use of paraprofessionals in practicing medicine; usually these are low-income and rural areas.

not fit Medicaid's eligibility categories for benefits. People without health insurance use community health centers where available (and pay on a sliding scale) or go to hospital emergency rooms when they have medical emergencies — a costly option. Often they forego regular health-care services, including preventive care.

U.S. Health-Care Reform, 2010

The federal health-care reform law is complex, misunderstood, and controversial. It addresses many problems, sometimes in ways that seem indirect and opaque. Many provisions came about through the long and tedious process of partisan congressional debate and compromise, and the long arms and deep pockets of health providers, insurance companies, industry representatives, and consumer advocates. Given this process, the law is surprisingly comprehensive and directed at reducing inequities. Here, we outline its main provisions and relate them to the problems they are asserted to solve.

Expansion of Access to Health Care and Health Insurance

The primary focus of the reform is to increase health insurance coverage and increase access to health care for citizens and legal immigrants. The law seeks to accomplish these goals through several changes.

Medicaid Expansion

Medicaid will be expanded in 2014 to cover everyone with income below 133 percent of the federal poverty line. Hence, state differences in eligibility levels will be eliminated as will the lack of coverage for individuals and couples without children. This expansion provides a true safety net for those with very low incomes, who gain generous coverage without required premium payments.

Income-Conditioned Subsidies

Those with low to moderate incomes will receive subsidies to achieve increased coverage and access. A variety of sliding-scale subsidies will be made available for persons whose income is at or below 400 percent of the federal poverty line; indeed, a family of four with an income less than \$88,000 (2010 dollars) can receive a subsidy. Moreover, health insurance premiums are capped for these families, again on a sliding scale. Out-of-pocket payments are capped for families with incomes below 400 percent of the federal poverty line. All of these changes will be implemented in 2014.

Coverage of People with Pre-Existing Conditions

Insurers are now prohibited from excluding from coverage children up to age 19 with pre-existing conditions, and states are required to set up insurance pools to offer coverage to individuals with pre-existing conditions or to rely on a federal program for “high-risk” persons. By 2014, private insurers will no longer be able to exclude any person with a pre-existing condition or charge them more for coverage.

Expansion of Private Job-Based Insurance Coverage

Private job-based insurance is required to include coverage for dependent children younger than 26 years who do not

have alternative coverage. Tax credits starting at 35 percent and going up to 50 percent will be given to small firms to encourage the offering of insurance to their employees. Also starting immediately, private firms are prohibited from setting lifetime maximums on coverage and are no longer permitted to deny coverage based on an individual having a new health shock. As of 2014, insurance exchanges will be established to enable individuals and small firms to purchase insurance at reasonable rates.

Finally, firms will be encouraged to offer coverage by the imposition of a sizable annual fee per full-time employee not offered coverage, and most families above a specified income level will be penalized if they are without health insurance.

Reorganization of the Health-Care System

Health-care reform will reduce complexity, increase transparency, broaden access in underserved areas, help low-income people, increase efficiency, control costs, change public programs, and modify insurer and provider incentives.

Introducing Health Insurance Exchanges

The U.S. private health insurance market will be fundamentally changed by the introduction of a set of organized health insurance exchanges. Once established in each state (or grouping of states), these exchanges will require insurers to offer four standard packages of benefits (three of varying coverage levels, and a basic plan for younger adults and people with limited resources). Premiums for these plans will differ only by age within a defined range. These well-specified packages are expected to reduce complexity and make “shopping” for a plan easier. The additional transparency of the products together with the size of the “markets” is expected to generate competition among insurers and act to control costs and price.

Targeting Health-Care Workforce Expansion

Health-care reform recognizes the problem of underserved areas and provides increased support for training additional health-care providers, including those providing pediatric services and physicians who are willing to work in underserved areas. In addition, funding to reduce student loan debt of medical students willing to serve in underserved areas is to be doubled.

More generally, the reform seeks to increase the supply of primary care providers, a group for whom earnings are much lower than those of other physicians. Medicaid and Medicare will pay bonuses for services provided by primary care physicians. While this provision may increase costs in the short run, the goal is to increase the proportion of recent and future medical school graduates who become primary care providers by increasing the return to these doctors.

Creating Institutions to Serve Low-Income Groups

Reform will increase funding for community health centers as well as new community-based collaborative care networks, which are consortia of providers operating under a joint governance structure and providing comprehensive health-care services to low-income populations. Such networks extend the traditional medical care model by performing health

outreach (using neighborhood health workers), providing transportation to reach the network, and offering “telehealth” and after-hours services. The goal is to encourage innovation to improve access to care by underserved populations. Community health centers in underserved areas care for about 20 million people and are funded by public sector grants, fee for service, and “pay-as-you-can” (sliding fees) but serve everyone regardless of ability to pay. Medicaid or Medicare covers about two-thirds of their patients. Under the new reforms, they are expected to expand to serve 20 million more patients with an additional 15,000 in staff.

Fostering More Efficient Service Delivery and Controlling Costs

The reform law addresses the high and rapidly growing cost of health care. Pilot projects focus on ways to improve efficiency and reduce costs. A new national Center for Medicare and Medicaid Innovation will oversee these projects and test approaches to reward providers for quality and improvements in efficiency (rather than the volume of services). A new federal independent advisory board will identify cost savings in Medicare without increasing cost-sharing, using rationing, changing eligibility or raising taxes. A new “Patient-Centered Outcomes Research Institute” will identify comparative effectiveness research priorities and conduct. It also will commission and make public research to improve health-care decision-making.

To address the many inefficiencies of the existing fee-for-service model, the reform law includes three constraints. To reduce administrative costs, insurers covering large firms that spend less than 85 percent of their premiums on health care are required to offer rebates to enrollees (80 percent for insurers covering small firms). Health insurers will be required to follow administrative simplification standards involving electronic exchange of health information to reduce paperwork and administrative costs, and reduce duplicative services. All insurance rate increases must be submitted to public boards for approval; companies must justify their requests and provide information on non-medical expenditures.

The new law provides a financial incentive for the creation of “accountable care organizations,” groups of doctors, hospitals, and other caregivers who will work together to improve the efficiency and quality of care and share in any savings. The accountable care organization concept is largely based on a health-maintenance-type organization that provides care to older adults enrolled in Medicare. Providers who join such organizations will receive “shared savings” from the efficiencies gained by coordinating care. Whether accountable care organizations will actually lead to higher quality of care at lower costs is not yet known, though efforts along this line seem somewhat promising.

The reform plan also provides incentives for health insurers to seek reduced

costs by offering “closed provider panel” plans. In these arrangements, a limited set of providers enables insurers to more effectively bargain over the terms of reimbursement and thereby to obtain “discounted” prices. While patients covered by such plans are able to seek services outside the panel, they will be required to share more of the costs. Such closed panel plans are likely to appeal to smaller firms that do not offer coverage but will be required to do so under the reform. They may also appeal to many larger firms as a way to reduce costs of coverage.

Combining these efforts and the other cost reduction measures in the reform, national health-care expenditures are estimated to grow 69 percent from 2009 to 2019, compared to 89 percent were the reform not to be undertaken. Given the significant growth in coverage and increases in access included in the legislation, this level of “savings” is impressive. In spite of these gains, a greater proportion of gross domestic product is expected to be spent on health care in 2019 than in 2009.

Reducing Complexity in Health Insurance Choices

The reform act recognizes the frustration of firms and workers regarding the complexity involved in offering and accepting private, job-related insurance coverage. The federal government has set up a web site (HealthCare.gov) to assist families choosing among health insurance options. The web site offers information about user-specific coverage, eligibility, and cost-sharing on private insurance plans and public programs, and on available high-risk insurance pools. It provides a limited amount of standardized quality information (more is promised) and, for firms, includes information on tax credits and other subsidies. In addition, employers are required to disclose to each employee the value of the benefits paid on their behalf for health insurance on the annual income statements used for tax reporting.

Expanding and Restructuring Existing Public Programs

The 2010 legislation contains numerous changes to and expansions of Medicare, Medicaid, and the Children’s Health Insurance Program.

Medicare is modified in many ways, most of which encourage cost reductions. Capitated payments (fixed payments per patient enrolled in a plan) to the most-generous (and generally acknowledged) over-paid plans will be reduced, the awkward subsidy arrangements in the drug benefit plan modified, and provider payments redesigned to increase access to care. The law establishes a temporary reinsurance program to offset some of the high coverage costs firms face and constrains the premiums charged for coverage to assist people who retire before age 65, the age when they become eligible for Medicare, and people who retired from firms that eliminated retiree insurance coverage.



Eligibility for Medicaid is made more uniform across states, and a benefit floor increases equity and encourages medical providers to offer care to this population. Medicaid and Medicare will pay bonuses for primary care services provided by primary care physicians and for service provision in underserved areas. Costs should be reduced by the expected decline in costs paid to hospitals that serve disproportionate numbers of low-income uninsured.

The Children's Health Insurance Program also has expanded eligibility and increased insurance coverage: any child in a family with income below 200 percent of the federal poverty line at the time a child is enrolled remains eligible for 12 months. The new law establishes more uniform eligibility levels across states and increases outreach and enrollment grants to increase participation. The reform legislation pays special attention to American Indians, whose reservations are among the most underserved areas. The law offers financial inducements to increase providers. With the goal of reducing long-term health disparities, the law includes demonstration programs and mental and behavioral health programs in addition to simplified enrollment in the Indian Health Service and increased benefits.

Financing Health-Care Reform

The legislation imposes taxes and fees to offset the public share of health-care costs. These include a tax (fee) on pharmaceutical companies and those who import brand-name drugs. The fee is based on market share and is expected to raise \$27 billion from 2014 to 2019. Beginning in 2018, a 40 percent excise tax will be imposed on high-benefit, high-cost insurance plans; this tax is expected to raise about \$15 billion per year. High-income individuals and couples will also face an increase in the payroll tax beginning in 2012; this tax, directed to supporting Medicare, is expected to raise \$210 billion from 2012 to 2019. Finally, an excise tax of 2.9 percent will be imposed on medical device manufacturers; it is expected to raise \$20 billion from 2012 to 2019. An additional tax is imposed on those who pay federal income tax if they do not have health-care coverage to decrease the uninsured population.

Modifying Provider and Insurer Incentives

Modifying incentives to providers is another vital component of the reform. For example, Medicare will reward hospitals that attain better patient outcomes (higher quality) and Medicare provider payments will reward productivity; these incentives are projected to generate cost savings of \$160 billion from 2010 to 2019, a controversial estimate. Finally, insurance companies will have to have rate increases reviewed by the appropriate level of government, and Medicare payments to high-cost managed care plans will be reduced. These changes are expected to result in cost savings of more \$200 billion from 2010 to 2019.



Will Reform Work? Will Problems Remain?

The changes introduced by the U.S. health-care reform of 2010 are enormous. While basic aspects of the existing system will be maintained — for example, the employer-provided insurance arrangement at the core of the system and the basic fee-for-service payment system — there is virtually no part of the nation's health-care system that will remain untouched. Throughout the new law, measures are introduced to increase access, reduce inequities, control costs, increase quality, and realign incentives.

Health-care coverage will be provided to an additional 32 million Americans, reducing the uninsured population from about 15 percent to 6 percent of the population. Sixteen percent of the newly insured have incomes below 133 percent of the federal poverty line; Medicaid will now cover them. Access to care of all of those covered by Medicaid should improve as provider payment rates in this program increase to those paid by Medicare. Health insurers will no longer be able to exclude persons with existing conditions. For the first time, people with low to moderate incomes (up to four times the federal poverty line) will receive subsidies to purchase coverage. In addition to these subsidies, there is a cap on co-payments for all these families (many of whom are already insured), greatly reducing potential out-of-pocket expenses and adding security. Small businesses are offered subsidies in the form of tax credits if they offer coverage, making it easier for them to hire workers. The expenditures on health care are expected to be reduced because of the reform, and the federal deficit will not grow as these expansions of coverage, quality improvements and financial protection are financed by payment and system reform and by new tax revenues.

Of course, problems will remain, and uncertainties in implementation are pervasive.

The remaining 6 percent of the population without coverage is troubling. The high administrative costs of the system, due largely to the need for many providers and insurers and to the bargained system of payment determination, will not be reduced easily. As the debate over the legislation revealed, some citizens who face a penalty as they exercise their right to remain without coverage are angry. Some inequalities in access will remain, and there will still be too few primary providers in certain areas. Employer-based health insurance will still be excluded from the definition of taxable compensation, continuing the huge and inequitable tax subsidy that contributes to high expenditures. Nevertheless, gains in the form of movement toward near universal coverage, a lower rate of increase in health-care costs and a realignment of incentives for cost-effective decisions by providers, insurers and consumers are major gains attributable to the reform. ♦

Wisconsin Poverty Report: New Measure, Broader View

By Joanna Marks, Julia Isaacs, Timothy Smeeding, and Katherine Thornton

For many years, researchers and policymakers in federal and state governments have called for a more complete picture of poverty in the United States. The official poverty measure, while useful, captures only pre-tax cash income. This approach is troubling because it does not help define who is living in poverty taking into account all resources available to the family, nor does it show the effectiveness of many antipoverty policies. Several states and localities have tried to address these limitations by developing their own alternative poverty measures. The Wisconsin Poverty Project builds on the poverty measurement efforts of the federal government and New York City to learn more about how federal and Wisconsin programs affect poverty.

This article presents initial results for the new Wisconsin Poverty Measure. This more complete accounting reflects not only income but also the value of tax credits and public benefits available to low-income Wisconsin residents. The strengths of the Wisconsin Poverty Measure are its ability to compare poverty across demographic subgroups within the state (in this report we focus on children and adults 65 years and older), to compare poverty across counties and regions within the state, and to reflect the specific policies and priorities of Wisconsin policymakers and residents as they affect poor people.

This article is adapted from a report produced by the Institute for Research on Poverty at the University of Wisconsin–Madison. **Joanna Marks** is an assistant researcher at the Institute for Research on Poverty and a 2010 La Follette School alum. **Julia Isaacs** is the child and family policy fellow at the Brookings Institution and a visiting scholar at the Institute for Research on Poverty. **Timothy Smeeding** is the director of the Institute for Research on Poverty and the Arts and Sciences Distinguished Professor of Public Affairs at the La Follette School. **Katherine Thornton** is a programmer analyst at the Institute for Research on Poverty. Two companion reports — *Wisconsin Poverty Report: Methodology and Results for 2008* and *Wisconsin Poverty Report: Technical Appendix* — are available via <http://www.irp.wisc.edu>.

Methods

All poverty measures require two components: a measure of economic need and a comparable and consistent measure of resources, such as income, to meet these needs. Our measure of resources includes cash income, plus major noncash benefits: tax credits and other tax provisions, food stamps (known as FoodShare in Wisconsin and as the Supplemental Nutrition Assistance Program on the federal level), public housing, and energy assistance, and subtracts work expenses like child care and transportation. Our measure of need is based on a threshold recommended by the National Academy of Sciences, but we adjust for Wisconsin's lower cost of living relative to the nation. We also make adjustments to need for families within Wisconsin based on differences in housing tenure (renting versus owning), regional differences in cost of living within the state, differences in family size and composition, and differences in expected out-of-pocket medical expenses. These adjustments determine a level of need specific to each family unit, which is then compared to the family's available resources to determine poverty status.

To assess resources and needs, we used the U.S. Census Bureau's 2008 American Community Survey, supplemented with administrative data collected in Wisconsin. The survey collects sufficient data to allow us to report poverty rates for the 10 largest counties in Wisconsin (including six sub-county breakdowns within Milwaukee County), as well as for 12 multicounty areas that encompass the rest of the state. In addition, the American Community Survey includes a vast amount of information on housing costs, allowing us to bore down within the state to adjust for regional differences in housing costs across Wisconsin.

The detailed housing data and large sample size are strengths of the American Community Survey; however, it also has drawbacks for our measure. For instance, the survey asks respondents whether they receive food stamps, but not the amount of the benefit. With the help of detailed administrative data, we were able to impute FoodShare benefit amounts. For other in-kind benefits such as energy assistance and public housing we had to estimate who received benefits and how much, based on American Community Survey income data and on detailed state administrative data on program participation, age, and other characteristics of

beneficiaries and amounts of benefits by local area.

To compare the resources families have to the needs they face, we grouped individuals into poverty units, which reflect patterns of income and consumption-sharing across families and individuals living within households. Our poverty unit is expanded beyond the Census Bureau family unit to include unmarried partners who cohabit, foster children, and unrelated minor children.

Poverty status is determined by comparing resources to need. The poverty threshold is a “line” based on a number of factors to capture a floor amount of income that is needed to get by. The basic starting point is the current experimental federal poverty lines, published by the Census Bureau and based on food, clothing, shelter, and other expenses set at roughly the 33rd percentile of national consumption for a two-child, two-adult family. In 2008, the national threshold for such a unit was \$27,043. Our base poverty threshold without medical expenses was \$24,842 for Wisconsin due to the state’s lower cost of living relative to many other parts of the United States. For comparison, the official U.S. poverty line for a two-child, two-adult family in 2008 was \$21,834.

We made additional adjustments to the poverty lines based on differences in housing costs (owners with mortgage, owners without mortgage, and renters); the cost of living around the state; family size and composition; and expected medical expenses (varying across families based on health insurance status, presence of elders, and health status). These measures of need were then compared to each poverty unit’s available resources to determine poverty status.

In summary, the new poverty measure takes account of federal and state policies to increase incomes for low-income

persons such as FoodShare, the Wisconsin Homestead Tax Credit, and the federal and state Earned Income Tax Credits. It also reflects state efforts to provide health insurance for families and children under BadgerCare and therefore reduce out-of-pocket health-care costs. And finally, it takes account of child-care expenses, transportation costs, and other work expenses that reduce resources available for low-income workers to meet their family’s basic needs. As we demonstrate, differences in benefits and expenses each have a large effect on poverty in Wisconsin.

Wisconsin Poverty under the New Measure

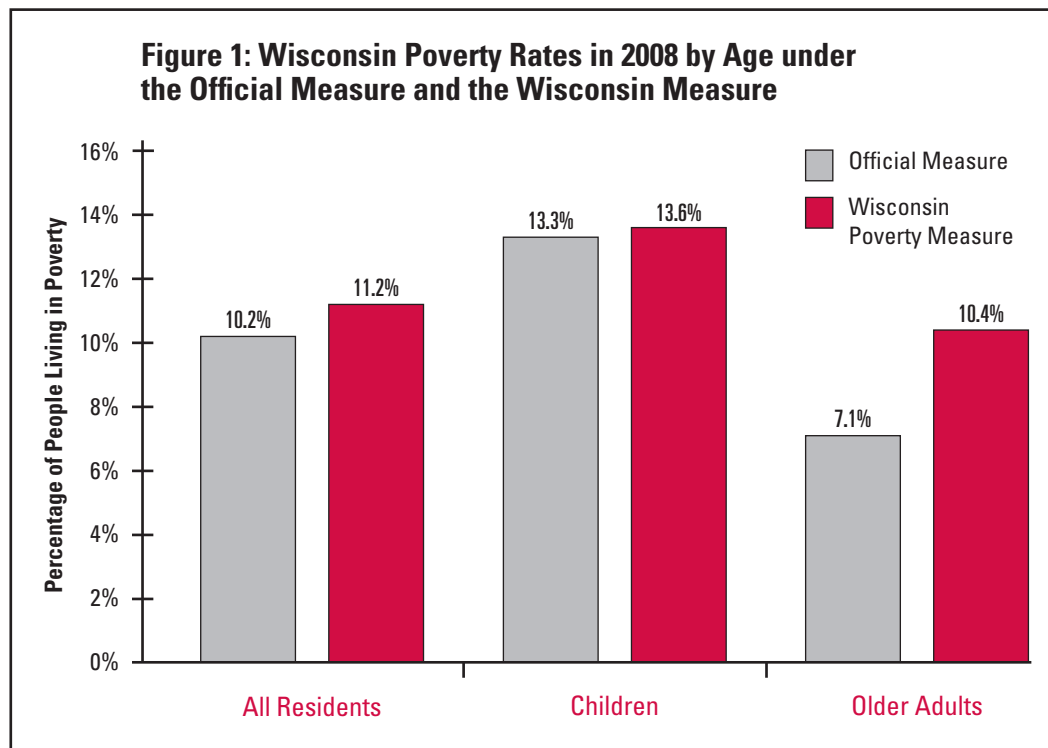
For 2008, our improved Wisconsin measure finds a somewhat higher poverty rate in Wisconsin: 11.2 percent, rather than 10.2 percent in the official measure. This difference is the net impact of many offsetting adjustments: noncash benefits and refundable tax credits that reduce poverty by increasing family resources, and adjustments for medical and work expenses that increase poverty rates.

Poverty rates under the Wisconsin Poverty Measure are higher than official poverty rates for children and older adults, as well as for the population overall (see Figure 1). The increase in measured poverty is particularly steep for older adults, whose poverty rate increases from 7.1 percent to 10.4 percent. Child poverty also increases, though by less, rising from 13.3 percent to 13.6 percent. Child poverty remains considerably higher than older adult poverty under the Wisconsin measure (13.6 percent compared to 10.4 percent).

We estimated poverty rates for the 10 largest counties in Wisconsin, as well as for 12 multicounty areas that encompass the remaining areas of the state. The multicounty areas

used in this report were predetermined by the boundary lines for the Census Bureau’s Public Use Microdata Areas and cannot be broken out further for single-year poverty estimates. While some of the multicounty areas comprise only two counties (e.g., Ozaukee and Washington), others require as many as seven to 10 of the more rural counties in order to gain sufficient sample size to obtain reliable estimates.

Under the Wisconsin measure, the poverty rate ranges from nearly 19 percent in Milwaukee County to less than 5 percent in the two-county area of Ozaukee/



Source: Institute for Research on Poverty tabulations of 2008 American Community Survey data

Washington, two of Milwaukee County's most affluent neighbors. Under the official measure, the range was slightly smaller, from 17 percent in Milwaukee County to less than 4 percent in Waukesha County (another wealthy suburb bordering Milwaukee). Most counties and multicounty areas have poverty rates that are roughly 0.5 to 2.5 percentage points higher under the Wisconsin measure than the official poverty rate.

The Wisconsin Poverty Measure allows us to examine the effects of a broader range of antipoverty policies than can be observed with the official measure. Our measure of resources includes cash income, plus the net effects of taxes (including refundable tax credits as well as the effects of payroll taxes for Social Security), major noncash benefits, such as FoodShare, public housing, and low-income home energy assistance. Current policies on taxes, food stamps, public housing, and energy assistance reduce poverty by 2 percentage points.

Most of this reduction results from refundable income tax credits and FoodShare assistance. The impact of tax credits alone is a reduction of 0.9 percentage points, and that of FoodShare benefits is slightly more than 0.9 percentage

Efforts across the Nation

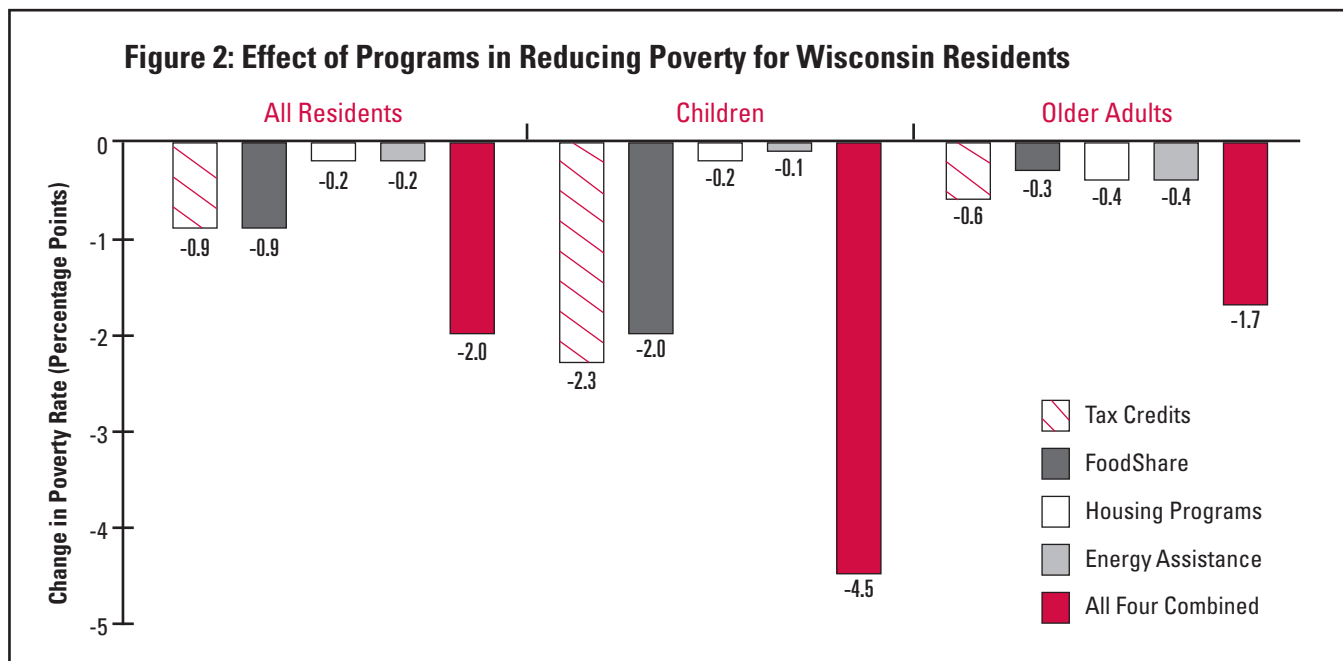
Work on the Wisconsin-specific measure is one of several research efforts of university, government, and private agency researchers across the United States to develop alternative poverty estimates at the local, state, and national levels. The Census Bureau and the Bureau of Labor Statistics are leading federal efforts to develop a Supplemental Poverty Measure based on recommendations from experts on the 1995 National Academy of Sciences' Panel on Poverty and Family Assistance, as well as on subsequent research on alternative measures of poverty. To support this work, the Institute for Research on Poverty at the University of Wisconsin-Madison is developing on its web site a technical resource on the Supplemental Poverty Measure to disseminate ongoing research to all researchers interested in this topic. The institute is also serving as a resource to other states and localities, offering technical resources from the development of the Wisconsin Poverty Measure to researchers interested in developing their own place-specific alternative measures of poverty.

points. Many poor people, especially those with children, receive tax credits that are larger than their owed income and payroll taxes, as a result of the federal and state Earned Income Tax Credits and the Wisconsin Homestead Credit. Thus, the net impact of federal and state income and payroll taxes is a reduction in poverty rates. FoodShare benefits also have a fairly large antipoverty impact, reflecting the size of the program (one out of eight people in Wisconsin received at least one month of these benefits in 2008) and its focus on providing food assistance to low-income populations.

Housing and energy assistance programs provide aid to fewer households and have a smaller marginal effect on poverty; the existence of these programs (and the inclusion

of their value in our poverty measure) reduces poverty by approximately 0.2 percentage points each.

The antipoverty effects of tax credits and FoodShare are much larger for children than for older adults. Figure 2 shows the impact of tax credits, FoodShare, housing assistance, the Low-Income Home Energy Assistance Program, and all four policies combined on poverty rates by age. The large impacts of tax credits and FoodShare benefits on child poverty are



Source: Institute for Research on Poverty tabulations of 2008 American Community Survey data

not unexpected, given that the Earned Income Tax Credit is largely restricted to families with children, which also have a particularly high participation rate in the FoodShare program. Older adults do gain a net benefit from tax credits, however, which is likely a reflection of the Wisconsin Homestead Credit. Under our measure, housing and low-income home energy assistance benefits reduce older adult poverty more than they reduce child poverty.

Adjustments to income for work expenses and the effects of necessary out-of-pocket health-care costs also make a big difference in poverty. The costs of medical care (even with the state's insurance program, BadgerCare), child care, commuting, and other work-related expenses have the effect of increasing poverty, reflecting the fact that these expenses reduce families' income available to meet food, clothing, shelter, utilities, and other basic needs. The higher poverty rates found here reflect the offsetting effects of higher expenses like health care and child care and increased resources due to food and housing benefits and refundable tax credits. Both are affected by policy, and both make a difference in outcomes for all people, for children, and for older adults.

Conclusion and Moving Forward

Using a more complete measure of the resources and needs of Wisconsin residents, we found higher overall poverty rates than under the official poverty measure. The Wisconsin Poverty Measure also allowed us to look within the state at variation by age and region, as well as at the effects of Wisconsin's policies that help individuals and families meet their basic needs.

Within Wisconsin, we trust our model reflects the Wisconsin Idea, offering a service to the state by providing a more complete picture of who lives in poverty, and a tool for estimating how antipoverty policies affect those they target. We also hope that the Wisconsin measure, both now and as it is refined, can serve as a national model so that other states and localities can follow our lead and create their own measures, substituting their own state and local data and their own choices for poverty measurement, given state and local needs.

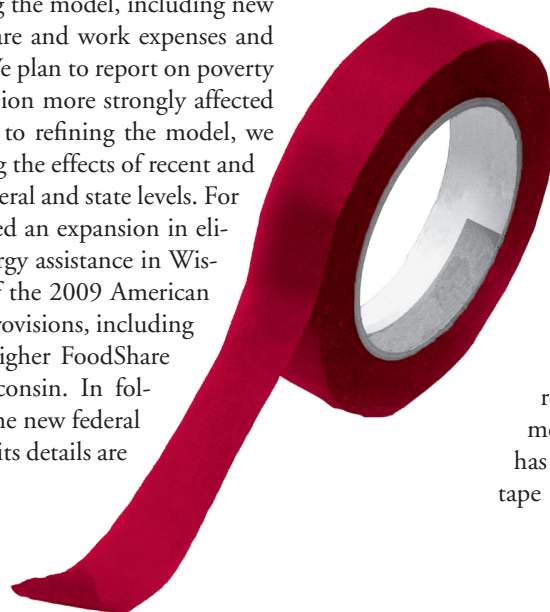
We plan to continue improving the model, including new work on the modules for child care and work expenses and out-of-pocket health-care costs. We plan to report on poverty in 2009, a period when the recession more strongly affected the state and nation. In addition to refining the model, we will expand capacity for simulating the effects of recent and proposed policy changes at the federal and state levels. For instance, we have already simulated an expansion in eligibility for low-income home energy assistance in Wisconsin and estimated the effect of the 2009 American Recovery and Reinvestment Act provisions, including higher levels of tax credits and higher FoodShare benefits, on poverty within Wisconsin. In following years, we will also mimic the new federal Supplemental Poverty Measure as its details are determined. ♦

Red Tape: Rethinking and Expanding the Study of Administrative Rules

By Donald P. Moynihan

While red tape is of long-standing interest to scholars and members of the public, only in the last two decades have scholars begun to develop empirical knowledge on administrative rules. To help them advance their understanding, more than 20 researchers convened a workshop to consider a research agenda for the next decade. The La Follette School of Public Affairs at the University of Wisconsin–Madison hosted the Red Tape Research Workshop: Rethinking and Expanding the Study of Administrative Rules in June 2010 with support from the University of Wisconsin–Madison's Center for World Affairs and the Global Economy, the Center for European Studies, and the European Union Center of Excellence. The meeting included researchers and Ph.D. students from 14 universities and five countries. We engaged in an enthusiastic discussion about expanding and improving red tape research and we developed a promising future for collaboration. The red tape research community is a good example of how the sociology of science works, with researchers continually making small, incremental steps toward better measures that ultimately help improve our societies.

Research to date tells us that perceptions of red tape matter and seem to affect loyalty, commitment, and satisfaction of individuals to organizations. Second, perceptions do not always align with objective measures of red tape. Third, red tape is usually more common in public services than in the private sector. This difference appears to hold even if the providers of public services are private actors with government contracts. With more outsourcing, red tape seems to be seeping from government into the private sector. Finally, research has not established a correlation between red tape and performance, although red tape does



delay outcomes and create negative perceptions among organization members.

One of the virtues of red tape is that it enjoys a basic level of recognition among members of the public (at least in the United States) relative to other public administration concepts. This identity gives scholars a recognizable brand and a chance to gain public attention. Red tape research must ensure it is relevant by linking to policies that citizens and media care about — for example, how citizens experience the tax process or deal with new health-care regulations.

Much of the modern empirical study of red tape originates with workshop attendee Barry Bozeman's definition of red tape as rules that serve no functional object or have no positive outcomes for an organization and its stakeholders. Participants noted this definition is too narrow and stringent: for example, participants argued that rules could have benefits but ultimately exert such negative impacts on citizens that the rules come to be considered red tape.

Workshop participants discussed the possibility of better assessments of stakeholder red tape, rule effectiveness, the multiple dimensions of red tape, and the interactions among those dimensions. We concluded that a broader definition of



red tape might enable researchers to better understand how red tape is related to efficiency, effectiveness, political values, fairness, equity, representation, and other values that are critical to public management research. A reconceptualization process was also seen as a valuable method to focus on questions about why red tape and rule dysfunction occur.

We reached a general consensus that the red tape research community, with limited resources, has done some good work in the areas of measurement and research development. For example, a scale that gauges red tape within an organization has been tested in different research settings: within single organizations, in comparisons across states and organizations, and in local English government. Workshop participants agreed that measurement research should focus on advancing our understanding of ways in which stakeholders and organizations conceptualize red tape and on developing more advanced methods for operationalizing these concepts. Researchers suggested using more and varied measures and research techniques. They also saw the value in qualitative analyses that could track the “natural history” of the development and implementation of a rule in particular policy areas.

Much time was dedicated to thinking about what the red tape research enterprise can achieve. Some key research issues emerged:

- ◆ The basics: How do we get red tape? What are the responses to red tape? What are the costs and benefits of responding to red tape? What can we do to fix red tape?
- ◆ An organizational focus: How does red tape interact with other organizational factors, such as culture and leadership?
- ◆ A stakeholder focus: Who is affected by red tape? Is red tape applied equally? Do different groups of citizens have different capacities to influence and overcome administrative rules?
- ◆ A policy focus: Red tape research can connect to policy studies by examining how red tape affects particular functions in different ways. For example, the definition and impact of red tape in crisis management and health care are likely to work quite differently.

For public policy practitioners, the research can lead to practical ways to minimize the negative impact of red tape within public organizations, and on citizens and regulated bodies. Issues such as the financial sector collapse and proposed health-care reforms illustrate the central importance of effective rules to current policy. ◆

La Follette School associate director **Donald P. Moynihan** was one of three red tape experts who served on the committee that organized the Red Tape Research Workshop. The others are Mary K. Feeney of the University of Illinois–Chicago and Richard M. Walker of the University of Hong Kong. The web site address for the Red Tape Research Workshop is <http://www.lafollette.wisc.edu/research/redtape>.

Voting Early, but Not So Often

By Barry Burden, David Canon, Kenneth Mayer, Donald Moynihan

When is Election Day? Traditionally, we think of the first Tuesday in November. But for more and more citizens, that is no longer the case. States have aggressively expanded the use of early voting, allowing people to submit their ballots before Election Day in person, by mail, and in voting centers set up in shopping malls and other public places. More than 30 percent of votes cast in the 2008 presidential race arrived before Election Day itself, double the amount in 2000, and quadruple the amount in 1992. In 10 states, more than half of all votes were cast early, with some coming in more than a month before the election. Election Day as we know it is quickly becoming an endangered species.

State governments have sought to make voting more convenient for citizens, at least partly because they hope to increase turnout at the polls. In addition to early voting, some states allow election-day registration, i.e. eligible voters can both register and vote on election day. Another option is same-day registration, which permits people to both register and vote in a single act prior to Election Day. The application of these reforms varies across states (see Figure 1). Some states have none, and some states, including Wisconsin, have all three.

Wisconsin was among the first wave of states to adopt election-day registration in the 1970s. In 2000 Wisconsin allowed a citizen to cast an in-person absentee ballot without an excuse, effectively creating the opportunity to vote early. Voters can also register at their municipal clerk offices at the same time they vote, even if they vote early. Wisconsin has been consistently near the top of states in terms of voter turnout, and an increasing portion of that vote (21.2% in 2008) comes via early voting.

Wisconsin is one of six states that offers the combination of early voting and same-day or election-day registration. The

most popular policy option, in place in 18 states for the 2008 election, is to offer early voting in isolation, without making registration easier. Our research suggests that this option actually reduces voter turnout.

Early voting offers convenience and additional opportunities to cast a ballot. Common sense tells us that this should mean higher turnout. But a thorough look at the data shows that the opposite is true: early voting depresses turnout by several percentage points.

Our research is based on a three-part statistical analysis of the 2008 presidential election. First, we analyzed voting patterns in each of the nation's 3,100 counties to estimate the effect of early voting laws on turnout. We controlled for a wide range of demographic, geographic and political variables, like whether a county was in a battleground state.

Controlling for all of the other factors thought to shape voter participation, our model showed that the availability of early voting reduced turnout in the typical county by three percentage points. Consider, as an example, a county in Kentucky, which lacks early voting. In comparing it to a similar county in neighboring Tennessee, which permits early voting, we observe, other things being equal, turnout that was 3 points lower.

Next, we studied the data on more than 70,000 voters and nonvoters from the Census Bureau's Current Population Survey, which asks respondents whether they voted. Once again, we employed a statistical model to control for demographic variables like education and race as well as geographic and political factors. The model showed that an individual living in a state with early voting had a probability of voting that was four points lower than a comparable voter in a state without early voting.

Third, we took advantage of a useful feature of the census survey, which asks individuals whether they voted early or on Election Day. We examined the characteristics of voters and nonvoters, and we found that the profiles of early voters and Election Day voters were mostly similar.

With one big exception: our model forecast that early voters had profiles that made them two percentage points more likely to vote than Election Day voters, whether there was an early option or not. Early voters were more educated, older, and had higher incomes, all traits associated with a higher probability of voting. A probability difference of 2 percentage points may seem like a trivial figure, but when applied to populations of millions, the difference can shift national and state elections.

The authors adapted this article from an October 24, 2010, *New York Times* op-ed. **Barry Burden, David Canon, and Kenneth Mayer** are members of University of Wisconsin–Madison's Department of Political Science and faculty affiliates at the La Follette School. **Donald Moynihan** is associate director of the La Follette School. The article draws from their work on the Election Administration Project at the University of Wisconsin–Madison to understand and improve the conduct of U.S. elections at all levels of government. The project's web site is <http://electionadmin.wisc.edu>.

Even with the added convenience and greater opportunity to cast a ballot, turnout actually falls with early voting. How can this be? The answer lies in the nature of voter registration laws, and the impact of early voting on mobilization efforts conducted by parties and other groups on Election Day.

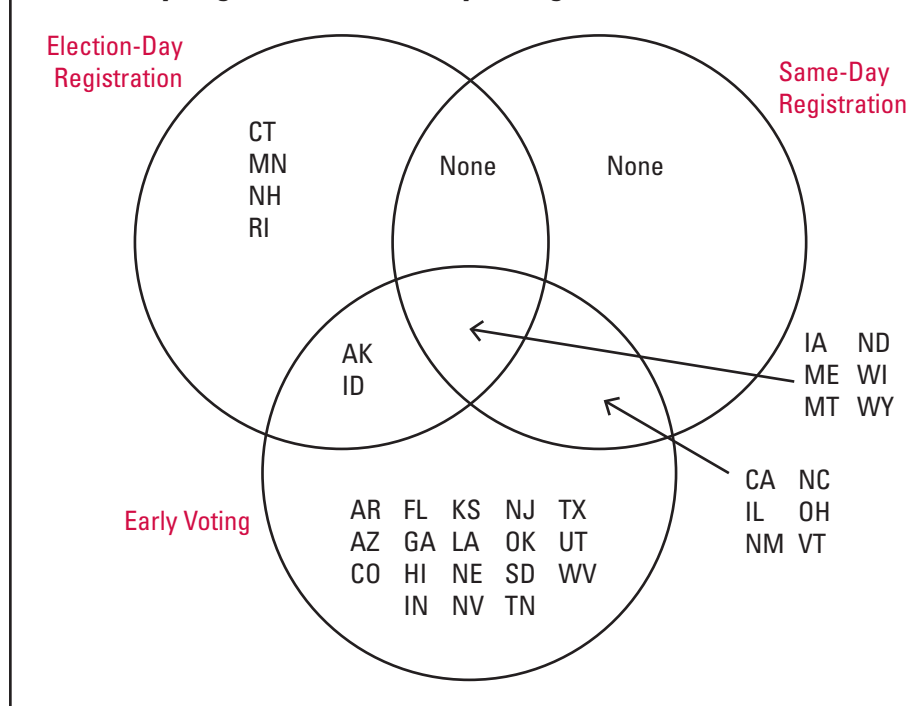
In most states, registration and voting take place in two separate steps. A voter must first register, sometimes a month before the election, and then return another time to cast a ballot. Early voting by itself does not eliminate this two-step requirement. For voters who missed their registration deadline, the convenience of early voting is irrelevant.

Early voting also dilutes the intensity of Election Day. When a large share of votes is cast well in advance of the first Tuesday in November, campaigns begin to scale back their late efforts. The parties run fewer ads and shift workers to more competitive states. Get-out-the-vote efforts in particular become much less efficient when so many people have already voted.

When Election Day is merely the end of a long voting period, it lacks the sort of civic stimulation that local news coverage and discussion around the water cooler used to provide. Fewer co-workers sport “I voted” stickers on their lapels on Election Day. In the age of electronic social networks, these informal influences remain: during the 2010 midterm elections 12 million Facebook users posted an “I voted” sticker on their profile. Studies have shown that these informal interactions have a strong effect on turnout, as they generate social pressure. With significant early voting, Election Day can become a kind of afterthought, simply the last day of a drawn-out slog. As a result, the informal social pressures to vote are harder to sustain and less effective in increasing turnout.

The experience of early voting offers a classic example of a popular policy that has generated a significant unanticipated negative impact. No state has reversed early voting reforms, and so proposals to eliminate early voting are unlikely. But there is a relatively simple policy fix that improves turnout while maintaining the convenience of early voting. Our research shows that when early voting is combined with same-day registration, the depressive effect of early voting disappears. North Carolina and Vermont, two otherwise very different states that combined early voting with same-day registration, had turnout levels in 2008 that were much higher than the overall national figure of 58 percent of the voting-age population. Turnouts in Vermont and North Carolina were, respectively, 63 percent and 64 percent.

Figure 1: Combinations of Election-Day Registration, Same-Day Registration, and Early Voting in 2008



Allowing election-day registration has the same positive effect on turnout. Our models show that the simple presence of election-day registration in states like Minnesota and New Hampshire increases turnout by more than six points. For states that do not have early voting, but that are interested in a single policy that will improve turnout, election-day registration offers the best prospects.

Why do election-day registration and same-day registration succeed where early-voting fails? The first key difference is that allowing voters to register late in the election season removes one of the most meaningful barriers to participation. Citizens no longer have to register weeks before a campaign reaches its height. As a result, less-engaged citizens can enter the voting process late — and political campaigns can respond by maintaining the intensity of their efforts through Election Day. While early voting might provide a benefit to the careful voter who made sure to register in a timely fashion, providing late registration benefits the marginal voter and, therefore, brings in more voters who might otherwise sit on the sidelines.

The second key difference is the benefit of “one-stop shopping.” The citizen only has to have one interaction with the state in order to register and vote, rather than two. This seems to offer a more meaningful form of convenience to voters than early voting, at least with respect to turnout.

The implications for policymakers are obvious. Adopting a form of “one-stop shopping” better facilitates turnout. Early voting may be the most popular reform sweeping across the states, but it alone is not the key to raising voter turnout. ♦



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Director's Perspective

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it is likely to go down in history as one of the most dense, complicated, and comprehensive reform bills to ever pass.

In this *La Follette Policy Report*, Professors Robert Haveman and Bobbi Wolfe do an outstanding job of summarizing what may be, for many, a poorly understood law. As they explain, much of what the new health-care system will become remains to be determined in implementation. State decisions in setting up health insurance exchanges and related provisions will be among the earliest, most significant developments in health-care reform. Access will clearly increase under the new law, but implications for health-care quality and costs will depend greatly on choices made in implementation and the effectiveness of incentives embodied in the Patient Protection and Affordable Care Act in guiding improvements.

Equally important, the article by Haveman and Wolfe, as well as the others in this report, emphasize the key role that policy analysis will play not only in informing these critical decisions, but also in evaluating the reform's effectiveness. The careful work of Joanna Marks, Julia Isaacs, and Timothy Smeeding on the Wisconsin Poverty Measure illustrates how important the assumptions that we make in conducting these analyses are — in codifying choices, operationalizing measures, and specifying models and methods for empirical assessment — and how imperative it is to be transparent in all aspects of analysis. Many assumptions were made in designing the health-care reform bill, and they are embedded in key measures such as the federal poverty line that determine access to publicly funded benefits. For the exceptionally well-trained policy analysts who come out of the La Follette School, including 2010 graduate Joanna Marks, this level of sophistication in their work is second nature.

With many new legislators and new leaders in the federal and state governments, uncertainty is bound to continue to keep many of us waiting and wondering about upcoming economic and policy developments. Sound policy analysis will play a critical role in reducing this uncertainty and guiding us toward a faster recovery and better future. Citizens as well as public leaders are increasingly demanding the kinds of information and means for accountability that such well-done policy analyses can deliver, and the La Follette School continues to offer the very best preparation for those interested in undertaking this vital work.

Federal Rulemaking and Agency Performance

By Susan Webb Yackee and Jason Webb Yackee

Federal agencies formulate the vast majority of government regulations through a process called “rulemaking.” As the 1946 Administrative Procedure Act dictates, agency policy initiatives often go through a notice-and-comment process, meaning that agencies must solicit and consider written comments before promulgating the final, legally binding rules. Most agencies rely on this process for their substantively meaningful regulatory undertakings. In fact, rules govern such important policy topics as warning labels on cigarette packages and permissible levels of arsenic and other contaminants in drinking water.

Figure 1 depicts the process by which rules are announced and promulgated. As the figure indicates, the president, Congress, and the courts have added procedural requirements to the notice-and-comment rulemaking process. Many scholars, policymakers, and members of the broader community believe these new procedural requirements greatly hinder the government’s ability to formulate administrative rules efficiently. In fact, some observers argue that the president, Congress, and the courts have imposed so many constraints on federal agencies that agencies only issue needed regulations after significant and unnecessary delay. Scholars of public administration, administrative law, and political science describe this perceived slowdown as “ossification.”

The academic literature on ossification emphasizes discretionary review by the Office of Management and Budget (OMB) as the main source of presidential delay. Congress has passed several statutes that have also come under fire, most notably the 1980 Regulatory Flexibility Act, which requires agencies to perform additional analysis for rules that affect small business. Court rulings have raised the standard of

agency scrutiny of comments from “consideration” to a “hard look” and mandated lengthier explanations of agency actions, requirements that are perceived to slow rulemaking.

The ossification thesis claims that the net effect of presidential-, congressional-, and court-mandated procedural constraints — all imposed after the 1946 Administrative Procedure Act — makes notice-and-comment rulemaking unduly costly and time-consuming. Agencies must expend scarce time and financial resources performing analyses. They must wait while the OMB reviews rules and then devote resources to the response. If agencies fear judicial review, they must expend time and resources on detailed scrutiny and compile lengthy justifications of their decisions, and perhaps defend their actions in court.

Findings

Our analysis contradicts one of the ossification’s thesis central tenets — that procedural requirements slow down rulemaking. Using data that cover all federal rule-writing agencies from 1983 to 2006, we find that procedural constraints do not appear to unduly interfere with the ability of federal agencies to act, or to act in a timely manner. In fact, for most rules, the imposition of procedural constraints is associated with a higher probability that a given rule will be promulgated. Stated differently, the finding suggests that some procedural constraints actually speed up — not slow down — rulemaking.

More specifically, we study the time a rule takes to move from the initial notice of proposed rulemaking to its finalized status. We find that about half of all rules are finalized within 14 months; 25 percent of those within just seven months. Three-fourths are finalized within 50 months. Overall, these results suggest that for the majority of rules, promulgation occurs much quicker than would be predicted by the ossification literature or others who lament the “problem” of regulatory delay.

Our quantitative analysis also suggests that rules that have procedural constraints imposed on them by the president, Congress, or the courts do not move more slowly through the regulatory process compared to rules not subject to review. In fact, the opposite appears to be true: procedural constraints may actually accelerate the promulgation of these rules. For instance, we find that an OMB-reviewed rule is 45 percent more likely to be finalized within seven months

The analysis on which this summary rests is among the first to empirically examine the federal rulemaking process in the United States. It does this by studying the volume and speed of regulatory decisions across all U.S. rulemaking agencies during a 24-year period. This summary is drawn from the authors’ article published in the *Journal of Public Administration Research and Theory* in 2010. **Susan Webb Yackee** is an associate professor of public affairs and political science. La Follette School faculty affiliate **Jason Webb Yackee** is an assistant professor of law. An earlier version of this article was the winner of the “Best Paper by an Emerging Scholar(s)” Award at the 2008 Midwest Political Science Conference.

than a non-reviewed rule, and 14 percent more likely to be finalized within 14 months. This time-advantage persists until 21 months have elapsed (and by 21 months, the majority of rules that are ultimately put into place have been promulgated). It follows, then, that the required OMB review slows down the process only for those rules that are in process for more than 21 months.

Ramifications

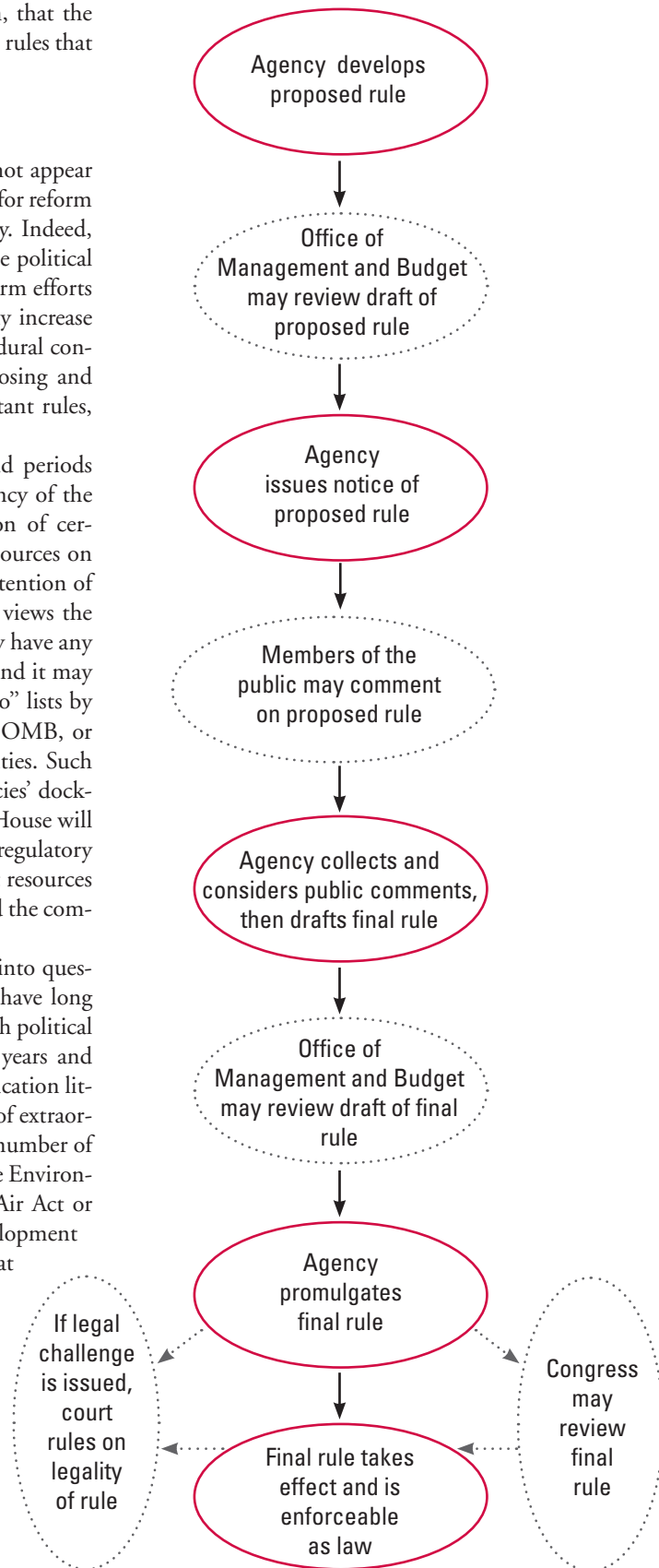
Contrary to what some experts believe, “ossification” does not appear to be a serious problem and cannot serve as the basis for calls for reform of the federal regulatory process in the interest of efficiency. Indeed, removal of procedural constraints is likely to reduce valuable political and public oversight. Moreover, our results suggest that reform efforts are unlikely to speed up most rulemaking or to significantly increase the volume of rulemaking. Despite the imposition of procedural constraints, federal agencies appear relatively capable of proposing and promulgating a fairly large number of substantively important rules, and of promulgating most of those rules relatively quickly.

How is it possible that requiring additional review and periods for commentary and response does not impede the efficiency of the federal regulatory process? We suggest that the imposition of certain procedural constraints might serve to focus agency resources on completing those rules that are more likely to attract the attention of Congress and the president, particularly when the agency views the rules as capable of being quickly finalized. Agencies typically have any number of regulatory initiatives ongoing at any one time, and it may be that agencies organize and prioritize their internal “to-do” lists by reference to whether a particular rule will be reviewed by OMB, or whether it will burden small businesses or other small entities. Such rules are likely to be the most important rules on the agencies’ dockets; their importance is reflected in the fact that the White House will review them or that they have to go through Congress’ regulatory flexibility analysis. In this interpretation, agencies may shift resources away from less important (and less constrained) rules toward the completion of important (but procedurally constrained) rules.

In closing, we emphasize that our analysis does not call into question the undeniable empirical fact that some rulemakings have long histories or that some agencies are more likely to struggle with political and court interference than others. Rulemaking can take years and involve a great deal of effort and expense. However, the ossification literature probably makes too much of the relatively rare cases of extraordinarily long-lived rulemakings, extrapolating from a small number of high-profile and exceptional regulatory “failures,” such as the Environmental Protection Agency’s implementation of the Clean Air Act or the Occupational Safety and Health Administration’s development and promulgation of ergonomics regulations, to conclude that the rulemaking process has failed overall.

Our conclusion that procedural constraints do not appear to unduly interfere with the ability of federal agencies to act or, in most cases, to act in a timely manner should hearten policymakers who labor over regulations and shepherd them through the rule, comment, and review processes. For most rules, the process does not appear to be broken or “ossified” and in fact may be made better by the political oversight and accountability provided by the president, Congress, and the courts. ♦

Figure 1: Administrative Rule Development and Review Process



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