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Do Local Governments Represent Voter Preferences?

Evidence from Hospital Financing under the Affordable Care Act

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One of the main reasons for the existence of local (as opposed to only state or national) governments is that they can better respond to differing preferences for the public provision of goods and services. However, scholars and practitioners have long expressed skepticism about whether decentralization works in practice, particularly because voters may not be able to monitor local government actors due to asymmetric information. Preemption policies (e.g., local tax and expenditure limits or Dillon's Rule) that grant states the power to constrain local governments are arguably motivated by the perspective that local voters systematically lack the capacity to constrain the actions of their local governments for their own benefit.

While much research in the political economy literature demonstrates government errors—particularly in the area of fiscal illusion, in which voters underestimate the cost of government spending—there is comparatively little research on government adherence to voter preferences. Another prominent critique of decentralization is that local governments will not be efficient providers of welfare or poverty assistance programs due to interjurisdictional competition: local governments compete for mobile actors who will support taxes only for services from which they directly benefit, hence it is argued that higher levels of government are better suited for the provision of social insurance programs. These competing

concerns regarding the trustworthiness of local governments to support efficient and equitable societies are important determinants in a long-standing debate over the appropriate degree and scope of government decentralization.

Local governments participate in the health care system as both health care providers and third-party payers. This paper provides evidence of local government adherence to voter preferences by treating state expansion of Medicaid under the 2010 Affordable Care Act (ACA) as an external price shock for public provision of health services. Specifically, by providing reimbursement to a previously uninsured pool of patients, the ACA allows local governments to reduce their financial role in supporting local hospitals and spend more on other public services or reduce tax burdens. Alternatively, the ACA represents an opportunity to expand local hospital provision given a new source of reimbursement for community health care activities that may not have been financially feasible prior to expansion.

The value of the ACA as a way to investigate local government responses to incentives lies in its contentious political and legal history. In 2012, the U.S. Supreme Court ruled the Medicaid expansion provision of the ACA to be voluntary for individual states. To date, 31 states have elected to expand Medicaid. Other provisions of the ACA, such as the creation of an individual health insurance marketplace and extensions of employer-sponsored health insurance to young

adults, were applied nationally. Subsequent state-level decisions to expand Medicaid under the ACA represent an arguably exogenous shock at the local government level. This expansion reduces the share of uninsured patients within local markets. We find that in 2013, county-level estimates of uninsurance among those meeting the Medicaid expansion provision's income criteria ranged from 9 to 65 percent of the population. Moreover, the federal government covered the cost in the initial years of the expansion, thus local governments acting to capitalize on this opportunity do not impose heavy costs on state budgets.

From the perspective of a voter with preferences regarding local public goods and services, the Medicaid expansion provision of the ACA resembles a matching categorical aid grant to local governments in that it offers reimbursements for previously uncompensated hospital-care services. A median voter whose preferences include delivering services to poor community residents might encourage an expansion of these services as they become further subsidized through Medicaid. On the other hand, if voter demand for public-sector altruism is already satiated near current levels, then local governments may take this opportunity to retreat from their role of underwriting hospital provisions and spend on other public goods or reduce taxes to increase private consumption. How these different possible financial reactions actually net out is an empirical question addressed by this paper. Assessing the effect of state Medicaid expansion on relevant local government fiscal variables enables us to study the sensitivity of local government support for hospitals to alternative sources of payment.

To test our central question of whether local governments behave in ways that are consistent with voter preferences, we split our sample based on whether the encompassing county voted for Barack Obama or Mitt Romney in the 2012 presidential election as a proxy for local voter preferences for the ACA and, more generally, for public intervention in the financing of health care. We believe that this proxy accurately reflects voter preferences for the local government response to ACA incentives because health care reform was the most divisive issue of the election. The assumption is that the propensity toward greater fiscal engagement with hospitals is greater in Obama-voting areas than in Romney-voting areas. Regardless of whether a state expanded Medicaid, in 2012 there was wide variation in the presidential preferences of individual local populations.

We examine local government behavior in areas that had high uninsurance prior to 2014, as these were the areas that would financially gain the most from Medicaid expansion,

compared with areas with low baseline rates of uninsurance. Using data from the U.S. Census of Governments for the years 2006–2015, we examine governments' fiscal decisions, paying special attention to hospital-related expenditures and to revenue raised from property taxes. We find that, on average, there was no response to ACA state expansion in terms of local hospital spending decisions: states that expanded and states that didn't expand saw similar changes post-2013. However, when we split our sample by 2012 presidential preferences, we find notable opposing effects: local governments in Obama-supporting areas increased their spending on local hospital services, whereas those in Romney-leaning areas reduced their spending and lowered property taxes. This pattern remains consistent among local governments with urban and rural designations. We also confirm that our findings are robust to controlling for other significant differences in demographic composition.

Local governments primarily support their local public hospitals. Increased local government spending after the ACA could reflect an effort to support public hospitals subjected to "cream skimming" if now-profitable patients relocate to nonpublic hospitals. In order to rule out competing explanations for the results we observe, we supplement our study with an analysis of financial data for hospitals receiving government support as well as for other competing hospitals in the area. Examining hospital financial records to rule out this alternative explanation, we find that low profits for public hospitals following expansion do not account for our observed result. Indeed, we find that public hospitals experienced profit increases.

Our study examines local government responsiveness to changes in the institutional setting (i.e., the exogenous incentive under Medicaid expansion), whereas prior work has examined cases in which government functions and purposes were realigned. That is, we study a moment when, due to a changing environment, local governments were presented with an opportunity in which they could respond in accordance with local voter preferences. Such a setting should carry greater external validity than the settings of previous case studies, since shifting vertical assignment functions within federalist systems are a less common occurrence than the many presumed environmental changes citizens expect their governments to respond to while representing their interests.

Finally, in addition to contributing to our understanding of representative democracy, the course of this research contributes to a generally understudied stakeholder in the public health service economy (local governments), making it policy-relevant research. In the aggregate, local governments

represent the majority contributor to public hospitals and to health-related services as measured by expenditures, as they have outspent state governments by about a \$3-to-\$2 ratio on hospitals and matched state spending on other public health care expenditures. While total spending is driven by a relatively small number of local governments (802 of 89,004), these entities serve one-third of the American population. Furthermore, hospitals are significant consumers of government inputs, with one-tenth of non-education-related local government employees working in hospitals. Despite this high level of fiscal involvement, almost no attention has been given to the public economics of health care delivery at the

local government level. We thus include an additional analysis of hospitals' profits, which separately contributes an empirical assessment of how publicly supported hospitals were affected by the ACA and state Medicaid expansion.

NOTE:

This research brief is based on Victoria Perez, Justin M. Ross, and Kosali I. Simon, "Do Local Governments Represent Voter Preferences? Evidence from Hospital Financing under the Affordable Care Act," NBER Working Paper no. 26094, July 2019, <https://www.nber.org/papers/w26094>.