Politics and Health Care Spending in the United States: A Case Study from the Passage of the 2003 Medicare Modernization Act*

Zack Cooper, Yale University and the NBER
Amanda Kowalski, University of Michigan and the NBER
Eleanor Neff Powell, University of Wisconsin-Madison
Jennifer D. Wu, University of Pennsylvania

March 2024

Abstract

This paper analyzes the interplay between congressional politics, the actions of the executive branch, and hospitals' regulated Medicare payments. We focus on the 2003 Medicare Modernization Act (MMA) and analyze a provision in the law— Section 508—that raised certain hospitals' regulated payments. We show, via our analysis of the Section 508 program, that Medicare payments are malleable and can be influenced by political dynamics. In the cross-section, hospitals represented by members of Congress who voted "yea" on the MMA were more likely to receive Section 508 payment increases. We interviewed the Health Secretary who oversaw the MMA, and he described how these payment increases were designed to win support for the law. The Section 508 payment increases raised hospitals' activity and spending. Members of Congress representing recipient hospitals received increased campaign contributions after the Section 508 payment increases were extended. Ultimately, our analysis highlights how Medicare payment increases can serve as an appealing tool for legislative leaders working to win votes for wider pieces of legislation.

Key Words: Health Care Spending, Political Economy, Congress, Lobbying
JEL Codes: I10, I18, H51, D72, P16

1   Introduction

In nearly all developed health systems, including the US Medicare program, governments set regulated prices for health care providers. There are inherent trade-offs between relying on markets versus governments to allocate resources and set providers' reimbursements (Acemoglu and Finkelstein 2008; Chandra, Finkelstein, et al. 2016; Clemens and Gottlieb 2017). At present, there is a well-developed literature on the imperfections of health care markets in general (e.g., Arrow 1963) and on the challenges with relying on bargaining between insurers and providers to set prices in particular (e.g., Cooper et al. 2019). However, much less is known about the political challenges and trade-offs inherent in regulating providers' reimbursements and, more generally, the influence of political dynamics on health care spending.

In the United States, Congress and the executive branch have significant capacity to influence health spending, particularly via reforms of the $800 billion Medicare program. Congress votes on the laws that define the scope and structure of the Medicare program, including those that determine how the program reimburses providers. The Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS), both of which are directed by political appointees, implement the laws passed by Congress, including those that dictate how providers get paid. However, despite the large role of Congress and the executive branch in shaping US health policy, outside of a handful of studies (e.g., Leider et al. 2015; Vladeck 1999; McKay 2019), there is scant empirical evidence on political economy issues in the US health sector, and political scientists have even asserted that variation in Medicare spending is unlikely to be explained by political dynamics (Berry, Burden, and Howell 2010).

In this paper, we analyze the interplay between congressional politics, the actions of the executive branch, and hospitals' regulated Medicare fee-for-service payments. Our focus is on examining whether Medicare payments are malleable and can be influenced by political dynamics and on testing for the presence of a feedback loop that allows legislative leaders to work with the executive branch to raise Medicare payments in an effort to pass wider pieces of social policy legislation. To do so, we study events leading up to and following the passage of the Medicare Modernization Act (MMA) of 2003, which was one of the largest expansions of social insurance in US history and gave government-funded prescription drug coverage to seniors via the introduction of the Medicare Part D program.

The MMA was a signature policy of the George W. Bush administration. The law was politically fraught and was passed in the US House of Representatives by a one-vote

margin. We focus on the impact of a provision inserted into the MMA of 2003—Section 508—which created a process through which hospitals could apply to receive an increase in their regulated Medicare payments. Of note, the rules governing which hospitals received increases in their reimbursements from Section 508 were written by the executive branch after the MMA was passed, allowing officials to steer funds to specific hospitals and regions (thus benefiting specific politicians).

In the canonical analysis of legislator behavior, Mayhew (1974) argued that the primary goal of members of Congress is to be re-elected. This pressure to be reelected drives members of Congress to pass legislation with direct benefits to their constituents, like grants to universities or the building of bridges, for which the legislators can directly claim credit (Mayhew 1974; Weingast, Shepsle, and Johnsen 1981; Rocca and Gordon 2013). The desire to be reelected also dissuades members of Congress from devoting time to forming the coalitions necessary to pass sweeping laws, such as expansions of the Medicare program, where credit claiming can be difficult (Evans 2004). To push members of Congress to form coalitions, legislative leaders in the US House of Representatives often include provisions with targeted benefits to get reluctant members to vote for sweeping laws where credit-claiming is difficult (Evans 2004). These provisions, such as the building of a train station in a district, are often referred to as "pork-barrel projects," "sweeteners," "earmarks," or "distributive policies."

This paper tests whether the Section 508 program in particular and Medicare payment increases in general can serve as appealing legislative sweeteners. Our analysis proceeds in three stages. First, we identify which hospitals received a Section 508 waiver, quantify the extent to which Section 508 waivers raised their Medicare payments, and test for a link between a hospital's receipt of a waiver and the vote its representative in Congress made on the MMA. To do this, we identify, via a Freedom of Information Act (FOIA) request, the hospitals that applied for and were granted a Section 508 waiver (hereinafter "Section 508 hospitals"). This FOIA also allows us to identify the 376 hospitals that applied for a waiver and had their applications rejected. These rejected hospitals form our control group. We illustrate that hospitals that received a Section 508 waiver — 120 in total — saw their Medicare prospective payment system (PPS) payments increase by approximately 7%. We then calculate what hospitals would have made in inpatient Medicare revenue with and without the Section 508 payment increases, ignoring any increases in activity that the rise in payments could precipitate.

We show that hospitals that received a Section 508 waiver were more likely to be

represented by a member of Congress who voted in favor of the MMA. To bolster this analysis, we also interview one of the key political architects of the MMA, Tommy G. Thompson, who was the secretary of Health and Human Services (HHS) in the George W. Bush administration from 2001 to 2005.[1] Thompson served as secretary of HHS when the MMA was being developed, during the passage of the MMA into law, and as the MMA was implemented. In our interview with him, Secretary Thompson confirmed that the Section 508 program was added to the MMA in an effort to secure votes for the passage of the law. His statements also dovetail with our empirical analysis and anecdotal press reporting at the time that suggested the MMA included a series of smaller provisions designed to win legislators' support (e.g., Lee, 2003). We also explored, with Secretary Thompson, the mechanism through which politically appointed officials at HHS and CMS could influence Medicare payments.

Second, we show that the Section 508 payment increases led to an 11% increase in Medicare spending at affected hospitals. These spending increases in spending were driven by the mechanical payment increases generated by the Section 508 program and hospitals' behavioral to the payment increases (e.g., hospitals responded to their payment increases by raising their activity). Hospitals that experienced larger increases in their Medicare payments responded with larger increases in their inpatient activity, highlighting how the increase in Medicare payments induced movement along the supply curve. Ultimately, we show that the Section 508 program did not simply lead to a reallocation of spending across hospitals. Rather, we illustrate that the Section 508 program led to an average increase in Medicare spending of approximately $10 million annually in congressional districts with Section 508 hospitals.

Notably, the Section 508 program led to large increases in health spending in a modest number of congressional districts. From 2005 to 2010, the 20% of districts that received the largest gains from the Section 508 program got hundreds of millions in additional Medicare payments. Measured in federal dollars per capita, this implies the Section 508 program led some districts to get increases in federal spending that were on the same order of magnitude as gains generated by the American Recovery and Reinvestment Act (Boone, Dube, and Kaplan 2014). Outside the health care sector, there is substantial evidence that elected officials often allocate state and federal resources in an effort to garner electoral support (Bickers and Stein 1996; Evans 2004; Levitt and Snyder Jr. 1997; Wright 1974; Clemens and Veuger 2021; Berry, Burden, and Howell 2010). As Clemens and Veuger (2021) note

---

[1]Please see Appendix A for more details of our interview with Secretary Thompson.

from their analysis of the distribution of COVID-19 aid, political considerations can shift the allocation of distributive policies by billions of dollars. Our findings echo that broader literature and underscore why adjustments to the Medicare fee schedule, which allocates billions of dollars in Medicare funding annually, can lead to substantial local benefits that are appealing to lawmakers, who can use them to claim credit on wider pieces of health care legislation.

Finally, we show that the Section 508 program precipitated large increases in campaign contributions for members of Congress representing recipient hospitals. The original language on Section 508 in the MMA allocated $900 million to fund the program and scheduled the program to expire three years after it was introduced (i.e., it included a sunset provision). As a result, the hospitals and wider constituencies that were aware of and benefited from the waivers had considerable interest in seeing the program extended by Congress beyond its slated expiration. Indeed, their shared financial interest in the program's continuation was so great that Section 508 hospitals formed the Section 508 Coalition, which, according to data obtained from the Center for Responsive Politics, spent millions lobbying to preserve the Section 508 program (The Center for Responsive Politics 2019c). Past work highlights how interest groups like the Section 508 Coalition can make legislators' actions more visible to voters and precipitate increases in campaign contributions that serve as ex post rewards for past actions (Stratmann 2005; Fox and Rothenberg 2011).

We find that, on average, a member of Congress with a Section 508 recipient hospital in her district received an increase in overall campaign contributions of approximately $191,000 after the Section 508 program was extended. Likewise, we observe suggestive evidence that there were increases in campaign contributions to members representing Section 508 hospitals from individuals working in the hospital sector immediately before the vote to reauthorize the Section 508 program and again after the law was passed. We do not find corresponding increases in campaign contributions from individuals working in sectors that were plausibly unaffected by changes in hospital Medicare reimbursements (e.g., donors working in the agriculture industry or the oil and gas industry). We also observe that the larger the gains a district received from the Section 508 program, the larger the increases in campaign contributions the members representing those districts received. We find, for example, that for each additional $1,000 in inpatient spending generated by the Section 508 program, members of Congress received an additional $61 in overall campaign contributions. These findings help underscore why inserting provisions like Section 508 into law can win the votes and support of members of Congress.

5

Our work contributes to and intersects with three literatures. First, this study highlights the impact of raising Medicare reimbursement rates on hospital volume. There is a growing literature that assesses the extent to which increasing provider payments raises the volume of care provided. Consistent with Clemens and Gottlieb (2014), Gross et al. (2021), Hackman and Pohl (2018), Dillender, Jinks, and LaSasso (2023), and Cabral, Carey, and Miller (2021), we find that when hospitals' Medicare rates are increased, it raises the quantity of care hospitals provide. These findings are vital for policymakers because they imply that the impact of increasing Medicare rates on spending will be a function of both the mechanical effect of the payment increases and the behavioral response (e.g., volume increases) those payment increases induce from providers.

Second, this work adds to the literature on political logrolling (trading favors for votes), the allocation of pork, and work that has assessed the influence of politics on the allocation of federal funds. Our discussion with Secretary Thompson suggests that the Section 508 program was used to win votes for the MMA, and that Medicare payments can be malleable and influenced by political dynamics. Likewise, our work highlights that, given the scale of the benefits they create, Medicare payment increases can be an appealing tool for steering local benefits and thus should be expected to be used for logrolling and the transfer of political rewards. Our findings on the allocation of the Section 508 waivers are consistent with predictions by Evans (2004) that distributive policies, like increases in regulated hospital payments, can be used to entice and reward legislators for "yea" votes on legislation where credit-claiming will be difficult. Whereas previous work, such as Berry, Burden, and Howell (2010), assumes that formula-based payment policies in the Medicare program are unlikely to be gamed, our interview with Secretary Thompson illustrates that the HSS can use the Medicare PPS program to steer federal funding. This is consistent with others' findings that the executive branch (e.g., the program administrators) can steer benefits to political allies and that federal aid from nationwide programs can be steered toward congressional districts in the majority (Kasdin and Lin 2015; Clemens and Veuger 2021). For example, Gordon (2011) finds that during the Bush administration, under pressure from the political staff at the White House, the General Services Administration, a US federal agency that allocates government contracts, steered a disproportionate share of government contracts to congressional districts with vulnerable Republican legislators. Thus, our work underscores the potential for regulated provider fee schedules, like the Medicare PPS, to be used as a tool to steer political benefits.

Third, we add to the literature analyzing the link between legislators' actions and

campaign contributions. Past work has argued that campaign contributions can serve as both ex ante inducements for legislators to act or ex post rewards for past action (Grossman and Helpman 1994; Grossman and Helpman 1996; Chamon and Kaplan 2013; Rocca and Gordon 2013; Powell 2014). Interest groups, such as political action committees, it is argued, can both sway legislators and mobilize the public to reward legislators ex post for their actions (Stratmann 2005; Fox and Rothenberg 2011). Our findings are consistent with work by Rocca and Gordon (2013) that has found, via analysis of earmarks for the defense industry, that donations tend to be ex post rewards for previous votes. Our work is also consistent with research suggesting that lobbying can be particularly effective when it targets specific, less salient provisions within a law (e.g., hospital payment increases in the MMA) as opposed to lobbying over whole pieces of legislation (McKay 2019; Kang 2015).

Collectively, the main contributions of this work are to show a link between domestic politics and health spending in the United States, and to illustrate how regulated provider payments can be used as a tool to steer benefits to specific geographic areas. Past work by Brown (1985) and Vladeck (1999) suggested Medicare policy can be meaningfully swayed by political concerns; Leider et al. (2015) has found that health care facilities represented by representatives or senators serving on appropriation committees receive more in earmarks. We highlight how the Bush administration and legislative leaders influenced the Medicare fee schedule and how changes in the fee schedule raised health spending. Our work is consistent with predictions that, when government policy transfers large amounts of capital from one group to another via regulatory interventions, the policy process grows susceptible to outside influence (Acemoglu and Verdier 2000; Chan and Dickstein 2016).

Going forward, this paper is structured as follows. In Section 2, we provide background information on the Medicare program and the Medicare Modernization Act of 2003. In Section 3, we describe the Section 508 program, identify recipient hospitals, quantify the payment increases they received via Section 508 waivers, and test for an association between hospitals' receipt of Section 508 waivers and votes by the members of Congress who represent them. Section 4 describes the impact of the Section 508 program on hospital behavior and health spending. In Section 5, we explore whether members of the House of Representatives were rewarded for reauthorizing the Section 508 program. We conclude in Section 6.

2 Background

2.1 The Medicare Program and the Medicare Modernization Act of 2003

The Medicare program, created in 1965, provides health insurance coverage to individuals aged 65 and older, as well as a subset of individuals under age 65 with disabilities. When the Medicare program was founded, it did not include prescription drug coverage for seniors. As the cost of prescription drugs increased in the 35 years after the program was founded, this gap in Medicare coverage became an increasingly prominent concern for seniors (Toner 2002). On December 8, 2003, President George W. Bush signed the MMA into law. The MMA provided prescription drug coverage to seniors for the first time via the creation of the Medicare Part D program. The MMA was the largest expansion in the Medicare program's 38-year history. The law, which was expected to cost approximately $400 billion over 10 years, was a political priority for the George W. Bush White House, which thought the coverage expansion would bolster the senior vote that Bush had lost to Al Gore in the 2000 presidential election (Oliver, Lee, and Lipton 2004). According to Bruce Bartlett, a historian and presidential advisor, "George W. Bush strongly supported this effort [to pass Medicare Part D]. Looking ahead to a close re-election in 2004, he thought a new government giveaway to the elderly would increase his vote share among this group" (Bartlett 2013). Similarly, as we note in Appendix A.1, Secretary Thompson said in our interview that he advised President Bush that expanding prescription drug coverage was vital to his reelection.

The passage of the MMA was politically fraught. The bill was introduced in the US House of Representatives by Speaker Dennis Hastert on June 25, 2003. Early roll call votes in the House indicated that the bill was unlikely to pass. The key vote that moved the bill from the House to the Senate (roll call vote 332) passed by a one-vote margin, 216 to 215, and was split along party lines. Democrats voted 9 "yea" and 195 "nay" while Republicans voted 207 'yea' and 19 "nay." In breach of congressional rules, this vote was kept open for an abnormally long period, during which Vice President Cheney visited the House floor and there was substantial arm-twisting (Oliver, Lee, and Lipton 2004). Ultimately, passage of the law hinged on keeping Republican members of the House from voting against the legislation and mustering support from conservative Democrats (Oliver, Lee, and Lipton 2004). Because the vote was so close, every member's vote could be considered a marginal vote. Section 508 was added immediately after this vote during roll call vote 332.[2]

After the Senate passed the bill, the final vote on the reconciled legislation in the House

---

[2]We spoke to individuals working on the staffs of members of Congress during the passage of the MMA, who indicated that Section 508 waivers were used as sweeteners during roll call vote 332.

of Representatives (roll call vote 669) was also extremely close. As was the case during the first House vote, rather than adhering to the standard 15-minute vote period and in contravention of the rules of the House of Representatives, the vote was kept open for an extended window, during which time HHS Secretary Tommy Thompson visited the House floor and President Bush phoned reluctant members of Congress (Oliver, Lee, and Lipton 2004). In the end, the law passed by a vote of 220 to 215.

Consistent with Evans' 2004 argument that targeted policies can be inserted to garner votes in the passage of sweeping legislation, the MMA contains a number of provisions, in addition to Section 508, that provide targeted benefits in an effort to win over particular legislators (Lee 2003; Abelson 2003). For example, the MMA included a large increase in funding for physicians in Alaska, the home state of Senator Ted Stevens, the chairman of the Senate Appropriations Committee. Another provision inserted into the MMA and championed by Senator Charles Grassley from Iowa contained significant funding for trials to determine whether the Medicare program should fund chiropractic services. Iowa is the home of a leading chiropractic educational institution (Lee 2003).

2.2 The Medicare Program and Political Logrolling

While the Medicare program is supposed to allocate funding based on local needs and not politics, the control and influence that Congress has over the program allows members to narrowly focus funds to specific districts and key constituencies.[3] Policymakers and journalists have argued that these types of narrowly directed funds have been used to curry favor with lawmakers and nudge them to vote for laws that were successfully passed, including the Children's Health Insurance Program, the Affordable Care Act (ACA), and the MMA (Vladeck 1999; Aaron and Reischauer 2015; Pear 1999; Cohn 2010; Abelson 2003). These kinds of logrolling efforts can involve significant sums of money. For example, a recent article on then-Senate Majority Leader Mitch McConnell's efforts to repeal the ACA and pass the Better Care Reconciliation Act of 2017 (BCRA) stated, "Using a combination of hardball politics, personal persuasion and lots of money – hundreds of billions of dollars were available to pay for more add-ons to the bill in order to get some votes — the Kentucky

---

[3]For example, within the 1999 federal budget, Representative Rob Portman successfully lobbied for an increase in Medicare payments for brachytherapy, a treatment for prostate cancer in which radioactive seeds are implanted in the prostate. The radioactive seeds subjected to the funding increase were produced by Indigo Medical, a firm based in Congressman Portman's district (Pear 1999). Similarly, the 1999 budget also increased funding for the radioactive dye used in imaging studies (Pear 1999). The provision for this funding increase was inserted by William Roth, the junior senator from Delaware, the state where the largest manufacturer of this product is headquartered.

Republican scrambled to round up 50 Republicans to support the motion to proceed to the bill" (Bresnahan 2017).

Hospital payment rules, in particular, which are written by policymakers at CMS, have been used to steer additional funding to particular hospitals and regions, often as part of efforts to help pass legislation. Most Medicare funds are allocated across the United States via formula-based payment programs for physicians and hospitals. The majority of hospitals in the United States are paid for treating Medicare patients under the formula-based PPS, which was passed into law by Congress via the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. The PPS reimburses hospitals a fixed payment per inpatient case. Ultimately, the key arbiter of what a hospital gets paid per case under the PPS is the hospital's physical location, which determines the hospital's wage index. The wage index is a measure of the labor costs hospitals face. Medicare payments vary across hospitals in the United States by a factor of approximately three (Institute of Medicine 2012). However, between 1997 and 2012, 16 statutory provisions were introduced that raised hospital reimbursements for small groups of providers (Government Accountability Office 2013).[4] As a result, by 2012, 29.7% of hospitals received some form of wage index reclassification that raised their reimbursement rate above what was originally set by the PPS formula (Government Accountability Office 2013).

While payment changes cannot be explicitly political, officials in the Executive Branch at CMS can write rules that are crafted to steer funds narrowly to specific hospitals or groups of hospitals. As Brown (1985) notes, CMS officials operate in ways that both execute on the mission of the agency and are influenced by the larger political environment. While some of the changes introduced to the PPS fee schedule since it was founded were merit-based, a number of provisions have produced large changes in hospital payments that are often credited to a particular lawmaker or were used to direct funds very narrowly to specific legislators. For example, "Lugar counties," authorized by and named after Indiana Senator Richard Lugar, were introduced in the Omnibus Reconciliation Act of 1987 and generated 10% increases in hospital payments for providers located in a small number of counties (American Hospital Association 2011). Likewise, within the 1999 budget, hospitals in districts represented by Representative Tom DeLay, the House Republican Whip, and Representative Dennis Hastert, the Speaker of the House, were reclassified into

---

[4]For a detailed description of the statutory provisions that have increased hospital payments, see the US Government Accountability Office's 2013 report to Congress, which describes all the policies that have increased Medicare hospital payments between 1997 and 2012 (Government Accountability Office 2013).

other regions, which significantly increased the hospitals' Medicare payment rates (Pear 1999).[5] More recently, legislative leaders added the Frontier States provision to the ACA before its passage. The program raised the minimum wage index of hospitals in Montana, Nevada, North Dakota, South Dakota, and Wyoming. This payment change was reported to be a vehicle to win support for the Affordable Care Act (ACA) from senators in these rural states (Cohn 2010).

3   The Section 508 Program

3.1   Background on the Section 508 Program

The Section 508 program, as Secretary Tommy Thompson described, was designed as a vehicle to win votes for the MMA. Speaking to us about the genesis of the Section 508 program, Secretary Thompson said in our interview, "And so 508 came along as a result of— [Senator Chuck] Grassley and I came up with it—trying to find ways to get rural hospitals a better shake." He continued, "The only way we were able to do it [get the MMA passed] was the benes [benefits] we put in with it: Medicare Advantage, Section 508." He explained, "The way we did it, we put these things [like Section 508] in, and then we would try them out. We'd take them out in our weekly meetings [with members of Congress]. And then we'd go out and talk to the congresspeople about if they could buy it [the MMA] with this [e.g., the Section 508 program] in it."

The Section 508 program created a process through which, in the months after the MMA was passed, hospitals could appeal their current wage index assignments and receive a time-limited change in their wage index that would increase their PPS payment rates. The provision was open to hospitals that were paid using the PPS that did not qualify for other changes in their wage index. According to the Federal Register (2004a), "a qualifying hospital...does not qualify for a change in wage index classification under paragraphs (8) or (10) of section 1886(d) of the Act on the basis of requirements relating to distance or commuting" (pg. 7341). The legislation did not specify the specific criteria hospitals would need to meet to qualify. Instead, it stated that a qualifying hospital "meets other criteria, such as quality, as the Secretary may specify by instruction or otherwise."

Ultimately, the specific rules and regulations that determined how Section 508 waivers were to be granted were written after members of Congress had cast their votes on the MMA. The broad language in Section 508 of the MMA created flexibility for the executive branch

---

[5]These changes resulted in annual increases in hospital funding of $380,000 and $750,000, respectively (Pear 1999).

to write rules that favored specific hospitals.[6] Originally, the law budgeted $900 million to fund the wage index changes from the Section 508 waivers, which were to run from April 1, 2004, to March 31, 2007. However, the program was extended several times until it finally expired on March 31, 2012 (Government Accountability Office 2013). As we highlight in Appendix A.2, Tommy Thompson noted that the HHS secretary has significant influence over how rules and regulations for Medicare are written and that the payment rules can be manipulated for political benefit.

Approximately two months after the MMA was passed, the first set of rules for judging Section 508 waiver requests was published in the Federal Register (Federal Register 2004a). A month later, the rules were updated with more detail and justification (Federal Register 2004b). In practice, the Section 508 program relaxed the criteria for hospitals to get their wage index changed. Historically, the Medicare Geographic Classification Review Board, the body responsible for assessing hospital wage index appeals, would allow hospitals to reclassify their wage index to an adjacent region if an urban hospital was within 15 miles of another hospital that was paid substantially more or a rural hospital was within 35 miles of a hospital that was paid substantially more (Federal Register 2004a). The Section 508 program allowed hospitals that did not meet those standard criteria to get a wage index change based on one of eight new criteria (Federal Register 2004a). These new criteria were quite specific and allowed policymakers to target funds narrowly to specific groups of hospitals. For example, the program allowed urban hospitals in states with fewer than 10 people per square mile to get a reclassification. Likewise, the program allowed hospitals to change their assigned wage index to a wage index from a region in another state if the hospital's average hourly wages were at least 108% of the average hourly wages at a hospital in the area where the hospital was arguing it should be reclassified.[7] While the Section 508 program was written with very specific criteria that allowed benefits to be directed to specific hospitals, other hospitals that were represented by politicians who were not part of the logrolling process around the MMA could apply and potentially get a waiver by qualifying under the rules for the Section 508 program.

---

[6]In 2014, we spoke to officials at CMS when the Section 508 program was introduced. They described how the program allowed them to write narrow rules so that the program could target funds at specific hospitals.

[7]The Federal Register, Volume 69, Number 30, printed on February 13, 2004, includes a detailed description of the quality criteria hospitals had to meet to receive a Section 508 waiver. Per federal law, the Federal Register also includes justifications for these changes.

3.2 Quantifying Medicare Payments and Gains from the Section 508 Program

We submitted a FOIA request to CMS and requested the criteria on which hospitals that applied for a Section 508 waiver were judged, a definitive list of hospitals that applied for and received a Section 508 waiver, and a list of hospitals that applied but were rejected for a Section 508 reclassification. Within a year of our submission, we received a detailed reply from CMS with the information we requested, including the names of the 496 hospitals that applied for a waiver and the 120 hospitals that had their applications approved. We followed the CMS payment rules presented in the Federal Register to construct hospital PPS payments for each inpatient case for each hospital in each year from 2001 through 2010.[8] Using this formula to calculate hospitals' Medicare PPS payments allowed us to create counterfactual payments and identify what hospitals would have been paid with and without the wage index changes generated by the Section 508 program. In Figure 1, we show Section 508 hospitals' base Medicare PPS payment rate with and without the wage index change generated by the program. Because of the immediate payment rules change, as we illustrate in the figure, the Section 508 program created a sharp and immediate increase in hospitals' payments in 2005 that persisted for the next five years. We find that the mean Section 508 hospital received a 6.90% increase in its Medicare PPS payment rates in 2005.

In Table 1, we describe the characteristics of hospitals that received a Section 508 waiver relative to hospitals that applied for a waiver but had their applications rejected and the universe of hospitals registered with the AHA that did not receive a Section 508 waiver. Section 508-recipient hospitals generally were larger than the average US hospital, and already had a higher wage index than other facilities even before receiving a payment increase. Section 508 hospitals tended to be represented by members of Congress with longer tenures in office, although their representatives did not earn a higher share of the vote in the last election.

Consistent with the Secretary's assertion, as we illustrate in Table 1, hospitals that received a Section 508 waiver were 10 percentage points more likely to be in districts represented by a member of Congress (60%) who voted for the MMA than hospitals that were represented by a member of Congress who did not vote in favor of the MMA (50%). Likewise, as we illustrate in Appendix Table A.1, we also show the cross-sectional relationship between whether a hospital received a Section 508 waiver and whether the member of Congress representing the hospital voted "yea" on the MMA, controlling for political party, incumbency, whether the member was in a congressional leadership position,

---

[8]See Appendix B.2 for more details about how we calculated Medicare PPS payments per hospital.

hospital characteristics, and local area characteristics. We show that having a member vote "yea" was associated with an 1.8-percentage point increase in the probability of receiving a Section 508 waiver off a base rate of receipt of a 508 waiver of 3 percentage points. Likewise, in Column (2), we show that having a member who voted "yea" on the MMA was associated with an additional $60,000 in predicted Medicare inpatient revenue from the Section 508 program.

Our goal for the analysis in Table 1 and Appendix Table A.1 is to illustrate a link between votes for the MMA and the Section 508 program. That is, we want to illustrate that the setting of the Medicare fee schedule is not wholly divorced from congressional politics. However, we do not think there is a single explanation for why members of Congress representing hospitals that eventually received a Section 508 waiver voted for the MMA. For example, it is possible that because of the Section 508 program, members of Congress were more likely to vote for the MMA because it steered money to their district and they would be able to claim credit for the benefit in the future. Likewise, it is equally possible that hospital associations made hospital CEOs who could benefit from the Section 508 waiver aware of the program, so that the CEOs pushed their members to vote for the MMA. Indeed, because we do not have quasi-random variation to exploit, the link we illustrate between votes for the MMA and the Section 508 program should not be interpreted as causal. However, assertions by Secretary Thompson and the circumstantial evidence (e.g., that the rules defining which hospitals received a Section 508 waiver were written after the law was passed) are both suggestive that, consistent with theory from Evans (2004) on legislative sweeteners, the Section 508 program was added in an effort to win votes for the MMA.

4 Section 508 Waivers, Hospital Behavior, and Health Spending

4.1 Estimating the Impact of the Section 508 Medicare Payment Increases

In this section, we examine the impact of the Section 508 Medicare payment increases on hospital behavior and hospital- and congressional district-level health spending. We use difference-in-difference regression to identify the outcomes for the hospitals that received a Section 508 waiver before and after they received their April 1, 2004, onward payment increase relative to the outcomes at various groups of control hospitals. Our estimator takes the form:

$$Outcome_{h,t} = \beta_t Section\_508\_Recipient_h \cdot \tau_t + \vartheta_h + \tau_t + \varepsilon_{h,t} \tag{1}$$

where we measure outcomes $Outcome_{h,t}$, such as inpatient Medicare discharges, at hospital h in year t. We interact our treatment indicator ($Section\_508\_Recipient_h$) with a vector of year fixed effects τ_t. We also include a vector of year fixed effects τ_t and hospital fixed effects ϑ_h, which capture the main effects of each interaction. Our data on inpatient discharges and Medicare revenue come from the Healthcare Provider Cost Reporting Information System (see Appendix B.1 for a description of the data used throughout this analysis). We inflation-adjust our spending measures into 2010 dollars. Our standard errors are clustered at the hospital level.

We use our FOIA request to define our treatment and control groups. Our treated group is composed of the 120 hospitals that had their Section 508 waivers approved. In our main estimates, we rely on a balanced panel of the 88 hospitals that remain in our treated sample the entire period (we later show robustness to using an unbalanced panel).[9]

Our primary control group is composed of the 284 hospitals in our balanced sample that applied for a Section 508 waiver but had their applications rejected. Hospitals had to apply for a Section 508 waiver after the MMA was passed, but before the rules for determining which hospitals would receive a waiver were written. At the time the Section 508 waiver was introduced, all that was publicly known about which hospitals could receive a waiver was what was written in the MMA. The MMA stated that hospitals were eligible for a waiver if they had not previously received a wage index reclassification. As a result, it is likely that many hospitals that applied posited they had a chance to get a waiver but ultimately did not because the rules were written in ways that excluded them. As we illustrate in Appendix Table A.2, these hospitals had similar numbers of Medicare discharges to treated hospitals and had a similar wage index but were less likely to be represented in Congress by a member who voted "yea" on the MMA ($p < 0.10$). However, these rejected hospitals were also more likely to be for-profit and were larger facilities (measured using bed counts).

As a result, we also show our results are robust to a range of other control groups and, in particular, to a control group constructed using propensity scores. In Appendix Table A.2, we compare the characteristics of Section 508 hospitals, hospitals that applied for a waiver and were rejected, all hospitals registered with the AHA from 2001 to 2010 that were paid using the PPS, and our propensity-score matched control hospitals (details on our matching procedure are discussed in Appendix C.1). As we illustrate in Columns (9) and (10) of

---

[9]We lose 17 from our analysis because they were not registered with the American Hospital Association (AHA) in at least one year. Fifteen hospitals dropped out during our sample period because they either were involved in a merger, closed, or ceased being listed in the CMS Impact Files (which identify how hospitals are paid).

Appendix Table A.2, whereas there are differences between treated hospitals and hospitals that applied for a Section 508 waiver and were rejected, our matched control group is well balanced relative to our treated group. As a result, we also use this matched group of hospitals as an alternative control group. Indeed, as we demonstrate, our results are largely robust to using a range of alternative groups of hospitals as control groups.

We also analyze how our treatment effects vary as a function of hospitals' potential gains from the Section 508 program. To capture this heterogeneity, we created a measure of hospitals' Section 508 treatment exposure, measured in dollars, which we estimate as the product of a hospital's pre-treatment (2003) Medicare inpatient patient volume multiplied by a treated hospital's change in Medicare reimbursement rates generated by the program. This captures hospitals' mechanical Medicare spending gains from the Section 508 program, ignoring any expansion of hospital activity induced by the payment increase (e.g., their behavioral response). As we illustrate in Appendix Table A.3, the median Section 508 hospital had mechanical revenue gains of $1.52 million from the Section 508 program in 2005.

4.2 Section 508 Waivers and Hospitals' Behavior and Spending

As we illustrate in Table 2, which presents estimates of Equation (1), we observe that the Section 508 program led to an increase in inpatient Medicare spending at treated hospitals of $4.28 million (9%) in 2005 (with a standard error (S.E.) of 1.00) and $5.23 million (11%) (S.E. of 1.54) by 2010. These were the result of both the Section 508 payment increases (e.g., a mechanical effect) and the increases in volume generated by the payment bump (e.g., a behavioral response). From 2005 to 2014, there was a widespread reduction in inpatient care as hospitals shifted many procedures to an outpatient setting (McDermott, Elixhauser, and Sun 2017). We observe that, while there was a national reduction in the share of hospital services performed in an inpatient setting in the 2000s, inpatient quantities went down less at Section 508 hospitals than they did at control hospitals. Estimates of Equation (1) presented in Column (1) of Table 2 and shown graphically in Figure 2 reveal that treated hospitals' inpatient admissions were 313.94 higher (7.1%) by 2010 than at hospitals that applied for a Section 508 waiver but had their applications rejected (S.E. of 119.87). Notably, we do not observe any economically meaningful or statistically significant differences in pre-trends between treated and control hospitals prior to the introduction of the Section 508 program. We present logged versions of these results in Appendix Table A.4

and Appendix Figure A.1.[10]

The scale of the spending increase the Section 508 program generated for specific hospitals was substantial. Collectively, from 2005 to 2010, the Section 508 program raised inpatient Medicare spending by approximately $25 million per treated hospital.[11] Across the 88 treated hospitals in our analysis, this resulted in more than $2.1 billion in additional inpatient Medicare spending from 2005 to 2010.[12]

In the right panels of Figure 2, we show that the impact of the Section 508 program was larger in hospitals more exposed to the program. In the treatment exposure estimates on the right of Panels A and B of Figure 2, each point represents an estimate of the 2010 treatment effect from Equation (1). Moving from left to right, the treated group is composed of hospitals that had increasingly large mechanical gains from the Section 508 program. The point estimate closest to the Y-axis shows the 2010 treatment effects when all Section 508 hospitals are included in the treatment group (All); the next point estimate is the treatment effect including the top 90% of hospitals (i.e., those that had exposure in the 10th percentile and upwards), and so on. The control group remains the same across all our estimates.

As these dose response graphs in Figure 2 illustrate, the larger the payment increases from the Section 508 program, the larger the increases in inpatient admissions. Likewise, for the 50% of hospitals with the largest mechanical gains from (exposure to) the program, the payment increases raised inpatient Medicare spending by $8.95 million per hospital in 2010. For the 20% of hospitals with the largest mechanical gains from the Section 508 program, the payment increases raised inpatient Medicare spending by nearly $15 million per hospital in 2010. In Appendix Figure A.3, we show event studies for the 50% of treated hospitals with the largest gains from the Section 508 program. Here, hospitals that received a Section 508 waiver were experiencing differential gains in inpatient admissions before their receipt of a waiver.

4.3 Section 508 Waivers and Congressional District-Level Health Spending

To measure the effect of the Section 508 program on congressional districts, we sum hospital spending across all hospitals in each district, estimate Equation (1) at the congressional

---

[10]These results are robust to the inclusion of outpatient spending (Panel A of Appendix Figure A.2). The Section 508 payment increases also raised total revenue at the 20% of hospitals with the largest mechanical gains (Panels B and D of Appendix Figure A.2).

[11]This number is obtained by summing the 2005 to 2010 interaction terms.

[12]We obtained this by multiplying 88 (the number of treated hospitals) by the $24.87 million in added spending per treated hospital.

district level, substitute district fixed effects for hospital fixed effects, and cluster standard errors at the congressional district level. Here, we define a congressional district as treated if it contained one or more hospitals that received a Section 508 waiver in 2004. Control districts are those that have one or more hospitals that applied for a Section 508 waiver and had their applications rejected and also did not contain treated hospitals.

This analysis, presented in Panel C of Figure 2, illustrates that, rather than simply producing a reallocation of spending across hospitals within districts, the Section 508 program raised aggregate inpatient Medicare spending in treated districts. The point estimates presented in Column (3) in Table 2 show that the program led to an $8.03 million increase (3%) in Medicare inpatient spending in 2005 (S.E. equals 4.05) and an $11.51 million increase (4%) (S.E. equals 6.06) in 2010. The increase in health spending we observe at the district level is proportional to the gains we observe at the hospital level.[13] We present a version of Table 2 where the dependent variables are logged in Appendix Table A.4. Our logged results are qualitatively similar to our estimates in levels.

The gains from the Section 508 program were concentrated in a small group of districts that had multiple Section 508 hospitals. As we illustrate in the treatment exposure estimates presented on the right of Panel C of Figure 2, the 20% of districts with the largest mechanical revenue increases saw an absolute increase in Medicare inpatient spending of $35 million in 2010. All but three of these districts had two or more Section 508 recipient hospitals. While it is unlikely that there is widespread public awareness of the Section 508 program, the local gains generated from the program were of a similar magnitude to much better-known pieces of stimulus legislation like the American Recovery and Reinvestment Act (ARRA). Collectively, summing up the gains from the Section 508 program from 2005 (the first full year of the program) to 2010, the most heavily treated 20% districts received an increase in Medicare spending of approximately $156 million and an increase in total health spending of $796 million. There are approximately 664,000 people per district in this cohort of treated congressional districts. As a result, from 2005 to 2010, the Section 508 program added between $223.17 and $251.84 (mean of $235.78) per resident in Medicare spending and between $1,137.06 and $1,283.11 (mean of $1,201.29) per resident in total health spending.[14] For context, the ARRA allocated between $316 and $613 per capita (Boone,

---

[13]The mean treated district had two treated hospitals. So, our $4.28 million per treated hospital gains in Column (2) of Table 2 scale up to the $8.03 million district-level gains in Column (3) of Table 2.

[14]We obtain these figures by dividing the average gains in Medicare spending ($156 million) or total health spending ($796 million) by the population of each congressional district in the top 20%. We use population figures for congressional districts in the 111th Congress (2009-2010) from IPUMS.

Dube, and Kaplan 2014).

4.4 Section 508 Waivers and Hospitals' Behavior and Spending — Robustness

We conduct a large number of robustness tests, which we present in Appendix Table A.5. First, we show in Columns (1) and (2) of Appendix Table A.5 that our results are robust when we rely on an unbalanced panel of treated hospitals. As we illustrate using this unbalanced panel, we observe a precisely estimated increase in spending in 2005 and 2010 that is modestly smaller in magnitude than the estimates in Table 2 (e.g., a 2010 point estimate of $5.23 using our balanced panel and a point estimate of $4.55 using our unbalanced panel). Likewise, we observe a modestly smaller scaled increase in admissions using our unbalanced panel (e.g., a 2010 point estimate of 314 using our balanced panel and a point estimate of 244 using our unbalanced panel).

Second, in lieu of using hospitals that applied for a Section 508 waiver but had their applications rejected as our control group, we show the robustness of our results to two alternative control groups: 1) the universe of hospitals paid via the inpatient PPS that did not receive a Section 508 waiver (Columns (3) and (4) of Appendix Table A.5) and 2) a set of control hospitals drawn from hospitals that did not receive a waiver and that we matched using propensity score matching (Columns (5) and (6) of Appendix Table A.5). Relative to our estimates in Table 2, when we use the universe of hospitals that did not receive a Section 508 waiver as a control group, our inpatient spending estimates remain precisely estimated but become smaller (our 2005 point estimate shift from $4.28 million to $1.27 million and our 2010 point estimate shifts from a point estimate of $5.23 million to a point estimate of $2.74 million). Likewise, our 2005 point estimate scaling the effect of receiving a Section 508 waiver on admissions shifts to 46.65 and becomes imprecise (with a t-statistic of 1.20), and the 2010 point estimate shifts to a precisely estimated 230.52.

In addition, our results remain similarly scaled and largely significant when we use matched controls. Relative to our 2005 and 2010 spending point estimates of $4.28 million and $5.23 million in our baseline analysis, we have point estimates of $3.30 million and $3.40 million when we rely on matched controls. For admissions, relative to our 2005 and 2010 point estimates of 146.33 and 313.94 in our baseline analysis, we have point estimates of 118.88 and 241.20, respectively. Showing that our results are robust to using a matched control group is particularly important, since this group of hospitals is balanced with our treatment group across various hospital characteristics (e.g., Medicare discharges, Medicaid discharges, for-profit status, whether they are teaching hospitals, and bed counts).

5 Section 508 Waivers and Political Donations

5.1 Background, Data, and Estimation

The Medicare payment increases created by the Section 508 program brought millions of additional federal dollars to congressional districts but were set to expire on March 31, 2007, three years after they were introduced. In this section, we explore lobbying efforts to extend the Section 508 program, describe the votes in the House of Representatives for the reauthorization of the program, and test whether the members of the House who had Section 508 hospitals in their districts received larger campaign donations in the run-up to and after the Section 508 program was reauthorized. We include excerpts from our conversation with Secretary Thompson to offer his perspective on the link between Section 508 payments and campaign contributions, given his role as one of the chief architects of the MMA.

After a short extension, on September 30, 2007, the Section 508 program expired and payment increases to hospitals were eliminated. In the intervening months, there was an intense lobbying effort to extend the program. On December 29, 2007, the President signed S.2499—the Medicare, Medicaid, and SCHIP Extension Act of 2007. This law included a long-term extension of the Section 508 program and restored the Section 508 payment increases retrospectively for October, November, and December. The law passed out of the House of Representatives via a 411 to 3 margin (roll call vote 1184). Forty of the 42 members of the House with Section 508 hospitals in their districts voted for the long-term extension of the Section 508 program. Two members of the House with Section 508 hospitals in their districts abstained from voting for the reauthorization; those members had among the smallest gains from the Section 508 program.[15]

Lee (2003) and Rocca and Gordon (2013) have argued that the extent to which a particular distributive policy will yield electoral gains and increases in campaign contributions is a function of the extent to which legislators can claim credit for the benefits (e.g., whether a legislator's efforts are salient to voters). Here, for example, it is plausible that the original funding from Section 508 was opaque and did lead to increases in contributions. By contrast, the expiration of the Section 508 program was easily observable to hospitals that previously received a Section 508 payment increase. As a result, we focus on the changes in campaign contributions around this visible reauthorization.

The Section 508 hospitals themselves endeavored to raise the visibility of the expiration

---

[15]The members who abstained from voting for the Section 508 extension represented districts that gained $96.8 thousand and $797.9 thousand, respectively, from the program. The mean gain across all recipients was $5.54 million.

of the program. In 2005, two years before the Section 508 program was slated to expire, hospitals that received Section 508 waivers came together to form the Section 508 Coalition. The stated goal of the Section 508 Coalition was to lobby on behalf of Section 508 hospitals. In 2005, 2006, and 2007, the period before the Section 508 program was reauthorized, the coalition cumulatively spent approximately $829 thousand lobbying members of Congress (The Center for Responsive Politics 2019c). The AHA spent approximately $54 million on lobbying throughout that same period (although the AHA funding included lobbying for the extension of the Section 508 program and lobbying on behalf of the interests of non-Section 508 hospitals) (The Center for Responsive Politics 2019b). Rocca and Gordon (2013) and Fox and Rothenberg (2011) have noted that although individual voters may not observe and reward members of Congress for contributing to distributive policies that benefit their district, interest groups, such as the Section 508 Coalition, can sharpen the incentives for members of Congress to act. Unlike the initial passage of the MMA, when the Section 508 program did not get press coverage, the reauthorization garnered press attention and was spoken about publicly by legislators.[16] [17]

This analysis of donations in the run-up to and reauthorization of the Section 508 program is directly related to the wider political science literature that has examined whether members of Congress receive benefits when they use distributive policies to steer funds to their district. As Levitt and Snyder Jr. (1997) noted, it is widely accepted by academics, the media, and politicians that members of Congress are rewarded for bringing additional federal funding to their districts. However, few studies have established a causal link between distributive policies championed by members of Congress and changes in fundraising. From an identification perspective, establishing a causal link between donations and distributive policies is challenging because donations could both lead members to push for specific

---

[16]For example, a 2007 Modern Healthcare article noted that "selected hospitals and systems stand to lose millions of dollars under a provision of the Medicare Modernization Act of 2003 that is set to expire in September [2007]" (Lubell 2007). The author continued, "Executives for hospitals and systems say that losing that extra Medicare reimbursement under Section 508 would be devastating. Layoffs and cutbacks would likely occur at St. Luke's Cornwall Hospital, said Allan Atzrott, president and CEO of the 282-bed hospital, which has campuses in Cornwall and Newburgh, N.Y."

[17]There is also evidence that politicians were aware of the Section 508 program and that they viewed supporting it as politically advantageous. In 2007, Senator Charles Schumer's office issued a press release that stated, "In light of todays [sic] announcement that Senate leaders will pursue an extension of Section 508 of the Medicare Modernization Act, US Senator Charles E. Schumer, a member of the Senate Finance Committee, pledged today to work to include all New York Section 508 hospitals..." (Office of Senator Charles Schumer 2006). In the remainder of the statement, the senator's office reiterated his commitment to increasing funding for New York hospitals.

policies that benefit donors and come as a reward for past actions.[18] However, the Section 508 program offers a unique opportunity to test the link between campaign contributions and targeted distributive policies because we can look at donations before and after the passage and reauthorization of the program, which, as we illustrate, was salient to politicians and many of their constituents.

In general, the academic literature is divided about the extent to which donations serve as ex ante inducements to sway votes or ex post rewards for bringing home local benefits. Some literature suggests that interested parties may donate in advance of legislation in an effort to persuade legislators to shift their votes (Grossman and Helpman 1994, Grossman and Helpman 1996, Chamon and Kaplan 2013). For example, Mian, Sufi, and Trebbi (2010) have found that members of Congress who historically had more donations from the financial industry had a higher likelihood of supporting the Emergency Economic Stabilization Act following the US mortgage default crisis. By contrast, interest groups, such as political action committees, both sway legislators and seek to mobilize the public to reward legislators for their actions (Stratmann 2005, Fox and Rothenberg 2011). Rocca and Gordon (2013) have found, for example, that donations from defense contracts tend to be rewards for previous votes and earmarks. Going forward, we test whether members of the House representing hospitals that received a Section 508 waiver received increases in donations in the run-up to and in the wake of the program's reauthorization.

When we asked whether he would be surprised if the Section 508 program led to increases in campaign contributions, Secretary Thompson, himself a former member of Congress stated, "No! Not a bit! I mean, it's good politics." When asked how the Section 508 program would generate increases in campaign contributions and who they would be from, he said, "Simple... you're the hospital administrator. You call the board. You put out a couple of fundraisers. And you bring in Congressman Thompson and say he just got you

---

[18]Two studies have used instrumental variable (IV) analysis to get around endogeneity issues and have found a causal link between federal funding and donations, and federal funding and votes. Rocca and Gordon (2013) analyzed whether representatives who allocate more defense-related earmarks receive more donations from political action committees (PACs) representing defense manufacturers. The authors instrument for defense industry earmarks using the total number of earmarks a representative makes, and they find that every $10,000 in defense earmarks raises PAC campaign contributions by $3.00. It is debatable whether instrumenting for defense earmarks using total earmarks (including defense earmarks) satisfies the exclusion restriction. Levitt and Snyder Jr. (1997) analyzed whether increasing federal funding for a district raises vote margins for the incumbent. The authors instrument for federal funding in the district using federal spending outside the district but inside the state and find that a $100 increase in per-capita federal spending (approximately $50 million per district) leads to a 2% gain in the popular vote for incumbents. We add to this literature by analyzing the impact of the Section 508 program on campaign contributions.

an increase of $20 million…the money rolls in…he [the member of Congress] probably didn't even know he did it!"

5.2 Estimating the Impact of the Section 508 Re-authorization on Campaign Contributions

To analyze whether members of the House with hospitals in their districts received an increase in campaign contributions in the run-up to and in the wake of the vote to reauthorize the Section 508 program, we estimate:

$$Donations_{c,t} = \beta_t Candidate\_With\_Section\_508_c \cdot \tau_t + \vartheta_c + \tau_t + \varepsilon_{c,t} \qquad (2)$$

where we observe campaign contributions $Donations_{c,t}$ from donors to a candidate for the House of Representatives c in each quarter t, all measured in 2010 dollars. We include a vector of quarter fixed effects τ_t and a vector of candidate fixed effects ϑ_c. We interact a vector of year dummies with our treatment indicator $Candidate\_With\_Section\_508_c$ which takes a value of "1" when a candidate has a Section 508 hospital in her district. We focus on the votes taken during roll call vote 1184. Our omitted category is the first quarter of 2007 (the quarter before the Section 508 program was slated to expire).

We also run estimates where we analyze whether members of Congress who represent a district that got more money from the Section 508 program received larger increases in campaign contributions. To do so, we estimate:

$$Donations_{c,e} = \beta_e Gains508_c \cdot \tau_e + \vartheta_c + \tau_e + \varepsilon_{c,e} \qquad (3)$$

where $Gains508_c$ is a continuous variable that measures the mechanical gains from the Section 508 program, measured in thousands of dollars, per two-year election cycle e. As a result, the β_e coefficient reports the dollars gained in campaign contributions from each thousand dollars gained in predicted revenue from the Section 508 program in the 2001/2002, 2003/2004, 2005/2006, 2007/2008, and 2009/2010 election cycles. In this specification, the variation is coming from the size of the gains generated by the Section 508 program. We illustrate these results are robust to relying exclusively on a sample composed of Section 508 hospitals (so the variation comes from differences in gains across recipient hospitals) and from using our standard control group of members of Congress representing a hospital that applied for a 508 waiver but had its application rejected.

We obtain data on campaign contributions from the Database on Ideology, Money in Pol-

itics, and Elections (DIME), which synthesizes data from the Federal Elections Commission (see Appendix B.1 for more information on the data source). We analyze the campaign contributions to members of the House from all donors, individual donors, and donors working in the hospital industry. We can identify donors' industry of employment by looking at the contributor categorization code in the DIME data and analyzing the self-reported "employer" or "organization" field in the DIME data and tagging a donor as working in the hospital industry if words such as "hospital" are included in their employer/organization field. Note that hospitals themselves cannot donate directly to individual candidates and that individual donors have a cap on donations to campaign committees of $2,300 in 2008.

We limit our analysis to candidates for office from 2001 to 2010 who were serving as representatives in 2003 when the Section 508 program was initially authorized, and were serving again in 2007 when the program was reauthorized (later, we show that our results are robust to not including the 2003 restriction). Treated candidates are those who were in office in 2003 who represented hospitals with Section 508 waivers when the extension of the Section 508 program was passed. Our main control group is composed of candidates who were in office in 2003, had hospitals in their district that unsuccessfully applied for a Section 508 waiver, and were in office in 2007 when the Section 508 program was reauthorized.

5.3 Section 508 Reauthorization and Campaign Contributions

From 2001 to 2010, the average member of the House of Representatives raised approximately $1.54 million per two-year election cycle (Table 3). Campaigns tend to bring in substantially larger campaign contributions in the immediate run-up to an election (i.e., in the year of a two-year cycle with an election) (Federal Election Commission 2023). In general, the majority of a candidate's campaign contributions come from committees, groups, or political action committees and not from individual donors. Indeed, across our sample, only 42% of campaign contributions came from individual donors. Approximately 71% of contributions from individuals come from donors living in the same state as the candidate to whom they donated. Individual donors who reported working for a hospital accounted for approximately 1.05% of the contributions from individuals from 2001 to 2010.

We observe that total contributions to members of the House representing Section 508 hospitals increased after the program was extended. The event study in Figure 3 shows estimates of Equation (2), where the dependent variable is the total campaign contributions to members of the House from all donors. The solid red line shows contributions to candidates and members of the House with one or more Section 508 hospitals in their districts; the

dashed blue line shows contributions to members of the House and candidates with a hospital that applied, but had its application rejected. As the result in Figure 3 illustrate, contributions to members of the House with Section 508 hospitals in their districts looked nearly identical to contributions to members without Section 508 hospitals in their districts throughout the period before the Section 508 program was reauthorized on December 19, 2007. However, during the year after the program was extended, campaign contributions increased markedly for members with Section 508 hospitals in their districts. The point estimates imply that in the third quarter of 2008 (the quarter leading up to the congressional election), across all members of the House with Section 508 recipient hospitals in their district, total campaign contributions increased by $191 thousand off a mean of $227 thousand in that same quarter that year (S.E. equal to 89.46). Complete results for this analysis are presented in Column (1) of Appendix Table A.6. We show these results graphically from donors in the same state, individual donors from the same state, and committee donors in Appendix Figure A.4 and observe similar patterns. We present a logged version of Figure 3 in Appendix Figure A.5. That the percentage increases we observe in donations from all donors nation-wide (i.e., approximately 120%) is markedly larger than the percentage increase we observe from individual donors (i.e, approximately 67%) potentially implies that a substantial portion of the increase in funding comes from outside entities, such as lobbying groups or political action committees.

Recall that approximately a third of treated congressional districts saw outsized gains from the Section 508 program. Consistent with the assertion that the gains from the Section 508 program are what drove donations from donors, the treatment exposure estimates on the right side of Figure 3 show suggestive evidence that members representing these most heavily treated districts saw the largest increases in campaign contributions in the third quarter of 2008. Among the half of congressional districts most exposed to the program, campaign contributions increased by $353 thousand in the third quarter of 2008 (SE equal to 156.9). Likewise, among the 20% of districts with the most exposure to the program, donations increased by $801 thousand that same quarter (SE equal to 354.9). However, the differences in contributions across groups are not statistically significant. We show the treatment exposure estimates for each quarter in 2007 and 2008 in Appendix Figure A.6.

To illustrate that the donation increases we observe are likely a function of the Section 508 program, we also analyze changes in campaign contributions from individuals plausibly affected and unaffected by changes in hospitals' Medicare reimbursements. While donations from individuals working in the hospital sector make up only approximately 0.4% of all

campaign contributions, this would be the group of donors most directly impacted by the Section 508 program. As a result, we compare changes in donations from hospital workers to donations from non-hospital workers in two unrelated industries—the crop production industry and the oil and gas industry—which each account for a similar share of individual donations.

In Figure 4, we estimate Equation (2) and focus on campaign contributions from individual donors living in the same state as the member of the House of Representatives to whom they contributed, broken down by the donors' industry. We focus on individuals likely to be directly affected by the Section 508 program—individuals working in the hospital sector—and individuals working in two industries that should not be impacted by changes in hospital payments: the crop production and basic processing industry and the oil and gas industry.[19] Complete results for this analysis are presented in Columns (4) through (6) of Appendix Table A.6.

In Panel A, we focus on contributions from individuals working in the hospital industry. We observe suggestive evidence that members of the House with Section 508 hospitals in their districts saw an increase in campaign contributions from individuals working in the hospital industry in the fourth quarter of 2007 (the quarter when the vote occurred to reauthorize the Section 508 program) ($\beta = 700.5$, SE = 461.1) and in the third quarter of 2008 (when there were elections after the program was reauthorized) ($\beta = 509.3$, SE = 340.8). On the right of Panel A, we present treatment exposure estimates for the point estimates in the fourth quarter of 2007 (included in black) and the third quarter of 2008 (included in red). During both periods, the treatment effects were larger and were statistically significant in districts more exposed to the Section 508 program.

We observe markedly different effects when we analyze campaign contributions to members of the House from individuals working in industries that were largely unaffected by the Section 508 program. In Panels B and C, we focus on contributions from individuals in the same state as the member to whom they donated who were working in the crop production industry (Panel B) and the oil and gas industry (Panel C). We do not observe that members of the House with Section 508 hospitals in their districts received increases in donations from individuals in these unaffected industries. Likewise, we do not observe any meaningful difference in our treatment effects between these two unrelated groups that is

---

[19]We chose these two industries because individuals in each sector gave at similar levels as individuals working in the hospital industry. These were two industries that did not have meaningful engagement with the hospital sector and would not benefit from increased hospital output, increased health sector salaries, or increased employment in the hospital sector.

correlated with each congressional district's exposure to Section 508 program.

Likewise, in Table 4, we show estimates of Equation (3) where we test the relationship between thousands of dollars gained from the Section 508 program and campaign contributions measured in dollars. Here, we focus on a sample composed exclusively of members of Congress who represented hospitals that received a Section 508 waiver. As a result, the variation we exploit here comes from differences in gains from the Section 508 program across members of Congress with Section 508 hospitals in their districts. Prior to the 2007/2008 Congress, we do not see a statistically significant relationship between gains from the Section 508 program and campaign contributions. However, in the 2007/2008 Congress, we see that for each additional $1,000 in inpatient spending generated by the Section 508 program, members of Congress received an additional $61 in campaign contributions. Likewise, in Column (2), we see for each $1,000 increase in inpatient payments there were $0.25 and $0.43 increases in campaign contributions from workers in the hospital sector in the 2005/2006 Congress and in 2007/2008 Congress, respectively. As we present in Appendix Table A.7, these results are robust to exploiting variation among all members of Congress and coding districts as receiving no inpatient spending gains from the Section 508 program if they did not have Section 508 hospitals within their borders.

Our evidence on the source of donations dovetails with Secretary Thompson's views of who would donate in response to Section 508 funding. When asked whether he expected donations to come from hospital workers directly, Secretary Thompson replied, "No." Likewise, our findings on overall contributions are consistent with predictions by Stratmann (2005) and empirical work by Rocca and Gordon (2013) that campaign contributions can serve as ex post rewards for actions taken by legislators. As Stratmann (2005), Rocca and Gordon (2013), and Fox and Rothenberg (2011) note, elected officials and donors likely engage in a dynamic game where lawmakers take votes with the understanding that rewards can come later.

5.4 Section 508 Reauthorization and Campaign Contributions - Robustness

In our main analysis, we limited our sample to candidates for the House who were in office in 2003 (when the Section 508 program was introduced) and in 2007 (when the program was reauthorized). In Panel A of Appendix Figure A.7, we show estimates of Equation (2) where we relax that assumption and only require that an individual was a sitting member of Congress when the Section 508 program was reauthorized. As we illustrate, this does not qualitatively change our results. We also illustrate that our results are robust across

two alternative control groups: 1) candidates for the House who were in office in 2003 and 2007 and had hospitals in their districts that were paid using the PPS program, but had no Section 508 hospitals (Panel B of Appendix Figure A.7); and 2) candidates for the House that were in office in 2003 and 2007, had no treated hospitals, and were matched using propensity scores (Panel C of Appendix Figure A.7).[20] Across these alternative control groups, we observe that our main result—that members of Congress with Section 508 hospitals in their districts received increases in campaign contributions after the program was reauthorized—remains qualitatively unchanged. Likewise, our results are robust to restricting our analysis to contributions from different subsets of donors. In Panel A of Appendix Figure A.4, we show results when we restrict our analysis to contributions from donors from the same state as the member to whom they donated. The increase we observe in this population is approximately $42 thousand (In Panel B, we limit our analysis to contributions from individual donors. In Panel C, we focus on contributions from individual donors from the same state as the candidate to whom they are donating. In Panel D, we focus on contributions excluding those from individual donors (e.g. we focus on campaign contributions from organizations and political action committees). Finally, we illustrate our results are robust to estimating them annually (Appendix Table A.8).

6 Conclusion

Rising health care costs are a core policy concern across the developed world. Until now, most academic research on health care spending has focused on the influence of demand- and supply-side factors on the variation and growth in health spending. In this paper, we present, to our knowledge, some of the first work that assesses empirically how political dynamics influence health care spending and, in particular, how they influence the setting of providers' regulated payments. Studying the influence of politics on heath is vital because of the central role of most countries' governments play in determining how health care funding is allocated. In particular, most governments set regulated prices for health care providers. In the United State, for example, the regulated Medicare payment program for hospitals is responsible for steering hundreds of billions of dollars annually.

Our work highlights that the Medicare fee schedule can be influenced by political dynamics. Our interview with Secretary Tommy G. Thompson confirms press reporting that Medicare reimbursements were used to win members' votes on the passage of the MMA of 2003. Consistent with his interview, we observe that hospitals represented by a member

---

[20]See Appendix C.2 for how our probit matching is constructed.

of Congress who voted "yea" on the MMA of 2003 were more likely to receive a Section 508 waiver. Our findings dovetail with numerous examples of the Medicare fee schedule being used in the past to win votes for key legislation. For example, Cohn (2010) has noted how the Frontier States program, which raised Medicare payments to hospitals in Montana, Nevada, North Dakota, South Dakota, and Wyoming, was used as a tool to win support for the ACA.

We observe that hospitals that received a Section 508 waiver, which increased their Medicare payments, increased their activity. That is, the increase in Medicare payments induced a behavioral response from hospitals. This result is consistent with other work, which has found that increasing providers' payments leads to increased activity (Clemens and Gottlieb 2014; Gross et al. 2021; Cabral, Carey, and Miller 2021). This increase in activity, together with the mechanical effect of their payment increase, led hospitals that received a Section 508 waiver to dramatically increase their Medicare inpatient spending in the five years after the program was introduced. We also show that congressional districts with Section 508 hospitals had large increases in health spending—that is, the Section 508 program did not simply lead to a reallocation of care across hospitals, it increased aggregate health spending. The 20% of congressional districts with hospitals that received the largest gains from the program saw increases in Medicare spending that, on a per capita basis, were similar to the gains generated by the American Reinvestment and Recovery Act. The scale of the gains from the Section 508 program for specific congressional districts highlights how altering the Medicare fee schedule can be a potent tool for steering distributive benefits.

The Section 508 program was written to expire three years after it was introduced. However, we show that hospitals spent millions lobbying to have the Section 508 program extended. The bill to extend the Section 508 payments was passed by a substantial margin in the House of Representatives, and 40 of 42 members of Congress with Section 508 recipient hospitals in their districts voted "yea" for the extension of the program. In the run-up to the vote to reauthorize the Section 508 program, members of Congress representing a district with Section 508 hospitals received increases in campaign contributions from individuals working in the hospital sector in their state. After the program was extended, members of Congress with Section 508 hospitals in their districts received large overall increases in campaign contributions from all donors, including those outside the health sector. The subsequent increases in campaign contributions were largest among the members of Congress whose districts received the largest gains from the Section 508 program. Our results are consistent with the suggestion that campaign contributions can be both ex ante

inducements for legislators and ex post rewards (Grossman and Helpman 1994; Stratmann 2005; Mian, Sufi, and Trebbi 2010; Fox and Rothenberg 2011; Rocca and Gordon 2013).

Ultimately, the critical finding from this work is that there is a close link between electoral politics, providers' regulated payments, and health spending. While we focus on a narrow program that was inserted into the MMA to illustrate the relationship between politics and providers' regulated payments, the type of provision we analyze in this paper has been present in virtually every piece of major health care legislation passed in the United States since 1980. Indeed, the Government Accountability Office identified 16 statutory provisions passed between 1997 and 2012 that modified Medicare payment policies and increased payments to specific subsets of hospitals (Government Accountability Office 2013). Moreover, while we focus this analysis on the impact of politics on spending in the Medicare program, regulated payments are a feature of nearly every health system outside of the United States. Likewise, in the United States, in addition to overseeing the Medicare program, lawmakers vote on provisions that impact private insurance markets, the pricing of pharmaceuticals, and the regulation of medical devices. As a result, there is scope for politics to have a large impact on health spending in aggregate. Going forward, we hope this paper motivates future work in this area, including testing how lobbying dollars influence health care spending and whether the spending increases they induce are (in)efficient, examining which stakeholders benefit from health care spending growth, and considering how political dynamics impact the variation and growth in health spending.

References

Aaron, Henry J. and Robert Reischauer (2015). "The Transformation of Medicare, 2015 to 2030". *Forum for Health Economics and Policy*. Vol. 18. 2. De Gruyter, pp. 119–136.

Abaluck, Jason and Jonathan Gruber (2011). "Choice Inconsistencies Among the Elderly: Evidence from Plan Choice in the Medicare Part D Program". *American Economic Review* 101.4, pp. 1180–1210.

— (2016). "Evolving Choice Inconsistencies in Choice of Prescription Drug Insurance". *American Economic Review* 106.8, pp. 2145–84.

Abelson, Reed (Sept. 2003). *Narrow Interest in a Broad Measure*. New York Times.

Acemoglu, Daron and Amy Finkelstein (2008). "Input and Technology Choices in Regulated Industries: Evidence from the Health Care Sector". *Journal of Political Economy* 116.6, pp. 837–880.

Acemoglu, Daron and Thierry Verdier (2000). "The Choice between Market Failures and Corruption". *American Economic Review* 90.1.

Albouy, David (2013). "Partisan Representation in Congress and the Geographic Distribution of Federal Funds". *The Review of Economics and Statistics* 95.1, pp. 127–141.

American Hospital Association (Nov. 2011). *Wage Index Chart Pack*. URL: `https://www.aha.org/system/files/content/11/11nov-wgindexchartpk.pdf`.

— (2016). *Trendwatch Chartbook 2016: Chart 6.10: Percent of Hospital Costs by Type of Expense, 2015*. URL: `https://www.aha.org/system/files/research/reports/tw/chartbook/2016/chart6-10.pdf`.

Ansolabehere, Stephen, John M. de Figueiredo, and James M. Snyder Jr. (2003). "Why is There so Little Money in U.S. Politics?" *Journal of Economic Perspectives* 17.1, pp. 105–130.

Arrow, Kenneth J. (1963). "Uncertainty and the Welfare Economics of Medical Care". *The American Economic Review* 53.5, pp. 941–973.

Baicker, Katherine and Douglas Staiger (2005). "Fiscal Shenanigans, Targeted Federal Health Care Funds, and Patient Mortality". *Quarterly Journal of Economics* 120.1, pp. 345–386.

Balla, Steven J. et al. (2002). "Partisanship, Blame Avoidance, and the Distribution of Legislative Pork". *Midwest Political Science Association* 46.3, pp. 515–525.

Bartlett, Bruce (Nov. 2013). *Medicare Part D: Republican Budget Busting*. New York Times.

Berry, Christopher R and Anthony Fowler (2016). "Cardinals or clerics? Congressional committees and the distribution of pork". *American Journal of Political Science* 60.3, pp. 692–708.

Berry, Christopher R., Barry C. Burden, and William G. Howell (2010). "The President and the Distribution of Federal Spending". *American Political Science Review* 104.4, pp. 783–799.

Bickers, Kenneth N and Robert M Stein (1996). "The electoral dynamics of the federal pork barrel". *American Journal of Political Science*, pp. 1300–1326.

Bombardini, Matilde and Francesco Trebbi (2011). "Votes or money? THeory and evidence from the US Congress". *Journal of Public Economics* 95.7, pp. 587, 611.

Boone, Christopher, Arindrajit Dube, and Ethan Kaplan (2014). "The Political Economy of Discretionary Spending: Evidence from the American Recovery and Reinvestment Act". *Brokkings Papers on Economic Activity*.

Bresnahan, John (July 2017). *McConnell Gets a Win in Obamacare Repeal Opening Round*. Politico.

Brown, Craig and I. Serdar Dinç (2005). "The Politics of Bank Failures: Evidence from Emerging Markets". *The Quarterly Journal of Economics* 120.4, pp. 1413–44.

Brown, Lawrence D. (1985). "Technocratic Corporatism and Administrative Reform in Medicare". *Journal of Health Politics, Policy, and Law* 3 (10), pp. 579–99.

Cabral, Marika, Colleen Carey, and Sarah Miller (2021). "The Impact of Provider Payments on Health Care Utilization of Low-Income Individuals: Evidence from Medicare and Medicaid". *NBER Working Paper No. 29471*.

Cameron, A. Colin, Jonah B. Gelbach, and Douglas L. Miller (2008). "Bootstrap-Based Improvements for Inference with Clustered Errors". *Review of Economics and Statistics* 90.3, pp. 414–427.

Centers for Medicare and Medicaid Services (2018). *National Health Expenditures Fact Sheet*. URL: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html.

Chamon, Marcos and Ethan Kaplan (2013). "The Iceberg Theory of Campaign Contributions: Political Threats and Interests Group Behavior". *American Economic Journal: Economic Policy* 5.1, pp. 1–31.

Chan, David C and Michael J Dickstein (2016). "Industry Input in Policy Making: Evidence from Medicare". *The Quarterly Journal of Economics* 134.3, pp. 1299–1342.

Chandra, Amitabh, Amy Finkelstein, et al. (2016). "Health Care Exceptionalism? Performance and Allocation in the US Health Care Sector". *American Economic Review* 106.8, pp. 2110–44.

Chandra, Amitabh and Jonathan Skinner (2011). *Technology Growth and Expenditure Growth in Health Care*. Working Paper. NBER.

— (2012). "Technology Growth and Expenditure Growth in Health Care". *Journal of Economic Literature* 50.3, pp. 645–80.

Chang, Tom and Mireille Jacobson (2011). *What do Nonprofit Hospitals Maximize? Evidence from California's Seismic Retrofit Mandate*. Working Paper. NBER.

Clemens, Jeffrey and Josh Gottlieb (2017). "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments". *Journal of Political Economy* 125.1, pp. 1–39.

Clemens, Jeffrey and Joshua D Gottlieb (2014). "Do Physicians' Financial Incentives Affect Medical Treatment and Patient Health?" *American Economic Review* 104.4, pp. 1320–499.

Clemens, Jeffrey and Stan Veuger (2021). "Politics and the distribution of federal funds: Evidence from federal legislation in response to COVID-19". *Journal of Public Economics* 204, p. 104554.

Coate, Stephen (2004). "Political Competition with Campaign Contributions and Informative Advertising". *Journal of the European Economic Association* 2.5, pp. 772–804.

Cohn, Jonathan (May 2010). *How they Did it: The Inside Account of Health Reform's Triumph*. The New Republic.

Cooper, Zack et al. (2019). "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured". *The Quarterly Journal of Economics* 134.1, pp. 51–107.

Cutler, David et al. (2013). *Physician Beliefs and Patient Preferences: A New Look at Regional Variation in Health Care Spending*. Working Paper. NBER.

Cutler, David et al. (2019). "Physician Beliefs and Patient Preferences: A New Look at Regional Variation in Health Care Spending". *American Economic Journal: Economic Policy* 11.1, pp. 192–221.

Dafny, Leemore (2005). "How Do Hospitals Respond to Price Changes?" *American Economic Review* 95.5, pp. 1525–1547.

Dieleman, Joseph L. et al. (Mar. 2020). "US Health Care Spending by Payer and Health Condition, 1996-2016". *JAMA* 323.9, pp. 863–884. ISSN: 0098-7484.

Dillender, Marcus, Lu Jinks, and Anthony T. LaSasso (2023). "When (and why) providers do not respond to changes in reimbursement rates". *Journal of Public Economics* 217, pp. 104781–91.

Duggan, Mark (2000). "Hospital Ownership and Public Medical Spending". *Quarterly Journal of Economics* 115.4, pp. 1343–1373.

Engstrom, Erik J. and Georg Vanberg (2010). "Assessing the Allocation of Pork: Evidence From Congressional Earmarks". *American Political Research* 38.6.

Evans, Diana (2004). *Greasing the Wheels: Using Pork Barrel Projects to Build Majority Coalitions in Congress*. Cambridge University Press.

Federal Election Commission (2023). *FEC Campaign Finance Data*. URL: https://www.fec.gov/data/browse-data/?tab=raising.

Federal Register (Jan. 2004a). *Medicare Program; Notice of One-Time Appeal Process for Hospital Wage Index Classifications*. Department of Health and Human Services.

— (Jan. 2004b). *Medicare Program; Revisions to the One-Time Appeal Process for Hospital Wage Index Classifications*. Department of Health and Human Services.

Finkelstein, Amy, Matthew Gentzkow, and Heidi Williams (2016). "Sources of Geographic Variation in Health Care: Evidence From Patient Migration". *The Quarterly Journal of Economics* 131.4, pp. 1681–1726.

Foo, Patricia K., Robin S. Lee, and Kyna Fong (2017). "Physician Prices, Hospital Prices, and Treatment Choice in Labor and Delivery". *American Journal of Health Economics* 3.3, pp. 422–453.

Fox, Justin and Lawrence Rothenberg (2011). "Influence without Bribes: A Noncontracting Model of Campaign Giving and Policymaking". *Political Analysis* 19.3, pp. 325–341.

Garber, Alan M. and Jonathan Skinner (2008). "Is American Health Care Uniquely Inefficient?" *Journal of Economic Perspectives* 22.4, pp. 27–50.

Gordon, Sanford C. (2011). "Politicizing Agency Spending Authority: Lessons from a Bush-era Scandal". *American Political Science Review* 105.4, pp. 717–734.

Government Accountability Office (2013). *Medicare: Legislative Modifications Have Resulted in Payment Adjustments for Most Hospitals*. United States Government Accountability Office.

Grimmer, Justin, Solomon Messing, and Sean Westwood (2012). "How Words and Money Cultivate a Personal Vote: The Effect of Legislator Credit Claiming on Constituent Credit Allocation". *American Political Science Review* 106, pp. 703–719.

Gross, Tal et al. (2021). "Regulated Revenues and Hospital Behavior: Evidence from a Medicare Overhaul". *NBER Working Paper No 29023*.

Grossman, Gene M. and Elhanan Helpman (1994). "Protection for Sale". *American Economic Review* 84.4, pp. 833–850.

— (1996). "Electoral Competition and Special Interest Politics". *Review of Economic Studies* 63.2, pp. 265–286.

— (2001). *Special Interest Politics*. MIT Press.

Hackman, Martin and Vincent Pohl (2018). "Patient vs. Provider Incentives in Long Term Care". *NBER Working Paper No. 25178*.

Institute of Medicine (2012). *Geographic Adjustment in Medicare Payment: Phase I: Accuracy*. The National Academics of Sciences, Engineering, and Medicine.

Joyce, Geoffrey F. et al. (2009). "Medicare Part D After Two Years". *American Journal of Managed Care* 15.8, pp. 536–544.

Kaestner, Robert and Jose Guardado (2008). "Medicare Reimbursement, Nurse Staffing, and Patient Outcomes". *Journal of Health Economics* 27.2, pp. 339–361.

Kalla, Joshua L. and David E. Broockman (2016). "Campaign Contributions Faciliate Access to Congressional Officials: A Randomized Field Experiment". *American Journal of Political Science* 60.3, pp. 545–58.

Kamal, Rabak and Cynthia Cox (2018). *How Has U.S. Spending on Healthcare Changed Over Time?* Kaiser Family Foundation. URL: https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-start.

Kang, Karam (2015). "Policy Influence and Private Returns from Lobbying in the Energy Sector". *The Review of Economic Studies* 83.1, pp. 269–305.

Kasdin, Stuart and Luona Lin (2015). "Strategic Behavior by Federal Agencies in the Allocation of Public Resources". *Public Choice* 164, pp. 309–329.

Khwaja, Asim Ijaz and Atif Mian (2005). "Do Lenders Favor Politically Connected Firms? Rent Provision in an Emerging Financial Market". *The Quarterly Journal of Economics* 120.4, pp. 1371–1411.

Lee, Christopher (Nov. 2003). *Medicare Bill Partly a Special Interest Care Package*. The Washington Post.

Leider, Jonathan P. et al. (2015). "Health Spending and Political Influence: The Case of Earmarks and Health Care Facilities". *Journal of Public Health Management Practice* 2 (21), pp. 161–166.

Levitt, Steven D. and James M. Snyder Jr. (1997). "The Impact of Federal Spending on House Election Outcomes". *Journal of Political Economy* 105.1, pp. 30–53.

Lubell, Jennifer (June 2007). *Section 508 nearing expiration: Loss of MMA wage index could spell trouble*. Modern Healthcare.

Marmor, Theodore R. (2000). *The Politics of Medicare*. Aldine de Gruyter.

Mayhew, David (1974). *The Electoral Connection*. Yale University Press.

McDermott, Kimberly W., Anne Elixhauser, and Ruirui Sun (May 2017). *Trends in Hospital Inpatient Stays in the United States, 2005–2014*. HCUP Statistical Brief 225. Agency for Healthcare Research and Quality.

McKay, Amy Melissa (2019). "Buying Amendments? Lobbyists' Campaign Contributions and Microlegislation in the Creation of the Affordable Care Act". *Legislative Studies Quarterly* 45.2, pp. 327–360.

Mian, Atif, Amir Sufi, and Francesco Trebbi (2010). "The Political Economy of the US Mortgage Default Crisis". *American Economic Review* 100.5, pp. 1967–1998.

Newhouse, Joseph P. (1970). "Toward a Theory of Nonprofit Institutions: An Economic Model of a Hospital". *American Economic Review* 60.1, pp. 64–74.

Office of Senator Charles Schumer (Oct. 2006). *Schumer Demands Orange and Dutchess County Hospitals Be Included in Hospital Reclassification Deal Announced Today*. URL: https://www.schumer.senate.gov/newsroom/press-releases/schumer-demands-orange-and-dutchess-county-hospitals-be-included-in-hospital-reclassification-deal-announced-today.

Oliver, Thomas R., Philip R. Lee, and Helene L. Lipton (2004). "A Political History of Medicare and Prescription Drug Coverage". *The Milbank Quarterly* 82.2, pp. 283–354.

Pear, Robert (Dec. 1999). *Health Industry Sees Wish List Made Into Law*. The New York Times.

Powell, Lynda W. (2014). "The Influence of Campaign Contributions on the Legislative Process". *Duke Journal of Constitutional Law and Public Policy* 9.1, pp. 75–101.

Rocca, Michael S. and Stacy B Gordon (2013). "Earmarks as a Means and an End: The Link Between Earmarks and Campaign Contributions in the US House of Representatives". *Journal of Politics* 75.1, pp. 241–253.

Shaw, Jonathan (July 2012). *A Radical Fix for the Republic*. Harvard Magazine.

Shen, Yujing (2003). "Selection Incentives in a Performance-Based Contracting System". *Health Services Research* 38.2, pp. 535–552.

Shepsle, Kenneth A. and Barry R. Weingast (1982). "Structure-Induced Equilibrium and Legislative Choice". *Public Choice* 27.3, pp. 503–519.

Skinner, Jonathan (2011). "Chapter Two - Causes and Consequences of Regional Variations in Health Care". *Handbook of Health Economics*. Ed. by Mark V. Pauly, Thomas G. Mcguire, and Pedro P. Barros. Vol. 2. Handbook of Health Economics, pp. 45–93.

Smith, Sheila, Joseph P. Newhouse, and Mark S. Freeland (2009). "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" *Health Affairs* 28.5, pp. 1276–1284.

Stratmann, Thomas (1995). "Campaign Contributions and Congressional Voting: Does the Timing of Contributions Matter?" *The Review of Economics and Statistics* 77.1, pp. 127–136.

— (1998). "The Market For Congressional Votes: Is Timing of Contributions Everything?" *The Journal of Law & Economics* 41.1.

— (2005). "Some talk: Money in politics. A (partial) review of the literature". *Public Choice* 124, pp. 135–156.

The Center for Responsive Politics (2019a). URL: https://www.opensecrets.org/federal-lobbying/industries?cycle=2006.

— (2019b). URL: https://www.opensecrets.org/orgs/lobby.php?id=D000000116.

— (2019c). *Client Profile: Section 508 Coalition*. URL: https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2012&id=D000056560.

— (2020). URL: https://www.opensecrets.org/industries/index.php?ind=A&cycle=2020.

Toner, Robin (June 2002). *The Nation: The Prescription Drug Debate; Why the Elderly Wait...and Wait*. The New York Times.

US Census Bureau (2016). *Health Care Leads in Employment in Most Congressional Districts*. URL: https://www.census.gov/newsroom/press-releases/2016/cb16-28.html.

Vladeck, Bruce C. (1999). "The Political Economy Of Medicare: Medicare Reform Requires Political Reform." *Health Affairs* 18.1, pp. 22–36.

Volpp, Kevin GM. et al. (2005). "The Effects of Price Competition and Reduced Subsidies for Uncompensated Care on Hospital Mortality". *Health Services Research* 4, pp. 1056–77.

Weingast, Barry R. (1979). "A Rational Choice Perspective on Congressional Norms". *American Journal of Political Science* 23.2, pp. 245–262.

Weingast, Barry R., Kenneth A. Shepsle, and Christopher Johnsen (1981). "The Political Economy of Benefits and Costs: A Neoclassical Approach to Distributive Politics". *Journal of Political Economy* 89.4, pp. 642–664.

Wright, Gavin (1974). "The political economy of New Deal spending: An econometric analysis". *The Review of Economics and Statistics*, pp. 30–38.

Figure 1: The Impact of Medicare Payment Increases on Hospitals' Base PPS Payment Rates
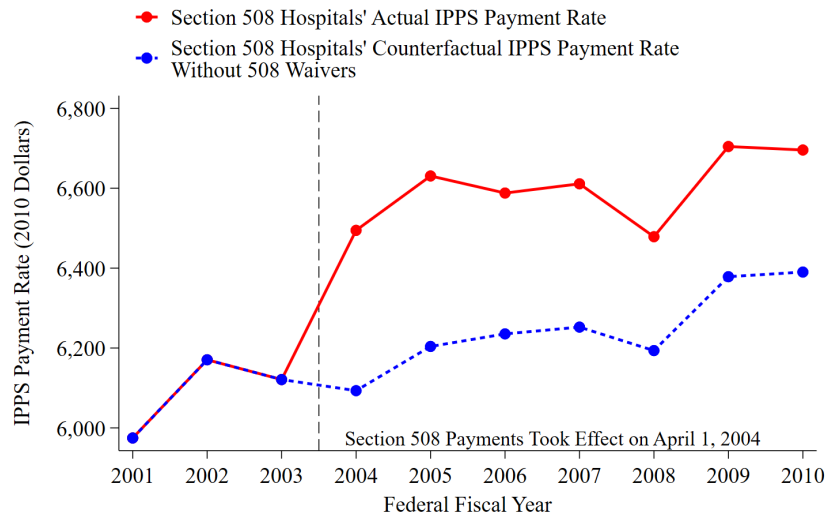
Notes: This figure shows the annual mean Medicare inpatient PPS payment rates in 2010 dollars for the 88 hospitals in our balanced analytic sample that received a Section 508 waiver. We show the actual PPS payment rates (red solid line) and the estimated payment rates the hospitals would have received without a 508 waiver (blue dashed line). To construct the latter, we recalculate payment rates using the wage index for each Section 508 hospital's pre-reclassification labor market area (CBSA), holding all other payment adjustments constant.

Figure 2: The Impact of Section 508 Waivers on Hospitals' Inpatient Medicare Admissions and Inpatient Medicare Spending

Panel A: Medicare Inpatient Admissions

Panel B: Medicare Inpatient PPS Spending ($ Millions, 2010 Dollars)

Panel C: Congressional District-Level Medicare Inpatient PPS Spending ($ Millions, 2010 Dollars)
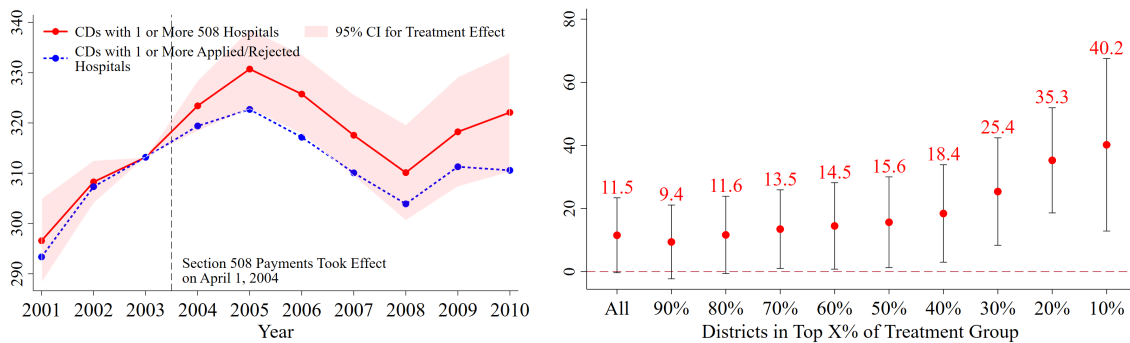

Notes: These panels present estimates of Equation (1) where we regress hospital (or CD) outcomes on a vector of hospital (or CD) fixed effects, year dummies, and interactions between the Section 508-recipient hospital (or CD) indicator and year dummies. 2003 is our omitted year. 95% confidence intervals are based on standard errors clustered around hospitals (or CDs). Control hospitals include those that applied for the Section 508 waiver but were rejected; control CDs include those with at least one such hospital. The rightmost figures plot the coefficient of the 2010 interaction term from Equation (1) as we vary the definition of the treatment group based on hospitals' (or CDs') predicted exposure to the Section 508 program. Moving left to right in each figure, each specification involves a treated group composed of hospitals/CDs that received increasingly large gains in total, predicted IPPS spending (based on quantities in 2003 and actual and counterfactual payment rates in 2005) due to the Section 508 program.

38

Figure 3: The Impact of the Re-Authorization of the Section 508 Program on Campaign Contributions from All Donors Nationwide

Notes: These figures present estimates of Equation (2) where we regress campaign contributions (in constant 2010 dollars) from all donors nationwide on a vector of candidate fixed effects, quarter dummies, and interactions between the treated candidate indicator and quarter dummies. Control candidates are those with one or more hospitals in their district that applied for a Section 508 waiver but were rejected. 2007-Q1 is our omitted time period. 95% confidence intervals are based on standard errors clustered around candidates. The rightmost figure plots the coefficient of the 2008-Q3 interaction term from Equation (2) as we vary the definition of the treatment group. Moving left to right, each specification involves a treated group composed of candidates from congressional districts with increasingly large gains in total, predicted IPPS spending (based on quantities in 2003 and actual and counterfactual payment rates in 2005) due to the Section 508 program.
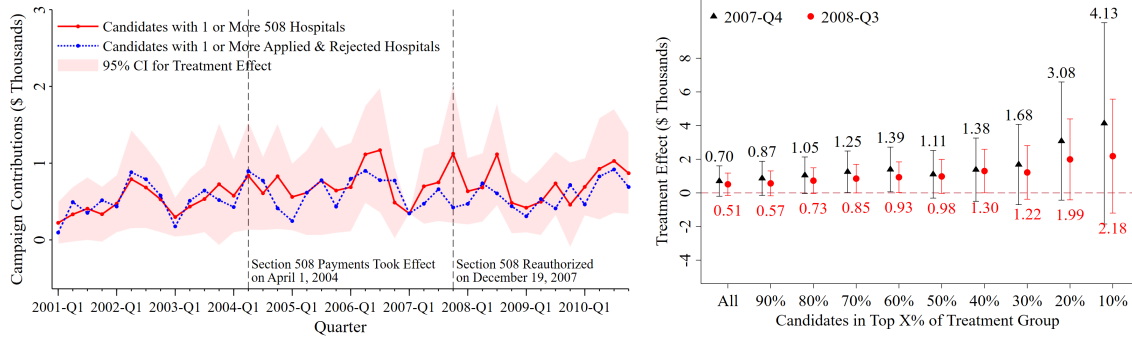
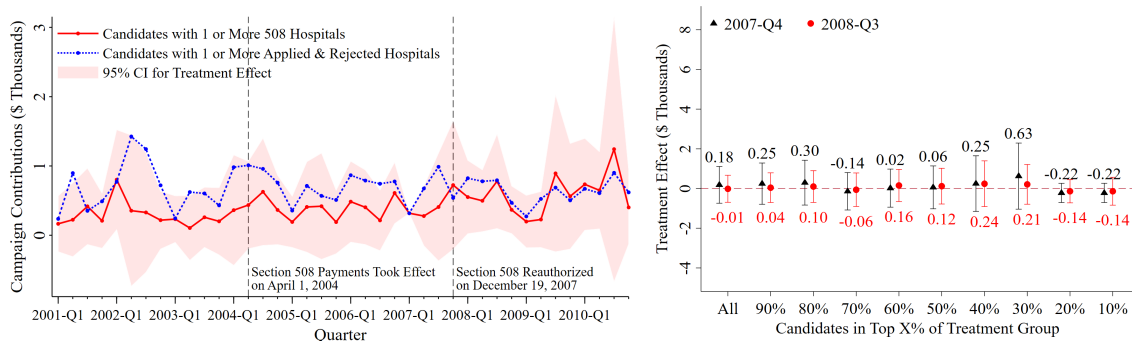# Figure 4: The Impact of the Re-Authorization of the Section 508 Program on Campaign Contributions from Individual Donors in Same State Broken Down By Donors' Sector of Employment

Panel A: Individual Donors in the Same State from the Hospital Sector

Panel B: Individual Donors in the Same State from the Crop Production & Basic Processing Sector

Panel C: Individual Donors in the Same State from the Oil & Gas Sector
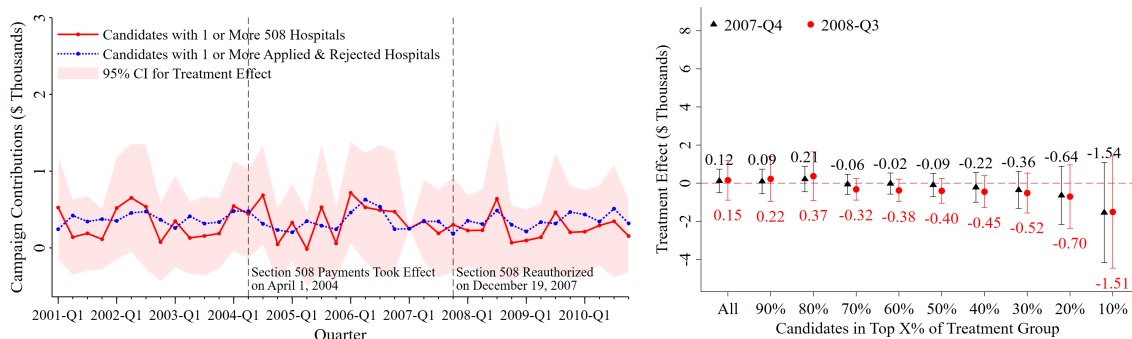
Notes: These panels present estimates of Equation (2) where we regress campaign contributions (in constant 2010 dollars) to candidates from individuals in the same state on a vector of candidate fixed effects, quarter dummies, and interactions between the treated candidate indicator and quarter dummies. Control candidates are those that have one or more hospitals in their district that applied for a Section 508 waiver but were rejected. 2007-Q1 is our omitted time period. 95% confidence intervals are based on standard errors clustered around candidates. The rightmost figures plot the coefficients of the 2007-Q4 and 2008-Q3 interaction terms from Equation (2) as we vary the definition of the treatment group. Moving left to right, each specification involves a treated group composed of candidates from congressional districts with increasingly large gains in total, predicted IPPS spending (based on quantities in 2003 and actual and counterfactual payment rates in 2005) due to the Section 508 program. The 2007-Q4 and 2008-Q3 coefficients are reported above and below the error bars, respectively.

Table 1: Characteristics of Hospitals with and without a Section 508 Waiver

	Hospitals with a 508 Waiver		Hospitals that Applied for a 508 Waiver and Were Rejected		AHA-Registered Hospitals Without a 508 Waiver	
	Mean (1)	SD (2)	Mean (3)	SD (4)	Mean (5)	SD (6)
Medicare Discharges (%)	0.48	0.09	0.45*	0.11	0.46	0.19
Medicaid Discharges (%)	0.16	0.09	0.17	0.10	0.18	0.23
Beds	249.56	225.81	263.92	205.04	209.74**	192.03
Medicare Wage Index	1.08	0.16	0.97***	0.15	0.98***	0.17
For-Profit (%)	0.05	0.22	0.23***	0.42	0.15***	0.36
Represented by a member of Congress who Voted for MMA	0.60	0.49	0.50**	0.50	0.52*	0.50
Represented by Republican Member of Congress	0.54	0.50	0.50	0.50	0.53	0.50
Member of Congress's Tenure in Congress (terms)	6.91	4.16	5.30***	3.37	5.54***	3.83
Member of Congress's Share of the Vote in 2004	0.70	0.14	0.69	0.12	0.70	0.12
N	120		376		3883	

Notes: This table shows hospital-level means for observations in 2004. *p<0.10, **p<0.05, ***p<0.01. The p-values are from t-tests comparing means in Columns (3) and (5) to means in Column (1). The Medicare Wage Index comes from Medicare Impact Files. The hospital-characteristics are from the AHA Annual Survey. Statistics are reported for the full, unrestricted sample of Section 508-recipient hospitals.

Table 2: The Impact of Section 508 Waivers on Hospitals' Inpatient Medicare Admissions and Inpatient Medicare Spending

	Hospital-Level		CD-Level
	Medicare Inpatient Admissions	Medicare Inpatient PPS Spending ($ Millions, 2010 Dollars)	Medicare Inpatient PPS Spending ($ Millions, 2010 Dollars)
	(1)	(2)	(3)
2001*Treated Group	-103.29 (83.52)	-0.92 (0.98)	3.22 (4.29)
2002*Treated Group	-60.22 (54.03)	-0.64 (0.55)	0.95 (2.19)
2003 - Pre-Treatment Year - Omitted Category (Section 508 Payments Took Effect on April 1, 2004)			
2004*Treated Group	53.14 (42.19)	2.28*** (0.68)	4.00 (2.58)
2005*Treated Group	146.33** (62.65)	4.28*** (1.00)	8.03** (4.05)
2006*Treated Group	197.77*** (73.98)	3.81*** (1.00)	8.59** (4.05)
2007*Treated Group	230.36*** (83.48)	3.95*** (1.00)	7.48* (4.15)
Section 508 Program Reauthorized on December 19, 2007			
2008*Treated Group	206.02** (96.33)	3.70*** (1.16)	6.22 (4.87)
2009*Treated Group	198.82* (106.98)	3.90*** (1.34)	6.94 (5.58)
2010*Treated Group	313.94*** (119.87)	5.23*** (1.54)	11.51* (6.06)
Year FE	X	X	X
Hospital FE	X	X	
CD FE			X
N	3,720	3,720	1,960
Mean of Dependent Variable in 2003			
Treated Group	4,420.34	48.86	308.17
Control Group	4,476.76	49.77	314.55

Notes: *p<0.10, **p<0.05, ***p<0.01. This table presents estimates of Equation (1) where we regress hospital (or CD) outcomes on a vector of hospital (or CD) fixed effects, year dummies, and interactions between the Section 508-recipient hospital (or CD) indicator and year dummies. 2003 is our omitted year. Standard errors clustered around hospitals are presented in parentheses. Observations (N) are hospital-years in columns (1) and (2), and CD-years in column (3). Control hospitals are those that applied for a Section 508 waiver but were rejected; control congressional districts are those with at least one such hospital. Dependent variables are derived from the RAND Medicare Cost Reports data.

Table 3: Yearly Average Total Campaign Contributions Per Member of the House of Representatives ($ Thousands, 2010 Dollars)

		Individual Donors in Same State		
	Donations ($) - All Donors	Donations ($) - Hospitals	Donations ($) - Crop Production & Basic Processing	Donations ($) - Oil & Gas
	(1)	(2)	(3)	(4)
2001	427.31	1.66	1.32	1.24
2002	733.19	3.06	2.69	1.75
2003	495.10	2.26	1.54	1.72
2004	943.67	3.04	2.90	2.02
2005	576.16	2.53	1.65	1.32
2006	1,018.11	3.18	2.65	1.93
2007	706.57	2.40	1.75	1.20
2008	1,063.26	3.27	2.39	1.91
2009	589.79	2.50	2.18	1.79
2010	1,141.02	4.21	3.65	2.58

Notes: This table presents the total campaign contributions received by the average member of the House of Representatives each year from 2001 to 2010. Column (1) measures campaign contributions from all donors and Columns (2) to (4) measure campaign contributions from individual donors in the same state broken down by industry.

Table 4: The Impact of Section 508 Waiver Gains on Political Contributions

	Donations ($) - All Campaign Donors	Donations ($) - Individual Donors in Same State, Hospital Sector	Donations ($) - Individual Donors in Same State, Oil and Gas Sector	Donations ($) - Individual Donors in Same State, Crop Production Sector
	(1)	(2)	(3)	(4)
2003/4 Elec. Cycle x Gain in IPPS	-9.53	0.06	0.02	0.05
	(8.56)	(0.05)	(0.06)	(0.05)
2005/6 Elec. Cycle x Gain in IPPS	-12.83	0.25***	-0.12	-0.03
	(10.67)	(0.07)	(0.09)	(0.05)
2007/8 Elec. Cycle x Gain in IPPS	60.95***	0.43**	0.07	-0.01
	(18.37)	(0.17)	(0.09)	(0.06)
2009/10 Elec. Cycle x Gain in IPPS	-18.15	0.07	-0.05	-0.12
	(42.61)	(0.16)	(0.07)	(0.08)
Year FE	X	X	X	X
District FE	X	X	X	X
N	168	168	168	168
Mean (2003/2004)	1,124,152	3319	3173	2525

Notes: *p<0.10, **p<0.05, ***p<0.01. Gain in IPPS scaled in thousands. Contributions are in dollars. Observations (N) are candidate-election-cycles, limited to candidates of districts that have a 508 hospital. Estimates are from a regression of campaign contributions (in 2010 dollars) on a vector of candidate fixed effects, election-cycle dummies, and interactions between the 2005 IPPS gain in the candidate's district and quarter dummies. The 2001/2 cycle is our omitted category. Standard errors clustered around candidates are in parentheses. Control candidates are those with at least one hospital in their district that applied for a Section 508 waiver but were rejected.

Appendix – For Online Publication

Appendix A   Interview with Secretary Tommy G. Thompson

On September 7, 2022, we interviewed Tommy G. Thompson, who served as the Secretary of Health and Human Services (HHS) in the George W. Bush administration from 2001 to 2005. The interview was conducted in Madison, Wisconsin by Zack Cooper and Eleanor Neff Powell. For interested parties, we can provide an audio recording of the interview.

A.1   Secretary Tommy G. Thomson on President Bush's Reelection and the Expansion of Prescription Drug Coverage

Secretary Thompson said in our interview, "After the election of 2002, I told the President that you're going to go into your reelection in 2004 and unless you've handled the prescription drugs, you're going to get clobbered because you promised it!"

A.2   Secretary Tommy G. Thompson on Political Influence over Medicare Payments

Secretary Thompson described how, as Secretary, he could influence the writing of the rules, stating "The secretary appoints the CMS Director and you're his boss and it all flows down from there." He continued, "If the president of your university, the dean of your college comes to you and says, 'Zack, you know, you better do this,' then it's time to do this...for the good of the order." He also noted how when "Republicans have control [of the White House], they're going to have a CMS director that's philosophically in their camp. And they are going to want to make sure Republicans have a better chance to win next time than they did last time."

Appendix B Description of Data and Data Cleaning

B.1 Datasets and Sources

American Hospital Association Annual Survey: We obtained data on hospital staffing, payroll, technology adoption, and other hospital characteristics from the American Hospital Association (AHA) annual survey. The AHA has surveyed hospitals annually since 1946. More information on the AHA survey data can be viewed at: `http://www.ahadataviewer.com/book-cd-products/AHA-Survey/`.

American Hospital Directory Data: We use data on hospitals' Medicare activity that we obtained from the American Hospital Directory (AHD). The AHD is a for-profit data vendor that sells cleaned Medicare claims data derived from the Medicare Provider Analysis and Review limited access database. This includes claims records for 100% of Medicare fee-for-service inpatient claims. Details on the AHD data can be found at `www.ahd.com`.

Center for Responsive Politics Data: We identified the Section 508 Coalition via data on congressional lobbying presented by the Center for Responsive Politics `https://www.opensecrets.org/lobby/clientsum.php?id=D000056560&year=2009`.

CMS Inpatient PPS Impact Files: We accessed historical Impact Files from the Centers for Medicare & Medicaid Services (CMS). These files list the parameters affecting each hospital's inpatient PPS payments for each fiscal year (e.g., hospital wage indices). We use these files to calculate Medicare inpatient PPS operating and capital payments as described in Appendix B.2. The files and more information are available at: `https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Historical-Impact-Files-for-FY-1994-through-Present`.

Database on Ideology, Money in Politics, and Elections (DIME): We accessed data on campaign contributions from the DIME database. The database was constructed by Adam Bonica. More information on the data is available at `https://data.stanford.edu/dime`. Their information on campaign contributions was collected from the Federal Election Commission. To calculate campaign contributions to a candidate, we remove transactions identified by FEC transaction type codes as loan repayments (codes starting with 16, 20 and 22), refunds (codes starting with 17 and 23), expenditures against the candidate (24A, 24N), contributions from the candidate themselves (15C), and other miscellaneous codes. In addition to direct contributions to candidates' campaigns, we include "independent expenditure[s] advocating election of [the] candidate" (code 24E), in-kind contributions (codes 15Z and 24Z), and communication/electioneering expenses (codes 24F and 29). A full list of FEC transaction type codes is available at `https://www.fec.gov/campaign-finance-data/transaction-type-code-descriptions/`.

Federal Register: We extracted data on Medicare labor market area (i.e., CBSA) wage indexes from the annual Hospital Inpatient Prospective System (IPPS) Final Rules published in the Federal Register. These wage indexes are typically listed in Tables 4A and 4B of the final rule for each fiscal year. We used these to estimate what each Section 508 hospital's wage index (and thus IPPS payment rate) would have been without its labor market

reclassification under Section 508. The Federal Register files are available at: `https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/IPPS-Regulations-and-Notices`. The wage index tables for 2007-2010 are also available at: `https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Acute-Inpatient-Files-for-Download`.

Freedom of Information Act Request: We filed a Freedom of Information Act (FOIA) request to the Centers for Medicare and Medicaid Services to obtain a list of hospitals that applied for a Section 508 waiver, a list of applications that had their applications approved, and the criteria on which hospitals' applications were judged. Our FOIA request was filed on December 1, 2014. We received a reply on March 3, 2015.

RAND Hospital Data: We accessed data on hospitals' total revenue, Medicare prospective payment system (PPS) payments, and Medicare inpatient discharges from the RAND Corporation, which sells cleaned Medicare Cost Reports (HCRIS) data. We use federal fiscal year-level year data with error corrections by RAND. More information on the data is available at: `https://www.hospitaldatasets.org`.

Voteview Database: We accessed data on the votes by members of Congress for the Medicare Modernization Act from the Voteview database. The database includes roll call votes for every vote taken by Congress and can be accessed at `voteview.com`. The database is hosted and maintained by UCLA's Department of Political Science.

B.2 Calculating Medicare Inpatient PPS Payment Rates

To calculate payments, we followed payment rules outlined each year in the Federal Register. We began by calculating the inpatient PPS operating payments and capital payments, which were adjusted using the hospital operating wage index, labor and non-labor shares, operating cost-of-living adjustment, disproportionate share payments, indirect medical education payments, geographic adjustment factors, and capital cost-of-living adjustments. We then used diagnosis related group (DRG) weights to calculate the standard payment amount for each inpatient case exclusive of outlier payments. Outlier payments are additional payments made to hospitals if specific cases involve atypically long stays in the hospital.

B.3 Identifying the Industry of a Donor

For identifying the industry of employment of the donor/contributor, we primarily use the contributor categorization code in the DIME database. Details on categorization can be found at `https://www.opensecrets.org/downloads/crp/CRP_Categories.txt`. We supplement this categorization by looking for specific words in the contributors' employer and organization field. For example, we categorized contributors to the hospital industry by looking for words "hospital", "healthcare system", "health system" and "medical center" in the employer and the organization field. We repeat the same procedure for other industries.

Appendix C   Construction of Propensity Scores

C.1   Hospital Propensity Score Matching

We use a probit model to construct propensity scores that match Section 508 hospitals to their 10 nearest neighbors. We estimate our probit to predict Section 508 receipt based on 2001-2003 mean Medicare discharges, Medicaid discharges, for-profit status, teaching hospital status, the bed count, a rural indicator, and the 2001-2003 (pre-treatment) mean value of the dependent variable of interest (i.e., inpatient Medicare spending and Medicare admissions). Specifically, we use STATA's psmatch2 function to perform the matching procedure, which implements full Mahalanobis matching (see http://repec.org/bocode/p/psmatch2.html).

C.2   Candidate Propensity Score Matching

We construct our control group using propensity score matching where we use a probit model to estimate a candidate's probability of having a hospital in her district that received a Section 508 waiver. In our probit, we control for the party of the candidate, the winning vote share in the 2001/2002 House election, the number of hospitals per district, the share of non-profit hospitals per district and the share of teaching hospitals per district.

Table A.1: Receipt of 508 and 2005 IPPS Gains from 508 based on Congressional Votes, MC Characteristics, and Local Area Characteristics of Districts and Counties

	Received 508	IPPS Gains (000s)
	(1)	(2)
Voted Yea to MMA	0.018**	57.923*
	(0.009)	(34.968)
Republican Party	-0.005	31.779
	(0.013)	(40.908)
Incumbent	0.018*	51.094*
	(0.011)	(29.307)
Vote Margin in 2002	0.044	-70.413
	(0.067)	(154.396)
Majority Leader	0.365***	-60.341
	(0.016)	(46.300)
Majority Whip	-0.019*	-85.295
	(0.010)	(59.907)
For-Profit Hospital	-0.018**	-32.021*
	(0.008)	(19.421)
Hospital Beds	0.000	0.657*
	(0.000)	(0.366)
Teaching Hospital	0.032	349.166**
	(0.024)	(155.683)
Hospital Technology Index	-0.000	-10.107
	(0.001)	(9.115)
Medicare Wage Index	0.172***	651.888***
	(0.055)	(246.260)
Population Density (County)	-0.000***	-0.017***
	(0.000)	(0.007)
Income per Capita (County)	-0.000	0.002
	(0.000)	(0.004)
N	2,606	2,606
Mean of Dependent Variable	0.030	71.730

Notes: *p<0.10, **p<0.05, ***p<0.01. Standard errors are clustered at congressional district. Medicare Wage Index from Medicare Impact Files. Average county-level income from the BEA and represents per capita income. Hospital-characteristics data from the AHA. Vote margins for 2000 election are only for MCs who were incumbents in 2004 (i.e., had served in 2001-2 and/or 2003-4). Gain in IPPS scaled in thousands and based on gains in 2005.

Table A.2: Hospital Characteristics

	All 508 Hospitals		Applied and Rejected		Eligible But Didn't Apply		Ineligible		Propensity Score Matched		All AHA Hospitals	
	Mean	*Std. Dev.*	*Mean*	*Std. Dev.*	*Mean*	*Std. Dev.*	*Mean*	*Std. Dev.*	*Mean*	*Std. Dev.*	*Mean*	*Std. Dev.*
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Medicare Discharges	5,022	4,198	5,498	4,190	4,258	3,951	3,853**	3,074	4,927	1,930	4,245*	3,688
Medicaid Discharges	1,681	1,959	2,105*	2,071	1,937	2,497	1,638	2,022	1,659	963	1,825	2,261
For-Profit Hospital	0.06	0.23	0.21***	0.41	0.13***	0.34	0.18***	0.38	0.06	0.17	0.16***	0.36
Not-for-Profit Hospital	0.88	0.33	0.69***	0.46	0.64***	0.48	0.65***	0.48	0.87	0.32	0.66***	0.48
Teaching Hospital	0.40	0.49	0.38	0.49	0.29*	0.46	0.23***	0.42	0.39	0.27	0.28**	0.45
Beds	235	184	274*	210	226	203	194**	164	239	74	218	190
Medicare Wage Index	1.10	0.16	0.96***	0.14	0.98***	0.17	0.98***	0.15	1.02***	0.10	0.99***	0.16
IPPS Payment Rate	5,626	1,019	5,200***	980	5,315***	1,229	5,206***	1,037	5,082***	450	5,269***	1,126
Urban Area	0.81	0.40	0.79	0.41	0.73	0.44	0.57***	0.50	0.84	0.21	0.68***	0.47
Member Voted Yea - MMA	0.61		0.49*		0.51*		0.53		0.62		0.52	
N	88		284		1,278		1,125		88		2,775	

Notes: All statistics (except MMA votes) are calculated using 2004 AHA Annual Hospital Survey data. We exclude Critical Access Hospitals, hospitals that are not registered with the AHA for all of 2001 to 2010, and hospitals that are not in our sample for all of 2001 to 2010. Asterisks indicate that the group's mean is statistically significantly different from the 508 hospitals' mean based on a t-test (***$p<0.01$, **$p<0.05$, *$p<0.1$). We do not conduct t-tests for the "All AHA Hospitals" group.

Table A.3: Distribution of Gains in IPPS Rates and Simulated IPPS Payments from the Section 508 Program

	Mean	S.D.	Min.	P5	P10	P25	Tercile 1	Median	Tercile 2	P75	P90	Max.
Predicted Gain in IPPS Payment Rate for Hospitals ($)	426.70	247.45	0	74.20	105.33	252.75	331.07	401.32	478.10	554.34	802.81	1,008.18
Predicted Gain in Total IPPS Payments for Hospitals ($ Millions)	2.64	4.05	0	0.06	0.16	0.51	0.77	1.52	2.45	2.89	5.90	27.04
Predicted Gain in Total IPPS Payments for Congressional Districts ($ Millions)	5.54	7.70	0.08	0.12	0.28	0.77	1.21	3.09	5.32	6.24	10.74	38.19

Note: Gains are in constant 2010 dollars. Gains in IPPS payment rates are calculated for 2005. Gains in total IPPS payments are calculated by applying actual and counterfactual payment rates from 2005 to Medicare inpatient quantities from 2003. Hospital-level gains are based on our analytic sample of 88 Section 508 hospitals. CD-level gains are based on the same sample of Section 508 hospitals, aggregated to the district level.

Table A.4: The Impact of Section 508 Waivers on Hospitals' Inpatient Medicare Admissions and Inpatient Medicare Spending, Logged

	Hospital-Level		CD-Level
	Medicare Inpatient Admissions	Medicare Inpatient PPS Spending ($ Millions, 2010 Dollars)	Medicare Inpatient PPS Spending ($ Millions)
	(1)	(2)	(3)
2001 X Treated	−0.008	−0.009	0.010
	(0.020)	(0.020)	(0.014)
2002 X Treated	−0.019	−0.023	0.002
	(0.015)	(0.015)	(0.008)
2003 - Pre-Treatment Year - Omitted Category			
(Section 508 Payments Took Effect on April 1, 2004)			
2004 X Treated	0.008	0.031**	0.014
	(0.008)	(0.010)	(0.008)
2005 X Treated	0.041**	0.080**	0.022*
	(0.015)	(0.016)	(0.011)
2006 X Treated	0.042*	0.068**	0.026*
	(0.016)	(0.018)	(0.012)
2007 X Treated	0.045*	0.068**	0.026
	(0.021)	(0.024)	(0.015)
Section 508 Program Reauthorized on December 19, 2007			
2008 X Treated	0.028	0.045	0.030
	(0.024)	(0.027)	(0.023)
2009 X Treated	0.010	0.038	0.044
	(0.026)	(0.029)	(0.030)
2010 X Treated	0.020	0.056	0.063*
	(0.031)	(0.034)	(0.032)
Year FE	X	X	X
Hospital FE	X	X	
CD FE			X
N	3,712	3,711	1,960
Mean of Dependent Variable in 2003			
Treated Group	4,420.34	48.86	308.17
Control Group	4,476.76	49.77	314.55

Notes: *p<0.10, **p<0.05, ***p<0.01. This table presents estimates of Equation (1) where we regress hospital (or CD) logged outcomes on a vector of hospital (or CD) fixed effects, year dummies, and interactions between the Section 508-recipient hospital (or CD) indicator and year dummies. 2003 is our omitted year. Standard errors clustered around hospitals are presented in parentheses. Observations (N) are hospital-years in columns (1) and (2), and CD-years in column (3). Control hospitals are those who applied for a Section 508 waiver but were rejected; control congressional districts are those with at least one such hospital. Dependent variables are derived from the RAND Medicare Cost Reports data.

Table A.5: Robustness, the Impact of Section 508 Waiver on Hospital Spending and Admissions

	IP Spending (1)	Admissions (2)	IP Spending (3)	Admissions (4)	IP Spending (5)	Admissions (6)
2001 X Treated	−0.595	−116.168	0.805	35.084	−1.176	−51.517
	(0.881)	(77.573)	(0.490)	(34.659)	(0.910)	(82.922)
2002 X Treated	−0.409	−71.771	−0.176	−4.708	−0.325	−35.552
	(0.558)	(51.472)	(0.296)	(21.125)	(0.527)	(53.276)
2004 X Treated	2.403***	47.872	0.821*	0.251	1.604***	52.601
	(0.632)	(38.910)	(0.472)	(28.599)	(0.539)	(35.717)
2005 X Treated	4.286***	137.724**	1.274**	46.650	3.298***	118.875**
	(0.964)	(59.227)	(0.611)	(38.715)	(0.877)	(55.933)
2006 X Treated	3.504***	136.566*	1.137*	68.511	3.025***	149.716**
	(0.965)	(70.186)	(0.649)	(42.275)	(0.858)	(67.921)
2007 X Treated	3.479***	153.247*	2.250***	149.491***	2.526***	106.650
	(0.966)	(78.941)	(0.702)	(50.147)	(0.864)	(80.076)
2008 X Treated	2.998***	126.821	2.911***	207.443***	1.925*	86.773
	(1.085)	(94.344)	(0.775)	(55.510)	(1.019)	(89.827)
2009 X Treated	3.280***	127.417	2.616***	224.716***	2.000*	108.642
	(1.256)	(104.722)	(0.850)	(66.351)	(1.215)	(97.077)
2010 X Treated	4.551***	243.491**	2.743***	230.523***	3.403**	241.195**
	(1.444)	(115.854)	(0.933)	(68.894)	(1.397)	(111.039)
Balanced Panel	No	No	Yes	Yes	Yes	Yes
Control Group	Applied/Rejected		Did Not Receive		Prop. Score Match	
Year FE	X	X	X	X	X	X
Hospital FE	X	X	X	X	X	X
N	4,317	4,318	30,770	30,773	6,620	6,850
Treated Mean (2003)	48.05	4515.31	48.05	4515.31	48.05	4515.31
Control Mean (2003)	46.89	4305.45	34.04	3397.46	46.89	4305.45

Notes: *p<0.10, **p<0.05, ***p<0.01. Applied/Rejected control hospitals are those who applied for a Section 508 waiver but were rejected. Did Not Receive control hospitals are those who did not receive a Section 508 waiver. Propensity Score Matched control hospitals are those matched using propensity score matching. See Appendix B.1 for a description of how our matching was executed.

Table A.6: The Impact of the Re-Authorization of the Section 508 Program on Campaign Contributions

Campaign Contributions From:	All Donors Nationwide ($ Thousands)	Individual Donors Nationwide ($ Thousands)	Individual Donors in Same State			
			All Industries ($ Thousands)	Hospitals ($)	Crop Production & Basic Processing ($)	Oil & Gas ($)
	(1)	(2)	(3)	(4)	(5)	(6)
2001-Q1*Treated	-11.44	-1.51	11.24*	126.70	-71.71	282.04
Group	(19.93)	(10.90)	(6.32)	(139.61)	(205.32)	(347.61)
2001-Q2*Treated	-80.10***	-34.86***	-20.84**	-159.36	-673.34**	-281.26
Group	(29.73)	(12.21)	(9.27)	(182.18)	(271.74)	(250.36)
2001-Q3*Treated	-15.95	-9.44	3.83	54.47	64.32	-154.35
Group	(22.14)	(9.33)	(9.55)	(208.98)	(280.64)	(249.93)
2001-Q4*Treated	-28.68	-11.58	-1.19	-181.62	-280.84	-261.29
Group	(22.15)	(13.72)	(10.15)	(183.69)	(202.00)	(202.34)
2002-Q1*Treated	0.40	1.82	6.24	36.25	30.38	166.41
Group	(23.41)	(14.26)	(9.12)	(190.80)	(367.36)	(340.54)
2002-Q2*Treated	14.64	5.02	-3.14	-90.47	-1,070.39*	195.86
Group	(41.35)	(29.43)	(18.40)	(326.82)	(555.76)	(359.57)
2002-Q3*Treated	-37.45	-38.59**	-24.79*	-107.79	-913.88**	63.23
Group	(32.35)	(18.26)	(13.89)	(270.29)	(440.40)	(415.21)
2002-Q4*Treated	-9.20	-1.85	-0.55	-48.85	-502.45**	-290.63
Group	(40.69)	(18.92)	(12.09)	(219.57)	(212.43)	(260.67)
2003-Q1*Treated	-21.49	-8.57	3.68	121.00	-10.10	88.29
Group	(19.98)	(10.62)	(6.85)	(131.13)	(171.31)	(307.77)
2003-Q2*Treated	-23.14	-17.99	-11.72	-76.12	-518.18**	-280.78
Group	(23.22)	(13.80)	(10.53)	(190.74)	(237.83)	(241.34)
2003-Q3*Treated	-17.93	-14.96	-3.61	-111.19	-344.10	-160.83
Group	(21.85)	(13.52)	(9.44)	(221.66)	(220.90)	(262.23)
2003-Q4*Treated	-19.94	-6.41	-2.63	206.74	-230.08	-147.79
Group	(18.95)	(9.27)	(9.02)	(405.71)	(247.18)	(236.04)
2004-Q1*Treated	-20.00	-16.85	-8.01	148.05	-619.92	64.89
Group	(21.61)	(11.26)	(9.15)	(244.77)	(406.51)	(299.27)

The Impact of the Re-Authorization of the Section 508 Program on Campaign Contributions

	(1)	(2)	(3)	(4)	(5)	(6)
2004-Q2*Treated	-23.08	-10.86	0.34	-60.43	-574.20*	-35.23
Group	(24.32)	(15.81)	(12.47)	(359.72)	(321.62)	(296.64)

Section 508 Payments Took Effect on April 1, 2004

	(1)	(2)	(3)	(4)	(5)	(6)
2004-Q3*Treated	-17.16	-3.72	7.97	-164.60	-330.91	372.67
Group	(32.72)	(20.82)	(16.99)	(245.41)	(394.65)	(332.04)
2004-Q4*Treated	-5.24	-16.12	-1.82	416.98	-393.90	-186.57
Group	(50.00)	(14.47)	(10.39)	(350.96)	(254.73)	(241.65)
2005-Q1*Treated	-25.30	-3.12	5.62	314.36	-163.99	125.71
Group	(19.97)	(10.97)	(6.00)	(223.00)	(187.98)	(259.83)
2005-Q2*Treated	-11.42	-9.10	-10.20	0.53	-304.78	-362.53
Group	(24.31)	(13.43)	(9.57)	(283.10)	(333.05)	(247.49)
2005-Q3*Treated	-23.15	-18.70	-10.18	-2.49	-149.40	240.46
Group	(19.86)	(12.56)	(9.94)	(363.85)	(391.00)	(427.78)
2005-Q4*Treated	3.24	10.61	-1.31	209.28	-319.19	-183.34
Group	(42.76)	(31.63)	(12.99)	(282.10)	(233.13)	(245.29)
2006-Q1*Treated	-0.99	3.95	1.52	-109.48	-381.76	256.86
Group	(27.88)	(17.41)	(11.85)	(294.85)	(297.64)	(339.96)
2006-Q2*Treated	4.10	0.89	4.29	214.87	-386.53	-100.95
Group	(31.65)	(20.50)	(13.94)	(324.03)	(274.21)	(361.85)
2006-Q3*Treated	-7.30	-25.03	-10.03	391.35	-528.63**	-44.96
Group	(40.31)	(20.49)	(15.72)	(414.36)	(222.84)	(434.16)
2006-Q4*Treated	-8.18	-10.11	5.61	-286.43	-165.87	227.02
Group	(31.87)	(18.71)	(12.13)	(239.21)	(225.60)	(403.28)

2007-Q1 - Omitted Category

	(1)	(2)	(3)	(4)	(5)	(6)
2007-Q2*Treated	-11.56	-14.33	-7.00	227.32	-397.48*	7.94
Group	(21.78)	(10.41)	(7.11)	(250.21)	(219.21)	(273.64)
2007-Q3*Treated	-12.82	-12.91	-4.02	89.35	-579.80	-155.44
Group	(18.55)	(10.76)	(9.58)	(258.32)	(396.52)	(292.39)
2007-Q4*Treated	-18.29	-17.51	-7.91	700.51	184.78	119.75
Group	(28.61)	(15.49)	(11.35)	(461.11)	(472.66)	(314.41)

The Impact of the Re-Authorization of the Section 508 Program on Campaign Contributions

	(1)	(2)	(3)	(4)	(5)	(6)
Section 508 Program Reauthorized on December 19, 2007						
2008-Q1*Treated	44.55*	20.88	22.24**	164.06	-271.06	-126.63
Group	(24.19)	(15.19)	(10.34)	(221.95)	(269.86)	(236.80)
2008-Q2*Treated	18.35	3.04	5.94	-54.52	-280.92	-81.12
Group	(32.72)	(24.07)	(17.38)	(228.33)	(227.14)	(271.77)
2008-Q3*Treated	190.56**	34.60*	32.70**	509.26	-14.27	153.53
Group	(89.46)	(20.40)	(15.22)	(340.77)	(347.50)	(531.71)
2008-Q4*Treated	48.90	-5.29	4.48	45.04	-101.87	-234.11
Group	(59.94)	(16.63)	(10.69)	(204.36)	(174.84)	(252.07)
2009-Q1*Treated	-26.69	-11.05	0.39	111.60	-74.32	-117.54
Group	(21.30)	(12.22)	(6.97)	(164.99)	(192.59)	(206.23)
2009-Q2*Treated	-4.92	-7.20	-2.12	-36.31	-297.43	-197.09
Group	(27.86)	(15.77)	(9.92)	(222.31)	(206.17)	(228.76)
2009-Q3*Treated	-17.83	-12.65	-6.80	325.48	205.61	145.75
Group	(27.90)	(13.51)	(9.25)	(211.93)	(577.22)	(396.63)
2009-Q4*Treated	-44.38	-31.83	-21.21	-256.73	58.97	-264.75
Group	(34.57)	(21.04)	(16.02)	(282.48)	(388.52)	(310.73)
2010-Q1*Treated	-10.35	-13.75	-4.41	229.12	64.86	-223.11
Group	(26.13)	(14.18)	(8.61)	(190.76)	(337.95)	(277.73)
2010-Q2*Treated	16.15	1.15	2.68	99.62	40.72	-51.05
Group	(32.74)	(17.42)	(10.96)	(337.92)	(283.83)	(267.33)
2010-Q3*Treated	22.15	-3.71	0.11	110.51	340.44	-164.31
Group	(54.52)	(20.11)	(11.79)	(345.24)	(975.29)	(375.85)
2010-Q4*Treated	4.65	-3.46	4.98	179.38	-217.23	-165.51
Group	(45.05)	(17.01)	(10.85)	(271.23)	(269.36)	(240.26)
Candidate F.E.s	X	X	X	X	X	X
Year-Quarter F.E.s	X	X	X	X	X	X
N	6,080	6,080	6,080	6,080	6,080	6,080
Mean of the Dependent Variable in 2007-Q1						
Treated Candidates	148.89	51.93	25.47	153.12	296.97	352.65
Control Candidates	136.31	44.74	31.92	396.92	318.73	214.47

Notes: *p<0.10, **p<0.05, ***p<0.01. This table presents estimates of Equation (2) where we regress campaign contributions (in constant 2010 dollars) on a vector of candidate fixed effects, quarter dummies, and interactions between the treated candidate indicator and quarter dummies. 2007-Q1 is our omitted category. Standard errors clustered around candidates are in parentheses. Observations (N) are candidate-quarters. Control candidates are those with at least one hospital in their district that applied for a Section 508 waiver but was rejected.

Table A.7: The Impact of Section 508 Waiver Gains on Political Contributions

	Donations ($) - All Campaign Donors	Donations ($) - Individual Donors in Same State, Hospital Sector	Donations ($) - Individual Donors in Same State, Oil and Gas Sector	Donations ($) - Individual Donors in Same State, Crop Production Sector
	(1)	(2)	(3)	(4)
2003/4 Elec. Cycle x Gain in IPPS	-13.276**	0.068	-0.015	0.046
	(5.845)	(0.055)	(0.033)	(0.059)
2005/6 Elec. Cycle x Gain in IPPS	-9.198	0.208***	-0.079***	0.024
	(6.037)	(0.074)	(0.029)	(0.052)
2007/8 Elec. Cycle x Gain in IPPS	58.917***	0.379**	0.039	0.081
	(17.046)	(0.151)	(0.025)	(0.076)
2009/10 Elec. Cycle x Gain in IPPS	-16.513	0.070	-0.054	0.095
	(33.335)	(0.129)	(0.036)	(0.106)
Year FE	X	X	X	X
District FE	X	X	X	X
N	743	743	743	743
Mean (2003/2004)	1,231,171	4452	2748	4896

Notes: *p<0.10, **p<0.05, ***p<0.01. Gain in IPPS scaled in thousands. Contributions are in dollars. Observations (N) are candidate-election-cycles. We include all candidates in this analysis, with Gain in IPPS equaling 0 if a candidate's district does not have a hospital that received a 508 waiver. Estimates are from a regression of campaign contributions (in 2010 dollars) on a vector of candidate fixed effects, election-cycle dummies, and interactions between the 2005 IPPS gain in the candidate's district and quarter dummies. The 2001/2 cycle is our omitted category. Standard errors clustered around candidates are in parentheses.

Table A.8: The Impact of Section 508 Waiver Gains on Political Contributions, by Year

	Donations ('000s $) - All Campaign Donors	Donations ('000s $) - Individual Donors in Same State, Hospital Sector	Donations ('000s $) - Individual Donors in Same State, Oil and Gas Sector	Donations ('000s $) - Individual Donors in Same State, Crop Production Sector
	(1)	(2)	(3)	(4)
2002 x Treated District	77.486	-0.018	0.463	-1.574
	(107.350)	(0.585)	(0.526)	(1.172)
2003 x Treated District	27.657	0.336	-0.170	-0.217
	(45.033)	(0.418)	(0.367)	(0.372)
2004 x Treated District	42.035	0.528	0.540	-1.041
	(102.876)	(0.697)	(0.533)	(0.748)
2005 x Treated District	54.086	0.719	0.153	-0.050
	(65.629)	(0.622)	(0.446)	(0.577)
2006 x Treated District	95.141	0.399	0.662	-0.585
	(114.981)	(0.832)	(0.925)	(0.627)
2007 x Treated District	65.551	1.221*	0.378	0.124
	(80.242)	(0.704)	(0.455)	(0.719)
2008 x Treated District	392.183**	0.749	0.002	0.174
	(187.883)	(0.669)	(0.771)	(0.706)
2009 x Treated District	-23.738	0.199	0.273	0.868
	(101.446)	(0.510)	(0.538)	(0.861)
2010 x Treated District	180.947	0.937	0.026	1.118
	(168.139)	(0.844)	(0.558)	(1.597)
District FE	X	X	X	X
Year FE	X	X	X	X
N	1,471	1,471	1,471	1,471
Mean (2003)	466.839	1.863	1.191	1.627

Notes: *p<0.10, **p<0.05, ***p<0.01. A treated district is one which has a 508 hospital. Contributions are in thousands of dollars. Observations (N) are candidate-years. Estimates are from a regression of campaign contributions (in 2010 dollars) on a vector of candidate fixed effects, year dummies, and interactions between the 2005 IPPS gain in the candidate's district and quarter dummies. The 2001 is our omitted category. Standard errors clustered around candidates are in parentheses. Control candidates are those with at least one hospital in their district that applied for a Section 508 waiver but were rejected.

Table A.9: The Impact of Section 508 Waiver Gains on Political Contributions, Candidates in Districts with Top 50% of IPPS Gains

	Donations ($) - All Campaign Donors	Donations ($) - Individual Donors in Same State, Hospital Sector	Donations ($) - Individual Donors in Same State, Oil and Gas Sector	Donations ($) - Individual Donors in Same State, Crop Production Sector
	(1)	(2)	(3)	(4)
2003/4 Elec. Cycle x Gain in IPPS	−12.47**	0.07	−0.01	0.04
	(5.95)	(0.06)	(0.03)	(0.06)
2005/6 Elec. Cycle x Gain in IPPS	−7.74	0.21***	−0.07**	0.02
	(5.91)	(0.07)	(0.03)	(0.05)
2007/8 Elec. Cycle x Gain in IPPS	58.78***	0.38**	0.03	0.08
	(17.07)	(0.15)	(0.02)	(0.08)
2009/10 Elec. Cycle x Gain in IPPS	−17.45	0.07	−0.05	0.10
	(33.25)	(0.13)	(0.04)	(0.11)
Year FE	X	X	X	X
District FE	X	X	X	X
N	678	678	678	678
Mean (2003/2004)	1,214,929	4,638	2,314	5,152

Notes: *p<0.10, **p<0.05, ***p<0.01. Analysis is limited to hospitals whose IPPS gains were in the top 50% of the distribution. Contributions are in dollars. Observations (N) are candidate-election-cycles, limited to candidates of districts that have a 508 hospital. Estimates are from a regression of campaign contributions (in 2010 dollars) on a vector of candidate fixed effects, election-cycle dummies, and interactions between the 2005 IPPS gain in the candidate's district and quarter dummies. The 2001/2 cycle is our omitted category. Standard errors clustered around candidates are in parentheses. Control candidates are those with at least one hospital in their district that applied for a Section 508 waiver but were rejected.

Figure A.1: The Impact of Section 508 Waivers on Hospitals' Inpatient Medicare Admissions and Inpatient Medicare Spending (Logged)

Panel A: Logged Medicare Inpatient Admissions
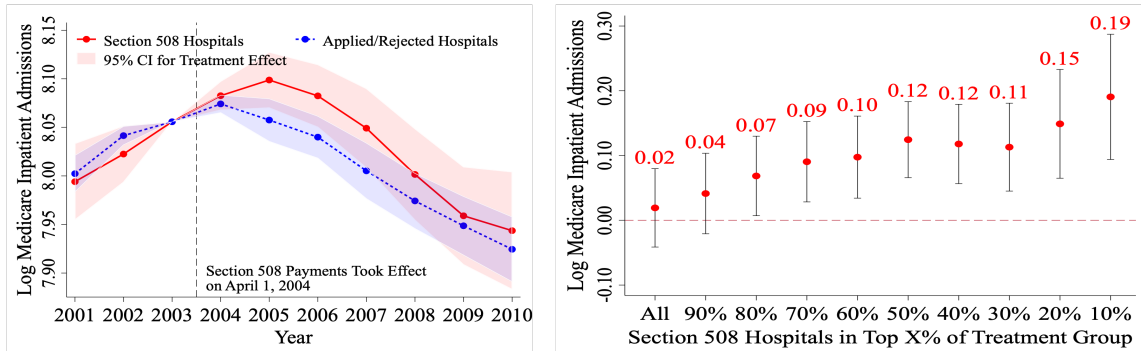
Panel B: Logged Medicare Inpatient PPS Spending ($ Millions, 2010 Dollars)
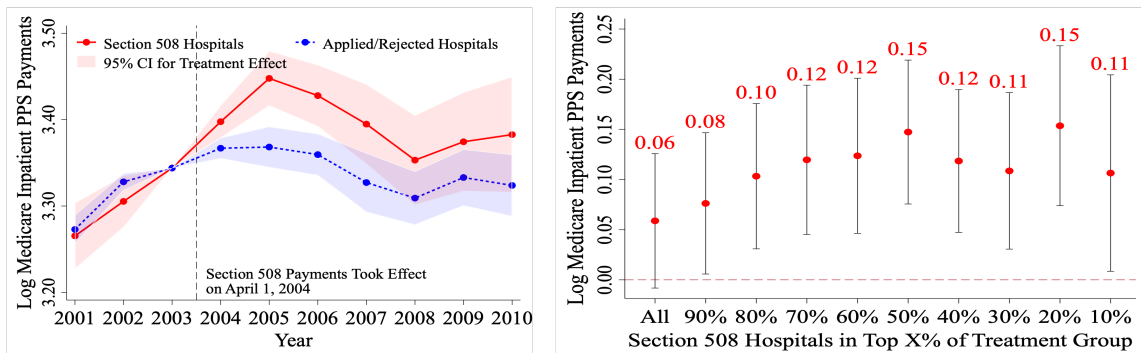
Panel C: Logged Congressional District-Level Medicare Inpatient PPS Spending ($ Millions, 2010 Dollars)
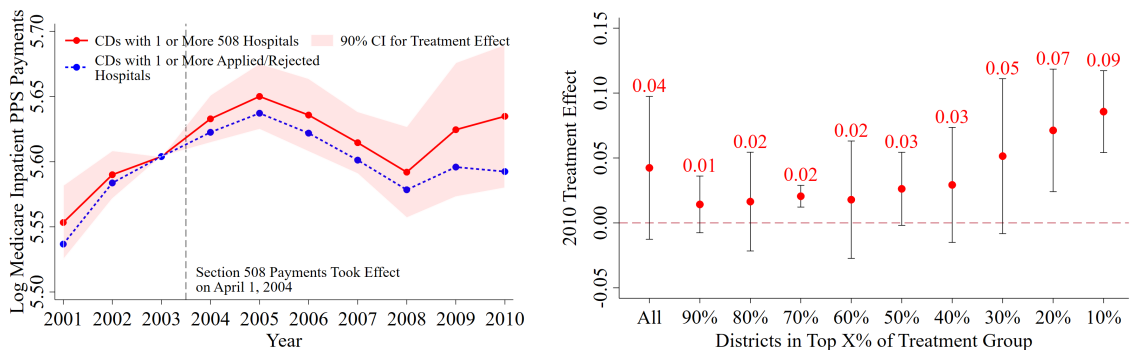
Notes: These panels present estimates of Equation (1) where we regress hospital (or CD) outcomes, logged, on a vector of hospital (or CD) fixed effects, year dummies, and interactions between the Section 508-recipient hospital (or CD) indicator and year dummies. 2003 is our omitted year. 95% confidence intervals are based on standard errors clustered around hospitals (or CDs). Control hospitals include those that applied for the Section 508 waiver but were rejected; control CDs include those with at least one such hospital. The rightmost figures plot the coefficient of the 2010 interaction term from Equation (1) as we vary the definition of the treatment group based on hospitals' (or CDs') predicted exposure to the Section 508 program. Moving left to right in each figure, each specification involves a treated group composed of hospitals/CDs that received increasingly large gains in total, predicted IPPS spending (based on quantities in 2003 and actual and counterfactual payment rates in 2005) due to the Section 508 program.

17

Figure A.2: The Impact of Section 508 Waivers on Hospitals' Medicare and Total Revenue

Panel A: Medicare Inpatient + Outpatient PPS Spending ($ Millions, 2010 Dollars)
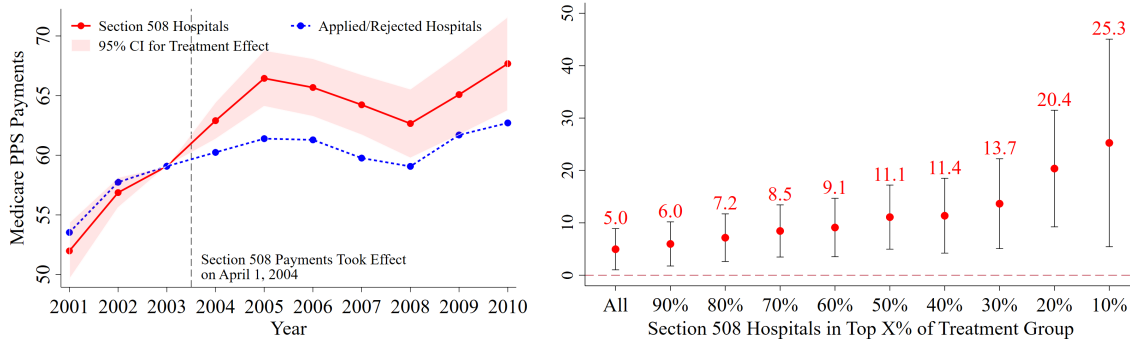
Panel B: Total Net Patient Revenue ($ Millions, 2010 Dollars)
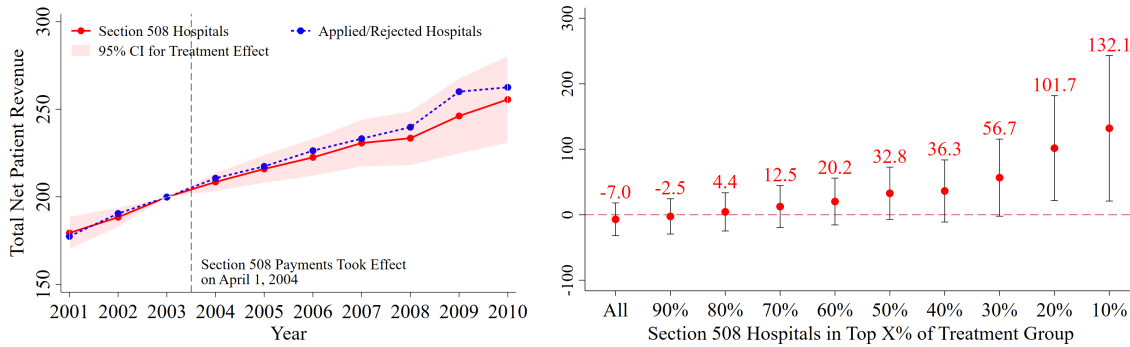
Panel C: Total Net Patient Revenue ($ Millions, 2010 Dollars), Treated=Top 50%
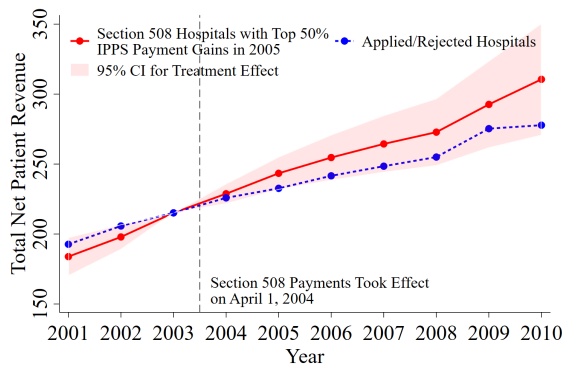
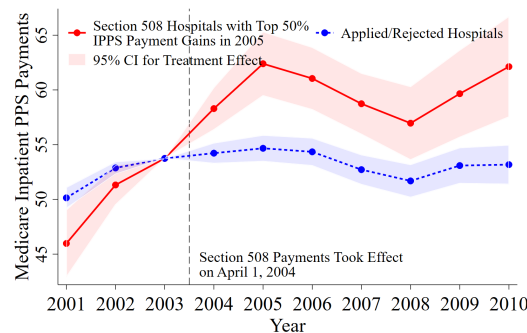**Panel D: Total Net Patient Revenue ($ Millions, 2010 Dollars), Treated=Top 20%**
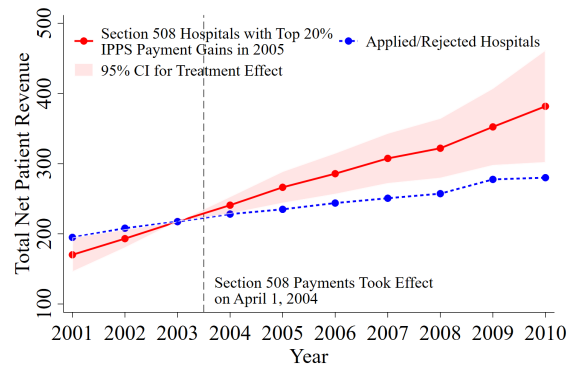
Notes: These panels present estimates of Equation (1) where we regress hospital outcomes on a vector of hospital fixed effects, year dummies, and interactions between the Section 508-recipient hospital indicator and year dummies. 2003 is our omitted year. 95% confidence intervals are based on standard errors clustered around hospitals. Control hospitals include those that applied for the Section 508 waiver but were rejected. The rightmost figures plot the coefficient of the 2010 interaction term from Equation (1) as we vary the definition of the treatment group. Moving left to right in each figure, each specification involves a treated group composed of hospitals that received increasingly large mechanical gains in total IPPS payments (based on quantities in 2003 and actual and counterfactual payment rates in 2005) due to the Section 508 program. Outcome measures are from the Healthcare Provider Cost Reporting Information System data. Panel A uses the sum of Medicare payments under the inpatient and outpatient prospective payment systems. Panels B, C, and D use "net patient revenue (charges minus contractual allowances and discounts)."

18

Figure A.3: The Impact of Section 508 Waivers on Hospitals' Inpatient Medicare Admissions and Inpatient Medicare Spending, Top 50% of 508 Gains
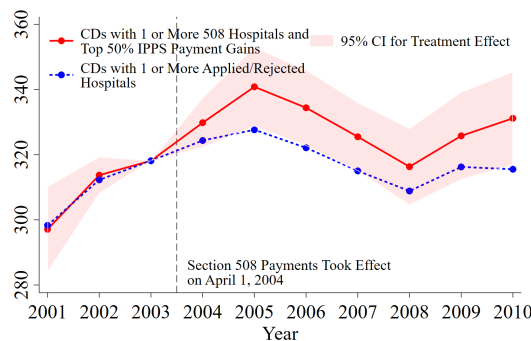
Panel A: Medicare Inpatient Admissions
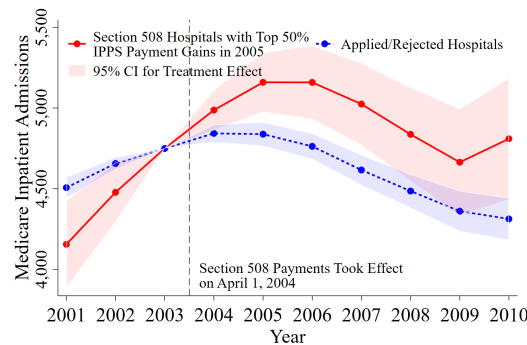
Panel B: Medicare Inpatient PPS Spending ($ Millions, 2010 Dollars)


Panel C: Congressional District-Level Medicare Inpatient PPS Spending ($ Millions, 2010 Dollars)
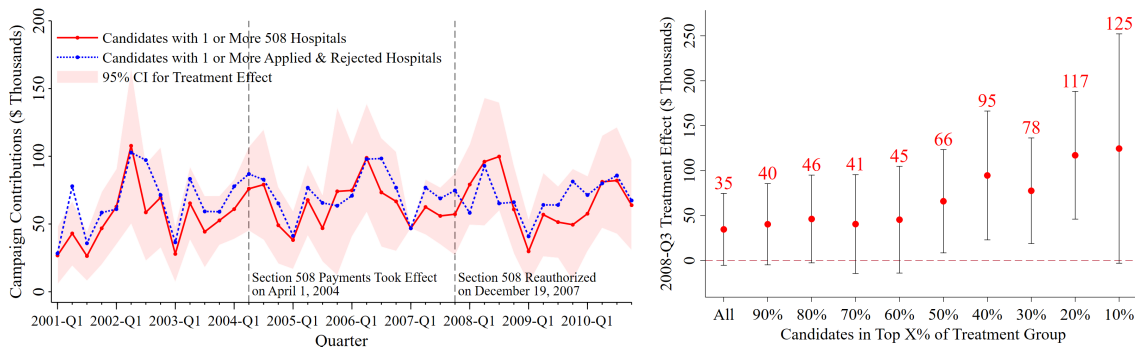

Notes: These panels present estimates of Equation (1) where we regress hospital (or CD) outcomes on a vector of hospital (or CD) fixed effects, year dummies, and interactions between the Section 508-recipient hospital (or CD) indicator and year dummies. We limited treated hospitals to Section-508 recipient hospitals that were in the top 50% of IPPS payment gains. 2003 is our omitted year. 95% confidence intervals are based on standard errors clustered around hospitals (or CDs). Control hospitals include those that applied for the Section 508 waiver but were rejected; control CDs include those with at least one such hospital.

Figure A.4: The Impact of the Re-Authorization of the Section 508 Program on Campaign Contributions

Panel A: Campaign Contributions from All Donors in Same State
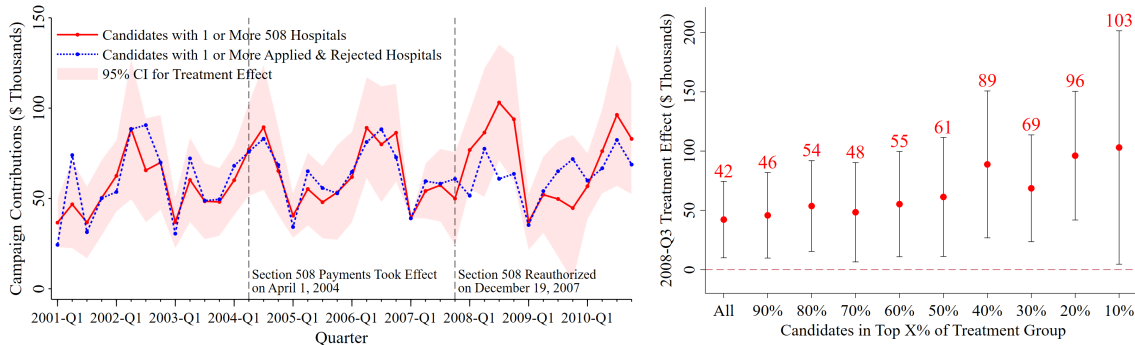
Panel B: Campaign Contributions from Individual Donors Nationwide
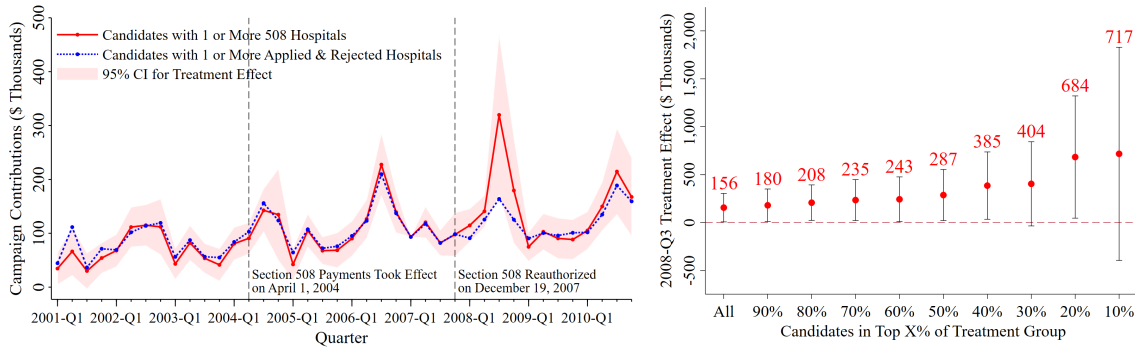

Panel C: Campaign Contributions from Individual Donors in Same State

Notes: These panels present estimates of Equation (2) where we regress campaign contributions (in thousands of constant 2010 dollars) on a vector of candidate fixed effects, quarter dummies, and interactions between the treated candidate indicator and quarter dummies. Control candidates are those that have one or more hospitals in their district that applied for a Section 508 waiver but were rejected. 2007-Q1 is our omitted time period. 95% confidence intervals are based on standard errors clustered around candidates. The rightmost figures plot the coefficient of the 2008-Q3 interaction term from Equation (2) as we vary the definition of the treatment group. Moving left to right in each figure, each specification involves a treated group composed of candidates from congressional districts with increasingly large gains in total IPPS payments in 2005 (based on quantities in 2003 and actual and counterfactual payment rates in 2005) due to the Section 508 program.

Figure A.4: The Impact of the Re-Authorization of the Section 508 Program on Campaign Contributions [Contd.]

Panel D: Campaign Contributions from Committee/Organization Donors Nationwide


Notes: These panels present estimates of Equation (2) where we regress campaign contributions (in thousands of constant 2010 dollars) on a vector of candidate fixed effects, quarter dummies, and interactions between the treated candidate indicator and quarter dummies. Control candidates are those that have one or more hospitals in their district that applied for a Section 508 waiver but were rejected. 2007-Q1 is our omitted time period. 90% confidence intervals are based on wild-bootstrapped standard errors clustered around candidates. The rightmost figures plot the coefficient of the 2008-Q3 interaction term from Equation (2) as we vary the definition of the treatment group. Moving left to right in each figure, each specification involves a treated group composed of candidates from congressional districts with increasingly large gains in total IPPS payments in 2005 (based on quantities in 2003 and actual and counterfactual payment rates in 2005) due to the Section 508 program.

Figure A.5: The Impact of the Re-Authorization of the Section 508 Program on Campaign Contributions from All Donors Nationwide (Logged)

Campaign Contributions from All Donors Nationwide ($, 2010 Dollars)
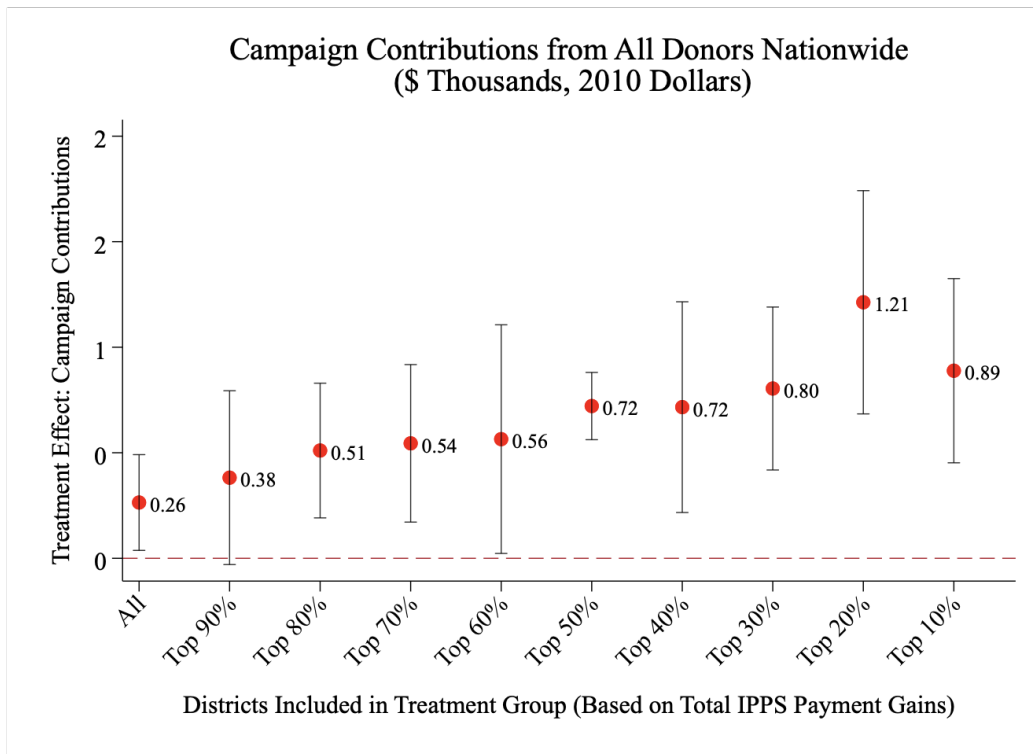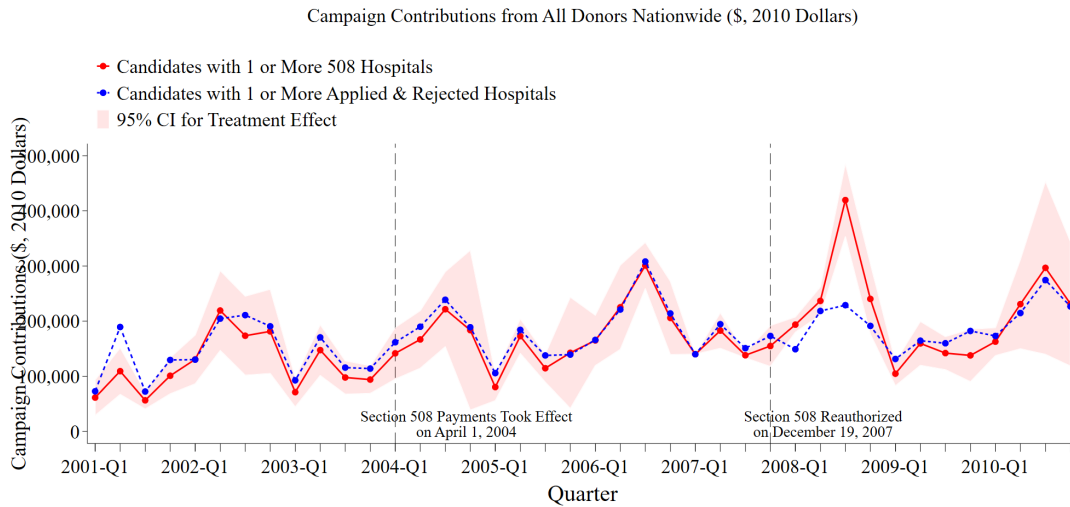
Notes: These figures present estimates of Equation (2) where we regress logged campaign contributions (in constant 2010 dollars) from all donors nationwide on a vector of candidate fixed effects, quarter dummies, and interactions between the treated candidate indicator and quarter dummies. Control candidates are those with one or more hospitals in their district that applied for a Section 508 waiver but were rejected. 2007-Q1 is our omitted time period. 95% confidence intervals are based on standard errors clustered around candidates. The bottom figure plots the coefficient of the 2008-Q3 interaction term from Equation (2) as we vary the definition of the treatment group. Each specification involves a treated group composed of candidates from congressional districts with increasingly large gains in total, predicted IPPS spending (based on quantities in 2003 and actual and counterfactual payment rates in 2005) due to the Section 508 program.

Figure A.6: The Impact of the Re-Authorization of the Section 508 Program on Campaign Contributions from All Donors Nationwide (Dose Responses)
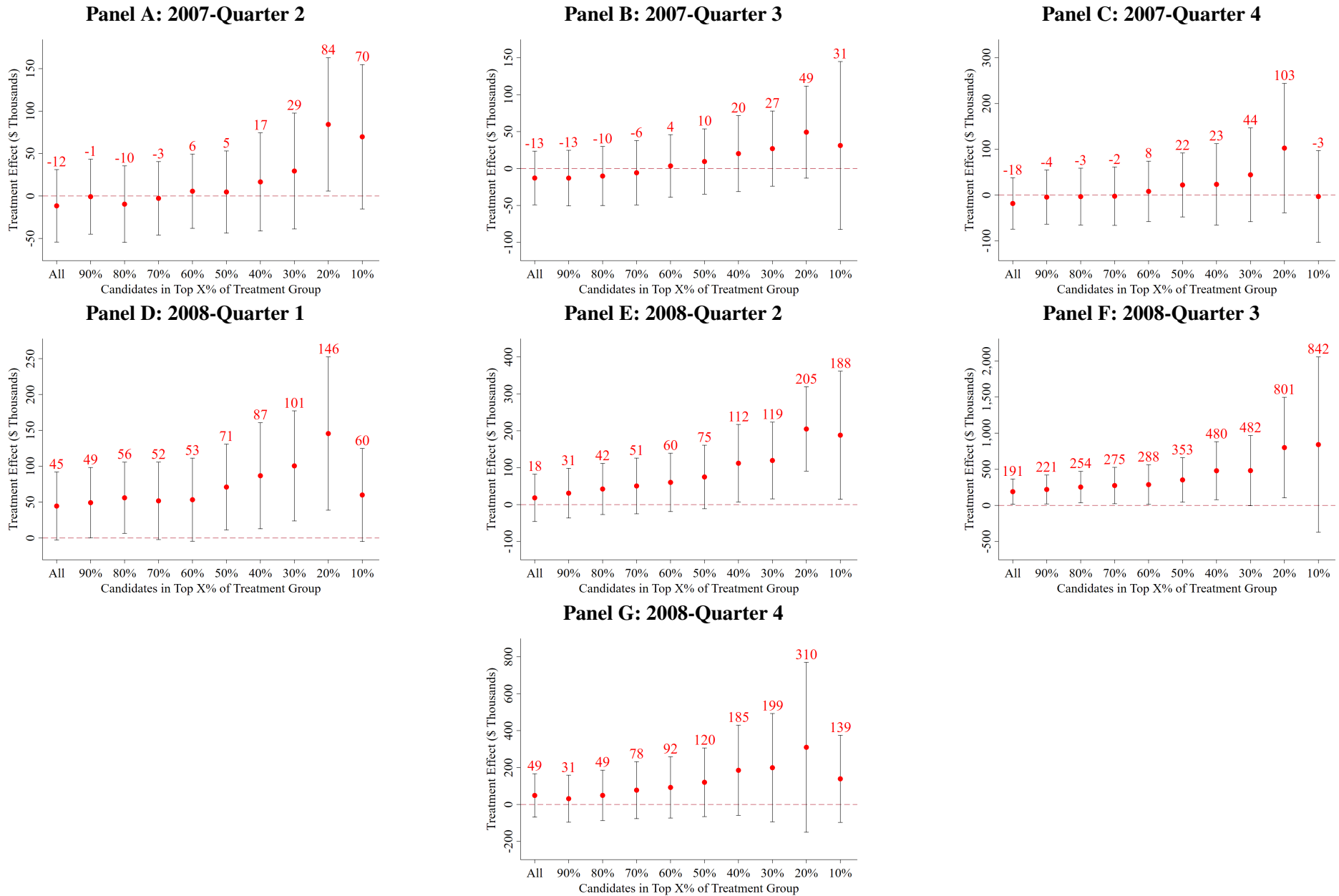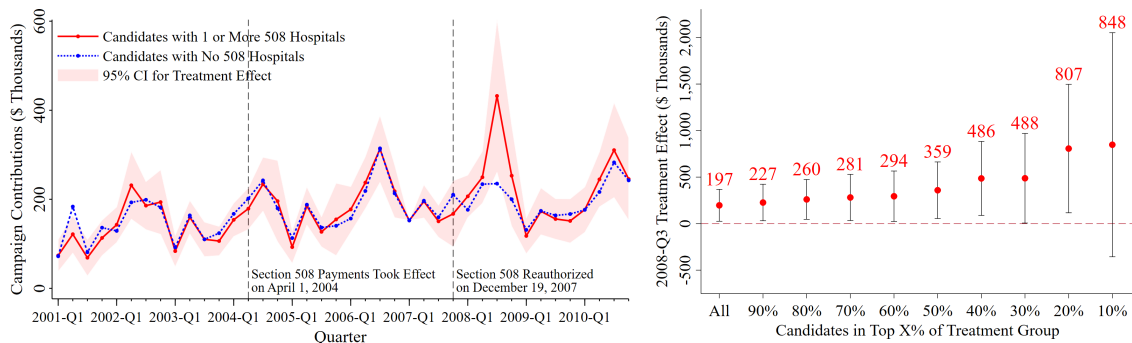

Notes: These figures plot the coefficient of the interactions between the treated candidate indicator and quarter dummies for all quarters in years 2007 and 2008 from Equation (2) as we vary the definition of the treatment group. Moving left to right in each figure, each specification involves a treated group composed of candidates from congressional districts with increasingly large gains in total IPPS payments in 2005 (based on quantities in 2003 and actual and counterfactual payment rates in 2005) due to the Section 508 program. Control candidates are those with one or more hospitals in their district that applied for a Section 508 waiver but were rejected. 2007-Q1 is our omitted time period. 95% confidence intervals are based on standard errors clustered around candidates. Campaign contributions are in thousands of constant 2010 dollars.

Figure A.7: The Impact of the Re-Authorization of the Section 508 Program on Campaign Contributions from All Donors Nationwide
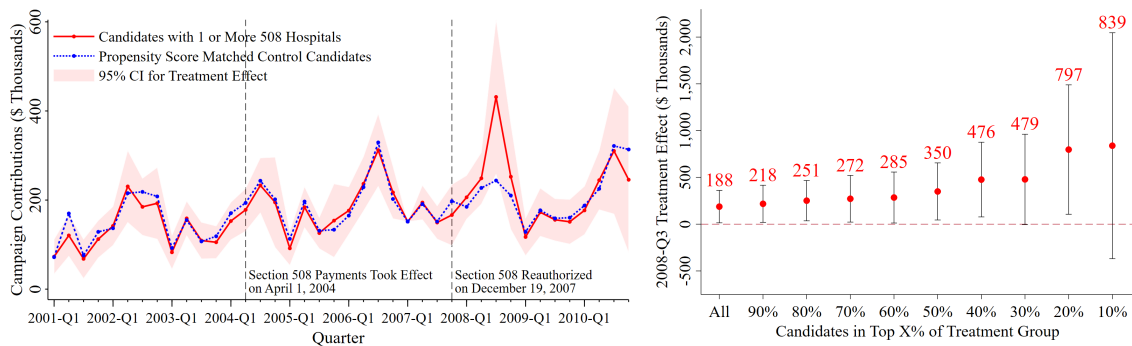
Panel A: Candidates in Office in 2007 (Control=Applied But Rejected)
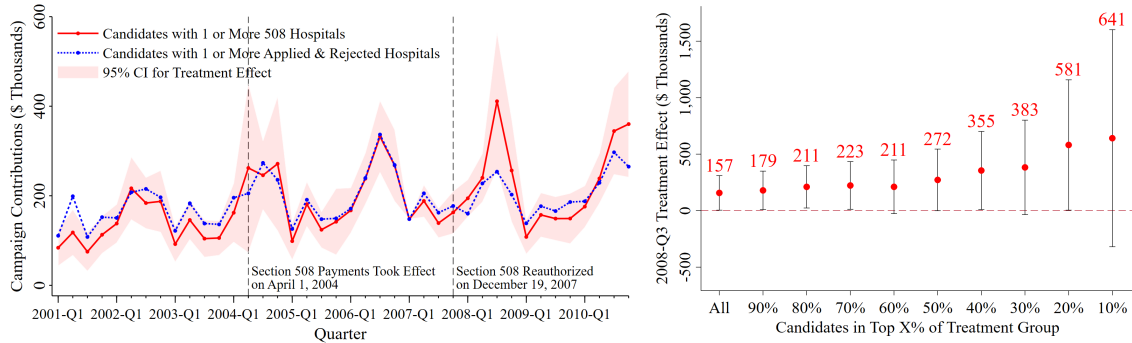
Panel B: Control=All Non-508 Candidates

Panel C: Control=Propensity Score Matched Candidates

Notes: These panels present estimates of Equation (2) where we regress campaign contributions from all donors nationwide (in thousands of constant 2010 dollars) on a vector of candidate fixed effects, quarter dummies, and interactions between the treated candidate indicator and quarter dummies. 2007-Q1 is our omitted time period. 95% confidence intervals are based on standard errors clustered around candidates. The rightmost figures plot the coefficient of the 2008-Q3 interaction term from Equation (2) as we vary the definition of the treatment group. Moving left to right in each figure, each specification involves a treated group composed of candidates from congressional districts with increasingly large gains in total IPPS payments in 2005 (based on quantities in 2003 and actual and counterfactual payment rates in 2005) due to the Section 508 program. Panel A relaxes the requirement that candidates are in office in both 2003 and 2007, and only requires candidates to be in office in 2007. Panels B to E change the control group to candidates with no Section 508-recipient hospitals in their district; candidates with one or more hospitals in their district that were eligible for a Section 508 waiver but didn't apply; candidates with one or more hospitals in their district that were ineligible for a Section 508 waiver; and candidates that are 10 nearest neighbors according to our probit model of propensity score matching, respectively.