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The Influence of Vested Interests on Healthcare Legislation in the USA, 2009–2010

Antoon Spithoven

Abstract: Collective lobbying organizations and some big companies acted as cautious partners in the design of the Affordable Care Act of the Obama Administration. In addition to being consulted by government executives, these entities intensively lobbied legislators. The qualitative and statistical analysis I conduct here shows a positive impact of healthcare lobbying. Collective lobbying organizations have a significant impact on lawmaking and complementary lobbying enhances their impact. However, not all (disjointed) lobbying is successful. Perspective-based distortion might explain why organizations lobby on issues against all odds of ever being effective.

Keywords: healthcare legislation, institutional design, lobbying

JEL Classification Codes: D02, D72, I18

Lobbying is deeply institutionalized in the United States. It is embedded in the first amendment of the Constitution, processed through Political Action Committees (PACs), and empowered by the Supreme Court's decision in *Citizens United v. Federal Election Commission*. Donations to PACs are facilitated by the Internal Revenue Service (Drew 2015). The Lobbying Disclosure Act of 1995 provides for the disclosure of lobbying activities.

Although President Barack Obama tried to curb lobbying practices (Spithoven 2011), he could not ignore the key healthcare reform lobbyists. They had to be appeased in order to avoid their potential activities toward undermining the reforms. Consultations, negotiations, compromises, and deals with collective lobbying organizations and Pfizer kept most of them on board (Emanuel 2014, 170;

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McDonough 2012, 76-78, 289). A side effect of this appeasement strategy is that it might have strengthened the culture of lobbying.

The prevalent empirical studies of the impact of lobbying are mainly focused on campaign donations. They provide mixed results. In addition to a qualitative study of lobbying by collective lobbying organizations in the healthcare sector, I analyze the impact of lobbying on Obamacare based on total spending for lobbying. My statistical analysis concerns an examination of lobbying by the collective lobbying organization Pharmaceutical Research and Manufacturers of America (PhRMA) and of complementary lobbying by disjointed organizations.

Empirical Research on the Relationship Between Lobbying and Healthcare Legislation

There are several meta-studies regarding the impact of campaign contributions on legislators' voting behavior (for example, Campos and Giavannoni 2007; Potters and Sloof 1996; Smith 1995; Wright 1990). These studies conclude that the existing literature gives mixed results. They ascribe these contradictory results to differences in the operationalization and research methods applied by scholars in the field.

The impact of lobbying is mainly analyzed by reducing lobbying efforts to campaign donations. The latter account for a marginal share of the total lobbying expenses (Richter, Samphantharak and Timmons 2008). Systematic empirical studies regarding the impact of the industries' total spending on lobbying are scarce (Bennedson and Feldman 2011). Total spending comprises the income of lobbyists and other expenses that industries incur to induce legislators to reciprocate. They do not include spending on advertising through which industries try to influence both public opinion and legislators' decision-making (McDonough 2012, 52, 57, 61, 76-78).

Theory on Lobbying

Lobbying is usually approached either through the perspective of exchange or through the perspective of persuasion. The former concerns "buying of votes," whereas the latter focuses on lobbyists as sources of information. A third theory approaches lobbying as the provision of information with the intention to subsidize strategically chosen legislators toward achieving objectives that are equal to those of the lobbyist (Hall and Deardorff 2006, 69).

All lobbying theories assume that lobbying is performed in order to serve certain interests. According to David Lowery (2007, 43, 53), these interests do not necessarily coincide with blocking, changing, or supporting legislation. Lobbyists may have multiple goals. For example, lobbying might be instrumental to one's survival, and strategic lobbying might explain that lobbyists follow legislators who shift committee assignments. Namely, it might be beneficial to lobby legislators who are assigned to committees dealing with issues other than those of main concern to the lobbyist. Regardless of their committee assignment, all Congresspersons have voting rights on all issues, including those that are important to a lobbyist.

It seems safe to assume that lobbying by commercial organizations and their collective lobbying organizations is instrumental in raising profits. The impact of lobbying depends on several variables. In addition to the amount of money spend on lobbying, the organization of a lobbying effort is another variable. Collective lobbying organizations might be assumed to communicate effectively on issues that are most important to a certain industry. This might strengthen by complementary lobbying, whether by disjointed commercial lobbying organizations or not. Also, sponsorship of a bill might be relevant to explaining the impact of lobbying. The lobbying of lawmakers as concerns bipartisan issues might be hypothesized to be more effective than lobbying in regard to partisan issues. The more partisan a bill, the less chance there is of influencing the vote of legislators from either party. Voting for partisan bills decreases the goodwill of the minority party.

With the exception of Lowery's (2007) multi-goal theory of lobbying, the theories on lobbying do not address the question why organizations lobby if lobbying seems at odds with their miniscule chances of success. Lowery's explanation might be supplemented with the theory of perspectivistic distortion (Reijnders 1988, 148). Perspectivistic distortion concerns decision-making under imperfect information, and occurs if one cannot differentiate the lobbying successes from their constituting factors. Because of imperfect information, one might easily overrate one's (complementary) influence over legislators or underrate the power of counteractive lobbying.

Research Design

My qualitative analysis of lobbying in regard to the Affordable Care Act (ACA 2010) focuses on collective organizations. Each organization represents a specific industry within the healthcare sector. I derive the successfulness of their lobbying by comparing their stance on industry-specific issues and the provisions of the Consumers Health Care Act of 2009 (S. 1278), the America's Healthy Future Act of 2009 (S. 1796), and the Patient Protection and Affordable Care Act (Public Law 111-148 & 111-152). If there is mixed information about the industry's position on a bill, I determine the stance of lobbyists by tentatively weighing the industry's pros and cons. If there is no information, I deduce it from the bill's plausible influence on profits.

My statistical analysis of the impact of lobbying concerns an inquiry of total lobbying expenses. I limit this analysis to the healthcare bills that are important for the pharmaceutical industry and were filed in 2009–2010. The analysis would become rather complicated by including other periods because the party composition of the U.S. Congress varies over time. I assume that the Congress party composition influences the drug industry lobbying. Namely, Republicans and Democrats differ in their stance on the governance of industries.

Because of multilinearity, colinearity, and perfect predictions, I limit the statistical analysis to eighteen pharmaceutical organizations that lobbied on issues, primarily directed at or heavily related to research and development, production, and

marketing or pricing of human medical drugs and vaccines. These core activities of the drug industry are addressed by legislators in 156 bills of the 111th Congress.

I calculate the lobbying expenses per bill for each organization through first dividing its total spending on lobbying by its total number of incidences of lobbying, and then through multiplying this result by the number of its incidences of lobbying per bill. This method smooths differences in lobbying intensities per bill. The equalization of lobbying intensities might have empirical relevance if legislators weigh an organization's lobbying per bill according to their total spending on lobbying. This weighing results in an upscaling of each organization's weak lobbying efforts and in downscaling of its strong lobbying efforts.

The institutional environment – that is, the healthcare bills – is the dependent variable in my analysis. The impact of lobbying on legislators' decision-making on bills is influenced by more variables than simply lobbying expenses. I assume that the outcome of lobbying is also influenced by sponsorship, cosponsorship, and partisanship of a bill. Sponsorship is about the party of the first sponsor. Cosponsorship concerns multiple sponsors. Partisanship pertains to the partisanship of cosponsors of a bill (Bierbooms 2012; Maas and Tindel 2011), as expressed by the equation:

$$R_{it} = \beta_0 + \beta_1 \cdot \log L_{ix} + \beta_2 \cdot S_i + \beta_3 \cdot CS_i + \beta_4 \cdot P_i$$

where R represents the regulatory environment, L is spending on lobbying, S is sponsorship, CS is cosponsorship, and P is partisanship. With the exclusion of L , all variables are binary variables. The suffixes i and x stand for the specific bill that is being lobbied on and the lobbying organization, respectively.

A Qualitative Analysis of Lobbying on Obamacare

Supported by several disjointed organizations, each industry within the healthcare sector lobbied through national political advocacy groups with the intention to influence legislators' decision-making. Some issues are clearly industry specific, whereas other issues are addressed by lobbyists from various industries. All healthcare industry advocacy groups supported the individual mandate and nearly all – except nurses – opposed the public option.

Lobbying by the PhRMA regarding the healthcare reform affected the following areas:

- The initially planned negotiation of prices of drugs was cancelled in exchange for its support of the reform (Hamburger 2009). This cancellation harms the balancing of Medicare prices against the comparative effectiveness of drugs (Brill 2015, 172) and, in combination with the legal stipulation that drugs are offered at their lowest rates to Medicaid, it causes U.S. patients to pay higher prices than patients in other countries (Jaffe 2015, 2128).
- The amendment to import drugs did not pass the U.S. Senate (Hamburger 2009; *Wall Street Journal* 2012, 16).

- The duration of the protection of profit promising biotechnical drugs is extended (Tumulty and Scherer 2009).
- The plan to bring generic drugs into the U.S. market more quickly has been largely abandoned, and the slow approval process could be speeded up by about four years (Jaffe 2015, 2128).

In exchange for these concessions, the drug industry has agreed to provide \$80 billion dollar worth of discounts over a ten-year period to Medicare D recipients, among others (McDonough 2012, 171).

Lobbying by the American Medical Association (AMA) affected several provisions in the Affordable Care Act. Examples include higher Medicare payment for “outlier” physicians, smaller reductions of Medicare enrollment fees for doctors (Maves 2009), and revoking the public option. According to AMA, the public option would push private insurers out of the market and consequently restrict a patient’s choice. The best deal it achieved was the fact that physicians do not have to pay for the reform in terms of reimbursement cuts. The House leaders promised to address the Medicare sustainable growth rate in separate legislation. It was not until June 2015 that they eventually did so with the adoption of Public Law No. 114-10. However, not all has been positive. The reform included only evaluations of alternatives to tort litigation (Brill 2015, 154; Emanuel 2014, 172; McDonough 2012, 175) and initiated the accountable-care organizations as well as the physician-quality reporting which AMA opposed.

A positive outcome of lobbying by the American Hospital Association (AHA) was the expansion of Medicaid eligibility, the temporary removal of Medicare hospital payment from the mandate of the Independent Payment Advisory Board (IPAB) (Brill 2015, 171), the expansion of the 340B program to buy cancer drugs at a discount and to allow hospitals to bill for the full cost, and the elimination of the public option. A negative outcome of the reform for hospitals pertained to Medicare spending reductions after 2019 (when these reductions will come into effect), penalties on readmissions, and bundled payments (Brill 2015, 130; Eggen 2009).

The U.S. Health Insurance Plans (AHIP) lobbying results, on balance, are much more disputable than those of PhRMA and AMA. AHIP engaged in some activities, the harmful impact of which far outweighed the negative consequences of the legal reforms for AHIP (McDonough 2012, 169). This took place notwithstanding the provisions already incorporated in the law, such as the individual mandate, the safety net offered by the employer mandate, along with changes in the law such as revoking the public option (Terhurne and Epstein 2009). The harming issues, among other things, are the 3:1 (instead of the 5:1) aging band, the excise tax on the insurance industry, the broad essential benefit package, the Medical loss ratio, the insurance premium rate review, and the ban of Medicare advantage plans.

For its part, the American Nurses Association (ANA) (ANA 2010) listed thirty-seven issues that it endorsed, including its successful lobbying for the strengthening of nursing and primary care. Thus, the Affordable Care Act increases funding for the National Health Service Corps, explicitly ensuring that midwifery education programs

are eligible for grants. Also, the Act declares that future amounts of the nurse faculty loans will become adjusted to provide for cost-of-attendance increases, and it expands the Nursing Workforce Diversity grant program. However, not all desires of ANA's Health System Reform Agenda of 2008 were fulfilled. The Affordable Care Act does not provide healthcare as a human right, excludes undocumented immigrants, does not include a single-payer option, and does not provide for public funding through Medicare expansion based on payroll taxes.

Ultimately, although lobbying by collective organizations and their allied advocacy groups produced mixed results, it was altogether successful (perhaps with the exception of AHIP). This might explain why the lobbying entities largely abstained from undermining the healthcare reforms, with PhRMA even supporting the reform in an advertising campaign (McDonough 2012, 76).

Probit Regression Analysis of Healthcare Lobbying by Drug Manufacturers

The probit analysis gives significant results only for PhRMA. When the analysis is split into partisan and bipartisan cosponsored bills, the significant PhRMA coefficients are higher for the latter. The analysis also shows that complementary lobbying improves the impact of collective lobbying – the significant Pseudo R^2 rises with every lobbying organization (see Table 1).

About 50 percent of PhRMA's members are also lobbying for themselves. They are assumed to be aware of the value of complementary lobbying. In addition, about half of the pharmaceutical organizations lobbying on bills that are important for the drug industry are not organized through PhRMA. Instead of "free-riding," they opt for lobbying. The disjointed organizations that lobbied in vain, along with the unproductive lobbying of collective organizations on specific issues, might be qualified as lobbying that is most subject to perspectivistic distortion.

Conclusion and Discussion

One of the lessons of the 1993–1994 healthcare reform debate is that it is important to include key stakeholders. In line with this lesson, collective lobbying organizations and some big companies acted as cautious partners in the design of Obamacare.

My qualitative study is limited to collective organizations within the healthcare industry. These entities received concessions in the form of specific deals and amendments to the reform bill. Additionally, complementary lobbying contributed to the successes of pharmaceutical companies' lobbying. For example, complementary lobbying can be credited for being the decisive factor in revoking the public option.

My statistical analysis is limited to drug organizations that lobby on issues in which they have a relatively high stake. I obtain a positive result for lobbying by PhRMA. My analysis also shows that complementary lobbying results into a higher impact of collective lobbying, especially with regard to bipartisan bills. However, these statistical results might be biased. First, the positive impact of lobbying might be the result of a spending bias. Spending on lobbying by the pharmaceutical industry was

highest during the 111th U.S. Congress. Second, one can argue that the estimated spending per bill is not a good indicator because the weighing according to organization's total spending on lobbying does not perfectly smooth differences in lobbying intensity. But it is the best I have.

Table 1. Probit Analysis of Lobbying Expenses for Bipartisan Cosponsored Bills and the Institutional Environment in the 111th Congress of the USA, for Different Sets of Pharmaceutical Organizations with Sponsorship as Control Variable***

Organizations*	Name of organization	Pseudo R ²	Prob.>chi ²	PhRMA coefficient	P> z
0**		0.0023	0.6307		
1	The PhRMA	0.2061	0.0001	0.2844794	0.000
2	+ Pfizer	0.2070	0.0003	0.3003131	0.001
3	+ Amgen Inc.	0.2080	0.0002	0.2957586	0.001
4	+ Eli Lilly & Co	0.2084	0.0019	0.2867759	0.005
5	+ Merck & Co	0.2182	0.0028	0.2923175	0.006
6	+ GlaxoSmithKline	0.2222	0.0049	0.2862179	0.007
7	+ Novartis AG	0.2393	0.0051	0.3091762	0.004
8	+ Bayer AG	0.3459	0.0002	0.3183469	0.006
9	+ AstraZeneca PLC	0.3581	0.0003	0.3352720	0.004
10	+ Abbott Laboratories	0.3617	0.0005	0.3291727	0.005
11	+ Bristol-Myers Squibb	0.3623	0.0009	0.3328992	0.005
12	+ Teva Pharmaceutical Ind.	0.3682	0.0014	0.3413009	0.004
13	+ Consumer Health Products	0.3839	0.0014	0.3541984	0.003
14	+ Generic Pharmaceutical Assn.	0.3990	0.0015	0.3367910	0.006
15	+ Mylan Inc.	0.3992	0.0025	0.3376873	0.006
16	+ Takeda Pharmaceutical Co	0.4474	0.0010	0.3382840	0.006
17	+ Apotex Inc.	0.4558	0.0012	0.3239886	0.010
18	+ King Pharmaceuticals	0.4558	0.0020	0.3233553	0.012

Source: Author's calculation based on data published by CRP (n.d.) and Tauberer (n.d.).

Notes: *The cumulative number of organizations are arranged from high to low spending on lobbying; **the coefficients for the control variable sponsorship vary a bit each time another private firm is added to the analysis; ***the control variable partisanship is omitted due to its statistical dependency on other independent variables.

The lobbying successes seem to have outbalanced the failures. This might explain why the collective lobbying organizations within the healthcare industry, with the exception of AHIP, abstained from activities that would have undermined the reforms. In fact, the key pharmaceutical organizations stayed on board with the reforms.

From a strategic perspective, a seemingly unsuccessful lobbying regarding marginal issues may turn out to be a success, because it ultimately aided lobbying regarding main issues. However, the failure of lobbying regarding specific issues might also be due to underestimating counteractive lobbying – that is, perspectivistic distortion. The latter also may explain lobbying by disjointed organizations, even if such a lobbying was unlikely to be successful.

The strategy of the White House and legislators to keep main stakeholders on board was successful, but the price they paid was high. The Democrats had to revoke

the public option, and they had to undergo consultations, negotiations, compromises, and deals with lobbying organizations. An additional cost was that the give-ins may have strengthened the idea that lawmakers are sensitive to lobbying, thereby enhancing the lobbying culture.

Although lobbying is a right in the United States, one may argue that democracy does not always benefit from lobbying. Even though advocacy groups like the Health Care for America Now are also heard, socio-economic minorities are at a disadvantage in getting access to legislators as they are not well organized and cannot afford the high cost of lobbying. This status quo skews decision-making in favor of vested interests.

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