

*Vested interest's influence over Health Care Legislation in the United States in 2009-2010*

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*Collective lobbying organizations and some big companies showed up as sparring partners in the design of the Affordable Care Act. In addition of being consulted by executives, they intensively lobbied on legislators. My qualitative as well as my statistical analysis show a positive impact of health care lobbying. Collective lobbying organizations have a (statistical) significant impact on lawmaking and complementary lobbying enhances their impact. However, not all (disjointed) lobbying is successful. Perspectivistic distortion might explain that organizations lobby on issues against all odds ever being effective.*

**Keywords:** institutional design, lobbying, health care legislation.

**JEL Classification Codes:** D02, D72, I18

Lobbying is deeply institutionalized in the United States of America. 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 health care reform lobbyists. They had to be appeased in order to avoid probable reform-undermining activities. Consultations, negotiations, compromises and deals with collective lobbying organizations and Pfizer kept most of them on board. (McDonough 2012, 76-78, 289; Emanuel 2014, 170) 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 upon campaign donations. They give mixed results. In addition to a qualitative study of lobbying by collective lobbying organizations in the health sector, I analyze the impact on Obamacare of lobbying on the basis of total spending on lobbying. This statistical analysis concerns an analysis of lobbying by the collective lobbying organization Pharmaceutical Research & Manufacturers of America (PhRMA) and an analysis of complementary lobbying by disjointed organizations.

### **Empirical research of the relation between lobbying and health care legislation**

There exist several meta-studies of the impact of campaign contributions on legislators' voting behavior. (For example, Wright 1990; Smith 1995; Potters and Sloof 1996, and; Campos and Giavannoni 2007) The authors of these studies conclude that the separate studies give mixed results. They ascribe the 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 total lobbying expenses. (Richter, Samphantharak and Timmons 2008) Systematic empirical studies regarding the impact of manufacturers' total spending on lobbying are scarce. (Benedson and Feldman 2011) Total

spending comprises income of lobbyists and other expenses that they incur to induce legislators to reciprocate. It is exclusive spending on advertising.

### **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 to achieve objectives which 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 multi-goals. For example, lobbying might be instrumental to one’s survival or strategic lobbying might explain that lobbyists follow legislators who shift committee assignments. Namely, it might be beneficial to lobby on legislators who are assigned to committees dealing with issues other than those of main concern of the lobbyist. Regardless their committee assignment, all Congressmen have voting rights on all issues including those that are important for the lobbyist.

It seems safe to assume that lobbying by commercial organizations and their collective lobbying organizations is eventually 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 lobbying is one of them. Collective lobbying organizations might be assumed to communicate effectively on issues that are most important for a certain industry. This might become strengthened by complementary lobbying, whether or not by disjointed commercial

lobbying organizations. Also sponsorship of a bill might be relevant for explaining the impact of lobbying. Lobbying on lawmakers concerning bipartisan issues might be hypothesized to be more effective than lobbying concerning partisan issues: Namely, the more partisan a bill is, the lower is the chance to influence voting by legislators from both parties. Voting for partisan bills decreases the goodwill of the minority party.

With the exception of Lowery's (2005) multi-goal theory of lobbying, the theories on lobbying do not address the question why organizations lobby if lobbying seems at odds with their ever being successful. 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 to their constituting factors. Because of imperfect information, one might easily overrate one's (complementary) influence upon legislators or underrate the power of counteractive lobbying.

### **Research design**

My qualitative analysis of lobbying upon the *Affordable Care Act* (ACA, 2010) is focused upon collective organizations. Each organization represents a specific industry within the health sector. I derive the successfulness of their lobbying from comparing their stance on industry specific issues with the difference(s) in provisions between the draft and the final bill. I assume lobbying is successful if a change in a bill's provision(s) coincides with a desired change. 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 upon profits.

My statistical analysis of the impact of lobbying concerns an inquiry of total lobbying expenses. I limit this analysis to the health care bills that are important for the pharmaceutical industry and which are filed in 2009-2010. The analysis would become rather complicated by including other periods because the party composition of the US Congresses vary over time. I assume that the party composition influences lobbying by the drug industry. Namely, Republicans and Liberals differ in their stance to the governance of industries.

Because of multi-linearity, co-linearity and perfect predictions, I limit the statistical analysis to eighteen pharmaceutical organizations that lobbied on issues that are primarily directed at or heavily related to Research and Development, production, marketing or pricing of human medical drugs and human vaccines. These core activities of the drug industry are addressed by legislators in 156 bills in the 111<sup>th</sup> Congress.

I calculate for each organization the lobbying expenses per bill through, first, dividing its total spending on lobbying by its total number of incidences of lobbying, and, second, 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 for each organization in an upscaling of its weak and in a downscaling of its strong lobbying efforts.

The institutional environment—that is, the health care bills—is the dependent variable in my analysis. The impact of lobbying on legislators' decision making on bills is influenced by more variables than lobbying expenses. I assume that the outcome of lobbying is also influenced by: sponsorship, co-sponsorship, and partisanship of a bill. Sponsorship is about the party of the first sponsor. Co-sponsorship concerns multiple sponsors. Partisanship concerns same partisanship of co-sponsors of a bill. (Maas and Tindel 2011; Bierbooms 2012) See Equation 1.

$$R_{it} = \beta_0 + \beta_1 \cdot \log L_{ix} + \beta_2 \cdot S_i + \beta_3 \cdot CS_i + \beta_4 \cdot P_i \quad [\text{Equation 1}]$$

In Equation 1, the symbol R represents the regulatory environment, L denotes spending on lobbying, S embodies sponsorship, CS means co-sponsorship, and P symbolizes partisanship. With the exclusion of L, all variables are binary variables. Finally, the suffix i stands for the specific bill that is lobbied upon and the suffix x denotes the lobbying organization.

### **A qualitative analysis of lobbying on Obamacare**

Supported by several disjointed organizations, each industry within the health sector lobbied through national political advocacy groups with the intention to influence legislator's decision making. Some issues are clearly industry specific, whereas other issues are addressed by lobbyists from different industries. All health industry advocacy groups supported the individual mandate and all, with the exclusion of the nurses, opposed the public option.

Lobbying by the PhRMA regarding the health care reform affected the following:

- 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 effectuates, in combination with the law that drugs are offered at their lowest rates to Medicaid, that patients pay higher prices than patients in other countries; (Jaffe 2015, 2128)
- The amendment to provide for importation of drugs did not pass the Senate; (the Wall Street Journal 2012, 16; Hamburger 2009)

- The duration of the protection of profit promising biotechnical drugs is lengthened; (Tumulty and Scherer 2009)
- The plan to bring generic drugs to the market more quickly is omitted, whereas the approval process could be speeded up by about four years. (Jaffe 2015, 2128)

In exchange for these successes, the drug industry agreed to provide eighty billion dollar worth of discounts over ten years to, among others, Medicare D recipients. (McDonough 2012, 171)

Lobbying by the American Medical Association (AMA) affected several provisions in the ACA. Examples of its successes are higher Medicare payment for “outlier” physicians, smaller reductions of Medicare enrollment fees for doctors, (Maves 2009) and the revoke of the public option. According to the AMA, the public option would push out private insurers of the market and consequently restrict patient’s choice. The best deal it achieved is that physicians do not have to pay for the reform in terms of reimbursement cuts. However, it is not all roses. The Medicare Sustainable Growth Rate is promised by House leaders to become addressed in separate legislation. The promise is eventually redeemed in Public Law No: 114-10. Additionally, the reform includes only evaluations of alternatives to tort litigation, (McDonough 2012, 175; Emanuel 2014, 172; Brill 2015, 154) and includes Accountable Care Organizations and the Physician Quality Reporting Initiative that the AMA opposed.

The positive outcome of lobbying by the American Hospital Association is the expansion of Medicaid eligibility, the temporary exclusion of the Medicare hospital payment from the purview of the Independent Payment Advisory Board (IPAB), (Brill 2015, 171) the expansion of the 340B program to buy cancer drugs at a discount and allowing hospitals to bill for the full cost, and the elimination of the public option. The negative outcome of the reform

for hospitals is the Medicare reductions, (McDonough 2012, 77 + 165-166) the penalties on readmissions and bundled payments, (Brill 2015, 130) and the IPAB after 2019. (Eggen 2009)

The America's Health Insurance Plans (AHIP) lobbying results are on balance much more disputable than those for the PhRMA and the AMA. Eventually, the AHIP decided to take up some opposing activities, (McDonough 2012, 169) notwithstanding that the initial incorporated provisions in the law, such as, the individual mandate and the safety net offered by the employer mandate, together with changes in the law such as the revoke of the public option might outbalance the harming provisions for the insurers. (Terhurne and Epstein 2009) The harming issues are, among other things: the 3:1 instead of a 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.

Finally, the American Nurses Association (2010) (ANA) listed thirty-seven issues that they endorsed. It successfully addressed the strengthening of nursing and primary care. For example, the ACA: increases funding for the National Health Service Corps, explicitly ensures that midwifery education programs are eligible for grants, declares that future amounts of the Nurse faculty loans will become adjusted to provide for cost-of-attendance increase, and expands the Nursing Workforce Diversity grant program. However, not all desires in the ANA's *Health System Reform Agenda* of 2008 are fulfilled. The ACA does not provide health care as a human right, does not include undocumented immigrants, does not include a single-payer option, and does not provide for public funding through Medicare expansion based upon payroll taxes.

Lobbying by collective organizations, together with their allied advocacy groups, gave mixed results but was, with the exception of probable the AHIP, on balance successful. This

might explain that they abstained from reform-undermining activities. PhRMA even supported the reform in an advertising campaign. (McDonough 2012, 76)

### **Probit regression analysis of health care lobbying by drug manufacturers**

The probit analysis gives only significant results for the PhRMA. If the analysis is split into partisan and bipartisan co-sponsored 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 R2 rises with every lobbying organization. (See Table 1).

INSERT TABLE 1 ABOUT HERE

The bipartisan bills in my data file also include the Health Care Reform Bill (H.R. 3590). Thirty-seven Democrats and three Republicans co-sponsored this initial Obamacare bill. If the analysis for the bipartisan bills is corrected for bill H.R. 3590 then the coefficients for the PhRMA in Table 1 become only marginally lower.

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

## Conclusion and discussion

One of the lessons of the 1993-1994 health reform debate is that it is important to include key stakeholders. In line with this lesson, collective lobbying organizations and some big companies showed up as sparring partners in the design of Obamacare.

My qualitative study is limited to collective organizations within the health industry. They enforced some concessions in the form of specific deals and amendments to the reform bill. Additionally, complementary lobbying contributed to the successes of lobbying. For example, complementary lobbying might be credited with being the decisive factor to revoke the public option.

My statistical analysis is limited to drug organizations that lobby upon lawmakers concerning issues in which they have a relative high stake. It gives a positive result for lobbying by the PhRMA, even if Obamacare lobbying is eliminated from the analysis. The analysis also shows that complementary lobbying results into a higher impact of collective lobbying especially with regard to bipartisan bills. However, the statistical results might be biased. First, the positive impact of lobbying might be the result of a spending bias. Spending upon lobbying by the pharmaceutical industry was highest during the 111<sup>th</sup> Congress. Second, one might argue that the estimated spending per bill is not a good indicator because its weighing according to organization's total spending on lobbying does not perfectly smooth differences in lobbying intensity. But it is the best I have.

The lobbying successes seem to have outbalanced the failures. This might explain that the collective lobbying organizations within the health care industry, with the exception of the AHIP, abstained from reform-undermining activities. The key organizations stayed on board of the reform.

From a strategical perspective, apparent unsuccessful lobbying regarding marginal issues might turn out to be a success, because it aids lobbying regarding main issues. However, the failure of lobbying regarding specific issues might also be due to underestimated counteractive lobbying—that is, perspectivistic distortion. The latter also might explain lobbying by disjointed organizations even if lobbying seems at odds with their ever being successful.

The strategy of the White House and legislators to keep main stakeholders on board was successful but it is performed at a high price: The liberals had to pay, first, in the form of the revoke of the public option and, second, in the form of consultations, negotiations, compromises, and deals with lobbying organizations. A third price they had to pay was that the latter might have strengthened the idea that lawmakers are sensitive to lobbying and, as such, it might have fed the lobbying culture.

Although lobbying is a right in the United States, one may argue that democracy is not always favored by lobbying. Namely, notwithstanding that advocacy groups like the Health Care for America Now are also heard, socio-economic minorities are in a disadvantage to get access to legislators if they are badly organized and cannot afford themselves high lobbying expenditures. This might bias decision making in favor of vested interests.

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## *References*

- ACA. *Patient Protection and Affordable Care Act*, Bill of the House of Representatives (H.R. 3590), introduced September 17, 2009, became Public Law No:111-148, March 23, 2010.
- American Nurses Association. "ANA Policy & Provisions of Health Reform Law April 27, 2010," [2010] <http://www.nursingworld.org/>. Accessed, July 9<sup>th</sup>, 2014.
- Bennedsen, Morten and Sven E. Feldmann. "Lobbying Legislatures." *Journal of Political Economy* 110, 4 (2002): 919-46.
- Bierbooms, Bas. *How Lobbying Influences the U.S. Congress*, Master thesis, Utrecht University School of Economics, 2012.
- Brill, Steven. *America's Bitter Pill*. New York: random House, 2015.
- Campos, Nauro F. and Francesco Giovannoni. "Lobbying, Corruption and Political Influence." *Public Choice* 131, 1-2 (2007):1-21.
- Center for Responsive Politics. "Influence & Lobbying," <http://www.opensecrets.org>. Accessed March 2014.
- Drew, Elizabeth. "How Money Runs Our Politics." *New York Review of Books* 62, 10 (2015).

Eggen, Dan. "Hospital Lobbyists Try to Minimize Damage." *The Washington Post*, July 25, 2009.

Emanuel, Ezekiel J. *Reinventing American Health Care*. New York:Public Affairs, 2014.

Hall, Richard L. and Alan V. Deardorff. "Lobbying as Legislative Subsidy." *The American Political Science Review* 100, 1 (2006): 69-84.

Hamburger, Tom. "Obama Gives Powerful Drug Lobby a Seat at Healthcare Table." *Los Angeles Times*, August 4, 2009.

Jaffe, Susan. USA grapples with high drug costs. *The Lancet* 386 (2015): 2127-2128.

Lowery, David. "Why Do Organized Interests Lobby? A Multi-Goal, Multi-Context Theory of Lobbying." *Polity* 39, 1 (2007): 29-54.

Maas, Thomas and John Tindel. "Rent-seeking and Lobbying in the Pharmaceutical Market; A Comparative Study of the US and Canada." bachelor thesis, Utrecht University School of Economics, [2011].

Maves, Michael D. (the Executive Vice President of the AMA). AMA letter to Senate Majority Leader Harry Reid on Senate Health System Reform Bill, December 1, 2009.

McDonough, John E. *Inside National Health Reform*, first paperback edition (University of California Press, Berkeley, Los Angeles, London), 2012.

Potters, Jan and Randolph Sloof. "Interest Groups: A Survey of Empirical Models that Try to Assess Their Influence." *European Journal of Political Economy* 12, 3 (1996): 404-442.

Reijnders, Jan P. G. *The Enigma of Long Waves*. PhD thesis University of Groningen, 1988.

Richter, Brian Kelleher, Krislert Samphantharak and Jeffrey F. Timmons. "Lobbying and Taxes." *American Journal of Political Science* 53, 4 (2008): 893-909.

Smith Richard A. "Interest Group Influence in the U.S. Congress." *Legislative Studies Quarterly* 20, 1 (1995): 89-138. White House Forum on Health Reform

Spithoven, Antoon. "It's the Institutions, Stupid! Why U.S. Health Care Expenditure Is so Different from Canada's." *Journal of Economic Issues* 54,1 (2011): 75-95.

Terhurne, Chad and Keith Epstein. "The Health Insurers Have Already Won." *Bloomberg Businessweek Magazine* August 6, 2009.

Tumulty, Karen and Michael Scherer. "How Drug-Industry Lobbyists Won on Health-Care." *Time*, October 22, 2009.

Wall Street Journal (European Edition). "ObamaCare's Secret History; How a Pfizer CEO and Big Pharma Colluded With the White House at the Public's Expense." June 13 2012.

Wright, John R. "Contributions, Lobbying, and Committee Voting in the U.S. House of Representatives." *The American Political Science Review* 84, 2 (1990): 417-438.

Table 1: Probit analysis of lobbying expenses for bipartisan co-sponsored bills and the institutional environment in the 111<sup>th</sup> Congress of the USA, for different sets of pharmaceutical organizations with sponsorship as control variable\*\*\*.

Organi- zations*	Name of the organization(s)	Pseudo R2	Prob > chi2	The PhRMA coefficient	P> z
0**		0.0018	0.6711		
1	The PhRMA	0.2155	0.0000	0.2887022	0.000
2	+ Pfizer	0.2163	0.0002	0.3035765	0.001
3	+ Amgen Inc	0.2179	0.0005	0.2972402	0.001
4	+ Eli Lilly & Co	0.2183	0.0011	0.2870458	0.005
5	+ Merck & Co	0.2285	0.0017	0.2926615	0.006
6	+ GlaxoSmithKline	0.2337	0.0030	0.2863425	0.007
7	+ Novartis AG	0.2491	0.0032	0.3086631	0.004

8	+ Bayer AG	0.3535	0.0001	0.3181036	0.006
9	+ AstraZeneca PLC	0.3656	0.0002	0.3350790	0.004
10	+ Abbott Laboratories	0.3688	0.0003	0.3288793	0.005
11	+ Bristol-Myers Squibb	0.3694	0.0006	0.3324473	0.005
12	+ Teva Pharmaceutical Ind.	0.3759	0.0009	0.3413489	0.004
13	+ Consumer Health Products	0.3926	0.0009	0.3542589	0.003
14	+ Generic Pharmaceutical Assn	0.4075	0.0010	0.3368109	0.006
15	+ Mylan Inc	0.4077	0.0016	0.3377019	0.006
16	+ Takeda Pharmaceutical Co	0.4552	0.0006	0.3382961	0.006
17	+ Apotex Inc	0.4635	0.0008	0.3240143	0.010
18	+ King Pharmaceuticals	0.4635	0.0013	0.3233809	0.012

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Legend \*= 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 statistically dependency of other independent variables.

Source: author's calculation based upon data published by the Center for Responsive Politics, "Influence & Lobbying." and <http://www.govtrackus>.