Winning the Battles, Losing the War:
Business Power and the Case of the American Pharmaceutical Industry

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If you were looking for a single person who best embodied the concept of the revolving-door politician, you would have to look no further than Billy Tauzin. Tauzin, a Louisiana native whose many years in Washington have still not fully covered up his Southern drawl, was first elected to Congress as a Democrat in a 1980 special election. He was one of the most conservative Democratic members of Congress throughout the 1980s and early 1990s, and helped found the House Blue Dog Coalition in 1995.[1] That August, claiming that "conservatives were unwelcome" in the Democratic Party, Tauzin moved across the aisle and became a Republican.[2] He went on to serve for another ten years in office, including two terms as chair of the House Energy and Commerce Committee – the House committee with jurisdiction over drug safety, among other policy issues – before retiring from Congress in 2005 and taking a job the next day as president and CEO of the Pharmaceutical Research and Manufacturers of America, the drug industry group better known as PhRMA (pronounced FARM-uh).[3] One of the most powerful special interests in Washington, PhRMA had long favored congressional Republicans in both their campaign contributions and public statements, and Tauzin fit right into the mold.[4]

Therefore, it was surprising to see Tauzin on CNBC's *Squawk Box* on March 4, 2009, touting the benefits of recently-elected President Obama's health care reform plan. Speaking with CNBC's pharmaceuticals reporter, Mike Huckman, Tauzin stated that PhRMA "very much support[s] health care reform," calling it a "very optimistic plan that's going to keep our companies working and producing great medicines."[5] Huckman, who could barely believe what he was hearing, asked Tauzin another two times to clarify what he was saying. Tauzin confirmed

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[1] In fact, Tauzin gave the Blue Dogs their name, distinguishing the group as "a little more discriminatin', more open-minded" (Safire).
[2] "Louisiana Congressman Tauzin Switches Parties"
[3] Welch
[4] Morgan and Campbell 138
[5] Tauzin

once again that the health reform plan is "a great win for American patients, for our companies, and for the U.S. economy."

This episode, coming the day before the Obama administration's first White House health care summit, signaled PhRMA's new stance on health care reform – a significantly more conciliatory stance than they had ever taken before. PhRMA went on to make a secret deal with the White House, trading $80 billion in cost savings and their massive advertising war chest in exchange for protection from several key policies that had long been priorities of progressive Democrats, policies which Obama himself had promised during his presidential campaign.[6] But what made PhRMA cut a deal? Why, after years of speaking out forcefully against government regulation in the prescription drug market, was PhRMA first in line to get on the administration's side in a process that was guaranteed to bring more regulation to the health sector of the economy? Most importantly, what from PhRMA's history brought them to this point? These questions provide the impetus for my research.

Over the course of this paper, I study the evolution of the pharmaceutical industry's political power, from the Medicare Catastrophic Care Act of 1988 to the Patient Protection and Affordable Care Act of 2009. I examine in close detail the key political battles over the past twenty years and inspect the industry's influence through the lens of strategic goals and preferences, structural and instrumental power, and political uncertainty and insulated bureaucracy. I find that the pharmaceutical industry is less dominant and more dependent on government than popularly believed, due largely to its weak structural power and inability to lock in its preferred policies. This conclusion has important ramifications in two areas: the conception of the drug industry as a political force and the study of business power in American

[6] Blumenthal

politics. From the former, we can conclude that PhRMA may, in the future, be more forthcoming and willing to work with, rather than against, government. From the latter, we can draw that business power as commonly understood is not uniform among all types of business, a theory heretofore unstudied.

This paper will be divided into four chapters. The first will address the common perceptions of the pharmaceutical industry's power, the theory behind those views, and how general opinion on PhRMA is largely misbegotten. The next will delve into the political history of the Medicare drug benefit and the lobbying history of PhRMA, going back to the ill-fated Medicare Catastrophic Coverage Act of 1988. The third chapter will apply the theories discussed in the first chapter to the story told in the second. The paper will conclude in the fourth chapter by addressing the lessons that we can draw from this story.

Chapter I: Theories and Common Misconceptions

The pharmaceutical industry is considered a "leviathan" in Washington, viewed with a mix of fear and respect for its ability to influence lawmakers and shape policy.[7] The industry's main lobbying arm is the Pharmaceutical Research and Manufacturers of America, or PhRMA, a trade group that was originally founded as the Pharmaceutical Manufacturers Association (PMA) in 1958.[8] Representing 48 of the nation's largest pharmaceutical companies, PhRMA lobbies on behalf of "broad patient access," "strong intellectual property incentives," and "transparent, efficient regulation."[9] In practice, however, these principles have found PhRMA fighting against

[7] Carpenter 306

[8] Throughout the paper, I will use the terms "PhRMA," "drug industry," and "pharmaceutical industry" interchangeably. Technically PhRMA is the trade group that represents the drug industry, but for our purposes I will use PhRMA synecdochally unless explicitly noted otherwise.

[9] Pharmaceutical Research and Manufacturers of America ("About PhRMA")

government regulation and generic drugs. In the process, it has become one of the most powerful interest groups on Capitol Hill, annually among the top ten highest spending lobbies.[10]

PhRMA's aggressive spending has given it an outsized reputation. This reputation has, in turn, given rise to misconceptions about the industry that this paper seeks to address. The first is the idea that PhRMA's hefty lobbying budget leads to direct influence over the legislative process. For instance, shortly after Tauzin's deal with the Obama administration was revealed, *Time* published an article titled "How Drug Industry Lobbyists Got Their Way on Health Care."[11] The article detailed PhRMA's victory, due largely to its heavy lobbying, on a pivotal vote during health care reform – the defeat of a proposal that would have repealed one of the industry's pet policies. As one economist recalled, "They give money to everyone and anyone."[12] What the article did not acknowledge, however, was the broader fight that government and the industry have been engaged in over the past twenty years – a fight that, I will show, PhRMA is, by all accounts, losing. The problem with this tendency toward myopia is the subject of the primary article from which this paper draws its inspiration, Jacob Hacker and Paul Pierson's 2002 essay on strategic goals and preferences, "Business Power and Social Policy: Employers and the Formation of the Welfare State."

Hacker and Pierson describe the role of business power in American politics and explain what they call "The Problem of Preferences." In order to understand political influence, they claim, we must know what political participants want. Working strategically, these actors will often not reveal their true preferences, instead proffering their tactical calculations for what is best given the circumstances. Because these strategic maneuvers are designed to maximize gains

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[10] Center for Responsive Politics ("Top Spenders: 1998-2011")
[11] Tumulty and Scherer
[12] *Ibid*.

in the current situation, Hacker and Pierson argue, "an actor's capacity to achieve its induced preferences should not necessarily be construed as a sign of great influence."

Hacker and Pierson make a distinction between preferences and strategic goals. The former is the actor's desired outcome, regardless of situation, while the latter is his temporary objective based on present circumstances. They use the example seen in Figure 1. Actor A has preferences on the left end of the spectrum, preferring A_0 over A_1 over A_2 and so on. Actor B has preferences on the right end of the spectrum, preferring B_0 over B_1 over B_2 and so on. Hacker and Pierson's insight is that "only a narrow subset of these policy alternatives is likely to be on a government's decision agenda" at any given point in time.

Figure 1: Ranked Policy Preferences of Two Political Actors

As a result, they find, "the most significant aspect of influence involves moving the decision-making agenda toward an actor's preferred end of the spectrum." If outcome B_2 is chosen over outcome B_1, for example, Actor A may have won the policy battle, but Actor B has won the policy war. In running a post-hoc analysis of any policy episode, "the crucial issue is to determine why the viable options were those at the right end of the spectrum, rather than why one or the other of the two options broadly favorable to Actor B was finally selected." This question – Which actor was able to bring the policy fight to his side of the spectrum? – is the vital driver of the paper. Answering it reveals the true extent of PhRMA's power, a conclusion that I find belies the industry's apparent victory during the Affordable Care Act.

The second misconception the public has about the pharmaceutical industry is one largely perpetuated by the industry itself. Throughout the health care reform negotiations, PhRMA regularly warned that any attempt to regulate the drug industry would lead to reduced innovation.

Decreased innovation would lead to fewer new drugs, which would inevitably hurt patients. Billy Tauzin made this argument in his CNBC interview, claiming, "We're going to be in there fighting to keep the private market going. Why? Because we want to continue stimulating innovation and invention, and… I'm alive today because of a great new medicine that was invented just a few years ago."[13] This argument is not new, either. Daniel Carpenter traces the idea of "drug lag" to the 1970s.[14] Drug lag is the notion that a delay in approval of a new pharmaceutical, due to overly-burdensome regulation, can lead to negative health consequences. One paper attributed many thousands of "excess deaths" each year in the United States to this phenomenon alone.[15] The threat that problems – like decreased innovation – will arise due to excess regulation of business is known as structural power, a concept first established by Charles Lindblom in the 1970s and 1980s.

Lindblom laid out what he called the "privileged power of business" over the course of his three landmark works: *Politics, Economics, and Welfare*; *Politics and Markets*; and "The Market as Prison." This "privileged position," as Lindblom and co-author Robert Dahl describe it in *Politics, Economics, and Welfare*, is the concept "that it becomes a major task of government to design and maintain an inducement system for businessmen, to be solicitous of business interests, and to grant to them, for its value as an incentive, an intimacy of participation in government itself."[16]

Though he never uses the term, Lindblom's work defines structural business power as the threat – real or not – implied by business that additional taxes or regulations will kill jobs, diminish efficiency, and smother innovation. Lindblom writes that with business as with no other

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[13] Tauzin
[14] Carpenter 377
[15] Wardell
[16] Dahl and Lindblom

group "is there so effective a set of automatic punishments established as a barrier to social change."[17] This structural, tacit power of business can be contrasted with the concept of instrumental power, where business uses its resources – money for lobbying, e.g. – in a more explicit attempt to get its way. Instrumental power is accessible to any interest group (the Sierra Club and National Rifle Association, for instance, both have powerful lobbying arms), while structural power is unique to business.[18] PhRMA lays claim to a strong structural power, but we will see that the threat of diminished innovation does not resonate nearly as deeply as the threat of lost jobs.

The third and final public misconception about the pharmaceutical industry involves another exaggeration of PhRMA's control over the legislative process. The ability to pass desired legislation and then guarantee its continued survival is a significant power in a Congress that is constantly changing. This capacity to "lock in" legislation was accorded the drug industry following the 2007 legislative session, when the Center for Public Integrity, an investigative journalism group, largely credited PhRMA's "banner year on Capitol Hill" to "getting two controversial laws extended."[19] The desire of interest groups to lock in their preferred policies so as to make them untouchable was first established by Terry Moe, in his 1990 essay, "The Politics of Structural Choice: Toward a Theory of Public Bureaucracy."

Moe describes how political uncertainty, the idea that all political power is temporary, drives actors to lock in their interests via insulated bureaucracies that they can design while in a position of influence. He writes that the decision is a simple one: "If today's authoritative decisions are to have staying power and continue generating benefits for their creators into the

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[17] Lindblom (1982)
[18] A more detailed description of both structural and instrumental business power can be found in Hacker and Pierson
[19] Ismail

future, they must somehow be insulated from tomorrow's exercise of authority."[20] Interest groups, he writes, think along similar lines. While in a powerful position (either because of strong public support or close ties to the party in power), interest groups look to design political structures that meet their priorities and "entail the 'separation of politics from administration.'" They do this not, Moe makes clear, because they are uninterested in controlling "their" agencies but because they don't want anyone else to control them either. As a result, these powerful interest groups "create structures that even they cannot control."

When these structures function correctly, they are built so that it is "difficult for [the interest group's] opponents to get control over later." When they do not work as planned, however, the structures can be open to modification or elimination, yielding outcomes that are potentially worse than what existed in the first place. This failure to properly insulate a new bureaucracy can prompt a need to defend it several years down the road, a situation that PhRMA faced in the aftermath of the Medicare Modernization Act that created Medicare Part D. This issue is of considerable importance if we want to fully understand the source of PhRMA's relative weakness.

In the next section, I take up a longitudinal study of PhRMA's political involvement over the past twenty years. A longitudinal study facilitates an examination of the drug industry's evolution from dominant business interest to weakened player in a larger health care system. Taking a detailed look at PhRMA's history shows us the major incidents where the industry's structural power was revealed to be less than effective, and where its inability to lock in favored policies signaled a major limitation. These two weaknesses lead us to the ultimate conclusion that PhRMA does not hold such a privileged position after all.

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[20] Moe

Chapter II: PhRMA and the Drug Benefit

The story of PhRMA's involvement with a Medicare drug benefit goes back to the late 1980s and the Reagan administration. But to understand why a fight over a drug benefit was necessary in the first place, we should ask why a benefit was not included at the beginning, when Medicare was founded in 1965. The simple answer is that outpatient prescription drugs were not much of an issue at the time.

Though they were not at the front of people's minds, prescription drugs were not an insignificant proportion of national health expenditures (NHE) in the mid 1960s. In fact, prescription drugs were approximately the same percentage of NHE in 1965 (9%) as they are today (10%).[21] While Theodore Marmor argues that a potential drug benefit was dropped "on the grounds of unpredictable and potentially high costs," consistent and stable annual spending on prescription drugs in the years preceding 1965 seems to contradict him.[22] More likely, as Andrea Louise Campbell and Kimberly Morgan write, prescription drugs' exclusion from Medicare in 1965 "was more an oversight than an intention omission."[23] Others agree, drawing attention to the fact that hospital costs, which were "far less predictable and potentially devastating to the individual retiree," were the priority of Medicare's designers.[24] Prescription drugs seem to have fallen by the wayside during Medicare's initial negotiation, and were not picked up again until the late 1980s.

The Medicare Catastrophic Coverage Act of 1988

The Medicare Catastrophic Coverage Act of 1988 (MCCA) was designed primarily to cover "catastrophic" health expenses that Medicare's 1965 architects had not foreseen, including

[21] Center for Medicare and Medicaid Services
[22] Marmor; Center for Medicare and Medicaid Services
[23] Campbell and Morgan (2005)
[24] Oliver, Lee, and Lipton

expensive physician visits and lengthy hospital stays. The bill was championed by Otis Bowen, President Reagan's Secretary of Health and Human Services, and it was designed to be deficit neutral by imposing any new costs on beneficiaries, yielding a progressively increased premium on Medicare Part B. The MCCA included prescription drug coverage only as a result of strong political pressure from the American Association of Retired Persons (AARP), a concession that Reagan and Bowen both resisted. In fact, the administration opposed drug coverage so strongly that they went so far as to threaten a veto of the whole bill in a closed meeting with Republican congressional leadership.[25] Despite the veto threat, however, the Democratic Congress knew that a Reagan administration weakened by public hearings over the Iran-Contra scandal would not pick a fight over a relatively small issue, and they pushed forward on the bill. The drug benefit remained true to the original intent of the legislation by maintaining only catastrophic drug coverage, with coverage kicking in after a $600 deductible.[26]

Along with AARP, groups such as the labor-backed National Council of Senior Citizens and Villers Advocacy Associates (the forerunner of health care consumer advocacy group Families USA) worked to drive public opinion toward the bill. The Pharmaceutical Manufacturers Association feared that a government-provided drug benefit would eventually lead to price controls and worked fiercely alongside the National Committee to Preserve Social Security and Medicare in opposition to the bill. Though the PMA was successful in directing the legislation to avoid any reference to cost controls on drugs (instead calling for beneficiaries to pay higher premiums over time if costs exceeded expectations), the MCCA's opponents' efforts were largely futile, as public support of the legislation drove its passage in Congress.[27] With 91%

[25] Himelfarb 30
[26] Oliver, Lee, and Lipton
[27] Rovner 154; Moon 121

of seniors supporting the legislation and only 6% opposing it, the conference report passed the House and Senate in June by votes of 328-72 and 86-11, respectively.[28]

Just as soon as the legislation passed, however, senior public opinion soured on the MCCA. Seniors quickly realized that the legislation was financed through a progressive tax that fell disproportionately on the wealthiest 30% of beneficiaries, a group that was most likely to already have insurance through other sources (typically Medigap coverage or an employer-sponsored pension).[29] Only five months after the MCCA's passage, "senior citizens were in open revolt against the program," and by December 1988 the public support of the legislation had fallen from 91% for and 6% against to 65% for and 21% against.[30] By August 1989, public opinion was nearly evenly split, with only 40% for and 37% against.[31]

The change in sentiment was driven by a number of factors, including interest group mobilization. Most notably, the National Committee to Preserve Social Security and Medicare, who had fought the legislation prior to its passage, produced a massive direct mail campaign targeted at seniors who were subject to the increased premium (and seniors who could be convinced that they would be subject to the premium, even if it was not the case). Derided by its opponents as a "direct-mail mill," the National Committee went on the offensive immediately after the MCCA's passage, announcing at the beginning of 1989 that it was mailing 3 million letters to its members, encouraging them to contact their representatives.[32] They were encouraged by the Republicans in Congress who had opposed the legislation from the beginning;

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[28] Himelfarb 43
[29] Moon 122
[30] Himelfarb 73; Himelfarb 62
[31] *Ibid*.
[32] Longman; Rovner 167

by this point, at least six bills had already been introduced to in some form delay, alter, or repeal the MCCA.[33]

The National Committee joined with several other groups – including the PMA (who contributed $3 million to the cause), the Gray Panthers, the National Association of Retired Employees, and the Retired Officers Association – under the banner of the Coalition for Affordable Health Care.[34] The group's campaign was notable for the misinformation in its mailers, asking in bold letters, "Will you get a $800 tax bill for Catastrophic coverage this year?," while disguising the fact that only about 5% of seniors would have to pay the maximum supplemental premium.[35] Other groups that organized and advertised for the MCCA's repeal included Seniors Against the Surtax, the Coalition for the Repeal of the Medicare Catastrophic Care Act, the Committee for the Repeal of the Catastrophic Health Act of 1988, and the Seniors Coalition Against the Catastrophic Act (SCACA). While most of these organizations were "largely storefront operations consisting of little more than a few dozen members and a letterhead," SCACA was credited with collecting over 300,000 signatures in support of repeal and bringing the Nevada congressional delegation on board as early proponents of the MCCA's repeal.[36]

The chance at a repeal of the MCCA also brought out wealthy seniors who were going to be hit hardest by the new supplemental premium. One of the biggest problems with the MCCA was how blatantly the rich were subsidizing the less well-off and, as Julie Rovner writes, "financially secure senior citizens rebelled when they realized they would have to pay for

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[33] *Ibid*.
[34] Rich
[35] Moon 127
[36] Himelfarb 78

expanded benefits they felt they did not need."[37] Polls showed that wealthy seniors were consistently less favorable of the MCCA than middle and low income seniors, and in early 1989, high income seniors who considered themselves knowledgeable about the bill were the only demographic group to show stronger opposition than support for it.[38] Not only were these seniors footing the bill for the benefit, they were also more likely to already have Medigap insurance or an employer-sponsored pension.[39] This was the biggest problem that seniors had with the MCCA: they were "against the very idea that they should be expected to pay themselves for any new government benefit that they might obtain."[40]

Senior anger peaked during the August recess of 1989. Just like their counterparts twenty years later, members of Congress returned home to meet their constituents and discuss the health reform legislation that was on everyone's minds. Representative Barbara Kennelly remarked, "I have never seen anything like the outcry… across this country from the elderly."[41] A *New York Times* reporter who followed Democratic congressman Mike Synar around his district in Oklahoma found that for seniors "other issues that have consumed Congress for months, issues that were widely expected to arouse people, barely registered."[42] The frustration came to a head when Congressman Dan Rostenkowski, one of the architects of the MCCA, was chased out of his own town hall meeting, pursued by seniors shouting "Coward," "Recall," and "Impeach."[43] Leona Kozien, a "petite, white-haired woman wearing heart-shaped, rose-colored sunglasses," draped herself over the hood of Rostenkowski's car as he tried to escape, "virtually face-to-face

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[37] Rovner 145
[38] Himelfarb 62; 47% of high-knowledge high-income seniors supported the MCCA while to 49% opposed it (*Ibid*. 68).
[39] Longman
[40] *Ibid*.
[41] Himelfarb 73
[42] Toner
[43] Recktenwald

with her congressman."[44] The scene was replayed repeatedly on network news over the next several days, and it came to symbolize seniors' frustration with the legislation.[45]

Understanding the virulence against the MCCA among both interest groups and seniors, members of Congress attempted to save the program by restructuring it in a more regressive way. By late 1989, however, such attempts were too late, and on November 21 the legislation was repealed by nearly as lopsided a margin as it was originally passed – 352 to 63 in the House and by unanimous consent in the Senate.[46]

The episode teaches a clear lesson: marshaling public opinion is essential to achieving political goals. The National Committee showed just as much when its massive direct mail campaign helped to turn seniors against the MCCA. The dramatic about-face in the polls shows that public opinion can be extremely pliable, and in this case special interests were able to bend it as they pleased. The National Committee, along with several other organizations and coalitions who were united in their opposition to the MCCA (including the still-growing PMA), used their spending power to reach out to millions of seniors and guide their decision making.

AARP was able to get a prescription drug benefit included in the MCCA by promising to withhold its endorsement, which served as an equally powerful threat. AARP made it clear to members of Congress that the bill would only receive the 28-million-member group's blessing if a drug benefit were included in the final conference report.[47] AARP targeted key senators who were involved in the negotiations – Lloyd Bentsen, a Texas Democrat, was one – and promised to fight the bill if their wishes were not accorded.[48] The viable threat of turning 28 million

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[44] *Ibid*.
[45] Himelfarb 74
[46] *Ibid*. 93
[47] Oliver, Lee, and Lipton
[48] England

seniors against the bill was more than enough for AARP to get its way when it came to adding a prescription drug component to the MCCA.

The power to change public opinion is not limited to large organizations with millions of dollars in their war chests, however. Leona Kozien did just as much to symbolize seniors' discontent when she threw herself onto Dan Rostenkowski's hood. The change she effected in public opinion caused Representative Robert Matsui to remark, "This is the most intense I've ever seen senior citizens in my 10 years in Congress."[49] More importantly, however, it led directly to the revocation of the MCCA.

The value in being able to move public opinion is an important lesson to take from the episode of the Medicare Catastrophic Coverage Act. Both large groups and passionate individuals were able to significantly shift public opinion on the issue, and the fledgling PMA took notice. These lessons were only multiplied in the next episode of the fight over a Medicare prescription drug benefit, in the late 1990s and early 2000s.

Clinton's Push for a Drug Benefit

The Balanced Budget Act of 1997 mandated three new Medicare policies. The first established a program called Medicare+Choice (today known as Medicare Advantage, or Medicare Part C), which allowed Medicare beneficiaries to choose from an assortment of private providers, including managed care plans. The second, which gave the legislation its name, established a series of Medicare cuts and reforms – including creating the Sustainable Growth Rate, or "doc fix" – that intended to help balance the federal budget over the next five years. The third was the establishment of the National Bipartisan Commission on the Future of Medicare, which was tasked with developing a report on the program's prospects in the face of the

[49] *Ibid*.

imminent onslaught of Baby Boomers. It was this commission – nicknamed the "Breaux Commission" after its Senate chair, John Breaux, a Louisiana Democrat – that occupied President Clinton's attention when he began planning his 1999 State of the Union.

When it was initially established, the Breaux Commission was required to issue its report to Congress and the Clinton administration by March 1, 1999. Its report would, on the condition of support by a supermajority of 11 out of the Commission's 17 members, lay before Congress a set of recommendations to ensure Medicare's solvency for the future. Knowing that the Commission was populated largely by political moderates, Clinton sought to use his State of the Union – which was to be delivered just over a month earlier, on January 19 – to set the agenda in liberals' favor and begin the reform process on Democratic terms.

Clinton crafted his State of the Union keeping in mind the federal budget surplus, which he had the luxury of using as he wished. As a result, in his speech he proposed adding a prescription drug benefit to Medicare in order to cover what he called "the greatest growing need of seniors." Clinton chose a drug benefit because, among other reasons, drugs were simply more salient to voters than more esoteric policies like catastrophic care or nursing home coverage.[50]

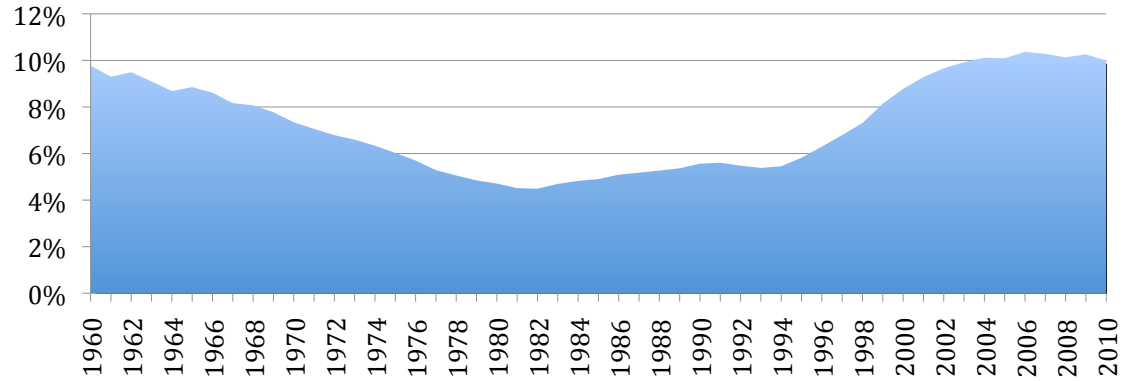
Clinton's choice to champion a drug benefit was interesting, however, because at the time it was not an issue that was on anyone's radar. Research on the issue found relative ignorance on the topic. An analysis of public opinion the same month as Clinton's State of the Union found that "most Americans do not know that Medicare does not pay for… outpatient drugs."[51]

Even if people did not think that there was a problem prior to Clinton's address, they came to realize that there was one soon afterward. As Figure 2 shows, the price of prescription drugs had shot up over the previous twenty years, nearly doubling as a percentage of national

[50] Campbell
[51] Bernstein and Stevens

health expenditures and increasing roughly 60% in the past decade alone. And even though outpatient pharmaceuticals were not covered under Medicare, various exemptions had been carved out over the years. As a result, the program still covered approximately 450 outpatient prescription drugs.[52] By 1999, this spending totaled nearly $4 billion – $4 billion that was going not toward the drugs that were most needed but toward drugs that were well-represented in Congress.[53]

Figure 2: Drug spending as a percentage of National Health Expenditures



(Center for Medicare and Medicaid Services)

It soon became clear that the prescription drugs issue was a larger problem than anyone was talking about. By 1999, 80% of Medicare beneficiaries regularly used prescription drugs, but retiree health plans were increasingly dropping drug coverage and Medigap plans with drug coverage were becoming prohibitively expensive.[54] By 2000, not a single Medicare HMO offered free drug coverage, and 37.7% of Medicare beneficiaries reported not having any coverage, which required them to pay the full cost of prescription drugs out of pocket.[55] The

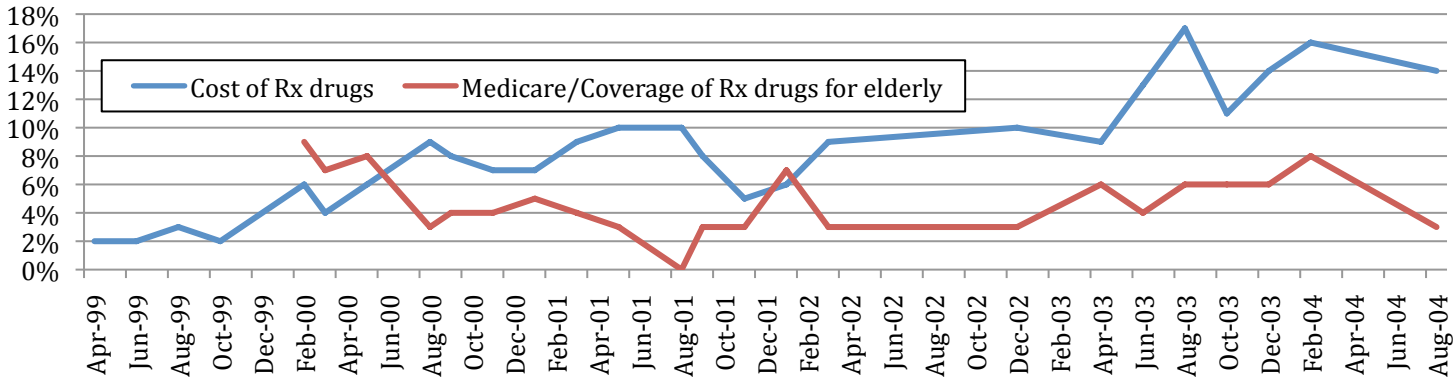
[52] Dummit
[53] *Ibid*.
[54] Campbell and Morgan (2005)
[55] Pear (1999); Laschober

beneficiaries who lacked coverage were often the worst off already. Seniors least likely to have drug coverage included those living in rural areas, those 85 or older, and the near poor (the poor were covered by the more generous Medicaid).[56] It was becoming clear that Americans "really couldn't say [they] had a very good medical plan when [they] did not have drug coverage."[57] These uncovered beneficiaries drew media attention, which continued the snowballing momentum toward a benefit.

As Figure 3 shows, barely anyone saw the cost of prescription drugs as a problem when Clinton delivered his State of the Union. The Kaiser/Harvard Health News Index tracks public sentiment on health issues in a poll every few months, and it found no awareness of the issue prior to Clinton's address. In fact, "Cost of prescription drugs" was only added as a possible response to "What do you think is the most important problem in health/health care for government to solve?" in mid-1999, after the State of the Union – before that, it had not even been deemed worth asking. Yet, as reflected in the poll, concern over the cost of drugs quickly increased and once a question about Medicare coverage of prescription drugs was added, that indicator followed suit.

[56] *Ibid*.
[57] Rother

Figure 3: Responses to "What do you think is the most important problem in healthfor government to solve?"



(Kaiser/Harvard Health News Index 1999-2004)

Additional problems slowly emerged surrounding Medicare's payment methods for the drugs that were already covered. In 2002, two reports were published that highlighted the problems Medicare faced with prescription drug coverage. The first was a report by the Inspector General for the Department of Health and Human Services.[58] It found that, in paying 95% of the Average Wholesale Price – or AWP, the price set by drug manufacturers without any negotiation – for drugs such as ipratropium bromide (the focus of this particular study), Medicare was paying over five times what the Veterans Health Administration (VHA) paid for the same drug. The report concluded that, by using competitive bidding and more informed purchasing decisions, Medicare and its beneficiaries could save nearly $300 million annually. The second revelation was testimony by Center for Medicare and Medicaid Services (CMS) Administrator Thomas A. Scully.[59] He addressed the problem of Medicare's over-reimbursement of the prescription drugs covered by Medicare Part B, calling the system "seriously flawed." Such a statement by the

[58] Rehnquist
[59] Scully

person in charge of overseeing all of Medicare drew significant attention to the issue and pushed the campaign for a Medicare prescription drug benefit forward.

Though these two reports were released several years after Clinton's State of the Union address, they serve to make two points. The first is how far public opinion had come since Clinton's speech, and how successful he had been in bringing the issue to the nation's attention. Pollsters were not even asking about drug costs at the beginning of 1999, but in September 2000, a *New York Times*/CBS poll found that 65% of respondents thought reducing the costs of prescription drugs for the elderly mattered "a lot" and a January 2002 poll found that support cut across ideological lines for a Medicare drug benefit.[60] The second is how quickly elites – interest groups, members of Congress, and presidential candidates – picked up on this support and ran with it. Support for changing how Medicare beneficiaries got their drugs went beyond just bureaucrats in the Department of Health and Human Services. The next section details the legislative attempts at adding a prescription drug benefit to Medicare in the lead-up to 2003.

Moving toward a Drug Benefit

Moving past the failure of the Breaux Commission (the report received only ten votes from Commission members when eleven were required to send their recommendations to Capitol Hill), President Clinton submitted legislation to Congress that offered prescription drug coverage under a separate program within Medicare, what he called Medicare Part D. The program would be administered with 50% coinsurance, no deductible, and 100% coverage once beneficiaries hit a "catastrophic limit" (originally set at $1,000 and pegged to increases in the consumer price index).[61] A voluntary program, it would be funded primarily through the surplus that Clinton had promised to spend down in his State of the Union. The most important development in the

[60] *Ibid*.
[61] Oliver, Lee, and Lipton

proposal, however, was the stipulation that seniors receive the benefit through existing health plans or a regional pharmacy benefit manager (PBM) that would be chosen by Medicare through selective bidding. This move to provide benefits through private firms made the legislation more palatable to both Republicans and drug manufacturers who had long been wary of a government drug benefit leading to price controls. Kimberly Morgan and Andrea Louise Campbell write:

> The reason for delegating the administration of the benefit to private firms was that, much like the liberal planners who developed Medicare in the 1960s, Democrats were leery of provoking a powerful medical interest group – in this case, the pharmaceutical industry. By creating an intermediary layer of private organizations, indeed a set of organizations with which pharmaceutical companies already worked, they sought to fend off assertions that the government would be directly involved in negotiations over the price of drugs or structure of formularies.[62]

Attempting to construct a layer between government and Medicare beneficiaries, Clinton and Democrats showed that they understood the power of the pharmaceutical industry to make or break their legislative ambitions. While the bill was initially popular among Democrats and moderates, the nonpartisan Congressional Budget Office (CBO) declared that Clinton's plan would cost 42% more than was originally projected (at $168 billion rather than $118 billion) and the legislation was dead on arrival in Congress.[63]

While lawmakers did not like Clinton's plan, one group unexpectedly did. In the July 1999 issue of *Health Affairs*, PhRMA president Alan Holmer penned an op-ed titled "Covering Prescription Drugs under Medicare: For the Good of the Patients." Showing strong support for a Medicare prescription drug benefit, Holmer wrote, "PhRMA supports expanding prescription drug coverage as part of a Medicare program that is modernized to allow beneficiaries to choose among qualified, private-sector health plans." His support was qualified, however, by a warning that government stay away from price controls. If anything approaching government-set prices

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[62] Morgan and Campbell 120
[63] *Ibid*. 118

were to accompany a drug benefit, "pharmaceutical innovation – especially with respect to medicines designed to treat the illnesses of aging – may suffer, thereby reducing hope for Medicare beneficiaries and their families."[64] While getting PhRMA's support for the drug benefit was a big win for Clinton, it was also an acknowledgment by PhRMA that the playing field had shifted.

More important than winning congressional votes or gaining the drug industry as an ally, however, was the progress Clinton made in ensuring that candidates for president picked up on the drug benefit. Vice President Al Gore, the Democratic nominee, and Texas Governor George W. Bush, the Republican nominee, both came out with prescription drug plans that they used to show their empathy with American seniors. Gore took a hard line against drug companies, accusing them of "price gouging" and "special interest schemes" to keep drug prices high.[65] His plan was similar to Clinton's: the campaign estimated the cost to be $253 billion over 10 years, though the CBO said $297 billion. It would completely cover drugs for the poorest beneficiaries; offer plans with a sliding premium and coinsurance of 50% up to a "catastrophic" limit; and provide the drug benefit through a single PBM per region, to be chosen through a competitive bidding process.[66]

Gore's plan put Bush on the defensive, and the Texas governor was forced to respond with a plan of his own lest he risk it seem like he was abandoning seniors, a key demographic in the 2000 election. Bush's plan came in the context of a broader plan to restructure Medicare, allowing private plans to compete directly with government-provided Medicare for seniors' business. The Bush plan was pegged at $198 billion, and while it would cover all of the costs for

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[64] Holmer
[65] Mitchell (2000a)
[66] Stolberg

seniors with an annual income of $11,300 or less, other seniors would have the option of choosing between a government-approved private insurance plan through a system of "premium support," or remaining in the current Medicare system and buying a subsidized prescription drug plan.[67] Both plans anticipated drawing on the federal budget surplus to finance the coverage expansion.

While the campaign was underway, House Republicans focused on a prescription drug plan of their own. Medicare spending had decreased for the first time ever in 1999, which gave legislators an opening to pursue the popular new benefit.[68] Republicans designed a plan that would allow for unlimited PBMs to enter a region and offer competing plans in order to force prices down through competition.[69] They also wanted the PBMs to share Medicare's risk, which would add incentives for the private providers to use generic drugs and keep costs under control. Democrats, who recognized this as a move away from government-supplied health care, strongly objected to the plan. Nevertheless, House Republicans were emboldened by a CBO report that found that allowing multiple PBMs in the same area would be more cost-effective than simply allowing a single PBM per region (as Clinton and Gore both proposed), and they pushed forward their legislation, a plan that would cost $40 billion over five years.[70]

The bill was brought to the House floor in April 2000, where one House Republican described it as "very similar to the president's, but better."[71] It passed the House on a largely party-line vote, 217-214, but could not overcome a filibuster in the Senate.[72] House Republicans understood that their bill was likely going to go down to defeat, but their legislating was

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[67] Mitchell (2000b)
[68] Campbell and Morgan (2005)
[69] Morgan and Campbell 121
[70] Crippen; Pear (2000)
[71] *Ibid*.
[72] Pear (2002)

motivated primarily by the need to fend off Democrats' accusations that Republicans were failing to lead on a now-popular issue. As one representative said, "Our guys couldn't go home empty-handed."[73]

Though nothing substantive came out of the attempt, a more subtle progress was achieved. Between House Republicans passing legislation and both presidential candidates proffering their own plans, a prescription drug benefit began to seem inevitable. When Bush won the election, he could not escape the promises that he had made on the campaign trail. Robert Reischauer, director of the Urban Institute, remarked at the time about the Republicans, "They have a gun to their heads. They have to do something. If they don't, they will give Democrats a club to beat them over the head with."[74] At this point, a drug plan was being wielded more for its power as a political weapon than as a quality policy. As Andrea Louise Campbell writes, "the last thing many Republican lawmakers wanted to do was to expand a big government program. However, seniors are an important constituency for both parties, and so Republicans felt they had to craft a drug benefit of some sort."[75]

Republicans showed just how committed they were to a drug benefit when the GOP-controlled House passed another prescription plan on June 28, 2002.[76] The plan was scored at $350 billion, significantly more generous than House Republicans' 2000 plan. [77] More importantly, it was the first attempt at a drug benefit after the Bush tax cuts, which had decimated the surplus that Clinton had originally looked to for funding Medicare prescription drugs. This effort was the first to offer a deficit-financed drug plan, though it would not be the

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[73] Pear (2000)
[74] Cagney
[75] Campbell
[76] Morgan and Campbell 131
[77] Pear (2002)

last.[78] Senate Democrats (holding a majority in the upper chamber as of June 2001, when Jim Jeffords of Vermont declared himself an Independent and joined the Democratic caucus) countered with a $600 billion plan, that offered lower premiums and deductibles and no coverage gap, or "doughnut hole" (included to keep the price of the plan down), which they saw as a weakness of the GOP's plan. Neither plan managed to overcome the other party's filibuster in the Senate, however, and both plans went down to defeat.[79]

PhRMA played a relatively small – and largely ineffective – role in the development of the prescription drug plans in the early 2000s (their lobbying efforts against the Clinton bill paled in comparison to what came in 2003), but that does not mean that they did not learn from the period.[80] A major lesson could be drawn from the repeated efforts at passing a drug benefit: there was widespread support for some sort of prescription drug benefit, even if the two parties were not in agreement of how such a program should be designed. PhRMA had long opposed such a program (and had played a role in successfully repealing one in 1989), but given this relative inevitability, they could shift their focus from defeating a benefit to shaping it to suit their interests. This was the tack that they would follow in future negotiations.

By 2003 the political winds had shifted. For the first time since 1934, an incumbent president's party gained seats in both the House and Senate. Bush had both a strong political majority and a public consensus on the need for a Medicare prescription drug benefit. House

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[78] This willingness – on both sides of the aisle – to deficit spend in order to enact a drug benefit spoke to the policy's political importance.

[79] Hook

[80] PhRMA ran a widely-viewed campaign across television, radio, print, and internet against the Clinton proposal through a front group called "Citizens for Better Medicare," which cost at least $65 million (Public Citizen). The ad campaign was largely considered unsuccessful, however, and even led to divisiveness between PhRMA and Republicans – one House GOP leadership aide even referred to Flo, an arthritic bowler who served as the protagonist of the campaign, as "a wretched old hag." (Eilperin) PhRMA appears to have learned that running advertising against an overwhelmingly popular program accomplishes little.

Republicans had delivered twice in the past three years, but their efforts had both times been thwarted by Democrats in the Senate. The next section brings interest groups including PhRMA back into the story, and describes the process by which Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Passing a Drug Benefit

The 108th Congress represented the first time Republicans held the presidency and majorities in both houses of Congress since the Eisenhower administration. Republicans controlled 51 seats in the Senate and 229 seats in the House – by no means an overwhelming supermajority, but certainly a working coalition that could pass legislation. Two of the Republicans most interested in Medicare reform – the new Senate Majority Leader, Bill Frist, and the House and Ways Committee Chair, Bill Thomas – were in positions of authority that allowed them to exert considerable control over the legislative proceedings of the next two years.[81] In many ways, the table was set for the addition of a drug benefit.

This does not mean, however, that the path to passing a bill was smooth. Republicans had long expressed a willingness to enact a drug plan conditional on much of the benefit being administered by the private sector – this is where the role of PBMs had first come into play. President Bush, understanding that the popularity behind a drug benefit offered further potential to take the provision of medicine out of government's hands, seized the opportunity. In early March, the administration released the "Framework to Modernize and Improve Medicare," which provided the structure for what Bush hoped would become an overhaul of Medicare, with a new prescription drug benefit at the center.[82] One aspect of the plan proved particularly unpopular. The Framework suggested that reformed (or what the administration called

[81] Oliver, Lee, and Lipton
[82] The White House

"Enhanced") Medicare would provide comprehensive drug coverage to the elderly, but only if they switched to subsidized private plans. This move away from "traditional" Medicare was met with significant pushback from congressional Republicans and Democrats alike. The understated *New York Times* described Republican leadership as "surprisingly cool" to the proposal, but Billy Tauzin, then the chair of the House Committee on Energy and Commerce, put things more bluntly: "You couldn't move my mother out of Medicare with a bulldozer. She trusts it, she believes in it. It's served her well."[83] Tauzin's response represented the general reaction to the plan by leaders of both parties, and the attempt was quickly killed.

Beyond the unpopularity of the move away from traditional Medicare, however, the Framework proved generally popular. While purposefully vague in its discussion of the details of the plan, the Framework established a $400 billion spending commitment over ten years, which came to be seen as a hard cap for whatever legislation eventually came out of Congress. $400 billion was not enough for a uniform universal benefit, catastrophic coverage, and low-income subsidies while still covering all drug costs, so something had to go.[84] Congressional Republicans took a page from their previous efforts at designing a drug benefit and included a "doughnut hole" of coverage, which allowed for first-dollar and catastrophic coverage while keeping the total cost under the $400 billion cap. Democrats were unhappy with a significant gap in coverage, but they hoped that supporting the doughnut hole now might ultimately provide pressure for further reform in the future, and as such they did not protest too much.[85]

This willingness to work with Republicans did not keep congressional Democrats from responding with two plans of their own, however. The first, offered by a moderate coalition

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[83] Pear and Toner (2003a)
[84] Blum
[85] Campbell and Morgan (2005)

calling themselves the "New Democrats," fit into Bush's $400 billion framework, but only by using a $4,000 deductible, after which Medicare would cover 80% of all costs.[86] This plan resembled the catastrophic care legislation of more than a decade earlier more than it did the contemporary reform bills that were being discussed, and it went nowhere. Another plan, offered by progressive House Democrats, aimed to provide fuller coverage with a $25 monthly premium, $100 annual deductible, 80% of costs covered up to $2,000 and 100% of costs covered afterward, but the cost of the bill was pegged at $800 billion.[87] With no remaining federal budget surplus following the Bush tax cuts and wars in Afghanistan and Iraq, such lavish spending on a social program was seen as out of the question, and the progressive proposal was never seriously considered.

Conservative Republicans pushed back against the proposed plans, showing reticence to agree to establish a new federal entitlement funded entirely via deficit spending. To sweeten the deal for those on the right, GOP leadership in the House added a version of premium support that would require the regular Medicare program to compete with private plans beginning in 2010, and tax-preferred health savings accounts that could be used to pay for medical expenses.[88] As Speaker Dennis Hastert put it, the House bill was "a mix of government entitlement… but it's also a commitment to the private sector that they will have a role, and cost containment will be a part of that role."[89]

The vulnerability of the legislation to change allowed interest groups to play a significant role in shaping the bill, and PhRMA was at the head of that charge. Having learned from earlier in the decade about the difficulty of getting through on a popular issue with public advertising,

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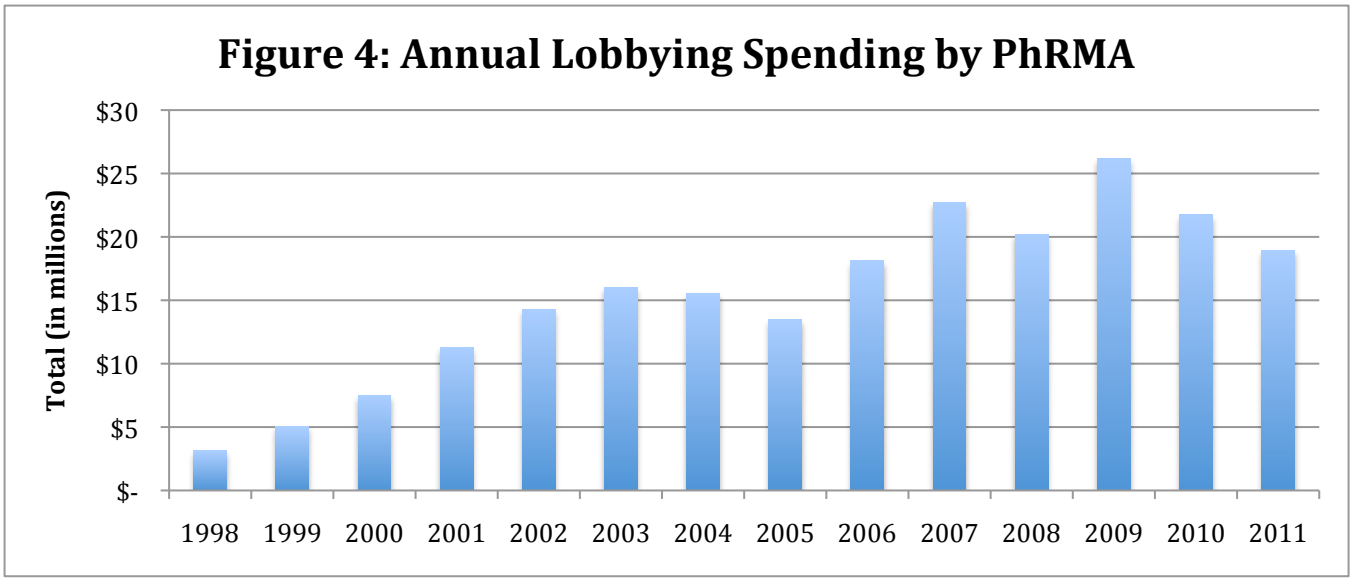
[86] Pear (2003)
[87] Zuckman
[88] Morgan and Campbell 133
[89] Jaenicke and Waddan

they primarily used congressional lobbying and directed campaign donations to exert their influence on the bill in what one commentator called "one of Washington's most elaborate advocacy strategies."[90]

Figure 4 shows how PhRMA ramped up its spending on lobbying in the lead-up to the 2003 negotiations. Their spending on lobbying had more than doubled from three years earlier, and more than quintupled since 1998. In 2003, PhRMA spent the fifth most on lobbying of any special interest group (behind such heavy hitters as the U.S. Chamber of Commerce and General Electric) and employed 156 lobbyists, including three former representatives – two Republicans and one Democrat.[91] In a study of influential policy makers, Michael Heaney found that lobbyists saw PhRMA as the third-most powerful group in Washington, while congressional staffers – the group most attuned to lobbyists' presence on Capitol Hill – ranked PhRMA as the most influential group in DC.[92] Two-oft repeated sayings on Capitol Hill reflected the power (or at least perceived power) of PhRMA: "PhRMA has more lobbyists than Congress has members" and "PhRMA has more money than God." Though clear hyperbole, these maxims nonetheless reflect a level of respect and fear that policy makers had for the pharmaceutical lobby.

[90] Igelhart
[91] Center for Responsive Politics ("Top Spenders"); Center for Responsive Politics ("PhRMA 2003")
[92] Heaney



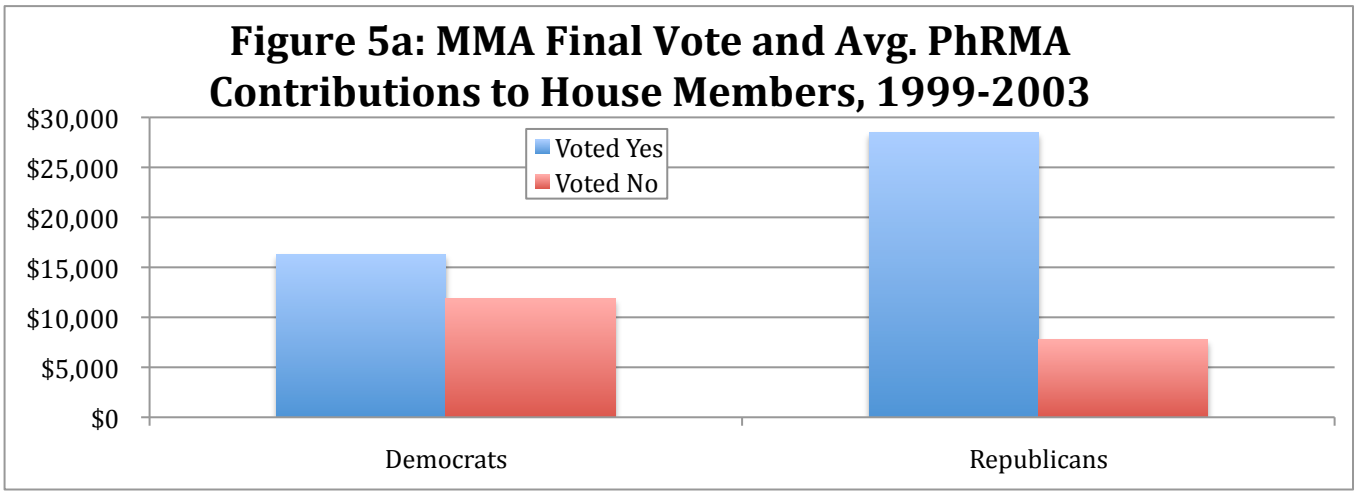
Center for Responsive Politics (PhRMA)

Lobbying wasn't the only area where PhRMA spent heavily, however. They also put a lot of money into campaign contributions, as Figures 5a and 5b, compiled by Kimberly Morgan and Andrea Louise Campbell, show. Apart from contributions going to Senate Republicans, PhRMA appears to have targeted their donations quite efficiently.

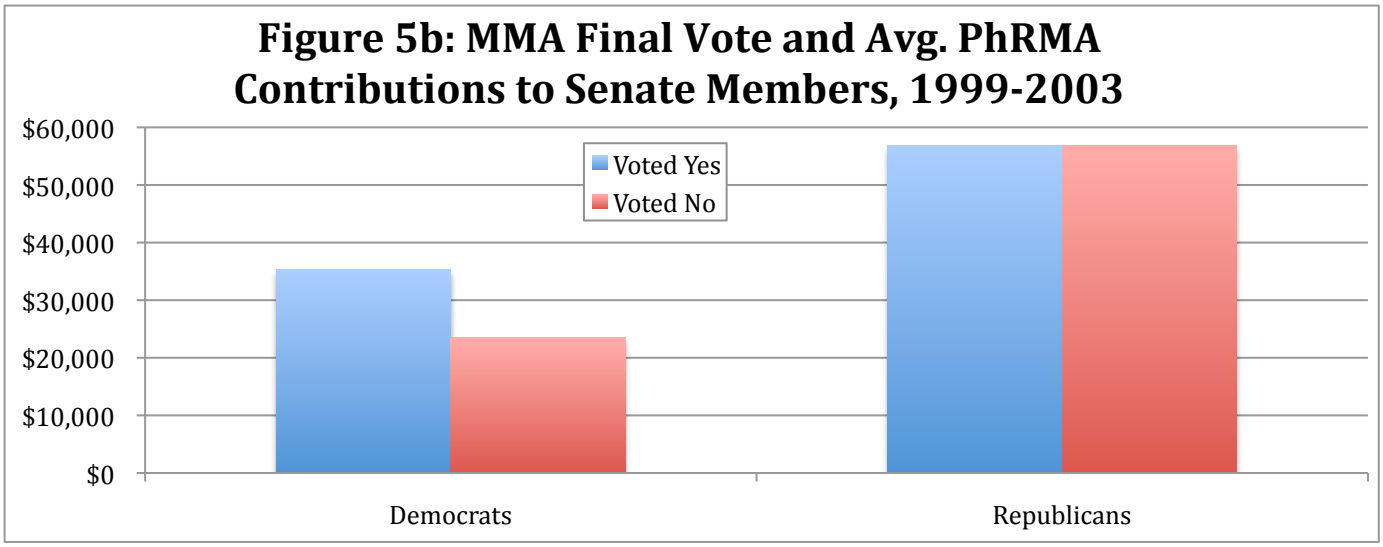
Campaign contributions serve an important purpose for PhRMA, and for interest groups more broadly. As opposed to lobbying, where legislators consider a group's strength only as a function of the number and passion of advocates they encounter on Capitol Hill – an admittedly subjective measure – campaign contributions are a direct and objective way for the pharmaceutical industry to show its "support" of a legislator. This money can be funneled through individual donations, PACs, or, more recently, direct corporate donations.

PhRMA's targeted campaign contributions raise an important question about the direction of causality: is the industry's money changing lawmakers' minds, or is it acting as a reward for those members of Congress who vote for the preferred legislation? The answer is a mix of the two. There is an extensive literature on the purpose of corporate campaign

contributions and the role that it plays in rent-seeking, or buying access to legislators.[93] This would seem to explain that campaign contributions change lawmakers' minds. On the other hand, however, if PhRMA's contributions were so effective that a simple campaign contribution could change a legislator's mind, we would be unlikely to see such a significant disparity between those who voted for and against the Medicare Modernization Act. This points to contributions as a "thank you" to legislators who vote in PhRMA's favor. Over time, the distinction blurs between the two, as the expectation of a reward causes lawmakers to vote in the industry's favor. As such, we should understand the contributions represented in Figures 5a and 5b to serve a dual purpose: both as an attempt to persuade lawmakers prior to a vote, and as a "thank you" afterward.



[93] Cf. Sabato



Morgan and Campbell (138)

While PhRMA spent a lot of money on lobbying and campaign donations, their money was going toward unambiguous goals. Having conceded that a prescription drug benefit was likely inevitable, the pharmaceutical industry aimed its advocacy at defeating two policies that they felt similarly threatened their interests: direct federal government negotiation over drug pricing, and prescription drug reimportation from Canada and Europe. The former would allow the federal government to use its buying power as the sole purchaser of Medicare's prescription drugs to drive a hard bargain with the pharmaceutical industry and bring down costs. The latter would piggyback on the lower prices that countries with single-payer health care systems are already directly negotiating with drug companies and allow Medicare to reimport those drugs – a significant percentage of which were originally designed and manufactured in the United States – to allow American beneficiaries to purchase the drugs for less. Both of these policies were frequently brought up by Democrats as potential ways to cut costs of a drug benefit, and though there are real questions as to the actual efficacy of either policy in saving a significant amount of

money, PhRMA nevertheless felt the threat to be real enough to warrant fighting.[94] Now that they had given up on trying to defeat a drug benefit, these policies – which the industry saw as leading down the road to government price controls – became the industry's two top targets, and the vast majority of PhRMA's ramped-up financial energy was directed toward it.[95]

PhRMA fought these policies in different ways. Government price negotiation was never seriously considered due largely to the implied threat PhRMA held over Congress. Just as Clinton had originally proposed that PBMs administer a Medicare drug benefit instead of the government, Republicans supported a decentralized system for providing drugs in response to PhRMA's potential power to come out against the bill (though the GOP, unlike Clinton, may have actually desired privatization of a Medicare drug benefit). Even if PhRMA's campaign would have proven unsuccessful in killing popular legislation, the hassle that it would have posed in passage was enough to make legislators wary of provoking the drug industry.

PhRMA had to take a more direct approach against drug reimportation. A program that the industry sees as "a proxy for price controls," drug reimportation has been one of the most

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[94] Reports by both the CBO and the Congressional Research Service (CRS) have raised questions as to how effective drug reimportation and direct government price negotiation would be in saving money for either the federal government or Medicare beneficiaries. In a 2004 report, the CBO found that drug reimportation "would not necessarily significantly enhance competitive pressure and yield cost savings to consumers" (Congressional Budget Office). A 2007 CRS study was equally equivocal, saying "It is unclear how much a new program might lower prices of pharmaceuticals for U.S. consumers – or if it would," and finding that "traders, rather than consumers, [would] profit most from the transactions" (Thaul). Research into direct federal negotiation over drug prices has found similarly inconclusive results. In a 2004 letter to Senator Ron Wyden, Douglas Holtz-Eakin, the director of the CBO, wrote that the "CBO believes that there is little, if any, potential savings from [such] negotiations…" (Holtz-Eakin). A 2005 CRS report found that while the Department of Veterans Affairs (VA) – a single-payer, single-provider system – had successfully been able to negotiate drug prices down at least 24%, the significant differences between Medicare and the VA led them to conclude that "the magnitude of the discount that the federal government might be able to negotiate is uncertain." (Hahn).

[95] Campbell and Morgan (2005)

disputed pharmaceutical issues over the past decade.[96] For several years before negotiations began, American seniors had been taking trips across the border to Canada, or, less commonly, Mexico, to purchase cheap prescription drugs.[97] A *Washington Post* investigation found that approximately 10 million American citizens were bringing prescription medications into the U.S. over land borders each year.[98] The pharmaceutical industry made an argument against drug reimportation on economic and safety grounds. Reflecting the industry's concern over the low price of drugs abroad, PhRMA spokesman Jeff Trewhitt said, "We believe there would be more innovation if price controls were lifted abroad."[99] PhRMA believed that reimportation of cheap drugs from abroad was hurting the industry's ability to research and develop drugs domestically. Beyond the economic case for banning drug reimportation, however, PhRMA made their position clear on their website's section on drug importation. They stated, "Simply put, importation schemes for prescription drugs are not safe."[100] When the Senate passed an amendment to their legislation allowing drugs to be imported from Canada (the House passed a similar, but not identical, amendment), the industry released a statement decrying the vote and saying, "Every relevant federal regulatory agency from the Food and Drug Administration to the Drug Enforcement Administration to the U.S. Customs Service has condemned importation as unsafe and risky for patients."[101] PhRMA managed to persuade 53 senators to sign a letter saying they opposed the provision, and the language was removed in conference.[102]

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[96] Anonymous (a)
[97] Hutter Epstein; Korcok
[98] Flaherty and Gaul
[99] Harris
[100] Pharmaceutical Research and Manufacturers of America ("Importation")
[101] Turnham
[102] Stolberg and Harris

Once both House and Senate bills reached conference committee (the former on a razor thin 216-215 vote, the latter passing 76-21), legislators set to work ironing out their differences. Of the Democrats appointed to the conference committee, only two centrist senators, Max Baucus and John Breaux, were allowed to remain in the negotiations with Republicans. GOP leadership hoped that Baucus could bring along moderate Democratic votes in the Senate, but it meant that the Montana senator assumed a new power as dealmaker, which frustrated conservative Republicans.[103] To satisfy the conservatives in the conference committee, Health Savings Accounts and increased Part B premiums were added to the report, and, to assuage Democrats' fears, language that had passed in the House allowing private health plans to compete directly with Medicare was made into a "demonstration project" beginning in 2010, essentially neutering it.[104]

The bill that came out of the conference committee, known as the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), still faced a difficult road getting through the Republican House. Staunch conservatives joined Democrats in voting against the bill, and Speaker Dennis Hastert kept the roll call vote open for several hours – the longest roll call vote in House history – while Majority Leader Tom DeLay and Majority Whip Roy Blunt brought wavering Republicans into line.[105] The bill passed the House, 220-215, at 5:51am on November 21, only after President Bush made personal calls to the final few voters.[106] Three days later, despite Ted Kennedy's filibuster threat, the MMA passed the Senate much less eventfully, 55 to 44.[107] President Bush signed it into law on December 8, celebrating a hard-fought political

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[103] Morgan and Campbell 135
[104] *Ibid*. 136
[105] Novak
[106] Pear and Toner (2003c)
[107] Hauser

victory.[108] Bush had been personally invested in passing the MMA, and failure to pass a bill could have been politically devastating considering future Republican electoral success leaned heavily on elderly support. Jonathan Oberlander considered Bush's victory the conclusion of a "realignment" in Medicare politics toward privatization of health provision.[109] Most of all, it was for our purposes a turning point, where PhRMA appeared to achieve a significant legislative victory and sought to lock in favorable policies for the foreseeable future.

While it is clear where PhRMA stood on the legislation, there were many more interest groups represented and involved in the negotiations for which we have yet to take account. Seniors, while initially enthusiastic about a new prescription drug benefit, were not thrilled with the end product. A Kaiser Family Foundation/Harvard School of Public Health poll conducted in August 2003 found that 34% of respondents had a favorable impression of the proposals on the table, while 37% had an unfavorable impression.[110] A poll taken the week after the legislation was signed by President Bush found that only 26% of seniors approved of the final bill, while 47% opposed the changes.[111] Seniors were especially unhappy with the prospect of having to pay the full cost of their drugs in the doughnut hole, purely a consequence of budget maneuvering. Marilyn Serafini, a reporter for the *National Journal*, described seniors as "reeling and confused at the prospect of limited help," certainly not the initial intention of the legislation.[112]

AARP, a group that typically found itself prominently involved in negotiations such as these, instead took a behind-the-scenes role until the very end. AARP's policy director, John

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[108] *Ibid*.
[109] Oberlander – Oberlander considers the first step to have been the move toward privatization that Republicans passed in 1995 (which was subsequently vetoed by President Clinton), followed by the establishment of Medicare+Choice in 1997 and the recommendations of the Breaux Commission in 1999.
[110] Kaiser Family Foundation/Harvard School of Public Health
[111] ABC News/*Washington Post*
[112] Serafini

Rother, explained that while the organization saw "drug coverage [as] a priority," the organization held back on fully entering the fray because "we weren't sure how it was going to turn out… We didn't go to national TV advertising until the end when we really needed it but we didn't think that that was necessary until the end."[113] When AARP did finally declare their support, however, it was seen as "a crucial turning point" since the group is by far the largest senior-advocate organization in the political sphere.[114] AARP's chief executive, William Novelli, made it clear that baby boomers – a soon-to-be constituency of the lobbying giant – had indicated in polls and focus groups that they were more open to privatizing aspects of Medicare than were current seniors. [115] Desiring to expand its membership by focusing on younger members, AARP catered to the group's wishes. AARP's entry spurred a massive backlash by both congressional Democrats and many of the group's own members, but its $7 million in newspaper and television advertising helped to push the bill to passage.[116]

Finally, the role of PBMs deserves attention. PBMs had originally found themselves skeptical of the legislation since increased competition among the third-party providers – an intended consequence of the bill – meant decreased profits.[117] As negotiations developed, however, PBMs came to understand the significant new business that they would win as a result of gaining both new seniors who were getting coverage for the first time and seniors who would move from retail pharmacies to Medicare-partnered PBMs. Mark Merritt, president of the Pharmaceutical Care Management Association, the trade group that represents PBMs,

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[113] Rother
[114] Serafini
[115] Stolberg and Freudenheim
[116] Pear and Toner (2003b)
[117] Morgan and Campbell 128

acknowledged the "broad new marketplace" in welcoming the passage of the legislation. PBMs were one of the biggest winners from the new drug benefit.

Having won guarantees that neither drug reimportation nor direct federal negotiation of prices would be in the bill, PhRMA might appear to have come out of the negotiating process with a strong victory. While this was the case to a certain extent, Jonathan Oberlander offers a reminder that things did not work out exactly as planned for PhRMA:

> The pharmaceutical industry got legislation largely on its terms, but this concession obscured the fact that the industry had to accommodate the Medicare drug benefit as well, an eventuality they had long opposed out of fear that it could set the stage for future government intervention in setting drug prices.[118]

PhRMA had won the battle, but they were losing the war. And still another larger question remained unanswered: were PhRMA's victories permanent? They had managed to get their way this time around, but was the matter settled? The answers come in the final section of PhRMA's story, the negotiations over the Affordable Care Act.

Defending PhRMA's Gains

By 2008, the political winds had shifted once again. In 2006, Democrats had taken back both the House and Senate, and two years later Senator Barack Obama was running for president. Evoking the theme of "Change" throughout his campaign, Obama focused on reforming Washington politics and transforming how the legislative game was played. During the Pennsylvania primary, his campaign ran an ad to that point. Titled "Billy," the ad was a clip of Obama speaking at an open house meeting, telling supporters:

> The pharmaceutical industry wrote into the prescription drug plan that Medicare could not negotiate with drug companies, and you know what? The chairman of the committee, who pushed the law through, went to work for the pharmaceutical industry making $2 million a year. Imagine that. That's an example of the same old game playing in

[118] Oberlander

> Washington. I don't want to learn how to play the game better, I want to put an end to the game playing.[119]

"Billy" was of course Billy Tauzin, and Obama was making the point that he was running for president to end the backroom-dealing revolving-door politics that had come to characterize pharmaceutical politics.

That was not the only promise Obama made during his campaign. The perennial targets of Democrats' ire remained the bans on direct federal negotiation over drug prices and drug reimportation from abroad, and the Illinois Democrat made it clear that in his administration these bans would not last. During a June 2007 Democratic primary debate in New Hampshire, Obama described the success that the VHA had had in driving down drug prices before lamenting Medicare's inability to do the same. He called the decision to include such a ban in the MMA "a profound mistake."[120] At a speech in Newport News, VA, in October 2008, Obama made a similar promise, only more explicitly:

> "First, we'll take on the drug and insurance companies and hold them accountable for the prices they charge and the harm they cause… And then we'll tell the pharmaceutical companies, 'Thanks but no thanks for overpriced drugs.' Drugs that cost twice as much here as they do in Europe and Canada and Mexico. We'll let Medicare negotiate for lower prices. We'll stop drug companies from blocking generic drugs that are just as effective and far less expensive. We'll allow the safe reimportation of low-cost drugs from countries like Canada."[121]

Obama's promises were not just for speeches. One of Obama's health care white papers also dictated that, if elected president, Obama would "Allow Medicare to negotiate for cheaper drug prices" and "Allow consumers to import safe drugs from other countries."[122]

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[119] Obama for America ("Billy")
[120] Obama (2007)
[121] Obama (2008)
[122] Obama for America (Health Care Plan)

When Obama was elected in November 2008 and made health care reform his top priority, his bold campaign promises came home to roost. And so he found himself face-to-face with Billy Tauzin on March 5, 2009 – the reformer-turned-president and the congressman-turned-lobbyist, willing to talk.

Obama had all the momentum in the world, having received an electoral mandate for change. Yet Tauzin represented a powerful and entrenched special interest, with hundreds of millions of dollars in lobbying and advertising money at the ready. What happens when an unstoppable force meets an immovable object? When the arena is politics, compromise happens. And so when the Obama administration (and Senate Democrats, led by Finance Committee chair Max Baucus) cut a deal with Tauzin and PhRMA, it was a deal that both sides were eager to make. For the White House and Senate Democrats, a deal offered the opportunity to neuter a potentially serious threat to health care reform's passage. Tauzin had privately boasted that the drug industry had a $200 million war chest that they could use to run television ads either for or against reform, depending on how negotiations played out.[123] For PhRMA, compromise brought safety from public attacks, and the chance to shape the future regulation of the industry. John Rother remarked that for PhRMA, the choice to deal was "a business decision as well as a public relations decision."[124]

The deal involved significant concessions on both sides. PhRMA agreed to $80 billion in cost savings over ten years to go toward the overall cost of health care reform, coming from four different places.[125] $34 billion would be saved in increasing the Medicaid drug rebate – a

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[123] Starr 204
[124] Rother; A prominent pharmaceutical industry executive disagreed, claiming that the willingness to negotiate was more "driven by fear" than anything else [Anonymous (b)]
[125] Kirkpatrick; a leaked memo was published by *The Huffington Post* (Grim) that gave a rough outline of the deal described above.

program that provides discounted drugs to Medicaid beneficiaries – from 15.1% to 23.1% of the original price. $25 billion would be saved via a 50% discount on drugs bought by seniors in the doughnut hole. $9 billion would be saved through a program to streamline the approval process for follow-on biologics. The final $12 billion would be saved through a new tax on the pharmaceutical industry. While this $80 billion seems like a lot of money, it is important to remember that the savings are coming over ten years, and the industry's twelve largest companies brought in $78 billion in profits (from $489 billion in revenues) in 2009 alone.[126]

In addition to the cost savings the industry provided, PhRMA proffered $150 million for advertising on behalf of health care reform. PhRMA's money funded two groups: Healthy Economy Now and Americans for Stable Quality Care.[127] The groups' ads were gauzy and positive, focusing on the good that reform could bring, not on greedy corporations or intransigent Republicans.[128] The money behind Healthy Economy Now and Americans for Stable Quality Care constituted the biggest paid advertising for reform, but the content was less meaningful than its funders. Much to the chagrin of the Obama administration, PhRMA strongly resisted drawing sharp contrasts with the insurance industry. As Richard Kirsch points out, it did not make sense for the pharmaceutical industry: "PhRMA would not tolerate a hard-hitting message that demonized their biggest customer."[129]

PhRMA was savvy to use advertising as a bargaining chip in negotiations. While the industry had already begun running pro-reform ads (as a good faith gesture) before a deal was struck, they made it clear that their war chest could easily be turned against reform if

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[126] CNN Money
[127] Smith and Vogel
[128] The ads can be seen at http://www.youtube.com/user/HealthyEconomyNow and http://www.youtube.com/user/stablequalitycare
[129] Kirsch 135

negotiations soured.[130] Indeed, locking in a guarantee that PhRMA would not advertise against reform was just as important – if not more so – to Obama and Senate Democrats as getting the industry to work on reform's behalf. Larry Atkins, an executive at Merck, claims that "Buying the silence of the industry was probably the smartest aspect of the whole deal."[131] This afforded PhRMA a great deal of leverage in working out what they wanted on their end.

In exchange for their concessions, PhRMA received a guarantee that the ban on the two policies that they had long fought – drug reimportation and direct federal negotiation over drug prices – would not be touched during health care reform negotiations. This victory was seemingly a coup for the industry. Beyond the fact that Obama had campaigned on repealing both of these bans, they were both policies that had appeared to be "done deals" once Democrats took back the House and Senate in 2006.[132] As a senator, Obama had voted against both policies when they had come to the Senate.[133] Guaranteeing that these top priorities of the industry were met had seemed to be a long shot entering negotiations, but PhRMA appeared to come away the big winners.

There was a significant backlash when details of the deal were announced, especially among progressive Democrats. On July 31, House Energy and Commerce Committee Chair Henry Waxman had passed the House Democrats' reform bill that allowed for government negotiation of prices and asked for $160 billion in concessions from the pharmaceutical industry.[134] On August 4, in an attempt to head off the bill's growing momentum, Tauzin

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[130] *Ibid*.
[131] Atkins
[132] Campbell and Morgan (Undated)
[133] "On the Cloture Motion (Motion to Invoke Cloture on the Motion to Proceed to the Consideration of S. 3)"; "On the Cloture Motion (Motion to Invoke Cloture on the Dorgan Amendment No. 990)"
[134] Pear and Herszenhorn

released details of PhRMA's secretly negotiated deal to the media. Calling it a deal that "the White House blessed," he recounted the administration's eagerness to compromise with the drug industry, recalling "We were assured: 'We need somebody to come in first. If you come in first, you will have a rock-solid deal.'"[135] Raul Grijalva, co-chair of the House progressive caucus, called Tauzin's comments "disturbing."[136] Both Waxman and Speaker Nancy Pelosi said that they would not be bound by the deal, to which neither had been a party.[137]

Democratic senators who were unhappy with the deal attempted to amend the legislation. In late September, Bill Nelson introduced an amendment to the Senate Finance Committee bill that would have undone the deal and brought in an additional $106 billion in revenue from the pharmaceutical industry, enough to completely close the doughnut hole on its own. The amendment failed 13-10 when Robert Menendez and Tom Carper (Democratic senators whose states are home to Merck and Bristol-Myers Squibb, and AstraZeneca, respectively) voted alongside Baucus and the committee's Republicans.[138] In mid-December, Byron Dorgan proposed an amendment to allow drug importation, but it would have broken the deal that Obama and Senate leadership had with PhRMA, so Obama and Harry Reid convinced 24 Democratic senators who had previously voted for it to reverse their votes.[139] Dorgan's amendment failed to break a filibuster, garnering only 51 votes.[140] These two failures to change the legislation allowed the bill to escape the Senate with the deal intact.

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[135] Hamburger; Kirkpatrick
[136] *Ibid*.
[137] Grim
[138] Frates (2009a)
[139] Kirsch 298
[140] Frates (2009b)

PhRMA left nothing to chance, even with a deal in place. They spent $26 million on lobbying members of Congress in 2009.[141] This was a huge amount, even for their typically high lobbying budget.[142] They retained a whopping 184 lobbyists, of whom 137 were former congressional staffers (including two former chiefs of staff to Max Baucus) and six were former members of Congress (including Senators Trent Lott and John Breaux).[143] Beyond lobbying, PhRMA continued to use targeted campaign contributions, much as they had done in 2003. They were cognizant of the shifting political influence in Congress, and as a result, for the first time since 1990, PhRMA donated more money to Democrats than Republicans.[144]

Despite everything PhRMA did to guarantee its passage, the deal may very well have been altered in conference committee had it not been for Ted Kennedy's death and Republican Scott Brown's election in January 2010. Brown's election destroyed the Democrats' filibuster-proof majority and forced Democrats to resort to a parliamentary tactic known as budget reconciliation. Reconciliation allowed the bill coming out of conference – a bill largely similar to the Senate's original legislation, with the deal intact due to reconciliation's restrictions – to pass without facing a filibuster. The new version of the bill passed both the House and Senate, and President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law on March 23, 2010.[145]

It seems as if both Obama and PhRMA got what they wanted out of the deal. Obama received $80 billion in cost savings and the support of the industry for a bill that eventually passed. PhRMA managed to keep their two policy bugaboos – drug reimportation and direct

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[141] Blumenthal
[142] cf. Figure 4, which shows how PhRMA spent more on lobbying in 2009 than it ever had before. 2009 remains the drug industry's high-water mark for lobbying expenditures.
[143] Center for Responsive Politics ("PhRMA 2009")
[144] Blumenthal
[145] Stolberg and Pear

price negotiation – off the table. The only person for whom the story does not end well is Billy Tauzin. Tauzin resigned in early February 2010, weeks after Brown's election put the brakes on health care reform.[146] While it was not immediately apparent why Tauzin left, commentators speculated that when Brown's election threw the future of health care reform into limbo, pharmaceutical executives felt that Tauzin had given up too much and that all of his negotiations had been for naught.[147] Tauzin called such claims "bullcrap" and "baloney," and asserted that his decision to step down was completely personal.[148] A post-mortem on Tauzin's resignation by *Politico* found that Tauzin's departure may indeed have been largely unrelated to his performance during health care reform.[149] Instead, Tauzin's influence had been weakened dramatically by turnover among congressional Republicans; Tauzin simply did not have as many contacts in Congress as he once had. He also had a "hands-off" negotiating style, and may not have been as involved in the day-to-day negotiations as he made it appear. One drug lobbyist said "Nothing changes on the PhRMA deal because the secret is that they weren't talking to him anyway."[150]

Regardless of Tauzin's actual involvement, PhRMA came out of the Affordable Care Act negotiations with what was considered a great win. The next chapter will examine whether their apparent victory was actually so great.

Chapter III: Applying the Theory

In the first chapter of this paper, I laid out the three theoretical frameworks from which I would be drawing: Hacker and Pierson's theory of strategic goals and preferences, Lindblom's

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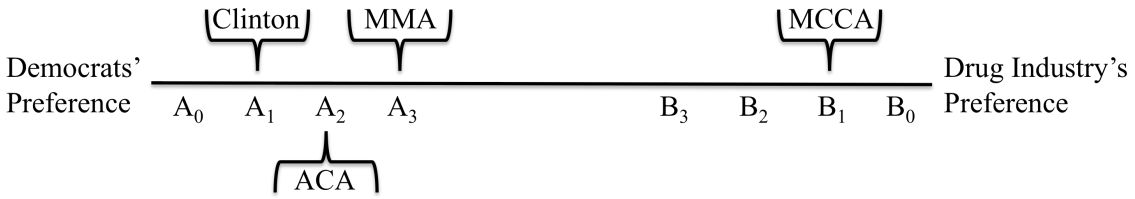
[146] Wilson and Kirkpatrick
[147] Frates and Brown
[148] Frates (2010)
[149] Cummings, Frates, and Brown
[150] Frates and Brown

outline of business's privileged position, and Moe's concept of interest groups' roles in establishing autonomous bureaucracies. In this penultimate chapter, I will walk through the three frameworks and see how they applied to PhRMA's story.

Strategic Goals and Preferences

PhRMA's fight over the prescription drug benefit can be neatly tracked onto the array developed by Jacob Hacker and Paul Pierson. Figure 6 shows the evolution of the policy fight over the course of the twenty years of our story. Instead of Actor A and Actor B, we have Democrats and the drug industry, arrayed from left to right.[151]

Figure 6: Ranked Policy Preferences of PhRMA and Democrats



Our story starts at point B_1, when the Medicare Catastrophic Coverage Act was passed and then repealed in 1988. The drug industry flexed its political muscle using strong lobbying and political mobilization, successfully repealing the drug benefit included in the MCCA. This was a significant victory for the industry, and the only reason the action ended up at B_1 rather than B_0 – the industry's ideal point – is that the legislation was passed in the first place. A truly unequivocal victory for the drug industry would never have seen the MCCA's passage.

The biggest shift in the action, and what I argue is a pivotal point in the drawn-out fight over a prescription drug benefit, was President Clinton's decision to pursue a government-provided plan in 1999. When Clinton highlighted the need for a plan in the 1999 State of the

[151] When I use "Democrats," I am referring to the general party sentiment over the past twenty years. There are obvious exceptions – Democrats who stood alongside PhRMA – whom I ignore here.

Union, he set in motion a series of events that eventually led to the passage of Medicare Part D four years later. A prescription drug benefit had been anathema to PhRMA for the previous ten years, and they had consistently claimed that its inclusion in Medicare would lead down the slippery slope to government price controls. Clinton's speech brought the parties to point A_1, a colossal swing that effectively kick-started the progress toward a drug benefit. This swing was quickly acknowledged by the drug industry – the president of PhRMA came out in support of what would become Medicare Part D only six months after Clinton's address. PhRMA was reeling and public support for a benefit was growing at a rapid rate. Democrats – largely on the back of Bill Clinton – won this round.

Four years later, George W. Bush and a Republican Congress passed the Medicare Modernization Act of 2003. While PhRMA had backed the legislation the entire time, managing to secure bans on drug reimportation and direct government negotiation over drug prices, the MMA's passage cannot be considered a victory for the drug industry. The passage of Medicare Part D legislation was the culmination of nearly fifteen years of work by Democrats who had finally managed to win a prescription drug benefit. Though PhRMA had gotten its two bans, a government drug benefit can only be seen as a loss for the industry, and until Medicare Part D is repealed, the ball will be firmly in Democrats' court. The passage of the MMA sits at A_3 because PhRMA managed to secure its top two priorities.

The most recent episode of the drug industry's fight over regulation and the prescription drug benefit came during the Affordable Care Act. Billy Tauzin struck a deal with the Obama administration, ensuring the continuation of the bans on drug reimportation and government price negotiation in exchange for an advertising cease-fire during health reform negotiations. Yet while it appeared that PhRMA clearly got the better of the deal, two things have become clear.

First, Medicare Part D remained fully intact, guaranteeing that government would have some involvement in the provision of prescription drugs for the foreseeable future. Second, when PhRMA was forced to renegotiate their two prioritized bans they implicitly acknowledged that these bans were up for debate. While Obama conceded defeat over the two issues on which he had campaigned, it was not for lack of trying. Instead, the president and his administration made the strategic calculation that the perfect should not be the enemy of the good, especially when antagonizing PhRMA could have given rise to the very real possibility that the industry would strike back and completely sink reform. Once again, PhRMA won the battle. But by showing their hand – revealing that their two bans were still on the table – PhRMA conceded important ground in the longer war over regulation, bringing us to our current position, point A_2.

While we've settled where action now stands, another issue remains: how did PhRMA end up in this weakened position? The next sections take up Lindblom and Moe's theories, which address this lingering question.

Structural and Instrumental Power

While PhRMA's instrumental power was never in doubt, the industry did not occupy the "privileged position" that Lindblom described as giving business more than "merely an interest-group role."[152] PhRMA lacked the strong structural power that businesses can usually threaten credibly. PhRMA's fatal flaw was that their negative reaction to regulation loomed not in terms of losing jobs, but in terms of harming innovation. Going back to Clinton's push for a drug benefit in the late 1990s, the president of PhRMA cautioned that the drug industry would be willing to cooperate, but that over-regulation would harm innovation. This threat was reiterated consistently during negotiations over both the MMA and PPACA. Regardless of the true harm of

[152] Lindblom (1977) 170

reform to drug industry innovation (some experts dismiss the existence of any real threat), PhRMA representatives made sure to spell out the risk to future development that reformers were running.[153]

When Lindblom described the market as a prison, he argued that government regulators were held hostage by the threat of jobs being killed, not innovation being stifled. There is a fundamental difference between destroying jobs that workers – and voters – already have and not creating a future, unknown, product: one is real, tangible, and measurable, while the other is nebulous and hypothetical. Even with no regulation, the industry cannot guarantee what new products will be developed. Lawmakers respond to the threat of destroyed jobs; they are significantly less concerned by the threat of suppressed innovation.[154] This may serve to explain why Republicans have taken to calling businessmen "job creators" rather than "innovators." More importantly, it explains why legislators were less worried by PhRMA's structural threats than the industry would have hoped. This lack of credibility in turn led to significantly less negotiating power.

Development of an Autonomous Bureaucracy

While Charles Lindblom can begin to explain PhRMA's weak leverage, Terry Moe is needed to complete the picture. In "Toward a Theory of Public Bureaucracy," Moe describes how, due to political uncertainty, interest groups will attempt to insulate their bureaucratic creations from future meddling by designing programs that "entail the 'separation of politics from administration.'"[155] While Moe describes interest groups as acting to create independent public bureaucracies, PhRMA, in helping to pass the MMA, established a *private* bureaucracy –

[153] Klein
[154] See Arnold for a more detailed discussion on what motivates legislators.
[155] Moe

a Medicare prescription drug benefit administered by private, for-profit PBMs. Guaranteeing that the drug benefit went through PBMs was intended to keep it from traveling down the slippery slope toward government price controls. Regardless of the means by which the benefit was provided, the goal of PhRMA was the same as the interest groups Moe describes: to ensure that their new benefit could not be altered by future generations of opponents. Along with securing private provision of the drug benefit, however, while negotiating Medicare Part D, PhRMA sought to lock in bans on two additional policies that it feared could lead to price controls: drug reimportation and direct federal government negotiation over prices. They managed to write these policies into the MMA, and hoped that in combining them with the establishment of the private provision of Medicare Part D, the two bans would remain untouched.

While PhRMA has so far been successful in ensuring that Medicare Part D remains run through PBMs, they appear to have been significantly less successful in making their two bans untouchable. The need to relitigate these two bans in the PPACA signals that the issue was not settled even six years after President Bush signed the MMA. The inability to establish path dependence on these two issues is a significant weakness of PhRMA's, and can be explained by two things: the issues' public popularity and Obama's strong campaign against the bans.

Even if the economic benefits of repealing the bans are questionable, its popularity among voters is not. Table 1 shows that, in the years between the passage of the MMA and the negotiation over the PPACA, there was consistent support for repealing the bans on both issues. The strong and steady popular endorsements for both policies made closing the book on the issue after the MMA nearly impossible.[156]

[156] This conclusion is largely of accord with Mark Smith's findings in *American Business and Political Power*

Table 1: Public Support for Drug Reimportation and Federal Negotiation of Drug Prices				
	Drug reimportation		Federal negotiation of prices	
	Support	Oppose	Support	Oppose
November 2003	64	25		
February 2004	70	24	71	27
June 2004	71	20		
October 2004			79	12
November 2004			80	13
March 2005			77	14
May 2005	79	18		
November 2005	75	20		
November 2006			85	9
January 2007	63	31	80	15
February 2007	77	16		
October 2008			89	10
December 2008			90	9

Source: Kaiser Family Foundation/Harvard School of Public Health (2008); *Los Angeles Times*/Bloomberg; Health Pulse of America Survey (2003); Health Pulse of America Survey (2004); Kaiser Family Foundation (2005); Kaiser Family Foundation (2004) Democracy Corps; CBS News/*New York Times*; AARP

If strong public support was not enough to necessitate another look at the bans, Barack Obama made their repeal a key campaign issue in 2008. As part of his emphasis on health care reform during the general election, Obama prioritized repealing the bans on drug reimportation and direct federal negotiation over drug prices. When Obama was elected and brought his momentum to the table, PhRMA recognized that the issues that they had previously thought settled were once again up for discussion. The combination of popular support and Obama's momentum necessitated the renegotiation of the bans, a reflection of PhRMA's relative weakness.

Lindblom and Moe's theories explain how PhRMA ended up in such a weak position. Their claim to structural power was significantly overrated, as no one in Congress responded to their threats of reduced innovation. Additionally, public popularity on repeals of both bans, along with a newly-elected president who brought significant momentum to the issues, meant that drug reimportation and federal price negotiation were back on the table. Having examined where the

action stands and the source of PhRMA's weakness, the final chapter can examine larger lessons that we can draw.

Chapter IV: Conclusion

What can we take from the twenty two-year history of PhRMA's involvement in politics? There are several lessons that stand out. First, and most significantly, we have seen that PhRMA is not as powerful as it appears. When PhRMA's deal with the Obama administration was revealed, charges of capture abounded. Critics on the left feared that this was the beginning of a process that would ultimately neuter any real reform.[157] Some of their fears are well-founded; the drug industry is certainly much stronger in the United States than in any other nation in the developed world.[158] Yet PhRMA's position was significantly less strong than it seemed. Obama's deal with Tauzin was a reflection of the drug industry's strong war chest, but what the president gave up – maintaining the status quo on two unpopular policies – was much less than what he gained – a ceasefire from a group that could have sunk reform by itself.

PhRMA had lost the real war more than ten years earlier when President Clinton first laid out his plan for a prescription drug benefit. The bans on drug importation and federal drug price negotiation are relics of their time, and likely to fall once a new president targets them directly. This then begs the question, might PhRMA's underlying preferences have changed? As their vulnerability to government regulation has increased, they may well have shifted their underlying preferences such that they now depend on and seek out government to provide a steady client base. This initial political weakness led to economic weakness, which has now

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[157] Cf. Hamsher, who called the deal "corrupt"

[158] Jacobson; her report found that Canada, Australia, and European nations use "reference pricing, price ceilings, parallel trade [another name for the drug reimportation that PhRMA has fought in the U.S.], profit sharing [and] value-based pricing policies to mitigate increases in pharmaceutical expenditures due to price increases."

come full circle, making the drug industry appear weak because its true preferences may be more closely aligned with Democrats' than previously posited. This subject requires further research, which is outside the scope of this paper. But these new developments ought to change the way PhRMA is seen in Washington. The industry is not as fearful as we all think, and may well be a potential ally of Democrats' in the future.

Secondly, we have seen the power of agenda setting to shift the political field. The most significant swing of the fight over a drug benefit came when President Clinton made it a priority in his 1999 State of the Union. His speech set in motion both a popular and elite shift in opinion. The drug benefit eventually gained the support of both parties' presidential candidates in 2000 before finally being signed into law in 2003. Clinton's speech made a powerful difference in overcoming opposing interest groups to enact a Medicare prescription drug plan.

Similarly, we have seen the power of public opinion and momentum to change the shape of political debate. PhRMA believed that it had successfully locked in the bans on drug reimportation and federal price negotiation after the Medicare Part D negotiations. Yet the combination of strong public opinion against the bans and Obama's emphasis on their repeal during his campaign suddenly brought the two issues to the fore. While Obama had to trade the continuation of the bans in exchange for PhRMA's agreement to not fight health care reform, this does not mean that the issue is settled. Just as it was in the lead up to the PPACA, repealing the bans remains popular, and a future president with a mandate for change could almost certainly end the interdictions if she took them on outside a broader health care reform

context.[159] This episode shows how policy lock-in is fragile when faced with strong public support and political momentum.

Finally, we reach the question of structural business power. PhRMA's threats that regulation would hamper industry innovation fell largely on deaf ears in Congress. While representatives of the pharmaceutical industry warned that decreased innovation would keep life-saving drugs off the market, PhRMA was significantly more successful at getting its way when it threatened to use its colossal war chest to sink reform. Their miscalculation was in the belief that their position remained privileged even if regulation of the industry would not kill jobs. The clear distinction between the threat of killing jobs and that of hampering innovation – along with the conclusion that the former is significantly more powerful than the latter – is important for understanding why employers have considerably more influence in Congress than those firms that are not human capital-intensive. There is a significant literature on types of business power. There ought to be more on the types of business that have power.

The drug industry's history is unique, but that does not mean that it is not worth studying. The lessons that we can draw with regards to structural and instrumental power, agenda setting and public opinion, and strategic goals and preferences are more broadly applicable and can help to shape our understanding of the influence of business in politics. The study of business power in American politics is developing quickly, and I hope that with this paper, PhRMA's story can make a small contribution to it.

[159] One drug industry executive believes that "importation will never go away" until it is passed in Congress [Anonymous (b)].

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