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VIEWPOINT

Financial Realities Affect Political Support for Health Care Reform

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INTRODUCTION

It is certainly not a surprise to anyone that the influence of lobbyists on many pieces of legislation is significant, pervasive, and effective in achieving specific goals of parochial interest groups. One can guess as to the influence the contributions have on many aspect of what extends into laws affecting many aspects of our lives. The effects (of perhaps funding shifts to other items) on health care, health care systems, health insurance programs, health professions, health professionals, and health professional educational programs are blatant and oppressive because of neglect of other worthy funding points. National Institutes of Health (NIH) funding for research, significant amounts of which can and has funded research conducted by faculty members within our academy in our schools and colleges of pharmacy, has remained virtually stagnant since 2003.[1] Other research funding has been neglected as well. How can worthy funding options, ever so important to our colleagues, compete with the entrenched special interest groups significantly impacting how money is spent in the United States? State legislative funding for public schools and colleges also entails examining competing options supported by lobbying entities with far deeper pockets that any public university can ever hope to muster. Our publically funded higher education institutions are expressly prohibited from political contribution schemes, as they well should be. Meanwhile, funding for higher education supported by state legislatures has at best remained stagnant or has been significantly reduced presently and in the recent and not so recent past.

Follow the Money

The passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) is a case in point of how funding follows lobbyists' collective activities. The Medicare Part D Drug Program as a part of this legislation overtly favored pharmaceutical manufacturers, insurers, and pharmacy benefit management companies in an egregious fashion. Pharmaceutical companies were and are allowed to do business as usual with multiple pricing levels, and they retain the ability to raise prices at will. The MMA legislation specifically prohibits the Centers for Medicare and Medicaid Services (CMS) from negotiating with pharmaceutical companies for advantageous prices that these same companies provide freely elsewhere. The Federal Supply Schedule (FSS) pricing has allowed the Veterans Health Administration (VA) to purchase drugs at reduced prices and the federal 340B Drug Pricing Program provides access to reduced price prescription drugs to over 12, 000 health care facilities certified in the United States. Pharmaceutical companies remain profitable even with these reduced pricing programs partly due to their ability to shift price hikes elsewhere in a multi-layered process of drug pricing.

The current health care reform proposal that has passed in the US Senate contains no requirement for governmental negotiation for prescription drugs within Medicare Part D. The House of Representatives bill does contain a requirement for direct price negotiation between the Secretary of Health and Human Services and pharmaceutical companies. This among other differences will be hammered out in the Senate and House joint negotiations in committee.

To provide for optimum participation by Medicare Part D prescription drug plans (PDPs) and Medicare Advantage (MA-PDPs, as a component of managed care Medicare Part C) drug plans, incentive were a component of the MMA legislation which provided PDPs and MA-PDPs significant subsidies containing upfront funding to allow for these companies to participate with an assurance of profitability.[2] In effect, participating plans were given a profitability fallback regardless of what happened with enrollment into their plans by eligible seniors, and were thus risk averse from a lack of enrollment and/or profitability with their proffered plans.

As the legislation was written and enabled, for the first year of the program, due to overpayment to PDP and MA sponsors, Part D plan sponsors owed Medicaid a net total of $4.4 billion for the year 2006. This amount of overpayment has been reduced to $600 million for

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2007—a significant reduction, but this amount remains sizeable. These overestimated payments provided to plans were to be returned to Medicare. However, to further complicate this matter, CMS had no mechanisms in place to collect funds from such overpayments. It was finally set in play and accomplished well into 2007 for the 2006 payments, as such, sponsors held significant amounts of money for an extended period of time. Lobbyists exerted pressure to pass the MMA in the form in which it was enacted.

The Current Health Care Reform Situation

The outcome of the current health care reform efforts in play at present is still very much in doubt and in obvious flux and will depend on House and Senate compromises in joint committee negotiations and final votes in both chambers. The timeframe and eventual scope of changes in the financing and delivery of health care and health care insurance are simply unknown at present. In the Senate, members of the Senate Financing Committee were key cogs in the passage of health reform legislation, and most certainly will majorly impact what the scope and extent of such reform might take. In light of this, it is interesting to observe what these key Senate members have received in the way of lobbyist support in the current year, and over a period of time.[3] Please see Table 1 for the amounts provided from "health sector" contributors during this past year and over their term of service (lifetime) in the Senate. Health sector contributions can come from pharmaceutical and/or device manufacturers and the health insurance industry.

The health care lobbyist influence on health care matters is significant.[4] According to Northwestern University's Medill News Service, the number of former House and Senate key staffers turned lobbyists is significant.[4] There are 14 former chiefs of staff and 4 former deputy chiefs of staff among the more than 200 former Congressional aides working now as lobbyists and registered in 2008-2009.[4] In the US Senate, Senator Harry Reid (D-NV), the Senate majority leader, heads the list with 13 former staffers turned lobbyists; Dick Durbin (D-IL), the Senate majority whip, has 8 former staffers; Mitch McConnell (R-KY), Senate minority leader has 5 former staffers; and Jon Kyl (R-AZ), the Senate Minority whip has 4.[4] In the US House, Representative Steny Hoyer (D-MD), House majority leader, leads with 14 former staffers turned lobbyists; Representative Nancy Pelosi (D-CA); and Speaker of the house has 5; Representative John Boehner (R-OH), House minority leader, has 4.[4]

Table 1. Lobbyist Support for US Senators Who are Members of the Senate Finance Committee

Senator	2008 Contributions - Health Sector	Lifetime Contributions - Health Sector
John Kerry (D-MA)	$289,430	$8,145,141
Max Baucus (D-MT)	$1,148,775	$2,797,381
Orrin G. Hatch (R-UT)	$122,300	$2,311,744
John Cornyn (R-TX)	$950,669	$1,994,353
John D. Rockefeller IV (D-WV)	$55,150	$1,674,229
Chuck Grassley (R-IA)	$334,237	$2,311,744
Jon Kyl (R-AZ)	$68,550	$1,971,968
John Ensign (R-NV)	$16,550	$1,795,899
Kent Conrad (D-ND)	$117,350	$1,331,363
Blanche Lincoln (D-AR)	$226,753	$1,281,608
Charles Schumer (D-NY)	$10,000	$1,402,358
Robert Menendez (D-NJ)	$81,650	$1,216,476
Debbie Stabenow (D-MI)	$239,018	$1,188,186
Bill Nelson (D-FL)	$60,015	$1,163,210
Ron Wyden (D-OR)	$96,925	$1,161,488
Jim Bunning (R-KY)	$40,450	$1,045,687
Pat Roberts (D-KS)	$657,749	$903,337
Jeff Bingaman (D-NM)	$14,151	$861,841
Olympia Snow (R-ME)	$6,000	$744,640
Mike Enzi (R-WY)	$287,549	$612,715
Maria Cantwell (D-WA)	$48,951	$573,076
Mike Crapo (R-ID)	$92,000	$549,192
Thomas Carper (D-DE)	$15,450	$452,000

Source of data: Visualizing the Health Care Lobbyist Complex. http://www.sunlightfoundation.com/projects/2009/healthcare_lobbyist_complex

These are significant contributions and contributors in the individual and collective sense. In my estimation, this is a significant sum of funds provided to many of both political persuasions. I will leave it to each reader to draw their own conclusions about these amounts and the results that might be seen or not seen in the final form of health reform.

These are Senators and they work at the federal level and greatly impact each of our institutions regionally and locally. Funding scenarios by these vested interests may be less intense in terms of dollar volumes in our states and state legislatures, but these groups in the health sector providing funding at the federal level also fund state legislators in each of our states. Here the competing interests for funding affecting state Medicaid programs most definitely intersect with states' funding for higher education and other funding options within our states for support of higher education.

As we see funding challenges and crises in our academy for teaching and research programs, our collective voice (regardless of how worthy our programs are for support and what we seek as support) seems inconsequential in comparison with what organizations and trade associations see and enable with their very deep and overtly generous pockets.

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