

The Role of Specific Political Factors
**Interest-Group Influence on the Patient
Protection and Affordability Act of 2010:
Winners and Losers in the Health Care
Reform Debate**

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On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act, achieving a feat that had eluded other presidents since the 1930s (Quadagno 2005). The main features of the legislation included state insurance exchanges, mandates on individuals and employers, an expansion of Medicaid, and subsidies to help low-income people afford coverage. Also included were stringent regulations on insurance companies, cuts to Medicare Advantage but an improved drug benefit for seniors, and restrictions on the use of subsidies to pay for abortion. Other features, such as Accountable Care Organizations, bundled payments, and funds for cost-effectiveness research, were designed to slow spending growth and to improve quality and efficiency. This conglomeration of measures was necessary not only to expand coverage, the key objective of the legislation, but also to reduce opposition from the numerous constituencies with a vested interest in the health care system. The preferences of these interest groups helped shape the final law in ways that had little to do with reducing the number of uninsured. This essay will focus primarily on the interest-group activity surrounding coverage expansions, although interest groups were involved in all aspects of the legislation.

A key constituency was the private insurance industry. Insurers were willing to accept stricter regulations, including price controls and guaranteed-issue health insurance without preexisting condition exclusions, *if* these regulations were accompanied by an individual mandate.

An individual mandate would bring young, healthy people into the system to help pay the costs of older, sicker people (Mitchell 2009). What was entirely unacceptable to insurers, however, was the public option, which would have offered an alternative to private insurance. Fearing that a new public program could outcompete private insurance on price and quality, insurers launched a campaign against it, arguing that a government-run plan, with its favorable tax and regulatory treatment, would undermine the private insurance industry (Harwood 2009). Leading insurer organizations set up advocacy hotline operations and prepared sample letters and statements to an army of industry employees. When members of Congress, home for the August recess, held town hall meetings, boisterous critics mobilized attacks on the as-yet unspecified plan, spurred on by conservative radio talk show hosts (Hamburger and Geiger 2009).¹

The final law did place more stringent regulations on insurers, including an unpopular rule requiring insurance companies to spend at least 80 percent of premiums on medical benefits for patients by 2011. More palatable to insurers were an individual mandate and the lack of a public option. Insurers are thus likely to do quite well in the long run. They will have a stable pool of clients, with government subsidies to help those with lower incomes purchase coverage, and they will be paid the full cost of the benefits they provide plus their administrative costs (Hamburger and Geiger 2009).

Employers and trade unions also had a huge stake in the outcome. Nothing less than the future of the employment-based health insurance system was at stake. Private health benefits attached to the job were first negotiated by the trade unions in the 1940s. They were constructed in an era when the goal, if not the reality, was to work continuously with a single employer across the life course, accompanied by benefits that would provide protection against the risk of unemployment, poor health, and old age. Even after the vision of lifetime employment had died and it was clearly normative for most people to work for multiple employers, health benefits remained tied to the employment contract.

When health care reform moved to the top of the political agenda during the 2008 election campaign, the trade unions were willing to discuss alternatives to the current system, given their worries about the costs and

1. See also White's essay in this issue for how legislators reacted to the public option, and see essays by Brasfield and Gottschalk for factors that impacted the emergence of the public option as a policy idea.

long-term sustainability of employment-based coverage. The American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) launched a major campaign in support of health care reform but took a hard-line stance favoring the public option. As newly elected AFL-CIO president Richard Trumka said, “It’s an absolute must. We won’t support the bill if it doesn’t have a public option in it” (Martin 2009). The Service Employees International Union (SEIU) was more pragmatic and agreed to support health care reform, even without a public program. Both unions worked for health care reform but the public option was deleted at the last minute. The AFL-CIO also opposed a new excise tax that was imposed on insurers of high-cost employer-based plans. Although an excise tax was included, the union did succeed in weakening the provision and delaying implementation. Still, the tax could have long-term ramifications that may further unravel job-based benefits.

Another constituency consisted of senior citizens who feared that health care reform would reduce their Medicare benefits. An ominous portent of their wrath was on view in the 2009 special election in Massachusetts to fill the seat of Senator Ted Kennedy, whose untimely demise put health care reform at risk. In that election people sixty-five and older voted overwhelmingly against the Democratic candidate. Their concerns about Medicare cuts made it easy for opponents of health care reform to convince them that they would lose benefits. Yet the final law improved the Medicare drug benefit and contained a new long-term care program. As these benefits become visible, concerns among this demographic nationwide are likely to lessen.

Pro-lifers also entered the fray, continuing a campaign begun in the 1970s against the use of federal funds to pay for abortions, either directly or through subsidies to insurance companies (Quadagno and Rohlinger 2009). During debate on the House bill, Catholic bishops worked behind the scenes to lobby for abortion restrictions. They succeeded in inserting language prohibiting government-run plans from paying for abortion (except in cases of rape or incest, or when the mother’s life is in danger) and in banning any health plan that received a federal subsidy from offering abortion coverage. The less-stringent Senate bill prohibited the use of taxpayer money to pay for abortions and required insurance companies to segregate private premium funds from government subsidies. In the final legislation, the compromise language dictated that federal premiums or subsidies could not be used for the purchase of abortion coverage and had to be segregated from private premium payments or state funds.

Physician organizations were less a factor in 2010 than in previous health care reform debates (Quadagno 2005).² One reason is that by the 2000s—unlike the 1960s, when the American Medical Association (AMA) represented the vast majority of doctors—physicians were divided among numerous specialty and special interest groups. Another reason is that, as a group, physicians were deeply divided about what form the health care reform should take. The liberal Physicians for a National Health Program (PNHP) wanted to eliminate the private insurance industry entirely and opposed any solution other than a single-payer system. In the view of PNHP members, the legislation was like “seeing aspirin dispensed for the treatment of cancer” (PNHP 2010). Further, they argued, “instead of eliminating the root of the problem—the profit-driven, private health insurance industry—this costly new legislation will enrich and further entrench these firms” (*ibid.*). In contrast, the AMA favored expanding tax advantages for health savings accounts. The disagreement among physicians reduced their influence on the final bill.

In 2010, as in the past, numerous groups had a vested interest in the health care system. Few of these groups received everything they wanted, but nearly all won some concessions that dampened their opposition. The final result was an imperfect bill that will restructure the health care system in ways that are yet to be determined. Nonetheless, millions more people will be covered, and the exchanges have the potential to slow health care inflation, simplify consumer choice, and reduce the worst abuses of insurers. As health care reform moves to the implementation phase, the interest groups are gearing up once again to be sure that their concerns aren’t ignored (Appleby, Carey, and Galewitz 2010). The devil is indeed in the details.

2. Please see Laugesen’s essay in this issue.

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