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A Just Framing of Healthcare Reform:
Distributive Justice Norms and the Success/Failure of Healthcare Reform in America

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Abstract

In 2010 President Obama did the politically unthinkable: he passed healthcare reform that has the effect of providing healthcare to all Americans. What makes this feat so impressive is that other presidents (Franklin Roosevelt, Harry Truman, Lyndon Johnson, Richard Nixon, and Bill Clinton) all tried and failed in their efforts. Why did Obama succeed and these other presidents fail? Using agenda setting and issue framing theories, this study explores how each of these presidents framed their healthcare reform efforts. In particular, this study focuses on how each president framed reform in terms of distributive justice and the four principles of allocation (equality, merit, need, and efficiency) available to them. Content coding major policy addresses of each president in order to generate frequency distributions, the analysis presented here demonstrates that President Obama was successful because he framed healthcare reform in terms consistent with the American public's distributive justice preferences. Unlike previous presidents who attempted to combine the principles of need and equality, President Obama combines need and efficiency in a policy frame that not only captures the preferences of the American public, but undermines the argument of his political opposition. The analysis and argument advanced here speak to the power of marrying language and politics in the rhetorical presidency and the ability of presidents to pursue political change. Future efforts in healthcare policy development created by the Trump administration and subsequent presidential administrations should attempt to follow President Obama's lead in creating policies that accord with Americans' understanding of distributive justice.

Chapter One

Introduction

On March 23, 2010 President Barack Obama signed into law the Affordable Care Act (ACA). The centerpiece of this legislation is the requirement that all Americans are required to have healthcare. Leaving aside the debate that continues over this landmark piece of legislation, a more fundamental question emerges when one considers the ACA: Why was President Obama able to pass significant healthcare reform and move the United States towards achieving universal healthcare coverage for all American citizens when other presidents who tried to enact universal healthcare coverage in the past have failed?

Prior to President Obama, five presidents--FDR, Truman, Nixon, Johnson, and Clinton--tried and failed to pass significant pieces of healthcare legislation which would ultimately provide a form of universal healthcare coverage to the American people. In the 1930s, FDR attempted to place a provision for publicly funded healthcare into the Social Security Act but this piece of healthcare policy legislation never made it onto the legislative agenda largely due to the lobbying efforts of the American Medical Association (AMA). Truman, moving past FDR, actively sought to propose and support universal healthcare reform as part of his 1949 Fair Deal Program. Johnson, taking a more pragmatic approach, succeeded in passing both Medicaid and Medicare legislation which aided both low-income and disabled American citizens. Johnson's efforts to move the United States any further toward universal coverage were not as successful. Looking to build on this success, Nixon (in February 1971) proposed an employer mandate and called for federal Medicaid for dependent children; Nixon sought to extend this proposal to effectively provide all American citizens with healthcare. Nixon's efforts ultimately proved to be unsuccessful. In February 1974, Nixon tried and failed to significantly expand health insurance

with his CHIP recommendation which sought to build on and adopt many of the ideas and strategies found in the proposals of FDR, Truman, and Johnson. Clinton's attempt at healthcare reform continues the trend of failure as he failed to persuade Americans that they would not have to rely on subscribing to purely government-subsidized health insurance and that they could keep the same primary care physician that they had always gone to. Like all previous efforts, Clinton was unable to overcome the opposition provided by many from within the healthcare sector: nurses, the AMA, primary care physicians, and medical insurance providers. Given this historical track record of previous healthcare reform efforts, a betting person would have felt very confident that Obama's reform efforts would enjoy a similar fate. This person would have lost a great deal of money. The question which remains to be answered is: How was Obama able to accomplish what many believed to be politically impossible? The answer provided here is that Obama succeeded because he was able to frame the issue of healthcare reform correctly and in such a way that his argument for reform accorded with the distributive justice principles of the American public.

This chapter begins by reviewing the scholarly literature on agenda setting, issue framing, and the rhetorical presidency. All three of these areas of scholarship bring politics and language together and speak to how attempts to change public policy both succeed and fail. This section also reviews relevant scholarship on distributive justice and the allocation principles of need, efficiency, equality, and merit. The second section discusses the data used in this study and the content coding methodology employed. Finally, the chapter concludes with an overview of the chapters that follow.

Literature Review

The intersection of politics and language is best understood in terms of agenda-setting

and issue framing. Public policy scholars use the theory of agenda setting to explain not only how issues move from private to public concerns, but why some policies succeed where others fail.¹ One school of thought (Kingdon 1980) contends that the three streams of politics, problems, and policy come together at critical times. At these moments solutions are joined to problems and both are joined to favorable political forces/circumstances (Kingdon 1980, 100). When this coupling occurs, a policy window opens and it becomes possible for a politician, in this case President Obama, to push through his legislative solution. According to this theory, Obama succeeded where other presidents did not largely because he was the right person in office at the right time. Another school of thought focuses on the internal quality of political systems to explain policy change (Baumgartner and Jones 1993). Generally speaking, there is not a great deal of policy change because of the presence of policy monopolies. Only when something alters a policy image is there an opportunity for policy change, as the policy equilibrium has been altered or punctuated (Baumgartner and Jones 1993, 200). Again, this understanding suggests that Obama achieved healthcare reform largely because of factors outside of his control. Either explanation by itself is problematic due to the fact that these explanations do not allow for the ability of political actors to fundamentally shape political discourse. While both theories allow for the importance of language and the efforts of political actors to move both public discourse and public policy in their desired direction, the explanations they offer for

¹ The focus on agenda setting and framing taken here should not be taken as evidence that other factors and understandings of the policy process are incorrect or do not help one to understand why the ACA was passed. As Jacobs and Skocpol (2012) remind their reader, President Obama's ability to pass the ACA depended on a myriad of factors including, but not limited to, the following: 1) electoral politics and the key roles played by congressional leaders; 2) interest group pressures; 3) congressional procedures (reconciliation and the filibuster in particular); 4) the precedent of a mandate-based program in Massachusetts; and 5) changes in public opinion. The narrowness of the focus taken here reflects the primary concern with the use of normative principles in healthcare reform efforts.

success and failure are largely dependent on factors outside of the control of these political actors. For this reason, it is necessary to supplement these understandings of agenda setting with an understanding of issue framing.

The origin of issue framing can be found in the seminal work of E. E. Schattschneider, *The Semi-Sovereign People* (1960). Focusing on the centrality of conflict to political action, Schattschneider concluded that the way an issue defines and describes a conflict is actually more important than the conflict itself (see also Rochefort and Cobb 1994). Defined as "the effects of presentation on judgment and choice," framing fundamentally has to do with the shaping of political reality with an aim to making it more comprehensible (Iyengar 1996, 61). Encompassing the ideological as well as the cultural elements of conflict (Lakoff 2002, 375), successful framing requires political actors to define problems and provide policy alternatives/solutions that are publicly salient (Entman 1993, 51). Failing to do this explains, in part, and helps one to understand why some issues get on the political agenda where others do not (Rochefort and Cobb 1994, 24) and why some policies succeed where others fail (Stone 2002, 200).

The ability of a president to place an issue on the political agenda and frame it in such a way as to pass the proposed legislation comes together in the idea of the rhetorical presidency (Tullis 1987, 179). Tullis argues that the rhetorical presidency is a large part of America's national political culture and the key to how presidents operate on a political level. He writes, "Today it is taken for granted that presidents have a duty constantly to defend themselves publicly, to promote policy initiatives nationwide, and to inspire the population. And for many, this presidential 'function' is not one duty among many, but rather the heart of the presidency- its essential task" (Tullis 1987, 4). Looking to the presidency for leadership and assurance, a

president's ability to marry politics and language is not only key to popular understandings of leadership, but resides “at the core of dominant interpretations of our whole political order, because such leadership is offered as the antidote for 'gridlock' in our pluralistic constitutional system, the cure for the sickness of 'ungovernability'” (Tullis 1987, 4). Given this view of the political order, Tullis argues that “The rhetorical presidency makes change, in its widest sense, more possible. Because complex arrangements of policies are packaged and defended as wholes (e.g., the New Freedom, New Deal, Great Society, New Federalism, War on Poverty, etc.), they are more likely to be rejected as wholes” (Tullis 1987, 178). Presidents are able to do this by “... reshaping the political world in which that policy and future policy is understood and implemented. By changing the meaning of policy, rhetoric alters policy itself and the meaning of politics in the future” (Tullis 1987, 179).

As agenda setting, issue framing, and the rhetorical presidency make clear, language matters a great deal in politics. Throughout this paper it is my contention that President Obama succeeded where other presidents before him failed because he framed healthcare reform in a manner that was consistent with how Americans understand justice. In other words, President Obama spoke to Americans about healthcare reform in their own terms. To test for this possibility, this paper focuses on the use of the language of distributive justice in framing healthcare reform. Any public policy can be understood in terms of justice; distributive justice is particularly relevant for healthcare reform. Generally speaking, distributive justice refers to how a good (in this case healthcare) should be allocated. While philosophers can agree on what distributive justice is, there is considerable disagreement over the question of what the principle of allocation should be (see Rawls 1971; Walzer 1983; and Miller 1999). A reading of the history of political thought indicates that there are four principles of allocation that can be used

as frames for public policy. They are as follows:

- Equality in an absolute sense. While initial understandings of equality focused on equality of rights, the understanding of equality is currently understood in terms of the equality of conditions. It is thus standard in empirical studies of distributive justice to operationalize equality as absolute equality of outcome (Scott et al. 2001, 750).
- Merit. With its origins in Aristotle's understanding of equity, allocation on merit contends that goods should be distributed in proportion to the contribution one makes where that contribution is due to qualities or activities thought to deserve reward (Scott et al. 2001, 751).
- Need. While need can be closely related to equality (equal need can be seen as a criterion for equal distribution), the standard is to treat need as an entirely different allocation principle (Miller 1999, 203-230). As such, need can be viewed as placing limits on inequalities. In particular, need is commonly conceptualized and operationalized in terms of meeting a minimum level of necessary social goods and this way of thinking is increasingly influential in both democratic theory and justification for social welfare programs in the United States and abroad (Marmor, Machaw, and Harvey 1990).
- Efficiency. Unlike the other three allocation principles, efficiency is not itself a normative principle. The argument for efficiency, however, raises normative questions thus justifying its inclusion here. Efficiency is an allocation principle used to justify inequalities in terms of aggregate benefit (Nozick 1974, Hayek 1976). Arguing for wealth maximization, proponents of efficiency argue that a greater amount of overall goods for the same amount of input is preferred because of the net aggregate benefit.

Using these principles of allocation, political scientists have devoted considerable attention to determining how people think about distributive justice. The general conclusion one draws from looking at the survey results is that the public has conflicting views of these principles (see McCloskey and Zaller 1984; Verba and Orren 1985). In contrast, experimental research suggests that people have complex rather than conflicting ideas about justice (see Miller 1999; Elster 1995; Frohlich and Oppenheimer 1992; Scott et al. 2001). These studies show that distributive justice behavior is complex but structured; they involve several distinct allocation principles and are influenced in predictable ways by independent factors. Comparative studies of distributive justice indicate that both the American public and elite members of society view distributive justice in terms of need and merit (Kluegel and Smith 1986).

Data and Methodology

Using the operational definitions of the four principles of allocation above, this study identifies key speeches which deal with healthcare reform from Presidents Obama, Clinton, Nixon, Johnson, Truman, and Franklin Roosevelt as well as arguments made by Republicans against the healthcare reform efforts of Presidents Clinton and Obama.² Each of these speeches was content coded for how they framed the issue of healthcare reform by the author and an outside reader. This was done in order to ensure the accuracy of the coding process in terms of whether or not a relevant piece of text within each speech should be coded and, if it should be coded, what allocation principle it should be coded as. Every individual reference to a particular allocation principle is counted as a single frame which allows for the counting of multiple frames within a single sentence. The more a president has recourse to a particular principle suggests that this particular principle is more important to his efforts to successfully frame healthcare reform. Approaching the framing of healthcare reform in this way is supported by Entman's (1993) understanding of the relationship between issue framing and saliency. Frames highlight pieces of information and in highlighting them the framer hopes to make this information more noticeable,

² The analysis presented in Chapter Three focuses on the following presidential addresses: 1) Franklin D. Roosevelt's "Message to Congress on the National Health Program (January 23, 1939) and supplement this address with his "State of the Union Message to Congress" (January 11, 1944); 2) Harry Truman's "Special Message to the Congress Recommending a Comprehensive Health Program" (November 19, 1945); 3) Lyndon B. Johnson's "Remarks with President Truman at the Signing in Independence of the Medicare Bill" (July 30, 1965); 4) Richard Nixon's "Special Message to the Congress Proposing A Comprehensive Health Insurance Plan" (February 6, 1974); 5) Bill Clinton's "Address on Healthcare Reform" (September 22, 1993); and 6) Barack Obama's "Remarks by the President to a Joint Session of Congress on Health Care" (September 9, 2009). Chapter Four's analysis of Republican opposition to the healthcare reform efforts of Presidents Clinton and Obama looks at William Kristol's (1993) "Defeating President Clinton's Healthcare Proposal" which was published by the Project for a Republican Future, a memo entitled "Healthcare Memo" published by the Heritage Foundation, and Presentative Charles Boustany (R-LA) official Republican response to the Obama remarks studied in Chapter Three.

meaningful, and memorable to the audience. In short, making this information more salient through repetition. By increasing the salience of particular distributive justice allocation principles in arguments for and against healthcare reform, the arguments examined here can be seen as satisfying the four requirements of issue frames: 1) defining a problem; 2) diagnosing the causes of the problem; 3) making a moral evaluation about the problem and its causes; and 4) suggesting a solution (Entman 1993, 53).

Table 1: Allocation Principles of Distributive Justice: Indicators

<p>Merit: equity of distribution based on one's contribution</p> <ul style="list-style-type: none"> • Equity/Equitable • Excellence • Distinction 	<p>Need: minimal level of necessary social goods</p> <ul style="list-style-type: none"> • Requirement • Essential • Necessary/Necessity • Want • Poverty • Deprived • Hardship • Destitute
<p>Efficiency: inequality justifiable as long as justified if there is aggregate net benefit</p> <ul style="list-style-type: none"> • Effective • Ordered • Profitable • Productive • Proficient • Expertise 	<p>Equality: absolute equality of outcomes</p> <ul style="list-style-type: none"> • Fairness • Equal Rights • Equal Opportunity • Egalitarianism • Unbiased • Comparability

Table 1 contains a partial list of indicators for each of the allocation principles. Merit's connections with equity speaks to excellence and distinction. Appeals to this principle should be to the excellence of the healthcare system. The fact that this study focuses on arguments for healthcare reform suggests that one would not expect to find frequent appeals to this concept by

those arguing in favor of reform. This, however, does present a complication for the argument made here as Americans generally view distributive justice as a combination of need and merit. The poor fit of merit for the argument in favor of healthcare reform suggests that an alternative principle should be incorporated into the issue frame and, as discussed below, there is good reason to believe that efficiency comes to perform this task. This does not present a problem for opponents of reform as one would expect this argument to employ merit against reform on the grounds that reform will result in a decrease in the quality of healthcare available to Americans.

The second concept in Table 1 is need and this should be the concept that those in favor of reform have the greatest recourse to in making their arguments. Not only is need a constituent aspect of the American conception of distributive justice, but establishing need would seem to be the foundation for the argument that America's healthcare system requires reform in the first place. It is very likely that efficiency is connected to need in these addresses. Anyone who has dealt with the forms at the doctor's office or hospital and the challenge of dealing with health insurance companies understands that the system is far from efficient. These facts suggest a symbiotic connection between need and efficiency that can be used to effectively shape the political conversation surrounding healthcare reform. That efficiency will replace merit is also suggested by the fact that citizens tend to make political decisions based on performance and not policy (Lenz 2003). One should thus expect two things in the presidential use of efficiency. First, one should see the current system characterized as inefficient and, second, that the reformed system of healthcare would be more efficient. For opponents of healthcare reform, one expects their frame to emphasize the loss of efficiency associated with greater government involvement in the area of healthcare. In other words, Republican opposition to the Clinton and Obama proposals should emphasize the inefficiency of these proposals.

Finally, Table 1 contains a series of possible indicators for equality of outcome. Concepts like fairness and comparability speak to a fundamental concern with equality. The problem with equality of outcome is that Americans are generally not in favor of this allocation principle (Verba and Orren 1985, 5, 124). This is especially the case in discussing the principles of allocation of distributive justice theory as they relate to the policy areas of economics and social welfare. Americans do believe in equal political rights (but generally do not view healthcare as a political right) and in equality of opportunity. Thus, to the extent that any of the frames analyzed here contain references to equality of outcome one would expect this argument to not be respected and valued given the American public's distaste for equality of outcome. If anybody wants to frame healthcare reform in terms of equality that appeal to American sensibilities, they should conceptualize equality in terms of the equality of opportunity.

Chapter Overview

Chapter Two provides the reader with a historical overview of mostly unsuccessful healthcare reform efforts in the United States (ca. 1900-2010). The chapter opens with an outline of the various healthcare reforms efforts that were developed but failed to be passed during the presidential administrations of Theodore and Franklin Delano Roosevelt. The chapter then proceeds to provide an overview of the healthcare reform efforts that were developed and failed during the Truman and Johnson administrations as well as the Nixon administration. This discussion is then followed by a detailed description of President Clinton's failed attempt at healthcare reform and President Obama's successful passage of the Affordable Care Act. Throughout the chapter, the analysis highlights the important political opposition provided by interest groups, Republicans, and members of the presidents' own party.

Chapter Three provides the content analysis of the six presidential addresses that were

identified above. Here, each president's rhetoric is analyzed with an eye to how they employed the distributive justice allocation principles in their respective arguments for healthcare reform. The individual content analyses that were conducted is followed by a comparative analysis of how each president framed their healthcare reform efforts according to a specific allocation principle. The results presented in this chapter indicate that a key reason for why President Obama was able to pass healthcare reform where other presidents were unable to do so is how he framed his argument. In particular, the results show that President Obama framed healthcare in a way that accorded with the distributive justice preferences of the American public.

Chapter Four looks at the Republican opposition frames used to counter the frames of Presidents Clinton and Obama. These three frames analyzed here suggests that Republicans did a better job of framing their opposition to the Clinton proposal than they did to the Obama proposal. In particular, the ability of Republicans to blend efficiency and merit in opposing Clinton spoke to how Americans view distributive justice. When one compares how Republicans framed their opposition to Clinton and Obama, one sees them repeat the mistake of Bill Clinton in paying too much attention to efficiency. In other words, the Republican frame lacks balance and fails to accord with the values of the American public.

Finally, Chapter Five closes this thesis by offering thoughts on the implications for the importance of language in politics and the policy process more generally. After situating the results of this study in the relevant scholarly literature, this chapter addresses the practical implications of the results presented here by making the case for framing issues in terms of distributive justice and suggesting some ways that politicians might best do this.

Chapter Two

A Historical Overview of Healthcare Reform Efforts in the United States

This chapter presents an overview of the efforts to pass universal healthcare reform in the United States over the past one hundred years. This overview reveals a tension at the core of American healthcare policy: although modern healthcare services have become better over time in improving people's lives, the cost for individuals and families to obtain these services has risen sharply. The reform efforts examined in this chapter all sought to address this tension by lowering the costs of healthcare through comprehensive, government-sponsored healthcare reform. These efforts failed because of harsh opposition from Republican politicians and interest groups who argued government-subsidized healthcare would result in higher costs, a decrease in the quality of healthcare, and that the specific proposals constituted socialized medicine which is un-American. This chapter takes a historical perspective in pursuit of the question of how various US presidents have attempted to resolve this tension through their respective healthcare reform efforts.

The history of healthcare reform efforts spans the time period from the attempted passage of Theodore Roosevelt's healthcare legislation to the enactment of Obama's Patient Protection and Affordable Care Act (ACA) legislation. Subsequent chapters analyze how presidents seeking healthcare reform framed their efforts in terms of the distributive justice allocation principles of need, efficiency, merit, and equality. They also discuss how Republicans framed their opposition efforts to the Clinton and Obama proposals by emphasizing different distributive justice allocation principles. The historical overview provided in this chapter provides one with a clearer sense of the political and policy environments the arguments for and against healthcare reform

were made. Thus, this chapter can be viewed as supplementing the analysis and argument that follows by placing the framing analysis in its proper contexts.

The overview provided here indicates that Americans have been predominantly supportive of the government's financing of healthcare reform and the idea providing greater access to healthcare coverage and insurance for all American citizens. However, when attempts to reform healthcare appear too costly, Americans become less supportive of such reform. This suggests that the American public employs a performance based criteria of policy evaluation. In other words, Americans tend to evaluate policy in terms of efficiency. Having said this, efficiency is not the sole lens through which Americans view healthcare reform. Besides being too expensive, other factors contribute to the failure of healthcare reform efforts prior to President Obama and these include the complex nature of healthcare itself, the diverse ideological positions taken by the American public regarding the question of what constitutes sufficient coverage, the influence of special interests, lack of presidential power, and the decentralization of Congressional power. Given the historical focus of this chapter, the analysis provided here proceeds chronologically.

Healthcare Policies of Theodore and Franklin Roosevelt

Theodore Roosevelt

In the early 1900s, progressive social reformers in the United States sought to emulate European healthcare reformers in order to provide better healthcare to American citizens. Subsequently, reformers from the American Association of Labor Legislation (AALL) built on these efforts in their 1915 proposal to provide low-income workers and their dependents with some form of adequate healthcare coverage. With its origins in AALL's efforts to implement workman's compensation guarantees, the AALL proposal broadened its scope significantly by

providing protection and benefits to the dependents of low-income workers. These efforts to cover injured workers ultimately led to a desire to design and implement legislation to adopt universal healthcare coverage in the United States. The AALL reform efforts were supported by Theodore Roosevelt, who ran for reelection for the presidency in 1912, but were ultimately defeated with the presidential election of Woodrow Wilson.

Despite this electoral setback, AALL continued to push for comprehensive healthcare coverage only to have their efforts thwarted by a coalition of interest groups and Republican opposition. What proves most interesting here is what groups specifically supported efforts to reform healthcare in the United States, rather than the idea that there was inevitable and inherent opposition to the idea of universal healthcare reform. Initially, the American Medical Association (AMA) supported the goal of national health insurance, although the AMA's support waned when Americans' support for universal health insurance was seen to increase. As support for the AALL proposal began to grow, the AMA came to oppose the plan. Progressive reformers in 1915 wanted to develop group-based healthcare practices run by physicians. They believed that this was a more efficient way to provide healthcare coverage than to have the American people be attended to by individual physicians. The AMA feared that physicians' incomes, as well as control of their individual practices, would be threatened. To this day, the AMA continues to oppose universal healthcare reform policies and the implementation of national health insurance for all Americans.

Other organizations, including the National Association of Manufacturers, the American Federation of Labor (AFL), and the insurance industry opposed healthcare reform as well. They did so largely for financial reasons and due to their desire to not lose power. Unions, in particular, opposed providing government-subsidized health insurance and healthcare coverage

to American citizens because they believed these services should be provided to American workers by labor unions themselves. During the early 1900s, industrial life insurance was sold to workers in the manufacturing industry. These policies constituted a significant source of revenue (Altman and Shactman 2011, 99). The AALL proposal covered the costs of funeral expenses while reducing the profits resulting from existing insurance plans. Thus, while political figures from across the political spectrum as well as the business, labor, medical, and insurance industries recognized the need for increases to healthcare coverage for Americans, they also agreed that this coverage should not be provided at the expense of reducing the profits of economic and medical actors.¹ Consequently, the goal of providing universal healthcare coverage to Americans would not occur during the first part of the twentieth century.

Franklin Roosevelt

The idea of reforming healthcare did not come up again until 1934, when President Franklin Roosevelt (FDR) appointed the Advisory Committee on Economic Security to devise a health insurance plan that would become a part of his New Deal legislative package. In order to achieve this goal, FDR would have to overcome the political opposition of Republicans and southern Democrats in Congress as well as the same coalition of interest groups that defeated the AALL proposal (Altman and Shactman 2011, 100). This opposition forced FDR into a political corner where he was forced to choose between healthcare reform and a key element of his New Deal legislative package-- Social Security. Thus, FDR was forced to choose between government-subsidized healthcare versus unemployment and retirements benefits. With

¹ The efforts of AALL to pass universal healthcare reform were further blocked as well due to the United States' entrance into World War I, which was further stalled by opponents suggesting that enacting universal health insurance would be similar to a plot instigated by German Kaiser Wilhelm's idea to take over the free world. Russia's Bolshevik revolution simultaneously occurred that same year, while opponents claimed that the prospective passage of national health insurance would be influenced by both communist and socialist rhetoric.

awareness of the political power lining up against him, FDR prudently chose the latter option over the former option. FDR feared that his Social Security legislation would not be passed if he openly supported the adoption of national health insurance. As a result, FDR instructed the Advisory Committee to not include any mention of a health insurance proposal in the pages of its report. Even though Social Security retirement benefits and unemployment benefits proved to be more pressing items on FDR's political agenda, he still instructed Henry Perkins, the head of the Advisory Committee on Economic Security, to draft healthcare policy recommendations related to national health insurance. Perkins wrote the recommendations and put them into his preliminary report, but President Roosevelt did not release them in his final report for fear of endangering his Social Security legislation even further. Even after the passage of the Social Security Act in August of 1935, FDR ordered that the contents of the healthcare report to remain secret. Even without the political leverage of the Social Security Act, the opposition coalition continued to thwart efforts to reform American presidents' efforts to enact universal healthcare coverage.

After passage of the Social Security Act in August of 1935, the Technical Committee on Health Care, a federal government-sponsored committee of government agency heads, was established in 1937 to consider further reforms in the area of healthcare. The Advisory Committee on Economic Security and the Technical Committee on Health Care both called for a state-run system with compulsory health insurance for state residents, but states could choose whether to participate (Altman and Shactman 2011, 100). The federal government was to provide some subsidies and set state minimum standards. There were other goals put forth by the committees as well, including expanding hospitals, public health, and maternal and child services. Recognizing strong opposition from the AMA, the Committees' leaders ensured that the

medical profession would maintain control over the practice of medicine.

In July 1938, a healthcare legislation commission met at the National Conference on Health in order to review the above recommendations. Despite controlling a majority in both the House and the Senate, progressive Democrats were unable to gather the necessary votes to defeat the coalition of conservative Republicans and Southern Democrats who opposed reform efforts. At the same time, the AMA supported private health insurance from insurance companies and other healthcare plans that did not include adoption of national, universal health insurance. In January of 1939, FDR forwarded his healthcare proposal to Congress without any endorsement or recommendation. One month later, Robert Wagner, a liberal Democratic Senator from New York, submitted a bill which discussed the recommendations created by FDR's committee. Without the formal endorsement of FDR, this bill was easily defeated.

The beginning of World War II that same year would help in shaping FDR's lasting impact on society regarding healthcare reform. In 1942, FDR implemented wage and price controls, as the demands for the production of goods during wartime could possibly cause inflation. Employers, rather than raise wages and in order to account for and increase the United States' lack of a labor force, provided an incentive to prospective workers in the form of health insurance coverage to encourage workers to continue working for low pay. FDR's War Labor Board ruled that employer-provided health insurance benefits did not count as wages and as a result these funds should not be taxed (Altman and Shactman 2011, 101). In October of 1943, the Internal Revenue Service (IRS) concluded that the cost of health insurance benefits would be a deductible expense for employers and that these deductible expenses would not be considered taxable income for employees. Because of this turn of events, FDR in effect provided government-sponsored efforts to create a private-insurance company led market to provide

health insurance to employees while limiting future presidents' abilities to develop comprehensive universal healthcare legislation and missing yet another opportunity to enact comprehensive universal healthcare legislation even as he tried to do so in future years.

In June of 1944, approximately a year before FDR's death, Robert Wagner (D-NY) introduced the Wagner-Murray-Dingell (WMD) Bill which further encouraged the development in the United States of a national health insurance plan (Altman and Shactman 2011, 102). Although supporters of the bill knew that the bill would not be passed in Congress, it put the issue of national health insurance on the national political agenda once again. Although FDR never endorsed the WMD Bill, he campaigned for the development of an "economic bill of rights" that also guaranteed the development and provision of a national health insurance bill. According to Altman and Shactman, "For the first time the bill departed from previous state-run proposals and recommended a universal, compulsory federal program financed by employer and employee payroll taxes. It was the forerunner to every serious universal health proposal that has been made since" (Altman and Shactman 2011, 102). In January 1945, FDR advocated for the development of a comprehensive bill which included provisions for national health insurance, disability protection, and hospital construction. FDR's death on April 12, 1945, from a cerebral hemorrhage, would prevent the development of comprehensive healthcare reform.

Healthcare Policies of Harry Truman and Lyndon Johnson

Harry Truman

After the end of World War II and upon FDR's death, Truman, who was passionate about the issue of universal healthcare, tried to garner support for his national health insurance program even when it was opposed by Congress and was certain to be defeated. Truman tried to follow up on FDR's public policies regarding universal healthcare by creating a new plan of public policies

called the "Fair Deal." Part of this new plan involved the attempted creation by Congress of a national health insurance plan which would provide national medical care to all American citizens as a right owed to them as American citizens. In November 1945, Truman supported FDR's national health insurance plan by discussing this plan in a special message to Congress. In that message, "Truman became the first president to support a single-payer, comprehensive, and compulsory program of national health insurance" (Altman and Shactman, 2011, 105). Truman believed every American, both rich and poor, should have access to quality and affordable healthcare. Truman's healthcare proposal was comprehensive and included federal aid for hospital construction, programs for public, maternal, and child health, federal aid for research and education, and protection against disability (Altman and Shactman 2011, 103). Truman expected that people would claim his policies were more socialist in nature and that his plan to pass healthcare reform would be actively opposed by the medical community. In response, Truman stated that doctors' participation would be voluntary, that patients' and doctors' freedom of choice would not be restricted, that doctors would receive higher pay, and that no organizational restrictions would be imposed on national health insurance (Altman and Shactman 2011, 103).

Truman would come to adopt many of the ideas for his proposed healthcare legislation plan from the WMD Bill which was first proposed in 1943 and subsequently redrafted in April 1946 in order to effectively incorporate Truman's ideas: that health insurance be national, universal, comprehensive, and run as part of Social Security. In April 1946, Truman's recommendations for national health insurance were included in the redrafted WMD Bill proposed by Senator Murray (D-MT), who headed the Committee on Education and Labor. Truman's own ideas for healthcare reform, which slightly differed from those originally proposed

in the WMD Bill, emphasized the development of a single insurance system that would provide the need for adequate healthcare coverage for all Americans while providing the poor with funds subsidized by the government and taxpayer dollars. That same year, Congress released the Hill-Burton Act, which provided money for the construction of new hospitals and the expansion of existing hospitals. Passage of the Hill-Burton Act effectively undercut one of the key arguments made by Truman in favor of healthcare reform. This, coupled with the continued opposition of the AMA and lobbying efforts to defeat Truman by the American Bar Association (ABA) as well as the American Hospital Association (AHA) proved insurmountable (Altman and Shactman 2011, 105). According to Altman and Shactman, "Even parts of Truman's own health administration opposed the bill, fearing it would diminish funds for their own particular programs" (Altman and Shactman 2011, 105).

After the midterm elections of 1946, Republicans took control of both the House and the Senate. Any attempt to pass universal healthcare reform, including the creation of a healthcare bill by Truman in 1947, was rendered virtually impossible given Republican control of Congress and the continued development of anticommunist attitudes held by the American people. However, after a surprise victory in the 1948 presidential election against Dewey and with the establishment of a primarily Democratic Congress, Truman was successfully able to submit his healthcare proposal in April 1949. Even with this politically advantageous situation, Truman was unable to overcome the opposition of the AMA who openly argued against Truman's reforms with the charge that it constituted socialized medicine. Truman also lacked support within his own party as southern Democrats could not support the legislation. Truman's efforts to provide federal healthcare benefits for all American citizens included providing healthcare for African-American citizens. Such a proposal was an unacceptable idea to Southern Democrats in 1949

(Altman and Shactman 2011, 105).

In 1952, Oscar Ewing, the first secretary of the Department of Health, Education, and Labor, encouraged Truman's health administration to draft a healthcare bill that would cover health insurance for elderly Americans over the age of sixty-four. According to Altman and Shactman, "In April 1952 Senators Murray and Humphrey (D-MN) and Representatives Dingell and Celler (D-NY) filed a new health bill. As expected, the initiative was largely ignored, and no congressional action was taken. However, the battle for Medicare had begun" (Altman and Shactman 2011, 105). This would be a battle taken up by President Lyndon Johnson.

Lyndon Johnson

The issue of adopting national health insurance did not resurface again until the 1960s, when Lyndon Johnson was elected President in 1964. Unlike Truman, Johnson was able to pass both Medicaid and Medicare in 1965 under the direction of Wilbur Cohen of the Ways and Means Committee and with a majority of Democrats in both the House and the Senate. Medicare is a social insurance program administered by the United States government that provides assistance to people aged sixty-five or older. It was enacted to help cover physician and hospital costs for the elderly while Medicaid was enacted to pay for care for some of the very poor. Johnson's plans were opposed both by the AMA and insurance companies on the grounds that the Social Security Amendments which were passed and which contained the provisions for Medicare and Medicaid legislation required that health insurance was to be compulsory, represented socialized medicine, would reduce the quality of care, and would be considered un-American.

The idea to pass Medicare healthcare legislation first occurred in the year 1961, with President John F. Kennedy's active endorsement for the passage of Medicare. Wilbur Cohen, the

Undersecretary for Legislation of Health, Education, and Welfare and the coordinator for President Kennedy's and Johnson's Medicare legislative activities, determined that Medicare benefits would be provided to the elderly. Cohen also stipulated that healthcare services be administered by hospitals, rather than by physicians at private medical practices (Berkowitz 2008, 82). While the campaign to enact Medicare legislation progressed, accommodating private health insurance providers proved to be important in the adoption and passage of Medicare. In 1962, Senator Jacob Javitts (R-NY), negotiated with the Kennedy administration to allow elderly American citizens that already possessed private healthcare coverage to keep their healthcare coverage. In return, he would help navigate the Medicare through the Senate. It was thought that Medicare would reimburse the private insurance companies for benefits that were originally intended to be provided by the federal government's Medicare program. This Medicare legislation was ultimately defeated by a narrow margin in the Senate's and was never voted on by the House of Representatives in 1962. In 1964, when the same Medicare legislation would be voted on again by Congress, the Senate, but not the House of Representatives, passed a Medicare Bill in order to accommodate the private sector but also to ensure that Medicare legislation would be viewed by the Congress which met in 1965.

Although Medicare failed to be enacted by the Johnson administration in 1964, parts of the 1964 debate surrounding the development of Medicare influenced the healthcare legislation that would be passed the following year. Wilbur Mills, the head of the Ways and Means Committee, suggested that the Social Security Administration develop a plan that allowed Blue Cross plans to be used in administering hospital health insurance. The idea of fiscal intermediaries came out of this plan; these fiscal intermediaries were primarily charged with the task of administering Medicare's billing operations. According to Berkowitz, "As originally

designed, the intermediaries, who were assumed by Mills and by administration officials to be local Blue Cross plans, would handle all the bills generated by hospitals for the care of Medicare patients and keep the Federal Government removed from getting involved in the routines of health care finance" (Berkowitz 2008, 85). Both Wilbur Cohen and Robert Ball of the Social Security Administration believed the intermediary plans were a good idea to enact, and believed that the Blue Cross plans, with "their wide reach and nonprofit status," would serve the purpose of covering Medicare costs well (Berkowitz 2008, 87). In 1964, Senator Jacob Javits (R-NY) accepted that hospital insurance would be covered by what was then referred to as "the social security mechanism." He also proposed the creation of "complementary private health insurance" to cover the costs for elderly people's insurance coverage. According to Berkowitz, "Senator Javits explained that he wanted to limit the Federal Government's role to covering the costs of hospitalization and skilled nursing home care. At the same time, Javits (1964c) hoped to cover doctor's bill and outpatient care through what he described as '...low cost private insurance plans to be developed on a non-profit, tax free basis with special provision for concerted selling and risk pooling'" (Berkowitz 2008, 86).

When considering the passage of Medicare legislation, the idea of choice was an important feature of Javits' and Representative John Lindsey's (R-NY) proposed legislation. In his healthcare legislation proposal, Lindsey claimed that consumers could either accept government-sponsored health insurance which would be governed by the states, or opt into a private health insurance plan that would significantly increase their Social Security benefits (Berkowitz 2008, 86). Javits' and Lindsay's ideas would ultimately be incorporated in the proposals drafted during the end of 1964 and the beginning of 1965. The idea of "complementary health insurance" that was proposed by Javits, as well as the idea of consumer choice in the form

of a Medicare benefits package covered under private insurance plans, were kept in the proposed Medicare legislation presented to Congress in 1965. During the course of congressional debates in 1965, the idea of choosing from among different health plans and Javits concept of "complementary private insurance" were met with harsh opposition from Democratic lawmakers and the private health insurance industry. As a result, these ideas were taken out of the final Medicare bill that was passed into law by Congress. The idea of consumer choice was kept intact in the Medicare legislation in the form of Medicare Part B. Initially developed in January of 1965 as an alternative healthcare proposal by Robert Byrnes, a respected Republican legislator on the Ways and Means Committee, Part B took the form of a "voluntary health insurance program that was to cover both medical and hospital costs, funded in part by the beneficiaries themselves and in part through general revenues" (Berkowitz 2008, 87). The Johnson administration's proposal, meanwhile, advocated for the use of private health insurance plans similar to those Blue Cross plans received by federal employees and workers through their employers. Republicans ultimately supported the Byrnes Bill, which became a significant part of the Medicare legislation which was sent by the Ways and Means Committee to the House of Representatives. On March 2, 1965, Mills, the head of the Ways and Means Committee, reviewed the multiple proposals submitted to the House of Representatives, suggested that the administration's plan regarding comprehensive hospital care and Byrnes' legislation regarding patient care by doctors be combined to form a more comprehensive form of healthcare legislation that served as the basis for Medicare Parts A and B which are still in existence today. (Berkowitz 2008, 86).

Medicaid legislation as well became an important component of healthcare legislation that was passed by Congress in 1965. In 1960, Congress established the Kerr-Mills program

which was created to aid in providing healthcare insurance to needy elderly citizens. Upon the death of Kerr in 1963, Mills claimed the program should be allowed time to develop to ensure that it would serve as an adequate program for covering elderly people's health insurance. Mills sought to expand the program in 1964 in order for it to become more accessible to the individual states in providing more comprehensive welfare coverage to other disadvantaged groups besides elderly citizens. This included the efforts of federal Welfare Administration officials in the Department of Health, Education, and Welfare to provide assistance to children in obtaining comprehensive welfare benefits through the development of the Child Health and Medical Assistance Act that would be considered in the Johnson administration's 1965 legislative program. Essentially, these officials felt that children should be able to receive equal federal welfare benefits for the provision of comprehensive medical care that are received by the elderly. According to Berkowitz (2008, 88), "In March 1965, Mills then decided to combine the administration's and the Byrnes approaches to health insurance, he also recommended that '...a supplemental and expanded KerrMills program along the lines of the Administration's Child Health and Medical Assistance Act...' be included in the package. In creating what became Medicaid, he managed to incorporate elements of proposal that had been pushed by the AMA, known as Eldercare, into the large omnibus legislation. The AMA wanted to expand the KerrMills program as a means of providing medical care to the elderly. The administration acquiesced in this request, but thought of a program like Eldercare as a supplement to Medicare rather than as a substitute for it. Medicaid made it into the 1965 law as a supplement, but one that would play a key role in the future of health care finance."

Medicaid and Medicare were introduced in the House Ways and Means Committee in March of 1965, gained final approval by the Senate on July 28, 1965, and were signed into law

by President Johnson on July 30, 1965. According to Berkowitz, "On July 30, 1965, President Lyndon B. Johnson signed the Social Security Amendments of 1965 into law. With his signature, he created Medicare and Medicaid, which became two of America's most enduring social programs. The signing ceremony took place in Independence, Missouri, in the presence of former President Harry S. Truman, as if to indicate that what President Truman and other Presidents before him had tried to get done had now been accomplished" (Berkowitz 2008, 81). As originally enacted, the Social Security Amendments of 1965 provided healthcare coverage to those sixty-five years of age and older and to the poor, blind, and disabled. Medicare was responsible covering healthcare services provided by hospitals, physicians, nursing facilities, and homecare providers.

Richard Nixon and Healthcare Reform

When Richard Nixon first considered running for president in the late 1940s, he submitted a proposal with the liberal Republican Jacob Javits for a system of private insurance with federal subsidies that would vary with income. When Nixon eventually did become president in 1969, he sought to enact similar national healthcare reform with the aid of Southern Democrat Congressman Wilbur Mills. Initially, Mills pledged his support for Nixon's healthcare proposal, but when the cost of Johnson's Medicare plan proved higher than projected, Mills withheld his support so as not to undermine his own presidential aspirations (Altman and Shactman 2011, 33). According to Altman and Shactman (2011, 33), Nixon came closer than any other president in passing universal healthcare reform than any other president until President Obama.²

² It is believed Nixon fought for universal health insurance because he was trying to take the issue away from the Democrats. In doing so, Nixon looked to undermine the presidential aspirations of Ted Kennedy.

In outlining his proposed universal healthcare efforts, Nixon wanted a larger variety of healthcare organizations to engage in the distribution of healthcare services to Americans. According to Shactman and Altman, "He [Nixon] wanted to include loosely affiliated groups of physicians (called independent practice associations) who could maintain their own private practices and see both HMO and fee-for-service patients" (Altman and Shactman 2011, 40). Having reached a compromise with Democrats and going against the preferences of his own party, Nixon launched the Health Maintenance Organization Act of 1973, which ultimately led to the development of a more comprehensive health care plan that would provide healthcare coverage to a wider section of the American population (Altman and Shactman 2011, 40). Although the Health Maintenance Organizations Act of 1973 was passed into law, a historical understanding of HMO's and their development during the Nixon administration provides context for this issue.

On February 3, 1970, Nixon's advisers met to discuss the creation of Health Maintenance Organizations (HMOs). Promoting the idea of group practices rather than fee-for-service reimbursements, Nixon believed that HMOs would significantly improve the state of national health insurance. Competition with the different practices would keep down the rising health care costs, and people would be treated more efficiently by doctors due to the ability of doctors to receive higher payments for their services provided to patients under the leadership of group practices. According to Altman and Shactman "If a group of doctors received a fixed annual payment in advance for each patient, it would behoove them to keep that patient as healthy as possible, and to provide preventive care in order to avoid an expensive illness or hospitalization. If the patient did become ill, the doctors' incentive was to provide the most efficient treatment, returning the patient to health in the shortest possible time, because the medical group would

have already received all the reimbursement they were going to get (Altman and Shactman 2011, 35-36). Two kinds of questions characterize the debate surrounding the implementation of HMO's. The first question is: "Do HMOs treat people more efficiently (less waste, fewer unneeded procedures and surgeries) or do they simply cut back on providing care?," while the second kind of question was "Should the process of receiving health care be managed, or should people be free to seek any provider or service they want" (Altman and Shactman 2011, 38)?

Nixon's HMO plan incorporated various types of health plans, such as for-profit plans and independent practice associations made up of groups of physicians that could see both fee-for-service patients and other patients. It also placed limits on the types of benefits that people could receive. As a result, the Health Maintenance Organization Act of 1973 required every company, with twenty-five or more employees, to offer health services to individuals and their families. Nixon was ahead of his time regarding his support of the act surrounding Health Maintenance Organizations to be passed into law by Congress, as the idea of group practice plans was a new idea which called for restructuring of the current healthcare system that foreshadowed Clinton's attempted restructuring of the healthcare system in the 1990s. Nixon was also ahead of his time, as the idea of HMO's was a new and novel idea which differed significantly from the fee-for-service healthcare plans that doctors subscribed to across the country. According to Altman and Shactman (2011, 40), "HMOs were to become the centerpiece of Clinton's failed health plan and the driving force behind the restructuring of health insurers and providers in the '90s." In being ahead of his time, Nixon was out of touch with the political reality of his day.³

³ The HMO legislation was amended over the next few decades, and according to Altman and Shactman (2011, 40), "As of January 2009, HMOs (or one of the looser forms of managed care) insured 74.6 percent of privately insured Americans."

After working on HMOs, Nixon turned his attention to developing the National Health Insurance Partnerships program. The National Health Insurance Partners program proposal provided resources that many subsequent healthcare reforms used. The Partners Program demanded that all full-time workers should receive health insurance benefits in the form of an employer mandate. The Partners Program would have gotten rid of Medicare due to its ability to provide health insurance to low-income families, and would provide subsidies to people earning less than five thousand dollars a year, but only to families with children. The program was criticized for being aimed at the rich rather than for actively helping to ensure poor citizens.

In addition to the National Insurance Partners Program, Nixon was responsible for introducing Medicare Parts A and B. Part A covers hospital insurance, referring to most medically necessary hospitals, skilled nursing facilities, home health, and hospice care. Hospice care is free if a person has worked and paid into Social Security taxes for at least ten years. If a person has worked for less than ten years, however, they will need to pay a costlier premium. Part B refers to the coverage of medical insurance, which covers most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, X-rays, mental healthcare, and some home health and ambulance services.

Nixon's plan required an HMO option, providing neighborhood health clinics in inner city and rural areas, granting loans for medical education, broadening the use of ancillary personnel such as physician assistants, and studying what could be done about malpractice insurance. More generally, Nixon wanted Americans to take greater personal medical responsibility for their health. He wanted to create a private health foundation that would introduce and educate Americans on health-related topics and concerns. Again, Nixon's proposal was seen as attacking those most in need of healthcare reform and not helping them. Not

surprisingly, this aspect of Nixon's healthcare reform efforts failed (Altman and Shactman 2011, 41).

Finally, Nixon sought to pass the Comprehensive Health Insurance Plan (CHIP). The CHIP proposal, which was completed by both Stuart Altman and Peter Fox, foreshadowed the healthcare proposals of both Presidents Clinton and Obama. On February 6, 1974, Nixon wrote a message to Congress introducing the CHIP program. Nixon described the program as "universal, comprehensive, and affordable health insurance that builds on the strength of existing public and private systems. He assured the Congress that citizens would still be able to choose their own doctor and he reassured everyone that no new taxes would be required" (Altman and Shactman 2011, 53). The CHIP plan included an employer mandate, a comprehensive benefits package, government subsidized coverage (the assisted health insurance plan), and continued regulation of wage and price controls for medical care. Nixon thought his plan would be approved and passed due to its emphasis on private insurance and because it allowed people to have private doctors, and required no new taxes. Despite his optimism, Nixon could not garner enough legislative support. His own party did not favor passage of such a large-scale proposal and Democrats supported a bill similar to Nixon's proposed by Senator Ted Kennedy (D-MA). For Democrats, it made no sense to work with Nixon when they could achieve a similar goal by supporting a member of their own party.

Clinton and Obama's Healthcare Policies

Bill Clinton

The idea of universal healthcare reform during the time of Clinton's presidency was first presented with the 1990 campaign and subsequent Senate election of Democratic Pennsylvania Senator Harris Wofford. Throughout his campaign, Wofford made clear that health insurance

costs too much for American citizens to afford while suggesting that the economy was in the midst of a recession because of its slow growth as felt by consumers, the business sector, and the United States' government; this idea precipitated the need for significant healthcare reforms (Altman and Shactman 2011, 66-67). In response, Bill Clinton and his transition team decided to focus on passing healthcare legislation which centered on the idea of managed competition. The idea of managed competition and the universal healthcare reforms which resulted from the implementation of this idea discusses how prepaid healthcare plans compete with each other in a structured marketplace (Altman and Shactman 2011, 73). In theory, prepaid plans are more efficient in their ability to manage the healthcare services provided to American citizens. Managed competition requires that employers partially pay for their employees' insurance premiums while submitting their share of the payments to intermediary organizations called health insurance purchasing cooperatives (HIPC's), whose purpose is to manage the competition among plans. Employees are required to choose from a variety of plans that are administered by the HIPC's, but the cost of their health insurance is based on the costs of the least expensive plan that has a standard benefits package attached to it. According to Altman and Shactman, "Each competing health plan is required to have open enrollment, community rating (everyone in the same plan pays the same amount regardless of their age or health status), standardized policies, standard quality and customer satisfaction reporting, and regulated marketing practices. Theoretically, with such standardization, plans have to compete on price and quality and not on selecting the youngest and healthiest enrollees. Hence, employees (and their employers) pay the same amount for similar plans, but the HIPC adjusts the payments to the health plan according to the risk profile of the enrollees" (Altman and Shactman 2011, 73).

The idea of managed competition was developed during the decade of the 1990s through

the collaborative efforts of David Cutler, a noted Harvard economist, in conjunction with other members of Clinton's economic transition team. The efforts of Clinton's economic transition team centered on devising a new way to reform healthcare through the idea of managed competition while simultaneously balancing the country's budget, an issue that had been the centerpiece of Clinton's, as well as Wofford's, campaign rhetoric and strategy. From Cutler's point of view, the idea of managed competition served as a radically different approach to reforming healthcare and one that had been proposed by previous presidents. According to Cutler, managed competition would help to control the rapidly rising costs of health insurance that had developed in the 1980s and into the early 1990s (Altman and Shactman 2011, 62). Stuart Altman, who had previously worked on formulating universal healthcare legislation during the Nixon administration, refuted Cutler's claim by suggesting that the idea of reforming healthcare according to the principles of managed competition would not be a worthwhile effort to pursue as it would require the United States' healthcare system to be overhauled and restructured in order to reflect a change in the ways Americans would go about choosing their doctors and hospitals (Altman and Shactman 2011, 63). Healthcare costs had risen greatly over the past decade, and too many Americans were not able to receive healthcare coverage due to the high costs of health insurance and because of the economy's slow growth during this time period (Altman and Shactman 2011, 65).

On January 11, 1993, Bill Clinton, along with the members of his Health Policy Group staff led by Judy Feder, began drafting a budget for his proposed healthcare plan, which was estimated to have projected costs of up to \$270 billion over the next five years after its adoption (Altman and Shactman 2011, 62). Stuart Altman, who had sought to reform healthcare under the Nixon administration and who hoped to create a reformed healthcare plan that would insure

every American, "believed that the best strategy to pass universal coverage was to build on the current system; to minimize the amount of change and reduce the numbers of winners and losers who would lobby against each other (Altman and Shactman 2011, 64). Clinton, though, opposed Altman's ideas, and adopted the idea of managed competition as his primary effort to combat healthcare reform, which inevitably was met with widespread opposition and would ultimately lead to its failed passage into law. On January 25, 1993, Clinton publicly announced to the media that he would be utilizing the Health Policy Task Force under the leadership of First Lady Hillary Clinton and its prospective policy director Ira Magaziner (Altman and Shactman 2011, 63).

Clinton had three alternatives to pursue in reforming healthcare that were suggested to him throughout his election campaign by campaign strategists James Carville and Paul Begala: single-payer healthcare, play-or-pay legislation, or tax incentive plans. Single-payer healthcare legislation refers to a comprehensive healthcare plan that combines public and private healthcare plans into a single plan that would be financed by the federal tax payments (payroll taxes similar to Medicare or Social Security benefits) of United States citizens and the federal government. An example of this is the Medicare entitlement program that provides aid to citizens aged sixty-five or older (Altman and Shactman 2011, 68-69). The government pays for all covered healthcare expenses and services, while every American is able to choose his own doctor or hospital to attend. As with the Medicare program, administrative costs are low and the financing is straightforward. In a play-or-pay system, by contrast, universal health care coverage is financed by an employer mandate, which means that employers are either required to provide a minimum amount of insurance to their employees through an insurance package or pay into a public fund which can either provide employees with insurance or be purchased by their employers (Altman

and Shactman 2011, 69-70). Play-or-pay healthcare reform builds on the current, employment-based system, which makes it the least disruptive form of healthcare reform. It is the least disruptive type of universal reform because it builds on the current, employment-based system. Play-or-pay healthcare systems do not alter the way most people get insurance or choose their doctors, and do little to decrease the costs of healthcare spending. Tax incentive plans, which differ from both single-payer and play-or-pay universal healthcare reforms, provide tax credits or vouchers that are more affordable to United States citizens while reducing the number of uninsured citizens throughout the country (Altman and Shactman 2011, 70). Tax incentive plans are mostly combined with health insurance reforms which are often easier and less expensive to purchase for individual and small group consumers while simultaneously not disrupting the current systems of financing that are in place and the provision of care to United States citizens. Tax incentive plans for this reason require extensive federal spending if they are to meet the goal of providing universal coverage to all United States citizens, and are often responsible for covering people who otherwise would have possessed health insurance coverage while not effectively covering the low-income demographic living in the United States.

During the beginning of his presidency, Clinton had pledged to support either the play-or-pay or managed competition theories of healthcare reform. Although managed competition theory had never been tried as a form of healthcare reform and had never been heard of by the general public before Clinton's election, Clinton was persuaded by Magaziner to reform healthcare using the theory of managed competition, which ultimately failed due to Clinton's desire to pay for healthcare reform by reducing other healthcare costs which required that the plan had to include budget cuts, premium limits, and regional spending limits or the Congressional Budget Office would not consider the plan budget neutral (Altman and Shactman

2011, 75). Another problem with Clinton and Magaziner's healthcare reform stemmed from the change that would take place regarding how Americans would receive their healthcare coverage. In particular, it would change the way Americans would have to choose their doctors and insurance companies. A reorganization of how care is delivered to patients would need to take place with the implementation of Clinton's healthcare initiative, making it clear that integrated healthcare plans managed by the HIPC's within the market would need to compete with each other for Americans' hard-earned tax dollars spent on healthcare coverage costs.

As healthcare reform related to the development of the federal budget, Clinton had wanted to debate healthcare reform according to the process of reconciliation, which requires that approximately twenty hours of debate take place without engaging in a filibuster. The process of reconciliation only requires that a simple majority of 50 votes, rather than a three-fifths majority of sixty votes, be had in order to pass a specific bill related to the budget. The Byrd Rule, created by Senator Robert Byrd, required that bills specifically related to the budget could only be passed using the procedure of reconciliation, and that healthcare reform was too broad of a measure to pass using this process and the concept of limited debate. Due to strong partisan opposition from Republican Senators and the requirement that sixty votes be had to enact healthcare reform, Clinton's healthcare initiative would not likely be passed into law.

Clinton ultimately supported the idea for managed competition which was then revised to reflect the idea of managed competition with a budget while opposing the single-payer or play-or-pay healthcare systems. Clinton opposed single-payer healthcare reform because he did not want the government to finance healthcare spending through requiring Americans to pay higher taxes (Altman and Shactman 2011, 71). Tax incentive plans did not lend themselves well to providing Americans with comprehensive universal health coverage while at the same time

limiting the costs of healthcare spending. Clinton at first appeared to support the play-or-pay type of healthcare reform, but only to the extent that it would hopefully aid in providing Americans with comprehensive healthcare coverage. Republicans objected to and subsequently attacked Clinton for his support of pay-or-play healthcare reform, claiming that it would be expensive to implement, run by the government, and disastrous for Americans' employment prospects. Clinton's healthcare reform efforts ultimately failed for two reasons: the idea of keeping healthcare reform budget neutral while financing this reform through the use of a high cigarette tax, but also through the provision of a type of reform that would appeal to both Democrats and Republicans (liberals and conservatives) through its emphasis on both universal healthcare coverage and private market insurance reform and competition (Altman and Shactman 2011, 71).

Barack Obama

Obama first mentioned his intention of pursuing healthcare reform on November 24, 2007, while attending a Democratic healthcare forum at the University of Nevada at Las Vegas that was co-sponsored by the Service Employees Union and the Center for American Progress, prominent organizations (a union and a think tank respectively) that served to promote Democratic party values and prepare the governing agendas for prospective and incumbent Democratic presidential candidates and incumbent Presidents (Jacobs and Skocpol 2012, 31). In attendance at the Democratic forum was Senator and former First Lady Hillary Clinton, a formidable contender for the presidential election in the year 2007 noted for her expertise regarding the development of healthcare reform as part of the Clinton administration during the 1990s. John Edwards, who had a fair chance at winning the Iowa Caucus of 2004 and who was expected to win the Iowa Caucus of 2008 due to his 2004 political performance, was also present

at this event. While Clinton and Edwards respectively possessed substantive knowledge regarding the development of specific universal healthcare reforms through their understanding of healthcare reform during the Clinton administration and by employing experts to devise universal healthcare reform plans, Obama merely promised to reform healthcare coverage but could not commit to any well-developed healthcare plans devised by experts that could successfully be passed into law by Congress. This initial mention and promise of passing comprehensive healthcare reform was given political weight when on August 28, 2008, Senator Obama said in his speech accepting the nomination of the Democratic Party for President of the United States: "Now is the time to finally keep the promise of affordable, accessible health care for every single American" (quoted in Skocpol and Jacobs 2012, 35)

Although Obama had repeatedly promised to bring about significant healthcare reforms throughout the course of his tenure as President, his first efforts to reform the state of United States' healthcare did not occur until February 17, 2009. That key date marked Obama's signing of the first piece of significant healthcare legislation into law: the American Recovery and Reinvestment Act, which "included significant health care funding, including \$87 billion in additional federal matching funds for Medicaid, \$25 billion for COBRA subsidies, and more than \$30 billion in other health-related spending (Jacobs and Skocpol 2012, 11). This bill was enacted in order to stimulate the economy and to implement policy changes in the area of healthcare reform, including expansions in health insurance coverage for children and the unemployed. Passage of this bill was met with total and harsh Republican opposition while only being passed into law by the votes of Democratic politicians who supported healthcare reform (Jacobs and Skocpol 2012, 39). Initially, Obama had wanted Tom Daschle, the former Senate Majority Leader and South Dakota Senator to serve as both the Secretary for the Department of

Health and Human Services and the White House coordinator for health policy, but due to his inability to pay taxes on money he had received as a political consultant, Daschle was unable to assume this central role in the Obama administration and would not be able to coordinate major health policy reforms between Congress and the White House. Three months followed until Kathleen Sibelius was elected as Secretary of the Department of Health and Human Services, while Nancy Ann DeParle was picked to be responsible for coordinating White House health policy efforts, ensuring that healthcare reform efforts could continue as planned under the guidance of less prominent but equally well-qualified healthcare experts (Jacobs and Skocpol 2012, 39).

Obama's plans for the passage of significant healthcare reform continued to progress when the annual fiscal year budget was proposed and released by Congress on February 26, 2009. The budget document, titled "A New Era of Responsibility: Renewing America's Promise," provided a detailed outline of reforms Obama would like to undertake to regulate and stimulate the economy and to reform education, energy, and healthcare (Jacobs and Skocpol 2012, 45). Obama's fiscal year 2010 budget was shown to have included approximately 630 billion dollars to partially, but mostly, cover healthcare reform costs, which pleased Democrats and progressives for its ability to effectively provide access to high-quality healthcare while ensuring that healthcare insurance costs remained low for American consumers.

To meet his election promise of providing affordable and accessible healthcare coverage to every American, Obama, on March 5, 2009, held his first summit on healthcare reform (Jacobs and Skocpol 2012, 46). In conducting this summit, Obama wanted to showcase his healthcare reforms while simultaneously recognizing that he was putting the prestige of his hard-won presidency at stake. In conducting the healthcare reform summit, President Obama still

thought as president that he "could help orchestrate a relatively broad consensus on strong but moderate legislation to achieve the twinned goals of access and affordability" (Jacobs and Skocpol 2012, 46). The summit sought to bring together Democratic and Republican congressional leaders and representatives from multiple interest groups that either supported or opposed healthcare reform, including traditional Democratically aligned unions and healthcare reformers, physicians groups, employers traditionally tepid or opposed to legislated health reforms, and insurers in order to receive votes from Democrats and Republicans in Congress while providing all members in the summit with a comprehensive understanding of President Obama's healthcare reform efforts. The President hoped that comprehensive healthcare legislation bills would be put through to both the House of Representatives and the Senate by the beginning of the summer 2009 recess while significantly revised and reform-minded healthcare reform legislation would get signed into law before Thanksgiving but ultimately this was not the case.

On May 11th, following the March 5th summit on healthcare reform, six major players in the health care industry and former opponents of healthcare reform (the Advanced Medical Technology Association (AdvaMed), the American Hospital Association (AHA), Pharmaceutical Researchers and Manufacturers of America (PhRMA), the American Medical Association (AMA), America's Health Insurance Plans (AHIP), and Service Employees International Union (SEIU) signed a letter which suggested their agreement to support major efforts in healthcare reform and the lowering of expected healthcare costs to pay for such significant reforms in healthcare legislation. According to Altman and Shactman, "major health industry stakeholders had pledged to reduce the rate of growth in health spending by 1.5 percentage points each year from 2010 to 2019 that would save 2 trillion dollars in healthcare spending" (Altman and

Shactman 2011, 257). Max Baucus, the Republican head of the Senate Finance Committee, began negotiations with Billy Tauzin, the head lobbyist for the pharmaceutical group Ph'Rma, in order to ensure that PhRma would aid in paying for Medicare costs that could not be covered by individual American citizens. PhRMA subsequently agreed to provide eighty billion dollars in savings over ten years to cover the costs of Medicare that many American citizens could not pay for themselves, known as the "Medicare donut hole," including the provision of 50 percent discounts on prescription drugs for people who fell within this category of Medicare coverage. Ph'Rma then agreed to cover the expenses of 150 million dollars of advertisements supporting health reforms. In return, the Obama administration would block any subsequent congressional effort to negotiate Medicare drug prices and to prevent the re-importation of prescription drugs.

Before negotiations could be finalized however, on June 15, 2009, President Obama addressed the AMA at Chicago's House of Delegates, saying "one essential step on our journey is to control the spiraling cost of health care in America. And in order to do that, we're going to need the help of the AMA" (Altman and Shactman 2011, 271). The first six months of 2009 saw the AMA spending \$8.1 million lobbying to influence the health reform debate. The AMA did not support the Medicare SGR (sustainable growth rate formula), which sought reduce the fees that Medicare provided to doctors and which Congress, since the year 2000, had partly or fully postponed each year. Further cuts to Medicare spending could reduce access to care for seniors as well as earn the AMA's opposition to continued healthcare reforms. According to Altman and Shactman, "The AMA wanted the SGR repealed, and the Democrats were sympathetic.

However, repeal would add over \$200 billion to the health care proposal and make budget neutrality nearly impossible" (Altman and Shactman 2011, 272). On June 15, 2009, President Obama addressed the AMA at Chicago's House of Delegates, saying "one essential step on our

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This agreement to provide significant funds for Medicare expenses was negotiated with Baucus in July at a meeting held in the White House's Roosevelt Room, with chief executives from Abbott Laboratories, Merck, and Pfizer, as well as Tauzin, Rahm Emanuel, and other White House aides in attendance. On July 14, 2009, following the initial meeting to negotiate Medicare expenses, three House committees—Energy and Commerce, Ways and Means, and Education and Labor also agreed to pass a single health care bill, the House Tri-Committee America's Affordable Health Choices Act (H.B. 3200) (Jacobs and Skocpol 2012, 12). The following day, on July 15, 2009, the Senate Health, Education, Labor, and Pensions (HELP) Committee passed their version of health care reform legislation, the Affordable Health Choices

Act (S. 1679) (Jacobs and Skocpol 2012, 12).

In August 2009, during the congressional recess, it was clear that efforts to enact bipartisan healthcare reforms would be stalled once more. Numerous members of Congress were met by angry constituents in town halls across the country seeking more comprehensive and less costly ways to reform healthcare policies while hoping that all Americans would be provided with a new form of affordable and accessible healthcare coverage that would include the payment of doctors for end-of-life counseling expenses for their loved ones (Altman and Shactman 2011, 283). The congressional debate and disagreement over the issue of retaining a public option in Obama's proposed healthcare legislation proved contentious as well and would further stall the enactment of significant healthcare reforms, from strengthening the rules governing insurance exchanges to expanding subsidies for lower-middle-income people (Jacobs and Skocpol 2012, 277). Chair of the Senate Finance Max Baucus, and Senator Chuck Grassley (R-IA), a noted member of the Senate Finance Committee who had been a key negotiator in an effort to produce bipartisan health care reform, sought to create a much more clearly defined healthcare bill without the inclusion of a public option (Jacobs and Skocpol 2012, 12). Their negotiations within the Senate Finance Committee would force President Obama to not include a public option in his final healthcare legislation plans. Hospitals did not want the government to set payment rates and instead would have preferred having rates determined through a competitive market (Altman and Shactman 2011, 267). Hospitals did not want to have to accept lower rates than the projected costs for Medicaid and Medicare patients that would normally be paid for to allow patients to stay in their facilities, and as a result these hospitals would not endorse the addition of a public option to Obama's proposed healthcare legislation.

The second week of September, on September 9, 2009, saw the release of Max Baucus'

draft healthcare reform plan that he pushed through the Senate Finance Committee without the benefit of bipartisan support, referring to it as a draft under discussion rather than as a comprehensive healthcare plan (Altman and Shactman 2012, 274). Baucus had removed the public option feature from his plan and had replaced it instead with Senator Kent Conrad's plan for state-run, nonprofit, member-controlled cooperatives, avoided the inclusion of an employer mandate, and avoided the inclusion of income or payroll tax increases through taxing expensive healthcare plans. That same day, on September 9, 2009 President Obama addressed a joint session of Congress urging action on health care reform. In this speech, according to Jacobs and Skocpol, Obama "reiterated his priorities for this legislation, including an end to pre-existing conditions and a new insurance exchange. He did not insist upon the inclusion of a public option, and emphasized the need for deficit reduction" (Jacobs and Skocpol 2012, 12). In this speech, Obama set the stage for numerous healthcare reforms to take place: "getting a bill out of the one remaining Congressional committee that had not acted, the Senate Finance Committee, which would finally act on October 14, 2009; second, getting a majority for the House bill passed on November 7, 2009; and third, assembling a "super-majority" of 60 Senators to enact comprehensive reform in the Senate on Christmas Eve (Altman and Shactman 2011, 55). Within the next two weeks, Baucus amended his plan to reflect the views of his fellow Finance Committee members through increasing subsidies for lower-income people and reducing the penalties for not complying with the provisions of his proposed healthcare plan. In drafting his plan, Baucus met the requirements Obama had set for drafting comprehensive healthcare reform: total spending for the bill was less than \$900 billion, and it did not add to the deficit. According to Altman and Shactman, "Baucus introduced his chairman's mark on September 22 and held a full committee vote on October 13, with one Republican, Olympia Snowe, voting for its passage

into law" (Altman and Shactman 2011, 277). On October 13, 2009, the Senate Finance Committee approves their version of health care reform, the America's Health Future Act, by a vote of 14 to 9. Despite fierce opposition from both conservatives and liberals for wasting so much time in drafting healthcare legislation that was not submitted for a full discussion, the Baucus bill served as a precursor to the final healthcare legislation that would be enacted into law on March 23, 2010 as the Patient Protection and Affordable Care Act.

The next few months saw an increased lack of support from Americans regarding the passage of universal healthcare reform, though Congress moved closer to passing a bill through the House and Senate, with a democratically controlled Congress (218 Democrats to 177 Republicans). After the summer protests during the August recess regarding the idea of "death panels" and the October vote in the Senate Finance Committee, five comprehensive healthcare bills had been passed by three House and five Senate congressional committees outlining plans for universal healthcare reform. According to Altman and Shactman, "Speaker Pelosi would combine the three House bills into one and vote in early November. Following that, Majority Leader Reid would combine the two Senate bills, which he could successfully pass with his sixty vote super majority. Then, a Democrat-controlled conference committee would iron out the differences and bring the bill to the floor of each house for a final vote. If all went smoothly, Barack Obama could sign the historic legislation before Christmas" (Altman and Shactman 2012, 85). A ideologically and demographically diverse Democratic caucus who held differing positions on issues surrounding healthcare reforms, differences in Medicare payments among high-cost and low-cost states, the issue of healthcare financing through the implementation of a tax on expensive insurance plans, whether or not to institute a public option and an employer mandate into the universal healthcare legislation, and the issue of abortion rights were all factors

that contributed to the complex and difficult nature of passing significant universal healthcare legislation into law. The bill eventually proposed by Pelosi would contain a public option, but payment rates would be individually determined by the states rather than determined by Medicare rates. On November 7, 2009, by a vote of 220 to 215, the House of Representatives passed a significant piece of healthcare legislation, the Affordable Health Care for America Act (H.R. 3962). The final bill included the "Stupak Amendment," an amendment created by pro-life Democratic Senator Bart Stupak (D-MI) which restricts abortion coverage by "forbidding any insurer that wanted to participate in the insurance exchange from including abortion coverage in its health plans because some of the purchasers might be receiving government subsidies," making it so that many low- and moderate-income women who purchased insurance would not be able to purchase a policy that covered abortion (Altman and Shactman 2011, 278). The House bill would cost \$1.05 trillion over ten years and insure an additional thirty-six million Americans.

In December, following November's passage of a healthcare bill by the House of Representatives, a significant piece of healthcare reform was passed by the Senate. On December 24, 2009, the Senate passed their health care bill, the Patient Protection and Affordable Care Act (H.R. 3590). The Senate's bill required that all fifty states, rather than the federal government, be charged with administering health insurance exchanges (Jacobs and Skocpol 2012, 100). Within this bill, the Senate made provisions for larger and smaller businesses not to directly comply with the ideas of universal healthcare coverage, while implementing cost controls into their plans such as the Medicare Payment Commission and taxes on expensive health insurance plans, known as "Cadillac insurance plans," which were refused by the House of Representatives during the passage of their healthcare bill by the House (Altman

and Shactman 2012, 100).

The month of January 2010 saw significant revisions made to the passed healthcare reform legislation in the House and Senate. On January 15, 2010, President Obama and top House and Senate Democrats agreed on making revisions to both the Senate and House healthcare bills, including, upon consultations with union officials, the implementation of a tax on high-cost insurance plans (Jacobs and Skocpol 2012, 13). A few days later (January 19, 2010) saw the election of Scott Brown, a Republican Senator from Massachusetts who adamantly opposed Obama's healthcare plan, to the Senate seat of former Democratic Senator Edward Kennedy, who had made the idea of providing universal healthcare coverage to all Americans his life's work. In winning the midterm Senate election, Brown defeated the Massachusetts Democratic Senator Martha Coakley in running for office and subsequently rid the Democratic party of its sixty-person majority in Congress. On January 19, 2010, the White House attempted to pass an unamended version of the Senate Bill into law under the direction of House Speaker Nancy Pelosi. Pelosi attempted to pass an unamended Senate Bill by excluding Republicans from the process and conducting negotiations within a purely Democratic Party caucus. Conducting negotiations using a purely Democratic caucus would not require Democratic politicians to focus on obtaining Republican support while successfully compromising on passing legislation by Democratic politicians in the House and Senate. When Congress brought the bill to the Senate, there would be still be the possibility of maintaining a sixty-person supermajority within the Democratic ranks. The election of Scott Brown, however, would not allow this to be the case.

The election of Scott Brown was followed on January 27, 2010 by Obama delivering a State of the Union Address that called for the passage of universal healthcare reform and

"warned Democrats dispirited by the Brown upset that "we still have the largest majority in decades and the people expect us to solve some problems, not run for the hills" (Altman and Shactman 2011, 13). Following the presentation of Obama's State of the Union Address, the idea for comprehensive healthcare reform received an endorsement from the insurance company Anthem Blue Cross in California when they increased premiums in the state by up to 30 percent in order to cover their expenses to company retreats. Furious, Henry Waxman, Chairman of the House Energy and Commerce Committee, required company executives to appear before Congress. According to Altman and Shactman, "Testimony revealed that Anthem had recorded \$4.2 billion in profits the previous year and had spent twenty-seven million dollars in 2007 and 2008 on company retreats to lavish resorts (Altman and Shactman 2011, 316). Later, on February 22, 2010, Obama released a comprehensive healthcare proposal that closely resembled the Senate legislation drafted previously. On March 3, 2010, Obama gave a speech in the East Room of the White House, stating that Democrats would use the concept of reconciliation in passing healthcare reform (Altman and Shactman 2011, 317).

The steps to enact comprehensive universal healthcare reform occurred quickly over the next two months. On March 21, 2010, by a vote of 219 to 212, the House of Representatives passed the Senate version of health care reform, the Patient Protection and Affordable Care Act. On that same date, by a vote of 220 to 211, the House passed a bill that revised the Senate legislation, the Health Care and Education Reconciliation Act (H.R. 4872) (Altman and Shactman 2011, 14). On March 23, 2010, President Obama signed the first part of the health care legislation, the Patient Protection and Affordable Care Act, into law, which was met by fierce opposition from attorney generals in fourteen states who sued to block this influential healthcare reform law from being passed by Congress. On March 26, after multiple delays in

Congress, the Senate voted for the reconciliation fixes, the Health Care and Education Reconciliation Act, by a vote of 56 to 43. Members of the House of Representatives were made to vote for the law again, as Republicans opposed some of the language written in this piece of legislation. This law passed a second time, with a vote of 220 to 207. Finally, on March 30, 2010, President Obama signed Health Care and Education Reconciliation Act into law. What was once thought a political impossibility, meaningful healthcare reform, became a reality.

Conclusion

The themes or trends which emerge from this historical analysis relate to the idea that there is a continued development in healthcare reform regarding the six presidents' collective efforts to pass significant pieces of healthcare legislation. This chapter documents the difficulties each president had in attempting, but ultimately failing (with the exception of President Obama) to pass significant pieces of healthcare legislation. The chapter ultimately does this by presenting a comprehensive historical overview of healthcare reform efforts from the beginning of the twentieth century into the early twenty-first century. This overview of healthcare reform suggests that although the quality of healthcare services have improved over time, the costs to provide healthcare services to American citizens has greatly increased over time. With the passage of President Obama's healthcare reform efforts in the form of the Patient Protection and Affordable Care Act, healthcare costs have been lowered through the implementation of comprehensive, government-sponsored healthcare reform but will ultimately increase due to President Trump's passage of a comprehensive healthcare bill by the House of Representatives that will lead to the increase in healthcare costs. The primary conclusion which can be drawn from this chapter is that presidents' efforts to pass significant pieces of healthcare legislation failed due to harsh opposition from Republican interest groups and politicians who claimed that

government-subsidized healthcare would result in higher costs, a decrease in the quality of healthcare, and that the specific proposals constituted socialized medicine which is un-American. This chapter takes a historical perspective in pursuit of the question of how various US presidents have attempted to resolve this tension through their respective healthcare reform efforts.

The common idea that all of these public policies share is that they all relate to the continual development of comprehensive pieces of universal healthcare legislation that were attempted to be passed into law by Congress and by various presidential administrations. The healthcare policies differ in their approach to outlining universal healthcare reforms regarding the pieces of healthcare legislation that were presented to Congress to be passed into law. From a broader political-historical perspective, healthcare policy was shaped by events which occurred during the time periods that each policy was attempted to be passed into law.

Chapter Three

Distributive Justice and Presidential Healthcare Reform Efforts

Introduction

This chapter analyzes the presidential arguments in favor of healthcare reform.¹ The analysis presented here focuses on the distributive justice principle or principles that is/are emphasized by each president, but also the principle or principles that each president does not have recourse to. Each allocation principle discussed in the first chapter suggests a specific research hypothesis. In arguing for healthcare reform, it is expected that merit is the least important allocation principle (H1) and that need is the most important allocation principle (H2). One should also expect that efficiency becomes an increasingly more important frame/hypothesis (H3) in recognition of the fact that the American public tends to evaluate candidates and the political world not in terms of public policy, but in terms of effectiveness (see Lenz 2013). Finally, given the fact that equality is conceptualized as the more specific allocation principle of distributive justice--equality of outcome--one would not expect to see this principle frequently used in presidential efforts to achieve healthcare reform (H4). Americans simply do not view equality in these terms. Thus, if a president were to use equality as a frame one would expect to see them employ an understanding of equality supported by the public--equality of opportunity.

Individual Presidential Addresses

Table 1 contains the frequency distributions for each presidential address analyzed here

¹ This study approaches the presidents considered here chronologically. This approach reflects the desire to determine whether or not the framing of healthcare reform changed over time and, to the extent that there is evidence of change, then ascertain the degree to which the use of distributive justice frames conform to what we know about the distributive justice values of the American public.

for each of the four allocation principles. The bottom section of the table also contains frequency distributions for the various ways equality can be conceptualized. Analysis of FDR's framing of healthcare reform provides support for the first two hypotheses. FDR makes only a single reference to merit and need is by far the principle he has the greatest recourse to (46%). The emphasis on need is consistent with how the public views distributive justice so FDR's frame is partially correct. He gets things wrong, however, in making equality his second most important allocation principle which does not support the fourth hypothesis. 37% of the frames used by FDR are to equality and of these 53% are to equality of outcome. FDR hardly has recourse to efficiency and, as argued here, one would expect efficiency to replace merit as the second allocation. Thus, there is no empirical support for the third hypothesis.

Table 1: Allocation Principles in Presidential Addresses						
	FDR	Truman	LBJ	Nixon	Clinton	Obama
Allocation Principle						
Need	19 (46%)	81 (55%)	24 (75%)	43 (32%)	35 (19%)	43 (39%)
Efficiency	6 (15%)	21 (14%)	2 (6%)	42 (31%)	95 (52%)	55 (51%)
Merit/Equity	1 (2%)	3 (2%)	0 (0%)	16 (12%)	22 (12%)	1 (1%)
Equality	15 (37%)	43 (29%)	6 (19%)	33 (25%)	32 (17%)	10 (9%)
Total	41 (100%)	148 (100%)	32 (100%)	134 (100%)	184 (100%)	109 (100%)
Types of Equality						
Outcome	8 (53%)	28 (65%)	5 (83%)	18 (55%)	26 (81%)	5 (50%)
Right	5 (34%)	5 (12%)	0 (0%)	0 (0%)	6 (19%)	0 (0%)
Opportunity	0 (0%)	9 (21%)	1 (17%)	14 (42%)	0 (0%)	1 (10%)
Partnership	2 (13%)	1 (2%)	0 (0%)	1 (3%)	0 (0%)	4 (40%)

The results for Truman add additional support for the first and second hypotheses. Merit is the least important principle for Truman (3%) and need is definitely the most important principle (55%). With regard to efficiency, Truman paints the same picture as FDR and Truman

follows FDR in making the mistake of having equality as the second most important principle (29%) which does not support the fourth hypothesis. Closer inspection of Truman's use of equality shows that 65% of the time he uses equality in terms of equal outcomes and 12% of the time he speaks in terms of healthcare as an equal right. This means that 77% of his appeals to equality are couched in such a way as to lose support amongst the American people. This being said, Truman does try to frame equality in terms of the equality of opportunity (21%), but even with this being said he would have been better off to not employ equality at all as an allocation principle of distributive justice for the policy area of healthcare reform policy legislation.

The results for Johnson to continue the trend of providing support for the first two hypotheses are presented next. Johnson makes no references to merit and 75% of all his references to distributive justice are to need. Johnson's lack of recourse to efficiency (6%) goes against the American public's expectations regarding their views of distributive justice as does the fact that he uses equality 16% of the time. In referencing equality, 83% of the time he speaks of equality of outcome and he makes only a single reference to equality of opportunity. Johnson's framing efforts, like those of FDR and Truman, are not consistent with the values of the American public. This, in part, explains why Johnson was unable to follow up his success in passing Medicare and Medicaid. With regard to the development of comprehensive healthcare legislation that would spur forward the process of creating universal healthcare coverage for all American citizens, Johnson seems guilty of oversimplification by emphasizing need almost exclusively. While need is important, experimental research on distributive justice allocation principles and norms shows that people think about distributive justice in more nuanced ways where they often combine multiple principles and that these principles vary by policy area (see Miller 1999; Elster 1995; Frohlic and Oppenheimer 1992; Scott et al. 2001). Had Johnson been

able to capture this concept in his efforts to frame healthcare reform he might have been successful.

Merit remains the least important principle for Nixon (12%) and need is still the most important principle (32%). Here, one finally finds support for the hypothesis that efficiency will replace merit in how the argument for healthcare reform should be framed. Closer inspection of Nixon's speech itself contains multiple passages where Nixon connects need and efficiency. Nixon (1974) states, "Only with effective cost control measures can States ensure that the citizens receive the increased health care they need and at rates they can afford." Based on these findings, Nixon's frame comes the closest to the mirroring the preferences of the American people. So, where does Nixon's frame go wrong? The answer to this question seems to be his recourse to equality (25%). The rate that Nixon has recourse to this concept is almost at the same level as his references to need (32%) and efficiency (31%). Thus, Nixon essentially makes a three-pronged argument in favor of healthcare reform. While Nixon smartly employs equality of opportunity (42%), the dominant understanding of equality used by Nixon remains equality of outcome (55%). Nixon would have been far better served to exclusively use equality of outcome or to drop any reference to equality all together.

The results for Clinton paint quite the interesting picture for his prospective take on devising comprehensive healthcare reform. While merit remains the least important allocation principle (12%), Clinton's rhetoric moves in a highly unanticipated direction as he only uses need 19% of the time! Not only does this fact contradict the public's view of distributive justice, but it ultimately seems strange and contradictory in that establishing need is the logical foundation of an argument for healthcare reform itself. If there is no recourse to the distributive justice allocation principle of need, then the question remains as to why it is that reform is necessary in

the first place? Clinton does provide support for the third hypothesis as he has recourse to efficiency 52% of the time and he continues the trend of not supporting the fourth hypothesis as well by employing equality 17% of the time with 85% of these references to equality of outcome. The efficiency results are striking. While one expects efficiency to have increased importance, it is a bit surprising to see it as the most important principle. While this does suggest that politicians recognize that the public evaluates things based primarily on a performance criterion, one would not expect the total abandonment of ethical criteria in arguing for healthcare reform. The fact that Clinton does this is suggested by the fact that his combined use of the two most relevant ethical principles available to him (need and equality) is 16% less than his use of efficiency. These results suggest that the way Clinton framed healthcare reform worked against him. He correctly recognizes the importance of efficiency, but seems unclear as to how to successfully to expand and complete this policy frame.

Finally, the results for President Obama provide empirical support for the more general argument made here; that Obama was able to pass healthcare reform because he framed his argument for reform in terms consistent with the public's views on distributive justice. Merit continues to be the least important principle (1%) and, unlike Clinton before him, Obama strikes a better balance between need (39%) and efficiency (51%). Not only does this provide support for the second and third hypotheses tested here, but this combination of allocation principles accords with the preferences of the American public. That Obama was successfully able to capture the values of the American people in his framing of healthcare reform is also suggested by equality's lack of importance in his framing efforts. Only 9% of Obama's use of distributive justice allocation principles refer to equality (by far the lowest of any of the six presidents looked at here) and while 50% of these are to equality of outcome the infrequency of these references is

important. Additionally, like Nixon, who ultimately sought to balance equality of outcome via recourse to equality of opportunity, Obama's use of equality of solution frames (40%) represents an important contribution to his efforts to pass healthcare reform. Previously, FDR, Truman, and Nixon had all spoken of the fact that the American people, Republicans, Democrats, the insurance industry, and healthcare professionals working in the healthcare sector are all equal partners in solving the problems of healthcare in America. By providing this understanding of equality of partnership, rather than merely a greater emphasis on the general distributive justice allocation principle of equality with greater weight than previous presidents, Obama effectively uses this rhetorical tool-the breakup of the policy monopoly used by the AMA-to efficiently combat previous reform efforts. This is evident when Obama (2009) speaks of reform efforts being “supported by an unprecedented coalition of doctors and nurses; hospitals, seniors' groups, and even drug companies -- many of whom opposed reform in the past.” Thus, one not only sees here evidence showing that Obama's framing of healthcare reform is the most consistent with the preferences of the American people, but that he is able to add something new to the issue frame (equal partners is equal to finding a solution) that serves the political purpose of releasing the AMA's strangle hold on this issue area.

Comparative Analysis of Allocation Principles

Having shown that Obama's efforts to frame healthcare reform are the closest to the preferences of the American people, one is provided with a clear sense of why he succeeded where previous presidents failed in their attempts to pass and officially enact comprehensive healthcare reform. Additional insight into this conclusion is provided by comparing each allocation principle across all six presidents' data, which can be found by reading across Table One. Doing so provides additional support for the argument made here.

The first research hypothesis is that merit will be the least important allocation principle and the results show this to be the case for each president. This idea is not emphasized by FDR, Truman, Johnson, and Obama; merit is only used with any frequency by Nixon (12%) and Clinton (12%). Instead of arguing that greater government involvement will improve the quality of healthcare in America, inspection of their use of merit shows both presidents attempting to use the connection between merit and excellence to decrease their intense and well-documented opposition of the AMA and others to healthcare reform. Nixon (1974), for example, speaks of sharing the costs of healthcare between the “employer and employee on a basis which would prevent excessive burdens on either.” Similarly, Clinton (1993) argues “We're blessed with the best health care professionals on Earth, the finest health care institutions, the best medical research, the most sophisticated technology. My mother is a nurse. I grew up around hospitals. Doctors and nurses were the first professional people I ever knew or learned to look up to. They are what is right with this health care system. But we also know that we can no longer afford to continue to ignore what is wrong.”

Through the presidency of Nixon need was the most important allocation principle which accords with the second research hypothesis. While FDR, Truman, Johnson, and Nixon all emphasized need, they all appeared to struggle to find that second principle to connect need to, with the principle of merit not an option available to them to connect with as a principle. Both FDR and Truman try to balance need with equality but this only leads to confusion as political theorists working in the field of distributive justice recognize the similarity between need and equality (see Miller 1999, 203-230; Stone 2002). Thus, this confusion leads to a muddled public message which undermines reform efforts. Nixon begins the process of identifying the all-important second principle as he makes efficiency his second most important principle (31%)

thus establishing the ascendancy of efficiency as an important allocation principle in accordance with the third hypothesis. The problem with Nixon's message, despite his efforts to appeal to equality of opportunity, is that he incorporated equality as a third allocation principle (25%). While Americans' understanding of distributive justice is complex, it is not that complex.

As already indicated, Clinton's framing efforts all seem to run counter to the positions held by the American people. Not only does Clinton not emphasize the principle of need (19%), but ultimately Clinton is unable to balance his appeals to efficiency with any normative allocation principle of distributive justice. Relying almost exclusively on efficiency, Clinton opens his argument for reform to the criticism that greater government involvement in any aspect of life runs counter to much of the argument for efficiency (see Tomasi 2012; Hayek 1976). Thus, when reform opponents argue that government involvement produces greater inefficiency Clinton is unable to adequately respond to this line of criticism as he did not give himself another principle he could use to deflect this line of criticism. It seems that Obama learned from the mistakes of past reform efforts. Following Nixon and Clinton, Obama emphasized efficiency. Unlike Clinton, who ignored the principle of need, Obama seems to have had to maintain an ideal balance between the principles of efficiency and need in accordance with the American public's viewpoints regarding the allocation principles of distributive justice. Unlike FDR, Truman, and Johnson, Obama gives little attention to equality and when he does speak in terms of equality he is able to use this concept to undercut arguments against reform.

Conclusion

Jacobs and Skocpol (2012) remind one that there are numerous factors that explain why President Obama was successfully able to pass healthcare reform. This study shows that one of these key factors was President Obama's use of language. When compared to the framing efforts

of previous presidents who sought, unsuccessfully, to enact healthcare reform, the framing efforts of President Obama stand out. Presidents Roosevelt, Truman, Johnson, and Nixon all recognized the centrality of framing reform in terms of need, but they failed to recognize the nuanced view of distributive justice held by the American people. Roosevelt, Truman, and Johnson all employed equality of outcome in their issue frames and this value is definitely not consistent with the preferences of the American people. In fact, one of the conclusions of this chapter is that presidents use equality of outcome as an allocation principle to their peril.

Instead of marrying need and equality, presidents would be better served to combine need with a performance measure like efficiency. Nixon begins to do this, but it is President Clinton who first emphasizes efficiency in his framing of healthcare reform. The problem with Clinton's efforts, however, is that he relies almost exclusively on efficiency. By neglecting need, Clinton effectively undermines his own efforts at healthcare reform. Ultimately, President Obama strikes the right balances between appeals to normative principles (need) and framing healthcare reform in terms of performance (efficiency).

Chapter Four

Republican Opposition to Healthcare Reform: Opposition Framing of the Clinton and Obama Reform Efforts

Introduction

The results and argument of the previous chapter suggests that President Obama was successfully able to pass healthcare reform because he framed his healthcare reform efforts using distributive justice principles that resembled America's understanding of distributive justice. Previous presidents framed healthcare reform using the primary allocation principle of need, while President Obama used multiple allocation principles in combination to frame his healthcare reform efforts. In particular, President Obama's recourse to both need and efficiency (which serves as a performance criteria) differentiates his from previous, unsuccessful frames. The Obama frame succeeds, in part, because it does a better job of capturing the distributive justice preferences of the American public.

In relying heavily on efficiency, Obama follows the example of Richard Nixon who was the first president to use efficiency as a distributive justice principle in his framing of healthcare reform. Obama's ability to successfully employ efficiency as an aspect of his frame of healthcare reform also raises an interesting question when one compares the Obama and Clinton frames. Like Obama, Clinton liberally used efficiency as a distributive justice principle in his healthcare reform efforts. Clinton's efforts failed, though, as he primarily relied on the principle of efficiency in framing his healthcare reform efforts while not using need as a distributive justice principle. President Obama, unlike previous presidents, invoked both normative and performance principles like need and efficiency, as well as sound political language and rhetoric and effective leadership, to ensure that his healthcare reforms were passed. This is, however, only half of the picture as the argument and analysis focuses only on the arguments in favor of healthcare reform.

In order to more fully understand the results from the previous chapter, it is necessary to have some sense of how opposition to healthcare reform was framed. The arguments in favor of healthcare reform analyzed in the previous chapter did not occur in a political vacuum. Opponents of healthcare reform anticipate arguments in favor of reform, respond to particular frames, and adjust their own frames in an effort to defeat reform efforts. That Republicans thought in these terms is suggested by William Kristol, who opposed Clinton's reform efforts. He writes: "These four pages are an attempt to describe a common political strategy for Republicans in response to the Clinton health care plan. By examining the president's own strategy and tactics, this memo suggests how Republicans might reframe the current health care debate, offer a serious alternative, and, in the process, defeat the president's plan outright" (Kristol 1992). In short, Kristol offers Republicans a frame and a political strategy for defeating President Clinton's healthcare reform efforts. By examining Clinton's tactics and strategy, it becomes possible for Republicans to first defeat the President and, second, develop and pass a healthcare reform package of their own. As the history of healthcare reform in the United States makes clear, opposition to reform efforts have won the political battle every time except one. Thus, it is important to consider how opponents of healthcare reform have framed the issue. In particular, one is interested in three questions: 1) Do opponents of healthcare reform employ distributive justice principles in their frames?; 2) If so, how do they employ these frames?; and 3) Is their use of distributive justice principles consistent with the values of the American public?

This chapter focuses on Republican opposition to the healthcare reform efforts of Presidents Clinton and Obama. In addition to the questions just mentioned, this chapter also considers the question of whether or not there evidence of a change in how Republicans framed their opposition? This question is important given the different outcomes of their opposition. If

there is evidence of a change in how Republicans framed their opposition, does this help one to understand why Clinton's reform efforts failed whereas Obama's succeeded? Finally, given what we know about the differences between the Clinton and Obama frames, does the evidence presented here support the possibility that one of the reasons Obama was able to pass healthcare reform and Clinton was not is because he did a better job of framing the issue than Republicans.

Data and Hypotheses

This chapter uses the operational definitions of need, efficiency, merit, and equality employed in the previous chapter and applies the same methodological approach to the Republican opposition considered in this chapter. In particular, this chapter focuses on three examples of Republican opposition. In opposition to the Clinton healthcare reform efforts, William Kristol's "Defeating President Clinton's Health Care Proposal" published by the Project for a Republican Future (1993) was selected. William Kristol is a conservative political analyst and commentator who is the chief editor of the *Weekly Standard*, an influential magazine that is geared towards a conservative political audience. The purpose of Kristol's memo is to examine Clinton's healthcare policy and then reframe Clinton's healthcare plan by creating a healthcare strategy which is more aligned with how Republicans believe healthcare legislation should be written. Two items were selected to gauge Republicans' response to President Obama's argument for healthcare reform. A memo titled "Healthcare Memo" put out by the conservative Heritage Foundation was selected as was Representative Charles Boustany's (R-LA) official Republican response to President Obama's healthcare address analyzed in the previous chapter. The Heritage Foundation is a conservative Washington, DC based think tank which has had a major influence in drafting scholarship on conservative public policies since the presidency of Ronald Reagan. Heritage Foundation scholarship is very influential in conservative policy circles.

Charles Boustany is a representative of Louisiana's Third Congressional District. Prior to serving in Congress, Representative Boustany was a renowned heart surgeon in the area.

As with the presidential addresses analyzed in the previous chapter, each of these items was content coded for how they framed the issue of healthcare reform by the author and an outside reader. Having two coders compare their respective results ensures the accuracy of the coding process in terms of whether or not a relevant piece of text should be coded and, if it should be coded, what allocation principle it should be coded as. Every individual reference to a particular allocation principle is counted as a single frame which allows for the counting of multiple frames within a single sentence. The more a particular allocation principle is employed in opposition to healthcare reform indicates that the particular principle is more salient to opposition frames provided by Republicans.

Four research hypotheses, one for each of the distributive justice allocation principles, are tested in this chapter. In terms of need, Republicans will not emphasize the allocation principle of need as they are generally opposed to reforming healthcare. To the extent that they do employ need as an issue frame, one would expect that need is connected to policy recommendations that are minor in nature and that do not require a reworking or rethinking of healthcare in the United States as it currently exists. In terms of efficiency, one would expect this to be the most important frame for Republicans. In particular, one should expect Republicans to frame the reform efforts of Clinton and Obama in terms of inefficiency. Republicans should have recourse to the tried and true argument that government controlled policies are inherently inefficient and that healthcare consumers would be better served by either making all healthcare decisions themselves or, to the extent that government must be involved, that the states are more likely to provide efficient reform. In terms of merit/equity, one would expect Republicans to emphasize

merit in their opposition to Clinton and Obama. One expects that Republicans would use this principle to argue that the proposed reforms would undermine the quality of healthcare provided under the current system in the United States. In terms of equality, one would not expect Republicans to emphasize equality as the requirements of equality are in tension with the expectation that they will emphasize merit. The latter point recognizes the justness of unequal distributions whereas the former point explicitly rejects this. To the extent that one finds Republicans to have any recourse to equality, one would expect that they would employ the logic of the equality of opportunity following the lead of President Nixon.

Analysis

The coding results for Republican opposition to the healthcare reform efforts of Presidents Clinton and Obama are presented in Table One. The analysis presented here proceeds chronologically in order to determine if there is a shift in how Republicans framed their opposition.

Republican Opposition to Clinton

Table 1: Allocation Principles in Republican Responses to Clinton and Obama

Allocation Principle	Kristol	Heritage	Boustany	Total
Need	9 (12%)	5 (11%)	4 (13%)	18 (11%)
Efficiency	48 (64%)	32 (73%)	24 (75%)	104 (69%)
Merit/Equity	17 (23%)	1 (2%)	3 (9%)	21 (13%)
Equality	1 (15)	6 (14%)	1 (3%)	8 (5%)
Other	0	3 (7%)	0	3 (2%)
Total	75 (100%)	44 (100%)	32 (100%)	151 (100%)
Types of Equality				
Outcome	0	0	0	0
Right	0	0	0	0
Opportunity	1	6	1	8
Partnership	0	0	0	0

Kristol cites inefficiency as a key allocation principle in his framing of distributive justice 64% of the time. This idea aligns with Americans' understanding of distributive justice and is consistent with the expectation that Republicans would emphasize the inefficiency of the Clinton proposal. The second most important allocation principle for Kristol is merit/equity, which is cited 23% of the time. This is also consistent with expectations and supports the research hypothesis for this allocation principle. That Kristol understands merit in the terms suggested by the research hypothesis is evident in the following passage from his memo: "Passage of the Clinton health care plan, in any form, would guarantee and likely make permanent an unprecedented federal intrusion into and disruption of the American economy--and the establishment of the largest federal entitlement program since Social Security. Its success would signal a rebirth of centralized welfare-state policy at the very moment we have begun rolling back that idea in other areas. And, not least, it would destroy the present breadth and quality of the American health care system, still the world's finest. On grounds of national policy alone, the plan should not be amended; it should be erased." What is particularly striking about the Kristol memo is recognition of the fact that using merit in opposition to the Clinton frame is consistent with the values of the American public. Citing survey results from a 1993 CBS/New York Times survey, Kristol highlights the public's concern with a decrease in the quality of healthcare. He writes, "Respondents to a mid-November CBS/New York Times poll say, by a two-to-one margin, that the Clinton plan is more likely to degrade than enhance the quality of their own medical care, and by an almost six-to-one margin that their personal medical expenses are more likely to go up under Clinton than down." These ideas show that the content of the frame speaks to a fundamental Republican concern with reform—that the quality of healthcare in America will

suffer under the proposed reform package.

According to Kristol, need is the third most important principle (12%), which is consistent with expectations for the Republican opposition frame. As expected, equality is the least important principle in Kristol's frame, as it only was referenced one time (15 %). Again, this result is consistent with expectations and supports the hypothesis for equality in the Republican frame. Kristol's frame focuses on promoting the needs of the American people by reducing the cost of healthcare and increasing the number of Americans covered in contrast to the inefficiency of big government and a decrease in the quality of healthcare coverage. He offers a nice summary statement of this approach in the following quote: "Republicans should ask: what will Bill Clinton's health care plan do to the relationship most Americans now have with their family doctor or pediatrician. What will it do to the quality of care they receive? Such questions are the beginning of a genuine moral-political argument, based on human rather than bureaucratic needs. And they allow Republicans to trump Clinton's security strategy with an appeal to the enlightened self-interest of middle-class America." When compared to the lack of focus that characterizes the Clinton frame in favor of healthcare reform and its lack of a clear connection to the distributive justice values of the American people, the results presented here speak to one of the reasons for why the Republicans were able to defeat the Clinton reform efforts. Simply put, Republicans did a better job of framing the issue than Clinton did.

Republican Opposition to Obama

Consistent with expectations, the memo from the Heritage Foundation emphasizes efficiency with 73% of the distributive justice frames in the memo appealing to this allocation principle. Contrary to expectations, equality was the second most important frame (14%). It was noted above, however, that if Republicans were to have recourse to equality that they would have

recourse to the equality of opportunity and this is what one sees here. The Heritage Foundation invokes the idea of equality of opportunity as follows: "But inertia leads some other Americans who can afford coverage not to acquire it, in many cases because they know they can rely on the taxpayer-supported emergency room. For those Americans, you should explore the idea of 'auto-enrollment' in private plans, in which the default is that working families are automatically signed up and must actively decline coverage if they don't want it. It turns out that default enrollment sharply increases sign-ups for pension plans, and you supported legislation to make it easier and affordable for firms to institute such enrollment procedures" (Owcharenko and Butler 2008). More striking is the result showing that the Heritage Foundation memo employs need (11%) more than merit (2%). This result is not consistent with expectations and the lack of emphasis on merit in the Heritage Foundation memo distinguishes it from the frame provided by Kristol in opposition to President Clinton. With regard to why need is emphasized more than merit, one finds the following suggestion to President Obama in the Heritage memo: "Use incentives and perhaps automatic enrollment in private plans, not government mandates, to foster wider coverage. You spoke eloquently during the primaries of the unfairness of forcing families to purchase coverage they couldn't afford. You also challenged your primary opponents to say which police powers they would use to enforce a mandate. As you explained, the main reason why working Americans are uninsured is that they cannot afford coverage" (Owcharenko and Butler 2008). Unlike the Kristol memo which downplays the need for healthcare reform, the Heritage Foundation's memo concedes that reform is needed. Obama and Republicans share the common ground of providing coverage for uninsured Americans at a reasonable price. Merit is surprisingly referenced only 2% of the time in the Heritage memo. Merit's lack of saliency in the Heritage memo suggests that Republicans might have shifted their opposition frame.

Specifically, it suggests that they are no longer arguing against healthcare reform in terms of a decline in the quality of healthcare coverage. Instead, they seem to oppose Obama's efforts on the single dimension of efficiency. More importantly, this result suggests that the Republican frame might not conform to the distributive justice values of the American public.

Boustany's response to President Obama's address is the shortest of the three pieces under consideration. Its brevity requires one to be cautious from drawing any generalizable conclusions. This being said, Boustany's frame supports the hypothesis that Republicans will emphasize the inefficiency of the Obama proposal. Boustany has recourse to efficiency in 69% of his distributive justice frames. The Boustany speech also supports the hypothesis that merit will also be an important frame for Republicans. The second most important allocation principle for Boustany is merit (13%). This being said, one would actually expect this to be more important to his framing of the issue, as Republicans' understanding of healthcare reform relies on the ability of consumers to have as much choice, flexibility, and competition in choosing a quality healthcare plan that can be bought at a lower cost. Kristol, as opposed to Boustany or the Heritage Foundation, references merit a total of 23%, the most of any Republican opposition memo, while merit is referenced 2% and 13% by the Heritage Foundation and Boustany memos respectively. Republicans pay too much to the allocation principle of efficiency in reference to making healthcare coverage more affordable, while not, like Obama, framing healthcare reform using multiple allocation principles like need and efficiency. The memos which document Republican opposition to Obama's healthcare reforms do not take into account that Americans view public policies in terms of the social welfare and economic well-being that they provide to the American population. That need is the third most important principle is not surprising, but that it the principle of need is almost as important as merit (11% to 13%) is surprising. Boustany'

lack of emphasis on merit suggests that an opportunity was missed in his efforts to frame Republican opposition to the argument in favor of healthcare reform made by Obama. Finally, Boustany makes only eight references to equality (5%) and all of these are to the equality of opportunity which is consistent with expectations.

Consistent with expectations, Republicans emphasize efficiency or, more accurately, the lack of efficiency in their opposition to the reform efforts of Presidents Clinton and Obama. Of the 151 individual frames identified in the three items, 69% of the frames are to efficiency. The second most important frame is merit (13%) and this is also consistent with expectations. What is not consistent is the lack of frequency which is used as a frame. While one would expect Republicans to employ merit less than efficiency, one would not expect to see it used so infrequently. The infrequency of its use is suggested when one sees that Republicans have recourse to need in 11% of all frames looked at here. Finally, equality is the least important frame for Republican opposition (5%) and when Republicans do have recourse to this principle, they do so in terms of equality of opportunity.

Comparing the Clinton and Obama Opposition Frames

The results presented in the previous section suggest that Republicans adjusted their opposition frame in their effort to defeat the healthcare reform efforts of President Obama. The purpose of this section is to explore this possibility with greater focus and to consider the implications of such a shift in Republican strategy.

In comparing the results of Republican opposition to the Clinton and Obama healthcare reform efforts, one is first struck by the centrality of efficiency to the frames. Efficiency was the most important allocation principle for Kristol (64%) and remains the most important principle for Republican opposition to Obama. What is interesting here is that when one combines the

results for the Heritage memo and the speech of Congressman Boustany, Republican emphasis on efficiency increases by ten percentage points. 74% of the Republican frame against the Affordable Care Act focuses on efficiency and, as noted earlier, efficiency is the most important principle of the Obama frame. Thus, one can conclude that there is very little to differentiate the frames in favor and against healthcare reform. This suggests that whoever does a better job of persuading the American people should win the political struggle.

The second finding the comparison illuminates is the decreasing reliance of Republicans on merit and the argument that healthcare reform will result in diminished quality of healthcare. Merit was the second most important principle for Kristol (23%) and the third most important principle for Republican opposition to Obama (12%). In fact, Republican use of merit in opposing President Obama is indistinguishable from their use of need (13%). This suggests that one of the problems with Republican efforts to defeat the Affordable Care Act is a lack of balance in the Republican frame. They seem to have put all of their eggs in the efficiency basket and in doing so they miss an important lesson provided by the Kristol frame: while it is important to emphasize the performance criteria of efficiency in a frame, one cannot focus exclusively on this principle as the distributive justice preferences of the American public contain other, normative principles as well.

Finally, one sees that need is emphasized at about the same level in the two Republican frames looked at here (12% and 13% respectively). One also notes that Republicans emphasize equality at a higher level in their opposition to Obama (8% to 1%), but that they rely on equality of opportunity here and not equality of outcome. While this result is not that surprising, what is surprising when one considers the aggregated results for the Republican opposition to Obama is the lack of a coherent, nuanced frame that indicates a clear sense of the values of the American

people. Besides emphasizing efficiency, the Republican frame lacks recourse to any other distributive justice principle. This is highly unanticipated as the arguments against healthcare reform in the United States have been remarkably stable over time and very successful. Why Republicans decided to deviate from the tried and true cannot be answered here. The only thing that can be said is that in doing so they contributed to the ability of President Obama to do what many thought was politically impossible—pass healthcare reform.

Conclusion

The previous chapter demonstrates that Obama's understanding of distributive justice principles aligns with how Americans conceptualize distributive justice. His use of multiple allocation principles, including the performance principle efficiency, accurately capture how Americans think about distributive justice in this particular policy area. Obama's ability to capture this in his framing of healthcare reform explains, in part, why he was able to successfully pass healthcare reform. As shown in this chapter, another factor explaining the success of President Obama is the way Republicans framed their opposition to his healthcare reform efforts. Comparison of the opposition frames to the Clinton and Obama healthcare proposals shows that Republicans shift the nature of their frames. Republican opposition to Clinton, while it emphasized the inefficiency of government-sponsored healthcare reform, included the argument that there would be a decrease in the quality of American healthcare. Thus, one finds that their frame employed two principles of distributive justice. This is not the case with their framing of the Obama proposal. Instead of creating a frame that capture the nuance of the American public with regard to distributive justice, Republicans put all of their political eggs in the basket of inefficiency. Moreover, they conceded a point that no opponent of healthcare reform had previously conceded—that there was a need for healthcare reform in America. These changes to

how opponents of healthcare reform framed their opposition speak not only to why President Obama succeeded where others had failed, but to the importance of getting the political language that one uses right. When this is done the chance of success increases, but when one does not get the language right, the probability of defeat increases.

Chapter Five

Putting Theory into Practice: Creating More Just Public Policies Through the Use of Distributive Justice Allocation Principles

President Obama's successful framing of healthcare reform and his ultimate success in passing the Affordable Care Act reminds us that in politics the language one employs matters. As such, the results presented here add support for the theoretical power of the rhetorical presidency. By framing healthcare in the way he did and going directly to the public, President Obama was able to garner support for healthcare reform and use this support to leverage Congress and pass reform into law. Not only did this serve as an effective antidote for gridlock, but, more importantly, in effectively using rhetoric and the tools at his disposal, President Obama satisfied what has become an unquestioned premise of our political system: The President ought to be a popular leader (Tulis 1987, 4). To all those who criticized President Obama for his lack of effective leadership, the evidence suggests quite the opposite—a strong President who effectively employed the power of language to accomplish what other presidents (more powerful, more popular, and better advantaged politically) failed to do.

The results presented here also speak to the importance of properly framing one's argument(s) for and against policy change. Obama's successful efforts are not simply a consequence of his frame being right, but the fact that Republicans made mistakes in framing their opposition to the ACA. Successful frames do not simply identify a problem and propose a solution. Good frames succeed when they make the frame salient and this happens when political elites tap into "culturally familiar symbols" (Entman 1993, 53). Given the focus on the various allocation principles of distributive justice taken here, one may conclude that one of these symbols is a sense of justice. The challenge this presents political elites is that they have to

accurately identify these symbols and properly blend them in a way that is consistent with the underlying sense of justice held by the American public. To complicate matters further, scholarship indicates that these principles may vary by policy areas (see Miller 1999; Elster 1995; Frohlic and Oppenheimer 1992; Scott et al. 2001, Kluegel and Smith 1986). Thus, the political elites first need to determine what principle or principles inform the public's perceptions of a particular policy area ahead of time.

To the extent that this argument holds, the results of this thesis require one to think about the policy process in terms that depart from convention. In *Policy Paradox*, Stone (2002) offers a political alternative to the dominant market based understanding of the policy process. The market model, which remains the dominant view of the policy process, contends that markets and not politics shape public policy. In particular, the market model is seen as preferable as it accords with the public's concern with maximizing personal welfare and economic well-being. In contrast, Stone argues for the centrality of politics and not economics. Using the word polis (the Greek word for city-state) Stone contends that policy is best understood in terms of community-based political activity. It is in recognition of this fact that policy is discussed in terms other than efficiency. In fact, it is only in a political context that values like need and equality have a place in one's understanding of public policy.

The results presented here suggest that Stone's either/or proposition is not quite accurate. It turns out that a proper understanding of the policy process is a hybrid model where the market and market based concepts like efficiency cannot be disregarded in favor of overtly political concerns. Similarly, economists and policy experts who focus exclusively on efficiency not only ignore the reality of politics, but as Stone's use of polity suggests, they ignore the normative underpinnings of all of politics. Politics and public policy should be seen in a more nuanced

light. Failure to do so provides one with an inaccurate understanding of the political world as President Obama's successful efforts to pass healthcare reform reminds the student of politics and policy that the actual world of politics is more complex than what a simple equation can capture.

So, what does all of this mean going forward? What lessons can policy makers and politicians take from this study? Besides the already mentioned conclusions of not ignoring language and getting the public's underlying sense of justice in the particular policy area right, this study suggests that there must be correspondence between the actual policy and the framing of that policy. In other words, and this is especially important for the party in power, it is not enough to be against something. One must be for something and the frame must reflect this. A possible example of failing to recognize this is the recent efforts of President Trump and congressional Republicans to repeal and replace the ACA.

The current debates surrounding how Republicans would like to reform healthcare legislation center around the rhetorical idea of "repeal and replace." Rather than completely dismantle Obama's currently enacted ACA legislation, certain features of Obama's Affordable Care Act should be kept intact, as it is clear Republicans have not yet developed a concrete plan to reform healthcare. One of the reasons for this that that factions within the Republican party cannot come to a consensus about how to revise the ACA. Conservative members of the Republican Party, such as the Freedom Caucus, would like to repeal the Affordable Care Act, while more moderate and liberal Republicans have aligned with Democrats in their political views surrounding healthcare by wanting to fix certain aspects of the Affordable Care Act (and not knowing how to do so) but keeping other parts of it intact. Since the election of Donald Trump as president in January 2017, lawmakers have not come up with a comprehensive

congressional plan to replace the Affordable Care Act. In the absence of such a plan, Republican efforts to frame their alternative to the ACA and assess its relationship to the values of the American public are compromised.

Part of the difficulty encountered by the Trump administration stems from the president's discussion of the topic. On one hand, Trump argues that the ACA is a complete disaster and that repealing and replacing it will lower people's insurance costs which speaks to a concern with efficiency. On the other hand, Trump has publicly opposed cuts to programs like Medicaid and Medicare which were designed to meet the healthcare needs of Americans and continue to do so. While Trump's recourse to efficiency and need might appeal to Americans more generally, his understanding and framing of the issue does not sit well with Republicans who are concerned that his rhetoric and promises do not align with how Republicans view healthcare policy and how to fund it. Republicans, for this reason, are not sure how they would like to proceed with healthcare reform, in terms of preserving their views on healthcare, meet the public's demands for affordable healthcare, and deal with President Trump's ideas on the subject. While there is certainly an element of political reality here—our political parties are large and contain a great diversity of interests and positions—it might also be the case that the distributive justice values of the Republican party are inconsistent with those of the American people. President Trump, who is not a traditional Republican in any sense of the term, is thus caught between his understanding of the issue and the frame he would like to employ (efficiency combined with meeting the healthcare needs of the American people) and the Republican party who, even after eight years of opposing President Obama and voting on a repeal of the ACA 52 times, has yet to formalize their own plan for healthcare reform. President Trump's dilemma is that while his own views seem to accord with those of the public, they do not accord with those (particularly at the

extreme of his party) with those who he must rely on to pass legislation.

Bibliography

- Altman, Stuart., and David Schactman. 2011. *Power, Politics, and Universal Health Care: The Inside Story of a Century-Long Battle*. Amherst, NY: Prometheus Books.
- Baumgartner, Frank R. and Bryan D. Jones. 1993. *Agendas and Instability in American Politics*. Chicago, IL: University of Chicago Press.
- Beland, Daniel., Philip Rocco, and Alex Wadden. 2016. *Obamacare Wars: Federalism, State Politics, and the Affordable Care Act*. Lawrence, KS: University Press of Kansas.
- Boustany, Charles. 2009. "Republican Rep. Charles Boustany's Response to Obama Healthcare Speech." ABS News Online. <http://abcnews.go.com/Politics/HealthCare/charles-boustany-republican-rebuttal-obama-health-care-speech/story?id=8527214>
- Brill, Steven. 2015. *America's Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix Our Broken Healthcare System*. New York, NY: Random House.
- Clinton, William J. 1993. "Address on Health Care Reform." Online Miller Center. <http://millercenter.org/president/speeches/speech-3926>
- Elster, Jon. 1995. "The Empirical Study of Justice." In *Pluralism, Justice, and Equality*, eds. David Miller and Michael Walzer. Oxford: Oxford University Press.
- Entman, Robert M. 1993. "Framing: Toward Clarification of a Fractured Paradigm." *Journal of Communication* 43(4):551-58.
- Frohlich, Norman. and Joe A. Oppenheimer. 1992. *Choosing Justice: An Experimental Approach to Ethical Theory*. Berkeley, CA: University of California Press.
- Hayek, Friedrich. 1976. *Law, Legislation, and Liberty. Vol. II: The Mirage of Social Justice*. London: Routledge and Kegan Paul.
- Iyengar, Shanto. 1996. "Framing Responsibility for Political Issues." *Annals of the American Academy of Political Science* 546(1): 59-70.
- Jacobs, Lawrence R., and Theda Skocpol. 2012. *Health Care Reform and American Politics: What Everyone Needs to Know*. New York, NY: Oxford University Press.
- Johnson, Lyndon B. 1965. "Remarks With President Truman at the Signing in Independence of the Medicare Bill." Online by Gerhard Peters and John T. Wooley, The American Presidency Project. <http://www.presidency.ucsb.edu/ws/index.php?pid=27123&st=&st1=>
- Kingdon, John. 1980. *Agendas, Alternatives, and Public Policies*. Boston, MA: Little, Brown, & Co.

- Kluegel, James R., and Eliot Smith. 1986. *Beliefs About Equality: America's Views of What is and What Ought to Be*. New York, NY: Aldine.
- Kristol, William. 1993. "Defeating President Clinton's Health Care Proposal." Online at Project for a Republican Future.
<http://talkingpointsmemo.com/edblogger/the-1993-kristol-memo-on-defeating-health-care-reform>
- Lakoff, George. 2002. *Moral Politics: How Liberals and Conservatives Think*. New York, NY: Oxford University Press.
- Lenz, Gabriel S. 2013. *Follow the Leader?: How Voters Respond to Politicians' Policies and Performance*. Chicago, IL: University of Chicago Press.
- Marmor, Theodore R., Jerry L. Mashaw, and Philip L. Harvey. 1990. *America's Misunderstood Welfare State*. New York, NY: Basic Books.
- McCloskey, Herbert. and John Zaller. 1984. *The American Ethos: Public Attitudes Toward Capitalism and Democracy*. Cambridge, MA: Harvard University Press.
- Miller, David. 1999. *Principles of Social Justice*. Cambridge, MA: Harvard University Press.
- Miller, David., and Michael Walzer. 1995. *Pluralism, Justice, and Equality*. Oxford: Oxford University Press.
- Nixon, Richard M. 1974. "Special Message to the Congress Proposing a Comprehensive Health Insurance Plan." Online by Gerhard Peters and John T. Wooley, The American Insurance Plan." Online by Gerhard Peters and John T. Wooley, The American Presidency Project. Presidency Project. <http://www.presidency.ucsb.edu/ws/?pid=4337>
- Nozick, Robert. 1974. *Anarchy, State, and Utopia*. New York, NY: Basic Books.
- Obama, Barack H. 2009. "Remarks by the President to a Joint Session of Congress on Health Care." Online by Office of the White House Press Secretary.
<https://www.whitehouse.gov/the-press-office/remarks-president-a-joint-session-congress-health-care>
- Oucharenko, Nina., and Stuart Butler. 2008. "Ensuring Access to Health Insurance: A Memo to President-Elect Obama." Online The Heritage Foundation.
<http://www.heritage.org/health-care-reform/report/ensuring-access-affordable-health-insurance-memo-president-elect-obama>
- Rawls, John. 1971. *A Theory of Justice*. Cambridge, MA: Harvard University Press.
- Rocheftort, David A. and Roger W. Cobb. 1994. "Problem Definition: An Emerging Perspective." In *The Politics of Problem Definition: Shaping the Policy Agenda*, eds.

- David A. Rochefort and Roger W. Cobb. Lawrence, KS: University of Kansas Press.
- Roosevelt, Franklin D. 1944. "State of the Union Message to Congress." Online by Gerhard Peters and John T. Wooley, The American Presidency Project. <http://www.presidency.ucsb.edu/ws/?pid=16518>
- Roosevelt, Franklin D. 1939. "Message to Congress on National Health Program." Online by Gerhard Peters and John T. Wooley, The American Presidency Project. <http://www.presidency.ucsb.edu/ws/?pid=15699>
- Schattschneider, Elmer E. 1960. *The Semisovereign People: A Realist's View of Democracy in American*. Belmont, CA: Wadsworth Publishing.
- Schneider, Anne L., and Helen M. Ingram. 2005. *Deserving and Entitled: Social Constructions and Public Policy*. Albany, NY: State University of New York Press.
- Scott, John T., Richard E. Matland, Philip A. Michelbach, and Brian H. Bornstein. 2001. "Just Deserts: An Experimental Approach to Distributive Justice." *American Journal of Political Science* 45(3): 749-767.
- Stone, Deborah. 2002. *Policy Paradox: The Art of Political Decision Making, 3rd Edition*. New York, NY: W.W. Norton & Co.
- Tomasi, John. 2012. *Free Market Fairness*. Princeton, NJ: Princeton University Press.
- Truman, Harry S. 1945. "Special Message to the Congress Recommending a Comprehensive Health Program." Online by Gerhard Peters and John T. Wooley, The American Presidency Project. <http://www.presidency.ucsb.edu/ws/?pid=12288>
- Tulis, Jeffrey K. 1987. *The Rhetorical Presidency*. Princeton, NY: Princeton University Press.
- Verba, Sidney. and Gary R. Orren. 1985. *Equality in America: The View from the Top*. Cambridge, MA: Harvard University Press.
- Walzer, Michael. 1983. *Spheres of Justice: A Defense of Pluralism and Equality*. New York, NY: Basic Books.