Media Representations of State-Level Health Care Reforms in the United States (2002-2011): Policy Narratives, Media Frames, and Legislative Outcomes in the Massachusetts and Utah Cases

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Abstract

This doctoral dissertation examines the relationship between newspaper media representations, health care reform efforts, and legislative outcomes in the United States. Offering valuable insights into media representations for researchers, decision-makers and activists, this research focuses on the editorials, opinion columns, and news stories from daily newspapers of the political right, left, and centre that helped structure public support for, and opposition to, two American state-level health care reforms: the Massachusetts Health Reform Law (Romneycare) (2002-2006) and the Utah Health System Reform (UHSR) (2004-2011). Insights gathered through this research may serve to inform future media communication strategies in health care and other policy reform campaigns.

More than a decade after the failure of the Clinton administration's Health Security Act (HSA), between 2002 and 2012, a number of state-level health reform efforts paralleled the federal Affordable Care Act (Obamacare) debates. Collectively, these reforms revealed greater political openness to health care policy change. My dissertation examines newspaper media coverage of the Massachusetts and Utah health reform efforts at three critical junctures: the preceding state election campaigns, the legislative debates surrounding the reforms, and the period following legislative passage. This study critically examines the movement of neoliberal language framing metaphors and narratives of health care within the state-based and national newspapers, as well as challenging narratives of the political left and the political right that offered alternatives to the meso-narrative of neoliberalism. This study reveals coalescence of health care reform narratives between national and local print media, between Democratic-leaning

and Republican-leaning newspapers, and between the Massachusetts and Utah health reforms.

This dissertation concludes by demonstrating that, although the Democratic-leaning national and state-level newspapers were somewhat more favourable to health care reform than Republican-leaning newspapers, both Republican-leaning and Democratic-leaning newspapers were largely favourable to reform in their coverage. Newspapers emphasized rising costs and inadequate access to health insurance as the central challenges of the health care system that served as the impetus for change. Interpreting the health care narratives of these two state reforms is particularly important in light of the ongoing federal reform efforts. The debates between libertarian, conservative, and moderate factions within and beyond the Republican Party in the efforts to "repeal and replace" Obamacare have been largely recycled from the Utah Health System Reform debates and the fringes of Republican resistance to Romneycare in Massachusetts.

Dedication

I dedicate this research project to my mother, who lost her battle for access to health care in the for-profit system, and to those within and beyond my family who continue to fight for the care they need in the United States. I further dedicate this work to the activists, elected officials, and scholars who carry on the struggle for a health care system that guarantees access to quality care for everyone. I believe that a more equitable and fairer system remains within reach.

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Glossary of key American health legislation and programs discussed in this dissertation

Massachusetts Health Reform Law (MHRL) of 2006	Popularly known as "Romneycare," and often referred to in short form as the 2006 Massachusetts Health Reform Law (MHRL). The full name of the law of the Commonwealth of Massachusetts is "An Act Providing Access to Affordable, Quality, Accountable Health Care."
Utah Health System Reform (UHSR) of 2008 - 2011	The Utah Health System Reform (UHSR) is the collective name for seven state health laws passed in the State of Utah from 2008 to 2011— HB 133, HB 188, HB 331, HB 165, SB 79, HB 294, and HB 128
Affordable Care Act (ACA) of 2010	Popularly known as "Obamacare," and often referred to in short form as the 2010 Affordable Care Act (ACA). The full name of this federal legislation is "The Patient Protection and Affordable Care Act."
Health Security Act (HSA) of 1994	Pejoratively known as "Hillarycare," the Clinton Administration's 1994 federal Health Security Act (HSA) was a federal attempt at comprehensive health care reform that failed to pass Congress. It would have transitioned Medicaid recipients into the private health insurance market with subsidies.
Health Insurance Portability and Accountability Act of 1996	Federal legislation signed into law by President Clinton, which established new regulations on the privacy of medical information (imposing fines for violations), created new guidelines for health savings accounts, and established new private insurance regulations.
Healthy Americans Act of 2009	Also known as the "Bennett-Wyden bill," it was a bipartisan federal bill that would have created a single national insurance market with portable, mandatory (with means-tested subsidies) health insurance. It would have transitioned Medicaid and CHIP recipients into the private health insurance market with subsidies.
Medicare (1965)	A universal, federal socialized insurance program for all Americans, age 65 and over. Established in 1965.
Medicaid (1965)	A means-tested socialized insurance program, jointly funded by the federal and state governments, with eligibility requirements that vary between states. Established in 1965.
CHIP / S-CHIP (1997)	The State Children's Health Insurance Program is a means-tested socialized insurance program for children (up to age 18) in low-income families. Created by the Clinton Administration in 1997, it is jointly funded by the federal and state governments.
Balanced Budget Act (BBA) of 1997	The federal legislation in which the State Children's Health Insurance Program (CHIP) was created.
Health Care for All Act (HCAA) (1988)	A Massachusetts health reform law that passed under the Dukakis Administration in 1988, partially setting the course for Romneycare in 2006.
Utah HB 133 of 2008	The first component of the Utah Health System Reform (UHSR), it created the Utah Health Exchange, a "task force" to review and make recommendations on the state's health care system, and a pilot health

	insurance program for employers. It mandated that the Governor's Office of Economic Development, the State Insurance Department, the state Department of Health, and the legislature develop and implement a strategic plan for health care reform.
Utah HB 188 of 2009	The second component of the UHSR, it created an online health insurance exchange and defined contribution health insurance. The law aimed to expand participation in the private health insurance market and to make it more transparent.
Utah HB 331 of 2009	The third component of the UHSR, this legislation required particular types of private contractors who held contracts with the State of Utah to offer health insurance coverage to workers.
Utah HB 165 of 2009	The fourth component of the UHSR, this legislation consisted of new privacy and medical information disclosure regulations for health care workers and private health insurance companies.
Utah SB 79 of 2009	The fifth component of the UHSR, this legislation created new minimum standards for malpractice lawsuits related to emergency medical services. This is often referred to as "torts reform" in the academic literature and in some media reports.
Utah HB 294 of 2010	The sixth component of the UHSR, this legislation consisted of amendments to address perceived problems in the pilot health insurance program for employers that had been created as part of HB 133 in 2008.
Utah HB 128 of 2011	The seventh component of the UHSR, this legislation made further amendments to HB 133 of 2008. These amendments included expansion of access to the online Utah health exchange (Avenue H) to the small businesses for which it was designed, moving beyond the initial pilot for large employers with 50 or more employees. HB 128 sought to improve the functionality of the exchange, such as clarifying benefit packages for consumers and regulations for participating insurance companies. It standardized and simplified the application forms for state insurance companies. It required the state's Health Data Committee to produce an annual comparative report on patient safety and health service charges at hospitals and other institutions that provide health services. HB 128 further required insurance market regulation to comply with new federal rules under the federal Patient Protection and Affordable Care Act (Obamacare) of 2010.
Vermont health system reform of 2011	In 2011, the state of Vermont passed an *Act Relating to a Universal and Unified Health System* (Vermont Health Reform, VHR, Green Mountain Care). The VHR aimed to expand insurance coverage to 100% of the state's population and to reduce state health outlays. It was the first state health legislation that explicitly aimed for universal coverage of state residents. It was the first state reform designed with the federal ACA in mind, seeking to fill perceived gaps in the ACA to ensure that all Vermonters would obtain health insurance coverage. In 2014, Vermont's Governor Peter Shumlin ceased implementation

	of the plan, citing economic reasons. The failure of the VHR was a terrible blow to single-payer advocates.
Oregon single-payer referendum of 2002	Oregon's Health Care for All Movement launched for a state-wide referendum to create a single-payer health care system in 2002 under Ballot Measure 23. While urban Oregonians in Portland and Eugene overwhelming supported Oregon Ballot Measure 23 on November 5, 2002, it was defeated by a substantial margin, arguably due in large part to a "no" campaign to which the private health insurance industry generously contributed.
Colorado single-payer referendum of 2016	In November 2016, Colorado voters held a referendum to create a state-level single-payer insurance system, "ColoradoCare." The referendum was defeated.
Utah HB 326 of 2008	Parallel to the UHSR, this legislation removed the State of Utah's ceiling on enrolment in the CHIP program.
Utah SB 14 of 2008	Parallel to the UHSR, this legislation banned smoking in automobiles in which children are passengers.
Utah HB 267 of 2009	Parallel to the UHSR, HB 267 failed in the Utah House of Representatives. If it passed, it would have provided protection against housing and employment discrimination for LBGTQ Utahns and facilitated the extension of employment-based health insurance for same-sex and other unmarried couples. The failure was symbolic of Utah's social conservatism.
Utah SB 119 of 2009	Parallel to the UHSR, SB 119 created a task force to study improvements to the triage systems in state emergency rooms to identify cost-saving opportunities.
Utah HB 171 and SB 225 of 2009	Parallel to the UHSR, HB 171 and SB 225 extended Medicaid and SCHIP coverage to qualified legal immigrant children under 18 years of age (Green Card holders) after a residency period.
Utah HB 124 of 2009	Parallel to the UHSR, HB 124 failed in the State House. The legislation would have required private insurance companies to cover "elemental formula" for babies with dangerous food allergies.
Utah SB 43 of 2009/2014	Parallel to the UHSR, SB 43 proposed requiring insurance companies to cover Autism treatments. Better known in the media as "Clay's Law," it was delayed in committees for years, but was eventually amended, reintroduced, and passed in 2014.
Utah HB 89 of 2009	Parallel to the UHSR, HB 89 mandated coverage for prosthetic limbs. It was sometimes framed as patriotic legislation to benefit Utah veterans of American wars.
Utah HB 66 of 2010	Parallel to the UHSR, HB 66 was an extension of HB 89, passed the previous year; it required private health insurance companies to provide coverage to amputees for prosthetic limbs.
Utah SB 79 of 2010	Parallel to the UHSR, SB 79 required insurance companies to provide greater clarity to customers, in writing, on pre-authorized coverage for medical procedures.
Utah HB 67 of 2010	Parallel to the UHSR, HB 67 sought to prohibit the application of the federal mandate under Obamacare that required individuals to

	purchase health insurance. It also required that the state legislature approve the implementation of any part of the federal ACA in Utah, despite warnings from Utah Democrats that it would be unconstitutional.
Utah HCR 8 and HJR 11 of 2010	Parallel to the UHSR, HCR 8 and HJR 11 urged the federal government not to interfere with the UHSR.
Utah HB 145 of 2010	Parallel to the UHSR, HB 145 was tort reform legislation that placed new limits on medical malpractice awards in civil court, reducing lawsuit award limits by 50%.
HR 1213 of 2011	The earliest of the anti-Obamacare protest bills, Republicans advanced HR 1213, which sought to defund and effectively undermine state health insurance exchanges. Republicans knew that their bill was vulnerable to Presidential veto because they lacked the necessary majority in Congress to override it. The bill passed in the House of Representatives, but it ultimately failed in the Senate (Library of Congress 2011).
Utah HB 353 of 2011	Parallel to the UHSR, HB 353 allowed doctors to refuse to perform abortions or any related medical procedure for religious reasons.
Utah HB 354 of 2011	Parallel to the UHSR, HB 354 gave private insurance companies the right to refuse to cover abortions or related medical services based on ethical objections.
Utah HB 171 of 2011	Parallel to the UHSR, HB 171 increased the number of state inspections (without prior notice) of any medical facilities that performed abortions, essentially sanctioning harassment of women's health clinics and other medical centres that provide abortions.
Utah SB 180 of 2011	Parallel to the UHSR, SB 180 aimed to transition state Medicaid recipients into a new kind of managed-care system. SB 180 was a pre-emptive effort to curb Medicaid spending before new federal rules under Obamacare took effect.
Utah HB 211 of 2011	Parallel to the UHSR, HB 211 required some newly eligible Medicaid recipients to perform community service to maintain their health benefits.
Utah SB 150 of 2011	Parallel to the UHSR, SB 150 was tort reform legislation that aimed to shield hospitals from lawsuits. The legislation prevented patients from suing hospitals that employed doctors who were guilty of medical malpractice.
Utah SB 294 of 2011	Parallel to the UHSR, SB 294 aimed to attract and retain insurance companies on the struggling state health exchange, reforming regulation of insurance premiums. It permitted private insurance companies to increase premiums for older consumers and for larger families.
Utah HB 404 and HB 18	Parallel to the UHSR, HB 404 and HB 18 aimed to transition state civil servants into high-deductible health insurance plans with combined HSAs, and to transition thousands of civil servants onto the state health exchange, in an effort to conceal low participation on the state health exchange.

The McCarran-Ferguson Act of 1945	McCarran-Ferguson Act of 1945 was federal legislation that limited the application of the Commerce Clause and antitrust legislation to the insurance industry, effectively undermining the ability of Congress to regulate health insurance, and devolving insurance regulation to the state level.
The Kerr-Mills Program of 1960	The Kerr-Mills program in 1960 provided federal grant funding to states in order to cover health care services for the poor. Through Congressional negotiations over Medicare, Kerr-Mills eventually became Medicaid, which was established in 1965 at the same time as Medicare as part of the Social Security Act.

Glossary of Key Acronyms and Terms

UHSR	The Utah Health System Reform (UHSR) (2008 – 2011)
MHRL	The 2006 Massachusetts Health Reform Law (MHRL), also known as Romneycare
ACA / PPACA	The 2010 Affordable Care Act, also known as Obamacare
HSA	The 1994 federal Health Security Act (HSA), pejoratively labelled "Hillarycare" by the political right.
HSA	Health Savings Account (HSA)
AMA	The American Medical Association
CHIP / S-CHIP	The State Children's Health Insurance Program
HCAA	The 1988 Massachusetts Health Care for All Act
Defined-benefit health insurance plans	In defined benefit, private health insurance plans, employers cover the majority of the costs associated with a health insurance package (so-called insurance premiums) for their employees. Employees do however typically pay some portion of the premium, though some employees do not pay insurance premiums. Most employees in this system pay an annual deductible, as well as insurance co-pays for medical services.
Defined-contribution health insurance plans	Defined contribution, private health insurance plans are increasingly popular due to cost increases in the medical system and rising insurance premiums in traditional, defined benefit insurance plans. In defined contribution plans, employers provide a cash benefit to employees to purchase their own health insurance on the private marketplace (such as the online health insurance exchanges). Employers do not contribute to premiums to offer health insurance packages for their workforce, thus, this system shifts most of the economic burden to employees.
Short-term health insurance policies / Fixed-term health insurance policies	In the pre-Obamacare era, "short-term health insurance policies," also called "fixed-term" policies, gained some popularity with consumers to cover periods between jobs, the time after university when young Americans may not yet be employed in jobs with insurance benefits and no longer qualify for their parents' insurance or student insurance, and for people starting their own businesses who could not afford traditional plans.
Managed care	Definitions of managed care have evolved over time and may vary between public and private health care systems. In basic terms, it is a system that seeks to control costs, quality, and access through formal, bureaucratic processes in either private insurance companies or government agencies (Halverson, Kaluzny, and McLaughlin, 1998: 14). Managed care health care systems are diverse, yet all assume some role for government in the health sector (Vann 2014).
Means-tested health care programs	A means-tested public health or welfare program is any program to which access depends upon falling within a qualifying income threshold, typically tied to some calculation of the poverty line. The federal Medicaid program and state programs like Medi-Cal in

	California are Examples of means-tested health care in the United States.

Chapter 1: Representations of health care reform in the media: Examining the influential Massachusetts and Utah cases in neoliberal policy contexts

1.1 Introduction: Representations of health care in the media

I start from the premise that, in all policy debates, the stories we tell matter. Extensive research in narrative, critical discourse, and metaphor has affirmed that our stories—and the manner in which we frame them—shape who we are and the ways we govern ourselves (Geary 2011; Lakoff and Johnson 1980; Roe 1994). This is perhaps nowhere more apparent than in the politics of health care reform. This policy sphere impacts our lives profoundly. Government regulations on its financing, delivery, access, and quality are often quite literally matters of life and death. As such, in representative democracies where elections periodically hold leaders accountable for their decisions, it is no surprise that different narratives of health care are articulated through competing media representations.

Media representation of policy debates can be understood as both an act of defining and assigning meaning, and as a process of contextualizing and (re)making public understandings of events or persons through narratives and frames (Chandler 2007: 2-9, 217-220; Chomsky and Herman 1988; Hall 1997: 1-12, 13-73, 223-290; Keren 2011; Orgad 2012). Abell (2004: 288-290) observes that social scientists adopting both positivist and postmodernist perspectives have paid increased attention to the role and function of narratives. While collaboration between the two groups remains limited, most social scientists would agree that narratives are comprised (at a minimum) of actors, actions, and "descriptive states of the world." For Somers (1992), narratives develop as sequential discursive formulations to which we become accustomed as means of disseminating and learning information. McBeth, Shanahan and Jones (2005) and Pitzer

(2010) add that narratives are composed of common character types (e.g. heroes and villains) who traverse vivid descriptive events that are often marked by significant symbolism. Finally, Roe (1994) and Verweij et al. (2006) describe lessons or "morals" as key elements of narrative that link to and emanate from the objectives of those who write or speak them.

Looking specifically at texts related to public policy, Roe (1994) states that narratives in the policy sphere, as elsewhere, always have a "beginning, middle, and end (or premises and conclusions, if cast as an argument)." Policy narratives portray positions or events through which change will allegedly occur or from which change has supposedly occurred; thus, they are often presented as parts of causal explanations or prescriptive solutions (Roe 1994: 36-37). Regardless of their veracity, narratives can have a significant impact in forming or reforming public opinion of policy (Jones and McBeth 2010; McComas and Shanahan 1999; Roe 1994). Jones and McBeth (2010) cite the media's representations of the Obamacare health reform debates to demonstrate that policy narratives need not be true in order to sway both popular opinion and the actions of decision-makers. Thus, building from the diverse definitions and discussions of narrative in public policy representations in Abell (2004); Jones and McBeth (2010); McBeth, Shanahan, and Jones (2005); McComas and Shanahan (1999); Pitzer (2010); Roe (1994); and Somers (1992), I define narratives as the collection of assumptions, social constructions, symbols and stories (often offering a moral and containing heroes, victims, and villains) that simultaneously construct and reinforce public perceptions of policies and policy contexts.

Narratives intersect with the important concepts of *media frames* and *policy*

windows. Framing can be interpreted as the way in which the media helps to set policy agendas by directing the attention of the public to particular aspects or details of a story, making claims of causation or morality, and by assigning meaning and roles to events and people (Entman 1993; Scheufele 1999). For its part, a policy window can be understood as moment of opportunity for policy change, one that is made possible when a problem is broadly acknowledged, solutions are identified and largely seen to be plausible and desirable after media scrutiny and political debate, and the political climate is conducive to change in the sense that decision-makers have come to agreement, or can be persuaded to collaborate on a solution through lobbying and advocacy (Buse et al. 2012; Guldbrandsson and Fossum 2009; Kingdon and Thurber 1984). Policy windows delineate the range of political possibility to take action on a particular issue and reflect the ideological climate or governmentality of a particular time. As such, one or more *narratives* may help the media to *frame* coverage of a health care reform effort or health care legislation, while media coverage will broadly mirror the *window* of political possibility.

In one poignant example of the ways in which narratives interact within a single frame in the newspaper media, the *New York Times'* account of Ming Qiang Zhao's experience as a critically ill undocumented immigrant demonstrates a common media representation of the harsh realities of health care in America:

> When Ming Qiang Zhao felt ill last summer, he lay awake nights in the room he shared with other Chinese restaurant workers in Brooklyn. Though he had worked in New York for years, he had no doctor to call, no English to describe his growing uneasiness. Mr. Zhao, 50, had been successfully treated for nasal cancer in 2000 at Bellevue Hospital in Manhattan, which has served the immigrant poor since its founding in 1736. But the rules there had changed, and knowing that he would be asked for payment and that security guards would demand an ID, he had concluded that he could not go back. So Mr. Zhao went to an unlicensed healer in

> Manhattan's Chinatown and came away with three bags of unlabeled white pills. A week later, his roommates, fellow illegal immigrants from Fujian Province in China, heard him running to and from the toilet all night. In the street the next day, July 6, he collapsed… After the Sept. 11 attacks, about the same time Bellevue security guards began demanding ID cards, clerks started collecting sliding-scale fees from the uninsured… By the time Mr. Zhao again ended up in a hospital, he was in a coma; just his intensive care bed, at St. Mary's and then at St. John's, cost Medicaid $5,400 a day. (Bernstein 2006)

Tragic anecdotal tales are common in so-called human-interest stories that portray the plight of the uninsured in America's newspapers. [1] In the above piece, readers saw not only the narrative of access challenges and inequity of care that marginalized people faced in the health care market, but the narratives of subordination of public health to security concerns and the exorbitant costs that plagued the system. On one hand, the article framed Zhao as a victim of circumstance (his undocumented status) who had been denied quality care despite his work ethic (a trope that tacitly reassured readers that Zhao was one of the so-called deserving or working poor); conversely, it framed the health care system as an abstract villain—unfair, inhumane, and economically inefficient. Thus, even a short passage in a single article sometimes offers a complex portrayal of systemic conditions. A mere passing mention of a person being uninsured, even in articles that do not primarily focus on health care, may exemplify access or cost challenges and reinforce the story of a health care crisis. While health care narratives are always present in the newspaper media, the amount of coverage tends to wax and wane—or "wave"—according to the trajectory of major policy reforms.

A "media wave" is a term in media effects and frame analysis literature that refers to a marked and often sustained increase in media attention to a particular issue. A

[1] The list of newspapers examined in this dissertation and justification of my choices is outlined in Chapter 2.

precipitous event incites the initial spike in media coverage, then media competition in the drive for readership or ratings sustains the wave for as long as possible (Giasson and Brin 2010; Giasson et al. 2010; Vasterman 2005). The precipitous events that tend to provoke initial spikes in media reporting intersect with the historical institutionalist concept of critical junctures—those periods in which path dependencies in policies and institutional arrangements may be broken, allowing for new ones to be established (Capoccia and Kelement 2007; Pierson 1994, 1997). Thus, the announcement of a major health care reform effort, or the creation of a substantial new health care program, is a potentially critical juncture and precipitous event that a wave of media coverage may follow.

The concept of "media waves" is a key element of Peter Vasterman's (2005) "media hype" framework, which explores the excitement that the media can create in response to policy debates, as well as the role of the media in framing processes and issue magnification. Other authors have used Vasterman's conceptualization to examine peaks and valleys in media coverage of different political events (e.g. Boily 2013; Boily and Epperson 2014; Giasson and Brin 2010; Giasson et al. 2010). According to Vasterman, the frequency and intensity of media coverage of a given event may make the story self-perpetuating, as various media outlets feed off of one another. A news story may incite an initial spike in media coverage, one that attracts different narratives of the same developments and initiates the competitive framing process. The competitive framing process involves efforts to offer more enticing, newer, and sometimes more detailed narratives and frames to attract and retain viewers or readers. Competition between narratives and frames may persist throughout the wave of reporting, or a dominant meso-

narrative and frame may emerge, creating a kind of "media tsunami" that obscures other narratives and frames (Giasson and Brin 2010; Giasson et al. 2010; Vasterman 2005). Perhaps the best-known recent example of a media wave of health care coverage was the extensive reporting on the federal Patient Protection and Affordable Care Act of 2010—or Obamacare, as it came to be called both pejoratively and admiringly.

1.2 Obamacare in the media and the inadequate attention to intersecting state health reform efforts

Observers around the world followed media coverage of the acrimonious debates on the federal Patient Protection and Affordable Care Act of 2010. For many, particularly those in other developed legislative democracies outside the United States; the controversy surrounding America's most recent health care reform was perplexing. How could over 46 million people in such a wealthy country with modern infrastructure and representative democratic government lack health insurance (DeNavas-Walt et al. 2009)? How could a country operate the most costly health care system in the world, yet still exclude so many of its citizens from care? Casual observers could be forgiven for thinking that health care reform was a recent polemic in America, in light of the Obamacare media waves. However, health care has been a divisive issue for over a century, supplying fodder for partisan political battles, yet resistant to comprehensive federal or state reform (Berkowitz 2010; Gordon 2005; Skidmore 2011; Starr 2011).

The dominant media narratives that surrounded the Obamacare debates—focusing primarily on expanding access and controlling costs—were already present in preceding and parallel state-level reform campaigns. Most notably, the cases of the Massachusetts Health Reform Law, or Romneycare (2002-2006) and the Utah Health System Reform (UHSR, 2004-2011)—states with very different political orientations—illustrated the

diversity of countervailing health care reform narratives well. While the national newspaper media referenced the Massachusetts and (to a lesser extent) Utah health reforms in the context of Obamacare coverage, the parallels between those state debates have been largely overlooked in both media reporting and prior academic inquiries.

1.3 Why the Massachusetts and Utah cases matter

In the state health care reforms of Massachusetts and Utah examined in this dissertation, I contend that both reforms reveal themselves to be pivotal to the Obamacare story. Obamacare was largely patterned after and inspired by the Romneycare initiative in Massachusetts. Obamacare's political and legislative successes—e.g. acquiescence of the health insurance industry to greater government regulation, expansion of health insurance coverage through a combination of means-tested Medicaid expansion, individual mandates to purchase health insurance, mandates on large employers to provide insurance, and subsidies to help lower-income people purchase insurance—as well its political and legislative failures—e.g. the abandonment of both single-payer[2] social

[2] In the American health reform debates, particularly in media coverage, the term "single-payer" is used loosely to describe health care systems in a number of different countries that offer universal coverage. In the American context (perhaps uniquely) single-payer is used to simply mean universal health care coverage, which is conceptually misleading. Granted, single-payer may be defined broadly as a system of universal health care "that relies on a limited number of revenue sources—that is, one in which financing is highly concentrated" (Glied 2009). The Glied definition is adequately broad to serve as a starting point, one from which to identify sub-categories or archetypes of universal health care systems. For instance, Dr. Richard Smith, former editor of the BMJ, categorized developed OECD country health care systems into four archetypes, two of which could be defined as authentic "single-payer" systems: (1) "socialized medicine" (e.g. Britain, Sweden, and the Veterans Health Administration in the United States) in which the health care system has a single source of financing, ensures universal coverage, employs physicians, and places limits on physician salaries; and (2) "socialized insurance" (e.g. Canada, France, Australia, and the Medicare, Medicaid, and CHIP programs in the United States) in which the health care system has a single source of financing (or in some cases joint federal-regional government funding in federal systems) and ensures universal coverage, but physicians essentially remain independent contractors with greater freedom to set their own service charges. A third archetype, "mandatory insurance" (e.g. Germany, Japan, and Obamacare and Romneycare in the United States) also aims for universal coverage, but is not truly single-payer. In mandatory

insurance (also known as socialized medicine reform) and a so-called "public option" to compete with private health insurance companies—essentially reaffirmed the Romneycare model as the new American status quo in health policy. Once Obamacare succeeded as a market-oriented health reform built upon a fragile coalition of historically competing interests, it set the tone and delineated the range of policy options that were available for consideration at the state level. As Obamacare took shape and became a political inevitability, state lawmakers knew that, without a successful court challenge to reverse the federal reform, whatever health legislation they passed in their states would have to fit into a new political and legal framework. Thus, as a revised reiteration of Romneycare, Obamacare severely limited the more conservative Utah Health System Reform (UHSR) experiment, and doomed more progressive and ambitious state reform efforts. [3] The narratives underpinning the Romneycare and USHR initiatives, for their part, offer highly relevant examples of competing accounts of health care reform within a neoliberal policy frame. Prior to this research, the important and interrelated media

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insurance systems, multiple health insurance carriers co-exist and there may be multiple streams of health care financing. These systems may also have both publicly salaried and private-contractor physicians. In the case of Smith's fourth archetype, "voluntary insurance" (e.g. South Africa, the pre-Obamacare United States and pre-Romneycare Massachusetts), coverage is neither universal nor an explicit political goal, and multiple sources of financing, public and private providers, and payment systems co-exist (Smith 1997). I use Smith's succinct definitions of socialized medicine, socialized insurance, and mandatory insurance systems to describe the various parallel systems of health care financing and delivery—both before and after Obamacare—in the United States. Post-Obamacare, the United States is best understood as a new archetype, existing in its own "mixed-payer/mixed provider" category, having moved away from the voluntary insurance model, and towards a mandatory insurance model, whilst maintaining parallel socialized insurance systems (Medicare and Medicaid) and a socialized medicine system (the Veterans Health Administration). To say the least, the American mixed payer/mixed provider model remains complex.

[3] The most notable state-level health reform efforts that would have been on the fringes of the neoliberal policy frame, or, perhaps more accurately, far outside of the neoliberal policy frame as "unthinkable" proposals, were the Vermont (2011) and Colorado (2016) reforms. These two single-payer social insurance initiatives are discussed in section 1.7 of this chapter.

narratives of Romneycare and the UHSR were hitherto underexplored fragments of the broader Obamacare story.

1.4 Research questions: exploring media frames and narratives

Examining newspaper media representations of these two influential state cases, and taking inspiration from literatures in policy diffusion, neoliberalism in health and social policy, narrative policy analysis, and media effects and framing, my research responds to the following central research question:

What newspaper media narratives of health care emerged in the Massachusetts (2002-2006) and Utah (2004-2011) health reforms—influential and hitherto largely unexplored cases that immediately preceded, set the stage for, and paralleled the Obamacare drama?

In order to further elucidate the central research question, my dissertation explores four sub-questions:

1) What narratives of health care reform that emerged in the newspaper media were neoliberal and what were the counter narratives?
2) Was there an overarching neoliberal narrative(s)—or neoliberal meso-narrative—apparent in newspaper media representations of either state reform?
3) Did narratives diffuse across states in the newspaper media coverage of the two reforms (was there convergence of media narratives of health care in the Massachusetts and Utah cases)?
4) How did the absence, and later the presence, of a parallel federal health reform effort (Obamacare) discursively impact media representations of the state health reforms?

Comparison of the media narratives that surrounded these two reforms revealed the surprising diffusion of health reform narratives between newspapers of these historically Democratic and Republican-dominated states. These media representations further revealed the ways in which the development—and eventually the passage—of Obamacare discursively overshadowed media representations of the state health reform debates. Examining these media representations through a narratological lens, in the

context of the disjointed health system—a system which, from a historical institutionalist perspective, retains unsustainable gaps inherited from 20th century legislative successes and failures (Marmor and Oberlander 2011; Steinmo and Watts 1995)—I argue that reporting in both the Republican-leaning and Democratic-leaning newspapers predominantly favoured *neoliberal* health reform narratives in lieu of challenging policy narratives of the political left and right that would have been perceived as beyond the neoliberal policy frame.

It is important to note that, instead of referring to health reform narratives as "conservative" or "liberal" (progressive), or arguing that health reform narratives are positioned on the political "right" or the political "left," I will categorize health reform narratives as either "Democratic-leaning" or "Republican-leaning" in order to differentiate along party lines. The overarching contexts of the Massachusetts and Utah health reform debates were neoliberal, with differences of degree along a neoliberal scale. As such, I did not find the left/right designation to be useful. The challenging narratives of health reform that were used to advocate for policy shifts that are more consistent with a social investment state—single payer socialized insurance, single payer socialized medicine, or regulated mandatory insurance—are identified to differentiate them from the dominant neoliberal narratives.

It is further noteworthy that neoliberal health policy narratives are not monolithic. As such, I account for the nuanced differences between Republican-leaning and Democratic-leaning narratives within the neoliberal policy frame—differences with notable implications for those who depend on the health care system. I further account for challenging narratives of the political left (in favour of single-payer social insurance or

socialized medicine, or mandatory insurance with the aim of universal coverage) and the political right (libertarian, anti-statist/anarcho-capitalist narratives)—the so-called fringe and unthinkable policy options that were less frequent in newspaper reporting on the Massachusetts and Utah reforms.

In response to the dual crises of rising uninsurance and skyrocketing health care costs, the health reform narratives most frequently deployed in the state-based and national newspapers were neoliberal in their policy orientations. These narratives emphasized personal responsibility in health care and health-care financing. They favoured devolution of policymaking to state governments, which, as subnational governments in a federal system, are less capable of independently regulating the "medical/industrial/insurance complex" than the federal government (Steinmo and Watts 1995: 363). They prioritized economic efficiencies and cost containment over equal access, and advocated public-private partnerships to create health insurance exchanges.[4] Neoliberal health care narratives treated the state as a deferential partner to the health care market; yet, as I show in subsequent chapters, it was in this regard that the Massachusetts and Utah reforms diverged most significantly. In contrast to Utah, Massachusetts established a more active role for the state in regulating the market with the goal of preserving it, essentially aiming to shelter the insurance industry from its own abuses that erode public support for the system.

[4] Health insurance exchanges are online marketplaces, established and operated by governments, in which private health insurance companies offer different policies to compete for customers. Participating insurance companies must conform to government regulations. The idea originated in the conservative Heritage Foundation think-tank. Massachusetts was the first state to apply the model, which was later imitated in Utah (with fewer regulations, no subsidies, and a much smaller state-level bureaucratic commitment to manage it), other states, and federally through Obamacare (along similar lines to the Massachusetts model) (Haislmaier 2006; Roy 2011).

1.5 Neoliberalism, the dominant neoliberal narratives of health care, and the subordinate challenging narratives

Neoliberalism can be seen from an institutionalist perspective as a set of policy preferences that establish path dependencies over time (Esping-Andersen 1990). From a neo-Marxist/class analysis point of view, it can be understood as the hegemonic ideology of the dominant class, one that supports the liberalization of global trade, privatization of public services, and market governance (Harvey 2005, 2007; Robinson 2004). Alternatively, for constructivist, Foucault-inspired scholars, neoliberalism can be interpreted as a governmentality or approach to governance that seeks to redefine conceptualizations of citizenship (Brodie 2007). In contrast to the neo-Marxist view of a hegemonic ideology, the constructivist interpretation holds that neoliberalism varies temporally and spatially (Larner 2000). Research from these three differing perspectives seems to largely concur that neoliberalism started to displace welfare liberalism and social democracy in the 1970s, accelerating during the 1980s. The pace and depth of the transition has varied between and within welfare regimes (Bevir 2013: 70; Leys 2010:7; Esping-Andersen 2009; Robinson 2004). All three of these conceptual frameworks make valuable contributions to understanding neoliberalism and its translation into policies.

For institutionalist scholars who compare and analyze social and health policy regimes—among them, notably, Gøsta Esping-Andersen, whose "worlds of welfare" framework offered a typology of welfare regime archetypes and incited decades of scholarly debate—the policies frequently associated with neoliberalism are most apparent in so-called "liberal welfare regimes," such as the United States or the United Kingdom. In liberal welfare regimes, the transition to neoliberal policies was accelerated in the

1980s, and social assistance tends to be less generous, less universal, and more focused on means-testing (Esping-Andersen 1990; Palier 2010). Institutionalist scholars of welfare and health policy recognize, however, that substantial variations exist, and persist, within all welfare regime types – for instance, in the gendered division of unpaid household labour and its relationship to social policy (Esping-Andersen 2009), and in differences in health care policy between countries of the same broad welfare regime type (Palier 2009, 2010).

From a neo-Marxist/class analysis perspective, neoliberalism is best interpreted as a transition in the global capitalist system from nationally-focused Keynesian-welfare capitalism to neoliberal, global capitalism (Leys 2001, Robinson 1996, 2003, 2004). In this view, it is important to identify neoliberalism as the dominant ideology because, for many class-analysis scholars, governing regimes buttress themselves through "ideological state apparatuses" (ISAs), one of which is the media ISA, which deploys and consistently favours policy narratives that conform to and reinforce the dominant ideology (Althusser 1970). Thus, for class analysts, neoliberalism is deeper than a set of government policy preferences; it penetrates into the social fabric, reproducing and reinforcing itself through a society's institutions. Neoliberalism, as the hegemonic capitalist ideology of its time, reveals itself through a combination of destructive economic and social changes; these effects, generated by policies and practices that emanate from centres of global capital such as the United States and Europe, are upending social orders and worsening inequality across the globe (Robinson 1996; 2003), including inequality of access to health care (Leys 2010).

However, as Larner (2000, 2003) argues, there is danger in interpreting neoliberalism as a monolithic ideology, one that underpins a wave of market-oriented reforms that supposedly originated in Reagan's America and Thatcher's Britain, then spread across the globe to undermine democracy. Neoliberalism encompasses a complex array of processes and socio-economic changes that vary across time and space (Larner 2003, 2011). For Larner and others, such as Nicolas Rose and Mitchell Dean, neoliberalism is better interpreted in terms of a shift in "governmentality" or a new "diagram of government" (Rose 1999; Dean 1999) instead of an all-encompassing ideology or set of path-dependent policy preferences. A neoliberal governmentality aims to redefine the "relationship between citizenship and social justice" (Brodie 2007: 94). Contrary to the actual social policy preferences and priorities of democratic citizens—under the guise of individualism, entrepreneurialism, and resilience as values of citizenship—the neoliberal governmentality unabashedly embraces a market fundamentalism that increases social precariousness (Brodie 2007).

Media narratives and accompanying frames can be understood as representations that either (a) are based in the dominant neoliberal rationality of governance or (b) challenge it. Relatedly, neoliberal narratives may be deployed in mainstream media to discredit social contestation movements that challenge the neoliberal status quo (Brodie 2015: 12). Brodie (1997) explains that "national policies," of which welfare, health, and citizenship policy regimes comprise interrelated and central features, evolve with dominant discourses. Brodie refers to these as shifting "meso-discourses" or "meso-narratives" (Brodie 1997). Under neoliberalism, a state's security discourse shifts away from an emphasis upon "social security," abandoning welfare universalism in favour of

targeted, means-tested social assistance (Brodie 2009). The neoliberal shift rewrites national myths of origin, instead favouring entrepreneurial and individualistic discourses of citizenship (Brodie 2002). Similarly, Nicolas Rose advances the concept of evolving "political rationalities." In their respective epochs, classical liberalism, Keynesian welfare liberalism, and (most recently) neoliberalism have served as the political rationalities according to which states have functioned; each of these rationalities has permeated political discourse (Rose 1999: 138-141).

In specifically considering narratives of health care in the United States, while he does not explicitly use the term "neoliberal," George Annas (1995) relatedly describes an overarching "market metaphor" of health care that has altered the ways in which Americans have perceived and discussed their health care system. Annas' (1995) claims with respect to this shift in American health politics are consistent with observations on trends in the politics of health care throughout Western developed countries in non-constructivist social science. For instance, writing from an institutionalist perspective, Palier (2009) noted that a common "orthodoxy" had held during the preceding two decades in the United States and several European countries; it had emphasized competition between providers and insurers, balanced budgets, and measurements of efficiency in the representation of health care systems as markets. Media narratives of health care during the Massachusetts and Utah health reform cases provide a focused lens to examine the claim of a dominant neoliberal shift in American health politics.

While the role of a dominant neoliberal meso-narrative (Brodie 1997) of governance, and an overarching market metaphor (Annas 1995) of health care, should be acknowledged, it is important to note that dominant narratives and metaphors of health

and social policy never remain fixed and unchallenged. Proponents of competing ideologies—or, if one prefers a constructivist frame of analysis, competing governmentalities—can eventually establish new dominant narratives and metaphors of the health care system or, more broadly, of social governance (Annas 1995; Brodie 1997). Furthermore, once public health care programs are in place—programs such as Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), the Veterans Health Administration (VHA), and even the insurance regulations that were instituted under Romneycare and Obamacare to expand access—they can serve as tangible and discursive bulwarks of public resistance to market expansion in the health sphere. Prior research in both the American and Canadian health and social policy contexts has noted that citizens tend to become deeply invested in universal public programs—such as Medicare in Canada or Social Security in the United States—once they are established and to resist attempts at privatization (Ferree 2009; Lazar and Church 2013: 279; Tuohy 1999: 102). In some instances, such as the implementation of Medicare in Canada, social insurance programs can become an engrained symbol of national identity (Lazar and Church 2013:279; Pal 2010: 413-415).

A dominant governmentality finds resistance in both the ways of governing that precede it and in new ideas—what Brodie (2007) refers to as the "residual" and the "emergent." Drawing on Raymond Williams' keywords, Brodie writes that neoliberalism "is invariably impeded, challenged and distorted by the residuals of the descending governing order" [social liberalism]. These residuals of social liberalism include "previously cultivated identities, political consensus, and cultural ideals, which are deeply embedded in social life, and tell us who we are and what we stand for…" (Brodie 2007:

100). Despite its own exclusions and policy shortcomings, social liberalism assumed that the state should actively pursue and manage the redistribution of wealth. Social liberalism further acknowledged the importance of some degree of equality between citizens, as well as embracing a commitment to universal rights to social security and some type of social safety net. It promoted progressive taxation to finance social programs that were believed to be for the common good of society—not only those who needed assistance. This embedded identity of the "social citizen" persists as a residual lens of interpretation of social change, and reflects a common sensibility vis-à-vis social justice that stands in opposition to neoliberal dominance (Brodie 2007). Relatedly, Annas (1995) suggests that opponents of the "market metaphor" of health care must consistently develop and promote new metaphors of health and health care to undermine the dominance of the market metaphor of health care. Thus, discursive resistance to neoliberalism may be based in either old or new ways of governing.

In the cases of the Massachusetts and Utah health reform debates examined in this dissertation, I argue that challenging health policy narratives—such as those on the political left, rooted primarily in social investment state (SIS) perspectives, which favour health care delivery through socialized insurance, socialized medicine, or more strictly government-regulated mandatory insurance, as well as libertarian narratives on the political right that oppose any government regulation of the private health care market—were in fact subordinate and appeared less frequently in the newspaper media than the dominant, neoliberal narratives of health care reform. However, the challenging narratives are an important part of the story, which may one day inform future policy

debates. It is therefore useful to understand the underlying ideological influences and policy orientations of the challenging narratives.

The social investment state (SIS) perspective that underpins the challenging narratives of the political left represents a range of social and health policies, which can be situated either at the fringes or the outer, unthinkable reaches of the neoliberal policy window. In the social policy sphere, this includes such policies as subsidized child care, subsidized access to educational and training programs to help people adapt to employment market fluctuations, and targeted assistance for groups who have been historically excluded from equal access to employment opportunities, such as women and visible minorities (Esping-Andersen 2002; 2009; Jenson 2012; Morel, Palier, and Palme 2012). For an influential segment of institutionalist scholars and advocates for the social investment state, it represents nothing less than "a fundamental break from the neoliberal view of social policy as a cost and a hindrance to economic and employment growth" (Morel, Palier, and Palme 2012: 2).

Specifically in health care policy, a social investment state perspective holds that governments should provide "universal access to safe, high-quality, efficient healthcare services, better cooperation between social and healthcare services and effective public health policies to prevent chronic disease [which can] make an important contribution to economic productivity and social inclusion" (European Commission 2013: 20). While governments have a range of policy options to accomplish this, they should consistently seek both to "guarantee universal access and increase the quality of health care" (European Commission 2013: 20). This may be achieved in principle through a socialized insurance system, a socialized medicine system, or even a regulated and

subsidized mandatory private insurance system that guarantees universal access (Palier 2009). For institutionalist social investment state scholars, this perspective diverges markedly from neoliberal conceptualizations of health care, which relegate the health sphere to the whims of the market (Jenson 2012: 73). Admittedly, most social investment state literature focuses on health policy in Europe. When the United States is included, it is often identified as a policy outlier, one in which social investment state reforms have gained the least ground (Sipilä 2008). However, I argue that the preferred policy aims found within challenging, subordinate narratives of the political left that emerged in newspaper coverage of the Massachusetts and Utah reforms clearly overlap with the social investment state perspective.

For their part, the challenging narratives of the political right primarily exhibited a libertarian perspective. It is noteworthy that the term "libertarian" (like the term "liberal," for that matter) has a different meaning in the United States than it does in most political contexts. In the American case, as Noam Chomsky has noted, libertarianism is a variant of anarcho-capitalism—one that favours the advancement of unbridled markets without government regulations or restraints (Chomsky et al. 2002: 200; Chomsky and Sedlak 2011). This political philosophy, pursued by think tanks such as the Cato Institute, treats private property as sacrosanct and opposes all public welfare programs (sometimes even all forms of taxation), which it perceives as a form of tyranny against individual rights (Chomsky et al. 2002: 200; Chomsky and Sedlak 2011). As I demonstrate in subsequent chapters, the libertarian, subordinate challenging narratives of the political right in newspaper media coverage of the Massachusetts and Utah health reform debates tended to oppose the Romneycare and Obamacare reforms because libertarian columnists viewed

the insurance mandates and government-regulated insurance exchanges as market infringements and violations of individual rights. In the United States, as Peck (2011) and Ball (2013) explain, libertarian, neoliberal, and social conservative economic preferences often coalesce, but these are distinct variants on the right of the American political spectrum, which exist both within and beyond the Republican Party (Ball 2013; Peck 2011). As such, it is not surprising that libertarians offered their own narratological critiques of the dominant neoliberal narratives of health care reform. The following table 1.0 outlines the dominant neoliberal narratives and the challenging narratives of health care that surfaced in newspaper media coverage of the Massachusetts and Utah health care reforms.[5]

Table 1.0 Newspaper media narratives of health reform explored in this dissertation

Narrative	**Neoliberal and/or Challenging?**	**Description**	**State reform(s) in which the media narrative surfaced**
1) Expanded access narrative	Neoliberal	This narrative emphasizes the need to expand access to health insurance in the existing system, without advocating in favour of a "single payer" model or a more regulated mandatory insurance system that would aim for universal coverage. In short, it advocates for expanding	Massachusetts and Utah

[5] Major narratives are those that account for at least 5% of total coverage. All other narratives are classified as "other."

		insurance coverage through private markets, without embracing universalism or accepting health care as a right. It is neoliberal in its acceptance of, and its aim to preserve, the private insurance market, and the existence of tiers of health care quality and access according to economic means.	
2) Economic security narrative	Neoliberal	This narrative emphasizes the need for health care reform to ensure economic security and prosperity. It is primarily concerned with the allegedly excessive costs in the system for governments, businesses, families, and individuals. It is neoliberal in the sense that it accepts health care as a market/commodity.	Massachusetts and Utah
3) Individual responsibility narrative	Neoliberal	This narrative treats health care as an individual responsibility. Variants appear in media coverage of both the Massachusetts and Utah reforms; however, in Massachusetts emphasis is placed	Massachusetts and Utah

		on supporting the individual insurance mandate that requires all residents whose income is above the poverty threshold to purchase private health insurance (with public subsidies for the lowest income residents who are not poor enough to qualify for Medicaid). By contrast, in Utah, emphasis on individual responsibility treats health care as a matter of individual or family responsibility in which there should be no government intervention. The narrative is neoliberal because of the individualization of responsibility in the health sphere.	
4) Narrative of Massachusetts leadership in national health reform	Neoliberal	This narrative treats Massachusetts as the reform model for the country to emulate. It celebrates the role of Massachusetts politicians, including Senators Kennedy and Kerry and Governor Romney, in advancing	Massachusetts

		Massachusetts' neoliberal health reform experiment on the federal level to expand insurance access or control health care costs, as opposed to advocating in favour of single payer reform or a system of regulated mandatory insurance to achieve universal access.	
5) Narrative of health reform activism	Neoliberal / Challenging	This narrative was mostly neoliberal during the Romneycare debates, since reporters tended to highlight the organized lobby and activist groups that worked in favour of Romneycare as a health reform model. Challenging activist voices were covered in a handful of pieces that were written in support of single-payer as an alternative, but large and well-funded health reform advocacy organizations such as Health Care For All, which favoured the neoliberal Romneycare plan, appeared in newspaper coverage more often.	Massachusetts
6) Narrative of	Neoliberal	This narrative	Massachusetts

leadership and innovation in state health reform		celebrates Romneycare as the best reform model for the Commonwealth of Massachusetts. It is neoliberal due to its advocacy of individual and employer insurance mandates and public subsidies to shore up the private health insurance industry as a strategy to preserve the health care market and prevent the employment-based insurance system from crumbling.	
7) Narrative of Massachusetts as a centre of the health care industry	Neoliberal	This narrative emphasizes the value of health care markets rather than focusing on care as a right by highlighting the strength and importance of the insurance, pharmaceutical, and other medical research industries in the economy of Massachusetts.	Massachusetts
8) Incremental reform narrative	Neoliberal	This narrative accepts the conceptualization of health care as a market and celebrates the Utah Health System Reform (UHSR) as a conservative,	Utah

		fiscally responsible approach to health care reform, one that is allegedly superior to the Obamacare or Romneycare models.	
9) Wrong reform narrative	Neoliberal/Challenging	This narrative on the right of the neoliberal policy window is challenging in the sense that it criticizes Obamacare and supports the UHSR as a reform model. It appeared when the federal and state reforms were advancing parallel to one another.	Utah
10) Inadequate reform narrative	Neoliberal/Challenging	A narrative on the left of the neoliberal policy window, this narrative is challenging in the sense that it rejects the UHSR as a too-modest reform effort, advocating in favour of universal access, and frequently treating Obamacare as a positive stepping-stone towards universal access.	Utah
11) Narrative of unethical health care regulation	Challenging (Right-libertarian)	A narrative of the political right (libertarian), this narrative opposes any government regulation in the health care market.	Massachusetts

12) Anti-Romneycare narrative	Neoliberal and Challenging (Right-libertarian)	A narrative on the right of the neoliberal policy window, it treats Romneycare as the wrong path to reform, often favouring less government intervention and more market oriented solutions.	Massachusetts
13) Narrative of inefficiency and unethical health care practices	Challenging (Social Investment State)	This narrative of the political left in favour of universal access highlighted the unethical behaviour of insurance companies and health care providers in the health care market.	Massachusetts
14) Pro-single payer narrative	Challenging (Social Investment State)	This narrative was used to advocate in favour of a transition to a single-payer health care system (socialized insurance or socialized medicine) or a more regulated mandatory insurance system to guarantee universal access.	Massachusetts
15) Other minor narratives	Neoliberal and challenging	This category includes minor narratives (comprising less than 5% of coverage) advanced by both the political left and right that	Massachusetts and Utah

		rejected the neoliberal frame of health care or focused on other aspects of the health care system, including: the manufactured crisis narrative (Utah), the pro-single payer and anti-single payer narratives (Massachusetts and Utah), the pro-Hillarycare and anti-Hillarycare narratives (Massachusetts and Utah) and a handful of other minor narratives, which are explained briefly in chapters 4-6, but are not included in the data tables devoted to major media narratives of health care.	

Evidence of neoliberal health reform narratives exists within and outside of the Massachusetts or Utah cases examined herein. For instance, between 2001 and 2008, the Bush Administration advocated strongly for Health Savings Accounts (HSAs), which individualize responsibility for health care financing. [6] As I show in Chapters 6 and 7,

[6] A Health Savings Account (HSA) is a tax-free bank savings account that typically complements a catastrophic (high-deductible) private health insurance plan. Conservative health reform activists have advocated these accounts as an alternative to greater government involvement in the provision and financing of health care; however, the record of HSAs as a solution to the American health care crisis is not particularly encouraging (Barabas 2009). President Bush expressed support for HSAs in his election platforms in 2000 and 2004. In the COBRA Handbook, for tax code purposes, Health Savings Accounts (HSAs) are defined as follows:

HSAs were also a key policy proposal for the conservative architects of the Utah Health System Reform (UHSR) (Bumiller 2006; *Deseret News*, October 18, 2004; Dionne 2006; Milbank 2006; Utah, Avenue H, May, July, September 2011; *WSJ* February 1, 2006). I further demonstrate in Chapters 4 and 5 that libertarian critics of the Massachusetts health care system and the Romneycare plan suggested deregulation to ease interstate health insurance purchases as an alternative to individual and employer insurance mandates between 2002 and 2006 (Vanderkam 2006). Finally, a desire of the federal government to disengage from Medicaid commitments can be traced back at least as far as to the Clinton Administration. A key feature of President Clinton's failed 1994 Health Security Act (HSA) was the proposed elimination of Medicaid and the transfer of its recipients into the private insurance market with means-tested subsidies (Beresford 1994; Budetti 2004;

"HSAs are established to receive tax-favorable contributions by or on behalf of eligible individuals and amounts in an HSA may be accumulated over the years or distributed on a tax-free basis to pay or reimburse qualified medical expenses. An HSA is, in essence, a tax-exempt trust or custodial account that an eligible individual may set up with a qualified trustee or custodian to pay or reimburse certain medical expenses. A qualified HSA trustee or custodian may be a bank, an insurance company, or any entity approved by the IRS to be a trustee or custodian (either for HSAs, individual retirement arrangements, or Archer medical savings accounts). To be eligible and qualify for an HSA, an individual must: (1) have a high deductible health plan (HDHP) on the first day of the month; (2) have no other health coverage (except for certain permitted coverage); (3) not be enrolled in Medicare; and (4) not be claimed as a dependent on someone else's tax return." (Golub and Chevlowe 2014)

HSAs are highly controversial because, as policy instruments, HSAs enable governments to individualize responsibility for health care financing, effectively helping both governments and employers to disengage from the public health sector. Critics charge that the rise of HSAs favours the wealthy, who can set aside large sums of money in tax-free accounts to pay for non-compulsory medical procedures, while they mislead poor and middle-income people into a false sense of security (when combined with high deductible health plans) that may prove inadequate to cover the costs of treating serious, long-term illnesses (Barabas 2009). The claim that HSAs reduce health care costs is, to say the least, dubious. Without the purchasing power of a government (state or federal), or at least a large pool of individual purchasers, HSAs are really only useful for minor medical expenses. Most individual "health consumers" cannot rely on them for catastrophic illnesses.

Hacker 1997a; Johnson and Broder 1996; Mariner 1994).[7] The history of neoliberal health reforms at both the federal and state levels makes it all the more important to explore media representations of the Utah Health System Reform (UHSR) as the closest example of a conservative health reform alternative to Obamacare, and Romneycare in Massachusetts as Obamacare's inspiration.

1.6 Prior Research on Health Care Reform in the United States

Much has been written, in both academic circles and the media, about the complexities of American health care reform, although most of this research has focused on federal initiatives. Institutionalist theorists, who focus primarily on the ways in which institutional structures delineate reform options, and rational choice theorists, who draw from neoclassical economics and classical liberal theory in order to refocus health care reform debates on the role of self interest in shaping policy, continue to dominate the academic literature (Brown 2010; Pierson 1994; Tuohy 1999). In broad terms, institutionalists focus on historical-institutional arrangements such as constitutional structures, federalism and the way such structures delineate health reform efforts and facilitate the diffusion of policies. Pluralist research focuses on the interactions between different political actors, resources, and democratic engagement in bringing about reforms. Rational choice theorists emphasize neoclassical economics and the role of people (patients, physicians, etc.) as rational economic actors who seek to maximize their

[7] President and First Lady Clinton's Health Security Act (HSA) legislation was disparagingly referred to as "Hillarycare" in the conservative press, and continued to be labeled as such through much of the media coverage of health care reforms throughout the 2000s. The tendency to associate a major health care reform effort with one of its political flag bearers persisted into the Massachusetts reform efforts under Governor Romney and the later federal health reform effort under President Obama. However, the battles of term appropriation over "Romneycare" and "Obamacare" were such that the terms were used both approvingly and disparagingly in the Republican-leaning and Democratic-leaning media.

own benefits within health care systems. For its part, the critical literature examines health care reforms through the lenses of political economy and ideology, social equality, and political rationality. Despite their inadequate emphasis on the role of state governments in health care, literature from these perspectives on national health policy development and reform provides essential context to interpret representations of state reform efforts. In particular, critical literature on neoliberalism in health and social policy, and institutionalist research in policy diffusion and critical junctures are central to this study.

Institutionalist research in federalism and policy diffusion

Research in the areas of federalism and policy diffusion investigates the ways in which states serve as policy laboratories and federalism acts as a policy incubator. The research asserts, among other things, that the states that implement health policy changes first are those states in which necessity mandates innovation, and where current state-level politics permit a higher level of risk-taking. When health policy experiments succeed politically and administratively, they diffuse horizontally to other states and, sometimes, vertically to the federal government (Carter and Laplant 1997; Holahan et al. 2003; Karch 2007; Weissert and Scheller 2008). In particular, cost-saving health policy changes are likely to diffuse; however, even health policy innovations that provide clear evidence of success are notoriously slow to spread between jurisdictions or organizations (Berwick 2003; Volden 2006). Partisanship plays a key role in policy diffusion. Prior research has demonstrated that when health policy changes circulate, they understandably tend to transfer to states with similar ideological leanings: in other words, from Republican or Democratic Party-dominated states to states under the control of the same

political party (Barrilleaux and Brace 2007; Volden 2006). However, I argue in the following chapters that some key narratives of health care reform diffused from Democratic Massachusetts to Republican Utah, despite the rhetoric of state politicians that disavowed the similarities. This diffusion was evidence of a common, overarching neoliberal meso-narrative in newspaper media representations of health care reform in the Massachusetts and Utah cases.

Policy diffusion research has further argued that the nature of health policy innovation within the American federal framework is "cyclical," affirming that even though states and the federal government innovate simultaneously, initial implementation depends on evolving political circumstances. States may act as health policy laboratories in conservative periods while the federal government leads in progressive times (Nathan 2005; Thompson and Burke 2001). The Massachusetts and Utah reform examples support this assertion, in the sense that Massachusetts Democratic politicians framed their reform as the progressive alternative to the Bush Administration's perceived inaction on the health care crisis, and Utah Republicans represented their reform effort as the embattled, underdog conservative response to the alleged tyranny of Obamacare. Mindful of the cyclical character of health policy innovation, health care reform advocates focus on the level of government that is most conducive to policy transformation at a given moment; this flux creates a gradual, inconsistent, and unpredictable climate for health care reform (Oliver 2006). Other research has examined the role of the media in health policy diffusion. For example, Wakefield et al. (2010) explore the uses of mass media campaigns to influence health behaviour across populations.

Other institutionalist and pluralist (interest-based) research in American health reform

Institutionalist and pluralist health policy research also offers important insights into the world of deal-making and some of the actors who influence health care reform efforts across time—such as state governments, presidents, congressional power-brokers, interest groups, lobbies, think tanks, the courts and policy elites in both politically appointed positions and the public service (Genieys et al. 2013; Starr 2011). For instance, Starr (2011) argues that political and corporate elites play key roles in the development and in the efficacy of implementation in health care reform efforts. Genieys et al. (2013) note the importance of Ivy League educated, advanced degree holders in American health policy formulation, as political appointees and as so-called "long timers" in health care policy-making who oscillate between roles over many years. The careers of many "long-timers," they note, demonstrate the presence of a "revolving door" between heath policy-making roles in the legislative and executive branches and elsewhere in the public sector (Genieys et al. 2013). Institutionalist and pluralist research has also examined the national hubris in health policy-making, a factor that dissuades American legislators from learning about health policy reforms abroad (Marmor and Oberlander 2011; Reid 2010).

Other researchers have minimized the importance of policy-making elites in health care reform efforts, arguing instead that policy elites counter-balance one another and thus have limited impact on public opinion during health care reform efforts (Davidson 2010: 210 – 211). Taking the argument on the limited influence of political elites in health care reform further, Saldin (2010) challenged whether even a president like Obama, who allegedly "realigned" the political status quo (as many early media observers claimed after President Obama's 2008 victory) really had the power to enact sweeping change in health care. For Saldin, Obamacare was arguably a lesson for

presidents that daring to reform the health care system may cost their party the next elections (such as the loss of Democrats in the 2010 midterm elections) and ultimately make any president less effective.

While informative, the institutionalist and interest-based interpretations of health care reform largely ignore factors such as ideology, sociological determinants of access to health care, and political rationalities in health care reform outcomes. Furthermore, these bodies of social science scholarship have not adequately examined the role of the media in state-level health policy change. Alternatively, critical social science researchers have asked other important questions about health care reform in America.

Critical Research on American health care and neoliberalism in health and social policy

Contrary to American health care research in the aforementioned institutionalist and pluralist traditions, the critical social science literature examines American health care reform through the prisms of ideology and political economy, social equality, and political rationality. This diverse research canon is central to understanding neoliberalism in the context of health and social policy reform. Critical scholars affirm that the influence of neoclassical economics in the social and health policy fields represents a larger trend, undermining other social science research and favouring questions of alleged economic efficiency over social justice and equality concerns (Brodie 2007; Daniels, Light and Caplan 1996: 11-14). Scholars in the critical political economy tradition treat neoliberalism as a barrier to radical change in health care and other policy areas, a barrier that pervades American institutions (Caplan 1989; Coburn 2000, 2004; Fisher 2007; Leys 2010; Lipset and Marks 2000; Navarro 2007, 2009; Quadagno and Street 2005).

Critical scholars of media effects have notably affirmed that the media act as gatekeepers of information. In this view, media advance the neoliberal ideological and policy status quo and limit coverage of policy alternatives that fall beyond the neoliberal policy frame (Budd et al. 1999; Chomsky and Herman 1988; Scheufele and Tewksbury 2007). Thus, fringe alternatives such as universal coverage through subsidized mandatory insurance or unthinkable policy proposals such as single-payer socialized insurance or socialized medicine only emerge in subordinate media narratives that are deployed less frequently. Both critical scholars and institutionalist researchers have devoted noteworthy attention to narratives and media frames in other policy areas, but greater attention must be given to the role of narratives in health care policy change.

A novel approach to examining media representations of recent, interrelated health reforms

In essence, instead of revealing a schism between the political right and left on health care, this dissertation reveals that reporting on these two state health reforms demonstrated coalescence between Democratic and Republican perspectives in the newspaper media on a neoliberal meso-narrative of health care reform. This coalescence around a neoliberal meso-narrative reflected both the concession of mainstream Democrats that the Clinton Administration's Health Security Act (HSA) of the early 1990s had delineated the frame of political possibilities, and the acknowledgement of mainstream Republicans that comprehensive health care reform was in fact necessary, albeit within an even narrower neoliberal policy frame. Thus, the acrimonious debates that surrounded these state laws that passed between 2006 and 2011 did not reflect a chasm between the health reform priorities or preferences of the right and left, but rather

a peculiar and bitterly politicized narcissism based upon small differences within a predominantly neoliberal policy window.

The declining importance of partisan political party differences (Republican and Democratic) has been noted elsewhere. For instance, Jordan (2011) asserts that, in the United States and seventeen other OECD countries, the de-facto consensus on a neoliberal politics of retrenchment in health care has reduced the importance of political partisanship and made expansions of the role of government in relation to the private sector less likely. On one hand, my research in the media representations of the Massachusetts and Utah cases—two states with marked historical differences in political partisanship—further supports the claim of a broad neoliberal consensus. While challenging fringe and unthinkable media narratives of health care policy emerged from both the political left and right, these subordinate narratives were less frequent in newspaper media coverage than neoliberal narratives. However, although representations of both the Massachusetts and Utah reforms were predominantly neoliberal, policy differences within the neoliberal frame—those pursued within a Democratic-leaning state versus those pursued within a Republican-leaning state—had important implications for those who use the health care system.

Before exploring media narrative and frame analysis as an interpretive framework for health care reform debates and outlining my research design (in Chapter 3), and prior to analyzing of the narratives and frames that defined these two influential state health reforms, it will be useful to summarize the piecemeal development of the complex federal health care system in which the Massachusetts and Utah reforms occurred. This legislative and institutional context includes (a) the American practice of providing

progressively elaborate public health care services exclusively to military veterans from 1865 to the present and the creation of the Veterans Health Administration (VHA) after World War II; (b) the employment-based private health insurance system that developed primarily in the post-WWII decades, and (c) the creation of Medicare and Medicaid as separate social insurance programs as part of the Great Society reforms of the 1960s. In addition, no explanation of the political context would be complete without summarizing the failed federal Health Security Act (HSA) of the Clinton Administration in 1994. Finally, the historical chapter that follows will summarize the State Children's Health Insurance Program (CHIP) of 1997 as the last successfully implemented federal social insurance program, the wake of state-level reforms that followed the failure of the federal 1994 HSA (including Massachusetts and Utah), and the debates and policy implications of the 2010 federal Patient Protection and Affordable Care Act (ACA, Obamacare) that intersected with media representations of the Massachusetts and Utah reforms.

Chapter 2: The Historical Arc of Health Care Reform in the United States: Situating the Massachusetts and Utah Cases

2.1 Rewarding patriotism and sacrifice: Public health services for veterans and the development of the Veterans Health Administration (VHA) 1865-present

Rather than treating access to health care in a publicly funded system as a right of citizenship, as countries like Canada or Britain did in the post-war decades, the United States first treated access to health care in a publicly financed system as a right that had to be earned through military service. Hospital care for American veterans expanded due to demand after the Civil War in 1865, then again after World War I (Skocpol 1995; USDVA 2006). However, it was after World War II, in 1946, that the Veterans Health Administration (VHA) emerged as a true single-payer health care system for veterans of the American armed forces (USDVA 2006). Just two years after the war, in 1947, the VHA was already managing 126 hospitals across the United States, employing thousands of physicians and caring for tens of thousands of patients in a publicly financed and publicly delivered health care system (USDVA 2006). The VHA was essentially established as a socialized medicine system exclusively for the use of veterans. All honourably discharged veterans, their immediate families, and surviving immediate families were made eligible for some level of VA benefits (Oliver 2006; USDVA 2006).[8]

The VHA (2006) reports that it manages over 150 hospitals in all 50 states and U.S. territories, as well as dozens of rehabilitation centres and elderly care centres. It employs approximately 200,000 health care workers (including more than 14,000 physicians). Over 60 million Americans qualify for some level of VA benefits as veterans, immediate families of veterans, or surviving immediate families of deceased

[8] This refers to so-called "active-duty" veterans of the Army, Navy, Marine Corps, and Air Force. It does not include the National Guard or Reserves.

veterans (USDVA 2006). However, access to VA health benefits is determined according to eight tiered "priority levels." First priority is accorded to disabled and unemployable veterans who were injured in the course of their military service. In 2007, 7.6 million Americans, of approximately 27 million eligible veterans, were enrolled in the VHA for their medical care; thus, the VHA is similar in scale to the public health care system of a small country (Oliver 2007; Perlin 2007).

By any measure, the VHA is a large socialized medicine system, comparable to single-payer systems abroad in its scope and delivery. It is unique in its service to a targeted segment of the population. It is also unique in operating parallel to both public and private systems of health insurance, financing, and delivery within a single country. Parallel to the progressive expansion of these health care services for veterans, which eventually developed into a vast socialized medicine system after World War II, other health care reforms for the civilian population were debated in the early decades of the 20th century.

2.2 A Bull Moose, a New Deal, and an (Un)fair Deal: Early American health reform debates and the specter of the American Medical Association (AMA), 1912 – 1950s

American progressives have been formally advocating for comprehensive health care reform since 1912. In that year, under the leadership of former President Theodore Roosevelt,[9] the progressive Bull Moose Party first advocated for the creation of a National Health Service and a system of social insurance in an official national election platform. While Roosevelt won more votes than Republican incumbent President William

[9] Roosevelt was seeking an unprecedented third term, after having served eight years as a Republican President; he was disgruntled with the platforms of the Republican and Democratic Parties. The Bull Moose Party took inspiration for the creation of social insurance and a National Health Services from reforms underway in England and Germany (Gable 1978; Lane 2009; Peters and Woolley 1912).

Howard Taft, and achieved a better election result than any third-party candidate in American history, he lost the election to Democrat Woodrow Wilson (Gable 1978; Lane 2009; Peters and Woolley 1912). The Bull Moose Party defeat pushed comprehensive health and social insurance reform onto the backburner of American politics until the 1930s.

It was then, in the midst of the Great Depression, that Theodore Roosevelt's cousin, President Franklin Delano Roosevelt (FDR), seriously considered legislative action on social and health reform as part of his "New Deal" reforms. Much of the health reform activism at the time focused on the plight of elderly Americans, millions of whom suffered without medical treatments that they could no longer afford after they stopped working. FDR established his "Committee on Economic Security" with the express intent of outlining national programs for social insurance and national health insurance. In both cases, the goal was universal coverage. However, the American Medical Association (AMA), conservative Republicans, and southern Democrats all lobbied hard against national health insurance, framing it as a sort of communist Trojan horse designed to subvert the American political system. [10] The narrative of universal health care as a communist contagion was a powerful one. It influenced the outcome of the debates in the 1930s, and reverberated in American political discourse well into the 21st century. President Roosevelt reluctantly dropped health care from his reform platform, believing it was more politically feasible to pass social insurance legislation. The Social Security Act

[10] This tactic of the AMA was not unique. In cooperation with the Saskatchewan College of Physicians and Surgeons, the AMA helped to fund a campaign against the socialized insurance proposal of the Co-Operative Commonwealth Federation (CCF), attempting to promulgate the same kinds of public misinformation and scare tactics that represented socialized insurance as a communist Trojan horse (Flavelle 2010).

of 1935 ultimately passed without the inclusion of a national health insurance plan, delaying reform for another decade (Benjamin et al. 2013; Oberlander 2003).

Arguably the most significant health care legislation in the immediate post-war period was the McCarran-Ferguson Act of 1945. McCarran-Ferguson undermined the ability of Congress to regulate health insurance, devolving insurance regulation to the state level. Congress passed the legislation following the United States Supreme Court decision in *United States Versus South-Eastern Underwriters Association,* which ruled that the federal government could use the Commerce Clause or federal anti-trust laws to regulate the insurance industry. This partial exemption to anti-trust legislation and the Commerce Clause for the insurance industry in McCarran-Ferguson, largely relegating regulation to the states, has remained controversial (Ackerman 2014; Macey and Miller 1993). Most recently, calls to appeal McCarran Ferguson emerged during the Obamacare debates of 2008-2010 (Sagers 2010).

In 1948, Harry Truman made health care reform a cornerstone of his presidential election campaign, placing particular emphasis on public health insurance for the elderly. Like FDR, Truman envisioned a universal social insurance model. In his second term as president, Truman advocated resolutely for comprehensive health reform in Congress as part of his "Fair Deal." However, the AMA once again allied with conservative Republicans and southern Democrats to undermine reform. The AMA bankrolled what was, until that time, the most costly political action campaign in its history to oppose Truman's Fair Deal. The AMA campaign capitalized on the American public's fears of Soviet expansion, framing Truman's plan as "socialized medicine" that would eventually

condemn the middle class to government servitude. Republicans made substantial gains in the 1950 midterm elections, effectively robbing Truman of the sizeable majority he would have needed to enact national health insurance legislation (Eberstadt 2014; Morone 2014; Potter 2013; Zelizer 2015).

Thus, health care reform legislation for American civilians was deferred until the turbulent 1960s, when progressive reformism resurged. However, in the absence of major federal or state legislation in the 1940s and 1950s, the health care system continued to evolve. As previously mentioned, the Veterans Health Administration (VHA) played an increasingly important role as America's first system of socialized medicine in the early post-war decades, a system that exclusively served military veterans and their families. Simultaneously, the employer-based private health insurance system established itself as an American way of life—thanks in part to political power of large labour unions in the automobile and other industries, and thanks in even larger part to the influential AMA, which continued nationwide campaigns to encourage patients to purchase private health insurance (Eberstadt 2014; Morone 2014; Potter 2013; Zelizer 2015).

2.3 The Post-WWII Rise of the American Employment-based Insurance System 1940s – 1960s

Employment-based insurance is an unusual American phenomenon that is uncommon in similarly developed countries—and the doubts over the success of the model largely explain why it has not spread. While private hospitalization insurance existed in the early 1900s, the private hospitalization and health insurance system primarily developed after World War II. Many large employers were already offering health insurance as a benefit to their employees before the war, but the percentage of Americans insured through their employers grew rapidly from 1945 through the 1960s

(Enthoven and Fuchs 2006; Skocpol 1995). The post-war growth in employer-based insurance stemmed in part from changes to Internal Revenue Service (IRS) regulations in 1943, allowing employers to receive tax deductions for contributing to employee insurance costs, and simultaneously rendering employee payments towards their own health insurance premiums tax-free (Gabel 1999). Fewer than 50% of Americans had hospitalization insurance in the 1950s, but the number had already increased to over 75% by the early 1960s. Furthermore, by the 1960s, 25% of Americans were further insured for routine medical expenses beyond hospitalization, which had been rare in the preceding decades (Enthoven and Fuchs 2006).

The system of employer-based, defined-benefit insurance[11] that developed in the prosperous post-war decades was not egalitarian or uniform. Critical health policy scholars like Dr. Jon Gabel have identified the link between tiers of health insurance plans and America's social hierarchy, which made reform politically difficult despite known systemic flaws (Gabel 1999; Stein, September 18, 2005). Better paying jobs typically offered better quality health insurance coverage; thus, the quality of a worker's health insurance plan came to be seen a symbol of secure middle class social status. The link between health insurance and social status generated support for the employer-based insurance system within the economic classes that benefited the most from it (Gabel

[11] Defined-benefit health insurance plans can be differentiated from defined contribution plans. Under defined benefit plans, employers cover most of the costs of a health insurance package (premiums) for workers. For their part, workers may pay a small portion of the premium or none of the premium. Employees typically remain responsible for an annual deductible and co-pays for medical services. In some cases, workers can choose between multiple insurance packages according to their individual and family circumstances. In contrast, in defined-contribution plans, which have become increasingly popular in light of the rising health insurance premiums and medical costs, employers provide a cash benefit to employees to purchase their own health insurance on the private marketplace, but employers do not contribute to premiums to offer health insurance packages for their workforce (Utah, Avenue H, May, July, September 2011).

1999; Stein, September 18, 2005).[12] The gaps in insurance coverage and access to quality health care for millions of Americans—in particular, the elderly and the poor—who were not veterans of the armed forces, increased pressure on the federal government to modernize health care programs in the 1960s.

2.4 The Universal Promise of Medicare (1965)

In a sense, Medicare was an accident of history with an unlikely champion. According to biographers and Great Society policy analysts, President Johnson was a highly capable and experienced politician; yet, he was a reluctant progressive and consistent pragmatist. Johnson understood the depth of political change afoot in the 1960s and quickly recognised political opportunities in the tumult (Eberstadt 2014; Goodwin 1991; Zelizer 2015). Johnson's Great Society reforms aimed to simultaneously reduce poverty, combat racism, and increase social equality and environmental protections. Citing only the highlights, the Great Society reforms increased funding for public schools (Secondary Education Act), preserved millions of acres of public land (Wilderness Protection Act), affirmed and protected voting rights for ethnic minorities (Voting Rights Act), ended racist quotas in immigration (Immigration Act), increased access to affordable housing for the indigent (Omnibus Housing Act), and established Medicare as

[12] Leading health reform advocates recognized the cultural challenge of the link between class identity and health care in late-20th century America as recently as 2005. In the midst of the Romneycare debates, the Executive Director of *Health Care For All* in Massachusetts, John McDonough, aptly described the problem: "There is no political consensus for significant change. Too many people, especially middle-class and affluent people who get insurance at work, have a stake in preserving the status quo. In the future we may reach a tipping point where the erosion of the employer market gets so severe we are forced to take action. In the meantime we will do what we always do - muddle through. We can tolerate a lot in America - as long as it happens slowly, and as long as the bad stuff happens to someone else" (Stein, September 18, 2005).

America's first single-payer socialized insurance system for citizens aged 65 or older (Eberstadt 2014; Zelizer 2015).

Johnson governed in a period of unparalleled economic growth and seemingly unlimited opportunity for America's white middle classes. Beginning his term in 1964, prior to the midterm election of 1966, and before the Vietnam War submerged his presidency in a political and military quagmire, Johnson held public trust thanks to his standing as Kennedy's unanticipated flag-bearer. He was elected with a strong Democratic majority in Congress (Eberstadt 2014; Goodwin 1991; Zelizer 2015). In fact, beyond reflecting this partisan majority, Julian Zelizer convincingly argues that the 89th Congress of 1964 was the most progressive in American history; it was replete with unrepentantly left-leaning activists such as Minnesota's Senator Herbert Humphrey, reformers who were committed to picking up the liberal agenda where President Roosevelt's New Deal of the 1930s had left off (Zelizer 2015).

Simultaneously, as the election pushed the political elite to the left and thus facilitated change from above, the Civil Rights Movement (under the charismatic leadership of figures like Martin Luther King Jr.,) demanded justice from below for racial minorities. The Civil Rights Movement coalesced with related movements for greater gender equality, economic justice, and environmental stewardship (Goodwin 1991; Zelizer 2015). In the face of fractured and demoralized Republican opponents, Johnson held the public's imagination and hopes, stood on a groundswell of progressive change in converging social movements, and possessed unprecedented political and economic power to implement major policy changes. He understood his rare opportunity in

America's complex political system and he left his mark in history with an ambitious change agenda.

Johnson signed Medicare into law as an expansion of the Social Security Act, presenting it to the American public as a historic extension of the social welfare promises of the New Deal. Once Medicare came into effect in 1965 in conjunction with other Great Society reforms, Johnson had succeeded in an expansion of the welfare state that President Roosevelt was not willing to risk politically, and one that President Truman had failed to accomplish. Medicare brought immediate health care access and security to nearly 20 million previously excluded and highly vulnerable aging Americans (KFF 2013; 2015 a, b, c; Zelizer 2015).

Although Medicare is a universal social insurance program that covers all Americans aged 65 and above, its governing principles are similar to those of the Veterans Health Administration (VHA), in the sense that access to the publicly funded health care program is *an earned right*. Except for the severely disabled and unemployable, Americans have historically been expected to work during their productive years, while they paid tax contributions for Medicare—and presumably participated in the employment-based insurance system, enrolled in Medicaid if they were eligible, or remained uninsured—before they earned the right to participate in Medicare when they retired (if they had recorded enough productive working years to participate). Additional reforms expanded Medicare to provide health insurance to many permanently disabled Americans. By 2007, Medicare insured over 44 million elderly or

permanently disabled people (KFF 2015d).[13] Another key legacy of the Great Society reforms was Medicaid, which offers means-tested health care to the poorest Americans.

2.5 Medicaid in the Shadow of Medicare (1965): Means-tested Healthcare, American-style

No president accomplishes major health reforms alone, and the importance of Congress should not be understated. In particular, Democratic Congressman Wilbur Mills of Arkansas, Chairman of the House Ways and Means Committee, and Democratic Senator Robert Kerr of Oklahoma played key roles in the health care debates of the time. Hesitant to support any major health care entitlement program, Congress established the more limited "Kerr-Mills" program in 1960, which provided federal grant funding to states in order to cover health care services for the poor. As debates over Medicare ensued, through a series of Congressional compromises, the Kerr-Mills program eventually became Medicaid, which was established in 1965 at the same time as Medicare, as part of Title XVIII and XIX of the Social Security Act (Berkowitz 1995, 2005; Zelizer 2015).

In a 2014 interview on the history and legacy of Medicaid and Medicare as Great Society programs, Tom Scully, former Chief Administrator for Medicare and Medicaid Services (2001-2003), described Medicaid as an "afterthought" for President Johnson (Scully 2014). In 1964-1965, the central preoccupation was access to medical care for aging Americans. In fact, improving access to health care for the elderly had been the primary goal for Democrats since the late 1940s, when President Truman failed in his health reform effort (Eberstadt 2014; Scully 2014; Zelizer 2015). In this sense, the

[13] Medicare enrollment continues to expand. By 2015, Medicare had grown to insure almost 55 million people over age 65 (or younger, with permanent disabilities) (KFF 2015e).

unfavourable description of Medicaid as an afterthought is probably fair. The reason for its secondary status in the minds of policymakers reflects 20th century social policy priorities of Democrats and intersects with notions of deservedness in social reform, since the elderly poor had been seen as the top priority and most deserving of health care since President Truman's failed Fair Deal reform effort (Preston and Silke 2011; Zelizer 2015).

Although Medicaid has always taken a backseat to Medicare, which has been regarded as the crown jewel of American public health care programs, the former has maintained broad public support and grown in enrolment during its five-decade tenure (KFF 2011; Scully 2014; Zelizer 2015). By 2013, the program was insuring 28 million Americans (Smith et al. 2013). While Medicaid is a means-tested program funded through both federal and state governments, one that has variable eligibility and cost-sharing approaches between states (more variable prior to the Obamacare reforms of 2010), it remains a socialized insurance program like Medicare despite its more complex financing structure (KFF 2015 c, e).[14]

2.6 The Decline of the Employment-based Insurance System and the Response of the Clinton Administration in the 1994 Health Security Act (HSA) 1970s – 1990s

According to Enthoven and Fuchs (2006), the employment-based system ultimately became a victim of its own success and complexity. The percentage of

[14] Medicaid eligibility requirements before Obamacare were complicated. In addition to the requirement to earn less than the Federal Poverty Level (FPL) (in some cases, only half the FPL), applicants were expected to meet state-specific requirements, such as already having children or having a medically-documented disability. Thus, even many of the poorest Americans were ineligible for Medicaid, if they were healthy and childless, or if they were simply unlucky enough to live in a state with a particularly low-income cut-off (KFF 2014, Snyder and Rudowitz 2015). Since states jointly fund Medicaid jointly with the federal government, they had a financial interest in setting the eligibility bar low before Obamacare. The Affordable Care Act expanded Medicaid eligibility to virtually all adults under age 65 who earned up to 138% of the FPL, preventing states that participated in the 2014 expansions from lowering the economic eligibility bar (KFF 2014, Snyder and Rudowitz 2015; Paradise 2015).

Americans with employer-based plans, they write, continued to expand through the mid-1980s. However, beginning in the 1970s, and increasingly through the 2000s, technological advances in medicine were driving up the costs of care (Wallner and Konski 2008). Simultaneously, private health insurance companies grew substantially, basing their rates on progressively complex actuarial calculations in order to minimize risks and maximize profits.[15] Employers, who had to pay higher insurance plan rates, inevitably sought to pass costs on to employees in order to protect their profit shares. Since workers had come to see health insurance as a right of employment, and unions saw generous insurance plans for unionized workers as a hard-won victory for organized labour, both individual workers and unions resisted employer attempts to download costs, resulting in political gridlock. Ultimately, both employers and workers paid higher premiums, and each side began to question the long-term viability of the system (Enthoven and Fuchs 2006; Manchester 2015).

The costly and inefficient employment-based health insurance system declined, without major government expansions of coverage in existing public programs or new healthcare programs in the 1970s or 1980s. By the early 1990s, an increasing number of Americans were therefore uninsured. Many more were frustrated with the dominant employment-based insurance model. In particular, public trust in private health insurance companies had eroded because of ethically questionable actuarial practices designed to maximize profits. People with serious pre-existing medical conditions such as cancer, diabetes, or any of a long list of other maladies that required costly treatments could be denied insurance coverage. Similarly, insurance companies imposed lifetime limits for

[15] In actuarial insurance practice, the more a given group in a health insurance pool uses health services, the more its premiums will increase (Enthoven and Fuchs 2006)

coverage of specific conditions; thus, patients sometimes found themselves without coverage in the midst of expensive chemotherapy, kidney dialysis, or other treatments, endangering their lives if they could not afford continued care out-of-pocket. Public and individual health spending was also increasing (Carter and Laplant 1997; Gauthier et al. 1995; Mechanic 1998; Skocpol 1996).

Keeping a 1992 election campaign promise, President Clinton set out to reform the health care system in his first term. He enlisted his wife, First Lady Hillary Clinton, to lead the charge both in the effort to persuade Congress and to win the hearts and minds of the broader American public. This initiative was the federal Health Security Act (HSA), which its opponents pejoratively labeled "Hillarycare." An ambitious reform project on which President Clinton spent tremendous political capital, the HSA set an acrimonious tone for the health reform debates that followed. It also largely introduced—and, perhaps more importantly, delineated—the range of health policy proposals on the 21st century policy agenda. In the simplest terms, the 1994 HSA would have transitioned all working age, non-disabled adults into the same employment-based, mandatory private health insurance system, with means-tested government subsidies. Medicare would have persisted as a socialized insurance system for retired and severely disabled Americans, and the VHA would have remained as a socialized medicine system for veterans, but America would have come much closer to a universal, mandatory insurance system (Beresford 1994; Budetti 2004; Hacker 1997a, b; Mariner 1994; Skocpol 1996).

While it did not challenge the neoliberal health and social policy narrative and aimed to preserve the private health insurance market, the 1994 HSA was somewhat more progressive and ambitious, both in its narrative and in its policy objectives, than

plans that ensued in the 2000s. First, the HSA would have expanded insurance coverage to nearly 40 million uninsured Americans. It would have accomplished this through the combination of an individual mandate to purchase health insurance (a determined minimum of coverage), an employer mandate to offer health coverage, and subsidies from both employers and government to help the poor purchase insurance. This strategy aimed for near-universal coverage with stricter insurance mandates and broader subsidies than the reform proposals that followed in the 2000s (Beresford 1994; Budetti 2004; Hacker 1997a; Mariner 1994; Skocpol 1996).

Second, the HSA aimed to control rising federal health care expenditures by managing competition[16] and placing new limits on health insurance premiums and insurance company practices. The HSA sought to expand consumer protection from unreasonable insurance claim denials through increased federal and state regulation, creating a government review process for rejected insurance claim appeals, and imposing fines for insurance company abuses. This aspect of the legislation was ideologically significant, demonstrating a moderate interventionist narrative, because it implied that the market could fail and required regulation—a notion that had become controversial in post-Reagan America. Thus, the HSA cast doubt on market fundamentalism in the health sphere, pursuing more government oversight over actuarial decisions within the health insurance industry—more so than any other federal or state reform until the equally ill-

[16] "Managed competition" or "managed care" definitions have evolved over time and may vary between public and private health care systems. Perhaps one of the more straightforward definitions remains: "a system of health care delivery that tries to manage the cost of health care, the quality of health care, and access to that care" (Halverson et al 1998: 14). Managed care health care systems are diverse, yet all assume some role for government regulation in the health sector (Vann 2014).

fated Vermont Health Reform in 2011 (Beresford 1994; Budetti 2004; Hacker 1997a; Johnson and Broder 1996; Mariner 1994; Skocpol 1996).

Third, the HSA would have eliminated Medicaid. In its place, it proposed insuring Medicaid beneficiaries through the same system as everyone else—a combined individual mandate with means-tested public and employer subsidies. This aspect of the HSA was ambitious because moving Medicaid prescribers under the umbrella of mandatory, subsidized private insurance would have brought the country even closer to the archetype of a universal, mandatory-insurance model than Romneycare in Massachusetts or Obamacare nationally later accomplished (Beresford 1994; Budetti 2004; Hacker 1997a; Johnson and Broder 1996; Mariner 1994; Skocpol 1996).

2.7 The Policy Failure of the 1994 HSA and the Inevitable Resurgence of its Debates

Literature on policy success and failure is useful in interpreting the fate of the HSA as well as the rhetorical and narratological uses of the legislation in subsequent health reform debates. Descriptions of policies as either successes or failures are often matters of biased political framing; thus, the same reform effort may be described as successful by one political actor and derided as a failure by another (McConnell 2010). McConnell suggests that, despite this inevitable partisan framing, there is a way to objectively characterize a policy as a failure. McConnell offers the following succinct definition: "a policy fails if it does not achieve the goals that proponents set out to achieve and opposition is great and/or support is virtually non-existent" (McConnell 2010: 356-357). Elaborating on this definition, McConnell (2010) writes that a policy may be judged to be a political failure if (1) it damages the electoral prospects of leaders or a political party without counter-veiling benefit, (2) it damages the ability of elected

officials to govern, (3) it undermines the values and preferred policy agenda of a government, and (4) opposition is "virtually universal" while support is "virtually non-existent." In keeping with the variables of the McConnell (2010) definition, the Clinton Administration's 1994 HSA was a clear policy failure. Skocpol (1996) explains that the HSA debates greatly weakened the Democratic Congress, leading to the so-called "Republican Revolution" and the election of the 104th U.S. Congress—arguably the most conservative Congress since the 1950s. It forced President Clinton to shift his legislative agenda to the right in order to protect his own electoral chances. The monumental failure of the 1994 HSA left Democrats defensive and reticent about health care reform in the face of rabidly emboldened anti-statist Republicans (Skocpol 1996).

Despite the potential of the reform to address the uninsurance crisis and control spending, final Congressional deliberations failed to pass the legislation in August 1994, ending the reform effort and marking yet another failed attempt to establish a health care system that would have achieved near-universal coverage. Extensive policy literature on American health care reform has cited a variety of causes to explain policy failures from Truman to Clinton. For example, political culture theorists have lamented the doggedly individualistic American political culture that illogically resists sensible welfare and health reforms (Jacobs 1993 a, b; Rimlinger 1971). Pluralist scholars have, for their part, favoured interest group explanations, citing the influence of groups such as the AMA and the insurance and pharmaceutical industries (Alford 1975; Poen 1979). While political-cultural explanations have a romantic appeal for their broad-brush approach, embracing such static and all-encompassing theories can encourage political defeatism—the belief that comprehensive health care reform to achieve universal coverage will never happen in

America due to the insurmountable barrier of the individualistic, anti-statist political culture. Similarly, while a pluralist emphasis on interest groups is valuable in elucidating the role of political actors in specific reform outcomes, the strongest explanations of the HSA failure are those that blend an emphasis on institutional and narratological factors.

Writing on the HSA outcome from a historical institutionalist perspective, Steinmo and Watts (1995) emphasize the role of institutions in delineating interests. They point out that institutional structures in large part determine the power of political actors, shaping both public and elite perceptions of the politically possible and the socially good. In the American institutional context, even powerful actors such as presidents are more limited than their executive counterparts elsewhere to force passage of their policy agendas. As such, Clinton faced the same kind of institutional limitations that caused Truman to fail in his health reform effort, and obliged Presidents Roosevelt and Johnson to limit their social and health reform visions. In Clinton's particular case, the unique American "fragmentation of political power" facilitated the task of Congressional Republicans, the AMA, and powerful insurance and pharmaceutical lobbies. Thus, it was not simply the case that Clinton faced even more political factions than his predecessors, and a "medical/industrial/ and insurance complex" that was more economically powerful than it had ever been before (the pluralist, interest-based explanations). More importantly, the institutional requirements of reform were nearly insurmountable since Clinton needed 60% of legislators to stay united while his opponents could lobby them strategically, undermining his support one legislator at a time. In this respect, the system is designed effectively to undermine progressive social reform agendas, since legislators have become increasingly independent "policy entrepreneurs" and presidents have

comparatively few tools to impose party discipline even in cases of Congressional majorities (Steinmo and Watts 1995).

In addition to these unique American institutional barriers to health reform, Steinmo and Watts (1995) importantly point out that Clinton faced a more complicated media environment than earlier health reformers—a media that had become more market-oriented, and more prone to unquestioningly accept and perpetuate deceptive representations that increase ratings and readership. Steinmo and Watts go as far as calling the changes in the American media environment "the most important change in modern politics" (Steinmo and Watts 1995: 364). As such, the HSA reform period marked a critical juncture in the representations of American health reforms in the media, a new paradigm that remained in place by the time of the Massachusetts and Utah reforms in the first decade of the 21st century.

The HSA failed notwithstanding the Clintons' attempt in media representations to portray their proposal as moderate, emphasizing such conservative principles as entrepreneurialism, individual choice and responsibility, security, and quality tiers in their health reform narrative. Indeed, Skocpol (1996) and others have argued that, far from aiding their cause, the Clintons' emphasis on conservative values—although intended to appease the political right—actually detracted from the message that America was facing a health care crisis that needed immediate attention (Annas 1995; Huebner et al. 1997; Johnson and Broder 1996; Skocpol 1996). Similarly, Vicente Navarro and other critical health policy scholars blamed class relations in the United States for what they saw as the Clintons' misguided decision to appeal to the political right with a centrist proposal, one that took progressives for granted. Instead, Navarro (1995) argued, Clinton should have

begun with a radical, single-payer proposal that could have inspired progressives in the working and middle classes. Knowing that a right-leaning Congress would have watered down the proposal and passed something similar to the HSA anyway, and keeping in mind the interest groups that were known to be aligned against reform in the early 1990s, it did not serve the Clintons to be conciliatory (Kemper and Novak 1992; Navarro 1994; 1995).

Beyond the institutional challenges that the Clinton Administration faced, the HSA story was a sadly avoidable case of legislative failure due to deficient priming, incorrect issue framing, and insufficient narrative control in both the media and Congress (Annas 1995; Johnson and Broder 1996; Huebner et al. 1997; Rhee 1997; West et al. 1996). The Clintons were ultimately out-manoeuvred in their effort, both in Congress by the Republicans and in the court of public opinion, thanks in part to framing of the HSA in the media. Media coverage of the HSA largely failed to explain the possible benefits of the legislation to the public; furthermore, opponents effectively framed the coverage, rejecting the health care crisis narrative and decrying the plan as a big-government takeover (Johnson and Broder 1996; Scarlett 1994; Skocpol 1997; West et al. 1996). The best example of the takeover narrative and effective framing by the 1994 HSA's opponents is the now-infamous "Harry and Louise" commercials, which condemned the 1994 HSA as an assault on the employer-based health insurance plans that had become a symbol of middle-class attainment, and other advertisements that the insurance industry generously helped to finance in mainstream media (West et al. 1996).

The Harry and Louise commercials, depicting conversations between two "normal" Americans—white, middle class, etc.—remain engrained in the minds of

Americans who are old enough to remember the 1993-1994 reform debates. These commercials appealed to middle-class and affluent voters, creating fear that "Hillarycare" would cause them to lose their high-quality insurance and force them into a substandard, government-managed plan. The take away message was "They [the government] choose, we [people with high quality, private health insurance] lose." The Health Insurance Association of America paid for the advertisements, which aired on national networks, under the guise of a so-called coalition that the insurance industry created itself, the "Coalition for Health Insurance Choices" (Holmberg 1999; Scarlett 1994; West et al. 1996).

Media strategies to undermine health reform efforts, such as the insurance industry's "Harry and Louise" campaign designed to denigrate the HSA, are of course not unique to the American context. Conservative proponents of market-oriented health and social policies have evoked so-called average citizens' interests to support privatization of health services elsewhere. For instance, in Canada, former Alberta Premier Ralph Klein regularly made reference to the alleged preferences and interests of "Martha and Henry"—two mythical, and supposedly typical small town Albertans—to advance neoliberal social and health policies that arguably harmed low-income people (Black and Stanford 2005). However, understanding the true impact of health care media representations requires attention to particular national and regional contexts in terms of interest networks and (especially) institutions.

Returning to the Canadian example for comparison, in Alberta, interest groups such as Friends of Medicare and organized labour that opposed Klein's drive to expand private, for-profit health care services were able to collaborate with the federal Liberal

government, in the institutional context of the Canada Health Act (CHA), to force the provincial Progressive Conservative government to regulate private health service delivery (Church and Smith 2009; 2013). In contrast, in the United States, interest group networks such as the much larger and more economically influential American "medical/industrial/insurance complex" were able to use the institutional context to their advantage to out-manoeuvre the Clinton Administration and proponents of health care reform (Steinmo and Watts 1995). Therefore, regardless of whether a particular health care narrative is the preference of progressive or conservative interest groups or politicians, the relative efficacy of media representations in reform campaigns depends in large part on the institutional arrangements in which they are debated.

Yet, even the most ardent proponents of institutionalist explanations for health reform outcomes acknowledge the increasingly pivotal role of media representations since the HSA policy failure (Steinmo and Watts 1995). Thus, while effective media representations of health care designed to progressively expand the policy window alone may not be adequate to achieve successful future health reforms in adverse institutional environments, advocates and politicians who hope to reform the health care system should give careful attention to media representations. While aspiring health care reformers cannot choose the institutional environments that serve as the battlegrounds for health reform campaigns, and they cannot fully control the actions of other political actors who may become either adversaries or allies in reform efforts, they can at least aim to strategically deploy and adapt their own media representations of health care.

Following the HSA failure, the unresolved dual crises of rising uninsurance and increasing public health spending remained for future federal and state governments to

fix. Fearing health policy as a political minefield, no state or federal politician attempted truly comprehensive health reform until 2002, when Massachusetts Democrats and a reluctant, opportunistic Republican Governor built on earlier state health reform efforts of the Dukkakis Administration and collaborated to tackle health care reform. However, the Clinton Administration left two important marks on the American Health care system through the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and through the creation of the State Children's Health Insurance Program (CHIP) in 1997.

2.8 HIPPA (1996) and the State Children's Health Insurance Program (CHIP) (1997)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was the most significant federal action in the private health insurance regulation debates since McCarren-Ferguson in 1945. HIPAA created new protections for private medical information and imposed fines for privacy violations. The legislation established new minimum guidelines for pre-taxed health savings accounts (HSAs), private group health insurance plans, and life insurance plans that some companies offer exclusively to their employees. It created national minimum standards for electronic medical records, in response to technological changes and the popular view that such records would create substantial savings in the health care sector. It created new restrictions on so-called pre-existing condition exclusions, and established mechanisms for consumers to retain their individual or family insurance coverage when they become unemployed involuntarily, or when they voluntarily leave employment search for another job or to start a business (Atchinson and Fox 1997; Eddy 2000; Nichols and Blumberg 1998).

The other key contribution of the Clinton administration to health care reform was the State Children's Health Insurance Program (S-CHIP, or CHIP), which was created in

1997 with Democratic and Republican support through the Balanced Budget Act (BBA) of 1997. [17] Like Medicaid, the means-tested program was financed jointly through federal and state governments. CHIP was designed to reduce uninsurance among American children whose families could not afford to purchase private health insurance, but who did not have sufficiently low incomes to qualify for Medicaid (Mann et al. 2003; Rudowitz et al. 2014; Paradise 2014). While CHIP faced an uncertain future in 2008, when President Bush vetoed reauthorization of the program, Congress re-authorized CHIP funding in 2009, and again in 2010 as part of President Obama's Patient Protection and Affordable Care Act.

If CHIP is judged based solely on the overarching goal of reducing uninsurance among American children, then the program succeeded. In 2012, fifteen years after its passage, CHIP participation had lowered the overall percentage of uninsured children from 14% to 7% (Rudowitz et al. 2014). While CHIP covers far fewer children than Medicaid—5.7 million CHIP enrolees as opposed to 28 million for Medicaid in 2013[18]—the two programs together constitute a central part of the American health care system, insuring approximately one-third of American children (Mann et al. 2003; Rudowitz et al. 2014; Paradise 2014, 2015).

President Clinton signed CHIP into law in 1997, and it is frequently cited as a major milestone in the historical expansion of public health care in the United States (Connors and Gostin 2010). Nonetheless, the accomplishment of CHIP was a meagre consolation prize in comparison to the ambitious, yet ill-fated 1994 Health Security Act.

[17] Senator Ted Kennedy of Massachusetts was the CHIP program's most prominent public advocate. The program was originally called the State Children's Health Insurance Program (SCHIP). The 'S' was eventually dropped.

[18] According to the Kaiser Family Foundation (Smith et al. 2013)

While CHIP was the last progressive, federal health reform victory before Obamacare in 2010, the failure of the 1994 HSA overshadowed it in the 1990s, reminding politicians of the perils of comprehensive health reform and dissuading new federal efforts. The reticence of politicians to pursue health reforms that are perceived to be politically risky has been noted in prior health policy literature in both American and Canadian cases (Lazar et al. 2013: 209; Skocpol 1996). While the reverberating political reticence following a health policy failure is not unique, without any successful wide-ranging federal reform in the 1990s, the number of Americans covered through employment-based health insurance continued to decline and public pressure for government action increased (Enthoven and Fuchs 2006). Before long, federal inaction spurred some states to tackle the health care crisis independently, adopting a variety of different approaches and paces to reform.

2.9 State Governments Respond to Shortcomings in the Employment-based Insurance System, 1990s - present

By the early 1990s, as the ranks of the excluded uninsured continued to swell, the shortcomings of the employment-based insurance model became apparent far beyond the halls of power in Washington DC. Both the employers and the employees who relied upon the system began to demand policy solutions in state capitols. States introduced thousands of pieces of legislation with the aim of expanding insurance coverage, deregulating or re-regulating the insurance industry (Kail et al. 2009). While most state efforts failed, a few succeeded in implementing minor reforms. Massachusetts and Utah stand out as notable legislative successes, and in representing themselves as models of comprehensive health reform for the country to follow.

Following the 2002 Massachusetts state election, building from a series of more modest health care reforms in the 1980s and 1990s, Republican Governor Mitt Romney and a determined General Court (state legislature) under Democratic control began cooperation to make Massachusetts the first state to achieve comprehensive health reform since the failure of the federal HSA. State lawmakers succeeded in passing the Massachusetts Health Reform Law (MHRL) of 2006, which later became the primary model for Obamacare to emulate federally (Burdett 2013; Gurley 2013). On the political right in the same period, between 2004 and 2008, Utah's Governor Jon Huntsman established a team of experts to study health reform options for his state, examining the reform in Massachusetts for inspiration. The work of Governor Huntsman and his Republican supporters in the Utah State Legislature successfully culminated in the series of laws between 2008 and 2011 that comprised the Utah Health System Reform (UHSR). The UHSR and Romneycare are therefore pivotal, overlapping parts of the Obamacare story.

2.10 Romneycare (2002-2006): Mitt Romney Remakes healthcare in Massachusetts (sort of…)

Prior to the passage of the Massachusetts Health Reform Law (Romneycare) in 2006, Massachusetts already had a long history of trailblazing health and social reforms ahead of the federal or other state governments. Governor Michael Dukakis's 1988 "Health Care for All Act " (HCAA) was the most recent major state health reform before Romneycare—a reform of which many provisions were still in place in 2006, and which had already set the direction for health reform in Massachusetts (Chen and Weir 2009; McDonough et al. 2006). In addition to partially following the course that the earlier Dukakis Administration had previously charted, Governor Romney and the Democratic

reformers in the Massachusetts General Court learned valuable lessons from the failure of the Clintons at the federal level to control media messaging on the Health Security Act. They kept a consistent reform message in the media, and countered their detractors with health reform narratives and frames that balanced optimism with urgency. Coverage in the major Massachusetts newspapers remained mostly positive between the 2002 election and 2006 when the reform passed. In terms of reform priorities and approach, much has already been written about the similarities between Romneycare, the 1994 HSA, and Obamacare, but it is nonetheless useful to summarize the Massachusetts reform here.

The Massachusetts Health Reform Law of 2006 (MHRL, Romneycare)[19] was more substantial than any health care reform achieved at the state level previously.[20] Taking inspiration from the 1994 HSA, it combined an individual mandate to purchase health insurance with a requirement for larger employers to offer insurance coverage as central features. Interestingly, the idea for individual health insurance mandates—a reform concept that became the target of bitter ire from conservatives during the Obamacare debates after 2008—had originated with the conservative Heritage Foundation in the 1990s. Prominent conservatives such as Newt Ginrich supported the idea as part of an alternative to the 1994 HSA. The individual mandate idea sat in political limbo after the failure of the HSA, until Romney and Massachusetts state Democrats resurrected it and successfully implemented it in their reform (Roy 2011).

[19] The full name is *An Act Providing Access to Affordable, Quality, Accountable Health Care*

[20] Until 2011, when the Vermont Health Reform Law surpassed Romneycare in both ambition and scope, Romneycare had been the most ambitious legislative success at the state level. Of course, Romneycare remained in place after the Vermont attempt at single-payer was scrapped in late 2016, and thus it stood out as the most progressive state-level health care reform within the realms of political possibility and legislative success.

Thus, between the time of the HSA and Obamacare, the insurance mandate evolved from a conservative idea that the left opposed, to a progressive idea that incited angry Tea Party demonstrations.

Unlike the 1994 HSA, Romneycare expanded state Medicaid outlays, increasing coverage for the indigent through socialized insurance. Romneycare included a substantial expansion and reorganization of the state bureaucracy to implement and oversee the reforms, including the creation of the "Commonwealth Connector" as a new state agency (primarily to manage the state's online health exchange, where individual health consumers could compare and purchase insurance plans). It further introduced a means-tested state subsidy to help low-income residents (those not poor enough for Medicaid) purchase private health insurance. Advocates expected the 2006 MHRL to decrease state health expenditures by reducing the financial losses incurred by hospitals that treat uninsured patients (Haislmaier 2006; McDonough et al. 2006).

The 2006 MHRL significantly expanded health insurance coverage, but failed to control costs or implement new quality controls in the state health system (Archer 2009; Long et al. 2012). Nonetheless, academic research immediately recognized the significance of the reform and suggested that it could serve as an example for the rest of the country (Haislmaier 2006; Holahan and Blumberg 2006). It resembled the 1994 HSA in both policy objectives and ideological foundations, but the state had to work within the existing federal Medicare and Medicaid program structures and lacked any equivalent to federal cost control powers (Haislmaier 2006; Holahan and Blumberg 2006). It nonetheless served as inspiration for the federal Patient Protection and Affordable Care Act that passed in 2010, and (at least at the outset) for the Utah Health System Reform.

2.11 The American Right Attempts to Forge an Alternative Path: The Utah Heath System Reform (2004-2011)

Beginning in 2004, the Utah Health System Reform (UHSR) spanned eight years of debate and included seven pieces of legislation—HB 133, HB 188, HB 331, HB 165, SB 79, HB 294, and HB 128—that the Utah Legislature passed between 2008 and 2011. In the early years of conceptualizing the reform, after the 2004 election, Utah's Governor, Jon Huntsman, a handful of leading legislators, and key advisors to the governor drew inspiration from Romneycare. Over time, through a series of compromises, the reform shed its strongest regulatory and social assistance aspects, eventually being represented (both by Utah politicians and by the newspaper media) as a reform model that could serve as an alternative to Obamacare or Romneycare (*Economist* 2012; Summerhays 2008; Thurston 2011; United Way 2006).

The UHSR took a much more incremental and market-oriented approach to health reform than Massachusetts took in the MHRL, one that emphasized the defined-contribution insurance model[21] and tort reform to reduce court awards in medical malpractice (Economist 2012; Summerhays 2008; Thurston 2011; United Way 2006). The dominant narrative of the UHSR held that competition in an open market could meet the health care needs of Utahns and reduce state health expenditures without government insurance mandates, new subsidies to help low-income people, expansion of public programs, or a stricter regulatory environment for insurance companies (*Economist* 2012;

[21] Under defined contribution systems, employers offer pre-determined financial contributions that individual consumers use to purchase private health insurance plans through the state health exchange. Individual consumers choose their insurance company and benefits packages and may change health insurance plans without the approval of their employers (a feature that is not often possible in the traditional employer-based, defined benefit private insurance system). The insurance plans are "portable" between jobs, since they are attached to the consumer instead of the job, and consumers can use pre-taxed health savings accounts (HSAs) to help pay for them (Utah, Avenue H, May, July, September 2011).

Thurston 2011; Utah 2008, 2010). If Obamacare can be understood as a reform in which the insurance industry compromised with government and gained much of what it wanted in the process, the UHSR can be seen as a health system reform that was designed with the interests of the insurance industry in mind, and, at least in part, one that the insurance industry designed for itself.

Ultimately, despite the legislative success that in part justifies my analysis of the case, Utah's effort to achieve a market-oriented health reform can be judged as a failure. While its Avenue H health exchange continues to operate for small businesses (alongside the federal insurance exchange for individual consumers), Utah struggled to increase consumer participation or control the prices on its exchange. Its uninsurance rate did not significantly decline until the provisions of Obamacare took effect between 2011 and 2014. In fact, recent media reports have shown that far more Utahns gained insurance coverage through the federal Obamacare provisions, and many were attached to keeping the federal law in place despite their state government's opposition to it (Goodnough 2017). Thus, without expanded public programs, insurance mandates, subsidies to low-income Utahns, or new insurance regulations, Utah demonstrated that comprehensive health care reform would have probably remained elusive.

2.12 Other noteworthy comprehensive state health reform efforts in the early 2000s

Utah and Massachusetts were not alone in implementing such state-level health reform efforts. Most recently, Colorado voters held a referendum to create a state-level single-payer insurance system, "ColoradoCare," in November 2016 (Japsen 2016; Young 2016). Notably, in the same decade as the legislatively successful reforms in

Massachusetts and Utah, social movements in Oregon (2002)[22] and Vermont (2010-2012)[23] received media attention for pressuring their state governments to take on single-

[22] Oregon's Health Care for All Movement opted for a state-wide referendum in 2002. While urban Oregonians in Portland and Eugene overwhelming supported Oregon Ballot Measure 23 on November 5, 2002, which would have created a state-level single-payer health care system, it was defeated by a substantial margin, 969,537 "No" votes to 265,310 "Yes" votes. With the backing of the private health insurance industry, opponents of Ballot Measure 23 outspent proponents on a margin of 40/1 in political advertising (Hoffman 2003; Oregon Secretary of State 2016).

[23] In 2011, the state of Vermont passed an *Act Relating to a Universal and Unified Health System* (Vermont Health Reform, VHR, Green Mountain Care). The VHR sought to both dramatically expand insurance coverage and reduce state health expenditures. It was the first state health legislation that not only sought to expand health insurance coverage to more people; instead, it explicitly aimed for universal coverage of state residents. The VHR was also unique in the sense that it was the first legislation since the 1993 federal HSA to emphasize the problem of market failure in health care, focusing more on regulation than the MHRL, UHSR, or the ACA. The VHR was the first major state-level reform designed with the federal ACA in mind, seeking to fill perceived gaps in the ACA to ensure that all Vermonters would obtain health insurance coverage.

Vermont's Act 202 created Green Mountain Care—Vermont's health care exchange—and set the objective of insuring all Vermonters by 2017. It formed a commission that was composed of economists, health policy academics, high-level civil servants, project analysts, and project managers to evaluate three options to achieve the goal of full coverage for state residents: (1) a government-managed single-payer health system, (2) a government-managed public insurance option to compete with private insurance companies, and (3) an alternative plan developed by the commission. Act 128 outlined the commission's recommendations and offered the health system design.

The commission ultimately recommended a third option: a public-private single-payer system. In concise terms, the VHR aimed to create a single insurance fund with a standard benefits package, leaving Medicare and Medicaid benefits intact and administering all claims through the same process to reduce costs. Employer and employee payroll deductions were envisioned to finance the plan, exempting workers in the lowest tax brackets. In order to reduce costs, the VHR would have transitioned all medical records to electronic files. The commission further suggested becoming a "no fault" state with regard to medical malpractice law; thus, tort reform was a unifying element of the VHR and the UHSR.

The VHR created an independent oversight Board, which was composed of civil servants and representatives from employer and employee organizations. The Board was responsible for determining annual benefits and payment rates. According to the VHR plan, the Board would have contracted out the claims administration process to a private insurance company through a competitive bidding process, but it would have retained final authority on insurance claim appeals. Provisions of the federal Affordable Care Act (Obamacare) prevented the VHR from going into effect before 2017, but the state of Vermont applied for a waiver to circumvent Medicaid and Medicare restrictions in order to implement VHR by 2015 (Hsiao et al. 2011; Hsiao 2011; Vermont 1992, 1997, 2006, 2007, 2008, 2009, 2010, 2011, 2015; Wilson 2014, Worthen 2014; Woolhandler and Himmelstein 2015).

However, Vermont's attempt to set a different course from the 1994 HSA-Romneycare-Obamacare line of reforms ultimately failed. In late 2014, Vermont aborted its single-payer reform effort. The state's Democratic Governor, Peter Schumlin, cited economic reasons for

payer health reform. Like Massachusetts, Colorado, Vermont and Oregon had both state-level social movements for health care reform and progressive state politicians who wanted to fill the gap left by perceived federal inaction in the health sphere. A series of increasingly ambitious Vermont legislation in the late 1990s and 2000s indicated that the state was inching towards its own comprehensive health system reform. Oregon's *Health Care for All* movement garnered national media attention as a well-organized grassroots campaign to establish a state-level single-payer health care system. In Colorado, progressive Democratic health reform advocates enlisted the help of Senator Bernie Sanders and popular filmmaker Michael Moore to support their campaign. While the Oregon, Colorado, and Vermont reform movement approaches were different, all three promised to be radical departures from the existing American health care system, departures that were intended to culminate in the creation of state-level, single-payer health care systems that would achieve universal health insurance coverage. Unfortunately for the Colorado, Vermont, and Oregon reform proponents, unlike their counterparts in Massachusetts and Utah, these efforts ended in crushing political defeats (Hoffman 2003; Hsiao et al. 2011; Hsiao 2011; Japsen 2016; Vermont 1992, 1997, 2006, 2007, 2008, 2009, 2010, 2011, 2015; Wilson 2014, Worthen 2014; Woolhandler and Himmelstein 2015; Young 2016).

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abandoning the plan, arguing that the income and business tax revenues necessary to finance the reform (higher than had been forecasted in 2011) would not have been acceptable burdens to impose on the state. The Vermont case demonstrates the difficulty that a small sub-national government faces in an effort to implement a more ambitious alternative reform than one that is already underway nationally. Yet, despite Vermont's renunciation of single-payer, the reform effort was noteworthy for keeping the single-payer reform option alive in the media as a progressive alternative to Obamacare, in the same sense that the conservative alternative to Obamacare that the Utah Health System Reform offered (McArdle 2014; Wilson 2014; Worthen 2014; Woolhandler and Himmelstein 2015).

In many respects—rising uninsurance rates, increasing public and private expenditures, and a political climate of federal inaction—the flurry of state-level reforms in the 1990s and 2000s were predictable. Focusing on the role of interests and institutions, policy literature on state health care reforms has nonetheless emphasized that most state reform efforts are doomed to fail due to the greater influence of the insurance industry at the state level, and the more limited regulatory power of states and the ability of insurance companies to move to less regulated markets within the federal system (Kail et al. 2009). Since most state health reform efforts fail, and even the legislatively successful efforts such as those of Utah and Massachusetts have experienced differing degrees of success in expanding insurance coverage, it is not surprising that dissatisfaction among both workers and employers continued to pressure American federal politicians of all stripes to take action. Despite state-level health reform efforts, by the 2008 election campaign period, federal politicians had to promise action on health care.

2.13 The Leap to Obamacare (2008-2010)

By 2007, the year before the federal Obamacare debates began, the Employee Benefits Research Institute (EBRI) reported that the employment-based system was approaching a "tipping point," in which the decision of a single major American employer to discontinue its contribution to health insurance coverage for its employees would risk igniting an exodus of businesses from the system and undermine the employment-based insurance model. Both the business community and American workers saw the need for systemic reform (Fronstin 2011; Helman and Fronstin, 2007).[24]

[24] EBRI's 2007 reports are based on 2006 U.S. Census data.

According to EBRI, while the employment-based health insurance model remained the dominant mode of provision in the health care system, covering 62.2% of Americans under age 65, this percentage had declined (continuously, albeit slowly) since 2000, inciting warranted fears about the sustainability of the model (Fronstin 2011; Helman and Fronstin, 2007).[25]

The 2010 Patient Protection and Affordable Care Act (ACA, Obamacare) was the most substantial national health reform since Medicare in 1965. Ideologically, however, Obamacare was not a descendant of Medicare or the activist politics of the 1960s, and was even less a child of President Roosevelt's New Deal. Obamacare and Medicare emerged in very different times and political contexts, diverging in their goals and in their philosophical underpinnings. Like President Johnson's other broad and ambitious Great Society reforms, Medicare depended on nearly ideal political conditions—circumstances that President Obama did not enjoy in 2008.

In essence, Obamacare was a far more modest reform than Medicare that developed at a time when the political and social ingredients necessary for more sweeping change were not in place. Between Medicare in 1965 and President Clinton's failed Health Security Act (HSA) in the early 1990s, the centre of political gravity had shifted to the right, to a neoliberal status quo. In his much discussed book on identity

[25] Prior research on both the United States and other OECD countries has unveiled the inadequacy of private insurance in market-based health care systems to achieve universal coverage (Wouters and McKee 2016). One of the great challenges of the American system is that, due to overreliance on private health insurance in a market system, whenever the economy slows and wages stagnate, rates of uninsurance increase in relation to flat or declining wages (Gilmer and Kronick 2001). The uninsured are less likely to seek medical treatment in a timely manner and do not have access to the same quality of health care for long-term illnesses, which is ultimately more costly for the system (Feder et al. 2001). Thus, the combination of economic turbulence and high-levels of privatization in health care bring risks of poorer population health.

politics and technology, *Bowling Alone,* Robert Putnam persuasively argues that, in the latter part of the 20th century, due to isolating technological advances and other factors, Americans' sense of social interconnectedness and responsibility towards the common good declined. For Putnam, the rise of individualism negatively impacted both public health and happiness, transforming America—albeit not irreversibly—for the worse (Putnam 2000). Similarly, after the Clinton reform effort collapsed in 1994, Theda Skocpol affirmed that the societal and political changes of the Reagan era had fundamentally changed America in ways that liberal health reformers underestimated. Obstructionist "states' rights" narratives and general hostility to government intervention in any form pervaded anti-health reform rhetoric in the early 1990s (Skocpol 1996). According to Putnam's and Skocpol's theses, the America of the 1994 HSA and Obamacare period (1993-2016) was a less cohesive and less empathetic place (at least as far as policies affecting the white middle classes are concerned) than it had been at the time of Medicare, thus making health or social policy reform more difficult.

Therefore, rather than thinking of Obamacare or the major state health reforms of Massachusetts and Utah that intersected with the federal reform debates as extensions of New Deal and Great Society social policy reforms, one may best understand the federal and state reforms of the 2000s as the culmination of health reform debates between Republicans and Democrats that began in the 1990s. These debates persisted in state-level politics after the 1994 HSA. Given both the failure of Clinton's health reform in the 1990s that left major systemic problems unresolved, and the 2006 bipartisan success in Massachusetts that reignited the old reform discussions, the Obamacare debates were a predictable development.

The Patient Protection and Affordable Care Act ultimately passed for three principal reasons. First, political pressure to fill the gaps persisted in the existing piecemeal system of employment-based health insurance, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Veterans Health Administration, which left nearly 47 million Americans uninsured by 2007—a number that had increased 5% since 2005 without any sign of abating (DeNavas-Walt et al. 2008). State governments were concerned about these gaps in the system and had begun to embark on their own reform efforts, which placed further pressure on the federal government to avoid appearing apathetic to an acknowledged problem. Second, per-capita health care spending was out of control. In 2005, the per-capita U.S. health spending rate of $6,401 was by far the highest in the OECD; yet, the complex and disjointed system only covered 26.2% of the population with various public programs, leaving the rest with variable coverage—that is, either being bound to employment-based insurance or remaining uninsured (Anderson and Frogner 2008). While rising uninsurance rates and health care costs were not new problems (they had been the main driving factors behind the Clinton Administration's ill-fated HSA more than two decades earlier), they were both worsening. Third, Obama had an adequate Democratic majority in Congress to pass the ACA without bipartisan Republican support, which helped to curtail some of the institutional and interest-based barriers that had undermined the Clinton Administration's HSA in 1994. Thus, the three primary driving forces behind Obamacare—rising uninsurance perceived as a crisis, increasing public health expenditures perceived as a crisis, and a combination of commitment to health care reform in the executive (governor or president) and legislative (state legislature or Congress) branches with an adequate

legislative majority that did not require bipartisan cooperation[26]—were the same as the motivating factors for state reforms in Massachusetts and Utah (Haislmaier 2006; McDonough et al. 2006). Beyond legislative success, uninsurance and cost concerns are clearly apparent in most of the media narratives of health care examined in this dissertation.

It is important to note that Obamacare narrowly survived attacks from Congressional Republicans, conservative state governments, and Republican-aligned business associations. Chapters 6 and 7 outline some of the State of Utah's efforts, in coalition with other Republican-leaning states, to prevent the implementation of Obamacare through court challenges. The broad opposition efforts culminated in the United States Supreme Court decision in *National Federation of Independent Business v. Sebelius* in 2012. The Supreme Court determined that Obamacare was an unconstitutional Congressional intrusion into the regulation of interstate commerce. This was significant with regard to the role of American federalism in health care reform efforts, since the court affirmed that, under the Spending Clause, the federal government could not threaten to terminate a state's Medicaid grants in order to pressure the state to accept the proposed Medicaid expansion under Obamacare. However, the *Sebelius* case narrowly saved Obamacare in a five-four decision that upheld the individual mandate to purchase health insurance on the basis of Congressional taxation powers (Law 2012; Reynolds et al. 2012).

[26] This is true despite the myth of bipartisanship in the successful passage of Romneycare, as I show in Chapters 4 and 5.

2.14 How Obamacare works

Unlike Medicare, which treated health insurance as a right of citizenship for the elderly (essentially guaranteeing access to care), and despite some of its inspirational rhetoric, no equal access narrative or notion of health care as a social right buttressed Obamacare. Instead, like the 1994 HSA and Romneycare before it, Obamacare sought to save the for-profit health care system from itself. In the face of skyrocketing health care costs, public dissatisfaction with rising uninsurance rates, and outrage at insurance industry abuses, Obamacare allowed health care to continue to exist as a commodity through new regulations that curtailed unpopular insurance company practices, such as pre-existing condition exclusions and lifetime limits for specific medical conditions (Jacobs 2008; Skidmore 2011; Skocpol and Jacobs 2010; White 2010).

By forcing insurance companies to behave more ethically, Obamacare alleviated public anger about insurance practices and helped ensure the survival of "Big Insurance." It borrowed the idea of online health exchanges in which consumers shop for portable private health insurance plans (some of which are government subsidized), and the individual and employer insurance mandates from Romneycare, demonstrating policy diffusion from the state to the federal scale.[27] In addition, Obamacare increased investment in means-tested health care for the poor (Medicaid outlays), introduced new public subsidies to help the struggling middle classes purchase private health insurance on the new health exchanges, and imposed insurance mandates both on employers with 50 or more employees and on individual workers who could afford to purchase their own health insurance. All of these measures were inspired by elements of Romneycare.

[27] And, indirectly and nearly two decades later, Obamacare borrowed the insurance mandates concept from a prominent conservative think tank, the Heritage Foundation.

Finally, Obamacare levied tax penalties on middle income and wealthy Americans who refused to purchase private health insurance. Thus, while Obamacare may have negatively impacted insurance industry profits by forcing companies to insure and consistently cover the least healthy and previously uninsurable Americans, it nonetheless appeased the industry. Arguably, Obamacare even served insurance industry interests above those of Americans who may have benefited from a publicly financed system of universal coverage (either a socialized insurance or a socialized medicine system) by legally requiring millions of people to become reliable customers of private health insurance companies (Skidmore 2011; Skocpol and Jacobs 2010; White 2010).

2.15 The record and future of Obamacare

While Obamacare cost less than was initially predicted and has succeeded in drastically reducing rates of uninsurance, it has not been as effective as the Obama Administration had hoped in reducing private health care spending. In some states, policies on the health insurance exchanges are too costly, and have failed to attract consumers. Major health insurance companies claim that they have lost money on their policies through the health exchanges; this has incited some companies to abandon the exchanges, and has left only one or two participating insurers in nearly half of all states. The flight of participating insurers undermines the concept of market competition, which, in theory, should have made policies more affordable on the exchanges (Birn and Hellander 2016; Dawes 2016; Cohn 2016; Oberlander 2016). Due to these challenges, more reforms in the coming decades are likely.

Beyond the challenges with the health insurance exchanges, researchers on the critical left have framed a broader argument: Obamacare, they charge, is a form of

corporate welfare for the insurance and pharmaceutical industries. Mainstream health policy research and media reporting reinforces this charge. Chapman (2016) and Waitzkin and Hellander (2016) point out the fundamental problem that, consistent with neoliberal ideology, and contrary to the promotion of fairness and equity in health care, Obamacare maintains health care as a market, instead of treating it as a social right. It funnels public revenue into private industry in order to bolster that market. It maintains, and in fact concretizes, the national private sector monopolies of Managed Care Organizations (MCOs) and Accountable Care Organizations (ACOs), which, for the most part, are under the umbrella of a handful of multinational insurance companies. Collectively, these MCOs and ACOs control most hospital networks, and they employ over half of all physicians and other health care providers in the United States (Chapman 2016; Gold 2015; Oberlander 2016; Wagner 1996; Waitzkin and Hellander 2016).

Researchers on the critical left further charge that, in keeping with neoliberal ideological principles, under the guise of "consumer choice," Obamacare fosters inequity in health care delivery (Waitzkin and Hellander 2016). The differentiation between "bronze" (catastrophic insurance), "silver," "gold," and "platinum" (so-called "Cadillac" health insurance) plans on the health exchanges is perhaps the best example of this inherent inequity (BCBS of Michigan 2016). This variation preserves differences in the quality of medical care available to citizens based on their social class and their ability to pay higher premiums. Despite the controversy it has created, and the difficulty of passing Obamacare in Congress, the legislation still leaves nearly 27 million Americans uninsured or under-insured, with limited access to a variety of medical services (Diamond et al. 2016; Uberoi et al. 2016). This includes disproportionate numbers of poor and

visible minority Americans, especially for elective and preventative services that are important to overall population health (Flores and Lin 2013; Oberlander 2016). Thus, nearly one in ten Americans remains excluded and lives at risk of premature and medically unnecessary death; these are the losers in the neoliberal health care model (Diamond et al. 2016; Uberoi et al. 2016).

In light of all of its flaws, progressive health reform advocates may wonder whether Obamacare should be scrapped. After all, President Obama himself once declared that, if he were starting "from scratch," he would have implemented a single-payer social insurance system in lieu of the poorly interwoven American system of programs (Hensley 2008). Over time, as the wheels of politics and real world policy-making turned, Obama moderated his stance on single-payer. Like Romneycare before it, the final draft of the Affordable Care Act legislation was built upon a delicate and complex series of compromises (Dawes 2016; Holan 2009). However, in spite of Obamacare's shortcomings, it is worth remembering the harsher realities of the health care system before it was implemented. Following the demise of the HSA in 1994, and until Obamacare passed in 2010, 45,000 Americans were dying every year simply because they were uninsured and could not afford to pay for medical care out-of-pocket (Wilper et al. 2009).

Through Obamacare, 20 million Americans obtained health insurance coverage through the health care exchanges and Medicaid expansions (Uberoi et al. 2016). Of the 27 million who remain uninsured, nearly 12 million would qualify for Medicaid under the new ACA rules, but these individuals simply have not enrolled, or have had their potential enrolment blocked by Republican-led state governments that did not accept the

Medicaid expansion (Oberlander 2016). Furthermore, health insurance companies can no longer function as gatekeepers to access to medical care due to pre-existing condition exclusions or lifetime insurance limits (Bernstein 2015; Cohen 2016; Cohn 2016; Oberlander 2016; Uberoi et al. 2016).[28] These changes are important victories for Democrats.

While Obamacare is unquestionably imperfect, it has improved and probably extended the lives of millions of Americans. Keeping in mind the complex institutional arrangements that have historically favoured powerful interest groups and right-leaning politicians that opposed progressive reform efforts (Skocpol 1996; Steinmo and Watts 1995), advocates for justice in the health care system who still seek universal coverage could build from these victories in their media narratives, and work towards universal coverage through regulated mandatory insurance. If that incremental course is followed, the American health care system may eventually look more like the regulated mandatory insurance systems of the Netherlands or Germany than the kind of single-payer, Canadian-style social insurance, or single-payer British socialized medicine system for which many progressive Americans pine. There is more than one way to achieve universal coverage. While there is no guaranteed path to success for future health care reformers, achieving several key communications objectives—carefully constructing the reform narrative, priming the American public, and framing the issue effectively in the press—are likely to be elements essential to a successful campaign. To that end,

[28] However, it is worth noting that the profit motive still produces atrocities in actuarial decision-making (e.g., insurance company haggling with patients and physicians about the medical necessity of prescriptions and procedures in an effort to control their costs, and thus putting profit before peoples' health, which still remains perfectly legal, albeit arguably reprehensible from a moral standpoint).

reformers need to understand the most recent reform debates as they unfolded in the media.

Media coverage of the Obamacare debates from 2008 to 2012 advanced parallel to health reform efforts in Utah and made consistent mention of Romneycare in Massachusetts. While Obamacare can be understood as the last in a line of three health reform efforts built upon similar premises—preceded by the ill-fated federal HSA and the successful Romneycare—the Utah Health System Reform was linked to Obamacare, both temporally and through media framing, as its conservative alternative. The success of the Romneycare/Obamacare approach, progressively advancing towards a regulated-mandatory insurance model, stands in stark contrast to the failure of Utah to offer an allegedly purer, market-oriented alternative. The media representations of the Massachusetts and Utah reform debates are therefore essential chapters in the story of American health care reform.

2.16 The importance of elucidating media representations of the crucial Utah and Massachusetts health reforms

The predominantly federal focus of both mainstream and critical research on health care policy in the United States, and in particular in the field of media representation studies, leaves the neglected accounts of state reforms as a glaring gap in the analysis of American health reform. Massachusetts and Utah are very different states politically, economically, and demographically; yet both of them pursued major health system reforms—in the case of Utah, parallel to Obamacare—frequently cited in the media. Examining media representations of these two contemporary reforms shows the ways in which health reform narratives moved between seemingly incomparable states, and how the national advancement and eventual passage of Obamacare impacted these

state reform representations. Specifically, the analysis of media representations at critical junctures across time unveils the ways in which the absence, introduction, and implementation of a federal program impacted, delineated, and discursively reinforced some state initiatives while undermining others.

Prior to analysing media representations of health reform debates during the Massachusetts and Utah reforms, it will be instructive to summarize prevailing and critical literature on American health policy. The following chapter reviews further institutionalist research on health care reform, including historical institutionalist studies on the valuable concept of *critical junctures*. Moreover, Chapter 3 explores media effects and media framing literature, from which I have taken the key concept of *media hype*/*media waves*, for the state health reforms explored herein. Chapter 3 further surveys the literature in ideology and representation, and narrative policy analysis that theoretically underpins this research. Exploring these scholarly perspectives, I examine narrative and media frame analysis as an interpretive framework for exploring the latest series of interrelated state-level health reforms. Chapter 3 concludes with an outline of the critical content analysis method used in the case studies of each subsequent chapter. The Massachusetts Health Reform Law (Romneycare) case is explored in Chapter 4 and 5, followed by the Utah Health System Reform (UHSR) case in Chapters 6 and 7.

Chapter 3: Health care and storytelling: Narrative and media frame analysis as an interpretive framework for health reform debates

3.1: Introduction

My research explores newspaper media representations of the state health care reform debates in Massachusetts (2002-2006) and Utah (2004-2011), during periods when each state was experimenting with varieties of health care reform that aimed to expand access to health insurance and to reduce both public and private expenditures. Although media representations were predominantly neoliberal and favourable to the state reform—for example, in the sense that they framed health care as a market, rejected the notion of health care as a right, and did not advocate for universal access—authors also deployed a variety of challenging narratives to contest the reforms. Some challenging narratives emanated from the political left—social investment state narratives that favoured universal social insurance, socialized medicine, or more regulated mandatory insurance reforms, all with the goal of universal access. Other narratives of the political right had ideological roots in libertarian, anti-statist views that opposed any hint of market regulation or perceived infringement on individual rights in the health sphere. I pay particular attention to the impact of the federal context on these two health reform initiatives—first by the absence of a federal reform effort, then by the arrival of the Obamacare debates, and finally by the eventual implementation of the Patient Protection and Affordable Care Act in 2010.

At the outset of this study, it was essential to settle on a framework of interpretation and a methodological approach. Social science researchers embrace a variety of theoretical perspectives and employ diverse methodologies and methods in the study of health care, and there were many research prisms through which I could have

chosen to examine the Massachusetts and Utah health reforms. In focusing on the most recent legislatively successful state reforms that surrounded Obamacare, I set out to fill crucial gaps in the story of American health care reform that previous research in both institutionalist and critical approaches had largely ignored. Thus, I sought not only to address but also to analyse these important blind spots. A novel question, I decided, deserved a novel approach—one that accounted for the political-institutional context and critically examined the media representations of these health reform debates. My choice of health care reform as a research *subject,* however, emanated from personal experiences, and my interest in media narratives was fortuitous.

3.2 A personal narrative: Origins of my interest in the American health reform debates and the choice of a narratological analysis

The caption on René Magritte's famous 1929 painting of a pipe, *La Trahison des images* (The treachery of images), reads: *Ceci n'est pas une pipe* (this is not a pipe). With Magritte's three versions of the painting as a point of departure, Michel Foucault explores multiple interpretations of the caption and images, for instance: (1) the two-dimensional painting is not made of the same substances as a physical/functional pipe; (2) the word "this" (*ceci*) is not a physical/functional pipe; (3) neither the word "pipe" nor the drawing of a pipe are directly equivalent to the discursive and imaginary meanings that we assign to them (Foucault 1983). A representation is not the thing that it captures. And yet, representations—for instance images and narratives—capture our imaginations and frame our views of the world. Much of Foucault's work and that of other critical theorists offers profound observations on the roles of representations and discourses in shaping the ways that societies govern themselves. And, although a growing proportion of institutionalist scholarship—much of which informs this dissertation—takes interest in policy narratives,

it would be incomplete to begin a narratological analysis of health care narratives in the media without acknowledging the origins of narrative analysis, discourse analysis, and inquiry into media representations in critical theory.

These ideas remain deeply relevant to the specific problems and questions that underpin this study. A newspaper's representations of the debates surrounding health reform legislation, after all, are not equal to the legislation itself. The representation is not equivalent to the actual intent of the policymakers or their advisors, nor is the representation equivalent to how the reform will work in practice. Such basic yet profound observations offer a pivotal opening perspective—a lens through which to evaluate representations of health care reform and the potential role of such representations in policy outcomes. However, prior to my doctoral studies, I had given little thought to the importance of media representations in policy debates, and most of the critical political and social theory in which these questions were being explored was alien to me.

My training was firmly grounded in institutionalist approaches to the study of politics. My interest in health care policy and, for that matter, in all aspects of politics and public administration, was centered on the ways to make government better by making public agencies and institutions fairer—increasing access to social and health services, establishing more robust frameworks of social governance, and implementing regulations to prevent abuses of power. Fairer institutions, I believed, were the basis of kinder, more compassionate, and more equitable societies. It was thus through an institutionalist lens, as a graduate student of public administration, that I first took interest in health care reform. And yet, although I had not made the link in my mind between

stories and policy reform, health care stories were all around me, deepening my interest in the American health care system and those whom the system excluded.

As an undergraduate student, studying and living with family in France, I found that the stories people told about health care were different from the ones I was used to in the United States. When, for instance, people recounted narratives of chronic illness, or even mentioned more banal contacts with the system such as dental appointments, they did not express anxiety that their treatments might not be covered, nor mention the need to delay medical procedures until they could afford them—things I had become accustomed to hearing whenever the subject of health care came up in conversations. In contrast to many Americans, it struck me that the French believed in their institutions and trusted their health care system. [29]

I returned to the United States in 2004 to serve as a campaign worker for the Democratic Party in Montana, during the 2004 elections, when health care was a contentious campaign issue. As I made the rounds with my colleagues, I saw the impact of stories and issue framing on public perceptions and on the behaviour of campaign workers and candidates. With the Clinton health reform defeat of the 1990s fresh in their memories, Democratic candidates were often afraid to talk about health care, and thus offered no compelling narrative of reform. I was given perfunctory talking points for cold-calling and canvasing in the effort to mobilize Democratic voters—talking points that were supposed to help evade prickly questions on health care (along with other issues that the Democrats perceived as vulnerabilities at the time, like same-sex marriage and gun control). Republicans, for their part, largely succeeded in reductively framing

[29] In fact, pride in the health care system and social security system is one of the most common markers of French national identity (TNS Soffres 2009), a sentiment that has no equivalent in the United States.

challenges in the health care system as minor issues that could be fixed with modest tax incentives and health savings accounts (HSAs). Regrettably, many voters perceived health care as a largely inconsequential issue in a post-9/11 climate defined by fear, and the Republicans swept most of the important elections, including the presidential contest, in 2004. Beyond a controversial Medicare reform that reinforced the slow push to privatization in President Bush's second term, no substantial changes came to the health care system for another four years.

A few years later, as a social worker in rural South Carolina, I witnessed first-hand the human toll of inequities in the health care system. Virtually all of the families with whom I worked were uninsured, underinsured, or, at best, underserved Medicaid patients—struggling people whose more privileged neighbours frequently maligned and humiliated as "welfare moms," "ne'er-do-wells," and "wastrels." During this period, I spent much of my time advocating for critically ill members in my own family, middle class Americans who were forced to fight tooth-and-nail with their health insurance companies to cover life-sustaining treatments for chronic medical conditions. In the twilight years of the Bush presidency, long periods of government silence on the health care crisis, and Band-Aid policy proposals such as HSAs and tax incentives for the purchase of health insurance, seemed profoundly disconnected from the narrative of my lived experience. I knew that the United States was embroiled in a health care crisis, and I was convinced that peoples' stories needed to be part of the health policy discussions.

One evening in a public library, I stumbled across Emery Roe's (1994) *Narrative Policy Analysis: Theory and Practice.* For me, this was a critical juncture in my academic and professional life, one that enabled me to bridge training in institutionalist approaches

into the world of policy narratives, critical discourses, political metaphors, media representations, and their relationship to health care reform. A fellow public administrationist who shared both my keen interest in applying research to policy and my appreciation for literature, Roe was a pioneer in the field of narrative policy analysis. His work helped me to reconcile my belief that institutions—e.g. constitutions, laws, conventions, and other historical arrangements that create path dependencies—are pivotal to understanding health care systems, with the realization that narratives matter and are in fact essential elements of policy development and change. It was this conversion to a blended approach, one that accounts for institutional contexts and critically examines narratives, that led me to undertake this doctoral research project. It is my hope that my study will inspire and inform researchers, policy-makers, and reform advocates who are struggling to harness the power of narrative to influence health reform outcomes. I begin here with an examination of literatures in critical analysis of ideology and media representation, public policy development and change, health care reform, media effects and framing, and narrative policy analysis.

3.3 Literature review

Critical origins of narrative analysis and studies of the media as both producer and vector of ideologies

In embarking on a study of media narratives of health care reform, it is important to acknowledge early work in critical media analysis and ideology. Louis Althusser's (1970) valuable concept of *appareils idéologiques d'État* (AIE) builds from Antonio Gramsci's 1930s theorization of hegemony;[30] in particular, it extends Gramsci's insight

[30] Gramsci built his theory of hegemony on Marx and Engels' work in ideology. Marx first related ideology to a "false consciousness" that incites the subordinate classes to support the interests of the dominant class against their own, thereby allowing the dominant class to maintain

that the influence of the state could not be reduced to its "repressive apparatuses" (e.g. military forces, police, etc.), but also extended into civil society to manufacture and maintain social order. Althusser distinguished the state's repressive apparatuses (those that depend primarily[31] on the state's claim to a monopoly on violence and the use of force) from AIEs, which operate through ideology to reproduce social relations. This process of reproduction involves instilling and consistently reinforcing certain values and cultural codes that produce and sustain docility in the working classes.

Althusser listed eight ideological state apparatuses (which, he added, are "relatively autonomous" from one another); they include the religious, academic, familial, judicial, political-systemic,[32] trade unionist, and cultural AIEs. The eighth apparatus, most important for my purposes here, is the information AIE, which includes all forms of media (Althusser 1970: 21, 27).[33] AIEs are essential to understanding both

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power (Morrison 2006). According to Gramsci, ideology forms part of the superstructure; mechanisms of indoctrination like education, the media, and mainstream political parties disseminate ideology, which dupes the masses into conflating the interests of the dominant class with national interests. Hegemony results from a historical process in which one class gains enough freedom to conspire against its enemies in a declining regime, and ensures the support or complacency of other subordinate groups in its aims against the declining regime. Gramsci held that international relations follow from social relations, and, thus, reflect domestic hegemonic relations. Once lost, re-establishing hegemony becomes difficult. Finally, Gramsci argued that the ascendency of a new group to a hegemonic position results in social reconstruction and generates new unifying myths as the basis of the group's power (Gramsci 2008).

[31] Althusser added the nuance that repressive state apparatuses, also rely secondarily on ideology; for instance, the military cultivates certain beliefs and behaviours in its recruits and promotes patriotic/militaristic values in broader society. In the same vein, ideological state apparatuses, such as educational institutions, have secondary recourse to repression (in a sense, to violence) through sanctions and exclusion. Thus, the "primarily" caveat is an important one; since Althusser asserts that there are neither purely repressive nor purely ideological state apparatuses (Althusser 1970: 22-23).

[32] Althusser did not include political parties in the political-systemic AIE.

[33] Althusser adds the qualifier that those who work in AIEs are not necessarily complicit in the reproduction of repressive social relations. Most, he posits, are largely unaware of their roles in

power and social class relations because, according to Althusser, no social class can maintain hegemony in the long-term through the exclusive use of repression and violence; it must control the AIEs as well. Importantly, AIEs such as the media may be both a tool and a place of struggle between social classes (Althusser 1970: 24-25). Finally, Althusser proposes the particularly powerful notion of ideology-as-practice, a practice that is always present in AIEs (Althusser 1970: 42).

Ideology as a "system of representation," and the power of media representations

While he takes issue with Althusser's conceptualisation of AIEs, in part due to their different interpretations of ideology in Marx and Gramsci's work, Stuart Hall acknowledges the importance of conceptualizing ideology as a practice that exists in all civil society institutions (Hall 1985 98-103). Hall returns to Althusser's earlier work from the 1960s to further develop another Althusserien concept, that of ideologies as "systems of representation" (Althusser 1965; Hall 1985: 103-105). Hall's notion conceives of ideology, in part, as a space in which we inhabit, experience, and interpret all that is happening to and around us (Hall 1985: 103-105). He adds that, in addition to reproducing social relations, ideology "sets limits to the degree to which a society-in-dominance can easily, smoothly, and functionally reproduce itself" (Hall 1985: 113).

Still taking inspiration from Althusser, Hall (1997) eloquently describes both the constructive and reproductive role of representations in mass media and advertising. In his view, media representations assign and reinforce meaning to objects and ideas. In other words, beyond merely portraying events and perspectives in policy debates—as

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the process. However, he praises those who are aware and deliberately work against the reproductive process, essentially practicing counter-hegemony from within AIEs (Althusser 1970: 33).

assumed in popular notions of media objectivity—media representations make and remake public understandings of people and policies in the process of reporting on a given polemic (Hall 1997: 1-12, 13-73, 223-290). For Hall and other critical scholars of media effects, media representation can thus be understood as both an action and the product of a process (Chandler 2007; Hall 1997). Images, descriptions, and metaphors compose particular narratives of events, which are then framed—depicted in ways that define, include, exclude, contextualize, and give meaning (Chandler 2007; Entman 1993, 2004; Keren 2011). These representations are simultaneously products of power relations, and (re)producers of power relations in society. Through its representations, the media is both a channel through which political elites deliver their desired understandings of debates and policies, and itself a constructive force. Media makes, defines, and assigns value to our knowledge, beliefs, and priorities that filter our interpretations of policy debates (Chomsky and Hermann 1988; Entman 2007; Hall 1997: 1-12, 13-73, 223-290; Orgad 2012: 15-32). Thus, in addition to applying the Althusserien concepts of media (*AIE de l'information*) as a space of ideological struggle and an ideological apparatus, we can view media as a set of metaphors and interpret the narratives and frames that compose media representations as ideological arms that are deployed, both by and through the media, to win the battle of public opinion in all policy reforms, including health care debates.

All of our ideas about health—from feelings of trust in health care providers and medical researchers, to beliefs in the morality and soundness of health care management and costs—are shaped by narrative forms: media representations of health care, personal experiences in the health care system that form our own stories, the experiential

narratives of family and friends, and cultural metaphors of health. Together these frames and narratives—what Foucault (1996) broadly described as the "anonymous murmur of discourse"—play a key role in defining the ways people think about health care and health reform efforts. Annas (1995) persuasively argues that the United States changed the stories it told about health care over the course of the 20th century, shifting in part from an overarching "military metaphor" in the post-war decades to an overarching "market metaphor" in the post-Reagan era that fundamentally changed the relationship between Americans and their health care system. Annas further argues that reformers who want to achieve universal health care first need to challenge the market metaphor (something he derides the Clintons for failing to understand) with a new one—the "ecological metaphor" (Annas 1995).[34] New metaphors of health care can help reformers reframe the conceptualizations of health, such as that of health care as a market, which limited the scope of the Clinton reform effort (Annas 1995). Similarly, more recent scholarship has emphasized the ongoing importance of effective metaphors to sway public opinion and influence outcomes in politics (Geary 2011), and the role of metaphors in media coverage of the Obamacare debates—including metaphors of warfare, which have been deployed between adversaries in the reform debates (Sikio 2011).

In addition to serving as critical tools for reformers during specific legislative debates, entrenched and broadly accepted narratives and metaphors of health can also

[34] The ecological metaphor, according to Annas, could reframe individual expectations of longevity and challenge the misconception that the longest life is necessarily the best life, moderating expectations with a renewed understanding of humans' place and responsibility in a world of limited resources. It is a metaphor that favours quality of life above length of life, and one that emphasizes high-quality health care for all who use the system rather than investments in costly technologies that only benefit a few to the detriment of many (Annas 1995).

lead to broader unintended policy consequences, or create barriers to necessary change. For instance, Annas (2010) notes that the "worst case scenario narrative" of planning for a nuclear or biological terrorist attack, and the related narrative of pre-emptive warfare to save American lives, helped to justify the costly and disastrous War on Terror and the 2003 invasion of Iraq. Narratives that represented longevity as the ultimate goal of medicine also accompanied the myth of "death panels," which conservatives deployed during the Obamacare debates (Annas 2010: xi – xiv, 2011: 394). Annas (2011, 2014) further argues that "quest myths"—such as the one used to justify the costly human genome project, which aims to defeat diseases like cancer and to increase human lifespans through so-called "personalized medicine"—actually work against the interests of the majority and tend to benefit the affluent. The metaphor of medical research as a quest to beat death serves to validate the dedication of extensive financial and human resources to medical research, resources that could instead be used to address tremendous inequities in health care and to create a more sustainable system (Annas 2011, 2014). Paradoxically, since the "quest narratives" in medical research do not prioritize equitable access or cost control (Annas 2011: 401-402), they actually run contrary to two frequently stated goals of contemporary health care reform—reducing cost and expanding access.

While critical research on the role of the media as a vector of ideologies is particularly informative for identifying neoliberal ideological undercurrents in the Massachusetts and Utah health reform case studies, it is important to acknowledge that interest in media representations is not limited to Marxist, post-Marxist, or Foucauldian critical theorists. As the subsequent literature review sections demonstrate, the elements

that compose media representations, and in particular well-crafted narratives, have attracted increasing interest in a broad range of policy literatures. Having examined some of the critical theoretical grounding of ideology and media representation, it will be useful to follow with a summary of institutionalist research in policy development and change, as well as research in policy narratives and media narratives and frames, which more directly inform my theoretical and methodological approach.

The policymaking process and policy change in health care

At the most basic level, many political scientists and public administrationists explain policy change through linear stages and phases. In 1956, Harold Lasswell first proposed seven stages to explain policy development in the United States: (1) intelligence, (2) promotion, (3) prescription, (4) invocation, (5) application, (6) termination, and (7) appraisal (Lasswell 1956). Although it has been criticized, this conceptualization of policymaking in stages has not evolved substantially in half a century. For instance, Jann and Wegrich (2007) identify the "conventional way to describe the chronology of a policy-making process" as (1) agenda-setting, (2) policy formulation, (3) decision-making, (4) implementation, (5) evaluation, and (6) termination (Jann and Wegrich 2007: 43). These somewhat reductive explanations of policymaking processes are common throughout public policy textbooks in Western democracies, with only minor variations between the American, Westminster parliamentary, and Semi-Presidential (French) systems (Cochrane, Blidook, and Dyck 2017; Jann and Wegrich 2007; Lazardeux 2014).

Building from sources that describe the presumed stages of policymaking in legislative democracies, *agenda setting* involves the identification of goals and demands.

This includes the desire of the political party in power to implement its election campaign platform (or at least major parts of it), as well as the efforts of advocacy groups and lobbies, other levels of government, senior bureaucrats, other nation states, supranational treaties and organizations, and of course the media to persuade a government to make an issue a priority. *Policy formulation* involves close consultation and coordination with experts in the public service, as well as consultation with advocacy groups and other affected levels of government. In this stage, decision-makers weigh their options to respond to a problem, contrasting available alternatives. *Decision-making* occurs as leaders in the executive and legislative branches have to consider competing demands, evaluate the financial and political costs, and decide whether to abandon commitments and reject outside demands, or to follow through to implementation. Decision-makers attempt to calculate long-term costs and anticipate potential consequences. If they follow through to change or introduce new policy, they must clarify where commitments to particular demands stand in relation to other demands. Through the process of legislative deliberation and debate, as a bill proceeds through the legislative committee process, and eventually becomes a law, decision-making theoretically involves democratic legitimation (Cochrane, Blidook, and Dyck 2017: 491-495; Jann and Wegrich 2007; Lasswell 1956; Pal 2010: 15-23).

Implementation includes the development of a regulatory framework to accompany the new laws, the process of working through the technocratic details, and sometimes the expansion of departmental bureaucracies or even the establishment of new government departments. With regard to *evaluation*, decision-makers in the legislative and executive branches and their advisors in the civil service compare policy impacts to

their predicted outcomes. In this phase, in the event of legal challenges to a new policy, the judicial branch has the power of review, which may include striking down all or part of any law that is not constitutional. The media and the public also have the opportunity to evaluate new policies, and their reaction may incite policymakers to change course. Finally, *termination* is the stage when a policy idea becomes the law of the land, having not only achieved democratic legitimation in the legislative branch, but also survived judicial interpretation (if challenged) and both media and public scrutiny (Cochrane, Blidook, and Dyck 2017: 491-495; Jann and Wegrich 2007; Lasswell 1956; Pal 2010: 15-23).

Beyond stages and rational explanations of policymaking: Frames, constructs, and policy metaphors in incremental policy change

The synopsis of policymaking in linear stages offers a comforting tale of democracy at work. Of course, this explanation is an incomplete narrative—a convenient framework to introduce students to the policy-making process in constitutional, representative democracies, while ignoring much of the overlap in processes, complexity and uncertainty (Lazardeux 2014: 181-182; Pal 2010). As Pal (2010) notes in his description of the challenge of explaining change in controversial policy spheres, the effort to identify linear phases or stages of policymaking, or any rational explanation of decision-making, is a vain attempt at "modelling chaos" (Pal 2010: 24-26, 354-361). The problem is "that 'facts' lie at the heart of the rational model, but 'facts' are constructed through values and theories" (Pal 2010: 24).

The concept of incrementalism, Pal (2010: 24) affirms, offers a better framework of explanation than that of rationality. Certainly in the American health care system, where the major programmatic elements developed over a century of fits and starts into

the current "patchwork" of systems (including Medicare, Medicaid and the State Children's Health Insurance Program (CHIP), the Veteran's Health Administration (VHA), the employment-based private health insurance market, and, increasingly, health insurance exchanges as online marketplaces) change has been incremental (Marmor and Oberlander 2011). Examples outside of the United States, moreover, offer further support to the argument that incrementalism is an effective lens of interpretation for policy change in the health sphere. For instance, in their study of multiple health reforms across diverse Canadian provinces in recent decades, Lazar and Church (2013) note that most "meso-policy level" health policy reforms were "incremental and slow, especially in the funding sphere." They add: "'Incremental and slow' is not a bad thing when a health care system is firing on all cylinders. That was not the case in Canada between 1990 and 2003" (Lazar and Church 2013: 263).

The synopsis of a system "not firing on all cylinders" certainly applies to the American system during the Massachusetts (2002-2006) and Utah (2004-2011) health reform periods as well. However, if incrementalism is the norm, then that which is "nonincremental, unpredictable to a certain degree, and not immediately controllable has the potential to create crisis" (Pal 2010: 355). Thus, incrementalism should not necessarily be associated either with progressive policy development in a single direction, or with constant improvement. Sometimes, instead of offering steady improvements, health reform efforts lead to massive policy failures and policy stasis, depriving the public of needed changes, such as the Clinton Administration's 1994 Health Security Act (HSA) (Skocpol 1996).

Policymaking is neither phased nor predictable. Competitive processes of framing and reframing are always in play during governmental reforms in any controversial policy sphere. As Majone (1989: 1) aptly put it: "public policy is made of language." All elected officials, branches of government, advocacy groups, the public, and the media discursively influence one another in an ongoing democratic deliberation that is partially delineated through institutions, laws, conventions, and cultural norms (Majone 1989: 1-7). Similarly, Fischer and Forester (1993: 2-4) remind us that policymaking takes place within a contested space in which problems are constantly redefined and reframed, and one in which meanings are assigned and reappropriated. Schön and Rein (1994) explain that, in the representation of policy problems, the manner in which a supposed problem is termed and framed in effect constructs societal contexts. For instance, in the health and social policy sphere, Schön and Rein cite designations such as "problem families" and the descriptive dichotomy of "healthy" versus "diseased" as frames that play on broadly accepted social constructions of the good and the bad to justify intrusive governmental interventions.

Much of this (re)productive process occurs at a subconscious level. Culturally significant values inform a handful of recurring metaphors, narratives, and frames that become generative and delineate conceptualizations of normality. As a consequence, metaphors, narratives, and frames influence the actions of policymakers, front-line public servants, and the interpretations of the public. Yet, it can be difficult to deconstruct and interpret the ideological drivers beyond the positions of policymakers that underpin policy frames (Schön and Rein 1994: 24-28; 34-36). These (re)productive narratological and metaphorical processes, as well as strict conceptualizations of normality, are

reinforced through hierarchical administrative structures that can have significant impacts in the health care sector (Winslade and Monk 2008: 242-282).

However, narratives can also be used as instruments of positive change from the micro level of health care practice to the development of macro level policies and procedures that are used to manage the system. For instance, in a practical example of employing narratives to achieve positive changes in health care, Winslade and Monk (2008) recommend that hospital ombudspersons and mediators employ a narrative mediation framework to repair harms and restore trust between health care providers, patients, and administrators after systemic failures. They suggest that narrative mediation in health care delivery (after a patient complaint or medical incident) follow four stages: (1) *separate sessions* between patients and their families and the health care providers are held to explain the narrative mediation process, lay the foundations for productive dialogues (outline the role of the mediator, confirm willing participation of parties), and impart communication skills for open, empathetic, and clear discussions to understand how different parties storied the incident; (2) a *joint session* takes place between affected patients (perhaps with their families) and the health care providers involved to identify their stories of the incident and its perceived impacts, and to build bridges of understanding in order to agree on resolution and to repair perceived harms; (3) *follow through* (from the mediator) to ensure that agreements are implemented; (4) the mediator *identifies potential changes in policy and protocol* to avert recurrence of the medical incident and advise policymakers (Winslade and Monk 2008: 242-282). Thus, narratives can be intentionally used through mediation processes that identify problems and influence health care policymaking.

According to Deborah Stone's frequently cited *Policy Paradox* (2012), the most common broad narratological categories in policy debates are "stories of change" (decline or rise) and "stories of power" (helplessness or control). These narratological categories are scattered with "synecdoches"—generalizations from anecdotal examples to explain broad perceived problems or phenomena—and with metaphors, which indicate equivalencies through comparison (Stone 2012: 158-182). Stone's framework offers a vision of a more deliberate use of frames and narratives in policymaking. Simplified dichotomies of good and bad, as well as "either-or" choices, are deployed to frame political narratives of policy problems and to make the public think that they have a limited policy window, when in fact societies usually have a broader range of policy options than those that are presented to them. Since decision-makers know that frames and metaphors have the power to undermine the public's capacity for rational evaluation, governments are strategic in their word choices—for instance, in using terms such as "poverty alleviation" instead of "welfare," since the latter is known to incite negative reactions (Stone 2012: 255-258).

Schneider and Ingram (1997) paint a more insidious and socially destructive picture of a manipulative interplay between power, policy framing, and the conflict-inciting and hierarchical social constructions of citizenship. In this view, different populations within a country are constructed through frames and narratives as either "deserving or undeserving" vis-à-vis policy reforms. Policy design and formation is a purely cynical process that aims to maximize political advantages, perpetuate privileges for particular groups, and maintain power dynamics and structures of social stratification. Schneider and Ingram describe this type of incessantly politicized policy environment as

"degenerative." It produces entitlement among the privileged groups and perpetuates itself. The groups affected by a given policy (the "target populations"), are themselves treated as discursive and tangible instruments to gain and maintain power (Schneider and Ingram 1997: 10-12; 102-149).

Arguably, one example of degenerative policymaking in health care reflects the politics of race in the United States and its role in health care reform. Boychuk (2008) states that 20th century policy debates over socialized insurance from the New Deal period through the Great Society era were inseparably interwoven with the racialized politics of the time. Segments of the political elite and national public opinion resisted new universal social and health programs as possible levelling actions that threated the racial hierarchy. As late as the mid-1990s, Boychuk notes that the Clinton Administration's Health Security Act (HSA) failed in part because the health reform debates were conflated with the racialized political discourses of welfare reform and the tough-on-crime policy proposals of the era (Boychuk 2008: 184-186).

While policy narratives, frames and metaphors have historically received inadequate attention in institutionalist literature—and, I would argue, continue to receive insufficient attention, despite greater interest since the 1990s—it is important to clarify that neither health care itself nor any specific policy reform outcome can be explained solely through narrative analysis, nor are effective media representations adequate tools in and of themselves to successfully reform a health care system. Tuohy (1999: 11) astutely notes the importance of a "consolidated base of authority" for "policy actions" to facilitate major reforms. Both Tuohy (1999) and Lazar and Church (2013) note that public opinion is neither an adequate basis for health care policy reform, nor a necessary

ingredient for success. Lazar and Church (2013) further note that both the public and specific advocacy groups are more focused on maintaining existing entitlements than on expanding health care access or services (Lazar and Church 2013: 280; Tuohy 1999: 114).

As such, without other variables in alignment, even the most persuasive media representations—marked by the best narratives, metaphors, and issue frames—may not be enough to achieve health care policy change. Yet, while effective media narratives and frames alone may not be adequate instruments to successfully reform a health care system, they can play a role in influencing outcomes. For instance McIntosh (2016) writes that media scrutiny played a noteworthy role in slowing the implementation of "Lean" public management reforms in the Saskatchewan health care system. Building from McIntosh's (2016) observations that the "Lean" reform initiative emphasizes narratives of patient empowerment, a nearly dogmatic mantra of permanent procedural improvement, cost reduction (cloaked in a pretence of eliminating waste to improve services), and that it relies on lavishly paid private consultants to oversee implementation, I would argue that the case provides an interesting example of the media helping to slow neoliberal public administration reforms in the health sector. Media coverage of such cases is instructive in the sense that it may inform opponents of neoliberal health care reforms elsewhere.

Variables to consider in the analysis of health care reform

Also examining the Canadian case, Harvey Lazar (2013) writes that health care is one of the most difficult policy areas in which to pursue reform. If health care reform is treated as a dependent variable, there is a complex interaction between "independent,

endogenous, and exogenous" variables that have the capacity to influence reform outcomes (Lazar et al. 2013: xi; Lazar 2013: 1-20). *Independent* variables are the array of "institutions, interests, and ideas" that impact a reform effort. *Endogenous* variables are the so-called "insider interests," such as politicians and senior civil servants, who have the potential to shape policy content and outcomes. Finally, *exogenous* variables include so-called "outsider interests" such as patient advocacy groups, the lobbies, unions, and associations that represent health care professionals, the voting public, and (most important for the purposes of my research) the media. Other exogenous variables include fiscal crises and technological changes (Lazar 2013:1-20). The complexity of variable interaction is central to interpreting health policy development and reform outcomes in specific cases. As such, I account for the key variables in the political and institutional context, as well as path dependencies in the Massachusetts and Utah case studies; however, my primary focus henceforth shifts to media representations (newspaper narratives and frames) of these two largely unexplored state health reform debates. I proceed here with a review of literature on policy and media narratives.

Narrative Policy Analysis (NPA) and narratives in the media

Deborah Stone defines "narrative stories" as "the principal means for defining and contesting policy problems" (Stone 2012: 158). Advocates of Narrative Policy Analysis (NPA) affirm that policy narratives are central to interpreting, changing, and implementing policy (Borins 2011; Van Eeten 2007; Roe 1994). Narrative analysis in policy and media studies is based in part on *narratology,* a sub-field of critical literary theory inspired by sources as diverse as Michel Foucault's conceptualization of discourse, Jacques Derrida's deconstructionism, and the research of critical semioticians

such as Roland Barthes (White 1987).[35] Policy-oriented scholars have only recently paid increased attention to the role of narratives in policy change (Bevir 2011). As part of the post-empiricist turn in policy analysis, political scientists and public administrationists began to explore narrative policy analysis (NPA) as a tool to interpret and reform public policies in the 1990s (Roe 1994). In health policy—a research area long dominated by quantitative approaches—scholars increasingly treat narrative as a useful tool to both interpret and produce change (Borins 2011; Hollaway 2005; Verghese 2006).[36]

From a Narrative Policy Analysis (NPA) perspective, competitive framing and deliberation produce public policies; participants in the debates rely upon mutually hostile narratives to retain public support. Policy narratives exist in competition with one another and with distracting "non-stories" (Roe 1994) or policy fictions—the circular arguments, red herrings, straw man fallacies, and deceptive accounts of events that play a key role in media framing and obscure policy debates (Borins 2011; Dryzek and Berejikian 1994; Fischer 2003; Roe 1994). For example, Haltom and McCann (2004) explain the ways in which "tort tales" in the media shaped public support for tort law reform in the United States. In the case of American tort reform debates, the media has frequently misrepresented jury awards, incorrectly citing or exaggerating the facts of relevant cases. Tort tales are false or exaggerated "anecdotal narratives" of abuses in the legal system, often involving unscrupulous plaintiffs and attorneys, which "convey serious meaning and exercise pervasive interpretive power in modern American society"

[35] I recognize the profound differences between the works of Foucault, Derrida, and Barthes. Here I only point out (following White 1987) that such critical theorists influenced later trends in narratology and narrative policy analysis.

[36] As demonstrated in the decision of the journal *Health Affairs* to add the section "Narrative Matters" (Verghese 2006).

(Haltom and McCann 2004: 5-6). Journalists, for their part, refine and reframe such stories to increase public appeal. The enhanced and colourful—albeit less accurate—narrative of a lawsuit "may be the first draft of history but for most people assuredly is the first (and perhaps only) draft of case law, [supplying] all or most of the elements of an arresting story, which tort reformers may then encapsulate further into tort tales" (Haltom and McCann 2004: 158-159). Politicians incorporate these inaccurate accounts into their own discourses; knowingly or unknowingly they re-publicize them, further implanting the exaggerated and inaccurate narrative in the public's perception (Haltom and McCann 2004).

NPA helps scholars and policy analysts to sift through the "uncertainty, complexity, and polarization" (Roe 1994: 4) inherent in any policy debate, with the goal of advancing more comprehensive reforms, reconciling competing and seemingly intractable proposals through the identification and advancement of a metanarrative—a new dominant narrative to destabilize the status quo and facilitate policy reform—which is the concluding step in NPA (Roe 1994). After identifying the competing narratives and non-stories that emerged at different junctures of a policy debate, narrative policy analysts may identify a new dominant narrative that emerged victoriously—the metanarrative—to displace the policy status quo; alternatively, a metanarrative could also be the narrative that analysts consider to be capable of displacing the policy status quo once it is clearly articulated to competing stakeholders (Roe 1994; Van Eeten 2007). In cases of political gridlock, more than one metanarrative may exist, while in other instances none exists. Finding and advancing a metanarrative requires identification of the current dominant policy narrative, competing narratives, and non-stories that compose

a policy debate, comparing them, and taking the compatible parts as building blocks of a metanarrative to underpin new policy assumptions and make stable policy (Roe 1994). Since the introduction of NPA into political science and public administration, scholars have used it in a growing number of policy areas and national contexts.

NPA has been a particularly useful tool to realise reform in cases of policy gridlock. In many such cases, issues such as the scarcity of resources, logistics, pragmatic decision-making (based upon differing perspectives of earlier policy experiences), and technological innovation underpin competing narratives. Examples in which NPA was used to reconcile competing narratives and help achieve reform include transportation system changes in the Netherlands (Van Eeten 2007), telecommunications improvements in New Zealand (Bridgeman and Barry 2002), water management in the United Kingdom and the Netherlands (Dicke 2001), recycling programs in the United States (McBeth et al. 2010), democratic engagement in the United States (Hampton 2005), reconciliation of the views of environmentalists and motorized recreational vehicle users in the Greater Yellowstone Area of the United States (McBeth et al. 2007), reintegration of people with dementia into predominant conceptualizations of full citizenship in Australia (Baldwin 2008), and of course health policy (Cohn 2007; Elliot 2006; Mullan et al. 2006).

The trend of reconciling narratology with empiricism in public policy research

Although the most reticent empiricists still reject the legitimacy of narrative policy analysis, recent NPA research has sought to reconcile empirical verification with NPA's poststructuralist roots. Affirming that "narratological and positivist analysis are not mutually exclusive," Borins (2011: 166) implores public administrationists to combine NPA with quantitative methods in case-oriented research, showcasing this

proposed dual method in his own study of public management innovation. McBeth et al. (2007, 2010) combine qualitative NPA with quantitative survey methodology to investigate policy support in the context of duty-based and engaged citizenship models and in conjunction with policy change theory. Similarly, Jones and McBeth (2010) and Shanahan et al. (2011) developed their own "Narrative Policy Framework" (NPF) to test narratives empirically, investigating how policy narratives influence elite and public opinion through the media.

In an interesting case study that illustrates the practical application of NPA in a unique policy debate, Shanahan et al. (2011) use the NPF to investigate the impact of media narratives on public opinion about snowmobile use and environmental conservation in Yellowstone National Park. After reading newspaper articles that favour particular narratives of snowmobile use in Yellowstone, respondents were tested to measure changes in their views on the policy, future regulation, and the tendency to associate their views with those of either snowmobilers or environmentalists. The authors assert that media narratives influenced public opinion of this policy controversy in two key ways. First, media narratives reinforced existing dichotomies. When individuals held strong views either for or against the use of snowmobiles in Yellowstone, media representations, regardless of perspective, buttressed their existing interpretations and convictions. Second, and in contrast, when readers to the subject were exposed to particular policy narratives and frames in newspaper articles, they were frequently inclined to align their interests with a particular position within the snowmobiler-environmentalist dichotomy (Shanahan et al. 2011). Similarly, in a study of the influence of the newspaper media on public opinions about the reintroduction of Wolves to

Yellowstone, Shanahan et al. (2008) observed that national and local media acted as more of a "contributor" to policy change—advancing particular narratives to shape public opinion and transform policy—rather than as a mere "conduit," indifferently disseminating multiple narratives without bias. The authors encouraged the use of the NPF in future studies, focusing on media influence on public opinion of health care reform and other persistent policy controversies (Shanahan et al. 2011). As a consequence of efforts by media narrative pioneers such as Shanahan, Jones, and McBeth, the tendency in American NPA research is now to combine qualitative and quantitative methods to demonstrate either correlation or causation; however, the earlier qualitative approach of Roe (1994) continues to inform NPA.

Media effects and media framing theory

Media framing is a foundational concept in both communications studies and social movement theory (Entman 2004; Scheufele and Tewksbury 2007; Snow et al. 1986, Snow and Benford 1988). Within both traditions, frames are understood to be a central part of policy narratives and a cornerstone of political and social change (Shanahan et al 2011; Snow and Benford 1988; Snow et al.1986). Media is important in any policy reform debate because, by deploying particular narratives and frames, the press advances specific, and sometimes incomplete or erroneous understandings of debates and policies to the public. While media narratives and frames may be intentionally deployed as political instruments to expand policy windows, they can also be used to challenge communities to learn from one another in order to improve population health (Levey 2013).

The media can distance an audience from an issue or alternatively solicit support for specific people affected by systemic failings or by proposed reforms. For instance, examining proposals for national pharmaceutical coverage in Canada, McIntosh (2004: 4) notes that those media narratives that reveal systemic inequities increase public attention to individual cases. McIntosh and Marchildon (2009) note that, in individual cases involving excessive wait times for elective surgeries in Saskatchewan during the 1990s, media coverage was one factor that incited the provincial government to take action on the issue. Yet, the data that the media favours and chooses to report during a debate may distort public perceptions. For example, in the Saskatchewan case, the media regularly mentioned a study on wait times that had been authored by the conservative Fraser Institute (McIntosh and Marchildon 2009).

While the media may bring much needed attention to an individual case in the health care system, it can also distort or mislead. For example, Levey (2013) pointed out that, despite the media wave in response to the Obamacare debates, the majority of Americans exhibited a poor understanding of the major tenets of the Affordable Care Act, such as the online health insurance exchanges. Levey argues that ideologically motivated, partisan distortions of health care reform debates had damaged public understandings of the actual policy proposals to such an extent that partisan misinformation was undermining the policymaking process and the foundations of democratic government (Levey 2013). Relatedly, in media representations of the Canadian health care system, McIntosh (2007: 9) notes that part of the problem in health care journalism is that attention-grabbing headlines, which can increase readership and ratings, are more tempting to the media than more complex narratives of health care reform, which may

articulate more nuanced or even positive understandings of the health care system. However, debate persists in the academic literature on the measurable effects of the media on policy change.

According to Chomsky and Herman's (1988) critical propaganda model of media effects, contemporary media frames and narratives do not challenge the political status quo. The propaganda model, or, similarly, Scheufele and Tewksbury's (2007) media effects model, holds that the media uses a number of rhetorical and narrative tools to maintain the political order. These include the following: agenda setting (that is, prioritizing news stories that correspond to the social and political biases of editors, comparative generosity of advertisers, or what editors believe the audience wants to read in order to increase readership); priming (that is, giving more attention to issues that editors and media elites want the public to prioritize in elections); and, perhaps most importantly, framing (Chomsky and Herman 1988; Scheufele and Tewksbury 2007). The profit motive, fear of political reprisal (such as denial of access to information and consequent loss of readership), and fear of lawsuits by powerful interest groups or politicians all restrain media activism (Chomsky and Herman 1988). Similarly, other critical media effects scholars have affirmed that the mainstream American media use narratives and framing to reinforce dominant conceptualizations of patriarchy, white privilege, heteronormativity, and market fundamentalism (Budd et al. 1999).

More recently, Thomas Frank (2017) outlined the schism between conservatives and liberals on the need for a "curated" professional media to serve as gatekeepers of public news consumption. According to Frank (2017), in the aftermath of the 2016 presidential election and the proliferation of so-called "fake news" websites on the far-

right that supported Donald Trump, American liberals have multiplied calls for "curatolatry," in which "lovable and benevolent" "authority figures" protect the public from predatory news sites that misinform. Yet, Frank warned progressives against this response to the onslaught of fake news websites:

> But follow our prestige media for a while and you will start to notice an uncanny unanimity of opinion. From TED talks to NPR, from the DNC to the *Washington Post* and on to the award-winning blogs, they all agree with each other, echoing and quoting and linking back and forth in a happy conversation, all the comfortable insiders welcoming one another with praise and prizes. What they don't agree upon, meanwhile, is simply ignored. It is outside the conversation. It is excluded. A world without fake news might really be awesome. So might a shop where every bottle of wine is excellent. So might an electoral system in which everyone heeds the urging of the professional consensus. But in any such system, reader, people like you and me can be assured with almost perfect confidence that our voices will be curated out. (Frank 2017)

Therefore, from the perspective of these above authors, much of the media simultaneously perpetuates existing hierarchies and acts as a mere conduit for the preferred policy narratives and issue frames of political and corporate elites, and manipulatively deploys narratives to produce these outcomes, serving as a complicit abettor.

In contrast to the critical propaganda model of media effects, frameworks deployed by other prominent communications scholars have emphasized the role of the media in shaping both public opinion and public policy—sometimes in unexpected ways (Entman 2004, 2005, 2007; Robinson 2002). These scholars acknowledge the claims that the American media perpetuates liberal capitalist and social conservative normative assumptions; however, they focus on the role of the media in determining contests between mainstream neoliberal—either Republican or Democratic—policy preferences (Entman 2007). While the American media may not favour radical political change, the

media may still affect policy outcomes in important areas such as health care, welfare, or foreign military interventions within the limits of the neoliberal, capitalist political spectrum, leading to substantial benefits or consequences for the American public (Cappella and Jamieson 1996; Hacker 1997a; Huebner et al. 1997; Rhee 1997; Robinson 2002).

It is also important to account for regional (or national) differences in the ways in which the media represents policy debates. For instance, comparatively examining American and Canadian media representations of immigration policy debates in municipalities, Abu-Laban and Garber (2005) note the Canadian media tends to frame immigrant settlement as a national policy issue, while the American media treats it as a matter of immigrant choice in local jurisdictions. The media may choose to construct and represent a political issue as either a "problem" or an opportunity. The meaning-making efforts of the media thus have the potential to be internalized by readers and viewers, shaping public interpretations, preferences, and demands (Abu-Laban and Garber 2005; Kellner 1997). This media construction of policy debates, moreover, is not limited to journalistic discourses; rather, the "social construction process" is a discursive interplay between politicians, academics, journalists, and advocacy groups (Abu-Laban and Garber 2005: 526). As I demonstrate in subsequent chapters, this discursive interplay was clear in media representations of the Massachusetts and Utah health care reforms.

According to one model for understanding the relationship between media representations, public opinion change, and policy transformation (the "CNN effect"), media coverage and public opinion co-constitutively shape one another and guide political elites, thus influencing policy outcomes. In this complex interaction, notes

Robinson (2002), the media initially frame the coverage to appeal to perceived public opinion. These crafted media representations themselves (re)shape public opinion; and political elites then interpret media coverage as straight-forwardly representative of that opinion. In some cases, therefore, elite perceptions of public opinion delineate policy choices and shape outcomes (Robinson 2002). While media framing and narratives may sway public opinion in favour of either Democratic or Republican policy preferences, much of the media effects literature attests to media bias, affirming among other things that the media have generally favoured Republican policy preferences, citing Republican affiliations of media executives and more effective Republican media manipulation as explanations (Baker 1995; Bennett 1990; Hacker 1997a; Hacker and Pierson 2005).

Importantly, media differentiation and polarization in recent decades has arguably undermined the capacity of progressive politicians and advocacy groups to successfully influence broad public opinion through media representations of policy debates. In an analysis of the American religious right and its attempts to influence judicial appointments, Garber (2006) notes that evangelical conservatives have successfully developed their own media to reach and mobilize the faithful in political causes, side-stepping the mainstream media and framing policy debates for likeminded Christian conservatives (Garber 2006: 25-31). The challenge of media differentiation and polarization is even greater in the current context of abundant "fake news" websites that intentionally misinform the public. While fake news exists on both the political right and left of the spectrum, the "alt-right" media outlets, which spoon-feed populism, xenophobia, and conspiracy theories to the people who want to consume them, have been particularly successful (Alcott and Gentzkow 2017; Joselit 2017).

Recent scholarship nonetheless continues to emphasize the importance of media narratives and framing to build public support for health care reforms (Gollust et al. 2009, 2014). Keeping in mind the complexities of the American political context, media frame analysis scholars recommend that reformers advance narratives and frames that shift public focus to social and structural determinants of health—consistent with the liberal health care agenda—without neglecting attention to personal responsibility—a *sine qua non* of conservative support for health reforms (Gollust et al. 2009; Niederdeppe et al. 2008; Forde and Raine 2008; Robert Wood Johnson Commission to Build a Healthier America 2009). For example, governments may want to favour policies that guarantee universal access to health insurance and care, combined with some form of individual mandate to purchase insurance, and a public information campaign promoted in the media and public school curricula reform to encourage healthier lifestyle choices. In this sense, identifying the right media frame is essential to advancing new health care metanarratives.

Prior research on the role of the media in specific health care reforms

A number of recent studies have explored the media's framing of the 1994 federal Health Security Act (HSA). Many have affirmed that media coverage eroded public support for the HSA by deriding President Clinton's approach to health reform, predicting legislative failure before the final Congressional deliberations, increasing public cynicism, and inadequately explaining the potential benefits of the Clinton plan (Cappella and Jamieson 1996; Hacker 1997; Huebner et al. 1997; Rhee 1997; Skocpol 1996). These studies concur that the media largely pushed public opinion against the 1994 HSA and emboldened Congressional opponents in at least four ways. First, the

media failed to explain potential social and economic benefits of the 1994 HSA in most reports, focusing instead on the political controversy and its potential impact on President Clinton's electoral fortunes. Second, the media afforded more space to opponents of the HSA than to proponents, allowing the former to advance the narratives that there was no health care crisis and that the HSA was an unnecessary government incursion into Americans' private health care decisions and options. Third, the media frequently questioned the economic soundness of the plan and the intentions of the Clinton administration. Fourth, the media predicted the failure of the HSA months before the end of legislative debates. Between 1993 and August 1994, public opinion and media representations converged in opposition to the HSA and the legislation failed (Cappella and Jamieson 1996; Huebner et al. 1997; Rhee 1997).

Six years after its passage in 2010, Obamacare has rivalled the 1994 HSA in regard to academic interest in its representations in the media. As early as 2008, when the details of reform remained unknown, scholarly observers were quick to point out that a complex combination of public dissatisfaction with the health system and contradictory uneasiness with the prospect of health care reform would make comprehensive policy change difficult. Thus, many scholars and advocates of health care reform expected media messaging to be pivotal in the outcome of the Obamacare debates (Blendon and Benson 2009; Gelman et al. 2010; Jacobs 2008; Pelika et al. 2010).

In various studies on the competing media representations of Obamacare, research notably demonstrated that the subjective reporting of "facts" about Obamacare in online media misled many Americans into distorted views of health care reform (Gollust et al. 2014; Jaworski 2012; Sikio 2011; YoussefAgha et al. 2010). In particular, media

representations of health care in the 2000s were influential in driving Americans apart in their competing perceptions of the social determinants of health (Gollust et al. 2009). Connolly (2015) found that viewers of Fox News network during the ACA debates were more than twice as likely to believe that Obamacare would lead to the creation of "death panels" to make end-of-life decisions for the elderly than viewers of CNN or MSNBC; somewhat counter-intuitively, she also observed that too much detail in media messaging actually undermined Democratic efforts to build public support for the legislation (Connolly 2015). Focusing on the online media instead of newspapers, YoussefAgha et al. (2010) affirmed that online coverage of the 2010 ACA (Obamacare) debates was highly subjective and less focused on communicating facts about health care delivery or access than appealing to partisans either for or against the ACA.

Finally, Pelika et al. (2010) demonstrated that media representations of health care reform tended to reinforce existing dichotomies that pre-dated Obamacare, and that the education level and political awareness of voters influenced their susceptibility to media messaging on health care reform. Focusing on newspaper media, Pelika et al. (2010) identified and tracked the occurrence of particular policy and procedural health care frames—such as universal, bipartisan, public option, access, uninsured, and children—in the media coverage of the federal ACA debates and compared their results to the Kaiser Health Tracking Poll to demonstrate correlation. They took into account such variables as political party affiliation, insurance status, and education level to measure changes in public opinion. According to their findings, insurance status did not appear to influence support for health care reform. Interestingly, Republicans became more supportive of the ACA as debates progressed while Democrats expressed disappointment and less support,

perhaps indicating that media frames increasingly appealed to Republican worldviews over time. Media frames had the most influence on "middle" education level observers, while the most and least educated observers resisted new media frames and maintained their opinions about health care reform throughout the ACA debates (Pelika et al. 2010).

While the abovementioned studies and many others on media representations of Obamacare help to tell an important part of the health reform story, they ignore the role of the media in overlapping state-level health care reforms. Attending to state reform efforts that surrounded the Obamacare debates may enhance our knowledge of the American health care reform trajectory. In particular, we can profit by devoting more attention to the ways in which health policy narratives diffused between states through the media, and to the story of diverging reform outcomes in states in relation to the introduction and passage of Obamacare.

For their part, the two state reforms examined in this dissertation, the 2006 Massachusetts Health Reform Law and the 2008-2011 Utah Health System Reform, revealed greater political openness to health care policy change on the part of policymakers and the media. Like the 1994 federal HSA and 2010 ACA, these reforms focused primarily on the health insurance access and public health expenditure dimensions of reform. Also like the federal HSA and ACA, these state reforms made noteworthy media waves in local print media during the legislative debates; however, less is known about the relationship between media representations of these legislative outcomes. I am aware of no existing research that explores the alignment between media representations of the two major and legislatively successful state health reforms that both paralleled and immediately preceded Obamacare.

Limitations of NPA research accounted for in the development of my methodological approach

NPA research entails its own limitations. Notably, the occasional practice of inferring causation based upon small-N case studies is ill-advised. For instance, the media framing and media effects research on health care often seeks to demonstrate causation between media framing and changes in public opinion or, in some cases, policy outcomes, examining single pieces of health legislation (Cappella and Jamieson 1996; Hacker 1997a; Huebner et al. 1997; Pelika et al. 2010; Rhee 1997; YoussefAgha et al. 2010). Similarly, much of the NPF and other quantitative approaches within the NPA literature seeks to identify correlation between policy narratives, or infers causation and shows correlation—in legislative debates, policy documents, or the media—and changes in public opinion or policy, focusing on local or single-country policy issues in single case studies (Shanahan et al. 2011; Van Eeten 2007). My use of narrative in subsequent chapters differs significantly from these analyses in the sense that I do not seek to demonstrate causation between media narratives and policy outcomes, nor do I rely solely on analysis of a single piece of health reform. Instead, I examine the alignment between narratives that were deployed in two separate state health care reform cases, and (after accounting for the political context and key endogenous and exogenous variables of these reforms), I trace the trajectories of those narratives across partisanship and scale (local-national newspapers) in the newspaper media. I identify the ways in which the absence of, then introduction of, and the eventual implementation of comprehensive federal reform (Obamacare) impacted media representations of the state cases, reflecting discursive changes in the state reforms themselves.

3.4 Research design: A structured, focused small-N comparative case study of similar and influential American health care reforms

Accordingly, this study offers a critical content analysis of newspaper media representations of the health reform debates during the Massachusetts and Utah reforms. I examine newspaper articles, and differentiate the narratives and frames of these health reform debates according to substance, scale diffusion, and partisanship variables (Republican-leaning and Democratic-leaning, in relation to the neoliberal policy frame). With regards to scale diffusion, I track narratives to verify whether they traveled horizontally to other state newspaper media or vertically between the local and national newspapers; in particular, I examine the ways in which the federal reform effort—by its absence, its introduction and debate, and its eventual passage and implementation—impacted the narratives of the state reforms. Finally, I investigate the role of political partisanship, determining whether narratives of the political right, left, or centre were more frequent, whether they diffused more easily among right, centrist, or left-leaning newspapers, and finally how effectively they diffused from historically Democratic Massachusetts to historically Republican Utah.

The Obamacare debates will be referred to throughout analysis of the Massachusetts and Utah case studies as an overarching controversy that weaves the two state reform stories together. Specifically, the Massachusetts health reform acted as the prelude to Obamacare. The Utah Health System Reform likewise began as a prelude to the federal effort, yet it transitioned into a parallel, competing approach to reform. It was thus an essential part of the recent American health care reform story—one that demonstrated the limitations of states that attempt to forge policy paths distinct from the

federal government. Thus, the two cases had different time and scale effects, but both intersected in important ways with the Obamacare debates.

Unlike the predominant NPA and media effects and frame analysis literature, I do not compare policy narratives and frames in the media with polling data or interviews for a single case of health care reform during a brief time period to demonstrate causation. Instead, I seek to identify alignment between health care narratives and frames in the media, telling the stories of the recent state health reforms as they were presented in the newspapers. Since most research on media representations of health care reform has focused on Obamacare, by instead focusing on key state reforms that preceded and paralleled it, my project fills key gaps in understanding the latest cycle of American health care reform as it unfolded. I draw insights from both narrative policy analysis and media frame analysis in a small-N comparative study of cases that I treat as influential and similar for reasons outlined in the following section.

The appropriateness of Small-N case study—similar and influential cases

According to Lijphart (1971), comparative case studies are useful because, "given inevitable scarcity of time, energy, and financial resources, the intensive analysis of a few cases may be more promising than superficial statistical analysis of many cases" (Lijphart 1971: 686). Similarly, Seawright and Gerring (2008) describe the case study as an appropriate approach to analyzing "a single unit or a small number of units (the cases) where the researcher's goal is to understand a larger class of similar units" (Seawright and Gerring 2008: 296). A researcher may classify a particular case as influential if it helps to develop a better understanding of a larger number of cases in the same political context (Seawright and Gerring 2008).

There have been, to be sure, many other American federal and state health care reform efforts that have made measurable media waves since the HSA debates began in the early 1990s. These reforms may well have served as effective case studies. Besides Massachusetts and Utah, however, other notable state health reform efforts did not discursively intersect with Obamacare while simultaneously standing out as legislative successes and as alleged national models for reform in newspaper media representations. Furthermore, those health care reform bills that passed Congress or state legislatures in the period between the 1994 HSA and the 2010 ACA did not receive as much media attention as the Massachusetts or Utah reforms. With the notable exceptions of failed reform efforts in Oregon and Vermont, most other reform efforts placed less targeted emphasis on the expanded access to health insurance coverage for *all* state residents (often only focusing on children's access to health insurance) and less emphasis on reducing public health spending.[37]

I treat the 2006 MHRL and the 2008 – 2011 UHSR as similar and influential cases for multiple reasons. First, by virtue of their legislative success, these cases are distinguishable within the context of a century of attempted American health care reforms that saw more legislative failures than successes. Second, these reforms both passed legislatures within a close timeframe, 2006-2011. Third, these two health care reform

[37] Besides Massachusetts and Vermont, other notable successful legislation and unsuccessful health care reform efforts between the early 1990s and 2010 include (but are certainly not limited to) the Title IV Subtitle of the 1997 Balanced Budget Act, which created the State Children's Health Insurance Program (SCHIP), the 1994 Oregon Health Plan (OHP), 1994 TennCare, 1992 MinnesotaCare, New Jersey's expansion of SCHIP eligibility to 350% of the poverty line in 2000, Oregon's Ballot Measure 23 in 2002, Maine's Dirigo health reform legislation of 2004, and the Vermont Health Reform of 2011 (Cantor 2006; Hoffman 2003; Hsiao 2011; Hsiao et al. 2011; Oberlander et al. 2001; Oregon Secretary of State 2016; Sommers 2007; Rosenthal and Pernice 2004; Wilson 2014; Woolhandler and Himmelstein 2015; Worthen 2015; Yawn et al. 1993).

efforts pursued the same objectives of expanding insurance coverage and reducing public health expenditures without treating health care as a right and aiming for universal access; thus, they remained within the dominant neoliberal policy frame.[38] These two reforms reproduced the same ideological struggles and arguments about health care that underpinned the 1993 federal HSA; yet, they succeeded in state legislatures while the HSA failed to pass through Congress. Fourth, both state health reform efforts made substantial media waves, especially in the ways each case related to the impassioned Obamacare debates. Together, the two cases demonstrate the opportunities for and limitations facing states seeking to act as health policy incubators in the context of a broader national reform effort. Media representations of the reforms unveil both the motivations of the reformers and the ways in which the trajectory of federal reform discursively impacted their policy scope and partially determined their legislative outcomes and political resilience.

This small-N comparative case study of influential American health care reforms broadly corresponds to the first steps of Alexander George's "method of structured, focused comparison" (George 2004). The comparison is focused in the sense that it is limited to recent health care reform efforts that succeeded in state legislatures. I have chosen the 2006 MHRL and 2008-2011 UHSR because they are influential cases, as outlined above (George 2004). Each chapter nonetheless provides context of the federal or state political environment at the time of the reform, including details of any campaign promises of health care reform, the political party in power, and state public health expenditures.

[38] I recognize, of course, that these health care reforms differ in other dimensions and in terms of their approach to expanding insurance coverage and reducing expenditures, as explained in Chapter 1.

3.5 The choice of newspapers as a medium

Newspapers—both online and in print—remain relevant in media communications about health issues. Regular newspaper readers are among the citizens who are most concerned about health care (Dutta-Bergman 2009). I acknowledge that television, radio, and social media sources produce and transmit health care narratives and frames as well. In particular, mediums such as Twitter, and the political blogosphere, have become important channels unto themselves. However, these mediums are often less well archived (and thus less accessible). Once letters to the editor have been triaged from a search, the choice of newspapers as medium allows a researcher to focus on the narratives that emanate from political and media elites, who often offer their own health reform narratives and frames in columns and editorials, and professional journalists who have as their vocation the reporting, production, and framing of news. Thus, while I acknowledge the importance of other media, I limit this research to the narratives and frames of daily newspapers that remain important building blocks—albeit not the only ones—in the (re)structuring of public support or opposition to health care reform.

Selecting newspapers and newspaper content for analysis

I evaluate three categories of articles: editorials (opinion pieces in the editorial section that reflect the collective opinion of the editorial staff and the position of the newspaper), columns (the opinion pieces of regular columnists of a newspaper, syndicated columnists, or contributions from politicians, academics, or reform advocates), and news stories (composed by journalists and published in the news sections of a given newspaper). I exclude letters to the editor (LEs) from my analysis because they are sometimes too brief to articulate a narrative, they are arguably less persuasive

instruments of narrative diffusion, and they typically do not originate from media or political elite sources. I intentionally chose not to differentiate news stories from the editorials or columns of media and political elites for two reasons. First, the news pieces in the state newspapers (especially in the Utah case) were often too short to justify separating them from the narratologically richer columns and editorials. Second, many of the opinion columns were penned by key elected officials involved in the reforms, leaders of health reform advocacy organizations, and academics who were advising the government or attempting to sway public opinion in opposition to government preferences. As such, the exclusion of opinion columns would have greatly diminished the accuracy of my analysis of the overall newspaper media representations.

The analysis is limited to eight American newspapers that represent the political "left," "right," and centre within a neoliberal political context and a strict two-party political system, as well as predominant national and state-based print media. The terms "left" and "right" are somewhat misleading within the broader political framework; as such, I employ the designations "Republican-leaning" and "Democratic-leaning." For both state health reforms, I examine media representations in four national newspapers—*The Wall Street Journal* (Republican-leaning), *The New York Times* (Democratic-leaning), *USA Today* (political centre), and *The Washington Post* (political centre)—for consistency. I further examine two broadly circulated state-based newspapers for each case; specifically: *The Boston Herald* (Republican-leaning), and *The Boston Globe* (Democratic-leaning) for the 2006 MHRL; and the *Deseret News* (Republican-leaning), and *The Salt Lake Tribune* (Democratic-leaning) for the 2008 UHSR.

My decisions to classify these publications as Democratic-leaning, Republican-leaning, or centrist were based on several criteria. At the outset, I examined the newspapers' presidential endorsements in the recent elections, which revealed that the *Boston Globe*, *New York Times*, and *Salt Lake Tribune* had endorsed the Democratic presidential candidate in 2008 and 2012, while the *Boston Herald* had endorsed the Republican candidate. The *Wall Street Journal*, *USA Today*, and the *Deseret News* do not typically endorse presidential candidates, and I therefore sought other sources of research on media bias, and relied in part on my own research for classification (Peters and Woolley 2012). The *Washington Post*, for its part, has also endorsed Democrats more often than Republicans in presidential elections. For instance, like the *New York Times*, *Boston Globe*, and *Salt Lake Tribune*, the *Washington Post* endorsed Democratic Presidential candidate Barack Obama in both 2008 and 2012. However, a closer look at the *Washington Post* helps to differentiate the newspaper. It demonstrated its more independent tendencies by refusing to endorse either the Republican or Democratic Presidential candidates in 1988, and it has a history of endorsing centrist Democratic and Republican candidates for public office (Pexton 2012). Other research on media bias, and my own research for this dissertation, indicated that the *Washington Post's* political orientation is more ambiguous, and as such I classify the newspaper as centrist (Blake 2014a, 2014b; Peters and Woolley 2012; Pexton 2012).[39]

After considering recent presidential endorsements, I examined state-based political blogs (for the state newspapers) to identify the ways in which the newspapers' political orientation is represented locally. For the national newspapers, my classification

[39] The *Washington Post* is arguably Democratic-leaning, though demonstrably less so than the *New York Times*, and therefore "centrist" for the purposes of my research.

is based in part on a 2014 Pew Research Centre study of media bias (Blake 2014a, 2014b). Through my own reading of the papers in the early stages of my research, certain patterns became apparent. While neither the *Wall Street Journal* nor the *Deseret News* endorses presidential candidates, their political orientation is clearly Republican-leaning. For its part, *USA Today's* political orientation is ambiguous, but because it is less Democratic-leaning than the *New York Times*, and less Republican-leaning than the *Wall Street Journal*,[40] I classify *USA Today* as centrist.

The analysis of media representations focuses on reporting that surrounded critical junctures of each reform effort. This is based on two concepts: *media waves* (from media effects literature) and *critical junctures* (from historical institutionalism). Critical junctures, or junctures where different policy choices or directions are available, can be understood as those periods in which path dependencies in policies and institutional arrangements may be broken, allowing new ones to be established (Capoccia and Kelement 2007; Pierson 1994, 1997). Media waves (from research in media hype/media effects) are spikes in media coverage that follow precipitous events (Vasterman 2005). Media waves build up several months before, and end several months after each of these critical junctures, after which the frequency of health reporting declines in frequency to more stable levels.

The elections that preceded reforms, periods of legislative debate, and the period immediately following legislative passage were critical junctures in each reform during which media waves occurred. In the case of health care reform research, court decisions or political renunciations of reform efforts can of course also be treated as critical

[40] While the newspaper itself is classified as centrist, *USA Today's* coverage of health care reform is arguably more Republican-leaning than Democratic-leaning, though still in the political centre when considered the broader context of coverage in the four national newspapers.

junctures because they could have either changed the course or outright terminated a health reform effort. For instance, if the Obamacare case was to be evaluated, it would be essential to examine media representations of the 2012 Supreme Court Decision in the *National Federation of Independent Business v. Sebelius,* which narrowly upheld Obamacare in a five/four decision on the basis of the Congressional powers of taxation, despite the fact that the court determined that the Patient Protection and Affordable Care Act amounted to unconstitutional regulation of commerce (Reynolds et al. 2012). Similarly, in the case of the Vermont health care reform, it would be important to evaluate media representations of the 2012 decision of the Vermont government to abandon its single-payer health reform effort. However, no court decisions that would have determined their political fate apply exclusively to the MHRL or the UHSR,[41] and the reforms, which successfully passed through state legislatures, were subsequently implemented as policy. Thus, the dates of publication from which I retrieved articles correspond to the state election preceding each reform, and to the periods during legislative debate and immediately after legislative passage for each applicable piece of legislation. Specifically, for Massachusetts, I examine media representations (narratives and frames) of healthcare during the 2002 gubernatorial and state legislative elections, media coverage surrounding the introduction of the MHRL bill, and the passage of the MHRL in 2006. For Utah, I examine media representations of the 2004 gubernatorial and state legislative elections, as well as media coverage of the introduction of each of the

[41] The lawsuit between Utah (and partnering, Republican-dominated states) and the federal government already fell within the periods of analysis in 2010 and 2011, and therefore did not have to be analyzed separately. I discuss that legal battle over the implementation of Obamacare in Chapter 6.

seven pieces of legislation comprising the UHSR, from 2008-2011 (during legislative debates and after legislative passage).

Content analysis of media sources

Media narrative and frame analysis generally follow stages in order to identify and differentiate media frames. Stages often include: issue identification, selection of defining-attitudes, development of analysis codes and initial frames based on review of prior academic literature and media, source selection, and content analysis (Chong and Druckman 2011; de Vreese 2004, 2005; Entman 2004). I use interpretive reading to identify particular health care narratives and frames, beginning with media coverage of the Massachusetts gubernatorial and state legislative campaign in January 2002 and ending with media coverage of the UHSR in 2011, focusing on critical junctures that produced media waves for each piece of legislation. This review and analysis thus involves both careful reading, in order to identify mentions of health reform narratives, and the classification of articles through six stages of analysis, using two units of analysis (articles and narrative mentions within articles).

How this content analysis proceeds

The case study related to each state is divided into two chapters. In the first chapter of each case study (Chapter 4 for Massachusetts and Chapter 6 for Utah), after outlining the political context and tenets of each reform, I examine national newspaper coverage of the state health reforms through six stages of analysis. In the first three stages of analysis, I first treat articles as the units of study. In the first stage of analysis I separate the duplicate pieces, letters to the editor, and articles that do not pertain to health care reform that make it through the *Factiva* triage. These latter pieces are excluded. In

the second stage of analysis, I separate the (typically brief) news stories that contain no developed narratives of health reform, and classify them as favourable, unfavourable, or neutral to health reform. These brief articles are relevant to the health reform debates, but they are not specific with regard to their object of criticism or praise, treating health reform or health care ambiguously. In the third stage, I categorize the more developed news stories, columns and editorials according to whether they contain more favourable, neutral, and unfavourable media representations (narratives and frames) in order to characterize and position them along the "left-right" spectrum (more Democratic-leaning versus more Republican-leaning or politically centrist coverage). The numbers of favourable, neutral, and unfavourable articles (including both brief and developed pieces) are then tallied in charts for the national newspapers. [42] Each article is reread and re-tallied to ensure that it is appropriately classified.

For the last three stages of analysis, I treat narrative mentions within articles as the units of study. Deepening the analysis, in the fourth stage, I identify narratives and frames in each longer, more developed article and then tally the narrative mentions manually. In the fifth stage of analysis, the brief articles that do not contain health reform narratives are classified as "other." Finally, in the sixth stage of analysis, I produce a single chart for each state case study to illustrate the frequency of the major health reform narratives in the national newspapers.

For the second chapter in each case study (Chapter 5 for Massachusetts, Chapter 7 for Utah), I focus on the state-based newspaper coverage. I follow the same six stages of

[42] The number of national newspaper articles on the UHSR case study was not adequate to justify the use of separate charts for the national newspapers. Instead, in order to provide context, the sections of Chapter 5, dealing with national coverage of the UHSR explain the main health care stories that were appearing concurrently in the national media.

analysis described above. Each article is reread and re-tallied to ensure that it is appropriately classified with regard to health reform narratives, and these narratives are illustrated in charts at the end of each case study chapter. Accordingly, Chapter 4, to which we now turn, begins with a summary of the political and economic context that preceded the Massachusetts Health Reform Law (MHRL) of 2006. In addition to context, national coverage provides a starting point to subsequently compare state-based newspaper representations, facilitating comparison on the national/local dimension in Chapter 5.

Chapter 4: A lesson in American brokerage politics: Romneycare and national newspaper coverage of the blueprint for federal reform (2002-2006)

4.1 Introduction

This chapter summarizes the key features of the Massachusetts Health Reform Law of 2006 ("Romneycare"), as well as the historical foundations of, and political context surrounding, the legislation. It subsequently outlines the representations in national newspapers—*The Wall Street Journal* (Republican-leaning), *The New York Times* (Democratic-leaning), *USA Today* (political centre), and the *Washington Post* (political centre)—of Romneycare and the Massachusetts health care system in the context of American health reform debates between the 2002 state election and the passage and implementation of Romneycare in 2006. The analysis examines Romneycare as the heir of the failed federal Health Security Act of 1994 and as the trail-blazing legislation that set the tone for the Patient Protection and Affordable Care Act ("Obamacare") and for other state-level health reforms in the early twenty-first century.

Based on these representations, I argue that centrist (largely neoliberal) policies—those in favour of implementing comprehensive, yet modest reforms to preserve and protect the private health insurance market—emerged more frequently in media coverage than narratives favouring single-payer or other more radical reform proposals. My research demonstrates that Republican-leaning and Democratic-leaning national newspapers favoured health reforms that emphasized personal responsibility, devolution to state governments, identification of cost-saving efficiencies, and public-private partnerships to create health insurance exchanges as the preferred approach to curbing rising levels of uninsurance and skyrocketing health care costs. Analysis of the

Massachusetts reform confirms the convergence of health reform narratives between Democratic-leaning and Republican-leaning national newspapers. I further show that the Massachusetts case demonstrates the capacity of a state government to innovate and discursively set the tone for health policy reform in the context of federal inaction.

4.2 Political Context and Summary of Romneycare

The 2006 Massachusetts Health Reform Law (MHRL), "An Act Providing Access to Affordable, Quality, Accountable Health Care," or *Romneycare*, as it came to be called colloquially, was the most substantial American health care reform effort to emerge in the decade following the failure of the federal HSA legislation in 1994. In the newspaper media, Romneycare was often represented as a shining example of bipartisanship—cooperation between a Democratic Massachusetts General Court (state legislature) and a Republican Governor, Mitt Romney, to pass an ambitious health reform law to help the uninsured and control costs. With the bitter federal debates over the ill-fated HSA still in memory, the bipartisanship narrative of the Massachusetts reform offered a comforting account of American democracy working. It gave hope that, in any state, Republicans and Democrats could follow the Massachusetts example, and work together to solve the health care crisis. However, in reality, Massachusetts was not just any American state in regard to the context of health reform; it was an outlier in two important respects.

The first of these was the economic context of health reform. During the state election campaign of 2002, Massachusetts had the highest per-capita health spending in the country, pegged at $6,094, which stood out noticeably from the national average of

$4,767 (KFF 2002).[43] In addition, according to the Massachusetts Division of Health Care Finance and Policy (DHCFP), health care outlays both per capita and in proportion to GDP in Massachusetts were increasing significantly faster than the national average throughout the MHRL period from 2002 to 2006 (DHCFP 2009). [44] The urgent need to control health care costs was evident in state newspaper media coverage, with articles by academic researchers and pieces quoting both Republican and Democratic politicians in favour of reform (Sager and Socolar 2002; Tierney quoted in McConville 2002). A related factor was the fact that Massachusetts had a lower rate of uninsurance than the national average (11.2%, or about 550,000 people, as opposed to the national average of 15.7% uninsured) (Zhang 2006). In other words, Massachusetts had a greater economic incentive to fix an easier problem.

The second differentiating characteristic of Massachusetts was its political and legislative context. The MHRL was not so much an example of bipartisan cooperation to navigate the treacherous political sea of health reform as it was a story of Republicans jumping on the health reform ship just as it left the dock, offering to help steer it, then telling the crew how to make every turn. Massachusetts had already gone through a series of health reform debates in the preceding decades, especially in the late 1980s under Democratic Governor Michael Dukakis, which laid the legislative and political foundations for the MHRL. Health care access and cost control were already important issues, and the Democratic majority in the General Court (state legislature) was

[43] For perspective on Massachusetts' spending challenges, it is useful to contrast it with Utah, the state with the lowest per capita spending at $3,604 (KFF 2002).

[44] According to the DHCFP, health spending increased 65% in Massachusetts in contrast to 54% national between 2000 and 2007 (DHCFP 2009: 8).

committed to another round of health care reforms with or without Governor Romney (a moderate Republican) (McDonough et al. 2006; Paul-Shaheen 1998). In this sense, the MHRL was a Democratic effort that built upon earlier Democratic successes, making "*Romneycare*" something of a misnomer.

For his part, however, Romney deftly played the political cards he was dealt. In 2002, when Governor Mitt Romney was elected, the Democrats held a "supermajority," or two-thirds of the seats in the General Court. Blocking health reform entirely or refusing to cooperate with Democrats was never an option for Romney, since the legislature had the necessary votes to overturn his veto power. A solid majority of Bay-Staters[45] supported health care reform for both economic and ethical reasons, and they wanted Democrats and Republicans to cooperate to control costs and expand access to health insurance. However, according to journalists such as Scott Greenberger, who was covering the state budget and health reform debates at the time, and later academic research on the context of the Massachusetts health care debates, Romney was keenly aware that any radical provisions would have divided the progressive and moderate wings of the Democratic caucus (and thus made any reform legislation more vulnerable to gubernatorial veto), and as such Romney was able to threaten to veto the most left-leaning provisions of any proposed health legislation (as line items) to steer the course of health reform. As governor, Romney was also in a position to insert himself into the media debates, playing the role of a mediator for competing interest groups who could shepherd the reform narrative toward the political centre. In both of those respects, as guardian of political moderation and as mediator of competing interests, Romney

[45] "Bay-Stater" is the common nickname in New England for residents of Massachusetts.

performed masterfully and took ownership of the reform in a way that influenced public consciousness (Blendon et al. 2008; Greenberger 2005).

When the balance of power in the General Court, economic context, and reform history are taken into account, in the early 2000s, Massachusetts stood out as a predictable candidate for state-level health reform. Prior to analyzing the national newspaper media narratives of health care reform during the Romneycare debates, it is useful to summarize the state-level health reforms that recently preceded the MHRL. It is further instructive to outline the political context of Massachusetts in the 2002-2006 period and the policy specifics of the MHRL.

You can't stop a moving train: Health reform in Massachusetts before and during the Romney years

Massachusetts had a long history of proactive government-led innovation in the health and social policy spheres before Romneycare. The commonwealth established a minimum wage in 1912, nearly three decades before the federal government followed suit in 1938 (Gertner 2006). In 1905, in *Jacobson v. Massachusetts*, the U.S. Supreme Court decided in favour of the City of Cambridge, MA, which had been one of the first American municipalities to mandate smallpox vaccinations in response to widespread infections. *Jacobson* remains a classic reference case in American health law, one that demonstrates the apparently timeless American pastime of rallying against government intervention (USSC Jacobson v. Massachusetts 1905; Mariner et al. 2005; Oliver 2006). The *Jacobso*n case stands as an early example of the willingness of Massachusetts' politicians to impose their informed perceptions of the common good in public health over individual liberty-based objections.

More recently, perhaps the best known of the pre-Romneycare Massachusetts healthcare reforms was Governor Michael Dukakis's 1988 "Health Care for All Act" (HCAA). The HCAA was framed as a four-year path to achieving universal health care, aiming to insure all Bay-Staters by 1992. It relied heavily on the existing employment-based system to cover most of the uninsured, introducing employer insurance mandates for businesses that had more than six people on their payroll and imposing tax penalties on non-compliant employers. A health insurance mandate for post-secondary students was another important part of the plan. The employer insurance mandate of the HCAA never enjoyed strong legislative support (even among Democrats), and the next governor, Republican William Weld, never put it into effect.

Although the controversial employer mandate of the 1988 HCAA died, other parallel Dukakis administration provisions remain in place today. For example, CommonHealth (for commonwealth residents of all ages with disabilities to access Medicaid in exchange for a small premium), Healthy Start (health insurance for uninsured or underinsured pregnant women under the poverty threshold), and the Commonwealth of Massachusetts Medical Security Plan (health insurance for children under the age of 19 in low-income families) persist as key state programs. Thus, while Governor Dukakis ultimately did not achieve universal health coverage through employer mandates and public program expansions, the Dukakis reforms nonetheless altered the health care landscape and established policy reform paths that remained in place when Mitt Romney was elected Governor in 2002 (Blendon et al. 2008; Catalyst Centre 2009; Chen and Weir 2009; Denison 2006; McDonough et al. 2006; McNamara 2006a, b, c; Vennochi 2005a, b).

The framing of health care reform in the HCAA reforms of 1988 is important to keep in mind since the representations of the commonwealth's health care problems and proposed solutions largely persisted into the Romneycare debates from 2002 to 2006. Health care was seen as an economic challenge because of rising costs. The uninsured were regarded as a social and economic burden. Not all groups, however, were assigned the same degree of responsibility for their plight; hence the so-called "deserving poor"—children from poor families, the disabled, and low-income pregnant women—were the populations of interest in the new means-tested public programs to reduce uninsurance (McDonough et al. 2006).

Implicit in the framing of the Romneycare debates was the role of local social movements demanding comprehensive health reform. These preceded Romneycare by two decades, starting even prior to the Dukakis reforms of the 1980s. The Massachusetts health reform movement differed from the kind of progressive, pro-single-payer social movement that sprang up in the same period in nearby Vermont, which in contrast treated health care as a social right. In Massachusetts, health reform advocacy was ambitious, yet it was built on delicate political alliances that were never fully aligned in support of single-payer social insurance or single-payer socialized medicine reform (Blendon et al. 2008; McDonough et al. 2006).

By the early 2000s, more than fifty disparate Massachusetts health reform advocacy groups (many of which had begun their health reform efforts in the 1980s and 1990s) had coalesced into the professional and highly effective *Health Care for All* movement in the *Affordable Care Today (ACT!!) Coalition*. The *ACT!! Coalition* was pivotal in the passage of Romneycare in 2006, and it was decidedly not a pro-single payer

coalition. Even the state's powerful health insurance industry came out in favour of Romneycare in alliance with *ACT!!*. Perhaps the best example of insurance industry support for state-level health reform remains the "Roadmap to Coverage" policy documents of the Blue Cross Blue Shield Foundation of Massachusetts, which were published between 2003 and 2005 (*ACT!!* 2016a, b; Berenson 2005; Blumberg et al. 2005; Bovbjerg and Wicks 2005; Cook 2005a; Holahan et al. 2005a; Holahan et al. 2005b; Reynolds 2005; Weil 2005; Wicks 2005).

Given their focus on specific aspects of reform, their eagerness to cooperate with the health insurance industry, and the lack of any consensus in support of single-payer, the interest and advocacy groups that played central roles in the passage of progressively comprehensive health reforms in Massachusetts from the 1980s through the Romneycare period should not be understood as protest movements. Broadly speaking, Massachusetts reform advocates were not aiming to overturn the status quo in health policy. Instead, they should be viewed as increasingly professional and politically strategic organizations that cooperated closely with the health insurance industry in order to fill the gaps—albeit without explicitly aiming for universal coverage—in access to health insurance and simultaneously sought to reduce costs in the health care system.

If you can't beat 'em, join 'em: Romney and the MHRL

The commonwealth's efforts to achieve these goals in the mid-2000s were pursued in a context and at a scale markedly different from those of the 1994 federal HSA. The MHRL had important parallels with the HSA, but the state legislation had to work within the existing federal program structures. Similar to the HSA, the MHRL focused on insurance market and tax reforms to tackle the uninsurance challenge, largely

relying on the existing employment-based system of private health insurance. However, unlike the proponents of the HSA in the 1990s, the Massachusetts reformers had to accept Medicaid and other programs as a *fait accompli*. There were key parts of the existing health system framework and a broader policy reality to which the state reformers had to conform; specifically, the existence of Medicaid as a means-tested, joint state-federal social insurance program from which states could not opt out; Medicare as a federal social insurance program that covers citizens of 65 years and over in every state; and the fact that Massachusetts (like every state) has military veterans who choose to get all or part of their health services through the federal Veterans Health Administration. The Commonwealth of Massachusetts further lacked federal cost control powers in such areas as negotiating for prescription drugs to regulate costs, or employing health care providers through a socialized medicine system such as the Veterans Health Administration. As such, the Massachusetts government had to focus on expanding the state's contribution to means-tested health programs linked to Medicaid, and on insurance market and consumer regulations to both expand insurance coverage and reduce healthcare outlays (Archer 2009; Haislmaier 2006; Long et al. 2012; McDonough et al. 2006).

The MHRL was a highly ambitious state-level reform, combining an individual mandate to purchase health insurance, a requirement for employers (with ten or more employees) to offer insurance coverage, an expansion of Medicaid coverage for the indigent, a reorganization of the state bureaucracy to implement and oversee the reforms, and a state subsidy to help low-income residents (those not quite indigent enough for Medicaid) to purchase private health insurance. Advocates expected the 2006 MHRL to reduce state health expenditures by decreasing hospital financial losses for treating

uninsured patients—losses that the hospitals were passing on to medical patients and health insurance companies through higher costs and new fees for health care services (Haislmaier 2006; McDonough et al. 2006). The 2006 MHRL significantly expanded health insurance coverage, but largely failed to control costs or implement new quality controls in the state health system (Archer 2009; Long et al. 2012). Nonetheless, academic research immediately recognized the significance of the reform and suggested that it could serve as an example for the rest of the country (Hager 2007; Haislmaier 2006; Holahan and Blumberg 2006). The reform has enjoyed widespread support from Massachusetts employers and workers, remaining popular long after its passage (Gabel et al. 2008; Gruber 2011).

"Romneycare," as noted above, is a somewhat misleading popular name for the initiative. Interestingly, far from initiating or championing the MHRL, Governor Romney actually vetoed eight key provisions of the legislation, including means-tested dental coverage, employer penalties, and assistance for legal immigrants who were affected by gaps in Medicare and Medicaid coverage. The Democratic supermajority in the General Court eventually overrode Romney's vetoes (Steinbrook 2006; Weeks 2006). Nonetheless, even though Romney was a latecomer to the Massachusetts health reform effort, he played an important role in the MHRL debates and negotiations as the Governor in office at the time of passage (Kranish and Helman 2012).

4.3 Depictions of the MHRL in national newspapers

The following sections summarize national newspaper reporting on Massachusetts in the context of American health reform debates between the 2002 state election and the

MHRL passage and implementation period in 2006. Using newspaper articles and narrative mentions as units of analysis, the section considers how the MHRL was represented in the national newspaper media. In addition to context, national coverage provides a base of comparison for state-based newspaper media representations in Chapter 5, facilitating a critical assessment of the national versus local dimensions. I scrutinize newspaper articles to comparatively scan favourable, unfavourable, and neutral coverage between the Republican-leaning, Democratic-leaning, and centrist dailies, unveiling the ways in which health reform preferences and priorities vary according to the writers' political orientation. Articles are classified in accordance with their overall favourable, unfavourable, and neutral representations of health care in Massachusetts. It is important to recall that these debates played out both in the shadow of the failure of the federal Health Security Act (HSA), and as a precursor to the federal Patient Protection and Affordable Care Act (Obamacare); thus, there are references and lines of debate that link the three reforms. My analysis demonstrates that the national newspaper media—*New York Times, Wall Street Journal, Washington Post*, and *USA Today*—featured limited coverage of the Massachusetts reform debates, and as such the parallels with the federal debates did not receive adequate attention. With notable exceptions, national reporting was far less detailed than the state-based media coverage of Romneycare examined in Chapter 5.

My research shows that the right/left/centre differentiation only reveals part of the MHRL story. As units of analysis, articles may be broadly characterized as presenting favourable, unfavourable, or neutral assessments of reform; but these parameters may not adequately portray the complex nature of the debates. A single article describing health

reform debates often contains more than one narrative and, if it seeks to explain differing perspectives, it may contain opposing narratives. Instead of limiting itself to articles as units of analysis, therefore, this study also monitors and analyzes *mentions* of each narrative as units of analysis. As such, Section 4.5 of this chapter, and subsequently Chapter 5, analyze health reform narrative mentions.

The overall analysis (combining an assessment of both articles and narrative mentions within articles) reveals that as early as 2002, Massachusetts was on the national media radar as a health policy leader and innovator. Later, during the Romneycare debates of 2005-2006, the media frequently represented Massachusetts as the instigator of the first major and controversial American healthcare reform—albeit one limited to the state-level—to follow the highly publicized failure of the federal HSA. The representations of Massachusetts that surfaced in limited national reporting largely represented the state as a courageous and inspirational change leader (in Democratic-leaning and politically centrist coverage), or as a jurisdiction responsible for a mismanaged health system that was worthy of national condemnation (in libertarian representations within the Republican-leaning press). As one might expect, the chapter shows that the Democratic-leaning newspaper (*New York Times*), and even the centrist newspapers (*USA Today* and *Washington Post*), were generally more supportive of Romneycare and the Massachusetts health care system than the Republican-leaning newspaper (*Wall Street Journal*). However, columnists across the political spectrum were more favourable than unfavourable to health care reform.

4.4 Favourable, Unfavourable, and Neutral Representations of Romneycare and the Massachusetts Health Care System (2002-2006)

This section treats articles as units of analysis to differentiate favourable, unfavourable, and neutral representations of Romneycare and the Massachusetts health care system. In the national newspaper media, a variety of health reform narratives framed representations of Romneycare and the Massachusetts health care system more broadly. My research demonstrates that 10 specific health reform narratives were used to represent the debates in detail in the national newspapers; however, not all of the narratives that framed coverage of Massachusetts were necessarily favourable or unfavourable to specific legislation or health care regulations and practices in the state. In particular, the *expanded access narrative*, *economic security narrative*, *narrative of Massachusetts leadership in national health reform*, and the *narrative of Massachusetts as a centre of the health care industry*, tended to articulate a more or less neutral perspective on the Romneycare reform and its outcomes. However, they were neoliberal narratives of health care reform that were used to represent the health care system, and they served as important parts of the Romneycare story.

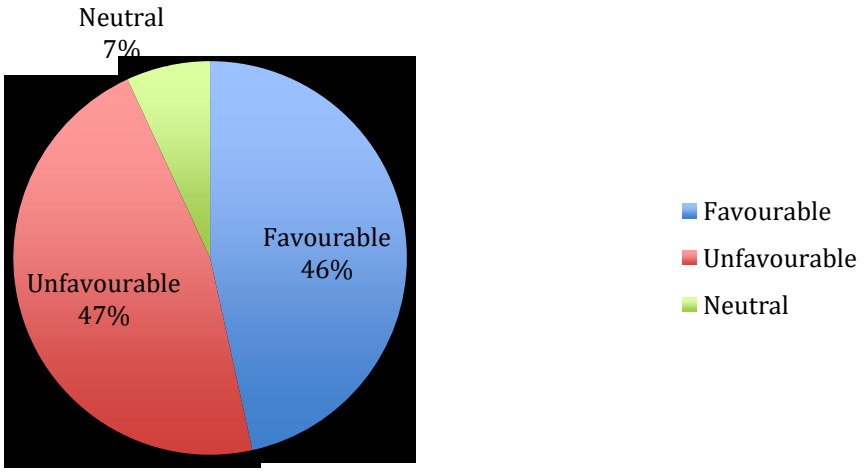
Articles that could be classified as favourable, unfavourable, or neutral typically had a dominant, overarching narrative related to Romneycare or the Massachusetts health care system, or contained only a single, classifiable partisan representation. The first of these, the *narrative of leadership and innovation in state health reform,* was a narrative favourable to Romneycare or other Massachusetts state health legislation that crossed the political spectrum. The second, the *narrative of inefficiency and unethical health care practices*, was unfavourable to the Massachusetts health care system, and arguably Democratic-leaning as a narrative critical of insurance practices and alleged price

gouging in health services; yet, it was found across the political spectrum, including in the *Wall Street Journal*. The third, the *individual responsibility narrative in favour of Romneycare*, was supportive of insurance mandates, and it was found across the political spectrum. The fourth, the *anti-Romneycare narrative*, was more common in the Republican-leaning *Wall Street Journal,* but present in the other newspapers. Finally, the fifth was the *narrative of unethical health care regulation*, which was a libertarian narrative that opposed insurance mandates and other perceived government infringements in the health sphere. It was more common in the Republican-leaning *Wall Street Journal*.

Charts 4.0, 4.1, and 4.2 on pages 148–150 illustrate the respective favourable, unfavourable, and neutral representations of Romneycare and the Massachusetts health care system during the 2002 election campaign (January 1 – November 4, 2002), the period of legislative debates surrounding Romneycare (January 1, 2005 – April 11, 2006), and the period following the legislative passage of Romneycare (April 12, 2006 – December 31, 2006), during which mentions of Massachusetts were sufficiently frequent to generate noticeable media waves. These charts also account for health care reform articles that contained neutral mentions of Massachusetts, without any classifiable, partisan health reform narrative. [46]

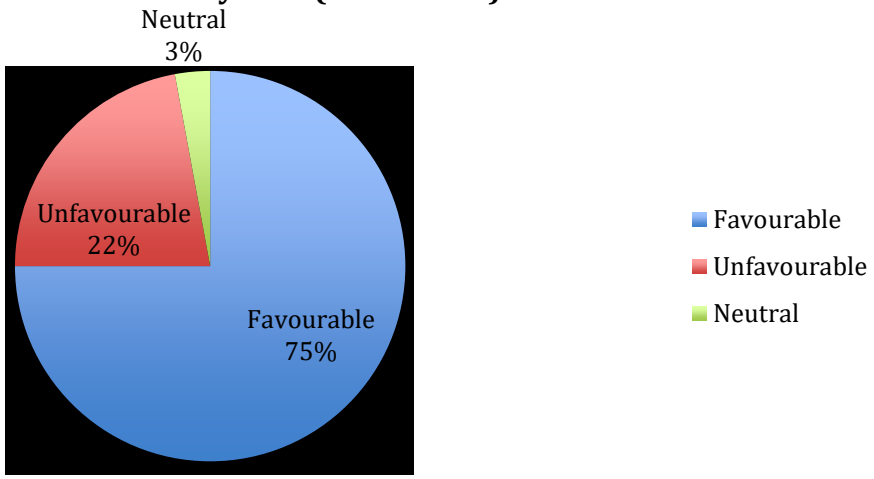
[46] With regard to the dataset for the four national newspapers*, Factiva* searches produced all articles. The initial dataset included all health care-related articles for the following key words: "healthcare reform OR health reform OR health care reform OR health care system OR healthcare system OR single payer OR health exchange OR health insurance." I further triaged by using the names of politicians, including Kennedy, Kerry, Romney, and Clinton.

Chart 4.0: *Wall Street Journal* (Republican-leaning) representations of Romneycare and the Massachusetts health care system (2002-2006)



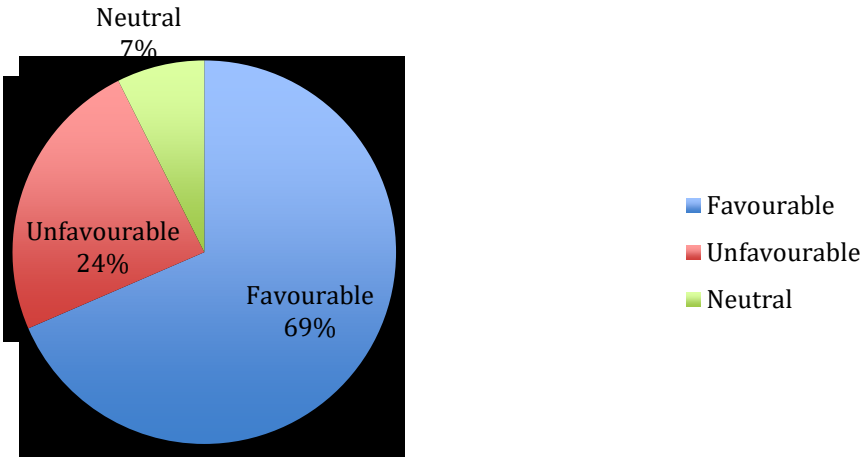
In terms of favourable reporting in the *Wall Street Journal*, 23 articles in that publication strongly emphasized the *narrative of leadership and innovation in the Massachusetts health care system*. These pieces mostly addressed the Romneycare debates. There were four articles that celebrated the responsibilizing approach of Romneycare through the *individual responsibility narrative*. With regard to unfavourable representations, five articles included the *narrative of inefficiency and unethical health care practices*, 12 were clearly opposed to Romneycare, and 10 were critical of the regulatory climate of healthcare in Massachusetts.

Chart 4.1: *Washington Post* and *USA Today* (political centre) representations of Romneycare and the Massachusetts health care system (2002-2006)



The *Washington Post* and *USA Today* were clearly more favourable than the *Wall Street Journal* in their representations of health care in Massachusetts. The *narrative of leadership and innovation in state health reform* was present in 39 articles that covered Romneycare and other state legislation. Twelve articles favourably represented the responsibilizing approach of Romneycare through the *individual responsibility narrative*; this was triple the number of such representations in the *Wall Street Journal*. In terms of unfavourable representations, five articles exemplified the *narrative of inefficiency and unethical health care practices*, and eight included the *anti-Romneycare narrative*. Interestingly, only two articles were critical of the healthcare regulations in Massachusetts.

Chart 4.2: *New York Times* (Democratic-leaning) representations of Romneycare and the Massachusetts health care system (2002-2006)



The percentage of unfavourable articles on Romneycare and the Massachusetts health care system was slightly higher in the Democratic-leaning *New York Times* than in the politically centrist *Washington Post* and *USA Today*. However, this was primarily due to the *narrative of inefficiency and unethical health care practices*, which appeared in 11 articles. Only two articles strongly criticized Romneycare, and none criticized the regulatory climate of the Massachusetts health care system. Favourable reporting in the *New York Times* included 32 articles that contained the *narrative of leadership and innovation in state health reform*, and five pieces in which the *individual responsibility narrative in favour of Romneycare* was emphasized. In the following section (4.5), I focus on the particular narratives of health care reform that surrounded the Romneycare debates and their evolution between the 2002 election campaign and the passage of the Massachusetts Health Reform Law in 2006.

4.5 Narrative analysis of national newspaper media coverage of the MHRL (*New York Times*, *Washington Post*, *USA Today*, and the *Wall Street Journal (2002-2006)* [47]

Differences between Republican-leaning and Democratic-leaning newspapers do not adequately explain the Romneycare story, with its complex economic factors, and the evolving dynamics between key political and business players. Closer examination of national newspaper coverage, looking beyond broadly favourable or unfavourable articles to carefully consider particular health reform narrative mentions in each article, reveals greater complexity in the debates. Even mainstream Republican-leaning columnists recognized the broader economic and access problems in the state health system and advocated some type of health reform, but they differed with Democratic-leaning columnists in terms of the types and degrees of reform they wanted the Massachusetts government to implement, and in the aspects of Romneycare that they viewed positively. The foremost critics of Romneycare were libertarian columnists, especially in the Republican-leaning *Wall Street Journal*, though examples of critical voices were also found in the centrist *USA Today* and *Washington Post*.

The broader context of reporting on the health care system in the Romneycare years (2002-2006): economic threat, social crisis, or both?

National reporters demonstrated attentiveness to health care-related stories during the MHRL reform period (the 2002 Massachusetts state election campaign and the period, between 2005 to 2006, in which the legislation was debated and passed). Most notably, national columnists focused on two overarching challenges. First, columnists

[47] To remain consistent with my subsequent scan of state-based newspapers, the dataset for the national newspapers consists of a *Factiva* search for the terms "healthcare reform OR health reform OR health care reform OR health care system OR healthcare system OR single payer OR health exchange OR health insurance." For each newspaper, I added "Massachusetts" and (separately) "Romney" to the search terms.

frequently referenced the country's increasing public and private outlays for health care, which were treated as comparatively high in the developed world, rising (and thus a risk), and unsustainable. Second, the alarming increase of uninsurance and the erosion of the employment-based health insurance system were depicted as generally unjust, and as a factor contributing to social inequality.

The *economic security narrative,* which was a neoliberal narrative focused on concerns over public and private health costs, surfaced in national coverage in favour of reform. It emphasized the need to change the health care system to ensure state or national economic sustainability and competitiveness, and/or economic stability for individuals and families. It was a discourse that viewed the provision of health care in terms of a market-based exchange and imparted a sense of urgency with regard to the state of the health care system. For example, in a 2006 *New York Times* column on the broader economic outlook, readers gleaned one of many instances of the *economic security narrative*:

> Part of the sluggishness of workers' wages is a result of the rising burden of health care benefits. In a study last year, Katherine Baicker and Amitabh Chandra, economists at Dartmouth College, found that rising premiums of employer-supplied health insurance were not only eating into workers' compensation, but they also discouraged employers from increasing their payroll. (Porter 2006)

The Porter (2006) piece clearly emphasized the burden of the faltering employment-based health insurance system on both employers and workers. In other instances, the *economic security narrative* focused on rising government outlays for health care programs and hospital subsidization for treating the uninsured. As I demonstrate throughout this section, in more detailed columns and editorials, the financial disadvantages that impacted governments, employers, and families were all evoked together as symptoms of

an untenable system for which intervention was required to preserve the market.

In another central narrative in favour of reform, columnists decried rising uninsurance rates as a moral crisis in the health care system, deploying the *expanded access narrative*. It is important to clarify that, while columnists who deployed this narrative often sought to pull on readers' heart strings, they did not espouse the notion of health care as a right instead of a commodity, nor did they combine the *expanded access narrative* with a narratives in favour of single-payer or other more radical reform plans to achieve universal access. The *expanded access narrative* favoured improving access to health care and expanding insurance coverage, but it was not a challenge to the neoliberal vision of health care as a market and means-tested social policy development in the United States.

Columnists quite frequently deployed the *economic security* and *expanded access narratives* simultaneously to emphasize the need for health care reform. A clear example in the *New York Times* described the state of the American health care system as a "medical dystopia," one in which the country "has the highest per-capita spending on health in the world—about $5,400 in 2002—[and yet] 8 percent of the population under 65 remains uninsured" (Porter 2005). Whether deployed together or separately, the *economic security* and *expanded access narratives* remained the most common discourses that journalists in favour of health care reform articulated between 2002 and 2006.

In analyzing cost and access challenges, it was not uncommon for journalists to mention past attempts to reform the health care system. In particular, as the most recent federal reform effort, the HSA was evoked in a consistent, yet small, number of articles.

There were also a handful of pieces both in favour of and opposing single- payer health care reform options. [48] However, the majority of references to the HSA or single payer reform options in national newspaper coverage of health care in the period did not make the link to the Romneycare debates in Massachusetts. For that matter, and despite some noteworthy reporting on Romneycare that I summarize in the next section, state-level health reform efforts in general did not attract substantial attention in the national newspapers.

[48] During the MHRL period, the media hostility that had been widespread in response to the federal HSA was not as pervasive as it was in the 1990s, though the unfavourable narratives of the HSA—derided by conservatives as "Hillarycare"—persisted in an attenuated form in national reform coverage. The most substantive national newspaper articles on health care reform commonly referred to the HSA, either favourably or unfavourably, indicating that the federal reform debates of the 1990s remained part of the media's memory and framing of the issue. For instance, on the more favourable side, commentators such as economist Paul Krugman were positive (yet nuanced) in their assessments of the HSA, mixing praise with criticism in what amounted to calls for universal health care in a *pro-single payer narrative,* combined with the *expanded access narrative* that praised the Clintons' HSA for an essentially courageous, yet misguided and poorly strategized effort (Krugman, NYT, June 13, 2005). Celebrated academics like Krugman were not the only proponents of single-payer. Sometimes, the *pro-single payer narrative* was particularly poignant when health care providers penned the columns. For example, in an column focusing on the challenges of the American health care system, a physician writing in the *New York Times*, Dr. Robin Cook, declared that, while he had once been skeptical of single-payer systems, he had come to believe that single-payer was the only real option for comprehensive health care reform (Cook 2005b). Such favourable (or at least nuanced) references to single-payer or the HSA were, however, were regularly countered by unfavourable representations. In fact, in the case of the HSA, unfavourable representations were the most frequent. The *anti-HSA narrative* was present in 93 articles, or 1.8% of overall health care reporting in newspaper media waves, between 2002 and 2006. Sometimes, mere passing descriptions of the HSA as a "failure" or "debacle" (Miller 2005), without any balanced reminder of its arguable merits, were adequate to reinforce the *anti-HSA narrative*. In other cases, however, columnists were more explicit in their persistent disdain for the Clinton-era reform effort, misleadingly and incorrectly likening the HSA to single-payer systems (*WSJ*, February 1, 2006) According to these critiques, the HSA was often framed as comparable to Canadian socialized insurance or British socialized medicine, single-payer systems. Single-payer was represented as an inefficient reform option that would threaten consumer freedom. In contrast, readers were led to believe that "market-based healthcare," through private health savings accounts and other non-governmental reforms, could fix the health care system.

Romneycare in the national newspaper media

The details of Massachusetts' reform agenda were not a clearly central feature of the national media's reporting. This was true even as national newspapers substantially covered health care challenges such as rising costs and pervasive uninsurance. The national newspaper media did however display limited interest in Romneycare as the first major—albeit state-level—American health care reform effort a decade after the failure of the federal HSA. The aspects of the Massachusetts health care system and the MHRL that national newspapers chose to report on from 2002 to 2006 were revealing. The remainder of Chapter 4 focuses on national newspaper coverage of the MHRL and other relevant mentions of the Massachusetts health care system.

The context of Massachusetts coverage: Major health care stories during the 2002 election campaign (January 1 – November 5, 2002), during the Romneycare debates (January 1, 2005 – April 11, 2006), and in the period following the passage of Romneycare (April 12 – December 31, 2006).

Although health care reform was a hotly debated and contentious issue in the Massachusetts election campaign of 2002 (McNamara 2002; Nangle 2002), Massachusetts did not figure prominently in health care reform-related articles in the *New York Times*, the *Wall Street Journal*, the *Washington Post*, or *USA Today*, garnering mentions in only 15.7% of coverage, or 73 articles out of 464 pieces on health care reform that appeared in the four national newspapers. [49] However, it is important to

[49] In the *New York Times*, during the 2002 election period (January 1 – November 5, 2002), the initial search for articles related to health care reform produced 191 articles. I excluded 25 articles from the initial search results because they were duplicates, letters to the editor, or focused on health issues but not health care reform debates. Thus, my analysis of *New York Times* coverage for the election period includes 166 articles. Adding "Massachusetts" or "Romney" to the search terms excluded most of the initial results, leaving 28 articles about health care reform that referred to Massachusetts in the *New York Times*. Similarly, in the *Wall Street Journal*, the initial search produced 130 articles. I excluded 23 articles because they were duplicates, focused on

understand the broader range of health care reporting within which those 73 articles linked Massachusetts to the debates during the election campaign. With regard to the context of health care reporting, national newspaper media coverage of health care in 2002 predominantly focused on challenges of cost and access in the American health care system as national problems, with limited coverage of state efforts. In particular, debates between the Bush Administration and Congressional Democrats on federal Medicare reform were a central focus of the national media.

By the time of the state legislative debates surrounding Romneycare in 2005 and 2006, the national newspaper media continued to focus predominantly on challenges of cost and access in the American health care system. The national newspaper media's attention to Massachusetts was modest (81 articles, or 2.7% of health care reporting during the state legislative debates), yet it increased with regard to the detail of reporting, deepening coverage in comparison to the more passing mentions that were more common

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health-related issues but not on the health care reform debates, or were letters to the editor, leaving a total of 107 articles reporting on the national health reform debates, of which only 25 *Wall Street Journal* pieces linked Massachusetts to health care coverage. The comparatively lower interest in health care reform in the *Wall Street Journal* as opposed to the *New York Times* based on the number of articles (166 in the *Times* as opposed to 107 in the *Journal*) may indicate that health care reform began as more of a priority for the political left than for the political right nationally. In *USA Today*, an initial search produced 51 articles. I excluded 18 articles from the *USA Today* results because they were letters to the editor, duplicates, or unrelated to health reform debates, leaving 31 articles relevant to the health care reform debates. Only 3 *USA Today* articles in the 2002 election period link Massachusetts to the national health care policy debates. In the *Washington Post,* my search produced 179 articles on health care policy issues. I excluded 19 articles from the results because they were letters to the editor, duplicates, or unrelated to health reform debates, leaving 160 relevant articles to the health care reform debates, of which 17 tied the health reform debates to Massachusetts. In total, between the 4 major national newspapers I analyzed, 15.7%, or 73 articles (out of a total of 464 pieces relevant to health care policy debates) in the 2002 state election period linked Massachusetts to health care reform.

during the 2002 election campaign. [50] This intensified attention was in large part due to reporting on Romneycare; however, other health care stories in Massachusetts were also covered.

After the passage of the Massachusetts Health Reform Law in the General Court on April 11, 2006, the national newspaper media continued to focus predominantly on challenges of cost and access in the American health care system throughout the year. [51]

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[50] In the *New York Times*, during the 2005-2006 legislative debate period (January 1, 2005 – April 11, 2006), the initial search for articles related to health care reform produced 1,189 articles. I excluded 131 articles from the initial search results because they were duplicates, letters to the editor, or focused on health issues but not health care reform debates. Thus, my analysis of *New York Times* coverage for the legislative debate period includes 1,058 articles. Adding "Massachusetts" or "Romney" to the search terms excluded most of the initial results, leaving 24 articles about health care reform that referred to Massachusetts in the *New York Times*. Similarly, in the *Wall Street Journal*, the initial search produced 822 articles. I excluded 74 articles because they were duplicates, focused on health-related issues but not on the health care reform debates, or were letters to the editor, leaving a total of 748 articles on the national health reform debates, of which only 18 *Wall Street Journal* pieces linked Massachusetts to health care coverage. As had been the case during the 2002 election period, there was comparatively less interest in health care reform in the *Wall Street Journal* as opposed to the *New York Times* based on the number of articles (1,058 in the *Times* as opposed to 748 in the *Journal*) perhaps indicating that health care reform remained more of a priority for the political left than for the political right nationally. On the political centre, in *USA Today*, an initial search produced 246 articles. I excluded 22 articles from the *USA Today* results because they were letters to the editor, duplicates, or unrelated to health reform debates, leaving 224 relevant articles to the health care reform debates. Only 16 *USA Today* articles in the 2005-2006 legislative debate period linked Massachusetts to the national health care policy debates. In the *Washington Post,* my search produced 1,037 articles on health care policy issues. I excluded 114 articles from the results because they were letters to the editor, duplicates, or unrelated to health reform debates, leaving 923 relevant articles to the health care reform debates, of which 23 tied the health reform debates to Massachusetts. In total, between the 4 major national newspapers I analyzed, 2.7%, or 81 articles (out of a total of 2,953 pieces relevant to health care policy debates) in the 2005-2006 legislative debate period linked Massachusetts to health care reform.

[51] In the *New York Times*, after the passage of Romneycare in 2006 (April 12, 2006 – December 31, 2006), the initial search for articles related to health care reform produced 622 articles. I excluded 56 articles from the initial search results because they were duplicates, letters to the editor, or focused on health issues but not health care reform debates. Thus, my analysis of *New York Times* coverage for the period after legislative passage includes 566 articles. Adding "Massachusetts" or "Romney" to the search terms excluded most of the initial results, leaving 27 articles about health care reform that referred to Massachusetts in the *New York Times*. Similarly, in the *Wall Street Journal*, the initial search produced 466 articles. I excluded 37 articles because they were duplicates, focused on health-related issues but not on the health care reform debates,

The media's attention to Massachusetts remained relatively scarce in the grand scheme of health care reporting; however, it increased as a percentage of overall health care coverage (4.4% of coverage in 2006 after legislative passage, compared to 2.7% during the legislative debates of 2005 and 2006.). This intensified attention was in large part due to reporting on Romneycare; other health care stories related to Massachusetts, however, also surfaced.

As had been the case during both the 2002 election campaign period and the period of legislative debates surrounding Romneycare in 2005 and 2006, the dominant narratives of reform in the national newspaper media after the passage of Romneycare were the *expanded access* and the *economic security narratives*. In one example of the *economic security narrative* (blended, in this case, with the *expanded access* and *individual responsibility narratives*), in coverage of Romneycare, a *New York Times* column offered the following praise for Romney's legislation:

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or were letters to the editor, leaving a total of 429 articles on the national health reform debates, of which 18 *Wall Street Journal* pieces linked Massachusetts to health care coverage. As had been the case during the 2002 election period, and during the period of legislative debates in 2005 and 2006, there was comparatively less interest in health care reform in the *Wall Street Journal* than in the *New York Times* based on the number of articles (566 in the *Times* as opposed to 429 in the *Journal*), which may indicate that health care reform remained more of a priority for the Democratic-leaning media than for the Republican-leaning media nationally. On the political centre, in *USA Today*, an initial search produced 138 articles. I excluded 11 articles from the *USA Today* results because they were letters to the editor, duplicates, or unrelated to health reform debates, leaving 127 articles relevant to the health care reform debates. Only 6 *USA Today* articles period after legislative passage of Romneycare linked Massachusetts to the national health care policy debates. In the *Washington Post,* my search produced 589 articles on health care policy issues. I excluded 53 articles from the results because they were letters to the editor, duplicates, or unrelated to health reform debates, leaving 536 articles relevant to the health care reform debates, of which 22 tied the health reform debates to Massachusetts. In total, between the 4 major national newspapers I analyzed, 4.4%, or 73 articles (out of a total of 1,658 pieces relevant to health care policy debates) in the period after legislative passage of Romneycare linked Massachusetts to health care reform.

> But a good chunk of the program's cost will come simply from acknowledging the obvious. Massachusetts now spends $320 million a year reimbursing hospitals for taking care of the uninsured. Soon, it will be able to spend that money helping people buy policies. "We should require them to have insurance," said Mr. Gruber, a Democrat who has been advising Mr. Romney, "because otherwise we're going to pay for it anyway." (Leonhardt 2006)

In the article, and many like it, the neoliberal policy undertones were clear. Romneycare was represented to readers as an economically sensible approach designed to reduce health care costs, expand health insurance coverage, and responsibilize allegedly free-loading, uninsured visitors to hospitals and clinics. It would do so, the author wrote, by providing the poor with a dose of means-tested, seemingly compassionate subsidies that would enable them to join the health care market as good consumers (Leonhardt 2006). This portrayal was representative of the ways in which Massachusetts entered coverage of the broader American health care reform debates in the spring and summer of 2006.

Representations of the Massachusetts health care system during the 2002 election campaign (January 1 – November 5, 2002), during the Romneycare debates (January 1, 2005 – April 11, 2001), and after the passage of Romneycare (April 12 – December 31, 2006)

Narrowing the focus to national newspaper articles on health care that included references to Massachusetts (227 articles in total during the 2002 election and the periods surrounding the Romneycare debates in 2005 and 2006), it is possible to differentiate between favourable and unfavourable coverage in the Democratic-leaning and Republican-leaning press. However, the need to reduce costs (public and private) and the necessity to expand access to health insurance were commonly alluded to in newspapers across the political spectrum as challenges in the state health care system. For instance, in order to highlight the inequities in access, some writers pointed the finger at a Massachusetts clinic that only provided “boutique” medicine to wealthy patients while

poor, local working people were deprived of primary care (Appleby, June 20, 2002; Connolly, May 28, 2002). In some cases, events in Massachusetts that were seemingly unrelated to health care reform debates helped to illustrate broader access problems in the national system. For instance, a piece on the bankruptcy of Polaroid Corporation in the *Wall Street Journal* served as an important reminder of the challenges in the employment-based insurance system:

> "This company should not be sold to any bidder who is not willing to keep the retirees' health plan alive," said Mr. Reilly, who said his office also will draft state legislation that would allow Massachusetts employees to retain their health insurance coverage after a company shuts down. Polaroid, based in Cambridge, Mass., filed for protection under Chapter 11 of the U.S. Bankruptcy Code in October. (*Wall Street Journal* April 30, 2002)

In the above example of the *expanded access narrative*, Polaroid's woes in Massachusetts demonstrated the vulnerability of workers in the employment-based private health insurance system as it operated across the country.

Many national columnists understandably treated access expansion and cost reduction as interrelated priorities, as opposed to favouring one objective over the other, though authors took divergent approaches to the issues. As such, the economic security narrative was almost as frequent as the expanded access narrative. For example, in one instance of the economic security narrative that emerged during the 2002 election campaign, a Massachusetts case was cited to decry malpractice lawsuits as the primary culprit for rising health costs (*Washington Post*, June 15, 2002).

Later, during the legislative debates surrounding Romneycare in 2005 and 2006, the major issues in national newspaper reporting remained the challenges of access (rising uninsurance) and cost (public and private). For example, a subset of stories

featuring the *expanded access narrative* linked health insurance access with the marriage equality debates. A handful of pieces mentioned Massachusetts as the first state to have legalized same-sex marriage, identifying health insurance access as one of the motivating factors for same-sex marriage advocates. A 2005 *Washington Post* article framed the issue well:

> Except in Massachusetts, same-sex couples do not [have the right to get married]. Even if they did, it wouldn't help with the tax treatment. Thus, same-sex couples, no matter what the states do, will remain unable to get federal-tax-free health insurance for one partner through the other's employer. (Crenshaw 2005)

Crenshaw's piece pointed out that, even if other states followed the Massachusetts example and legalized same-sex marriage, thus enabling same-sex couples to access one another's employment-based health insurance benefits, such couples would still not be able to take federal tax deductions for their insurance costs due to federal law.

On the whole, the media treated Romneycare, and the Massachusetts health care system more broadly, favourably. The same seven narratives of health care reform that had been present in 2002 all remained in the 2005-2006 legislative debates—the *leadership and innovation in state health policy, expanded access, leadership in national health reform, health reform activism, inefficiency and unethical health care practices, Massachusetts as a centre of the health care industry, and economic security* narratives. However, three new narratives emerged during the Romneycare debates: the *anti-Romneycare narrative,* the *narrative of unethical health care regulations* (unfavourable to different aspects of government health care regulation in Massachusetts) and the *individual responsibility narrative* (deployed in favour of Romneycare).

In national newspaper coverage after the passage of Romneycare (April 12 –

December 31, 2006), the *expanded access narrative* and the *economic security narrative* remained the most frequent. A subset of stories featuring the *expanded access narrative* still tied health insurance access with the marriage equality debates. These writers typically mentioned Massachusetts as the first state to have legalized same-sex marriage, and identified health insurance access as one of the issues that same-sex marriage advocates emphasized in their campaigns for equal rights. Another subset of pieces featuring the *expanded access narrative* in this period focused on the need to expand access for children.

The national newspaper media continued to represent Romneycare, and the Massachusetts health care system more broadly, favourably. The same ten narratives of health care reform that had been present during the 2005-2006 legislative debates—the *leadership and innovation in state health policy, expanded access, leadership in national health reform, health reform activism, inefficiency and unethical health care practices, Massachusetts as a centre of the health care industry, economic security, individual responsibility, anti-Romneycare, and unethical health regulations* narratives—continued to be deployed after the passage of Romneycare and through the end of 2006.

Predominantly Democratic narratives during the 2002 election campaign, during the Romneycare debates (January 1, 2005 – April 11, 2006) and after the passage of Romneycare (April 12, 2006 – December 31, 2006)

Some national columnists during the 2002 election campaign period depicted Massachusetts through the *narrative of health reform activism*. For instance, coverage of the seemingly unrelated scandal concerning pedophile priests told the story of Catholic health reform activists in Massachusetts who took advantage of the Church's weakened political position to successfully lobby the state legislature. The activists persuaded

legislators to mandate health insurance coverage of birth control for the high number of non-clergy Catholic Church employees in the state (*Washington Post* July 6, 2002; *Washington Post* April 21, 2002). Similarly, a *Wall Street Journal* article on the single-payer reform movement in Oregon cited Massachusetts as one of a handful of states with organized health reform movements and a level of support for single-payer comparable to that found in Oregon (Wysocki 2002). Another piece on Oregon's single-payer referendum campaign mentioned Massachusetts as another state with a pro-single-payer movement; however, that *Washington Post* article affirmed that support for single-payer in Massachusetts was waning (Booth 2002). Such pieces were important, since they attested to the political complexity of realizing changes in the state health care system and indicated that there was an above-average level of health reform activism in Massachusetts.

The favourable *narrative of Massachusetts' leadership in national health reform* framed Massachusetts positively in health care reporting. In many cases, Massachusetts entered the media frame through coverage of its high-profile national politicians. In particular, Senator Edward ("Ted") Kennedy, Senator John Kerry, Congressman Barney Frank, and Gubernatorial Candidate Mitt Romney were national household names as Massachusetts politicians (admittedly, to varying degrees) who were linked to health reform debates. For example:

> Senator Edward M. Kennedy of Massachusetts sounded themes sure to be echoed in Democratic campaign commercials this fall. 'Republicans put a higher priority on tax breaks for the wealthy than on prescription drugs for the elderly,' Mr. Kennedy said. 'Seniors may be better off purchasing a bus ticket to Canada than relying on the Republican proposal.'(Pear 2002)

Others referred to Kennedy as the "champion" of the State Children's Health Care

Plan (CHIP) (Jones 2002). In most cases, these articles included either quotes from Massachusetts politicians, or references to their important roles in the debates over Medicare reform. However, the narrative of Massachusetts leadership in national health reform also included mentions of well-known state academics and health reform advocates in order to support particular views of health care reform. For instance, a group of prominent health policy researchers in Massachusetts universities were cited as criticizing the overreliance on tax credits in President Bush's health plan, which they deemed as wholly inadequate with regard to helping the poor and uninsured. The article favourably highlighted the suggested alternate approaches of these academics (Connolly, May 11, 2002).

A number of columnists deployed the *narrative of state leadership and innovation in health policy*, drawing attention to Massachusetts as a state health policy trailblazer. This included articles that praised health-related legislation or proposed legislation in Massachusetts. One article pointed to the efforts of state political leaders who were attempting to form an alliance with seven other politically progressive states (including Vermont) to control Medicaid drug costs (Freudenheim, January 5, 2002), while another suggested that Massachusetts was an example for California in its regulation of the nurse-to-patient ratio in hospitals (*NYT*, January 5, 2002). Another columnist praised Massachusetts as one of the twelve states that had laws regulating access to health insurance to curtail the unethical coverage-exclusion practices of insurance companies (Brock 2002). Similarly, a *Washington Post* news story praised a Massachusetts law that mandated health insurance coverage for fertility drugs as a courageous example for other states (Page 2002). Still other columnists praised Massachusetts as a national health

policy leader in tracking and regulating vaccine supplies (de Lisser and Spencer 2002) and for taking the initiative to implement a Medicaid prescription drug coverage plan for elderly Bay Staters who were living under the poverty threshold (Lueck 2002).

Massachusetts was further alluded to as a centre of the insurance, medical billing, and pharmaceutical sectors through the *narrative of Massachusetts as a centre of the health care industry*. This was not particularly surprising, since the presence of major research universities such as Harvard and MIT, some of the country's leading hospitals, and decades of state efforts to attract these companies, have led over 1300 pharmaceutical and biotechnology firms to establish themselves in the Bay State (EDCWM 2008; Koehler 2016). Even passing mentions of the location of insurance billing companies were noteworthy for the health reform story in the sense that they revealed the importance of the health care business sector in the state. For instance, one human-interest story in the *Washington Post* described the case of Marcia Goldberg, a Washington D.C. woman who felt harassed by a barrage of invoice statements from a Massachusetts-based health insurance billing company, following cancer treatment and hospice care for her deceased spouse (*Washington Post*, August 13, 2002). To be clear, articles that mentioned the economic importance, or, as in the above example, simply the location, of pharmaceutical, biotech, health insurance, and medical billing companies in Massachusetts were not necessarily unfavourable representations of the state health care system. The significant presence of the health care industry was an important contextual factor in the Massachusetts health reform story that surfaced in newspaper media reporting. Directly or indirectly, these pieces reinforced the neoliberal conceptualization of health care as a market and discursively normalized profit-seeking in the health sphere.

By the time of Romneycare debates in 2005 and 2006, the media's proponents of Romneycare continued to represent Massachusetts through the favourable *narrative of leadership and innovation in state health policy*, which had already been present in the newspapers during the 2002 state election campaign in response to earlier Massachusetts health policy innovations. In coverage related to Romneycare, it tended to depict the Commonwealth of Massachusetts as an avant-garde example both to other states and to the federal government. Consistent with broader national reporting on health care in 2005 and 2006, which focused largely on the challenges of rising uninsurance and health care costs across the country (the *expanded access* and *economic security narratives*), reporting on Romneycare and other Massachusetts health policy often predictably emphasized the potential impacts of reforms on cost or access.

The *narrative of leadership and innovation in state health policy* was similar to what it had been during the 2002 election campaign period, though journalists unsurprisingly focused most of their attention on the Massachusetts Health Reform Law that was under consideration at the time, expressing particular support for the "nearly universal" nature of the expanded insurance access that the Romneycare legislation promised (O'Neil 2006). This framing of "nearly universal" access in a for-profit, market-based system as progress, subversively rejecting the notion of the right to health care through a single-payer or well-regulated mandatory insurance system, was key to neoliberal framing of systemic challenges and solutions. The *narrative of leadership and innovation in state health policy* was most common in Democratic-leaning newspapers. For instance, a 2006 *Washington Post* piece included the following assessment, which illustrated both the *narrative of leadership and innovation in state health policy* and the

expanded access narrative in conjunction with the *individual responsibility narrative*:

> NOT FOR the first time, innovative social policy is coming from a state. On Tuesday the Massachusetts legislature passed a bill that would require all residents to buy medical insurance and that would aim to make insurance affordable; the ambition is to extend coverage to more than 90 percent of the state's 550,000 uninsured residents. (Washington Post, April 6, 2006).

Governor Romney pursued a similar approach in his own careful framing of the MHRL. It is noteworthy that Romney chose the conservative *Wall Street Journal* as the venue for his message and strategically blended the *individual responsibility narrative* with the *narrative of leadership and innovation in state health policy* and the *expanded access narrative*:

> Only weeks after I was elected governor, Tom Stemberg, the founder and former CEO of Staples, stopped by my office. He told me that "if you really want to help people, find a way to get everyone health insurance." I replied that would mean raising taxes and a Clinton-style government takeover of health care. He insisted: "You can find a way." I believe that we have. Every uninsured citizen in Massachusetts will soon have affordable health insurance and the costs of health care will be reduced. And we will need no new taxes, no employer mandate and no government takeover to make this happen…One great thing about federalism is that states can innovate, demonstrate and incorporate ideas from one another. Other states will learn from our experience and improve on what we've done. That's the way we'll make health care work for everyone. (Romney 2006).

Governor Romney's desired narrative of the MHRL was clear. He wanted Romneycare to be seen as a conservative, business-friendly and business-inspired plan that would reduce costs and expand access to insurance. He sought to clearly differentiate his plan from the Clintons' HSA, which he framed as a "government takeover." His opinion column further represented the health care crisis as a "personal responsibility" issue, celebrated the legislation's allegedly bipartisan foundations, credited the conservative Heritage Foundation with contributing to the plan, and emphasized the extensive efforts to which his administration had gone in order to find efficiencies (Romney 2006). A cynical

observer might assume that the governor tailored the message, and chose the conservative newspaper venue, to appeal to the health policy preferences of conservatives and political moderates, perhaps even as a prelude to seeking higher political office.

Even as Romney tailored his appeals to these voter groups, other writers framed the *narrative of leadership and innovation in state health policy* with more explicit emphasis on bipartisanship (Abelson 2006; Belluck 2006; Belluck and Zezima 2006). For example, a 2006 *New York Times* article offered a clear and strong focus on bipartisanship:

> The bill does what health experts say no other state has been able to do: provide a mechanism for all of its citizens to obtain health insurance. It accomplishes that in a way that experts say combines methods and proposals from across the political spectrum, apportioning the cost among businesses, individuals and the government. "This is probably about as close as you can get to universal," said Paul B. Ginsburg, president of the nonpartisan Center for Studying Health System Change in Washington. "It's definitely going to be inspiring to other states about how there was this compromise. They found a way to get to a major expansion of coverage that people could agree on. For a conservative Republican, this is individual responsibility. For a Democrat, this is government helping those that need help. (Belluck and Zezima 2006)

In another spin on the *narrative of leadership and innovation in state health policy*, the national newspapers sometimes favourably represented Romneycare in juxtaposition to inaction at the federal level. For example, a 2006 *Washington Post* article offered the following comparison:

> President Bush inadvertently underscored the weakness of the Republican agenda when he flew to Bridgeport, Conn., on Wednesday to campaign for his health savings accounts, known as HSAs. Virtually no one other than the president -- oh, and perhaps a few ideologues and insurance companies – sees HSAs as anything approaching a comprehensive solution to the nation's growing health-care problem. In Massachusetts, a bipartisan majority in the legislature was passing a visionary plan requiring all residents to buy health insurance and providing subsidies for those who can't afford the full freight. The contrast between the policy energy that exists in many states and the intellectual torpor in

Washington could not have been more stark. (Dionne 2006)

While the *narrative of leadership and innovation in state health policy* was most frequently used in reference to Romneycare, praise for Massachusetts in health policy innovation did not always focus on that legislation. Other columnists celebrated the state's decision to require Wal-Mart store pharmacies to offer the Plan B contraceptive pill, distinguishing itself as the first state to take such action against the controversial retail chain (Barbaro 2006). Still others gave accolades to Massachusetts and a handful of other states (including Utah) for being proactive in implementing legislation that increased the maximum coverage age for unmarried dependent children on their parents' employment-based health insurance plans (McQueen 2006).

Massachusetts politicians themselves benefited from this praise. National newspapers continued to report on their policy leadership during the Romneycare debates through the *narrative of Massachusetts leadership in national health reform*, which had already been present in the national newspapers in 2002. For instance, a *New York Times* article on President Bush's health care reform plan—a vision that relied heavily on health savings accounts (HSAs)—highlighted Senator Ted Kennedy's opposition:

> Democrats criticized Mr. Bush's plan as a windfall for the rich and said that a fast-food cook making $15,000 a year could not afford to set aside $5,000 in a health savings account or pay $1,050 in medical bills. "Sadly, the president's health care plan will only make a bad situation worse," Senator Edward M. Kennedy, Democrat of Massachusetts, said in a statement. Mr. Kennedy said the plan "just helps the healthy and wealthy, and leaves the rest of America behind. (Bumiller 2006)

Others went as far as calling Kennedy "the Democrats' senior strategist on health care issues" (Pear 2006).

Senator Kennedy was commonly cited as an outspoken critic of the Bush health

plan, whose concerns about health policy extended beyond its emphasis on HSAs. For example, in a 2005 *New York Times* piece, Kennedy was quoted:

> Senator Edward M. Kennedy, Democrat of Massachusetts, said Wednesday, "The president's medical malpractice plan is nothing but a shameful shield for drug companies and health maintenance organizations that hurt people through negligence. (Pear, January 6, 2005)

References to Kennedy's key role in the national health reform debates almost always occurred in articles that advanced the *expanded access narrative*, focusing on the plight of the uninsured as victims of life's vicissitudes. In some instances, Kennedy was quoted in more nuanced versions of the *expanded access narrative* that focused on access for specifically excluded groups. For example, a 2005 *USA Today* piece quoted Kennedy as follows:

> The state of U.S. minority health is an embarrassment to the nation," Sen. Edward Kennedy, D-Mass., writes in the issue. "They live sicker and die sooner from a wide variety of acute and chronic conditions." Kennedy recommends expanding health insurance programs, such as Medicaid and the State Children's Health Insurance Program. (Szabo 2005)

Of course, Senator Kennedy was not the only Massachusetts politician who attracted national media attention for advancing positions on federal health policy debates. Governor Romney was covered for his stance in defence of Medicaid transfers, in opposition to the Bush Administration, at the National Governors' Conference. For example, a *Washington Post* piece cited Romney as follows:

> "Governors such as Massachusetts Republican Mitt Romney said any extra Medicaid dollars are being used to extend health care to the needy. "We think they're totally appropriate," he said." (Connolly and Balz 2005)

Outside of the major reform underway in his own state, national newspapers focused on Romney's outspoken stance in the Medicaid debates, sometimes citing Romney as a possible Presidential candidate in 2008.

As had been the case in 2002, a handful of articles in the 2005-2006 legislative debate period included the *narrative of inefficiency and unethical health care practices*. The narrative did not specifically relate to the Romneycare debates; instead, as had been the case in 2002, it brought attention to the dubious actions of health insurance companies and medical practitioners in Massachusetts as examples of broader national problems. While critical of either the Massachusetts or the national health care system, it was a progressive narrative in favour of reform. Finally, a pair of articles contained the *narrative of health reform activism* during the Romneycare debates.

Later, in the period after the passage of Romneycare (April 12 – December 31, 2006), the *narrative of leadership and innovation in state health reform* persisted as the most common element in coverage that favoured Romneycare. The representation of Romneycare as a bipartisan success story was often part of the narrative. For instance, in an example of the *expanded access narrative* (one focusing on children as a marginalized, deserving group), and the *narrative of leadership and innovation in state health reform*, Senator Hillary Clinton was quoted in the *New York Times*:

> [Quoting Clinton] “I think you should cover all children who don't have other access to coverage. We shouldn't have any uninsured children. But we have to take that step by step." Mrs. Clinton said she was also closely watching the bipartisan health plan recently approved in Massachusetts. "If you've got an executive and a legislature who are willing to work together," she said, "you can actually make progress." In a sense, though, the heart of Mrs. Clinton's message seems to be that she is back in the debate. "It's one of my passions, it's what I care deeply about," she said. "It would not be possible for me not to talk about it and try to help change it." (Toner and Kornblut 2006)

Senator Clinton was not the only one watching the Massachusetts reform and evaluating it as a possible example for the rest of the country. The perceived problem of federal inaction on the health file seemed to inspire journalists to emphasize the role of the states

in innovation. Some detailed editorials combined the *narrative of state innovation and leadership in health reform* with the *expanded access, economic security, and individual responsibility narratives* to praise Romneycare. For instance, a *New York Times* piece offered the following synopsis:

> The federal government has done such a miserable job of providing health insurance for the 46 million Americans who lack it that states around the country have been forced to step in with their own plans. The latest and boldest effort was signed into law this week in Massachusetts. It is a carefully crafted plan with elements that could serve as a model for elsewhere, provided Massachusetts finds sufficient funds to make it all work. The cornerstone of the program is a requirement that everyone have a health insurance policy or pay a financial penalty. States have long required drivers to carry liability insurance, but this is the first time any state has imposed a health insurance mandate. The move is already raising hackles among libertarians, who consider it an unwarranted government intrusion into decisions that should be personal. But the truth is, very few of the uninsured go entirely without medical care. When they get sick, they typically show up at emergency rooms, where they get very expensive care without paying. By forcing all residents to assume responsibility for their own health coverage, Massachusetts should largely solve this "free rider" problem and tilt treatments back toward routine and preventive care and away from emergency care. (*NYT*, April 16, 2006)

In the example above and in similar pieces, coverage of the tenets of Romneycare was more comprehensive than it had been during the legislative debates, demonstrating that the media was perhaps more interested in the final product than in its conceptualization and the surrounding debates. Other columnists praised the legislation for the nearly-universal nature of the coverage expansion, pointing out that, if successful, Romneycare would lead to approximately 515,000 of the state's 550,000 uninsured obtaining health insurance, making it the most aspirational state-level plan to date (Belluck and Zezima, April 13, 2006).

Still others pointed out that, despite successful reforms in states like Maine and Vermont, the Massachusetts reform model was the one that attracted the attention of

other state governments, federal health officials, and think tanks as a possible model to emulate. The reason for paying greater attention to Massachusetts, according to a December 2006 *Wall Street Journal* piece, was Romneycare's unique combination of expanding insurance coverage, reducing reliance on means-tested government programs, reducing public and private health care costs (at least in theory, since cost-savings were only predictions), and responsibilizing citizens (*WSJ*, December 26, 2006). These neoliberal discourses of responsibilization, economic efficiency, and public-private sector cooperation to resolve a pressing policy problem made the plan appealing to mainstream Democratic and Republican media alike. It is therefore not surprising that the main detractors of Romneycare came from either the more libertarian fringes of Republican-leaning media (which espoused more market-fundamentalist health policies), or the more social democratic and social investment oriented fringes of the Democratic-leaning media (which advocated single payer, or more regulated mandatory insurance reforms).

Although some insurance companies expressed only tepid support for Romneycare in the press, while they awaited details on the regulations, the industry was generally supportive. Some insurance companies in fact seemed unequivocal in their backing. For example, a *Wall Street Journal* article quoted a spokesperson for Aetna Corporation (one of the state's largest health insurers), who described the Massachusetts plan as "a common sense approach to addressing the single-greatest strain on the health care system—the uninsured" (Bulkeley 2006). In the same way that a professor or a university administrator might warmly welcome a law that required post-secondary enrolment (with public subsidies for students who could not afford it, and fines on non-compliant citizens that partly funnelled revenue back to universities), it was not

surprising that the insurance industry welcomed Romneycare. After all, the industry stood to gain millions of dollars in reliable revenue and a lot of job security for the large private bureaucracy it had built since the 1950s. This reform was essentially set to replace parts of both means-tested and universal social assistance with corporate welfare. For the insurance industry, there was little not to like.

National columnists also continued to focus on Massachusetts through the *leadership in national health reform narrative* after the passage of Romneycare, emphasizing the role of the state's widely recognized elected officials. Senators Kennedy and Kerry, and Governor Romney, were the most frequently cited Massachusetts politicians in coverage of the national health reform debates. In particular, in the summer and fall months of 2006, Senator Kennedy's *Healthy Families Act* garnered noticeable media attention. For example, a *New York Times* column offered the following description: "Senator Edward Kennedy's proposed *Healthy Families Act* would guarantee seven days paid sick leave to full-time workers and prorated benefits for part-time employees" (Gotbaum and Rankin 2006). Senator Kerry also attracted some attention by advocating for a national health reform plan comparable to the HSA or Romneycare. A *Washington Post* article, containing the *individual responsibility narrative* as well as the *expanded access* and *economic security narratives* of reform, summarized Kerry's position:

> Sen. John F. Kerry (D-Mass.) yesterday renewed proposals from his 2004 presidential bid for expanding health insurance to all Americans. "The health-care crisis has grown steadily worse," he said in a speech in Boston. Kerry, who is considering another run for president in 2008, said the government should require all Americans to have health insurance by 2012, "with the federal government guaranteeing they have the means to afford it…. It is time to jump-start a debate around the country that can shake Washington into action before the health-care crisis devastates millions more of America's families," Kerry said. "We can no

> longer accept a 20th-century health-care system for a 21st-century economy." (Goldfarb 2006)

After the successful implementation of Romneycare in 2006, the Kerry position, one in favour of an individual insurance mandate with means-tested federal subsidies, appeared to be a consensus position amongst leading centrist Democrats and Republicans. It seemed that, discursively, the country's political leadership was moving in the direction of a semi-mandatory insurance model to cure the ills of the health care system and to preserve the private insurance market, and Massachusetts was regarded as a test case.

Beyond the coverage of Kerry, Kennedy, and Romney, there were also a handful of epitaphic pieces on former U.S. Representative Gerry Studds that contained the *leadership in national health reform narrative*. Studds (then recently deceased) was the first openly gay U.S. Congressman in the 1980s. He was a tireless health reform advocate, both for poor, uninsured Americans and for those afflicted with AIDS (Lamb 2006). The references to Congressman Studds in the post-Romneycare period of 2006 were important in the sense that they demonstrated the noteworthy role that Massachusetts politicians had played in national health reform debates for decades.

A few articles after the passage of Romneycare also featured the *narrative of activism in state health reform*, which had been present at least since the 2002 election campaign period. For example, a *Washington Post* piece included the following observations:

> We've made Massachusetts the best state to live in for struggling working families," said Carl Nilsson, an activist for poor people, citing the higher minimum wage and an earlier state law that requires health insurance for all… Massachusetts's new health-care law hits a new milestone, allowing those earning up to 300 percent of the federal poverty level to buy into subsidized plans. (Those at or below the poverty level are already eligible for virtually free health care).

(Tanner 2006)

References to the role of health reform activists, such as Carl Nilsson in the Tanner (2006) example, added greater clarity to the Massachusetts reform story. So did columnists that informed readers that health reform in Massachusetts would not have been possible without many years of pressure from single-payer advocates (e.g. Dionne, May 12, 2006). Like so many legislative breakthroughs, Romneycare was a carefully orchestrated and negotiated political compromise, one that resulted from organized demands for more radical health reform that had been articulated in earlier periods (Dionne, May 12, 2006). The *individual responsibility narrative in favour of Romneycare*, the *narrative of inefficiency and unethical health care practices*, and the *narrative of Massachusetts as a centre of the health care industry* also remained in the national newspapers in the period after legislative passage in 2006.

Predominantly Republican narratives (favourable) during the Romneycare debates (2005-2006)

It is noteworthy that Romneycare also had its proponents on the political right and centre, and the mainstream Republican perspective in favour of Romneycare deserves separate attention. As a narrative explicitly in favour of Romneycare and other simultaneous health policies in Massachusetts, the *individual responsibility narrative* was more common in the newspapers of the political right and centre. It celebrated Romneycare as a responsibilizing initiative that punished alleged free-loaders in the health care system. A 2005 *USA Today* column illustrated the individual responsibility narrative (in conjunction with the expanded access narrative) well:

> Massachusetts Gov. Mitt Romney…announced a plan to expand health coverage to all the state's residents, with a caveat that those who don't buy coverage could face a penalty. "We can't have as a nation 40 million people -- or, in my state, half

> a million -- saying, 'I don't have insurance, and if I get sick, I want someone else to pay,'" says Romney, a Republican who says he might run for president in 2008…. It's the question behind all health care debates: Who should pay? Romney's plan says everyone should…Failing to sign up could lead to a loss of a personal tax exemption or garnishment of wages. Romney's plan comes as politicians, employers and benefit consulting firms are focused on the latest trend in health care cost control: "personal responsibility"…."It's a conservative idea," says Romney, "insisting that individuals have responsibility for their own health care. I think it appeals to people on both sides of the aisle: insurance for everyone without a tax increase. (Appleby, July 5, 2005)

Clearly, this narrative in favour of Romneycare—one that Romney himself was careful to restate frequently—had little or no notion of community responsibility for the downtrodden uninsured. Instead, it was perfectly consistent with the American myth of rugged individualism, and, furthermore, it was a discourse that placed government in the role of punishing allegedly irresponsible consumers instead of lending a helping hand to the uninsured. Interestingly, as the above example (Appleby, July 5, 2005) illustrates, the *expanded access narrative* typically emerged in a subordinate position to the *individual responsibility narrative* when deployed simultaneously.

Unfavourable narratives of the Massachusetts health care system and Romneycare during the 2002 election campaign, during the Romneycare debates (January 1, 2005 – April 11, 2006) and after legislative passage (April 12 – December 31, 2006)

Through the unfavourable *narrative of inefficiency and unethical practices*, national newspaper reporting criticized health care system management and insurance practices in the state (11 articles, 15% of coverage), negatively portraying the Massachusetts health care system. In a handful of news stories, Massachusetts was cited as a state in which so-called short-term health insurance policies[52] were gaining in

[52] In the pre-Obamacare era, "short-term health insurance policies" gained some popularity with consumers as a means to cover periods between jobs and/or the time after university when young Americans may not yet be employed in jobs with insurance benefits and no longer qualify for their parents' insurance or student insurance. They were also appealing to people starting their own businesses who could not afford traditional plans. The problem with such policies was that

popularity due to rising premiums for traditional policies:

> But groups such as the American Cancer Society point out the great-sounding deals could mean trouble for anyone who gets diagnosed with a serious illness." Health insurance shouldn't put a person at risk," says Jose Vincenty, director of government relations and advocacy at the New England division of the American Cancer Society in Boston. "We're concerned about the person who is healthy now and gets the insurance and is diagnosed with cancer. What's going to happen with their health care? (Chaker 2002)

The above example combined the *expanded access narrative* with the *narrative of inefficiency and unethical health care practices* to criticize an evolving trend in private health insurance company practices in Massachusetts.

While health care providers also sometimes drew scorn from the media, insurance companies were often the target of columnists. A *Wall Street Journal* column denounced the region of Eastern Massachusetts—where three health insurance companies controlled 75% of the health insurance market—as an example of an "oligopoly" that was corrupting business practices in America (Dreazen, Ip, and Kulish 2002). Two other *Wall Street Journal* pieces criticized insurance practices in Massachusetts: specifically, overbilling by physicians that allegedly drove increases in health insurance costs for all consumers (Martinez 2002), and the practice of "securitization" in which insurance billing agencies purchase claims from health care providers for cash (shortening provider wait times for payment from insurance companies, Medicare, and Medicaid), and subsequently keep a portion of the total claim for their own profit once it is paid (Beckett and Sapsford 2002). Columnists derided practices such as securitization by so-called "insurance middlemen" and fraud at different levels of the system as culprits in the

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they had fixed terms (and thus would not continue to pay for medical services if people remained sick and needed treatment after the term) and often covered fewer services and procedures than traditional policies.

increasing costs of health service delivery. While national newspapers did not describe such problems as unique to Massachusetts, the fact that Massachusetts examples were cited to illustrate these challenges constituted derogatory media frames for the state health care system.

Predominantly Republican (libertarian) narratives against Romneycare and the Massachusetts health care system during the legislative debates (January 1, 2005-April 11, 2006) and after the passage of Romneycare (April 12 – December 31, 2006)

Not all journalists were enamoured with Romneycare as the model solution to America's health care crisis. As such, the *anti-Romneycare narrative* emerged in opposition to the reform effort in a handful of articles. For instance, in the subtly titled *USA Today* article "Massachusetts will fail," conservative health policy researcher Sally Pipes—Director of the Pacific Research Institute, a prominent conservative think tank, and former Associate Director of Canada's very right-leaning Fraser Institute—declared:

> Massachusetts' health care plan won't lead to universal care through private insurance. It just might, however, give the Bay State government-run single-payer health care. Individual health insurance is not always a good deal in Massachusetts, thanks to state-imposed community rating regulations that require companies to charge the sick and healthy the same rates. The result: Some people elect not to purchase it. An innovative approach would deregulate the individual market and allow insurance companies to design policies that are attractive to the non-needy uninsured. (Pipes 2006)

The argument Ms. Pipes deployed against Romneycare was based in libertarian, market-oriented ideology, which holds that government intervention in the health care system is undesirable and frequently detrimental. This was a common refrain in the *anti-Romneycare narrative*.

Other critics used humour to denounce the plan along similar lines, attacking it on both ideological and economic grounds. In the *Wall Street Journal*, Arnold Kling, libertarian economist at the Cato Institute, offered the following synopsis of the

Massachusetts reform plan:

> The elected leaders of Massachusetts have come up with a novel solution for the vexing problem of paying for health care: abolish the laws of arithmetic. Their new plan is a perfect illustration of what happens when politicians approach a problem unconstrained by reality…The problem of paying for health-care coverage, which politicians are declaring they have "solved," is really just beginning. The only way to make zero-deductible health insurance available at low cost is with a large subsidy; how much will depend on negotiations with insurance companies. Only when the size of the necessary tax increase becomes clear will Massachusetts's leaders learn the laws of arithmetic. (Kling 2006).

For critics from the libertarian political right, such as Kling and Pipes, Romneycare was a case of the cure being worse than the disease, an example of the government interfering in a health care market without understanding the real problems—problems that they saw as products of earlier ill-advised government interventions and wasteful public programs that corrupted the market.

Another unfavourable, predominantly Republican (libertarian) narrative of health care in Massachusetts, the *narrative of unethical health care regulation,* surfaced for the first time during the Romneycare debates. While it did not focus on Romneycare, it was a noteworthy narrative. For example, in the *Wall Street Journal*, Dr. David Gratzer, a Canadian physician and scholar at the Manhattan Institute (a conservative policy think tank), stated: "In New York, Massachusetts and a handful of other over-regulated states, HSA products are absent from the individual insurance market" (Gratzer 2005). Like President Bush[53] at the time, Gratzer was promoting health savings accounts (HSAs) as a

[53] Tax-free Health Savings Accounts (HSAs) were the hallmark of President Bush's second- term health reform plan, which had five objectives. After the often touted HSAs, the other four major tenets of the Bush plan were tort reform (focusing on medical malpractice lawsuits), "transparency" in prices for medical services, improved technology for medical records, and insurance pools to reduce risks for smaller businesses that would allegedly encourage them to offer health insurance to their employees (Milbank 2006). While hardly slogan-inspiring, the Bush health reform plan was intended to be an easy political win for a second-term President who was mired in an unpopular war, and who was facing a far more difficult Social Security reform

key solution to America's health care crisis. It was part of a familiar refrain that advanced the notion of market-oriented health care reform and simultaneously expressed disdain for government regulation in the health sphere.

Later, in the period after the passage of Romneycare (April 12 – December 31, 2006) the critics of Romneycare, and of the Massachusetts health care system more broadly, remained in the minority after the passage of the legislation. However, these critical columnists continued to advance both the *anti-Romneycare narrative* and the *narrative of unethical health regulation*. For instance, a blending of both narratives in *USA Today* presented America's health care challenges, and the allegedly misguided policies of Massachusetts, in these terms:

> I'm reminded of Ronald Reagan's adage: Government is not the solution to our problem. Government is the problem, at least when it comes to health insurance. Well-meaning but misguided states such as New Jersey and Massachusetts have priced young people out of the market by keeping laws on the books that force plans to cover everything, take all comers or treat young and old, healthy and sick, roughly the same. It's nice that legislatures then try to mop up the mess by passing "slacker mandates" that pretend 30-year-olds are dependents, or, in Massachusetts, forcing people to carry coverage. But if this country truly wants to cover the uninsured, we should remember that rates aren't high everywhere. Insurance companies have come up with cheap ways to get young people covered in states that don't tie insurers' hands. The answer is not to pass more laws. (Vanderkam 2006)

The Vanderkam (2006) piece repeats the refrain that the market, not government, must fix the health care system. The problem, from this perspective, was that Romneycare and the state legislation that preceded it had corrupted the health insurance market. Other columnists (especially in the Republican-leaning *Wall Street Journal*) warned that Romneycare would incite employers to lay off workers, or at least to try to limit their workforces to ten employees to avoid the insurance mandates. These opponents of

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fight, just as his War on Terror and Ownership Society rhetoric were losing whatever allure they had once had for Middle America.

Romneycare were concerned that the $295 annual fine (per employee) imposed on employers for not offering health insurance, together with other possible penalties such as the employer requirement to reimburse hospital expenses for uninsured employees and their families, would drive up the unemployment rate (McCaughey 2006; Miniter 2006). Typically combining both the *anti-Romneycare narrative* and the *narrative of unethical health care regulation*, their arguments held that the regulations included in the Massachusetts reform would worsen the health care crisis and entail new economic risks. As such, Romneycare was portrayed as a model to avoid, not imitate (McCaughey 2006; Miniter 2006; *WSJ* May 2, 2006; *WSJ* April 24, 2006; *WSJ* April 12, 2006).

Another article in the *Washington Post* by John Graham (a conservative health policy researcher and former Director of Health and Pharmaceutical Policy Research at Canada's Fraser Institute), offered one of the most creative analogies used by a pundit to characterize the health care crisis. The American health care system, Graham wrote, was like a dystopic restaurant industry in which restaurateurs were required to serve all patrons, regardless of their ability to pay. In the analogy, most people carried "food insurance," but the food insurance business was overly bureaucratic, and both patrons and restaurateurs had to haggle with food insurance companies over bills. Food prices had to be inflated to compensate for the "freeloaders" who never paid for their meals. As a result, governments decided to make food insurance mandatory. However, for Graham, this state "coercion," even if well intentioned, was wrongheaded in the sense that it contributed to cost-inflation and failed to responsibilize everyone (some people would always ignore all government mandates). Instead, Graham argued, the solution to the health care crisis was to deregulate both hospitals and the insurance industry, thus

allowing the market to naturally correct itself (Graham 2006).

The nature and diffusion of right-libertarian narratives critical of the health care system, such as Graham's creative analogy (a straw man argument to be sure, but pithy and articulate), merits some reflection. This case offers an interesting instance of narrative diffusion across borders. Graham, as noted above, is a Canadian researcher with ties to the Fraser Institute, a think tank that notably receives generous funding from the Koch brothers—conservative American billionaires who also fund and maintain professional relationships with so-called "alt-right" American media outlets, such as the *Daily Caller*, and the libertarian Cato Institute (Robbins 2016; Tencer 2014). His column, which appeared in a centrist American newspaper, denounced government insurance mandates, which aimed to expand access to health care during the Romneycare debates of 2006. Eleven years later, after his tenure with the Fraser Institute and a number of conservative and libertarian American think tanks from California to Michigan (where Graham contributed to work that opposed Obamacare), he was appointed by the Trump Administration to serve as Acting Assistant Secretary and Principal Deputy Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services (Graham 2017; Hasson 2017). Graham's career trajectory seems to demonstrate that narratives diffuse, in part, because the political, academic, and media elites who deploy them change their roles and advance ideologically comparable narratives across regional and national borders, in different sectors and through different media. The example is also consistent with the research of Genieys et al. (2013) on the "revolving door" of elite "long timers" in American health care policy-making.

Beyond Graham's focus on Romneycare in the *Washington Post* example above,

as had been the case during the 2002 election campaign and the 2005-2006 legislative debate periods, the *narrative of unethical health regulation* was used after the passage of Romneycare to critique Massachusetts for a host of policies. For instance, the following excerpt from a November, 2006 *Wall Street Journal* article illustrated this narrative well:

> The biggest disappointment is that the insurers aren't calling for a national market in health insurance -- which is essential if their Universal Health Accounts are to work as well as they should. In addition to the tax code, one of the biggest obstacles to portability and individual policy ownership is that insurance is governed by 50 different sets of state regulations. These rules can make insurance needlessly expensive (as in New York and Massachusetts), and the balkanized market curbs innovation and prevents the development of larger risk pools and economies of scale. (*WSJ*, November 20, 2006)

Once again, the *narrative of unethical health regulations* framed government as a key part of the systemic problem, rather than a potential source for solutions.

Summary of national newspaper coverage of Romneycare and the Massachusetts health care system during the state legislative election campaign (January 1 – November, 2002) the debates surrounding Romneycare (January 1, 2005 – April 11, 2006), and after the passage of Romneycare (April 12 – December 31, 2006)

During the 2002 election campaign period, the national newspaper media typically brought Massachusetts into the health reform discussion inadvertently by citing examples of cost and access challenges (the *expanded access* and *economic security narratives*) that affected the country as a whole. However, Massachusetts stood out as a health policy innovator at the state level (*narrative of leadership and innovation in state health policy*), as a leader in national health reform debates through its prominent politicians (*narrative of Massachusetts leadership in national health reform*), and in terms of its state-level health care reform activism (*narrative of health reform activism*). It was also sometimes disparagingly depicted as a microcosm of systemic inefficiencies and unethical practices on the part of health insurance companies and health care

providers (*narrative of inefficiency and unethical health care practices*). Finally, beyond reform leadership, policy innovation, and the fact that the state was a microcosm of broader American health care problems, a few national newspaper articles in 2002 also portrayed Massachusetts as a state where the health insurance, medical billing, and pharmaceutical industries were economically significant and carried political clout (*narrative of Massachusetts as a centre of the health care industry*). Thus, during the 2002 state election campaign, a total of seven health reform narratives framed representations of the Massachusetts health care system. These early media frames and narratives of health care in Massachusetts were previews of the state to the American public before the Romney debates.

Later, during the Romneycare debates from January 1, 2005 to April 11, 2006, the national newspaper media continued to bring Massachusetts into the health reform discussion inadvertently through references to cost and access challenges (the *expanded access* and *economic security narrative*s) that were impacting every state. However, Massachusetts was again portrayed as a health policy innovator at the state level (*narrative of leadership and innovation in state health policy*), as a leader in national health reform debates thanks to the prominent roles played by its senators, members of congress, and outspoken governor (*narrative of Massachusetts leadership in national health reform*), and in terms of its state-level health care reform activism (*narrative of health reform activism*). It also remained subject to disparaging depictions as a microcosm of systemic inefficiencies and unethical practices on the part of health insurance companies and health care providers (*narrative of inefficiency and unethical health care practices*).

A few national newspaper articles during the legislative debates represented Massachusetts as a state where the health insurance, medical billing, and pharmaceutical industries were economically significant and carried political clout (*narrative of Massachusetts as a centre of the health care industry*), as some columnists had suggested during the 2002 election campaign. However, *the narrative of unethical health regulation* was deployed as a new narrative of the political right to critique aspects of the Massachusetts health care system. Similarly, both the *anti-Romneycare narrative* and the *individual responsibility narrative in favour of Romneycare* were new narratives used in direct response to the MHRL legislation. In total, ten health reform narratives framed representations of the Massachusetts health care system in the Romneycare debates.

In the period following the passage of Romneycare (April 12 – December 31, 2006), while there were noteworthy critical pieces that included the *anti-Romneycare narrative, the narrative of unethical health regulation*, and the *narrative of inefficiency and unethical health care practices*, representations of Romneycare and the Massachusetts health care system were predominantly favourable. A *Washington Post* column offered a summary of the Massachusetts legislation that was at once admirably balanced and broadly representative of the consensus of most national outlets:

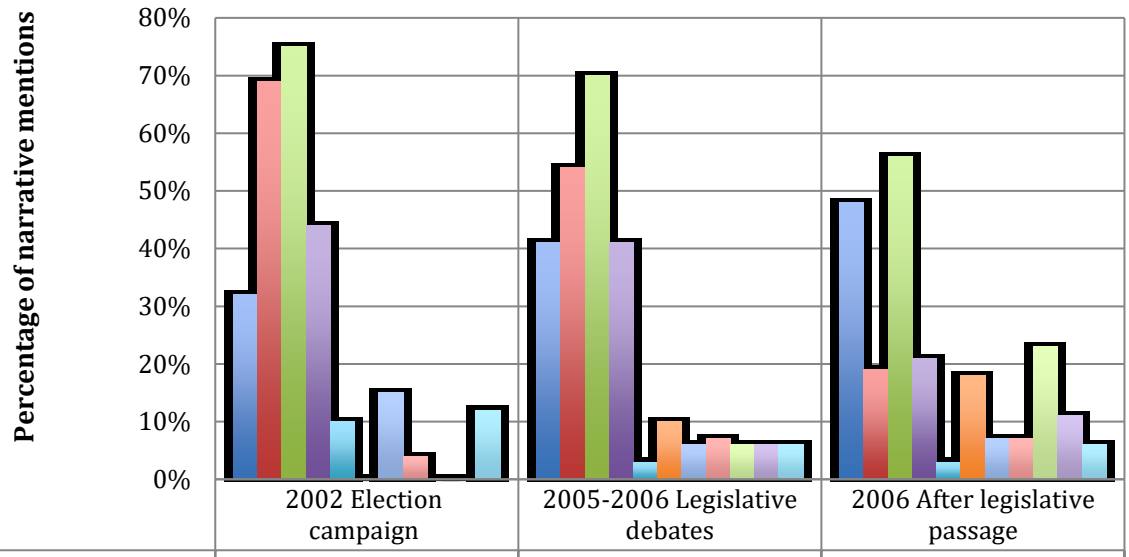
> This is a rare and exotic political hybrid, with a basis in a conservative think tank and the blessing of a Democratic legislature and Sen. Ted Kennedy. The passage of such a program with overwhelming bipartisan support is a notable achievement in a time of polarized, partisan politics. But is it still just an idea. (Broder 2006)

In a tone that was at times jubilant, and at times more reticent, Broder (2006) deftly described Romneycare's less known ideological origins (in the conservative Heritage Foundation think tank), as well as the complex brokerage politics required to achieve it in

a post-HSA political environment, one that remained unfavourable to grandiose health reform agendas. The seed of doubt at the end of Broder's synopsis—that it remained "just an idea"—was further explained as a reference to the uncertainty over how the health exchange would work, and whether or not its insurance policies could actually be affordable (Broder 2006). The national newspaper media liked Romneycare, and, since the legislation included elements likely to please both mainstream Republicans and Democrats, the legislation's appeal to the media was as understandable as it was predictable. Chart 4.3 on page 190 illustrates the ten health reform narratives that framed national newspaper representations of Romneycare and the Massachusetts health care system at critical junctures between 2002 and 2006.[54]

[54] Percentages in Chart 4.3 are based on a total of 237 articles in the four national newspapers that mentioned Massachusetts in the context of reporting on health care during the critical junctures of the 2002 Massachusetts election campaign (January 1 – November 4 2002), the period of legislative debates on Romneycare (January 1, 2005 – April 11, 2006), and the period after legislative passage (April 12, 2006 – December 31, 2006).

Chart 4.3: Influential health reform narratives in national newspaper (*New York Times, Wall Street Journal, USA Today, and Washington Post*) coverage of Romneycare and the Massachusetts health care system (2002 - 2006)



	2002 Election campaign	2005-2006 Legislative debates	2006 After legislative passage
Narrative of leadership and innovation in state health policy	32%	41%	48%
Economic security narrative in Massachusetts coverage	69%	54%	19%
Expanded access narrative in Massachusetts coverage	75%	70%	56%
Narrative of Massachusetts leadership in national health reform	44%	41%	21%
Narrative of health reform activism	10%	3%	3%
Individual responsibility narrative in favour of Romneycare	0%	10%	18.00%
Narrative of inefficiency & unethical health care practices	15%	6%	7.00%
Narrative of Massachusetts as a centre of the health care industry	4%	7%	7%
Anti-Romneycare narrative	0%	6%	23%
Narrative of unethical health care regulation	0%	6%	11%
Other	12.00%	6.00%	6.00%

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[55] Note that the category of "other" in Chart 4.3 contains articles that were more peripherally related to the Massachusetts debates, such as those containing mentions of the Clintons' HSA (favourable and unfavourable), single-payer health care (favourable and unfavourable), or other narratives of health care in Massachusetts. None of these narratives was deployed in 5% or more of overall coverage during the 2002 election campaign, the Romneycare debates in 2005 and

4.6 Lessons from the Massachusetts case in the national newspaper media and the role of neoliberalism in national newspaper representations of Romneycare and the Massachusetts health care system

Ten major health reform narratives—those that surfaced in at least 5% of articles—were deployed in the four national newspapers during the critical junctures that surrounded the Massachusetts Health Reform Law. Between 2002 and 2006, only limited attention was paid to Massachusetts in the national media. In total, only 4.7% of reporting (237 articles out of 5,075 relevant pieces on health care in the United States) included narratives of Romneycare or the Massachusetts health care system. [56] National journalists largely focused on the challenges of cost and access in the health care system in the periods of analysis, and Massachusetts coverage was no exception. Among ten health reform narratives analysed in this chapter, seven were already in the newspapers in 2002 before Romneycare. Three narratives, the *anti-Romneycare narrative, the narrative of unethical health care regulation*, and the *individual responsibility narrative in favour of Romneycare*, all emerged in 2005 in response to the Massachusetts reform effort. Interestingly, none of the ten major narratives challenged the neoliberal conceptualization of health care as a market—a market that involved hierarchies of access to care and quality of care, one with winners and losers that accepted profit-driven medicine. Instead, the major narratives largely advocated the improvement and preservation of the market. None of the challenging, pro-single payer voices accounted for 5% or more of reporting at any of the three critical junctures.

2006, or in the period following the passage of Romneycare in 2006. As such, these narratives are not listed individually.

[56] There were in fact 247 articles that mentioned Massachusetts; however, 10 of these articles contained neutral mentions with no relevant narrative of reform.

At the first critical juncture of the 2002 state election campaign, when health care reform was a contentious issue, Massachusetts typically entered the press peripherally, either through coverage of its prominent politicians, such as Senator Kennedy, or in articles in which it was portrayed as a microcosm of broader access and cost challenges. On occasion, stories about dubious insurance industry practices and medical malpractice, or about health reform activism drew attention to Massachusetts. The limited reporting in 2002 nonetheless depicted Massachusetts as a state with powerful elected representatives in Washington who were playing key roles in the health reform debates. The newspapers further portrayed Massachusetts as an important centre of the health care industry, and as a state with an above average level of health reform activism that suffered from the same systemic problems as the rest of the country.

By the time of the Romneycare debates and after passage of the legislation in 2005 and 2006, the peripheral mentions of Massachusetts gave way to reporting on the Romneycare. It is clear that the media took interest in the reform in part because Massachusetts succeeded where the federal government had failed. This fact seems to indicate that health care journalism gives greater attention to sub-national governments when there is comparable inaction at the federal level. Favourable narratives, in particular the *narrative of leadership and innovation in state health policy*, traveled easily between newspapers across the political spectrum and was deployed more frequently over time. In contrast, the unfavourable *anti-Romneycare narrative* and the *narrative of unethical health care regulation* were predominantly found in the Republican-leaning *Wall Street Journal*. Similarly, the unfavourable *narrative of inefficiency and unethical health care practices*, which tended to be critical of either the insurance industry or health care

providers in allegedly contributing to access challenges or unreasonable costs, was more common in the Democratic-leaning *New York Times*. Most importantly, analysis of national newspaper coverage of the Romneycare debates demonstrates that the national newspaper media were attentive to the major systemic challenges of rising health care costs and increasing uninsurance, yet surprisingly hostile—or at least uninterested—in more radical health reform solutions, such as single-payer socialized insurance or socialized medicine, or more regulated mandatory insurance such as the Clintons' HSA model.

Narrowing the focus specifically to Massachusetts coverage, and examining unfavourable versus favourable representations, it is revealing that the *narrative of inefficiency and unethical health care practices*—a discourse that was critical of health insurance companies and health care providers for increasing costs or limiting access—was only present in 21 articles, or 8.8% of Massachusetts reporting. In contrast, criticism of Romneycare and the Massachusetts health care system from the libertarian political right for allegedly being overregulated, coercive, and interventionist (*anti-Romneycare narrative* 22 articles; *narrative of unethical health care regulation* 13 articles) together accounted for 14.5% of Massachusetts coverage. Across the four newspapers, favourable representations of Romneycare and the Massachusetts health care system through the *narrative of leadership and innovation in state health care policy* (91 articles) and the *individual responsibility narrative in favour of Romneycare* (21 articles) together accounted for 47.2% of reporting on Romneycare and the Massachusetts health care system. Thus, based on the frequency of health reform narratives, the national newspaper media favourably represented the neoliberal health reform model; one that emphasizes

the devolution of policymaking to state governments, which have less regulatory power over the insurance industry than the federal government. The neoliberal health care model favoured in these narratives further emphasized individual responsibility in health care and health care financing, and preservation of unequal market-based health care financing and delivery. This tendency was repeated, albeit with some important differences, in coverage at the state level. The following chapter explores publications within Massachusetts – specifically the *Boston Herald* (Republican-leaning) and the *Boston Globe* (Democratic-leaning).

Chapter 5: Massachusetts newspaper media representations of Romneycare across time (2002-2006)

5.1 Introduction

This chapter examines representations of the Massachusetts Health Reform Law as well as key healthcare issues and priorities in the major state-based dailies—*The Boston Herald* (Republican-leaning), and *The Boston Globe* (Democratic-leaning)—to differentiate representations on the basis of authors' political leanings as well as the comparative frequency of health reform narratives across time. In contrast to the national newspapers that were analyzed in Chapter 4, the leading state-based print media demonstrated wide-ranging and deep interest in the state health reform debates. My research shows that the ten major narratives (those that surfaced in at least 5% of articles in one or more of the three periods of analysis) that I identified in the national newspapers in the previous chapter were also deployed in the state-based dailies, suggesting that there was narrative diffusion from the national to the local media. However, the greater quantity and depth of health care reporting in the Massachusetts newspapers also prompted two other narratives—the *pro-single payer narrative* and the *narrative of political gridlock in health care reform*—to emerge, and contributed a number of additional minor narratives in the "other" category. Based on these newspaper media representations, I argue that, as had been the case in the more limited national coverage, centrist (predominantly neoliberal) policies—involving comprehensive yet modest reforms—were largely favoured in state newspapers. Specifically, the *expanded access, economic security, state leadership and innovation, and individual responsibility narratives* constituted the most frequently deployed mainstream Democratic-leaning and

Republican-leaning viewpoints in favour of healthcare reform in the two major state newspapers.

State-based newspapers, moreover, offered a clearer picture of the diverse opposition to the neoliberal health reform model than did the national newspaper reporting analyzed in the previous chapter. This opposition spanned the political spectrum. In the Democratic-leaning press, it was primarily visible through the *pro-single payer narrative* and the *narrative of inefficiency and unethical health care practices*. This critical health care coverage mainly included social democratic perspectives that prioritized social investment in a new health care system (proposals ranged from single-payer social insurance to visions of more regulated mandatory insurance models than that which the Romneycare plan proposed) and accusations of greed and callous practices in the health care and insurance industries. In the Republican-leaning press, through the *anti-Romneycare narrative* and the minor *narrative of unethical health regulation*,[57] opposition mostly consisted of libertarian appeals for a market-driven health care system, one with less government regulation and less support for existing government programs (especially Medicaid) than the Romneycare model.

This chapter reveals a complex situation, involving both competition and convergence between Democratic and Republican perspectives in the newspaper media. It reveals that more radical health reform voices—particularly the aspirations of single-payer reform advocates and the calls from libertarians for more market-oriented, less

[57] The *narrative of unethical health care regulation* is not depicted in Chart 5.2 because it surfaced in less than 5% of articles in any of the three periods; however, while this minor narrative technically falls in the "other" category of minor narratives, it was often deployed with the *anti-Romneycare narrative* and it was a recurring frame on the fringes of the political right. Because it had been a more major narrative in the national newspapers that I analyzed in Chapter 4, I mention it here.

regulated health care delivery options—tended to be excluded from or marginalized in media reporting. Finally, it shows that the frequency of health reform narratives oscillated at critical junctures—from the 2002 election to the legislative debates and after legislative passage the MHRL in 2005 and 2006. The chapter thus demonstrates the ways in which health reform preferences and priorities varied according to the political orientations of columnists and at critical junctures across time.

5.2 Depictions of Romneycare and the Massachusetts health care system in the *Boston Globe* and the *Boston Herald*

The *Boston Globe* and *Boston Herald* featured much more extensive reporting on the Massachusetts reform debates than the national newspapers. The following sections summarize state newspaper reporting on Massachusetts in the context of American health reform debates between the 2002 state election campaign and the MHRL passage and implementation period in 2006. Using newspaper articles and narrative mentions as units of analysis, this chapter examines newspaper articles to comparatively scan the favourable, unfavourable, and neutral coverage appearing in Republican-leaning and Democratic-leaning newspapers.

It is important to note that this distinction between generally conservative and liberal sources tells only part of the MHRL story. As units of analysis, newspaper articles offer only a broad perspective on media representations; characterizing their general political orientation does not necessarily clarify the complexity of the debates contained within them. Thus, after analyzing articles according to their overall favourable, unfavourable, and neutral representations of health reform debates in section 5.3, I delve deeper into state-based newspaper reporting, examining health reform narratives of the

MHRL debates. Instead of using articles as units of analysis, the narrative analysis in section 5.4 analyzes *mentions* of each narrative, scrutinizing the trajectory of health reform narratives across several critical junctures of the reform period.

The analysis reveals that, already in 2002, the cost and access challenges of the commonwealth's health care system were key points of debate between gubernatorial candidates both during the Democratic primary and in the general election. Later, during the Romneycare debates of 2005-2006, *Boston Herald* and *Boston Globe* writers viewed Massachusetts as the site of a major and controversial American healthcare reform—one that would likely influence future state and federal reform debates; however, they were less likely to link the state-level reform proposals to the federal health reform debates than their counterparts in the national press.

As had been the case in the national media, the representations of Massachusetts that surfaced in mainstream Democratic-leaning and Republican-leaning coverage largely represented the commonwealth as a courageous and inspirational change leader. However, critical columnists depicted the commonwealth as a jurisdiction that was plagued by a mismanaged and socially unjust health system (especially in social-democratic representations in the *Boston Globe*) or as a system that had been rendered ineffective and unsustainable through excessive government regulation (in libertarian representations in the *Boston Herald*). As one might expect, my analysis reveals that, on the whole, the Democratic-leaning *Boston Globe* was more supportive of Romneycare and Massachusetts health care legislation in general than the Republican-leaning *Boston Herald*. However, columnists across the political spectrum were more favourable than unfavourable to health care reform. Journalists seemed to agree that the health care

system was broken and reform was necessary. They disagreed on the necessary scope and potential approaches to health care reform.

5.3 Favourable, Unfavourable, and Neutral Representations of Romneycare and the Massachusetts Health Care System (2002-2006)

Coverage of the Romneycare debates in both the *Boston Herald* and the *Boston Globe* communicated a sense of pride in the state's health reform efforts. For example, an October 2005 *Boston Herald* article went as far as likening the Commonwealth's health reform to a spiritual mission:

> We are on the eve of historic health-care reform in Massachusetts… Make no mistake: What is happening at the State House right now is sacred work. The task of providing quality, affordable health insurance for the 750,000 Massachusetts residents currently without, and of easing the burden on small businesses and moderate-income families who are struggling with outrageous insurance premiums, is divinely inspired. (Kaufman and Hamilton 2005)

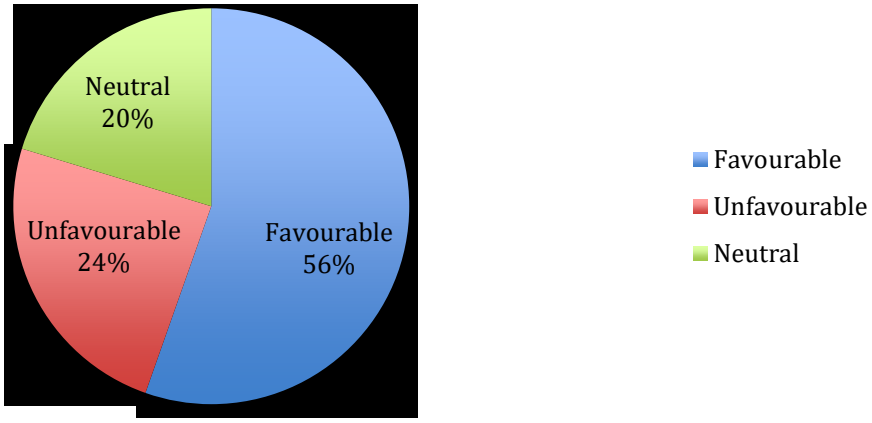
While most favourable reporting was not quite so adulatory, the numbers of favourable versus unfavourable and neutral articles clearly indicated strong media support for the MHRL and for health care reform in general between the 2002 election campaign and the Romneycare debates of 2005 to 2006. The Democratic-leaning *Boston Globe* was more favourable in its reporting on Romneycare than the Republican-leaning *Boston Herald* (68.1% in the *Globe*, as opposed to 55.5% in the *Herald*). However, this seemingly favourable bias was not due primarily to more unfavourable reporting in the *Herald*. In fact, unfavourable coverage of Romneycare and related state health legislation was comparable in the two dailies (21.3% unfavourable reporting in the *Globe*, compared to 24.3% in the *Herald*). The greatest difference between them lay in the proportion of passing or neutral mentions of Romneycare and related state health legislation, which accounted for 20.3% of *Herald* reporting and only 10.6% of *Globe* coverage.

Charts 5.0 and 5.1 on pages 201-202 illustrate the neutral, favourable, and unfavourable representations of Romneycare and related Massachusetts health legislation that appeared during the 2002 election campaign (January 1 – November 4, 2002), the period of legislative debates surrounding Romneycare (January 1, 2005 – April 11, 2006), and the period following the legislative passage of Romneycare (April 12, 2006 – December 31, 2006).[58] Neutral mentions of Massachusetts health reforms are those that do not encode any classifiable, partisan health reform narrative.

It is important to note that the present section, which includes Charts 5.0 and 5.1, does not account for all narratives of health care appearing in the *Boston Globe* and *Boston Herald* during these periods. In the three critical periods analyzed between 2002 and 2006, there were 542 relevant articles on health care reform and the Massachusetts health care system in the *Boston Globe*, and 696 relevant pieces in the *Boston Herald*. The broad range of health care narratives—beyond those that were specifically favourable or unfavourable to Romneycare and related Bay State health legislation—is explored in section 5.4. This section focuses specifically on the politically favourable and unfavourable reporting on Romneycare and related state health legislation and neutral mentions of such legislation in the two major dailies, which included 207 pieces in the *Boston Globe* and 276 articles in the *Boston Herald*.

[58] With regard to the dataset for the *Boston Globe*, *Factiva* searches produced all articles. For the *Boston Herald* dataset, *LexisNexis* searches produced all files. The initial dataset included all health care-related articles for the following key words: "healthcare reform OR health reform OR health care reform OR health care system OR healthcare system OR single payer OR health exchange OR health insurance." I further triaged newspaper articles by using the names of politicians, including Kennedy, Kerry, Romney, Frank, and Clinton, and through a search for single-payer references.

Chart 5.0: *Boston Herald* (Republican-leaning) representations of Romneycare and related Massachusetts health reform legislation (2002-2006)

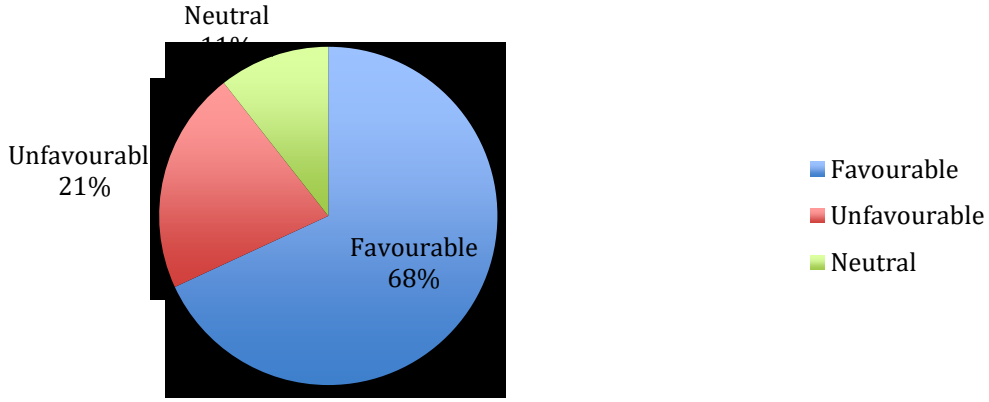


In terms of favourable reporting in the Republican-leaning *Boston Herald*, 64 articles in that publication strongly emphasized the *narrative of leadership and innovation in the state health care system*. These pieces mostly praised Romneycare. Another 29 articles specifically extoled the responsibilizing approach of Romneycare or related state reforms through the *individual responsibility narrative*. Still another 60 pieces favourably represented the efforts of Massachusetts elected officials (such as Senators Kennedy and Kerry, and especially Governor Romney) to improve the national health care system through the *narrative of leadership in national health reform,* which included portraying Romneycare as a model to emulate beyond Massachusetts.

With regard to unfavourable representations in the *Herald*, 21 pieces were opposed to Romneycare without always clearly outlining the reasons for their opposition (*anti-Romneycare narrative*), although some contained libertarian undertones of concern regarding government infringement in the health sphere. Another 26 were critical of the

regulatory climate in Massachusetts (*narrative of unethical health care regulation*).

Chart 5.1: *Boston Globe* (Democratic-leaning) representations of Romneycare and related Massachusetts health reform legislation (2002-2006)



In the Democratic-leaning *Boston Globe,* 85 articles contained the *narrative of leadership and innovation in the state health care system*: significantly more than the 64 pieces in the Republican-leaning *Herald* featuring the narrative. As was the case in the *Herald*, those pieces that emphasized leadership and innovation in Massachusetts health policy primarily focused primarily on Romneycare. Only 18 *Globe* articles (in comparison to 29 articles in the *Herald*) celebrated the responsibilizing approach of Romneycare or other state legislation through the *individual responsibility narrative*. Only 38 *Globe* articles (as opposed to nearly twice that number [60] in the *Herald*) included the *narrative of leadership in national health reform* to praise the national health reform efforts of Bay State political leaders.

With regard to unfavourable representations in the *Boston Globe*, only 12 *Globe* pieces were clearly opposed to Romneycare (*anti-Romneycare narrative*), compared to 21 in the *Herald.* Similarly, only 16 articles (versus 26 in the *Herald*) criticized the

regulatory climate in Massachusetts (*narrative of unethical health care regulation*). A comparable number criticized the politics of reform (12 pieces in the *Globe*, compared to 14 in the *Herald*) via the *narrative of political gridlock in health reform*. Together, these figures testify to significant differences in the ways writers in the Democratic-leaning and Republican-leaning newspapers tended to interpret progress in health care – even when they were celebrating (or critiquing) the same legislation. All of this, moreover, occurred within a more complex field of coverage. The following section (5.4) moves beyond these broadly favourable and unfavourable articles on Massachusetts health reform efforts to explore the broad range of narratives of health care that surrounded the Romneycare debates between the 2002 election campaign and the passage of the law in 2006, uncovering complex interplay between narratives deployed within articles.

5.4 Major health care narratives, representations of Romneycare and the Massachusetts health care system during the 2002 election campaign period (January 1-November 5, 2002), the debates surrounding Romneycare (January 1, 2005 – April 11, 2006), and the period following the passage of Romneycare (April 12 – December 31, 2006)

The context of reporting on the health care system in the Romneycare years (2002-2006) [59]

In light of the complex economic factors and the evolving political climate influencing health care discussions in Massachusetts, careful consideration of particular health reform narrative mentions in each article helps to clarify the nature of the debates. The findings of this analysis are revealing: even when they defended Romneycare,

[59] To remain consistent with my scan of national newspapers, the dataset for the state-based newspapers in the election period consists of a *Factiva* search for the terms "healthcare reform OR health reform OR health care reform OR health care system OR healthcare system OR single payer OR health exchange OR health insurance" for the *Boston Globe*. Since the *Boston Herald* is not available in *Factiva*, I conduced a search using the same terms in *LexisNexis*. For each newspaper, I added the terms "Kennedy," "Kerry," "Frank," "Romney," and single-payer (separately) to search within results for other pieces relating Massachusetts to health reform debates.

mainstream Republican-leaning and Democratic-leaning writers tended to emphasize different alleged strengths in the proposed legislation. The foremost critics of Romneycare were libertarian columnists, especially in the Republican-leaning *Boston Herald*, and advocates of single-payer social insurance or more regulated mandatory insurance models in the Democratic-leaning *Boston Globe*.

Like the national newspaper media, *Boston Herald* and *Boston Globe* reporters mostly focused mainly on two overarching systemic challenges. First, columnists frequently referenced the commonwealth's increasing public and private outlays for health care, which were represented as being too high, increasing at an alarming rate, and unsustainable. Second, state-based columnists depicted the increase of uninsurance and the erosion of the employment-based health insurance system as generally unjust, and as a factor contributing to social inequality. Despite the latter moral critiques of the health care system, most coverage emphasized the *expanded access* and *economic security narratives* in support of reforms that were intended to leave the existing health care system intact.

The *expanded access narrative* was the most common reform narrative in state-based newspaper coverage at each of the critical junctures between 2002 and 2006. One of the best examples appeared in the *Boston Globe* during the 2002 election campaign:

> Hundreds of thousands of Massachusetts residents are losing health care or social services as a direct result of the more than $500 million cut from the state's human services budget over the last two years, according to a Globe analysis. The four waves of cuts made by the Legislature and acting governor in the face of a drastic decline in state revenues touch nearly every class of disadvantaged residents - abused elders losing protective services, unemployed adults losing health insurance, and children of the working poor being denied subsidized day care. Some 530,000 Medicaid recipients alone will no longer be covered for eyeglasses and dentures. In addition, nearly half-a-million people, some of whom also are on

> Medicaid, will lose other benefits, according to figures gathered from service providers…. Amid the turmoil, some argue for other solutions to the budget crisis – through new taxes, spreading the cuts to the less vulnerable (by increasing state employees' health premiums, for example) and consolidating agencies - if the next governor, legislators, and service providers can come together. "This is a wake-up call for the Commonwealth at large," said Charles Welch, president of the Massachusetts Medical Society. "We really do have to raise more money to take care of these people. But it's also a wake-up call for providers. We're going to have to do a better job at a lower cost." (Dembner 2002)

Dembner's piece offers an excellent example of the *expanded access narrative* (in conjunction with the *economic security narrative*) in the sense that it represents an image of crisis and outlines the human toll; yet, it stops short of calling for more radical reform, such as a systemic transition to single-payer social insurance. Instead, the author hints at incremental, means-tested measures to help the low-income people who have suffered as a result of health budget cuts. Other columnists focused on the need to hire more nurses or other health care providers, and to re-imagine provider roles in the provision of health services, in order to make the system more accessible (Higgins 2002). In the state-based newspaper media, as in the national newspaper media, the *expanded access narrative* was used to defend a reinforced social safety net, and often to call for assistance to the losers in the health care market. It did not, however, challenge the "health care market" itself.

The *economic security narrative* was also invoked frequently in the Boston press, just as it had been in national newspaper reports. When deployed alone, the *economic security narrative* was used to emphasize the costs instead of the human toll of uninsurance and inadequate health care access. For example, a 2002 *Boston Herald* columnist declared:

> People in Massachusetts paid 15 percent more for health care during the 1990s than people in most other states, a government study to be released today shows. And the study found that Massachusetts led the nation in health care spending per resident, at $ 4,810 in 1998. (McCart 2002)

McCart's cautionary point with regard to Massachusetts' health spending woes is a characteristic representation of the ways in which the *economic security narrative* regularly emerged in the media during the election campaign. It was a common warning to readers that spending was increasing and that the state government was already spending more than its counterparts.

However, very frequently, the *economic security* and *expanded access narratives* were combined. One early example of this combination focused on the fiscal challenges facing the next governor (before anyone knew who that would be). The piece, in the *Boston Globe,* raised an alarm about Medicaid outlays:

> Medicaid benefits have already been scaled back in several areas; adult recipients can no longer get teeth cleanings, hearing aids, or eyeglasses under the program. There could be pressure to cut further, particularly by eliminating benefits for large groups, such as some low-income adults. But it's hard to save large amounts of money in Medicaid, which is ballooning along with other health-care costs. (Klein 2002)

Similarly, another *Boston Globe* article focused on the untenable costs of prescriptions for seniors:

> This year's gubernatorial campaign may be about Massachusetts, but in Marlborough everybody's talking about Canada. That's where more and more elderly residents, struggling with the cost of drugs, are getting their prescriptions filled these days. Among voters in this city of 36,000 along the state's high-tech corridor, the cost of health care is not only the number one concern - at times it seems the only concern. They say the candidate for governor who offers a convincing plan for affordable health care could clean up here. And so far, despite an initial flurry of proposals put forth on the campaign trail, no candidate has broken through on the issue. (Abraham 2002)

As they sounded alarms over rising costs facing governments, individuals, families, and businesses (sometimes all together), it was common for authors to outline, or at least

allude to, the human impacts. It was therefore often natural to pair together the *economic security* and *expanded access narratives* in favour of health care reform.

While the *expanded access* and *economic security narratives* of health care reform were as clearly dominant in state-level coverage as they had been in national reporting, and the same health reform narratives were present in both the national and state-level newspapers, the frequency of many of these narratives varied substantially between national and state-level media. For example, the single-payer debate was more frequent and more emphatic in the *Boston Globe* and the *Boston Herald* than it had been in national newspapers.

As early as 2002, advocates of single-payer were articulating their proposals clearly in the state newspapers. For instance, a *Boston Globe* article cited Green Party gubernatorial candidate Dr. Jill Stein:

> First of all, [single-payer] was adopted in Saskatchewan, and worked so well there, it was within a few years adopted by all the provinces in Canada. So there are precedents for this. In addition, the two independent studies commissioned by the Massachusetts Medical Society also determined that it would be cost-saving, even simply as a state program…. are we saving money by throwing people off of Medicaid? Many would say we are not saving money by throwing people off of Medicaid. They are going to come for their health care anyhow, but they are going to come when they are really sick. And remember, by the way, that on Medicaid, those costs are shared with the federal government, 50 percent, and by depriving those people of health care, we are paying for it all. There's about 6 percent of Massachusetts' population that's not covered right now. What's the savings in moving to single payer? Right off the top, it's 10 percent from cost savings in the insurance bureaucracy. (*Boston Globe*, October 31, 2002).

Stein makes a clear economic and administrative case for single-payer. Coverage of her arguments may have had an influence on progressive voters, siphoning votes away from Democrat Shannon O'Brien and facilitating the election of Governor Romney. The

pro-single payer narrative remained in the state-based media throughout the Romneycare debates, although it declined after the election.

By the time of the Romneycare debates in 2005 and 2006, the details of Massachusetts' reform agenda were a central feature of the coverage in the *Boston Globe* and *Boston Herald*. Yet, despite substantial media interest in Romneycare, columnists only infrequently identified the policy similarities between Romneycare and the federal HSA or the federal reform debates more broadly. The aspects of the Massachusetts health care system and the MHRL that state-based newspapers chose to report on from 2002 to 2006 largely mirrored those featured in the national media. However, the *narrative of Massachusetts as a leader in national health reform* appeared less frequently in the state-level newspapers than in the national press. For its part, the *narrative of innovation and leadership in state health reform* emerged less frequently during the 2002 election campaign in the state newspapers; its use then increased sharply during the Romneycare debates from 2005 to 2006.

The evolution of coverage and changes in narrative trajectories across time

Health care coverage was substantial in 2002 due to the gubernatorial election campaign. [60] During the Democratic primaries, two candidates for governor, Robert Reich

[60] In the *Boston Globe*, during the 2002 election period (January 1 – November 5, 2002), the initial search for articles related to health care reform produced 701 articles. I excluded 56 articles from the initial search results because they were duplicates, letters to the editor, or focused on health issues but not health care reform debates, leaving 645 articles. Further triaging to separate articles that were not applicable to the Massachusetts case excluded an additional 469 articles, leaving 176 articles about the Massachusetts health care system in the *Boston Globe*. Similarly, in the *Boston Herald*, the initial search produced 886 articles. I excluded 71 articles because they were duplicates, focused on health-related issues but not on the health care reform debates, or were letters to the editor, leaving 815 articles on the American health reform debates. After a subsequent triage of health reform articles that did not apply to the Massachusetts case excluded 544 pieces, I determined that a total of 271 *Boston Herald* articles covered health care in the commonwealth during the election campaign period. In total, between the two major state-based

(formerly of the Clinton Administration) and Warren Tolman, favoured transitioning to a single-payer social insurance system, but disagreed on the pace at which the single-payer transition should happen. The other two Democratic candidates (Shannon O'Brien[61] and Thomas Birmingham) frequently employed the *expanded access narrative*, combining it with the *economic security narrative* and a general insistence on incrementalism with universal access as a long-term objective (Abraham and Phillips 2002). O'Brien won the nomination, which left some progressives disgruntled with the Democratic Party. Newspapers frequently covered O'Brien's appeals for incrementalism in health reform, and alluded to fears that her approach would cede progressive votes to the outspoken Green Party candidate, Jill Stein, who advocated for single-payer. For instance, a *Boston Herald* piece captured both O'Brien's use of the *expanded access narrative*, and the election fears of the Democratic establishment:

> "As the election draws near, people who support expanding access to health care, who support a clean environment and fair tax policy should understand there's one alternative . . . . and that's me," O'Brien said. O'Brien's powerful surrogates hammered Stein as a bad choice for anyone other than Romney supporters. "If people want a progressive philosophy in our state to govern over the next four years, they have to vote for Shannon O'Brien," said U.S. Rep. Edward J. Markey (D-Malden), dean of the state's congressional delegation, campaigning with O'Brien in Framingham (Guarino et al. 2002)

Articles such as this one revealed the divisions between progressive and moderate Democrats in the state health reform debates, and served as a sign that Romney might

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dailies, 31%, or 447 articles (out of a total of 1,460 pieces relevant to health care policy debates in the United States) reported on aspects of the Massachusetts health care system and health care reform in the commonwealth.

[61] O'Brien was the outgoing State Treasurer, a former state senator, and interestingly a former health care industry executive for Community Health, a then-bankrupt private health care company that had managed hospitals throughout New England. O'Brien drew criticism for her ties to the health care industry (Bailey 2002).

reap the benefits of those divisions.

While the competing health reform proposals of Democratic candidates attracted the most media attention during the summer primaries (and the competition between Democratic and Green Party approaches to health reform made waves in the fall), Republican gubernatorial candidate Mitt Romney also drew scrutiny for his health care reform plan. Romney focused on alleged waste in the health care system and the need to find efficiencies to control costs, suggesting some controversial reforms. For example, a *Boston Globe* article included this synopsis of some of the key aspects of Romney's perspective on health reform:

> Looking for new revenue to finance health care, Republican Mitt Romney has called for increased copayments from higher-income Medicaid recipients and for more federal help for MassHealth. But analysts are skeptical as to whether any recipients can chip in meaningful amounts and point out that the state has virtually no control over the share picked up by the federal government. (Klein, August 25, 2002)

Similarly, in regard to Romney's plans for health care reform, another *Boston Globe* columnist offered this synopsis:

> [Romney opposes] requiring employers to contribute to cost of health care plans for their employees, preferring subsidies for health coverage for low-income individuals and providing tax incentives to individuals, including the unemployed and the self-employed, for the purchase of health insurance… [Romney favours] creating voluntary purchasing pools through which small businesses and individuals could buy insurance . . . [He pledges] to cut health care costs through market-based reforms such as providing information on the price and quality of health care services to consumers. (Ebbert, March 19, 2002)

The above examples were consistent with other media summaries of the Romney health reform plan, in which Romney opposed employer-insurance mandates, endorsed voluntary mechanisms, promoted tax incentives, and essentially argued in favour of

requiring the least-poor-among-the-poor to pay out-of-pocket for a portion of their basic health care as a budget-cutting measure (Ebbert, August 7, 2002).

While Romney acknowledged that health care was a key issue for voters, the question of reform was not as important to Republicans as for Democrats, whose internal divisions were significant despite their agreement that systemic changes were needed. Perhaps the most controversial of Romney's health care proposals was his suggestion that the Executive Office of Elder Affairs be eliminated as a cabinet-level position. Romney had alleged that the work of the office was duplicated elsewhere in government; however, once senior citizen lobbying groups and others criticized the position, Romney removed it from his health reform platform (*Boston Globe*, August 25, 2002).

After the primaries, the health policy proposals of the two major gubernatorial candidates, Democrat Shannon O'Brien (outgoing State Treasurer) and Republican Mitt Romney, and the competing fringe candidates, Jill Stein of the Green Party, and Libertarian candidate Carla Howell, all drew media attention with their competing health reform proposals. In the course of the gubernatorial debates, the commentary of O'Brien and Romney on the appropriate path to health care reform overlapped substantially. To sum up the health care challenges at the forefront of many voters' minds in the general election, a *Boston Globe* article offered a succinct description:

> The next governor will inherit a system where the problems are back with a vengeance: Insurance premiums are soaring, the number of uninsured residents is climbing, and the state is withdrawing dollars for crucial programs such as Medicaid. And of all the decisions the new governor will grapple with, few will have more personal consequences for more people. (Kowalcyzyk, March 5, 2002)

As Kowalcyzyk observes, health care reform was not a new issue for Massachusetts (as I

outlined previously in Chapter 4, health care had been a major issue since the Dukkakis administration in the 1980s, and Massachusetts had been a trailblazer in health and social policy legislation much earlier). The next governor would have to address rising costs, increasing rates of uninsurance, and an allegedly underfunded public program on which many Bay Staters relied.

Many examples of the *expanded access narrative* that year pertained to the Janitors' Union (SEIU Local 254) strike in which the janitors were demanding employment-based health insurance. The strike attracted broad media coverage, and was controversial in part because these uninsured janitors were responsible for cleaning prominent public buildings for the City of Boston and the Commonwealth of Massachusetts (Blanton 2002). The many articles on the centrality of health care to the janitors' strike exemplified one of the particularities of the *expanded access narrative* in state-based newspapers—the fact that this narrative often emphasized access challenges for specific, marginalized social groups. Key sub-categories of marginalized and, according to the authors, deserving groups within the *expanded access narrative* in 2002 included the so-called working poor, or those Americans who earn too much to qualify for Medicaid, yet not enough to afford private health insurance. Other sub-categories of people invoked in the *expanded access narrative* included immigrants (documented or undocumented), children, senior citizens, women, and ethnic minorities (Smith, June 28, 2002). In addressing the situation facing all of these marginalized groups, columnists focused on the need to improve health care access and systemic outcomes for the group(s) of their choice, without advocating major systemic change or challenging for-profit health care. This type of advocacy for improved access was consistent with a

neoliberal vision of health care as a market, but a market in which the government should institute policies to promote equality of opportunity and facilitate market access for marginalized people.

Later, when the Romneycare debates were taking place between January 2005 and April of 2006, the proposed legislation became the primary health care story in the *Boston Globe* and the *Boston Herald*. [62] The newspapers covered the evolution of the proposed legislation well, carefully reporting and often interrogating the arguments presented by the various parties interested in the legislation. In the first place, advocacy groups such as Health Care for All, The Greater Boston Interfaith Organization, and Families USA, which collaborated through the Affordable Care Today (ACT!!) Coalition, lobbied with determination to extend insurance coverage through a new payroll tax on businesses and more generous Medicaid eligibility standards. The groups threatened to launch a ballot initiative for a constitutional amendment to achieve "universal coverage" if they were not satisfied with the eventual legislation—and they had the signatures to move the ballot measure forward. Meanwhile, the insurance

[62] In the *Boston Globe*, during the 2005-2006 Romneycare debates (January 1, 2005 – April 11, 2006), the initial search for articles related to health care reform produced 1079 articles. I excluded 97 articles from the initial search results because they were duplicates, letters to the editor, or focused on health issues but not health care reform debates, leaving 982 relevant articles on the American health reform debates. Further triage to separate articles that were not applicable to the Massachusetts case excluded an additional 758 articles, leaving 224 articles about the Massachusetts health care system in the *Boston Globe*. Similarly, in the *Boston Herald*, the initial search produced 962 articles. I excluded 77 articles because they were duplicates, focused on health-related issues but not on the health care reform debates, or were letters to the editor, leaving 885 relevant articles on the American health reform debates. After a subsequent triage of health reform articles that did not apply to the Massachusetts case excluded 592 pieces, I determined that a total of 293 *Boston Herald* articles covered health care in the commonwealth during the legislative debates on Romneycare. In total, between the two major state-based dailies, 27.7%, or 517 articles (out of a total of 1,867 pieces relevant to health care policy debates in the United States) reported on the Romneycare debates or other aspects of the Massachusetts health care system and health care reform in the commonwealth.

industry supported individual and employer insurance mandates, but predictably opposed more government regulation of its own business practices. Business lobby groups beyond the insurance industry, for their part, opposed employer insurance mandates, and only supported the individual mandate. The state government tried to balance the competing demands in a way that would reduce public health care outlays and expand insurance coverage in order to declare a political victory before the November 2006 election (Helman and Greenberger 2006). By the autumn of 2005, three competing proposals were in play—a House bill, a Senate bill, and the Governor's alternative plan—which had to be reconciled if the Commonwealth was going to realize comprehensive reform (Kuttner, November 26, 2005).

The hallmark of the Senate bill was the promotion of a state-wide "high risk" insurance pool to offer so-called "catastrophic insurance" plans (low premiums, high deductibles, and a lot of uncovered health services). The Office of the Governor was the foremost advocate for the individual insurance mandate to responsibilize health consumers. For its part, the House bill was the most ambitious in aiming to achieve near-universal coverage through a state-wide employer insurance mandate and a tax penalty on businesses for non-compliance (Kuttner, November 26, 2005).

Ron Preston, Governor Romney's first Health and Human Services Secretary—a man whom the governor once lauded as the "best in the nation," before replacing him, reportedly because of disagreements over health policy that coincided with critical media claims that Romney was opportunistically using health reform to propel his Presidential aspirations—was one of the key policy developers of the Romneycare plan (Bailey, January 11, 2006). In the early stages of development, Preston aptly declared:

> "If our proposal goes anywhere, its elements will undoubtedly be heated, cooled, split, and recombined. But our premise will stand….Everyone must pay some or give some, and most must do both. If we all do our parts, we can do this task. We will see everyone insured, and we will thereby lay a foundation for a better Commonwealth and a better health care for all." (Bailey, January 11, 2006)

Preston's description of the complex political road ahead for what he saw as a worthy cause turned out to be accurate. It was so complex, in fact, that it led to Preston's own precipitous exit (Bailey, January 11, 2006). The compromises, negotiations, and horse-trading necessary for the reform to succeed drew extensive media attention, and even led to a new unfavourable narrative that journalists deployed to criticize the politicization of reform efforts—the *narrative of political gridlock in health reform*.

Debates between supporters of different health care reform strategies and priorities raged on into early April 2006. Although they were key supporters of the MHRL as a bill, the *ACT!! Coalition* and other advocacy groups continued to threaten to spearhead their ballot initiative for "universal health care" if the MHRL failed to pass, or if it failed to substantially reduce insurance rates in the months after passage in 2006 (Helman 2006; Levenson 2006). It is therefore not surprising that the *narrative of health reform activism* was a more important element of media coverage during the Romneycare debates than it had been during the 2002 election. More columnists covered the central role of advocacy groups; as a result, they generously afforded free publicity through columns, to the leaders of organizations such as *Health Care For All,* the *Greater Boston Interfaith Organization*, and *Families USA* (Rowland, January 18, 2006).

As had been the case during the 2002 election campaign, the *expanded access narrative* and *economic security narrative* were the most common narratives in both the Democratic-leaning *Boston Globe* and the Republican-Leaning *Boston Herald* during the

Romneycare debates. Interestingly, the overall frequency of the *pro-single payer narrative* declined slightly between the 2002 election campaign and the 2005-2006 debates; this fact seems to indicate that the media were more interested in the concrete reform proposals that had enough political support to potentially succeed in the legislature than the proposed models of health reform that progressive activists viewed as ideal.

Interestingly, while still a minor narrative that surfaced in less than 5% of articles during the debates, the *narrative of unethical health regulation* was deployed more frequently during the Romneycare debates than it had been during the 2002 election campaign, often (albeit not exclusively) in conjunction with the *anti-Romneycare narrative*. This opposition to the Romneycare legislation on pure free-market grounds was at first glance perplexing. After all, the mainstream Republican-leaning press also defended Romneycare as responsible, conservative policy through both the *economic security* and the *individual responsibility narratives*. This apparent contradiction revealed an important schism on the political right, which a June 2005 *Boston Herald* column fittingly described as "free-market purity vs. a sort-of-free-market pragmatism" (Fitzgerald, June 27, 2005). Just as columnists in the Democratic-leaning press fell into two distinct groups – the minority of "purists" who staunchly supported single-payer and the progressive pragmatists who favoured Romneycare as a responsible approach to expand access and control costs – the Republican-leaning media was similarly divided in terms of the narratives of reform it embraced.

Later, after the passage of Romneycare in April, 2006, and throughout the remainder of that year, the new legislation was predictably the health care story in the

Boston Globe and the *Boston Herald* that attracted the most attention from the spring to the winter of 2006. [63] The newspapers generally presented a positive view of the legislation. In fact, the *narrative of state leadership and innovation* became the most frequent narrative of reform for the first time, surpassing both the *expanded access* and the *economic security* narratives. There was continued coverage of advocacy groups such as Health Care for All, the Greater Boston Interfaith Organization, and Families USA, which were portrayed via the *narrative of health reform activism*. Advocacy groups had previously attracted attention for their lobbying efforts during the reform debates, and were then partially credited with the passage of the legislation. There was less coverage of the allegedly unsavoury politics of reform; as such, the *narrative of political gridlock in health reform* disappeared entirely from the newspapers. On the whole, the major health reform narratives remained the same as they had been during both the 2002 election campaign period and the legislative debates surrounding Romneycare in 2005 and 2006.

The *expanded access* and *economic security* narratives were the most commonly

[63] In the *Boston Globe*, after the passage of the Massachusetts Health Reform Law in April 2006 (April 12 – December 31), the initial search for articles related to health care reform produced 590 articles. I excluded 29 articles from the initial search results because they were duplicates, letters to the editor, or focused on health issues but not health care reform debates, leaving 561 relevant articles on the American health reform debates. Further triage to separate articles that were not applicable to the Massachusetts case excluded an additional 419 articles, leaving 142 articles about the Massachusetts health care system in the *Boston Globe*. Similarly, in the *Boston Herald*, the initial search produced 413 articles. I excluded 21 articles because they were duplicates, focused on health-related issues but not on the health care reform debates, or were letters to the editor, leaving 392 relevant articles on the American health reform debates. After a subsequent triage of health reform articles that did not apply to the Massachusetts case excluded 260 pieces, I determined that a total of 132 *Boston Herald* articles covered health care in the commonwealth after the passage of Romneycare. In total, between the 2 major state-based dailies, 28.8%, or 274 articles (out of a total of 953 pieces relevant to health care policy debates in the United States) reported on the legislative passage of Romneycare or other aspects of the Massachusetts health care system and health care reform in the commonwealth.

deployed narratives after the *narrative of leadership and innovation in state health reform* in both the Democratic-leaning *Boston Globe* and the Republican-Leaning *Boston Herald*. The *narrative of unethical health regulation* was invoked less frequently than it had been during the Romneycare debates. Similarly, the *individual responsibility narrative* declined in frequency to minor narrative status, emerging in fewer than 5% of articles.

While there was a general holding pattern in the overall frequency of narratives between the period of legislative debate and that following the passage of Romneycare (with the notable exception of the *narrative of leadership and innovation in state health reform,* which was deployed more frequently), the newspaper media continued to paint a worrisome picture of the state of health care in Massachusetts. One of the best examples of the critical assessment of Massachusetts overall health care challenges was found in the *Boston Globe* in the fall of 2006:

> Massachusetts faces a dose of double trouble when it comes to controlling healthcare costs: It has among the highest such costs of any state, and they are increasing at a faster rate than in most other states. (Krasner, November 20, 2006)

Thus, despite a generally positive representation of Romneycare, and a tendency to credit the legislation as a positive step forward even in pieces that treated it as an inadequate response to the health care crisis, journalists acknowledged the ongoing systemic challenges.

Predominantly Democratic narratives 2002 – 2006

During the 2002 election campaign, the *expanded access* and *economic security narratives* were the two most frequently deployed in 2002 in the Democratic-leaning *Boston Globe*. Interestingly, as I note in the section on predominantly Republican

narratives, these were also the most common narratives to appear in the Republican-leaning *Boston Herald*. The difference between the two newspapers' coverage in 2002 was the greater emphasis placed on access in the *Globe* and on economic security in the *Herald*.

Reporting on the health care reform ideas of Democratic gubernatorial candidate Shannon O'Brien often cited the candidate using the *expanded access narrative*, which was consistent with her party's record of incremental health reform. A *Boston Globe* piece quoted O'Brien on responding to the challenges in the health care system:

> Health care is that one cost-of-living item that I think has many people across the state terrified….My fix for that is to take the opportunities that the Republican governors have failed to take advantage of. The Legislature passed a bulk purchasing program for prescription drugs. Two successive governors failed to implement it and as a result, consumers have paid an additional $400 million for their drugs here in this state. So that's one of the solutions: immediately work to implement the bulk-purchasing program for prescription drugs to finally get some of those cost savings….If I could blow up the whole health care system and start over, I'd probably start over there [by implementing a single-payer, social insurance system, as Green Party Candidate Jill Stein was proposing]. But I look at the experience of Oregon, and they're going to - if they pass the referendum question out there, it will call for an 11 percent increase in the payroll tax and I think a 9 percent increase in the income tax. I understand the theory, I understand the ultimate goal. But, I believe that by better managing our Medicaid system, by cutting the cost from overhead, that we can significantly expand coverage for people in this state. I'm proud of the work that the Democrats have done to extend full coverage to children in this state, and it's going to be my goal to achieve universal coverage. I just believe that a more incremental approach is a smarter way to go. (*Boston Globe*, November 2, 2002)

O'Brien clearly acknowledged that health care was a key issue in the gubernatorial debates. She rejected single-payer on economic grounds, and for reasons surrounding the alleged impracticality of implementation. The *expanded access narrative* was thus a key part of the mainstream Democratic discourse on reform, one that acknowledged inequality and exclusion in the system; it was often invoked alongside the *economic*

security narrative in an overall appeal to stay the course and continue implementing incremental reforms (in particular, finding savings through Medicaid reform and creating a bulk-purchasing program for prescription drugs) and keeping ill-defined "universal coverage" in mind as the long-term goal.

The *narrative of state leadership and innovation in health reform* was also present in the state newspapers during the election campaign, and was more common in the Democratic-leaning *Boston Globe*. For example, a September news article on a federal Bush administration proposal to extend federal health benefits to unborn foetuses offered the following synopsis of the Massachusetts health care system:

> State health officials and advocates like James W. Hunt Jr., the president of the Massachusetts League of Community Health Centers, said yesterday that the state is already a national leader in providing health care to moderate- and low-income pregnant women through programs such as Medicaid and the Children's Medical Security Plan and through networks of nonprofit, community-based clinics. (Ranalli 2002)

The article noted that Massachusetts had an admirable history: it had both extended government health coverage to low-income pregnant women before the federal government did, and encouraged local innovation in efforts to provide for community health needs. Similarly, other columnists lauded the commonwealth's health care system for achieving far better health outcomes in cancer and heart disease treatment than the national average (Smith, April 24, 2002).

A handful of articles contained the *narrative of activism in state health reform*, which was more common in the Democratic-leaning *Boston Globe*. Most of these were mentions of Health Care for All and other advocacy groups that resisted the commonwealth government's proposal to cut $70 million from Medicaid, a measure that effectively excluded 50,000 poor people and added them to the ranks of the uninsured, as

a budget-saving measure (Beardsley, July 30, 2002). However, a few articles contained more detailed accounts of health reform activism and advocacy. For instance, a *Boston Globe* business section story on the efforts of residents, business owners, and a hospital board of directors in the town of Waltham to save their community hospital from bankruptcy deployed the *narrative of activism in state health reform* in conjunction with the *economic security narrative*:

> The recent reprieve for Deaconess-Waltham Hospital is a testament to the power of creative collaboration among unlikely bedfellows. It opened a new chapter in Massachusetts health care, one in which community stakeholders push back and say, "We no longer will allow our vital community institutions to be forfeited to destructive market forces created by a flawed health care system"….The odyssey of this hospital illustrates that the free-market system of health care without appropriate government oversight creates pandemonium that is destroying the Commonwealth's capacity to meet the needs of health care consumers. The financial pressures on health care providers continue to tighten, and further erosion of the system is imminent….It is time that hospital boards and the leaders of business, community, and government create a collaborative hospital survival plan. They should start by modeling the passionate community response witnessed in Waltham. (Bender 2002).

The story showed the collaborative efforts of diverse actors in Massachusetts civil society to address health care challenges. It was further interesting for the sense of urgency it communicated, through the use of terms, such as "stakeholders" and "health care consumers," that were consistent with neoliberal conceptualizations of health care; and for its criticism of the inadequately restrained market. In summary, the story indicated that communities in Massachusetts were united in support of health care reform that expanded access, controlled costs, and increased government regulations of market forces, without calling for radical systemic change.

Finally, columnists in both the *Boston Globe* and the *Boston Herald* frequently deployed the *economic security narrative*, making it the second most common narrative

during the election campaign period. It was essential to representations of health care in both the predominantly Democratic-leaning and the predominantly Republican-leaning print media. As such, like the *expanded access narrative*, the *economic security narrative* largely bridged health care reporting between the two major newspapers.

By the time of the Romneycare debates (January 2005 – April 2006), the most common narratives deployed in favour of Romneycare in the Democratic-leaning *Boston Globe* were the *expanded access* and *economic security* narratives; this is consistent with what one would expect in a state known to be more politically progressive. The *expanded access narrative* remained the most commonly cited, though by a smaller margin than during the 2002 election campaign. The tone and content of the narrative did not change substantially; it was deployed to decry the inequality of access as unjust and to call for reforms in the existing system, without endorsing single-payer or a full mandatory insurance system. Although Massachusetts had a lower rate of uninsurance than the national average, columnists sounded alarms about the comparative rate of increase in uninsurance statewide. For example, according to an August 2005 piece in the *Boston Globe*:

> The number of Massachusetts residents without health insurance jumped about 10 percent last year, surpassing the growth in the uninsured nationally and raising concerns whether climbing private health insurance premiums are shutting out middle-income workers. (Kowalczyk, August 31, 2005)

The *expanded access narrative* was typically invoked within calls to action that appealed to broad middle-class interests in the health care system—mostly middle-income workers who had the benefit of employment-based health insurance.

The *economic security narrative* was a close second in frequency during the

legislative debates. For instance, one of the clearest examples in the *Boston Globe* presented this description:

> The cost of healthcare benefits for Boston-area employers this year rose at a rate 44 percent higher than it did nationally, according to a study by one of the nation's largest benefits consultants…The figures include premiums for medical and dental plans for employees and their dependents who also receive coverage, but exclude employees' out-of-pocket expenses. (Krasner, November 21, 2005)

Comparing the costs or rates of premium increase in Boston or Massachusetts with other jurisdictions or with the national average, as in this piece, was a common discursive element in the *economic security narrative*.

In terms of other predominantly Democratic narratives, a handful of columnists during the debates deployed the *narrative of inefficiency and unethical health care practices*. Examples included stories of doctors referring patients requiring MRIs to private companies in which they were shareholders (Rowland, December 1, 2005), and criticisms of insurance companies for paying allegedly excessive salaries to senior administrators (Krasner, November 16, 2005; Rowland, August 16, 2005). The *narrative of leadership and innovation in state health reform* was also deployed in both the Democratic-leaning *Boston Globe* and the Republican-leaning *Boston Herald*, though it was more common in the former. This narrative commonly mentioned the diverse bases of support for the MHRL. For instance, a *Boston Globe* piece in April, 2005 offered a clear example:

> Hospitals, insurers, and business groups are rallying behind Beacon Hill[64] leaders' efforts to expand healthcare coverage, praising Governor Mitt Romney and Senate President Robert E. Travaglini for unveiling plans yesterday that would achieve that goal in large part by allowing insurance companies to offer less expensive

[64] Note that this is a common way to refer to the state government in Massachusetts.

> policies with scaled-back benefits. Peter Meade, executive vice president of Blue Cross/Blue Shield, described the day as "a great beginning," and Bill Vernon of the National Federation of Independent Business said, "Trusting the market to provide flexibility and choice of products is critical to solving the healthcare crisis in our state." (Greenberger, April 7, 2005)

In the Greenberger (2005) piece and many like it, the message was clear: Romneycare was a business-friendly reform and a bipartisan effort to solve a pressing economic and social challenge. Praise for the novelty of the MHRL approach and its bipartisan support, and claims that the legislation may be a model for the rest of the country were typically central to the *narrative of leadership and innovation and state health reform*. In fact, even Barack Obama—then a junior Senator from Illinois, best known for his rousing speech to the 2004 Democratic National Convention—was quoted in the *Boston Herald* in February 2006, praising Romneycare as a model to emulate nationally even as his friend Deval Patrick, the leading Democratic candidate for Governor of Massachusetts, was endorsing single-payer as a superior reform option (Atkins, February 2, 2006).

Other columnists who deployed the *narrative of leadership and innovation in state health reform* focused on the specific features of the MHRL bill that they found to be most innovative. For instance, *Boston Herald* readers were presented with the following synopsis of Romneycare in 2006:

> Massachusetts consumers may be able to shop for a doctor in much the same way they do for an airline, car or hotel room under the massive health-care reform bill approved by lawmakers last week. The plan calls for a user-friendly Web site that will provide information about cost and quality. Someday, patients may be able to even compare how much doctors charge for physicals and how well they do at treating certain diseases…. It has drawn support from all sides of the debate – providers, consumer advocates and health insurers. (Heldt-Powell, April 9, 2006)

Heldt-Powell (2006) emphasized consumer choice and the creative use of technology in the MHRL reform, as well as the support of diverse stakeholders in order to argue that it

was balanced and responsible legislation. This was a common refrain for columnists who supported Romneycare and deployed the *narrative of leadership and innovation in state health reform*.

After the passage of Romneycare in April of 2006, and throughout the remainder of the year, the narratives most commonly deployed in favour of Romneycare in the Democratic-leaning *Boston Globe* were the *narrative of leadership and innovation in state health policy*, the *expanded access narrative,* and the *economic security narrative*. The *expanded access narrative* remained more common than the *economic security narrative*, indicating that the mainstream Democratic media was more concerned with the access aspect of the health care crisis than the economic challenges it presented. The tone and content of these narratives did not change significantly. It was in the period following the legislative passage of Romneycare that some of the best examples of the *narrative of leadership and innovation in state health policy* were deployed. For example, according to a December *Globe* piece:

> It's been an extraordinary year for health care in Massachusetts, with the approval of landmark legislation that makes the state a pathfinder toward near-universal health insurance coverage for its residents. The law mandates that everyone obtain insurance, establishes a new authority to manage the insurance programs, and has already expanded coverage to thousands of people. (*Boston Globe,* December 29, 2006)

Portraying Romney care as "extraordinary," "landmark," and a "pathfinder" communicated the sense of pride that many journalists held in the period. Massachusetts newspaper reporting after the passage of Romneycare conveyed the sense that the state had taken ownership of the health reform challenge—Massachusetts had done what others in federal or state government thought to be impossible. The state had distinguished itself as a trailblazing leader in a complex policy sphere. Similarly, other

Globe columnists were unrestrained in their praise:

> Universal healthcare, an issue the White House and Congress have largely abandoned since the early 1990s, has remerged as an issue on Capitol Hill and around the country, with lawmakers looking to Massachusetts' landmark plan as a political and structural model for the nation's 46 million uninsured. Healthcare specialists and government officials across the political spectrum say the healthcare debate has reached a turning point, with both liberals and conservatives ready to compromise. Liberals are setting aside old demands for a single-payer system, while conservatives are showing a willingness to consider more government involvement in the provision of healthcare. (Milligan 2006)

In Milligan's article, the success of Massachusetts in solving a problem that had stumped the federal government and other states is framed as a story of bipartisan policy cooperation. Other columnists cited the attention paid to Massachusetts by advocates across the nation who viewed it as an example for the country to follow:

> The national group, America's Health Insurance Plans, borrowed some ideas from the Massachusetts law, approved last April. The group wants coverage for all 12.7 million adults below the poverty line – $9,800 of income for a single person - who are now without insurance. On Oct. 1, Massachusetts began offering coverage to its 50,000 poor people in this category. The national insurance association also wants to cover all American children in families with incomes under 200 percent of the federal poverty line. Massachusetts already covers these children at no charge. As Robert Blendon, Harvard School of Public Health professor and veteran healthcare pollster, said yesterday, "There is no other state doing what we are talking about" – providing health insurance to just about everyone through a combination of state subsidies, employer-based coverage, and an individual mandate. (*Boston Globe,* November 16, 2006).

As the November 2006 example from the *Globe* demonstrates, it was common for columnists to cite both business leaders and policy researchers to praise the MHRL.

Predominantly Republican narratives (2002-2006)

During the 2002 election campaign, the two most frequent narratives in the Republican-leaning *Boston Herald* – as in the Democratic-leaning *Boston Globe* –were the *expanded access* and the *economic security narratives*. The difference, however, was

the greater emphasis on economic security in the *Herald*. This indicated that the Republican-leaning press was somewhat more likely to see health care as an economic than a social challenge.

Although it had not yet evolved into an argument "in favour of Romneycare" in 2002 (when the legislation had not yet been conceived), the *individual responsibility narrative* was present as a minor (and clearly neoliberal) narrative in a handful of articles in the Republican-leaning *Boston Herald*. A number of columnists praised Romney's health reform proposals during the campaign. In particular, Romney's call for Medicaid co-payments, so the least-poor Medicaid recipients would allegedly learn to be more responsible health care consumers by paying a portion of their health care out-of-pocket, attracted limited praise in the media (Macero, November 1, 2002). These columnists sometimes highlighted Romney's call to improve "basic health literacy," so health care consumers would take responsibility for themselves and make better choices that reduced systemic costs (Macero, October 28, 2002).

Later, during the Romneycare debates in 2005 and 2006, the *expanded access* and *economic security narratives* were those most commonly deployed in the Republican-leaning *Boston Herald*, as they had been in the Democratic-leaning *Boston Globe*. Interestingly, the distribution of the two dominant narratives was nearly identical in both newspapers, with the *expanded access narrative* receiving slightly more mentions (94 *expanded access* to 89 *economic security narrative* mentions in the *Herald*, versus 104 to 99 mentions in the *Globe*). Thus, the health care crisis that justified reform was presented as an economic and a social crisis in the mainstream Republican-leaning and Democratic-leaning print media alike.

With regard to the *economic security narrative* as it was frequently deployed during the Romneycare debates, an October 2005 column offered the following assessment to *Herald* readers:

> Some changes would help ease Boston's skyrocketing health care costs, which have risen 73 percent over five years, far more than the 57-percent increase to insure state employees. ``We certainly agree it's a crisis and there has to be changes made on a state level," Boston Chief Operating Officer, Dennis DiMarzio, said. (Rothstein 2005)

The Rothstein (2005) piece, focusing on the City of Boston's woes regarding health care costs for employees, was representative of the most common type of health care story in both the *Herald* and the *Globe,* in which economic factors were emphasized.

The *individual responsibility narrative in favour of Romneycare* was deployed in both the *Boston Globe* and the *Boston Herald*, though it was more common in the latter, Republican-leaning newspaper. Columnists deployed the narrative in essentially the same way they had during the 2002 election period, although more frequently and often in conjunction with the *expanded access* and/or *economic security narratives*. Writing in the *Boston Globe,* a columnist offered the following example:

> DiMasi suggested…"We will ask individuals to take more responsibility for obtaining health coverage, and we will also try to assist them as they do so," DiMasi said. A few moments later he said: "We want to encourage employers to maintain their commitment to their employees. Good behavior should be rewarded. Businesses that currently do not offer insurance will be encouraged to do so." (Greenberger, October 8, 2005)

Greenberger's column depicted the uninsured business owners who did not offer insurance benefits as irresponsible, assuming that many had the means to pay for health insurance, but chose to spend their money differently.

After the passage of Romneycare in April 2006, much of the coverage in the Republican-leaning *Boston Herald* was as adulatory as the reporting in the Democratic-leaning *Boston Globe*. Columnists frequently deployed the *narrative of state leadership and innovation in state health reform* during the months following passage of the MHRL (which proved to be the most common reform narrative appearing in both newspapers). For example, *Herald* contributors wrote in December of 2006:

> New beginnings. High expectations. That is the spirit that also propels the landmark health reform that became law this year. It, too, is the start of a more promising future, one in which more people are insured and healthy. With the eyes of the nation upon us, America's health care future begins now, in Massachusetts….Health care coverage is the issue that Massachusetts staked its reputation on this year. We must ensure that the promise of responsible, affordable health coverage for everyone is realized. Our governor-elect [Democrat Deval Patrick] has pledged to "implement the new health care law from the perspective that health is a public good, and that we owe every man, woman and child in the commonwealth a decent, affordable, patient-centered health care system." All of us must collaborate to meet the new commitments. (Moen and Hollander 2006)

The Moen and Hollander piece clearly advanced the idea of Massachusetts as a trailblazer for the nation to follow. It further contributed to the story of bipartisan cooperation, explaining that the Democratic governor-elect embraced the health reform of his Republican predecessor, and would quickly work to implement it.

Beyond the *narrative of leadership and innovation in state health reform*, and as in the *Globe*, *Herald* columnists often deployed the *expanded access* and the *economic security narratives* when covering ongoing challenges in the state health system. Finally, in a pair of noteworthy pieces, *Boston Herald* columnists advanced the *individual responsibility narrative* in support of Governor Mitt Romney's proposal (seen as an indirect addition to the MHRL) to require fathers of children born outside of marriages to pay for their health insurance premiums for 18 years, an initiative which had been

ignored or treated less positively in the *Globe* (Atkins, June 1, 2006).

Unfavourable narratives of the Massachusetts health care system and Romneycare (2002-2006)

During the 2002 election period, right-leaning and left-leaning commentators alike found reasons to criticize the Massachusetts health care system. From the fringes of the Republican-leaning media, especially from libertarian columnists, there were a handful of examples of the *narrative of unethical health care regulation* as a minor narrative at the time. For instance, a gubernatorial candidate profile story in the *Boston Globe* included the following synopsis of the challenges in the Massachusetts health care system according to Libertarian Party candidate Carla Howell:

> We have close to 1 million people on Medicaid in this state – one-sixth of the state population on a poverty program. This is absurd. Why are they there? That's the first question we need to ask. Big government health care rules and regulations drive up the cost of health care dramatically, and particularly drive up the cost of health insurance. Catastrophic care for example is prohibited in Massachusetts. It's illegal. You can't buy it. It's the most logical form of health care for most families - a policy that kicks in only in extreme financial hardship. But you can't buy it. The only thing you can buy is very, very expensive. It's common for (insurance) for a family of four, a healthy family of four, a relatively young healthy family of four to cost $10,000 a year in cash, which is absolutely crippling to families. (*Boston Globe*, November 2, 2002)

The libertarian message was clear. Government rules and regulations were the supposed culprit for the high cost of health insurance policies; in particular, authors blamed the government's exclusion of low premium, high deductible "catastrophic" insurance policies for high rates of uninsurance. Finally, means-tested social insurance (Medicaid) was viewed as undesirable and not part of the solution. Between the lines, the message was that the market would naturally fix itself if the government would just leave it alone.

Business association leaders, adopting a similar approach, advanced the *narrative*

of unethical health regulation in response to insurance mandates. For instance, writing in the *Boston Herald*, Bill Vernon (Director of the Massachusetts Chapter of the National Federation of Independent Business) offered the following critique:

> For the past 10 years, small-business owners have named the ability to provide affordable health care to their workers as their top concern. Health-care mandates are a major contributor to the skyrocketing cost of health insurance for the small and independent businesses that employ half of Massachusetts' 3.3 million workers. These are laws that require all health plans to cover services by a particular type of provider or to cover specific diagnostic or treatment services. Massachusetts already has at least 27 mandated-benefit laws, 11 enacted in the past five years and two within the past year. That conservatively adds between 15 percent and 30 percent to the cost of health-care premiums. And the Legislature has received favorable committee reports on not one, not 10, but 36 additional new mandates this session. Rising health-insurance premiums resulting from mandates force employers to either decrease coverage by increasing deductibles, ask employees to contribute a larger share of the cost or drop coverage altogether. When small businesses drop coverage or employees decide they can no longer afford their share of the cost, the ranks of the working uninsured grow. (Vernon 2002)

From the perspective of the business community, as Vernon outlined it, health care reform as a priority; but business leaders believed they could do a better job of improving the system without coercive government intervention and mandates.

The *narrative of inefficiency and unethical health care practices* was also present as a minor narrative in less than 5% of articles during the election campaign. Some columnists condemned the exorbitant, multi-million dollar salaries paid to health insurance executives at companies that were raising premium rates (Kowalzyk, June 19, 2002), while others criticized physicians for opening "boutique" medical clinics for the rich, which reduced access for most Bay Staters (Kowalcyk, March 5, 2002; Stewart 2002). A number of pieces focused on Democratic gubernatorial candidate Shannon O'Brien's two-year history as a vice-president of the bankrupt, for-profit health care

management company, Community Care Systems, which had left a number of insolvent hospitals throughout New England and closed its doors in the midst of a government corruption inquiry (Bailey 2002; Guarino et al., August 13, 2002). The *narrative of inefficiency and unethical health care practices* was sometimes deployed as a primer for the *pro-single payer narrative*, one that treated social insurance as a morally superior method of health care financing to replace the profit-driven health care system.

The *pro-single payer narrative* for reform in Massachusetts newspapers surfaced more frequently in state-based coverage than in the national newspapers during the election campaign, appearing in about 5% of articles. It was an unfavourable narrative of the commonwealth's health care system in the sense that it rejected market-based health care and, in some instances, treated the perspective embodied in the *expanded access narrative* as inadequate. In 2002, this claim typically appeared in quotes from gubernatorial candidates, in particular Representative Warren Tolman and candidate Robert Reich during the Democratic primary, and Green Party Candidate Jill Stein throughout the campaign period. However, there were other poignant examples of the *pro-single payer narrative* that were not tied to progressive political candidates. A *Boston Herald* piece offered the following endorsement of single-payer, without using the term:

> The Massachusetts Nurses Association is also raising alarms about the future of the health-care system. "We believe the free-market, deregulated and corporatized approach to the delivery of health care in the commonwealth.... is an abject failure, and it is the primary cause of the crisis we now face," the group said in a statement. The group is calling for a single administrator to coordinate all payment systems, including private and public payers in the short run, while more extensive reforms are made. Ultimately the group wants a system that would use public funding to provide health-care coverage to everyone in the state. (Heldt-Powell 2002)

As in the above example, support for single-payer was sometimes carefully veiled, yet

articulate and well framed, as a way to avoid raising alarm by advocating the often-maligned concept of "socialized medicine."

A few years later, during the Romneycare debates of 2005 and 2006, a noteworthy portion of critical health care reporting focused on the new landmark legislation. The *anti-Romneycare* and *pro-single payer* narratives were present in both newspapers, though, perhaps counter-intuitively, they were actually more minor narratives during the debates, although the *anti-Romneycare narrative* became slightly more common only after the MHRL passed in the legislature. *Globe* reporters who opposed Romneycare often alleged that it did not go far enough and gave away too much to the insurance companies. Reform activists, such as leaders of the Greater Boston Interfaith Organization, denounced Romney's earliest articulations of his health care plan as "Yugo health care," in reference to the infamously unreliable 1980s car (Hamilton and Pesner 2005). In particular, the requirement of "product flexibility" that forced insurance companies to develop and market so called "catastrophic" (low premium, high deductible) plans was seen as a dishonest way to reduce uninsurance rates—one that filled insurance industry coffers and gave consumers of these plans a false sense of security (Hamilton and Pesner 2005).

In the *Herald*, anti-Romneycare columnists more frequently denounced the legislation as a stealth corporate tax increase and as an infringement on individual rights, thus deploying the *narrative of unethical health regulation* along with the *anti-Romneycare narrative* and echoing libertarian arguments that are commonly levied against government programs. For instance, an April, 2006 piece in the *Boston Herald* offered the following critique:

> "This is certainly a tax increase on business," declared Mike Tanner, health-care analyst at the free-market Cato Institute in Washington, D.C. He called the requirement that everyone get health insurance "unprecedented in terms of government interference in people's lives." (Arends 2006)

The identifying feature of the *anti-Romneycare narrative* in both newspapers, whether columnists argued that the legislation did not do enough to address the crisis (Hamilton and Pesner 2005), denounced it as corrupt corporate welfare for the insurance industry (Abramson 2006), or claimed that it violated individual rights and unreasonably raised taxes (Arends 2006), was that the columnists who deployed it focused specifically on the MHRL, rather than on other aspects of the Massachusetts health care system (practices or legislation), which other narratives were sometimes used to target. This differentiated pieces that featured the *anti-Romneycare narrative* from other articles, such as those in which the *pro-single payer narrative* or the *narrative of unethical health regulation* were deployed alone—pieces that at times had a broader focus than Romneycare.

Sometimes, proponents of the *anti-Romneycare narrative* criticized the assumptions upon which Governor Romney and Senate President Robert Travaglini based the MHRL; specifically, they rejected the notion that a private insurance plan could be purchased for $2400 per year; the claim that the "health insurance connector" would adequately re-orient the market to find substantial savings; and the claim that the individual insurance mandate would reduce uninsurance without more generous subsidies than those offered under the Romneycare plan, since most of the uninsured were low-income Bay Staters (Kuttner 2006).

The *pro-single payer narrative* was an important counter-narrative to those deployed in favour of Romneycare. Massachusetts nurses were some of the most vocal single-payer advocates. In fact, Sandy Eaton, the Chair of the *Massachusetts Campaign*

For Single-Payer Health Care, was a registered nurse with close ties to organized labour (Knudson 2005). Health policy scholars such as Alan Sager and Deborah Socolar also advocated strongly for single-payer as a reform option superior to Romneycare (Kowalczyk, July 20, 2005).

A new unfavourable narrative that appeared during the legislative debates was the *narrative of political gridlock in health reform.* It criticized the political machinations of health care reform instead of the tenets of the legislation itself. In terms reminiscent of the Bismarkian analogy of politics-as-sausage-making, these columnists told readers that the political realities and negotiations underlying reform efforts were unpleasant, even unsavoury. A *Boston Globe* piece in November of 2005 demonstrates this unfavourable narrative of the politics of reform well:

> A curious mix of political will and calculation, fuelled by powerful business interests, is helping Romney so far…Now to the politics: A one-term governor with a thin political resume, Romney needs a major accomplishment. After settling on healthcare as the goal, he is allowing Democrats to control the public debate. (Vennochi, November 13, 2005)

A later description of the reform politics in February 2006 was not much more complimentary:

> Romney has attempted to push the Legislature into doing something partly as a credential for his expected presidential campaign and many legislators believe this is the time to address a longstanding problem. But what does it say when the governor and both houses of the Legislature agree broadly on the need to fix a major problem, but still can't figure out how to do it?.... Only a fool would bet on what the finished healthcare bill will look like, though full coverage seems the least likely outcome. One thing is likely, though: Whatever is passed, no matter how short it falls of what might have been, our lawmakers are sure to congratulate themselves. (Walker 2006)

Similarly, a January 2006 column in the *Boston Globe* offered the following description

of the negotiations:

> Negotiations between the House and Senate on a healthcare reform package on Beacon Hill appear to be sputtering, despite earlier hopes that a bill would be hammered out early this year. Three state senators involved in the talks said in a letter yesterday that they have "serious concerns" about a House-proposed payroll tax designed to fund a significant expansion of the state's healthcare system. The three Senate members of the six-member conference committee sent the letter to the House chairwoman of the committee yesterday. They also sent copies to reporters, a rare move that gave outsiders a window into ongoing closed-door negotiations. The House proposal, which includes a payroll tax aimed at companies that do not offer health insurance to workers and which seeks to insure nearly all the uninsured in Massachusetts, has faced a growing chorus of criticism recently from business groups, warning it will hurt the state's economy. (Ranalli, January 6, 2006)

Examples such as these depicted a legislative reform process plagued with political calculations, underhanded manipulation of the press in response to internal legislative disputes, and a manner of governing in which the public interest was neglected in favour of private interests.

The *narrative of unethical health care regulation* persisted as a minor theme deployed in criticism of Romneycare. It remained more common in the *Boston Herald*; however, *Boston Globe* columnists also employed it in voicing specific opposition to the proposed employer insurance mandate. Some columnists supported the individual insurance mandate as an appropriate first step, yet they rejected the proposed employer mandate as economically risky government overreach (Bailey, November 2, 2005). Outspoken critics of the employer mandate who penned op-eds included prominent CEOs and other business leaders (Fish 2005).

Following the passage of Romneycare in 2006, unfavourable narratives of the legislation persisted in both the *Boston Globe* and the *Boston Herald*. One common object of criticism when the *pro-single payer narrative* was deployed in the Democratic-

leaning *Globe* was the rise in so-called "catastrophic health insurance plans." Critics charged that such plans (defined by low premiums, often high deductibles, and extensive coverage restrictions) should not have been authorized through the MHRL. For instance, one *Globe* columnist offered the following critique:

> The policies – mostly purchased by people who work for small businesses - feature premiums as low as $300 for a family, less for individuals. But they also contain a confusing mix of deductibles, co-payments, and coverage maximums on physician visits, hospital stays, and tests. Consumers contacted by the *Globe* said agents aggressively promoted the policies' $1 million lifetime benefit, with a single deductible of $1,000 for hospital stays. But limitations make the coverage illusory, say critics. "These Swiss-cheese plans attract people with lower premiums, but they have lousy coverage," said Stephen D'Amato, a public interest lawyer and former Massachusetts state insurance regulator. "These kinds of plans should never hit the market." (Rowland, October 31, 2006)

Rowland's piece was particularly clear in arguing that the expansion of coverage in the context of a for-profit system had notable drawbacks. While many Bay Staters obtained health insurance to avoid tax penalties and comply with the individual mandate of Romneycare, many of the newly "insured on paper" remained under-insured in practice.

Other columnists who advanced the *pro-single payer narrative* treated the MHRL legislation as a distraction from what they believed should be the real goal of reform: the transition to single-payer coverage (Angell 2006; Woolhandler and Hochman 2006). Prior to making a case for single-payer, writing in the *Boston Globe*, Dr. Steffie Woolhandler and Dr. Michael Hochman (two Massachusetts physicians) derided the individual mandate of Romneycare as a misguided and inadequate step.

> The individual mandate is another ill-fated Band- Aid….Massachusetts residents will continue to be covered by the existing patchy network of insurance groups. The options are complicated, and the costs are steep: a typical group policy in costs about $5,000 annually for an individual and more than $11,000 for a family. Many of the state's approximately 618,000 uninsured residents will still fall

through the cracks. (Woolhandler and Hochman 2006)

As in the Woolhandler and Hochman piece, the individual mandate was a popular target of Romneycare opponents after the passage of the legislation. However, support for single-payer as an alternative was expressed less frequently. Most critics stopped short of advocating for single-payer and instead focused on what they believed to be ongoing challenges in insurance market affordability. For example, a *Boston Globe* piece offered the following critique:

> It is clear to Dr. Paul Hattis [Professor of Health Policy at Tufts] how few actual low-income people state regulators spoke with before they set insurance rates for the Commonwealth's new universal healthcare law. Although dramatically cheaper than market rates, the subsidized premiums are beyond the reach of a large swath of the working poor in Massachusetts. (McNamara, September 13, 2006)

The McNamara piece was particularly representative of unfavourable coverage after the passage of Romneycare in the sense that it did not disavow the legislation or suggest that more radical reform was needed. Instead, McNamara and many other columnists argued in favour of ongoing, piecemeal reforms to build on Romneycare, which, although insufficient on its own, was in their view still a positive step toward addressing the challenges of the health care system.

The *narrative of inefficiency and unethical health care practices,* which had been present in the media since at least the 2002 election campaign as a minor narrative, became a more frequently deployed narrative after the passage of the MHRL, surfacing in about 8% of articles. For example, a handful of articles strongly critiqued the practices of insurance companies and health care providers, with the former remaining the most

common target of columnists' frustrations. For instance, writing in the *Boston Globe*, Dr. Stephen Hoffmann offered the following condemnation of insurance business practices:

> MANY ARE AWARE of the obstacles patients and physicians have to contend with in pursuit of quality healthcare. A watershed moment came for me last year when I diagnosed liver cancer in a 23-year- old man. No one wearing a clinical hat would disagree that this young man's future hinged on what a PET scan would show whether the cancer was confined to the liver or had spread, but you wouldn't know that from the battle I waged with his insurer. It took more than three hours, culminating in an impassioned plea to a senior insurance company executive, to obtain the precious approval number for the scan. A major casualty was a cancelled morning of patients. Over the past few years insurers have heightened pressure on physicians to do what is in their best interest, as opposed to the patient's. They dock our pay for ordering more tests or using more expensive medications than they deem desirable. They throw obstacles in our paths really in the way of our patients banking that we won't go forward, because surmounting them takes so much of our already limited time. (Hoffmann 2006)

While insurance companies frequently attracted criticism, a sexual harassment scandal in Caritas Christi Health Care System (Boston's Catholic hospital system) attracted broad media attention because of the alleged mishandling of the case under the Archdiocese of Boston, indirectly drawing attention to exorbitant salaries in private health care administration (McNamara, May 24, 2006; Robinson and Paulson 2006).

Similarly, the *narrative of unethical health regulation* continued to be deployed as a minor narrative in the latter half of 2006, appearing in fewer than 5% of articles. For example, a few *Boston Herald* columnists criticized the new state regulations on minimum hospital nurse staffing (modeled after a California law) as disadvantageous to rural and suburban hospitals (*Boston Herald*, May 29, 2006). The narrative was often deployed in conjunction with the *anti-Romneycare narrative*, as columnists wrote disapprovingly of the individual insurance mandate, decrying that particular aspect of Romneycare as incongruent with traditional American values on individual liberty (Buckingham 2006; Cannon, May 3, 2006). In one of the best examples of the *narrative*

of unethical health regulation, in the aptly titled *Boston Herald* piece "Critics slam insurance plan as intrusive and unwieldy," the writer offered the following synopsis:

> Conservatives bashed the law as an unwarranted government intrusion that will fail to achieve universal coverage or widespread public support. "It represents an unprecedented level of interference with personal decision-making," said Michael Tanner of the Cato Institute, a libertarian think tank. "Simply by breathing in Massachusetts they're saying you must buy the product they say you should have"…. The law's lack of built-in cost controls will quickly result in higher premiums, new taxes and larger fines. Barbara Anderson of Citizens for Limited Taxation applauded Romney's core goal of encouraging personal responsibility for medical costs, but she said the law is going to "end up accomplishing a lot less than they're saying and it's going to cost a lot more." (Ross 2006)

The Ross piece was unique in the sense that it combined a subordinate (and perhaps backhanded) message of praise by means of the *individual responsibility narrative* with the critical *narrative of unethical health regulation* and the *anti-Romneycare narrative*. The complexity of interwoven favourable and unfavourable narratives demonstrates the need to carefully evaluate each article in order to determine the ways in which reform proposals and the health system were represented to readers.

Other noteworthy health reform narratives (2002-2006)

The state newspaper media used two other health reform narratives in their depictions of the health reform debates during the election campaign. First, the *narrative of Massachusetts leadership in national health reform* was present in *Boston Globe* and *Boston Herald* reporting. Typically, as had been the case in national newspapers, these instances involved mentions of Massachusetts politicians such as Senators Kennedy and Kerry, and Congressman Frank, in the national health reform debates. Second, the *narrative of Massachusetts as a centre of the health care industry* was also present as a notable narrative of health care in the commonwealth.

By the time of the Romneycare debates in 2005 and 2006, as had been the case during the 2002 election campaign, the *narrative of Massachusetts leadership in national health care reform* surfaced primarily in articles that focused on the role of Massachusetts members of Congress in the federal policy debates. For example, a February 2006 *Boston Herald* piece quoted Senator Kennedy stating that "like his Social Security privatization fiasco, President Bush's health savings accounts are a gimmick that will only make a bad situation worse" (Fitzgerald and Heldt-Powell 2006). At that time, Kennedy was advocating for the expansion of Medicare to cover all Americans (the last version of Kennedy's career-spanning push for single-payer) as an alternative to President Bush's market-driven health care plan.

The *narrative of inefficiency and unethical health care practices*, targeting insurance companies and health care providers for practices that allegedly increased costs, reduced access, and undermined quality, continued to appear in both newspapers. For example, writing in the *Boston Herald*, Dr. John Abramson declared:

> Taxation without representation, pure and simple. That's what American health care has become – an enormous burden not just on American families, but on our businesses and government as well. It's not our representatives who levy this tax, though many are unable to stand up to medical-industry pressure because they are so bloated by its money and insulated from reality by its lobbyists….Today, drug and other medical industries commandeer more than 15 percent of all the goods and services we produce. By comparison, health care consumes only 9.6 percent of Canada's GDP, and the health of its citizens is better and has been improving faster than the health of white Americans for the past 40 years. (Abramson, October 2, 2005)

Abramson was of course targeting the inefficiency and injustice of the for-profit health care system as a whole. He concluded his argument by advocating for a transition to single-payer. This particular rhetorical move, however, occurred in only a few columns

that combined the *narrative of inefficiency and unethical health care practices* with the *pro-single payer narrative*. More often, columnists deployed the *narrative of inefficiency and unethical health care practices* in order to denounce specific instances of inappropriate behaviour on the part of insurance companies or health care workers. The *narrative of Massachusetts as a centre of the health care industry* persisted—most frequently in the business section of the *Boston Herald*.

Summary of Massachusetts newspaper coverage (2002-2006)

In the 2002 election period, columnists in the *Boston Globe* and the *Boston Herald* covered the health care reform debates widely. The *expanded access* and *economic security* narratives were the narratives most commonly deployed in favour of health care reform. As in national reporting, the state-based media depicted Massachusetts as a health policy innovator (*narrative of leadership and innovation in state health policy*) and a leader in national health reform debates through its prominent politicians (*narrative of Massachusetts leadership in national health reform*), and made note of state-level health care reform activism (*narrative of health reform activism*).

Despite the overall positive representations of the health reform proposals of mainstream Democratic and Republican politicians, other columnists deployed the *narrative of inefficiency and unethical health care practices* to criticize allegedly greedy health insurance companies and health care providers. Critical columnists on the left (mostly in the *Globe*) advanced the *pro-single payer narrative,* while critical columnists on the right (mostly in the *Herald*) advanced the *narrative of unethical health regulation* to propose reforms that were more radical than those of the leading Republican and Democratic gubernatorial candidates. A handful of national newspaper articles in 2002

further depicted Massachusetts as a state where the health care industry was economically significant and politically influential (the *narrative of Massachusetts as a centre of the health care industry*).

Interestingly, the same health reform narratives that framed representations of the Massachusetts health care system in the national print media were present in state-based coverage in 2002. These media frames and narratives of health care set the stage for media coverage prior to the Romneycare debates of 2005 and 2006. Perhaps the factor that most differentiated state-based newspaper coverage from that of national newspapers was the greater complexity of the *expanded access narrative* in the *Boston Globe* and the *Boston Herald*. Massachusetts columnists often focused on the need to expand access to health insurance or medical care for particular, marginalized groups. These groups included the so-called "working poor," children, the elderly, women, minorities, and immigrants.

During the 2005-2006 legislative debates on Romneycare, columnists in the *Boston Globe* and the *Boston Herald* continued to report frequently on health care reform. The *expanded access* and *economic security narratives* remained the narratives most commonly deployed in favour of health care reform. In addition, given that coverage of the Romneycare debates came to dominate health care reporting, most news stories, columns and editorials deploying the *narrative of leadership and innovation in state health reform, narrative of health reform activism, expanded access narrative, economic security narrative, narrative of unethical health regulation,* and *individual responsibility narratives* during the period pertained directly to the MHRL legislation. Of course, all articles in which the *anti-Romneycare narrative* was used also related directly

to the MHRL. In direct response to the Romneycare debates, columnists also began to deploy the *narrative of political gridlock in health reform* to criticize the politics behind reform. However, the role of Massachusetts's politicians in national health reform (*narrative of Massachusetts leadership in national health reform*), and other systemic and political issues in the state health system (*narrative of inefficiency and unethical health practices* and the *narrative of Massachusetts as a centre of the health care industry)* also continued to attract media attention.

In sum, although the *narrative of political gridlock in health reform* was new to the period in which the legislative debates took place, the established health reform narratives that had framed representations of the Massachusetts health care system during the 2002 election campaign period persisted into the Romneycare debates and dominated health care reporting. Therefore, there was clear continuity in the major health care narratives between the 2002 state election campaign and the period of legislative debates surrounding Romneycare in 2005 and 2006. Finally, the *expanded access narrative* in the *Boston Globe* and the *Boston Herald* continued to be regularly used to focus on the need to expand access to health insurance or medical care for marginalized groups, including the so-called "working poor," children, the elderly, women, minorities, and immigrants.

After the passage of Romneycare in April 2006, it remained the health-related story most frequently analyzed by *Boston Globe* and *Boston Herald* columnists for the rest of the year. The *narrative of leadership and innovation in state health reform* became the most frequently deployed narrative for the first time, surpassing both the *expanded access* and *economic security narratives*. Most pieces in which journalists and columnists deployed the *narrative of leadership and innovation in state health reform, expanded*

access narrative, economic security narrative, narrative of health reform activism, individual responsibility narrative and *narrative of unethical health regulation* referred directly to the MHRL legislation. The roles of Massachusetts politicians such as Senator Kennedy, Governor Romney, Senator Kerry, and Congressman Frank in national health reform (the *narrative of Massachusetts leadership in national health reform*), and other systemic and political issues in the state health system (the *narrative of inefficiency and unethical health practices* and the *narrative of Massachusetts as a centre of the health care industry)* still remained in other stories of the state health care system and health care politics beyond Romneycare.

The *narrative of political gridlock in health reform,* which had been present during the legislative debates, was no longer deployed after passage. The only new narratives to emerge in 2006 after the passage of Romneycare were minor "other" narratives. It is noteworthy that within the category of the *expanded access narrative*, the proportion of deployments that included notions of deservedness (e.g. senior citizens, the working poor, immigrants, etc.) increased after passage of the MHRL.

5.5 Lessons from the Massachusetts case

The Romneycare case is a story of neoliberal health care reform—a plan that instituted corporate welfare for the insurance industry, coerced Bay Staters and employers into participating in the private health insurance market, and buttressed the market through both public subsidies for the purchase of private insurance policies and an expansion of means-tested social assistance (Medicaid) as a safety net for market failures. Out of the eleven major narratives, four were unequivocally neoliberal in their political

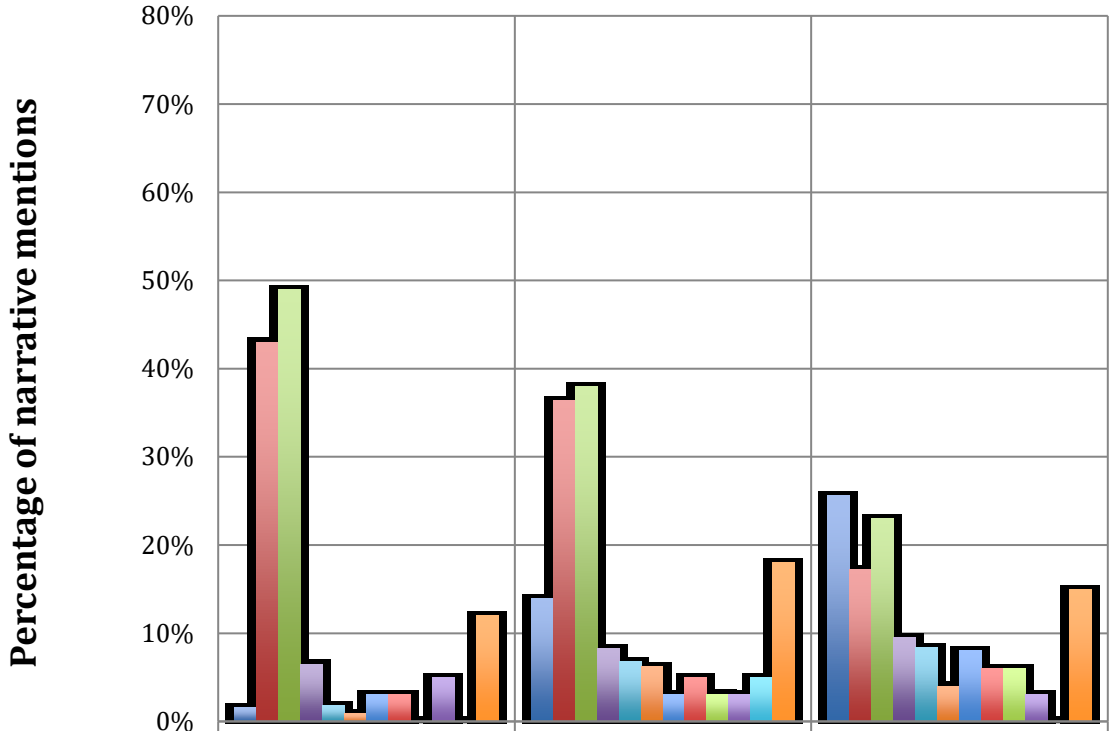
orientation: (1) the *narrative of leadership and innovation in state health policy*; (2) the *economic security narrative*; (3) the *expanded access narrative*; and (4) the *individual responsibility narrative in favour of Romneycare*. These four narratives all explicitly favoured reforms that preserved the private health care market in broad terms, or specifically advanced Romneycare as the model reform to emulate.

Three other major narratives were often (though less explicitly) neoliberal. They were as follows: (1) the *narrative of Massachusetts leadership in national health reform* (highlighting the role of Massachusetts politicians in national reform debates, often advancing neoliberal perspectives on health care reform, but also including Senator Ted Kennedy's pro-single payer statements to the media that challenged the neoliberal status quo); (2) the *narrative of health reform activism* (highlighting the efforts of advocates who had largely rejected or abandoned single payer as a goal); and (3) the *narrative of Massachusetts as a centre of the health care industry* (normalizing the profit-oriented nature of the health care system).

Three other narratives were critical of Romneycare and the health care system, but they did not clearly challenge the neoliberal conceptualization of health care as a market: (1) the *narrative of political gridlock in health care reform* (critical of the allegedly politicized process of reform, but not analytically critical of underlying reform ideologies); (2) the *anti-Romneycare narrative* (a mix of reporting that was united in its opposition to Romneycare, including both right-libertarian and more mainstream Republican critiques); and (3) the *narrative of inefficiency and unethical health care practices* (critical of the health care and insurance industries, though not necessarily in favour of systemic change towards single-payer or another model that guarantee universal

access). Thus, only one narrative, the *pro-single payer narrative*, clearly rejected the neoliberal conceptualization of health care as a market with winners, losers, and a justifiable hierarchy of access to, and quality of, care based on one's economic means. As such, there was an overarching neoliberal representation of health care throughout the debates at critical junctures from 2002-2006. Chart 5.2 on page 237 illustrates the comparative weight of the narratives of health care reform in the Romneycare debates across time.

Chart 5.2: Influential health reform narratives in state-based newspaper (*Boston Globe* and *Boston Herald*) coverage of Romneycare and the Massachusetts health care system (2002 - 2006)



	2002 Election campaign	2005-2006 Legislative debates	2006 After legislative passage
Narrative of leadership and innovation in state health policy	2%	14%	26%
Economic security narrative in Massachusetts coverage	43%	36%	17%
Expanded access narrative in Massachusetts coverage	49%	38%	23%
Narrative of Massachusetts leadership in national health reform	7%	8%	10%
Narrative of health reform activism	2%	7%	8%
Individual responsibility narrative in favour of Romneycare	1%	6%	4.00%
Narrative of inefficiency & unethical health care practices	3%	3%	8.00%
Narrative of Massachusetts as a centre of the health care industry	3%	5%	6%
Anti-Romneycare narrative	0%	3%	6%
Pro-single payer narrative	5%	3%	3%
Narrative of political gridlock in health reform	0.00%	5.00%	0.00%
Other	12.00%	18.00%	15.00%

As depicted in Chart 5.2,[65] analysis of the eleven major health reform narratives reveals ascendant, descendant, and undulating, and fleeting news cycle narratives of health care and reform in Massachusetts deployed across all time periods (2002 election campaign, 2005-2006 legislative debates, and 2006 passage). The fleeting news cycle narrative—the *narrative of political gridlock in health reform*—was written in response to passing events, similar to minor fleeting narratives (in the "other" category in Chart 5.2) that emerged in less than 5% of articles, sometimes in only one period of analysis. It is however noteworthy that the *anti-Romneycare narrative* was both an ascendant and a fleeting news cycle narrative. Contrary to what one might expect, it appeared more frequently after the passage of Romneycare than during the debates, when negative reporting may arguably have influenced the legislative outcome.

The remaining narratives were deployed consistently between 2002 and 2006. The five ascendant narratives that increased in frequency (as a percentage of overall health care reporting) over time—the *narrative of Massachusetts as a centre of the health care industry*, the *narrative of inefficiency and unethical health care practices*, the *narrative of health reform activism*, the *narrative of Massachusetts leadership in national health reform*, and the *narrative of Massachusetts leadership in state health policy*—all

[65] Percentages in Chart 5.2 are based on a total of 1,238 articles (447 during the 2002 election campaign from January 1 – November 4, 2002; 517 during the Romneycare debates from January 1, 2005 – April 11, 2006; and 274 after the passage of Romneycare legislation from April 12 – December 31, 2006) in the *Boston Herald* and the *Boston Globe* that covered Massachusetts health care reform debates. The 11 major narratives depicted in Chart 5.2 are classified as "major" because they emerged in at least 5% of articles in at least one period of analysis. Note, however, that the "other" category in Chart 5.2 accounts for articles that pertained to some aspect of health care in Massachusetts, but did not contain a developed narratives of health reform or the state health care system. These "other" pieces often focused on health issues (such as flu clinics, community health forums) but not health care reform debates. The "other" category also includes minor health care narratives that were deployed in less than 5% of articles (sometimes 1% or less) in any of the three periods of analysis. Note that percentages are rounded.

contributed to the image of Massachusetts as a place where health care was an important issue, where residents and the media were paying attention to health issues and health care-related industries, and where health policy innovations were taking place. The two undulating narratives—the *pro-single payer narrative* and the *individual responsibility narrative in favour of Romneycare*—peaked during the legislative debates of 2005 and 2006, and then declined after the passage of the MHRL. Finally, the two descendant narratives that decreased in frequency over time—the *expanded access narrative* and the *economic security narrative*—were not tied to health policy proposals, but rather to perceived problems in the health care system that were represented as reasons for reform. It appears that, as the Romneycare reform progressed from idea to debate to implementation, media interest in problems with access to the health care system, and in the economic challenges it faced, declined. Taken collectively, the various deployments of the eleven major health narratives over time demonstrate that the newspaper media increasingly viewed and represented Massachusetts as a state that acknowledged its major health care challenges, and was resolved to meet those challenges with politically balanced innovations, before other states or the federal government were able to do so.

The newspaper media was arguably a political accomplice in the Romneycare reform, or was at least complicit, in the sense that the newspapers advanced neoliberal health reform narratives more frequently than the social-democratic or libertarian alternatives. More radical narratives articulated by critics on the political left and right were thus comparatively marginalized in newspaper media reporting. There was diffusion of major narratives between the Republican-leaning *Boston Herald* and the Democratic-leaning *Boston Globe*, and a general convergence of media representations between the

newspapers. Massachusetts newspapers also largely mirrored national newspaper coverage, though the greater quantity and detail of reporting provided a more complex picture of the Romneycare debates at the local print media level. However, despite the dominance and convergence of neoliberal representations, the Romneycare case is also a story of a political success in a notoriously difficult sphere of policy reform in the American context—a success that improved access to health care for nearly half a million people.

The Massachusetts case demonstrates that the local newspaper media takes particular interest in state-level health reform. While the dominant neoliberal narratives of health care reform diffused between the Democratic-leaning *Boston Globe* and the Republican-leaning *Boston Herald*, the challenging (mostly minor) narratives distinguished health care reporting in the margins. The only challenging narrative to attain about 5% of coverage was the *pro-single payer narrative*, and, even in that case, only during the 2002 election campaign period. The other most common challenging narratives emerged in fewer than 5% of articles in the three periods of analysis, and are thus relegated to the "other" category in Chart 5.2 above. However, these minor narratives (*narrative of unethical health care regulation* and the *anti-single payer narrative*), which are not depicted in Chart 5.2, but were often deployed in conjunction with the *anti-Romneycare narrative* to denounce government intrusion in the health sphere should not be completely disregarded, since these libertarian voices were more frequent in the Republican-leaning *Boston Herald* and helped to differentiate *Herald* coverage from *Globe* coverage in the margins.

One of the often-unanticipated pitfalls of being first at solving (or appearing to

solve) a substantial policy problem, especially one that has consistently stumped others, is that success attracts both admiration and envy. This is especially true when the trailblazers, such as the Commonwealth of Massachusetts, proclaim their legislation to be a model to emulate. While governments, or individual policy-makers, bask in the success of a new and popular reform, they tend to welcome admirers, some of whom become imitators. And, invariably, some imitators become competitors—determined to prove they can do better than those they are emulating. This story of innovation, followed by admiration, imitation, and competition, is the story of the health reform efforts in Massachusetts and Utah. Massachusetts broke the mould and attracted widespread media attention for its efforts. Utah tried to follow Massachusetts and establish a superior, conservative alternative; yet, the media paid far less attention and the reform itself was less successful in terms of increasing insurance coverage. The following chapters (6 and 7) explore the Utah Health System Reform (UHSR) and its representations in national and state-based newspapers.

Chapter 6: Pioneering reform or undermining progress? National Newspaper Media representations of Utah's effort to forge a market-oriented path to health care reform after Massachusetts (2004-2011)

This chapter focuses on the development of the Utah Health System Reform (UHSR) and its national newspaper media representations from 2004 to 2011. My analysis demonstrates that Utah's health reform effort, like that of Massachusetts, arose in the absence of a major federal reform, in response to concerns over both uninsurance rates and health care costs. Essentially, the UHSR began as a prelude to Obamacare; however, unlike Massachusetts, at least at this juncture Utah does not appear to have set a new direction for state-level health reform efforts. Furthermore, the UHSR came to compete with the federal reform effort in the latter period from 2008-2011. After providing a summary of the Utah political context, this chapter explores the national newspaper representations—*The Wall Street Journal* (on the political right), *The New York Times* (on the political left), *USA Today* (political centre), and the *Washington Post* (political centre)—of Utah within the broader American health reform debates between the 2004 state election and the passage of the final legislation and implementation of the UHSR in 2011.

6.1 Introduction

In 2004, Utah, a state known for its frontier spirit and social conservatism, seemed like an unlikely candidate to pursue major health care reform. While health care had been a subject of major debate in the 2002 Massachusetts election prior to that state's major reforms, one that both Democrats and Republicans had promised to prioritize in the next legislative session, Utah had an entrenched Republican majority in the state legislature that had not focused significant attention on health care in the 2004 campaign. In fact,

none of the factors that led to reform in Massachusetts clearly applied in Utah. No organized statewide social movement sought substantial changes to the health care system. [66] No charismatic liberal politician championed the cause of the uninsured within a moderate, bipartisan legislative and gubernatorial coalition. Utah, indeed, had not witnessed any notable attempts to comprehensively reform health care in recent history.

Moreover, Utah's health profile was relatively unremarkable in the gradual implementation period of the Utah Health System Reform (UHSR) from 2008-2011. The two driving factors of contemporary American health care reform—namely, rising public and private costs for health insurance and medical care, and increasing uninsurance—were both near the national medians and therefore did not appear to disproportionately burden the state. Whereas Massachusetts had been plagued with one of the highest per capita public health spending rates in the OECD and some of the most expensive individual health insurance rates in the country during the 2002-2006 period (McConville 2002; Sager and Socolar 2002), Utah did not have comparable spending fears, nor did it face bad publicity for the costs of operating its health care system. In 2008, 85% of Utahns had health insurance, mirroring the national median of 85.3%.[67] In terms of

[66] This is not to say that there were no grassroots citizens' groups fighting for health care reform in Utah. It is important to acknowledge the hard work of the Utah Health Policy Project (UHPP) in advocacy, outreach, and citizen mobilization for equal access and improved quality in the health care system. It is also vital to recognize groups such as The Coalition for Medicaid Consumers and the Medically Underserved, the People's Summit on Poverty, Voices for Utah Children, Crossroads Urban Center, and the "White Coats" coalition (in 2009-2011). However, these initiatives, events, and movements were smaller and less coordinated than their counterparts in Massachusetts and were largely concentrated in Salt Lake City.

[67] Admittedly, this does not reflect the so-called "underinsured," which refers to those who have health insurance, yet still spend a high proportion of their income on medical expenses. As one might expect, there is ongoing debate as to what constitutes a high percentage of income on medical expenses for an insured person; however, for the purposes of my research, I accept the definition of Schoen et al. (2014) that underinsurance is the condition in which an insured person

spending, in 2004 Utah had the lowest per capita health expenditures (what individuals pay annually for their own health care) at $3,972, compared to $5,283 per capita nationally (DHHS 2009).[68] Utah was also among the lowest in state spending (i.e. in the total amount that state governments dedicate to public health per capita, including Medicare and Medicaid outlays) at $4,087 compared to the national median of $5,411 (Cuckler et al. 2011).

It is certainly true some minor differentiating statistics made Utah seem like a state with a more health-conscious population, one that would perhaps be more inclined to innovate and to experiment to improve the performance of its health care system. For example, only 10.8% of Utahns described themselves as unhealthy compared to 14.6% of respondents nationally. The rates among Utahns of some lifestyle-related risks to health, such as obesity (25.2% as opposed to 28% across the U.S.) and excessive alcohol consumption (8.8% compared to 15.5% nationally) were slightly better than the American average (Balluz et al. 2011). Nonetheless, despite the state's modestly better population health profile, its unremarkable economic context and comparably calm political environment vis-à-vis health care incites questions on the motivations for and elements of the reform, as well as the relevance of the UHSR to the overlapping

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still spends 10% of more of his or her income on medical care. This population includes those Americans who enroll in so-called "catastrophic," low-premium, high-deductible health plans that cover hospital stays in the event of accidents or long-term illnesses, but pay little or nothing for primary care, preventative care, or prescription drugs. Many Americans working in the service industry have employer-provided health insurance that falls in this category. Even post-reform, in 2013 Utah retained one of the worst underinsurance rates in the United States, with 16-17% of the population underinsured (Schoen et al. 2014). Nonetheless, Utah was not unique in this challenge and other states with comparably underinsured populations did not embark on substantial health reforms in the same period.

[68] 2004 was the most recent year prior to the UHSR with comparative Centers for Disease Control (CDC) statistics.

Obamacare debates.

The UHSR was essentially a top-down initiative that took place at the impetus of Governors Huntsman and Herbert, through the methodical mobilization of the state legislature, business community, think tanks, and public service. Collaborating closely with the corporate and charitable sectors throughout the process, influential state politicians—including Jim Dunnigan (R-Taylorsville, who later became House Majority Leader in 2015),[69] Dave Clark (R-Santa Clara, House Majority Leader 2007-2009, Speaker of the House 2009-2010), Michael Morley (R-Spanish Fork), and Sheldon Killpack (R-Syracuse, Senate Majority Leader 2008-2010)—reached agreement with the governors that reform should be incremental. This strategy would later provoke designations like "unObamacare" from outside the state (Clark 2008; Economist 2012; Gehrke 2008). The series of reforms aimed to control future expenditures and facilitate access to the insurance market, all while moving indigent Utahns off of Medicaid. The dominant narrative of the UHSR held that competition in an open market would meet the health care needs of Utahns and reduce state health expenditures without government mandates to purchase or provide insurance, new public programs, or new subsidies to help low-income people purchase health insurance (Economist 2012; Utah 2008, 2010).

6.2 Political Context and Summary of the Utah Health System Reform

A reform emerging from rivalry and forged through brokerage politics

In the early years of the UHSR debates, from 2004-2007, it was an open secret in

[69] Jim Dunnigan is a successful insurance executive, who maintained close business ties to the health insurance industry throughout the UHSR effort (Utah 2015)

Utah political circles that Governor Huntsman took inspiration from Romney's health reform strategy and the 2006 Massachusetts Health Reform Law. There was a history of friendly rivalry between Romney and Huntsman, whose families were both linked to Utah's political elite. Governor Huntsman instructed his advisers to study the Massachusetts model. Although Huntsman later tried to distance himself from insurance mandates when seeking the Republican Presidential Nomination in 2012, he initially supported an early plan that included an individual health insurance mandate. In addition to the individual mandate, Huntsman's ambitions included the objective to reduce uninsurance among Utahns by 50%, create an online health insurance exchange (again, based on Massachusetts' model), expand participation in the Children's Health Insurance Program (CHIP), provide subsidies to low-income Utahns to purchase health insurance, and require health insurance companies to accept any customers regardless of pre-existing medical conditions (Burr 2011; Stewart and May 2011).

Thus, not only did the UHSR architects study Massachusetts in the early stages; with the exception of the Massachusetts goal to attain universal coverage that never seems to have been an objective of the Utah reform, the UHSR shared many of the ambitious early objectives of the Massachusetts Health Reform Law (and, consequently, the federal Affordable Care Act that took inspiration from Romneycare as well). The history justifiably leads us to question how the UHSR became the archetype of health care reform for many opponents of Obamacare and simultaneously the target of other opponents of health care reform on the political right. The answers lie in the lengthy process fraught with compromise, a process in which Utah's insurance industry and the broader business community played a key role in framing problems and solutions; and in

the evolutionary interpretation of insurance mandates and exchanges as either conservative or liberal policies.

It is important to acknowledge the allegedly longstanding rivalry between Governors Huntsman and Romney, and the usual hubris that drives politicians to leave behind a policy legacy. It is also useful to account for both the force of policy diffusion and competition between states to resolve complex problems and set new policy standards. However, it is more revealing to unpack the development of Utah's health reform demands with particular attention to the role of the small business community—those companies that employ 50 or fewer workers, organize in associations, and lobby for business-friendly policy—and the state's insurance industry (Oldham 2012; Rucker and Horowitz 2012; Small Business Majority 2009). As groups exercising influence from the inside with close ties to decision-makers in government, their role is particularly important as exogenous variables in the outcome of the UHSR.

A product of business community preferences and discourses

Prior to the UHSR, the majority of Utah's small businesses (60%) had not offered health insurance to their employees, citing high cost as the primary reason for their choice (Small Business Majority 2009). Long before the UHSR debates, Utah's organized small business leaders and the state's major health insurance companies demonstrated partiality towards market-based health care policy approaches. They emphasized quality (albeit an ill-defined notion of quality), cost-control, and consumer empowerment. In response to business community lobbying efforts, in the state government's public outreach to build support for reform, small business owners and employees were a target group, and small

business owner associations were a driving force for the reform (Small Business Majority 2009; Tozzi 2009). Vocal representatives of the small business community and the state's insurance industry were intimately involved in the UHSR's conceptualization and implementation (Lord and Braun 2011). The push from and emphasis on small businesses is apparent in the unique nature of Utah's online health insurance exchange, Avenue H, which was designed for individual consumers and businesses that employ fifty or fewer people (Manfred 2013). The influence of the business community—in particular, the insurance industry—is also revealed in the debates on insurance mandates in the UHSR.

Governor Huntsman had purportedly supported an individual insurance mandate as late as 2007, in spite of his later claims to the contrary during the 2012 Republican Primary (Cherkis 2011; Cherkis and Ward 2011). Huntsman reportedly sent his health reform advisor, John Nielsen, to try to broker a deal with Republican leaders in the House and Senate that would have included an individual mandate. As the story goes, Nielsen and the proponents of the mandate lost the brokerage game to conservative opponents of mandates, who had the backing of the state insurance industry. Both Dave Clark and Jim Dunnigan were named in the media as possible culprits in undermining efforts to include mandates. Neither Clark nor Dunnigan, however, was quoted as having taken responsibility for removing the mandates, despite the fact that Dunnigan was more publicly forthcoming vis-à-vis his role in opposing the idea. Dunnigan's close ties to the insurance industry could certainly have enabled him to build strong opposition in both the business community and the legislature (Cherkis 2011; Cherkis and Ward 2011). However, precisely who, or what coalition of influential individuals actually killed the mandates, remains unclear based on analysis of media reports.

Notwithstanding the UHSR's more aspirational origins and Governor Huntsman's desire to implement legislation similar to Romneycare, despite the length of debate and fanfare it produced, and although it encompassed seven pieces of legislation over three years, the UHSR was ultimately a modest reform of limited ambition. The reform that was eventually implemented, through phased legislation between 2008 and 2011, reflected the ethic of limited government and the centrality of the business community. The UHSR did not aim for universal coverage. Its insurance reforms were minor. It did not increase taxes, implement new user fees on public health services, or impose taxes on luxury health insurance plans to finance other health services or programs. It did not provide subsidies to low-income Utahns for the purchase of health insurance; on the contrary, the architects of the UHSR vehemently resisted the expansion of Medicaid in the federal Affordable Care Act provisions. The UHSR did not ultimately impose requirements on individuals to purchase health insurance or on employers to provide insurance to their workers. The model did not clearly account for unemployment, since health care consumers were expected to pay premiums to remain insured, regardless of their employment status (Utah, Avenue H—May, July, September 2011).

The UHSR instead sought to standardize insurance practices throughout the state and revolutionize public perceptions of health care, implanting the business community's dominant neoliberal perception of health care as a commodity onto public discourse. The reform is best understood as a gradual and systematic initiative to individualize responsibility for all aspects of health, deploying narratives of consumer empowerment through choice and investment to justify government disinvestment from means-tested programs such as Medicaid and to challenge notions of collective responsibility in health

care (Utah, Avenue H, May, July, September 2011; Thurston, 2011). Avenue H, the online insurance exchange or "health insurance marketplace," was established as a place for Utah's individual healthcare consumers and small businesses to find information, compare plan offerings of private health insurance providers, and electronically purchase health care plans. Dr. Norman Thurston, the Utah Health Reform Implementation Coordinator who reported to the Governor's Office, described the underlying logic of the UHSR in his "Brief History of the Utah Health System Reform":

> The invisible hand of the marketplace, rather than the heavy hand of government, is the most effective means whereby reform may take place….Utah's approach to health system reform is to move toward a consumer-based system, where individuals are responsible for their health, health care, and health care financing. A major step in that direction is the development of a workable defined contribution system….Utah's approach to health system reform relies on the fundamental principles of personal responsibility, private markets, and competition. To promote competition in the health care system, consumers need three things – accurate and relevant information, real choice, and the opportunity to benefit from making good choices. The exchange model enhances private competition in the health care system by providing all three elements of increased competition. (Thurston 2011)

The political orientation of Thurston's quote could not be clearer in a parody of neoliberal health care representations. Building from his Adam Smith reference, Thurston decries government intervention, describes patients as responsible consumers, and frames the health care system as a market. He acknowledges the centrality of defined contribution insurance to the model, extols competition, and frames Utahns as rational consumers who will make good choices if the health exchange arms them with the right information. This type of narrative, which appeals unabashedly to a conservative political base, had been less common in the official discourse of the Massachusetts health reform that depended on delicate alliances between a Republican governor, a Democratic legislature, determined and well-organized progressive social activists with sophisticated

statewide networks, and the powerful insurance and pharmaceutical business communities. In Utah, conservative Republican rhetoric pervaded the official narrative throughout the UHSR's implementation.

Thurston's reference to defined contribution insurance and its centrality to the UHSR approach merits further explanation. Under defined contribution systems, instead of employers providing and guaranteeing a particular level of health insurance coverage to employees, employers offer pre-determined financial contributions that individual consumers use to purchase private health insurance plans through the state health exchange. Individual consumers choose the insurance company and benefit packages and may change health insurance plans without the approval of their employers (a feature that is not often possible in the traditional employer-based private insurance system). The insurance plans follow consumers between jobs, and consumers can use pre-taxed health savings accounts (HSAs) to help pay for them (Utah, Avenue H, May, July, September 2011).

A conservative alternative for export?

The UHSR was noteworthy primarily because its framers aimed to export the UHSR model across the United States—with the Avenue H health exchange as a centrepiece—as a conservative alternative to Romneycare and Obamacare. The UHSR spanned eight years of debate, including seven pieces of legislation—HB 133, HB 188, HB 331, HB 165, SB 79, HB 294, HB 128—that the Utah Legislature passed between 2008 and 2011. It included multiple events for statewide citizen engagement, and involved substantial legal wrangling with the federal government. The legislation aimed

to steadily expand access to health insurance and reduce state health expenditures, building upon the existing system without individual or employer insurance mandates.

To achieve the goal of expanding access to insurance and controlling costs, the state legislature followed a planned, phased implementation plan. Specifically, in 2008 HB 133 created the Utah Health Exchange, a new Health System Reform Task Force, and a pilot program for a few larger employers (with over 50 employees). The legislation mandated that the Governor's Office of Economic Development, the State Insurance Department, and the state Department of Health work in conjunction with the legislature to develop and implement a strategic plan for health care reform. In 2009, four separate bills were passed – three in the state House, one in the Senate – that offered further opportunities for users of the exchange. HB 188 created a "virtual store" for the health exchange and defined contribution health insurance. The law sought to expand access to the insurance market and make it more transparent. HB 331 required particular categories of private contractors to offer health insurance coverage while working with the state. Designed to protect patients' personal medical information, HB 165 consisted of new privacy and information sharing rules for health care workers, patients, and private insurance companies. SB 79 was essentially torts reform legislation, providing new minimum standards for malpractice lawsuits related to emergency medical services.

More pieces of legislation were passed in subsequent years to refine the exchange. In 2010, HB 294 consisted of amendments to address perceived problems in the pilot program. Finally, in 2011 HB 128 made further amendments, including expansion of access to the Utah health exchange to the small businesses for which it was designed, moving beyond the initial pilot for large employers. HB 128 made functional

improvements to the exchange itself, such as greater clarity of benefit packages for consumers and regulations for participating insurance companies. It standardized and simplified the application forms for state insurers. It also required the state's Health Data Committee to produce an annual comparative report on patient safety and health service charges at hospitals and other institutions that provide health services. Finally, despite the lawsuit against the federal government and all of the posturing in response to Obamacare, HB 128 required insurance market regulation to comply with new federal rules (Lord and Braun 2011; Utah 2008, 2010; Utah: Avenue H; UHPP 2008, 2009, 2010, 2011).

The Utah health exchange (Avenue H) is the cornerstone of the UHSR. In reality, Avenue H served as a venue for new market creation, reinforcing the neoliberal conceptualization of health care as a primarily for-profit sphere with hierarchies of quality and access to services. As it was framed to the public, the Avenue H website serves as a convenient venue for consumers to shop for the variety of insurance plans available to them. It is a place for the state's private insurance companies to compete for new customers. At the beginning of the UHSR process in 2004, when Governor Huntsman identified health reform as a priority and charged the state health department with the task of developing a strategic reform plan, establishing an exchange was a priority. After the more ambitious provisions were abandoned in 2007, the health exchange was the most important element to survive the series of compromises with legislators, business associations, the insurance industry, and the medical establishment. Governor Huntsman and his key supporters in the legislature settled on a reform plan that they would frame as the path to empower the market and consumers to resolve the challenges of the health care system without greater state or federal government

involvement. They were determined to demonstrate that insurance coverage could be expanded while simultaneously reducing government spending on means-tested public health care programs (Summerhays 2008; Utah 2010).

In advocating for their efforts, Dr. Thurston affirmed that any state could imitate the Utah model of defined contribution health reform as long as it included seven elements:

> (1) electronic application procedures, (2) electronic and publicly available risk assessment, underwriting, and rate setting, (3) broad choice and online shopping for individual consumers, (4) seamless electronic enrolment and information transfer, (5) enrolment flexibility and easy information updating for employers and individual consumers, (6) electronic and traceable financial transactions, and (7) clearly delineated and logical customer service functions (ensuring that employers and consumers knew who provided policy information and advice at all times) (Thurston 2011).

According to proponents of the UHSR, reforms should be based on "rational human behaviour," and on the premises that patients are consumers, health care is a commodity, and the best health and economic outcomes result in a free market context. The role of the state in this model is to facilitate access to the market and strongly discourage participation in public programs like Medicaid that allegedly distort market efficiency (Thurston, 2011; Utah, Avenue H, May, July, September, October 2011, Corlette et al. 2011).

A practical failure?

Despite Thurston's claims regarding the applicability of the Utah model to meet health care challenges across the United States, Utah's approach did not succeed as well as the Massachusetts model in expanding insurance coverage, failing in several of its key

objectives. Even though the reform architects emphasized user-friendly technology, the Massachusetts Health Connector offered more website features to narrow the search for insurance plans according to individual economic and demographic factors. The Massachusetts Health Connector was far more successful in ensuring affordable and competitive insurance rates on the health exchange and in expanding enrolment in private health insurance plans (Alker and Corlette 2011). Small businesses in Utah persistently resisted offering health insurance and participated minimally in Avenue H. As of 2011, when the UHSR reforms were completed, insurance premium rates on Avenue H were not lower—and in some cases were actually higher—than those in other states or even rates offered by private insurance companies outside of the exchange in Utah [70] (Hillman 2012; Nehring 2012).

To understand why premiums on Avenue H were initially high, it is important to once again consider defined contribution insurance. The defined contribution model of the UHSR aimed to expand insurance coverage through enrolment in so-called catastrophic health insurance plans (low premium, high deductible). Unlike the designers of the Massachusetts Health Reform or the federal Affordable Care Act, the architects of the UHSR adopted the defined contribution insurance approach to reduce costs for employers and shift the financial burden to individuals and families. On the state's external insurance market (the private insurance companies that sell health insurance in Utah off of the state's Avenue H health exchange website), employers were required to contribute 75% of employee premiums; however, on Avenue H, participating employers

[70] It is important to note that private insurance companies continued to sell health insurance in Utah off of the state health exchange website. Thus, the Utah health exchange was merely an insurance market within a larger market.

determined the percentage of the premiums they would pay. Employers had the option to contribute nothing, downloading all costs to employees (Hillman 2012; Nehring 2012). To complicate matters, Utah's budget to operate the exchange was so small that improving identified weaknesses in the system was slow. Utah initially spent about $600,000 annually for Avenue H, serving about 2,000 Utahns who were mostly middle-income consumers, and employing only a few administrators to manage operations (Corlette et al. 2011). In contrast, the Massachusetts Health Connector required nearly 50 full-time staff, and had an annual budget of over $30 million. It served more than 220,000 enrolees who were predominantly low-income and previously uninsured Bay Staters. Without more investment in Avenue H, insurance mandates, or subsidies for low-income Utahns, substantially expanding access to health insurance proved more difficult than the architects of the UHSR predicted (Buettgens et al. 2011; Corlette et al., 2011).

By 2010, state newspapers had begun to report that Utah's online health insurance exchange was not working well. In fact, had it not been for federal health care programs (Medicaid, SCHIP, Medicare, and the VHA), Utah's uninsurance rate would have been closer to 20% than 10% in the 2010-2011 period. The insurance plans offered on the Avenue H exchange were too costly for average Utahns, and very few consumers were purchasing insurance through the exchange website. David Clark and other key architects of the UHSR in the state legislature even acknowledged that the exchange was not functioning as they had hoped. The early challenges of unanticipated low participation and high costs largely explain the succession of piecemeal reform bills. The later legislative components of the UHSR and parallel state health reform legislation included various attempts to improve the UHSR and increase participation in the exchange. Clark

even went as far as encouraging the state to cooperate with the federal government, in an effort to help both the UHSR and ACA (Obamacare) to succeed, rather than trying to undermine ACA implementation. Media criticism, and legislative second-guessing and tweaking, continued through 2011. Even conservative commentators from outside of the state were disparaging the UHSR in 2010 and 2011, demonstrating the generalized anti-exchange sentiment that had been normalized on the political right after the passage of Obamacare (*Salt Lake Tribune* February 2010, Stewart 2011b, d, f).

Despite the noteworthy weaknesses of the UHSR and Utah's ultimate failure to prove that it could reduce costs and expand access without increased insurance regulation, expansion of public programs, insurance mandates, or low-income subsidies, it was a substantial reform effort. Its political proponents tried to build broad public support and took corrective steps when they understood their policies were not adequate. The Utah reformers became some of the most vocal defenders of states' rights in the national health reform debates, and they faced off directly with President Obama and Congressional Democrats in both the courts and media to bring their vision of the health care system to fruition. Their determination was reflected not just in the seven pieces of legislation related to the UHSR and other state health reform bills they passed, but also in several events of 2011 that proved central to Utah's reform efforts. In May 2011, the state held an invitational event to explain the reform process and seek input from healthcare professionals, citizens' groups, and other stakeholders. In July, the state's Medicaid Waiver Proposal was put forward, which aimed to use Medicaid funds to help low-income Utahans purchase private health insurance through the state health insurance exchange. The waiver sought to move low-income people from Medicaid onto the private

insurance market. In September, the state held the Governor's Health Summit, engaging hundreds of state politicians, public administrators, business leaders, and health care professionals. Finally, in October, the state published its comments in response to the new federal proposed rules on the implementation of health insurance exchanges under the Affordable Care Act (ACA). Utah's response to the federal ACA rules alleged that the federal legislation violated state sovereignty, did not offer adequate flexibility, forced states to participate in a new social program, and imposed inconsistent regulations. The response further alleged that the Obama administration did not properly consult with the states during planning and implementation (Utah, Avenue H, October 2011).

6.3 The reform seen through the newspapers

As the above-described events unfolded between 2004 and 2011, in large part parallel to federal health reform, the dominant state-based print media—the *Deseret News* and the *Salt Lake Tribune*—and the national newspaper media—*New York Times, Washington Post, Wall Street Journal, and USA Today*—represented the health reform debates through a variety of narratives and issue frames. These representations brought the differences between the right and left (Republican-leaning versus Democratic-leaning) to the fore and revealed the reform's origins, development, and objectives. They demonstrated different degrees of interest in the reform debates between national and state media, and clarified the trajectory of particular reform priorities and proposed legislation at critical junctures.

This chapter proceeds with an analysis of national newspaper coverage of Utah in the context of American health reform debates between the 2004 election and the UHSR

passage and implementation period from 2008-2011. Using newspaper articles as units of analysis, section 6.4 provides broad context to the UHSR through the lens of the national newspaper media. In addition to context, national coverage serves as a basis of comparison for state-based newspaper reporting, allowing for comparison on the national/local dimension in Chapter 7. My research reveals that the national newspaper media took noticeably less interest in the UHSR than it had in the Romneycare debates in Massachusetts. Yet the image of Utah that surfaced in limited national reporting—that of a state government that was an independent-minded, conservative, and innovative health system reformer—corresponds to the reality that was revealed in close examination of the UHSR debates in the state newspapers that are later examined in Chapter 7.

6.4 Analysis of National Media Coverage of the UHSR (*New York Times*, *Washington Post*, *USA Today*, and the *Wall Street Journal* [71]

National media covered health care extensively during the UHSR (2004 election period and the timeframes of legislative debate and passage from 2008-2011). [72]

[71] To remain consistent with my scan of state-based newspapers, the dataset for the national newspapers in the election period consists of a *Factiva* search for the terms "healthcare reform OR health reform OR health care reform OR health care system OR healthcare system OR single payer OR health exchange OR health insurance." For each newspaper, I added "Utah" and (separately) "Huntsman" or "Herbert" to the search terms.

[72] During the 2004 election period, in the four national newspapers, the initial *Factiva* search produced 2,423 articles on health care policy issues (863 in the *New York Times,* 411 in the *Wall Street Journal,* 894 in the *Washington Post*, and 255 in *USA Today*). I excluded 464 pieces from the initial analysis (155 in the *New York Times*, 74 in the *Wall Street Journal*, 197 in the *Washington Post*, and 38 from *USA Today*) because they were duplicates, letters to the editor, or focus on health issues but not health care reform debates. Thus, in total, during the 2004 election period, my analysis included 1,959 articles. Later, during the legislative debates from 2008 to 2011, the initial *Factiva* search during the legislative debate periods produced 4,438 articles on the American health reform debates in the four national newspapers. I excluded 598 articles that were either duplicates, letters to the editor, or related to health issues but not health policy reform, leaving 3,840 relevant health reform articles during legislative debates. In the months following legislative passage of each part of the UHSR, my initial *Factiva* search produced 6,532 articles on health care reform. I excluded 686 articles that were either duplicates, letters to the editor, or

However, Utah's reform agenda barely registered on the radar of the national newspapers. The lack of national attention stood in contrast to the earlier Massachusetts Health Reform Law debates, which garnered noticeably more national coverage from 2002-2006. Despite this very limited reporting, it is nonetheless contextually useful to extrapolate national newspaper representations of Utah during key periods from 2004-2011. This section focuses solely on national coverage of the UHSR and other mentions of Utah within the context of national health reform.[73]

National newspaper reporting on health care in Utah during the 2004 election period

During the 2004 election period (January 1-November 1, 2004), Utah was virtually absent in health care reform-related articles in the *New York Times*, the *Wall Street Journal*, the *Washington Post*, and *USA Today*, garnering only five mentions in health care coverage between the four newspapers. This was far lower than the (albeit still low) seventy-three mentions of Massachusetts during the 2002 election period, which was the lowest number of mentions garnered by Massachusetts in any of the timeframes analyzed. National newspaper media reporting on health care in 2004 mostly focused on the differences in the policy proposals and orientations of the two presidential contenders—incumbent President George W. Bush and Senator John Kerry. In particular, President Bush's emphasis on the so-called "ownership society," which individualized responsibility for health and wellness, was reported on frequently. The media often

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related to health issues but not health policy reform, leaving 5,846 articles from the periods of legislative passage. Thus, the total number of articles on health care reform during the periods of legislative debate and passage from 2008-2011 was 9,686.

[73] Because there were so few articles on Utah in the national newspapers, I do not present the data in charts.

covered President Bush's endorsement of Health Savings Accounts (HSAs); in some cases, Bush's partiality to HSAs was juxtaposed with Senator Kerry's preferences for managed care and modest expansion of means-tested public health care programs (e.g. Medicaid, CHIP). References to the Clintons' Health Security Act and Romneycare also emerged in the context of the Kerry-Bush health policy divergence. Other major health reform-related stories included New York Attorney General Eliot Spitzer's insurance industry fraud investigation (which spread to other states), state lawsuits against Wal-Mart for encouraging its low-paid workforce to apply for Medicaid instead of offering affordable health insurance, and the rising popularity of HSAs as a possible solution to the national crisis (beyond President Bush's endorsement of the new practice).

There were no articles directly related the Utah election to national health reform debates. However, it is worth noting that the five articles that connected the national health reform debates to Utah during the 2004 election period collectively portrayed the state as struggling with a crisis of access to health insurance and rising costs. Utah was represented as being prone to market-oriented health policy innovations and unlikely to embrace extensive health care reforms that would have expanded the role of government. In one notable *New York Times* column, author Milt Freudenheim focused on the efforts of several western states to increase health insurance coverage and reduce public costs, as well as the substantial differences in the depth of the crisis of the uninsured between states:

> With the number of uninsured Americans rising to new heights, some policy makers and influential health care experts are saying that the best way to give health coverage to more people is to give some people less…. Experiments in several states are establishing stripped-down packages of basic benefits intended to be affordable for employers and uninsured workers, including young, middle-

> class people who have dropped out of the health insurance pool…. The idea is one of several ways that state officials, hemmed in by tight budgets and impatient with the federal government, are striving to address the consequences of 43 million Americans' going without health coverage…. What the proposals have in common is that, one way or another, they call on consumers and employers to share the burden of extending coverage, rather than relying on fresh doses of government money…. The basic-coverage notion is being tested in Utah, Oregon and Idaho and by counties in several other states. (Freudenheim 2004)

The Freudenheim article was significant because it identified Utah as one of a group of states that were struggling with health care and attempting to innovatively develop their own solution without federal government involvement. The article unveiled the early ideological underpinnings (limited government, individual responsibility in health care, and health care as a market) and the attention to employer priorities that were later identified as hallmarks of the UHSR.

The ideological tendencies thought to underpin Utah's reforms were also referenced in articles that made predictions on the likely outcome of the presidential contest in different regions and states. In a September 2, 2004 *Wall Street Journal* column, describing the supposedly neck-and-neck presidential election campaign between President George Bush and Senator John Kerry, John Harwood and Greg Hitt identified Utah as one of the states that President Bush could "count on winning…without breaking a sweat" (Harwood and Hitt 2004). With regards to health care policy preferences, the article described likely Bush voters as:

> [people who were] more interested in practical solutions than big ideas to solve problems such as the lack of health insurance. That helps explain Mr. Bush's emphasis on a select series of proposals, such as helping small businesses pool their risk to offer insurance and tax-preferred health savings accounts, over Mr. Kerry's more sweeping plan. (Harwood and Hitt 2004)

The Harwood and Hitt piece was noteworthy because of its description of Utahns and

other rural westerners as people who would only be open to moderate changes to the health care system and who preferred market-driven solutions and individual responsibility in health care.

Beyond such descriptions, Utah was also framed as a state that was concerned with the costs of healthcare, as a place where social conservatism influenced health policy, and as a state that was prone to innovation in the health sector. In a September 9, 2004 *USA Today* article on the gradual improvement of the economy, Barbara Hagenbaugh and Stephanie Armour categorized Utah with several other Western states, affirming that "rising health insurance costs contributed significantly to increases in overall compensation costs for employers" (Hagenbaugh and Armour 2004). In another piece on medical privacy, Julie Appleby described a novel development in Utah in which a chartered bank had also become a health insurance company, offering debit cards tied to health savings accounts; the article thus identifies Utah as a state at the forefront of the HSA trend (Appleby 2004). A *Washington Post* article related the health care reform debates in Utah to the same-sex marriage and domestic partnership controversy, citing Utah as a state that was likely to pass a ban on same-sex marriage, which would impact the extension of employment-based health care benefits to same-sex partners and other family members. In summary, the three above pieces tied health reform in Utah to concern for the impact of health care outlays on employers, policy innovation, and social conservatism.

National newspapers' reporting on health care policy in Utah during the 2004 election period was inadequate to substantially influence the state-based newspaper coverage. The relative absence of attention to Utah indicates that the state was not

perceived as a key player in the effort to set the national health care policy agenda. Utah had not yet become the health reform "poster child" of political conservatives who were determined to find an alternative to expanding the role of the federal government in the health care system. National newspaper media interest in health care centered on differences between the health care policy preferences of President Bush and Senator Kerry, the Spitzer investigation of the insurance industry in New York, Wal-Mart's off-loading of health care costs to means-tested government programs and charities, and the increasing popularity of health savings accounts (HSAs). There were a few (mostly positive) references to the Massachusetts Health Reform Law, but the national media largely represented health care as a federal challenge that would require federal policy changes.

National coverage of Utah during the UHSR and federal ACA debates (2008-2011)

During the Utah state legislative debates and the months following legislative passage of each component of the UHSR between 2008 and 2011, the national media covered health care widely. However, even at the peak of state legislative debates on key components of the UHSR, Utah's health system reform did not attract as much national media attention as the earlier Massachusetts Health Reform Law. During the period, coverage of Utah in the context of the national health reform debates was notable for its absence. [74]

[74] My review of the four national newspapers included the following date ranges during the state legislative debates and after legislative passage of each component of the UHSR:

January 1, 2008-Mar 18, 2008 for the period of legislative debates on House Bill 133;

Utah's limited connection to the national debates largely depended on its two federal senators, Bob Bennett and Orin Hatch, who played key roles in the congressional reform battle and whose relationship with President Obama and respective political fortunes evolved over the course of the UHSR, attracting media scrutiny. While the passage of HB 133, 188, 331, 165, and SB 79 was virtually ignored in 2008 and 2009, it was the arrival of Mitt Romney and Jon Huntsman on the national political scene as Republican presidential candidates in 2010, and later Utah's legal threat as part of a coalition of conservative states to use the courts to prevent the implementation of Obamacare in 2011, that inspired some interest in the national newspaper media, intersecting with the debate and passage of Utah's HB 294 and 128 in the 2010-2011 period. Utah thus came to be viewed as a conservative health policy innovator and a defender of states' rights in the health policy realm.

This image, however, was depicted in a remarkably small sample of articles in the national newspapers. Notwithstanding the increased attention to Utah late in the UHSR

March 19 – June 30, 2008 for the period following legislative passage of House Bill 133;

January 1, 2009-March 10, 2009 for the period of legislative debates on House Bill 188, House Bill 331, House Bill 165, and Senate Bill 79;

March 11-June 30, 2009 for the period following legislative passage of House Bill 188, House Bill 331, House Bill 165, and Senate Bill 79;

January 1, 2010-March 21, 2010 for the period of legislative debates on House Bill 294;

March 22-June 30, 2010 for the period following legislative passage of House Bill 294;

January 1, 2011-May 29, 2011 for the period of legislative debate on House Bill 128;

May 30-August 30, 2011 for the period following legislative passage of House Bill 128, Utah's lawsuit, launched in conjunction with other states, to prevent implementation of the ACA, and state events organized to bring attention to the UHSR.

debates, out of 9,686 articles on the national health reform debates, only 90 (0.93%)[75] mentioned Utah during the periods of legislative debate and following legislative passage between 2008 and 2011. Despite the increase from the 2004 state election period (5 articles, or 0.26% of national coverage at the time), Utah largely remained absent in the *New York Times*, the *Wall Street Journal*, the *Washington Post*, and *USA Today*.

The absence of coverage surrounding UHSR legislation

In 2008, no national newspaper covered HB 133, which was the foundational piece of the UHSR that created the Utah Health Exchange and established the Utah Health System Reform Task Force. Similarly, the purposes and contents of the legislative components of the UHSR that followed—HB 188, HB 331, and SB 79 in 2009; HB 294 in 2010; and HB 128 in 2011—were completely ignored in the national newspapers. Utah was, however, peripherally connected to the national reform debates through coverage of its representatives in Washington. In particular, Senator Bob Bennett (R-Utah), and his co-sponsorship with Senator Wyden (D-Oregon) of the bipartisan *Healthy Americans Act (HAC),* which was the leading national health reform proposal in 2008, attracted some media interest. While it is difficult to imagine comparable bi-partite cooperation in the more acrimonious political climate of 2017, the approach of the Bennett-Wyden HAC bill was similar to that of Romneycare, the 1994 federal HSA, and Obamacare. The legislation aimed to increase health insurance access and control health expenditures with a combination of regulations and subsidies to improve the functioning of the private health insurance market. However, the Health Americans Act (HAC) of 2009 differed

[75] 48 articles during the legislatives debate periods, then 42 during the periods following legislative passage.

from Romneycare in the sense that its ultimate goal was to establish a single private health insurance market in which health insurance would have been mandated for individuals (barring religious exemptions) and portable between jobs or self-employment. It planned for private health insurance plans to be administered through state governments. Similar to the 1994 federal HSA, it planned to eliminate Medicaid (and, in the 2009 HAC, CHIP as well) to transition low-income people into the private insurance market with subsidies (Park 2008).

Utah's connection to the national reform debates was further reinforced when Senators Bennett and Wyden wrote their own piece in the *Wall Street Journal*, defending their bipartisan proposal:

> The Healthy Americans Act would tackle these problems [modernization and moderate expansion of Medicaid, inadequate competition between health insurance plans, exclusions for pre-existing health conditions, and the decline in employer-sponsored insurance] by giving individuals private sector choices not tied to their employment, fixing the tax code to eliminate inefficient subsidies for health care, and providing sliding scale subsidies to ensure health care is affordable and accessible for all Americans. (Wyden and Bennett 2008)

The *Wall Street Journal* article was notable because a federal politician who represented Utah was defending a health reform bill that had more in common with the 1994 federal HSA or Romneycare—expanding public coverage in a means-tested program, imposing more regulation on health insurance companies, and providing public subsidies to purchase private insurance—than the latest health policy proposals in Bennett's home state. Conservative Republicans were critical of Senator Bennett, referring to him as one of the so-called "dirty dozen" senators who were trying to build Congressional support for a universal health care bill that included proposals similar in principle to those of Romneycare and the HSA (Marcus 2008). Therefore, it is noteworthy that the national

political climate, at least in the Republican Party, had shifted between celebrating Romneycare as a bipartisan success (regardless of the fictional nature of the bipartisan label) in 2006, to condemning Republican lawmakers for bipartisan reform efforts in 2008. At that juncture in the UHSR debates, state and federal proposals from Utah's political leaders appeared to be disconnected, and (unlike Massachusetts) Utah remained largely irrelevant in the national health reform discussions as a state-level policy example.

Utah's other federal senator, Orrin Hatch, also appeared in health care reporting. Articles in 2008 mentioned Senator Hatch's friendly relationship with Senator Kennedy (D-Massachusetts) and his interest in achieving bipartisan national health care reform. Utah's limited connections to the national health reform discussions through its two senators indirectly depicted it as a state inclined to bipartisanship, and interested in national health reform efforts, neglecting any mention of the state-level reform debates. For instance, in the *Washington Post*, an article mentioned Senator Orrin Hatch's cooperation with Senator Ted Kennedy on the State Children's Health Insurance Program (SCHIP) in 1997 as an example of bipartisanship in health reform (Slevin 2008). Thus, on the eve of the controversial Obamacare debates in 2008, beyond human interest stories on the insurance crisis that contained passing mentions of Utah as a place where some anecdotal stories of suffering in the health care system unfolded, the only trace left by Utah on the health reform radar of the national media lay in the coverage of its two federal Senators, Bennett and Hatch, who were both instrumental figures in the Congressional discussions and the health care tug-of-war between Congress and President Obama.

As the Obamacare debates amplified in 2009, continued coverage of the Bennett-Wyden Healthy Americans Act and a few other pieces that portrayed Senator Hatch as a moderate, bipartisan health care reformer maintained Utah's image as a collaborative player in national health care reform. However, the media reported on the first hints of tension between Senator Hatch and President Obama with respect to the possibility of a public insurance option in an eventual federal reform law, indicating that the Hatch-Obama alliance was built on unstable ground. The first pieces to represent Utah as a health innovator emerged in 2009, but the lack of national media interest in the state legislative debates on Utah's HB 188, 331, 165 and SB 79 was noteworthy. These bills were important because they introduced defined-contribution health insurance, largely delineated participation in the health exchange, and reformed malpractice insurance law. Utah's specific health reform efforts, however, still did not attract any national newspaper attention. In contrast—yet not surprisingly—overall reporting on the national health policy debates increased in light of the reform promises of the newly elected Obama administration.

In terms of Utah's intersections with media reporting on national health reform, in the *New York Times*, a March 2009 article identified Utah Senator Orrin Hatch as a friend of Senator Ted Kennedy (a Democratic champion of health care reform for over three decades) and one of the Republican senators that the Obama administration was trying to persuade to support sweeping health reform (Harwood 2009). A second *Times* article the same week indicated that Senator Hatch was one of the Republicans who acknowledged the necessity of comprehensive health system reform. However, the article noted that Hatch had been one of five senators to send a letter to President Obama, stating that they

refused to support any health reform bill that created a public health insurance option. According to the report, Senator Hatch and other conservative senators believed that a public health insurance option—a new socialized insurance program to compete with private insurance plans, like Medicare, but open to younger Americans—would constitute unfair competition on the market, eventually evolving into a single-payer system (Pear and Stout 2009). A January 2009 article briefly mentioned Utah as a health reform innovator, noting that it was the first state to increase the age limit for dependants in 1994, allowing children to remain covered under their parents' health insurance longer (Buckley 2009). Finally, one *Times* piece related the national reform debates to the Utah economic context, pointing out that the state expected its Medicaid enrolment to increase 13% in 2009. The article went on to explain that Utah was lowering its Medicaid payment rate to health care providers, which could have reduced the number of providers who were willing to treat Medicaid patients in the state (Sack and Zezima 2009).

Utah mentions were not limited to the *New York Times*. A *USA Today* piece mentioned Utah as one of a handful of forward-thinking states that had benchmarked money to help finance future medical costs for retired civil servants (Cauchon 2009). In the *Wall Street Journal*, another article celebrated Wyden and Bennett's Healthy Americans Act as the best hope for health reform early in the Obama Presidency, again emphasizing the centrality of one of Utah's federal senators (Levy 2009). In the *Washington Post*, a news story quoted Senator Bennett on the unusual friendliness of the Congressional health reform dialogue at that stage, affirming that the acrimony would come later:

Sen. Robert F. Bennett (R-Utah) said he recalled agreeing with "absolutely

> everything" Bill Clinton said in his 1993 address to Congress, while agreeing with almost nothing in his actual plan. “Bipartisanship is not just a nice thing we say to each other before we touch gloves, go to our corners and come out swinging when the bell rings," Bennett said. Health reform will require "wrenching change," he added. If it is to succeed, political leaders in both parties will have to "join hands and jump off the cliff together." (Connolly, March 6, 2009).

Of course, Bennett’s prediction proved to be accurate over the course of President Obama’s first term, as debates became increasingly bitter. Another article by the same author mentioned Utah, again emphasizing the important role of the state’s senators, Hatch and Bennett, in President Obama’s effort to achieve broadly supported and bipartisan health reform (Connolly, January 30, 2009).

Thus, in the heat of the Obamacare debates in 2009, national newspapers framed Utah as a state whose senators were deeply involved in the federal debates. Utah stood out as a state that was vocally opposed to single-payer as a reform option, and was increasingly unfriendly to President Obama’s reform preferences. National reporting also depicted Utah as a state with a government that was concerned about the costs of health care, as a place with a propensity for innovation in the health sector, and—like every state—as a place where people were suffering from the inadequacies of the health care system.

By 2010, the year Obamacare passed in Congress, the image of Utah as a collaborator in the effort to achieve bipartisan national health reform (thanks to earlier coverage of Senators Bennett and Hatch) had disappeared. The Bennett-Wyden Healthy Americans Act failed to pass in Congress. Congress was submerged in debates on the simultaneously maligned and celebrated Obamacare legislation. The media had begun to portray both Hatch and Bennett as prominent critics of the ACA—Bennett as a discontent

whose own major reform bill had failed, and Hatch as a turncoat adversary of the President. Both Hatch and Bennett were targets of the far-right Tea Party movement for allegedly being too moderate and part of the political elite; as such, a reputation of bipartisanship had become a clear political liability. 2010 was also the first year in which the Utah state government and its own health reform effort were mentioned—albeit without naming the specific legislation. Utah was depicted as a state that was opposed to Obamacare and was proud of its own health reform effort, which could serve as an alternative to the federal reform. Its politicians were viewed as being determined to prevent the implementation of Obamacare through the courts.

In the *New York Times*, a columnist reported Utah's opposition to the federal legislation based on states' rights arguments:

> In Utah, lawmakers embraced states' rights with a vengeance in the final days of the legislative session last week. One measure said Congress and the federal government could not carry out health care reform, not in Utah anyway, without approval of the Legislature. (Johnson 2010)

This story announced the great subsequent legal battle, when several states would file lawsuits against the federal government to try to prevent the implementation of Obamacare, eventually losing their fight before the U.S. Supreme Court. While the article said nothing of Utah's own health reform efforts, readers might have been intrigued. If the Utah state government opposed Obamacare so strongly, what if any health reform was it advocating?

In the *Washington Post,* one piece cited Senator Hatch, criticizing Obamacare's insurance mandate (Pershing 2010). Senator Hatch wrote columns himself in the *Washington Post* and the *Wall Street Journal*, condemning the president for manipulating

Senate procedures to pass health reform (Hatch 2010a, b; Hatch, Blackwell, and Klukowski 2010). Still other articles identified Senator Hatch as a key opponent of the reconciliation process to push through health reform legislation (*Washington Post* February 25, 2010).

In *USA Today*, a noteworthy piece reported that Utah and several other states were contemplating legislative measures to limit the application of the federal Affordable Care Act within state borders (Hall 2010). Similarly, a *Washington Post* article reported that the Utah Attorney General had joined a coalition of thirteen conservative state attorneys in a letter to President Obama, threatening a lawsuit to challenge the constitutionality of the federal health reform (Kinnard 2010). Still other columnists named Utah as one of the states that was pursuing health reform legislation parallel, or as an alternative to, Obamacare – states that were opposed to implementing some aspects of the federal reform, such as insurance mandates (Barnes 2010; Simon 2010; *Wall Street Journal* 2010). One writer, for example, observed that:

> [In addition to state laws in opposition to the ACA] The courts would also get involved. In anticipation of passage of the president's health-care plan, three states -- Virginia, Idaho and Utah -- have passed laws to nullify ObamaCare's mandate that everyone purchase health insurance. Other states are expected to follow suit. (Barnes 2010)

Similarly, another article reported:

> Lawmakers in at least 19 states—from Pennsylvania to Georgia to Utah—have filed bills that aim to nullify key provisions of the federal legislation, according to the National Conference of State Legislatures. Their primary target is the requirement in both the House and Senate bills that all individuals purchase health insurance or pay a fine, though it isn't clear that states have the legal authority to block such a mandate. (Simon 2010)

The *Wall Street Journal* articles above that described the mounting legal opposition from

conservative state governments were unfavourable of the federal ACA. None of the *Wall Street Journal* pieces defended the legality of Obamacare against the state attacks. One article emphasized the political risks that moderate Republicans faced for supporting federal health reform, citing Utah's Senator Bennett as one of the centre-right Republicans whom conservative groups had targeted in their attack campaigns (Seib 2010). Finally, one key *Wall Street Journal* piece was the first among the four national newspapers (February 22, 2010) to mention Utah's health reform effort as a possible alternative to the federal Affordable Care Act:

> Utah Gov. Gary Herbert, a Republican, said his state already was working on its own 10-year health-care overhaul plan, which he said would help businesses struggling under the weight of the recession and of spiralling health-care costs. Utah's House of Representatives this month approved a measure that would require the governor and legislature to sign off on any changes in the health-care system mandated by federal legislation. (Thiruvengadam 2010)

The brief passage in the Thiruvengadam piece framed Utah simultaneously as offering another path to reform and as an opponent to the federal effort.

Several articles in 2010 focused on Utah Congressman Jim Matheson's electoral challenge as a "Blue Dog" Democrat who had been the only member of his party to oppose the ACA in the House of Representatives. Some columnists covered Bob Bennett's difficult Republican Primary challenge and eventual defeat in Utah as evidence of a national shift to the right and anti-incumbent sentiment. Far-right Tea Party activists had targeted Senator Bennett to show that cooperation with Democrats on health reform or other issues would lead to electoral defeat. One article made a side-by-side comparison of the Affordable Care Act and the Bennett-Wyden Healthy Americans Act to explore whether the Bennett-Wyden proposal would have been more successful in reducing

uninsurance than Obamacare if it had not failed to pass in Congress. Two other articles relatedly addressed Senator Bennett's alleged attempt to thwart the Affordable Care Act by attaching a red herring amendment against same-sex marriage in Washington D.C. to the bill, perhaps in a desperate effort to appeal to conservative voters in his home district in order to deflect Tea Party attacks.

Thus, 2010 was a pivotal year for framing Utah's image in the national reform debates. The evolution of political relationships and debates surrounding Obamacare at the federal level shaped health policy formation in Utah. Coverage demonstrated that Senator Hatch had evolved from being a courted ally of the President in the early federal reform discussions of 2008, to a determined advocate of moderate, bipartisan federal reform in 2009 (albeit one whose relationship with the president had grown colder), to a die-hard opponent of Obamacare whose rhetoric had aligned with Utah state legislators in 2010. Senator Bennett had gone from being the champion of moderate, bipartisan federal reform and the key proponent of promising federal legislation in 2008-2009, to suffering a crushing electoral defeat at the hands of Tea Party activists and withdrawing from the health reform discussions in 2010.

It was likewise in 2010 that Utah state politicians first garnered national media attention for their health reform legislation, which was juxtaposed against the Affordable Care Act as a conservative alternative. Utah was represented on one hand as an opponent of federal legislation and champion of states' rights (through media reporting on efforts to pursue the lawsuit preventing the implementation of the Affordable Care Act), and on the other as a policy innovator with a 10-year health reform plan. While Massachusetts had served as the policy incubator for Obamacare, Utah eventually came to be perceived as a

bulwark of resistance against federal interference.

In 2011, after Obamacare had passed and the implementation of its components had begun, Utah's federal senators and members of the House of Representatives continued to be depicted as vocal and sometimes incensed critics of the new federal legislation. Utah garnered further media attention as a health policy innovator, and new attention as a voice for American conservatives who were concerned about the possibility of health coverage for abortions under the ACA. The limited national newspaper coverage more clearly differentiated the UHSR from Romneycare and Obamacare as a reform option, though defenders of the federal ACA argued that the plan was flexible enough to allow for health policy innovation and diversity at the state level. Reports also provided some detail on the elements of the UHSR, such as the health exchange and lack of individual or employer insurance mandates.

In the *New York Times*, one article cited Utah's elected federal senators and congresspersons as opponents of the federal Affordable Care Act (Pear, January 6, 2011). Another article represented Utah's Governor Herbert as one of the leading state voices in the demand for more federal Medicaid funds to cover the costs of expanded eligibility under the Affordable Care Act (Pear, March 2011). A *Times* article also mentioned Utah as one of the first states to ban abortion coverage for private insurance companies that were competing on the public health exchange (Tavernise 2011).

In the *Washington Post,* an article defended the federal Affordable Care Act by arguing that state reform efforts as diverse as those of Massachusetts and Utah could easily operate within the federal framework. Kathleen Sebelius, former Secretary of

Health and Human Services under the Obama administration wrote:

> [W]hat these critics miss is that the law already gives states most of the resources and flexibility they're asking for. States have discretion, for example, to offer a wide variety of plans through their exchanges, including those that feature health savings accounts. Utah and Massachusetts already operate exchanges but take very different approaches: Utah allows all insurers to participate; Massachusetts has stricter standards. Under the law, both approaches could work. (Sebelius 2011)

The Sebelius article painted Obamacare as a flexible, overarching health care framework in which the states were still free to innovate. Sebelius' representation stood in stark opposition to other articles that described the frustrated Utah state government and its federal politicians as some of the leaders of the movement against the federal reform. The Utah government and the state's federal senators allegedly opposed the Affordable Care Act because of its perceived inflexibility (Goldstein 2011; Klein, March 14, 2011).

One *Washington Post* piece pointed out that Senator Bennett had actually favoured the health insurance mandate and integrated it into his own bill, before joining the Republican Party chorus against it (Klein, March 8, 2011). As in the *Times*, one *Washington Post* article identified Utah as one of the states that were implementing abortion coverage bans on private insurance plans that operated on the public exchanges (*Washington Post* 2011). Another article described the efforts of Hatch and other key Republicans to oppose the appointment of Donald Berwick as Medicare Administrator because of his public statements in favour of single-payer health care systems (Alonso-Zaldivar 2011).

It is noteworthy that Governor Jon Huntsman surfaced in 2011 media reporting as a health care reformer who envisioned an alternative to Romneycare: "Jon Huntsman,

former governor of Utah, also initiated health-care reform in his state, though of a different order than Romney. The point again: States come up with programs that suit them best" (Parker 2011). In the same vein, a *Washington Post* piece explained that Utah, like Massachusetts, was one of the trailblazing states that enacted substantial health reform, including a health insurance exchange, before Obamacare (Gugliotta 2011). Articles like those of Parker and Gugliotta were important, even though the Utah mentions were brief, because they were among the first in the national print press to represent the government of Utah and its leaders as health policy visionaries. These representations in the national newspaper media differentiated the health policy visions of Republican-leaning Utah and Democratic-leaning Massachusetts—albeit with both reform agendas firmly within a neoliberal policy frame—in terms of the level of government intervention to preserve and manage the health care market that the state governments perceived as acceptable.

In the *Wall Street Journal*, two articles described Jon Huntsman as an innovative health system reformer. In one instance, Neil King wrote: "Mr. Huntsman won high marks for his overhaul of Utah's health-care system during his two terms as the state's governor, which ended in 2009" (King 2011). The second article described Jon Huntsman's past support of health reform in Utah as a potential political liability because so much of the Republican base was unreceptive to any notion of health system reform. The article simultaneously presented Huntsman's approach as an alternative to Romneycare and Obamacare:

> Mr. Huntsman's support for a health care overhaul in Utah [could be seen] as a potential flashpoint for GOP primary voters, much like a state health plan that has caused problems for former Massachusetts Gov. Mitt Romney….Huntsman

> signed legislation that created a health insurance exchange similar to the one in Massachusetts, where consumers, using a fixed contribution from their employers and pre-tax funds from their own paychecks, can buy and compare plans. The Utah law lacked an individual mandate, which is part of the new Democratic-backed federal law and the one Mr. Romney signed in Massachusetts….[The] former governor supported a "market-based" health reform plan different from Mr. Romney's law. (Lee 2011)

This was the first time that any national newspaper suggested that ties to Utah's reform effort could hurt a political candidate. However, it also clearly affirmed that Utah offered a different, more market-oriented approach to health care reform, which could have attracted greater national attention to the UHSR.

A handful of columnists explicitly covered the UHSR in 2011 or related Utah to the national debates, sometimes evening linking the UHSR to Romneycare. Writing in the *Washington Post*, for example, Alec Macgillis noted:

> "When they set out to reform health care in their states, both Jon Huntsman, former governor of Utah, and Tim Pawlenty, former governor of Minnesota, considered the same tools that Romney adopted, including a mandate that people obtain health insurance and a state "exchange" where they could buy it. Both men ended up settling for reforms far more limited than Romney's. But their records have left them open to charges of hypocrisy when they blast the Massachusetts and national health-care laws." (MacGillis, 2011)

The MacGillis piece went on to explain the similarities between the UHSR and Romneycare, including Governor Huntsman's support for the health insurance mandate and other aspects of the MHRL that did not make it into the final draft of the UHSR. Other columnists in 2011 examined the impact of the UHSR on Huntsman's political fortunes. One piece addressed Huntsman's reputation as a healthcare reformer and the potential upsides and downsides of that reputation in the Republican Primary. A second article cited Huntsman's criticism of similarities between Romneycare and Obamacare. Finally, another writer covered a conservative think tank's criticism of Huntsman for his

role in the UHSR, in its evaluation of the field of Republican presidential candidates. It is noteworthy that, already in 2011—perhaps as a precursor to the shift to the right in the 2016 American presidential election—any hint of progressive health or social reform tendencies, and any indication of bipartisan cooperation with Democrats, was perceived as a liability in the Republican Party.

Other articles that linked Utah Republicans to the health care reform debates signalled the sharp turn away from bipartisanship and towards what could be described as destructive obstructionism as a matter of principle. In *USA Today*, a piece mentioned Senator Orrin Hatch's opposition to Supreme Court Justice Elena Kagan, arguing that she should not be the judge to hear the legal challenge of state governments to the constitutionality of the Affordable Care Act. Hatch alleged that Kagan had a conflict of interest because she served as Solicitor General in the Obama Administration when the law was enacted (Biskupic 2011). As in the earlier *Washington Post* piece, which depicted Senator Hatch as a critic of the appointment of Donald Berwick as Medicare Administrator because he had made favourable statements about single-payer health systems, Hatch was represented here as a consistent opponent of any expanded government action in health care who was committed to limiting any influence of Obamacare or single-payer advocates in national debates. By 2011, any previous record of positive statements on Obamacare or single payer health care made judicial appointees or senior civil servants the targets of Republican ire. For Republicans, a record of consistent commitment to health care as a market with little or no government intervention had become a litmus test for their support.

6.5 Summary of national coverage of the UHSR at critical junctures from 2004 to 2011

There were very few national newspaper media mentions of Utah during the 2004 election period, and references remained sparse in the context of national health reform debates from 2008-2011. Specific remarks on the UHSR were even scarcer. As a reform effort, the UHSR progressed in near isolation, attracting little national media attention and rarely being linked to the national reform debates. There was no detailed national coverage of the individual legislative components of the UHSR. It is unlikely that the trickle of stories that referenced Utah among thousands of articles on national health reform had a substantial impact on the coverage of the debates within Utah's state-based media (none of the pieces in the *News York Times*, *Washington Post*, *USA Today*, or *Wall Street Journal* were syndicated in the *Deseret News* or the *Salt Lake Tribune*). There is also no indication that the national newspaper media picked up on competing health policy narratives within Utah's state-based newspapers.

In 2008-2009, the only links perceived by national newspapers between Utah and the national health care reform debates were the actions of its two federal senators—Bob Bennett as one of the proponents of a prominent, albeit ultimately unsuccessful, reform plan; and Orin Hatch, who was sometimes represented as a bipartisan reform advocate and other times as a reform spoiler. Even the passage of the UHSR legislation was ignored in the national media in 2008-2009. It was not until 2010-2011 that the national newspapers began to pay more attention to Utah, even though that attention was not due to the passage of state legislation or ongoing debates within the state-based media. National coverage also remained limited compared to the reporting on the Massachusetts Health Reform from 2002-2006.

It was during the 2010-2011 period that Utah distinguished itself, and that a national media narrative/frame of Utah within the American health reform debates began to take shape. More importantly, coverage in 2010-2011 began to link and compare the state and federal reforms. The handful of columns, editorials and news stories about Utah, and about leading state politicians who had implemented a different type of health care reform, all constructed and reinforced *a narrative of Utah as a conservative health policy innovator and opponent of federal government intervention*. The overarching narrative of Utah—which was, admittedly, minor in the grand scheme of national health care reporting—included articles on Utah politicians criticizing President Obama and the federal health reform effort, articles on the lawsuit of Utah and other states to challenge the constitutionality of the Affordable Care Act, and even seemingly less relevant pieces such as those that described the abortion coverage ban that had been imposed on the Utah health exchange.

The impetus for greater national interest in Utah seems to have been linked to several events that were not directly tied to the passage of UHSR legislation; notably, the rumour, and later the confirmation, that Utah and other states planned a lawsuit against the federal government to impede the implementation of the Affordable Care Act; and coverage of Jon Huntsman as a candidate in the Republican Primary. It was the brief attention to Jon Huntsman during the Republican primaries that incited some journalists to explore his record on health care reform, and to compare the UHSR to Romneycare and Obamacare. The following chapter now explores the more extensive reporting on the UHSR in state newspapers.

Chapter 7: Representations of the Utah Health System Reform (UHSR) in state-based newspapers across time (2004-2011) [76]

7.1 Introduction

This chapter examines state newspaper representations of UHSR as well as key healthcare issues and priorities in the *Deseret News* (Republican-leaning), and the *Salt Lake Tribune* (Democratic-leaning) [77] to differentiate media coverage on the right-left divide and to uncover the narratives of health care reform in the Utah media across time. Building from the summary of the UHSR and analysis of national newspaper media representations in Chapter 6, through analysis of health reform narratives deployed Utah's two major dailies, I argue that neoliberal (market-oriented, aimed at preserving the existing private health insurance markets) health reforms were largely favoured in the print media, while libertarian narratives against government intervention and social investment state (pro-single payer) narratives were also present. This chapter further demonstrates that media representations of state-level health policy innovation and the alleged capacity of a state to implement health policy reform are largely framed by the context of federal health policy reform. The context of federal inaction at the time of

[76] Based on analysis of 1,734 articles in the *Salt Lake Tribune* and the *Deseret News* at key junctures between 2004 and 2011. Articles serve as the units of analysis in section 7.2. Deployments of each health reform narrative, not articles, are the units of analysis in section 7.3.

[77] My decision to label the *Salt Lake Tribune* as a newspaper on the political left is open to debate. It is true that, compared to national newspapers such as the *New York Times* or state newspapers in Massachusetts that I have analyzed for other chapters, the *Salt Lake Tribune* is a fairly conservative or at least centrist publication. However, such designations are contextual and, in a conservative state with only two broadly circulated newspapers, Utahns generally consider the Salt Lake Tribune to be more left-leaning than the *Deseret News*. A quick search of the state's political blogs demonstrates this perception of the state's two major dailies. Furthermore, the *Salt Lake Tribune* endorsed Barack Obama for President in both 2008 and 2012, creating some surprise in the national media (Davidsen 2012). The *Deseret News* does not endorse presidential candidates as a matter of policy.

Romneycare, versus the context of federal action through the implementation of Obamacare parallel to the UHSR, led to different media representations of state reform efforts.

My research shows that Utah's political left (represented in the Democratic-leaning *Salt Lake Tribune*) was generally more supportive of health care reform than the political right (represented in the Republican-leaning *Deseret News*). However, closer examination of the health policy narratives that were deployed in favour of, and in opposition to, health care reform revealed that the debates were more complex. Most conservative columnists favoured some kind of health reform, but they differed with progressive columnists in terms of the types and degrees of reform they advocated and in the narratives they chose to emphasize. As had been the case in Massachusetts, the frequency of health reform narratives fluctuated across time, and new ones emerged at each critical juncture—that is, during the 2004 election, and during the legislative debates and passage of each piece of the UHSR between 2008 and 2011.

Although the national/state media and the right/left binaries explored in this chapter are valuable heuristic tools, they tell only a part of the UHSR story. The use of articles as units of analysis—while useful in demonstrating favourable and unfavourable representations—does not capture the full complexity of the debates. Thus, Chapter 7 further includes a deeper analysis of state-based newspaper reporting, identifying and deconstructing the particular health reform narratives of the UHSR that emerged between 2004 and 2011. A single article may contain many reform narratives or, in the cases of superficial or unexplained praise or criticism, no developed narrative at all. Therefore, instead of employing articles as the sole units of analysis, this chapter considers mentions

of each narrative as units of analysis (see section 7.2). It categorizes articles that do not contain policy narratives as "other," and differentiates them separately according to favourable, unfavourable, and indifferent representations. It is noteworthy that the category of "other" media coverage made up a larger overall proportion of health care reporting in the *Salt Lake Tribune* and the *Deseret New* during the UHSR than it had in the *Boston Globe* and the *Boston Herald* during the Romneycare debates, both because health care reporting was more intense during the Obamacare debates and because that reporting was rendered more diverse by a larger number of minor narratives (those that surfaced in less than 5% of articles in any period of analysis).

This chapter reveals that the Democratic-leaning *Tribune* was more favourable to health care reform than the Republican-leaning *Deseret News*. Specifically, during the UHSR debates from 2004-2011, the *Tribune* coverage was more favourable to expanding access to health insurance and more supportive of the federal Affordable Care Act. In contrast, *Deseret News* reporting was more favourable to the UHSR. Finally, the need to reduce or control public health expenditures was a priority in the reporting of both newspapers. Prior to a deeper analysis of health reform narratives across time, the following section examines differences on the right-left dimension between the two newspapers.

7.2 Analysis of Media Coverage on the Left-Right Dimension in the *Salt Lake Tribune* and the *Deseret News*

Within Utah's dominant print media, columnists on both the political right (writing in the *Deseret News*) and the political left (writing in the *Salt Lake Tribune*) argued in favour of reforming some aspects of the health care system. However, they differed in their reform priorities and in their preferences for state or federal legislation to

address the acknowledged systemic challenges. Analysis of media coverage at key junctures from 2004-2011 in the two major dailies shows that most articles revealed either favourable or unfavourable biases in the health care reform debates. A noteworthy feature of Utah's state newspaper coverage that differentiates it from Massachusetts newspaper coverage is that the remaining approximately 17% of reporting (296 neutral articles) in both newspapers were news pieces that mentioned health reform or a facet of the health reform debates without clear preferences; in other words, many neutral articles reported health news without apparent bias either in favour of, or opposed to, any aspect of reform, and without offering a narrative of reform. [78]

Charts 7.0 and 7.1 on the following pages show favourable, unfavourable, and neutral articles for all time periods between 2004 and 2011, bringing to light the contentiousness of the health care debates and the differences on the left-right dimension. The *Salt Lake Tribune* demonstrated more neutrality (20.4%, 193 articles) in its coverage than the *Deseret News* (13.1%, 103 articles). *Salt Lake Tribune* articles were noticeably more favourable to some type of health reform (70.7%, 669 articles) than *Deseret News* pieces (62.9%, 496 articles). A greater percentage of *Deseret News* pieces were

[78] With regard to the dataset for both the *Deseret News* and the *Salt Lake Tribune, Factiva* searches produced all articles. The dataset included all *Desert News* and *Salt Lake Tribune* articles from January 1 – November 1, 2004 (state election period), January 1 – March 18, 2008, January 1 – March 10, 2009, January 1 - March 21, 2010, January 1 – May 21, 2011 (legislative debates), March 19 – June 8, 2008, March 11, 2009 – June 30, 2009, March 22 – June 30, 2010, and May 30 – August 30, 2011 (following legislative passage) for the following key words: "healthcare reform OR health reform OR health care reform OR health care system OR healthcare system OR single payer OR health exchange OR health insurance." This search produced 2,499 articles for all periods (1,221 in the *Deseret News* and 1,278 in the *Salt Lake Tribune*). I excluded 765 pieces (433 in the *Deseret News* and 332 in the *Salt Lake Tribune*) that were either duplicates, letters to the editors that slipped through the *Factiva* search triage, or articles that covered some aspect of health that were not relevant to the reform debates. Thus, my analysis included 1,734 articles (788 in the *Deseret News* and 946 in the *Salt Lake Tribune*) in the two major dailies at critical junctures of the UHSR between 2004 and 2011.

unfavourable overall to health care reform (24%, 189 articles) than were articles in the *Salt Lake Tribune* (8.9%, 84 articles).

Chart 7.0: Global portrait of health reform coverage in the *Salt Lake Tribune* (political left) during the 2004 Utah election and during periods of legislative debate and post-legislative passage 2008-2011 (946 total articles)

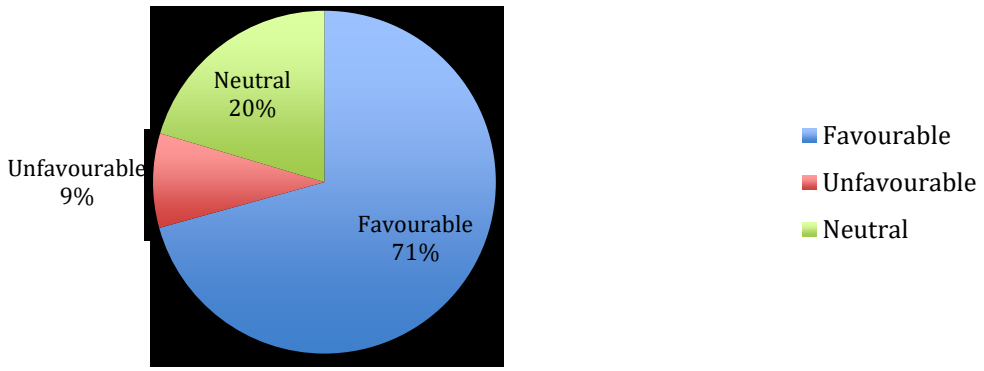
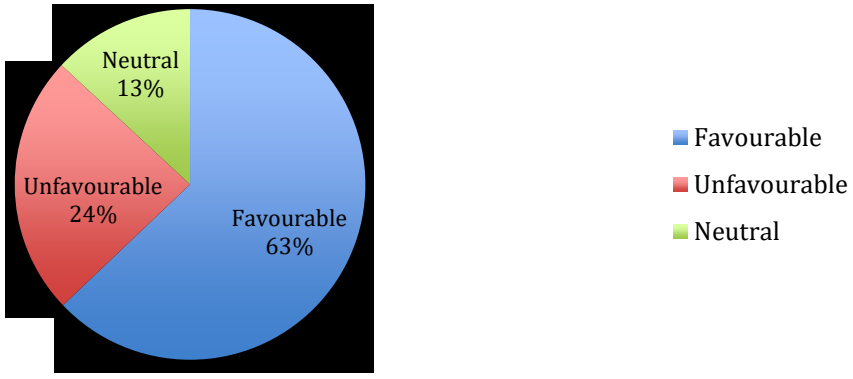


Chart 7.1: Global portrait of health reform coverage in the *Deseret News* (political right) during the 2004 Utah election and during periods of legislative debate and post-legislative passage 2008-2011 (788 total articles)



Reactions to the dimensions of reform

Despite the common view that progressive, Democratic-leaning media is more

supportive of health care reform than conservative, Republican-leaning media in the United States, the deployment of media representations in the Utah case, like that of Massachusetts before it, turns out to be more complex and nuanced. UHSR media coverage offers a useful opportunity to delve into representations of each dimension of the health debates, most notably the expansion of access to health insurance, single-payer health care, and the control or reduction of public health expenditures. Media reporting also offers a window into competing reform laws, most notably the UHSR legislation, and the federal ACA legislation. Analysis of state media coverage during the UHSR period demonstrates that authors focused both their praise and their criticism predominantly on particular aspects of the reform agenda, or on the UHSR and/or ACA legislation specifically. In fact, more nuanced and targeted favourable or unfavourable media coverage accounted for 83% of reporting (1438 articles) in the two major dailies. Media representations further brought to light the multifaceted divisions on the left-right dimension. For example, certain health reform priorities, such as the control or reduction of public expenditures, bridged the left-right divide and could be found in both the two major dailies. The expansion of access to health insurance also attained notable levels of favourable coverage in both newspapers.

As decades of research on media effects have demonstrated, even casual mentions of widely publicized policy reforms can help reinforce existing dichotomies and public perceptions (Chomsky and Herman 1988). With regard to the category of non-specific health care reform articles, which includes those pieces that expressed vague and unspecific support or criticism of health care reform, the amount of unfavourable coverage in the *Deseret News* (22 articles, 2.8%) was essentially equal to the quantity of

favourable coverage (21 articles, 2.7%). In the *Salt Lake Tribune*, this type of vague praise or criticism was less balanced in terms of favourable versus unfavourable articles. Non-specific articles in favour of health reform accounted for 4.9% of total coverage (47 articles), while the *Tribune* only published 15 (1.6%) unfavourable pieces of this type. While these articles did not offer substantial narratives of health reform, they nonetheless played a role in framing the debates. [79]

A substantial part of the coverage in both newspapers treated the expansion of access to health insurance as a priority in the reform debates (*expanded access narrative*). These articles sometimes represented the expansion of access to insurance coverage as reason for endorsing the ACA or the UHSR. Other articles focused on the need to expand access to insurance coverage as a priority in its own right, without referring to any specific legislation. They included many so-called human-interest stories that depicted the suffering that often results from uninsurance or underinsurance, offering anecdotal evidence of the need for health care reform. For example, a *Deseret News* article in 2004 reported that:

> [t]he downturn in Utah's economy has left many parents using a new kind of health insurance for their sick children: prayer. “Their only insurance is prayer, and they have to hope nothing bad happens,” said Karen Crompton, executive director of Voices for Utah Children…They share medications. They have to decide which kid is sicker. (Bryson, January 2004)

Such quotations gave a human face to the health care reform debates, helping many

[79] Articles classified as non-specific did not mention UHSR or ACA legislation explicitly, nor did they clearly define challenges in the health care system—such as uninsurance or the cost of insurance, medical services, or public expenditures. These authors praised or criticized health reform without explaining the aspect of reform they supported or opposed. Health care was often not the primary subject of these pieces; thus, commentary sometimes related health care reform loosely to the primary topic of the article.

readers relate to the circumstances of the uninsured.

Articles favourable to the expansion of access to health insurance accounted for 49.5% (468 articles) of reporting in the *Salt Lake Tribune* and 55.1% (434 articles) in the *Deseret News*. However, these percentages are somewhat misleading, as they indicate that the more Republican-leaning newspaper (the *Deseret News*) was slightly more favourable to reform than the more Democratic-leaning one (the *Salt Lake Tribune*). In fact, it shows that the Republican-leaning *Deseret News* was supportive of the more limited, and more market-oriented health reform underway at the state level than of the more sweeping insurance reforms proceeding under Obamacare at the federal level. The *Deseret News* figure gives an inflated impression of the level of interest in expanding access on the political right, since the percentage calculation is based on a smaller total sample size.[80] More importantly, different narratives were used to support expanding access to health insurance to varying degrees, depending on authors' positions on the left-right political spectrum. The health reform narratives deployed more frequently in the *Salt Lake Tribune* were those that treated the uninsurance challenge with a sense of urgency and supported expansion of access for larger numbers of Utahns.

Three different narratives—the evolution of which is carefully analyzed in their chronological evolution in section 7.3—emphasized the need to expand access to health insurance: the *expanded access narrative*, the *incremental reform narrative*, and the *inadequate reform narrative*. In all three narratives, columnists stopped short of supporting universal access; instead, they focused on increasing access for the middle

[80] A total of 788 relevant articles on health care reform surfaced in the *Deseret News*, as opposed to 946 in the *Salt Lake Tribune*, as noted in Chart 1 and 2 on pages 38-39.

class or for groups who were supposedly disadvantaged in the employer-based insurance market. Similar to the *expanded access narrative* (341 articles or 36.1% in the *Salt Lake Tribune*, 207 articles or 26.3% in the *Deseret News*), in emphasizing the need to expand access without advocating single-payer, other writers criticized the UHSR as too tepid and gradual in its reforms and called for broader insurance and other systemic changes, deploying the *inadequate reform narrative*. Not all articles that deployed the *inadequate reform narrative* to criticise the UHSR focused on access, but many articles in which the narrative was deployed mentioned access as a particular point of discontent vis-à-vis the UHSR legislation (27 articles or 2.9% in the *Salt Lake Tribune*, 7 articles or 0.9% in the *Deseret News*). In each of the three abovementioned cases, a narrative emphasizing access was deployed more frequently in the *Salt Lake Tribune*, reinforcing the common view that Democratic-leaning media was more concerned with access than conservative media.

Interestingly, the narrative in favour of increasing access that appeared the most frequently on the right was the *incremental reform narrative* (187 articles, 23.7% in the *Deseret News*, in contrast to only 140 or 14.8% in the *Salt Lake Tribune*). The *incremental reform narrative* resembled the *narrative leadership and innovation in state health policy*, and the *narrative of Massachusetts leadership in national health reform* that was deployed during the Romneycare debates; however, it was not always clearly invoked in support of the UHSR or the actions of Utah politicians in health reform. The *incremental reform narrative* either supported UHSR legislation, advocated other conservative state or federal health reform legislation, or proposed modest changes in the health care system, such as tax-free health savings accounts (HSAs) in conjunction with

high-deductible private health insurance plans, which were developed to increase health insurance access with minimal government regulation or investment. Columnists who advanced the three aforementioned narratives—*expanded access, inadequate reform,* and *incremental reform*—agreed that uninsurance was a problem; however, they disagreed on the severity of the problem, on the solutions, and on the role that the state and federal governments should play in resolving it.

The right-left divide was clear in representations of the UHSR legislation. In terms of attention given to the UHSR within the broader context of all health reform coverage (the combined total of favourable and unfavourable UHSR reporting), 290 articles (15.5%) in the two major dailies mentioned the UHSR.[81] The percentage of articles mentioning the UHSR either favourably or unfavourably was comparable in the two newspapers (15.5%, or 147 articles, in the *Salt Lake Tribune,* and 18.2%, or 143 articles, in the *Deseret News*). However, the frequency with which narratives were deployed to support or oppose the UHSR differed. The *incremental reform narrative*, which, as mentioned above, was often used to support the UHSR, appeared more frequently in articles supporting the UHSR legislation in the *Deseret News* (134 articles, or 17%) than in the *Salt Lake Tribune* (101 articles, or 10.7%). In contrast, the *inadequate reform narrative*, which was deployed in articles criticizing the UHSR for not sufficiently addressing access, insurance company regulation, or cost control concerns, was more common in the *Salt Lake Tribune* (47 articles or 5%, compared to only 9 articles or 1.1% in the *Deseret News*).

[81] This number includes all of the articles in which the *inadequate reform narrative* (unfavourable to the UHSR) was deployed between 2008 and 2011, and many (though not all) of the articles in which the *incremental reform narrative* (often favourable to the UHSR) surfaced from 2008-2011. Both narratives are analyzed in detail in Section 4.

In contrast to reporting on Romneycare, media coverage of the UHSR was practically inseparable from coverage of Obamacare between 2008 and 2011. On the surface, right-left divisions were less obvious in reporting on Obamacare. With regard to coverage of the federal ACA and the 2008 national health reform debates that preceded its passage, within the broader context of all health reform coverage (the combined total of favourable and unfavourable reporting), 44.6% (773 articles) made references to the federal ACA in the two major dailies. Obamacare was addressed in 37.7% of articles in the *Salt Lake Tribune* and 52.8% in the *Deseret News*. Many articles in which the *expanded access narrative* was deployed made favourable references to the yet-undetermined federal reform (in 2008) or Obamacare specifically (2009-2011) as the path to resolving the uninsurance crisis (161 articles or 20.4% in the *Deseret News*, and a nearly equal number, 163 articles or 17% in the *Salt Lake Tribune*). Other articles advocated the *economic security narrative* in support of federal reform or the ACA legislation in particular as the solution to America's spiralling healthcare spending (94 articles or 11.9% in the *Deseret News*, 90 articles or 9.5% *in the Salt Lake Tribune*). [82]

The right/left divide on Obamacare was most apparent in the distribution of articles that were hostile to the legislation. Columnists deployed the *wrong reform narrative* to criticize the cost, approach, or timing of Obamacare between 2009 and 2011 (140 articles or 17.8% in the *Deseret News*, 45 articles or 4.8% in the *Salt Lake Tribune*).

[82] The *expanded access* and *economic security narratives* are examined in detail in Section 7.3. Both were stand-alone narratives that had been present in the Massachusetts debates and persisted in media coverage through all years of the UHSR from 2004-2011. Obamacare (or the 2008 federal debates that preceded it, before it was named) was often mentioned favourably in the same articles in which these two narratives were deployed in the 2008-2011 period, though that was not always the case.

Thus, while favourable reporting on the ACA was comparable in the two major dailies, unfavourable coverage was more than three times more frequent in the Republican-leaning media. More specifically, the numbers depict unambiguous support for the federal reform effort among the most liberal commentators in the *Salt Lake Tribune* (with some notable exceptions), and comparable levels of support for some level of federal reform on the political right that was counter-balanced by a consistent flow of conservative opposition articles in the *Deseret News*.

Next to the particular elements of the ACA and UHSR legislation, and the need for expanded access to health insurance, the challenge of reducing or controlling public health expenditures garnered the most media attention in the broader context of the reform debates. Articles in this category included both pieces that supported healthcare reform to reduce both government outlays for health programs (Medicare, Medicaid, Veterans, and other public programs) and those that emphasized the cost of health care for individuals and families (insurance co-payments, insurance rates, hospital costs, doctor fees, etc.). These articles, which articulated the *economic security narrative,* are explored in greater detail in Section 7.3. As one might expect, many articles that focused on access to health insurance, the UHSR, or the ACA, also addressed health expenditures as a motivation for reform. However, some of the articles that deployed the *economic security narrative* emphasized the need to control or reduce health expenditures without addressing access to health insurance and without mentioning specific legislation. Interestingly, support for the reduction or control of public health expenditures bridged the right-left divide more than any other reform priority, accounting for 15.9% (276 articles) of coverage in both newspapers (14.3% or 135 articles in the *Salt Lake Tribune,*

and 17.9% or 141 articles in the *Deseret News*). This may reflect the opposition of a large portion of the public to greater public funding of health care programs or the use of deficits to finance health care. No article in either newspaper was unfavourable to reducing or controlling public health expenditures.

Relative inattention to the single-payer health reform option during the UHSR debates indicates that the political margins (at least on the left) were closer to the centre, within a neoliberal health policy window, than they had been in Massachusetts. The *anti-single payer narrative* accounted for 5% of coverage in 2009, but it was a minor narrative in all other periods of analysis, and the *pro-single payer narrative* was a minor narrative (appearing in less than 5% of articles) at every critical juncture of the UHSR. Articles rarely pointed to the Canadian and various European public health care systems as models to emulate, as had been more common in Massachusetts during the Romneycare debates. Similarly, few Utah commentators presented the so-called "public option" as a *sine qua non* condition to supporting federal health care reform, further demonstrating the weak base of support for universal access in Utah. As Chapters 4 and 5 on Massachusetts demonstrate, this tends to differentiate Utah from Massachusetts, where the push for universal access played a stronger, albeit still clearly subordinate, role in the reform debates.

Many of the articles that were unfavourable to the UHSR or the ACA were explicitly critical of the approaches to expanding health insurance coverage in those specific pieces of legislation; yet the same pieces often advocated some other approach to increasing insurance coverage. Articles unfavourable to the ACA or the UHSR were not necessarily unfavourable to health care reform as a broad idea or to the expansion of

access to health insurance or reduction of expenditures. The distinction is important because the few articles unfavourable to health care reform in general were not attacking any single legislative approach to expanding health insurance coverage; instead, they advanced the view that there was no immediate need to expand access to health insurance at all, or advanced the argument that government should not lead health care reform.

The few columnists who came out explicitly against expanding access to health insurance for more people, or reforming the health care system in general, deployed two interrelated narratives in opposition to reform that had either not surfaced at all or had been deployed differently in the Massachusetts debates: the *individual responsibility narrative* (5% of articles during the 2004 election campaign period) and the more minor *manufactured crisis narrative,* which rejected the need for health care reform and appeared in fewer than 5% of articles at each critical juncture. These conservative, anti-reform narratives were used together or separately, and both were more common in the *Deseret News*.

The *individual responsibility narrative* was not always used in articles favouring the status quo; some authors acknowledged the systemic challenges of cost and access. Opposing government intervention, however, they used the narrative to argue for individual, family, and charitable sector leadership in the effort to improve the healthcare system. This raises an interesting point of comparison between media coverage of the Massachusetts and Utah reforms; in the former case, individual responsibility was the basis of a conservative argument sometimes deployed in favour of Romneycare; in the latter, it was marshalled in conservative arguments against government health care reform efforts during the UHSR. The *individual responsibility narrative* was deployed in 26

articles (1.5%) between the two dailies; yet it was equally distributed, with 13 articles in each the *Deseret News* (1.7%) and the *Salt Lake Tribune* (1.4%). In a particularly self-deluded form of American exceptionalism, conservative columnists sometimes combined the *individual responsibility* and *manufactured crisis narratives* together, arguing that the United States already had the best health care system in the world; and that the requirement to purchase health insurance, the use of subsidies to help low-income people purchase insurance, and even government action to improve the functioning of the market through online public health insurance exchanges, undermined freedom and distorted capitalism (e.g. Parker, February 9, 2008). The relatively small percentage of such articles opposed to any expansion of insurance coverage is important because it speaks to the public mood regarding reform. Improving health care was a priority that crossed the right-left divide, and few in the media opposed change entirely. Disagreement about how and what to change about the system and the appropriate pace of reform animated the UHSR and parallel Obamacare debates.

When all aspects of health care reform are considered—including non-specific statements on health care reform, the reduction or control of public health expenditures, the expansion of access to health insurance, the single-payer reform option, the federal Affordable Care Act, and the Utah Health System Reform—the Democratic-leaning media represented health care reform more favourably than the Republican-leaning media. In particular, the political left was more supportive of the federal Affordable Care Act. *Salt Lake Tribune* reporting further treated the expansion of access to health insurance as a more pressing priority than *Deseret News* coverage, even though that objective seemed to bridge the political divide. While it was not an important proposal at

the state level at any juncture of the UHSR between 2004 and 2011, and mentions were sparse, writers on the left were also more favourable to exploring a single-payer reform option. The reduction or control of public health expenditures was the issue that bridged the right/left divide most effectively, attracting similar percentages of favourable coverage in both newspapers. For its part, the Republican-leaning press was more favourable to the UHSR than the Democratic-leaning press. Having thus examined representations of state and federal health reform legislation as well as key issues and priorities in the *Salt Lake Tribune* and the *Deseret News* to differentiate representations on the right-left divide, it will be instructive to explore the particular health reform narratives that were deployed in these newspapers to both support and oppose health reform, and the respective frequency of deployment for those narratives throughout the UHSR debates.

7.3 Health Reform Narratives During the 2004 State Election Campaign and Surrounding the UHSR Debates 2008–2011

In total, I identify seven major recurring narratives (those that appear in at least 5% of articles in at least one period of analysis) of health care reform in the *Deseret News* and the *Salt Lake Tribune* during the UHSR debates between 2004 and 2011. As had been the case in Massachusetts, health policy narratives in Utah were largely built upon competing values of fairness, equality of opportunity, individual responsibility, and economic sustainability.

Three major health reform narratives that had been present during the Massachusetts Health Reform Law debates again surfaced in Utah as major reform narratives. First, the *expanded access narrative* re-emerged as a narrative in favour of

reform, emphasizing access to health insurance and care as a matter of fairness. As had been the case in Massachusetts, the *expanded access narrative* was often a crisis discourse, one that encouraged immediate action to achieve comprehensive reform and increased access to care, albeit not universal access. The *economic security narrative* resurfaced as a major narrative in favour of reform, focusing on the need to reform the health care system to ensure state or national economic sustainability and competitiveness. Like the *expanded access narrative*, the *economic security narrative* was also a discourse of crisis that conveyed a sense of urgency. Finally, the *individual responsibility narrative*, which was unfavourable to health care reform, was also present in UHSR debates between 2004 and 2011, but it appeared less frequently as times passed. Individual responsibility was invoked somewhat differently in Utah from the way it had been used in Massachusetts to defend Romneycare from a conservative perspective (neoliberal responsibilizing market citizenship). In Utah, the *individual responsibility narrative* often acknowledged that there was room for improvements in the health care system; however, it held that the onus of reform rested with individuals, families, and charities instead of governments.

Four major health reform narratives that appeared during the UHSR had not been major narratives during the Massachusetts Health Reform Law debates. The *inadequate reform narrative* (2008-2011) was a major narrative that was unfavourable to the UHSR, yet favourable to more ambitious health reform, and sometimes specifically favourable to the federal ACA. Articles advancing the *inadequate reform narrative* argued that the UHSR would not do enough to address the challenges of the health care system, particularly with respect to access. The *wrong reform narrative* (2009-2011 of the

UHSR) was deployed as a major narrative in opposition to Obamacare, sometimes supporting the UHSR as an alternative, and in other instances supporting a variety of conservative health care reforms (e.g. HSAs and other tax incentives to purchase insurance, tort reform, and individual-responsibilizing public health campaigns) as better options than Obamacare. The *anti-single-payer narrative* (unfavourable, 2004-2011 of the UHSR) emerged in the UHSR debates as an unfavourable narrative, opposing single-payer as a reform model and criticizing the quality of care in countries that operate universal health care systems. Finally, the *incremental reform narrative* appeared in support of UHSR legislation, other conservative state or federal health reform legislation, or modest systemic reforms such as tax-free health savings accounts (HSAs).

Health reform narratives were not mutually exclusive. As examples in this chapter demonstrate, columnists sometimes deployed different health reform narratives simultaneously as they had during the Romneycare debates. The force and frequency of narratives were inconstant across time, and some complex narratives had subsets; for example, as in the Romneycare case, the *expanded access narrative* included many articles that focused on access to health insurance and care for specific, allegedly marginalized groups, such as the poor or same-sex couples. Selected narratives effectively bridged the right-left divide, appearing in comparable numbers of articles in both the *Salt Lake Tribune* and the *Deseret News*. Other narratives were limited to right-wing or left-wing opposition to particular reform ideas.

Narratives of Health Care During the 2004 Election Period

Coverage of Utah health care debates in the 2004 election period demonstrated

the diversity of opinion about the American healthcare system that existed before the state reform began. During the election campaign from January 1 to November 1, 254 articles covered health care reform—150 news stories, columns and editorials in the *Deseret News* and another 106 in the *Salt Lake Tribune*. I identify five of the seven narratives of the UHSR during the 2004 election period. Some articles (typically columns or editorials) contained a single, well-developed narrative of health care reform, while others included several interwoven narratives. When examining the media's overarching story of health care reform in Utah, it is useful to begin with two narratives—the *individual responsibility narrative* and the *incremental reform narrative*—that demonstrated the complex deployment of individual responsibilization in the health care reform debates of the period. [83]

Predominantly Republican (and libertarian) narratives during the 2004 election campaign

The *individual responsibility narrative* was the most common narrative used to oppose health care reform during the 2004 election campaign, in particular the idea of federal reform. It acknowledged systemic challenges, but it charged individuals, families, and charities with the obligation to meet the challenges. In essence, as it was used in the UHSR case, the *individual responsibility narrative* was built on the belief that good citizens should lead healthy lives, make good choices, and live with the consequences of

[83] All articles resulted from a *Factiva* search for the terms "healthcare reform OR health reform OR health care reform OR health care system OR healthcare system OR single payer OR health exchange OR health insurance." With regard to the dataset for the *Deseret News* and the *Salt Lake Tribune* in the election period (January 1-November 1, 2004), a *Factiva* search produced 364 articles. I excluded 110 articles from the initial search results because they were duplicates, letters to the editor, or focused on matters related to health but not health care reform debates. For example, I dismissed an October 31, 2004 article, describing the Veterans' Administration flu clinics schedule and an October 24, 2004 book review of a Florence Nightingale biography. Thus, my analysis of coverage for the election period includes 254 articles.

their choices. It treated the purchase of private health insurance as an individual duty. It held that families should help their members financially and emotionally during health crises. When individual resourcefulness and family supports proved inadequate, private (often faith-based) charities were expected to intervene with temporary, means-tested assistance. The *individual responsibility narrative* opposed greater government involvement in health care and new government programs (especially those emanating from the federal government). If writers deploying the narrative were not entirely opposed to existing means-tested government assistance and entitlements (Medicare, Medicaid, Veterans Administration, etc.), they were at least hostile to their expansion.

The notion that individuals and families should lead healthier lifestyles and take greater responsibility for financing health services sometimes led commentators to oppose government action and defend aspects of the current system. Articles advancing the *individual responsibility narrative* put the onus of change on health care consumers, rather than the government or insurance providers, to bring about change. For example, some pieces highlighted unorthodox suggestions from the business community regarding how health consumers could change their behaviour:

> If prescription costs have got you down, ask your doctor about upping the strength of your medication. That's the advice of Utah's second largest health insurance company…Regence claims its voluntary "half-tablet" program could reduce co-payments by up to $5 million per year. (Fantin 2004)

While it is likely that many doctors would have questioned the suggestion that patients who could not afford prescription co-payments should reduce medication dosages, it made business sense to some insurance executives. These mentions sought to convince Utahns that changes to their individual behaviour would be adequate to address the

challenges in the health care system.

Proponents of the *individual responsibility narrative* avoided endorsing any government action, even conservative reform proposals such as HSAs, public information campaigns, or new tax credits that may have still have required legislation. For example, the *Salt Lake Tribune* quoted Scott Ideson,[84] President and CEO of Regents Blue Cross Blue Shield, who argued in favour of self-rationing and leading healthier lifestyles:

> Many of us demand that all existing services and technology be made available to us because the true costs are hidden. Consumers can help slow the rising cost of health care by using generic drugs, using the emergency room only for true emergencies, and not engaging in unhealthy lifestyle choices such as smoking, poor diet, lack of exercise, etc. Remember, the more each of us use the health-care system the more we all have to pay. We are in this together and together we can find a solution. (*Salt Lake Tribune*, February 23, 2004)

It is remarkable that a key stakeholder in the state health reform debate, a senior insurance company executive, was afforded this media space and allowed to amplify his voice without having any counterarguments juxtaposed against his. Before the UHSR began in earnest, it appears that, thanks in part to the amplified voice of the insurance industry, the *individual responsibility narrative* was poised to underpin the efforts of those seeking to frame the state health reform debates, later emphasizing market-based proposals. Perhaps more importantly, powerful actors in the Utah business community were publicly individualizing responsibility for health care as early as the 2004 election period.

Partisans of the *individual responsibility narrative* sometimes downplayed the

[84] Subsequent pieces demonstrate that Mr. Ideson was frequently featured and cited as a commentator on the state health reform debates in both the *Salt Lake Tribune* and the *Deseret News* from 2004-2011.

seriousness and severity of the health care crisis. The narrative was built in part on the idea that change was unnecessary, and that there should not be government intervention in the health policy realm. For example, in an October 2004 *Deseret News* column, syndicated columnist and well-known polemicist Walter Williams wrote:

> So what does the absence of health insurance mean?....[Y]ou don't receive medical treatment on the same terms as a person with health insurance. You might spend a day waiting for treatment at a clinic instead of having an appointment at a chosen time at a physician's office….[Y]ou'll receive a smaller quantity and lower quality of medical care such as hospitalization in a ward instead of a private room, interns rather than specialists, and treatment at voluntary clinics and free hospitals such as Shriners. (Williams 2004)

After listing all of the consequences of uninsurance/underinsurance, Williams proceeded to explain why he thought the systemic inequality and resulting human suffering was acceptable:

> Let's face it: People who can buy insurance get benefits that those who cannot afford it don't. Those with lots of money get things that those with little money don't. Whether we like it or not, these are facts of life. By the way, a healthy young person might opt for self-insurance and not purchase health insurance because he believes that the money could be better spent elsewhere. (Williams 2004)

For authors like Williams, private, for-profit health care was the American way. They viewed inequality, both in access to health care and in the quality of care that patients received, as a natural and justifiable feature of a market-capitalist economic system. To have health insurance was an individual choice; not to have health insurance was an individual burden.

Individual responsibilization emerged in support of conservative reform proposals, and later in support of the UHSR legislation, through the *incremental reform narrative*. In the *incremental reform narrative*, individualism was celebrated as an

American value; yet imperfections in the system were acknowledged and reform was encouraged. These authors saw a role for government through such individualizing policies as tax-free health savings accounts (HSAs), tax credits for the purchase of health insurance, government campaigns to change individual behaviour in matters of health, and, in the later years of the debates, the UHSR legislation.

The most common articles that exemplified the *incremental reform narrative* in the 2004 election period were pieces that made favourable references to health savings accounts (HSAs). For example, an October 2004 *Deseret News* piece affirmed: "If pre-existing conditions aren't a concern...you may be able to keep costs down by getting a high-deductible policy twinned with a tax-cutting health savings account" (*Deseret News*, October 18, 2004). Similarly, a *Deseret News* interview cited Beau Babka, a candidate for the U.S. Congress, endorsing HSAs:

> [An] alarming number of Americans are without any type of health insurance. The federal government must help small businesses to shoulder some of their health care needs so that all of their workers have coverage. Health savings accounts would be a positive step forward to reduce the costs of health care. (*Deseret News*, October 10, 2004)

Proponents of the *incremental reform narrative* advocated a substantial shift in public health policies that emphasized changing public perceptions and behaviour as the best way to achieve systemic change. In addition to HSAs, these writers sometimes stressed publicly financed information campaigns against obesity, smoking, or alcohol consumption. While the *incremental reform narrative* was favourable to changing the health care system, it was a narrative built upon a foundation of individual responsibility and economic conservatism, emphasizing legislative gradualism as the best means to reform the system.

Similarly, the *anti-single-payer narrative* (unfavourable) also emerged as a minor anti-reform narrative in 2004—one that would later become more common during the UHSR reform, in 2009 during the heat of the Obamacare debates. At times, it was framed in the context of conspiratorial thinking. For example, in an October *Salt Lake Tribune* piece, universal health care was affiliated with revolutionary socialism:

> Socialist Workers Party U.S. Senate candidate Brian Taylor wants to unionize Utah's working class and plant a seed of revolution in the Beehive State to help overthrow America's capitalist system…. The party is also in favour of a universal health care system, affirmative action in employment, education and housing, the right of a woman to have an abortion and the end to "Washington's economic war against Cuba," Taylor said." (Bergreen 2004)

On the surface, the Bergreen piece merely covered the socialist candidate's speech to a few supporters from the mining community. More importantly, however, it associated universal health care with radicalism without discussing any of the potential merits of single-payer systems.

At other times, the *anti-single-payer narrative* was less conspiratorial. A September *Deseret News* article, covering a Salt Lake City conference of health reform experts, reported the following:

> For the most part, they focused their attention on an American Medical Association-backed system that would more fairly allocate the tax burden for federal medical subsidies and a "single-payer" system similar to Canada's universal coverage. Dr. Jeremy Lazarus, vice speaker for the AMA, said that their system would allow people to choose any insurance coverage they desired and provide every taxpayer with a refundable credit to help pay for that insurance. (Loftin, 2004)

In this article, single-payer health care reform was juxtaposed against the more moderate proposal of the American Medical Association, which sought to expand insurance coverage through incentives and possible subsidies to purchase private health insurance.

Single-payer reform was pejoratively associated with economic irresponsibility and loss of individual choice.

Predominantly Democratic narratives during the 2004 election campaign

As had been the case in Massachusetts, other health reform narratives focused less on matters of individual responsibility or the alleged economic soundness of incremental reform, discursively focusing on health care reform as a matter of fairness and justice. The *expanded access narrative* was the most common health reform narrative invoked in favour of reform in 2004. It emanated more frequently from the political left and held that too many Americans—sometimes specifically Utahns—lacked access to health insurance and subsequently could not obtain quality health care (113 mentions—58 in the *Deseret News,* 55 in the *Salt Lake Tribune*). The *expanded access narrative* often included notions of deservedness, emphasizing particular groups who allegedly warranted health insurance and care, in particular: children, single mothers, poor working families, same-sex couples, and veterans.[85] Each supposedly deserving segment of the population constituted a subset of the narrative. It was not a narrative in favour of a universal or single-payer system; rather, as had been the case in Massachusetts, it advocated expanding access for more people while maintaining and reinforcing the private health insurance markets.

The *expanded access narrative* was often deftly cloaked in human-interest stories. For instance, an article might have described a single working mother whose family lacked health insurance despite her two minimum wage jobs; or it might have portrayed a

[85] It is noteworthy that emphasis on notions of deservedness in articles that exemplified the *expanded access narrative* was slightly more common in *Deseret News* pieces.

mentally ill veteran who could not provide health insurance to his family because he could no longer work, being psychologically scarred from war and discarded after service. Human-interest stories that depicted the challenges of the uninsured and underinsured were some of the most common in the early stages of the Utah media's representations of health care reform. In those articles, the victims (some segment of the deserving poor or same-sex couples), villains (profiteering health insurance companies or unresponsive governments), and heroes (reformers seeking to expand access to affordable health insurance) largely remained the same. At other times, as had been the case in Massachusetts, the *expanded access narrative* was buried in seemingly banal news stories, articles in which the reform narrative had to be teased out through critical textual analysis to ensure that the media framing role of these pieces was not lost. A casual mention that a person worked a full-time job and did not have health insurance (even if the article was not about health care reform) may have contributed to advancing the *expanded access narrative*.

The titles and introductory paragraphs attached to articles in my sample were sometimes misleading. It was therefore important for me to comb carefully through health-related articles that were not directly related to the state and federal health care debates, since powerful examples of the *expanded access narrative* were sometimes hidden in news stories. For instance, in the following news story from the *Deseret News*, summarizing state legislative committee testimony, Steve Mascaro, a Republican state legislator, was quoted in favour of government support for Utahns who were suffering

from severe blood disorders and faced lifetime insurance limits.[86]

> If you listen to these stories, it has been as emotionally draining as any committee I have ever sat on....In our desire to be nice, conservative legislators looking out for the tax dollar, as we are charged with doing, we also forget that the role of government is also to give a helping hand. Clearly this is one of those times. (Bryson October 21, 2004)

Without a counter-argument in the news story, I interpreted this genre of affirmation as favourable to health care reform in general and categorized the quotation as a mention of the *expanded access narrative*. While it did not endorse specific reforms, it acknowledged the problem of insurance limits in the existing system and suggested that government had some (unelaborated) obligation—albeit vague—to help the uninsured and underinsured.

Articles exemplifying the expanded access narrative combined evidence-based and emotional appeals. In the 2004 election period, editorials, columns and news stories generally focused on the national health care debates; in fact, none addressed health care as an issue in the state legislative or gubernatorial elections, even though many sought to tie the national discussion to the Utah context. An editorial in the *Deseret News* serves as an example of the *expanded access narrative*:

> In Utah, some 300,000 people either cannot afford health coverage, can't get it through their places of work, or elect not to purchase it. Utah's uninsured includes about 73,000 children. The vast majority of Utah's uninsured hail from working families. Some of the consequences of not having insurance are obvious. People put off seeking health care. They live with illnesses and die younger than people who have health-care coverage. Uninsured women who develop breast cancer are twice as likely to die as women with breast cancer who have health coverage, according to some studies. Some people can pay as they go so long as they are not

[86] Before the passage of the federal Affordable Care Act in 2010, private health insurance companies frequently imposed "lifetime insurance limits" on the amounts they would pay for care of particular, chronic conditions. These limits became illegal after passage of the ACA.

beset by a serious illness or injury. (*Deseret News*, May 10, 2004)

This quotation emphasized human suffering in the policy context of the time. It serves as an example of the many pieces that focused on consequences of uninsurance or under-insurance for allegedly deserving vulnerable groups—women, children, veterans, working poor, and others.

Among mentions advancing the *expanded access narrative* that focused on particular segments of the population, 14 specifically mentioned health insurance or access for children. Relatedly, another 11 articles emphasized the feminization of poverty—focusing in particular on women with children. For instance, one editorial declared: "if a parent doesn't have a full-time job, chances are she doesn't have health insurance, and neither do her children. This suggests that the state should concentrate policy efforts on things like expanding health coverage for the working poor" (*Salt Lake Tribune*, June 5, 2004).

Another subset of *expanded access narrative* articles linked uninsurance with the marriage equality debates, focusing on health insurance access for same-sex partners (14 mentions). Of those 14 mentions, six focused on same-sex couples with children and eight mentioned same-sex couples in general. Like other instances of the *expanded access narrative*, this version was often deployed in human-interest stories (and a few news pieces) to make an emotional case to readers in favour of health reform. In these access mentions, gay and lesbian Utahns in committed relationships were framed as families who deserved access to health insurance as a civil right. The emotional appeal was particularly clear in articles that linked access to health insurance for gay and lesbian couples with health care for their children. For example, in an October 2004 *Deseret*

News piece featured the following comments:

> "By denying recognition to gay and lesbian families, states deny their children stability and other benefits such as health insurance," said Joseph Hagan, past chairman of the American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health. Hagan was an author of his association's statement advocating same-sex parent adoption. (Bulkeley 2004)

Similarly, an October *Salt Lake Tribune* piece represented a gay couple and their adopted children as an ordinary family that deserved the same rights as other Utahns:

> Grandma Bobbie and Grandpa Ed tend the toddlers most mornings to give stay-at home dad Paul a reprieve and time to catch up on chores. "They are such great parents," said Bobbie Butterfield of Paul and Tony. "They want children so badly and they appreciate them so much, their whole lives revolve around them." Which is why she wants Tony and Paul's family to have the "same civil rights as our other seven children" -- the social and legal safety nets that allow parents to provide their children with inheritance rights, access to health insurance coverage, the uncontested right to parental involvement in hardships like illness, death or the collapse of a relationship. "What people need to realize is that….gays and lesbians are still going to have kids and do [their] best to be productive members of society," said the community center's Larsen. "Passing laws that are discriminatory affects these children more than their parents." (Adams 2004)

In other examples, the link between health care reform and the same-sex marriage debates was understated; for example, some articles merely mentioned domestic partners who did not have access to their partners' health insurance plans or hospital visitation rights.

In the additional articles that contained the *expanded access narrative* with notions of deservedness for particular groups, emphasis was placed on veterans (four mentions), or the non-gendered working poor (nine mentions). Veterans were portrayed as a deserving group because of their heroism and sacrifices, while the government was chided for failing to honour their service with better care. The working poor were depicted as deserving because of their work ethic, directly or indirectly juxtaposing the

image of the deserving poor (those who toiled in menial jobs) with the allegedly lazy, undeserving poor (who lived on public assistance).

The remaining 61 articles that advanced the *expanded access narrative* during the election did not include notions of deservedness, but instead focused on the need for broader access to insurance for Utahn and American society. These proponents of the *expanded access narrative* often strategically framed uninsurance as a middle class problem, countering the perception that it primarily affected the poor: "America's health-insurance system is sick….[T]he health problems of uninsured Americans are not going away, and as the ranks of the uninsurables swell to include even well-to-do professionals, the impetus for reform is growing" (*Salt Lake Tribune*, May 16, 2004). Another piece cited Utah's high rate of insurance fraud as evidence of a flawed health care system that did not work in the state's predominantly Mormon context, where people get married much younger, forcing more young people to choose between defrauding insurance companies or joining the ranks of the uninsured after marriage (*Salt Lake Tribune*, March 27, 2004). Thus, the *expanded access narrative* was not always a plea to help the so-called sinners and socially excluded—but often an appeal to mainstream Utah conservatives for reform in their own interest, arguing for fairness to the benefit of society as a whole.

Other narratives focused less on health care as an issue of fairness or justice. The *economic security narrative* (favourable to reform) held that inefficiencies in the American health care system had created economic disadvantages for the state or country. It was the second most frequent narrative in the election period after the *expanded access narrative* (78 mentions—41 in the *Deseret News*, 37 in the *Salt Lake Tribune*), as it had

been throughout much of the Romneycare period. According to the *economic security narrative*, health care reforms were necessary to control rising public health expenditures—for individuals, families, private business, governments, or all sectors. In contrast to the *incremental reform narrative*, which emphasized caution and gradualism in the reform approach, the *economic security narrative* was built upon a greater sense of urgency, often arguing that the future stability of the state or national economy depended on substantially reforming the health care system. While proponents of the *incremental reform narrative* also often foregrounded the economy when advocating for reforms like HSAs or the UHSR legislation, the two narratives were quite distinct. The *economic security narrative* was often deployed in support of comprehensive federal reform, and was even sometimes marshalled specifically in favour of the federal ACA in later years (2009-2011). While focusing on the economic aspects of the health care crisis instead of the humanitarian aspects (as was common in the *expanded access narrative*), the *economic security narrative* nonetheless emanated somewhat more frequently from the Democratic-leaning media because it often supported government actions—e.g., legislation to more strictly regulate health insurance company practices, investment in means-tested health care programs such as Medicaid to reduce financial losses from treating the uninsured—as part of the solution.

The *economic security narrative* often included statistics that portrayed Utahns' deepening struggles to afford quality healthcare—insurance premiums and prescription drugs, in particular—without, or even despite, holding private health insurance coverage. For example:

Health insurance premiums paid by workers in Utah have risen over the past four

> years five times faster than incomes in the state, according to a study prepared for Families USA, a health-care coverage advocacy group. According to the report, premiums paid by Utah workers rose 66.3 percent from 2000 to 2004, much higher than the national average increase over the same time period of 35.9 percent. Average worker earnings in Utah rose only 13.2 percent during the same time period compared with 12.4 percent nationally, leaving many Utah workers with less take-home pay today than four years ago. (Mitchell 2004)

In such pieces, the authors did not appeal to readers' sympathy to garner support for the uninsured. Rather, they made the case that the status quo was economically unsustainable and action had to be taken to reform the system. They appealed to readers' economic anxiety and self-interest to achieve a better health care system. The problem framed in the *economic security narrative* was not that more people needed access to health insurance or care, but that people and/or governments could not afford to maintain the system as it functioned at the time.

Summary of Narratives of Health Care During the 2004 Election Period

In contrast to the newspaper articles that appeared in Massachusetts during that state's 2002 election campaign, coverage in the *Deseret News* and *Salt Lake Tribune* tended to frame healthcare as a private market or commodity. *Deseret News* and *Salt Lake Tribune* coverage in the election period of January 1 to November 1, 2004, before the state of Utah even embarked on its own reform effort, demonstrated that a portion of the media had already rallied against substantial changes to the existing system, deploying narratives against reform such as the *anti-single-payer narrative* and the *individual responsibility narrative*—along with a handful of minor narratives that together formed a disparate collection of neoliberal and neoconservative media representations. Nonetheless, most newspaper articles written by Utahn columnists (and syndicated journalists republished in the two major dailies) acknowledged that there was

a crisis in health care. They offered competing interpretations of the situation and deployed a variety of narratives, including the *incremental reform narrative*, the *expanded access narrative*, and the *economic security narrative* in order to support health care reform. As had been the case in Massachusetts, the primary targets of proposed reforms were the expansion of access to health insurance and the control or reduction of public health expenditures. Therefore, in the initial election periods before the Massachusetts (2002) and Utah (2004) reforms, the central health reform objectives portrayed in the media were the same though the level of ambition and approaches to reform differed.

7.4 The period of silence (2005-2007)

Since Governor Huntsman had decided to address health reform shortly after the 2004 election, important discussions that shaped the trajectory of the state reform effort were almost certainly happening behind the scenes. However, from 2005-2007, the state government did not publicly take any concrete steps to reform the health system, and media coverage of health reform specific to Utah was virtually non-existent in the two major dailies. Granted, a small yet steady stream of health care stories focusing on the national reform debates continued to appear in the *Salt Lake Tribune* and the *Deseret News*. However, the 2005-2007 period did not offer any new health reform narratives or shifts in the complexity or scope of the two most important narratives that had carried over from Massachusetts and resurfaced in Utah newspapers in 2004: the *expanded access narrative* and the *economic security narrative*. As such, my analysis of media representations proceeds directly from the 2004 election to the UHSR implementation period of 2008-2011. During this time, as the UHSR took shape and legislation was

passed, some health reform narratives declined in frequency as new ones emerged and others were transformed into more complex narratives.

7.5 Health reform narratives during the UHSR (2008-2011)

While access to health insurance and the costs of care were already dominant issues in 2004, they were debated in the context of larger questions about the necessity and merits of health care reform. By the 2008-2011 period, [87] when the various pieces of

[87] The dataset for the *Deseret News* and the *Salt Lake Tribune* during the legislative debates and in the periods following legislative passage of each element of the UHSR resulted from a *Factiva* search for the terms "healthcare reform OR health reform OR health care reform OR health care system OR healthcare system OR single payer OR health exchange OR health insurance." In the two major dailies, the search initially yielded 1,924 articles during peak coverage periods of legislative debates and after legislative passage from 2008-2011. However, I excluded 444 articles from the search results because they were duplicates or letters to the editor, or because they focused on health issues, but not health care reform debates. Thus, in total, I searched for and differentiated health reform narratives in 1,480 separate articles between the two newspapers from 2008-2011. The articles are not units of analysis in this section, since a single article may contain several narratives of reform or none at all. Thus, the units of analysis are mentions of each narrative. My review of the *Deseret News* and the *Salt Lake Tribune* included the following date ranges during the peak periods of state legislative debates and after legislative passage of each component of the UHSR:

January 1, 2008-Mar 18, 2008 for the period of legislative debates on House Bill 133;

March 19 – June 30, 2008 for the period following legislative passage of House Bill 133;

January 1, 2009-March 10, 2009 for the period of legislative debates on House Bill 188; House Bill 331, House Bill 165, and Senate Bill 79;

March 11-June 30, 2009 for the period following legislative passage of House Bill 188, House Bill 331, House Bill 165, and for Senate Bill 79;

January 1, 2010-March 21, 2010 for the period of legislative debates on House Bill 294;

March 22-June 30, 2010 for the period following legislative passage of House Bill 294;

January 1, 2011-May 29, 2011 for the period of legislative debate on House Bill 128;

May 30-August 30, 2011 for the period following legislative passage of House Bill 128, Utah's lawsuit with other states to prevent implementation of the UHSR, and state events organized to bring attention to the UHSR;

UHSR legislation were passed, the attention of most reporters had shifted beyond the question of whether or not to reform the health care system to questions regarding the best approaches to reforming it. Furthermore, the progress, proposals, and tone of the national health reform debates affected the health reform representations in the Utah media. The narratives that appeared the most frequently and had been the most complex of 2004—the *expanded access narrative*, the *economic security narrative*, and the *incremental reform narrative*—carried on as major narratives. For its part, the *individual responsibility narrative* persisted as a minor narrative in fewer than 5% of articles during the UHSR period. The *individual responsibility narrative* declined as a stand-alone narrative against reform, in part, because of emphasis on individual responsibility in a new narrative, the *incremental reform narrative,* which favoured either the UHSR legislation or other minor, gradual changes that aimed to appeal to Republicans. Finally, the *anti-single payer narrative*, which existed as a minor narrative in 2004, became a more prominent narrative in 2009, in the heat of the Obamacare debates.

It is no coincidence that three major narratives—the *incremental reform narrative*, the *expanded access narrative*, and the *economic security narrative*—were present in the parallel national debates over Obamacare, and that the latter two narratives had already been a major part of the earlier Romneycare debates in Massachusetts. Indeed, the *expanded access* and *economic security narratives* run through the reform debates of Massachusetts and Utah, and connect the state and national scales. These two narratives endured in large part thanks to their high early frequency and their complexity. Both narratives zeroed in on a specific problem as the root cause of health system

dysfunction—either the cost of care or insurance, or access to insurance and care—and often offered solutions to the stated problem. It is noteworthy that the challenges of access and cost coalesced in the same articles that deployed the *incremental reform narrative*—editorials and columns that identified access to insurance and/or the costs of care as problems, but subsequently endorsed the UHSR or other minor reforms such as HSAs, electronic medical records, tax credits, entitlement reforms to reduce Medicare and Medicaid outlays and subsequently re-appropriate funds for other health reforms, or public health campaigns to change individual behaviour (anti-smoking, better nutrition to combat obesity and diabetes, etc.) instead of more comprehensive health system reform. Access and the economy thus maintained their central importance as the foremost drivers that underpinned reform narratives.

However, perhaps the most notable differences between 2004 and the 2008-2011 period were the meteoric rise of the *incremental reform narrative*, the arrival of the *inadequate reform narrative* in 2008 in response to the UHSR, and the arrival of the *wrong reform narrative* in response to Obamacare in 2009. The *incremental reform narrative* was frequently deployed to support the specific legislative elements of the UHSR. It simultaneously rivalled (in frequency) and sometimes converged with both the *expanded access narrative* and the *economic security narrative*. Arguments that had been used to oppose reform in 2004, such as the idea that health care was a personal, family, or charity responsibility (*individual responsibility narrative*) were attenuated and re-appropriated to argue in favour of a modest, gradualist approach to reform. In addition to reinforcing the 2004 tenets of pride in the American and Utahn identity and conceptualisations of health care (capitalism, individualism, traditional families caring for

the needs of their members) and the culture of gradualism and constant improvement (resistance to any radical change in policy, tempered with the acceptance of minor changes such as the creation of HSAs and tax deductions for health expenditures that remained consistent with the values of the existing health care system), the *incremental reform narrative* embraced new tenets in the 2008-2011 period. Specifically, it adopted and began to emphasize states' rights discourse, tort reform as a necessary and responsibilizing element of change in the health care system, and the vision of Utah as a health reform trailblazer, offering a path that differed from the HSA-Romneycare-Obamacare approach of increased insurance regulation, insurance mandates, and subsidies to low-income people for the purchase of insurance.

For its part, the *inadequate reform narrative* was the mirror discourse in response to the *incremental reform narrative*—one that was favourable to health care reform, yet critical of gradual or piecemeal changes. It derided the UHSR for its incrementalism and either advocated for a more ambitious state-level reform effort or supported more comprehensive reform proposals federally or in other states. In some articles, the *inadequate reform narrative* praised the HSA, Romneycare, the Bennett-Wyden bill, or Obamacare as superior reform options to the UHSR; in others it simply derided the UHSR while advocating more ambitious, albeit unspecified reforms.

Similarly, the *wrong reform narrative* arrived in 2009 in reaction to the federal Obamacare debates. Columnists who first used this narrative argued that health care reform was an ill-timed priority in the midst of an economic recession. These authors often acknowledged problems in the health care system, but they insisted that other priorities should take precedence and suggested that President Obama and Congressional

Democrats should delay any comprehensive health reform efforts until other challenges were addressed, or until the economy improved. Other authors, treating the uninsurance crisis as a red herring, insisted that the real priority should be cost-saving entitlement reform to reduce outlays for Social Security and Medicare. The *wrong reform narrative*—like the *anti-single-payer, individual responsibility, incremental reform, expanded access*, and *economic security narratives*—varied in terms of how frequently it appeared in state newspapers at different junctures of the UHSR debates from 2008 to 2011.

In 2008, media narratives surrounding HB 133 and the state and federal elections renewed state media interest in health care reform. The legislation from Utah's House of Representatives created a new Health System Reform Task Force; it established a pilot program, mandating that the Governor's Office of Economic Development, the State Insurance Department, and the state Department of Health work in conjunction with the legislature on a strategic plan for health care reform. The legislation paved the way for the Utah Health Exchange. Media coverage rarely juxtaposed the Utah and federal health reform debates at that stage, primarily because the details of the federal ACA were still being worked through and debated. Reporting of the 2008 state election also focused substantially on health care reform. During the campaign, Governor Huntsman and leading Republican legislators defended HB 133 and the Governor's broader health reform ideas, handily defeating Democratic challengers to retain power in both the executive and legislative branches. A handful of articles covered other State of Utah health legislation that was parallel to the UHSR, including HB 326, which removed the state cap on CHIP enrolment, and SB 14, which outlawed smoking in cars in the presence

of children.

The dominant progressive narratives of 2008 were the *expanded access* and *economic security narratives*. The *inadequate reform narrative* also emerged for the first time in articles that supported comprehensive health reform, yet simultaneously criticized HB 133 as a tepid approach to the crisis. In terms of narratives of the political right, a few articles still contained the *individual responsibility* and the *anti-single payer narratives* to oppose to comprehensive reform. However, the *incremental reform narrative* was the most frequent narrative articulated in the Republican-leaning media. Unlike the other narratives of the right, the *incremental reform narrative* continued to be used to shape and restrain reform instead of preventing it, as it had been deployed in 2004.

A holding pattern of media coverage largely continued from 2008 to 2009, the period when several UHSR bills – HB 188, HB 331, HB 165, and SB 79 – were passed. It was also in 2009 that federal reform narratives became noticeably more impactful. Both state lawmakers and the media were thinking about the ways in which it was possible—and, by later in 2009, appeared likely or inevitable—that federal reform would affect Utah's efforts. Reporting focused both on the federal health reform effort and on a flurry of state health reform bills, including the four pieces of UHSR legislation that passed that year. The most significant of these bills, as noted in the previous chapter, was HB 188, which created the Utah Health Exchange, later renamed "Avenue H." It served as an online store for consumers to compare and purchase private insurance plans. It was initially open to both individuals and small businesses, until changes under the federal Affordable Care Act in 2012 directed individuals to the federal exchange, leaving only Utah's small businesses to shop for plans on Avenue H. HB 188 also clearly established

the preference for defined contribution health insurance. It was intended to expand access to the insurance market and make it easier for individual and business consumers to navigate their choices. [88]

HB 331 mandated that particular categories of private contractors offer health insurance coverage to their employees while working with the State of Utah on contract. The state had previously been criticized for working with contractors who did not offer health insurance to their employees; thus, the law had symbolic as well as practical importance. HB 165 instituted new privacy and information sharing rules for health care workers, patients, and private insurance companies. Finally, SB 79 increased the necessary standards of proof required for malpractice litigation against physicians. This law was consistent with the conservative problematization of the health care system, partially blaming lawyers and litigious patients for rising health care costs and insisting on torts reform.

In addition to the legislative components of the UHSR in 2009, several other pieces of proposed state health reform attracted media attention. HB 267 failed in the Utah House of Representatives. Had it passed, it would have provided protection against housing and employment discrimination for gay Utahns and facilitated the extension of employment-based health insurance for same-sex and other unmarried couples. It would have been landmark legislation, in line with legal changes in other American states at the time, adding sexual orientation to the existing list of protected human rights in the employment and housing spheres, such as race, religion, and gender. SB 119 created a

[88] Only larger businesses, with over 50 employees, were included in the pilot period of 2008, even though the stared long-term intention was to serve small business with fewer than 50 employees.

task force to study improvements to the triage systems in state emergency rooms in order to identify cost-saving reform options. HB 171 and SB 225 extended Medicaid and SCHIP coverage to children of qualified legal immigrants (Green Card holders) after a required period of residency. HB 124, which failed in the State House, would have required private insurance companies to cover "elemental formula" for babies with dangerous food allergies. Similarly, SB 43 proposed requiring insurance companies to cover treatments for Autism, and HB 89 mandated coverage for prosthetic limbs. HB 89 passed in 2009, while SB 43, later known at "Clay's Law," was delayed in committee but eventually re-introduced and adopted in 2014. While not part of the UHSR, HB 267, SB 119, HB 171, SB 225, HB 124, HB 89, and SB 43 were important because they helped to frame the media coverage of health care in 2009. Collectively, media narratives of the state health legislation that year depicted an economically cautious and socially conservative legislature that was sensitive to the interests of the private insurance industry and reluctant to impose new industry regulations.

Beyond the state health reform efforts, much of the newspaper media's attention had shifted to the increasingly contentious federal reform debates. 2009 began with hopeful reporting on the possibility of a bipartisan reform in Congress. As the year progressed, coverage made it clear that federal debates had become positional and acrimonious. State newspapers portrayed a policy debate that divided the country into more defined partisan camps, and put the federal government at odds with the states. Media coverage also made it clear that the hyper-partisan positioning and inflammatory rhetoric reflected a political context in which President Obama and Congressional Democrats would have to spend substantial political capital to achieve comprehensive

reform.

In 2010, media reporting on health reform was the most extensive of any year during the UHSR. The controversial passage of the federal ACA dominated state newspaper media coverage. Health care was at the forefront of media attention to such a degree that it was frequently mentioned in passing, or linked to other seemingly unrelated stories. In addition to the broader focus on the contents of the ACA, several state-specific issues—including a number of health policy bills, notably HB 294, under discussion in Utah's legislature; comparisons of the UHSR to the ACA; and the news of a coalition of conservative states (including Utah) planning a lawsuit against the federal government to prevent ACA implementation—also garnered media attention.

The most important of the local legislative initiatives was HB 294, a part of the broader UHSR that amounted to a collection of amendments intended to address perceived problems in the pilot online health insurance exchange, which aimed to increase participation and reduce costs. It also included new transparency requirements on private insurance companies in regards to actuarial procedures and the communication of insurance claim decisions. In addition, it ended so-called "gender rating," which often resulted in unfair insurance rates for women.[89] Before HB 294, critics in the legislature and in the media charged that too few insurers were taking part in the pilot program for selected small businesses (those companies with fifty employees or less) and insurance premiums on the exchange were actually higher than rates on the external private insurance market. The passage of HB 294 amounted to a tacit admission that the Utah

[89] The gender-rating ban had previously permitted insurance companies to charge women higher insurance premiums if they had medical histories of pregnancy, domestic violence, or a list of other medical realities that uniquely or disproportionately affect women.

health exchange was not functioning as well as the UHSR architects had planned. Yet Republican House Speaker David Clark—who was Chairman of the UHSR Taskforce, the sponsor of the HB 294, and one of the key architects of the UHSR—framed the bill in a positive light without mentioning the difficulties in attracting consumers or controlling prices. As he defended his own health reform effort, Clark took the opportunity to criticize the federal reform law:

> Utahns deserve health care reform that works in Utah, not a one-size-fits-all approach from Washington. That's why my colleagues and I at the Utah legislature have been working on common sense changes that will make health care work better for every Utahn. This past legislative session, we passed a significant health care reform bill, HB 294, Health System Reform Amendments…. Many have likely heard about the changes we made to our new health insurance exchange, which applies a market-based approach to improving access to health insurance. One component of this bill, which received little fanfare during the session, also took effect in March. This provision of the law requires insurance companies to give patients 30 days notice before changing any prescription drug benefit they offer as part of a health insurance plan. (Clark, May 22, 2010)

Thus, in correcting the shortcomings in their own reform, state Republicans sought to maintain the *incremental reform narrative*, celebrating their plan as a superior, conservative alternative to Obamacare.

While HB 294 was the only component of the UHSR that passed in 2010, several other pieces of state health legislation were covered in the media during the same period. HB 66 was an extension of HB 89, passed the previous year; it required that private health insurance companies provide coverage to amputees for prosthetic limbs. SB 79 required insurance companies to provide greater clarity to customers, in writing, on pre-authorized coverage for medical procedures. The fact that both of these bills – which required insurance companies to be more transparent in how they made decisions about

claims, and obliged them to provide coverage to a clearly vulnerable segment of the population (amputees) – were necessary in the eyes of conservative legislators serves as a stark reminder of the social conditions and insurance practices that made health care reform such a pressing policy issue at both the state and federal levels.

Other bills proposed and passed in 2010 were hostile responses to the federal ACA. HB 67 sought to prohibit the application of the federal mandate on individuals to purchase health insurance. It also required that the state legislature approve the implementation of any part of the federal ACA in Utah. HB 67 passed despite warnings from Democrats that it may be unconstitutional and could cost the state high legal fees. In a similar vein, the state legislature passed HCR 8 and HJR 11, urging the federal government not to interfere with state health reform efforts. Finally, consistent with the emphasis on tort reform and the scapegoating of trial lawyers for America's skyrocketing health care outlays, both of which were common in the *incremental reform narrative*, HB 145 placed new limits on medical malpractice awards in civil court, reducing lawsuit award limits by 50%. These bills all reflected the conservative values of the state and served as a reminder of the ideological cleavages that inevitably made the federal health care reform effort so controversial.

In 2011, newspaper media reporting on health reform dropped significantly, from 634 articles in 2010 to only 231 in 2011. While the lawsuits launched by conservative state governments to prevent the implementation of Obamacare moved through the courts and inspired sporadic news stories, columns and editorials, the federal ACA and the UHSR legislation made fewer media waves. By 2011, both reforms were more entrenched and people had already had months to adapt to the new policy context. It was

probably obvious to both Democratic-leaning and Republican-leaning journalists that the U.S. Supreme Court would have to hear a number of cases on the ACA, and until each of those cases was decided, health care reform was a *fait accompli*. [90] Media attention centered on a number of new health policy bills—related to, yet not part of, the UHSR or the ACA—in both Congress and the state legislature. Newspapers continued to compare the UHSR to Obamacare and Romneycare, though most of these references emerged in the coverage of Romney and Huntsman as Presidential hopefuls in the Republican primary campaign. Interestingly, not a single news story, column or editorial in either of the major dailies specifically covered HB 128, which was the final component of the UHSR.

Despite the lack of focused media interest, it is worth recalling that HB 128 was significant in the sense that it aimed to correct a number of inadequacies in the UHSR. On the surface, the bill appeared only to be a planned step within the phased reform effort; it opened access to the health exchange for small businesses, given that the initial pilot of the exchange had only included a handful of larger employers. However, through this bill, legislators also sought to improve the operation of the exchange, providing a better explanation of benefit packages and regulations for both consumers and insurers. It created a single, improved application form for all state insurers to use. In an attempt to increase transparency, it mandated annual reporting on patient safety and health service charges at hospitals and other health care institutions. It also modified insurance market regulations to comply with new federal rules under the ACA. Each of the additional features in the bill that went beyond opening up the exchange to small businesses was

[90] The most significant Supreme Court decision, affecting both insurance exchanges and mandates, was not decided until 2012.

corrective, either responding to problems that lawmakers perceived themselves, or reacting to public or media criticism (Lord and Braun 2011; Utah 2008, 2010; Utah: Avenue H; UHPP 2008, 2009, 2010, 2011).

Instead of covering HB 128, the print media reported on a number of other related health bills that year. At the federal level, Republicans advanced HR 1213, which sought to defund and effectively undermine state health insurance exchanges. The efforts of conservative Republicans in this regard seem ironic, given that health insurance mandates and exchanges had both initially been proposals of the conservative Heritage Foundation, before Romney and Massachusetts Democrats adopted the ideas in the 2002-2006 Massachusetts reform effort. HR 1213 seemed more like a protest bill to appease the Republican base than an authentic effort to reverse Obamacare. Republicans knew that their bill was vulnerable to Presidential veto because they lacked the necessary majority in Congress to override it. The bill passed in the House of Representatives, but to no one's surprise, it failed in the Senate (Library of Congress 2011).

Coverage of HR 1213 in Utah newspapers revealed telling divisions between state and federal conservatives. State Republicans defended Utah's Avenue H exchange as a market capitalist innovation, distancing themselves from Congressional Republicans and conservative pundits and bloggers who were attacking health exchanges as part and parcel of allegedly liberal insurance mandates. The few articles that highlighted these differences were an important part of the UHSR story as it related to the ACA. Stewart (2011b), for instance, wrote that:

> Utah's health exchange has become the subject of squabbling among conservatives. California-based health policy analyst John R. Graham, a self-

> described conservative, has been sceptical of the web-based health insurance shopping portal and its potential as a market-based alternative to federal health reform, publishing his opinions in such forums as the *National Review* and *Forbes* magazine. Last month, he kicked things up a notch with a blog post asserting that Utah's exchange had "gone from being a marginally interesting side show to a seriously cognitive obstacle" to conservatives' rejection of the Patient Protection and Affordable Care Act passed in 2009.[91] "If a venture capitalist had funded the Utah health exchange, it would have certainly been shuttered on its first anniversary," wrote Graham, director of Health Care Studies at the Pacific Research Institute in San Francisco, Calif. "So, conservatives, please stop citing [it] as a successful example of a non-Obamacare exchange." (Stewart 2011b)

This article and other mentions of conservative disagreement on the UHSR and the merits of health exchanges in general seemed to reveal a level of disarray within the Republican political establishment. Both the passage of Obamacare (a symbolic Democratic victory, despite the arguable merits of the federal reform) and the attacks by Tea Party populists had shaken and divided the Republican Party in 2010-2011.

A number of state bills also drew media attention. First, a trio of anti-abortion bills—so-called "freedom of conscience" legislation—passed the state legislature in response to conservative fears that Obamacare would allow for easier insurance coverage for abortions. Such fears persisted despite President Obama's executive order, part of a brokered deal to secure moderate Democratic votes in Congress, which restricted abortion coverage under the ACA. HB 353 afforded doctors the freedom to refuse to perform abortions or any related medical procedures for religious reasons. HB 354 gave private insurance companies the right to refuse to cover abortions or related medical services based on ethical objections. Finally, HB 171 increased the number of state inspections (without prior notice) of any medical facilities that performed abortions. For critics, the latter law amounted to government-sanctioned harassment of abortion

[91] The federal ACA of course passed in 2010. The errant 2009 date was included in the Stewart article, and left unchanged in the quote.

providers and women patients (Stewart 2011c; Utah 2011 b, c, d).

In addition to the abortion bills, state Medicaid reform legislation was also passed in response to the federal ACA. SB 180 aimed to transition state Medicaid recipients into a new kind of managed-care system. Instead of the pay-for-service model that had been the norm in Medicaid billing for decades, SB 180 developed an "outcome-based" Medicaid billing model. Since the federal ACA loosened Medicaid eligibility requirements, and Medicaid is a jointly funded program between the federal government and the states, Utah and other state legislatures feared that Medicaid outlays would outpace other spending and create deficits. Thus, SB 180 was a pre-emptive effort to curb Medicaid spending before federal rules took effect. A related and more controversial Medicaid reform bill, HB 211, required some newly eligible Medicaid recipients to perform community service in order to maintain their health benefits (Utah 2011e, f). The bill reflected dislike for entitlement programs, as well as a preference for strict means-testing, individual responsibilization, and public shaming for recipients of social assistance.

In another symbolic bill that reflected conservative belief in the need for tort reform, blaming allegedly excessive medical malpractice lawsuits for rising health care costs, SB 150 protected hospitals from lawsuits when physicians made medical mistakes. The legislation prevented patients from suing hospitals that employed doctors who were guilty of malpractice. The legislation further limited recourse for victims of medical malpractice, following HB 145 in 2010, which had already halved the maximum award that claimants could obtain in civil court (Utah 2011g).

Finally, media reported on other legislation that aimed to rectify deficiencies in the UHSR. In a fix that was based on principles of actuarial risk calculation and attention to the interests of insurance companies, Jim Dunnigan, one of the architects of the UHSR, proposed and successfully passed SB 294. The legislation is not considered part of the UHSR, but it was clearly related to the broader state reform efforts and sought to attract and retain insurance companies on the struggling state health exchange. SB 294 reformed regulation of insurance premiums. It allowed insurance companies to increase premiums for older consumers and for larger families, who were more likely to make health insurance claims, while decreasing rates for lower-risk consumers. Similarly, HB 404 and HB 18 sought to transition state civil servants into high-deductible health insurance plans with combined HSAs, and to transition thousands of civil servants onto the state health exchange, which critics interpreted as an attempt to conceal low participation. Only a few journalists, such as Kirsten Stewart of the *Salt Lake Tribune*, reported critically on this controversial legislation, but these pieces offered an important narrative of the UHSR and the challenges of the market-based approach to achieve comprehensive reform without mandates, subsidies, or stricter regulation of the insurance industry (Stewart 2011a, c; Utah 2011h, i, j).

Despite the unimpressive record of the UHSR by 2011, and notwithstanding the courage that journalists demonstrated in investigating and critiquing claims that, they believed, were designed to protect the image of the reform as a working, conservative alternative to Obamacare—and, in some critiques, to Romneycare—Republican-leaning narratives of health reform played a significant role in 2011 coverage. Some columnists defended the UHSR as an overall reform effort, or praised other conservative legislation

that emerged in 2011. Other columnists focused on attacking Obamacare.

Predominantly Republican (libertarian) narratives during the UHSR debates (2008-2011)

In 2008, during the earliest debates on the UHSR, the *incremental reform narrative* continued to be used to oppose comprehensive reform. In this case, however, it was deployed in support of the UHSR and other modest changes to the health care system such as public health campaigns (anti-smoking, etc.) and innovations such as HSAs, other tax credits, and cost-saving technological and administrative innovations. In one of the best examples of the *incremental reform narrative*, Brice Wallace quoted Scott Ideson, Chairman of the United Way of Salt Lake City Policy Committee and CEO of Regent Blue Cross Blue Shield (one of the state's largest private health insurance providers) who had been quoted in earlier pieces during the 2004 election period:

> "Meaningful reform of our health-care system will take several years to implement and must address the challenges of cost, access and quality together," [Ideson] said, adding that the United Way supports efforts to have a conservative, market-driven framework for reform that will enhance individual responsibility and consumer choice, while improving overall quality and access. (Wallace 2008)

Ideson's assertion was significant at the time. This article and a handful of similar pieces early in 2008 marked a shift in the complexity and target of the *incremental reform narrative*. By the time of the UHSR debates, the narrative had grown beyond its 2004 focus on individualism as an American value, and its favourable emphasis on such modest reforms as tax-free HSAs and other tax reforms designed to promote the purchase of health insurance, technology-driven solutions to reduce medical costs, and publicly financed healthy behaviour campaigns, even though those rather modest ideas remained, to be sure, a noteworthy part of the narrative. Now, however, it also emphasized options

such as tort reform, blaming the so-called litigation crisis for rising health care costs. For instance, a May 2008 *Salt Lake Tribune* piece on the national election campaign, criticizing John Edwards, stated the following: "[O]ne reason that health insurance rates are so high—and so many poor rural folks lack quality medical care—is because of Edwards' and other trial lawyers' success in convincing jurors that doctors owe the world always-perfect results" (Parker 2008).

The most important development in 2008, however, lay in the use of the *incremental reform narrative* – and the emphasis upon certain of its underlying values – to promote the merits of HB 133 as the Ideson quotation above demonstrates. In yet another example, Republican State Legislator David Clark and State Senator Sheldon Killpack wrote:

> True health care reform will not be quick or easy. Our current system has taken decades to evolve, and we do not presume to reform such a complex system overnight. With that in mind, we urge you to understand that it will take a period of time to change the system. There are broad interests that need to shift over time and the most difficult change will be ourselves and how we interact with the system. This past session, the Legislature approved a one-year task force that will begin building the framework for meaningful reform. However, this is by no means a one-year process. As we take the first important steps forward, we invite all of you to take these steps with us. In order for reform to take root, all stakeholders must come together and stay together. (Clark and Killpack 2008)

Clark and Killpack went on to emphasize the importance of small business interests, physician interests, cost containment, individual responsibility, and insurance portability. The article only mentioned uninsurance and access as a secondary, symptomatic by-product of cost. The values and priorities underlying the UHSR—gradualism, cost control, individual responsibilization in health, and government meekness in the face of insurance and other industry interests (a meekness cloaked in the guise of "solidarity")—

were clearly evident here.

Of course, architects of the UHSR such as Killpack and Clark were not the only writers who deployed the *incremental reform narrative*. In a February *Salt Lake Tribune* piece, Judi Hillman (Executive Director of the Utah Health Policy Project) declared:

> House Bill 133 is nicely positioned to take policymakers down the long, twisted path toward meaningful reforms….[The] bill has just enough hooks to address such hot-button issues as risk-management, affordability, mandating participation in coverage, the need to bring financing decisions into alignment with evidence-based medicine, etc. (Hillman 2008)

The Hillman quote is revealing in that it demonstrates that even reform advocates in civil society—people associated with the progressive, urban-based health reform movement—were using market-oriented language in their advocacy. Many other columnists used the *incremental reform narrative* to support the UHSR on both moral and economic grounds. According to one morning news section piece:

> Perhaps one of the most important issues handled by lawmakers was HB133, which sets in motion a task force process to reform Utah's health-care system. The underlying goals are to improve quality, ensure every Utahn has coverage and reduce costs. House Majority Leader David Clark, R-Santa Clara, has led thoughtful debate of these highly complex issues. (*Deseret News*, March 7, 2008)

With regard to the government's market-oriented approach, conservative reform proponents often celebrated Utah as the flag-bearer for a conservative approach to health reform as an alternative to federal intervention:

> Utah has the best chance of any state in the country to find real solutions for a consumer-driven, market-based system that places responsibility on individuals empowered with good information and choice. But it's going to require a few years of hard study and implementation. Anyone who thinks otherwise is terribly naïve. (Pignanelli and Webb, 2008)

Once again, the message was that Utah was a health reform leader, health care was an

individual responsibility, the best solution was market-oriented, and reform would be gradual. Typical of the *incremental reform narrative*, the above examples gratefully celebrated the efforts of state legislators, stressed the importance of the UHSR, emphasized the complexity of the issues in order to justify slower reform, and either framed Utah as a national leader in health reform or framed the UHSR as the best suited made-in-Utah approach in the context of national debates.

Although it was slightly less frequent in overall coverage, the *incremental reform narrative* remained the most important discourse of the political right throughout the UHSR debates. In some instances, it simultaneously attacked Obamacare and defended the UHSR, advancing the idea of Utah as the leader of the opposition. For example, according to a January, 2009 *Deseret News* editorial:

> The Legislature has other pressing issues before it, such as health-care reform….With a new federal administration in place, it is possible that Utah's health-care reform efforts could be overtaken by federal policy. In many respects, it makes more sense for Utah to craft its own programs and reforms. House Speaker Dave Clark, who has led Utah's reform efforts, must continue to make this a front-burner issue, continuing to involve all the major stakeholders. Somehow, the state must find a means to contain health-care costs, maintain quality care, provide access and create mechanisms that allow as many people as possible to obtain health-care coverage. (*Deseret News,* January 25, 2009)

In the above quote, the David-versus-Goliath depiction of the federal government as an aggressor and Utah as a besieged innovator was subtle. This type of states' rights argument was important because it represented Utah as an alternative to Obamacare and highlighted the state as the conservative reform leader that sought to liberate health care as a market and defend patients' rights as consumers.

By 2010, the *incremental reform narrative* expanded to include states' rights

discourse; this, together with favourable comparisons of the UHSR to the much-maligned ACA, was part of the general conservative backlash against Obamacare. For example, a *Salt Lake Tribune* piece in February 2010 juxtaposed the two reform programs in a way that clearly favoured the former:

> [Unlike the ACA, the] bill contains no mandates on consumers or small businesses to change their health care plans as the state shifts the system toward being more transparent and open to the 380,000 Utahns who have no medical care coverage now. The language directed at insurance carriers is not some kind of government "hammer" but a "firm hand in the back" that says the state trusts that insurance risk pools are shared as equitably as possible, but the state is going to verify that companies follow through on their commitment to do so. (Thalman, 2010)

This example and other instances of the *incremental reform narrative* throughout the year celebrated the UHSR while disparaging federal government intervention.

Interestingly, in a few nuanced articles that praised the UHSR and condemned the ACA in general terms, columnists celebrated the new federal tax on tanning salons that was included in the ACA, comparing it to Utah's tobacco tax and describing both as smart policy. These two rare examples of conservative support for tax increases to finance health care changes were consistent with the *incremental reform narrative*'s focus on individual responsibility, punishing unhealthy behaviour with so-called "sin taxes."

Some mentions of health care that fell within the *incremental reform narrative* emphasized the need to invest in prevention to encourage healthier lifestyle choices, or in technology to improve health outcomes or streamline program administration. Other conservative columnists celebrated state health policy innovation in general terms, or advocated entitlement reform with reference to Medicaid. The common link between the

different mentions of Republican-leaning health policy reforms within the *incremental reform narrative* remained a prioritization of cost containment over expansion of access (even though both priorities were acknowledged), and a preference for phased or minor changes in lieu of sweeping reform.

In contrast to the *incremental reform narrative* in favour of gradual reform, the *individual responsibility narrative* continued to appear in a handful of articles that were clearly opposed to health care reform. For example, conservative political activist and syndicated columnist Star Parker wrote:

> Suppose I tell you that the government will design a product and make you buy it. If you say no thanks, that's too bad. The government will decide what you need and what you will buy. If you say you can't afford it, [they say] we'll send in government investigators to check, and if they conclude, indeed, you can't afford it, we'll tax your neighbours and make them subsidize you so you can pay for it. We'll set up a government bureaucracy to monitor and make sure you're cooperating. If they discover you haven't made the purchase, they'll go to your employer and have your wages garnisheed. Let's assume further that total spending for this government-designed-and-mandated product accounts for about a fifth of the nation's total economy. The former Soviet Union? Communist China? No, this is the new Hillarycare. (Parker 2008)

In Parker's rather piercing and hyperbolic excerpt, we see perhaps the clearest manifestation of the conspiratorial thinking that was sometimes apparent in the individual responsibility narrative during the UHSR debates. According to this view, the system did not need to change, government intervention in health care was universally detrimental, Obamacare was "the new Hillarycare," and health reform advocates were determined to twist America into the Soviet Union or Communist China. As the exaggerated nature of these claims tends to suggest, writers such as Parker, speaking from less nuanced and more extreme positions, were part of a minority of conservatives who opposed comprehensive reform, informing at best a trickle of the extensive media coverage of the

UHSR.

By 2009, interestingly, the *anti-single-payer narrative* began to appear more frequently, becoming a major narrative. The increase in anti-single-payer mentions was directly linked to the federal reform debates; in fact, none of the anti-single-payer commentary focused specifically on Utah, where the incremental and moderate approach of the UHSR had already been established. More importantly in 2009, a new conservative reform narrative emerged in response to President Obama's federal health reform initiative. The *wrong reform narrative* held that health care reform was a misplaced priority. Columnists who advanced the narrative argued that the government should focus on improving the economy after the 2008 economic recession, or on other initiatives such as entitlement reform (Social Security or Medicare) to either privatize existing social programs or find ways to make them sustainable without tax increases. This narrative depicted Obamacare as an economically irresponsible expansion of the welfare state at a time when the government should have been implementing austerity measures. For example, according to one June 2009 *Deseret News* article:

> In theory, expanding public welfare could offset eroding private welfare. President Barack Obama's health-care proposal reflects that logic. The trouble is that the public sector also faces enormous cost pressures, driven by an aging population and rising health costs. The Congressional Budget Office projects the federal debt to double as a share of the economy (gross domestic product) to 82 percent of GDP by 2019. Any sober examination of figures like these suggests that the system has promised more than it can realistically deliver. We are borrowing not to finance investment in the future but to pay for today's welfare – present consumption. Sooner or later, the huge debt will weaken the economy. Nor would paying for all promised benefits with higher taxes be desirable. Big increases in either debt or taxes risk depressing economic growth, making it harder yet to pay promised benefits. The U.S. welfare state is weakening; insecurity is rising. The sensible thing would be to decide which forms of public welfare are needed to protect the vulnerable and begin paring others. (Samuelson 2009a)

Similarly, according to another *Deseret News* column in June:

> It's hard to know whether President Barack Obama's health care "reform" is naïve, hypocritical or simply dishonest. Probably all three. The President keeps saying it's imperative to control runaway health spending. He's right. The trouble is that what's being promoted as health care "reform" almost certainly won't suppress spending and, quite probably, will do the opposite. (Samuelson 2009 b)

Like the increase in anti-single payer coverage, the arrival of the *wrong reform narrative* was part of a broader shift in focus of the Utah newspaper media from the UHSR to the federal debates.

By 2010, the *wrong reform narrative* appeared more frequently, claiming the dominant position in health care coverage on the political right in 2010. It was typically used to attack Obamacare without referring to the UHSR as the alternative. It continued to be deployed against federal government involvement in health care reform in general, but the types of coverage became more diverse during the final tense Congressional debates from between January and March of 2010, and after the passage of the ACA. One of the most common arguments against the ACA in 2010 was that it was too expensive and would fail to control costs. In a few cases, criticism of Obamacare simultaneously condemned Romneycare. For example:

> Government-run health care has been tried in Massachusetts…and it's a disaster. According to Peter Suderman, Associate Editor at *Reason* magazine, "since 2006, the cost of the state's insurance program has ballooned by 42 percent, or almost 600 million. According to an analysis by the Rand Corporation, 'in the absence of policy change, health care spending in Massachusetts in expected to nearly double to $123 billion in 2020, increasing 8 percent faster than the state's gross domestic product.' Insurance costs in Massachusetts are the highest in the nation and double-digit rate increases are expected again this year. Yet, President Obama claimed Saturday that under the Democrats' plan, rates would go down. How is this possible? The only reason Massachusetts hasn't become insolvent is because of large transfusions of cash from Washington, which perpetuates the illusion the program works." (Thomas 2010)

Other versions of the *wrong reform narrative*, while consistently condemning both insurance mandates and the cost of the reform, expressed concern that abortions might be funded by insurance plans through Obamacare (despite an executive order to the contrary, which President Obama signed to appease moderate Democrats). It was also common for these commentators to cite Scott Brown's victory in Massachusetts (in the late Senator Ted Kennedy's former district) as evidence of public outrage against health care reform; the outcry and promise of lawsuits from the legislatures of Utah, Virginia, Idaho, and other states; the vote of Representative Jim Matheson (Utah's only Democrat in Congress) against the ACA; and allegations of corrupt deals and "pork" spending said to have persuaded various Democratic members of Congress to vote for the bill. These writers also frequently celebrated the Tea Party campaign against Utah Republican Senator Bennett, a campaign reflecting members' anger over his sponsorship of a similar, yet ultimately unsuccessful bill (the Healthy Americans Act), which, as noted above, Bennett had co-sponsored with Democratic Senator Wyden. Particularly infuriating to far-right conservatives, the Bennett-Wyden bill contained insurance mandates similar to those of Romneycare and Obamacare. For many columnists who advanced the *wrong reform narrative*, any record of bipartisanship or cooperation with Democrats was worthy of condemnation and ire. Of course, more progressive narratives were deployed to depict these same intersecting events differently.

By 2011, towards the end of the UHSR debates, the *wrong reform* and *incremental reform narratives* remained the dominant discourses on the right. Columnists often opposed Obamacare because they thought it was too expensive. In some cases, even if they begrudgingly admitted that the ACA improved access, they represented it as a

failure for not controlling costs. For example: "What we have discovered is that although the law ham-fistedly addresses some of the issues regarding access, it does nothing to control spiralling health care costs, and likely adds to them" (*Deseret News,* March 25, 2011). Similarly, other critics charged that the Obama Administration had resorted to dubious budgeting practices to conceal the real price of reform:

> Consider Democrats' mishandling of $500 billion in Medicare funds. Rep. John Shimkus, R-Ill., grilled Health and Human Services Secretary Kathleen Sebelius at a March 3 Capitol Hill hearing. "Your law cuts $500 billion in Medicare," Shimkus reminded Sebelius. "Then you're also using the same $500 billion to say you're funding health care (reform). Your own actuary says you can't do both." So, Shimkus continued, "are you using it to save Medicare, or are you using it to fund health care reform? Which one?" Secretary Sebelius confessed: "Both." "So, you're double-counting," Shimkus replied. "The same dollar can't be used twice," observed Rep. Joe Pitts, R-PA. (Murdock 2011).

This sort of juxtaposition—apparently deceitful Democrats, hiding the true costs of Obamacare, set against fiscally responsible Republicans looking out for taxpayers—was a favoured portrayal of health reform politics in the *wrong reform narrative*.

Other state newspaper critics treated Obamacare as an affront to the principles of Republican government:

> To highlight the offensiveness to liberty that democracy and majority rule is, just ask yourself how many decisions in your life you would like to be made democratically. How about what car you drive, where you live, whom you marry, whether you have ham or turkey for Thanksgiving dinner? If those decisions were made through a democratic process, the average person would see it as tyranny and not personal liberty. Is it no less tyranny for the democratic process to determine whether you purchase health insurance or save for retirement? (Williams 2011)

The individual mandate to purchase health insurance was a frequent target of Obamacare opponents, and critics like Williams often wrote as if the mandate was an unprecedented

imposition upon individual consumers by government for the sake of the common good (in this case, with the goal of achieving economic and social stability through more equal access and cost control). They mostly ignored existing legal requirements to purchase car insurance, licensing rules to practice many professions, and other individual restrictions that were designed to protect the public interest—constraints that had already become broadly accepted duties of good citizenship.

In addition to venting their anger at individual and employer mandates, and launching partisan economic arguments against Obamacare within the *wrong reform narrative*, Republican-leaning columnists found other reasons to decry the federal reform. The fear of increased abortion rates and the view that health care reform was the wrong priority during the recession, both of which had emerged as part of the narrative in 2010, remained current through 2011. Other columnists alluded to the infamous (and entirely fictitious) "death panels" of bureaucrats who would make life-or-death health care decisions (e.g. *Deseret News*, January 3, 2011); alleged that the reform was unconstitutional and supported the state lawsuits to prevent implementation (e.g. *Deseret News*, March 13, 2011); or argued that the need for temporary waivers for some employers and labour unions proved that the ACA was misguided and unworkable (e.g. Pear 2011c). Interestingly, none of the same columnists decried the terror and suffering that the private insurance industry had imposed on millions of Americans through its actuarial practices—practices that denied and delayed essential medical treatments, and sacrificed quality health care on the altar of profit.

In sum, Obamacare was a target that attracted a complex range of criticisms. While rationales for opposition differed, the common threads in the *wrong reform*

narrative were appeals to readers' fear of government and their sense of traditionalism. These authors emphasized the costs of reform and increased bureaucratic power and interference. They likewise depicted Obamacare as a threat to American traditions of constitutionalism (limited government), market capitalism, and conservative family values. They wanted to see Obamacare repealed and, in some cases, replaced with a health reform plan that reflected their values and priorities.

Predominantly Democratic narratives during the UHSR debates 2008 - 2011

In 2008, the shapes of progressive narratives were largely consistent with the forms they took during the 2004 election campaign. The *expanded access narrative* was the most frequently deployed in the two major dailies. The tone of the articles in which it emerged was not noticeably different from that of stories in 2004—or, for that matter, from that of the *expanded access narrative* during the Massachusetts debates. Most of these examples were either human-interest stories that depicted the struggles of the uninsured and underinsured, or news pieces that foregrounded access to health insurance as the primary problem or at least a major challenge in the health care system. Sometimes, the crisis of access to insurance and care was the focus of an entire article, while at other times articles only included a single mention of increasing access as the primary challenge or goal of reform. Bernick (2008), for example, described the task as follows: "Lawmakers must continue down the road to health-care reform, aimed at getting health care for Utah's 300,000 uninsured."

Notions of deservedness within the *expanded access narrative* were articulated in more diverse over time. New groups that had not been previously singled out previously

as people who suffered from unequal access—undocumented immigrants, women (without children), young adults, and the disabled—began to be mentioned in 2010 within the context of perceived winners and losers in the passage of the ACA, and in reporting on the removal of the "gender-rating ban" in Utah's HB 294. As the foci of articles that drew attention to cases of alleged exclusion from the system became more diverse, the lists of victims in question expanded to include aging Americans who did not yet qualify for Medicare, recent university graduates, and ethnic minorities. For example, a March 8, 2008 *Salt Lake Tribune* piece zeroed in on racial inequality in health insurance coverage: "Among blacks, 20 percent lack health insurance, compared with 11 percent of whites" (Jackson 2008). Notions of deservedness continued within the *expanded access narrative* through 2011. Nonetheless, many columnists still focused on insurance access as a middle class, generalized problem without invoking notions of deservedness.

The *expanded access narrative* maintained its dominant position through 2010, appearing in coverage more frequently than any other narrative. The tenets of the *expanded access narrative* remained unchanged throughout the UHSR debates, though they adapted in response to changing circumstances. For instance, in 2010, newspaper media reporting on the "White Coats" campaign—a coalition of Utah physicians, academics, and a variety of other health care and medical research professionals who favoured the federal ACA, and sometimes criticized the state government for opposing federal reform—was a new variation on the *expanded access narrative* deployments.

As provisions of the federal ACA were implemented in phases, and the challenges of uninsurance and the lack of insurance portability continued to impact millions of

families, the *expanded access narrative* remained an important and effective way to depict the health care crisis. For instance, the circumstances of one family in Taylorsville, Utah, were described in a June *Salt Lake Tribune* piece:

> Jonah [a seven-year old] suffers from blood problems—sickle haemoglobin D disease and pyruvate kinase deficiency. He has undergone open-heart surgery, and he's waiting for a bone-marrow donor. "You always have to be on guard," his mother said. "You always have to make sure that he's taken care of. Every day, you have to make sure you're on your game." She had to give up her job to care for him, which meant she lost the family's health insurance. (Pierce 2011)

In addition to the human-interest stories, other examples of the *expanded access narrative* cited statistics or described the access challenges that Medicaid recipients faced, since Medicaid payment rates to physicians were lower than those of private insurance companies, and doctors were not required to accept any particular insurance plan.

Similarly, the *economic security narrative* was another pro-reform holdover from 2004; as in the past, it tended to emphasize the financial impacts of the high-cost health care system on either the national or state economy. Writing in the *Deseret News*, for example, Thalman (2008) noted: "Whether by fate or by choice, the state can no longer put off a revolution in the health-care system that, if left to its own devices, would account for every dollar in the state economy in about 30 years." The Thalman article highlighted Utah's broader reform effort and gave a rough timeline to the impending economic crisis, a timeline that varied between articles over the course of the UHSR debates. In other pieces, the *economic security narrative* focused on federal reform and ignored Utah's health debates entirely.

Like the *expanded access narrative,* the *economic security narrative* also declined

in frequency over the course of the UHSR; yet it remained one of the driving discourses in favour of comprehensive reform. The *economic security narrative* continued to be an important progressive narrative in favour of healthcare reform, but its frequency declined noticeably between 2009 and 2010. By 2011, instead of presenting economic arguments in favour of passing Obamacare, it evolved slightly to make the case that Obamacare would eventually reduce health care costs or that it was already beginning to help control costs, but needed more time before it could be evaluated.

Since the *economic security narrative* had been deployed to help make the case for health reform in Massachusetts and federally in the Obamacare debates, it is not surprising that it declined during the UHSR debates across time, since Obamacare was passed by Congress in 2010 and seemed to have a reasonable chance of surviving over the long term. In fact, the decline in deployment of both the *economic security* and *expanded access narratives* is at least somewhat explained by the passage of the ACA and the continued implementation of the UHSR legislation, which partially mitigated the need to argue for moderate reform on economic grounds, and simultaneously reduced attention to the crisis of access.

Progressive writers did not, however, limit themselves to earlier narratives of health care reform; events over the course of the UHSR caused them to adopt other strategies. As Republican lawmakers decreased the comprehensive ambitions of the UHSR and HB 133 took shape in 2008, some critical journalists came to promote the *inadequate reform narrative*. Early supporters of the UHSR, such as Judi Hillman of the Utah Health Policy Project, were quick to point out perceived shortcomings in the legislation:

> However, HB 133 contains a provision that would harm low-income children. It prohibits enrolment of a child in the Children's Health Insurance Program if the child's parent qualifies for a premium subsidy under the Utah Premium Partnership Program. (Hillman 2008)

Thus, as the Hillman piece demonstrates, the *inadequate reform narrative* sometimes appeared alongside the *incremental reform narrative*, supporting the reform legislation while revealing its potential inadequacies in an attempt to push legislators to pass more comprehensive reform over the long-term. Later, as the shape the legislation was taking began to disappoint more journalists and health reform advocates, the *inadequate reform narrative* became more critical.

A noteworthy subset of columnists who deployed the *inadequate reform narrative* suggested that the UHSR had been more ambitious at the outset, arguing that its scope at the beginning was similar to that of Romneycare. These articles revealed, however, that over time legislative debates held behind closed doors, together with the influence of the insurance and pharmaceutical industries, had shaped the UHSR into a less comprehensive plan. The initial reform strategy that Governor Huntsman allegedly preferred would have included an individual mandate, much like Romneycare or Obamacare; but the mandate lacked legislative support (Gehrke 2011). According to columnist Paul Rolly:

> The original plan was to insure all Utahns through a clearinghouse based in the Governor's Office of Economic Development. By the time Clark introduced his bill that had deteriorated into a baby-step measure to help more Utahns get private insurance through tax credits and/or subsidies. But now even those proposals will be delayed. (Rolly 2008)

In a similar March 2008 editorial:

> So where does all this leave us? We like the idea of making health insurance more affordable to individuals who must buy their own coverage. It is a very small down payment on health-care reform, although without major

> structural overhauls, it's not very meaningful. (*Salt Lake Tribune,* March 3, 2008)

Other articles that included the *inadequate reform narrative* emphasized the vagueness and limited scope of the legislation:

> But the language of HB133 makes any real ox goring unlikely. Twenty-three of the 35 pages of the bill represent no (or very little) change in current statutes dealing with health insurance rating, the tax code, and the workings of the small group and individual health insurance markets. In the remaining few pages of the bill, the departments of health, insurance, workforce services and the Governor's Office of Economic Development are given various tasks related to health-system reform, but with no real force of intent. (*Salt Lake Tribune,* February 18, 2008).

Still other authors focused on the resistance of powerful insurance and pharmaceutical lobbies:

> In an early draft, HB133 would have required every Utahn to have health insurance by 2010 and called for new insurance plans to cover everyone without charging higher premiums based on medical history. But those ideas met resistance from lawmakers opposed to mandates and insurers who believe health reform first should zero in on wasteful spending, not improved access. (Rosetta 2008)

Key words in the above quotations, such as “deteriorated,” “baby-step measure,” “very small down payment,” “not very meaningful,” “very little change,” and “no real force of intent” are indicative of the manner in which this narrative played a key role in media coverage of the UHSR. These simultaneously qualifying and derogatory descriptions demonstrated substantial nuance in media coverage, since they occurred in articles that were favourable to health care reform in general, yet simultaneously criticized aspects of the state reform effort.

In some cases, the *inadequate reform narrative* was apparent in brief mentions of what the UHSR did *not* set out to accomplish. For example, citing Medicaid subscribers

in a protest at the Capitol building during the HB 133 debates, Thalman writes:

> A letter from the group given to House and Senate leadership states that whatever reform initiatives are approved, "if basic healthcare services like Medicaid vision and dental are cut then this year's healthcare reform efforts will have been a failure. (Thalman 2008)

Here the *inadequate reform narrative* functioned discursively as a twist on two logical fallacies—a red herring and a straw man. It ignored what the UHSR aimed to do, emphasised what it did not aim to do, and derided the legislation for not doing something that was never part of its mandate. Some columnists who employed the *inadequate reform narrative* against the UHSR defended the Obamacare/Romneycare approaches to health care reform as the best alternative.

By 2009, however, as the UHSR progressed parallel to the increasingly acrimonious Obamacare debates, perhaps the most interesting change in the Democratic-leaning media was the conspicuous decline in the *inadequate reform narrative*, which became an infrequent and very minor narrative. This may have been due to the media's broader shift in focus to the federal debates, since the *inadequate reform narrative* was critically focused on the UHSR. Despite the decline, columnists who advanced the *inadequate reform narrative* continued to suggest that the UHSR did not go far enough, arguing that government should play a more active role in addressing the health care crisis. The narrative remained important to understanding the debates, since the journalists who advanced it brought to light perceived shortcomings in the UHSR through comparison to other reforms. On piece, for example, combined mentions of the *inadequate reform* and *expanded access narratives* with support for single-payer as another alternative:

> They want to try to fix Utah's health-care system with market principles and personal responsibility. Fair enough. We like markets, too, especially when they contain costs and reward innovation. Trouble is, health care is a broken market, or a captive one, its facets are mind-numbingly complex, and Utah legislators are trying to re-invent it incrementally. If this effort works, great. If not, Utah leaders will have to try something else, such as the Massachusetts model that mandates that everyone buy coverage, or a single-payer plan. We believe either of these is more likely to achieve universal coverage than the Utah plan. (*Salt Lake Tribune*, February 21, 2009)

This passage and others indicated that Utah's effort to expand insurance coverage with market logic was not working as well as state planners had hoped, and it was not instilling universal confidence in the press. The *inadequate reform narrative* emphasized the potential insufficiency of the Utah approach to reduce expenditures and insisted that the state should consider the Massachusetts model (or even a single-payer plan) as plan B.

In 2010 and 2011, journalists continued to criticize the UHSR as they had in previous years, arguing that the state's approach was not aggressive enough to reduce uninsurance. By that time, however, reporters had more data to support their arguments. For instance, one *Salt Lake Tribune* column cited a recent state report on uninsurance trends:

> There was little change last year in the number of Utahns who went without health insurance. The state's ranks of uninsured included 301,700 people in 2010, about 10.6 percent of the population, according to an annual census by the Utah Department of Health. That's a slight improvement over the 314,300 Utahns who went without coverage in 2009, but statistically insignificant, say health officials. "Despite the fact that nearly 13,000 fewer Utahns were uninsured last year, it's tough to take any comfort in these data," said state health director David Patton in a prepared statement on Wednesday…Under national health reform, all citizens will have access to federal exchanges by 2014. And most moderate-income families will qualify for subsidies to help pay for their health plans….Wednesday's report also emphasizes the importance of such low-income public health benefits as Medicaid and the Children's Health Insurance Program (CHIP). Without these programs, Utah's uninsurance rate would exceed 20%.

(Stewart 2011d.)

The Stewart piece not only presented a story of failure for the UHSR, arguing that the state health exchange had an insignificant impact between 2009 and 2010, but it also pointed out that without means-tested federal programs that provided health insurance to poor children and adults, Utah's uninsurance rate would have nearly doubled.

Beyond the criticisms of the UHSR that had existed since 2008, controversial state legislative reforms related to the UHSR prompted new, especially poignant critiques in 2011. For example, in response to the proposed Medicaid reforms that the state was planning in order to reduce its outlays when new federal eligibility requirements took effect, Stewart (2011) wrote:

> A surprise late addition proposes allowing eligible Utahns to forgo Medicaid in favour of subsidies to purchase private health policies on Utah's Health Insurance Exchange. Whether families would jump at the offer is unknown. "There is no reason to suppose Utah's health insurance exchange, with its bewildering choice of 142 plans, will serve the Medicaid population at all adequately," Hilman said. But assuming it could, research has shown Medicaid to be a more cost-effective alternative to subsidized insurance, at least for the poorest of the poor, she said. (Stewart 2011e)

In the above instance, the author used a typically conservative argument for cost-effectiveness to defend what was broadly perceived as a liberal federal program. In addition to providing unfavourable representations of the state's Medicaid reforms, other critical pieces criticized the anti-abortion bills. They also drew attention to Utah legislation that progressive reporters interpreted as disingenuous attempts to increase consumer enrolment and retain insurance providers on the exchange to create an illusion of successful reform:

> Federal health reform will bring exchanges to all states in 2014, though they'll

> look much different from Utah's, which has been plagued by high premiums and low enrolment. "We need to make Utah's exchange more enticing, not less," said Lincoln Nehring, senior health policy analyst at Voices for Utah Children. The latter is what Nehring fears would come of legislation that would bar insurance companies from marketing on the exchange policies that cover elective abortions. Sponsoring Rep. Carl Wimmer, R. Herriman, pitches HB 354 as a way to guard against public money, in the form of federally subsidized insurance, being used to fund abortions…Another bill, meanwhile, could artificially boost enrolment in the exchange. HB 404 would direct lawmakers to scour the Public Employee Health Plan for places to cut costs and consider dumping its 25,000 beneficiaries, mostly state workers, into the exchange. Insurance companies, brokers, and the union representing public employees oppose the bill, sponsored by Rep. Don Ipson, R-St. George. "There are forces at play to say that the way to make the exchange look successful in Utah is to drive public employees into it. Instantly, you'll have 25,000–30,000 belly buttons in it," said Kelly Atkinson, a lobbyist for the Utah Health Insurance Association. "If the exchange is to be successful, it should stand on its own." (Stewart 2011f)

In the last example, the state government was portrayed as both destructively partisan and deceitful, simultaneously preventing Utahns from benefiting from federal reform and hiding the challenges of the UHSR. While the *inadequate reform narrative* accounted for only a small overall percentage of coverage by the end of the UHSR period in 2011, the representations in these mentions were an important part of the story.

7.6 Lessons from the Utah Case

Similar independent, endogenous, and exogenous variables in the Utah and Massachusetts reform efforts

The legislative successes witnessed in Utah and Massachusetts are related to a set of variables common in the two cases. In analyzing them, we can look to Canadian scholars Harvey Lazar, John Church, John N. Jarvis, and Pierre-Gerlier Forest, who (examining a number of health reform efforts in Canada) note that "independent," "endogenous," and "exogenous" variables are part of a complex interaction that influences reform outcomes (Lazar et al. 2013: xi; Lazar 2013: 1-20). Lazar identifies

independent variables as the "institutions, interests, and ideas" that impact reform outcomes. *Endogenous* variables include the "insider interests," such as politicians and senior civil servants, who can set the direction of reforms or redirect them. *Exogenous* variables are those "outsider interests" such as lobbies, health care worker unions, and physician associations that represent health care professionals, the voting public, economic conditions, technological changes, and the media that can impact reform efforts (Lazar 2013:1-20).

In both Massachusetts and Utah, notable independent variables included the broader institutional and programmatic framework—the existing federal programs and systems within which the state governments had to operate as they pursued policy changes. The state governments could not change Medicare or the Veterans Health Administration since these are uniquely federal programs. They only had partial control over Medicaid and CHIP as jointly funded state-federal, means-tested programs. Arguably, the ideological delineation of the neoliberal health policy window was another independent variable to which the states had to adapt as competing interests attempted to shape the legislation. While more progressive reformers might have preferred fringe social investment state policies that would have guaranteed universal access, and more libertarian reformers would have preferred fringe policies tailored to create a type of health market anarchy without government oversight or interference, both states settled on reforms that fit within a neoliberal health policy window.

Of the two states, Massachusetts settled on a version of reform located relatively closer to the left side of the neoliberal policy window: individual and employer insurance mandates, subsidies to assist lower income people to purchase private insurance, more

investment in Medicaid to cover the poorest residents, a more complex and regulated online health insurance exchange, and greater regulation of the insurance industry. The architects of Romneycare essentially saw the state as the handmaiden of the health insurance market—using a combination of corporate welfare, subsidies and regulations to protect the insurance industry from its own abuses that undermined consumer confidence, and to preserve the faltering employment-based insurance system. For its part, Utah settled on a reform that tended more toward the right side of the neoliberal policy window: a less regulated online health insurance exchange, a greater focus on tort reform, a state government that encouraged and facilitated market participation without compelling it (no insurance mandates), no subsidies for the purchase of private health insurance, and no Medicaid expansion. The architects of the UHSR had a more market-purist view, albeit one in which the state took minor steps to aid market functioning and control costs.

There was also noteworthy overlap in endogenous variables in the two cases. Both states had moderate Republican governors with broader, national political ambitions who wanted to cite successful health care reforms on their political resumes. Both states had legislatures in which a single party (Massachusetts Democrats and Utah Republicans) enjoyed such significant majorities that they did not rely on substantial collaboration across party lines. Legislators in both states had close working relationships with the private health insurance industry, as did key advisors to Governors Romney and Huntsman. In fact, some of these insiders in the executive and legislative branches, such as Massachusetts gubernatorial candidate Shannon O'Brian and Utah House Majority Leader Jim Dunnigan (to cite just two noteworthy examples), had previously worked in

health-care-related industries, and these links were exposed in newspaper media coverage (Bailey 2002; Utah 2015).

Finally, in terms of exogenous variables, rising health care costs and uninsurance rates were motivating economic and political factors for both states (although to a much greater extent in Massachusetts). The arrival of online health insurance exchanges was a motivating variable as a technological innovation. Physicians and the leaders of associations that represented physicians and other health care workers, as well as the insurance industry and business lobbies, weighed in on the reform debates in the media, largely favouring reform yet seeking to direct the new policies that were under debate. The influential role of the insurance industry and medical lobbies in the Massachusetts and Utah cases is consistent with other research on the influence of these groups in shaping health policy in the United States (Potter 2013). The newspaper media in both states was mostly supportive of health care reform, and articles included far more neoliberal than challenging narratives of health care.

Lessons from media reactions to the UHSR

The media treated the UHSR as a determined health care reform effort that stemmed from sincere intentions to address the challenges of cost, access, and quality in the Utah health system. Media representations also made it clear that the architects of the reform—including Governor Jon Huntsman, Representative Jim Dunnigan, Representative Dave Clark, Senator Sheldon Killpack, and later Governor Herbert (to name few key leaders)—decided to diverge from the Massachusetts model that eventually informed Obamacare. The UHSR reformers did not include insurance mandates, new broad insurance industry regulations, or subsidies to help low-income Utahns purchase

insurance. They believed they could achieve comprehensive health reform by relying on market principles, implementing torts reforms, and facilitating access to a private health insurance exchange. State lawmakers simultaneously sought to ensure that their health reforms would not indirectly facilitate abortion services.

It is clear from newspaper media reporting that, in the effort to expand access for the uninsured and to control both public and private health care outlays, state lawmakers aimed to reassure the insurance industry that its profits and traditional role in the employer-based private health insurance market would be protected. The state's health insurance industry and broader small business community were closely consulted as the UHSR legislation was developed, and leading insurance executives contributed to the media debates on health reform, helping to advance the *incremental reform narrative*. The overall tone of UHSR newspaper coverage in the media was more conservative than it had been in Massachusetts, with the frequency of Republican-leaning reform narratives increasing and the Democratic-leaning narratives decreasing across time. Despite this, many of the same Democratic-leaning narratives that had been deployed during the Romneycare debates in Massachusetts were present in the UHSR debates in the state newspaper media—especially in the *Salt Lake Tribune*—where a handful of reporters tried to advance a diversity of views during the UHSR debates, holding lawmakers accountable for compromises that these journalists believed would limit the effectiveness of the reform.

For its part, the national newspaper media was less interested in the Utah Health System Reform than it had been in the Massachusetts Health Reform Law. The gap in national media interest in the two state reforms may have stemmed from the fact that the

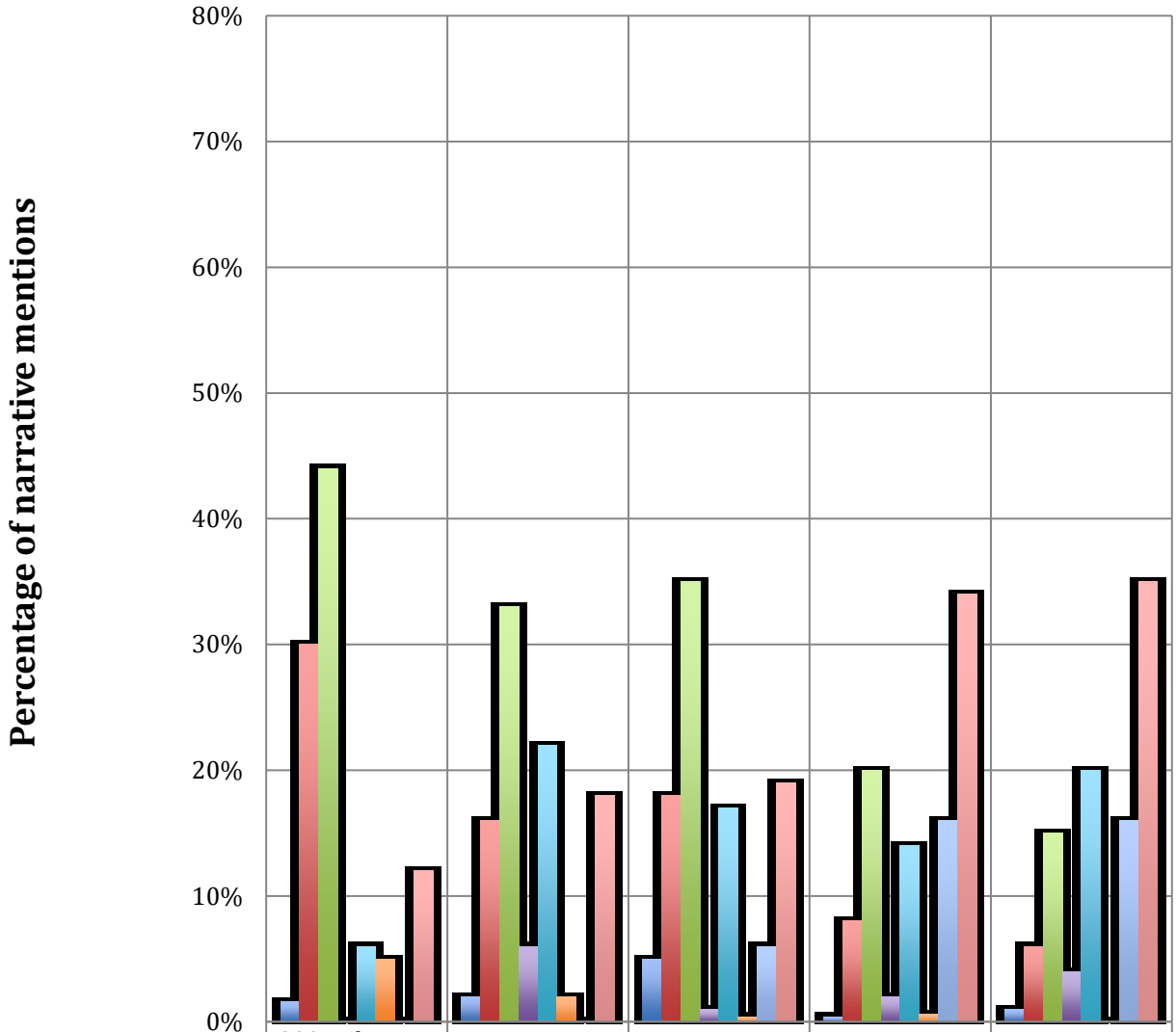
Massachusetts reform took inspiration, and was less than a decade removed, from the Clinton administration's failed 1994 Health Security Act that had created so many media waves. The national newspaper media virtually ignored health care in Utah from the 2004 election period through the UHSR implementation of 2008-2011. National interest in Utah's contribution to the health care debates reached its high point in 2009-2011, when a handful of conservative journalists and Republican politicians were trying to frame Utah as the ready-made alternative to Obamacare; but the coverage remained negligible.

The state newspaper media followed the evolution of the UHSR with variable interest. After all, the reform spanned so many years that media attention was bound to wax and wane. Interestingly—though perhaps not surprisingly—health care reporting often focused more on the national debates after 2008 than the ongoing state debate, sometimes without linking the simultaneous efforts. The contradiction, in terms of both ideological foundations and characteristics between the UHSR and the federal ACA—as well as the standoff between the state and federal government—nonetheless inspired noticeable media waves in the *Deseret News* and the *Salt Lake Tribune,* especially in 2010-2011. Democratic-leaning writers (represented mainly by the *Salt Lake Tribune*) were more interested in expanding access quickly, more supportive of Obamacare, and more critical of the UHSR. Republican-leaning columnists (whose work appeared mainly in the *Deseret News*) were more supportive of the UHSR and more critical of Obamacare. Both sides were concerned with reducing or controlling public health expenditures. Thus, the Obamacare debates had the effect of both multiplying and fragmenting lines of debate at the state level, and of re-directing media attention away from state-level reform to focus on the federal health policy controversy.

Chart 7.2[92] depicts the frequency of the influential health reform narratives of the UHSR at critical junctures, demonstrating the comparative trajectory of the *expanded access, economic security, incremental reform, individual responsibility, inadequate reform, wrong reform,* and *anti-single-payer narratives* during the Utah health system reform.

[92] Based on 1,734 articles in the *Salt Lake Tribune* and the *Deseret News* between the 2004 Utah election campaign period and the periods surrounding legislative debates and passage of the seven components of the UHSR from 2008 – 2011.

Chart 7.2: Influential health reform narratives and other health news in the *Salt Lake Tribune* and the *Deseret News* (UHSR) 2004, 2008-2011



	2004 Election campaign	2008 UHSR	2009 UHSR	2010 UHSR	2011 UHSR
Anti-single payer narrative	2%	2%	5%	0.40%	1%
Economic security narrative	30%	16%	18%	8%	6%
Expanded access narrative	44%	33%	35%	20%	15%
Inadequate reform narrative	0%	6%	1%	2%	4%
Incremental reform narrative	6%	22%	17%	14%	20%
Individual responsibility narrative	5%	2%	0.40%	0.60%	0%
Wrong reform narrative	0%	0%	6.00%	16.00%	16%
Other	12%	18%	19%	34%	35%

As had been the case in media coverage of the Romneycare debates in Massachusetts, analysis of major health reform narratives at critical junctures during the UHSR reveals ascendant, descendant, undulating, and fleeting news cycle narratives of health care and reform from 2004 to 2011. Collectively, the deployments of the seven major health narratives in Utah demonstrate that the newspaper media increasingly represented Utah as a state that acknowledged its need for health care reform and showed exceptional initiative as a state government in taking on the challenge; these phenomena likewise mirrored trends in Massachusetts. In this case, however, Utah was represented as a state resolved to meet its challenges through conservative policy innovations, even in opposition to the reform preferences of the federal government. Massachusetts, by contrast, had been represented as a state that took the initiative to innovate in the face of federal inaction.

Like that of Massachusetts, Utah newspaper reporting was, on the whole, favourable to some type of health care reform. Newspapers in both states favourably represented the expansion of access to insurance coverage and the reduction of public health expenditures as necessary and appropriate reform objectives, without advocating radical—which, on the social investment left of the political spectrum, would mean either single-payer or more regulated mandatory insurance with an explicit goal of universal insurance coverage; or, on the right of the political spectrum, libertarian market-fundamentalist restructuring to deregulate the health insurance market and eliminate existing public programs in order to compel market participation— systemic reform.

Three of the same major neoliberal narratives that had previously appeared during the Massachusetts debates—the *expanded access, economic security,* and *individual*

responsibility narratives—resurfaced in Utah. The diffusion of these narratives from media coverage of the Romneycare debates from 2002-2006 to the UHSR debates of 2004-2011, and their status among the most frequent journalistic representations of health care, broadly demonstrates neoliberal supremacy in conceptualizations of health, demonstrating an overarching neoliberal meso-narrative. However, the trajectories of these narratives across time differed in the two reforms, demonstrating Republican and Democratic differences within the neoliberal policy window. The frequency of Democratic-leaning narratives as a proportional percentage of newspaper coverage decreased or stagnated across time in Utah, while that of key Republican-leaning narratives—namely, the *incremental reform narrative* and the *wrong reform* narrative—increased; whereas in Massachusetts, the Republican-leaning narratives were less significant, and the frequency of Democratic-leaning narratives that celebrated state health reform efforts (e.g. the *narrative of leadership and innovation in state health policy*, and the *narrative of Massachusetts leadership in national health reform*) increased across time.

In Utah, the number of articles in the "other" category—those favourable, unfavourable, and neutral pieces that did not include developed health reform narratives, as well as minor narratives of health care that appeared in fewer than 5% of articles—also increased proportionally over time and accounted for a greater percentage of coverage than they had in Massachusetts. The higher percentage of "other" health care reporting in Utah related to the fact that the UHSR paralleled the Obamacare debates and, as such, casual mentions of health care reform that provided little detail and made no reference to either favourable or unfavourable narratives, became more common. In Utah, as had been

the case in Massachusetts, some major health reform narratives were one-year-wonders (appearing in 5% or more articles at only one critical juncture) or were only deployed in two or three periods of analysis. In each case, these narratives were context-dependent, linking to other stories that were making media waves at that particular time.

Some health reform narratives stand out as defining and differentiating in UHSR coverage, as they remained prominent in newspapers over several years. The neoliberal *expanded access* and *economic security narratives*—both of which had carried over from the Massachusetts debates—were in favour of health care reform, yet differed vis-à-vis the problem they treated as the primary impetus of reform (the economy or access), though they frequently appeared together. Columnists who deployed the *economic security* and *expanded access narratives* supported comprehensive changes to reduce costs and increase systemic sustainability or expand access to insurance and care (without calling for universal access). These two major narratives were neoliberal in the sense that they rejected the notion of health care as a right. They did not call for universal access, but instead sought to improve and preserve private health care markets in which both the quality of, and access to, health care were unequal and hierarchical (based on ability to pay). Both the *expanded access* and *economic security narratives* were deployed less frequently over time, as the UHSR and Obamacare reforms progressed. Proponents of the *incremental reform narrative,* which was new to the UHSR debates*,* for their part favoured minor changes, such as HSAs and public health campaigns or economic incentives that encouraged individuals to live healthier lifestyles and take more responsibility for their own health. Finally, two other new narratives that had not existed in Massachusetts because the reforms had not yet occurred—the *wrong reform* and

inadequate reform narratives—were critical narratives that were used in opposition to either the UHSR or Obamacare and often favoured the other competing reform.

The Utah case shows that the newspaper media took noticeably less interest in a major state-level health reform when it coincided with a federal health reform. In other words, while Massachusetts had helped to set the federal health reform agenda at a time of federal inaction in health policy (2002-2006), the Utah reform effort was essentially dwarfed by the federal Obamacare debates (2008-2011). As Obamacare took shape in terms of policy proposals, and progressed through Congress in a partisan battle that attracted incessant media scrutiny, even Utah's state level media paid more attention to the federal reform that the state's own efforts. As was the case in Massachusetts, the most common neoliberal narratives of health reform and the health care system in Utah diffused across Republican-leaning and Democratic-leaning newspapers. As in Massachusetts, too, more radical narratives—regardless of whether they advanced social investment state, single-payer reform, or market fundamentalist, libertarian reform proposals—were mostly minor (appearing in less than 5% of articles in any reform period) and diffused less effectively across newspapers. The comparative deployment of ascendant, descendant, undulating, and fleeting news cycle narratives again demonstrated the dominance of neoliberal narratives of health, narratives which stressed better access (without embracing universal access) and economic efficiency.

Neoliberal emphasis on personal responsibility in health care was even stronger in the Utah case than it had been in Massachusetts. Emphasis on personal responsibility in the Romneycare debates most frequently occurred in the context of support for the individual insurance mandate in the MHRL legislation (*individual responsibility*

narrative in favour of Romneycare). In contrast, in Utah, emphasis on individual responsibility manifested itself both through the *individual responsibility narrative* that argued for delegating health care financing and decisions to individual and families (an allegedly private sphere that should be free from government interventions, except through the imposition of socially conservative values such as restrictions on abortion), or through the *incremental reform narrative*, which held that governments should enable people to act as informed and responsible consumers on the health care market through provision of information and encouragement of healthy lifestyles, without mandating particular behaviours or market participation.

Chapter 8: Conclusion – Lessons from newspaper media representations of health care reform in Massachusetts and Utah

8.1 Significance of this dissertation in the context of ongoing federal reform debates and key lessons on narrative analysis of the Massachusetts and Utah cases

This dissertation has aimed to respond to the following central research question: *What newspaper media narratives of health care emerged in the Massachusetts (2002-2006) and Utah (2004-2011) health reforms—influential and hitherto largely unexplored cases that immediately preceded, set the stage for, and paralleled the Obamacare drama?*

To this end, my dissertation explored four sub-questions:

1) What narratives of health care reform that emerged in the newspaper media were neoliberal and what were the counter narratives?
2) Was there an overarching neoliberal narrative(s)—or neoliberal meso-narrative—apparent in newspaper media representations of either state reform?
3) Did narratives diffuse across states in the newspaper media coverage of the two reforms (was there convergence of media narratives of health care in the Massachusetts and Utah cases)?
4) How did the absence, and later the presence, of a parallel federal health reform effort (Obamacare) discursively impact media representations of the state health reforms?

I have argued that, while the Democratic-leaning national and state-level newspapers were somewhat more favourable to health care reform than Republican-leaning newspapers, both Republican-leaning and Democratic-leaning newspapers were largely favourable in their coverage throughout the preceding state election campaigns, legislative debates, and periods following legislative passage. The national and local newspapers depicted rising costs and inadequate access to health insurance as the central challenges of the health care system that served as the impetus for reforms.

I have further argued that many of the same major narratives of health care reform were deployed in both states at critical junctures. These included the state election

campaign period before each health reform effort began, and the periods of legislative debate and following legislative passage of each component of the reforms. Major neoliberal narratives identified in the newspaper media during the two reforms and explored in this dissertation include the *expanded access narrative*, the *economic security narrative*, and the *individual responsibility narrative* (of which there were two variants). I have likewise identified twelve additional major neoliberal and challenging health reform narratives that were contextually specific to either the Massachusetts or the Utah reform efforts and the national health news stories that paralleled or preceded them (the HSA and Obamacare). Importantly, the narratives that appeared in predominantly Democratic Massachusetts and predominantly Republican Utah reveal variations within the neoliberal health policy window with regard to the level of appropriate individual and government responsibility in health care financing, and concerning the degree to which governments should compel or facilitate individual and business participation in the private insurance market.

Following the inauguration of a president who promised to repeal Obamacare, in the national health reform battle that began in 2017, understanding the health care narratives of the most recent state-level reforms offers valuable clues on the possible character of the coming debates. The arguments that far-right Republican and libertarian opponents of Obamacare have used in the case to "repeal and replace" the ACA—the rejection of individual and employer insurance mandates, states' rights arguments to devolve more health care policymaking authority to the states (for example with regard to the level of Medicaid funding, and the degree to which the insurance industry is regulated), opposition to government interference in the health sphere (such as moves to

require insurance companies to cover certain medical conditions), were present in the UHSR debates and in the fringes of Republican resistance to Romneycare.

While the media took more interest in the Massachusetts reform effort than that of Utah, comparing the media representations of the two cases offers key lessons on narrative analysis in a neoliberal policy context. As outlined in the conclusion of Chapter Seven, media coverage of Romneycare and the UHSR included ascendant, descendant, undulating, and fleeting news cycle narratives of health care reform from 2004 to 2011. Thus, the frequency of narratives is not constant over the course of a reform cycle. The major narratives that surfaced in both Massachusetts and Utah simultaneously represented the states as being in need of reform, and as capable of taking on the policy challenge. However, media coverage minimized narratives of the political right and the political left that challenged dominant neoliberal representations of health care. Specifically, narratives of the political right that would have supported an even less regulated insurance market, and a generally more market-driven system—including the *individual responsibility narrative* in Utah (treating health care as an individual and family responsibility), or the *anti-Romneycare narrative* in Massachusetts (supporting more market-driven insurance reforms as an alternative to Romneycare)—were largely minimized in the newspaper media. Similarly, narratives of the political left such as the *pro-single payer narrative* or the *narrative of inefficiency and unethical health care practices* in Massachusetts surfaced comparatively infrequently in the media compared to dominant neoliberal narratives.

Media representations revealed differences in the two state reforms within the neoliberal policy window. Specifically, Utah was portrayed as a state resolved to meet its

health care challenges through alternative, Republican-leaning policy innovations that differentiated its political agenda from the reform preferences of the federal government, such as the Obamacare/Romneycare model of insurance mandates, regulated health insurance exchanges, and increased investments in Medicaid. Massachusetts, for its part, was described as a trailblazing state that took the initiative to innovate in a context of federal inaction, without challenging the market-oriented nature of the system. Specifically, Massachusetts renewed the Clinton-era reform idea of insurance mandates in a more regulated insurance market, while adding greater investments in means-tested health care programs. Newspaper reporting in both cases was mostly favourable to some type of health care reform—while avoiding framing health care as a universal right. Coverage favourably represented the expansion of access to insurance coverage and the reduction of public health expenditures as worthwhile policy goals. This was clear through the frequent appearance of the *expanded access, economic security,* and *individual responsibility narratives* in the two cases. The dominance of such narratives demonstrates neoliberal underpinnings in conceptualizations of health. However, the nuanced differences between these narratives in Utah and Massachusetts, which reflect stronger Republican commitments to market-driven reform options, demonstrate that Republican and Democratic preferences correspond to different policy outcomes. Republican-policy biases against subsidies to assist the poor to purchase insurance, against insurance mandates, against investment in means-tested health care programs, and against greater regulation of insurance industry practices all entail notable consequences for health care system users with regard to cost and access.

Personal responsibility in health care was emphasized more strongly in Utah

reform coverage than in Massachusetts. In Romneycare reporting, personal responsibility was typically a focus limited to newspaper articles that supported the individual insurance mandate of the MHRL legislation (*individual responsibility narrative in favour of Romneycare*). In Utah, individual responsibility was emphasized more frequently through the *individual responsibility narrative* that favoured delegation of health care financing and decisions to individuals and families. Emphasis on individual responsibility also appeared as part of the *incremental reform narrative*, which treated people as responsible consumers on the health care market who would make the best decisions for themselves as long as they had adequate information. In the Utah case, the state government also prioritized personal responsibility by promoting healthy lifestyles, without mandating insurance market participation. Differences in neoliberal media representations in the Massachusetts and Utah cases were clear with regard to the position on insurance mandates; the level of insurance industry regulation that the state reformers thought to be acceptable; and the level of public investment and role of state governments in operating their respective health insurance exchanges.

The discursive variations in media reporting in the two cases align, on the right of the neoliberal policy window in Utah, with a reform of limited scope that created a modest online health insurance exchange. The Utah exchange depended on a small operating budget and involved no major expansion of the state bureaucracy to ensure its operation. It included tort reform to limit litigation and (in theory) reduce costs in the health care system. The Utah reform further standardized insurance operating and billing practices, and made moves to transition to a defined-contribution insurance model in order to reduce uninsurance rates. If the federal Patient Protection and Affordable Care

Act had not passed in 2010, it is difficult to know how effective the UHSR would have been on its own in increasing the number of insured Utahns.

In contrast, on the left of the neoliberal policy window in Massachusetts, the reform narratives in the media aligned with a reform that led to a much more elaborate and regulated health insurance exchange, one that required an expansion of the state bureaucracy and a substantial annual operating budget. The Massachusetts reform included broader insurance regulations to protect consumers and expanded the state's Medicaid eligibility requirements and investment in means-tested programs. Perhaps most importantly, the Massachusetts reform implemented individual and employer insurance mandates to increase health insurance enrolment and reduce financial losses of hospitals in the treatment of uninsured patients. Romneycare did not aim to achieve universal coverage, but it substantially reduced the number of those uninsured in the state. Thus, the different pathways of health reform narratives in the two cases show considerable variation within a broadly neoliberal frame.

8.2 Lessons on narrative diffusion between state and national newspaper media

In the Utah and Massachusetts cases, national and state-level newspaper media representations of health care were broadly similar. Both states were represented in the limited national media coverage as health policy innovators, which was an important part of local newspaper representations as well. In both cases, however, national media coverage was less frequent and less detailed than reporting in local newspapers; this was especially true of coverage of the Utah reforms. Part of the explanation for this variance, to be sure, may lie in the differences in media themselves: the national mandate of

national media versus the local mandate of city-based newspapers. Yet, the fact that Utah was nearly ignored in comparison to Massachusetts may point to the role of other variables in that case – the fact that Utah is a smaller state and, significantly, the fact that Obamacare debates were competing with local debates for national media attention. The Utah case shows that national newspapers took far more interest in the federal Obamacare reform debates, which accounted for most health care reporting in the *New York Times, USA Today*, the *Washington Post*, and the *Wall Street Journal* from 2008-2011, when the implementation of the components of the UHSR paralleled the Obamacare debates. This suggests that, when federal reform efforts coincide with state health reforms, the state reforms risk being overshadowed in the media. Massachusetts reformers such as Governor Romney may have benefited from more media attention thanks to the absence of a concurrent federal reform (even though critical conservative references to "Hillarycare" debates, which occurred a decade earlier, were a minor part of the Romneycare critique) that might well have competed for national and local media interest.

One may wonder why the opposite effect did not take place: that is, why did the Utah experiment not get greater prominence nationally given that it coincided with Obamacare and presented an alternative vision of health reform? It could be argued that its concurrent status might just as easily have brought it to greater prominence in the national media, depending how reporters were inclined to frame the national story and how the various narratives were interacting. In light of my findings, Utah was overshadowed rather than being highlighted because its reform effort was offering a less ambitious and less comprehensive solution to a national policy challenge than the

coinciding federal reform effort. Furthermore, the more conservative Utah approach to reform seemed out of step with the seemingly dominant Obamacare/Romneycare approach of individual and employer insurance mandates, coupled with subsidies for low-income people to purchase private insurance, and increased investment in means-tested public health care (Medicaid, etc.). In light of efforts to replace Obamacare with some version of Trumpcare, there is a distinct possibility that a more conservative approach to health care reform looms at the federal level, one that shares more in common with the UHSR than with Obamacare or Romneycare. In this context, Utah's reform effort may attract a new wave of media and academic inquiry.

8.3 Lessons on narrative diffusion between Republican-leaning and Democratic-leaning state newspapers

The narratives deployed in Republican-leaning and Democratic-leaning local newspapers largely overlapped in the Utah and Massachusetts reforms. The *expanded access, economic security, individual responsibility, pro-single payer, and anti-single payer narratives* were deployed in the *Salt Lake Tribune*, the *Deseret News*, the *Boston Globe*, and the *Boston Herald*. The reform-specific narratives of health care that were not deployed in both states nonetheless diffused between the Republican-leaning and Democratic-leaning local newspapers within states. There were however differences in the frequency of deployment of these narratives. The Republican-leaning *Boston Herald* and *Deseret News* deployed the *individual responsibility, anti-single payer*, and *economic security narratives* more often than the Democratic-leaning *Boston Globe* and *Salt Lake Tribune*, which for their part featured the *expanded access* and *pro-single payer narratives* more often. Thus, while both Republican-leaning and Democratic-leaning

newspapers supported health care reform, they differed in their emphasis (cost versus access) and in the type and scope of reforms they advocated.

Interestingly, although it would take further study of media representations of the 2017 national health reform debates to be certain, at least within Congress, the Obamacare repeal debates appear to be shaping up differently. Democrats are wholly committed to preserving the emblematic Obamacare legislation, a reform that the most progressive Democrats only tepidly supported as a compromise that gave away too much to the health insurance and pharmaceutical industries at the time of its passage. Mainstream Republicans are advocating reforms to the ACA that would still fit within the neoliberal policy window, and which are similar in several particulars to the UHSR (no insurance mandates, less regulated insurance exchanges). In contrast, far right and libertarian Republicans denounce these changes as "Obamacare light," and demand that the legislation be completely abolished, including the insurance regulations that were designed to protect health care consumers from discrimination (Associated Press 2017; Lee et al. 2017). Thus, the dimensions of the debate among political elites seem to have shifted to the right, with Democrats fighting for the neoliberal status quo (Romneycare-Obamacare model), and Republicans divided between those who want something similar to the UHSR at the national level, and those who desire health market anarchy. My research may also suggest that, since discourses on the political right vary to such an extent, it is challenging to construct a common vision of health care to displace the neoliberal status quo. It was popular election rhetoric to call for repealing Obamacare, but once it was apparent that actual policy change would create new winners and losers, it became extremely difficult to achieve political consensus.

On the surface, none of these latter differences seems particularly counterintuitive, as they play out along traditional Democratic and Republican lines. They do however offer broader insights into the *déroulement* of health reform debates. On the one hand, differences between primarily Republican and primarily Democratic narratives suggest that readers of Republican-leaning and Democratic-leaning newspapers are locked into narratives that make meaningful and constructive debate—the kind that leads to legislative compromises that may serve the public interest, increasing access, controlling costs, and preventing insurance industry abuses—less likely. On the other hand, the existence of some shared narratives that pertain to challenges of costs and access to insurance, as well as perceptions of private versus public responsibility in matters of health care and financing, suggest common values within the neoliberal policy window. These shared neoliberal values might serve as sites of negotiation and constructive debate that leads to new state and federal health legislation, as the values are contained by the social-investment state and right-libertarian perspectives at the margins; however, the 2017 balance of power in Washington that largely favours Republicans appears to be pushing the debates toward the right side of the neoliberal policy window (or even beyond it, into the libertarian margins).

8.4 Lessons on narrative diffusion between state reforms: The importance of narrative persistence and trajectories

Comparison of national newspaper coverage of the Utah and Massachusetts health reform debates is difficult, since Utah reporting in the *New York Times, Wall Street Journal, Washington Post*, and *USA Today* was so sparse, and even national coverage of Romneycare was markedly more limited than local newspaper reporting. However,

analysis shows a substantial diffusion of narratives between the local newspapers. Three narratives—the *expanded access, economic security,* and *individual responsibility narratives* (two different variants)—were deployed in the local newspapers throughout the Massachusetts and Utah reforms. This diffusion is revealing, as it demonstrates common concerns over access to health insurance and the costs of medical care for individuals, families, businesses and governments. Although individual responsibility was evoked differently during the two reform campaigns (in favour of Romneycare in Massachusetts, then later against government interference in the health sphere in Utah), individual responsibility was important in both instances. Arguably, in light of the fact that it was instrumentalized in the framing of both the UHSR and Romneycare, a shared discursive focus on individual responsibility in the era of still ill-defined "Trumpcare" might provide a framework in which advocates from the political left and right might come together and find common ground. Remembering that individual mandates were originally a conservative idea developed at the Heritage Foundation, and that Democrats and Republicans collaborated in passing Romneycare to significantly expand insurance coverage, it is possible that a new generation of health care reformers will be able to re-emphasize bipartisanship and celebrate workable ideas wherever they may originate. A health reform package that is closer to the left of the neoliberal policy window, such as Romneycare or Obamacare, may still serve as a basis for later expansion to a more regulated mandatory insurance system with the goal of universal access.

Local newspaper media coverage in Massachusetts and Utah converged in emphasizing cost and access challenges and in offering competing views on the merits and flaws of single-payer and the appropriate degree of individual responsibility in

matters of health care and health financing. However, narratives that connected other health care stories that coincided specifically with either Romneycare or the UHSR made the difference in reporting on the two state reforms. In sum, narrative persistence and trajectories across time and between different state reforms also matter because they reveal the constancy of some priorities and controversies—access, cost, single-payer, and individual responsibility—as well as the capricious nature of media attention in health care reporting, attention that shifts towards or away from state health reform efforts as surrounding health news stories evolve.

8.5 Storying Versus Living Neoliberal Health Care

Having seen the American health care system as a patient; as the son and sibling of loved ones who anguished about how to pay for life-sustaining care while they faced terminal and chronic illnesses; as a Democratic Party campaign worker; as a caseworker in social services who worked with vulnerable populations; and most recently as a researcher, I acknowledge that there is plenty of cause for disillusionment. In a sense, the health care system is the most representative symbol of American politics itself. American history is, after all, not a hopeful story of progress. It is not a story of a society inching towards ever-greater inclusivity, justice, equity and benevolence. The history of American politics, like that of the country's health care system, is a pendulum of uprising and repression; one marked by unresolved and former injustices that have often been ignored. Progress occurs, and sometimes it is overturned. Progressive reformers re-emerge and the cycle starts over. Obamacare is one poignant example and, as a *de-facto*

extension of Romneycare in principle and in its key tenets, it is relevant to consider the debates on the fate of the federal legislation here.

Since the surprise election of Donald Trump to the Presidency in November 2016, the future of Obamacare has been an open question. While Trump promised to "repeal and replace Obamacare" during the presidential campaign, his platform was vague on what "repeal and replace" meant in terms of actual policy proposals (Trump 2016). Based on Trump's election period "Contract with the American Voter," it has been clear that he supports replacing Obamacare with some combination of Health Savings Accounts (HSAs), deregulation to facilitate the purchase of private health insurance across state lines, and the creation of block grants to devolve Medicaid funding—and, presumably, the administration of the program—to state governments (Trump 2016). These three proposals are consistent with the proposals underpinning the UHSR, which are closer to the right side of the neoliberal policy window—individualize health care choices and financing to a large extent; allow the insurance market to regulate itself through competition by removing regulations; and let the states largely decide for themselves how much they want to invest in means-tested health care programs. It is also very probable that the Trump administration will seek to defund and undermine the Obamacare health exchanges through executive fiat and move quickly with Congress to scale back Medicaid expansions. The non-partisan Committee For a Responsible Federal Budget (CFRFB) has estimated that so-called "Trumpcare" will cost an additional $550 billion over the next decade, and add over 20 million Americans to the precarious ranks of the uninsured—conditions similar to pre-Obamacare America (CFRFB 2016).

House and Senate Republicans developed two competing health reform bills in June of 2017 as the first post-election attempts to repeal Obamacare. Both the House and Senate versions proposed eliminating the individual and employer mandates to purchase or to provide private health insurance, and discontinuing tax penalties for those who choose not to purchase or provide health insurance. In this sense, both Republican proposals were similar to the UHSR, which rejected the individual and employer insurance mandate ideas. Both bills proposed to discontinue the Medicaid expansions under Obamacare (by 2020 in the House version, or 2024 in the Senate version). While Obamacare protected Americans with pre-existing medical conditions from insurance company discrimination, the doomed 2017 House bill would have allowed states to apply for exceptions to that rule, and the Senate bill would have weakened protections for pre-existing conditions without allowing for state waivers. Neither bill would have required insurance companies to cover so-called essential medical conditions such as pregnancy, ambulance services, mental health and addiction treatments (offering the option for states to apply for waivers in order to avoid the requirement). Both bills would have eliminated taxes that were created under Obamacare, and weakened Obamacare requirements for insurance companies to cover contraception-related costs (Krieg 2017; Watson 2017). At least in the debates surrounding these two bills, it proved impossible for Republican factions to reach a consensus on a new vision of health care in America.

The competing GOP bills were criticized in the media during the 2017 debate as legislation that would have represented a step backward to pre-Obamacare conditions, depriving millions of Americans of health insurance coverage, increasing health care costs, and weakening the middle class (*NYT* Editorial Board June 24, 2017). However,

little or no media coverage highlighted the fact that the Republican proposals and priorities were similar to those of the UHSR, and in at least one respect (support for HSAs), to the Bush administration's reform proposals (Bumiller 2006; Utah 2008, 2010). The UHSR architects rejected the concepts of individual and employer insurance mandates that would be eliminated through either of the 2017 GOP bills. Both the Bush administration and the UHSR proponents emphasized the potential role of health savings accounts (HSAs) in conjunction with bare-bones, high deductible health insurance plans as key elements of health care reform. The UHSR reformers also opposed Obamacare's Medicaid expansions and new insurance regulations to require insurance companies to pay for certain essential medical services (Bumiller 2006; Clark 2008; Economist 2012; Gehrke 2008, 2011; Stewart 2011a, c; Utah 2008, 2010). After the passage of Obamacare, Utah and other conservative states went so far as to initiate lawsuits to attempt to prevent the insurance mandates and Medicaid expansions under Obamacare (*Deseret News* March 13, 2011; Kinnard 2010). Furthermore, in 2011, Utah state legislators who had been key proponents of the UHSR advanced new state-level legislation to allow insurance companies to charge higher premiums to customers who were thought to be greater risks (Stewart 2011a,c). Such blatant pandering to the insurance industry is consistent with the proposed state waivers to shortcut Obamacare regulations on insurance coverage for essential medical services, placing states' rights and the interests of insurance companies above those of American medical patients.

It is also worth noting that the obvious schism between the moderate right, far-right and libertarian factions within the Republican Party's ranks on the direction of Trumpcare (Associated Press 2017; Lee et al. 2017; Roy 2017) can be traced back at least

to earlier state-level debates in Utah and Massachusetts. While Romney supported individual insurance mandates as a moderate Republican governor after the idea was conceived at the conservative Heritage Foundation think tank (Appleby, July 5, 2005; Haislmaier 2006; Romney 2006; Roy 2011), and Utah's moderate Republican Governor Jon Huntsman initially supported insurance mandates until he was outflanked by more conservative state Republicans (Cherkis 2011; Cherkis and Ward 2011), the libertarian and most conservative elements of the Republican Party have opposed mandates for years. This schism within the Republican ranks was aptly described in relation to the differing reactions to the Romneycare debates as "free-market purity vs. a sort-of-free-market pragmatism" (Fitzgerald, June 27, 2005). However, while these divisions in Republican perspectives on health care have been consistent since the Romneycare debates (Fitzgerald, June 27, 2005; Ross 2006), the balance of power in Washington in the early months of the Trump administration favoured far-right and libertarian Republican perspectives on health care reform—specifically, no mandates, reduced support for means-tested health care for the poor, fewer public protections from insurance company abuses, fewer insurance industry regulations, and more devolution of health policymaking power to the states (Krieg 2017; Watson 2017). Thus, a health policy context on the right of the neoliberal policy window—or even in the fringe libertarian realm—appeared inevitable at least until the midterm Congressional elections in 2018.

8.6 Contribution of this dissertation: The cracks where the light gets in

> "Ring the bells that still can ring. Forget your perfect offering. There's a crack, a crack in everything. *That's how the light gets in*." (Cohen 1992)

In his 1992 song "Anthem" from the album *The Future*, the poet and songwriter Leonard Cohen describes the endless cycle of suffering—wars, political corruption, and

other persistent injustices—that chip away at our hope in humanity. Waking any given day, and examining the world around us, it is easy for a person to succumb to disillusionment and disengage from struggles for social justice (Cohen 1992). The story of the Massachusetts and Utah cases examined in this dissertation could be interpreted as disheartening tales of triumphant neoliberalism—a set of narratives that pervades political and journalistic discourses, and undermines the kind of health care reform that would guarantee access to quality care for all Americans regardless of their socio-economic circumstances. Despite over a century of sporadic progressive health care reform campaigns, and legislative successes at the federal and state levels, the United States continues to spend excessively to maintain a system that achieves comparatively unimpressive results among wealthy developed countries, and remains an outlier in its failure to ensure the "perfect offering" of universal access to health care (Osborn et al. 2016; Palier 2009).

And yet, despite this gloomy picture, the Utah and Massachusetts cases also offer reasons for hope. Two challenging narratives during the Romneycare debates—the *narrative of inefficiency and unethical health care practices* and the *pro-single payer narrative*—confront the neoliberal conceptualization of healthcare as an appropriately market-oriented sphere. The *narrative of inefficiency and unethical health care practices* drew attention to insurance industry, physician, and other health care provider abuses that occur as a result of profit-seeking activities, at the expense of patient well-being (Chaker 2002; Krasner, November 16, 2005; Rowland, August 16, 2005 and December 1, 2005). While this narrative did not always appear as a direct challenge to the neoliberal conceptualization of health care as a market, the stories in which it emerged served as

reminders that market-based health care was not always the most effective or efficient; in fact, these stories show that the distorting influence of profit prioritization often leads to poorer health care services.

For its part, the *pro-single payer narrative* reminded readers that they had other options beyond the neoliberal policy frame that could guarantee universal access to quality health care. Whether these authors extolled the benefits of socialized insurance, socialized medicine, or regulated mandatory insurance systems abroad, celebrated and called for the expansion of domestic public health care programs such as Medicare or the Veterans Health Administration, or simply rejected the perverse national myth that market-oriented health care is the best health care, they kept hope alive for an alternative to neoliberal health care (Heldt-Powell 2002; Kowalczyk July 20, 2005; Woolhandler and Hochman 2006). In one of the most concise and articulate critiques of market-oriented health care, the Massachusetts Nurses Association was quoted in the *Boston Herald* during the 2002 election campaign: "We believe the free-market, deregulated and corporatized approach to the delivery of health care in the commonwealth . . . is an abject failure, and it is the primary cause of the crisis we now face." The Massachusetts Nurses Association proceeded to call for a phased transition to a single-payer, social insurance system (Heldt-Powell 2002).

Even the *inadequate reform narrative* of the UHSR debates offers reason for hope. While this was a neoliberal narrative (on the left of the neoliberal policy window) that either was deployed in defence of Obamacare as a plan superior to the UHSR, or appeared in articles that emphasized the shortcomings of the UHSR and expressed support for more extensive health care reforms to increase access and control costs, it

served as a reminder that the neoliberal conceptualization of health care as a market sphere was not monolithic. The neoliberal policies of Romneycare and Obamacare—insurance mandates, subsidies to help lower income people purchase private health insurance, greater government regulation of the insurance industry and oversight of health insurance exchanges, and greater investment in means-tested health care for the poor without an explicit goal of universal access—proposed a more egalitarian and humane health care system than the UHSR model or the House and Senate Republican bills that were under debate in the summer of 2017. There are differences within the broad window of neoliberal health policy that entail real consequences for the people who rely on the system.

Finally, we may derive some hope from reflecting on the things that the Romneycare and UHSR neoliberal reformers *could not* do to existing health policy framework and programs. At the state level, these reformers had to accept and work within the boundaries of Medicare as an established socialized insurance system and the Veterans Health Administration as an established socialized medicine system. While they could seek to increase funding and access (as in Massachusetts) or to further restrict access to Medicaid as a means-tested, jointly funded state-federal socialized insurance system (as in Utah), the program could not be eliminated in either state. Even though the 2017 congressional Republican bills under debate in the House and Senate may harm millions of people through reductions in federal Medicaid funding and enabling states to further restrict access to Medicaid, these draconian measures cannot eliminate Medicaid, the State Children's Health Insurance Program (CHIP), the VHA, or Medicare.

Previous research has emphasized the importance of such existing public health care programs, as well as the kind of progressive, challenging voices in health and social policy debates. Janine Brodie (2007) emphasizes the importance of "residual" and "emergent" social policy narratives. Residual programs of 20th century social liberalism (such as Medicare, Medicaid, the VHA, and CHIP in the American context) are reminders of a time of greater social investment and solidarity. Social liberalism placed emphasis on equality between citizens, and embraced a more universal conceptualization of social rights for the common good. Brodie describes this as the "social citizen" identity, which may still inspire movements for social justice in opposition to neoliberal dominance (Brodie 2007). Similarly, George Annas (1995) argues that opponents of the "market metaphor" of health care must advance new metaphors of health care to progressively chip away at the market-oriented representations of health care. As such, there is an important place for residual reminders of where we have come from in the history of social and health policy development, as well as new narratives of health care that challenge the neoliberal status quo.

The case studies of health care reform in Massachusetts and Utah are not stories to dismay progressive health care reformers; they are reminders that no matter how dominant neoliberal policies and narratives appear, *there are always cracks where the light gets in*. This is perhaps the most important thing this dissertation has taught me about discourse analysis: hope and inspiration is often buried in unexpected and less visible places—the minority voices that offer us paths to build more inclusive, just, equitable, and compassionate health care systems, and for that matter, more equitable and fairer societies. This realization leads, I think, not to despair, but to a perspective similar

to what Foucault called "hyper and pessimistic activism" in which "we always have something to do" (Foucault 1997: 256). The opposition of researchers and activists to neoliberal conceptualizations of health care, and to the even more sinister alternatives on the libertarian right, is unquestionably an uphill battle in America; yet it is one that can and should continue, taking inspiration from both the residuals of social liberalism and the nascent challenging narratives of the social investment state such as the *pro-single payer narrative*. Things may get worse before they get better. But progressive health reformers will re-emerge and the cycle will start over; if nothing else, the history of American health care reform has taught us this with certainty.

8.7 Scope and limitations of this dissertation

This dissertation has focused on analysis of health narratives that were deployed in four national and four local newspapers during the reform debates of Massachusetts (2002-2006) and Utah (2004-2011) at critical junctures—the state election preceding each reform, the period of state legislative debates, and the period after legislative passage. The two cases were chosen for analysis due to their legislative success, and because of their particular intersections with the federal Obamacare debates—Massachusetts as the precursor, and Utah as the competitor to the federal reform. I have argued that newspaper reporting largely converged around neoliberal narratives that emphasized the expansion of access to health insurance (without advocating universal access), the control or reduction of public and private health expenditures, and individual responsibility in health. More radical narratives of either the political left (advocating forms of single-payer health care) or the libertarian political right (opposing government interference in the health care market and advocating forms of health market anarchy)

were comparatively marginalized. Taken collectively, the most commonly deployed narratives of health care reform in the Massachusetts and Utah cases offer an overarching neoliberal representation of government as a caretaker and servant of the private health insurance market, one that protects the insurance industry from its own excesses and buttresses claims of free market efficiency. This was apparent in the neoliberal *expanded access, economic security*, and *individual responsibility narratives* (both variants) in the Massachusetts and Utah reforms, as well as the other case-specific neoliberal health care reforms.

Admittedly, this dissertation has offered a limited analysis of the possible spectrum of narratives of health reform and the health care system, focusing on the most frequently deployed major narratives in each debate. An analysis of other state or federal reform debates, or an examination of such questions that includes additional forms of media, may reveal a broader spectrum of health reform narratives and frames and paint a clearer picture of overall media representations. Furthermore, the choice to limit this analysis to two legislatively successful state reforms that intersected with the Obamacare debates might have resulted in my overlooking narratives that were limited to, or more frequent in, unsuccessful health reform attempts, such as the single-payer campaigns in Oregon (2002), Vermont (2011-2014) and Colorado (2016), which occurred within the same decade as the Massachusetts and Utah reforms. As such, the next section examines future possible research on the representations of the health care in America.

8.8 Opportunities for future research

As noted above, I chose the Utah and Massachusetts health reform cases in part because of their intersection with the Obamacare debates. Future research that explores

media representations (those in newspapers and on political blogs, social media, television, and radio) of the most recent major federal reform debates (the HSA and Obamacare) could shed further light on media narrative convergence and differentiation in Republican-leaning and Democratic-leaning media, as well as on the comparative consistency and strength (based on frequency of appearance) of major health care narratives over time. It goes without saying that, should "Trumpcare" emerge as the next major American health reform effort, a comparative analysis of media narratives of health care between the Trumpcare, Obamacare, and possibly the HSA debates, such as what I have revealed about the Massachusetts and Utah health reform campaigns, would uncover even more about media representations of health care in the United States.

In addition, the limited yet consistent presence of single-payer narratives in the Massachusetts case, and the fact that single-payer was always off the political agenda in Utah, would justify exploration of media representations of single-payer health care during the three most recent, failed single-payer campaigns in Colorado (2016), Vermont (2011-2014), and Oregon (2002). These cases could reveal convergence between representations appearing in Republican-leaning and Democratic-leaning media. A clearer understanding of the media representations of single-payer (socialized insurance or socialized medicine) could help to explain the reasons that these reform options have been such a difficult sell in the American context, helping to explain why the country remains stuck in a cycle of periodic, "patchwork" reforms that continue to exclude so many people from access to quality health care. While the success of future American health care reform efforts will depend on a complex interplay of independent,

endogenous, and exogenous variables, the stories we tell about health care will always matter.

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