No We Can't: Struggles in U.S. Health Care Reform

A historical analysis of American health insurance reform from the Social Security Act to Obamacare

BACHELOR THESIS

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Abstract

The Patient Protection and Affordable Care Act (ACA) was passed in 2010 as the first comprehensive national health insurance program designed to cover all American citizens. The ACA was not the first attempt to reform the health care system. Obama was preceded by Roosevelt who introduced the Social Security Act, Truman who failed to have his proposal for national health insurance legislated, Johnson who enacted Medicare and Medicaid, and Clinton who also ultimately failed miserably. Initially these attempts did not bode for Obama's proposal. Yet, he managed to get his plan passed without a single Republican vote. In order to answer the question of this thesis why he was successful whilst others was not, I will undertake an analysis of previous literature to create a historical framework of prior attempts. I will also analyze other studies that will offer a range of explanations and strategies implemented by Obama during and after the passage of the ACA. The findings indicate that Obama strategically framed his proposal before the enactment with a "market" frame, and after its passage to a "rights" frame. Also, Obama made strategical use of the Democratic majority in Congress. These strategies may have secured the passage of the ACA.

***Keywords**: ACA, Barack Obama, Clinton, framing, health care reform, historical framework, Johnson, majority, national health insurance, strategies, Roosevelt, Truman*

Introduction

In 2010 history was made with the passage of the Patient Protection and Affordable Care Act (PPACA). Barack Obama managed to implement such an extensive piece of health care reform which would have been unimaginable for decades. This thesis will study and analyze what kind of strategies have helped Obama's quest in introducing a health insurance system the American people were unfamiliar with. This topic is relevant because implementing national/universal health insurance has meant a big change in the American health care system and has caused a lot of controversy along the way. In order to understand the significance of this legislation this thesis will give an historical analysis of the attempts made by presidents preceding Obama. The main focus will be on President Franklin D. Roosevelt, Lyndon B. Johnson, and Bill Clinton. All three presidents introduced health care reform that has presumably set the stage for the passage of the PPACA. I will begin with looking into literature of how the health care system and insurance system developed over the years. The first chapter "The History of American Health Insurance" will be divided into five sub-chapters: 1) "The Beginning and Roosevelt's New Deal (early 1900s-1940s)," 2) "Truman's Efforts," 3) "Lyndon B. Johnson's Great Society: Medicare and Medicaid (1950s-1960s)," 4) "Clinton and the Healthcare Plan of 1993 (1990s)," and 5) "Strategies."

Along with the historical overview, the second chapter "The Opponents" will try to shed light on which agents have opposed national health insurance, and why they did so. Two sub-chapters will be dedicated to two major interest groups and the Republican Party: 1) "The American Medical Association (AMA) and the Health Insurance Association of America (HIAA)," and 2) The Grand Ol' Party: The Grand Obstruction Party."

The final chapter "Finally Victorious After Sixty Years" will provide a case study on the passage of the PPACA, or in other words Obamacare. This case study will address what the PPACA is, which setbacks it encountered, and which strategies Obama implemented to secure its passage in the following three sub-chapters: 1) "The New Medicare: Obamacare," 2) "A Long and Difficult Road?" and 3) "Strategies."

the rest of the system developed over the years: what other attempts have been made by presidents, why they failed, and the contrast between insurance implemented by state governments and the attempts of the Federal Government. Furthermore I will look into literature which will help explain why the Patient Protection and Affordable Care Act (PPACA) eventually got passed in 2010.

With this research I hope to give a clear and succinct explanation as to why health care reform,

in particularly national health insurance, has been a contested issue in the United States and where the difficulties why trying to pass this kind of legislation. The study conducted for this thesis will therefore help answer the following research question

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Which aspects of the American political system have prevented presidents preceding Barack Obama from passing health insurance and why did Obama finally succeed in doing so by passing the Patient Protection and Affordable Care Act after almost sixty years?

We as Europeans who are familiar with a system in which the government is in part responsible for the care of its population may find it difficult to comprehend how come a modernized nation such as the United States lacks such a concept. Therefore, regardless of the answer to this question, this thesis will hopefully create some insight and understanding as to why national health insurance is not a given right.

Chapter 1: "The History of American Health Insurance"

Chapter 1.1 The Beginning and Roosevelt's New Deal (early 1900s-1930s)

There has not been an American president that did not meet resistance from all sides when it comes to pursuing health care reform. Particularly proposing and implementing laws regarding national health insurance have not been very successful. The journey towards any kind of health insurance, whether it be national/universal or not, has been a difficult one. In this sub-chapter I will give a historical oversight of the accomplishments and failures when proposing national health insurance by President Franklin D. Roosevelt.

It was in 1935 when President Roosevelt created a first step to health insurance for a large part of the American people by signing the Social Security Act. Although it did exclude certain groups of people, it showed promise that nationwide health insurance was a possibility. This act was defined by the provisions that it provides:

> For the general welfare by establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provision for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes ("The Social Security of 1935").

The Social Security Act did not represent all of the American people and it only provided benefits to indigents and not actually insurance, but it was a step that could potentially lead to a national health insurance plan. In order to understand the process that led to the first form of health insurance and how come it has been such a difficult one, it is important to be aware of the different conditions and needs in America in the early 1900s till 1935. In his work "Medicare and Medicaid: The Past as Prologue" Edward Berkowitz, Professor of History at George Washington University, explains how differences in the political as well as economical landscape at the time can explain the desire for other solutions rather than national health insurance. In the time prior to 1935 the concept of health insurance was known as sickness insurance. This form of insurance was based on the idea that the worker and his family were protected against the loss of income because of his absence due to illness. To reimburse the costs made by this absence the Social Insurance Committee of the American Association Committee put forward a plan that would both offer provisions for lost wages and payment of medical services (Berkowitz 81). This form of insurance was already known in Europe. For example, Great Britain passed the British National Insurance Act which was modeled

after existing programs in countries such as Germany, Austria, Hungary, and parts of Scandinavia and eastern Europe (Berkowitz 81). The Americans were interested in sickness insurance as a study conducted for the Commission on Industrial Diseases showed that the amount of lost wages due to sickness were significantly higher than the expenses for medical care. At the time it was believed there was hardly any need for national health insurance and so sickness insurance—later to be called disability insurance—was preferred (82). Thus, because of different needs at the time less attention was paid to creating national health insurance laws. Sickness insurance may have been beneficial for many and States thoroughly investigated the need for it and considered creating such programs between 1918 and 1920. However, these programs never came into being because the measure was defeated in every State. It proved to be a relatively controversial item and the factors mentioned above in combination with the fact that sickness insurance was closely associated with Germany—its role during the First World War not being a positive one—detracted from its popularity (82). These factors indicate that there were many backlashes that prevented any kind of government supported health insurance during the first part of the 20th century.

There were, however, more factors that played a role as to why national health insurance did not take precedence at the time. Firstly, social reform was focused on the States and not on the Federal Government. Even if reform took place on a national level, the Federal Government was constrained in their actions making it harder for them to pass legislation. With the creation of the Constitution it was established that the powers of the Federal Government would be restrained as to avoid tyranny. There was also the matter of heterogeneous conditions across America, meaning that a health insurance program that might have worked well in rural areas may not have had the same effect in urban areas, making it irrelevant. A factor that may have contributed as the biggest obstacle regarding health insurance was the existence of private insurance companies (83) and the American Medical Association (AMA), who represented the interests of doctors across America. According to Berkowitz this organization thought of medical care “as largely a private transaction between a medical practitioner and a patient” (82). The AMA believed that not only the Federal Government, but the State as well did not need to intervene in this relationship. Universal health insurance may have been possible had it not been for the hostility of the medical community who opposed the idea of government assistance in paying health costs (Skidmore 387). The role of the private insurance companies and AMA will be discussed in further detail later on.

Regardless of the mentioned setbacks reform began with Theodore Roosevelt, leader of the Progressive Republicans, who called for social insurance outlined in his proposal titled “New Nationalism” (385). Roosevelt's work was eventually continued by Franklin D. Roosevelt who

signed the Social Security Act in 1935 as part of the New Deal almost a quarter of a century later. This was made possible because of the transformation of the measure from sickness insurance to that of health insurance. As shown by I.S. Falk, who wrote a New Deal-Era study of health insurance, the costs of medical care at that time exceeded and were of greater concern than the costs of foregone wages due to illness, thus the circumstances had changed compared with twenty years earlier (Berkowitz 82). This renewed interest in health insurance was sparked by reports by the Committee on the Costs of Medical Care during the twenties (83). In their reports they highlighted the costs of and need for medical care and it became evident that people required the needs to pay for these costs. This led to the belief that some type of medical insurance was needed, however, they did not necessarily endorse national health insurance. Many of the committee members believed that a private system was capable of providing adequate insurance (83). Also, because Roosevelt knew that physicians and the AMA were "ideologically opposed to governmental social provision, and were organizationally present in every congressional district" he decided not to include health insurance out of fear that the entire Social Security bill would fail (Skocpol 77). Yet, all these studies, reports, and decisions led to the Social Security Act and thus provided the basis from which national health insurance advocates could continue to work.

In conclusion of this sub-chapter, the mindset towards what was needed for American citizens in order to assure their health and coverage of health care costs began to change. During the early 1900s the population and government itself was hesitant of providing health insurance for its 'socialist' characteristics. However, Franklin D. Roosevelt and progressive thinkers slowly started to think about an insurance system that at least provided benefits for some of the most indigent of the population and the passage of the Social Security Act of 1935 ensued from this new way of thinking. Thus, the 1930s can be defined as a historic moment in health care reform. Yet, change was only gradually and time would tell that the road to national health insurance was a difficult one with many struggles along the way. In the 1940s President Truman continued the journey, but unfortunately was not successful. The next sub-chapter *Truman's Efforts (1940s)* will therefore cover his attempt at passing legislation on national health insurance.

Chapter 1.2 Truman's Efforts (1940s)

The 1940s were for the most part defined by the second World War. During this period the general attitude towards national health insurance began to change. Most significantly the Federal Government became the preferred administrators of health insurance and other forms of social insurance rather than State governments, as these were seen as unreliable and inefficient partners unable to handle the same social problems (Berkowitz 84). Federal bureaucrats hoped to "establish a unified comprehensive system of contributory social insurance with no gaps, no overlaps, and no discrepancies" by creating a national, rather than State, health insurance as well as disability programs (84). In 1945 and 1947 two legislative proposals for national health insurance, under federal administration, were introduced with the endorsement of President Truman (84). Truman clearly stated his progressive stance towards health insurance in his 1945 message on a National Health Program to the 79th Congress. In it he pleaded for government interference in assuring that all citizens will be able to enjoy the benefits of what he calls modern medical science. He also addressed the fact that those with low or moderate incomes often lacked the needed medical attention, even though they often had more sicknesses. Similarly those in rural areas received less medical attention than those who lived in the cities. Truman therefore wanted a new economic bill of rights that would have meant "health security for all, regardless of residence, station, or race—everywhere in the United States" (Truman 271).

At the time, President Truman knew what kind of insurance was needed but he also realized what the difficulties were when proposing a national health insurance program. He believed that the American people would oppose a system where doctors were to work as employees for the government, something which in the early 1900s became known as socialized medicine. However, he emphasized that this would not be the case. The system would stay the same consisting of receiving medical and hospital services on the basis of voluntary decisions and choices. The only major difference would be that it would not depend on how much a patient could afford to pay for the services at the time (Truman 274). Truman's proposed plan was supposed to be an extension of the social insurance system they had the time. However, he wanted it to have the broadest coverage as possible, i.e. not just the elderly and other dependently, but rather all persons who worked for a living (from farmers to government employees to those in business for themselves etc.) and their families (274). He wanted this because not just the needy but a large portion of normally self-supporting persons were unable to pay for individual medical care at the time they need it (272). In his message, Truman also addressed another reason regarding the necessity of health insurance to make health care affordable. He pointed out that in both war- and peacetime doctors offered their

services day and nights often not expecting to be paid for their efforts by those who were unable to pay for it. The fees or parts of fees they did receive were usually used to buy medical supplies for those who could not afford them (272). Thus, to lighten the heavy load these physicians had to carry, Truman proposed in his national insurance program that the federal funds needed to be increased in order to reimburse the states for part of premiums (the coverage people would receive paid by public agencies), as well as pay for the medical services provided by doctors, hospitals, and other agencies that offered help to those who need it. Payment of medical bills would be guaranteed and doctors would be spared of having to collect it from individual patients (274). Truman proposed a plan appealing to both the population that would receive insurance as well as physicians who needed to be compensated for their work.

All in all, Truman's program could be summarized (in his own words) as a "program for improving and spreading the health services and facilities of the nation and providing an efficient and less burdensome system of paying for them" (Truman 274). Yet it failed and never came into being during his time in office. According to Berkowitz, one of the two reasons for the failure of a national program in the 1940s could be that the idea of national health insurance was attached to the Social Security Program which was—because of its narrowed scope of coverage—not yet widespread enough to be popular among the American population (Berkowitz 84). Probably the most important reason, however, may have been the fact that as the forties progressed private health insurance became the prevailing form of insurance, and so undercut the political support for public/ national health insurance (85). Although more people did have some form of private insurance, it blocked the passage of a universal program and resulted in another obstacle to cross: because private health insurance was regulated at State level, health insurance in general was seen as a State program rather something that should be managed by the Federal Government (85). In the 1950s, the Federal Government managed to expand Social Security benefits to the elderly as they saw the opportunity and reasons to do so. Younger individuals made use of private health insurance, while the elderly often fared less well in the private sector because they had lost their ties to their employers and the morbidity rate lay much higher among this group making them a bad risk to insure. The Federal Government could once again step forward as the main provider of health insurance to the elderly by expanding the Social Security program through what came to be known as Medicare. This program was eventually signed into law in 1965 by President Lyndon B. Johnson's.

Thus, even though President Truman offered a solid program that could have meant health insurance provided by the Federal Government for all Americans, it did not succeed in the end.

However, with each setback and failure in the history of health reform, there has been a slight progression as well. So far it showed that although a major change and switch to national health insurance did not occur, there were small changes that bode well for the future. The next sub-chapter *Lyndon B. Johnson's Great Society: Medicare and Medicaid* will therefore focus on another era in which health reform took precedence and during which two new larger programs were introduced: Medicare and Medicaid. I will explain what successes were achieved and what went wrong as well when President Johnson set his 1960s program, the Great Society, into motion.

1.3 Lyndon B. Johnson's Great Society: Medicare and Medicaid (1950s-1960s)

1965 proved to be another historic moment in the fight for American health care reform. With the passage of Medicare and Medicaid President Lyndon B. Johnson momentarily broke the pattern of setbacks and defeats that persisted the past decades during the struggle for universal health insurance. In this sub-chapter I will explain how and why Medicare and Medicaid came into existence, and I will disclose some the upsides and downsides of the programs.

First and foremost, it is important to understand that both Medicaid and Medicare, despite being two big reform programs in the American health care system, are not a national form of insurance. Neither program was designed to cover the entire American population, however both had the intention of covering as many people as possible with a special focus on those who needed it the most. By the 1960s most proponents had given up the hope for universal health care after the failed attempts in the 1930s and 1940s. However, it had not shattered their belief in health reform entirely. Out of Truman's Social Security Act and with the endorsement of President John F. Kennedy emerged the program Medicare which would cover insurance for the elderly. Two developments halted the program at the time: Kennedy's assassination in 1963 and a massive propaganda campaign against the plan mobilized by the American Medical Association. The AMA made use of phonograph recording's made by actor Ronald Reagan titled "Ronald Reagan Speaks Out Agains Socialized Medicine." In this recordings Medicare was claimed to be "socialized medicine" and it warned its listeners that it would bring an immediate totalitarian dictatorship (Skidmore 389). Despite the harsh propaganda campaign against the program, after Kennedy's assassination President Lyndon B. Johnson continued supporting the program and he succeeded in securing the passage of Medicare in 1965. Supporters of the program hoped to ultimately expand the program to include the entire population, however, with the exception of Medicaid, health care reform stagnated until President Bill Clinton's health care plan of 1993. In the next sub-chapter "Clinton and the Healthcare Plan of 1993 (1990s)" I will describe his plan more elaborately.

Around the same time as Medicare, the social federal-state program titled Medicaid that would support the poor was signed into law as well. In 1960, Congress established the Kerr-Mills program that "initiated Federal grants to the States to pay for medical services for the medically indigent elderly," however in 1963 Mills argued that the Kerr-Mills approach needed time to develop and to determine whether it would be capable of handling the problem of health insurance for the elderly (Berkowitz 88). The program started slowly, but this did not hold Mills back from pushing for its expansion. By implementing provisions Mills wanted to make the program more acceptable to the States, and at the same make sure that it would cover the medical expenditures of

people on welfare, and by doing so expanding the Kerr-Mills program from the elderly to other welfare beneficiaries. They wanted in particular children on welfare to have access to health care. This resulted in a development separate from the Kerr-Mills program called the Child Health and Medical Assistance Act which became part of the administration's legislative proposal of 1965. In that same year Mills decided to combine two approaches (that of the administration and the Byrnes' approach) to health insurance and recommended that a supplemental and expanded Kerr-Mills program be included as well in the package (Berkowitz 88) These three plans combined resulted in what came to be known as Medicaid.

David G. Smith and Judith D. Moore, professor of political science at Swarthmore College and senior fellow respectively, claim in their book *Medicaid Politics and Policy: 1965-2007* that Medicaid can be seen as a manifestation of the American system of government as they are both "weakly institutionalized" (Smith & Moore 1). The Constitution was designed in such a way that "federalism and the separation of powers would operate together to check the accumulation of power, contain factionalism and sectionalism, and prevent political extremism" (1). Similarly, Medicaid was meant to reinforce checks on the government and limit or fragment government and counter politics. However, the most notable characteristic of Medicaid may be that it was created to be a state-based and administered policy, and thus putting checks on federalism. (2). The way Medicaid was designed perhaps indicates as to why national health insurance has not been created thus far. Medicaid is a representation of one of the biggest weaknesses of the Federal Government (their power is restricted to prevent federalism) making it almost impossible to implement a national insurance policy because of this lack of power and authority. Nevertheless, despite these weaknesses Medicaid proved to be a significant development in health care reform providing insurance to a broad group of people.

In conclusion, health care reform had made a huge transition in the 1960s. Both Medicare and Medicaid were two great accomplishments in the 1960s, and the prospect of universal health insurance seemed to become more of a reality. Yet, it was not until almost two decades later that another major attempt was made again. President Bill Clinton's proposed Healthcare Plan of 1993 was supposed to be the reform the US health care system needed. The next sub-chapter Clinton and the Healthcare Plan of 1993 will explain the details of this plan and why this too ultimately failed to bring about change.

1.4 Clinton and the Healthcare Plan of 1993 (1990s)

Bill Clinton was the last president before Obama to put great effort in trying to make national health insurance a reality. He believed the American health care system could be one of the best systems in the world, however, two problems made this unlikely: health care costs were to high and still rising, and not all Americans were sure whether they had health care coverage when they needed it (Clinton 804). During the presidential debates of 1992 he proposed a plan that constituted of four main goals. These were summarized by the late Thomas P. Weil, who was a professional on the organization, management and financing of health services, in the article "The Clinton Health-Care Reform Plan: Does it Serve the Underserved." The plan constituted of the following main points: providing every American citizen with at least a basic benefits package so that the poor and independent would also have health-insurance coverage, controlling national health care costs which were increasing and bankrupting Americans, consumers would be able to choose what kind of health insurance coverage they wanted and it allowed them to select their own physicians and hospitals, and lastly implementing a U.S. health care reform plan interwoven as a component into the nation's economic future (Weil 6). Clinton was elected president in 1993 which gave him the opportunity to realize the plan. It was ambitious and extensive, and could have been a turnaround in the history of health care reform, but it eventually resulted in a great defeat for him and proponents of universal health insurance. This sub-chapter will look into detail at this elaborate plan, and why it did not succeed.

Clinton proposed the plan in 1992 during the elections whilst still being a Governor at the time. He wanted to implement a plan that would avoid the poorest of the population to be denied health care coverage and therefore wanted insurance system that would include the entire population. Although there were programs such as Medicaid and Medicare, these were only exclusive to those who were eligible. Thus, accessibility to basic health insurance for all was needed to cover high medical costs. Not only were the health care costs too high and rising, employers who offered insurance plans via private companies would reduce or even drop health benefits and providers of health insurance would limit or eliminate coverage for the sickest, resulting in American families to live in constant uncertainty whether they were able to cover the costs (Clinton 804). Therefore the rise of health care costs had to be controlled, a basic health benefits package should be provided for every American citizen, and consumer choice in coverage and care had to be maintained, or so Clinton argued. Although he believed that the entire health care system needed to be changed, and that this would be an important component of restructuring the national economy as a whole, he proposed that a combination of the government (albeit appropriate and revised) and the private

sector was a requirement in order to provide care and simultaneously maintain competition to serve every citizen in the US (805).

Once in office, Clinton appointed his wife, Hillary Rodham Clinton, to chair The White House Task Force on Health Care Reform which existed to carry out the plan. This task force was eventually disbanded, but the plan was carried on without the task force. Clinton and his administration adopted a particular strategy in order to gain support. Health care advisors began to focus on "preparing an astutely conceived health-care reform plan that potentially provided universal access to a comprehensive range of services without requiring additional taxes or adding to the federal budget deficit" (Weil 6), or in other words avoiding additional taxation or spendings to make the health care plan appealing to the opposition. What made the plan even more appealing perhaps was by describing it as "managed competition under a global budget" (6). By focusing on "strong endorsement of managed competition, and the use of health alliances" and making it compatible with the "Reagan/Bush theme of market-driven competition" Clinton and his administration hoped to gain more support (6). In order to keep the immediate costs constrained the National Health Board put ceilings on increases for insurance-premiums and global budgetary targets for providers. This approach was opposed by health insurance providers as it established a limit on the nation's health expenditures and thus creating a "playing field whereby various providers then compete for maximum share of available dollars" (8). However, health care reformers justified this approach with the mindset that providing universal access and controlling health costs had been successful in other countries for many years, and thus disregarded any criticism.

Weil argued that there were difficulties with Clinton's proposal and raised some critical questions. The first problem he perceived was the question of who would be covered (who is eligible and who is not) in a system that was in theory designed to provide coverage for everybody. It was debatable whether the plan was feasible in practice. Secondly, could sufficient and proper care be offered in rural and inner cities which often required "alternative forms of organizing and regulating health-care providers to improve quality and economy" (Weil 8). Geographical dissimilarities could hinder the goal of universal access to health care. The third question he raised was what kind of insurance the newly insured would require, considering that the uninsured usually made less frequently use of the services of physicians and hospitals, but when they did the costs where often higher because the illness were more severe (9). Also, would the plan be affordable granted that to constrain the costs a consensus needed to be reached on an approach whereby every citizens had to pay their fair share for health services. This could have resulted in tax increases for

or out-of-pocket expenditures by the recipients of Medicare and Medicaid in order to pay providers the full costs of the services the recipients had received. This requirement was based on the premises of fair share that the already existing health insurance plans needed to be equal to Clinton's proposed plan. Also, the plan required employers to pay 80 percent of the employee's premium, possibly bankrupting smaller businesses. The additional 20 percent that needed to be paid by employees themselves would result in a great lose of income for low-wage earners. Finally, premiums would increase year by year because of managed-care plans, resulting in more Americans becoming uninsured in the end. All in all, Clinton's plan was hardly reachable on a financial level (Weil 11). The final question Weil asked was whether the quality of care for the poor would improve? In this regard, the plan was vague and did not offer any reassurance that it would be. Weil was skeptical of the success of the plan, and as it turned out with reason. It eventually failed partially because of its vague and complex construction. Also, it received criticism from many opposing groups before the plan even reached voting in the House.

According to Jacob S. Hacker and Theda Skocpol Clinton and his administration did not met a significant conservative opposition like previous presidents, but particularly encountered an "offensive orchestrated national and in many congressional district by small businesses, commercial insurance companies, and members of the Christian Coalition and other right-wing advocacy groups" (Hacker & Skocpol 319). The Republican Party also opposed Clinton's health care plan and the political battles that followed demonstrated to Republicans the "power of denouncing taxation and government as the source of public anxiety and discontent," thus thereby cutting into funding for health care and turning the population against the government. Over the course of time Republicans became skilled in using modern mass media politics against their adversary: they made use of polls, focus groups, political advertising, talk radio, and targeted media appeals and linked these tactics to grassroots such as "the Christian coalition, the National Federation of Independent Business, the National Rifle Association, and other conservative advocacy groups with a strong presence in congressional jurisdiction" (327).

Skepticism about the efficiency of the health care proposal and the opposition it faced contributed to its failure. However, promoting the plan as well as maintaining and finding support also proved to be a challenge. To promote the plan the Clinton administration attempted to set up a nominally nonpartisan "National Health Care Campaign." It was designed to raise its own funds whilst targeting twenty-one states who they had identified as keys to the ultimate passage of the plan. Because of its nonpartisan approach it came under legal attack and the White House moved it "under the auspices of the Democratic National Committee, which resulted in reduced funding and

less capacity to mobilize coalitions that included groups that had to maintain nonpartisan identities" (Skocpol 73). Perhaps, more devastating was the fact that reform-minded politicians and groups in and around the Democratic party were unable to unite on even some of the basic "how-to" features of health reform. The president did not manage to attract most Democrats to his approach of which most favored major alternative plans. Policy disagreement remained and had eventually undercut the explicability and credibility of Clinton's proposal by the time it was officially announced. Any possibility for compromise in Congress had virtually disappeared (Skocpol 73).

David W. Brady and Kara M. Buckley from Standford University observed another deeper and more accurate reasoning why the plan failed. They argued that it did not pass because "the proposals made by Clinton and members of Congress were too far form the preferences of critical voters in both the House and Senate" (Brady & Buckley 448). They continued with the following explanation to support their assumption: "a simple median voter model shows that to win, legislation must appeal to the median voters in the House and to those members who could induce a filibuster in the Senate. Considering both the preferences of legislators and the super-majority institutional arrangements in the Senate, the Clinton plan was doomed from the start" (448). Their hypothesis was supported by what may be a logical theory. By ranking the senators and representatives from most liberal to most conservative, followed by defining what the position of the existing policy is and the proposed policy change, it can be predicted whether a proposed policy will pass, according to Brady and Buckley (448). By adjusting a proposed policy to a certain extent that it lies closer to what the median voters want (those in the Senate and House), a filibuster can be either avoided or broken with enough support for the proposed plan (448). Mainly focusing on the Senate, Brady and Buckley analyzed Clinton's proposal and came to the conclusion that because it diverted too much from the median it was destined to fail.

As this sub-chapter has shown, there are multiple diverging reasons as to why Clinton's plan of reform failed. While some argued that it was because the plan was broad and vague and left many holes to be filled, others claimed that he met a particular kind of opposition who knew how to use the media in their advantage, and an alternative analytical view explained that the strategy used by Clinton failed to appeal to the larger portion of the Senate and the House. Altogether, there are many studies that have an explanation why the plan was unsuccessful. Clinton was eager, to get legislation on health care reform passed but ultimately did not have the right plan and support to realize this goal. The next sub-chapter will look at the strategies used by president and we will try to understand what went wrong with their approach.

1.5 Strategies

Throughout history it seemed that the American society was not ready for a different system, however, the strategies used to push legislation regarding health care also played a significant role in the success or failure of the attempt. Although some of these strategies have already been discussed to some extent in the previous sub-chapters, we will look again in this part at how presidents and their administrations have tried to pass health care reform and national health insurance legislation, e.g. which strategies they used to gain support.

Going all the way back to the beginning of this chapter, the time before and of the enactment of the Social Security Act in 1935, it was evident that reformers were less concerned with passing national health insurance. They were aware of the fact that not every area (particularly rural versus urban) had the same access to health care, therefore getting support for legislation that would be nationally orientated yet unevenly distributed had little chance of success. Also, the limits on federal activity made proponents focus more on the States rather the Federal Government. The supporters were therefore more active in progressive areas such as Sacramento, California, and Albany, New York, rather than in Washington itself. Furthermore, national health insurance was not very popular because it was similar to the German system which had gained a bad reputation after the war (Berkowitz 82). Knowing these circumstances, reformers had to take a different approach that would not result in an immediate and vital change. In the 1930s, when around 25 European countries already had some form of national health insurance, reformers put more thought in strategically arguing for something that came close to national health insurance. New conditions and improvements in medical care, along with reports of the Committee on the Costs of Medical Care in which they claimed that provisions were necessary to assure an "adequate supply of medical care and a means for people to pay for it" did not result in health insurance for every citizen, but it did open the door for the Social Security Act (83). Although not everybody saw the need for national health insurance, there was ample support for health insurance for the dependent.

Three decades later, Lyndon B. Johnson's Great Society was a strategical move that was supposed to bring about change. A different strategy was adopted that consisted of trying to find common ground with private health care providers (who had become increasingly more popular the years before). Wilbert Cohen coordinated the legislative activities surrounding Medicare for both President Kennedy and President Johnson. In order to gain understanding and support, he made clear that the proposal would "…not provide a single medical service…physicians' services would not be covered or affected and the proposal provides that the government would exercise no supervision or control over the administration or operation of participating institutions or agencies" (qtd. in Berkowitz 85). While campaigning for Medicare, reformers wanted to

accommodate to private health providers by allowing elderly people with private health insurance coverage to keep their coverage. According to Berkowitz the case would be that "Medicare would reimburse the private carriers for benefits that coincided with those covered by the program" and by doing so hoping to gain support leverage in the Senate (Berkowitz 86). In 1962 this approach did not have the desired results and the Senate defeated the measure. Another attempt was made again in 1964 this time developing a plan that assured "the use of the Blue Cross plans to administer hospital insurance. That plan led to what would later be called fiscal intermediaries, charged with the task of administering Medicare's bill operations" (86). This measure meant that the Blue Cross would handle all the bills generated by hospitals for the care of Medicare patients and it avoided the Federal Government's involvement in routines of health care finance.

During the Medicare debate, Republican Representative John Byrnes proposed a voluntary health insurance program that would cover both "medical and hospital costs, funded in part by the beneficiaries themselves and in part through general revenues" (Berkowitz 87). Eventually, Byrnes' approach was adopted into the plan along with the administration's Medicare plan. By catering to the wants of the private insurance companies, and likewise accepting an additional proposal supported by Republicans (Byrnes' proposal) the Johnson administration strategically gained support from what usually were influential opponents. Similarly in the debates around Medicaid the administration incorporated elements of a proposal pushed by the AMA known as Eldercare (88). Realizing what was attainable and what was not at the time, both Roosevelt and Johnson managed to get health care and insurance passed albeit not universal. They listened and catered to their opposition and thereby gained support. Perhaps this is why Clinton's approach did not had the desired effects. Brady and Buckley's research showed that the status quo of the 1990s was significantly different from Clinton's Healthcare Plan. Had he put more effort in adjusting his plan to what his opponents would have accepted, it may have been more successful. Or perhaps, he should have gone with his own plan completely without compromise. As we will see later on, this tactic was used by Obama and may have contributed to his success. Not long after the proposal had failed during the 1994 campaign it became evident that there was little enthusiasm for health care reform. Polls showed that not many voters saw health care as a major concern at the time (Brady & Buckley 454).

In conclusion, each important moment in the history of health care reform showed that expectations needed to be adjusted along with the appropriate strategy. In important factor of the success of a plan is the status quo is at that time. When there is an urging for change the need for government involvement is often more desired than usual. The next chapter will look more closely at the opponents of national health insurance and what their influence and role has been over the course of history.

Chapter 2: "The Opponents"

Chapter 2.1 The American Medical Association (AMA) and the Health Insurance Association of America (HIAA)

The previous chapter looked back at failed attempts trying to pass universal health insurance. The difficulty often lay in the opposition who did not belief in the success of a system that could provide affordable health insurance for every American citizen. Two opponents were the American Medical Association (AMA) and the Health Insurance Association of American (HIAA) who represented physicians and insurance companies respectively. These opponents had tried for instance to block legislation through propaganda methods. This sub-chapter will therefore be dedicated to what the AMA and HIAA are, and why and how they obstructed national health insurance.

Starting off with looking at the AMA's resistance and obstruction of health care reform it all began with the Roosevelt administration. In the 1930s the association pressured the administration to drop health care from the Social Security Act of 1935. It continued lobbying against what was known as socialized medicine during the 1940s (Lee 139). Summarized in one sentence by John W. Cline in the article "Socialized Medicine," socialized medicine is any program of medical care for the American population that is tax supported and governmentally controlled (Cline 658). By campaigning against socialized medicine they managed to successfully obstruct amendments for national health insurance legislation, despite the fact that the need for some collective payment program that would help Americans pay for rising health care costs remained. The AMA was their for its own members and therefore only wanted a system that worked in their favor.

The AMA wanted to obstruct any form of socialized medicine (i.e. any federal supported program) and so Truman's administration was no exception. Although he tried to avoid the term socialized medicine because of its somewhat negative connotation, Truman was a great advocate of a federal-supported insurance system (see the previous chapter). Not long after his re-election in 1948, the American Medical Association House of Delegates met in St. Louis where they issued a statement of principles, began another campaign against socialized medicine and had their members pay a $25.00 fee in order to finance the campaign (Cline 659). The AMA wanted to convince the American population of the harm that would be done to their medical care as a result of socialized medicine. They attempted to show the people how it would result in a loss of freedom by securing medical care and how other aspects of their freedom would be threatened in the prospect of wider socialization. Simultaneously they tried to show the advantages of voluntary health insurance as a

mechanism of spreading the cost of illness (659). With this campaign they sought the support of the people by focussing on their discontent about federal control in private matters.

Initially, the AMA was opposed to any kind of corporate organization of medicine and ways of financing. This included the financing of medical costs via private insurance companies. However, in the 1930s and 1940s when the calls for federal health reform persisted, the AMA approved some health insurance plans but only those underwritten by insurance companies, but still successfully avoiding governmental support in the matter (Chapin 144). The AMA's acceptance of this system and the failure of Truman's plan on the other hand did not signify the end of attempts at health care reform. The voluntary insurance provided by private insurance companies still faced the threat of reform because it was considered extremely expensive. Political pressure therefore did not subside after Truman's defeat which resulted in the continuation of reformers pleading for an alternative form of financing medical care on the one side and the organized physicians and insurance companies battling these reform proposals by elected officials on the other side. These proposals, as we already have learned, were intended to be universal or at least cover a large mass of the population. In response, the AMA in cooperation with the HIAA wanted to "meet social goals without federal reform by rapidly developing organizational capacity around the commercial-insurance model" which they adhered (144). This meant transforming what used to be accessible to only a select few into a mass consumer good and thus making health insurance slightly more accessible to a larger group with the help of federal support.

Thus, eventually the AMA came to support a system where private insurance companies were to ones to provide insurance to the people. It was not so much the matter of universality of national health insurance that they opposed, but rather that it would mean more governmental influence and interference in what they considered a private matter. As mentioned earlier the AMA had also launched a campaign against Medicare and they condemned Social Security claiming that these programs were socialized medicine and would lead to a dictatorship (Skidmore 388). By focusing on the fears of the American people (e.g. dictatorship, tyranny) they garnered support. The AMA found a lot of support in the HIAA. They were also keen in fighting off health insurance legislation albeit less radical. The two associations used to form a strong political alliance against the reformers of health insurance and have managed to block several health insurance proposals whilst working together.

The AMA and HIAA both pursued a system that would prevail in American health care for decades. They also pursued political strategies that "created a distinct approach to "private" medical care—a high-cost, corporate model based on insurance-company funding and

management" (Chapin 144). This expensive model was threatened by proposals that offered an alternative to this system. In response the AMA and HIAA wanted to demonstrate that they could build up a model that did not require federal reform and by doing so developed organizational capacity around this so called commercial insurance model (144). The associations had a common interest, yet, the diverging economic roles between insurance companies and physicians caused a drift in the alliance in the 1950s and 1960s. The insurance companies underwrote the risks related to medical services and decided when payment of medical expanses would be covered, however they expanded their authority even further by managing the health care system. Medical costs rose and so they waded deeper into the systems operations and extended their power beyond payment of and risk related medical services: "underwriters became experts in the practice of medicine, introduced cost-containment measures, and established a supervisory function, albeit weak, over physicians work" (147). The fact that private insurance companies exercised more power over the physicians caused a widening of the economic rift between both interest groups and altered the political AMA-HIAA alliance (147).

Despite changing economic roles, both still opposed federal health care reform. Also, because of the costs associated with broad coverage and generous benefits the HIAA reconsidered their views on mass coverage. They became less enthusiastic about extending private coverage to all of the people, thus making support for national health insurance less likely. For instance, the HIAA officially opposed federal programs for aged insurance. Strangely enough they offered less resistance to Medicare. This may have been thanks to the fact that the policymakers of Medicare designed it in such a way that it fitted in with the insurance-company-funded model. The policymakers adopted several institutional arrangements already created by insurers. One of these arrangements was that insurance companies would play an intermediary role between the government and service providers. This institutionalized their position as managers of the public-private health care system. The insurers got more authority as they successfully managed to adapt to the political environment. Their political influence strengthened and their economic position was enhanced thanks to the role as the medical system's financiers (Chapin 145). Their overall position was more secure than that of the AMA and therefore they offered less resistance to federal health insurance reform.

The question that now remains is to what extent these association had an influence on health care legislation. K. Robert Keiser and Woodrow Jones, Jr. carried out a study to find out whether the AMA's contributions had an important impact on policy. They claimed that the "political power of the AMA has tended to be overestimated," whilst believing that if proposals failed in Congress it

most likely had to with the fact that the majority in Congress belonged to either the conservative coalition of Republicans or the southern Democrats who were both "philosophically unsympathetic to such policies" (Keiser & Jones 761). The study confirmed their hypothesis: "The influence of the AMA's contributions was less than the impact of party and ideology" (766). However, it did indicate that campaign contributions produced more results over a series of decisions in the long run, as opposed to a single roll call. This meant that legislators might not return the favor in one case, they often would help out on another measure (766). The study also showed that the AMA's contributions made a greater difference in the committee votes, and less on the floor the House. In conclusion, the ideology of the decision-makers in the government is the most important factor explaining how ideas are resolved. Yet, the power of the AMA should not be disregarded. Nowadays they remain influential and are a potent political force.

Concluding, both associations had reasons to oppose national health insurance, mostly because many of the proposed legislation on national health insurance would introduce a system that would not work in their favor. The AMA and HIAA (which is now known as America's Health Insurance Plans since it merged with the American Association of Health Plans in 2003) can both be seen as powerful lobbyists against universal health insurance ("Health Insurers Gain A Huge New Lobby"). They were not the only opponents health reformers faced, however. The Republican Party within the realm of the political arena have been and still are one of the biggest enemies of national health insurance legislation. In the next sub-chapter titled "The Grand Ol' Party: the Grand Obstruction" I will explain how they offered resistance and what their rationale was behind their decisions.

Chapter 2.2 The Grand Ol' Party: the Grand Obstruction Party

In the previous sub-chapter I explained why some lobby groups such as the AMA and HIAA were against national health insurance, and how they tired to block health care reform, particularly when it comes to universal health insurance. Of course they are not the only agents that put an immense amount of pressure on American health care politics: the Republican Party has been the main opponent on the political platform. Similar to those raised by the previously mentioned lobby groups there are two plausible reasons why this party opposes national health insurance: they are against high taxes and want to avoid federal interference as much as possible. Just like the AMA and HIAA, the Republican Party opposed the principle of socialized medicine because it required federal support, meaning creating taxes to pay for the medical costs. However, the Republican Party has been a supporter of health insurance, albeit individual private insurance provided by the States rather than the Federal Government. Therefore in this sub-chapter I will try to create a framework which explains why they oppose national health insurance and therefore how come their general beliefs block attempts at health care reform.

The Republican Party has been a long time opponent of universal health insurance. The Republican Party's attitude towards health care reform in general has been difficult. One explanation given for why Republicans often are reluctant in accepting health care reform has to do with their ideological beliefs and patriotism. For instance, the Social Security Amendments of 1960 which augmented the Federal Government's role in financing health care coverage for elderly citizens provided the foundation for the establishment of the Medicare and Medicaid programs. However, there was the fear that health care costs would rise because of this legislation which led to Wilbur Mills, the Chairman of the House Ways and Means Committee, to block consideration and passage of Medicare legislation until 1965 (Peters 441). The seating of the committee may have also contributed to the delayed passing of legislation that could have benefited a great portion of the elderly population: 10 out of 25 committee members were Republicans. Peters explains: "Due to the Republicans' aversion to a significant expansion of federal power, these committee members were predisposed to oppose such an initiative, especially during the 1960 presidential campaign season" (444). Several other proposals followed, after which Representative Mills and Senator Kerr (D-OK) opted for an alternative proposal which became the Kerr-Mills bill (448). This constant rejection of social insurance approach to health care coverage also occurred in the Senate Finance Committee. For instance, during the Senate floor debate the Republican members referred back to their party's platform which consisted of the belief in "a federal-state-local approach that retained the states' rights to define their level of participation, preserved the individual's right to choose, and

minimized the expansion of federal power" (Peters 451). Proposals such as the Anderson Amendment, which espoused a social insurance approach, were rejected also. As seen with the rationale of Republicans and southern Democrats, the Anderson Amendment was unappealing to them as a majority of their state's farmers would not have been eligible for health care coverage under the Amendment (458). The committee itself proposed a bill as well. To the South (mainly Republican representatives and southern Democrats) this was more interesting as it authorized the states to define the number of eligible services that would be included in their plans and the maximum coverage for each service that would be provided to eligible patients (460). Southern states traditionally supported maximizing state control, meaning that they supported the state's rights and had a related aversion to the centralization of power. The Republican Party's support for state's rights and preference for limiting the power of the Federal Government is reflected in this study on Republican opposition against universal health insurance bills during the 1950s and 60s.

During the 1990s health care reform was looked at favorably even by Republican leaders. Many realized the need for comprehensive health care policy. Also, the 103rd Congress consisted of a Democratic majority who were in general known for being favorable towards health care reform ("Congressional Profiles"). The Clinton administration therefore had many advantages that could have worked in their favor when trying to pass national health insurance. Yet Clinton's proposal failed and Congress abandoned the plan without even a single vote (Brady 447). Professor William P. Brandon and Keith Carnes argue that the single most important reason for the failure of Clinton's health care plan may have been "the opposition of House Republicans in 1994 to the concept of health reform, its scope, and its sponsor" (Brandon & Carnes xli). In 1993 and 1994 William Kristol, a young Republican strategist, managed to convince Republicans through a series of memos to defeat any health reform efforts undertaken by Clinton. He noted that he did not want Clinton to take credit for any reform, stoking fire in an already hostile Congress (xli). He believed that by defeating the Clinton plan through an aggressive and uncompromising counterstrategy the Republican Party could eventually take control of Congress and the presidency (Skocpol 75). In a letter to the Wall Street Journal Republican Representative Richard K. Armey said: "the Clinton health plan would create 59 new federal programs or bureaucracies, expand 20 others, impose 79 new federal mandates and make major changes in the tax code… [T]he Clinton plan is a bureaucratic nightmare that will ultimately result in higher taxes, reduced efficiency, restricted choice, longer lines, and a much, much bigger government" (qtd, in Skocpol 75). Christian Coalition groups began to devote substantial resources to an anti-health care reform crusade. This resulted in strong anti-reform pressures within the party and caused moderate Republicans who

initially were inclined to work out some compromise to backpedal. Similar, interest groups whose leaders were also willing to bargain over reforms were pressured by constituents and Republican leaders to back off from cooperation with the Clinton administration and congressional Democrats. The Republican Party had channelled all their energy and resources in making sure the health care plan had no chance of succeeding. Thus, the party's ideological beliefs, fearing big-government and that the quality of health care would deteriorate, were stronger than the need for a national health insurance plan that could have covered many uninsured Americans as early as in the 1990s.

In conclusion, by looking at previous health care reform attempts we have come to understand the ideological views of the Republican Party. Although they did not started out as a very conservative party, the Republican Party loathed the idea of giving the government too much power, believing that the people should be represented by their States, and thus they should be responsible for private matters such as health care and insurance. Therefore, comprehensive government plans and programs such as Medicare and Medicaid, Clinton's Health Care plan, and the Affordable Care Act were all heavily contested issues, and the possibility of another health care reform plan to succeed seemed slim. Yet, the next chapter will show it was possible when President Barack Obama passed his health insurance plan in 2010.

Chapter 3: "Finally Victorious After Sixty Years"

Chapter 3.1 Obamacare: The New Medicare

This final chapter will look at one of the most memorable and thus far greatest victory achieved in health care reform: the Patient Protection and Affordable Care Act of 2010 (ACA or sometimes nicknamed Obamacare) signed into legislation by President Barack Obama. The second sub-chapter will go into detail on which difficulties President Obama faced trying to get the ACA passed. The third sub-chapter explains the strategies that were used that led to the success of the Obama administration. By comparing the strategies used by Obama in order to get the ACA passed and up and running with those implemented by previous presidents, I will hopefully come to an answer to this thesis: Why did Obama succeed whilst others did not? This introductory sub-chapter "Obamacare: The New Medicare" will first review some the key features of the ACA.

The passage of the ACA constitutes a major change in health care reform, which was an unimaginable development during most of the 20th century as we now know. Comparing Obama's success to the achievements of other presidents regarding health care reform, he has come closest to a national health insurance system that is able to provide coverage to almost every citizen of the United States. Overall, the ACA had the same primary goals as previous health insurance proposals: Improving the quality of health care and simultaneously lowering the costs, increasing access to health care, and providing greater consumer protection in health care (Fitzgerald et al. 28). Of course the ACA was more complex and elaborate than those primary goals. Commitments such as fining employers who did not offer coverage, mandating individuals to purchase health insurance, offering subsidies to those with a low income, modifying programs such as Medicare and countless other rules showed the complexity of this legislation (Quadagno 35). This approach offered a new health insurance system unknown to Americans. For decades the health care system in the United States used to be based on the services provided by private companies (for instance private health insurance provided by employers), with later on the occasional interference of the government. It was not until insurance programs such as Medicare and Medicaid came into existence that the Federal Government started to play a bigger role (Leimbigler 470). This created a hybrid public-private health care system where the private sector still played a greater role than the government (Béland et al. 428). Obama's plan, however, would give the government even more power and influence regarding health insurance.

Contrary to the American system, other liberal welfare regimes in countries such as Canada and the UK were already familiar with forms of government-supported universal access to health

care. The United States is a unique case among the developed countries when it comes to welfare. Their approach to health-care has been market-based for a long time, which may be explained by factors such as American liberalism, the growth of insurance companies and employer-based insurance companies (Leimbigler 470). On account of problems such as high medical costs, insufficient medical care, lack of coverage and so on, many came to realize that this approach did not result in the best services for the American people. Despite all the resistance health care reform encountered in a polarized political environment and the controversy surrounding the ACA because of its different approach to health care, the act passed legislation indicating a major change in the American mindset. The next sub-chapter will give an overview of the steps made by Obama that led to the ACA, some of the setbacks he and his administration encountered and the resistance he was offered, but also the support he gained along the way. Later on I will analyze in more depth the strategies he and his administration pursued. These parts will be determining for answering the thesis question.

Chapter 3.2 A Long and Difficult Road?

The road to the Affordable Care Act (ACA) has been a strenuous and difficult one. The previous chapters gave a historical overview of health care reform and have set out a framework explaining why health care reform has been such a difficult, almost impossible goal to attain. Jacob Hacker, known for his expertise on U.S. health and social policy, summarized the problem clearly: "they have always involved the frightening claim that government involvement will lower the quality and raise the costs of medical care, threatening the wellness and financial security of those who are already insured" (Hacker 4). Thus one of the biggest problem is distrust of the government and the aversion against governmental influence fearing that it would diminish the freedom of the American people. Hacker continues with explaining that the political framework existing know in the United States, one that is skeptical of egalitarian government efforts and is designed to make major policy transformation difficult, has resulted in a long list of failed attempts at reform. Public concerns and interest-group opposition have put too much pressure on proposals, often leaving reformers short of their ultimate goal of universal health security (Hacker 4). The ACA has been considered controversial because of its reliance on governmental interference and so met resistance as well. In "A Long and Difficult Road?" I will try to analyze whether and, if so, what kind of problems the Obama administration encountered during and after the passage of the ACA. I will also look at the opposition against and support for the ACA. I hypothesize that these elements, combined with the strategies implemented by the Obama administration, made the passage of the ACA possible.

In 2008, Obama's controversial health care plan was the highlight of his campaign. During the presidential campaign it was evident that the Democratic presidential candidate, Obama, and Republican candidate, John McCain, had polarized views on how to reform the health care system. Their views represented the sharp division between the Democratic and Republican Party on the issue. McCain's plan, for instance, would have eliminated a tax exclusion. Workers did not have to pay health insurance premiums to their employers but under his plan they would be obligated to do so. The generated revenues would have been used to pay for refundable tax credits for Americans who wanted to obtain private insurance. These tax credits would eventually go to both working and unemployed Americans (Oberlander 781). However, the plan was uncertain about how it would affect costs and coverage. Even with the tax credit health insurance would have most likely remained expensive and thus did not solve the problem of the high number of uninsured Americans. Obama's plan offered more assurance that the problem could be resolved. His plan required employers to offer their workers insurance or to pay a tax to help finance coverage for the uninsured. It also offered two new options regarding health insurance: "a new government plan

(similar to Medicare) and a national health insurance exchange (a purchasing pool analogous to the Massachusetts Connector) what would offer a choice of private insurance options" (Oberlander 782). The people were offered a choice, rather than offering a limited solution. Oberlander pointed out one flaw: the proposed plan lacked an individual mandate. The plan offered universal access rather than universal coverage. In 2014, however, the individual mandate was implemented and so the ACA truly became a universal health insurance plan (Courtemanche 778). What made this plan controversial was that under governmental oversight and regulation it required more taxes and it displaced the existing private sector. Yet, many people realized that health care reform was needed. Whether this helped Obama during the election is not a question I will answer in this thesis. However, knowing that he proposed such an intricate health care plan similar to Clinton's plan for instance, shows again that the United States was ready for change and raises the question what made this change possible.

Once he was elected President in 2008, Obama had the opportunity to carry out his elaborate health care reform plan, and the ACA became law in 2010. Nevertheless, early on after its passage the ACA was under attack by the Republican Party. The opposition discharged its legitimacy by challenging it through legal actions and pushing legislative efforts to repeal or defund the ACA (Rigby 58). The Republican Party claimed that the health care reform was "one-sided and undemocratic, with inadequate debate, consideration, and compromise" (58). This criticism came because of the fact that the Democratic majority party managed to pass the ACA despite the minority party's opposition. This polarized partisan support for the bill was not surprising and the final bill did not receive any Republican votes in either the House or the Senate (58). Support for the ACA in the House or the Senate was one-sided, and this lack of aid persisted during Obama's presidential term.

Contrary to the Republicans position, Obama did manage to find support in a group that has opposed health care reform for a long time: the American Medical Association. On 15 June 2009, at a meeting of the AMA's policy making House of Delegates in Chicago Obama asked for the association's support for his health care reform initiative. The association was willing to express support, but still awaited the plans that would emerge from Congress (Tanne). About a month later on 16 July 2009, the article "Powerful doctors group backs Obama's health care reform plan" written by Daniel Nasaw stated that the AMA decided to endorse Obama's proposal for a new health care system. Their support removed a substantial hurdle to legislation that had blocked previous proposals. The association had opposed Clinton's health care plan of 1993 for instance, opposing government intervention for fear that physician members' pay would decline. However,

on that day in July they pledged to work with congressional leaders to make sure legislation would soon be passed. “The medical association’s surprise turnaround may be an indication they see reform as inevitable and hope to influence the legislation at the margin” so Nasaw reports, showing that the AMA handled out of own interest by supporting the ACA, but it also indicated that the general mindset even among large lobby groups such as the AMA moved towards the realization that reform was necessary. In a statement issued almost eight years later, their support remains unwavering:

> Health system reform is an ongoing quest for improvement. The AMA supported passage of the Affordable Care Act (ACA) because it was a significant improvement on the status quo at that time. We continue to embrace the primary goal of that law—to make high quality, affordable health care coverage accessible to all Americans. We also recognize that the ACA is imperfect and there a number of issues that need to be addressed. As such, we welcome proposals, consistent with the policies of our House of Delegates, to make coverage more affordable, provide greater choice, and increase the number of those insured. (“AMA Letter to Congressional Leaders”)

Initially supporting a private based system, and somewhat later a hybrid system, the AMA shifted more towards a health care structure which requires tight cooperation between the Federal Government and private agents in order to have the system work sufficiently.

In conclusion, this sub-chapter defines some of the setbacks the Obama administration encountered along the way, such as resistance from the Republican Party, but also how they acquired support from the AMA, something which had not happened before for any other health reform plan. In the next sub-chapter “Strategies” I will try to define the strategies implemented by the Obama administration which may have contributed to the passage of the ACA.

Chapter 3.3 Strategies

Within a relatively short period of time, many scholars have written about Obama's success (against all odds) that changed the health care system. In this sub-chapter, perhaps the most defining one in answering the question of this thesis, I will analyze academic articles and research done by multiple scholars on the Affordable Care Act in order to comprehend the strategies implemented by Obama that led to the passage of the act. An analysis of these strategies may help explain why Obama was successful where others failed. I hypothesize that some of these findings will show that Obama made use of different strategies to make the ACA seem appealing, but more importantly that he made strategical and effective use of the Democratic majority in the House and the Senate, which resulted in a successful enactment of the ACA despite its controversial status.

One strategy proposed by Betsy Leimbigler and Christian Lammert, PhD candidate and Professor of North American Politics and Policy at the Freie Universität at Berlin respectively, to the question how Obama managed to get his health care reform plan passed is that he "used specific frames in order to get the support he needed to convince Congress to pass his reform proposal" (468). As previously mentioned the ACA passed without a single vote of the Republican representatives. Leimbigler and Lammert argue instead that Obama built on the interests of the major stakeholders in the bargaining process prior to the passage of the ACA, as well as the opinion of the American people with regards to the major health care problems in the United States. By doing so he focused on a broader audience who according to him held a greater stake in receiving better health care and insurance (468). They propose that Obama implemented this strategy the following way: "Through Speech analysis, we highlight how the presidential discourse on Obamacare was framed using economic terms prior to its passage" (468). Leimbigler and Lammert argue that Obama and his administration used that strategic instrument of framing speech to get support for the bill considering that the nation was in a time of economic austerity. They explain that Obama made use of two frames: 'rights' and 'market' frames. The 'rights' category is defined as the human right, meaning the right of every American citizen, to health care. The 'market' category looks at the employer-based system and references to economic gains or losses. The economic-climate in 2009-2010 was ruled by insecurity and so the widespread economic fear contributed to the health care debate at the time. Although it appeared that many Americans opposed Obama's plan, they did want to see major change (471). Leimbigler and Lammert claim that "the White House can exploit existing public opinion as a resource for changing the direction of public policy by making appeals on policies that already have public support" and by doing so "encourage members of Congress to support White House Initiatives to please the public" (472).

This strategy of framing is according to them a "rational method to influence the way citizens think about issues, and the way people think and feel about issues" that translates to their voting patters and political preferences (473). This strategy can be seen as a way of manipulating people into thinking what you want to them to think about at the time. In other words, be framing the health care proposal as a solution to the economic uncertainty prevalent in the U.S., Obama managed to put it on the public's agenda, which was then eventually picked up by Congress to satisfy their constituents.

Leimbigler and Lammert selected a number of speeches, remarks, and one letter to Senate Democratic leaders and analyzed these using critical discourse analysis composing of qualitative analysis of sections, wording, framing and terminology that relate to either rights or market framing. The conclusion of their analysis was that Obama used predominantly market frames in order to support his proposed reform plan. He did this in particular in the time leading up to the passage of the bill by linking the cost argument (i.e. the spiraling out of control of the costs in the health care sector) to public expenditures and the deficit problem, which also resonated well with major stakeholders (477). Not until after its passage did Obama move towards focusing on the rights frame in order to defend the reform plan against criticism. This strategical set indicated that Obama wanted to diverge the people from the economic crisis by claiming that was no longer the main problem, but rather the right to have access was the main concern which needed to be solved. In response, the 111th Congress took the ensuing concerns and pleas for change of the public into consideration. Leimbigler and Lammert's research indicates that Obama made use of a strategy that may have helped him gather support for a plan that was not desired, but believed to be needed in order to provide economic betterment for the American people as well as secure their rights to accessible health care.

However, Leimbigler and Lammert's research on strategical framing does not offer sufficient explanation why the bill got passed when none of the Republican representatives in Congress voted for its enactment. Elizabeth Rigby et al. offered in the article "Party Politics and Enactment of "Obamacare": A Policy-centered Analysis of Minority Party Involvement" a better look at majority and minority party power and how this effected the legislative process. She explained the research as a way of "conceptualizing the legislative politics leading up to health care reform as a political contest over policy design," while simultaneously illuminating "the process by which members of the minority party and their ideas get incorporated in (and potentially excluded from) the policy agenda within our legislative process" (Rigby et al. 59). In other words: this research may help us understand how the legislative process excluded the Republican Party and so

confirm our hypothesis that Obama made effective use of the 111th Congress which consisted of a Democratic majority.

During the congressional debates over health care in of 2009-10 the Democrats formed a strong electoral and governing coalition. They had a solid majority of the popular vote for the president, a large partisan majority in the House, and also a filibuster-proof majority in the Senate. According to Marl Carl Rom, Director of the MA in American Government program and Associate Professor of Government and Public Policy at Georgetown University, the Senate contained 58 Democrats and two Independents who caucused with the Democratic Party (Rom 5). This resulted around the time of the passage of the ACA in a needed 60 votes (three-fifths of the Senate members) to invoke a cloture needed to break a potential filibuster (Beth & Heitshusen 23). As a result of this strong position in Congress the Democratic Party held dominating institutional powers: they were able to set the agenda and shape legislative outcomes via their power to appoint committee chairs, schedule debate, and establish the rules governing floor debate (Rigby et al. 61).

However, a Democratic majority is not to say that health care reform is guaranteed. During President Clinton's campaign for his health care plan in 1993 Congress also consisted of 258 Democrats, 176 Republicans, and one Independent, yet the plan failed miserably ("Congressional Profiles"). Craig Volden and Alan E. Wiseman conducted an extensive research on the fates of bills' and the effectiveness of their sponsors in hiding these proposals through Congress. By examining thousands of bills regarding other matters and comparing these with thousands of health policy bills introduced in Congress across the recent decades, they have tried to explore whether "health policy making in Congress is plagued by legislative gridlock, whether such gridlock is more pronounced in the area of health politics than elsewhere, what the potential causes of health policy gridlock are, and how such gridlock has been overcome in the many successful health policy reforms that were signed into law over the past four decades" (Volden and Wiseman 229). They hypothesized that a health policy proposal needs a strong majority party and committee leadership support to achieve legislative success (233). They concluded the following: "proposals that are advanced by health policy experts in Congress, that build coalitions with strong majority party base, and then engage in limited (but sufficient) compromise with supportive minority party members have been, and likely will be, the most successful path to health policy reform in Congress" (260). Relating this to the legislative process of Obama's proposal they continued: "Along these lines, the ultimate success of the 2010 reforms followed from abandoning the quest for bipartisan support, form actions of key committee and party leaders (including the speakers of the House), and from building on a strong majority party base" (260). Therefore, their research supports the hypothesis of my thesis that

Obama made strategical and effective use of the Democratic majority in the House and the Senate. Instead of making compromises and building a bipartisan support in Congress, Obama solely focused on gaining support and votes from the Democratic Party, which thus has worked in favor of the passage of the ACA.

Conclusion

This thesis has shown that health care reform, especially when it comes to insurance programs, is not an easy task to accomplish. As a European outsider, the fact that health care and health insurance in the United States has been such a controversial item for decades baffled me. Therefore I wanted to study why the process of health insurance reform has been so complicated in the United States, but also what eventually made change possible.

To refresh your memory of the history of health care we have covered in this thesis, it all began at the beginning of the 20th century when President Franklin D. Roosevelt proposed and signed the Social Security Act of 1935 into legislation. This act did not provide universal coverage, but showed that the Federal Government felt some degree of responsibility regarding the health of the American population by providing benefits for those who needed it. This act was the first step towards creating a system that would enhance the influence of the Federal Government as time went by. The act was followed by a failed attempt at national health insurance by President Harry Truman. President Lyndon B. Johnson, however, gained success in the 1960s when he passed two major programs: Medicaid and Medicare. These two programs broadened the scope of Americans eligible for insurance. These legislations eventually opened the door for future universal health insurance. However, for every two steps forward, there will be one step back. Clinton's Health Care Plan of 1993 turned out to be a complete failure and it would take twenty more years until another president attempted to reform American health care.

Each president and his administration countered opposition from all sides. In this thesis I have covered three of the main opponents of national health insurance: the AMA, the HIAA, and the Republican Party. By using their influence and political power these agents have managed to block health care legislation for decades. However, they failed or declined to do so with the ACA in 2010. Thus, the question that he question I asked my self at the beginning of the thesis was the following:

Which aspects of the American political system have prevented presidents preceding Barack Obama from passing health insurance and why did Obama finally succeed in doing so by passing the Patient Protection and Affordable Care Act after almost sixty years?

Previous presidents have either proposed a plan that was to complex at the time or the population was often not ready for such a major change. When they would propose a health reform plan, they often sought a compromise with their adversaries after which the plan usually resulted in failure.

Obama took another approach and strategically framed his plan by focusing on the economic austerity of the nation before the passage of the ACA, and after its passage on the rights of the people to health care. He therefore strategically framed the plan to gain support. Also, he made use of the Democratic majority in Congress and managed to have the ACA passed without a bipartisan approach.

Thus, Obama was successful because of his different approach to the matter, but also thanks to a new era where the United States was in need of change. This thesis on the ACA and health care reform offers ample room for further research. For instance: Is the ACA effective, and what problems have developed because of it? But even more interestingly is the influence of the current president, Donald Trump, on the ACA, for he is eager to repeal or replace it with his own insurance program. This raises the question what his presidency will mean for the future of the ACA and universal health insurance in general. Perhaps he will bring about unexpected, but positive change, or he will undo what health care reformers have been fighting for the past sixty years. Regardless of what the future will bring, today America possess an insurance system that is able to provide universal coverage and hopefully it will be given many more years to develop and prosper.

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