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## The rhetoric of reform : examining the role of political language in Rhode Island's health care debate

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**THE RHETORIC OF REFORM:  
EXAMINING THE ROLE OF POLITICAL LANGUAGE IN  
RHODE ISLAND'S HEALTH CARE DEBATE**

A dissertation presented

by

Kevin P. Donnelly

to

The Department of Political Science

In partial fulfillment of the requirements for the degree of  
Doctor of Philosophy

in the field of

Public and International Affairs

Northeastern University  
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ABSTRACT OF DISSERTATION

Submitted in partial fulfillment of the requirements for the  
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Northeastern University, August 2009

## ABSTRACT

Political language refers to the way in which public policy issues are portrayed, discussed, and ultimately perceived by the community at large. Focusing specifically on two case studies in Rhode Island – the efforts of two policy entrepreneurs to enact comprehensive health care reform, and Governor Donald Carcieri’s successful pursuit of a Medicaid “Global Waiver” – this thesis begins with a description of the social, political, and economic contexts in which these debates took root. Using a “framework of analysis” developed for this thesis, attention then centers on the language employed by the political actors involved in advancing health care reform, along with the response of lawmakers, organized interests, and the public. A major finding is that the use of rhetoric has been crucial to the framing of policy alternatives, constituency building, and political strategy within Rhode Island’s consideration of health care reform. In addition, statistical analysis of original survey data shows that political language orientations are related to the public’s policy preferences, a fact that has long been assumed but seldom investigated empirically.

## ACKNOWLEDGEMENTS

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– Chapter 1 –  
**Political Language: A Framework of Analysis**

Language is integral to the human experience. The words we speak enable us to communicate ideas, relate to one another, express emotions, persuade and dissuade each other, and even process thoughts. Language touches every aspect of our lives, and the words we choose – whether deliberate or not – shape our laws, institutions, policies, and politics. *Political language* refers to the way in which public policy issues are portrayed, discussed, and ultimately perceived by the community at large (see Beard, 2000, among others). The study of language in the political realm rests on the assumption that the dynamics of public discourse play a powerful – and often overlooked – role in shaping the public policy process (see Elder and Cobb, 1983; Edelman, 1988; Rochefort and Cobb, 1994; Stone, 2002). Research in this area is very much an interdisciplinary field of study, drawing on concepts from sociology, linguistics, cognitive psychology, political science, and other fields. As a result, the political language literature is highly compartmentalized and rather difficult to apply in a systematic fashion. In this study, a holistic “framework of analysis,” integrating the conceptual tools developed in a range of disciplines, will be used to explore several questions related to how political language has shaped health care reform policy in the state of Rhode Island.

### **I. Developing a Model of Political Language**

Scholarly literature related to the use of political language can be categorized into three broad topics of interest: the *messenger*, *message*, and *response*. The “messenger” refers to individuals and/or groups who are communicating, as well as their resources,

motivations, and the intended purpose of their use of language. The “message” represents the content of the language itself. Lastly, the “response” refers to the influence of language on political thought and public policy. Despite a proliferation of research related to each of these core components of political language, and the fact that they are vitally interconnected, there has never before been an integrated analytical framework that ties together the conceptual tools that have been developed in these research areas.

The need for this type of holistic framework of analysis is great. While much can be gained by simply studying the language used in the political sphere, without taking into consideration the motivations, goals, and resources of those who are communicating, as well as the ultimate impact of those words, it is not possible to capture the full scope of political language. Figure 1 represents not only the three critical elements of the study of political language, but also – and perhaps more importantly – their overlapping nature, the details of which will be elaborated on in the pages that follow.

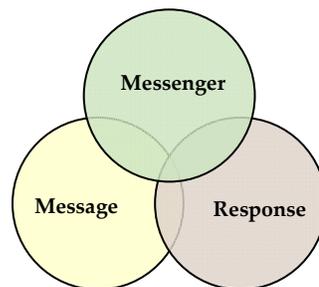
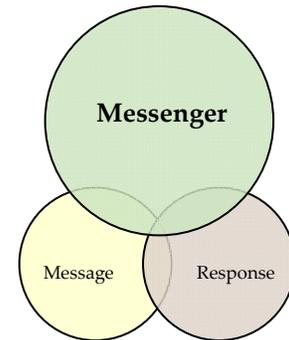


Figure 1: A Holistic Model of Political Language

## II. Political Messengers

Political messengers are those groups and individuals who create and advance political messages for public consumption. These drivers of political language come in a number of forms, but can be broken down into four main categories: political leaders, policy

entrepreneurs, organized interests, and the media. Sometimes the messages delivered by these political messengers are completely in sync, helping to create an overriding, widely-accepted narrative, or storyline, about a particular issue. More often than not, however, one or more political messengers offer competing narratives, forming the basis of much of political conflict (Stone, 2002).



Political messengers convey messages in a variety of contexts, including written or prepared statements, testimony, speeches, interviews, and campaign slogans (Beard, 2000). Political messengers also use language for a variety of different purposes. For example, political leaders may use language to explain a policy proposal or political decision, persuade the public to support a particular point of view, or generate enthusiasm about an ambitious goal. The underlying premise in each of these situations is that through the use of language, one “can not only achieve an immediate result but also win the acquiescence of those whose lasting support is needed” (Edelman, 1964, p. 114). Thus, political language is about more than the content of what is being said – it also matters *who* is speaking and *to what effect*.

### **A. Political Leaders**

Political leaders have a considerable capacity to convey political messages due to their unparalleled access to the public through campaign events and paraphernalia, keynote speeches, press conferences, community meetings, and other forms of outreach (Perloff, 1998). This broad reach gives them the capacity to inform, motivate, and mobilize the public using the words they choose. As a result, they are the foremost communicators of political messages and of significant importance to the study of political language. Additionally, Teena Gabrielson (2005) notes that political leaders are distinct from other political communicators in that their constituents hold them accountable for what they say. Therefore, Gabrielson argues, the “mood” of the public, organization of interests, and partisan composition of a representative’s constituency can actually constrain how elected officials talk about certain issues.

Much of the work related to the study of language and political leaders centers on presidential rhetoric, and with good reason. More than any other political figure in American politics, presidents have virtually instantaneous access to the ears of millions of people. Be it the State of the Union Address, a primetime television address, or a brief stop in the Rose Garden, presidents hold a unique capacity to convey and shape political messages. As a result, a president’s strategy of “going public” has been the focus of considerable scholarly attention (See Kernell, 2007, for a recent example).

When it is said that a president “goes public,” it simply means that he has chosen to go over the heads of legislators, promoting his policy ideas directly to the American people. A recent example of this approach was George W. Bush’s 2005 “60-day Social

Security Tour,” in which he traveled coast-to-coast in order to promote his plan to implement a partial privatization of the program (Simon and Vieth, 2005). Of course, this strategy is not always effective in bringing about the desired policy change (the President’s plan was ultimately rejected). Regardless of outcome, however, the president has the potential to capture media attention and shape public and legislative debates in a way that no other individual could.

Many presidents have had a substantial impact on public policy. The words spoken by Abraham Lincoln during and after the Civil War helped to usher in a magnanimous reconstruction policy and changed the way in which Americans viewed the United States—it has been said that prior to the Gettysburg Address, the United States was a plural noun, and after the speech was delivered, it was perceived as a singular word (Wills, 1992, quoted in Perloff, 1998). Franklin Delano Roosevelt took the power of words to the radio to build support for his sweeping legislative agenda, inspiring confidence and trust through “fireside” chats with the American people (Perloff, 1998). These efforts bolstered confidence in the President’s “New Deal,” which, among other things, transformed the nation’s social welfare system. More recently, “The Great Communicator,” Ronald Reagan, relied on his renowned rhetorical skills to conduct a number of successful policy campaigns, including substantial federal budget cuts and tax reform initiatives (Tulis, 1987).

Presidents are not the only political leaders who have an ability to communicate and shape political messages, however. In 1994 House Speaker Newt Gingrich ushered in the “Republican Revolution” by offering a “Contract with America” (with the

help of pollster and wordsmith Frank Luntz) that clearly delineated the legislative agenda of Republican congressional representatives (Luntz, 2007). The easy-to-digest and carefully crafted words included in the “Contract” not only helped bring an end to a 40-year Democratic dominance in the House of Representatives, but also contributed to the passage of a number of significant reform bills, including a major restructuring of the nation’s welfare program (Tanner, 1996).

Finally, although they are not often studied as closely, political leaders at the state level have similar advantages as national figures to shape political messages within their borders. In particular, governors hold the ability to direct the political debate concerning important state issues such as education, taxes and spending, crime, and, increasingly, health care (Dukakis, 2001). Bold health care reform initiatives have been adopted in Maine, Vermont, Massachusetts, and elsewhere in recent years, and in each case the state’s governor played an important role in communicating a political message that fostered support for groundbreaking legislative action.

Through the communication of political messages, national and local political leaders have an extraordinary capacity to set the legislative agenda by drawing attention to issues that might otherwise be outside of public awareness. Moreover, political leaders can employ language to “sanctify action” and shape debate in such a way that it renders the opposition “quiescent” (Edelman, 1964). Thus, the language of political leaders can help to usher in lasting policy changes.

## **B. Policy entrepreneurs**

Communication of political messages is not only the purview of elected officials. Political dialogue also includes the voices of policy entrepreneurs – people who spend considerable time and resources to advocate for policy change. These individuals often play an important role in creating a climate ripe for legislative action by offering the public new policy definitions, images, and solutions. Through their efforts to inform and engage the public in campaigns and cultivate legislator support for reform, policy entrepreneurs are key players in two well-established theories of the policy process (Sabatier, 1999).

John Kingdon, who introduced the term “policy entrepreneur” to mainstream political science as part of his agenda-setting model, offers one of those theories. Kingdon defines policy entrepreneurs as individuals who show a “willingness to invest their resources – time, energy, reputation, and sometimes money – in the hope of a future return” (Kingdon, 1995, p. 122). According to Kingdon’s model, policy entrepreneurs are often the agents that draw together the three “streams” (politics, problem, and policy) needed to produce a “window of opportunity” for policy change.

Baumgartner and Jones (1993) offer a different model of the policy process in which policy entrepreneurs seek to produce policy change through the multiple venues that exist within the American political system, including numerous distinct levels of government, separated powers, and jurisdictional overlaps. For example, if seeking change at the federal level proves fruitless, an individual can turn to the states for action. Following the demise of President Bill Clinton’s 1993 health care reform plan, the

phenomenon of “venue shopping” has been used successfully by many health care reform advocates who have sought change at the state level.

In each model, the targeted use of language has been identified as an important part of a policy entrepreneur’s broader effort to enact policy change. Kingdon argues that effective policy entrepreneurs will “redefine” their preferred policy solutions in order to fit existing problems (this theme is elaborated on in the “Problem Definition” section of this chapter). An example of this strategy can be found in the ongoing efforts of those advocating for a national health care system in the United States. At different points in time, national health care has been offered as a solution that addresses the problem of the uninsured, rising health care costs, or underinsurance in the private market. According to Kingdon, an astute policy entrepreneur will define national health care as solution to whichever problem is most acute in the public’s eye. Similarly, Baumgartner and Jones suggest that policy entrepreneurs may seek to change a policy image—for example, moving from images of health care as a privilege of employment to images of health care as a social right—in order to mobilize previously uninterested citizens toward political action. In either case, the political language used by policy entrepreneurs is central to ushering in policy change.

While policy entrepreneurs can be political leaders, they are often private individuals who are working from outside the political system. This “outsider” status creates a category of political messengers with distinct opportunities and, in some cases, advantages. The language used by policy entrepreneurs who are not in public office is likely to be quite different from those who hold elected office, since they are free from

electoral accountability but also lack the easy and broad access to media and the public. Few studies examine the distinctions between public and private policy entrepreneurs, despite their very separate approaches and resources. Since the concept of a policy entrepreneur is relatively new to political science, more work is needed to understand how their position in the policy community might influence how they employ political language as a strategy of reform, a topic explored in Chapter Three of this thesis.

### **C. Organized Interests**

Well-organized advocacy organizations and groups with vested interests in public policy represent a growing voice in American politics. These broadly defined groups include lobbyists, policy analysts, political action committees, faith-based organizations, advocacy organizations, and other politically-active groups that routinely engage in the policy process. Their combined efforts are widely recognized to have a substantial influence. Sabatier and Jenkins-Smith (1993) argue that “advocacy coalitions” are the central drivers of the policy process. Organized interests have also been shown to advance their political interests through campaign contributions, grassroots organizing, and other forms of political mobilization. What is not often noted, however, is that many of these groups have also become adept at using political language to advance their policy agendas, and the diffusion of Internet resources has allowed these groups to transmit political messages to more people than ever before, magnifying their growing role as political messengers (Bimber, 2003).

The importance organized interests place on political language is exemplified by an extensive study conducted by the Herndon Alliance, a nationwide progressive coalition of more than 100 minority, faith, labor, advocacy, business, and health care provider organizations. Using innovative methods of value-based polling and focus group research, the Herndon group identified a number of “strong health care messages” they suggest coalition members and other health care advocates use when talking about their reform ideas, including “quality affordable health care,” “American health care,” “choice,” and “control.” They also identified language to avoid using, such as “universal coverage,” “Canadian-style health care,” “government health care,” “required,” and “regulations” (Herndon Alliance, 2007).

Going a step further, the Herndon study also included measures of how specific political language influences support for a particular reform idea. The report shows that the level of support for a plan they call “Guaranteed Affordable Choice” increased if respondents were first exposed to rhetoric that “taps into key health care values,” and decreases to varying degrees according to different angles of “attack” rhetoric (Herndon Alliance, 2007).

Results of this report and similar studies have been disseminated widely, becoming absorbed into the language used by advocacy organizations. Ultimately, these political messages find their way into the broader public debate through rallies and demonstrations (which are often covered by the media), testimony before lawmakers, community meetings, and other forms of public outreach (Rochefort and Donnelly, 2008). The tremendous emphasis on language among advocacy organizations

is further testament to the “real-world” role that language plays in shaping public policy.

Vested policy interests are another voice commonly heard within political discourse. For example, the American Medical Association (AMA) is a well-financed political power that has long been a voice for free enterprise and fee-for-service medical practice (Patel and Rushefsky, 2006). The AMA has been at the forefront of opposition to universal health care for decades – in fact, this group was even instrumental in purging the idea from President Franklin Roosevelt’s 1935 Social Security Bill (Kronenfeld, 2002). The AMA’s success is due, in part, to the group’s argument that a national health care system, or “socialized medicine,” would lead to a reduction in consumer choice, waiting lines for treatment, and lower quality health care. To date, the AMA and other political messengers who have opposed a national health care system have been successful in communicating a message that cultivates a political environment inhospitable to reform (Starr, 1982; Morone, 1990).

Organized interests have long played a role in American politics, but today their role as political messengers has become increasingly prevalent, particularly through the use of targeted ad campaigns (West, 2000). From advocacy organizations to industry professionals, groups that have a stake in policy outcomes include targeted language as a key component of their political strategy. Therefore, in order to understand the shape and scope of policy discourse, it is essential that the voices of these groups are clearly distinguished, a topic that will prove to be of importance in tracking the health policy process in Rhode Island and elsewhere.

#### **D. The Media**

Unlike politicians, policy entrepreneurs, and advocacy organizations, the media both *reflect* and *create* political messages by paraphrasing or quoting language from ongoing discourse involving specialists, public officials, and interest groups, while offering their own language in reporting and interpreting issues and events (Gamson and Modigliani, 1989). The media's primary function is to describe important issues and events to the general public, who rarely have the time, resources, or opportunity to gain full exposure to the breadth of unfolding events. Simultaneously, certain elements of the media create their own unique political messages. Newspaper editorial pages and political commentators offer distinctive – and often colorful – interpretations of issues and events much like any other political messenger. With the advent of 24-hour news stations and the diffusion of Internet access, news organizations are increasingly influential in shaping not only the news that people hear, but also the analysis and editorial perspectives to which people are exposed. As a result, the media function as both a selective conduit and creator of political language.

One of the most important roles played by the media – and in particular, media executives – is that of “gatekeeping” (DeFleur and Larsen, 1987). Due to the sheer volume of reportable news and the limited time and space that news organizations have at their disposal, it is necessary for media executives to select which political events, individuals, and stories they will cover. This process of deciding what is “newsworthy” naturally weeds out certain political messages and emphasizes others, a fact that has far-

reaching implications since the vast majority of people rely on news outlets to keep them apprised of what is going on.

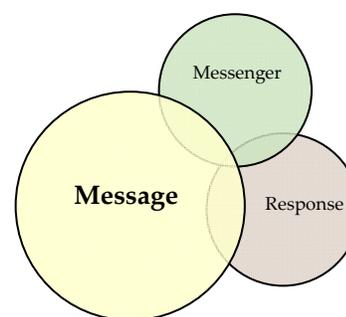
Similarly, in deciding the breadth of exposure given to certain issues, news organizations play a central role in setting the public agenda (Iyengar and Kinder, 1987; McCombs, 1981). Political leaders and policy entrepreneurs who wish to draw attention to their policy ideas benefit greatly from media coverage. Of course, the news media do not dictate the entire political agenda. Some events and issues are so mainstream that the media simply report based on public demand. A sudden collapse of the stock market, domestic terrorist attack, or major policy debate is unlikely to be left from any organization's news coverage. However, the media do select which *aspects* of the issue they will cover. This necessary process of deciding what to emphasize and what to ignore characterizes the media's "parallel" (and rather subjective) political language. By using certain linguistic cues to convey information, the media define and give meaning to issues in the context of the larger political environment (Callaghan and Schnell, 2005). Therefore, the emphasis and presentation of the facts of one particular event might vary considerably from one source to another.

News organizations also offer political commentary and editorial pages to which many people turn for yet another source of political messages. Many newspapers offer endorsements for specific policies or candidates, and many take positions on issues that are not otherwise heard in the political sphere. Moreover, the views of vocal individuals within the political community are transmitted in newspaper opinion sections, local television broadcasts, and more recently, the Internet "blogosphere," all of which

combine to form an arena in which “symbolic contests are carried out among competing sponsors of meaning” (Gamson, 1992, p. 55). Thus, the media represent a multi-faceted and complex political messenger, deserving of close attention with regard to both the delivery and construction of political messages.

### III. Political Messages

In the realm of public policy, political messages are used to convey information, ideas, and attitudes pertaining to public issues and problems. Political messages in this area of study can be broken down into two broad categories:



message *structuring* and message *augmentation* (see Nimmo, 1999; Stone, 2002). Message structuring refers to the way issues are framed and defined by political messengers for public consumption and use in public discourse. This dimension of political messages sets parameters around which issues are considered important and worthy of government attention and which policy solutions are deemed appropriate to address the given problem. Message augmentation involves the language used to communicate and supplement the structural message. Symbolism, statistical argument, and storytelling are all used to inform (and sometimes confuse) the public about political issues. These aspects of political messages may either serve to develop an issue frame or to denigrate it, often with potent effect. Identification of each of these concepts helps to untangle the complexity inherent in political messages.

### **A. Issue Framing**

In this study, the phrase “issue framing” stems from the field of political communication and includes “selecting and highlighting some facets of events or issues, and making connections among them so as to promote a particular interpretation, evaluation, and/or solution” (Entman, 2004, p. 5). In other words, frames set parameters around how a public issue is understood and discussed, thereby structuring how political decisions are made.

Most issues of public concern are complex and multidimensional, meaning that there are many different angles from which an issue can be discussed. It is rare that every angle is explored thoroughly in public discourse, however. Instead, a select dimension of an issue typically becomes the dominant frame of reference. Knowing that the outcome of public policy is shaped according to which frame becomes dominant, much political conflict centers on competition over how an issue is framed.

A recent example of this process is found in the debate over embryonic stem cell research, which features two competing frames: opponents of federal funding for stem cell research emphasize the morality of the issue, arguing that the procedure requires the destruction of human life; proponents of federal funding focus their attention on the scientific promise offered by this research, noting that it could lead to cures for debilitating conditions. Competition over which frame characterizes the issue is at the center of the debate—so much so that it prompted a 2001 primetime television address by President Bush in which he emphasized his belief that the extraction of stem cells from an embryo “destroys the potential for life” (Bush, 2001). The President’s address

was largely successful in shaping stem cell research as a moral issue, which in turn fostered (at least for a short period of time) strong opposition to federal funding (Nisbet, 2004). In subsequent years, however, proponents of stem cell research worked to shift the frame away from the destruction of life and toward emphasis on social progress and economic competitiveness (Nisbet and Mooney, 2007). Public support for conducting stem cell research seems to have responded to these efforts, shifting from 43 percent in 2002 to 56 percent in 2006 (Pew Research Forum on Religion in Public Life, 2006). This case illustrates that the way an issue is framed can often be as important as the policy itself.

Issue framing can also play a role in how a political messenger structures his or her presentation of available policy solutions. An advocate or policy entrepreneur interested in advancing a particular policy idea might present what is known as a “Hobson’s choice” to the public, meaning a list of options designed to make the messenger’s preferred solution appear to be the only logical choice (Stone, 2002). For instance, a policy entrepreneur interested in reforming a bankrupt social program might state that the only alternatives to their proposed comprehensive reform would be dispensing with the program altogether or doing nothing at all. This list would set arbitrary parameters around the scope of possible alternatives, leaving “comprehensive reform” appearing to be a reasonable choice because it promises to both save the program and implement some corrective action.

Similarly, framing can play a powerful role in coercing the public to behave a certain way. Consider the following example, offered by Thaler and Sunstein (2008), of

two environmental campaigns designed to change how people use energy: (1) If you use energy conservation methods you will save \$350 a year; (2) If you do not use energy conservation methods, you will lose \$350 a year. Even such a subtle difference in language has a considerable impact on how people react. The second campaign, framed in terms of how much people would “lose,” was far more effective than the first campaign. Although the net result was exactly the same, one frame apparently offered a more powerful incentive for people to change behavior.

## **B. Problem Definition**

Problem definition has emerged as an important dimension of political language. Problem definition refers to the way in which issues are identified and discussed in the public realm (Rochefort and Cobb, 1994). Similar to issue framing, the way a problem is defined adds finer contours to the shape and structure of policy issues.

The concept of problem definition has only been thoroughly explored in recent years, but its importance has long been recognized. E. E. Schattschneider (1960) was among the first to point out that the supreme instrument of power in waging political conflict is the “definition of alternatives.” He described the struggle for political priorities as analogous to the “fog of war” made murky by competing definitions of the policy issues at hand. Problem definition has also been identified as an important part of the agenda setting process, and is often associated with the notion of dynamic policy changes. As noted previously, John Kingdon (1995) observes that policy entrepreneurs will often attempt to “redefine” preferred policy solutions to fit existing problems in

order to advance a policy idea. Baumgartner and Jones (1993) expanded on Kingdon's concept of issue redefinition, however, noting that this process can mobilize those left outside the system either to construct new institutional structures or break up existing arrangements, thereby creating a fundamental shift in the policy "equilibrium."

In an effort to promote a more systematic application of the problem definition framework, Rochefort and Cobb (1993) presented an "anatomy of problem description" delineating the main categories of discourse by which a problem is constructed. These categories include problem causation, the nature of the problem, characteristics of the problem population, ends-means orientation, and the nature of the solution.

According to Rochefort and Cobb, problem causality includes some claim about who or what is to blame – be it a particular group or individual, or some systemic process or force – without which there would be no basis for government action. Allocation of blame can be communicated in a variety of ways, including the creative use of "causal stories," which often include an emotionally compelling narrative outlining a sequence of events and assigning responsibility (Stone, 1989).

How the nature of the problem is defined can powerfully affect both the likelihood of political action and the design of policy solutions. Problem attributes can include its severity, incidence, novelty, proximity to the individual, or classification as a crisis (Rochefort and Cobb, 1993). In some cases, policy disputes center not around the technicalities of the policy itself, but rather around whether a problem exists at all. For example, proponents of national health care reform commonly refer to the uninsurance "crisis," citing a dysfunctional system with millions of uninsured (Rochefort and Cobb,

1994). Opponents of an overhaul of the nation's health care system, on the contrary, commonly deflect such appraisals – declaring instead, as former presidential candidate Rudolph Giuliani frequently did during the 2008 presidential primaries, that America has the “best medical care in the world” and is in need of only marginal reform (Giuliani, 2007). A clear difference of policy separates these two sides, with the main point of disagreement hinging on whether it is a major social problem needing to be solved or only a minor one.

Definition of a public problem also typically focuses on the affected population, which can be described as worthy or unworthy of government assistance, threatening and strange, or as individuals who are generally familiar and foster feelings of sympathy (Rocheftort and Cobb, 1993). For instance, are welfare recipients lazy, unproductive citizens taking advantage of a government system, or are they victims of an unbalanced market economy? The way the majority of people answer that question will likely affect the amount of public support for welfare programs and, hence, the amount of money allocated to welfare programs. Ultimately, the characteristics associated with the population impacted by a policy can have a substantial impact on the scope and political viability of government intervention.

In some policy disagreements, political actors define their positions in terms of a stated outcome. Other times, the means, rather than the end, are the focus of the debate. Rocheftort and Pezza (1991) illustrated this phenomenon as it played out during the height of debate over a needle-exchange program. Proponents argued that the distribution of clean needles to intravenous drug users reduced transmission of the

AIDS virus; many opponents felt that any form of government support for illegal drug use was inappropriate, and therefore reason to block the proposed program regardless of its possible effectiveness in reducing the AIDS virus.

In describing the nature of the solution, Rochefort and Cobb build on Wildavsky's (1979) argument that a problem will only receive the attention of policymakers if there is also an available solution. As Wildavsky states, "a problem is only a problem if something can be done about it" (Wildavsky, 1979, p. 42). Therefore, in some cases, the availability of a policy solution can actually precede the identification of a problem. Rochefort and Cobb note that the definitional struggle also extends from aspects of the problem to the "descriptive qualities of the solution" (Rochefort and Cobb, 1993). For example, disagreement can unfold around the viability of a proposed solution—even if it can be agreed upon that a problem exists, policymakers must also agree that the proposed government intervention will have a desired effect. Therefore, the nature of a policy solution can be defined as being an acceptable or unacceptable method of government intervention (Ibid., 1993). The recent debate regarding the government "bailout" of major American corporations serves as an example of how this dynamic can shape the political discussion. During the height of the debate, little public attention was paid to the amount of money to be distributed. Instead, the focus of the debate—particularly for those who opposed the plan—was whether or not it was the government's place to intervene in a market economy in the first place.

### C. Symbolism

A symbol is anything that stands for something other than itself and evokes an impression or attitude about what it is meant to represent (Edelman, 1964; Elder and Cobb, 1983; Stone, 2002). A symbol can come in many forms—a phrase, a metaphor, an object, a place, an event, or even a person. All good symbols conjure up certain images in one’s mind, but they do not necessarily mean the same thing to all people. For example, the image of an American flag will likely stir very different sentiments in a war veteran, child, college student, and recent immigrant. Unlike issue frames or problem definition, political symbols are communication shortcuts that transform messages into compact representations, inducing support or opposition through appeals to personal experience, ideology, values, or morals. In doing so, symbols shape perceptions and attach strong attitudes to public policies, though often in unpredictable ways.

To some extent the meanings of symbols are highly subjective and personal, reflecting an individual’s own experience and cognitive disposition (this theme is elaborated on in the following section). However, symbols also function as creators of a broader social reality. In fact, much of the work related to symbolism in politics stems from the idea that reality is a “social construction.” Peter Berger and Thomas Luckman (1966) introduced the notion of “socially constructed reality” to the social sciences, suggesting that over time, people operating in a social system form concepts or mental representations of each other’s actions, which become habituated into reciprocal roles and ultimately institutionalized. This process of institutionalization embeds a framework of knowledge and belief of what reality is into the fabric of society.

The implications of this perspective on the way we understand politics are profound. Murray Edelman (1966) argues that political developments are ambiguous entities that derive their meaning from what concerned observers construe them to mean. As a result, the “political realities” most people experience are not a product of direct experience; rather, politics for most is merely “a passing parade of political symbols,” leaving the meaning of political events, facts, and related policy alternatives subject to interpretation.

Edelman (1964) identifies two types of political symbols: referential and condensational. Referential symbols are simply economical ways of referring to objective facts. For example, aggregate statistics or cost figures function as useful symbols because they help in logically conversing and thinking about particular situations. It is important to note, however, that referential symbols, though rooted in hard facts, can also be used to manipulate how one interprets a situation. Numbers and statistics are commonly used to build support for policy initiatives, either by alarming those who hear them or by distorting reality (Stone, 2002). One of the most commonly heard statistics in the debate over national health care in the United States is that there are “47 million uninsured Americans,” a staggering figure lending support to the notion that reform is needed. Opponents of restructuring the nation’s health care system, however, could fairly point out that 84 percent of Americans have health coverage, conveying the message that the vast majority of people are insured.

Condensation symbols are designed to trigger emotions associated with a given issue or situation (Edelman, 1964). For example, during the 1980s the “welfare queen”

became a common symbol of the problems that plagued the welfare system. This phrase was meant to conjure up images of a mother who had many children simply to increase the size of her welfare payment and adopted a life in which the government took care of her every need. Condensation symbols such as these can often arouse strong emotions and are rarely, if ever, checked with reality (Ibid., 1964). Thus, many people, though they have only a vague knowledge of public policy, can form intense political preferences based almost solely on symbolic cues.

Symbols also routinely appear as political slogans, which are devised to sell parties, candidates, or public policies. Much like slogans that are used in business to market products, slogans in politics often play with words and meaning in order to catch the attention of the public (Beard, 2000). The “Yes We Can” slogan of President Barack Obama’s 2008 campaign proved to be a powerful rallying cry for voters hungry for hope and a new brand of citizen-led politics. Contemporary public policy debates are also laden with political slogans. “No Child Left Behind” in education; “A Woman’s Right to Choose” an abortion; “Remember 9/11” when considering homeland security; and “Play-or-Pay” health care reform are all recent examples of policy slogans.

#### **D. Storytelling**

Storytelling as a means of conveying political messages can appear in many forms. The stories that will be focused on here, however, are those stories that “humanize” an issue or policy. Unlike causal stories (mentioned previously), humanizing stories transform a relatively remote and abstract policy into one that is

potentially relatable to everyone. Such stories are often used to draw attention to the actual or potential human impact of a public policy initiative. Consider the following excerpt from a story featured in *The Providence Journal* just after implementation of a law that cut roughly 2,800 immigrant children from Rhode Island's Medicaid program:

Ana Beltre watches her 13-year-old son with great anxiety these days, urging him not to run around too much. She fears he'll set off an asthma attack. That will mean the terror of watching her tall, lean youngster gasp for air as she rushes him to the emergency room. Her boy, Brian Cordones, had been able to keep his asthma under control with regular puffs from an albuterol inhaler. But a couple of weeks ago, Brian lost his health insurance. Albuterol costs \$100 per canister, and Beltre, who works in a jewelry factory, says she can't afford the medication. Brian came to Providence from the Dominican Republic in 2005. He is among some 2,800 immigrant children who were removed from RIte Care, the state-run health plan for poor families, on June 1, as the state reacted to a deficit in the current fiscal year (Freyer, 2008).

This news article, which conveys a rather vivid image of the human cost paid by the government's decision to scale back the Medicaid program, was accompanied by a picture of the young boy perched on the side of his bed entranced in a video game he is playing – a common and easily relatable scene – making the story all the more powerful. This was a front-page news article written as an informative piece – not an editorial or opinion piece – but the author's effort to humanize the situation was clear. This approach to delivering the news is not uncommon. Newspapers often write informative columns that include personal stories simply as a means of capturing the reader's interest. In doing so, newspapers (and other news media) expose readers to the people who are directly impacted by public policy, either bolstering the audience's original

policy position or perhaps encouraging some to reconsider what they previously supported.

Humanizing stories are not just found in the media. Politicians and policy advocates also use stories to build support for their preferred policy solutions. During the 2008 presidential primaries Hillary Clinton routinely shared personal stories as a means of connecting her proposed health care solutions to a person or population with whom most people could identify. In one instance on the campaign trail, Clinton shared the following story about Ms. Viera, “a 75 year-old woman in Oregon who suffered from five chronic illnesses, including diabetes, high blood pressure, and mild congestive heart failure” as a means of building support for streamlining health care services into what are known as “medical homes.”

Now, in most clinics across this country, Ms. Viera would receive care from qualified, capable doctors and nurses. But her care would likely not be coordinated – her providers wouldn’t be talking to each other, making sure that the treatments they were prescribing were working together. This ends up raising costs and increasing the chances that she will suffer complications or end up back in the hospital. Anyone who has ever tried to coordinate their own care, or the care of a loved one, knows that this is all too common a situation. Fortunately, her care was addressed comprehensively through Care Management Plus in Oregon, an IT system with trained care managers in primary care clinics to treat older adults with complicated conditions. She’s in good hands. Her care managers and her primary care physician addressed her symptoms early, preventing problems rather than treating them after they occurred. And she is helped to navigate the system (Clinton, 2007).

Rather than simply referring abstractly to how an unspecified “patient” would benefit from a medical home, Senator Clinton very deliberately used the name of a real

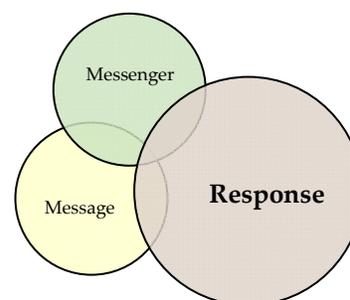
person who could be anyone’s mother or grandmother – while drawing attention to that fact by explicitly stating that “Anyone who has ever tried to coordinate their own care, or the care of a loved one” could relate to the situation. For those who may not have agreed with Clinton’s plan or knew nothing about medical homes, this approach offered a vivid image of the people who supposedly would benefit from such an arrangement.

Deborah Stone outlines other types of stories that help to advance issue frames and definitions of policy problems, including what she terms stories of “decline,” “stymied progress,” “change as an illusion,” “helplessness and control,” “conspiracy,” and those that “blame-the-victim” (Stone, 2002). Though each type of story differs in important ways, the underlying theme throughout is that each offers a narrative giving life to otherwise abstract public policies and leading the audience toward a particular policy decision. Thus, humanizing stories can strongly influence the way people respond to broader political frames and definitions.

#### IV. Political Response

The study of political language raises the question: Does the way in which a politician, advocate, or media figure describes an event or issue influence people’s response in a meaningful way? George Orwell

was among the first to answer this question with an unequivocal “yes.” The following passage, from Orwell’s 1946 essay “Politics and the English Language,” outlines how the careful selection of words and phrases can significantly impact the way people view the meaning of events.



In our time, political speech and writing are largely the defense of the indefensible. Things like the continuance of British rule in India, the Russian purges and deportations, the dropping of the atom bombs on Japan, can indeed be defended, but only by arguments which are too brutal for most people to face, and which do not square with the professed aims of the political parties. Thus political language has to consist largely of euphemism, question-begging and sheer cloudy vagueness. Defenseless villages are bombarded from the air, the inhabitants driven out into the countryside, the cattle machine-gunned, the huts set on fire with incendiary bullets: this is called *pacification*. Millions of peasants are robbed of their farms and sent trudging along the roads with no more than they can carry: this is called *transfer of population* or *rectification of frontiers*. People are imprisoned for years without trial, or shot in the back of the neck or sent to die of scurvy in Arctic lumber camps: this is called *elimination of unreliable elements*. Such phraseology is needed if one wants to name things without calling up mental pictures of them (Orwell, 1946).

The implications of what Orwell is suggesting in this passage are profound. He argues that by using a rather benign word like “pacification” to describe the bombing of defenseless villages, many people will be deceived into supporting (or at least accepting) an act they would otherwise deplore. On its face this argument may seem to be rather obvious, and volumes have been written about the deliberate use of such “doubletalk” in modern-day politics (see Szanto, 2007, for a recent example). However, given the simplicity and strength of Orwell’s thesis, some may be tempted to make accusations of “doubletalk” without fleshing out some basic (and sometimes erroneous) assumptions.

Michael Geis (1987) offers a number of mistakes that are often made by those in search of the type of deliberate manipulation Orwell warned against. First, people who make accusations of “doubletalk” often get the facts wrong. The example Geis uses to illustrate this is Nixon’s use of the word “incursion” to refer to the military operation he ordered in Cambodia. Critics argued that Nixon intentionally chose the word

“incursion” in order to avoid the more negative (and presumably more accurate) term “invasion.” However, Geis points out that this charge has no merit due to the simple fact that the definition of the word “incursion” fit the details of the operation precisely, and therefore should not have been viewed as a “softer” or less accurate term in the first place. Moreover, there was no proof offered to suggest that the general public, or Nixon himself, interpreted the word “incursion” the same way as his critics did.

Similarly, Geis notes that many charges of Orwellian deceit may be misplaced for the simple reason that the language someone uses may simply reflect his or her perceptions of an issue and therefore be a quite natural way of expressing oneself. Charges of “doubletalk” in this case are typically more political than objective in nature. The point is not that political language is rarely deliberate; in fact, subsequent chapters will show that much of what is said in the political sphere is carefully scripted, but in the pursuit of objective analysis this sort of intention must be proven, not assumed.

Geis also notes that those who believe most people are fooled by the use of Orwellian “doubletalk” implicitly include themselves among a select few who are not fooled. In other words, Orwellians are somehow capable of pointing out something that average people cannot do for themselves. This view is not only arrogant, but also rather naïve. Everyday use of the term “Orwellian,” as well as the sheer number of books and articles that have been written on the subject, suggest that people are generally aware of such blatant uses of political language and are probably less susceptible to attempts at linguistic trickery than some would suppose.

This is not to suggest that language has no effect on political thought, only that the “strong” version of Orwell’s thesis – that political thought is determined by creative political language – may be saying too much. Rather than assuming that language controls thought, Geis suggests a “softer” version of Orwell’s thesis – that political language influences what we think when we accept uncritically the political presuppositions of that language. He uses Whorf’s (1964) simple observation to illustrate what he means. While working for a fire insurance company Whorf wrote:

Thus, around a storage of what are called “gasoline drums,” behavior will tend to a certain type, that is, great care will be exercised; around storage of what are called “empty gasoline drums,” it will tend to be different – careless, with little repression of smoking or tossing cigarette stubs about. Yet the “empty” drums are perhaps more dangerous, since they contain explosive vapor (Whorf, 1964, quoted in Geis, 1987, p. 7).

Whorf’s key insight is that the “cognitive presuppositions of our languages are largely of a background character and so tend to be out of conscious awareness” (Geis, 1987, p. 20). Therefore, political language most effectively influences how one might act by evoking preexisting cognitive assumptions about the way things are. Thus, political language as a prompt for existing beliefs, versus as a creator of political conviction, is an important (and sometimes convoluted) distinction.

This “softer” version of the Orwellian thesis is completely in line with Edelman’s (1964, 1988) approach to language in politics. Edelman argues that most people have a “mythic” view of politics and that political language simply evokes these “mythic” (or widely held) assumptions. One may view someone living in poverty as being responsible for his own troubles, while others may view him as a victim of capitalist elites. Both are widely held beliefs about what causes a common social problem, and

although they are rather simplistic, they help people to make sense of policies related to economic inequality. The language used by political messengers simply evokes such previously held assumptions and connects them to specific policies. Recent work by cognitive scientist George Lakoff (2002, 2004) and others have further buttressed this interpretation of how people respond to political language, suggesting that political messages evoke policy preferences from preexisting cognitive frameworks.

### **A. Public Opinion**

Discoveries in cognitive psychology have helped to shed light on how political language influences those members of the public who hear it. It is now believed that “frames in communication” (outlined previously) also interact with “cognitive frames” in the brain that are used to help sort out information (Kinder and Nelson, 2005). In particular, linguist and cognitive scientist George Lakoff (2002, 2004) suggests that Americans’ political orientations and policy preferences diverge based on fundamentally different conceptions of government.

According to Lakoff, both conservatives and liberals view government from a parent-child perspective, but conservatives more often apply a “Strict Father” understanding of government, viewing political leaders as responsible for protecting the family, enforcing right and wrong, and maintaining order. Liberals, on the contrary, more often employ a “Nurturing Parent” view of government, in which people are to be protected, but at the same time nurtured, trusted, and communicated with openly. Lakoff argues that the language used to describe policy issues naturally evokes one

cognitive frame or the other, which, in turn, leads to a preference for a policy agenda consistent with the values inherent in that frame.

For example, Lakoff argues that the Bush Administration effectively framed the terrorist attackers on September 11<sup>th</sup> as “evil,” naturally evoking the desire to show superior military strength to those who wish us harm. Consistent use of the “good versus evil” metaphor, Lakoff believes, led many people to support an aggressive military response (the “Strict Father” frame). Arguing from a liberal perspective, Lakoff suggests that reframing the discussion to call for “justice” rather than “vengeance” would evoke a foreign policy reaction from the public that prioritizes understanding and restraint (the “Nurturing Parent” frame), rather than use of overwhelming military force.

Similarly, Schlesinger and Lau (2000, 2005) suggest that Americans comprehend complex issues through “reasoning by policy metaphors.” This method of understanding complex issues is another form of cognitive framing in which people use commonly understood “social institutions,” or common ways of allocating responsibility and distributing resources and judgments about their effectiveness to form “archetypes” against which proposed policy solutions and new problems are compared (Schlesinger and Lau, 2005). Thus, if one were to view health care as a “social right,” existing arrangements where health care services are not available to all populations would be problematic, and the appropriate solution might look something like the American public education system. Therefore, if a new policy proposal can be described as being

“like” some more familiar institution, then it has a strong advantage of being understood by the general public (Ibid., 2005).

Ultimately, changes in public opinion translate into changes in public policy only if elected officials choose to respond accordingly. While it is not always the case that representative institutions reflect majority opinion, the primary goal and most pressing concern of a representative is election or reelection (Mayhew, 1974). As a result, more often than not, changes in public opinion eventually translate into public policy.

## **V. Political Language and Health Care Policymaking**

The purpose of this thesis is to shed light on the language dimension of health care policymaking in the state of Rhode Island. In order to conduct this case study, each major component of the political language literature has been drawn into an integrative framework of analysis. This framework represents a distinctive analytical perspective that will shed light on the formative stages of the policy process when issues first emerge and alternative policy proposals are debated. It will also serve as a guide to research on health policy discourse and its impact not only with regard to the message, messenger, and response, but also with regard to the relationships that exist between these components. To this end, several additional dimensions of the policy process will now be explored, including the use of language in the process of political rivalry; the relationship between symbolism and policy substance; and the process by which both elites and the public respond to policy issues. Results of this study are expected not only to illuminate new dimensions of health care policymaking in Rhode Island, but also to

produce empirically grounded, generalizable insights into the role that each component of political language plays throughout the public policy process.

The principal tenet of this approach to policy analysis is that language is central to politics, or as Murray Edelman more explicitly wrote, “political language is political reality” (Edelman, 1988, p.104). At first glance, Edelman’s assertion may seem like an overstatement – is it not political action that represents reality rather than mere words? To a large degree, yes; but as Paul Chilton and Christina Shaffner argue, “Political activity does not exist without the use of language. It is true... that other behaviours are involved and, in particular, physical coercion. But the doing of politics is predominantly constituted in language” (Chilton and Schaffner, 2002, p. 3). Therefore, it is not that political action is unimportant, but that political language is at least as important. In fact, one could argue that political action is in some ways secondary to language, since language often functions as the precursor to, justifier of, and even substitute for, political action.

In politics, words can be used to inspire, argue one’s case, or rally support for a cause – thus, words have played an important role in shaping some of the most important political movements in history. Culturally resonant language often serves as an essential organizing tool for social movement activists (Kolker, 2004). Similarly, words can be used to justify a political action or event that is either ongoing or part of the past, and, as Edelman notes, it is language that is used to describe these events that most people experience, not the events themselves (Edelman, 1988). Therefore, it is the use of language that gives political meaning to many historical events, and in the

process, shapes their implications for the future. Moreover, when action is not possible or desirable, language may be used as a substitute for political action. This is particularly true in an era during which international organizations, such as the United Nations, seek to leverage the collective voice of the global community as a method of coercion rather than military force. Finally, the mere act of speaking is an important political action in and of itself since words communicate ideas, stir emotions, and constitute the policies of government. Viewed in this light, Edelman's bold assertion that "political language is political reality" is quite reasonable and serves as the foundation on which this thesis is built.

Although few are willing to state the relationship between language and politics so bluntly, the perspective used in this study is not unusual. Along with Edelman's work, the political scientists, sociologists, and cognitive scientists noted earlier – as well as others – have each documented the importance of language during various stages of the political process. Previous work in the field of political language has two weaknesses, however. First, much of the literature related to language in politics, including Edelman's indispensable contributions, tends to be highly abstract in nature and lacks a strong empirical foundation. In fact, one critic of Edelman's work noted that his "systematic amassing and relating of evidence leaves much to be desired" (Dawson, 1965). Second, much of the literature pertaining to language and public policy focuses on a singular component of political language. For example, a number of case studies that have been conducted explore the evolution of a particular public policy through the problem definition perspective (Rochefort and Cobb, 1994). While such work has added

considerably to our understating of problem definition, case studies that focus exclusively on this dimension fail to capture the additional components of political language that are also at work, presenting an incomplete account of the broader role language plays throughout the policy process.

This thesis differs from previous research in that it simultaneously (1) examines the dynamics of political language in the context of a case study, (2) grounds inferences in solid empirical evidence, and (3) utilizes the framework of analysis discussed previously to draw attention to each of the various components of political language as they appear in the health care policymaking process in Rhode Island. Combined, these three approaches will help to project a more complete picture of the language dimension of public policy and politics.

This study will use the described holistic framework of analysis to examine two health policy reform movements taking place in Rhode Island. First, Chapter Three will examine the differing language strategies of two policy entrepreneurs (one operating from inside government and one operating from outside government) who are currently advocating for their own reform proposals. Second, Chapter Four will analyze the political language used by Governor Donald Carcieri and his administration to advance a Medicaid waiver proposal, contrasting that language with the words of his opponents. Next, both the policy entrepreneur case and the waiver case will be examined from an additional perspective. Chapter Five will analyze an original public opinion poll in order to gain insight into the connection between political language and policy perceptions among Rhode Island voters.

The integrative framework for analyzing political language that is applied here will serve not only as a guide to researching health policy discourse with regard to the message, messenger, and response, but also to exploring relationships among such factors. Do policy entrepreneurs, political leaders, and organized interests deliberately construct their messages, and if so, what sort of process does this involve? What considerations are taken into account before a messenger speaks publicly about a particular policy issue? Using the findings of elite interviews conducted with two health policy entrepreneurs, officials working within the governor's office, and leaders of organized interests throughout the state, Chapters Three and Four will explore these questions in order to better understand how political messages are constructed.

Chapters Three and Four will also investigate the "Orwellian" presumption that political language is often designed to manipulate public opinion. True, charges of this nature can be politically motivated and supported by nothing more than speculation (Geis, 1987). Yet this does not mean that rhetoric is never used to advance a particular policy idea or agenda. In fact, as Edelman (1988) argues, political language consists of a blend of symbolism, ideology, emotional appeals, and policy substance, ultimately resulting in a "political spectacle" designed to "mystify" an uninformed public (Edelman, 1988). In examining the current health care reform efforts in Rhode Island, Chapters Three and Four will consider two critical questions with regard to political language as "mystification." First, when it comes to health care issues in Rhode Island, is language being used as a tool for manipulation of public opinion as Orwell suggests, and if so, when and how? Second, what is the relationship between symbolism and

policy substance with regard to the “political spectacle” that surrounds health care reform efforts in Rhode Island?

Finally, the cases outlined in Chapters Three and Four will be used to examine the role political language plays in the process of political rivalry. Health care is a prominent agenda item in Rhode Island, and political leaders who are vying for power and influence align themselves with certain approaches to solving the problems associated with the health care system. The political language perspective will shed light on this process and help us to explore whether language is used as a method of political advancement on issues such as health care. This analysis will not only define the dimensions of the policy debate, but it will also illustrate how political leaders position themselves relative to each other on the major health care issues.

In Chapter Five, questions related to the seldom-explored relationship between political messages and the perceptions of responders will be addressed. It is widely assumed that political language can contribute to how members of the public view a particular policy issue, but evidence to prove this assumption is often hard to come by. This study, through the use of public opinion polling research, will explore the relationship between language and policy perception and seek to answer whether or not people do in fact respond in a meaningful way to changes in political language. The public opinion poll data will also allow for an examination of the reaction of Rhode Island voters to specific political messages, offering insight into whom they turn to for leadership on the problems that plague the health care system.

Also included in Chapter Five is a new area of inquiry that has emerged in the area of problem definition. Based on an original public opinion poll carried out in 2007 in Rhode Island, Rochefort and Donnelly assessed how problem definition related to public responses to health policy issues. Among their findings was the fact that support for health care reform is significantly greater among Rhode Islanders who defined the problem of uninsurance in “favorable” terms, meaning that these respondents believed in the urgency and morality of addressing the problem, considered it a matter of rights, and believed that intervention in the contemporary health sector is a necessary government action (Rochefort and Donnelly, 2007). Building on this finding, the present study will explore how problem definition compares with political ideology as a basis for understanding how both elites and the public respond to policy issues.

## **VI. Thesis Methodology**

In order to effectively investigate the questions noted, and to understand how each component of the political language framework is linked, a case study research design is essential. This type of investigation requires elite interviews, a public opinion survey, and extensive content analysis, all of which can be most effectively executed and interrelated by means of a multifaceted case study. This study will focus exclusively on health care issues in the state of Rhode Island. Both this issue area and location are ideal for applying the political language perspective.

Health care is uniquely suited for this type of analysis for several reasons. First, health care is a highly personal and often emotional issue, which means that changes to

the status quo are often seen as threats – both to one’s own well-being and to the well-being of loved ones – and can be resisted as if (rather literally) one’s life depended on it. Calls for the expansion of health care services are often pursued with equal vigor, leading to the use of strong rhetoric on both sides of the debate. Also, unlike most issues, health care affects everyone – young and old, rich and poor, liberal and conservative, sick and well. This means that the full spectrum of ideological and cultural perspectives is invoked by the debate. Health care is also one of the most complex policy areas in the public domain, which renders the debate open to oversimplification, misinterpretation, frustration, and countless layers of symbolic rhetoric. Finally, the health care issue is saturated with vested interests, from hospitals to providers, insurers to employers, and patients to advocates. With the livelihoods of so many people at stake, advancing vested interest through the use of language in the health domain has become a multi-million dollar industry (West, 2000).

This debate has often been the purview of the national government, but as noted earlier, health care reform legislation is developing with increased frequency at the state level. Geographically, Rhode Island is located next to a national pioneer in health care reform, and for reasons none other than proximity to Massachusetts, the topic of health care reform is frequently up for discussion. More importantly, however, two policy entrepreneurs, including the Lieutenant Governor, along with a number of organized interest groups, are actively pursuing comprehensive health care in the state, assuring that the issue keeps continued prominence as a topic of political discourse. At the same time, Rhode Island’s Governor recently introduced and successfully pushed through the

legislature a landmark “Global Medicaid Waiver,” which drew strong opinions from all of the major health care stakeholders in the state, as well as keen interest and opinions from around the country. For these reasons, Rhode Island is ideally suited as a location for examining the dynamics of contemporary health care policymaking.

A common concern associated with the case study method is whether or not the findings will be “generalizable,” meaning whether the conclusions drawn can be presumed to apply to a broader population. Is the case of health care reform in the state of Rhode Island too narrow to allow for the findings to be applied anywhere else? The health care debate that is ongoing in Rhode Island actually shares remarkably similar characteristics to health care debates ongoing in other states and at the national level. The relevant institutions responsible for health care are the same throughout the country. Health care in the United States is a blend of private insurance, which includes both non-profit and for-profit insurers, and public programs, including Medicare and Medicaid. Both for-profit and not-for-profit health insurers are present in Rhode Island, and like every other state in the nation, Rhode Island administers the Medicaid program and shares responsibility for the funding of the program with the federal government. Rhode Island also faces the same problems of cost and access as do other states, and the available policy alternatives are virtually identical to those in every other state. Thus, the results of this study can be generalized across the American states. Furthermore, since political language is a phenomenon that spans all public issues, a close examination of the political language used in Rhode Island’s health care debate should

produce generalizable insights into how political language impacts the policy process overall.

## **VII. Conclusion**

Despite having been identified by ancient philosophers as a critical area of study, political language is still gaining scholarly acceptance as an important dimension of the public policy process. This may be due, in part, to the fact that much of the literature pertaining to political language is scattered among numerous fields of social science, including sociology, linguistics, political communication, psychology, political science, and others. The model outlined above represents an attempt to integrate this diverse body of literature into a holistic analytical framework. It is hoped that arranging each conceptual tool by the source of political language (the messenger), the characteristics of the language itself (the message), and its influence on political thought (the response) will be useful in mapping the origin, shape, and potential implications of political language on public policy.

In the chapters that follow, this framework of analysis and the concepts included in it will be used to penetrate the often obscure politics of health care reform in the state of Rhode Island. At the same time, the framework will serve to guide a research perspective on the language dimension in health care policymaking generally, offering a distinctive perspective from which to examine the dynamics of lawmaking and administration. By calling attention to seminal questions related to language and the policy process, the model will help expose gaps that exist in the current literature,

providing the opportunity not only to utilize the model but also to add to it. Utilization of a case study design allows for an in-depth analysis of each of the of core components of political language, and the common institutional elements of health care policy throughout the United States ensure that the conclusions drawn will be applicable beyond the state of Rhode Island. Therefore, this singular case study should be viewed as a modest yet meaningful step toward the larger goal of unraveling the complex relationship that exists between political language and public policy.

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– Chapter 2 –  
**Rhode Island Politics and the Emergence of Two Health Care Reform Initiatives**

This study is focused on two health care reform initiatives in Rhode Island. The first is an attempt on the part of two policy entrepreneurs to enact universal health care in the state. The second is a gubernatorial campaign to push a “Global Medicaid Waiver” proposal through the state legislature. Before delving into an examination of these two cases, two critical questions must be answered: First, what is the political environment within which these reforms have been deliberated? Second, what is the structure of the state’s health care system? Answers to both of these questions will provide the historical, political, and organizational context necessary for understanding the complexities that surround current health care reform efforts in Rhode Island.

In order to parse out the myriad forces at work in the political sphere, John Kingdon’s (1995) agenda-access model, designed to help explain how issues reach the legislative agenda, will be used to describe how both comprehensive health care reform and Medicaid reform became major issues in Rhode Island. Kingdon’s model consists of three “streams”: problems, policies (solutions), and politics. According to the model, a problem can become prominent following a dramatic shift in a social indicator, feedback from government officials, the diffusion of a powerful symbol, or a crisis, which creates a “focusing event” that invokes widespread attention to the issue. Policies stem from the gradual accumulation and diffusion of knowledge among experts in the field; Kingdon describes policy alternatives as part of a “primeval soup” that evolves over time. Lastly, the politics stream refers to events within the constantly changing political

environment—i.e., changes in administration, swings in the public mood, or key election results. Kingdon asserts that when these three streams meet at critical points in time they create “policy windows” that are essential to getting an issue on the agenda.

### **I. Rhode Island Politics: A Primer**

In 1959, Duane Lockard published the landmark book *New England State Politics*, which provides a useful point of departure for an overview of Rhode Island politics. Lockard noted that at the time of his writing, Rhode Island differed from the other New England states, “for here as nowhere else in New England the Democrats have the dominant position” (Lockard, 1959, p. 172). This, however, was not always the case. Prior to the 1930s, Republicans dominated in Rhode Island. The 1930s brought sweeping political change to the state. The election of President Franklin Delano Roosevelt and the introduction of his New Deal platform resulted in a shift toward Democratic Party control, and the state has not reversed course in the years since (Lockard, 1959). Two main reasons are cited for the state’s commitment to the Democratic Party: first, Rhode Island was one of the most urbanized states in the nation, with almost 85 percent of the population living in urban areas. Second, Rhode Island had a higher proportion of immigrants than any other state, including such traditionally Democratic-leaning ethnic groups as the Irish, Italians, and French-Canadians. Despite the Democratic Party’s broad reach, however, Republicans managed to retain a strong influence in policy formulation throughout this period, due primarily to the “warped apportionment of the Rhode Island General Assembly,” which weights the Senate in

favor of small, rural, and traditionally conservative towns (Lockard, 1959, p. 177). As a result, Rhode Island maintained enough of a conservative influence to prevent a complete one-party rule.

Throughout the 1950s, Rhode Island's Republicans were largely successful in utilizing the press, radio, and television as outlets to argue that the high unemployment rates resulted from a heavy tax burden and high labor costs, putting the state at a great disadvantage with other competitors (McLoughlin, 1986). When Republicans began to make modest electoral gains, including taking the governorship in 1958, Democratic Party leaders began distancing themselves from labor leaders, fearing the Party had become too "pro-labor." As a result, labor leaders reconsidered their once unshakable party allegiance to the Democratic Party in Rhode Island. Simultaneously, an increasing ethnic migration out of urban areas was taking place. In combination, these two movements led to a gradual breakup of the usually strong Democratic Party machines. This trend provided a rare opportunity for the minority party to gain political power, and John H. Chafee, a Republican who captured both rural Protestant and urban Catholic votes, went on to win the governorship in 1962. Chafee lost his re-election bid, but gained perhaps an even more important position in Rhode Island politics when he won a Senate seat in 1976. Chafee joined Democrat Senator Claiborne Pell in representing one of the most Democratic states in the nation. The election of some notable Republicans to top political positions, however, should not be considered proof that Rhode Island was no longer a state dominated by Democrats. In 1976, the same

year Rhode Island voters elected Chafee into the Senate, only 19 out of 150 state legislators were Republicans.

Democrats' tepid support for industrial unions gave rise to what Moakley and Cornwell (2001) refer to as the "politics of accommodation," an arrangement of sorts between business elites and the Democratic Party that lasted up until the late 1980s. Under this political framework, Democratic leaders allowed business leaders (typically aligned with Republicans) to offer lower wages and negligible job security to their industrial workforce and to maintain control of key business and media establishments. Meanwhile, Democrats, typically working class and ethnic, took over state government and enjoyed the "perks and power of office" (p. 7).

What followed was a strong patronage system in Rhode Island government, particularly rampant throughout the 1970s and 80s, where jobs, favors, and appointments were frequently handed out on the basis of political connections. Often, political appointments and public contracts came with financial and political kickbacks (Moakley and Cornwell, 2001). In fact, the level of corruption was so great that it has yet to be fully overcome. In 2001 Providence Mayor Vincent "Buddy" Cianci was arrested and sentenced to five years in prison on a federal charge of racketeering conspiracy, a scandal that captured nation-wide media attention (Stanton, 2003). Just this year, Robert Whitcomb, editorial page editor of *The Providence Journal*, described the political system in Rhode Island as one that is "based on back scratching and getting things for your friends" (Goodnough and Zezima, 2009, p. 1).

If Democratic support for industrial unions was only modest, the opposite was certainly true of public employee unions. During the 1980s state and municipal employee unions gained influence with the General Assembly, where legislation was being passed in their favor to such an extent that it was, to at least some observers, “over the top” (Moakley and Cornwell, 2001, p. 8). Throughout the 80s public employee unions were able to secure well-paid employment, along with generous pensions, disability benefits, and salary credits for continuing education, all under a cloak of secrecy guaranteed by a 1936 law that mandated the privacy of state records. By the late 80s and early 90s, however, a number of factors led to a backlash against this system. First, a suburban middle class had begun to emerge in Rhode Island, many of whom were becoming highly critical of the political maneuvering on Capitol Hill. Second, rumors about exorbitant pension provisions spread by means of the close-knit social fabric of the state, as well as the “enormous influence” of *The Providence Journal*, the only state-wide paper and driving force behind much of the political agenda (p. 9). Public outcry against political abuses grew.

In 1991 Bruce Sundlun was elected governor and helped to usher in a period of dramatic political reform. Following a court challenge by *The Providence Journal*, the Democratic governor ordered that records of state pension files be opened, revealing to citizens the insider deals that had pervaded the General Assembly during the 1980s (Moakley and Cornwell, 2001). This era of reform was also marked by significant changes to the state’s Constitution, including implementation of a four-year term for the office of governor (the former term had been two years), the elimination of legislative

pensions, and a downsizing of the General Assembly following the 2000 Census – the House would go from 100 member to 75, and the Senate would go from 50 to 38.

Sundlun only served two terms as governor, losing a re-election bid to Republican Lincoln Almond, but his time in office marked a turning point in Rhode Island politics.

Rhode Island's current political environment is not unlike the one Lockard described some 50 years ago. At present, Democrats control both the House (with 60 Democrat representatives, 13 Republican, and one Independent) and the Senate (where four Republicans and one Independent sit with 33 Democrats) (Rhode Island General Assembly, 2009). The governor, Donald Carcieri, is widely considered to be a conservative Republican, indicating that, as Lockard noted, despite its Democrat leanings Rhode Island is not a one-party state. The imbalance in the legislative branch sets the stage for strong ideological differences with the governor, creating a hostile environment that nearly guarantees a legislative impasse whenever issues concerning the size and scope of government are being considered. This tendency toward hostility between the two sides is perhaps best exemplified by a political battle that took place over the state's 2008 fiscal year budget.

At the time, Rhode Island was facing a \$300 million budget deficit. In early June 2007, frustrated with how the House budget was being devised and with failing negotiations with labor leaders, Governor Carcieri unleashed a marketing crusade not unlike a tenacious election campaign (MacKay and Arsenault, 2007). In one particular radio ad, Carcieri derided Democratic leaders as "big spenders" and implored Rhode Islanders "to call your state rep and senator and demand they pass a responsible

budget” (p. 2). The very next day, public employee unions, still an influential part of the Democratic base, fired back with an advertisement using Carcieri’s own words to paint him as a “snake oil” peddler. Carcieri, a former CEO, added to the feud by announcing a plan to cut 1,000 state jobs and completely reform state government by privatizing “every state service that could possibly be performed more efficiently by the private sector” (Peoples, June 20, 2007, p. 2). Furthermore, Carcieri promised the General Assembly that he would veto any budget that did not meet with his approval, just as he had done during his first two years in office.

On June 16, at the end of an arduous few weeks (and a marathon final session ending at 1:30 a.m.), the House passed its reworked \$6.99 billion budget by 57 votes to 16. The new budget total was up 4.8 percent from the prior year (MacKay and Arsenault, 2007). Less than 12 hours later, the governor released a much-anticipated blistering critique, declaring that the Democratic leadership had decided “to take money out of the pockets of schoolchildren, to bilk taxpayers and to rob future generations” (Landis, 2007, p. 2). The “robbery” charge Carcieri levied against the House members was in reference to their choice to use \$154 million of the state’s share of a federal tobacco settlement that brought a windfall of cash to many states in 1998. Such a “quick fix,” according to the governor, would do nothing more than gloss over deep-seated financial deficiencies within the state’s economy. At one point, he even brandished an “easy button” (made popular by a Staples marketing campaign) during a press conference, visually illustrating his feeling that the legislature had avoided confronting real problems and ultimately decided to take the easy way out.

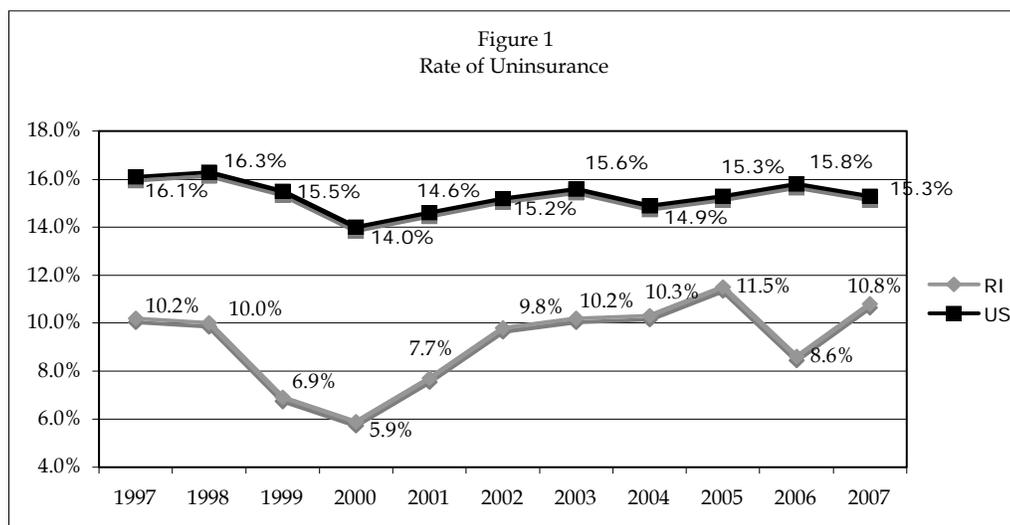
House Finance Committee Chairman Representative Steven Costantino fired back at the governor, claiming that Carcieri's portrayal was "far from truth or reality" (Bakst, 2007). Costantino went on to claim that it was easy for the governor to criticize from the sidelines, absent from the grueling committee hearings and meetings with constituents. The chairman, along with his fellow lawmakers, clearly felt that the legislature made painful but responsible decisions, took a modest step toward improving Rhode Island's finances, and protected the jobs of state employees. The House budget also received support from the Senate: Senate Finance Committee Chairman Stephen Alves called the final budget "responsible, responsive, and most of all realistic" (Peoples, June 20, 2007, p. 2). Therefore, it was no surprise when the Senate passed the House version of the fiscal year 2008 state budget on June 19th. The governor's response was swift and intense.

On June 21, Governor Carcieri vetoed the entire budget and chastised the General Assembly for putting "the burden of the state's fiscal crisis squarely on the backs of Rhode Island families" (Peoples, June 22, 2007, p. 1). He also decried the Assembly's final-hour decision to adopt a law creating strict oversight and reporting requirements that would apply to any privatization efforts initiated by the governor, claiming that it amounted to turning "over the keys of state government to the unions" (Peoples, June 20, 2007, p. 2). The General Assembly was apparently undeterred by the governor's highly publicized comments, however. A mere five hours later, both chambers of the General Assembly easily overrode the veto by the necessary three-fifths margin (largely along party lines), turning the new budget into law.

The political wrangling that characterized the fiscal year 2008 budget debate are indicative of the bitter political battles that have often occurred between the executive and legislative branches of government in Rhode Island. Perhaps more importantly, the 2008 budget battle is indicative of the larger ideological divide that has marked the Rhode Island political landscape for generations. In recent years, Governor Carcieri and the General Assembly have been at odds on a number of substantial issues beyond the annual budget, including tax reform policy, separation of powers legislation, the salaries and pensions of state workers, and, of course, health care. As a result, Rhode Island's political culture provides the ingredients for a volatile, and unpredictable, policy environment ideally suited for a study of the use of political language.

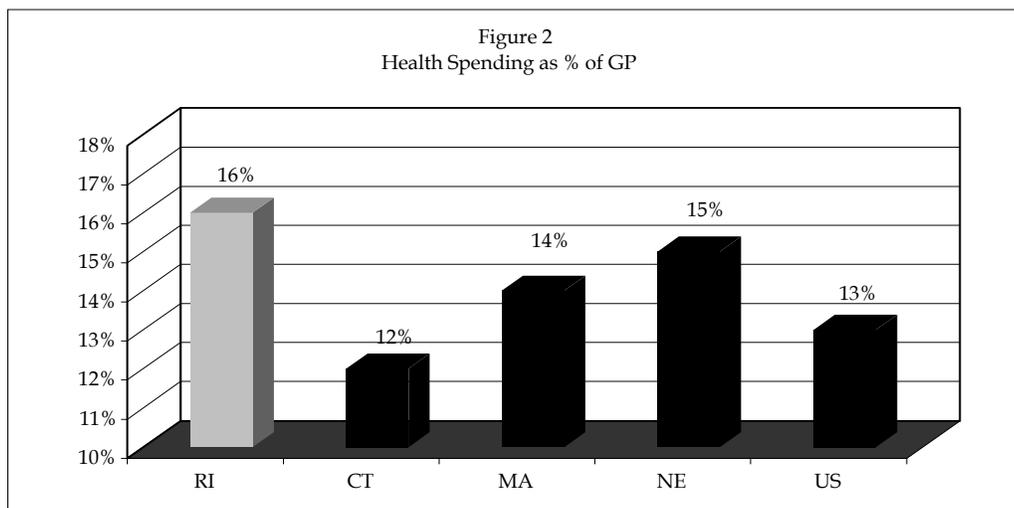
## **II. Rhode Island's Health Care Landscape**

Like many states, Rhode Island has been faced with increasing rates of uninsurance and escalating health care costs in recent years. According to the Current Population Survey (CPS), conducted annually by the U.S. Census Bureau, Rhode Island's rate of uninsurance nearly doubled from 5.9 percent in 2000 to 10.8 percent in 2007 (CPS, 2009). This increase represents approximately 58,000 residents who have lost their health coverage in the last seven years, a drop substantially steeper than the national average. In 2000 the average uninsurance rate across all states was 14 percent, more than double the rate of uninsurance in Rhode Island, but in 2007 the national rate had increased only slightly to 15.3 percent. If current trends continue, Rhode Island's rate of uninsurance will soon surpass the national average (see Figure 1).



The increase in Rhode Island's uninsured largely results from an erosion of employer-based coverage. The share of the state's population covered by employer-based insurance dropped from 77.7 percent in 2000 to 67.6 percent in 2005 (RIOHIC, 2007). This sharp decrease is perhaps not surprising due to the fact that Rhode Island employers pay the second highest premium rates in the nation at \$4,368, second only to Alaska. The uninsured in Rhode Island are predominately low-income and minority populations. Those earning below 300 percent of the federal poverty level (FPL) make up 78 percent of the total uninsured population. Hispanics have the highest rate of uninsurance at 20 percent; 15 percent of the black population is uninsured; and 7 percent of whites are without health insurance. Finally, it is also worth noting that Rhode Island commits a greater portion of its gross product (GP) to health care services than its neighbors (Connecticut and Massachusetts), the broader New England region, or the United States as a whole. Health care expenditures total 16 percent of Rhode Island's

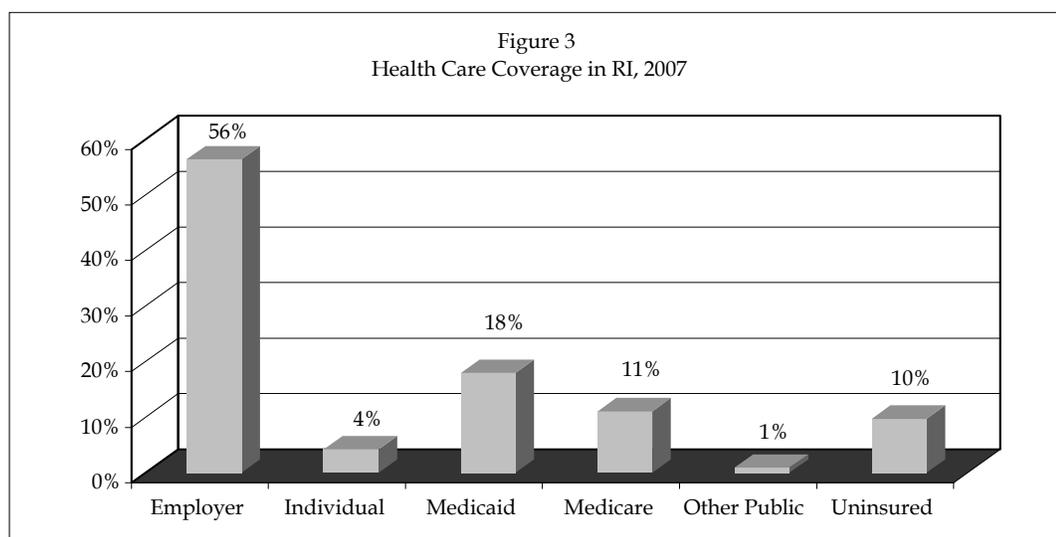
GP, compared to 12 percent in Connecticut, 14 percent in Massachusetts, 15 percent across New England, and 13 percent across the United States (see Figure 2).



The institutions responsible for health care coverage in Rhode Island are quite similar to those in other states in that there is a blend of both public and private health care insurers. In the public realm, there are two principal insurers, Medicare and Medicaid. Medicare is a federally-run program for seniors aged 65 and older and covers approximately 11 percent of the state's population (Kaiser, 2007). Since the state government has little involvement in the operation of the Medicare program, it will not merit further attention in this overview. Medicaid is a health insurance program for individuals and families with low incomes and limited resources and covers another 18 percent of Rhode Island's total population. Like every other state in the nation, Rhode Island administers the Medicaid program and shares responsibility for its financing with the federal government. States are given wide latitude in how they choose to administer the Medicaid program, however, and Rhode Island's program reflects that freedom. Since the state's Medicaid program is the focus of one of the health reform initiatives

under examination in this study, details about its unique features will be elaborated upon later in this chapter.

The remainder of the state's insured population receives coverage through the commercial market, gaining access either through an employer (56 percent) or as an individual (four percent). (See Figure 3 for a full breakdown of coverage in Rhode Island). Blue Cross Blue Shield of Rhode Island, a not-for-profit insurer, dominates the commercial health insurance market with a market share of about 65 percent (Cryan, 2006). This position affords the company a strong political presence in matters of health care policy in Rhode Island. The state's only for-profit insurer is United Healthcare of New England, which maintains roughly a 15 percent market share.



As a for-profit insurer with reciprocal obligations to an out-of-state parent company, United Healthcare has been the recent target of negative attention from health care providers, consumers, the advocacy community, and others. In 2007, United Healthcare proposed moving \$36.8 million in profits out of state at a time when

insurance premiums were going up and the state's health care system was under strain. The state's Health Insurance Commissioner, Christopher Koller, held a public hearing on the issue and large numbers of outraged Rhode Islanders attended in order to voice their concern about sending that much money out of the state's health care system. One person in attendance was a spokesman for the Rhode Island Medical Society, who called the proposal "obscene" (Freyer, March 19, 2007). One year later, Ocean State Action, a local arm of the national advocacy coalition Health Care for America NOW, held a rally in front of United Healthcare's offices to decry "skyrocketing profits" in the face of decreased membership, suggesting that the company was "skimming" profits from health insurance premiums (Arditi, August 14, 2008). Such criticism is significant because the reform proposal favored by one of the policy entrepreneurs in this study, Dr. Nick Tsiongas, calls for the ouster of United Healthcare from the state – a seemingly extreme measure made more plausible by such negative sentiment. The remaining 20 percent of the commercial insurance market is made up of a number of smaller insurers. At this point in time, however, the state is largely considered to be a two-option market for those seeking private insurance.

The state's commercial health insurance market only recently assumed its current form, following the collapse of Harvard Pilgrim Health Care in 1999. Harvard Pilgrim, a non-profit health maintenance organization (HMO) that originated in 1970, shut down operations in Rhode Island as a result of financial insolvency (Ritchie and Mor, 2005). At the time of its closure, the locally-based insurer consisted of five staff model care centers, an extensive network of providers throughout the state, and was

serving approximately 177,000 Rhode Island residents. As a result of the closure, thousands of subscribers found themselves forced to find new insurance and many providers lost their practices. Harvard Pilgrim's departure had a particularly disruptive impact on the state's mental health care services, since the staff model offered by the insurer was considered to provide some of the best outpatient care for persons with serious mental illness in Rhode Island (Sahlin and Earls, 2004). Today the state's insurance market is undergoing yet another shift. Tufts Health Plan, a Massachusetts-based insurer, announced that it will be returning to Rhode Island to challenge the two insurers now dominating the state's commercial market (Scharfenberg, 2008). Over time, this move could alter the state's commercial health coverage market considerably.

There are also two dominant hospital groups in Rhode Island: Lifespan and Care New England. These two groups are important to the health care landscape because they are currently in the process of seeking state and federal approval to merge. If approved, this action would create a powerful new health care entity that would control nearly three-quarters of all hospital services in Rhode Island (Freyer, 2008). Critics of the plan fear that too much power would be nested in one organization, while proponents feel that the merger could lead to job growth, leverage for better management of reimbursement rates, and the ability to compete with hospitals in Boston. At this point in time, the perceived economic benefits seem to be outweighing the drawbacks, as hospital groups, state regulators, and union organizations all express support for the merger. This level of agreement is perhaps not surprising given the prominent role health care plays in the state's economy. Lifespan, which includes

Rhode Island Hospital, is the state's largest private employer, and health care is Rhode Island's largest employment sector overall (Goodnough and Zezima, 2009). The health care industry is also one of the few that is expected to grow in the short term in Rhode Island. This expansion will be driven largely by the state's aging population – with approximately 14 percent of the state's residents over 65, compared to 12 percent nationally.

This proposed hospital merger would not help the state's community hospitals, however. Six community hospitals (out of seven) would be left out of the proposed health care conglomerate (Freyer, July 29, 2007). Rhode Island's community hospitals have received considerable attention recently because of their deteriorating financial situations. In March of 2008 the heads of four community hospitals appeared before the state legislature to protest a \$32.7 million dollar hike in licensing fees – a decision born of the state's ongoing budget deficit. As part of their testimony, the community hospitals announced they were on the “brink of financial disaster” and asked that the decision be overturned (Peoples, March 12, 2008). Community hospitals in Rhode Island have been under increased financial strain in recent years because of cuts to Medicaid coverage and the growing number of uninsured. Typically, these populations seek care in community hospitals, which, like all public hospitals, are obligated by law to provide treatment regardless of ability to pay.

Another important organizational feature of Rhode Island's health care system is the state's Office of the Health Insurance Commissioner (OHIC). In 2004 the Rhode Island legislature passed the “Rhode Island Health Care Reform Act – Health Insurance

Oversight,” creating the nation’s first cabinet-level Health Insurance Commissioner post at the state (or national) level. The purpose of the OHIC, according to then-Senator Elizabeth Roberts, a key sponsor of the legislation, was to “change the way the industry is regulated and overseen, and encourage continual improvement” (Rhode Island General Assembly Press Release, May 11, 2004). The commissioner has “sole and exclusive jurisdiction over those statutes with respect to all matters related to health insurance” and is tasked with four broad responsibilities: guarding the solvency of health insurers; protecting the interests of consumers; encouraging fair treatment of health care providers; and encouraging policies that improve the quality, accessibility, and affordability of the health care system (H8513, 2004). The Act also created the Health Insurance Advisory Council (HIAC), a roundtable of consumers, businesses, labor organizations, and medical representatives tasked with making recommendations to the commissioner. The Department of Business Regulation (DBR), which previously held jurisdiction over all health insurance matters, now provides the infrastructure and staff for the OHIC.

Christopher Koller, who has held the commissioner’s post since it was created, flexed his regulatory muscle recently by denying a request from Blue Cross Blue Shield of Rhode Island to raise premiums for some subscribers by almost six percent. A spokesman for Blue Cross said the company was “disappointed” with the decision but would not appeal (Freyer, 2009). Another example of regulatory action by Koller took place in June of 2008, when the OHIC reduced premium rate increases by Blue Cross Blue Shield and United Healthcare, saving large employers almost \$20 million in health

care costs (RIOHIC Press Release, 2008). Koller's office also plays a prominent role in developing health care reform legislation and is currently working closely with the lieutenant governor (one of this study's "policy entrepreneurs") to develop her idea of a "Health Hub" as a critical component of reform.

The OHIC grew out of legislation developed by Rhode Island's Permanent Joint Committee on Health Care Oversight. Created in 2000, the Committee was formed in order to "review or study any matter related to the provision of health care services and long-term care that it considers of significance to the citizens of Rhode Island" (Rhode Island General Laws 40-8.4-14). Until 2007 the Committee was co-chaired by then-Senator Roberts and Representative Steven M. Costantino. Explaining the legislative role of the Joint Committee, the co-chairs wrote, "While the oversight committee does not vote on bills, we will be exploring policy options for further consideration in our respective chambers. The oversight committee will offer us the opportunity to delve more fully into the potential consequences of various reform proposals on health care costs, access and quality" (Rhode Island General Assembly Press Release, January 8, 2004). Following the election of Elizabeth Roberts to the office of Lieutenant Governor in 2006, the Joint Committee lost its most ardent health care advocate. As a result, it has not contributed to any significant changes in the state's health care system in recent years. However, the Committee continues to meet on a quarterly basis and remains one of only three permanent joint committees in the Rhode Island General Assembly.

Rhode Island's Department of Health (DOH) is another pillar of the state's health care system. The primary role of the Department is to "prevent disease and to protect

and promote the health and safety of the people of Rhode Island” (RIDOH, 2009). Comprised of four main divisions, the Department as a whole is responsible for offering a wide range of health care services and protections. The Division of Community, Family Health, and Equity promotes health and wellness, offers perinatal and early childhood services, and works to mitigate health disparities among minority populations. The Office of Communicable Diseases is responsible for the detection, control, and prevention of the spread of communicable (or contagious) diseases. The Division of Environmental and Health Services Regulation monitors the public’s drinking water, food supply and state beaches, assures the safe use of radiological materials, distributes licenses to health facilities and professionals, and regulates health care services. Finally, the State Health Laboratories provide technical support to state and national disease prevention programs, as well as forensic science services (RIDOH Programs and Services, 2009). Given the resources and expertise of the Department, it also plays a critical advisory role to policymakers on matters related to health care.

### **III. The Emergence of Comprehensive Health Care Reform**

Only five years ago comprehensive health care reform at the state level would likely have been considered a political impossibility, but today Rhode Island is only one of many states where universal health care is at the forefront of the political agenda. Public opinion polling shows that Rhode Island voters want something to be done about increased rates of the uninsured and rising health care costs, and some leaders have answered their call, including two policy entrepreneurs who are actively working to

reform the state's health care system. What led to this latest movement toward comprehensive health care reform at the state level? What were the political forces at work? Answers to these questions are offered below.

### **A. Background**

Comprehensive health care reform has been an elusive goal in the United States, marked by sporadic legislative activity at the national and state levels of government. Consistent failure at the national level, along with increased governing capacity at the state level, has helped to usher in what could be called a new era of state-led reform. Today's state-led health care reform efforts should not be seen as a novel development, however, but as part of a larger historical trend. The history of health care reform in the United States is one that reflects the dynamics of a federal system where at certain points in time opportunities for reform are more available at the national level, while at other times the states are a more conducive venue for reform. This bi-level process of health care reform in the United States began nearly a century ago.

Universal health care was first given nationwide attention by Theodore Roosevelt, whose 1912 run for president as a Bull Moose candidate marked the first time a presidential platform stressed the need to provide health insurance for all Americans. However, universal health care was not given serious consideration by a sitting president until the 1930s as part of Franklin Roosevelt's New Deal. After the Great Depression began to take its toll on American society, Congress ceded a great deal of power to a president who favored the establishment of a universal health care program.

The American Medical Association (AMA) strongly opposed inclusion of universal health care in the Social Security Bill, however, and the proposal was promptly jettisoned from the national agenda (Kronenfeld, 2002). Harry Truman attempted to bring universal health care back to the national agenda as part of his Fair Deal platform during the 1948 presidential campaign, but even after his convincing electoral victory a conservative Congress refused to move forward on President Truman's proposal (Ibid., 2002).

In 1961 President John F. Kennedy ushered in the next major health care reform initiative, fulfilling a campaign promise to promote the enactment of a compulsory health insurance law for social security beneficiaries (Marmor, 1970). Kennedy's efforts laid the foundation for the Medicare program, but it took until 1965, when President Lyndon Johnson ushered in his Great Society programs, for legislation creating this program to get passed into law. The Democrat Party's sweep of the 1964 election, growing public awareness of poverty, and Johnson's legislative savvy combined to create a "window of opportunity" (Kingdon, 1995) for the expansion of health care access (Patel and Rushefsky, 2006). The result of this legislative opportunity was the establishment of Medicare and Medicaid. In addition to expanding access, this era marked the beginning of considerable state involvement in the financing and administration of health care—state contributions to the Medicaid program were matched by federal funds and the program was entirely administered by the states.

In 1971, Senator Edward Kennedy, in response to escalating health care costs, proposed his Health Security Act, which would have created a federally run, single-

payer health care system (replacing all public and private health plans), established a national budget, and obligated physicians and hospitals to keep within predetermined budget constraints. President Richard Nixon, who faced reelection in 1972, responded to Kennedy's plan by proposing the National Insurance Partnership Act, which would have provided health insurance for low income families and mandated that employers provide health coverage to their employees. Neither Kennedy's nor Nixon's proposal had enough support to pass through Congress, however, which meant, among other things, that health care costs would continue to escalate (Patel and Rushefsky, 2006).

In an effort to control the rate of cost increases, Congress passed the National Health Planning and Resources Act in 1974, which effectively mandated a new health care regulatory approach on a nationwide basis (Moran, 2005). The law required all states to adopt Certificate of Need (CON) programs by 1980, thereby establishing a state-run approval process for all major capital and technology investments in the health care industry. The purpose of CON programs was to coordinate health care infrastructure expansion with the needs and interests of the particular state (Patel and Rushefsky, 2006). Incidentally, Rhode Island was among the first states to establish a CON program, doing so nearly ten years before the 1974 law. During the following decades, the states' capacity to implement and maintain new programs moved steadily forward as they began to take on insurance and hospital regulation, rate regulation, licensing, and the delivery of public health services. The Reagan revolution and the era of "new federalism" further shifted responsibility for implementing health services under the direction of state agencies. In short, the 70s and 80s marked the first time that state

governments had the capacity and professionalism to attempt comprehensive health reforms, thus launching a period of intensive state-level health reform activity (Dukakis, 2001).

The earliest pioneer in the health reform effort was Hawaii, where legislators mandated in 1974 that employers provide health insurance to all employees working 20 or more hours per week (Neubauer, 1993). One of the more radical attempts at health care reform came in 1989 when Oregon sought to impose a detailed rationing program with its Medicaid plan (Brown, 1991). This was done by ranking medical procedures and drawing a line between what the state would and would not cover. The plan was politically unpopular with many groups, including Americans with disabilities, who felt they would be unduly burdened by the restrictions. Still, the boldness of the plan represented the increasingly strong measures that states were willing to take in an effort to control costs.

In fact, it was the double-digit rise in health care premium rates that prompted the business community, historically resistant to health care reform measures, to rally around Governor Michael Dukakis' 1988 "play or pay" reform effort in Massachusetts (Dukakis, 2001). This partnership marked a fundamental shift in stakeholder positioning around the health care issue and another strong movement by the states to move toward universal health care. Although the Massachusetts initiative, like others, met with mixed success, the appearance of such plans reflected a significant development in the evolution of state-led health care reform. States, increasingly

burdened by the rising costs of caring for the uninsured, were becoming willing to work to change the system in ambitious ways.

Also marking this period of state legislative activity was the absence of comprehensive health care reform from the national political agenda. Despite reviving the issue as a primary focus of his 1976 presidential campaign, Jimmy Carter chose to push for hospital cost-containment rather than universal health care upon election. The latter issue did not resurface during the three presidential terms of Ronald Reagan and George H. W. Bush. In fact, a strong conservative current and deep distrust of government regulation throughout the 1980s and early 90s kept most national leaders from even exploring the concept of universal health care coverage. Among the stalwart few who continued to pursue this objective was Senator Edward Kennedy who, among other legislative achievements, secured passage of the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, which afforded some employees the ability to continue their health insurance coverage after leaving employment.

The untimely death of Senator John Heinz in an airplane crash just before the 1992 presidential election helped trigger the return of universal health care to the top of the national agenda. Pennsylvania was forced to hold a special election to fill Heinz's seat, a contest pitting former Governor and U.S. Attorney General Richard Thornburgh, a Republican, against his unlikely challenger, Democratic political activist Harris Wofford. Wofford began the campaign substantially behind in the polls but ended up winning by a convincing ten percentage points. What was most interesting about the election, besides the unexpected outcome, was Wofford's emphasis on the notion that

every American should have the right to health care. According to Jacob Hacker, the national attention that Wofford's election received brought a "prompt, unambiguous, and consequential" response from Washington politicians on the health care issue, including the soon-to-be Democratic presidential nominee, Bill Clinton (Hacker, 1997).

President Clinton was voted into office on the promise of reforming the nation's health care system as well as a general platform of economic betterment and "change." Not long after entering office, Clinton delivered a well-received speech before Congress in which he famously promised to deliver "health security that can never be taken away." He also appointed his wife Hillary to the Task Force on National Health Reform, a bold move that signaled health care reform was of personal, as well as political, importance. Before long, however, it became clear that the process of drafting comprehensive health care reform was going to be far more time consuming than originally estimated. Missed deadlines, combined with the sheer complexity of the issue, rendered the final proposal vulnerable to criticism. Conservative media became increasingly critical of Clinton's inability to draft a proposal, and public opinion gradually began to turn (Skocpol, 1995). Rhetorical attacks against the plan gained traction and proved to be relentless. The most striking example of the campaign to derail the Clinton proposal is the now infamous "Harry and Louise" television ad campaign, in which a husband and wife lament the loss of their private health insurance plan and worry about the fate of their health care if placed in the hands of government officials. As the couple shuffles through a pile of papers gathered on their kitchen table, a voiceover informs viewers that they will soon be forced to "pick from a few health care

plans designed by government bureaucrats.” With the camera closed tight on her concerned face, Louise complains that “Having choices we don’t like is no choice at all.” “They choose, we lose,” the couple concludes with obvious disapproval. These ads, along with similar rhetorical attacks, contributed to a devastating message portraying the Clinton plan as the archetypical “big government” program, fraught with inefficiency and bureaucratic layering. Ultimately, opponents of the Clinton plan were able to capitalize on Americans’ skepticism of government intervention. Within less than a year, the issue of comprehensive health care reform fell from the national agenda (Bok, 2003).

The failure of the Clinton plan, along with the growing capacity of state governments to provide and regulate health services, culminated in a proliferation of state-led health reform initiatives. During the “backlash” against managed care in the mid to late 1990s, all 50 states adopted some form of legislation to expand control over the managed care industry, far ahead of national action in this area (Rochefort, 2001). State regulations included provisions for mandated benefits, benefit disclosures, privacy assurances, and other consumer and provider protections (Ibid., 2001). Beginning in 1997, the federal government offered states the freedom to expand their Medicaid programs, or start an entirely new program for children in low-income families, through the State Child Health Insurance Program (SCHIP) (Brandon, Chaudry, and Sardell, 2001). The SCHIP program marked a significant growth in state responsibilities for providing health care coverage, helping to set the groundwork for the current era of state-led comprehensive reform initiatives.

In 2003 Maine passed the Dirigo Health Reform Act, which aimed to control costs and provide universal coverage by 2009 (a goal the state eventually failed to achieve) (Belluck, 2007). In 2006, Massachusetts and Vermont both passed laws to achieve near-universal health care coverage. According to the National Council of State Legislatures, at least 11 additional states, including such diverse states as Minnesota, New Jersey, Missouri, and New Mexico, put forth a variety of universal health care plans for debate during the 2008-2009 legislative session (NCSL, 2009).

Today's health care reform debate in Rhode Island grew of this recent burst of diverse state-led initiatives. The current debate is the product of a long and multifaceted history of reform efforts, marked by a host of legislative failures and successes alike. This history of failure and sporadic success helps to explain both the fresh optimism with which the two policy entrepreneurs in this study pursue their respective agendas and the reasons why they should anticipate deep-seated resistance. Kingdon's "three streams" model (1995) will help to unravel the trends, both internal and external to the state, that have given rise to Rhode Island's health policy debate.

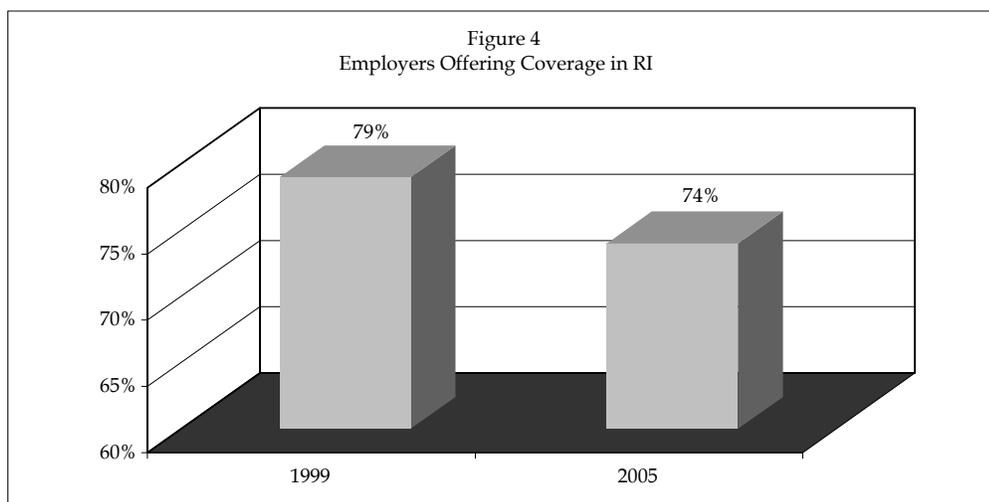
## **B. Application of Kingdon's Agenda Access Model**

### **The Problem Stream**

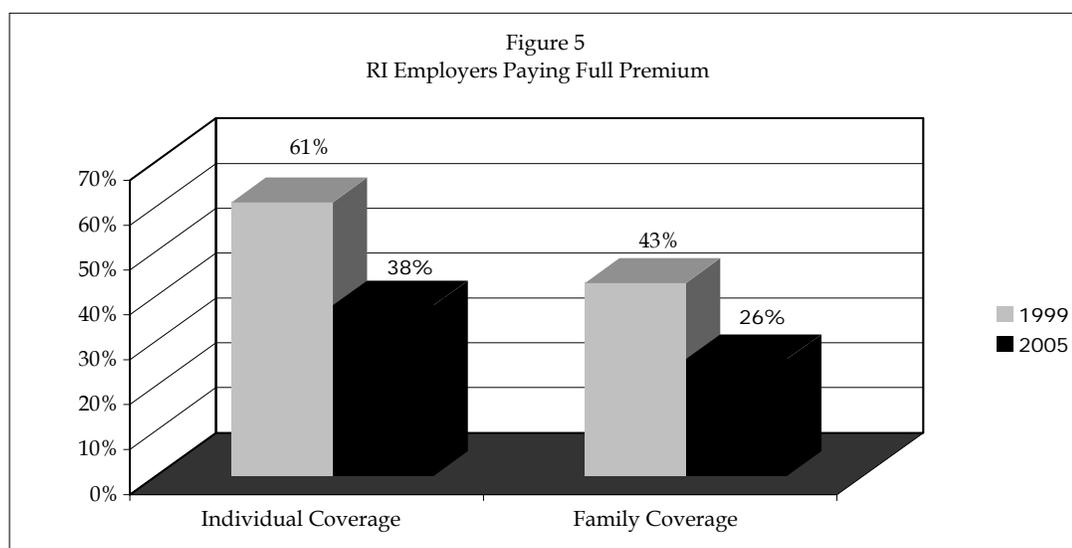
According to Kingdon's model, a problem may come to the attention of government decision makers when a systematic indicator, tracked either by government or nongovernmental observers, including the media, documents there is a problem (Kingdon, 1995). Just such a scenario played out in Rhode Island when the Office of the

Health Insurance Commissioner released two key reports in the current decade. The first report was an “Employer Survey” that outlined the rates of employer insurance and workers’ required premium contributions (RIOHIC, 2006). The second report was an overview of the state’s current uninsurance rate, as well as prior trends and a forecast for the future (RIOHIC, 2007). The combination of these reports, delivered by the office created to protect consumer interests, sent a clear message to lawmakers that health insurance coverage in the state was quickly eroding.

The 2006 OHIC “Employer Survey” focused on the source from which most Rhode Islanders (and most Americans) receive their health insurance. The report included concerning details about a growing problem within this staple of the American health care system – the rate of employers offering coverage had dropped from 79 percent in 1999 to 74 percent in 2005, translating into thousands of people losing their insurance (see Figure 4). Furthermore, less than half (48 percent) of low-wage employers were offering health coverage to full-time employees (RIOHIC, 2006).



The report also discussed the impact that rising health care costs were having on the employer-based insurance system. The study indicated that employers were paying monthly premium costs of \$398 for individual coverage and \$1,033 for family coverage, putting Rhode Island among the highest states in the country in terms of health care costs. Only 38 percent of employers were paying their employees' full premiums for individual coverage in 2005, compared to 61 percent in 1999; and full payment of family premiums was down from 43 percent in 1999 to 26 percent in 2005 (see Figure 5) (Ibid., 2006). Governor Carcieri and Commissioner Koller presented these findings during a



meeting of the Greater Providence Chamber of Commerce, during which the governor offered comments that underscored the political importance of the OHIC report: “The results of this survey of employer-sponsored health insurance demonstrate that this problem is only getting worse, and is becoming a significant obstacle to economic development and to job growth in the Ocean State. Rhode Island businesses, particularly small businesses, are finding it increasingly difficult to offer health

insurance to their employees. We cannot allow this trend to continue indefinitely” (RI.gov Press Release, 2005).

The following year, OHIC released its second troubling report, which noted that the rate of uninsurance in Rhode Island had increased from 6.9 percent in 2000 to 13.3 percent in 2005 (RIOHIC, 2007). (Note that these figures are slightly higher than the CPS data cited previously – CPS calculates the uninsurance rate based on those who have been without health coverage for the entire year, whereas the RIOHIC uninsurance rate is calculated based on a snapshot of how many people were uninsured at the time of data collection). Even more alarming, the report projected that, if the prior trend were to continue, uninsurance in the state could climb to 20 percent by 2010. Perhaps not coincidentally, only one month after the release of this second report, Rhode Island Lieutenant Governor Elizabeth Roberts officially launched the start of her health care reform campaign by delivering a keynote address at the University of Rhode Island (Mooney, 2007).

Although the problems involving health coverage and affordability in Rhode Island are linked to broader nationwide trends, erosion of coverage has been particularly acute in the Ocean State due to an exceptionally poor economic climate that has continued to deteriorate in recent years. Rhode Island was among the first and hardest hit by the current economic downturn. During 2007 the state had already lost 8,000 payroll jobs and was one of only two states in which payrolls were down from the prior year (Arditi, March 31, 2008). This trend only accelerated thereafter. By January of 2009, the state’s unemployment rate rose to 10.3 percent, the second worst in the country

behind Michigan (where job loss is more easily explained by the collapse of the auto industry) and considerably higher than the national average of 7.6 percent (Gedan, 2009). Rhode Island's unemployment problems stem, in part, from an outdated economic infrastructure. Rhode Island continues to rely heavily on blue-collar and service-industry jobs, while its neighbors, Massachusetts and Connecticut, have substantially modernized their economic base (Goodnough and Zezima, 2009). These economic factors have exacerbated the problems identified by the OHIC, helping to assure that health care reform will remain a prominent political issue in Rhode Island.

### **The Politics Stream**

Around the same time that problems with Rhode Island's health care system were drawing public attention, Massachusetts was implementing its landmark health reform bill designed to achieve near-universal coverage. The central component of this innovative plan was an "individual mandate" that took effect on July 1, 2007. This legislative accomplishment served as a "focusing event" (Kingdon, 1995) for reformers around the nation, and was most certainly a catalyst for discussion of reform in Rhode Island. In a news article titled "All eyes on Mass. insurance initiative" published in *The Providence Journal*, Commissioner Koller was quoted as saying "People have already approached me [asking], 'What would it take to do something like that here?'" Koller also added that not only were people curious, but that "There is a real appetite for looking at this. There [are] a lot of potential applications for Rhode Island" (Freyer, 2006). The "appetite" Koller referred to is exemplified by the emergence of two policy

entrepreneurs in Rhode Island, both of whom were determined to reform the state's health care system. The actions and language of the two policy entrepreneurs – Lieutenant Governor Roberts and Dr. Nick Tsiongas – are a primary focus of this study and will be elaborated on in Chapter Three. However, it is important to note that the timing of their emergence was not arbitrary. Their efforts began at the same time as problems with Rhode Island's health care system were being made vividly clear, while a successful reform effort had just been achieved by Rhode Island's next-door neighbor, Massachusetts.

Kingdon notes that a shift in public "mood" may contribute to an issue capturing the attention of lawmakers. A poll conducted in 2007 by Northeastern University (Rochefort et al., 2007), which aimed to measure the public's opinion (or mood) about health care reform issues, showed that Rhode Islanders were open to, and in fact eager for, health care reform. The poll found health care to be one of the top two issues most respondents (51 percent) believed should be among the government's highest priorities, considerably outpacing jobs and the economy (17 percent) and education (14 percent). Moreover, the majority (55 percent) believed the state's health care system had "major problems," and another 15 percent described the health care system as being "in a state of crisis." Finally, a large majority of respondents (68 percent) rejected the statement that the "problems of the health care system will be solved by private businesses and health insurance companies" without government intervention. In short, Rhode Islanders, who were very well aware of the problems associated with their health care system, did not see government inaction as an acceptable option on this issue.

### **The Policy Stream**

As the health reform issue was taking shape on the political agenda in Rhode Island, Kingdon's policy "primeval soup" pot was boiling over (Kingdon, 1995). The Massachusetts reform law encouraged many other states to consider their own brand of comprehensive health care reform. Consider the following two state-based reform plans, both of which received considerable attention from the national media in 2007.

California's Governor Arnold Schwarzenegger proposed a \$12 billion plan for expanding health insurance to 6.5 million uninsured residents (Governor Schwarzenegger Plan, 2007). The governor's plan was built on a combination of individual and employer mandates, provider and hospital taxes, and subsidized health care plans for low-income individuals and families. The California plan was similar to the Massachusetts plan but opened up some very different (and politically controversial) revenue streams. On the other end of the spectrum, the Wisconsin State Senate approved a plan for universal health care paid for with a \$15 billion payroll tax. All residents and workers in Wisconsin would be covered by a "Healthy Wisconsin" plan unless they received health care through Medicare, Medicaid, BadgerCare, or a federal employee health insurance plan. In essence, the Wisconsin plan would have created a single-payer health care system in the state (Healthy Wisconsin, 2007). Although neither plan was passed into law, they both represent the increase of state legislative activity that coincided with Rhode Islanders' own consideration of comprehensive health care reform.

Although it may have been an exciting time for health care reformers, the plethora of policy options under review around the country also made it difficult to achieve consensus on what would be best for Rhode Island. In fact, it will be shown later that the inability to agree upon a single reform proposal continues to be a difficult challenge in the politics of health care reform in Rhode Island. Regardless, there is no question that this burst of legislative activity helped set the stage for a vigorous debate about health care reform. Not only were the politics ripe for tackling the problems of the state's health care system, but lawmakers, reformers, and the public also had a variety of solutions to entertain. So began the politics of comprehensive health care reform in Rhode Island.

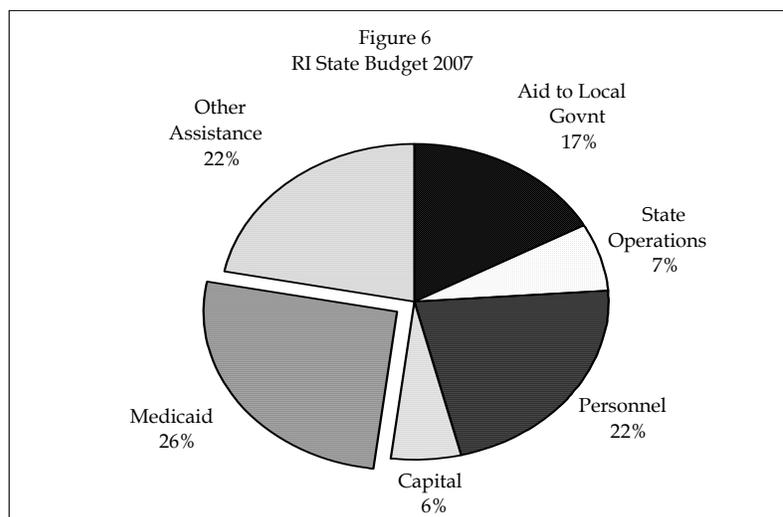
#### **IV. The Emergence of Medicaid Reform**

Medicaid is the nation's primary health insurance program for low-income individuals and families. The program is administered at the state level but jointly funded by the states and federal government. In January of 2008, Governor Carcieri proposed a Medicaid Global Waiver, a sweeping transformation of Rhode Island's Medicaid program designed to trim the cost of administering the program. The waiver proposal included an agreement to accept limited federal contributions in exchange for unprecedented state authority. What were the political forces that gave rise to the Global Waiver, and who had a say in its development? These questions are considered here following a brief overview of Medicaid in Rhode Island.

## A. Background

Since 1965, Medicaid has served as the nation's health insurance program for low-income parents, children, seniors, and people with disabilities. States enjoy considerable autonomy to administer their own Medicaid programs, but they must follow certain guidelines outlined by the Centers for Medicaid and Medicare Services (CMS) in order to receive federal matching dollars. Matching funds are determined by a formula called the Federal Medical Assistance Percentage (FMAP). FMAP is calculated by comparing a state's per capita income to the national per capita income average. States with lower per capita incomes receive higher matching rates, whereas states with higher per capita incomes receive lower matching rates. In 2008, Rhode Island received \$.53 from the federal government for every Medicaid dollar spent (Kaiser, 2008).

Currently, about 180,000 Rhode Islanders receive Medicaid benefits, the majority of whom are enrolled in a managed care program called RItE Care (Peoples, July 30, 2008). RItE Care was implemented 15 years ago under a Section 1115 waiver and provides health care coverage to low-income families, children under 19, and pregnant women (RIEOHHS, 2007). Enrollees in the RItE Care program pay premiums based on a sliding scale, from no cost at all to \$92 per month, depending on their income. Remaining costs are subsidized by the state and federal government (RIDHS "Factsheet," 2008). Medicaid costs paid by the state have grown at an average rate of between six and seven percent over the last six years. In 2007 the state's Medicaid expenditures totaled \$826 million, or 26 percent of the General Revenue budget (See Figure 6) (RIEOHHS, 2008).



In February of 2001, the RIte Share Premium Assistance Program was added to Rhode Island's Medicaid system in order to increase access to employer-sponsored insurance. RIte Share is a premium assistance program designed to help families purchase health insurance coverage through their employer. If a family qualifies, RIte Share will pay for all or part of the employee's share of the health insurance premium (RIDHS "Factsheet," 2008). The primary distinction between RIte Care and RIte Share is whether or not an employer offers a qualified health insurance program: if an employer does, then the participant will enroll in RIte Share; if an employer does not (or there is some other circumstance, such as unemployment or the inability to pay the employer premiums), then the participant will enroll in RIte Care.

Blue Cross Blue Shield of Rhode Island and United Healthcare of New England both offer Medicaid coverage, but Neighborhood Health Plan of Rhode Island (NHPRI) covers more than half of this population (56 percent) (RIDOH, 2005). Created by the 13 Community Health Centers in Rhode Island following the implementation of RIte Care

in 1993, NHPRI has a distinctive relationship with Medicaid patients. Also known simply as “Neighborhood,” NHPRI serves more than 75,000 members, including low- and moderate-income families, children with special health care needs, and all children in the Rhode Island foster care system (Neighborhood “Fact Sheet,” 2008). Although Neighborhood covers the majority of Medicaid enrollees in the state, all three insurers have been recognized for their Medicaid plans. A 2007 joint ranking by *U.S. News and World Report* and the National Committee for Quality Assurance named all three plans among the top ten Medicaid plans in the United States (*U.S. News and World Report*, 2007).

Thus, the history of Medicaid in Rhode Island has been one of expansion and national recognition, making it an integral part of the state’s health care system. However, faced with historic budget deficits in recent years and a reduction in federal matching rates, lawmakers have made cuts in the RIte Care program, including a reduction of more than 2,800 immigrant children from the rolls in May of 2008 (Peoples, April 26, 2008). In addition to the reality of fiscal pressures, Rhode Island’s distinctive political environment and available policy options combined to launch Medicaid reform onto the state’s political agenda. John Kingdon’s “three streams” model (1995) will help to categorize these political forces.

## **B. Application of Kingdon's Agenda Access Model**

### **The Problem Stream**

As mentioned previously, many of Rhode Island's economic indicators rank among the worst in the nation, including unemployment and foreclosure rates and personal income growth (Peoples, April 29, 2008). This distressing economic reality is relevant to the Medicaid program because the amount lawmakers can spend is tied directly to the state's economy – as the economy slides, so do sales tax revenues, thereby creating state budget deficits. In order to close these budget gaps, state-funded programs have undergone significant reductions in recent years, and as the single largest state expenditure, Medicaid has been a primary target for cuts. The federal government has also been gradually reducing its portion of Medicaid contributions, further straining the state's ability to sustain the program.

Federal Medicaid matching rates for Rhode Island have dropped precipitously in recent years, from 58 percent in fiscal year 2004 to 53 percent in 2008 (Kaiser, 2008). Though this may not appear to be a large drop, even a one percent change in federal contributions can significantly impact state finances. In fact, FMAP reductions led to a decrease in federal dollars of \$92.5 million from 2004 to 2007 (RIEOHHS, 2007). This dramatic reduction in federal contributions required state lawmakers to spend more money simply to maintain current Medicaid coverage levels, all in an environment when cutbacks were seen as essential.

To make matters worse, despite a year of deep spending cuts in 2008, the Rhode Island budget shortfall for fiscal year 2009 was \$425 million, the largest in nearly two

decades. Among many additional cuts in state spending, the 2009 budget included a moderated version of the governor's original plan to narrow the RIte Care eligibility standard from 185 percent of the federal poverty level (FPL) to 133 percent. Ultimately, the 2009 budget cut eligibility from 185 percent of the FPL (or \$32,560 for a family of three) to 175 percent (\$30,800 for a family of three). As a result, an estimated 1,000 parents lost RIte Care coverage (Peoples et al., June 12, 2008). The 2009 budget also relied on a proposed \$67 million in reduced Medicaid spending. This figure was put forward by the Governor's Office as savings expected to result if the General Assembly approved a Medicaid "Global Waiver," a plan that included a five-year block grant that would limit federal contributions to a set dollar amount in exchange for state flexibility to implement sweeping changes to the program. The governor's proposal, which will be elaborated on in Chapter Four, was, therefore, born in the wake of deep budgetary problems without which the waiver would not likely have reached the legislative agenda.

### **The Politics Stream**

Prior to the announcement of Governor Carcieri's waiver proposal, there was no public outcry for Medicaid reform in Rhode Island. Nor was there a strong political current moving in this direction. In fact, one might say that the governor's waiver proposal came almost entirely out of the blue. The governor's plan took so many people by surprise that critics suggested he was simply looking for a windfall of federal money to carry him through the remaining two years of his term. The proposal, they claimed,

was politically motivated, shortsighted, and bound to “handcuff the next governor” (Peoples, July 30, 2008). The governor’s Deputy Secretary of Health and Human Services, Adelita Orefice, disputed this criticism, telling *The Providence Journal* “This is not just about getting the governor through [his term]. If it were just about getting the governor out, it would be much easier to just ride it out and cut programs the next couple of years.” Instead, she said, “This is about legacy.” This was a revealing statement. Viewed in this light, the motivation behind the governor’s wide-reaching Medicaid reform proposal was not simply to close the state’s yawning budget deficit. Rather, it was driven by the governor’s desire leave behind a policy change that would influence future generations of Rhode Islanders.

The governor’s reform effort can also be viewed as part of a larger national trend, the rise of what Gais and Fossett call “executive federalism” (Gais and Fossett, 2005). Executive federalism refers to the relatively recent shift in programmatic decision-making from the legislative branch to interactions between the executive branches of state and national governments. This emerging pattern was most certainly the case in Rhode Island, where the waiver was created in the governor’s office and negotiated with officials from the outgoing Bush Administration. Although the state legislative branch could have blocked the waiver from being implemented, its role in the development of the plan was largely peripheral. Therefore, the governor’s ambitious goals were complemented by a trend toward executive-to-executive decision-making, creating a rare political opportunity to transform Rhode Island’s Medicaid program.

### **The Policy Stream**

Governor Carcieri's Medicaid waiver contained both existing and original ideas. The Global Medicaid Waiver consisted of three main components designed to decrease the overall cost of the program. First, the waiver would allow willing beneficiaries to be redirected away from costly long-term settings to less expensive community-based settings; second, the waiver plan would include the creation of a managed care program in which all beneficiaries would be enrolled; third, the plan would introduce greater cost sharing requirements for beneficiaries. In order to gain the wide-reaching authority necessary to make these changes, the state had to petition for a waiver from the federal government and agree to receive a five-year block grant. This means the federal government would give a set amount of money to Rhode Island to use over a five-year period.

Although the waiver as a whole is one of a kind, the long-term care component of the plan is not a new idea; in fact, it has been percolating in Rhode Island's "policy primeval soup" for some time. An interview with Marie Ganim, Director of Policy for the Rhode Island Senate, revealed that "The long-term care reform in [the waiver proposal] is long-term care reform we have been working toward for 20 years" (Ganim, 2009). Moreover, this component of the plan enjoyed a long-standing and broad base of supporters, including advocates for the elderly. Kevin McKay and James Nyberg, president and director of the Rhode Island Association of Facilities and Services for the Aging respectively, called the governor's long-term care goals "both laudable and timely given the state's fiscal crisis and demographics" (McKay and Nyberg, 2009). In effect,

the long-term care provision was a well-developed solution that was waiting in the wings for something to carry it to the fore, and the governor's waiver proposal did just that.

The plan as a whole, however, did not arise from a general consensus, nor had it been churning in the policy community for any length of time. In fact, the waiver was widely considered to be "unprecedented" in its scope (Montgomery, 2008). The only previous example that bears similarity to the Rhode Island waiver proposal took place in Vermont three years prior. In that case, officials applied for two separate waivers, one to grant them authority to reform the state's long-term care system; the other to implement a Medicaid managed care system (Peoples, October 5, 2008). The governor's waiver proposal aimed to do as much as Vermont and more, and all under one Global Waiver. In addition, the unique features of the final proposal in Rhode Island, including new cost sharing provisions, were based on the ideas developed by the governor and his staff, without the benefit of input from a broader policy community.

John Kingdon suggests that a policy idea tends to reach the legislative agenda once a general consensus emerges from the "policy primeval soup" (Kingdon, 1995). In fact, the long-term care component came from two decades of attention within Rhode Island's policy community and had the support of most people, including those groups who would be directly affected. However, the additional features of the waiver, along with the unprecedented authority that would come with it, originated entirely with the governor and a small number of his staff. This split sourcing of the governor's policy proposal was not enough to keep it off the legislative agenda, but it could help to

explain the compelling and spirited political language that characterized the ensuing political process, a subject for extensive attention later in this thesis.

Governor Carcieri's proposal reflected still another trend involving the growing use of what are called Section 1115 demonstration waivers. These waivers stem from section 1115 of the Social Security Act, which was established in 1962 prior to the creation of Medicaid. The provision was designed to give the nation's executive branch authority to experiment with different state approaches to program delivery, but it has recently begun to play a substantial role in the evolution of the Medicaid program (Thompson and Burke, 2007). For the first 25 years of the Medicaid program, Section 1115 waivers were relatively scarce. Then, during the presidential administrations of Bill Clinton and George W. Bush, there came a flood of 1115 waivers— from January 1993 to August 2006, 48 states and the District of Columbia submitted 195 Medicaid waiver proposals, 149 of which were approved. Thus, the Rhode Island Governor's proposal, though rather unique in scope, grew out of both locally-based policy ideas and a larger national trend toward the increased use of 1115 waivers.

## **V. Conclusion**

State government in Rhode Island is currently split between a conservative Republican governor and a Democratically-dominated General Assembly. The state's exceptionally poor economic climate, combined with deep and recurring budget deficits, has only added fuel to the ongoing discord between the two branches of government. Myriad forces both within the state and external to it have combined to propel two

major health care reform issues – comprehensive health care reform, and the Medicaid Global Waiver – to the forefront of the political agenda.

This brief analysis and compilation of background information have set the stage for the coming chapters. Understanding the forces that brought both comprehensive health care and Medicaid reform to the forefront of Rhode Island’s political agenda is critical to understanding the dynamics that followed. The rhetorical campaigns, public deliberation, media coverage, and, ultimately, the response of lawmakers and Rhode Island voters to these issues will be the focus of following chapters and interpreted from a political language perspective.

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– Chapter 3 –  
**Policy Entrepreneurs and the Language of Comprehensive Health Care Reform**

Failure of reform at the national level, along with increased governing capacity at the state level, has helped to usher in what could be called a new era of state-led health policy reform. Massachusetts, Maine, Vermont, and other states have adopted innovative initiatives, encouraging many others, including Rhode Island, to consider similar health care reforms within their own borders. Political scientists note that the concerted efforts of “policy entrepreneurs” typically drive, at least in part, this type of policy diffusion. According to John Kingdon, policy entrepreneurs are “advocates for proposals or the prominence of an idea,” characterized by their “willingness to invest their resources – time, energy, reputation, and sometimes money – in the hope of a future return” (Kingdon, 1995, p. 122). Kingdon and others have observed that successful agenda-setting efforts typically are shaped by the political language policy entrepreneurs use to describe an issue and their proposed solution, which in turn can produce shifts in the way that issue is perceived by the public and voted upon by lawmakers (see Baumgartner and Jones, 1993; Rochefort and Cobb, 1994). Thus, policy entrepreneurs are important political messengers who often play a central role in driving political debate and shaping public policy.

Although the use of language as a political strategy is well-documented, little work has been done to examine *the process* by which policy entrepreneurs create political messages to advance their reform agendas. In fact, the behavior of policy entrepreneurs is a seldom-researched area overall. Of the few studies that exist, most are singular profiles, and as a result little is known about how the reform strategies of policy

entrepreneurs operating from various positions in the policy community might differ. Roberts and King (1991) conducted a longitudinal case study featuring six policy entrepreneurs from various positions outside government. Their study offers a valuable description of the behavior of each policy entrepreneur, but does not include policy entrepreneurs operating from within government. Similarly, Oliver and Paul-Shaheen (1997) examined the enactment of major pieces of health care reform legislation in several states in order to determine what political factors led to the creation of such receptive environments. The authors conclude that a critical factor in each state was skilled and committed leadership from a single policy entrepreneur. While this research adds weight to the notion that policy entrepreneurs play a central role in advancing comprehensive reform proposals, it remains to distinguish between the roles played by policy entrepreneurs operating in official and unofficial capacities.

The first objective of this chapter is to begin filling this gap in the academic literature by tracking the organizing and rhetorical strategies of two policy entrepreneurs currently advocating for distinctly different versions of health care reform in Rhode Island. One policy entrepreneur is an elected official, Lieutenant Governor Elizabeth Roberts, and the other is a politically-active medical doctor, Nick Tsiongas. Lieutenant Governor Roberts and Dr. Tsiongas are attempting to enact reform in the same social, political, and economic contexts, yet from contrasting vantage points with respect to the policy community. Therefore, an ideal opportunity exists to isolate the influence of their positions in the policy community on their approaches to reform, including development of their proposals and construction of their political messages.

Second, this chapter will include a rich description of the content of Roberts' and Tsiongas' political messages. The purpose of this effort is to highlight the language dimension of the health care reform process in Rhode Island. By shedding light on how each policy entrepreneur frames the health care issue and defines the problems facing the health care system, and by identifying the values each individual uses to guide their policy solution, this study will serve not only to outline the contours of Rhode Island's unfolding health policy debate, but also expose the principles that both bind and divide the state's most prominent spokespeople for reform.

## **I. Methodology**

In order to offer an in-depth examination of the reform activities of Lieutenant Governor Roberts and Dr. Tsiongas, a participant observer research approach was employed beginning in January 2007. The purpose of this approach was to gather first-hand empirical data documenting differences in the reform approaches of both policy entrepreneurs. This research effort included attendance at numerous public meetings held by the lieutenant governor as well as participation in private meetings convened by Dr. Tsiongas as he worked to build a coalition of supporters. Participation in Dr. Tsiongas' meetings included presenting policy research briefs related to comprehensive reform efforts taking place in other states. This research approach also included attendance at other reform-based events sponsored by the policy entrepreneurs, including formal and informal speeches, rallies, roundtable discussions, information sessions, and community meetings. In all, the participant observation research approach

included the author's presence at over 50 separate events related to the advancement of comprehensive health care reform in Rhode Island.

Data gathered as a participant observer was supplemented by ten recorded elite-level interviews (see Appendix A for sample interview questionnaires). Among those interviewed were both policy entrepreneurs (Elizabeth Roberts and Nick Tsiongas) and a selection of the people they work closely with, such as Daniel J. Meuse, Deputy Chief of Staff to Lt. Governor Roberts, and Ted Almon, CEO of the Claflin Co. and co-founder of Dr. Tsiongas' health reform coalition. Other interviewees included Dr. Marie Ganim, Director of Policy for the Rhode Island Senate; David Gifford, M.D., Director of the Rhode Island Department of Health; Christopher Koller, Rhode Island Health Insurance Commissioner; Karen Malcolm, Executive Director of Ocean State Action (an advocacy coalition concerned with health care issues); Josh Miller, Rhode Island State Senator; and Craig O'Connor, Senior Advocacy Coordinator, Neighborhood Health Plan of Rhode Island. A complete list of persons interviewed in this chapter and subsequent chapters, their positions, and dates of interview appear in Appendix B. Except where otherwise noted, all quotations in this chapter come from this series of interviews by the author.

To examine the political messages of each policy entrepreneur, an extensive content analysis was also conducted. This approach included analysis of formal written documents, such as editorial columns and speeches written or delivered by the policy entrepreneurs, quotes from Roberts and Tsiongas in newspaper stories and websites, and other written material related to organizing and mobilizing support for health care reform. All research data – including the policy entrepreneurs' written documents,

participant observation data, and elite interviews – were collected in Rhode Island during the same two-year time frame (2007-2009), holding constant the social, political, and economic contexts in which the two policy entrepreneurs were operating.

## **II. An Introduction to Rhode Island’s Health Care Reform Policy Entrepreneurs**

Lieutenant Governor Roberts and Dr. Tsiongas both have many years of experience working on issues that concern the state’s health care system. Furthermore, both have viewed health care from a variety of perspectives. Over the last few years, these two individuals have devoted a great deal of time and professional resources to reforming Rhode Island’s health care system, rightfully qualifying them as “policy entrepreneurs” according to Kingdon’s definition of the concept noted earlier. In principle, their efforts are closely aligned – they both want to see the establishment of a universal health care system in the state. Their efforts are distinct however, in that Roberts and Tsiongas are pursuing legislative change from two fundamentally different positions in the policy community. Roberts and Tsiongas also have different personalities, motivations, goals, and ultimately different stakes in the outcome of their reform efforts, all of which are important to understanding their role in the policy process.

### **Lieutenant Governor Elizabeth Roberts**

Elizabeth Roberts graduated from Brown University in 1978 and earned an MBA in health care management from Boston University. A longtime resident of Rhode

Island, she has lived in the city of Cranston for more than 20 years. Before entering government, Roberts worked in a variety of roles in the private sector, as a business strategy consultant, policy analyst, and health care manager. During an interview with the author, Roberts noted that her work in the private health care industry rendered her one of the few legislators “who had the expertise to carry the issue”; thus she felt that she “had a role and an obligation” to become a leader in the area. Roberts also noted that she “saw during [her] campaigning that [health care] was a very important issue for people.” Furthermore, Roberts believes personally that health care “is one of the most important public policy issues facing this country.” Each factor has sustained her motivation to pursue comprehensive health care reform in Rhode Island.

Roberts is a member of the Democratic Party and widely considered to be a cautious and pragmatic politician. She was first elected to public office in 1997 as a Rhode Island state senator. During her time in the legislature, she served as co-chair of the Permanent Joint Committee on Health Care Oversight and as chair of the Senate Health and Human Services Committee. In January of 2007, Roberts was inaugurated as the 68th lieutenant governor of Rhode Island, making history as the first female elected to the position. Speaking before a group of Brown University students Roberts said that she was attracted to the lieutenant governor position because, unlike the legislature, the office offered her the flexibility and independence for which she yearned (Liss, 2009). Under state law, the lieutenant governor is responsible for working on a number of policy areas in state government through the councils she chairs, including the Long Term Care Coordinating Council, Small Business Advocacy Council, and the Rhode

Island Emergency Management Advisory Council. The lieutenant governor also appoints public members to a number of boards and commissions (RI Secretary of State, 2009).

During the time frame of this study, it was widely believed, though not confirmed, that Elizabeth Roberts would use her position as lieutenant governor to launch a bid for governor, just as her predecessor, Democrat Charles Fogarty, had done. (Subsequent to the writing of this chapter, Lieutenant Governor Roberts announced her decision not to run for the governor's post.) In fact, it was reported on Rhode Island's branch of National Public Radio in April 2009 that Roberts had hired Joe Slade White, a long-time advisor to Vice-President Joseph Biden, as her gubernatorial campaign media strategist (MacKay, 2009). The current governor, Republican Donald Carcieri, has reached his term limit and will not be eligible to run for reelection. Although they share occupancy of the executive branch, Carcieri and Roberts do not share the same position on most issues, including health care reform. This ideological divide constitutes a significant political barrier to Roberts' efforts to advance the cause of universal health care in Rhode Island.

#### **Dr. Nick Tsiongas**

Nick Tsiongas graduated from Brown University Medical School and Harvard School of Public Health and is a specialist in occupational health. He is currently the Senior Medical Director for the Northeast Area of the United States Postal Service. Although now out of public office, Dr. Tsiongas served as a Rhode Island state

representative from 1985 to 1993, representing the city of Providence as a member of the Democratic Party. While in office, Tsiongas worked on a range of health care issues and is known, at least in part, for authoring the state's first lead poisoning prevention act. During his time in the state legislature, Tsiongas also served on the Mercury Reduction and Oversight Commission.

Dr. Tsiongas is well known for his liberal stance on political issues, including health care reform. His interest in health care policy has spanned decades. During an interview, Tsiongas explained that "for the last 30 years – since medical school – I have been interested in how health care is delivered and why it is organized the way it is in this country." Tsiongas noted, further, that "although I did not focus on it as a priority until the last few years, I have always been a student of the organization of the delivery of health care in the country in general, and in Rhode Island particularly, especially around questions of equity." Therefore, his current efforts to reform Rhode Island's health care system are part of a lifelong interest in the area.

In addition to being a care provider for almost 30 years, Dr. Tsiongas also served as the 2007-2008 President of the Rhode Island Medical Society, a position he says he "took advantage of" as he worked to build a health reform coalition. The prominence of this position in the health care community allowed Tsiongas to "bring together folks that often aren't in the same organization to try to bring about a restructuring of the delivery system." This position also thrust Tsiongas into the public eye, where he earned a reputation as an outspoken advocate for vulnerable populations on issues related to health care.

### **III. Diverging Approaches to Reform**

To date, little is known about how the reform activities of policy entrepreneurs might differ based on their position relative to government. It is clear, however, that the resources available to an individual who holds public office differ from those available to one who does not. Thus, the following question deserves close attention: How do the reform strategies of a policy entrepreneur operating from within government compare with those of one who does hold elected office? Taking this line of inquiry one step further: Does a policy entrepreneur's position in the policy community influence the substance of the policy they support?

#### **Lieutenant Governor Roberts**

Lieutenant Governor Roberts' central goal as a reformer is to use her position as lieutenant governor to "reach out to people, from inside and outside government, and bring them together around a common table." She did not always approach health care reform in this way. During her time in the legislature, Senator Roberts was as committed to health care reform as she is today, but the structural realities of that position required her role to be one of marshaling support for reform among lawmakers. According to Roberts, one of the biggest challenges of "being one of 113 legislators" is that "one individual develops a piece of legislation, but there isn't a broader understanding as to why it's there and why it's important." As a result, despite valiant attempts at reform, "nothing gets done." To help rectify this situation, Roberts worked to create a Joint Committee on Health Care Oversight, which brought together House

and Senate committee chairs in order to add to the number of “people within the legislature that understand the topic.” In effect, Roberts’ role as a policy entrepreneur began in the legislature, where she worked to rally support among fellow lawmakers so that they could appreciate the complexity and urgency of health care reform.

Lieutenant Governor Roberts now plays a very different role as health policy entrepreneur, but her earlier role provides evidence to support the idea that committed policy entrepreneurs adapt to their position within the policy community, seeking the strategy that best suits the resources available to them. Upon entering the executive branch in Rhode Island, Roberts’ reform strategy shifted dramatically. Whereas her previous position had limited her role to working with legislators who may or may not have understood the complexities of health care reform, her new position as lieutenant governor brought with it the power to convene a range of individuals from both inside and outside government, all of whom had expertise in various aspects of the health care issue.

As lieutenant governor, Roberts launched her health care reform effort by establishing an advisory “work group” of stakeholders that included representatives from the medical community, the insurance industry, and hospitals, as well as business owners, labor leaders, consumers, and advocates. The group, which she named “Mission: Healthy RI,” met every Friday morning for a period of about two months. According to the lieutenant governor, the central purpose of these meetings was to “encourage open participation” from a variety of groups throughout the state in order to “focus on the challenge of insurance expansion and what we could do [in Rhode Island]

based on the structure of our market and resources available.” In short, the meetings afforded an opportunity for the lieutenant governor to listen to the advice and perspectives of anyone who could be in attendance and to foster discussion around a variety of health care reform alternatives.

Free and open to the public, these meetings were highly structured and professional in nature. About 50 of the most prominent leaders in the health policy community attended. Lieutenant Governor Roberts spoke little during these meetings; rather, she listened to the presentations and to those who came to express their concerns, adding general comments only on occasion. Each gathering was launched by a presentation from an expert in the area of health care reform, including such noted guests as Dr. David Cutler, Dean of Social Sciences at Harvard University; Dr. John McDonough, executive director of Health Care for All in Massachusetts; and Christopher Koller, Rhode Island Health Insurance Commissioner. Presentations were typically followed by a question and answer segment, and then by a more informal discussion period during which Lieutenant Governor Roberts made herself accessible to anyone who had concerns to share. The culmination of “Mission: Healthy RI” came in February 2008 with the introduction of Roberts’ own legislative package, the Healthy Rhode Island Reform Act of 2008.

There is no doubt that the weight of Roberts’ office and position within the policy community made these types of gatherings possible, and it is unlikely that many other individuals in the state could have created an environment so conducive to fostering the health reform discussion in a public arena. Marie Ganim, Director of Policy

for the Rhode Island State Senate, noted during an interview that through this all-inclusive approach to drafting health care reform, the lieutenant governor was “able to gain some real broad-based support” for her legislative package. Ganim added that the lieutenant governor’s approach allowed her to “put forward the most credible policy proposal” in the state because of the broad array of stakeholders involved. Ganim also noted that when it came time for the lieutenant governor to present her legislative package, “she wasn’t out there by herself...other individuals came to offer support for it.” Therefore, the weekly meetings convened by the lieutenant governor were not only a mechanism for gaining valuable input from the health policy community, they were also an opportunity for Roberts to bolster her standing in the policy community and to gather backing from myriad stakeholders who would be willing to speak on her behalf.

The Healthy Rhode Island Reform Act of 2008 proposal was a comprehensive health care reform package, drafted by the lieutenant governor and her staff but featuring a clear expression of the dialogue associated with the “Mission: Healthy Rhode Island” meetings. Roberts described the Healthy Rhode Island Reform Act as a culmination of the “expertise presented” and the “dialogue between the audience and the speaker” at her gatherings. The Act consisted of eight parts, most of which were not very controversial. On the whole, the package represented a moderate approach to comprehensive health care reform. While four parts of the package arguably would have made significant changes in the state’s health care system, the other four components concerned only minor alterations. The four parts of the package ultimately

passed into law (parts I, III, VII, and VIII) belonged to the latter category. All eight components of the proposal are outlined below.

- I. “Healthy RI Strategic Plan and Chronic Care Management Plan”: an effort to reward doctors for keeping patients healthy\*.
- II. “Cutting Edge Innovations”: two requirements related to publicly purchased insurance, that all individuals must have a primary physician, and that those physicians would be subject to “pay for performance” measures.
- III. A “Quality and Value Database”: new technology designed to track cost and quality information\*.
- IV. A “Health Hub”: Rhode Island’s would-be version of the Massachusetts “Connector.”
- V. An individual mandate and employer “play or pay” requirement.
- VI. An expansion of coverage to all dependent children up to the age of 25.
- VII. A “Regional Health Insurance Market”: an initiative that would allow private insurers from outside the state to enter into the market\*.
- VIII. A “Joint Legislative Task Force” aimed at continuing the health reform discussion and developing recommendations.\*

*\* Indicates component passed into law*

Roberts’ strategy of subdividing her legislative package could be seen as an adroit political move. According to Ted Almon, CEO of a local company that distributes medical and surgical products and a regular attendee of the “Mission” meetings, the lieutenant governor’s proposal was politically safe because there was “something in it for everybody.” Most groups represented at the “Mission: Healthy RI” meetings could see tangible evidence that their voices were heard by the lieutenant governor.

Another reason the lieutenant governor's approach could be seen as a savvy is that the partitioning of the Act meant each component could be voted on separately. As noted, four of eight components of the Healthy Rhode Island Reform Act were passed into law. Although resulting changes to health policy in the state were not substantial, Roberts was able to claim credit for a small legislative "victory," which not only helped strengthen her image as a reformer, but also to potentially build momentum for future legislative plans. In sum, these tactics resulted directly from Roberts' many years as a public official and her prominent position within state government.

Yet the lieutenant governor's position in government may have also constrained her approach to policy development. CEO Almon suggested that her position actually acted as a *negative* influence, preventing Roberts from working toward more meaningful reform. Almon offered the following explanation: "The essential paradox of politics is that you can't accomplish anything if you don't keep getting elected, and the process of pleasing a broad enough spectrum of your constituents sometimes interferes with making definitive policy moves." As a result, "getting a piece of legislation, regardless of how ineffectual it might be, passed is an end to [the lieutenant governor]. She has accomplished something. To me, she has accomplished nothing." Thus, Almon identifies the lieutenant governor with a timid reluctance to call for aggressive change because of a fear of electoral backlash.

In April and May of 2008, following introduction of the Healthy Rhode Island Reform Act in the legislature, Lieutenant Governor Roberts launched a series of 16 "neighborhood meetings" all around the state in order to explain her plan to the people

of Rhode Island. She held evening events in public libraries, senior centers, and other locations deemed appropriate for an intimate conversation with everyday Rhode Islanders. The lieutenant governor held these meetings in order “for people from the community to come hear about what I was doing and share their thoughts, criticisms, and things they saw as possibilities.” Through the process of listening to the concerns, criticisms, and priorities expressed at these meetings, Lieutenant Governor Roberts was able to solicit the views of people who would not normally be part of the policy discussion.

Again, Roberts’ approach was made possible by her position in state government. The community meetings were fairly low-key, but they allowed the lieutenant governor to explain her perspective on health care reform to people all across Rhode Island. Perhaps more importantly, these events were usually covered by state and local media, providing a conduit for transmitting her political message to an ever broader audience. Therefore, not only did Roberts’ position within government influence her reform strategy, the weight of authority of her office made available two useful venues through which to disseminate her political message.

### **Dr. Nick Tsiongas**

Having worked toward reform as a legislator and a private citizen, Dr. Tsiongas can speak to the advantages and limitations of each position. When interviewed for this study, Dr. Tsiongas offered the following insight based on his experience as a state legislator:

The advantage of being in office is that you actually have influence on the individuals you meet on a personal basis, who are other public officials. You get to have the ear of decision-makers much more effectively when you're inside. That works both ways, however...you can move them in your direction more easily up to a point. I think that nonetheless their bosses are the people who vote for them and if they feel that they can't sell what you're selling to their constituents, or to influential members of their constituents, then that is a limit on you...The rate-limiting step for all [lawmakers] is the next election, and getting past the next election. If they feel that a policy is perceived as being hurtful of their electoral chances they won't support that policy.

These observations support what political scientists have long suggested: that the primary concern of public officials is being elected (or reelected) (Mayhew, 1974). In fact, Tsiongas mentioned that he showed a preliminary sketch of his health reform ideas to a number of "otherwise progressive elected officials," including Lieutenant Governor Roberts. Even though Roberts and others said that they supported his plan "in principle," their resounding response was that they could not run the electoral risk of supporting it.

Upon leaving office, and after observing first-hand how lawmakers became beholden to the wishes of constituents and powerful stakeholders, Dr. Tsiongas chose to shift focus by making "[his reform] ideas more mainstream among people with influence who are not in government, and thereby make the ideas more palatable to those that are in government." In other words, he redefined his role as a policy entrepreneur who would work to *create a political environment* in which legislators need not feel they are sacrificing their electoral chances for supporting his ambitious brand of health care reform – to use a military analogy, he now sees himself as working to provide political cover for those public officials supportive of reform who are on the

frontlines of facing difficult health policy choices. This strategy, which can be defined more as cultivating a social movement than a political campaign, clearly distinguishes Tsiongas as a policy entrepreneur who is working for reform from outside of government. This approach does not mean that Tsiongas is averse to ideological conflict. His intent to provide political cover is clearly meant for Democratic legislators who are already predisposed to supporting his reform agenda.

Dr. Tsiongas began his work as a health policy entrepreneur in late 2006 surrounded by a very small, hand picked group of relatively like-minded reformers. Members of the group included academics, business and labor leaders, former government officials, and representatives of a number of local advocacy organizations. For nearly a year, these devoted individuals met secretly in a space donated to them by a local labor organization sympathetic to their cause. Under the direction of Dr. Tsiongas, members of the ad hoc coalition spent their time together working toward the formulation of three “principles” that all could agree to include in any health reform proposal they would support. Ultimately, the three principles agreed upon were:

- (1) Aggregating all health care dollars into a single purchaser system;
- (2) Controlling costs by restructuring health care and health planning; and
- (3) Insuring all Rhode Islanders.

These principles were not arrived at easily or quickly. The group met every other week for almost a year before coming to agreement. With a consensus within the group not to waver on those core principles, Dr. Tsiongas eventually gave the green light to slowly add to the group’s membership by fanning out in what he called “concentric circles.”

The “low hanging fruit,” those groups most likely to sign on to the established principles, were approached first in order to gradually add weight to this nascent reform movement. Even during this process, however, the ad hoc group maintained an air of secrecy in order to prevent opposition groups from prematurely mobilizing against its mission.

Nearly a year and a half after its first meeting, the reform coalition, under Dr. Tsiongas’ leadership, stepped out into the public eye. As first order of business, the group registered as a non-profit organization named HealthRIght. The name “HealthRIght” was itself an example of self-conscious use of political language: a great deal of deliberation went into the selection of a name that was “catchy” but also communicated values intrinsic to the group. Members felt the word “right” expressed their fundamental belief in health care as a right, not a privilege; the “catchiness” lies in creative incorporation of the state’s abbreviation. In August of 2008, HealthRIght became a fully established entity, hiring a full time project director with funding from local foundation grants.

Current organizational membership of HealthRIght includes representatives from a local Chamber of Commerce, the Rhode Island branch of the AFL-CIO, and a number of state-based advocacy organizations concerned with health care issues. Although HealthRIght continues to grow, it still represents a very small part of the larger policy community. This is due in large part to the fact that Dr. Tsiongas, as a private individual, simply does not have the resources, public prominence, or political weight necessary to consistently gather a large number of people around the table. In

fact, there were times when only four or five people attended the HealthRight meetings convened by Dr. Tsiongas. This stands in stark contrast to the broad input and public involvement garnered by the lieutenant governor during her policy brainstorming sessions.

The small size of the HealthRight coalition is also due to the inside-out approach Dr. Tsiongas chose to take as a policy entrepreneur. Quite unlike the lieutenant governor, who began with a room full of people and a blank slate, Dr. Tsiongas began with the establishment of a set of principles that reflected his core requirements and those of his close associates. Once that policy framework had been solidified, other groups were brought to the table one by one and allowed to sign on as members of HealthRight only if they agreed to the group's core principles. The central goal of meeting with new groups, therefore, was not necessarily to incorporate their particular stances into a piece of legislation; it was to convince them that implementation of a health reform package based on the group's foundational "three principles" was in their best interest and in the interest of the community at large. This approach is indicative of a reform effort led by a private citizen, rather than a public official who is expected to represent a broad constituency. The result thus far has been a very time consuming process with no specific legislative proposals and a rather small coalition membership. However, Dr. Tsiongas has managed to attract a coterie of backers fiercely committed to reform—an advantage that could prove indispensable in keeping this issue on the political agenda.

#### **IV. The Political Messages of Rhode Island's Policy Entrepreneurs**

This study presents an opportunity to examine the seldom-explored process by which policy entrepreneurs construct their political messages. During interviews, the policy entrepreneurs were asked not only about their reform strategies, but also about their *linguistic* strategies. As the two most dominant voices calling for comprehensive health care reform in Rhode Island, Lieutenant Governor Roberts and Dr. Tsiongas play an important role in setting the terms of the broader debate through their political messages. Following is an analysis of the content of those messages, focusing on many of the themes introduced in Chapter One, including issue framing, problem definition, and the use of symbolism.

##### **Lieutenant Governor Roberts**

As Teena Gabrielson (2005) has argued, elected officials have certain constraints on how they are able to frame a political message based on the fact that their constituency includes organized interests, some of whom may have strong ideological predilections. In the case of Lieutenant Governor Roberts, the awareness of her position as a representative of diverse interests shaped the process by which she developed her political message. Much like the development of her health reform policy proposal, Roberts' approach to constructing political language was calculated and deliberate. In fact, the lieutenant governor emphatically expressed during her interview that she, along with her staff, "deliberated a lot" over the language they used to describe her health reform goals.

Daniel Meuse, the lieutenant governor's deputy chief of staff, offered one example of this deliberation. Meuse noted that considerable thought went into the construction of the one-sentence catchphrase that would become the mantra of Roberts' campaign to pass the Healthy Rhode Island Reform Act. The lieutenant governor and her staff decided to fashion her message around the promise that her legislative package would ensure that "all Rhode Islanders would have access to high quality health care they could afford." Meuse said the staff was vehement about sticking to this phrase and consciously avoided alternatives such as "we want to make sure everyone has health care," or "we want Rhode Island to have the Massachusetts plan." He emphasized "We were very cautious on what we said because of the connotations."

Similarly, Lieutenant Governor Roberts felt it was necessary to exercise caution with regard to use of language because opponents were always working to redefine her plan, "push it to universal coverage, socialized medicine, et cetera," and using damaging rhetorical questions like, "how are you going to pay for it?" In addition to her carefully crafted catchphrase, Roberts frequently employed the more targeted phrase "market-based reform" to counter these efforts. In using these words, however, the lieutenant governor lamented that "some people in the advocacy community weren't happy," and a local columnist "wrote a piece saying I was a Republican." In other words, each phrase that Roberts delivered spurred a reaction from at least one segment of the community, making her acutely aware of the power of her words. As a result, her language construction was calculated, thoughtful, and routinely checked by the reaction of constituents.

The sheer complexity of the health care issue was another consideration of the lieutenant governor as she constructed her political message. Roberts frequently acknowledged that health care is a highly complex issue, and that few people outside the policy community have the expertise necessary to grasp the full range of problems associated with the current system or the details of their policy solutions. Therefore, she took care to ensure that her message included language to make each of these components easy to understand. Moreover, Roberts believed this was a necessary strategy in achieving sustainable reform. The lieutenant governor explained these dual considerations:

One of the biggest challenges facing the health care reform issue is the fact that the consumer, the patient, the public person is not really involved in health care reform right now, and for it to be sustainable I believe they have to be. They have to understand what is going on, understand how it is going to impact them, and what their responsibility is, but also what it will mean going forward in terms of a system that will continue to work for them.

In order to move in this direction, when the lieutenant governor speaks out in the community, her message is constructed in such a way that she is talking “about how insurance impacts each one of us individually, whether it’s the cost of premiums or how we each use the system...things that really relate directly to people.” Furthermore, she maintains that “it is really important not to get into the jargon of health care reform” when talking with the general public, but rather to talk about “chronic disease like diabetes,” and to “make things specific so that they can think about how it’s impacted their lives or someone they know.”

Lieutenant Governor Roberts publicly introduced her health care initiative with a prominent speech delivered before more than 100 invited guests, including representatives from the business, health care, and political communities, as part of the University of Rhode Island's 2007 Distinguished Lecture series. The title of her speech, "Life, Liberty, and the Pursuit of Health Care," is a good place to begin a close analysis of her political language. Her title selection was an obvious play on words connecting the modern issue of health care reform with one of the most familiar phrases from the founding of American democracy. The original phrase, "Life, liberty, and the pursuit of happiness," was used to convey three aspects that are among the "inalienable rights of man" in the Declaration of Independence, so by inserting "health care" in place of "happiness" Roberts implies that health care deserves a place among this time-honored list of American rights. At the same time, this clever semantic construction associates health care with the word it replaced, implying a strong relationship between one's access to health care and personal happiness. Finally, its connection to the American Revolution suggests that the "pursuit of health care" reform will require unity, courage, and a rebellious spirit. Perhaps most plainly, it conveys the notion that this is a cause worth fighting for.

These themes are consistent with the lieutenant governor's overall framing of the health reform issue, both within her kick-off speech and beyond. Harkening back to the "rancorous partisanship" of the Clinton health care debate, Roberts admitted during her speech that she often wonders "Will we ever find common ground on health care again?" Pushing doubts aside, however, her answer is a firm one: "I believe we will; I

believe we can.” Much of this speech sounds the same chord, urging all sides to “come together around a table...put aside the rancor, the posturing, the pandering, and the personal agenda, and work together” (Roberts, 2007). Such language indicates that Roberts remains keenly aware of the partisan deadlock that has marked previous health reform episodes, and she communicates that it is her intention to move beyond traditional ideological feuds. This particular language also represents her pragmatic approach to finding a broadly acceptable policy position.

During this high-profile kick-off speech, the lieutenant governor steered well clear of policy specifics. In fact, following her remarks she made a point of telling *The Providence Journal*, “This is not a piece of legislation that I spoke about today, because what I want [is] people in this room, people who care about this issue, consumers, providers, government [to] start participating and finding the solutions. I may not have every single right answer” (Mooney, 2007). However, Roberts’ speech was also devoid of any concrete description of the problems facing the state’s health care system. The closest she came to identifying a specific problem was in stating her commitment to “addressing the fears and frustrations of so many Rhode Islanders who see a health care system that is cumbersome, complicated, and too often inaccessible” (Roberts, 2007). Yet such an abstract formulation offers little guidance as to what the lieutenant governor would identify as the focus of action in any health care overhaul to come.

Equally vague in the lieutenant governor’s speech was her commentary on the causes of problems within Rhode Island’s health care system. Rather than offering details, Roberts relied on what Deborah Stone calls a “causal story,” a rhetorical strategy

built on an emotionally compelling narrative outlining a sequence of events with implicit assignment of responsibility (Stone, 2002):

Joe Cannon of CAS America, a Rhode Island-based cabinetry manufacturer, is trying to keep coverage for his employees. He always paid 100 percent of their health care; but for the past five years he has seen health care costs increase by 25-30 percent each year. Last year they went up 50 percent. For the last few years Joe has switched between Blue Cross and United because – every year – the insurer he didn't have offered him a lower rate, so he switched back. But overall cost increases have forced him to reduce coverage and increase deductibles. His insurance agents have advised him to ask his employees to pay part of their premiums, but Joe believes that paying for his employees' health care is the right thing to do. It's what he's always done (Roberts, 2007).

In describing “Joe’s” struggle with health care “cost increases,” the lieutenant governor appears to convey, albeit in indirect terms, the cause behind the erosion of employer-based insurance in Rhode Island. She offers no analysis, however, concerning who or what is driving these cost increases. Roberts also uses this story to inject a moral theme, noting that “Joe believes that paying for his employees’ health care is the right thing to do.” This portrayal casts Joe (and presumably other business owners) as a sympathetic victim worthy of government intervention (Rocheftort and Cobb, 1994).

Vagueness, generalities, and indirection have permeated the lieutenant governor’s subsequent campaign for reform, coming to stand as a hallmark of her political message. Even when asked during a recent interview – more than two years after her health care reform launch – about the specific problems of Rhode Island’s health care system and who or what might be to blame, Roberts’ language was remarkably non-committal and imprecise. She noted first that “most of the problems facing Rhode Island, I think, are the same ones facing the country; I don’t think our

problems are particularly unique.” Following that qualification, the lieutenant governor offered two broad problems: “unsustainable cost increases” and a “lack of [state] resources.” The driving forces behind the cost increases, according to Roberts, are “demographics,” “the proliferation of technology and pharmaceuticals that we have access to,” and “conflicting incentives within the system.” Such observations, regarding both the problems and their causes, remain imprecise, unthreatening, and, so, unlikely to provoke much disagreement. It is a linguistic approach that fits perfectly with her attempt to form a broad consensus based on the theme that all Rhode Islanders are in this together and all have a stake in making the system work better.

A year after her initial speech, Lieutenant Governor Roberts launched “Mission: Healthy Rhode Island,” the several-week long “dialogue” that included diverse local stakeholders. Despite the passage of time, her political message still lacked detail – a fact that was not lost on *The Providence Journal*, which covered the first Friday morning meeting. An article recapping the event began with a description of Roberts as someone “who has been involved with health-care issues at the State House for years,” but one who “is long on rhetoric and study and short on specifics” (MacKay, 2007). Roberts only furthered this reputation by announcing the same day that when it comes to a health care reform solution she might support, “all options are on the table.”

It was three months later, in February of 2008, when the lieutenant governor announced her legislative reform proposal, the Healthy Rhode Island Reform Act. Perhaps not surprisingly, the description of her legislative solution was fuzzy at best. From the State Room in Rhode Island’s State House, surrounded by her closest

supporters, Roberts explained her proposal in this way: “What is unique about this package is that it calls on policymakers, state officials, and citizens to work together to establish the infrastructure for change and set clear priorities on strict time lines before new public funds are invested” (Needham, February 13, 2008). This is hardly a statement to inflame passions on either side of the health care debate. In fact, Roberts’ proposal seemed to have been offered simply as a prop in the ongoing theatre of deliberation. House Finance Chairman Steven M. Costantino echoed this tone, calling the lieutenant governor’s package “a template for the future.” He added, “I think this is the year you start the discussion. You start it now and you have a year behind you working out all these details. [Next year] if things change [with the state’s deficit situation] you’ve done all the groundwork on something like this.”

Viewed in isolation, the chairman’s reaction may seem odd. One might expect a prominent legislator to offer a comment either supporting the bill or expressing concerns, especially considering that the bill had been personally drafted by the lieutenant governor, a fellow member of the Democratic Party. Instead, Costantino’s reaction was the muted appreciation that we can now “start the discussion.” However, the chairman’s response does mirror the lieutenant governor’s own subdued rhetoric. On the day Roberts announced her plan, Jennifer Wood, the lieutenant governor’s policy director, told *The Providence Journal* that “This is about starting the most substantive dialogue we could in the General Assembly and moving as many pieces of this puzzle forward” (Needham, February 12, 2008). Once again, this is hardly an urgent call for comprehensive reform.

Tracing the lieutenant governor's language from her initial speech in 2007 to the release of her reform package, one could reasonably conclude that she submitted her reform proposal merely to advance the dialogue surrounding comprehensive health care reform, not to pass legislation. Ultimately, the four components of her plan that might have fundamentally reshaped the system were rejected, and there is simply no indication in Roberts' own words to suggest that she wanted anything more than a conversation about these more significant health care reforms. In this regard, it is worth considering what Roberts did *not* say as well as what she *did*. Her record of public comments contains no expression that the four fundamental components of her plan were an urgent necessity. Her cautiousness stands in sharp contrast to the noted propensity of health policy reform advocates to evoke dire terms, including "crisis" rhetoric, in order to advance their proposals (Rochefort and Cobb, 1994). But nothing of the sort was found in the lieutenant governor's message. Nor did her message declare that her proposed reform measures were the only viable solution. In fact, she often explicitly left the door open for better ideas. Immediately following the General Assembly's rejection of the major components of her policy proposal, Roberts expressed disappointment with the Assembly's decision, saying only "I look forward to working this summer and fall to bring a new set of ideas for further health reform next session" (Roberts, February 13, 2008). It was an expression both conciliatory and oddly out-of-sync with the rebuff received by the lieutenant governor for all her hard work. Yet Roberts seemed content that a serious conversation about health reform in Rhode Island had at least begun.

**Dr. Nick Tsiongas**

Unlike the lieutenant governor, Dr. Nick Tsiongas has a full-time professional position separate from his drive to reform the state's health care system. He does not stand to gain either financially or professionally from successfully leading this movement. Rather, his effort is seemingly driven by his principles. Therefore, it should not be surprising that Tsiongas' personal values shaped the construction of his message.

During his interview with the author, Dr. Tsiongas made it clear that he feels accountable only to himself, and he does not claim to represent anyone's views but his own. As a result, his language during the interview was almost entirely unchecked, routinely including words that were highly charged when talking about his reform position. Tsiongas referred to an imbalance in "equity" and "fairness" in the way health care is delivered in the state, and he described the inability of many people to easily access coverage as a "social disgrace." Inflammatory language of this type bears little resemblance to the deliberative and careful approach taken by the lieutenant governor and her staff. Furthermore, as will be shown, this rhetoric was by no means restricted to the intimacy of an interview setting. Dr. Tsiongas frequently employs highly charged, value-laden language when he writes and speaks publicly. Given his position in the policy community, such discourse makes good political sense for he can use it to draw attention to his cause and fire up core supporters with little concern for any backlash he might excite.

One consideration that Dr. Tsiongas took into account when constructing his political message is the history of previous health reform debates and the negative

baggage associated with certain language. He suggests that “the ability to manipulate language has delayed reform” in the United States, and cited the dismantling of President Bill Clinton’s health care campaign as the most glaring example of this fact. Tsiongas also noted the use of “banner headlines” by organized interests, such as the American Medical Association (AMA), to critique the Canadian system and “scare people” about the prospect of comprehensive health care reform. As a result of these historical lessons and others, Dr. Tsiongas said he deliberately selected new terms such as “central purchaser” to describe the government’s role in his plan so that skeptics would not view it as a “single-payer” or “government-run health care” plan.

Dr. Tsiongas frames the health care issue in the most comprehensive terms: his message does not just focus on the number of uninsured, rising health care costs, quality of care, or the proper role of government, but on the entire system. In fact, in an op-ed piece printed in the *Rhode Island Policy Reporter*, titled “Thoughts on the Rhode Island Cure,” Tsiongas explicitly stated that “The large number of uninsured is *not* the problem that needs solving. This is only a symptom of the real problem.” The problem, as he defines it, is “a dysfunctional health care delivery and finance system” (Tsiongas, 2006, p. 4). More specifically, money that goes into the health care system comes from an array of places, and “not any one entity owns the system.” As a consequence, “you can find all the money in the world to expand insurance to everyone, but if you’re still pouring it into the same...very cost generating structure, that will just make inflation worse.” In short, the issues surrounding health care result from a systemic deficiency, and the problems people traditionally associate with today’s health care system,

including the rate of uninsured and rising costs, he casts as “symptoms” of this larger problem.

Use of the term “symptoms,” of course, is quite befitting a doctor’s diagnostic approach. No surprise, then, that Tsiongas invoked the following medical analogy to augment his message:

Merely insuring the uninsured and not restructuring the system that helped create them is like giving aspirin for pneumonia. In the short run the fever goes down—but it’s the pneumonia that’s the problem, not the fever. Cure the pneumonia and the fever stops (Tsiongas, 2006).

Who or what is to blame for this systemic problem? Dr. Tsiongas offers a striking answer. Referring to the rising cost of state-provided health care for children and the governor’s recent proposal to cut the program, Dr. Tsiongas asserts that “you can’t blame the bleeding heart liberals who resist such program cuts for the increasing costs of RIte Care and other health care services—it’s the right-wingers who don’t have the guts or the interest to place controls on the health care market who are costing us both taxpayer and private dollars! The right wing doyens of the market are willing to see increased burdens on our businesses and taxpayers because they cannot stomach a planned health care system” (Tsiongas, 2006). Defining the cause of the problem (particularly in such partisan terms) is not only attention-grabbing, it also communicates a number of underlying messages.

For one, Dr. Tsiongas defines the health care debate as an ideological battle. He vividly pits the “bleeding heart liberals” against the “right wing doyens of the market.” This construction of political extremes challenges the audience either to side with Tsiongas or against him, leaving little room for compromise or a middle ground.

Tsiongas' language also conveys several dimensions of problem causality, which is of special prominence in the problem definition literature. Rochefort and Cobb note that "a decision about problem causality can be the linchpin to a whole set of interdependent propositions that construct an edifice of understanding about an issue" (Rochefort and Cobb, 1994, p. 16). Thus, a series of perceptions can be invoked from a single statement of causality. Dr. Tsiongas' definition strongly implies that the "market" has been a destructive force on the health care system. He argues, instead, that a "planned" health care system is a more appropriate mechanism for driving down costs. Tsiongas' statement of causality also implies that reform will take "guts" and a new way of thinking, predicting that only those who could "stomach" the change necessary will be up to the challenge. This is at once a rallying call and an insult, depending on one's perspective. Regardless of how one takes it, there is no doubt that Tsiongas is issuing a call to arms. Finally, and perhaps most importantly, Tsiongas identifies the cause of the health care problem as a group of greedy and misguided people, rather than the ambiguous institutional mechanisms and demographic trends cited by the lieutenant governor. The villains of Dr. Tsiongas' health reform narrative are clear enough to recognize, for supporters and adversaries alike.

In the work of his ad hoc reform coalition, Dr. Tsiongas has been equally straightforward in defining the "principles" of a "uniquely Rhode Island" health policy solution (HealthRIght Presentation, 2009). The first principle is to streamline the system, "consolidating all public and private health care dollars into a single public or not-for-profit purchaser of health insurance and/or health care services." The second core

principle is to “control health care costs by implementing a coordinated health planning process and restructuring delivery of health care to achieve more equitable and efficient allocation of health care resources.” Finally, a policy solution must ensure that “all Rhode Islanders have timely access to appropriate, affordable, quality health care.” These objectives and the language of their representation merit closer attention.

Tsiongas’ core principles reflect a deeply-held set of political values. First is an economic-based value, which comes in the form of an outright rejection of a role for for-profit, and possibly even all private, insurers. This is not a goal that can be taken lightly. In Rhode Island, this means at the very least forcing United Healthcare of New England, which has a commercial insurance market share of about 15 percent (Cryan, 2008), out of the state. More ambitiously, it could also lead to removing *all* insurers from the state, including Blue Cross Blue Shield, with its 65 percent share, in order to create an entirely new publicly-run health care system. A strong role for government informs the second principle communicated by Dr. Tsiongas, in which a proposed process of “control,” “coordination,” and “planning” ensures the “equitable” and “efficient” use of resources. Although a precedent for this type of government regulation can be found in the activities of the Office of the Health Insurance Commissioner and operation of the state’s Certificate of Need Program, one could easily imagine conservatives, or even moderates, cringing at what begins to sound like centralized bureaucratic planning. Lastly, Tsiongas communicates the somewhat less controversial principle that quality health care is something all Rhode Islanders are entitled to access and afford, a value that is mirrored in the name of the coalition he chairs, HealthRIGHT.

While the vast majority (84 percent) of Rhode Islanders agree with this general notion of health care as a “right” (Rochefort et al., 2007), other aspects of Tsiongas’ message are decidedly more controversial. Not only is Tsiongas calling for a complete overhaul of the current system and a rejection of the market-based approach, he also seems to be proposing a new regulatory body with vast authority over health care costs and resources. Moreover, the message offered by Dr. Tsiongas strongly describes any policy proposal that falls short of a comprehensive overhaul of the health care sector as “naïve” or even “dangerous” (Tsiongas, 2006). Even the landmark legislation passed in Massachusetts does not escape his scorn. Tsiongas suggests that all Bay State policymakers have accomplished is to “buy off competing interests by finding them more money to work with.” In short, Tsiongas offers a powerful message that is bold, value-laden, and at times downright sarcastic. Significantly, however, it is a message that resonates with the dedicated members of his HealthRIght coalition.

## **V. Conclusion**

The results of this two-year study provide a number of insights regarding the opportunities and limitations inherent in a policy entrepreneur’s position within the policy community. Lieutenant Governor Roberts, pursuing health care reform from within government, clearly has enjoyed greater access to the media, industry stakeholders, and legislative decision-makers than has Dr. Tsiongas. This advantage has afforded her greater opportunity to disseminate her political message and to garner the support of those in positions of power. However, Lieutenant Governor Roberts has

been limited in the extent to which she can pursue her own policy preferences by her awareness that, as a public official, she must represent diverse constituencies, develop policy in a transparent public forum, and compromise with other elected officials. Finally, the lieutenant governor's goals as a policy entrepreneur have been oriented toward achieving her own political rewards, such as reelection and the passage of incremental legislative fixes.

Dr. Tsiongas, operating from outside government, may not have had easy access to the state's media outlets or prominent decision-makers, but he does have the ability to meet with supporters away from the spotlight and absent the expectation of inclusiveness. This approach has allowed him to build momentum toward the creation of his nonprofit group, HealthRIght, without interference from groups that might oppose such a coalition. Tsiongas' position as a private citizen has also allowed him to develop a policy position based exclusively on core principles. Similarly, although Tsiongas' HealthRIght coalition is small in size, members are fiercely committed to his guiding principles and the cause of comprehensive reform. With nothing to gain financially or professionally, Dr. Tsiongas' goal as a policy entrepreneur has been to found an idealistic political movement, one that would translate his principles into public policy.

Another important finding from this study is that not only were the political tactics of these policy entrepreneurs strongly influenced by their positions in the policy community, so too was their formulation of policy goals and their construction of political messages. The lieutenant governor's eight-part Healthy Rhode Island Reform

Act was calculated to gain broad-based appeal, and this is reflective of the diverse constituency she represents. Carefully constructed and deliberate, her political language conveys a message that embraces unity at the cost of ambiguity. As a private citizen, Dr. Tsiongas will only support a policy embodying his principles. His political message reflects the freedom of action and speech that he enjoys as a private citizen, but his use of bold, attention-grabbing language has also been a strategy for capturing media attention and attracting like-minded allies.

It is interesting to note that the messages of both these entrepreneurs, whether constrained or transformational, favor politics over policy. The lieutenant governor has largely aimed at building a network of stakeholders interested in commencing the process of health reform. Even as she has advocated for her own health reform legislation, Roberts focused on the need to promote continued dialogue among diverse groups and interests. Dr. Tsiongas' message was geared toward building a groundswell of activist and popular support for overhauling the existing health care system, with a primary focus on the principles and values he believes should guide that change. In both cases, there has been an avoidance of policy details that would come as no surprise to Murray Edelman (1988), an expert on the strategic use of ambiguity in political language. Ambiguity, according to Edelman, helps the speaker to avoid offending "those who might find a clear promise offensive" and "encourages everyone to read their own preferences into the language" (p. 50). As both policy entrepreneurs worked to consolidate their base of support, it is clear they have preferred to leave the legislative specifics of reform for a later time.

If one is tempted by the flurry of attention surrounding the issue to think Rhode Islanders might now be close to adopting a far-reaching health care reform, the strikingly different messages of these two policy entrepreneurs should give reason for pause. The lieutenant governor favors a “market-based” reform modeled on the Massachusetts plan that is designed to leave much of the current system in place. Dr. Tsiongas rejects outright the notion of a health care market, and he argues the unqualified necessity of rejecting the organizational status quo. It is hard to imagine a compromise between these conflicting visions and equally difficult to imagine either policy entrepreneur forfeiting their supporters or central political message.

The most hopeful possibility is that the messages and tactics of the lieutenant governor and Dr. Tsiongas could somehow complement each other. Marie Ganim, Director of Policy for the Rhode Island Senate, was helpful in shedding light on this perspective. She described Dr. Tsiongas’ vision, and that of his HealthRIght coalition, as “the hope and the light.” She said that “Their proposal will garner both support and opposition, but it will bring the discussion to us in a more visible and much louder way.” By contrast, Ganim believes that the lieutenant governor’s reform efforts have been instrumental in “building the bureaucratic structure” and “gaining public attention” for advancing health care reform, although her low-key approach would never “bring protesters and advocates running through the halls of the State House.” The HealthRIght proposal coming from “outside of government will garner more grassroots support” and be a “more forceful” means of advancing the prospect of a health care reform that is truly comprehensive in scope.

Given the unpredictable nature of politics, there is simply no way to tell how this scenario will play out in Rhode Island. Whatever the outcome – and the current health policy debate of the Obama Administration in Washington, D.C., has largely overtaken state action, at least for the time being – there is no question that both figures discussed in this chapter have made a lasting mark on the politics of health care reform in Rhode Island. Whether it is in terms of problem definition, the voice of personal conviction, or political stratagem, no full understanding of these developments is possible without a political language perspective.

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– Chapter 4 –  
Rhode Island’s Medicaid Waiver Debate

Like many states throughout the country, Rhode Island is currently facing a period of budgetary distress. A faltering national economy, rising public expenditures, shrinking revenues, and at the time of this writing, a nation-leading rate of unemployment, have combined to form unprecedented, multiyear budget deficits in the Ocean State. As a result, Governor Donald Carcieri and state lawmakers have turned their focus to slashing public expenditures – the 2009 budget included deep cuts in aid to cities and towns, the state workforce, state universities, and community service grants such as Meals on Wheels, and removed hundreds of people from the state’s health care and welfare rolls (Gregg, et. al, June 20, 2008). The 2009 state budget also included a projected savings of \$67 million in Medicaid spending, based on a bold new plan to overhaul the program put forward by Governor Carcieri. The governor’s plan, termed a “Medicaid Global Waiver,” is a proposal to grant the state’s executive branch unparalleled authority to revamp the health care program for poor children and adults while capping federal contributions for these services.

The Carcieri Administration launched its ambitious Medicaid reform proposal with remarkably little detail, introducing the program as a one-page “placeholder” in the governor’s 2009 state budget proposal where a lengthy Medicaid budget might have been expected (Peoples, February 15, 2008). Despite this glaring lack of public information and detail, the governor’s office forecasted a total savings of \$67 million dollars to the Medicaid program if its recommended programmatic changes were implemented by July 1, the start of the state’s fiscal year. This lack of policy detail on the

one hand, and the promise of projected savings on the other, would become defining characteristics of the governor's Medicaid Global Waiver proposal, giving rise to a public debate based less on specific elements of the waiver and more on competing attitudes toward government and its proper role in the provision of health care services.

The rhetorical battle between the governor's office and opponents of this far-reaching proposal, which lasted almost exactly one year from when the program was first announced in January 2008 to its passage by the state legislature on January 15, 2009, will be the focus of this chapter. In order to map the linguistic terrain of Rhode Island's Medicaid debate, the political language framework outlined in Chapter One will be employed. To recap briefly, this framework focuses on tying together the use of language by political messengers; the political messages the messengers construct; and the political response. Political messengers can come in a number of forms, including political leaders, policy entrepreneurs, organized interests, and the media. The waiver debate included each of these actors, save for policy entrepreneurs. A political message refers to the way an issue is framed, defined, and communicated to the public. This component of the political language framework will be useful in outlining the competing narratives offered on both sides of the Medicaid debate. Finally, political response refers to the relationship between political language and public policy, on the one hand, and public opinion, on the other, aspects of which will be examined here.

This framework will be used not only to guide an investigation of Rhode Island's Medicaid waiver process, but also to delve into broader questions related to political language. For example, what is the relationship between symbolism and policy

substance in the use of language during the health policy process? To what extent does the “Orwellian” presumption that those in power construct political language as a means of public manipulation hold true in Rhode Island politics? How does language animate and give expression to the dynamics of political rivalry on health care?

This case study reveals a health policy debate that was bitterly divided, where both sides offered drastically different accounts of the governor’s Medicaid waiver proposal. The governor and members of his administration put forward a consistent and cogent political message that emphasized the need for consumer choice, administrative flexibility, and policy innovation to replace a financially “unsustainable” and outdated Medicaid program. Meanwhile, opponents decried the persistent lack of detail in the waiver plan and questioned whether the Republican governor, known for his previous efforts to restrict Medicaid eligibility, could be trusted to implement a plan that would both save money and provide for Rhode Island’s most vulnerable citizens. Utilizing language more often associated with their conservative counterparts, liberal advocacy organizations and Democratic leaders in the state constructed a “rhetoric of reaction” (Hirschman, 1991) by casting the waiver as needlessly “risky” and a threat to the traditional intent of the Medicaid program. Both sides used language as a tool for manipulating public opinion, constructing an image of the Global Waiver that was more “mystifying” (Edelman, 1988) than clarifying. *The Providence Journal* – Rhode Island’s only statewide newspaper – provided its readers with mixed political messages, offering strong editorial support for the waiver while at the same time placing greater emphasis on the potential problems that could come with the plan’s implementation in day-to-day

news reporting. In the end, the state's exceptional budgetary predicament, along with the administration's successful salesmanship of policy innovation, combined to usher in the most sweeping Medicaid waiver in the nation's history.

## **I. Methodology**

In order to conduct an in-depth examination of the language of Rhode Island's Medicaid waiver debate, two qualitative methods were employed. First, data was gathered through ten recorded interviews. A list of prearranged questions was used to guide the interviews, but spontaneous follow-up questions often took the interviews in unexpected and fruitful directions. The content of the questionnaires was geared toward capturing how each individual viewed the role of language in the development of the Medicaid waiver. The political messengers were also asked probing questions regarding the process by which political messages were constructed (see Appendix A for a sample of interview questionnaires). The list of those interviewed includes Governor Carcieri and a selection of people with whom he works closely, such as Gary D. Alexander, Director of Rhode Island's Department of Health and Human Services; Timothy M. Costa, Director of Policy for the governor; and John Robitaille, Senior Communications Advisor to the governor. Other interviewees include Ted Almon, CEO of the Claflin Co.; Dr. Marie Ganim, Director of Policy for the Rhode Island Senate; David Gifford, M.D., Director of the Rhode Island Department of Health; Dr. Linda Katz, co-founder and Policy Director of the Poverty Institute; Karen Malcolm, Executive Director of Ocean State Action; and Josh Miller, Rhode Island State Senator. These

individuals were selected for an interview either because they were prominent political messengers in the waiver debate, or because they could offer a unique insight on the waiver issue.

To examine the political messages put forward by the Carcieri Administration and opponents of the Global Waiver, an extensive content analysis was conducted. This approach included analysis of formal written documents, such as the 91-page waiver proposal titled “The Rhode Island Global Consumer Choice Compact Waiver,” editorial columns, and speeches. All research data collected in Rhode Island date from the same one-year time frame (2008-2009) as the policy process for this issue. Thus, the social, political, and economic contexts in which the political messengers are operating can be held constant.

## **II. A Review of the Governor’s Waiver Proposal**

Since 1965, Medicaid has served as the nation’s health insurance program for low-income parents, children, seniors, and people with disabilities. States are given considerable autonomy in administering their own Medicaid programs, but must follow certain guidelines outlined by the Centers for Medicaid and Medicare Services (CMS) in order to receive federal matching dollars. Currently about 180,000 Rhode Islanders receive Medicaid benefits, the majority of whom are enrolled in the managed care program called RItE Care that was discussed in Chapter Two. First implemented 15 years ago under a “Section 1115” federal waiver, RItE Care provides health coverage to low-income families, children under 19, and pregnant women. Beneficiaries in the RItE

Care program pay premiums based on a sliding scale, from no cost at all to \$92 per month, depending on income. Remaining costs are subsidized by the state and federal government. Medicaid costs paid by the state have grown at an average rate of between six and seven percent over the last six years. In 2007 the state's Medicaid expenditures totaled \$826 million, or 26 percent of the General Revenue budget (Executive Office of Health and Human Services Medicaid Global Waiver Presentation, 2008).

In addition to the rising costs associated with Rhode Island's Medicaid program, the state has been stuck in a cycle of deep and recurring budget deficits in recent years. Although the nation's economic downturn created substantial fiscal challenges for most states, Rhode Island was among the first and hardest hit. By the end of 2007, Rhode Island stood as the only northeastern state to be "in recession," and analysts suggested that the state's fiscal situation was the worst it had been in decades (Peoples, April 29, 2008). One result of the downturn was a drastic reduction in public revenue and a gaping \$300 million budget deficit for fiscal year 2008. Despite difficult spending cuts by state officials and the adoption of a mid-year "supplemental" budget that cut 2008 current-year spending by an additional \$168 million, the approach of fiscal year 2009 came with a \$425 million budget deficit – the largest in nearly two decades and an undeniable sign of the state's deteriorating fiscal climate (Peoples et al., 2008).

Once again, lawmakers were forced to make painful spending reductions, which included \$90 million in cuts to the state workforce, \$12.5 million in aid to cities and towns, \$9 million in community services grants such as Meals on Wheels, and a reduction in maximum stay on welfare from five to four years. Significantly, with

prodding from the governor, lawmakers also tightened Medicaid eligibility, dropping an estimated 1,000 parents from RIte Care coverage (Gregg et. al, December 24, 2008). In addition to these spending and eligibility reductions, the 2009 state budget relied on a projection of \$67 million in reduced Medicaid spending, a figure generated by the governor's office to represent savings that would result if implementation of a new Medicaid waiver began by the start of the 2009 fiscal year (Peoples et al., 2008).

The governor first announced his "Global Waiver" initiative in January of 2008 during his annual State of the State Address, proposing to transform the Rhode Island Medicaid program by shifting federal funding, which accounts for roughly half of the state's total Medicaid spending, from an annual matching grant into a five-year block grant. In return for Rhode Island's agreeing to a capped dollar amount, the federal government would be asked to allow much greater state flexibility in reshaping the program. The governor attributed projected savings to four main reform components. First, the administration proposed to "rebalance" the long-term care system by "transitioning" beneficiaries – on a voluntary basis – away from nursing homes, residential care, and other high-end services to community-based care settings. Second, all Medicaid beneficiaries would be enrolled in a managed care program, thereby assuring the use of health care services at the appropriate time and setting. Third, some Medicaid beneficiaries would be required to assume greater cost sharing, with the intent of rewarding healthy choices and encouraging more effective utilization of the system. Fourth, the state proposed to adopt a practice of competitive contracting when purchasing health services in an effort to stimulate competition among providers and

drive down prices (Rhode Island Global Consumer Choice Compact Waiver). Taken together, these changes would amount to a complete overhaul of the state's Medicaid system in the pursuit of greater efficiency and state control.

The governor's Global Waiver proposal was formally released on July 29, 2008, after which the Rhode Island General Assembly was given a ten-day review period before the proposal was sent to the federal government. During that ten-day period, a legislative hearing was held, during which administration officials presented details of the waiver before a Joint Committee of House and Senate Finance. Next, the proposal went to the Centers for Medicaid and Medicare Services (CMS) in Washington. Negotiations between CMS and the Rhode Island governor's office lasted until December 19<sup>th</sup>, when the federal government granted its approval of the waiver (Peoples, December 20, 2008). The final step in the process was a self-imposed 30-day review period during which the Rhode Island General Assembly could choose to reject the waiver or allow it to take effect. This review period was punctuated by 11 hours of legislative testimony, featuring an unprecedented appearance and show of support by the governor, along with many other stakeholders who voiced their fervent opposition. In the end, the General Assembly did not vote to block the waiver; however, it did pass legislation that gives the legislature substantial oversight of any changes that would impact the eligibility, benefits, or payment structure of the state's Medicaid program (Peoples, January 16, 2009).

As noted, almost exactly one year passed from the governor's first announcement of his Global Waiver proposal to its final approval. Considering the

scope of the proposal as well as the various levels of bureaucratic and legislative approval that were required, this was a fast-moving process. Indeed, public debate was confined to just a few days of public hearings and intermittent bursts of media attention. This accelerated process was also marked by a glaring absence of policy details. Administration officials were quick to acknowledge this fact, but claimed that the federal negotiation process, and in fact the waiver itself, would be fruitless if precise policy commitments were offered in advance. This combination of a relatively brief public review and the lack of mutually agreed upon facts made for an intense debate centered on competing views of government and a controversy over whether such a bold new plan could, or should, be used to alter existing provisions in health care for low-income children and adults. A political language framework offers the means for describing these clashing points of view and their deeper political significance.

### **III. Political Messengers**

An important dimension of the political messenger is the motivation behind their use of language. What was at stake for each political messenger in the Rhode Island Medicaid debate, and what goals did different participants hope to achieve through the use of language? Moreover, what was their broader strategy toward winning the public debate? To assess the strategic intent of parties on either side of the waiver debate, it is instructive to note Schattschneider's (1960) conception of politics as the "socialization of conflict." Schattschneider writes that "the outcome of every conflict is determined by the *extent* to which the audience becomes involved in it" (Schattschneider, 1960, p. 2).

Those in a position of power seek to contain the scope of conflict, while those with limited resources seek to expand the scope of conflict in an attempt to shift the balance of power in their favor (Ibid., 1960). In the Medicaid waiver debate, therefore, it is to be expected that the Carcieri Administration would seek to contain the scope of conflict, while opponents worked to draw in outside help in order to gain the upper hand.

#### **A. The Carcieri Administration**

The most prominent political messengers in the Rhode Island waiver debate were the governor and his top administration officials. Governor Carcieri was described during an interview with Dr. David Gifford, Director of the Rhode Island Department of Health, as a “very effective salesman” and someone who is “able to explain things in a way that people understand” (Gifford, 2009). Dr. Gifford’s assessment mirrors a widely held view that Governor Carcieri is a skilled communicator; therefore it should be no surprise that he was a prominent spokesman for the waiver proposal, appearing on talk radio and television, and delivering legislative testimony in support of the waiver. Two head officials at Rhode Island’s Department of Health and Human Services (HHS) also made the administration’s case for the waiver. Adelita Orefice, who was at the time the Deputy Secretary of HHS, formally introduced details of the waiver during the first Joint Committee of House and Senate Finance on August 5, 2008. Her presentation was one of the first public explanations of the governor’s waiver proposal and will receive considerable attention in the analysis that follows. Perhaps the most frequently heard voice in support of the waiver, however, was that of Gary Alexander, who at the time

was director of HHS and primary author of the Global Waiver. Accordingly, excerpts from a personal interview with Alexander, as well as his legislative testimony and other public comments, will be a key focus of this language analysis.

As noted in Chapter Two, there was a personal element to the governor's introduction of the Global Waiver proposal. Responding to critics who claimed the waiver was a way to capture a windfall of federal money that would carry the governor through his remaining two years in office, Deputy Secretary Orefice told *The Providence Journal* that the waiver proposal was about more than closing the state's budget gap in the short term. The Global Waiver, she said, was about the governor's "legacy" (Peoples, July 30, 2008). This revealing statement is critical to understanding the governor's motivation in advocating for the waiver. According to Orefice, Carcieri's goal was to leave behind a policy change that would influence future generations of Rhode Islanders, raising the stakes far beyond a mere preference in policy. This level of commitment also raised the stakes for administration officials responsible for selling the governor's plan.

As predicted by Schattschneider's conflict expansion model, the Carcieri Administration sought to contain the scope of conflict in order to maintain its position of power on the waiver issue. This strategy is evident in the administration's consistent failure to provide specific details about the waiver proposal, thereby limiting the number of groups that might find reason to oppose the plan. It will be shown later in this chapter that the Carcieri Administration further contained the scope of conflict by limiting the time during which public hearings could be held to openly debate and

critique the final waiver proposal, making it exceptionally difficult for opposition groups to “socialize” the waiver conflict.

### **B. Opponents of the Waiver**

The strongest voices of opposition to Governor Carcieri’s waiver proposal came from the advocacy community. In particular, Dr. Linda Katz, co-founder and Policy Director of the Poverty Institute, gave strong testimony against the waiver. Her statements came during the 30-day review period that followed federal approval of the waiver, in which public hearings were held on January 9<sup>th</sup> and 12<sup>th</sup> of 2009. Based at Rhode Island College, the Poverty Institute is a respected policy research organization that seeks to “promote economic security for low and moderate-income Rhode Islanders and ensure that tax and budget policies are equitable and adequate to fund vital public services” (The Poverty Institute, 2009). As a result of her position, Dr. Katz’s testimony carried considerable weight and was covered closely by *The Providence Journal*. In accordance with Schattschneider’s (1960) conflict expansion model, her goal, and the goal of other political messengers who opposed the waiver, was to convince the largely Democratic Rhode Island General Assembly to join in opposition to the waiver and act as a counterweight to the governor’s authority. This strategy was executed largely through the use of strong language in delivering legislative testimony.

Other advocacy groups that added to the political message opposing the governor’s waiver through legislative testimony included the Rhode Island Chapter of the National Association of Social Workers; RI Kids Count, a “statewide children’s

policy organization dedicated to improving the health, education, economic well-being and safety of Rhode Island's children" (Rhode Island Kids Count, 2009); Ocean State Action (OSA), a "progressive coalition of community organizations, environmental groups, professional associations, and labor unions" (Ocean State Action, 2009); and OSA's affiliate organization, the Health Care Organizing Project. Opposition from these groups stems, in large part, from strong ideological differences with the governor, and reflects a fundamental difference of opinion regarding the proper role of government in providing health care services. This deep ideological divide has made it such that the aforementioned advocacy groups are practiced opponents of the governor, having offered opposition to a range of his legislative initiatives during the last several years, including repeated efforts on the part of the governor to scale back the Medicaid program. It is important to note, however, that the groups making up the state's advocacy community exist primarily for the purpose of representing specific segments of the population. Thus, the foremost priority of each group is to ensure that the interests of those populations are advanced.

Former Rhode Island Department of Administration Director Robert Carl added to the opposition message during the January hearings, delivering a blistering critique of the waiver. Due to his years of experience in the state bureaucracy, and perhaps because of the strong language he used, Carl's testimony gained prominent coverage in the press following the January 9<sup>th</sup> hearing in which it was delivered. Joan Alker, Deputy Director of the Center for Children and Families at Georgetown University's Health Policy

Institute, furthered the opposition's message, presenting both a more analytical contribution and an "outsider" perspective to the debate ongoing in Rhode Island.

Few political leaders within the state raised strong opposition to the waiver. One exception was Lieutenant Governor Elizabeth Roberts, who was mentioned in Chapter Three as a policy entrepreneur seeking her own comprehensive health care reform. However, Roberts' comments were largely muted in the scope of the larger debate. The same was true of members of the Rhode Island state legislature, who despite their authority to hold hearings and vote to block the waiver, played a conspicuously nominal role in the larger debate. In what appeared to be an effort to fill the void left by the local political leadership, Rhode Island's Washington delegation, which includes Senators Jack Reed (D) and Sheldon Whitehouse (D), and Representatives Patrick Kennedy (D) and James Langevin (D), advanced the most prominent opposition to the governor's waiver proposal. The delegation expressed its objections to the waiver in two public letters to the governor, one co-authored by Reed and Whitehouse, and the other co-authored by Kennedy, Langevin, and two other U.S. Representatives.

#### **IV. Political Messages**

Murray Edelman assigns a powerful role to language in the political realm, suggesting that, through its use, political messengers can "distort" reality and "mystify" unknowing spectators. Political messengers do so, according to Edelman, by using language to link isolated facts to conventional assumptions to create an "ideologically constructed political world" that bears little resemblance to reality (Edelman, 1988, p.

120). Thus, political language serves as an effective strategy to “legitimize favored courses of action and threaten or reassure people so as to encourage them to be supportive or remain quiescent” (Ibid., 1988, p. 104). This perspective is a useful lens through which to view the competing political messages offered by the Carcieri Administration and opponents of the Global Waiver. In line with Edelman’s perspective, both sides employed language as a tool for manipulating public opinion in such a way as to promote a favored course of action.

#### **A. The Carcieri Administration**

As the governor’s senior communications advisor, John Robitaille was in charge of developing a strategy to communicate the details of the waiver to the broader public. Asked about what his strategy was in developing this message, Robitaille gave the following response:

Our strategy is to do our very best to simplify the message, to answer the question, ‘what does it mean to me?’ and to not get into the weeds, because that’s where you lose people. The messages [specific to the waiver] that we tried to hone in on were: the current system is unsustainable financially, the social services part of the budget was growing by leaps every year, and it’s a win-win. It’s a win for the taxpayers, and a win for families and seniors to have more choices. People got that. The other key point that was easy to get out there and would get a ‘wow’ is how out of balance we were with the national averages on how many seniors were in nursing homes... and how much of an expense that was. So we tried to break it down into the most simple concepts that most people would understand (Robitaille, 2009).

Thus, there was a conscious effort by the administration to communicate a few key points, and to make sure that the message was easy for a wide audience to comprehend. At the same time, this approach had the added effect of drawing attention

away from the implications of these programmatic changes that many could find troubling. A deliberate attempt to “not get into the weeds” sounds much like what George Orwell has called the “sheer cloudy vagueness” of political language when used as a tool for manipulation (Orwell, 1946). Robitaille explained further that by focusing on one aspect of the waiver in particular, the administration was able to narrow its broader message. As noted earlier, the proposal possessed three core components, but Robitaille said he felt the need to pick a “poster area that most people would understand,” and that was the provision aimed at “rebalancing” the long-term care system for seniors. Robitaille explained the reason for selecting this area as a focus:

That was the [reform] that most people would get, especially when you have hard data saying we’re way out of balance. So the governor kept going out there and saying ‘we’re out of balance.’ And the governor could tell personal stories about his mother and the choices they had to make, so we had kind of a story to tell there with the governor personally, but also something people could relate to more so than some of the other more complicated issues (Robitaille, 2009).

In addition to keeping the message simple, therefore, the administration’s strategy was to focus on an aspect of the waiver that could be not only easily understood by a large segment of the population, but also augmented by numbers and statistics as well as personal, first-hand accounts shared by the governor. Robitaille’s explanation of the administration’s communication strategy lends considerable support to much of what has been written in the political language literature, particularly Stone’s work that emphasizes the important role numbers and stories play in shaping perceptions about public policy (Stone, 2002). His comments reveal a carefully deliberative process involved in incorporating such linguistic strategies into the realm of policy discourse.

More importantly, however, Robitaille's statement shows that there was a conscious effort on the part of administration officials to draw attention to an aspect of the proposal that could be expected to elicit public sympathy. Keeping elders in their homes is a goal that few would find objectionable – particularly when it is supported by stories about the governor's mother. However, this strategy patently ignores other aspects of the proposal that might provoke a more negative response, such as cutting Medicaid benefits for low-income families.

The thought process behind other aspects of the administration's political message construction was equally strategic. For example, the waiver proposal was originally introduced to the public as the "The Rhode Island Consumer Choice Compact Waiver." When asked during an interview how the proposal got its name, Gary Alexander – the principal spokesman and author of the waiver – offered the following explanation:

The governor liked the name 'consumer choice.' Compact is my word. I come from a religious background and the very earliest documents and charters of our nation prior to the Declaration of Independence, a lot of them carried the name compact; and they carried that name because it created a sense of covenant, a sense of binding people together, a sense of unity, and that's what this waiver is about. That's why I chose the name 'compact' (Alexander, December 3, 2008).

This disclosure of the waiver's naming process is important because it shows that a great deal of thought, and even personal reflection, went into the words that would portray the waiver proposal to the wider public. However, Alexander's linkage of the Global Waiver – a proposal that includes cuts to the Medicaid program – to the nation's religious history is perplexing. It is not likely that most people would make the

intended connection in the first place, and even if some did, it is doubtful that the “sense of unity” Alexander wanted to convey would be widely felt.

Similarly, an interview with the governor revealed how he decided that ‘choice’ would be a central word that he would use to characterize the waiver proposal: “I would hear the refrain time and time again... families would come to me and say we don’t feel that we have many options for the care of our loved one here” (Carcieri, 2009). Therefore, the governor’s decision to use the word ‘choice’ was, at least in part, a reflection of a value that he had internalized through listening to his constituents. “Choice” is a word he believed people wanted to hear, and something he believed was important. It should be noted, however, that conservatives have employed the phrase “consumer choice” for years to describe health policy reforms that shift risk and costs to consumers. It remains unclear to what extent the governor was intentionally drawing on language that is widely known to be part of the conservative lexicon, or merely using words that reflect his own values and perceptions, but use of such a phrase undoubtedly assigned a positive connotation to the broader waiver proposal.

Under the broad strategy of obscuring complex policy details and creating a message to which the people of Rhode Island could relate, the Carcieri Administration framed the Global Waiver along several dimensions. The first was along ideological lines. A strong conservative thrust was evident in the “Guiding Principles of Reform” included in the 91-page waiver application, ranging from core social and economic values such as “Competition,” “Personal Responsibility,” and “Consumer Empowerment and Choice” to the latest health care management catchphrases like “Pay

for Performance” (Rhode Island Global Consumer Choice Compact Waiver, 2008). In the waiver application, as well as in legislative testimony and other statements to the media, the governor and administration officials persisted in coupling these broad ideological themes with descriptions of the “bureaucratic” obstruction the waiver was designed to penetrate. In their words, Medicaid as we know it is “fragmented,” “prone to inefficiencies,” and difficult for beneficiaries to “navigate and understand” (Ibid., 2008). Speaking before the legislature, Gary Alexander offered a good example of this message frame: “We call it a person-centered approach and it ends the idea that government knows how to care for people better than they can care for themselves” (Alexander, 2009).

This conservative framework was complemented by the administration’s insistence on the need for programmatic “flexibility,” a theme which had the dual effect of appearing as a refreshing alternative to bureaucratic rigidity and deflating persistent criticism regarding the lack of policy detail. When the waiver proposal document was released in late July, Adelita Orefice explained: “You’re going to see some of the larger concepts in here about the direction and the values and that sort of thing, but not a whole lot of detail about programs specifically, in part because we want to preserve that flexibility. If we propose right now the details... then we’re going to be wedded to that. And if in a year that doesn’t work, and that kind of program makes no sense, we’re stuck” (Peoples, July 30, 2008). While it is certainly true that painstaking detail might not be appropriate when the goal is a more fluid system, one cannot overlook the relevance here of Edelman’s observations about the “strategic uses of ambiguity”

(Edelman, 1988). Thus, even as the administration “reserve[d] the right” to make future changes in eligibility and benefits under the Medicaid program, the avoidance of policy specifics effectively served to hinder the organization of opposition.

Inherent in this notion of flexibility was the idea that the administration should be trusted to use this freedom in a way that protects those whom the program is designed to serve. George Lakoff has observed that “trust” and “protection” are integral components of what he calls a conservative “paternal-moralistic” view of government (Lakoff, 2002). The governor and administration officials repeatedly appealed to this conception of government, assuring skeptics that broad authority to reform Medicaid would be used to “protect the individuals it serves and create a stronger, more responsive system” (Alexander, August, 28 2008). The Carcieri Administration also sought to frame the waiver early on as a response to dire circumstances, bolstering the view that a strong protector was needed. In his State of the State address, when he first introduced his plan to reform Medicaid, the governor declared the state to be “at a tipping point. It is teetering, ready to move dramatically in one direction or another” (Carcieri, 2008). Lakoff also suggests that, under the conservative interpretation, growth of government spending is not just a problem of economics, but also one of waste and irresponsibility. With this in mind, consider the governor’s use of language as he personalized the state’s fiscal problem: “Our government has been spending beyond its means, and has been depleting its savings to pay the bills. It’s just like any one of you out there tonight who has been spending beyond your income, using a credit card to support yourself and then paying off the credit card by taking money from your savings

account. When the savings account is empty, you have to stop the spending!” (Ibid., 2008) (Rochefort and Donnelly, 2008).

Issue framing can also be defined very simply as “a boundary that cuts something off from our vision” (Stone, 2002, p. 248). In this respect an issue frame results in a picture that appears complete, but in reality represents only a portion of the larger image. This form of framing often surfaces when political leaders present a seemingly complete list of policy options that is actually designed to make one choice appear as the only logical option, and is also known as a Hobson’s choice (Ibid., 2002).

In a June 2008 Executive Office of Health and Human Services presentation of the Global Waiver proposal (EOHHS, 2008), the following list of policy alternatives for reforming the Medicaid system was presented:

1. Remain the same – unsustainable inflation and massive reduction in services, populations and eligibility.
2. Enhance existing waivers – piecemeal approach [which includes a] lengthy process, little flexibility, [and] limited ability to innovate.
3. Global Waiver – a new design and innovation.

Not only does this obvious Hobson’s choice arbitrarily limit the scope of possible alternatives, it was also clearly designed to make the Global Waiver appear to be the only reasonable policy option. In reality, the spectrum of possible reform alternatives could have been much wider. In fact, the Poverty Institute issued a report two months later showing that much of the savings goals outlined in the waiver proposal could be achieved either by implementing changes that did not require federal approval; through state plan amendments; or via a separate 1115 waiver that targeted only increased access to community-based services, the core component of the Global Waiver (The Poverty

Institute, 2008). Despite the Poverty Institute's report, however, no viable alternative to the Global Waiver was offered within the public realm, adding support to the administration's message that the Global Waiver was the only practicable mechanism to reform the Medicaid program.

Rallying of opposition was also made difficult by the administration's effective use of language associated with problem definition, linking the waiver proposal to the state's recurring budget shortfalls (Rochefort and Donnelly, 2008). The Medicaid waiver was characterized as nothing less than an urgent response to the state's fiscal "crisis." While there is no doubt that Rhode Island's increasingly difficult budget situation has been cause for concern in recent years, the word "crisis" often is used in politics to support a plan of action that might not otherwise be viewed as necessary or acceptable. In this way, crisis rhetoric serves as one of the most effective tools for problem definition and for elevating some issues above others on the political agenda (Rochefort and Cobb, 1994). The administration argued: "It has only been over the last year, as the scope of the State's fiscal crisis became clearer, that support for full-scale [Medicaid] reform...began to build momentum" (Rhode Island Global Consumer Choice Compact Waiver, 2008). During this time, the "impetus for reform had become an imperative" (Ibid., 2008). Although many individuals and groups—both proponents and opponents of the waiver—have referred to Rhode Island's budget deficit as a crisis, the administration stands alone in having seized on the associated sense of anxiety to introduce a massive overhaul of the Medicaid program.

The administration connected Medicaid to the “crisis” in Rhode Island by noting that “without significant changes in the program, overall Medicaid costs may consume as much as fifty cents or more of every general revenue dollar by 2011” (Rhode Island Global Consumer Choice Compact Waiver, 2008). Projecting even further, Alexander wrote, “Some forecasts show that by 2050, Medicaid will exceed the state’s budget” (Alexander, August 28, 2008). The use of numbers and statistics is a common way to augment and support problem definition rhetoric (Stone, 2002). When delivered in isolation, figures like these are hard to argue with because they can often deliver a semblance of objectivity. What these figures do not include, however, is any alternative scenario. For example, there may be other possible reasons for rising Medicaid costs beyond the organization of the current system, such as the increasing cost of health technology. If that were labeled as the primary cause of the problem, the necessary solution would be of a very different form. Also, the state’s financial future may hold a different statistical fate if other reforms – besides a complete system overhaul – were implemented. Finally, a forecast that projects state budget numbers a full 41 years into the future is so fraught with speculation that it can only be described as a symbol used to generate the perception that Medicaid is “unsustainable” (Peoples, July 30, 2008).

The waiver solution was described by the administration as an “innovative” method of organizing health care services. In fact, Adelita Orefice put forward the reform package as a “21st century” idea, thereby depicting the current system as an outdated relic of the past. Much like the “crisis” narrative, this past versus future dichotomy suggested that there was no good choice but to adopt a bold solution

departing dramatically from the status quo (Rocheport and Donnelly, 2008). In legislative testimony, Gary Alexander suggested that the waiver precisely fit this prescription: “Rather than a piecemeal approach to reform – which we could do if we tinkered all our waivers and optional services and populations in our Medicaid program – the Global Waiver offers the best chance for innovation” (Alexander, 2009). What is curious about the waiver’s characterization as innovative, however, is that part of what the administration sought to implement was mandatory enrollment in a managed care program, a policy idea that suffered rebuke during the 1990s and could hardly be considered a leap into the future. Nonetheless, the administration judged that the word “innovative” had broad symbolic appeal and could be an effective way to sell its reform proposal.

Additional symbolic language was scattered throughout the political messaging used by the governor and his administration in order to bolster the image of the Global Waiver. For example, “greater personal responsibility for health care” was a central goal of the waiver proposal. This is an appealing phrase that would, in practice, be implemented through two principal initiatives: first, the creation of Healthy Choice Accounts that supply Medicaid beneficiaries with information about the amount and costs of services they use, while providing modest incentives for certain “targeted healthy behaviors”; and second, the adoption of increased co-payments by beneficiaries. The second measure is the more controversial, and has been put forward by the administration using a number of appealing catchphrases. Symbolic terms as such as “cost-sharing” and “smart payments” have also been used to describe the coupling of

co-pays with increased monthly premiums (Rochefort and Donnelly, 2008). In an age when we have “smart phones,” “smart cars,” and even “smart buildings,” one might be surprised to know that “smart payments” are not efficient and environmentally friendly purchases. In this case, it is a phrase that means cost-shifting, from the state government to low-income individuals receiving Medicaid services.

In sum, the governor’s waiver proposal was framed from the outset as a “flexible” and necessary reform of a program that was outdated, inefficient, and most of all, “unsustainable.” This broader framework was supported by a definition of the problems associated with the Medicaid program in terms of a “crisis,” and directly linked to the state’s difficult budget situation. These broader themes were advanced through the use of ominous numbers, positive-sounding phrases, and other symbolic cues, making even the less attractive aspects of the Global Waiver appear both essential and appealing. Critics stepped forward to offer a different interpretation of the waiver proposal, however, and in doing so constructed a strikingly dissimilar counter-political message.

## **B. Opponents of the Waiver**

The narrow time frame during which lawmakers and the public could deliberate the waiver, combined with the lack of policy detail or a viable reform alternative, made the establishment of an organized opposition message to the Global Waiver very difficult. Adding to this challenge, groups opposing the waiver were put in the rare position of fighting *against* reform, which required a dramatic shift in their use of

political language. This shift in perspective seemed to produce something of a conundrum within the advocacy community in particular. In an interview, Ted Almon, a well-known reform activist in Rhode Island, summarized the challenge facing the reform community:

One of the clever things the administration, specifically Gary [Alexander] and the governor, have done is that they caught the reform movement off guard by having their own reform proposal for a change. Instead of just being negative about ours now they've got their own idea, and it's very difficult and inconsistent intellectually to be opposed to any kind of reform unless you can analytically and categorically poke holes in it.

Thus, Rhode Island's reform community, which includes liberal advocacy organizations, Democratic Party leaders, and other left-leaning groups, found itself in a position of opposing a health care reform proposal, which put them in very unfamiliar territory. Rather than fighting to convince legislative leaders and the general public that reforming the state's health care system was an urgent necessity, they were in a position more often occupied by their conservative counterparts – fighting to preserve the status quo.

In their attack on the governor's reform proposal, these groups employed what Albert Hirschman (1991) has termed the "rhetoric of reaction." Hirschman breaks down the themes of reactionary rhetoric into three main categories. First is "perversity," or the prediction that government actions will backfire, only worsening the social problem that is being addressed or yielding the opposite of the intended effect. According to Hirschman, those who use this type of language focus on negative effects of government action, while deliberately ignoring the positive. Second is "futility," or the general assertion that government action is incapable of improving the status quo. Third is

“jeopardy,” or the idea that a new reform will undo an existing reform or threaten established values. This last argument is more nuanced than the others in that it may acknowledge that the proposed reform is desirable. The criticism is that the achievement will be had only at the expense of valued traditions. Although Hirschman associates use of such “reaction rhetoric” primarily with the conservative movement, he notes that when “conservatives or reactionaries find themselves in power and are able to carry out their own programs and policies, they may in turn be attacked by liberals or progressives along the lines of the perversity, futility, and jeopardy theses” (Hirschman, 1991, p. 7). Just as Hirschman predicts, these three arguments were all clearly in evidence on the opposition side of the debate over Rhode Island’s Medicaid waiver.

In an effort to advance the political message offered by the Carcieri Administration, Gary Alexander wrote an op-ed in *The Providence Journal* insisting that the Global Waiver would “ensure the long-term viability of Medicaid, create program integrity and financial stability, protect the individuals it serves and create a stronger, more responsive system” (Alexander, August 28, 2008). Opponents of the plan responded to this message in part by predicting that the waiver would actually produce the opposite effect—a linguistic strategy characteristic of Hirschman’s “perversity” rhetoric. Contrary to what the governor and his administration were saying, Joan C. Alker, a professor at Georgetown’s Health Policy Institute, argued before the Rhode Island General Assembly that the waiver proposal “represents a radical and risky departure from the way Medicaid currently operates... In a world where it is extraordinarily difficult to predict health care costs, this is a high stakes gamble—both

for the future of the state's economy as well as the hundreds of thousands of Rhode Islanders who depend on the program for their health and long term care services" (Alker, 2008). The use of the term "risky" was a common theme in the opposition message, and one that was advanced particularly vigorously by the advocacy community.

In a rather glaring example, Maureen Maigret, Policy Director for the Senior Agenda Coalition, told *The Providence Journal* that "There's enough uncertainty on this proposal that we can't tell seniors that they will have access to services they currently have access to. A global cap presents risks to the state. It also puts elders at risk for service denials. This is a risk we do not support" (Peoples, May 23, 2008). Similarly, Karen Malcolm, Executive Director of Ocean State Action, said:

The prospect of this Global Waiver at this particular political and economic moment is tremendously dangerous to the people of Rhode Island. The waiver would cap Medicaid dollars our state receives from the Federal Government and would open the door to significant cuts in Medicaid services and eligibility for thousands of seniors, children and disabled Rhode Islanders that depend on the program for critical health care needs (Health Care Organizing Project, 2008).

Far beyond a mere disagreement on policy, the portrayal of the Global Waiver as "risky" and "dangerous" was, very simply, a message designed to sow apprehension. This ominous portrayal was often coupled with the equally frightful charge that the proposal was wrought with "unknowns." On its own, the word "unknown" is a rather innocuous term—in principle something that is unknown has an equal chance of turning out to be good or bad. However, when placed in the context of risk, the term becomes more menacing. Consider the following criticism offered by Rhode Island's Lieutenant

Governor Roberts: “The risks and unknowns of this global waiver as presented are too great for our state to bear at this crucial financial crossroads” (Peoples, August 6, 2008). In a similar statement, the lieutenant governor expressed “grave concern about the lack of specifics” included in the waiver proposal (Peoples, March 6, 2008). Combining the terms “risk” and “unknown” clearly raises the stakes for someone who might be skeptical of wholesale change, and strongly suggests that the governor’s plan could backfire. It is an argument that contains powerful rhetoric, but is devoid of any substantive policy critique.

The opposition message also included language that strongly resembles Hirschman’s notion of “futility” rhetoric. In this case, opponents argued that, despite existing problems with the state’s Medicaid system, the governor’s waiver proposal simply would not be successful in improving upon the status quo. This dimension of the opposition message targeted two different aspects of the waiver proposal. First, opponents argued that the funding arrangement included in the waiver proposal – the shift from a matching financing system to a modified block grant – would be a fool’s errand given the unpredictability of the economic and health care environments. In a public letter to Health and Human Services Secretary Michael Leavitt, Senators Reed and Whitehouse communicated this message:

We have significant concerns about this proposed funding arrangement. Significant shortfalls may emerge if enrollment or health care costs grow faster than projected due to a prolonged economic downturn, further erosion in employer-based coverage, an epidemic, a natural disaster, or legislation that expands coverage of mandatory populations or benefits. Under any of these circumstances, Rhode Island would be forced to either bear the full cost above the cap, or to cut benefits, eligibility, or payment to providers. Considering the dire fiscal situation that led the State to

seek this waiver in the first place, we have little doubt that Rhode Island would be forced into the latter option (Reed and Whitehouse, 2008).

In other words, the senators predicted that the governor's plan to move toward a more predictable Medicaid budgeting system would likely be unsuccessful because no one can know what the future might bring. Of course, one might be convinced of the futility of just about any public policy if its potential for failure was weighed on balance with the occurrence of a hypothetical "epidemic" or "natural disaster." Nonetheless, this particular message helped call into question the choice of departing from the status quo.

The second feature of the waiver proposal that opponents targeted in this fashion was the plan to move nursing home residents who did not need that level of service into less costly community-based settings. Most who commented on this provision were not critical of the goal; rather, their message was that the state simply did not have the existing capacity to make the proposed transition possible. Once again, Senator Whitehouse was among those who communicated this criticism, pointing out that "While Rhode Island talks a good game about reducing costs, there isn't much in the way of infrastructure to suggest that they can actually turn that talk into reality" (Henry, 2008). In a separate statement, Whitehouse added to this message, arguing that "There is no indication that the state has the work force, physical infrastructure, or administrative capability in place to implement the sweeping changes envisioned by this waiver without risking the health care benefits thousands of Rhode Islanders rely on" (Gregg and Needham, 2008). In yet another example, Dr. Nick Tsiongas, the former President of the Rhode Island Medical Society discussed in Chapter Three, offered testimony before the state legislature conveying a similar message:

We find it troubling that the state has presented no implementation plan for your committee or the public to review or comment upon, nor do we have the confidence that the state has a realistic comprehension of the extent of the time and effort that will be required to build the infrastructure necessary to transition a population of patients sufficient to meet the ambitious financial goals set forth in the waiver (Tsiongas, 2009).

Numerous other examples exist where opponents expressed deep reservations regarding the state's capacity to achieve the ambitious goals outlined in the waiver proposal. However, in a public letter to the governor, Rhode Island's Washington delegation appeared to disparage the competence of the governor and his administration more directly, writing "we are aware of grave concerns over the State's own administrative preparation and capability to effect these complex and substantial changes in a timely manner, and our inquiries into the State have given us little basis for comfort or reassurance" (Reed, Whitehouse, Langevin, and Kennedy, 2009). These remarks not only further the rhetoric of "futility," but also seem to reflect a political division between the all-Democratic delegation and the Republican governor that extends far beyond the waiver dispute.

Perhaps the strongest language put forward by opponents of the waiver was related to how the proposed reforms could endanger those populations who currently benefit from Medicaid services and undermine the traditional intent of the program—both examples of what Hirschman describes as "jeopardy" rhetoric. Testifying before the Joint Committee of House and Senate Finance, Robert Carl warned state legislators that the lives of every Medicaid beneficiary would be in jeopardy under the waiver proposal. "The suggestion that there will be no harm to almost 200,000 Medicaid beneficiaries in Rhode Island when tens of millions of dollars are cut annually defies

logic,” Carl said (Carl, 2009). Advocacy groups who spoke in defense of RIte Care employed a similar approach. In testimony before the General Assembly Elizabeth Burke Bryant, Executive Director of RI Kids Count, warned that “If budget constraints force the state to reduce Medicaid eligibility for families enrolled in RIte Care during the period of the waiver, there are thousands of children and adults who could lose coverage – which would set Rhode Island back decades in our advances toward leading the country in the number of children with health insurance coverage” (Bryant, 2008). Although this line of attack does not include direct criticism of the waiver, it strongly delivers the case that its implementation could threaten the viability of RIte Care, a program that has been widely recognized as a success and is highly popular among Rhode Island voters (Rochefort and Donnelly, 2007).

Similarly, opponents claimed that implementation of the Global Waiver would undermine the traditional intent of the Medicaid program, particularly in terms of the state-federal partnership for which the program is known. For example, Judith Solomon of the Center on Budget and Policy Priorities pointed out in a report that the unique nature of the Global Waiver would grant the state “permission to bypass many of the federal legal limits on states’ authority to alter Medicaid eligibility, services, and cost sharing. Under the proposal, for example, the state could place eligible low-income people with medical conditions on waiting lists for eligibility and services, and give different groups different benefits based on where they live or for other reasons. Many low-income people could lose coverage entirely” (Solomon, 2008). In other words,

Solomon raised the question of whether breaking away from federal oversight would be worth the potential payoffs if it would put beneficiaries at risk of losing coverage.

Joan Alker also made this point during her testimony, and in doing so shrewdly used the administration's term "flexibility" against it. Rather than "flexibility" being a desirable break from bureaucratic red tape, Alker argued that this term was actually a code word for cutting services: "Federal rules typically allow states to add benefits and populations without seeking a waiver; 'flexibility' sought through this waiver is primarily to limit services or cut people from the program in new and different ways" (Alker, 2008). This message bolstered the view that, in moving away from the traditional role played by the federal government, the state could transform the Medicaid program in ways likely to put the well-being of beneficiaries in jeopardy.

Rhode Island's Washington delegation echoed this message, writing in its co-authored letter to the governor that "the waiver proposes specific changes in eligibility, benefits, and cost-sharing by establishing an unprecedented, expedited approval process. Under this process the scope of the changes that could be made is seemingly unlimited, and such changes could fundamentally alter the Medicaid program and the safety net on which hundreds of thousands of Rhode Islanders rely" (Reed, Whitehouse, Langevin, and Kennedy, 2009). In a separate letter to Secretary Leavitt, Representatives Kennedy and Langevin, along with two other representatives from outside of Rhode Island, wrote that the "unfettered flexibility to cut back on eligibility and services" sought by the Carcieri Administration ran "counter to the Medicaid law which

guarantees access to health care for low- and moderate-income Americans” (Dingell, Pallone, Kennedy, and Langevin, 2008).

This criticism, combined with the more pointed disparagement of the Carcieri Administration noted earlier, suggests that the language used by the Washington delegation in the waiver debate may have been fueled by something more than a policy disagreement. Its message was also out of step with most of the state’s legislative leaders, almost exclusively Democratic, who largely refrained from criticism of the waiver. In fact, *The Providence Journal* noted a “deep disparity in how Rhode Island’s state and federal lawmakers view[ed] the waiver” (Gregg, and Needham, 2008).

One possible reason for this disparity could be that the waiver’s final consideration by the state legislature coincided with the early days of Barack Obama’s presidency, during which he announced imminent and sweeping federal action in the realm of health care reform. Perhaps the delegation’s involvement marked a federal-state rivalry, where policy control, not policy substance, was the underlying premise of the opposition. When asked in an interview for his reaction to the delegation’s involvement in the waiver debate, Governor Carcieri offered the following speculation: “What you had was some philosophical and policy approaches, or attitudes, at work in Washington that were pressuring our delegation to try and slow this thing down... they don’t want experiments like ours demonstrating that there are some other ways to approach this” (Carcieri, 2009). If the governor is correct, perhaps federal politics explains the delegation’s prominence in the state’s waiver debate. It is also possible,

however, that the Washington delegation simply felt it necessary to fill in the void in the opposition left by the Assembly's silence on the issue.

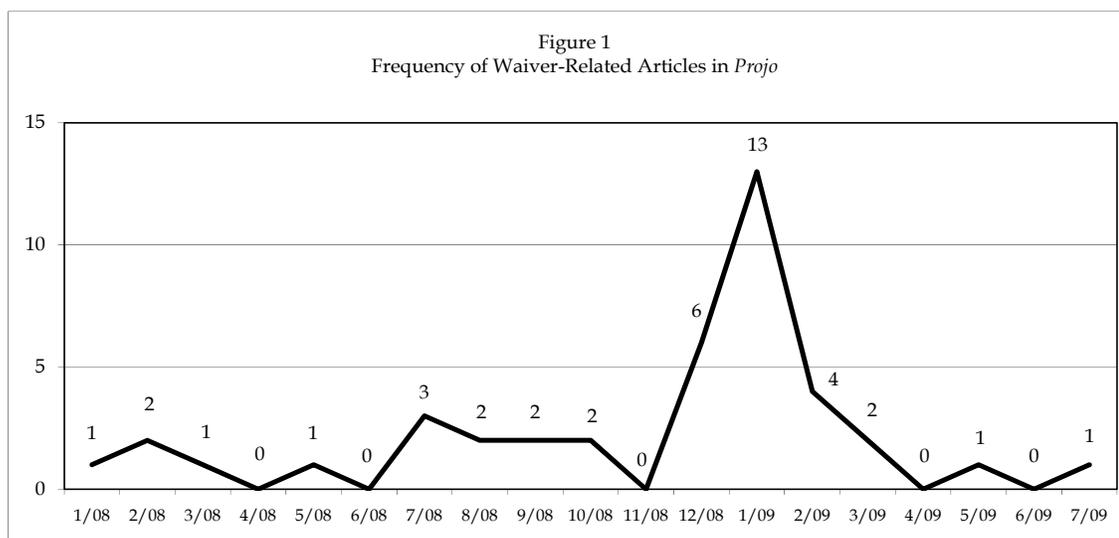
Regardless of motivation, the delegation members were key political messengers in the waiver debate. They, along with local advocacy organizations, policy research organizations, and others, contributed to the communication of a message that predicted the initiatives set forth in the Global Waiver were bound to backfire, producing results exactly opposite what was intended. Similarly, opponents sowed doubts about the state's capacity to achieve the goals outlined in the waiver, arguing that it would fail upon implementation. Finally, critics said that both the beneficiaries and the traditional intent of the Medicaid program would be in jeopardy if the waiver were allowed to become law.

#### **V. Coverage of the Waiver Debate in *The Providence Journal***

As noted in Chapter One, the media are important political messengers, possessing the capacity to emphasize or mute certain political messages used in public debate, and to offer a distinct interpretation of policy issues. As the only statewide newspaper, *The Providence Journal* plays a particularly prominent role in shaping political discourse in Rhode Island (Moakley and Cornwell, 2001). In the newspaper medium, distinct political messages often come in the form of editorials. However, much like other political messengers, newspapers can also shape public perceptions about policy issues through the dissemination of news stories with a distinctive humanizing tone and subject matter. In order to capture the political messages offered

by *The Providence Journal*, a content analysis of every article, news and opinion, pertaining to the waiver was conducted.

Beginning in January 2008, when the governor first announced his intent to reform the Medicaid system, to the time of this writing in July 2009, 41 articles published in the *Journal* directly related to the Medicaid waiver proposal. Three were editorials, two were opinion columns written by outside contributors, and 36 were news articles. As illustrated in Figure 1, the bulk of the coverage was during December 2008 and January 2009, a span of time which included the 30-day legislative review period, the second round of public hearings, and the passage of the waiver into law.



A review of *Journal* editorials reveals that the governor and his administration found early success in connecting the proposed Medicaid reforms to the state's budget gap. In an editorial titled "Waiting for a Waiver," published in July of 2008, the *Journal* mildly criticized the Carcieri Administration for missing "several self-imposed deadlines for filing the waiver application." More notable, however, was the fact that

the *Journal's* critique focused solely on the process by which details of waiver were being released, and not on the plan's substance. One could argue that no substantive critique could have been offered until the proposal and its potential impact were made clear. If that were the case, however, a policy position should have been equally off limits. However, after echoing the administration's message concerning Medicaid's "unsustainable annual rate" of cost increases and the state's "sluggish revenues," the *Journal* declared its view that "it's vitally important the governor succeed with the waiver." Hence, according to this particular commentary, the details of the waiver were only important to the extent that their slow release might hold up their "vital" implementation (Rochefort and Donnelly, 2008; *The Providence Journal*, July 29, 2008).

During the 30-day review period during which the state legislature could decide whether to approve or reject the federally approved waiver proposal, *The Providence Journal* published another editorial titled "Try Medicaid experiment," which definitively conveyed its support of the Global Waiver. Leading with a description of the governor's "brave" confrontation of "out-of-control Medicaid costs," the *Journal's* editorial board reiterated the mantra of the administration that "the federal government has given Rhode Island greater flexibility than any other state in providing Medicaid-financed health care." The board wrote further: "Medicaid costs are rising 7 percent a year, even as overall consumer prices in America are falling, pulled down by the recession. This can't go on." As a result, "We hope that legislators approve the agreement so that the experiment can begin" (*The Providence Journal*, December 30, 2008).

As if outright support was not enough, the *Journal* published a third editorial less than three weeks later, this time taking Rhode Island's Washington delegation to task for its opposition to the governor's proposal. The brief and biting commentary, titled "An easy opposition," read in part:

Of course, the four-man Rhode Island congressional delegation would oppose the Carcieri administration's plan to reform the state Medicaid program: It's so easy for them to do so. They don't have to try to run a state in the throes of a deep recession and they can appeal to the assorted constituencies (nursing homes, some of the elderly, etc.) who benefit from the current system, whose cost have been rising 7 percent a year — two or three times the general inflation rate. Ah, the joys of not having to run anything or balance a budget!

In addition to explicit editorial support, the *Journal* also printed two op-ed columns written by proponents of the waiver. Gary Alexander authored one column titled "Sustainable Medicaid reform for R.I." in which he echoed the administration's message and expressed the urgent need for reform — the absence of which, he wrote, could "bankrupt Rhode Island" (Alexander, 2008). Kevin McKay and James Nyberg, president and director of the Rhode Island Association of Facilities and Services for the Aging, co-authored the other opinion column, in which they called the goal of the waiver "both laudable and timely given the state's fiscal crisis and demographics" (McKay and Nyberg, 2009).

Given such strong support from the *Journal's* editorial board one might assume that the governor and his administration would be pleased with the coverage they received from the paper. This, however, could not be further from the truth with regard to the news items published by the *Journal*. Asked during an interview about coverage

of the waiver in *The Providence Journal* John Robitaille, the governor's senior communications advisor, gave the following account:

There are about a handful of reporters, and I mean a handful, in one hand, who are true journalists. Most of the reporters in this marketplace are social activists. In particular on [the waiver] issue, the information was distorted. In most instances they went to the advocates, rounded them up, got sound bites and comments from anyone who you could think of who could possibly be convinced that they would be adversely affected by the waiver. Distortions. We had people saying the governor was going to throw people out of nursing homes against their will. That was played up upon even though members of the media were told repeatedly that was not the case. They kept spinning it the opposite way to strike fear into people. I have never seen such a biased set of people who try to influence public policy in such a way as there is here in Rhode Island. It is absolutely incredible how they twist, bend, and manipulate information to only show one side of the story.

Employing a methodology developed by Baumgartner and Jones (1993), the "tone" of each *Providence Journal* news article related to the Medicaid waiver was coded as "positive," "neutral," or "negative" in order to test the accuracy of Robitaille's scathing critique. The coding criteria are as follows: a "positive" article is one that emphasizes the potential benefits of the plan; a "neutral" article is purely informative in nature or includes an even balance of positive and negative coverage; and a "negative" article is one that emphasizes the potential problems of the waiver. A portion of an article from each category is offered below.

### **Positive Tone**

Peoples, Steve. 2008. "Facing the deficit: Cut Medicaid \$67 million." *The Providence Journal*. January 31.

Carcieri's goal to transform the long-term care system in Rhode Island is not new. Study groups for decades have promoted the benefits of a

system that diverts the elderly and disabled away from costly institutional care to home-based care, which senior advocates say is the preference anyway. The General Assembly also adopted legislation last year to begin such a transition. Carcieri said the state's looming budget deficit – projected at between \$384 and \$450 million next year – motivated his staff to act now.

### **Neutral Tone**

Peoples, Steve. 2008. "Governor seek waiver to cap Medicaid at \$12.4 billion." *The Providence Journal*. July 30.

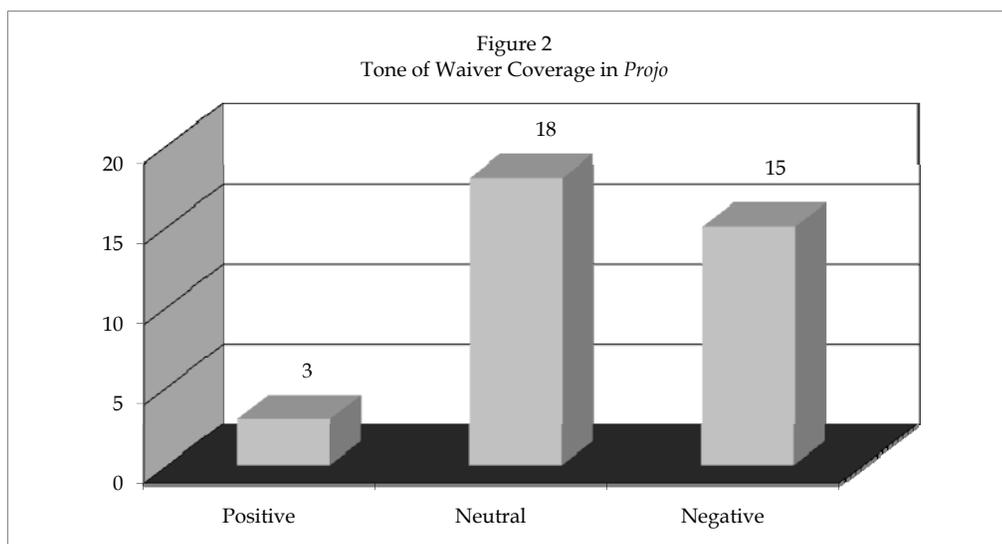
Rhode Island is trying to do what no state has done before. In adopting a global waiver, the governor would agree to limit Medicaid spending – which constitutes one quarter of the state budget – through 2013 in exchange for broad authority to change services such as nursing home care, subsidized transportation for the disabled and elderly, health insurance for low-income children and their parents, and prescription drug coverage for seniors.

### **Negative Tone**

Needham, Cynthia. 2008. "Questions abound over Rhode Island Medicaid plan." *The Providence Journal*. September 17.

... But those possibilities seem to generate more questions than they answer. Among them: Who will care for elderly Rhode Islanders who are no longer placed in nursing homes? What will happen if low-income residents cannot keep up with increased RIte Care co-payments? Will doctors and health centers that accept Medicaid be reimbursed at lower rates? The fate of nursing home residents seems to cause greatest anxiety. The waiver proposal outlines stricter eligibility standards for those wishing to enter nursing homes, saving money while allowing seniors to stay in their homes. But it remains unclear who will step in to lend a hand to those who cannot afford to care for themselves.

Most of the new articles related to the waiver were neutral, but there was a strong tendency to emphasize the potential problems that could result from the waiver as opposed to the potential benefits. Of the 36 total news articles, only three were positive in tone, 18 were neutral, and 15 were negative (see Figure 2). These results

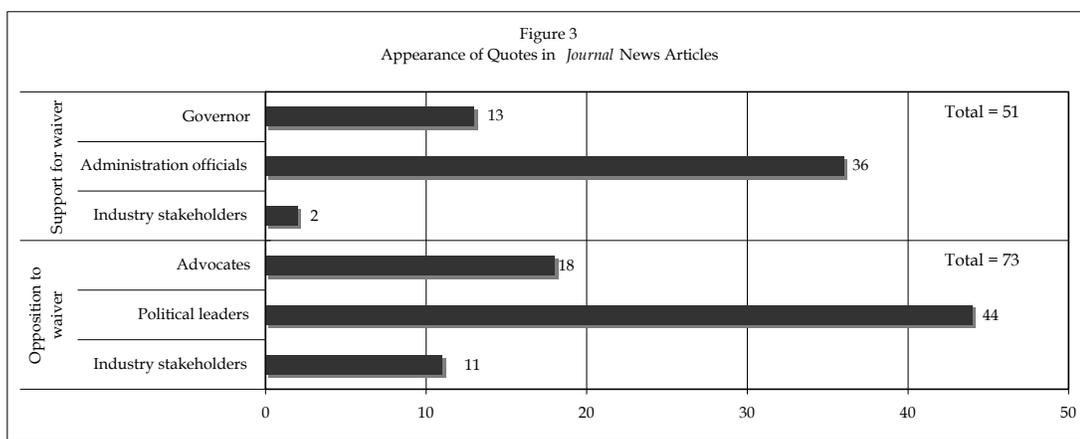


stand in stark contrast to the *Journal's* editorial support of the proposal, and lend credence to the frustration expressed by Carcieri's senior communications advisor. It also indicates that the *Journal* was sending mixed messages to its readers about the Global Waiver. On the one hand, the editorial board communicated a strong message of support, calling its passage "vitaly important." On the other hand, coverage of the waiver debate itself was either neutral or emphasized the problems that might occur with its passage.

In addition to a general tone, every news article related to the waiver included direct quotes from various political messengers involved in the waiver debate. To determine which voices received the most coverage, the distinct political messengers

quoted in each article were counted and labeled as either: the governor, administration official, industry stakeholder in support of the waiver, advocate in opposition, political leader in opposition, industry stakeholder in opposition, or neutral expert. The appearance of a political messenger was only counted once per article, regardless of how many times a quote from that individual appeared within that article. Categories that included multiple distinct political messengers, such as “advocates in opposition,” received a count of each advocate quoted in the article. Aggregated data of the tallies from each article represents the total political messengers quoted across all 36 news articles.

Results show that individuals speaking in support of the waiver appeared in *Journal* news articles a total of 51 times, compared to 73 speaking in opposition. Of those speaking in support of the waiver, the governor appeared in 14 of the news articles, quotes from individual members of his administration appeared 36 times, and quotes from supportive industry stakeholders appeared twice. Political leaders in opposition were the most frequently quoted political messengers, appearing 44 times in *Journal*



news articles. Most of the political leaders included in this total were state legislators who expressed skepticism or concern when asked about the governor's proposal. Coverage of the political messages expressed by advocacy groups opposed to the waiver were printed 18 times, and the voices of industry stakeholders who opposed the waiver appeared 11 times (see Figure 3). Thus, in addition to the largely neutral or negative portrayal of the waiver in *Journal* news coverage, the political messages of those opposed to the waiver received more coverage than those supportive of the proposal.

In addition to direct quotes, newspapers often rely on personal stories to “humanize” an issue or policy. Such stories help to illustrate the actual or potential impact of a complex policy proposal. Stories can also bolster the reader's original policy position or perhaps encourage some to reconsider what they previously felt. *The Providence Journal* included four personal stories among all the news articles related to the waiver, three of which portrayed the potential effects of the waiver in a negative light. Consider the following example, printed just days prior to the end of the 30-day legislative review period:

Danny Fernandez is no dentist, but once he pulled his own tooth. Back then he was a young truck driver hauling through Texas when he bit down too hard on a spare rib. His tooth cracked. So, he reached for his needle-nosed pliers. He wound up in a hospital emergency room. People with no access to a dentist have been known to take drastic measures. Fernandez, now 56, recalled that painful day in Texas while lying in a dentist's chair last week, cupping his swollen cheek. He is 1 of 180,000 Rhode Islanders who are eligible for dental coverage through Medicaid, the government-financed health care program for the elderly, poor, and disabled... State lawmakers are considering an agreement with the federal government to cap Medicaid spending over the next five years. In return, the federal government would lift some of the regulations that now govern Medicaid coverage. A hearing on the agreement will continue tomorrow. Dental coverage for adults – which is “optional”

under the current Medicaid program – stands an easy target (Arditi, 2009).

In using Danny's story to convey the fact that passage of the waiver could mean elimination of dental coverage for Medicaid enrollees, the author vividly illustrates the potential human cost of the governor's plan. The image of a young truck driver pulling out one of his teeth with a pair of pliers is not one people are likely to soon forget. This story connects a portrait of a sympathetic victim to the governor's cost-savings plan, which could lead some to reconsider whether the potential benefits described were worth the risks. The *Journal* printed two more similar stories, one that highlighted a 53 year-old Vermont woman who, almost unbelievably, suffers from "muscular dystrophy, cerebral palsy, poor vision, a neurogenic bladder, chronic urinary tract infections, and arthritis," and faced reduced services under a state waiver program that bears similarity to Carcieri's plan (Peoples, October 5, 2008). The other story was of an elderly couple caring for an adult son with Down syndrome, and had sought in vain to find specific details of how the waiver proposal might impact their lives (Needham, 2009).

However, in July of 2009, several months after passage of the waiver, the *Journal* shifted focus, highlighting an elderly woman eager to move out of a nursing home. The story read in part:

Rose Belanger is a fighter, a 79-year-old spitfire raised in the Italian neighborhoods of Federal Hill. She reluctantly became a nursing home resident in January, hobbled by her second serious fall in two years. "They said I'd be wheelchair-bound. I fooled them," she said with a defiant grin this week, sitting in what has been her home for the last six months, Elmhurst Extended Care. Now Belanger is fighting to go home. It doesn't matter that she has poor hearing, kidney disease, and needs to use a walker. Backed by the Carcieri administration's push to rebalance

Rhode Island's long-term care system, Belanger – and dozens more nursing home residents – plan to leave costly medical institutions voluntarily in the coming months (Peoples, July 9, 2009).

Unlike the previous stories published by the *Journal*, Rose's story puts the reader in the shoes of someone who will benefit from the governor's waiver. Printed alongside the article was a picture of Rose looking every bit as feisty and excited as her story suggests, heightening the impact of the positive image conveyed by the author.

The *Journal's* use of stories, along with its overall coverage of the waiver debate, communicated a mixed political message to its readers. In fact, there appeared to be a conflict within this publication regarding the preferred message to convey – the editorial page offered a message of unequivocal support for the governor's proposal, yet day-to-day news reporting portrayed the waiver largely in negative terms. In offering such mixed messages the *Journal* reflected the deep divide that characterized the larger waiver debate. In doing so, however, the paper failed to offer a distinct political message, or alternative interpretation of the issue. Thus it is doubtful whether the *Journal's* role as a political messenger made any distinctive mark on the larger debate other than to help publicize it to a larger audience.

## **VI. Political Response**

With two starkly different images of Rhode Island's Global Waiver having been offered to legislative decision makers and the Rhode Island public, the last remaining component of the political language framework requires establishing the response. First, how did the legislature ultimately vote on this issue, and in what ways did its

decision reflect the language used in the waiver debate? Second, to what extent were Rhode Island voters supportive of the governor's proposal?

Despite strong opposition to the Global Waiver, the state legislature did not vote to block the overhaul of the Medicaid system. In the legislature's decision to allow passage of the waiver proposal one cannot overlook Rhode Island's deep budget deficit and the lure of the \$67 million dollars in savings that the governor insisted would come with overhauling the state's Medicaid program. In an interview, Rhode Island Senator Josh Miller said that from his perspective the legislature was in the position of asking itself, "If we don't take this, how are we going to find the \$67 million dollars?" In fact, Miller said that the fiscal context of the debate was such that "We're not really talking about the underlying policy that the bill would create. We're talking about... Here's \$67 million dollars, if we don't do this, how are we going to find the \$67 million dollars that this bill offers us in savings" (Miller, 2009). Therefore, according to Senator Miller, budgetary savings were the major driver in the Assembly's decision to allow the waiver to go forward, a sign that the Carcieri Administration successfully relegated programmatic changes to the backs of the minds of legislators with the promise of much needed revenue.

A second factor playing into the waiver's success is that the legislature had little time to consider the complexities of the proposal. As mentioned previously, the legislature imposed a 30-day review period that would begin after the federal government approved the waiver, so that it could have time to consider whether or not to block implementation. According to Ted Almon and many other close observers of

Rhode Island politics, the governor and his administration exploited this 30-day window through a clever bit of “political gamesmanship” (Almon, 2009). Consider how the timing of the review period played out. Federal government officials, who were supportive of the governor’s initiative, approved the waiver on December 19<sup>th</sup>, which, according to Senator Miller, was “probably one of the last days [of the year] that anybody would be around in any [government] building.” Miller also noted that the following Thursday was Christmas, which meant that “there was really two weeks there between Christmas and New Year’s when government was, for all intents and purposes, not functioning.” The state’s legislative session and swearing in of new members took place on January 6<sup>th</sup>, leaving only 12 days in which to consider potential repercussions of the federally approved waiver proposal. While it would be difficult to prove that this period was deliberately chosen by the governor to diminish public scrutiny of the waiver (or that the administration had any influence over announcement of the federal government’s approval), Senator Miller concluded that “the political timing was suspicious” (Miller, 2009). It should be noted, however, that during testimony before the House and Senate Committees on Finance, some advocates, including Rick Harris of the National Association of Social Workers, recommended that “since the deadline of January 19<sup>th</sup> appears to be self-imposed by the legislature, an extension be considered” (Harris, 2009). In other words, Harris was suggesting that the legislature counter the governor’s alleged political maneuvering by simply extending the review period, yet the legislature never showed any interest, at least publicly, in pursuing this option.

Lawmakers' only tangible response to the waiver debate was to draft what House Committee Chairman Steven Costantino called "legislative protections" – explicit language designed to safeguard Medicaid services (Needham, 2009). At the time of this writing a final bill has yet to be passed – differences between the House and Senate versions are still being worked out – but the draft bill states in part that "No changes in the state Medicaid program shall be made without the express approval by a legislative body..." including "a change that may affect benefit packages, overall health care delivery systems, cost sharing levels, post-eligibility contributions to the cost of care, levels of care, and the imposition of wait lists for service" (Rhode Island Senate Bill No. 53, 2009). Language in the draft bill suggests that the opposition narrative offered by the advocacy community and others, while ultimately not successful enough to result in the blockage of the proposal, was at least successful in influencing the General Assembly to "protect" the Medicaid program as the changes granted by the Global Waiver are implemented.

In order to assess the public's response to the language used on either side of the waiver debate a public opinion poll was conducted, the results of which will be analyzed in Chapter Five. It is worth noting here, however, that when voters in Rhode Island were asked "How much have you heard or read about the Medicaid Global Waiver?" 43 percent said "nothing at all." Another 26 percent reported hearing "only a little" about the waiver and 20 percent heard "just some." Only 11 percent of voters in the state reported hearing "quite a bit" or "a great deal" about the waiver. These results are somewhat troubling considering the Global Waiver represented the most dramatic

overhaul of the Medicaid system in the nation's history. These results also show that the Carcieri Administration was highly successful, and the opposition quite unsuccessful, in controlling the "expansion of conflict" (Schattschneider, 1960). Those who offered opposition to the waiver might be especially troubled to know that, after survey respondents were read a description of the governor's Global Medicaid Waiver, only 35 percent were supportive of the idea and 50 percent were opposed. In light of these results, one could expect that if the scope of conflict were expanded to include greater public input, the outcome of the waiver debate could have been very different.

## **VII. Conclusion**

The political language perspective reveals a number of insights about Rhode Island's Global Waiver debate that may have otherwise gone undetected. The waiver debate lent itself particularly well to this type of analysis due to the fact that policy details were in short supply – a point that the two sides readily acknowledged and admonished, respectively. Much of the discussion, then, was built around competing uses of symbolic language, not policy substance. A variety of political actors – including the governor and his administration, advocacy organizations, policy analysts, and local political leaders – offered a combination of words and phrases designed to evoke an array of public sentiments, including both trust and fear, and competing perceptions of government. As a result, two strikingly different characterizations of the governor's waiver proposal emerged, between which lawmakers (and, by extension, Rhode Island voters) were forced to choose.

It is argued here that the governor and his administration put forward a stronger political message than those who opposed the waiver proposal, and therefore won not only the debate, but also passage of the proposal. The administration's broad strategy of obscuring policy details and limiting public debate allowed it to contain the scope of conflict, and maximize the political leverage of the governor's office. Further, John Kingdon has noted that policy reformers are successful in advancing a policy solution if they are able to link it to an existing problem (Kingdon, 1995). The administration was able to do just that, depicting the waiver proposal as a solution to the state's budget crisis. During an interview, Marie Ganim, Director of Policy for the Rhode Island Senate, bolstered this view, noting that the governor's message "played a major role" in the proposal's acceptance by the state legislature, "particularly in its ability to tie the theme of budget savings to the waiver proposal" (Ganim, 2009).

The narrative spun by the administration also depicted the Medicaid program as "outdated," "unsustainable," and biased toward providing costly long-term care options. Therefore, not only was Medicaid reform sold as a way to bring about budgetary savings, Medicaid in its current form was also portrayed as contributing to the state's current financial woes. These dire themes contrasted with the waiver alternative, which proponents said offered "flexibility" and "choice," and a "person-centered" approach to delivering health care services. The Global Waiver was made even more appealing through the use of such positive sounding phrases as "smart payments" and "cost-sharing," language that obfuscated provisions heralding greater *cost-shifting* on the part of state government. Overall, the governor's political message

was timely and persuasive, and all members of his administration delivered it consistently.

Conversely, opposition groups worked largely independent of each other and delivered a message that was less convincing. In an interview, Linda Katz, a leading voice of opposition to the waiver, explained that “we tried to just coordinate the message as opposed to having just one message” (Katz, 2009). Lack of a unified voice was apparent to those who observed the ongoing debate, and it contributed to a negative perception of the opposition’s message. For example, in an interview, Health Director David Gifford said that a consequence of this fragmented approach was that “It looked like many of the advocates were trying to just preserve the status quo and preserve their own economic revenue streams for the stuff they do, and so that discredits their message.” Moreover, Dr. Gifford noted that “Most of the people [he] talked to—even those that don’t support the waiver—support the concepts behind the waiver” (Gifford, 2009). This is particularly true of the effort to establish more options for community-based care. As a result, the opposition had little substantive policy criticism to offer, relying instead on “reaction rhetoric.” This strategy proved to be effective in gaining legislative “protections” from the General Assembly, but not in blocking the waiver’s passage into law.

Ultimately, the governor’s convincing political message was a key factor in moving forward the most sweeping Medicaid reform in American history, a testament to the potential long-term implications of the use of political language. The “political spectacle” created by those involved in the waiver debate also serves to illustrate the

importance of critically assessing the language of politics. Therefore, as its advantages and disadvantages play out, it will be useful to continue to monitor the language surrounding implementation of the Global Waiver, paying attention to the linguistic cues used by proponents as well as opponents who seek to combine emotive and value-based appeals with rational discourse.

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– Chapter 5 –  
**Political Language and Public Opinion in Rhode Island**

President Barack Obama has launched the issue of comprehensive health care reform to the top of the national political agenda. In a series of town hall meetings across the country and in a prime-time press conference, Obama has advocated for such reforms as the creation of a government-run health insurance plan that would compete with private insurers as a means of expanding health insurance to all Americans, restrictions on cost-sharing, a prohibition against discrimination on the basis of pre-existing conditions, and government subsidies for those unable to pay for health coverage, the latter to be funded by proposed savings in Medicare and Medicaid and tax increases on wealthy Americans. On the surface, public support for the president's reform initiative appeared high at the outset. A *New York Times*/CBS News poll conducted in June of 2009 found that "85 percent of respondents said the health care system needed to be fundamentally changed or completely rebuilt," while "72 percent of those questioned supported a government-administered insurance plan – something like Medicare for those under 65 – that would compete for customers with private insurers" (Sack and Connelly, 2009). The same poll also found, however, that 77 percent of respondents were "very or somewhat satisfied with the quality of their own care." These results suggest that despite strong support for reform, the status quo may remain for many a viable, or even preferable, option to dramatic policy change. More importantly, this recent poll illustrates the multi-dimensional and often-conflicting nature of American public opinion on issues related to health care reform.

Despite recent activity at the national level, the locus of health care reform during the last several years has primarily resided at the state level. As discussed in previous chapters, Rhode Island is home to two major health reform initiatives. Two policy entrepreneurs, along with the constituencies of organized interests and stakeholders they have developed, are actively pursuing health system changes in the state, giving the issue prominence as a topic of political discourse. At the same time, the governor has succeeded in pushing through the legislature his landmark “Global Medicaid Waiver,” which galvanized strong opinions from supporters and opponents alike. Both policy episodes featured competing political messengers who employed language as a tool for shaping public opinion and promoting their desired courses of action. These activities now raise the following questions: What do Rhode Islanders think about the state’s current health care reform efforts and other health care reform issues? How do the opinions of Rhode Islanders compare with the opinions of other Americans? Moreover, how have Rhode Islanders’ attitudes changed in recent years (if at all)?

To explore these topics, an original survey of public opinion among Rhode Island registered voters was conducted for this thesis, the methodological details of which appear in the following section. Using information from this survey, along with data from a previous Rhode Island survey and a number of national polls, popular sentiment for health care reform in Rhode Island will be gauged and characterized, drawing on conceptual frameworks for public opinion analysis from the discipline of political science. The survey included several items specifically designed to focus on the role of

political language in the health care debate, including questions concerning trust of political figures, perceptions of the media, the use of problem definition and storytelling, and competing perceptions of government. These items will be reviewed in the third section of this chapter. Finally, attention will be given to the utility of “political language variables” as predictors of public support for specific health policy proposals.

Although many scholars have written about the importance of political language in shaping public perceptions, few have sought to document this link empirically. By integrating the study of political language and public opinion research, it will be possible to contribute to a neglected avenue of research in this area. In addition, the data presented in this chapter will shed light on the response of Rhode Island voters to the discourse of health care reform in a way that expands upon, and interrelates, the discussion of political language in previous chapters.

## **I. Methodology**

The public opinion survey created for this thesis was designed for the dual purposes of gauging public perceptions about health care reform issues in Rhode Island and exploring dimensions of political language and their link to policy preferences. Polls conducted nationally and in other states, along with input from local community stakeholders and public officials in Rhode Island, guided the development of a number of survey questions. Other survey questions were the same as those used in a similar poll conducted in 2007, in which Northeastern University’s Community-Based Research Initiative collaborated with Ocean State Action, a grassroots advocacy organization, to

study health care reform issues in the state. Repetition of these items will make it possible to establish trend lines and identify possible shifts in public opinion over a two-year period. The majority of survey questions included in the poll, however, were original and developed through a process of operationalizing key concepts from the political language literature (See Appendix C to view the complete survey instrument).

Survey questions cover a range of topics, including the importance of the health care issue relative to other policy issues, the desire for government action, and concerns about health care coverage. Certain items target respondents' preferences with regard to specific policies, including a variety of comprehensive health care reform proposals as well as Rhode Island's Global Medicaid Waiver. Other topics explored in the survey include the moral component of health care reform, trust in political figures, and the allocation of blame for problems associated with Rhode Island's health care system. Finally, data were gathered with regard to the respondents' age, economic status, gender, party identification, ideological affiliation, overall health, and insurance coverage status.

Quest Research and Opinion Factor, Inc., a survey research calling center located in Warwick, Rhode Island, implemented the survey. Quest Research interviewed a total of 400 adults age 18 and older, randomly drawn from a statewide list of registered voters, by telephone between April 21 and May 4. Results have a margin of error of +/- 4.9 percent at a 95 percent confidence level.

## II. An Overview of Public Opinion on Health Care Reform in Rhode Island

Summarizing a 50-year historical overview of American public opinion on health care reform, Blendon and Benson (2001) write that “It is striking to see how many conflicting views the public holds on health care policy issues” (p. 43). Indeed, American attitudes toward health care reform are as complex and multidimensional as the health care issue itself. According to Blendon and Benson, the majority of Americans have been generally dissatisfied with the health care system since the early 1980s. During that same time, however, most years Americans did not see health care reform as a top priority for government action, and more than 80 percent reported being satisfied with their own medical care.

Similarly, Blendon et al. (2006) found that in 2006 most Americans believed that rising health care costs (followed closely by shrinking health care access) was the most important problem with the nation’s health care system. However, the majority of Americans also thought that the United States as a country was spending too little on health care in the aggregate. A similar paradox in public opinion arises with regard to how such problems should be addressed. In 2006 Berk et al. (2006) asked Americans to indicate their level of support for six different approaches to reforming the health care system. A majority said they supported five out of the six approaches, “despite the fact that several of the approaches are in direct conflict with each other” (p. 601). Strongest support was found for expanding coverage through employers, but nearly two-thirds favored completely changing the system from an employer-based system to one in which the government supplied universal health care. These results show confusion on

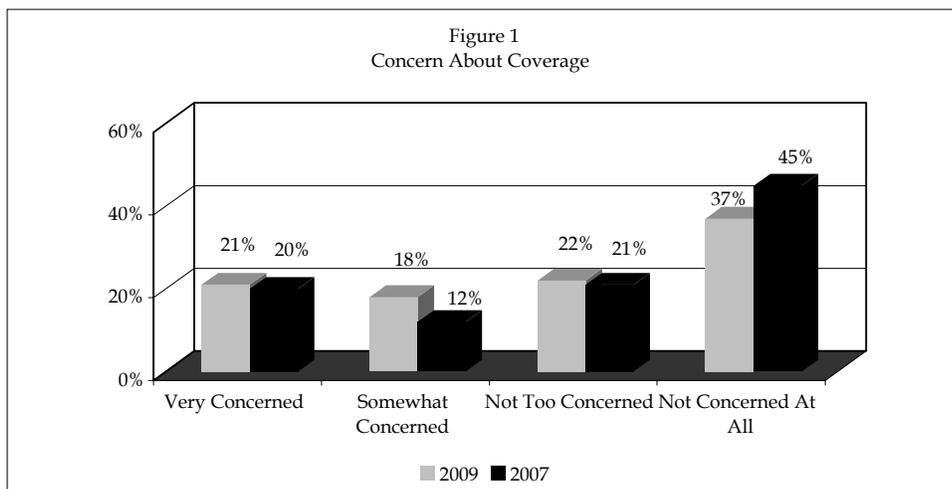
the part of the American public concerning the direction of reform, and they are also indicative of what Blendon et al. (2003) call a “persistent” lack of consensus on any single approach to helping the uninsured.

Americans’ conflicting views and lack of agreement on health care reform issues have not been without consequence. Blendon et al. (2001) note that prior to the introduction of both President Harry Truman’s proposed national health insurance plan and President Bill Clinton’s universal health care proposal, the majority of the public supported some type of national health insurance. However, after each plan was introduced and publicly debated alongside alternatives, support for reform eroded rapidly (Blendon et al., 2001). Stanley Greenberg, a former Clinton advisor, draws similar parallels between the Clinton debate and President Obama’s recently proposed health care reforms. “Then and now,” Greenberg finds in a study of public opinion gathered during the early part of both reform debates, “about 60 percent of the public feels dissatisfied with the current health insurance system. Yet three-quarters are satisfied with their own insurance” (Greenberg, 2009, p. 1). Further, “the country divides evenly on whether the greater risk is an unchanged status quo or government reforms that ‘create new problems’” (p. 1). Greenberg’s findings, along with those of Blendon and others, show that Americans have long been supportive of comprehensive health care reform in the abstract, but are deeply conflicted with regard to what form such a reform should take.

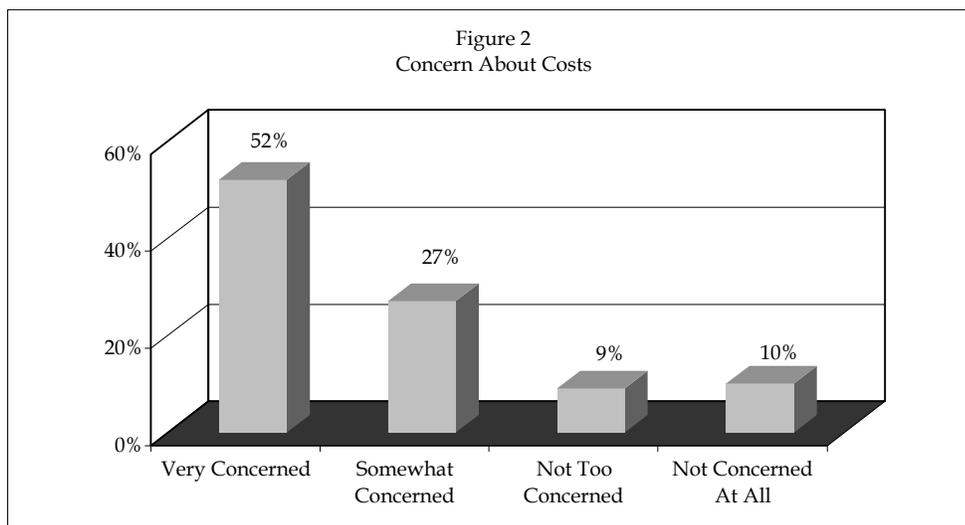
Despite clear overall trends in how the American public views the issue of health care reform, significant variation of opinion exists among states. Berk et al. (2006) found

that Californians had different views on health care issues than people residing elsewhere in the country. According to these authors, variations in opinion might result from cultural differences, including Californians' distinctive emphasis on health, fitness, and diet. Findings of this kind illustrate the importance of state-level public opinion polling on the issue of health care. Compounding the potential influence of cultural variation is the fact that many states, including Rhode Island, continue to consider their own brands of health care reform apart from national activity. The combination of these factors makes state-level public opinion data critically important for any understanding of the political challenges of health care reform

Among the 400 Rhode Island voters included in the survey created for this thesis, six percent reported having no health insurance coverage. This figure jumps to nine percent when only those in the sample under the age of 65 are considered. The most recent data compiled by the United States Census Bureau estimate Rhode Island's uninsured under-65 population at 12 percent (CPS, 2009). This discrepancy is most likely a result of difference in sampling methodology, i.e., the Rhode Island survey included only registered voters, whereas the Census Bureau data provide an estimate based on the entire population of the state. Among those respondents with health insurance, a combined 39 percent were "very" or "somewhat" concerned about losing coverage. This is a higher level of concern than was expressed in the 2007 Rhode Island survey, when 32 percent of insured Rhode Islanders were "very" or "somewhat" concerned about losing their current insurance. (See Figure 1).



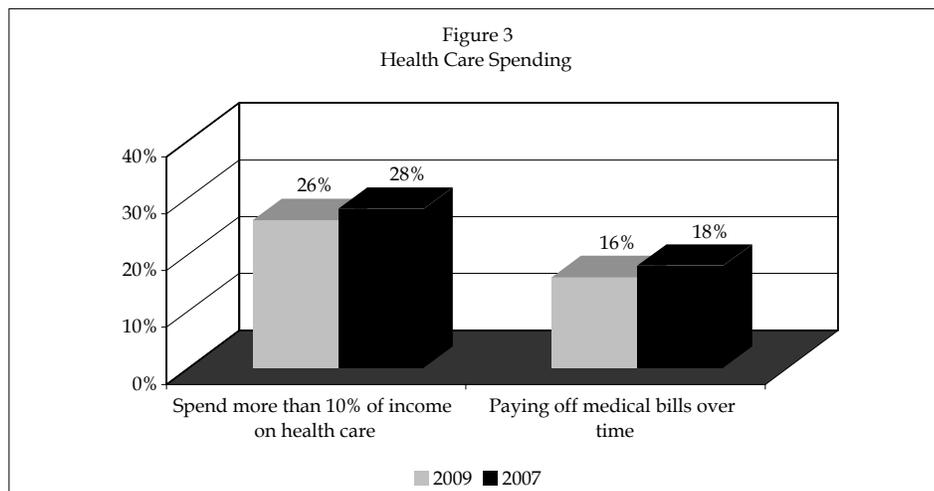
Even among those with health insurance, rising health care costs were a major concern. A majority (52 percent) of respondents who have health insurance said they were “very concerned” that health care costs might go up, and another 27 percent were “somewhat concerned.” (See Figure 2). Concern about costs in the abstract is one thing,



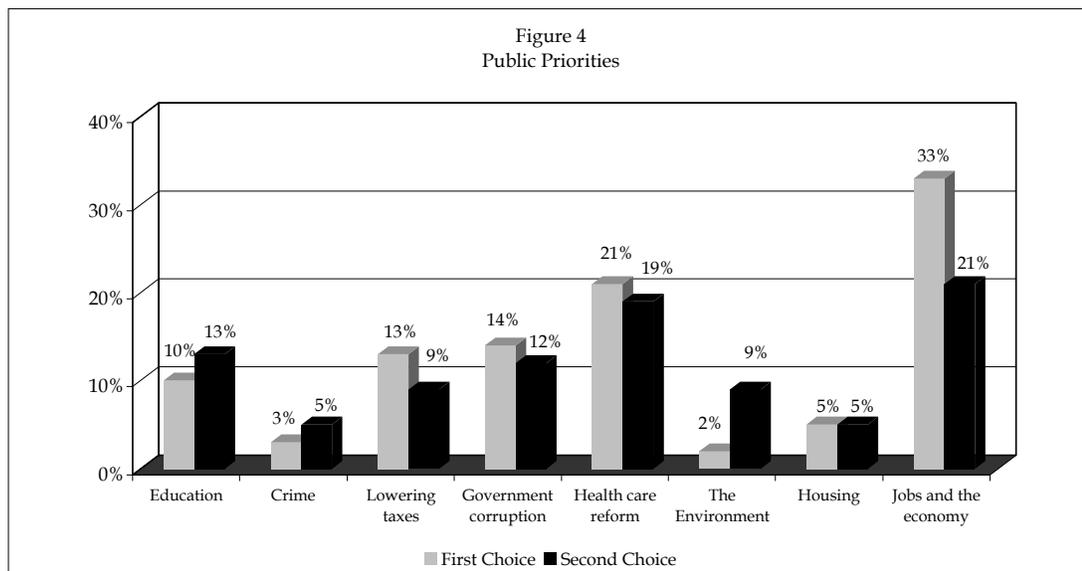
but 20 percent of all survey respondents said that in the last 12 months they, or a member of their family, had put off medical treatment because of cost. Both results are

quite similar to concerns expressed nationally about the cost of health care. A *New York Times*/CBS News poll administered in April of 2009 found that 57 percent of Americans were “very concerned” about their health care costs, while another 32 percent were “somewhat concerned.” The same poll also showed that 21 percent of Americans had “not received a test, treatment, or procedure recommended by their doctor” because it was not covered by their health plan (*New York Times*/CBS News, 2009).

Another problem related to health care costs is that of “underinsurance,” which refers to a situation in which an individual has health insurance coverage but is not fully protected from paying high medical expenses. Employing a common definition of the term “underinsurance,” 26 percent of survey respondents responded affirmatively when asked if they spend “more than 10 percent” of their annual income for health care services in out-of-pocket costs. In 2007, 28 percent of Rhode Island voters reported having spent more than 10 percent in out-of-pocket costs, suggesting that underinsurance is a continuing problem, but not one that has gotten worse in recent years. (It should be noted here that the wording of this question was slightly changed in the 2009 survey to clarify that “out-of-pocket-costs” does not include any money spent on the purchase of health insurance.) A final issue related to health care costs in this survey was the accumulation of medical debt. Sixteen percent of survey respondents said they have medical bills they are paying off over time, down two percent from 2007. (See Figure 3).

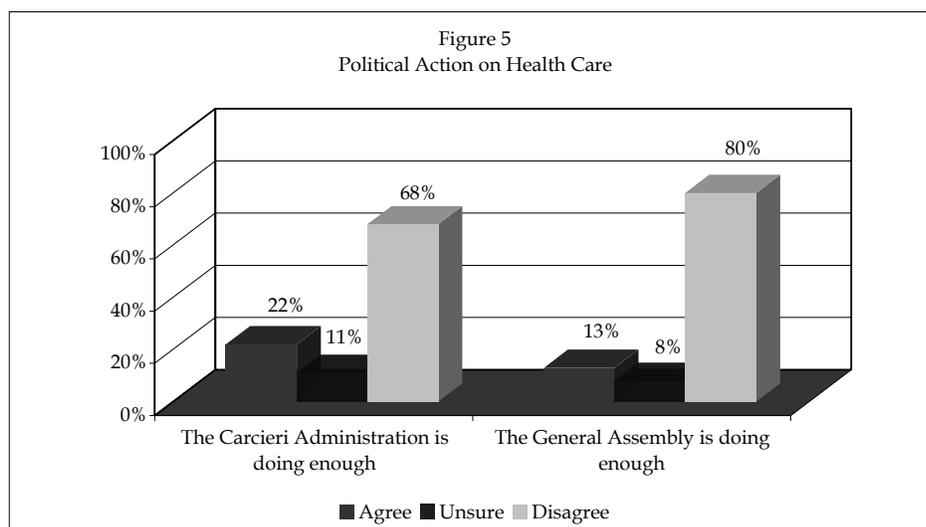


Given widespread concerns related to health care costs and coverage, it is not surprising that Rhode Islanders view health care reform as a high priority. Survey respondents were read a list of eight current political issues and asked to select the two that “deserve to have the highest priority for government to work on.” As their first choice, 33 percent of respondents named “jobs and the economy,” while 21 percent named “health care reform.” “Jobs and the economy” was also the highest second choice, with 21 percent, but another 19 percent named “health care reform.” Overall, then, 54 percent of respondents named “jobs and the economy” as one of their two top priority issues, while 40 percent named “health care reform.” Both findings considerably outdistanced the third highest area of concern, “government corruption” (26 percent). (See Figure 4).



These results largely mirror those of a national poll administered by the Kaiser Family Foundation in April 2009, in which 66 percent of Americans named jobs and the economy as the top priority, and 43 percent named health care reform (Kaiser, 2009). The recent survey results also reflect a substantial shift in the priorities of Rhode Island voters from only two years ago. In 2007, 51 percent of Rhode Island voters named health care reform as one of their two top priority issues, followed by “education” (41 percent) and “jobs and the economy” (27 percent). This change suggests a public reaction to the economic recession, which, as noted in previous chapters, is particularly severe in Rhode Island. Yet the data also show that Rhode Island voters are persistent in their belief that health care reform should be a high priority for government officials.

Much like the national trends noted earlier, there was broad agreement among Rhode Island voters that the state's political leadership should take action to address the problems associated with the health care system. In fact, this support exists despite the poor economic climate. For example, a large majority of survey respondents (68 percent) believed that Governor Carcieri and his administration are not doing enough about health care reform at this time, and an even larger number of voters (80 percent) believed the General Assembly is not doing enough. (See Figure 5).



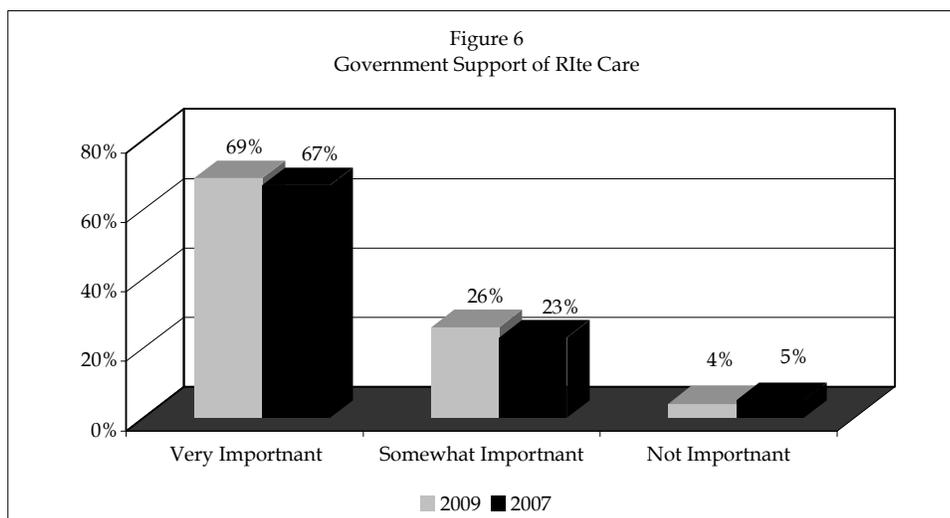
Such broad agreement is indicative of what public opinion scholars refer to as a “consensus.” It also resembles a “J curve” because of the shape of the distribution on a graph like the one above. According to V.O. Key (1961), whose early foundational work regarding the link between public opinion and public policy continues to inform contemporary scholarship, the concept of public consensus is a “significant distribution of public opinion” that derives its importance from the fact that it “may condition the behavior of those in positions of authority” (p. 27). Key notes that while a consensus is

easily distinguished numerically by a unimodal (or one-sided) distribution on a public opinion attitude scale, the term can have “multiple meanings” politically. Key identifies three types of consensus in public opinion: supportive, permissive, and directive. While each situation represents broad public agreement, they differ on their connection to government action.

According to Key, a “supportive” consensus compels public officials to sustain an existing program. “Permissive” consensus indicates that broad support exists for government action, but supporters are generally not strongly committed to any particular policy. According to Key, when this type of agreement exists, a large majority of the public supports a policy initiative, but it may not get transmitted into government action because the majority is not strongly attached to the idea and thus has no “directive power” (p. 33). As a result, the government is free to take action, or do nothing at all, without suffering a widespread political backlash either way. A “directive” consensus is distinguished by a majority opinion that is “so closely articulated with government action as to appear to be decisive” (p. 35). When such a consensus exists, there is a strong public desire for action towards a specific type of policy or reform. Key’s consensus typology is useful in examining the views of Rhode Island voters relative to their support for existing health care programs and desire for legislative reform.

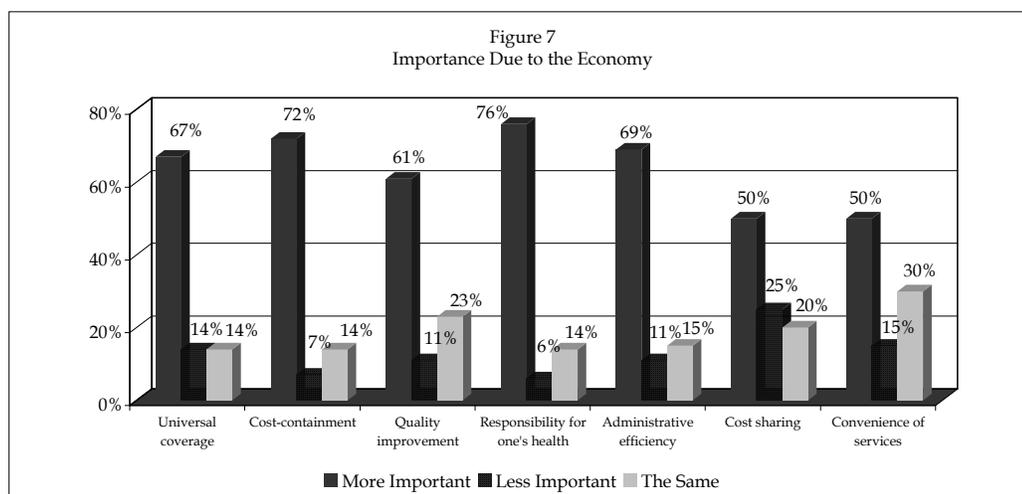
Survey respondents in the state exhibited a supportive consensus with regard to the RIte Care program, Rhode Island’s health plan for low-income families, children under 19, and pregnant women. Ninety-five percent of respondents said that it is

“very” or “somewhat” important for state government to continue to support the RItE Care program. Not only is this an overwhelmingly supportive consensus, it also represents a growing level of support – in 2007 slightly fewer respondents (90 percent) said it was “very” or “somewhat” important for state government to support RItE Care. (See Figure 6.) These results suggest that the RItE Care program has achieved wide political acceptance as a worthy public program, and any attempt to substantially scale back this program would likely meet with strong opposition.



Respondents displayed a permissive consensus with regard to the general notion of health care reform, much like the national trends noted earlier. In fact, Rhode Island voters granted “permission” for government action even in the context of the poor economic climate. For example, 69 percent of survey respondents said they agreed with the following statement: “Even though the state has a large deficit, an important new health program could be funded if priorities were shifted.” Similarly, 64 percent of respondents said “a very good use of part of Rhode Island’s share of the federal

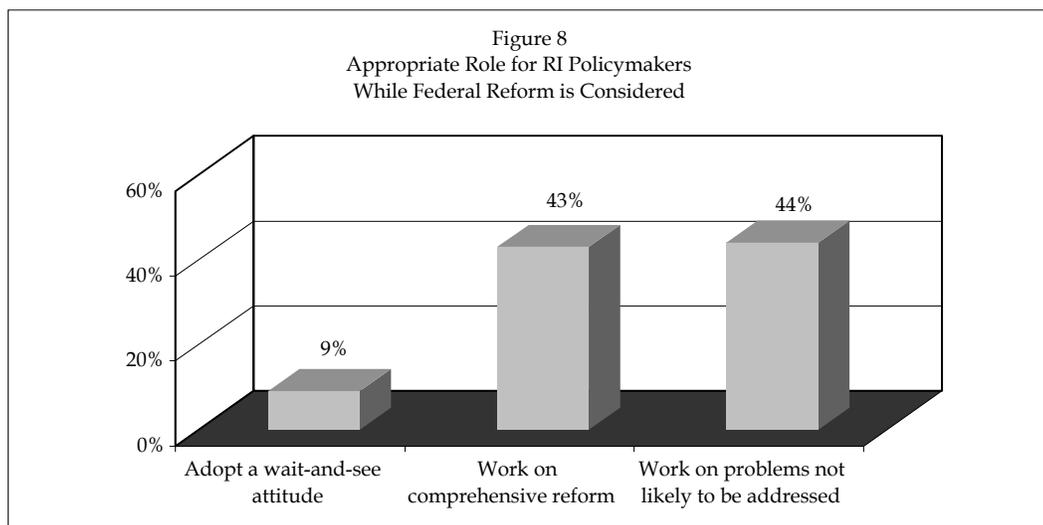
stimulus money would be to expand health care coverage.” A large majority of respondents also believed the following aspects of health care reform policy are “more important” due to current economic conditions: insurance coverage for everyone (67 percent); cost-containment (72 percent); quality improvement (61 percent); administrative efficiency (69 percent); and personal responsibility for one’s health (76 percent). A near majority believed two additional aspects are “more important” given the economic climate: use of more patient cost-sharing and deductibles (50 percent), and greater convenience of services (50 percent). (See Figure 7.) While these data do not



indicate a clear directive on the part of Rhode Island voters, they do show that respondents are open to supporting general aspects of reform, and that economic conditions have only expanded the extent to which permission is granted to government officials to take action.

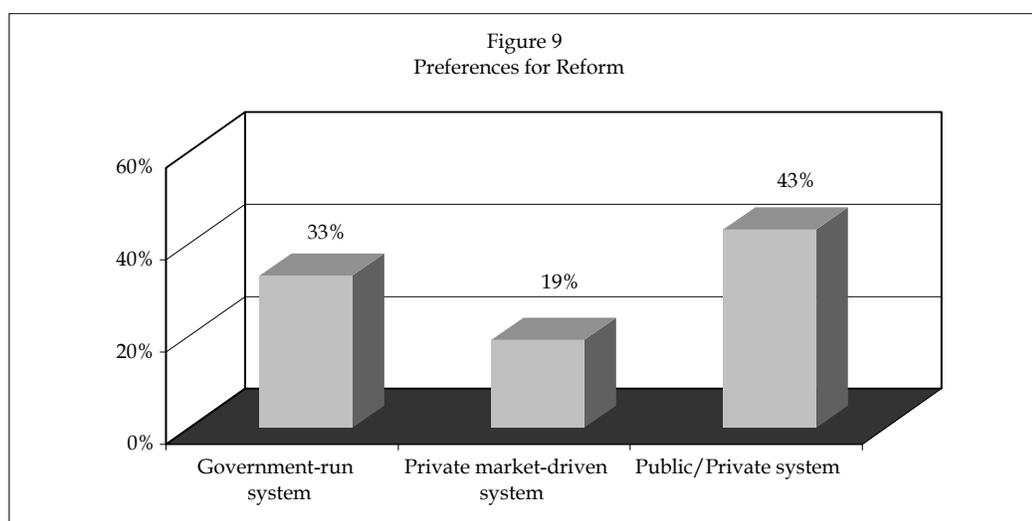
Survey respondents also displayed a permissive consensus for state government action in the context of ongoing health reform deliberations at the national level. Only nine percent of respondents wanted Rhode Island policymakers to “do nothing and

adopt a wait-and-see attitude toward federal action,” whereas 43 percent wanted lawmakers to “work on a comprehensive reform without assuming a new federal policy will be passed,” and 44 percent wanted them to “work on problems in the health care system that are not likely to get addressed by federal law.” Taken together, 87 percent of respondents supported some type of state activity on health care reform, despite the fact that such legislation is undergoing serious consideration at the national level. (See Figure 8).



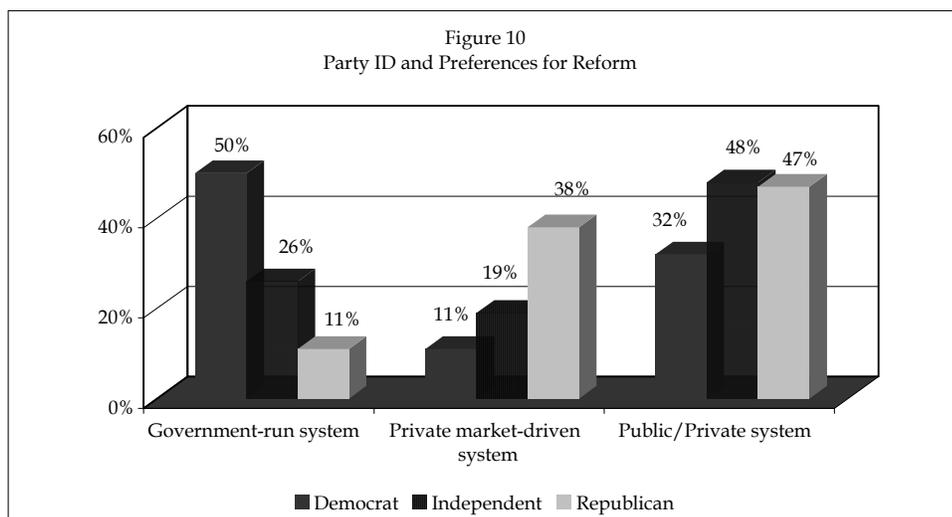
It should be noted, however, that no consensus among Rhode Island voters exists when it comes to policy choices regarding comprehensive reform. Much like the long-standing national trends noted earlier, when asked to respond to specific policy alternatives, the level of agreement among survey respondents quickly eroded, providing not a “directive consensus,” but instead what Hooghe and Marks (2009) call a “constraining dissensus.” A constraining dissensus is simply the antonym of Key’s permissive consensus, representing a level of disagreement likely to make political

leaders wary of taking action. When survey respondents were asked which approach best described their preference for “the direction health care reform should take,” 33 percent said “a government run health care system,” 19 percent said “private market health care system,” and 43 percent said “a continuation of our current public/private balance.” (See Figure 9).



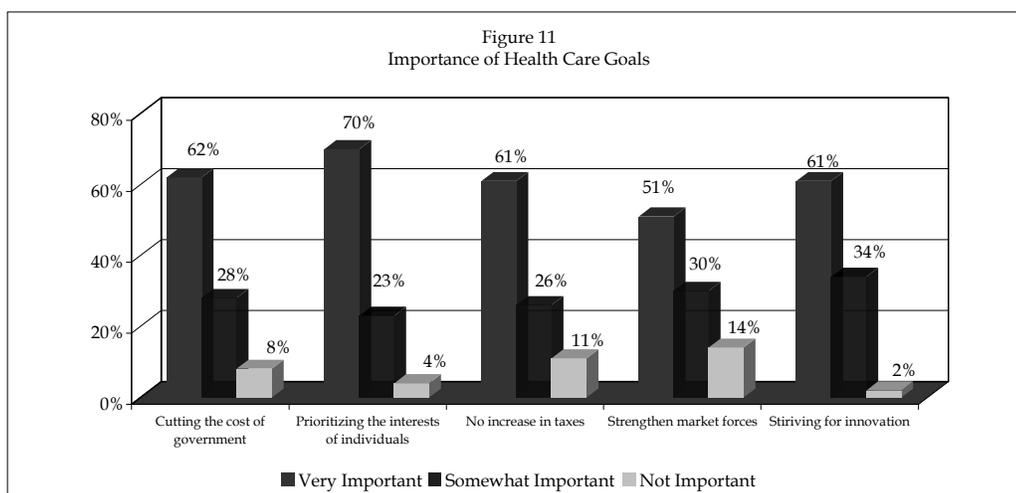
Disagreement among Rhode Island voters about how best to approach health care reform was further pronounced when broken out by party identification. Survey respondents who identified themselves as Democrats or Republicans diverged sharply with regard to the direction of health care reform, displaying what is known as “partisan polarization” (Erikson et al., 1994). Half of all survey respondents who identified themselves with the Democratic Party preferred a “government-run health care system,” whereas only 11 percent of Republicans favored this approach. Republicans and Democrats were equally polarized with regard to a “private market-based health care system.” While 38 percent of Republicans would like to see health reform move in this

direction, only 11 percent of Democrats felt this way. More Republicans (47 percent) supported a continuation of the public/private health care system than strictly one or the other, but only 32 percent of Democrats preferred to retain the current balance. (See Figure 10). These results show that although Rhode Island voters grant political leaders permission to take some type of action to solve the problems associated with the health care system, a deep partisan divide presents policymakers with uncertainty about the appropriate course of action.



In stark contrast to legislative stagnation on the issue of comprehensive health care reform in Rhode Island, the Carcieri Administration aggressively pursued, and eventually achieved, passage of a sweeping Global Medicaid Waiver. Chapter Four of this thesis argues that Carcieri and other administration officials were successful, in part, because of their use of a strong political message. Survey data add weight to this interpretation by indicating that key components of the administration's message resonated with Rhode Island voters. For example, each of the following stated goals of

the Global Waiver was seen by survey respondents as being “very important” in health care reform policy: “cutting the cost of government” (62 percent); “making sure the interests of individuals take priority over those of health care institutions and agencies” (70 percent); “taxes will not be increased” (61 percent); “strengthening competition and market forces” (51 percent); “striving for innovation” (61 percent). (See Figure 11).



In sum, Rhode Island voters display attitudes similar to those of most Americans: they are deeply concerned about health care costs and access, consider health care reform a top priority, and have a strong desire for government action. Beneath this layer of permissive consensus, however, opinions regarding the best approach for government to take in achieving comprehensive health care reform are polarized along party lines. Finally, the language used by the Carcieri Administration to sell the Global Waiver clearly resonated with survey respondents, which could help to explain the largely quiescent response among Rhode Island lawmakers and the general public to such a sweeping overhaul of the Medicaid system.

### III. Review of Political Language Items

As noted throughout this thesis, knowledge of motivation, vantage point, and priorities is important in understanding political messengers' use of political language. Equally important, particularly with regard to gauging influence, is how the public views these public actors. Murray Edelman (1988) writes extensively on this topic, arguing that political leaders serve as "symbols" who contribute meaning to political issues:

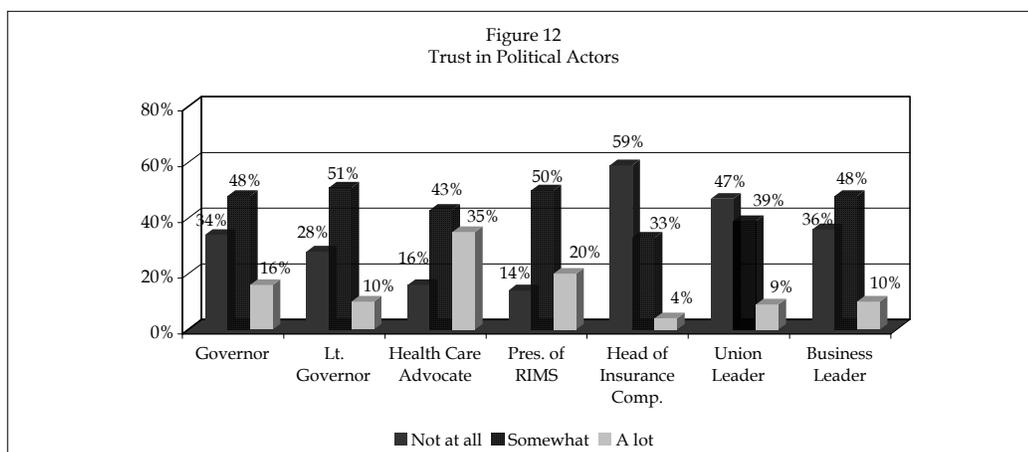
Political leaders become signs of competence, evil, nationalism, future promise and other virtues and vices and so help introduce meaning to a confusing political world. In assigning meaning to leaders, spectators define their own political postures. At the same time belief in leadership is a catalyst of conformity and obedience (p. 37).

Thus, according to Edelman, the public helps to create leaders by assigning meaning to them and then follows or ignores their lead based on those creations. Inherent in this complex understanding of leadership is the assertion that trust in political figures is an important indicator of the extent to which the public would be willing to support a proposed government action.

Based on this perspective, the Rhode Island survey asked respondents to report how much they trusted that specific types of people were acting in their "best interest when it comes to reforming Rhode Island's health care system." Respondents could say they trusted the individual "a lot," "somewhat," or "not at all." Results show that only 16 percent trusted the governor "a lot," while 34 percent of respondents had no trust in him at all. Voters reported even less trust in the lieutenant governor, who, as noted in Chapter Three, is a committed policy entrepreneur in the area of health care reform.

Only 10 percent said they had “a lot” of trust in the lieutenant governor, and 28 percent reported having no trust at all.

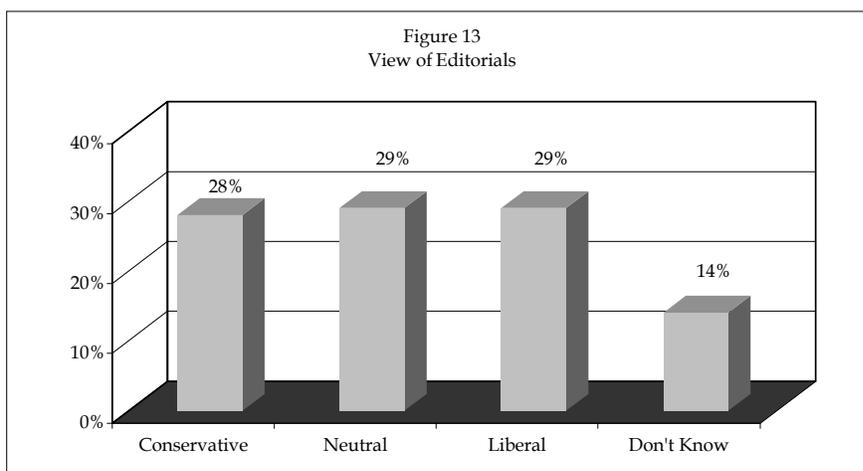
By contrast, survey respondents expressed a somewhat higher degree of trust in the president of the Rhode Island Medical Society – a position previously held by Dr. Nick Tsiongas, the “outside policy entrepreneur” in Chapter Three. Twenty percent had “a lot” of trust in someone who holds this position, while 14 percent had no trust at all. Interestingly, the most trusted type of person included in the poll was a “health care advocate,” with 35 percent reporting “a lot” of trust. The least trusted type of person was the “head of a health insurance company,” with 59 percent expressing no trust at all in such a figure. (See Figure 12).



As noted in Chapter One and elsewhere, the media also play a distinct role as political messengers. The media’s primary function is to describe issues and events to the general public, but certain elements of the media also work at constructing their own political messages through editorials and other forms of commentary. In Rhode Island, *The Providence Journal* is the only statewide daily paper, and some have argued that it

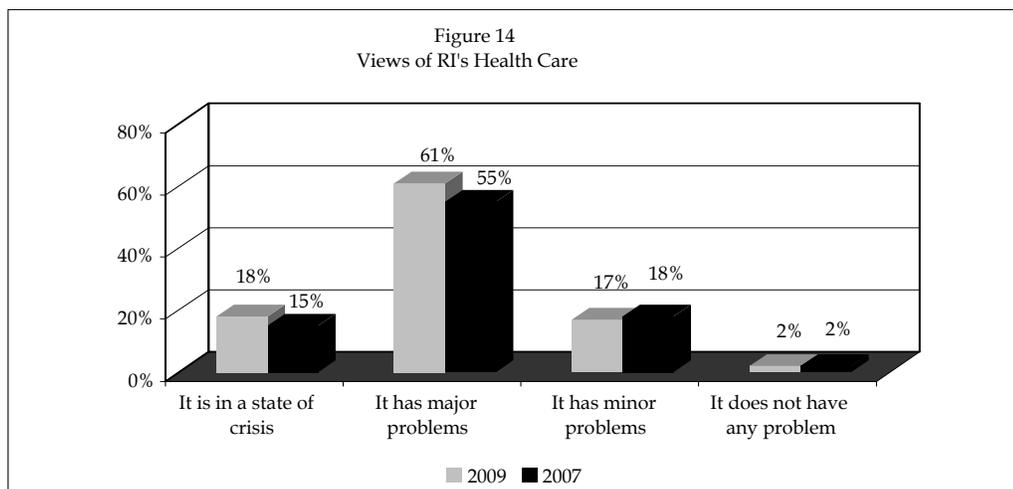
wields “enormous influence” in shaping the political agenda (Moakley and Cornwell, 2001). Given the prominence of the *Journal* as a political messenger, a number of questions in the survey aimed to capture the paper’s use as a news source, as well as its credibility and political influence with Rhode Island voters.

Only 33 percent of Rhode Island voters reported receiving their news primarily through reading the newspaper, whereas 45 percent got most of their news by watching television. A substantial majority of survey respondents viewed *The Providence Journal* as a credible source of news: 28 percent believed the *Projo* was “very credible” and another 55 percent felt it was “somewhat credible.” Of those surveyed, 77 percent had at some point read the editorial page of the *Journal*, and those respondents were almost identically split in their assessment of the paper’s ideological point of view. Twenty-eight percent felt *Journal* editorials were conservative, 29 percent believed they were neutral, and another 29 percent viewed them as having a liberal point of view. (See Figure 13).



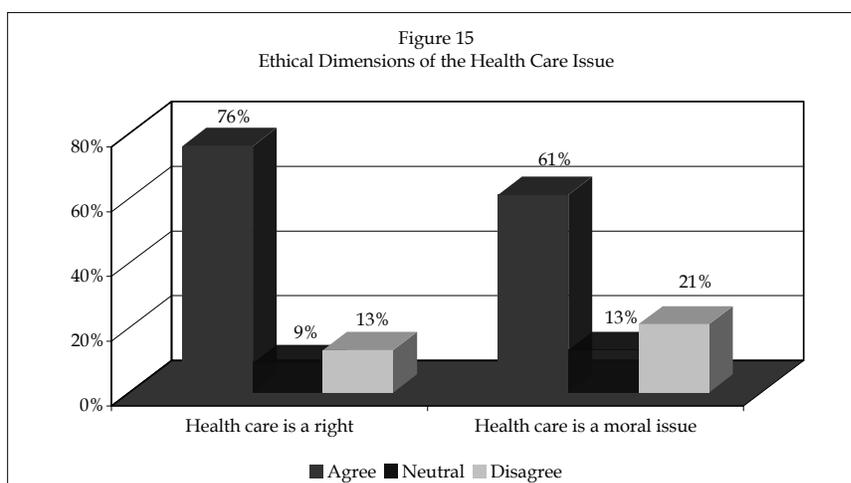
Further analysis reveals that the ideological orientation of respondents is a statistically significant predictor ( $p = .001$ ) of how they perceive the point of view of *Journal* editorials. Of those respondents considering themselves to be “liberal,” 48 percent said the paper had a conservative point of view, while only 22 percent viewed the *Journal* as being liberal. Similarly, 50 percent of “conservatives” viewed *Journal* editorials as being liberal and only 22 percent said the paper’s point of view was conservative. Thus, it appears that the values respondents bring to reading the daily paper strongly influence how they assess its political point of view. Perhaps the perceived ideological point of view of the paper is a moot point, however, because the majority (57 percent) of editorial readers said their opinions were “never” influenced by *Journal* editorials “on matters of public policy like health care,” 38 percent said they were “sometimes” influenced, and only four percent said they were “very often” influenced.

With regard to the content of political messages, it has been noted in Chapter One and elsewhere that the way in which a problem is defined can have a profound impact on the how the public understands the broader issue. A problem that is perceived as a “crisis,” or that is successfully defined in terms of “rights” or fairness, for example, is likely to be given special attention in the political realm (Rocheftort and Cobb, 1994). In this light, it is noteworthy that 18 percent of respondents believed Rhode Island’s health care system is “in a state of crisis.” and another 61 percent felt “it has major problems.” Only two percent felt the state’s health care system “does not have any problem.” These figures are slightly higher than in 2007, indicating that Rhode Island voters perceive the problems facing the health care system as becoming



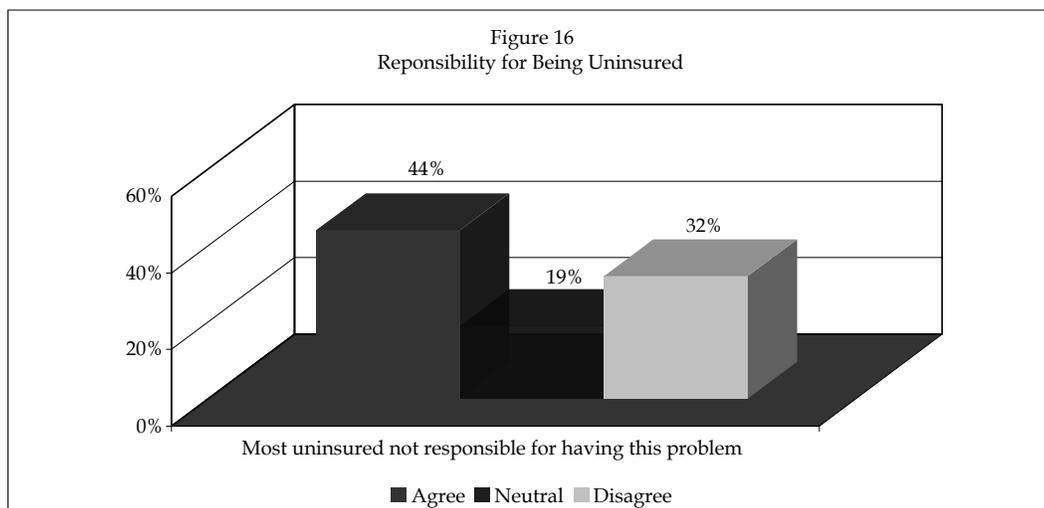
increasingly severe. Based on these results, it is somewhat surprising that neither policy entrepreneur discussed in Chapter Three regularly employed language to characterize the health care system as being in a state of “crisis.” This disparity between elite discourse and public views suggests that a rhetorical opportunity may have been missed. (See Figure 14).

Equally notable, 76 percent of respondents felt that “health care coverage is a right that no one should be denied,” while only 13 percent disagreed with this position.



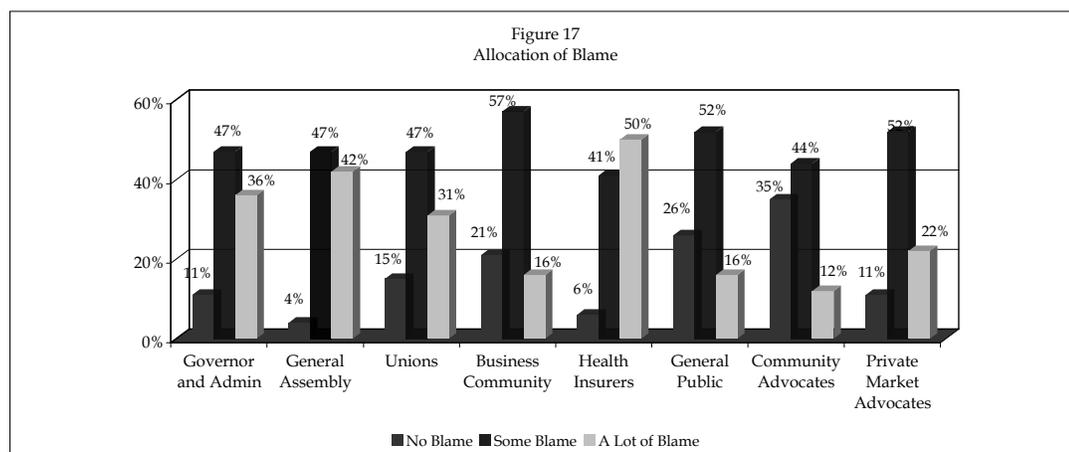
Similarly, 61 percent of voters felt that “health care reform should be seen by state policymakers as a moral issue.” Only 21 percent disagreed with this statement. (See Figure 15). These results indicate that Rhode Island voters view the issue of health care reform as having an important ethical dimension. In 2007, 64 percent felt that health care should be seen as a moral issue, three points higher than in 2009. In 2007, 84 percent of Rhode Island voters believed health care was a right no one should be denied, eight points higher than in the 2009 survey, when respondents were asked whether they agreed with the statement that “health care coverage is a right that no one should be denied.” The addition of the word “coverage” after “health care” in the 2009 survey may have narrowed the scope of how some respondents interpreted the question—respondents in the 2007 survey may have understood the statement to imply that no one should be denied access to a hospital or medical treatment, whereas in 2009 it was made clear that health insurance was the topic at issue.

Another important category of problem definition is causation, which, according to Rochefort and Cobb (1994), includes some claim about who or what is to blame for a given problem—be it a particular group or individual, or some systemic force. Causality is so important because it helps not only to establish broader understanding of an issue, but can also mold what would be seen as an acceptable solution. When asked to respond to the statement that “most people without health insurance are not personally responsible for having this problem,” 44 percent of survey respondents said they agree. Another 19 percent were undecided and 32 percent disagreed. (See Figure 16). A similar question was asked in the 2007 survey. However, in that survey respondents



were asked to respond to the assertion that “most people without health insurance are partly to blame for having this problem.” In this case a large majority (62 percent) disagreed. Since the 2009 and 2007 questions were the same in principle, the disparity in responses suggests that use of the term “responsibility” versus “blame” may have had an impact on how Rhode Island voters assigned culpability, a testament to the powerful influence of political language. To agree with the statement that one is “to blame” for lacking insurance coverage implies that the uninsured individual has acted irresponsibly at best and negligently at worst. Such a statement reflects little—if any—sympathy for the predicament of the uninsured. To agree with the statement that one is “not personally responsible” for being uninsured implies that factors outside of the individuals’ control can influence whether or not they are insured. This statement reflects compassion for the uninsured and an understanding that lack of employer-based health insurance, or the high costs associated with health insurance premiums, may prevent an individual from becoming insured.

Another part of the survey asked to what extent specific groups and individuals were to “blame for the fact that government action on health policy problems in Rhode Island has not been more effective to date.” The options given were “a lot of blame,” “some blame,” or “no blame.” Rhode Island voters assigned “a lot of blame” primarily to health insurers (50 percent), the General Assembly (42 percent), and the governor and his administration (36 percent). The majority of respondents assigned at least some blame to each group, but “no blame” was associated primarily with community advocates (35 percent), the general public (26 percent), and the business community (21 percent.) (See Figure 17). The key takeaway here is that Rhode Islanders assigned a



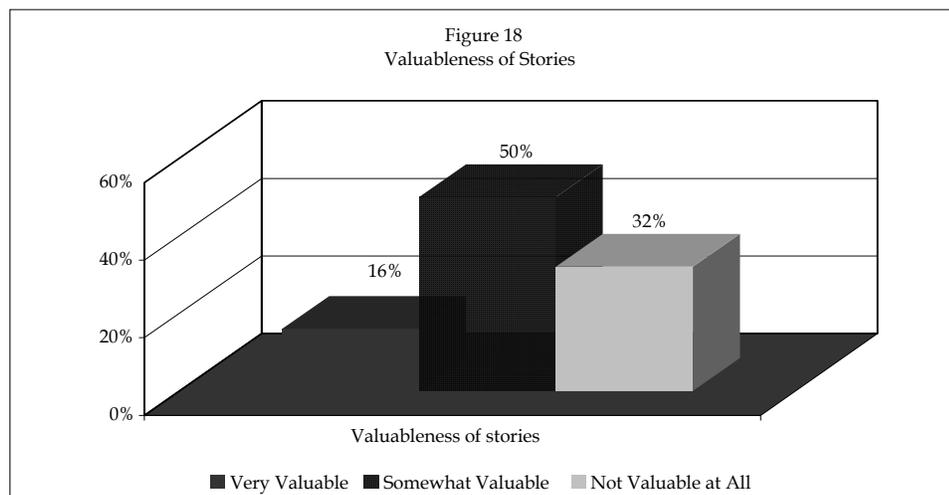
wide variety of groups with at least some, or a lot, of blame for the lack of government action to address the health policy problems, but most voters did not believe the uninsured are responsible for their situation.

This finding indicates that blame for lack of action on health care reform resonates with Rhode Island voters. There was an apparent resistance on the part of Lieutenant Governor Roberts to assign blame for the problems with the state’s health

care system beyond abstract “cost increases,” and demographics. To the contrary, Dr. Tsiongas deliberately cast blame, referring to the “right-wingers who don’t have the guts or the interest to place controls on the health care market” (Tsiongas, 2006) as the cause of problems. Survey results suggest that both policy entrepreneurs may have missed another opportunity here: Had Dr. Tsiongas expanded his circle of blame beyond conservative extremists, he may well have attracted more listeners and possibly supporters; and had Lieutenant Governor Roberts assigned any type of blame, her message may have convinced members of the public that she shared their frustration with the current system.

According to Deborah Stone (1989), problem causality is often communicated through “causal stories.” Storytelling is also a common way for policy entrepreneurs to “humanize” reform proposals and communicate ideas in a way both compelling and easily accessible for a diverse population. One example of such storytelling was given in Chapter Three with regard to Lieutenant Governor Roberts’ first major health reform speech, which contained a moving account of a local small business owner who could no longer afford to provide health insurance for his employees despite his desire to continue doing so. This story drew a powerful connection between “cost increases” and the problem of uninsurance in the state of Rhode Island. Given the prominence of storytelling in the political language literature, and its common use by political messengers, one might not be surprised to find that 52 percent of Rhode Island voters found stories to be “somewhat valuable” in explaining “how individuals would be helped by a proposed new policy” and 16 percent said they believed the use of such

stories are “very valuable.” Thirty-two percent said they are “not valuable at all.” (See Figure 18). This finding helps confirm that storytelling can be an effective and appealing



tool when used to supplement a broader description of the impact of reform. Since storytelling works at an emotional, symbolic, and even unconscious level of identification for the listener, however, this is a difficult area to explore with standard survey research items. Ironically, one could hypothesize that if survey respondents were aware of the efficacy of storytelling, they would be largely immune to its influence as a rhetorical device.

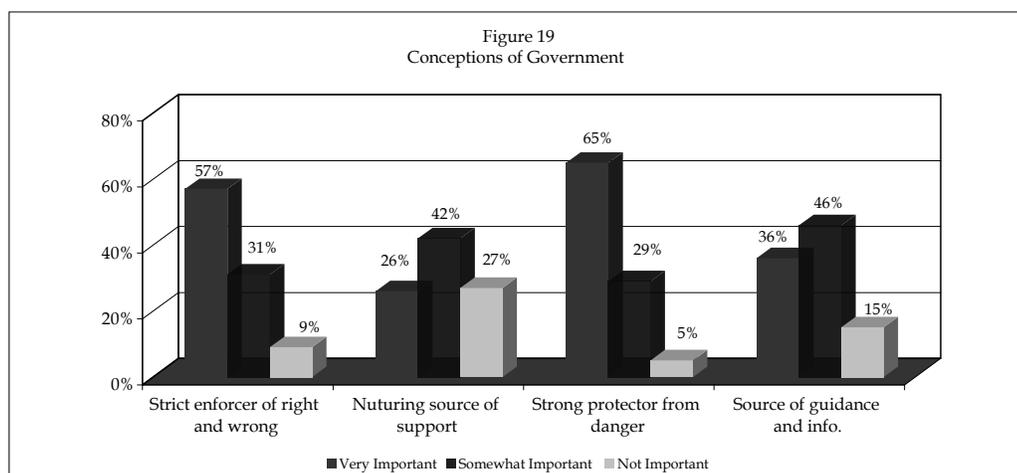
Respondents were also asked what they felt was most important when deciding to support a new government proposal. A large majority (63 percent) preferred “detailed information about the proposal,” while 32 percent preferred a “statement of principles underlying the proposal.” These findings show that personalized stories and vague language are not what Rhode Island voters say they want to hear when deciding matters of public policy. Again, however, this finding does not necessarily indicate

whether or not such language is effective in shaping public responses to the messages of leaders who rely on such narrative devices.

Researchers in the field of cognitive psychology have recently added to our understanding of how political language might influence those who hear it. It is now believed that “frames in communication” interact with “cognitive frames” in the brain, which people use to help sort out complex information (Kinder and Nelson, 2005). Linguist and cognitive scientist George Lakoff (2002) has applied this emerging area of study to the field of political science, suggesting that Americans’ political orientations and policy preferences diverge based on fundamentally different conceptions of government.

To recap briefly from Chapter One, Lakoff argues that both conservatives and liberals view government from a parent-child perspective, but conservatives more often view government as a “Strict Father” responsible for protecting people from danger and enforcing right and wrong. Liberals, on the contrary, more often view government as a “Nurturing Parent” responsible for providing protection, but also as a nurturing and trusted source of guidance. Lakoff argues that the language used to describe policy issues naturally evokes one cognitive frame or the other, which, in turn, leads to preference for a policy agenda consistent with the values inherent in that frame.

Contrary to what Lakoff might anticipate, however, Rhode Island voters, who are among the most solidly Democratic in the nation, believed “very important” roles for government to play are “a strict enforcer of right and wrong” (57 percent) and “a strong protector from danger” (65 percent). Only nine and five percent believed these respective roles are “not important.” Only 26 percent believed a “very important” role for government is to be a “nurturing source of support,” while 36 percent believed it is “very important” for government to be “a source of guidance and support,” both conceptions of government Lakoff claims are more typically associated with liberal-leaning Americans. (See Figure 19). These findings recall the often conflicted political behavior and beliefs of Rhode Island voters. As noted in Chapter Two, despite its strong

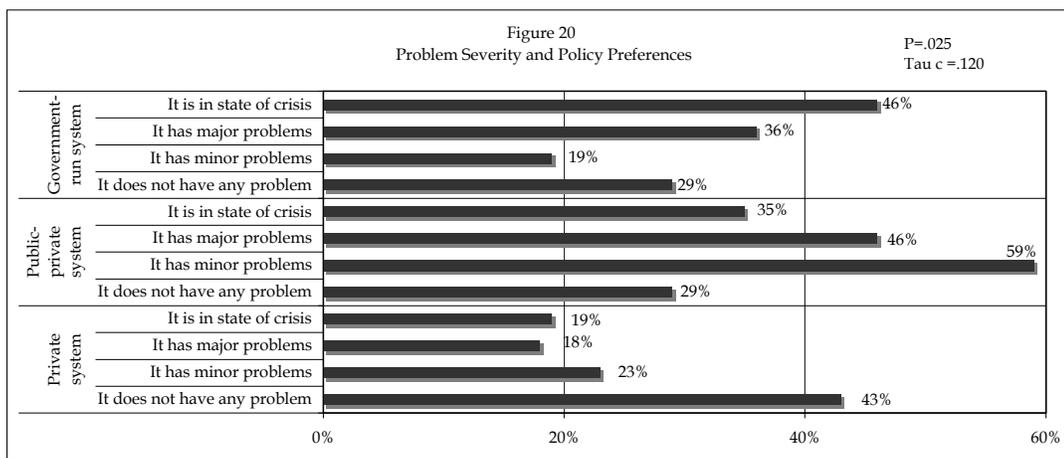


Democratic leanings, Rhode Island is not a one-party state, frequently electing Republicans to prominent political offices. These results also illustrate the difficulty of categorizing individuals as strictly liberal or conservative, when their actual preferences may be far more nuanced.

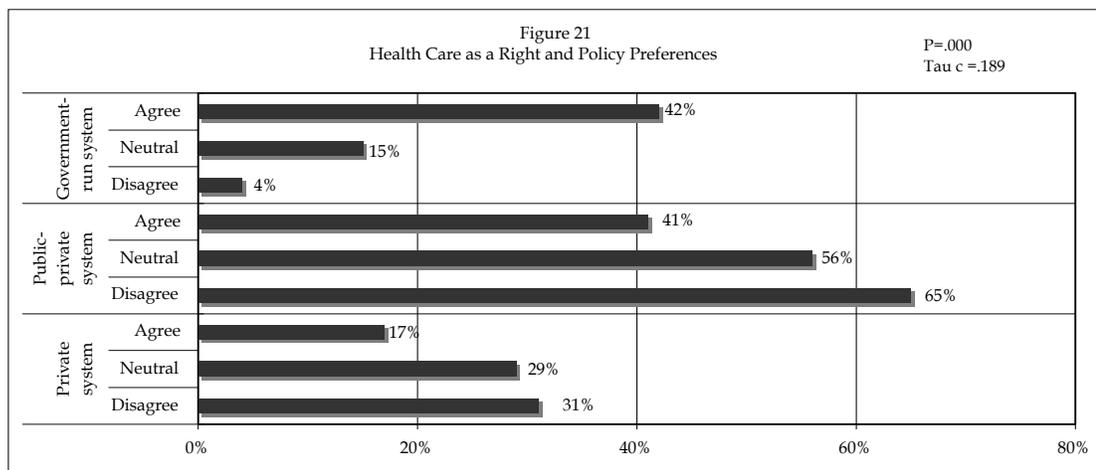
#### **IV. Exploring the Link between Political Language and Policy Preferences**

Although much has been written about the importance of political language in the policy process, little research has been done to explore the extent to which political language orientations can predict policy preferences (see Rochefort and Donnelly, 2007, for one example). The recent Rhode Island survey, which gauges voter reaction to important themes of political language as well as to health policy proposals, allows this link to be examined. Using various political language measures as independent variables, on the one hand, and support for reform policies as dependent variables, on the other, a series of cross-tabulations was run to identify statistically significant relationships.

Results show, first, that the more Rhode Island voters defined the problems associated with the state's health care system in critical terms, the more likely they were to support a more comprehensive reform policy. For example, 46 percent of respondents who defined the state's health care system as being in a "state of crisis" also said they preferred a health care reform to move in the direction of a "government-run health care system," and only 19 percent favored a "private market-driven health care system." On the opposite end of the spectrum, of those who said the health care system "does not have any problem," 43 percent preferred a private market-driven reform approach and only 29 percent preferred a government-run health care system. This relationship between perceived problem severity and preferences for specific reform alternatives is statistically significant at the .025 level. (See Figure 20).



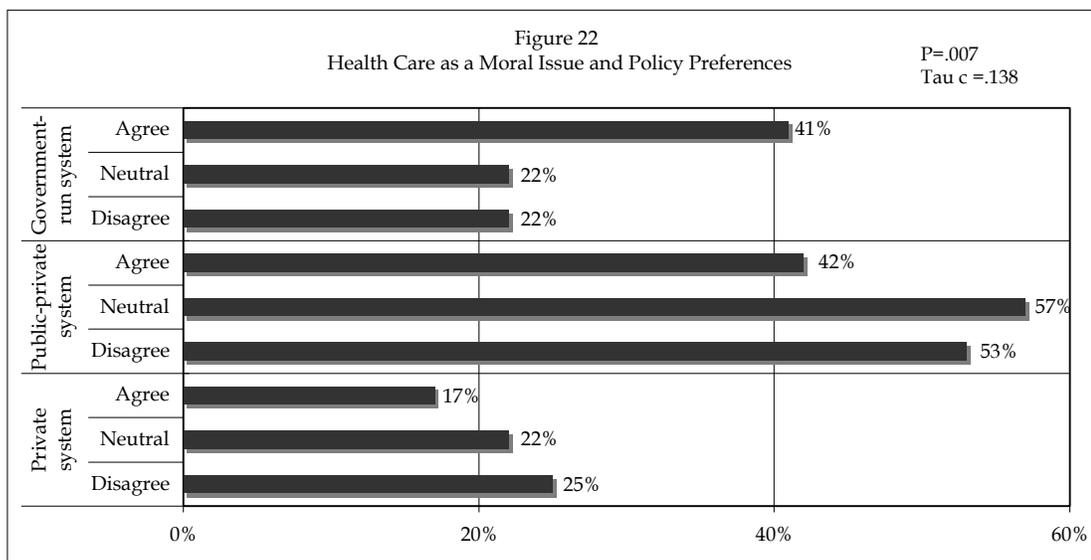
Similarly, respondents who defined health care as a “right” were more likely to favor a “government-run” approach to health care reform than those who did not. Forty-two percent of those who agreed with the statement “health care coverage is a right no one should be denied” supported a government-run system, while only 17 percent of those who agreed with that statement supported a “private market-driven health care system.” A very small number (four percent) of respondents who did not



define health care coverage as a right favored a government-run system. (See Figure 21).

The relationship between these responses is significant below the .001 level.

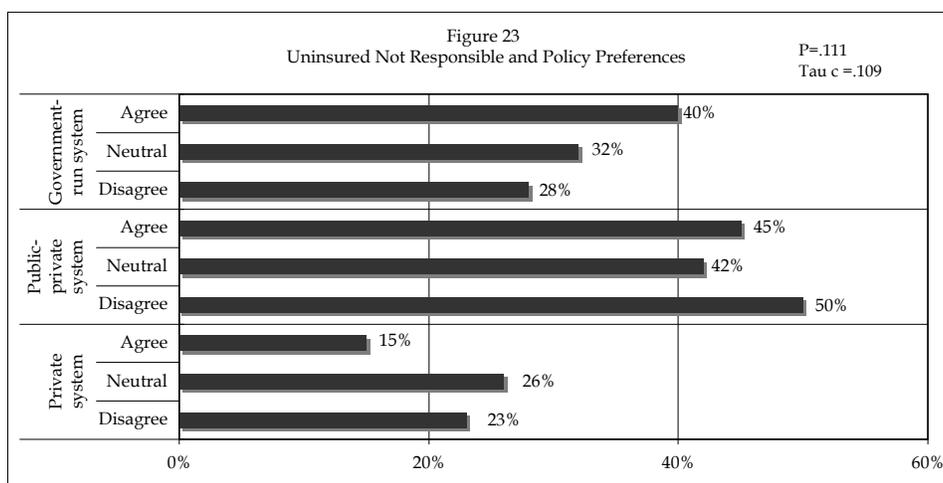
Data analysis also shows a statistically significant ( $p = .007$ ) relationship between defining health care reform as a “moral issue” and preferences for comprehensive health care reform. Those respondents who agreed with the statement “health care reform should be seen by state policymakers as a moral issue” were more likely to favor a government-based reform plan; those who disagreed were more likely to favor a private-market solution. (See Figure 22). Taken together, these results show that those



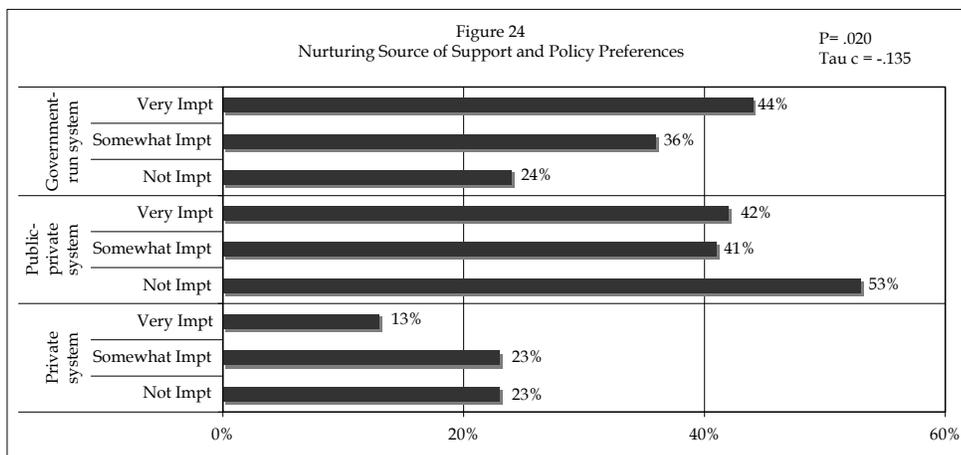
Rhode Island voters who defined the problems facing the state’s health care system in terms of a “crisis” and believed health care reform to be a moral imperative were significantly more likely to support a government-run system. However, as voters moved away from these views, their level of approval for government involvement in the health care system decreased.

Voters who believed the uninsured are “not responsible” for their situation also tended to favor a “government-run health care system,” however the relationship between these variables is not statistically significant ( $p = .111$ ). This means that

although respondents who believed lack of insurance is not the fault of the uninsured tended to support greater government involvement in the health care system, many also favored a continuation of the public-private mix (45 percent), or a private market-based system (15 percent). Furthermore, 28 percent of those who felt the uninsured are at least partly responsible, and 32 percent of those who felt neutral, also supported a government-run system. (See Figure 23).



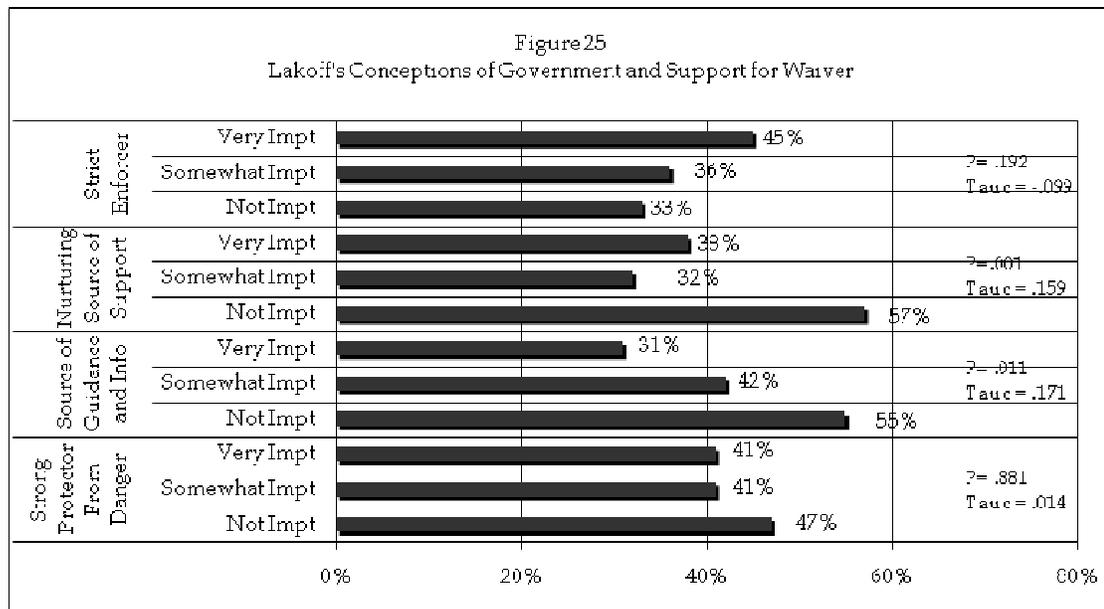
An analysis of Lakoff's liberal-conservative conceptions of government reveals that those who believed a "very important" role for government to play is a "nurturing source of support" were more likely to favor a "government-run health care system." Only 13 percent of those who believed such a role for government is "very important" supported a "private market-based system," compared to 44 percent who supported a government-run system ( $p=.020$ ). (See Figure 24). Since the independent and dependent variables represent a liberal conception of government and a liberal approach to reform respectively, this finding adds statistical support to part of Lakoff's thesis. However, none of Lakoff's other conceptions of government included in the survey



proved to be statistically significant predictors of preferences toward comprehensive health care reform.

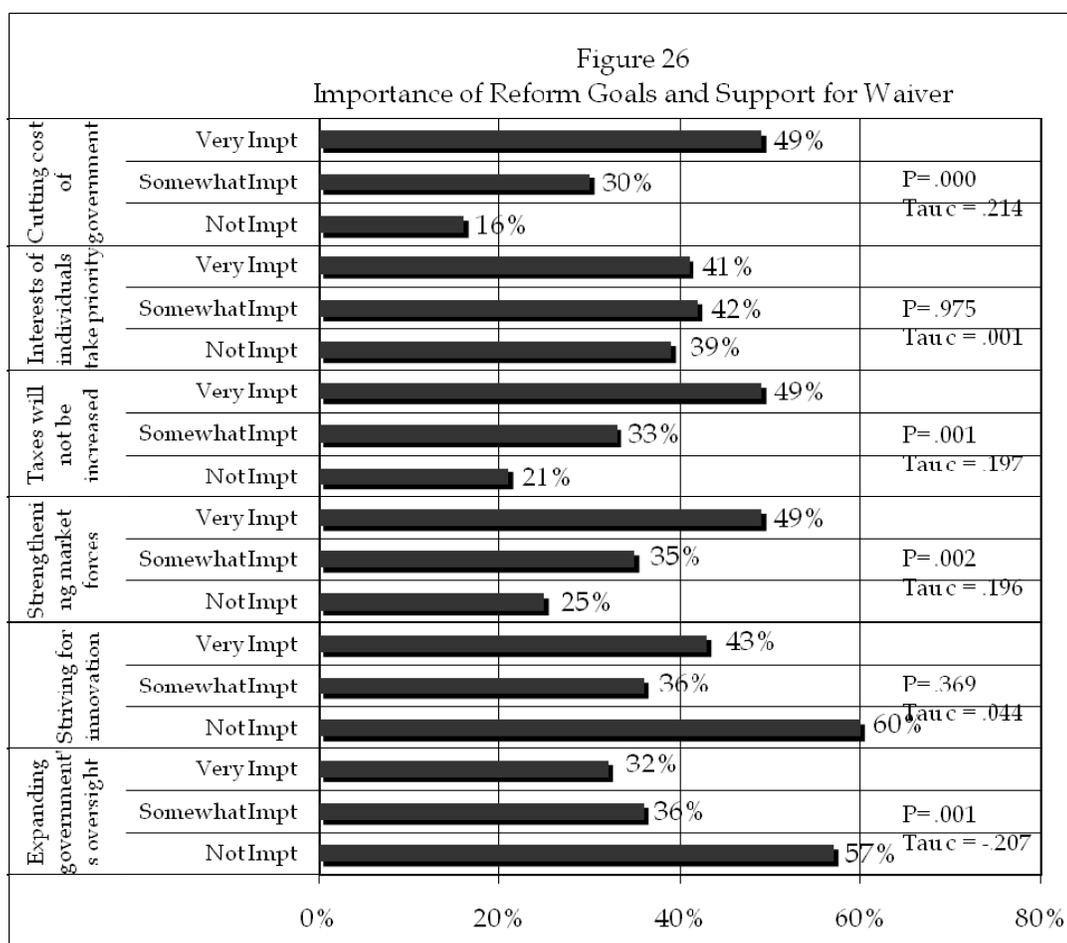
Lakoff's conceptions of government are slightly better predictors when it comes to support for, or opposition to, Governor Carcieri's Medicaid waiver. In fact, both of Lakoff's liberal conceptions of government included in the survey are statistically significant predictors of opposition to the waiver. Respondents who believed an important role for government is "a nurturing source of support" were significantly more likely to oppose the waiver ( $p=.001$ ), as were those who believed an important role for government is providing "a source of guidance and information" ( $p=.011$ ). Although significant, both relationships are weak, at Tau-c= .159 and .171, respectively. Each finding is consistent with what Lakoff's thesis would predict—Rhode Island voters who conceive of government's role along the lines of Lakoff's liberal terms were more likely to oppose a conservatively-based reform initiative. However, neither of Lakoff's conservative conceptions of government included in the survey prove to be statistically significant predictors of support for the governor's waiver. In fact, the plurality of those

believing government's role as a "strong protector from danger" is "not important" said that they supported the waiver, representing a weak and inverse relationship (Tau-c=.014) with respect to what Lakoff's thesis would predict. (See Figure 25).



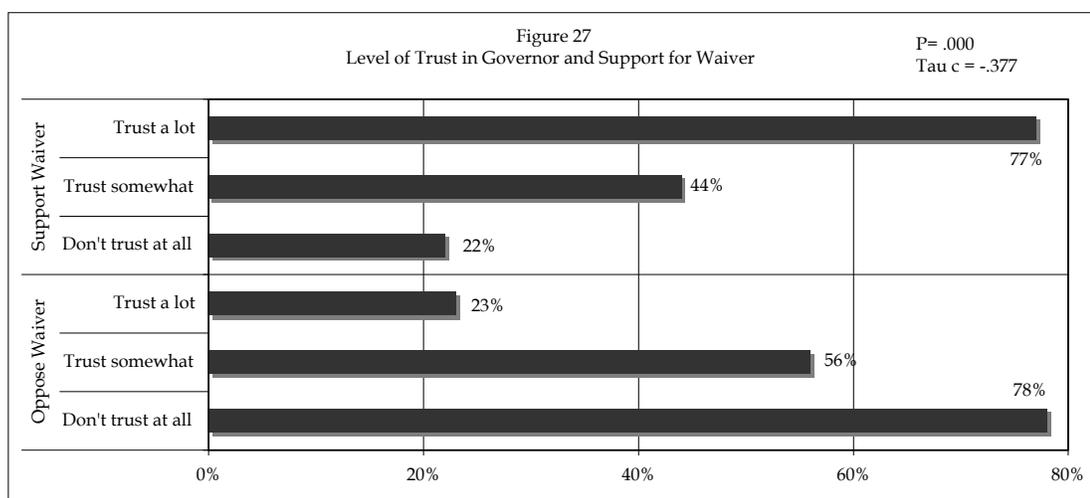
Earlier in this chapter, it was noted that the language used by the governor and his administration to sell the Global Waiver resonated with Rhode Island voters, bolstering the argument that legislative success relied, in part, on a strong political message. Statistical analysis of the administration's language adds another layer of support to this argument. The greater importance respondents placed on the specific reform goals outlined by the administration, the more likely they were to support the waiver proposal. In fact, three of the five phrases used by the administration were statistically significant predictors of support for the waiver: "cutting the cost of government" (p= .000); "taxes will not be increased" (p= .001); and "strengthening competition and market forces" (p= .002). Considering the time and effort

administration officials devoted to constructing a political message, they would no doubt find these results gratifying. However, two reform goals the governor and his administration commonly associated with the waiver – “making sure the interests of individuals take priority over those of health care institutions and agencies” and “striving for innovation” – were not significantly related to voter support. Also, a statistically significant ( $p = .001$ ), negative relationship ( $\text{Tau-c} = -.207$ ) exists between the



importance voters placed on “expanding government oversight” – a goal that the waiver was specifically designed to avoid – and support for the waiver. (See Figure 26).

Lastly, the greater level of trust voters placed in the governor, the more likely they were to support the waiver, a finding that underscores the importance Edelman (1988) places on public perception of political leaders. Seventy-seven percent of Rhode Island voters who had “a lot of trust” that the governor is acting in their best interest supported the waiver, while only 22 percent who did not trust the governor “at all” supported the waiver. Strikingly similar results are seen in opposition to the waiver: 78 percent who said they do not trust the governor “at all” opposed the proposal, while 23 percent of those with a “lot of trust” in Carcieri opposed it. (See Figure 27). The



relationship between trust in the governor and support for the waiver is statistically significant ( $p = .000$ ) and moderate in strength ( $\text{Tau-c} = -.377$ ).

## V. Conclusion

American public opinion on the health care issue bears two primary characteristics: broad support for comprehensive reform and a persistent lack of

consensus on how it should be done (Blendon et al., 2003). Opinions of Rhode Island voters largely mirrored this national trend. Survey data collected in 2007 and 2009 showed that voters were increasingly concerned about losing their health care coverage and rising costs, and believed state lawmakers should be doing more to solve these problems. There was strong support for reforming the health care system despite the poor economic climate in Rhode Island, but opinions regarding specific approaches to comprehensive reform were deeply divided, particularly along party lines.

Beyond these descriptive trends, the 2009 survey captures numerous dimensions of political language, presenting a valuable opportunity to test the degree to which political language orientations serve as predictors of policy preferences. Analysis of these data shows that support for a government-run system was significantly greater among those who defined health care reform as having a strong ethical dimension and who viewed the problems facing the state's health care system in terms of a "crisis." Those respondents who believed it is important for government to be a "nurturing source of support" were also significantly more likely to support a government-run health care system, a finding consistent with one of Lakoff's conceptions of government.

Lakoff's thesis also helps to predict support for the Global Waiver – those who believed it is important for government to be "a nurturing source of support" and "a source of guidance and information" – both liberal conceptions of government – were significantly more likely to oppose Governor Carcieri's Medicaid waiver. With regard to the language used by the Carcieri Administration to sell the Global Waiver, those who agreed with key components of the governor's political message were significantly more

likely to support his proposal, adding weight to the notion that effective messaging can help pave the way to legislative success. Finally, those respondents who expressed trust in the governor were also significantly more likely to support his waiver plan.

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– Chapter 6 –  
Orwell and Beyond

Writing about the upsurge of state health policy activity following defeat of the Clinton plan in the early 1990s, Robert Hackey commented that “The events of the past decade have raised new hopes – and questions – for those who turn to the states as leaders in health reform” (Hackey, 2001, p. 25). As recent developments in Rhode Island make plain, today that ambivalent observation rings as true as ever. Seeking to solve budgetary problems, achieve greater program efficiency, and reshape the provision of long-term care, Governor Donald Carcieri successfully pursued the most comprehensive Medicaid waiver in United States history. More ambitious still, two energetic policy entrepreneurs, one working from within government and one from without, aimed at developing comprehensive solutions for the twin problems of uninsurance and rising system costs in the state. Previous chapters described these episodes, noting the social, economic, and political contexts in which they took root. More than this, particular attention was paid to the political language dimension of these health policy cases, relying on a framework of analysis fashioned for this study. The underlying hypothesis has been that the use of rhetoric was crucial to the framing of policy alternatives, constituency building, and political strategy. Further, an analysis of public opinion data has made it possible to explore the extent to which discursive themes and techniques contributed to voter response to these initiatives.

Time has come to review the results of this research investigation and its broader implications. This chapter will be organized into three sections. First, the principal findings will be summarized. Second, areas of needed future research will be identified.

Third, elements of the “Orwellian” perspective, a foundation for this as well as for most modern works of political language analysis, will be revisited and reconsidered based on insights gained from the Rhode Island experience.

### **I. Principal Findings**

Previous research in the area of political language has led to a better understanding of the role language plays in the process of public policymaking. Development of important concepts, such as issue framing, problem definition, and the use of symbolism, have broadened awareness of language and the formation of perceptions and policy preferences (see Callaghan, and Schnell, 2005; Rochefort and Cobb, 1994; and Edelman, 1964, among others). To date, however, most research studies in this area have tended to focus selectively, without capturing the multifaceted contributions of language to public policymaking, considering not only public policy origins and content, but also the influence of political leaders and their rhetoric on public opinion and legislative decision-making. To help fill this void, Chapter One of this thesis integrated the political language literature into a “framework of analysis” consisting of the following categories: the “political messenger,” “political message,” and “political response.”

To recap briefly, “political messengers” are those groups and individuals that offer political messages for public consumption. In order to fully understand the use of language in the development of public policy, it is necessary to first determine the goals of the political messenger, the audience for whom messages are intended, and how

language fits into the political messenger's broader political strategy. Such information is helpful in explaining the thought process behind the construction of political language. "Political messages" represent the content of the messages themselves and can be examined along several dimensions. Issue framing and problem definition set parameters around political discourse, shaping perceptions about the scope of policy issues and the appropriate course of government action (see Callaghan, and Schnell, 2005; Rochefort and Cobb, 1994). Symbolism, statistics, and stories are also important aspects of political messages, and are often used to supplement or support broader political messages (See Edelman, 1964; Stone, 2002). Identification of each of these dimensions helps to reveal, and make sense of, the complexity inherent in political language. Lastly, "political response" simply refers to the implications of the use of political language, including its influence in shaping public opinion and the decisions made by lawmakers (see Lakoff, 2002; Schlesinger and Lau, 2005).

Employing this overarching framework of analysis as a guide, Chapter Three undertook an examination of two health policy entrepreneurs distinguished by their field of action. One policy entrepreneur, Lieutenant Governor Elizabeth Roberts, was a government official, while the other, Dr. Nick Tsiongas, operated as a kind of "freelance" health policy activist. This situation provided a natural experiment for considering how a different location within the policy community can lead to distinctive reform strategies. It was also found that the positions occupied by each policy entrepreneur corresponded with starkly different political messages. Exhibit 1 offers an

overview of the differences found to exist between these two policy entrepreneurs operating from inside and outside of government.

Exhibit 1 - Policy Entrepreneurs and the Role of Position in the Policy Community		
	In Government	Outside of Government
<b>Opportunities</b>	Regular access to the media, making it easier to capture public attention Access to industry stakeholders and legislative decision-makers	Ability to promote dramatic reform ideas reflective of personal principles Freedom to meet with supporters in secret and maintain total control over the reform process
<b>Limitations</b>	Need to represent a range of constituent views Expectations of transparency and inclusion in the reform process	Limited access to the media Lack of prestige and recognition that comes with public office
<b>Reform Approach</b>	Public outreach in an attempt to find middle ground and forge consensus	Outreach in concentric circles beginning with core supporters in an attempt to create a movement supportive of reform
<b>Political Message</b>	Carefully worded, moderate language <i>"[Health care reform] can happen if we come together around a table... put aside the rancor, the posturing, the pandering, and the personal agenda, and work together"</i> – Lieutenant Governor Roberts	Bold, attention-grabbing language <i>"The right wing doyens of the market are willing to see increased burdens on our business and taxpayers because they cannot stomach a planned health care system"</i> – Dr. Nick Tsiongas

A key finding of this study, then, is that a policy entrepreneur's position within the policy community is associated with certain opportunities and limitations that shape overall approach to reform. A policy entrepreneur working within government has easier access to the media, industry stakeholders, and legislative decision-makers than one who is not in government. Public office also comes with a certain legitimacy and prestige, making it easier to "command" public attention. Lieutenant Governor Roberts' reform strategy, which consisted of weekly meetings with the major health care stakeholders in the state and a series of neighborhood meetings, clearly reflected her resources as a public official.

As representatives of diverse constituencies, however, public officials are limited by their position in that they may be wary of supporting a reform plan viewed as too radical or disruptive of the status quo. Public officials are also expected to hold

meetings and draft legislation in a transparent fashion, thereby forfeiting a measure of control over the reform process. This was apparent in the legislation put forward by Lieutenant Governor Roberts. The “Healthy Rhode Island Reform Act” was an outgrowth of her community-based meetings and generally considered to be a moderate, incremental approach to reform. Further, Roberts used political language that was carefully constructed, ambiguous in its definition of the problem, and centered on the feel-good principles of unity and bipartisanship.

A policy entrepreneur working from outside of government is not saddled by the limitations that come with public office. As a private citizen, one has the advantage of pursuing a reform solution viewed as controversial. Moreover, someone who does not hold public office has the flexibility to meet in private with like-minded reformers and is not beholden to an election cycle. This freedom of movement was seen in the reform activities of Dr. Tsiongas, who spent the first year of his grassroots effort building support for his policy principles outside of the public eye. The result was a policy position calling for a complete overhaul of the health care system, which was supported by a relatively small, but highly committed political coalition.

A policy entrepreneur who is a private citizen does not have easy access to the media or political powerbrokers in the way that a public official has, making it more difficult to communicate a political message to a wide audience. This low level of public exposure, combined with the freedom to speak for oneself, can induce bold political language calculated to grab attention. Dr. Tsiongas’ use of language, which was highly ideological, partisan, and pointed in its definition of the problem, clearly demonstrated

this phenomenon. Although the resources and limitations that political positioning brought to bear on both Dr. Tsiongas and Lieutenant Governor Roberts led to two very different political messages, both entrepreneurs largely avoided speaking about public policy details. Instead, Roberts and Tsiongas spoke about the generalities guiding their reform initiatives – intentions, objectives, values – a tendency also shared by Governor Carcieri and his administration as they built their case for a Medicaid Global Waiver.

The governor's Medicaid waiver, which was the focus of Chapter Four, was a sweeping initiative marked by the aim of limiting future federal funding for the program in exchange for greater state control over the benefits package, settings of care, and costs to be shared by enrollees. Ultimately, the ability of the governor and his administration to construct a convincing political message contributed to the waiver's passage into law. The strength of the governor's message was twofold. First, the administration was able to effectively link the waiver solution to the budget "crisis." John Kingdon (1995) notes that the ability to connect a policy solution to a problem is crucial to those attempting to advance a reform initiative. Second, while the administration omitted specific policy details, it supplemented the broader crisis narrative with the lure of a precise \$67 million dollars in savings. This strategy made it such that lawmakers were forced to decide between accepting the waiver plan and finding some other way to raise \$67 million.

The administration's linguistic approach made forming an effective opposition message challenging, indeed. Lack of policy substance left those who opposed the waiver with little to critique other than the "risks" associated with deviating from the

status quo. In doing so, opponents employed what Albert Hirschman (1991) describes as “reaction rhetoric.” Despite predictions that the Global Waiver would backfire and harm the very people it was purportedly intended to help, however, lawmakers were not convinced by the opposition message to vote against the waiver. The waiver case illustrates the extent to which strategic political messaging can lead to long-term policy implications. This case also exemplifies what Edelman (1988) describes as a “political spectacle,” one in which the political messengers involved in the waiver debate used language to “legitimize favored courses of action” (p. 104).

Taken together, the two case studies showed that those who are forging health policy reform in Rhode Island, particularly Lieutenant Governor Roberts and Governor Carcieri and his administration, are acutely aware of language and devote time and energy to constructing their political messages. This is a point often assumed, but rarely investigated and confirmed. Roberts noted during an interview that she, along with her staff, “deliberated a lot” over the language describing her health reform goals, and they carefully devised such phrases as the one-line mantra: “All Rhode Islanders would have access to high quality health care they could afford.” Similarly, Governor Carcieri’s communications director revealed during an interview the painstaking process by which he developed and executed the administration’s linguistic strategy, coming up with appealing words and phrases to help sell the waiver proposal to the broader public. The close attention paid by these public officials to political messaging attests to their conviction that language plays a major role in shaping public preferences.

Results from the public opinion poll developed for this thesis added statistical support to this idea. Using political language as an independent variable, an analysis of survey results showed that respondents who accepted a definition of the health care issue as having a strong moral and ethical dimension were significantly more likely to support comprehensive health care reform than those who did not have this belief. Similarly, a statistically significant positive relationship was found between those who viewed the health care system as being in a state of “crisis” and support for comprehensive health care reform. This finding adds empirical weight to the growing body of literature that stresses the connection between problem definition and policy preferences (see also, Rochefort and Donnelly, 2007).

The opinion survey also made it possible to test the qualitative argument of George Lakoff (2002) that the policy preferences of liberals and conservatives reflect these two groups’ differing conceptions of government. Interestingly, most Rhode Islanders, among the most solidly Democratic voters in the nation, say they prefer government to act in a way associated by Lakoff with conservative conceptions. Lakoff’s liberal conceptions of government do, in fact, serve as statistically significant predictors of health policy preferences. For example, those who believe that it is important for government to be “a nurturing source of support” and “a source of guidance and information” – conceptions associated by Lakoff with liberals – were significantly more likely to oppose Governor Carcieri’s Medicaid waiver than those who did not view those as important roles for government. Similarly, a significant positive relationship was found between the belief that it is important for government to be a

“nurturing source of support” and support for a government-run health care system.

However, Lakoff’s conservative conceptions of government were not reliable predictors of policy preferences.

Results of the opinion survey bolster the qualitative arguments made in Chapter Four that the strength of Governor Carcieri’s political message was a contributing factor to passage of the Global Waiver. Each of the following stated goals of the Global Waiver was seen by a majority of survey respondents as being “very important” in health care reform policy: “cutting the cost of government,” “making sure the interests of individuals take priority over those of health care institutions and agencies,” “taxes will not be increased,” “strengthening competition and market forces,” and “striving for innovation.” Evidently, the Carcieri Administration’s careful selection of wording and priorities accurately gauged public sentiment.

## **II. Future Research Directions**

Political language is a complex subject, and this research study has raised as many questions as it has answered. For example, although analysis of public opinion data showed the relationship between political language and favored policy options, it remains unclear to what extent language is more or less predictive of public opinion than the independent variables traditionally associated with policy preferences, such as party identification, gender, and socio-economic status. Further analysis of the survey data gathered for this study could begin to tackle this question.

A related issue for future research is whether dimensions of political language correlate with ideological variables. For example, are those who define health care as a

right simply those who associate themselves with liberal ideology? Likewise, are those who define health care as a personal responsibility simply the same people who believe in a conservative, limited government? This line of inquiry could help sort out whether political language variables are better seen as alternatives to, or intermediaries in, the relationship between ideology and policy choice.

This thesis focused briefly on the political message delivered by *The Providence Journal* regarding the Medicaid waiver, but analysis only captured a small part of the media's role in the state's ongoing policy debate. In order to comprehend the full scope of political language within both policy episodes, all aspects of local media would need to be tracked. In fact, public opinion poll data gathered for this thesis showed that 45 percent of Rhode Island voters receive most of their news from television, 11 percent from radio, and another 11 percent from Internet sources other than newspaper sites. This leaves a great deal of room for future research, even as it pertains to this particular study. Future exploration of the role of the media is important because the media reach a far wider audience than any one political messenger. Also, it is often the case that different media outlets will offer distinct interpretations and opinions of policy issues, thereby adding another important voice to the policy debate.

Little is known about how the use of political language changes over time. The model of political language analysis in Chapter One is actually deficient in that it omits specification of an encompassing cultural and political environment within which the message-messenger-response interaction occurs. Figure 1 illustrates a revised model of political language based on this broader perspective. Where in the culture do shifts in

political language begin? How do political elites gauge the effectiveness of their rhetoric? What are the tools available to organized interests who have their own objectives in molding public perceptions? Answers to these questions could help further elucidate the link between political language and policy change, on the one hand, and important aspects of political culture, on the other.

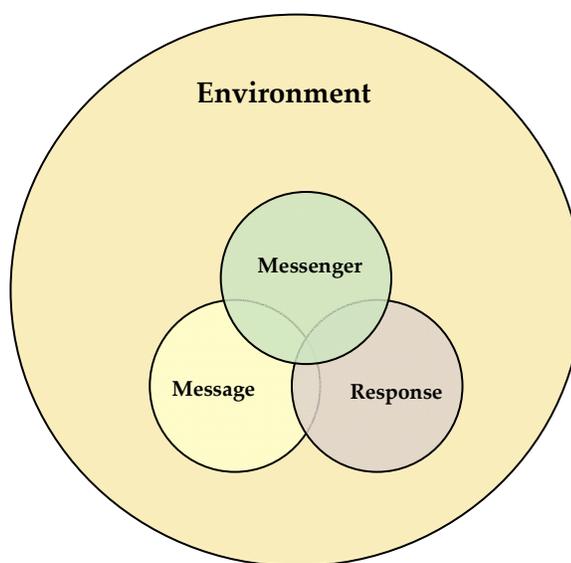


Figure 1: A Revised Model of Political Language

As we have seen, use of public opinion polling to study political language marks a new and useful research approach. Other forms of empirical research also need to be explored. For example, at this point it is difficult to measure the influence of storytelling in policy discourse. Deborah Stone (2002) offers a convincing argument that stories have a powerful impact on how people learn about policy issues, assign causality, and form opinions about the appropriate course for government action. According to survey data

in this study, the majority of respondents said they found stories to be valuable in explaining how individuals would be helped by a new policy. Yet Stone's work could be further investigated using an experimental research design. By exposing groups to various forms of communication, including policy descriptions that feature stories and policy descriptions that do not feature stories, the influence of storytelling to communicate policy details could be isolated and measured. Given the prominence of storytelling in practice, and the importance of narrative within the academic literatures of multiple disciplines, such a study could prove interesting to a range of audiences.

Another methodological approach well suited for the study of political language is use of focus groups. Political consultant Frank Luntz (2007), who is known for his work in this area, draws on this technique to find "words that work" for politicians and businesses alike, but there are additional possibilities for this research method. While public opinion polling may be useful in gauging how respondents react to specific words and phrases, the population survey approach does not allow for in-depth probing of participant responses. In a focus group, participants could be asked to elaborate on what specific words and phrases mean to them. For example, this study found that survey respondents varied their opinions considerably when the word "blame" was replaced with "responsibility" in reference to the problem of uninsurance. What connotations are associated with these words, and what types of emotion do they elicit?

This thesis focused on the development of two areas of health care policy in a single state, but future research could delve into other policy areas at different levels of government. Social issues such as abortion, same-sex marriage, and stem cell research

certainly involve intense debate and layers of complex political rhetoric on all sides. Illuminating the language dimension of these issues could yield new insights about the politics of social issues in the United States. Other policy areas, such as immigration, the war on terrorism, global warming, and the recent economic stimulus, also include many different dimensions of competing political language. The language of these debates could speak volumes about American belief systems and varying perceptions of government.

Thus, in many ways, the conclusion of this study marks a starting point. Despite what has been learned in recent years about the dynamics of political language, it remains an emerging area of study with extraordinary potential for scholarly exploration. Moreover, in an era marked by both the simplicity of the sound byte and the intricacy of policy issues such as health care reform, examining the role that language plays in bridging the gap between “Joe six-pack” and the “policy wonks” suggests an increasingly important avenue of critical analysis. Given both the room for scholarly growth and the promise of practical value, the study of political language is an area that will likely keep political scientists and public policy scholars busy for years to come.

### **III. Orwell Revisited**

Over 60 years ago George Orwell wrote his classic essay, “Politics and the English Language,” in which he lamented the degradation of the English language and chastised scholarly writing for its “staleness of imagery” and “lack of precision” (Orwell,

1946, p. 158). Orwell also used his essay to draw a connection between the decline of the English language and political reality, arguing that the corruption of the latter required the former. He wrote: "In our age there is no such thing as 'keeping out of politics'. All issues are political issues, and politics itself is a mass of lies, evasions, folly, hatred, and schizophrenia. When the general atmosphere is bad, language must suffer" (p. 167).

Thus, viewed from Orwell's perspective, political language both reflects and constructs the political environment in which it is being used. Although Orwell ends his essay on an optimistic note, suggesting that a conscious effort to add precision to language would translate into better politics, he is highly critical of the current state of political language. What, if anything, has changed since Orwell penned his essay urging clarity of political language? How would he react to the types of rhetoric analyzed in this study?

Although we can never know for sure what Orwell might think about the state of today's political discourse, the enduring nature of his thoughts on language and politics makes such speculation an irresistible exercise.

Use of language in the development of health care reform policy in Rhode Island reveals a political atmosphere similar to the one Orwell described in his essay, where ambiguity in language is widespread. Governor Carcieri's senior communications advisor, John Robitaille, made it clear that the employment of ambiguous language to sell the Medicaid Global Waiver was deliberate. Robitaille stated in an interview that "our strategy is to do our very best to simplify the message... to not get into the weeds" (Robitaille, 2009). This approach lays bare the calculated use of amorphous, imprecise language in modern-day political discourse. In a similar fashion, opponents of the

waiver did not offer a substantive critique of the governor's plan; instead, they sowed apprehension about the risks associated with deviating from the status quo. As a result, the outcome of the debate relied heavily on emotion- and value-laden political messages. The language on both sides of the waiver debate represents just the kind of "sheer cloudy vagueness" that Orwell cautioned against (p. 166).

Orwell also bemoaned the pervasive use of "meaningless words" in political discourse, arguing that political language "consists less and less of words chosen for the sake of their meaning, and more and more of phrases tacked together like the sections of a prefabricated hen-house" (Orwell, 1946, p. 159). In interviews with the policy entrepreneurs seeking comprehensive health care reform, both individuals displayed a knee-jerk aversion to using phrases like "universal health care" to describe their policy proposals. The reason cited by both was that, since President Bill Clinton's failed reform effort, they learned to be wary of the negative connotations associated with certain words and phrases in the service of health care reform. It is hard to believe that political discourse has progressed very far since Orwell's time when seemingly innocuous words are considered liabilities rather than modes of communication. Perhaps more importantly, the war of words surrounding comprehensive health care reform has also led to the adoption of phrases that do not make sense, other than in the context of political marketing.

Consider the lieutenant governor's use of the phrase "market-based reform" to describe her health reform proposal. Roberts stated in an interview that she chose the phrase to counter the efforts of her opponents to redefine her plan, "push it to universal

coverage, socialized medicine, et cetera” (Roberts, 2008). Thus, Roberts’ decision to use the phrase was explicitly *not* based on her intent to use a more accurate descriptor for her plan, but instead to use a politically “safe” catchphrase. In doing so, Roberts chose a phrase that completely misrepresents her plan—she actually favors a government-run “Health Hub,” an individual and employer mandate, and a strong role for the health insurance commissioner to approve or disapprove increases in health insurance premiums. It is unlikely these features would fit comfortably with most people’s perception of a “market-based reform.”

In “Politics of the English Language,” Orwell noted similar “abuse” of the word “democracy”: “It is almost universally felt that when we call a country democratic we are praising it: consequently the defenders of every kind of regime claim that it is a democracy, and fear that they might have to stop using that word if it were tied down to any one meaning” (p. 162). “Words of this kind,” Orwell wrote, “are often used in a consciously dishonest way. That is, the person who uses them has his own private definition, but allows his hearer to think he means something quite different” (p. 162). There seems little doubt that Orwell would include “market-based reform” among the contemporary political phrases that are “almost completely lacking in meaning” and thus entirely unhelpful in advancing the level of political discourse.

The lieutenant governor was not alone in her use of “meaningless” words to advance reform. Dr. Tsiongas noted in an interview that he deliberately chose the phrase “central purchaser” to characterize the role of government in his health reform plan so as to avoid the label of single-payer or government-run health care (Tsiongas,

2008). While this may have been a politically expedient choice, few would have any idea what role a “central purchaser” would play in the state’s health care system. Similarly, the Carcieri Administration described the waiver proposal using such positively charged words as “person-centered” and “flexible.” Not only is it doubtful that anyone would be in favor of a system that is “person-neglectful” and “rigid,” it is equally unlikely that anyone could explain precisely what each of these phrases means in terms of specific policy changes. These are but a few of the many examples of imprecise and meaningless phraseology identified in previous chapters, but they serve to illustrate the pervasive abuse of language castigated by Orwell so many years ago.

Poor use of the English language was only part of what Orwell warned against, however. He also claimed that “the slovenliness of our language makes it easier for us to have foolish thoughts” (Orwell, 1946, p. 157). Orwell’s essay was not simply a guide to better writing and speaking, he also used it to draw a connection between the decline of language and an inability to engage in constructive political discourse. The connection between language and thought was only a subtle part of Orwell’s essay, but he made this point more powerfully in his novel *1984*, published only a few years after “Politics and the English Language.”

In *1984*, Orwell wrote about a fictitious society ruled by a repressive, totalitarian regime. The novel is best known for its portrayal of government as “Big Brother” that controls every aspect of political and social life. One way in which the government controls thought in *1984* is through promotion of a new language called “newspeak.” Newspeak includes a reduced vocabulary consisting largely of empty euphemisms in

order to quell dissent and prevent debate among the populace. The popularity of Orwell's thesis has made it such that critics often charge government officials with the deliberate use of language as a means of manipulating public opinion (see Szanto, 2007).

The point was made earlier in this thesis that one must be careful of making accusations of calculated deceit without confirming intent, and no evidence of such diabolical scheming was uncovered in this thesis. However, the political messengers included in this study often chose their language based on symbolic appeal, not its ability to clearly communicate policy details, and the language resulting from this approach often resembled Orwell's newspeak. Recall the Carcieri Administration's use of the terms "cost-sharing" and "smart payments" to describe the imposition of co-pays and increased monthly premiums for Medicaid beneficiaries. Though evidence of deliberate deception was not uncovered, the use of such terms clearly amounts to an effort to quell potential opposition to the governor's proposal.

It was also argued earlier that the "strong version" of Orwell's thesis – that political thought is *determined* by the use of targeted political language – is saying too much. Michael Geis (1987) suggests a "softer" version of Orwell's thesis, that language influences what people think only when the political premise of that language is accepted uncritically. Similarly, Murray Edelman (1964, 1988) argues that most people have a "mythic" view of politics, and that the language used by political messengers simply evokes preexisting assumptions. In other words, the way people perceive language is based largely on their preexisting worldviews, and not molded from scratch by the creative use of language.

Recent work by George Lakoff (2002) has advanced this idea, arguing that political messages evoke policy preferences from preexisting cognitive frameworks. Reflecting on Orwell's "Politics and the English Language," Lakoff notes that "Orwell's essay belongs to an earlier time, a time that lacked our deepening understanding of how the human brain works" (Lakoff, 2007, p. 67). According to Lakoff, Orwell was wrong in assuming that the use of precise political language would lead to decisions being made based on logical thinking. That is because "98 percent" of reasoning is unconscious and "inherently emotional" (p. 68). Far from being a rational process, thought is structured in terms of frames, metaphors, and narratives, which connect to "high-level moral worldviews" (p. 69). These worldviews are modes of reasoning that tell us what is right and wrong. Viewed from Lakoff's perspective, the relationship between politics and language is much more complex than Orwell could have known.

A more sophisticated reading of Orwell's thesis could be useful in directing scholarly attention toward language that might otherwise be considered mundane, or simply part of established vernacular. Describing health care as a "right," for example, might not be considered "Orwellian," but analysis of public opinion data collected for this thesis showed that use of this term is significantly correlated with an increased preference for comprehensive health care reform. Use of similar terminology, such as "personal responsibility," "choice," and "competition," often go unchallenged, or even unnoticed, during the course of policy debates, but based on the preliminary finding of this study, the ability of these words to evoke calculated policy preferences could be substantial.

Modern political science has greatly advanced the study of political language since Orwell's time. New concepts, such as framing, problem definition, causal stories, and the like allow for a more systematic examination of the type of political language Orwell railed against. Armed with these new tools, political scientists and other critical analysts have greater means to illuminate the language dimension of public policymaking, and to draw connections between the use of language and the formation of policy preferences. Statistical analysis, focus groups, and experimental research methods further our capacity to understand the role language plays in the creation of public perceptions. A more advanced appreciation of the dynamics of political discourse may not lead to better use of the English language, as Orwell once hoped, but there is reason to be optimistic that critical analysis of the sort he prescribed will lead to heightened awareness of the role of language in politics.

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**APPENDIX A**

Interview Questionnaire

**Interview with Lt. Governor Elizabeth Roberts**  
**December 4, 2008 at 8:30 AM**

**Section I**

1. I requested an interview with you because I know that you spend considerable time and energy advocating for health care reform in Rhode Island, and have a unique vantage point from which to survey the health reform landscape. Let me begin by asking, what has motivated you to become so active in the area of health care reform?
2. What do you think are the most pressing problems facing Rhode Island's health care system today?
  - a. Follow-up: What do you think the primary causes of these problems are?
3. Describe the process of how your reform proposal (Healthy Rhode Island Reform Act) was developed. For example, how was it conceived of, how has it been shaped over time, and who (other than you) has contributed to its development?
4. Some of the components passed, some did not. What are the next steps in order to move toward comprehensive health care reform?
5. How do you view your role in the broader effort to achieve comprehensive health care reform in Rhode Island, and what are some of the activities you are involved with to help move closer to your goal?
6. Having worked in both the legislature and the executive branch, what are some of the advantages and disadvantages that come with trying to influence health care reform from each branch of government?
  - a. Follow-up: Would the reform package you presented have looked different if you were advocating for reform from outside of government or from the legislature?
  - b. Follow-up: Do you feel limited at all in terms of what you can achieve in your current position?
7. As you might know, Dr. Nick Tsiongas and the coalition he leads (HealthRIght) are also pursuing their own health care reform proposal. How do you view the consequences – both positive and negative – of their reform efforts on your own goals?
  - a. Does he have an advantage?

**Section II**

8. One of the challenges of implementing a major new reform initiative is convincing people that it is a good idea. What did you say to lawmakers, voters, and stakeholders as you were working to convince them that the Healthy Rhode Island Reform Act is the right solution for Rhode Island?
  - a. Follow-up: In what ways did the language you use vary depending on the group you were speaking with?

9. Advocates for reform often seek outside guidance, such as polling results or focus group data, in an effort to select words and phrases that resonate with the majority of people. What kind of rhetorical advice (or at least deliberation) was included in the process of drafting and presenting the Healthy Rhode Island Reform Act?
  - a. Follow-up: Have you ever considered a PR strategy?
  - b. Follow-up: What are some of the words and phrases that you have used in advocating for the Healthy Rhode Island Reform Act?
10. Describe the process of how you came up with and decided on the name Healthy Rhode Island Reform Act.
  - a. Follow-up: Were there any other names in the running that were rejected?
11. What types of groups in Rhode Island offered opposition to your reform proposal, and how did they frame your policy solution?
  - a. Follow-up: How did they frame the two aspects of your reform package (Hub and Mandate) that did not pass?
  - b. Follow-up: Did such criticisms (or the prospect of them) alter the way you presented your reform proposal?
  - c. Follow-up: Do you think these could have passed had they been framed differently?
12. In creating the Healthy Rhode Island Reform Act, I know that you have gained advice from a wide variety of groups (Mission: Healthy RI), including business, labor, insurers, providers, academics, etc. How do each of these groups “frame” the debate?
  - a. Follow-up: In what ways do the rhetoric you employ, your presentation style, and your overall communication strategy differ when presenting your reform proposal to each group?
  - b. Follow-up: Do you make an effort to consult with someone who “talks their language” before approaching a new group?
13. Sometimes the most interesting aspect of political language is what is *not* said. What are some words or phrases that you deliberately avoided using when speaking about your health care reform proposal?
  - a. Follow-up: How did you learn to avoid using those words?
14. The language used in politics is often marked by ambiguity, sometimes out of necessity and sometimes because of strategy. Can you give an example of when you replaced precision with ambiguity in presenting your policy ideas?
  - a. Follow-up: What do you think are the benefits and drawbacks to this strategy?
15. How did Rhode Island’s reoccurring budget deficit affect how you discussed reforming the state’s health care system?
  - a. Follow-up: Do you find that people are more or less open to comprehensive reform when you refer to the budget “crisis?”
16. When you are constructing your narrative about the need for health care reform in Rhode Island, and how your ideas will work, who are you primarily gearing your message to?

- a. Follow-up: What is the desired reaction?
- 17. Based on your experience, do you think people respond better to symbolic gestures, such as appeals to ideology, values, and so on, or specific policy details when you are talking about your health care reform ideas?
  - a. Follow-up: What have you found to be the pitfalls of using one strategy versus the other?
- 18. States all around the country have enacted, or are actively considering, bold health care reforms – Rhode Island’s next-door neighbor being one of the most notable, and one that I know you have studied closely. How have the health reforms in other states impacted the rhetoric surrounding health care reform in Rhode Island?

### Section III

- 19. You spent a lot of time framing your own policy proposal as a champion of reform. In a reverse role, you have made your opposition to another reform solution, the Medicaid waiver, pretty clear. How has the rhetoric you have used changed in this role?
- 20. Proponents of the waiver have argued that one of the reasons it should pass is because of the state’s budget deficit. You have said that, “The risks and unknowns of this Global Waiver as presented are too great for our state to bear at this crucial financial crossroads.” This is in direct opposition to how proponents view the waiver in the context of the state’s budget situation.
  - a. Follow-up: How do you convince the public who is right when you are both using the same bargaining chip?
  - b. Follow-up: How do you win that debate, is it best to use fact-based appeals, symbolism, or ideology?
  - c. Follow-up: Does your rhetorical strategy depend on who you are talking to?
- 21. During the presidential debates, Tom Brokaw asked the candidates if they thought health care was a “right” or a “responsibility.” How would you have answered that question?
  - a. Follow-up: What do you think are the consequences of describing health care as a right or responsibility?
  - b. Follow-up: How important do you think it is for Rhode Islanders to view health care in the same way as you if they are going to support your reform proposal?

Interview Questionnaire

**Interview with Gary Alexander, Director of the Rhode Island Department of Human Services**

**December 3, 2008 at 8:00 AM**

**Section I**

1. Why is Rhode Island's Medicaid program in need of reform?
  - a. Follow-up: What are some of the problems that have been brought on by the current system?
2. How will the Global Waiver help to address these problems?
  - a. Follow-up: What are the alternatives to this solution, and why is the waiver the best?
3. Describe the process of how the Global Waiver was developed. For example, how was it conceived of, how has it been shaped over time, and who has contributed to its development?
4. How has your involvement with the Global Waiver evolved throughout this process?
5. What role did the state's budget crisis play in the decision to move forward with the waiver proposal?
  - a. Follow-up: In your opinion, would the waiver have been submitted if Rhode Island were not facing recurring budget deficits?

**Section II**

6. One of the challenges of implementing a major new reform initiative is convincing people that it is a good idea. What have you said to lawmakers, voters, and stakeholders in the health care system to convince them that the Global Waiver is the right solution for Rhode Island?
  - a. Follow-up: In what ways does the language you use vary depending on the group you are speaking with?
7. Advocates for reform often seek outside guidance, such as polling results or focus group data, in an effort to select words and phrases that resonate with the majority of people. What kind of rhetorical advice (or at least deliberation) was included in the process of drafting and presenting the Global Waiver?
8. You have used the words "flexibility," "predictability," "person-centered," "re-balancing" and other positively charged words to characterize certain aspects of the waiver proposal. Were these deliberately chosen words?
  - a. Follow-up: Given that we are in a "sound-bite" era of politics, what are some of the words and phrases that you think best characterize the Global Waiver?
9. The waiver has been named the Global Consumer Choice Compact Medicaid Waiver, and more recently it has also been presented as the Global Consumer Choice Compact *to Health* Medicaid Waiver. Why the change?
  - a. Follow-up: Describe the process of how the waiver got its name.

10. Sometimes the most interesting aspect of political language is what is *not* said. What are some words or phrases that you deliberately avoid using when speaking about the waiver proposal?
  - a. Follow-up: How did you learn to avoid using those words?
11. The language used in politics is often marked by ambiguity, sometimes out of necessity and sometimes because of strategy. Can you give an example of when precision has been replaced with ambiguity in presenting the Global Waiver?
  - a. Follow-up: What do you think are the benefits and drawbacks to this strategy?

### Section III

12. Given some of the problems you outlined, why do you think no one else has offered a solution?
13. Has the lack of other solutions made it easier or more difficult to define your plan?
14. What types of groups in Rhode Island have offered opposition to the waiver, and how do they describe the various components of it (i.e. “risky,” and “uncertainty” are commonly used)?
  - a. Follow-up: Why do you think they settled on those words? Do you hear them often?
  - b. Follow-up: Have such criticisms altered the way you talk about the Global Waiver?
15. Do you feel that you are more on defense or offense when talking about the waiver proposal?
16. Lieutenant Governor Elizabeth Roberts said during the summer that “The risks and unknowns of this global waiver as presented are too great for our state to bear at this crucial financial crossroads.” This is in direct opposition to how you view the waiver in the context of the state’s budget situation.
  - a. Follow-up: How do you convince the public who is right when you are both using the same bargaining chip?
  - b. Follow-up: How do you win that debate, is it best to use fact-based appeals, symbolism, or ideology?
  - c. Follow-up: Does your rhetorical strategy depend on who you are talking to?
17. When you are constructing your narrative, who are you primarily gearing it toward?
  - a. Follow-up: Assuming the waiver gets approved by CMS will your narrative have to change?
18. When you write an editorial, or speak to the media what is the message you are trying to convey about the waiver proposal?
  - a. Follow-up: What components of the waiver do you feel are most important to convey?

**APPENDIX B**

### **List of Interviews**

Gary D. Alexander, Director of Rhode Island's Department of Health and Human Services, December 3, 2008.

Ted Almon, CEO of the Claflin Co., January 15, 2009.

Donald L. Carcieri, Governor of Rhode Island, March 20, 2009.

Timothy M. Costa, Director of Policy for Governor Donald L. Carcieri, April 2, 2009.

Marie Ganim, PhD, Director of Policy for the Rhode Island Senate, January 12, 2009 and June 17, 2009.

David Gifford, M.D., Director of the Rhode Island Department of Health, March 31, 2009.

Linda Katz, co-founder and Policy Director of the Poverty Institute, April 23, 2009.

Christopher Koller, Rhode Island Health Insurance Commissioner, February 2, 2009.

Karen Malcolm, Executive Director of Ocean State Action, January 28, 2009.

Daniel J. Meuse, Deputy Chief of Staff to Lt. Governor Roberts, December 4, 2008.

Josh Miller, Rhode Island State Senator, February 25, 2009.

Craig O'Connor, Senior Advocacy Coordinator, Neighborhood Health Plan of Rhode Island, February 19, 2009.

Elizabeth Roberts, Lieutenant Governor of Rhode Island, December 4, 2008.

John Robitaille, Senior Communications Advisor to Governor Donald L. Carcieri, April 2, 2009.

Nick Tsiongas, M.D., Former President of the Rhode Island Medical Society, November 17, 2008.

**APPENDIX C**

**Public Opinion on Health Care Reform in Rhode Island**  
**April 2009**

Hello, my name is \_\_\_\_\_ and I'm calling from Quest Research, the public opinion firm in Greenville, RI. We're calling for Northeastern University and we'd like to include you in a poll on health care issues in Rhode Island. You must be at least 18 years old to participate in this survey and it should take approximately 10 minutes. Your responses will be anonymous and no one, including the researchers, will know whose answers these are. Also, you don't need to answer any questions you choose not to. There are no direct benefits to you for participating in this study, but the results may shed light on public attitudes regarding health care reform. If at any time you have questions, we can give you contact information for the researchers in this study.

1. Of the following public issues in Rhode Island, which two do you think deserve to have the highest priority for government to work on?

(INTERVIEWER: RANDOMLY ROTATE BEGINNING POINT OF LIST)

- |                           |                    |
|---------------------------|--------------------|
| (1) Education             |                    |
| (2) Crime                 |                    |
| (3) Lowering taxes        |                    |
| (4) Government corruption | Two choices: _____ |
| (5) Health care reform    |                    |
| (6) The environment       | _____              |
| (7) Housing               |                    |
| (8) Jobs and the economy  |                    |

2. To what extent do you think the following roles are important for government to play? Please tell me if you think each is very important, somewhat important, or not important.

	Very important	Somewhat important	Not Important	DK
A strict enforcer of right and wrong	_____	_____	_____	_____
A nurturing source of support	_____	_____	_____	_____
A strong protector from danger	_____	_____	_____	_____
A source of guidance and information	_____	_____	_____	_____

3. Which one of these following statements do you think best describes the health care system in Rhode Island today?

- (1) It is in a state of crisis
- (2) It has major problems

- (3) It has minor problems
- (4) It does not have any problem
- (5) Don't know

4. In Rhode Island and elsewhere, the idea of health care reform usually focuses on two main objectives: expanding health insurance coverage and controlling health care costs. Please tell me if you agree or disagree with each of the following statements about health policy making in the state at this time: (INTERVIEWER: ROTATE ORDER)

	Agree	Disagree	Unsure
The Carcieri Administration is doing enough about health care reform at this time.	___	___	___
The General Assembly is doing enough about health care reform at this time.	___	___	___
The state's current budget deficit makes it impossible to consider any new public health programs at this time.	___	___	___
Even though the state has a large deficit, an important new health program could be funded if priorities were shifted.	___	___	___
A very good use of part of Rhode Island's share of federal stimulus money would be to expand health care coverage.	___	___	___

5. How much do you trust that the following types of people are acting in your best interest when it comes to reforming Rhode Island's health care system? Please tell me whether you trust them a lot, somewhat, or not all.

	A lot	Somewhat	Not at all	DK
The Governor	___	___	___	___
The Lieutenant Governor	___	___	___	___
A health care advocate	___	___	___	___
The President of the Rhode Island Medical Society	___	___	___	___
The head of a health insurance company	___	___	___	___

A labor union leader                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_

A business leader                        \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_

6. How effective do you think Rhode Island state government has been in addressing health care problems in this state?

- (1) Very effective
- (2) Somewhat effective
- (3) Not at all effective
- (4) Don't know

(INTERVIEWER: FOR ALL EXCEPT THOSE WHO ANSWERED "VERY EFFECTIVE," ASK THEM 6a)

6a. To what extent do you think each of the following groups is to blame for the fact that government action on health policy problems in Rhode Island has not been more effective to date?

	A lot of blame	Some blame	No blame	DK
The Governor and his Administration	_____	_____	_____	_____
The General Assembly	_____	_____	_____	_____
Union organizations	_____	_____	_____	_____
The business community	_____	_____	_____	_____
Health insurers	_____	_____	_____	_____
The general public	_____	_____	_____	_____
Community advocacy organizations	_____	_____	_____	_____
Private market advocates	_____	_____	_____	_____

7. With the federal government now considering health reform legislation, should Rhode Islanders be more or less interested in what neighboring states like Massachusetts are doing in the area of health policy?

- (1) More interested
- (2) The same
- (3) Less interested
- (4) Don't know

8. What would you say is the most appropriate role for Rhode Island policymakers in regard to health care reform now that new proposals are being considered on the federal level in this area?

- (1) Do nothing while adopting a wait-and-see attitude toward federal action.
- (2) Work on a comprehensive reform without assuming a new federal policy will be passed.
- (3) Work on problems in the health care system that are not likely to get addressed by a federal law.

9. To what degree do you worry about any of the following concerns when it comes to adoption of a new federal health reform policy? (INTERVIEWER: ROTATE ORDER)

	Worry A Lot	Worry Somewhat	No Worry Worry at all	Don't Know
Important differences in values across states will not be recognized.	_____	_____	_____	_____
Important differences in the organization of health care across states will not be recognized.	_____	_____	_____	_____
The policy may sound good, but it will be too difficult to implement on the state level.	_____	_____	_____	_____
States will be stuck with too much of the cost.	_____	_____	_____	_____
State officials will not be given enough authority in operating the system.	_____	_____	_____	_____
Political corruption could interfere once the new policy arrives on the state level.	_____	_____	_____	_____
Existing local programs that work well could be damaged.	_____	_____	_____	_____
The program's future will depend on uncertain political developments on the federal level.	_____	_____	_____	_____

10. Please tell me whether you agree or disagree with the following statement: Despite any worries I have about health care reform on the federal level, I am hopeful that national leaders will take quick action in this area.

- (1) Agree
- (2) Disagree

(3) Don't know

**11.** RIte Care is Rhode Island's public health insurance program for low-income families and children. How important do you think it is for state government to continue to support this program?

- (1) Very important
- (2) Somewhat important
- (3) Not at all important
- (4) Don't know

**12.** As you may know, Governor Carcieri and the state legislature recently passed a "Medicaid Global Waiver." How much have you heard or read about this Medicaid Waiver? Would you say a great deal, quite a bit, just some, only a little, or nothing at all?

- (1) A great deal
- (2) Quite a bit
- (3) Just some
- (4) Only a little
- (5) Nothing at all
- (6) Don't know

**13.** To review briefly, the Governor's Medicaid Waiver agrees to limit future federal funding for this program in exchange for greater state control over the benefits package, settings of care, and costs to be shared by enrollees. Based on what I've just told you, do you support or oppose the Governor's Medicaid Waiver plan?

- (1) Support
- (2) Oppose
- (3) Don't know

**14.** Generally speaking, what is most important to you when you're deciding whether to support a new government proposal?

- (1) Detailed information about the proposal
- (2) A statement of principles underlying the proposal
- (3) Don't know

**15.** Public officials and other leaders often use stories to explain how individuals would be helped by a proposed new policy. To what extent do you find such stories valuable as you decide whether to support a proposal? They are...

- (1) Very valuable
- (2) Somewhat valuable
- (3) Not valuable at all
- (4) Don't know

**16.** For each of the following list of statements about health care reform, please tell me if you agree, feel neutral, or disagree. (INTERVIEWER: ROTATE ORDER)

	Agree	Neutral	Disagree	DK
Health care coverage is a right that no one should be denied.	_____	_____	_____	_____
Most people without health insurance are not personally responsible for having this problem.	_____	_____	_____	_____
If there is going to be new health reform legislation, it should be done on the state level rather than federal level.	_____	_____	_____	_____
Health care reform should be seen by state policymakers as a moral issue.	_____	_____	_____	_____

**17.** Which approach best describes your own preference for the direction health care reform should take?

- (1) A government-run health care system
- (2) A private market-driven health care system
- (3) A continuation of our current public/private balance in health care

**18.** Which of the following aspects of health care policy have become more or less important due to current economic conditions?

	More Important	Less Important	The Same
Insurance coverage for everyone	_____	_____	_____
Cost-containment	_____	_____	_____
Quality improvement	_____	_____	_____
Personal responsibility for one's health	_____	_____	_____
Administrative efficiency	_____	_____	_____
More patient cost sharing	_____	_____	_____

through co-pays and deductibles

\_\_\_\_\_

Convenience of services

\_\_\_\_\_

**19.** To what extent do you think the following goals are important in health care reform?

	Very important	Somewhat important	Not Important	DK
Cutting the cost of government	_____	_____	_____	_____
Making sure the interests of individuals take priority over those of health care institutions or agencies	_____	_____	_____	_____
Taxes will not be increased	_____	_____	_____	_____
Strengthening competition and market forces	_____	_____	_____	_____
Striving for innovation	_____	_____	_____	_____
Preserving what already works in the health care system	_____	_____	_____	_____
Expanding government's oversight role	_____	_____	_____	_____

**20.** Do you personally have health insurance?

- (1) Yes
- (2) No
- (3) Don't know

(INTERVIEWER: FOR THOSE WHO SAY YES ASK THEM **20a**, **20b**, and **20c**)

**20a.** Are you in the RItE Care program?

- (1) Yes
- (2) No
- (3) Don't know

**20b.** How concerned are you that you personally might lose your current health insurance coverage?

- (1) Very concerned

- (2) Somewhat concerned
- (3) Not too concerned
- (4) Not concerned at all
- (5) Don't know

**20c.** How concerned are you that the cost of your health care coverage might go up?

- (1) Very concerned
- (2) Somewhat concerned
- (3) Not too concerned
- (4) Not concerned at all
- (5) Don't know

**21.** Which following statement accurately describes the overall level of health insurance coverage inside your household?

- (1) Everyone in the household has health insurance coverage
- (2) Some people in the household have health coverage and some currently do not have coverage
- (3) Nobody in the household currently has health coverage
- (4) Don't know

**22.** Now thinking about your own health status – in general, would you say your health is...

- (1) Excellent
- (2) Good
- (3) Fair
- (4) Poor

**23.** In the past 12 months, have you or a member of your family put off any sort of medical treatment because of the cost you would have to pay?

- (1) Yes
- (2) No
- (3) Don't know

**24.** Do you currently have any medical bills you are paying off over time?

- (1) Yes
- (2) No
- (3) Don't know

**25.** Would you estimate that you spent more than 10% of your annual income for health care services last year in out-of-pocket costs, that is, without counting any money that you may have also paid for the purchase of health insurance?

- (1) Yes
- (2) No

- (3) Don't know

I JUST HAVE A FEW FINAL QUESTIONS TO HELP US WITH OUR ANALYSIS.

**26.** Where would you say that you receive most of your news?

- (1) Television
- (2) Newspapers, either in print or online
- (3) Radio
- (4) Other Internet news sources
- (5) Don't know

**27.** How regularly do you read the Providence Journal?

- (1) Daily
- (2) More than once a week
- (3) Once a week
- (4) A few times a month
- (5) Never

**28.** To what extent do you think the Providence Journal is a credible source of news coverage? Do you think it is...

- (1) Very credible
- (2) Somewhat credible
- (3) Not credible at all
- (4) Don't know

**29.** Have you ever read the editorial page of the Providence Journal?

- (1) Yes
- (2) No
- (3) Don't know

(INTERVIEWER: FOR THOSE WHO SAY YES ASK THEM **29a** and **29b.**):

**29a.** Do you feel that Providence Journal editorials are generally conservative, neutral, or liberal in political point of view?

- (1) Conservative
- (2) Neutral
- (3) Liberal
- (4) Don't know

**29b.** How often would you say Providence Journal editorials influence your opinion on matters of public policy like health care?

- (1) Very often
- (2) Sometimes
- (3) Never

(4) Don't know

30. Which political affiliation do you generally favor?

- (1) Democrat
- (2) Republican
- (3) Independent
- (4) Other

31. Politically speaking do you consider yourself to be...

- (1) Liberal
- (2) Moderate
- (3) Conservative
- (4) Don't know

32. What is your age category? Please tell me when I read the one that applies to you?

- (1) 18-24
- (2) 25-34
- (3) 35-44
- (4) 45-54
- (5) 55-64
- (6) 65 and over
- (7) Don't know/Refused

33. What is the last year of schooling that you have completed?

- (1) Below high school
- (2) High school/GED
- (3) Some college/technical training
- (4) Bachelors degree
- (5) Graduate or professional training

34. Does your annual household income fall within:

- (1) \$0-20,000
- (2) \$20,001-40,000
- (3) \$40,001-60,000
- (4) \$60,001-80,000
- (5) \$80,001-100,000
- (6) Over \$100,000
- (7) Don't know

(INTERVIEWER: PLEASE MARK GENDER)

Male\_\_\_\_\_

Female\_\_\_\_\_