REPRESENTATIONS OF THE AFFORDABLE CARE ACT IN OKLAHOMA GOVERNMENT PRESS RELEASES 2010 TO 2015

By

ELIZABETH G. ARMSTRONG

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Oklahoma State University

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Thesis Approved:

Dr. Rebecca Sheehan

Thesis Adviser

Dr. Tom Wikle

Dr. Eve Ringsmuth

Committee

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Name: Elizabeth G. Armstrong

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Abstract:

In 2010, the Affordable Care Act (ACA) passed, expanding healthcare access to all uninsured U.S. citizens. Specific provisions included expanding Medicaid coverage to individuals with incomes up to 138% of the Federal Poverty Line (FPL) and providing federal subsidies to purchase private health insurance to individuals with incomes between 100% and 400% of the FPL. Despite Oklahoma's 18% medically uninsured rate, Oklahoma legislators opted to deny expansion and its associated federal funds to expand healthcare services within Oklahoma. This decision by lawmakers to deny healthcare expansion, juxtaposed next to Oklahoma's historically unhealthy population, suggests the need to examine Oklahoma's political representation of underinsured citizens through government press releases.

Accordingly, I use discourse analysis to review press releases retrieved from government websites between 2010 and 2015. I use these press releases to determine how government media and individual legislators use political, economic, or social themes to garner support for or against ACA expansion and associated healthcare reforms. I then relate this information to the voting patterns, distribution of underinsured constituencies, and the overall health status of Oklahoma. This analysis shows government media and Oklahoma legislators discuss healthcare reform to address constituency needs and interests concerning healthcare reform in Oklahoma between 2010-2015.

This study may be used to encourage legislative and constituency awareness of healthcare issues in Oklahoma. It also reveals important information for constituencies about how media and legislators tailor their political discussions to garner support for political positions that may or may not represent Oklahoma's best interests. The context of this research rests in both health and political geographies, as the issue of healthcare policy is specific to place and maintains a mutually constitutive relationship between its development, government, and the people.

Key Words: Affordable Care Act, Oklahoma

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CHAPTER I

INTRODUCTION

In 2010, the Patient Protection and Affordable Care Act (PPACA), later known as the Affordable Care Act (ACA) passed, expanding healthcare access to all uninsured U.S. citizens. ACA healthcare expansions included multiple programs to expand health insurance coverage. Three specific provisions included expanding Medicaid coverage to individuals with incomes up to 138% of the Federal Poverty Line (FPL), providing federal subsidies to purchase private health insurance to individuals with incomes between 100% and 400% of the FPL, and extending affordable health insurance coverage to those with pre-existing conditions. However, due to the polemical nature of the ACA, many conservative states, traditionally identified as "southern states," voted against the ACA (Frakt and Carol 2013). As one of these conservative states, Oklahoma opted to deny ACA expansion and associated federal funds to expand healthcare services in Oklahoma, despite Oklahoma's 18% medically uninsured rate. This decision by lawmakers to deny ACA expansion, juxtaposed to Oklahoma's historically unhealthy population, suggests the need to examine the state's political representation of underinsured citizens, an avenue of which is through government press releases.

Accordingly, I develop my research on two main premises: 1) Every person needs healthcare services, and 2) healthcare is not intrinsically linked to economic or political interests. However, I recognize the unique and often polemical connections between healthcare, economics and policy in the U.S. As such, I use discourse analysis to examine the political, economic, and social themes Oklahoma government media offices and key legislators use to frame their position for or against ACA and its associated Medicaid expansion in Oklahoma between 2010-2015. I also examine the discourse surrounding state-based topical healthcare reforms developed as a byproduct of the fluid development of the ACA.

In Chapter Two, I include a literature review that defines and contextualizes terms such as healthcare, FPL, Medicaid and the ACA. I then explain how "need" for healthcare reform emerged, outlining the political nature of healthcare reform in the U.S. Lastly, I elaborate on the role of political figures and media in influencing public opinion. Then, I explain Oklahoma's healthcare situation as a good case study for political representation research. Next, in Chapter Three, I explain my methods including data collection, data analysis using GIS and discourse analysis, and the means of disseminating my analyses. In chapters four and five I discuss the results of my research. Lastly, in chapter six I conclude with the implications of my findings.

In Chapter Four, I assess how press releases from the governor's, senate and house offices guide the interpretation of ACA expansion in Oklahoma. In Chapter Five, I show how select legislators, key in healthcare policy discussions, influence healthcare reform in Oklahoma. In each of these discussions, I analyze how particular ideas and information (as well as the omission of these) create overarching political, economic, and social themes by

which Oklahoma government guides public opinion on healthcare policy. I discuss how press release and legislator's partial coverage results in imbalanced healthcare policy production in Oklahoma. I also discuss how balanced coverage might improve the health of Oklahomans across the state or how the use of certain types of rhetoric may encourage greater legislative support.

Lastly, in Chapter Six, I discuss the implications of my findings, with consideration about how both government press releases and legislators' interpretations of ACA reforms have shaped the information made available to the public. I also consider how this has the potential to influence the public's perception of healthcare policy. I end my conclusion with suggestions concerning how lobbyists and policy makers may use my research to create more balanced coverage of policy discussions and discuss how imbalanced coverage fosters support for political positions. In the case of my research, I include suggestions that could foster policy decisions to create a healthier Oklahoma. I conclude with suggestions for later studies that can add to my research.

CHAPTER II

LITERATURE REVIEW

Health Geography, Health and Healthcare

Health geography establishes a connection between health outcomes and place using a combination of environmental, cultural, and socio-political factors (Gregory, et al. 2009). As a sub-discipline of medical geography, health geography focuses on how daily life affects overall health outcomes concerning factors such as income, educational attainment, healthcare access, healthcare markets, health insurance policies, etc. Two words that are commonly used when discussing factors of health geography are "health" and "healthcare." These terms are different yet connected.

According to Merriam Webster, the definition of health is, "the general condition of the body" (Merriam-Webster 2015). Conversely, the definition of healthcare remains, "Efforts made to maintain or restore health especially by trained and licensed professionals" (Merriam-Webster 2015). The definition of "health" indicates an individual state of wellness whereas "healthcare" involves a connection between people, for instance, the patient-provider relationship. In the U.S. however, healthcare markets, via health insurance companies, broker the patient-provider, healthcare service relationship.

Healthcare Service in the U.S.

In the U.S., health insurance companies operate on independent free-market principles that allow health service managers to determine service prices without, as Scott et al. (2001) discuss, a true market-value. In other words, this means that market participants (patients) lack the ability to change healthcare markets because these markets lack feedback mechanisms present in regular economic practice. As such, regular rules of economics cannot apply to healthcare markets (Scott et al. 2001). Thus, since everyone in the U.S. must buy into a fixed healthcare market, healthcare industries can price services for elevated profit rather than consumer benefit. Many hospital leaders recognize the inability of consumers to effectively navigate healthcare prices but do not believe that current healthcare systems are equipped to handle empowered consumers (Anonymous 2006). Additionally, Mills (2016) outlines the implications of the McCarran-Ferguson Act of 1945, which made insurance companies exempt from federal regulation. He goes on to discuss the implications of this legislation that supports fixed pricing, effectively disabling a system of competitive pricing for expensive programs such as Medicare in contrast to agencies such as the Veterans Administration and Medicaid that maintain an ability to negotiate prices.

The Nature of Privatized Healthcare Pricing in the U.S.

Due to a combination of these economic factors, the United States, on average, spends more on its healthcare per individual than any other nation (Ciric 2012; Kane 2012). This spending, however does not relate to the average quality or quantity of care received but instead to economic and social factors. Ritzer describes the over-use of tests and procedures as "McDonaldized" healthcare in which health industries earn profit from patients who expect a "one-stop-shop visit[s] that include[s] lab work, needed drugs, and

consultations with physicians," (1996: 45). In his research, Ritzer remarks on both the nature of patients' service demands as well as the healthcare industry's willingness to cater to them, despite lacking medical necessity.

Kearns and Barnett (1997) elaborate on the processes by which for-profit specialized care markets, although elite in the standard and breadth of services available, tend to inflate overall basic healthcare prices. They show that healthcare industries, in order to make more profit, capitalize on the health complex experience. Health complexes commodify the healthcare experience by maintaining chic offices, over-providing unnecessary care, and offering elective healthcare procedures. These practices can result in higher operating costs for hospital complexes, which often results in higher basic care costs for patients. Kearns and Barnett (1997: 171) state,

> A common feature of health reforms in western nations has been an introduction, to variable degrees, of the market-based ideology advanced by so-called "right wing politics." This has resulted in an infusion of competitive practices and greater levels of advertising. An outcome of this process has been the construction of health and healthcare as, respectively, a commodity and product, rather than a quality and service. Users of healthcare services have been refashioned as "consumers."

Kearns et al. (2000) later expound on this, discussing how health complexes invite businesses to rent out spaces in hospitals, thus restructuring and commodifying the experience of the patient in the healthcare complex. In a similar vein, Ciric highlights the problems associated with U.S. healthcare system as one of irresponsible spending. He cites, "high-end technology and prescription drugs, failure of competitive market forces, and administrative costs," as explanations for inflated healthcare costs (2012: 694). Through the process of commodification, hospitals over-provide care to compensate for inflated operating costs which consequently results in patients over-paying for unnecessary

procedures. In doing so, healthcare markets become monetarily exclusive, serving higher socioeconomic classes better and leaving stranded those lower socioeconomic classes who cannot realistically afford to purchase basic healthcare services (Kearns 2000; Ciric 2012; Kenny, et al. 2012; Magge, et al. 2012).

Origins of Subsidized Healthcare in the U.S. and the FPL

Due to rising prices in healthcare, the U.S. determined federally subsidized healthcare plans for low-income Americans in the form of Medicaid and Medicare. Developed in 1965 under President Johnson's "War on Poverty," these programs provide subsidized public health insurance to individuals who are elderly and eligible for social security and low-income populations (Kaiser Family Foundation 2015).

Eligibility requirements are based off of the Federal Poverty Line, developed in 1963 by Mollie Orshansky. The FPL uses a matrix of social factors and U.S. food prices to determine the lowest income on which a particular family-size can survive in the U.S. (Fisher 1992). Congress adopted the FPL matrix as a format to estimate eligibility levels for families applying for social programs such as Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Medicaid and Medicare. Table 1 illustrates the FPL as of 2016. Family incomes that fall below these levels can often apply to various programs for federal assistance.

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$11,880	$15,800	$17,820	$23,760	$29,700	$35,640	$47,520
2	16,020	21,307	24,030	32,040	40,050	48,060	64,080
3	20,160	26,813	30,240	40,320	50,400	60,480	80,640
4	24,300	32,319	36,450	48,600	60,750	72,900	97,200
5	28,440	37,825	42,660	56,880	71,100	85,320	113,760
6	32,580	43,331	48,870	65,160	81,450	97,740	130,320
7	36,730	48,851	55,095	73,460	91,825	110,190	146,920
8	40,890	54,384	61,335	81,780	102,225	122,670	163,560

Table 1: Federal Poverty Line, Source: familiesusa.org 2016

The amounts for the FPL change yearly based on inflation but do not take into consideration regional influences on market prices for essential goods and services such as food, housing, and healthcare.

Additional legislation modified Medicaid and Medicare since its implementation to expand healthcare services to specific populations. For instance, in 1972, Republicans expanded services to individuals with long-term disability and end-stage renal disease. They also extended various services to the states between the 1980s and 1990s to expand optional programs for children, pregnant women, and those with certain types of cancers (Kaiser Family Foundation 2015). The rate of healthcare expansion, however, fails to match U.S healthcare costs that are more than twice those of other industrialized nations (Ciric 2012). As such, while healthcare costs rise and wage and benefit programs remain relatively stagnant for low-income Americans, health disparities continue to increase (Webb, et al. 2011; Kaiser Foundation 2015).

Current Healthcare in the U.S.

Although researchers such as Grossman, et al. (2003), recognize that Americans achieve improved health outcomes by acquiring health insurance that gives them access to

preventative care, the U.S. remains one of the last advanced industrialized nations without universal healthcare (OECD 2016). Accordingly, Americans maintain several options for health insurance: (1) public health insurance in the form of Medicaid and Medicare, and (2) private health insurance, offered through a variety of competitive market companies. However, whether by choice or due to limited access to health insurance coverage, some citizens go without health insurance. Media surrounding the ACA often refers to those in the third option as "The Gap" or citizens who make too much money to qualify for state-based insurance yet too little money to qualify for federally-subsidized health insurance. "The Gap," however, also includes people who choose not to purchase health insurance. Figure 1 illustrates a diagram by the Kaiser Family Foundation that details "the gap."

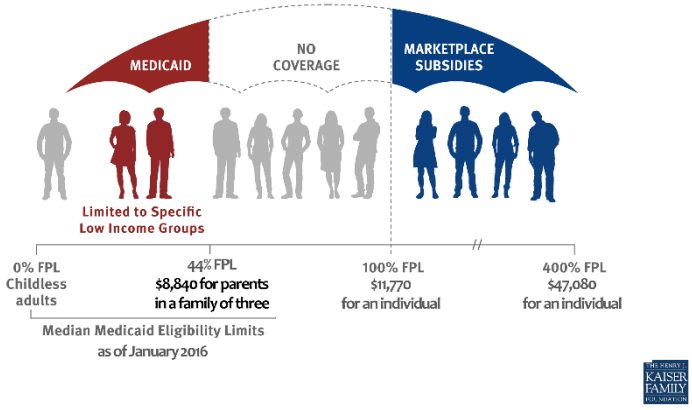

Figure 1: "The Gap," Source: Kaiser Family Foundation 2013

In both private and public health insurance markets, research shows that health insurance enrollment fluctuates due to a variety of reasons pertaining to employment, income level, state residency, regional availability of insurance, personal perceptions of health insurance programs, and healthcare policy (Kearns et al. 2000; Levy and Deleire 2008;

Magge, et al. 2012). In order to mitigate some of this fluctuation and reduce medical costs, Congress passed the ACA in 2010 (Beland, et al. 2014) ensuring Medicaid coverage for uninsured persons with incomes at or below 138% of the FPL. Individuals within incomes between 100-400% of the FPL also qualified for federal subsidies to purchase health insurance on the federal healthcare exchange (Kaiser Family Foundation 2015). Several states, however, opted out of ACA and Medicaid expansion due to political, economic, and social factors.

The "Great Divide" of ACA Expansion

The division of healthcare expansion falls along an ideology that views healthcare as a right versus a privilege, noting that privilege can be misunderstood as one's personal responsibility (Maruthappu et al 2012). Maruthappu et al. 2012 discuss this ideological division stating that it generally falls along party liness. This results in the polemical nature of healthcare reform. They cite presidents such as Roosevelt and Obama, among others that encourage a political stance that healthcare is a right. With our current healthcare system, however, Marruthappu et al. (2013) share concerns with Kearns and Barnett (1997) and Scott, et al. (2001) that the U.S. healthcare market is unethically constructed based on a system that distributes healthcare unevenly and devoid of necessity. With that in mind, the ACA and associated expansions were designed to mitigate some of that uneven distribution. For instance, research shows that universal healthcare approaches, such as the ACA, have the potential to provide equitable healthcare access for a wider range of recipients (Cheng 2005; Hoffer et al. 2011; Oklahoma Policy Institute 2012; Frakt et al. 2012). This is due in part to low-income populations having limited access to preventative care (Marruthappu, et al. 2013). Accordingly, research by Webb et al. (2011) shows that healthcare expansion,

particularly in the form of Medicaid expansion, has the potential to alleviate increasing health disparities across all demographics, particularly non-whites and Hispanics, by increasing access to healthcare. Additionally, research by Caswell et al. and Cummings et al. (2013) show that lower income populations pay more for healthcare services because they lack affordable primary healthcare and thus rely upon more expensive emergency care for preventable illnesses. Some families, however, cannot afford to pay their medical bills which results in uncompensated care (Caswell et al 2013; Cummings et al. 2013; Leavitt Partners 2013; Oklahoma Healthcare Authority 2016). By insuring these low-income families, the ACA has the potential to reduce uncompensated care expenses. For instance, according to the Kaiser Family Foundation (2011) current Medicaid reimbursement rates are between 50% and 75%. Under healthcare reform, ACA legislation offers reimbursement of 100% for newly added recipients through 2016, with 90% reimbursement through 2020. This means that states accepting expansion need to increase revenue by only 10% in the first 10 years of expansion. Research offered by the Leavitt Partners (2013) indicates that investment in healthcare services would more than compensate additional expenses accrued by states.

Despite potential for the success of expanded healthcare services, some policy-makers suggested that healthcare should be left to free-market principles. Others argued against free-market principles but discuss the economic follies of the ACA. For instance, Tanner (2013) argues that the ACA is unsustainable given the lack of monetary resources available for distribution by the federal government to fulfill an uncapped, for-profit healthcare market. Essentially, the federal government cannot continue subsidizing healthcare without introducing cost-restrictive measures for health service companies. This includes regulating the profit margins on pharmaceutical and medical technology producers who maintain the largest lobbying campaigns in Congress (Ismail 2005). Tanner (2013)

shows that although increasing access to insurance is a social positive, the lack of financial management via stabilizing healthcare prices included in the ACA results only in additional sources of revenue for health industry companies.

Others policy-makers conclude that the ACA is an overreach of legislative powers, and thus a mechanism to weaken the U.S. Constitution. This division resulted in three landmark Supreme Court cases including *NFIB v. Sebelius* (2012), *Burwell v. Hobby Lobby* (2014) and *King v. Burwell* (2015). In *National Federation of Independent Business* (NFIB) *vs. Sebelius*, the Supreme Court ruled that states could opt-out of Medicaid expansion due to an unconstitutional linkage that required state participation to receive federal funds for existing portions of Medicaid (Supreme Court 2012). Opponents of the ACA showed that the undue linkage would have resulted in undue financial burden on the states that opted out. The Supreme Court ruled in favor stating that states could opt out rather than additionally burden the thousands of low-income individuals whose plans would be eliminated if states chose to opt-out (Supreme Court 2012; Frakt and Carroll 2013; Rosenbaum et al. 2013). This decision allowed states to opt out of expanding Medicaid to 138% of the FPL, resulting in uninsured rates remaining high in states that could have most benefited from Medicaid expansion (Frakt and Caroll 2013; Richardson et al. 2013; Oklahoma Policy Institute 2014).

In *Burwell v. Hobby Lobby*, the Supreme Court upheld a religiously-based company's right to select health insurance plans that were compliant with the owners' belief systems (Supreme Court, 2014). This developed due to the contention among conservatives that ACA compliant insurance plans cover certain types of birth control measures including abortion. Lastly, in *King v. Burwell*, the Supreme Court upheld the constitutionality of the federal government to provide healthcare subsidies to ACA compliant health insurance

(Supreme Court 2015). This allowed individuals to continue to receive healthcare subsidies to purchase health insurance in the federal healthcare exchange. Each of these decisions continues to dramatically impact the healthcare landscape of the U.S.

Thus, researchers recognize the ACA as one of the most hotly contested laws in recent history (Townes, 2014). In part, this is due to the necessity of many synchronized portions of the ACA (Beland, 2014). Beland, et al.'s (2014) research reviews each moving component of the ACA and the complex actions necessary within different departments of both state and federal governments to maintain successful healthcare reform. They cite partisan politics as central to expanding Medicaid services with Republican governments resisting its expansion and the resulting reduction in ACA effectiveness nationwide. Additionally, they mention that some states preferred expansion of public-private partnerships, rather than relying on Medicaid services to address the coverage gap. For example, Insure Oklahoma is a public private partnership designed to insure working Oklahomans who earn up to 200% of the FPL. However, as with Oklahoma, many of these state-based programs fail to comply with ACA regulations that require broader coverage. Accordingly, federal funding ceased for the state-based Insure Oklahoma, as state leaders failed to expand health services to comply, resulting in thousands of Oklahomans loosing insurance coverage. Researchers explain that Republican legislator resistance stems from the belief that their constituency would not benefit from ACA and Medicaid expansion (Hudak 2012; Beland et al. 2014).

Extensive research reviews the mechanisms by which legislators select political positions. For example, the seminal work of Fenno (1973) discusses committee membership as an influencing factor on legislators' decision-making capability. In this comprehensive

review of congress, Fenno discusses how certain committees provide services for congressmen and their constituencies in varying ways. For instance, Appropriations and Ways and Means membership ensure representatives positions of power among other legislators because they effectively hold the purse strings for all projects. Conversely, members of congress seeking to serve their constituencies might seek membership on committees such as Interior and Post Office because they deal with projects that directly influence constituencies back home. Fenno also relates that members of congress might seek positions on the latter committee to ensure re-election. In Mayhew's 1974 *Congress: The Electoral Connection,* he reviews the transitions in congressional service from voluntary membership to career positions, recognizing the change in mentality from services to obtaining re-election. Although both of these studies took place at the congressional level, similar sentiments can be applied at the state level due to the mirroring of house and senate structure at the state legislature. Accordingly, he also reviews the mechanisms by which legislators obtain re-election by serving one's constituency. He includes the rise in electoral demand to please middle class constituencies via congressional leaders perceived need to take positions on key issues (1974: 121). Adding to the research of committee membership and electoral connections, other researchers, such as Coker and Crain (1994), found that committee membership fosters vote-loyalty among legislators. This then has the potential to sway a legislator's vote away from his constituency for sake of committee loyalty. If committee members fail to express certain vote loyalties, they risk committee exile (Grimmer and Powell 2013). This affects both a politician's career and the ability of a particular committee to maintain a homogenous political position among its members (Grimmer and Powell 2013). However, he expands his ideas to include other factors that sway members of

congress' activities including greater importance for political donors and subsequent increased attention to party-line positions (Mayhew, 2016).

Concerning conservative party-line membership, Smith discusses two types of conservatism including "the traditional and religious right [and] the libertarians," (1998:5). In his research, he shows that despite minor variation in topics such as drugs, abortion, prayer, etc., by the 1970s, mainstream conservative rhetoric shifted to economically based arguments, solidifying their place in common discourse. From a conservative perspective, deregulation of markets and reduced taxation results in economic growth because business entrepreneurs secure the financial freedom to reinvest in their business and workers. He shows that during times of economic insecurity, economically cast political sentiments increased. This is pertinent to current conditions considering economic fluctuations after the 2008 U.S. Recession. In contrast to Smith (1998), Rose (2011) elaborates on the *conservative pro-life* movement, discussing the shift in the conservative party after the 2007 Supreme Court decision in *Gonzales v. Carhart* in 2007 from "pro-life" to also "pro-woman." She elaborates on how *conservative pro-life* politicians and interest groups now use information garnered from "pseudo-science" about the potential complications of receiving an abortion that may cause harm to the woman as another form of rhetoric to encourage traditional conservative "pro-life" policy interests.

In the case of current conservatism, Disch (2011) reviews the uptake in power experienced by far right Tea Party conservatives. Their upsurge in power can be traced, in part, to marketing via Fox News which, as Disch relays, has allowed a "much more ideologically cohesive [movement] than would be expected given its geographical diversity," (2011:128). Tea Party politics directly pertain to Oklahoma conservatives due to the

Republican composition of the State Legislature. Accordingly, the manner in which conservative parties determine positions and associated rhetoric with which to discuss policy development influences the ways in which constituencies understand, in this case, healthcare reform.

Producing Healthcare Knowledge for the Public

Research by Lynn and Timothy Walters (1992) illustrates the circumstances by which press releases are produced. They highlight how media outlets select particular positions that they want to report on and thus rely upon select news sources to "determine not only who will be heard, but also what will be heard" (1992:33).

Kuklinski et al. (2000) recognize three distinct groups that exhibit substantial influence on public perceptions of political issues including media outlets, politicians or lead figures, and interest groups. These groups have influence because the public believes them to embody knowledge. Their involvement is somewhat mutually constitutive and converge to produce knowledge that is consumed by the public. Shapiro and Block-Elkon explain this relationship stating "...the public is only as wise as the available information enables it to be," (2008:117). This means that media messaging serves as a prime source of information for people as it is the site where knowledge of political issues is consumed. For the purposes of my research, I focus on reviewing research on how media gathers and disseminates news and how legislators help to shape policy discussions in the media.

As scholars show, the public largely gains "wisdom" from political figures via media outlets (Shapiro and Block-Elkon 2008; Rabinowitz 2010). Accordingly, the relationship between the media and political figures create a mutually constitutive relationship by which political figures help to shape media outlets and media outlets also shape the perception of

political figures. The resulting portrayal presented by the media in turn influences the way in which the audience views both the media source and the political figure (Shapiro and Block-Elkon 2008).

Wallington et al. (2010) examine how the media, through journalists, inform the public about political issues. Journalists report two primary approaches, one that highlights health disparities and another where journalists channel attention to the political debate surrounding healthcare reform. They report that the public favors coverage dealing with political views rather than factual coverage of health disparity. Thus, journalists produce more coverage of political views surrounding healthcare debates to boost ratings. This channeled media coverage, focusing on political views rather than health disparity information, reduces the amount and quality of information constituencies can use to understand the status of health. It also fosters a belief gap which concerns the difference between factual knowledge based on empirical data and perceived factual information that is generated through specific ideology such as political messaging (Hindman 2012; Gaziano 2014).

Hindman (2012) argues that belief gaps are created when partisan beliefs surpass content-oriented information. This differs from knowledge gaps associated with the idea that higher socio-economic groups maintain greater access to information and as such make better informed decisions than lower socio-economic groups. However, Hindman's study reveals that even the knowledge gap can no longer base itself on educational attainment. This is because misconceptions of factual information are spread across educational attainment groups. Additionally, the findings suggest that people adhere to partisan beliefs rather than factual information. Similarly, Veenstra et al. (2014) show that more people rely

on partisan new sources and social media for news updates in lieu of seeking non-partisan information to establish beliefs or to gain knowledge. Moreover, Gaziano (2014) finds that Conservatives maintain insular media environments, thus enhancing their belief gaps through minimal and selective news exposure. Conversely, liberal groups tend to consume a wider range of media coverage to inform their beliefs of socio-political issues. In both groups, however, belief and knowledge gaps of social issues is more diverse than in previous generations due to the increasing reliance on and availability of information garnered from social media (Rojas 2010; Gaziano 2014). This means that a wider demographic of people no longer need a higher-level of education or socio-economic status to access information to inform political ideology. This increased access effectively opens the conversation of socio-political issues to the greater public.

Rojas (2010) examines the relationship between media as well as attempts at correcting perceived "misinformation" on social media. He explains that if individuals felt that mass media messages contradict their own beliefs, then they are more likely to use "corrective" measures, like posting opinions on social media, in order to mitigate the perceived misinformation. While Rojas (2010) acknowledges the influence of politicians on public opinion, Matsubayashi (2012) makes this the direct subject of her study. She shows that when politicians differ from their constituencies beliefs, they opt to use persuasive tactics to shift constituency mindsets to the politician's position. This strategy works to serve the purposes of the politician rather than shifting political platforms to reflect the mindsets of constituencies.

Several scholars examine how politicians and other influential figures achieve their goals of persuading their constituencies to a different opinion or belief through media

messaging. Rabinowitz (2010) analyzes newspaper articles surrounding the 1999 Patient's Bill of Rights debate, showing that in states where political advocacy campaigns aired, news articles tended to be more critical of healthcare reform policy and lacked discussion of the positive aspects of healthcare reform. Without political advocacy influence, local news media coverage tended to be more favorable to healthcare reform. Rabinowitz (2010) acknowledges that political ads also provide an opportunity for minority viewpoints to gain more saliency in news media coverage. Further, Wear (2011) reviews the rhetorical devices used in political media coverage by politicians such as Sarah Palin, Rush Limbaugh, and Dick Armey to determine the validity of information produced and consumed by followers of these influential persons. He highlights that these figures, opponents of the ACA healthcare expansions, provided misleading information that gained political traction, resulting in a confusing web of misinformed constituencies. In a nationwide analysis of media messaging surrounding the ACA, Gollust et al. (2014) determines that regional variations exist in the amount of ACA coverage as well as the tone in which ACA was addressed on local television networks. Variation in the tone of media messaging influences public perception of healthcare expansion and shapes the way in which different regions within the U.S. have responded to healthcare with more favorable responses in the North and West, mixed responses in the Midwest, and negative responses to ACA expansion in the conservative South.

Oklahoma's Healthcare Landscape

Accordingly, within southern states, a conservative mindset dominates the political and economic playing fields. Policies supported by Conservatives result in a less favorable health markets for wide-reaching public services. The South lacks business incentives to

attract quality healthcare services, as compared to other regions which invest more in community healthcare services, noted in the insufficient amount of tax dollars earmarked for healthcare services by state governments (Zuckerman et al. 2010).

Conservative states such as Oklahoma, however, could benefit most from Medicaid expansion by receiving the highest percentage of federal subsidy at 30% in order to insure individuals and expand healthcare services (Brodie et al. 2011). For instance, Oklahoma represents one of the unhealthiest states in the nation with an uninsured rate of 18% or approximately 650,000 Oklahomans (Oklahoma Policy Institute 2010, U.S. Census Bureau 2015; CDC 2015). Research by Richardson and Yilamzer (2013) shows that ACA and Medicaid expansion could cover approximately 8% of this population via public insurance with the remaining 10% gaining access to the private health marketplace. This expansion could effectively reduce underinsured rates, resulting in less health disparity as well as a reduction of uncompensated healthcare costs (Webb et al. 2011; Kaiser Family Foundation 2013; Leavitt Partners 2013).

In order to manage healthcare expansion in Oklahoma, the Federal Government awarded Oklahoma an Early Innovator grant of $54.4 million to establish a state-based health exchange. Oklahoma could have used this money to expand the existing state-based, public-private partnership Insure Oklahoma. However, in 2014, Governor Fallin returned the money to the federal government which ultimately resulted in Oklahomans relying on the federal healthcare exchange to shop for health insurance. Some Oklahoma voters support denying some parts of the ACA, as outlined in State Question 756, which challenged the constitutionality of forcing individuals to purchase health insurance. This decision eventually escalated to the aforementioned Supreme Court Case *NFIB v. Sebelius* in 2012.

Additional cases supported by the Oklahoma legislature include the following cases, *Brown v. Hobby Lobby* (2014) and *King v. Burwell* in 2015. Despite allowing the federal healthcare exchange in Oklahoma, legislators refused to all the expansion of Medicaid services despite the relatively low-costs and potential for growth associated with expansion such as higher paying jobs, attracting more highly educated individuals for work at new hospitals, etc. (Oklahoma Policy Institute 2012; Leavitt Partners 2013).

The lack of healthcare expansion in light of Oklahoma's poor healthcare ratings highlights a juxtaposition noteworthy of research. In the next chapter, I outline the methodology by which I address my research questions that explore the discourses of government media and legislators associated contributions concerning the development of healthcare policy in Oklahoma. I pay particular attention to the ways in which government media addresses uninsured Oklahomans as well as the information omitted for the sake of party-line support.

The goal of this research is to provide constituencies with a better understanding of the ways in which government media and legislators shape conversations of policy development to encourage or discourage constituency support for policy initiatives. Academically, this research provides a template for qualitative research in political science and political geography that could be performed in other states and countries to better understand different framing of political issues. This information will be published in an open access journal, available to and for the public. Ultimately, a greater understanding of government media influence and legislator and constituency healthcare awareness is essential to the creation of an inclusive healthcare policy in Oklahoma.

CHAPTER III

METHODOLOGY

In this project, I seek to explain the relationship between Oklahoma legislators discourse and healthcare reform. My research questions include:

1. How have government press releases framed legislative discussion of ACA healthcare reform in Oklahoma between 2010 and 2015?
2. How does the distribution of underinsured constituencies relate to voting patterns and the positions of Oklahoma legislators surrounding healthcare reform?
3. In what ways have Oklahoma legislators (mis) represented the underinsured, Medicaid eligible, and Medicaid participating constituencies in government press releases?
4. How have Oklahoma's State Legislators (mis) represented the healthcare needs of their constituencies' between 2010 and 2015?

I chose the time frame of 2010 to 2015 due to the passage of the ACA in 2010, and thus the heightened political discussion surrounding federal healthcare reform in Oklahoma. This period covers three landmark Supreme Court cases including *NFIB v. Sebelius* in 2012 that allowed states to opt-out of the ACA expansion, *Burwell v. Hobby Lobby* in 2014 that allowed religiously based organizations to opt-out of insurance coverage for some birth control

practices, and *King v. Burwell* 2015 decision that kept healthcare markets open by solidifying the constitutionality of federal subsidies. This time frame encompasses significant opportunities where Oklahoma legislators took decisive political stances on healthcare reform, creating Oklahoma's current healthcare landscape.

To address the scope of this research, I rely upon thematic discourse analysis, supplemented by mapping. This approach enhances the analytical quality of this research because the mapping compliments the qualitative analysis to better illustrate relationships between rhetoric used in government press releases and quantifiable boundaries of Oklahoma's healthcare landscape. The results provide readers with multiple ways in which to engage in the research's findings (Fielding 2012).

Discourse analysis, according to Doel (2010, 490), "discloses how [the] constellation of knowledge and power is structured, and situates it within its appropriate social, cultural and geo-historical context." Discourse analysis provides an avenue to extract meaningful messages and themes present in government press releases and subsequent legislator contributions. However, I also pay equal attention to themes that are not present which primarily deal with more liberal or Democratic-based positions. I use a thematic discourse analysis that explores the language and rhetoric used by Oklahoma legislators to garner support or dissent for healthcare expansion in Oklahoma. In short, discourse analysis allows me to determine how representatives frame their position and how press releases present coverage of healthcare reform. From this, I am able to extrapolate the mechanisms by which government press releases either garnered or weakened support for health policy positions between 2010 and 2015.

According to Tyner (2010), visual interpretations such as maps are positive ways to draw viewers into the research, giving them tangible, contextual, and spatial means of viewing data. As such, I include maps and charts to visualize findings for the reader. For instance, I include a map detailing the vote for SQ 756 and a map of the United States that highlights states that legislators mention when comparing healthcare policy. Additionally, I include charts that show category and code counts throughout my analysis. This provides an accessible way in which I can engage my reader through both narrative and visual representations.

Data Collection

In order to collect media representations of each Oklahoma representative, I gathered press releases found on Oklahoma's government websites including ok.gov, oksenate.gov, okhouse.gov. I consider these government websites as the primary source of legislative discussion made available to the public. These websites include all press releases from both houses and the Oklahoma Governor's Office; however, for the purpose of my research, I limited my search to those that pertain to ACA healthcare reform in Oklahoma between the years 2010-2015. For the purpose of this study, ACA and related reforms include press releases that discuss the restructure of Insure Oklahoma and those that discuss birth control related legislation in Oklahoma. It is important to note that Oklahoma enacted various other minor reforms; however, I did not include those because they lacked direct connection to ACA reform. In total, my data includes 186 ACA related government press releases that address healthcare reform in Oklahoma.

Between Oklahoma's governor, senate, and house offices, the amount of press releases varies, with decreasing coverage for ACA reforms from 2010 to 2015. As shown in

Figure 2, both the Governor and Senate release fewer statements than the media-prolific House.

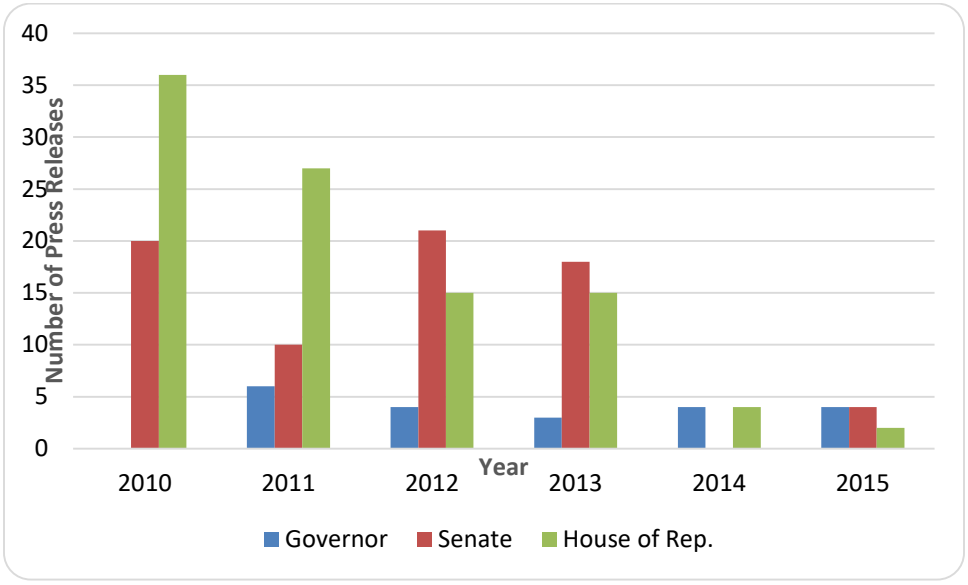

Figure 2: Number of ACA Government Press Releases by Year and Government Office

This may be due to differences in media funding between offices but may also relate to the perceived need to publish based on term limits. For instance, both the Governor and members of the Oklahoma Senate serve six year terms whereas the members of the House of Representatives serve two year terms.

Additionally, substantial overlap occurs in content and quotes in press releases from the Oklahoma Governor's Office, House and Senate. This is in part due to the nature of legislation that passes between each House and the Oklahoma Governor's Office as well as the conservative nature of the legislature. These press releases include direct quotes from legislators, and I use them as sources for individual legislator analysis. I chose to use direct quotes because the authorship of each press release is unknown, providing information only for contact persons or offices. For a legislator to be selected for this research, I relied on

legislators with a minimum of ten substantive press release contributions between 2010-2015. I chose ten substantive contributions due to a natural break in the data. Accordingly, because a majority of Oklahoma's Legislature is Republican, the contributions made by Republicans dominate the discussion of ACA. Additionally, I suspect that the contributions of these legislators will follow the larger party platform and negatively inform ACA discussions with little variation between statewide and local representation. This is in part due to Mayhew's (2016) review of *The Electoral Connection* which suggests that larger party politics serve as more influential to legislator's voting decisions than their constituencies. I also suspect larger party platform involvement because four of the five legislators analyzed hold additional offices that represent the majority Republican party at the state level. The legislators I analyze include Governor Mary Fallin, R; Sen. Dan Newberry, R-Tulsa; Sen. Brian Bingman, R-Sapulpa; House Speaker Rep. Chris Benge, R-Tulsa; Rep. Mike Ritze, R-Broken Arrow; and Sen. Dan Newberry, R-Tulsa, shown in Table 2.

Legislator	Affiliation	Years Served	Additional Offices Held
Gov. Mary Fallin	Republican	2010-Present	U.S Representative, District 5
Sen. Brian Bingman	Republican, Tulsa	2006-Present	President Pro Tempore
Sen. Dan Newberry	Republican, Tulsa	2008-Present	NA
Rep. Chris Benge	Republican, Tulsa	1998-2010, 2013-Present	Speaker of the House, Secretary of State
Rep. Mike Ritze	Republican, Broken Arrow	2008-2014	Medical Doctor

Table 2: Oklahoma Legislators Analyzed

In addition to press releases, I gathered county level information from the Oklahoma State Election Board including voter registration, voter turnout for SQ 756, and congressional district divisions. I used congressional district divisions because they provide boundaries along like areas in Oklahoma via similar socioeconomic status, insurance rates, education,

and employment status (U.S. Census Bureau 2016). Figure 3 shows the division of congressional districts in Oklahoma reference.

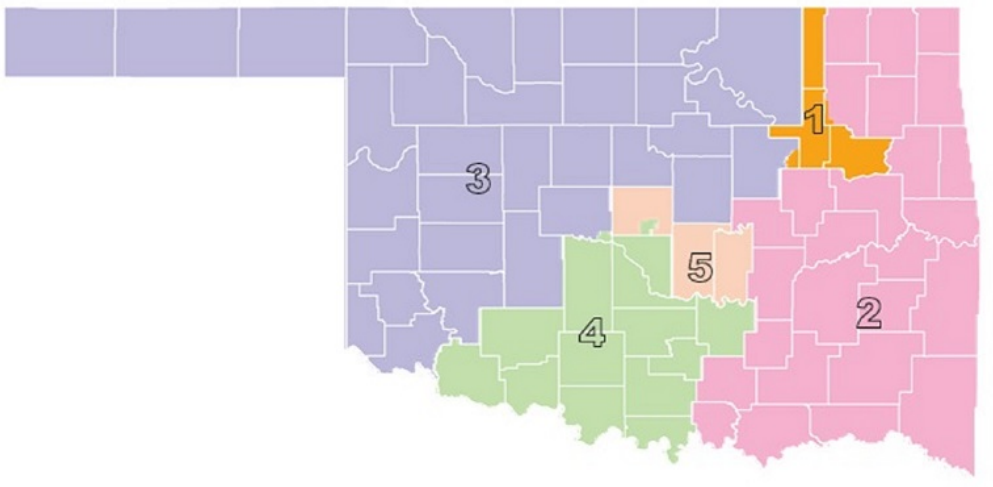

Figure 3: Oklahoma Congressional District Map, Source: Oklahoma Department of Agriculture 2015

For instance, according to the U.S. Census Bureau, Districts 1 and 5 represent the urban centers of the Tulsa and OKC metros and have a similar mix of educational attainment, race, business involvement, and health insurance rates. District 2 represents the eastern most portion of Oklahoma and has a lower educational attainment than Districts 1 and 5 as well as greater racial diversity, an agriculturally-based economy, and poorer health overall. District 3 represents the western portion of Oklahoma and maintains less diversity among race than Districts 1 and 5. This region contains much of Oklahoma's farmland agricultural production and oil and gas industries and accordingly, like District 2, represents a large portion of rural Oklahoma. Lastly, District 4 encompasses the area south of Oklahoma City and is relatively less racially diverse and with lower educated populations than the urban centers but maintains a greater variety of urban businesses and agriculture than Districts 2 and 3.

The selection of Congressional Districts to represent regions also provides the foundation for future research at the Congressional level concerning healthcare representation. Accordingly, I collected information from the U.S. Census Bureau American Community Survey (ACS) five-year 2009-2013 estimates for underinsured adults and children by county. I used these to create maps of the underinsured to supplement my discourse analysis.

Data Analysis

First, I organized each press release as commentaries on ACA expansion and those that resulted directly from ACA. Directly related press releases include coverage of reforms for Insure Oklahoma, some changes in insurance coverage, and birth control. Then I coded the press releases and developed a system of umbrella categories to represent groupings of codes. Then I associated these umbrella categories to overarching Political, Economic, and Social themes. I detail the components for each part in the following sections.

Codes and Categories

After I organized the press releases, I coded each press release that developed into six different categories. I use the term category in this analysis to describe the general theme of the codes used under the umbrella category. In this analysis, I pay attention to both where, when, and how government press releases use and do not use each code. However, throughout this analysis, I discuss the codes in terms of their umbrella category. My categories include *Oklahomans*, *conservative pro-life*, *conservative hegemony*, *divisive speech*, *charged speech*, and *place*. I give a brief overview of these categories and associated codes in Table 3.

Category	Code Examples
Conservative Pro-Life	Sanctity of Life, Pro-Life
Oklahomans	Working Class, Business Owners, Uninsured
Conservative Hegemony	Free-Market, Pro-Business, Freedom of Choice
Divisive Speech	Constitutionality, Obama, Either/Or
Charged Speech	Destructive, Monstrosity, Suffocate
Place	Oklahoma, State-Based Branding: Insure Oklahom

Table 3: Categories and Codes from Oklahoma ACA Government Press Releases 2010-2015

The category for *Oklahomans* refers to the people referenced in the press releases with specific attention to Oklahomans that are systemically underinsured or directly affected by healthcare legislation. Codes include groups such as the elderly, women, children, veterans, and those referred to as "the majority," voters or constituents. This category primarily relates to the overarching theme Social.

The category *conservative pro-life* concerns reference to codes that include terms and concepts such as morality, sanctity of life, pro-life, and other references with religious associations. In the discussion for *conservative pro-life*, I note where, when, and how *conservative pro-life* is used and its inconsistent relevancy in legislative discussions concerning healthcare initiatives. Due to the conservative make-up of the Oklahoma legislature, I pay attention to religiously undertone messages that follow party-line rhetoric. This primarily relates to press releases covering birth control. Lastly, this category mostly relates to the overarching Social theme but maintains undertones in the theme Political.

The category of *conservative hegemony* delves into rhetoric used in political agenda setting. The term *conservative hegemony* refers to "the social, cultural, ideological, or economic influence exerted by a dominant group" (Merriam-Webster, 2016). I use the term *conservative hegemony* in this analysis to encompass *conservative hegemony*, or conservative ideals such as free-

markets, pro-business, and state-based policies (Smith 2006). Accordingly, I include codes, for example, that relate to concepts such as freedom of choice, free-market principles, individualism, independence, and idealistic concepts such as the American Dream. The concept of independence in this category includes codes that detail an idealized concept of states' rights and do not include codes based on State vs. Federal Rights as guided by the Constitution of the United States of America. The code of freedom of individual choice is separate from, but closely linked with, the codes in the category of Oklahomans such as working-class and women. In the discussions for hegemonic concepts of freedom, I note the contradictions that exist between two freedom-based terms, freedom of individual choice and freedom of *conservative pro-life*, particularly in the discussion of birth control. In contrast to conservative hegemonic codes, I also detail references that counter dominant hegemonic concepts. These include codes that indicate legislative support of conservatively perceived socialist programs such as Medicaid, support of controlled or regulated business along with acknowledgment of the effects of free-market principles in Oklahoma healthcare, and concepts dealing with community support outside of *conservative pro-life* or business-based communities. Thus, the code *conservative hegemony* deals with all three political, economic, and social overarching themes but relies most heavily on Political and Economic themes in this analysis.

The codes that make up the category *divisive speech* include phrases that promote division along party lines and between federal and state governments such as ObamaCare, federal healthcare, and President's healthcare plan. This category also includes codes for constitutionally-based representations of State vs. Federal Rights to influence readers to choose sides on the issue of healthcare reform. *divisive speech* overlaps in part with *conservative*

hegemony but focuses on the nature of the division rather than the topic addressed within the discourse.

The codes that make up the category *charged speech* is separate from *divisive speech* in that the discourses used in this category are more hostile in nature including codes such as ramming, destruction, takeover, and suffocate. These codes are used to villainize a particular position or induce fear in constituencies. Conversely, this category also encompasses its opposite discourse such as those that are overly positive or more neutral, such as discourse designed to gloss over substantial healthcare policy issues.

The category of *place* includes discourses that use a *place*-based component. Codes include references to towns, districts, states and terms with specific significance to Oklahoma such as "Sooner." This allows for references that endorse Oklahoma-branding such as SoonerCare and Insure Oklahoma to stand out within the analysis. This branding is related to *conservative hegemony* under the code for state-based discussion but remains distinct under this category for its state-centric nomenclature. Additional codes under the *place*-based category include those that foster state, regional, or national affiliation such as Oklahomans, Southerners, or Americans.

In the following chapters, I select specific examples that illustrate how each press release and legislator contribution relates to different categories. These examples often contain illustrations of other categories, however, I only discuss their significance in relation to the overall categorical discussion in which I place the example. The following example in Table 4 illustrates how I code, categorize, and ultimately place sections in a particular Political, Social, or Economic theme:

President Obama's healthcare policies will limit patients' healthcare choices, reduce the quality of healthcare in the United States, and will cost the state of Oklahoma approximately a half billion dollars in the process (Gov. Mary Fallin, R, Oklahoma Governor's Office, 2011d). Negative: Relies on economic undertones, disregards positive potential, passively suggests division between fed. govt. vs. state govt. Emphasis on Economic and Political Theme, relatively devoid of Social.	*conservative pro-life*: 0
	Oklahomans: 1, patients w/o potential for more patients via ACA
	conservative hegemony: 1, limit choice/reduction of quality (hint to free-market)
	divisive speech: 3, President Obama, reduction of quality w/out potential for improvement, mention cost w/o potential for savings
	charged speech: 0
	place: 2, United States, state of Oklahoma

Table 4: Example Code, Category, Theme Structure

After I highlighted the codes in each press release, I placed them into their corresponding category and counted them. Based on the category use and overall tone of the article, I then categorized the press release into its corresponding theme. Some press releases contain content that pertains to each Political, Economic and Social theme; accordingly, I mark the relevancy on each press release. Substantial overlap of content and direct quotes exist between the houses due to the revolving and iterative nature of legislation. I include each press release that contains duplicate text in this analysis because the press releases with duplicate text often originate from separate media sources (either the House, Senate or Oklahoma Governor's Office). Additionally, duplicate publication creates greater media coverage for the healthcare topic addressed. I also review the number of terms for relevancy within the text. Although frequency does not always denote significance in research, these numbers, in conjunction with context, illustrate that the use of terms within press releases play a significant role in shaping the way in which Oklahoma government websites establish government positions, therein informing public opinion. Likewise, I do not intend for my data to focus only on conservative rhetoric, and I do pay attention to liberal rhetoric;

however, the data details primarily conservative rhetoric because of the conservative homogeneity of Oklahoma's legislature which consists of predominantly Republican legislators (oklegislature.gov 2016). This conservative focus is particularly apparent in the individual legislator review because each of the contributing legislators are Republican.

Each of these categories resulted in overarching political, economic, or social themes. Accordingly, the categories and associated codes for *conservative hegemony*, *charged speech*, *divisive speech*, and *place* related most heavily to politically themed positions. Economically themed positions also used the categories and associated codes for Oklahomans, *conservative hegemony* and *place*. Lastly, socially themed positions include categories and codes for *Oklahomans* and *conservative pro-life*. I detail these themes below.

Themes

Press releases with Politically-themed positions focus coverage on party-line issues, rhetoric that is couched in liberal or conservative ideals, and Federal Government vs. State Government conflict. This theme is the most commonly used theme in healthcare policy in Oklahoma and most closely relates to the categories of *conservative hegemony*, *divisive speech*, *charged speech*, and *place*. In this theme, politicians' discussions include rhetoric that creates a sense of unity or "other." For example, referring to the ACA as "ObamaCare" or as the "President's healthcare reform" is a branding method that produces a sense of other, or non-state centric governing. This is important when analyzing conservative rhetoric because state-based solutions often receive more support compared to federally- based assistance. Additionally, I include the category *charged speech* that contains codes such as "mandate" and "force" in reference to federal healthcare reform under the political theme because they present the public with negative connotations concerning laws generated at the federal level.

In this case, the use of words such as "mandate" and "force" in conjunction with ObamaCare portrays the ACA as something that Oklahomans should fear at the expense of their perceived freedom and healthcare choice. This sense of other also encourages the message of an oppressive federal government that works against state-based initiatives. The production of "other" in these arguments obfuscates the nationwide effort via a conglomeration of U.S. representatives, both conservative and liberal, that has worked to create a universal healthcare plan that remains economically viable.

The second theme, Economic, includes categories concerning the cost of healthcare reform, as well as the lack of discussion for long-term cost savings associated with healthcare reform. This includes discussions that enumerate the costs to businesses as well as the individual. The overarching theme of economics also includes discussions of small businesses, small business owners, and free-market principles, which are codes under the category for *conservative hegemony*.

The last theme, Social, deals with the social well-being of Oklahomans. In this theme, I note press releases that focus their attention on the benefits or hardships for certain groups such as the elderly, women and children. This theme includes the discussion of healthcare legislation as a "greater good" for all Oklahomans. The social theme also encompasses concepts of social or moral interest, generally found in conjunction with religiously-based arguments surrounding birth control and abortion. Under this theme, I note the importance of legislators' selective engagement with social themes to further agendas, disregarding other germane social themes concerning the political and economic interests in Oklahoma healthcare policy. The theme of Social most closely relates to the categories *Oklahomans* and *conservative pro-life*.

For the mapping portion of my project, I use ArcMap 10.2 to generate maps. I use data from the U.S. Census Bureau American Community Survey (ACS) five-year estimates for the 2009-2013 to create maps of the underinsured adults and children within Oklahoma. I also created map that details the distribution of votes for SQ 756 as well as a map of the U.S. that details place-based mentions garnered from my discourse analysis. I used Excel to generate all graphs and additional figures.

Limitations

Press releases serve as filtered representations of the overall legislative discussion on healthcare issues as they do not encompass the entire dialogue carried out in special committees or debates on the Oklahoma House and Senate floors. Thus, press releases published by each office are selective in their legislative coverage and show only a narrow view of the possible discourses among Oklahoma legislators. Despite the potential for gaps in legislative discussion, the number of press releases provides ample data for this analysis. I recognize that additional avenues for research including analysis of additional media sources, interviews with the publishers of legislative journalists, and direct interviews with legislators, could contribute significantly to this initial analysis and supplement my findings. However, due to the time constraints and scope of this research, limiting my study to three data sources for press releases provides an important starting point to understand how legislators, public opinion, and healthcare policy interact to create Oklahoma's healthcare landscape.

I am aware that my positionality may influence my research. As a native to Oklahoma and previous user of state sponsored health insurance programs in Oklahoma, I recognize my worldviews could impart bias on my analysis of the Oklahoma Legislature as they consider cutting healthcare programs. I also recognize my previous positions taken in

articles written for the Oklahoma Policy Institute that staunchly support healthcare expansion in Oklahoma. As I worked through my analysis, I attempt to set aside any emotional connections with my research that might influence my interpretation of the data. I do this by using a system of impartial codes to create a quantitatively informed qualitative analysis. In my discussion, I remain mindful of my interpretations of my research findings, providing quantitative data to further illustrate my conclusions and eliminate biased language in my results. As I have manually coded and counted my data, my research maintains a possibility of human-error that could manifest in miscalculation of codes or overlooking content in the press releases. Additionally, due to the newly elected expansion of insurance, the SAHIE 2013 and ACS 5 Year Estimates may provide less accurate interpretations of the healthcare landscape in Oklahoma because of their slightly dated information; however, these sources also provide averaged and comprehensive insurance information as compared to the one year 2014 estimates which are less reliable due to their small sampling.

Conclusion

In the following sections, I separate my analysis into three chapters in which I discuss the results of my research and their implications on healthcare policy development in Oklahoma. In Chapter Four, I discuss how press releases from the Governor, Senate, and House use categories and associated codes to guide the interpretation of ACA expansion in Oklahoma. Then, in Chapter Five, I provide individual legislator analyses that detail how select legislators, key in healthcare policy discussions, discuss healthcare reform in the state of Oklahoma. In each of these discussions, I build upon codes and categories to show an overarching political, economic, or social themes by which Oklahoma government guides Oklahomans opinions on healthcare policy. I discuss how press release and legislator use of

imbalanced information coverage results in imbalanced healthcare policy production in Oklahoma. I also discuss how balanced discussion might improve the health of Oklahomans across the state or how the use of certain types of rhetoric may encourage greater legislative support for particular positions on healthcare reform.

Lastly, I conclude with a summary of how I addressed each of my research questions. I end my discussion with suggestions concerning how lobbyists and policy makers may use my research to create a more balanced coverage of policy discussions in the future and how imbalanced coverage fosters support for a particular political position. Finally, I include suggestions that could foster policy decisions to create a healthier Oklahoma. I conclude with suggestions for future studies.

CHAPTER IV

AFFORDABLE CARE ACT IN OKLAHOMA GOVERNMENT PRESS RELEASES

In the following chapter, I provide an overview of legislative positions taken in Oklahoma's government press release coverage of the ACA between 2010 and 2015. This analysis includes representations of both conservative and liberal interpretations of the ACA; although, the liberal positioned contributions are extremely minimal due to the make-up of the Oklahoma legislature. This chapter focuses on two of my research questions: 1) How have government press releases framed legislative discussions of healthcare reform in Oklahoma between 2012 and 2015?; 2) How does the distribution of underinsured constituencies correlate with voting patterns and the political positions assumed by Oklahoma legislators? This chapter also lays the groundwork for my remaining questions: 3) In what ways have Oklahoma legislators represented the underinsured, Medicaid eligible, and Medicaid participating constituencies in government press releases?; and 4) How have Oklahoma's State Legislators (mis) represented the healthcare needs of their constituencies' between 2010 and 2015? The latter of which I further discuss in chapter five.

In this chapter, I present the results of my analysis that details how press releases from the Governor, Senate, and House use each categories and associated codes to foster support for or against the ACA. I show how this discourse gives an imbalanced

interpretation of the potential for ACA expansion in Oklahoma, leaving Oklahoma in its longstanding healthcare predicament. I then show how press releases generate an overall reliance on political and economic themes at the expense of germane social coverage of the ACA in Oklahoma. Lastly, I discuss the implications of imbalanced press release coverage of the ACA on healthcare policy production. I conclude with steps legislators can take to develop informed press releases to create quality, balanced healthcare policy coverage.

Overview of Press Releases

Oklahoma's government press releases, overall, convey a negative interpretation of the ACA as they fail to provide a balanced conversation about the positive and negative factors associated with ACA's expansion. In turn, this means that the public is exposed to negatively-based commentary from government sources. As the Shapiro and Block-Elkron state, "the public is only as wise as the available information enables it to be," (2008:117) thus implying that Oklahoma constituencies maybe negatively biased towards the ACA as a byproduct of negative press coverage. Such actions have the potential to inform healthcare policy in Oklahoma.

Overall, the number of government press releases directed specifically towards the ACA decreases over the five-year period with greater coverage during the implementation of the ACA in 2010 and subsequent challenges to its constitutionality in 2010 with *NFIB v. Sebelius* (2012), *Burwell v. Hobby Lobby* (2014), and 2015 with *King v. Burwell.* Accordingly, I address additional coverage of healthcare reform, such as Insure Oklahoma and subsequent insurance changes including birth control legislation, that have developed as a result of Oklahoma's denial of ACA.

Government press releases generally give a limited and negative view of the ACA due to selectively informed coverage of federal healthcare reform. Note that I do not purposefully focus this analysis on the negative interpretations of healthcare reform in Oklahoma; rather, the data lead to an analysis that requires greater discussion about negative coverage of the ACA. In the following section, I review the Oklahoma Governor, Senate, and House offices use of each category and associated codes in press releases. I also elaborate on how their use particular ideas and information concerning the ACA in press release coverage and subsequent production of Oklahoma healthcare policy.

Category: ***conservative pro-life***

The category *conservative pro-life* refers to codes that reference concepts such as morality, sanctity of life, pro-life and other religiously-under toned references. Conservative party platforms, as Smith (1998) notes, include these concepts in their political agendas. In this instance, I separate the category of *conservative pro-life* from *conservative hegemony* because of the masked nature of political undertones in pro-life discussions as well as the singular nature by which legislators use pro-life sentiments. Figure 4 represents the number of codes used in the category, *conservative pro-life*, by each government office.

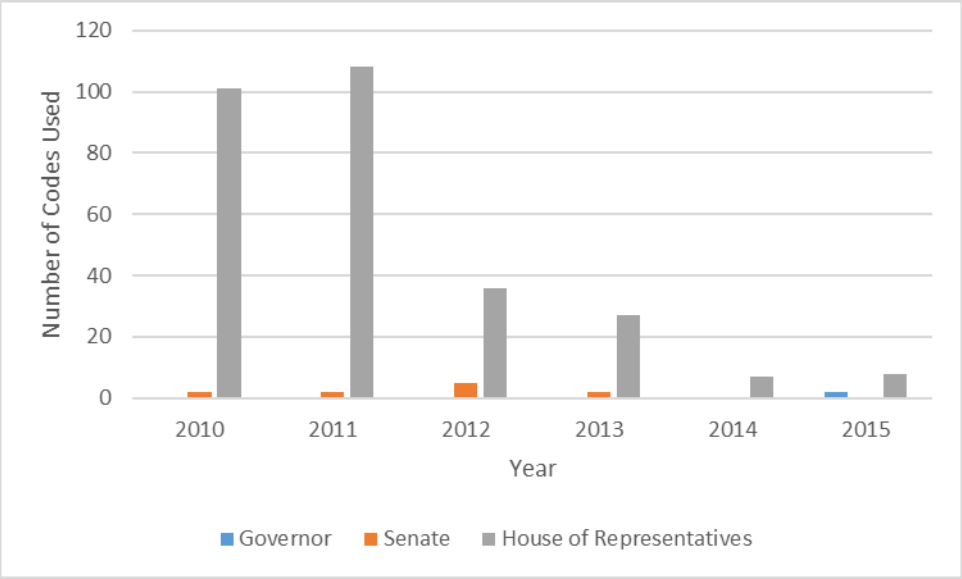

Figure 4: Code Use for *conservative pro-life* by Year and Government Office

Accordingly, government press releases and legislators use *conservative pro-life* most often in conjunction with unsupportive discussions of birth control and abortion access. These legislative movements gained greater traction in the Oklahoma legislator with ACA legislation that labeled birth control as a preventative care, ultimately resulting in the aforementioned *Burwell v. Hobby Lobby*. (Supreme Court Decisions 2014). This label thus required ACA compliant health insurance plans to include birth control coverage. Some legislators, such as Sen. Connie Johnson, D-Oklahoma City "…praised President Obama's administration [this week] for transforming women's healthcare in America by classifying birth control as preventative care" (Oklahoma Senate Office 2011k).

Requiring birth control coverage, however, caused most Oklahoma legislators to take action against the federal plan by passing state-based regulations that limited the extent to which a woman could access birth control, particularly limiting access to abortion inducing medication. For instance, press releases from 2010 to 2015 include coverage for a variety of

bills including the following: SB 1890, that "forbids an abortion based solely on the sex of the child;" SB 1891 that "creates the Freedom of Conscience Act, which protect[s] the right of healthcare professionals to refuse to take part in the destruction of innocent life;" and SB 1902 which "makes it illegal for a person other than a physician to provide or administer the chemical abortion pill, RU-486 for the purposes of inducing an abortion" (House of Representatives 2010h2). Other legislation such as HB 2780 (House of Representatives 2010w) and SB 1274 (Oklahoma Senate Office 2012z) increases access to ultrasounds and fetal heartbeat monitoring, respectively, for expectant mothers seeking an abortion. Additionally, legislation, HB 1409 increased the wait time from 25 hours to 72 hours between doctor visits for women seeking abortions. With each of these laws, legislators lack a medical reasoning behind the legislation. Instead, legislators question the decision-making capability of the mother seeking an abortion. They suggest that if healthcare providers present an expectant woman with enough information, then she will change her decision to receive an abortion. In this way, conservative legislators adopt the pro-woman position, outlined by Rose (2011). The following illustrate those common statements:

Governor:

> This legislation will help women get the information they need before making a decision they can't take back (Gov. Mary Fallin, R, Oklahoma Governor's Office 2015d).

Senator(s):

> As more information is made available to patients, my hope is that they will choose life for their children (Sen. Dan Newberry, R-Tulsa, Oklahoma Senate Office 2012z).

> This law is part of a broader effort to establish a culture of life in our state – one which places protection of the innocent and vulnerable among our greatest values and priorities (Sen. Dan Newberry, R-Tulsa, Oklahoma Senate Office 2012z).

Representative(s):

> …is about giving mothers as much information as possible in advance about this irrevocable, life-altering decision. We must do all we can to ensure every woman has all the facts so she can make the most informed decision possible (Rep. Lisa Billy, R- House of Representatives' Office 2010w).

> This bill protects Oklahoma mothers from making a decision the may later regret (Rep. Chris Benge, R-Tulsa, House of Representatives' 2010w).

Beyond educating mothers, this legislation works to further pro-life sentiments in Oklahoma. For example:

Senator(s):

> I'm grateful to my colleagues who stood with me today, and helped send a message that we value the sanctity of life. I believe every life has value and is sacred. It is my hope we can continue to make our state a safer place for the unborn (Sen. Dan Newberry, R-Tulsa, Oklahoma Senate Office 2012f).

> Oklahoma is blessed to now have a governor who recognizes and defends the value of human life. This legislation protects women and the unborn from potentially deadly medicine (Sen. Greg Treat, R-Oklahoma City, Oklahoma Senate Office 2011o).

Representative(s):

> In light of the passage of the federal healthcare bill in Congress over the weekend, we must be more vigilant than ever in protecting life here in Oklahoma (Rep. Chris Benge, R-Tulsa, House of Representatives' Office 2010h2).

In both sets of statements, legislators fail to engage in conversation that considers socioeconomic or other situational pressures faced by women that may encourage them to seek an abortion. They also express pro-life sentiments for an unborn child without consideration to the effects of life for the mother. In this instance, legislators may be considered pro-birth rather than pro-life or pro-woman (Rose 2011).

Although press releases from legislators use religious codes concerning birth control and abortion regulation, they do not mention *conservative pro-life* in conjunction with the ACA. Press Releases from all three sources lack any religious context when addressing the ACA. For instance, legislators who occasionally chose to use religious references to bolster other legislation failed to give similar religious context in terms of broader-based healthcare assistance, such as the ACA. Sen. Connie Johnson, D-Oklahoma City (Oklahoma Senate Office 2013k) points this out stating, "This is very much a humane issue in which we have a duty to be accountable to our fellow man. Everyone deserves access to basic healthcare. After all, are we not our brother's and sister's keepers?" In this way, she highlights how legislators ignore religious rhetoric that encourages taking care of those in need or those who are less fortunate and unable to access healthcare services. Instead, press releases give greater focus to the political and economic issues associated with expanding healthcare to the underinsured.

Category: Oklahomans

The category for Oklahomans refers to the people referenced in press releases with specific attention to Oklahomans who are or are prone to be underinsured in Oklahoma or affected by healthcare policy changes. These codes include groups such as elderly, women, children, veterans, working-class, voters, constituents, and those simply referred to as "the majority." Figure 5 is a graph of the use of codes that form this category from each government office.

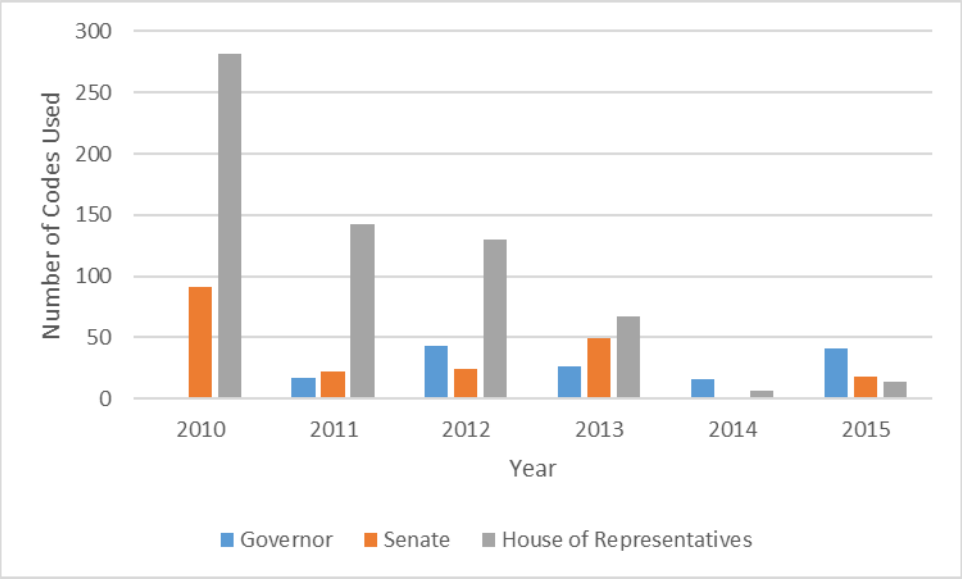

Figure 5: Code Use for Oklahomans by Year and Government Office

Few government press releases address the ACA as a positive healthcare reform initiative for Oklahomans. For example, only one press release from the Oklahoma Governor's Office and several contributions from the Senate directly address the positives of the ACA. For example:

Governor:

> The exchange will empower consumers and help individuals and small businesses to shop for and enroll in affordable, quality health insurance plans. This is a step in the right direction for Oklahoma and its citizens. (Gov. Mary Fallin, R, Oklahoma Governor's Office 2011a)

Oklahoma Senate Office:

> "For years, the debate on true healthcare reform has not been fact-based. It has been fear-based, driven by the greed of those who profit most from a broken system. As a result, hundreds of thousands of working Oklahomans have not been able to afford insurance." (Sen. Jim Wilson, D-Tahlequah, Oklahoma Senate Office 2010k)

In these press releases, legislators list the benefits of the ACA such as reducing the number of underinsured and expanding general medical services across the Oklahoma. However, legislators discuss the underinsured, referring to them as entitled, indigent, and needy populations. For instance:

Governor:

> Furthermore, the proposed Medicaid expansion offers no meaningful reform to a massive entitlement program already contributing to the out-of-control spending of the federal government (Gov. Mary Fallin, R, Oklahoma Governor's Office 2012b)

Representative(s):

> The commitment is also critical to ensure doctors continue to serve the medical needs of the indigent population in northeastern Oklahoma (Rep. Chris Benge, R-Tulsa House of Representatives' Office 2010p).

> The resolution notes that Oklahoma has worked diligently and effectively in making healthcare available to its neediest citizens through the Advantage Program, SoonerCare and Insure Oklahoma (House of Representatives' Office 2010o)

> States should be free to develop their own approaches to healthcare for the needy (Sen. Mike Ritze, R-Broken Arrow, House of Representatives" Office 2011v).

However, Rep. Mike Ritze addresses the lack of desire to expand Medicaid services in Oklahoma due to negative perceptions of the federally subsidized program.

> I have to wonder about a 'health reform plan' whose goal is to put the uninsured in Medicaid when many doctors already decline to see new Medicaid patients and where quality is overall, pretty poor, (Rep. Mike Ritze, R-Broken Arrow, House of Representatives 2010c2)

His sentiments oppose those that favor state-based health insurance programs, particularly Insure Oklahoma which I discuss in the section *place*. This statement also dismisses the

concept that some preventative care may be more beneficial than either no care or costly emergency room visits for low-income families. Furthermore, referencing doctors' reluctance to serve Medicaid patients illustrates the potential need to 1) restructure how doctors serve Oklahomans concerning percentages of Medicaid patients, 2) understand why Medicaid services are poor, and 3) how to encourage doctors to offer quality care to all patients without recognition to health insurance coverage.

However, on press release by the governor indicates that legislators understand the connection between healthcare and economic productivity. For example:

> Health is such an important issue in Oklahoma because it affects both our quality of life and our economy. For families, poor health can mean personal tragedy and medical bills that break the bank. For business, it means lower workforce productivity (Gov. Mary Fallin, R, Oklahoma Governor's Office 2012d).

Despite this recognition for the necessity of healthcare for working Oklahomans, there is little consistency in determining a solution via the ACA for healthcare expansion for these low-income families. Additionally, within a majority of the press releases, state legislators often refer to the working-class as an at-risk population for losing health insurance, should Oklahoma accept the ACA. Legislators suggest that Oklahoma's healthcare system has something to lose for those who already maintain health insurance with little regard to those who are priced out of participating in Oklahoma's free-market healthcare system. For example, Mike Ritze's (2010q) explained that, "Oklahoma has an extremely low physician–to-patient ratio, which will only be exacerbated by the federal mandates." Like most of Ritze's sentiments, which I discuss further in Chapter Five, his remarks suggest that adding more people into the insurance market is a burden not only on doctors but also to maintaining the quality of healthcare for other taxpayers. His statement disregards the opportunity for healthcare infrastructure expansion in Oklahoma.

Additionally, these sentiments fail to address the underinsured populations that do not qualify for insurance from their employers or who cannot afford insurance even as working Oklahomans. As shown in Figures 6 and 7, the press releases offered by legislators do not mention the populations of medically uninsured adults or children. Moreover, none of the press releases from the government offices pertain directly to regional differences of underinsured rates. As depicted in Figures 6 and 7, the eastern half of the state maintains a higher uninsured risk than the rest of Oklahoma, excluding Oklahoma City. Arguments presented by legislators suggest that working-class Oklahomans deserve healthcare, yet fail to recognize which classes of working-Oklahomans can actually access healthcare. Thus, the press releases concerning the ACA reveal the privilege experienced by the upper class and some in the middle classes who likely have access to healthcare with little regard to the fact that hundreds of thousands of Oklahomans do not have an opportunity to develop relationships with any type of physician.

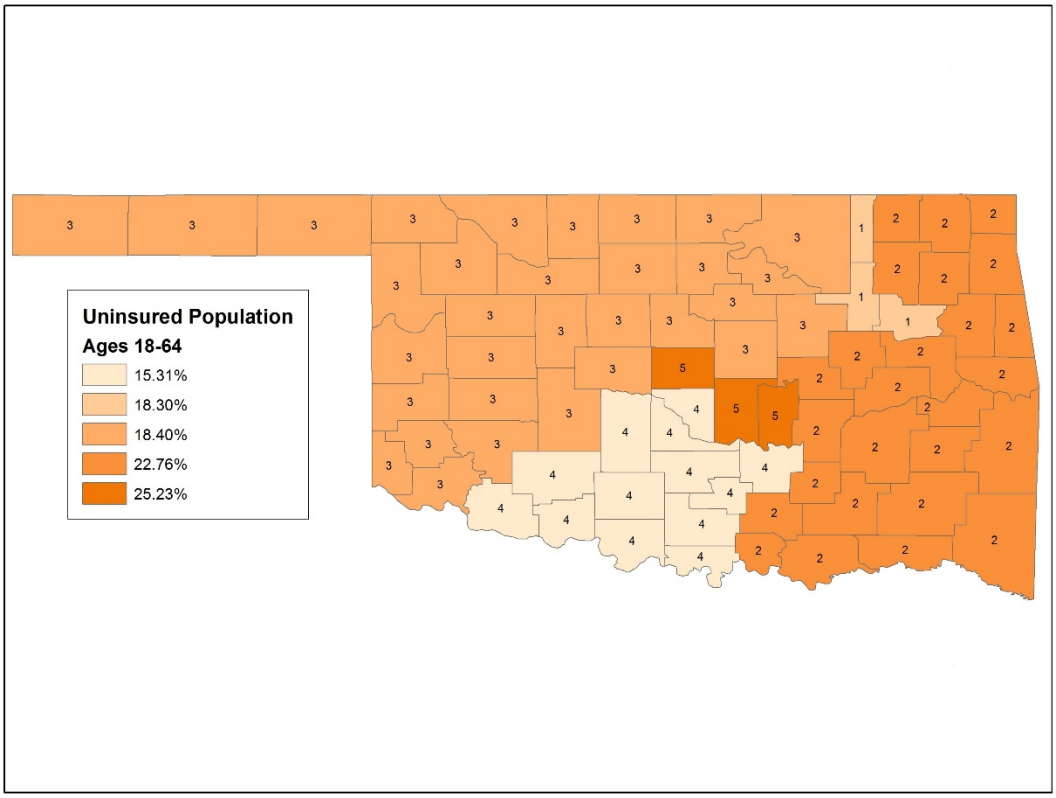

Figure 6: Medically Uninsured Adults by Congressional District, Source: Created by Author, SAHIE 2014 5yr Estimates, www. census.org

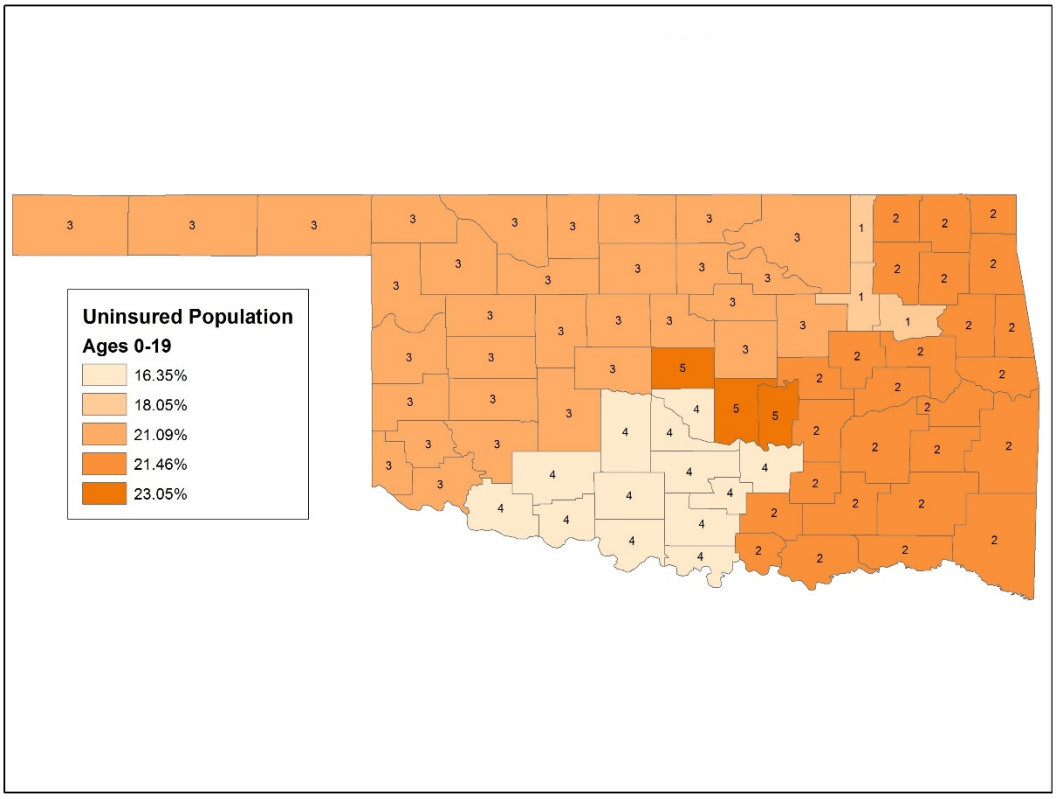

Figure 7: Medically Uninsured Children by Congressional District, Source: Created by Author, SAHIE 2014 5yr Estimates, www. census.org

Legislators often reference that a majority of voters or constituents exhibit a lack of support for the ACA. However, the context given in press releases for negative support is often unlisted in the press release or generated from the 2010 vote for SQ 756. This state question developed in response to two components of the ACA: 1) amending the Oklahoma Constitution to make it illegal to penalize those who do not purchase health insurance, and 2) protecting fee-for-service payment to healthcare providers. Nevertheless, legislators use lack of voter support for the ACA as a *generalized* statement to foster, in many of these instances, support against ACA expansion, as the following examples illustrate:

Governor:

> This choice has been forced on the people of Oklahoma by the Obama Administration in spite of the fact that voters have overwhelmingly expressed their opposition to the federal healthcare law through their support of State Question 756, a constitutional amendment prohibiting the implementation of key components of PPACA (Gov. Mary Fallin, R Oklahoma Governor's Office 2012a).

Senator(s):

> A broad majority of Oklahomans want to retain their freedom of choice regarding access to healthcare (Sen. Dan Newberry, R-Tulsa 2010d).
>
> Oklahomans simply do not want anything to do with ObamaCare, and Senate Republicans stand firmly with Governor Fallin in rejecting it (Brian Bingman, R-Sapulpa, Oklahoma Senate Office 2012l).

Representative(s):

> When voters approve this amendment, the Oklahoma Constitution will tell the federal government that they would like to pursue their own course when it comes to healthcare, Ritze said. Though a national majority opposes the healthcare overhaul, here in Oklahoma opposition is even greater and there is no reason we can't do things our way (Rep. Mike Ritze, R-Broken Arrow, Oklahoma House of Representatives' Office 2010e2).

Additionally, less than half of Oklahoma's registered voters turned out to cast a ballot for SQ 756; thus, press releases effectively dismiss: 1) the 35% of registered voters who did not support SQ 756, 2) the majority 52% of registered voters who chose not to or were unable to vote on SQ 756, and 3) the remainder of the constituency unable to vote on SQ 756, including Oklahomans who were not registered to vote, those who could not vote due to confines such as work or felony charges, and those who were too young to vote. To further illustrate the low turnout for SQ 756, Figure 8 represents the counties where there was either greater than or less than 50% turnout of eligible voters. It shows that of only 32 of 77 Oklahoma counties had greater than 50% of its eligible voters present for SQ 756. Additionally, Figure 9 shows the averaged vote by congressional district of the vote for SQ

756. This can be compared to figures 6 & 7, which ultimately show little relationship between underinsured rates and SQ 756.

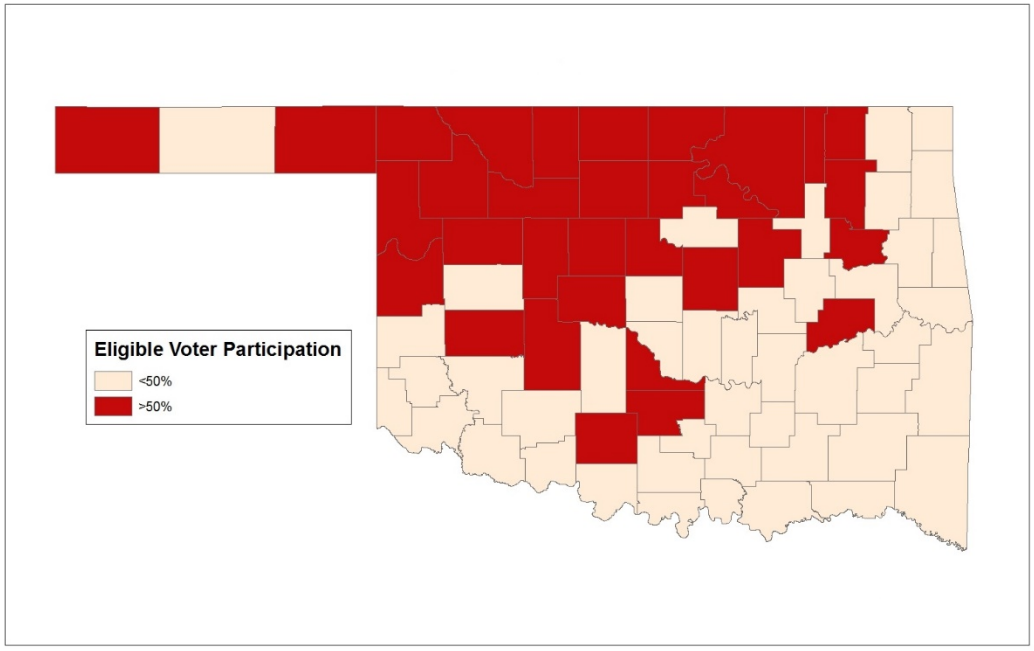

Figure 8: Eligible Voter Participation for SQ 756 by County, Source: Created by Author, Oklahoma State Election Board 2010.

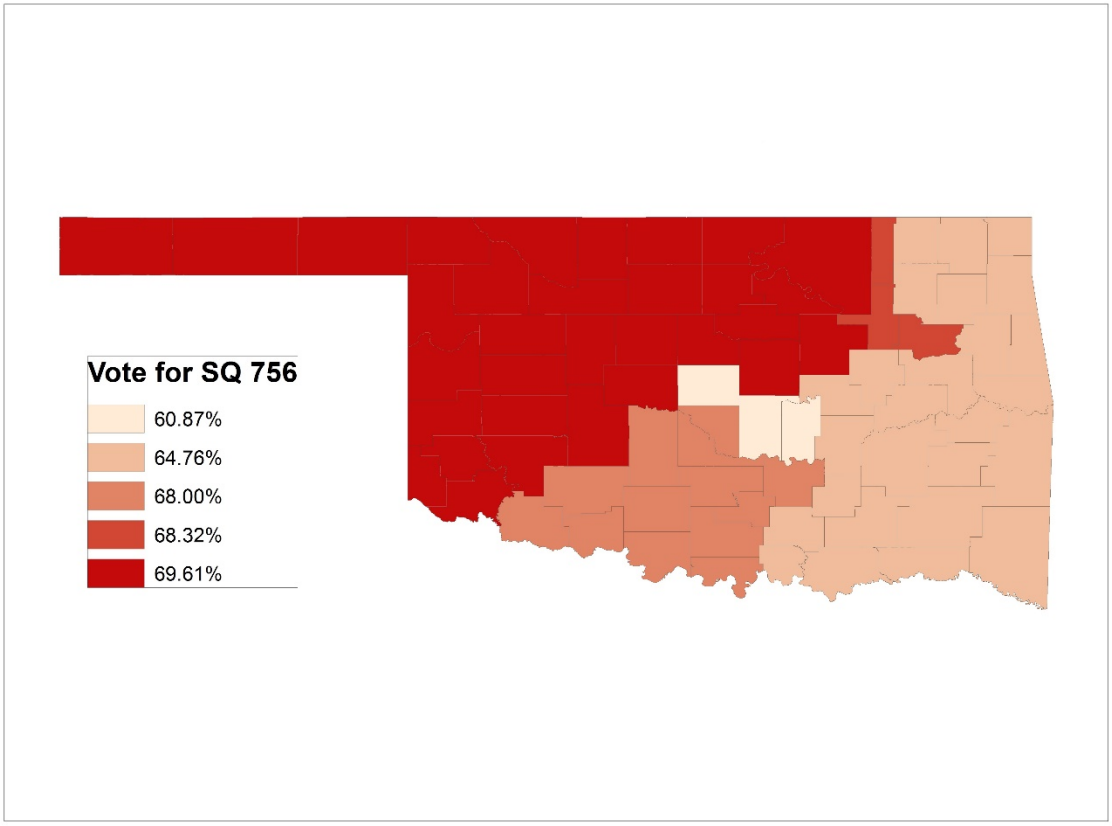

Figure 9: Averaged Vote for SQ 756 by Congressional District, Source: Created by Author, Oklahoma State Election Board 2010.

There is, however, one press release from the House that details a more substantive poll taken in 2010 (Derby 2010). Although the report indicates a lack of support from Oklahomans for federal healthcare reform, it does not indicate the level of knowledge assumed by the respondent about the ACA. In addition, the press release describes those that responded on the site as likely voters. In this instance, legislators: 1) recognize only the voting population, and 2) if the population pooled is truly "likely voters," then based on voter turnout statistics, the responding population polled most likely represents registered voters who are white, college educated, and older than 65 (Pew Research Center 2012).

By realizing only a fraction of the voting constituency base, legislators effectively dismiss the beliefs, statements, and opinions of the *majority* of Oklahomans concerning the ACA. Effectively, legislators view only those participating in the voting process as valid contributors to their political position. Recognizing only the voting population, combined with the lack of recognition for the public healthcare services utilized across the state, illustrates legislators disregard for their total constituency and preference only for the few that vote and those with preexisting access to health insurance. Additionally, their reliance on SQ 756 as a general understanding of Oklahoman's support for or against the ACA provides a distinctly narrow view of the encompassing nature of the ACA. For instance, had the vote pertained to more favorable components of the ACA, such as allowing children to stay on parents' insurance until age 26 or requiring insurance companies to accept those with pre-existing conditions, the interpretation of the vote for ACA may have resulted in those Oklahomans favoring the ACA.

Category: Conservative Hegemony

The category of *conservative hegemony* encompasses the most prevalently used concepts in this analysis. The most predominant discussion that deals directly with the ACA pertains to press releases and legislator use of free-market principles and freedom of individual choice. The concepts are primarily used in the discussions of health insurance market reform and relate most closely with political and economic themes. The category for *conservative hegemony* details legislative discourse that oppose mainstream liberal principles in favor of conservative values. Figure 10 shows a graph of the codes use that form the category *conservative hegemony* by each office.

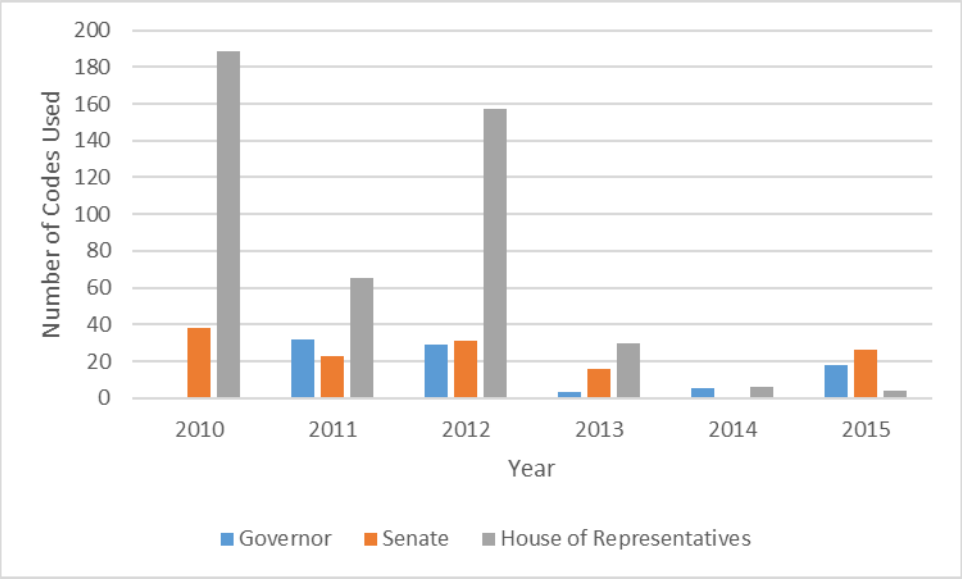

Figure 10: Code Use for *conservative hegemony* by Year and Government Office

Some legislators believe that the ACA will reduce competition between health insurance companies and providers by stabilizing the pricing structures within health insurance markets. In this way, legislators believe that reducing competition also reduces the quality of care received by Oklahomans. The press releases fail to cover the potential of the ACA to expand business—particularly small business—throughout the state. In fact, legislators assert that the ACA Act will *harm* Oklahoma's economy and *reduce* jobs, as the following statements show:

Governor:

> Any exchange that is PPACA compliant will necessarily be 'state-run' in name only and would require Oklahoma resources, staff and tax dollars to implement (Gov. Mary Fallin, R, Oklahoma Governor's Office 2012a).

Senator(s):

> The Democrat Jobs Elimination Bill of 2010, as Coffee referred to it… (Sen. Glenn Coffee, R-Oklahoma City and Rep. Chris Benge, R-Tulsa, House of Representatives' Office 2010f2).

Representative(s):

> The legislation passed over the weekend is a partisan plan and bad fiscal policy, which will cost teachers, corrections officers, state troopers, firefighters, and many others their jobs when taxes are raised to fund ObamaCare (Sen. Glenn Coffee, R-Oklahoma City and Rep. Chris Benge, R-Tulsa House of Representatives' Office 2010f2).

The Governor, Senate, and House press releases echo the concept of free-market principles. The press releases present the ACA as a mechanism by which the Federal government infringes upon states' rights to manage private health insurance markets that use free-market principles. Particularly in Senate press releases, legislators herald free-market principles as the best solution to maintain and stabilize the health insurance market in Oklahoma. Conservatives from all three sources state that free-market business models create competition and, as such, have the ability to lower prices for consumers:

Governor:

> As this case moves through the federal court system, I look forward to continued validation that the 'individual mandate' is unconstitutional and in contradiction with the free-market principles that have made this nation great (Gov. Mary Fallin, R, Oklahoma Governor's Office 2011e).

> We believe that, rather than Big Government bureaucracy and one-size-fits-all solutions, the free-market principles of choice and competition are the best tools at our disposal to increase access to healthcare and reduce costs (Gov. Mary Fallin, R Oklahoma Governor's Office 2012b).

Senator(s):

> It will spur competition among providers, encouraging innovation and improved service. Governor Fallin and Republican leadership stood on principal today, opposing a pernicious federal mandate with a forward-thinking plan to empower Oklahomans through free-market tools. (Sen. Dan Newberry, R-Tulsa, Oklahoma Senate Office 2011d).

> Beginning development of our own state-based, free-market exchange is clearly the best way to stop the federal government from barging into Oklahoma to build a highly-regulated, anti-free-market federal exchange we don't want or need. The last thing any state

> needs is a government healthcare takeover (Sen. Gary Stanislawski, R-Tulsa, House of Representatives' Office 2012h).

Representative(s):

> Because this proposal relies on the free-market, it will give greater power to consumers and, ultimately, a better product (Rep. Mike Ritze, R-Broken Arrow, 2011h).

Assuming that Oklahoma consumers benefit from free-market principles, press releases and legislators use free-market in conjunction with a sense of individualism and freedom of choice to indicate that free-markets allow consumers to individually choose their health insurance plans while, as presented in the text, the ACA would limit the choice of health insurance. For example:

Governor:

> President Obama's healthcare law is unconstitutional and unaffordable. Not only will it limit choice and undermine the quality of American healthcare, it stands to cost the state of Oklahoma about half a billion dollars in the process (Gov. Mary Fallin, R Oklahoma Governor's Office 2011b).

Senator(s):

> This ballot proposal would allow Oklahomans to opt-out of any healthcare system dictated by Washington, and preserve their freedom to choose a plan that best suits their needs (Sen. Dan Newberry, R-Tulsa, Oklahoma Senate Office 2010d).

> I believe Oklahomans should have the freedom to choose their own healthcare and insurance plans… (Sen. Randy Brogodon, R-Owasso, Oklahoma Senate Office 2010p).

> Depriving citizens of the right to make their own choices about health care runs contrary to American ideals (Sen. Nathan Dahm, R-Broken Arrow, Oklahoma Senate Office 2013a).

Representative(s):

> My hope is that ObamaCare will be repealed, but I do not think that means we have to wait for the repeal to happen. Oklahoma lawmakers should do what they can to support our choice to make our own healthcare decisions (Rep. Mike Ritze, R-Broken Arrow, Oklahoma House of Representatives' Office 2014e).

The concept of individual choice, as presented, in most legislative discourse pertaining to freedom of choice assume that *all* Oklahomans inherently have and maintain freedom to access health insurance markets. This free-market idealization, however, disregards the nature of healthcare services in that healthcare markets maintain an independent economy for an essential service. Some legislators, however, recognize the ideological differences between healthcare as a right versus an economic privilege. For example,

Senator(s):

> Healthcare is a right, and Oklahoma has already paid a high price in senselessly lost lives due to a lack of proper and timely healthcare access and treatment. Businesses continue to suffer low productivity because of the poor health of workers who often don't have insurance to cover healthcare costs (Sen. Connie Johnson, D-Oklahoma City, Oklahoma Senate Office 2013k).
>
> Health care is not a right, it is an enterprise, and it works best with fewer market distortions and the incentive to improve the services it offers customers (Sen. Nathan Dahm, R-Broken Arrow, Oklahoma Senate Office 2013a).

This means that because everyone needs healthcare services—just like food, shelter, water, and energy—people must purchase healthcare as presented by healthcare markets. This also means that without regulation, healthcare market pricing lacks measures to keep prices down (Scott, et al. 2001; Tanner 2012; Mills. 2016). Thus, elevated health insurance prices limit the "freedom of choice" for low-income Oklahomans to purchase health insurance.

Press releases discussing free-market principles reveal two essential points. First, each of these statements indicates that free-market principles remain a mechanism by which healthcare markets experience greater competition and thus lower prices for better quality care. Second, these statements indicate that free-market principles grant greater power to consumers by increasing choice. The extreme support for free-market principles, however,

failed to empower Oklahomans when Insurance Commissioner John Doak recruited insurance companies to Oklahoma that failed to provide plans for young children. These health insurance companies also used pricing policies that allowed upwards of 80 cents of every dollar spent to fund resources that remained irrelevant to healthcare service (Oklahoma Senate Office 2012o Oklahoma Senate Office 2012q). This meant that for every dollar Oklahomans spent on these insurance plans, only 20 cents actually went towards health care services. Legislature support against these free-market health insurance plans rested on the realization that companies benefited far more than consumers. Sen. Adelson, D-Tulsa (Oklahoma Senate Office 2012o) states, "…the Commissioner is protecting insurance company profits at the expense of Oklahoma consumers."

In response to the federal governments relative inability to regulate insurance markets via the McCarran-Ferguson Act of 1945 (Mills 2016), several legislators pushed through legislation similar to other states' regulations for insurance companies, setting minimums on the amount of money spent by each insurance company on healthcare services and thereby reducing free-market practices in Oklahoma (Oklahoma Senate Office, 2012). Despite Oklahoma's mishaps with free-market health insurance plans, conservative legislators in Oklahoma still support idealized free-market principles. For example:

> I disagree with Senators Burrage and Adelson and the aid they are giving to President Obama in his war on the private healthcare system. As their plans are being discussed, it is important to remember that many Democrats don't actually want the private health care system to succeed, and so the failures they've created in the health insurance market are as much by design as by mistake. The child-only policy is just one example of a Democrat created failure.
>
> What is happening is that the Democrats are trying to legislate a long list of utopian healthcare mandates that will guarantee the business of insurance cannot be conducted profitably. If they are successful, no one will be capable of operating profitably in the healthcare market,

> and only the government will be willing to operate in the market at a loss. At that point the Democrats will have finally achieved their decades-long dream of completely socializing healthcare in America.
>
> Oklahomans reject ObamaCare and I'm confident they will likewise reject the attempt of Senators Burrage and Adelson to socialize Oklahoma's healthcare system. Commissioner Doak has a track record of finding free market solutions to our healthcare problems, and I'm confident he'll be able to clean up the child-only mess the Democrats have left Oklahoma without the help of any legislation proposed by Senators Burrage and Adelson (Sen. Ralph Shortey, R-Oklahoma City, Oklahoma Senate Office 2012x)

This press release also shows the inability of lawmakers to take responsibility for state-based mistakes concerning healthcare policies, instead placing the blame on the Affordable Care Act. The Oklahoma Governor's Office expresses similar sentiment stating,

> The lack of child-only policies in the Oklahoma marketplace was an unintended consequence of the federal Affordable Care Act. (Oklahoma Governor's Office 2012e)

Supporting free-market principles, in these was, gives an unrealistic interpretation of healthcare market structure. For instance, free market principles, ideally, create a competitive market in which the consumer is favored. However, as Scott et al. (2001) and Mills (2016) point out, health care markets operate under fixed-market enterprises meaning that these health insurance companies are able to set healthcare prices because they realize that every person will purchase some form of health care services. This is why, without regulation, an insurance company can legally operate using only 20% of its income to afford for actual medical costs for its customers and offer exclusive policies, effectively increasing health insurance prices for consumers.

However, although legislators promote free-market principles when they discuss the folleys of ACA reforms, legislators fail to consistently apply their free-market positions across *all* healthcare reforms. For example, prior to and during ACA restructuring and

Oklahoma's simultaneously failing budget, state agencies looked for ways to reduce costs. Several legislators considered a series of initiatives to reduce the cost of pharmaceuticals for HealthChoice employees. Under the proposed plan, OSEEGIB would save $75 million by outsourcing HealthChoice members' pharmaceutical purchases to New Jersey. However, legislators decided to keep an insurance plan that supported in-state purchasing of pharmaceuticals, causing state agencies to reconfigure their budgets. Press releases and legislators marketed the decision to support in-state business by highlighting the $13.1 million in savings for the state.

> …option of supporting home town pharmacies while enjoying significant savings. OSEEGIB is leading by example— just like any small business does, the Board encouraged competition to lower costs while providing a quality product. This vote means members will see $6.7 million in savings, while the state will save $13.1 million. This is good news for Oklahoma taxpayers and for Health Choice members throughout the state, especially in our rural communities (Sen. Brian Bingman, R-Sapulpa, Oklahoma Senate Office 2011z)

Press releases and legislators fail to recognize that by forcing in-state pharmaceutical purchasing, they contradict hegemonic principles of free-market principles by effectively limiting where agencies purchase health insurance plans. Despite state legislators effectively limiting the free-choice market, they still compare it to the ACA. Sen. Anderson, R, states,

> This plan is a great example of what we can expect under Obama-care…Under the new pharmacy plan, this state agency has dictated that you can no longer choose who you want to use as your pharmacist – you must instead use the company in New Jersey that the state agency has preselected for you. (Oklahoma Senate Office 2011w)

In this instance, however, state legislators support hegemonic principles by supporting state-based pharmaceutical purchases. Press releases and legislators fail discuss effectively the repercussions to the state agencies and corresponding service users such as increased healthcare spending in favor of Oklahoma business-owner interests, keeping state-based pharmaceutical companies intact. Within the discussion, economically conservative codes

contradicted the small business codes in that choosing out-of-state insurance coverage would save the state millions, but also reduce in-state pharmaceutical commerce.

Category: *Divisive Speech*

The category for *divisive speech* includes codes that encourage a division along party lines including divisive use of the term "ObamaCare" and constitutionally-based representations of State vs. Federal Rights to influence readers to choose sides on the issue of healthcare reform. Press releases and legislators' contributions that use *divisive speech* generally fail to support federal healthcare reform. In contrast, legislators use unifying speech, discussed in the section *place*, to create a sense of state-based unity against federal reform. Figure 11 shows the distribution of the use of *place* by government branch and year.

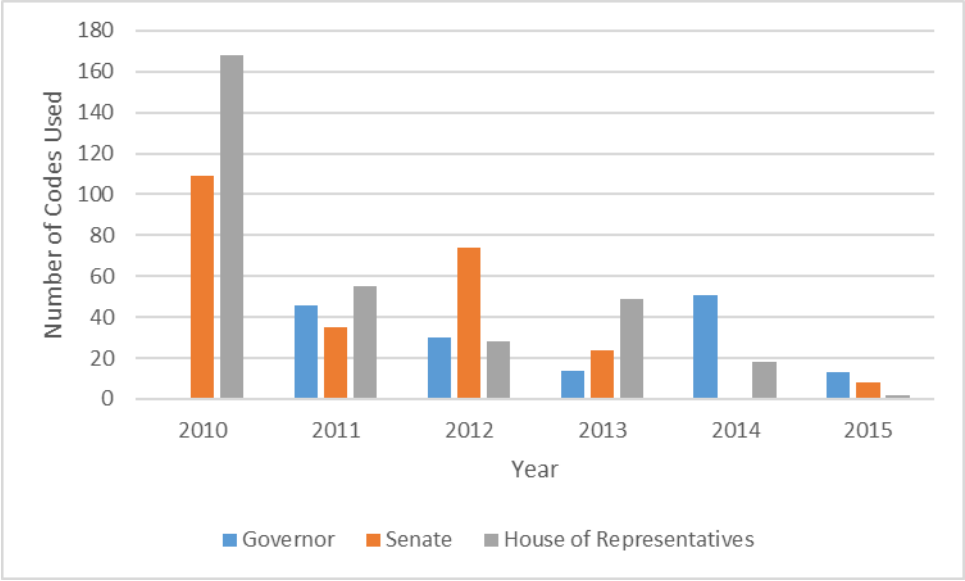

Figure 11: Code Use for *divisive speech* by Year and Government Office

Additional divisive language used to foster support against the ACA included statements that create an artificial either-or option between highly valued priorities. For example:

Governor:

> On a state level, massive new costs associated with Medicaid expansion would require cuts to important government priorities such as education and public safety (Gov. Mary Fallin, R, Oklahoma Governor's Office 2012a).

Representative(s)

> The legislation passed over the weekend is a partisan plan and bad fiscal policy, which will cost teachers, corrections officers, state troopers, firefighters and many others their jobs when taxes are raised to fund ObamaCare (Oklahoma House of Representatives' Office 2010f2).

Instead of fostering an understanding of correlative policy decisions, the governor relies on an incorrect interpretation of causation to encourage the decision to refuse healthcare expansion in Oklahoma. This sense of urgency does not foster a balanced analysis of all policy options available or convey a realistic interpretation of the state budget to constituencies.

One of the primary sentiments that arises from *divisive speech* concerns the conservative interpretation of the Constitution of the United States that suggest that the ACA is unconstitutional. The discussion of constitutionality primarily surrounds the impetus for SQ 756, which dealt with taxation due to opting-out of federal healthcare reform. Additional issues of constitutionality also surfaced under *NFIB v. Sebelius* in 2012, *Burwell v. Hobby Lobby* in 2014, and *King v. Burwell* in 2015. The following examples show how press releases use constitutionality as a pillar of their positions in discussions for health policy reform:

Governor:

> The Supreme Court should strike down the president's health care reform as unconstitutional as soon as possible. The uncertainty

> surrounding the future of PPACA is frustrating to those who believe it stands as an obvious affront to constitutional principles, and a hindrance to crafting serious budget and health care policy on both the state and federal levels (Gov. Mary Fallin, R, Oklahoma Governor's Office 2011b).

Senator(s):

> Repeal of this law is a real possibility, and it needs to be the rallying cry for those who value our constitutional freedoms (Sen. Bill Brown, R-Broken Arrow, Oklahoma Senate Office 2012d).

Representative(s):

> Some, even in Oklahoma will suggest that Article VI of the Constitution makes ObamaCare the 'supreme law of the land. But he added; "In doing so, they fail to understand as Alexander Hamilton did when he wrote in Federalist No. 33 'it expressly confines this supremacy to laws made pursuant to the Constitution….' Alexander Hamilton got it right, Congress and the Supreme Court got it wrong (Rep. Mike Ritze, R-Brokwen Arrow, Oklahoma House of Representatives' Office 2013o).

Other references that create a division along party lines or state v. federal affiliation include references to health policy reform that place blame or exhibit support for particular positions. The following include examples from press releases and legislators' contributions:

Governor:

> President Obama's healthcare policies will limit patients' healthcare choices, reduce the quality of healthcare in the United States, and will cost the state of Oklahoma approximately a half billion dollars in the process (Gov. Mary Fallin, R, Oklahoma Governor's Office, 2012b).

Senator(s):

> Governor Fallin needs to make Oklahoma's position clear and tell President Obama that she will not choose to implement this new tax on the taxpayers of Oklahoma (Sen. Patrick Anderson, R-Enid, Oklahoma Senate Office 2012b).

Representative(s):

> Few of the assorted promises that were made about ObamaCare are being kept, as should have been obvious from the beginning to anyone who was paying attention," said Ritze, R-Broken Arrow. "Premiums are rising, total health spending continues to jump, coverage is being cut back and cancelled, and employment itself is suffering from what has already occurred and what is around the corner (Rep. Mike Ritze, R-Broken Arrow, Oklahoma House of Representatives' Office 2013n).

In these instances, legislators blame the President, his administration, or *his* ObamaCare for: 1) limiting healthcare choice, 2) reducing quality of care, and 3) and budget shortfalls. Legislators provide little mention that: 1) not all Oklahomans have healthcare access and thus 2) access to quality care, and 3) that Oklahoma budget problems predate healthcare expansion and could be helped by investing in Oklahoma's healthcare infrastructure (Leavitt Partners 2013; Oklahoma Senate Office 2013q). In response to these tactics used by conservative legislators, Sen. Sean Burrage, D-Claremore states,

> "We just wasted $500,000 in taxpayer dollars to learn what we already knew – the only way to provide health insurance to Oklahomans currently covered by Medicaid is to take the federal dollars being offered to us to expand the program…We have also wasted two years scoring political points and thumbing our noses at the Obama administration when we could already have a model program up and running that could be an example for the nation.

In his statement, Sen. Burrag recognizes that Oklahoma leaders in the legislature have used their political positions to espouse negativity towards ACA expansion at the expense of improvements to Oklahoma's healthcare. Thus, a majority of legislators disregard their position in the hiccups experienced through ACA implementation. For example, Beland, et al. (2014) shows that the ACA is a law with many moving parts that requires the assistance of multiple state and federal offices to execute a successful implementation. However, as state legislators continuously challenge the ACA through a variety of court cases and refuse

to take part in the nationwide healthcare reform, they effectively dismiss the positive potential of ACA expansion on Oklahoma's healthcare landscape.

Category: *Charged Speech*

The category for *charged speech* includes codes which are more hostile in nature than the category of *divisive speech* and that are used to villanize a particular position or induce fear in constituencies. This category also covers speech that overly exaggerates either positive or negative interpretations of healthcare controversy. The use of *charged speech* is predominantly used in statements that do not support federal healthcare reform than those that support healthcare reform. Press releases from conservative legislators use terms such as "force" rather than terms such as "adopt" to illustrate the government's perceived control over the states. Figure 12 shows the distribution by government branch and year for *charged speech*.

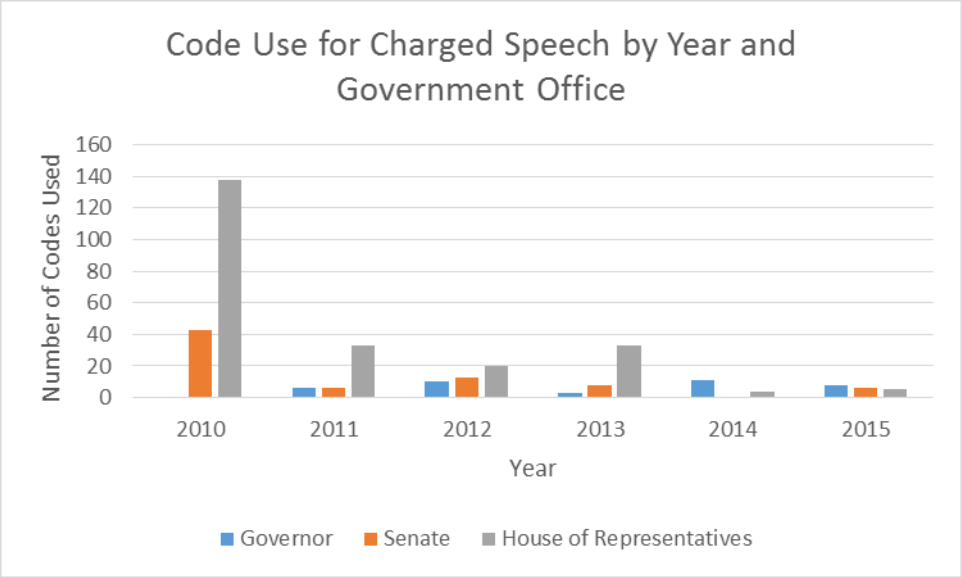

Figure 12: Code Use for *charged speech* by Year and Government Office

Press releases that use *charged speech* refer to the perceived repression experienced by Oklahomans using exaggerated terms such as outrageous, suffocate, monstrosity, and tyrannical. The following provide examples of *charged speech*:

Governor:

> For years, I have argued that ObamaCare represents bad policy, irresponsible spending, an outrageous expansion of federal authority into the private sector, and unconstitutional law (Gov. Mary Fallin, R Oklahoma Governor's Office 2014f)

Senator(s):

> At a time when our focus should be on stabilizing the economy and creating jobs, the federal government has chosen to interfere and suffocate our liberties and the American dream (Sen. Todd Lamb, R-Edmond, Oklahoma Senate Office 2010u)

> Washington has turned a deaf ear to the people this monstrosity would most directly effect (Sen. Glenn Coffee, R-Oklahoma City, Oklahoma Senate Office 2010i)

Representative(s):

> I believe what Congress did is unconstitutional and I am going to do everything I can to stand between the people and a tyrannical federal government (Rep. Randy Brogdon, R-Owasso, Oklahoma Senate Office 2010l)

In each of these instances, the legislators use language that is both divisive and hostile. Hostile language in this case works to induce fear within the constituency towards: 1) Federal Government, 2) Associations of the Federal Government such as the Democratic Party or Obama (thus the use of ObamaCare in conjunction with force, and 3) The ACA as a byproduct of the Federal Government. These press releases and legislators fail to recognize that passage of the ACA required bipartisan support (Govtrak 2010). Furthermore, the rhetoric used in this type of *charged speech* does not explain how the underinsured benefit from ACA expansion.

Category: *Place*

The category of *place* includes codes that reference a *place*-based component. *place*-based mentions are important for several reasons in this analysis because they can be used to modify positions to create a sense of unity as the people of Oklahoma and conversely, a sense of other when placed on a national scale. Examples of *place*-based codes include references to towns, districts, states, and terms with specific significance to Oklahoma such as "Sooner." Additional codes under the *place*-based category include those that foster state, regional, or national affiliation such as Oklahomans, Southerners, or Americans. For instance, the Rural Republican Caucus addresses the need for expanded healthcare access in each of their annual press releases. They also consequently dismiss the ACA as a possible solution to rural health issues, particularly primary care services. In any case, government press releases and contributions by legislators in the Governor, Senate, and House offices' used *place*-based mentions in healthcare policy discussions as depicted in Figure 13.

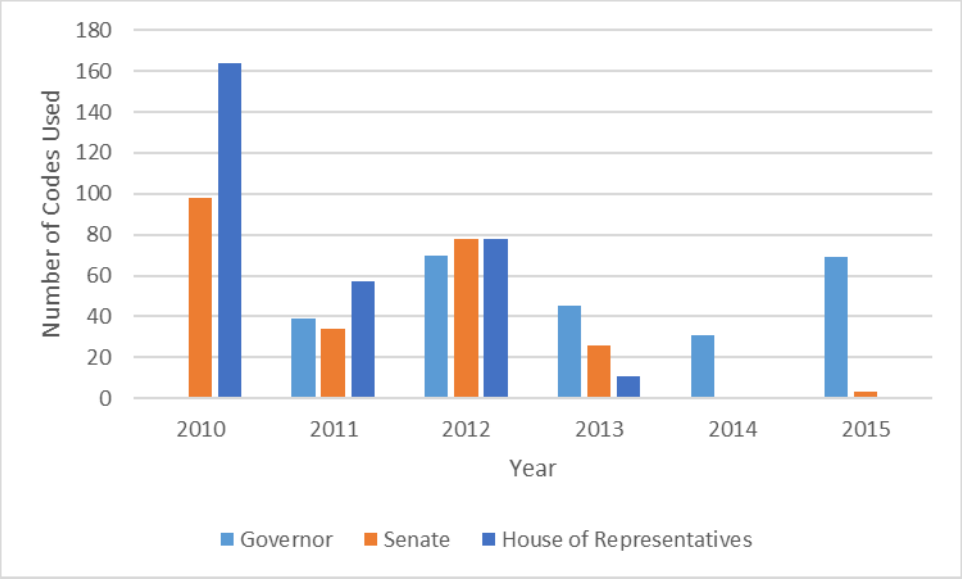

Figure 13: Code Use for *place* Year and Government Office

Accordingly, the sense of unity as "the people of Oklahoma" is especially apparent in press releases and legislator contributions that favorably discuss state-based healthcare reforms via Insure Oklahoma as a way to best serve Oklahomans' needs. Likewise, legislators sometimes create a sense of "other" against federal involvement in Insure Oklahoma. The following statements show this othering:

Governor:

> After thoroughly reviewing the 'early innovator' grant, I am happy to say that the federal assistance we are being offered is consistent with our mission to design and implement an Oklahoma-based health insurance exchange. That exchange will empower consumers and help individuals and small businesses to shop for and enroll in affordable, quality health insurance plans. This is a step in the right direction for Oklahoma and its citizens (Gov. Mary Fallin, R Oklahoma Governor's Office 2011f)

Senator(s):

> Beginning development of our own state-based, free-market exchange is clearly the best way to stop the federal government from barging into Oklahoma to build a highly-regulated, anti-free-market federal exchange we don't want or need. The last thing any state needs is a government healthcare takeover (Sen. Gary Stanislawski, R-Tulsa, Oklahoma Senate Office 2012h)

Representative(s):

> Our state is poised to build on the successes we have seen with our nationally-recognized Insure Oklahoma program and other efforts to reduce the uninsured (Rep. Chris Benge, R-Tulsa, Oklahoma House of Representatives' Office 2010g)

> This would be an Oklahoma exchange run by Oklahomans the way Oklahomans want it run. It would have no federal hands on it whatsoever (Rep. Glen Mulready, R-Tulsa Oklahoma House of Representatives' Office 2012h)

Although the support for state-based healthcare reforms remains fairly consistent throughout press releases, legislators expressed greater distain for federal involvement as the roll-out of ACA expansion continues through 2015. This is in part due to the perceived loss

of state control over healthcare resources. Accordingly, Governor Fallin returned the $54 million Early Innovator grant that could have been used to bolster the state-run program Insure Oklahoma, stating that any healthcare exchange in Oklahoma funded by federal dollars would be run in state-name only (Oklahoma Governor's Office 2012a). Although other states, such as neighboring Arkansas expanded their state-based programs, Oklahoma refused the opportunity to expand its state-based programs to fit a modified version of the ACA expansion plan.

By returning federal funds and failing to expand healthcare services, for instance, through the pre-existing state option Insure Oklahoma, the state-based program lost its portion of federal funding. This cessation of federal funds for the state-based, public-private partnership, in conjunction with legislators' refusal to expand Medicaid, resulted in thousands of Oklahomans losing their health insurance coverage. Rather than taking responsibility for the legislative mishap; however, policy-makers, such as Governor Fallin, further encouraged an othering against the federal government. She states, "Insure Oklahoma is the kind of state-based healthcare option the federal government should be supporting" (Oklahoma Governor's Office 2014a). These statements, however, fail to recognize that Oklahoma legislators could have developed better systems to serve the underinsured via state-based legislation prior to ACA expansion or developed a similar state-based system, as in other neighboring states.

place-based mentions give relational context to the people in Oklahoma and also create a sense of regional unity where Oklahoma legislators compare Oklahoma's progress to that of other states with similar conservative ideology on healthcare policies. As previously discussed under subsection *Oklahomans*, a majority of press releases lack a discussion of the

distribution of the underinsured and the *place*-based barriers associated with accessing healthcare services for many Oklahomans. As a whole, the Governor's press releases do not mention the regionality of the underinsured, nor do they address the issues concerning access for the underinsured in certain areas of the state. However, regionality is covered as a unifying entity. For example, Coffee (Oklahoma Senate Office 2010i) states, "Our purpose is to make our voices heard from the Heartland to the Washington Beltway." Furthermore, Oklahoma legislators particularly those in the house, compare Oklahoma to states such as Idaho, Tennessee, Arkansas, Texas, etc. Figure 14 shows states mentioned by state legislators. The count for Oklahoma was not included due to its disproportionate amount of uses. Accordingly, it is designated by a star.

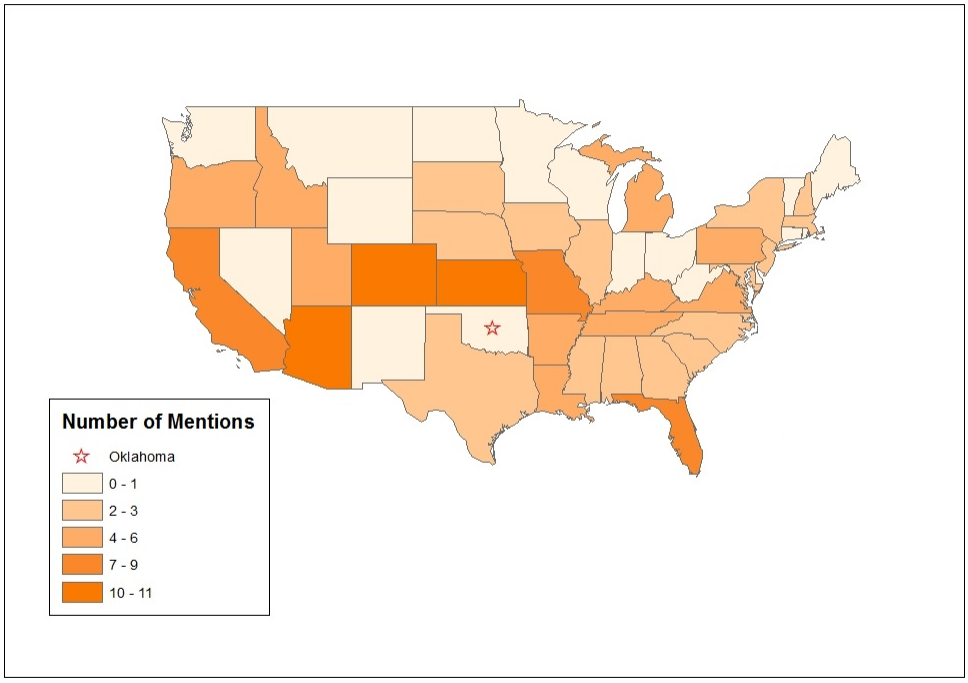

Figure 14: State Mentions in ACA Government Press Releases, Source: Created by Author

Southern and Midwest states most often compared with Oklahoma generally oppose federal healthcare expansion and maintain similar political ideology to that of Oklahoma. For example:

Senator(s):

> This is a bipartisan concern, Coffee noted. Just last week, the Democrat controlled Virginia state senate passed a bill that would block the implementation of the individual mandate of ObamaCare in that state, and many leading Oklahoma Democrats, including some statewide elected officials, have expressed their concern (Sen. Glenn Coffee, R-Oklahoma City, 2010i)

Congressional Leader:

> The state of Tennessee had an especially painful experience with its state Medicaid program, TennCare. The program nearly bankrupt the state and thousands of individuals were eventually cut from the rolls (Sen. Tom Coburn and Jonathan Small, Governor's Office 2014e)

In each of these examples, however, legislators use *place*-based comparisons in press releases but they lack information concerning the "why" behind a state's decision to support or deny healthcare reform.

Summary of Themes

In press releases from the Governor, Senate, and House, legislators discuss the ACA using Political, Economic, and Social themes. Based on my codes and categories, the prevalence of political and economic is not surprising due to the overlap of economic involvement in political decisions in conservative politics. Furthermore, this coincides with Smith's (1998) research that shows how conservative rhetoric has increasingly relied on economic positions. The categories and associated codes that pertained most to the political theme include *divisive speech*, *charged speech*, and *conservative hegemony*. Likewise, the categories *conservative hegemony* and Oklahomans deal most closely with economic themes. Based on the

discussions present in the press releases, Oklahoma legislators reportedly want to protect conservative ideals and state-based systems that favor local economies. This may be due to legislators perceived need to comply with voting constituencies, previously outlined by Mayhew (1974). With that in mind, press releases and legislator contribution depicted the ACA as an invasive federal measure to decrease state control of healthcare services. Via this push for conservative political and economic ideals, government press and legislators fail to recognize and consequently publicize the potential for federal funds to improve state-based programs such as Insure Oklahoma. In this way, the press releases work to promote the conservative agenda by focusing press releases that cover conservative healthcare policy coverage and, in part, remain responsible for misinforming Oklahomans (Shapiro Block-Elkron 2008). The discourse fails to address the opportunity for economic growth in Oklahoma via healthcare systems investment, which could result in job creation, support of small businesses, a healthier and more productive working-class, and increased appeal of Oklahoma as a stable place to live for prospective transplants (Leavitt Partners 2013; Maruthappu, et al. 2013).

Although the press releases and legislator contributions extensively referenced conservative political and economic ideals, they gave little attention to conservative social themes that would hint at accepting the ACA as a social good. In fact, the theme Social, which included categories and associated codes such as *conservative pro-life* and Oklahomans, was the most selectively used theme found in my analysis. Legislators dedicated a majority of their *conservative pro-life* rhetoric to pro-life, anti-abortion legislation. Likewise, their focus on Oklahomans in these press releases centered on the health of women and children, but that focus pertains primarily to women as expectant mothers for the sake of fetuses. In other words, the focus on social themes surround pro-birth conservatives but fail to conform to a

liberal interpretation of comprehensive pro-life positions. In considering the ACA, legislators rarely mention morality, social good, or religiously-under toned concepts that encourage Oklahomans to expand healthcare coverage to the underinsured. A majority of the discussions that pertained to specific groups focused on those who might lose their current insurance with little recognition of those who would gain health insurance. Little concern was also granted to Oklahomans who lacked health insurance or those who were spending exorbitant amounts on health insurance. This is due to conservative rhetoric that generally encourages economic positions rather than socially-based positions (Smith 1998).

In accordance with a majority of press releases and legislator contributions using politically and economically based positions, legislators in Oklahoma appear more concerned with espousing conservative rhetoric and supporting small business initiatives. Socially, legislator consider the working class as an at-risk population for loosing health insurance and various healthcare services; however, press releases and legislators provide little consideration to the actual hardships working-class Oklahomans face when seeking healthcare services including cost, availability of insurance plans, and access to nearby health service providers. Additionally, legislators disregard other essential preventative care discussions that include services not covered on basic health insurance like dental and optometry services.

Overall press releases and legislators fail to address the social implications of healthcare. This suggests legislative shortsightedness when considering the economic longevity of Oklahoma. As the social theme is left virtually untouched by a majority of press releases, outside of references Oklahomans with pre-existing access to health insurance or to the voting population, legislators effectively recognize only interests of their more privileged

constituencies, disenfranchising a majority of their actual constituency. In this way, legislators align with Mayhews (1974) research that indicates members of congress work to serve their voting electorate. Additionally, by not addressing the implications of the underinsured, legislators render the state of Oklahoma subject to the rarely discussed economic implications of maintaining a largely underinsured population. Underinsured populations have less access to preventative care, thus utilizing emergency services for basic care. This results in an abundance of high fees that families cannot afford and increases the amount of uncompensated care that taxpayers effectively absorb as hospitals use this expense as a tax credit (Leavitt Partners 2013). In this way, while increasing the number of insured people has the potential to increase taxes on Oklahomans—even though the federal government subsidizes a majority of Medicaid expansion under the ACA, not expanding preventative care to underinsured individuals guarantees additional taxes on Oklahomans due to uncompensated care (Leavitt Partners 2013).

Additionally, by not providing affordable health insurance to an already burdened constituency, Oklahoma creates an unfavorable environment for upward mobility of lower-income Oklahomans. Not only does limiting upward mobility harm that demographic, it also hurts Oklahoma's overall economic landscape by limiting the economic potential locked in unhealthy populations. As Maruthappu et al (2012) state, "Healthcare is an essential requirement for well-being, conferring on one the ability to do other activities; it is therefore, a condition upon which many other factors are determined." Thus, not addressing implications of social themes surrounding the underinsured disregards their potential to affect positively Oklahoma's political and economic landscapes. Due to the interconnected nature of quality policy development, government offices need to find more balance in their

discourses as they discuss the political, economic, *and* social implications of health policy in order to produce a healthier Oklahoma landscape.

CHAPTER V

KEY LEGISLATORS IN OKLAHOMA'S ACA HEALTHCARE REFORM

Chapter 5

KEY LEGISLATORS IN OKLAHOMA'S ACA HEALTHCARE REFORM

In the following chapter, I discuss the role of key legislators in ACA healthcare reform discussions through government office press releases. This analysis only includes Republican legislators and corresponding conservative view points because they were the legislators who contributed at least ten substantive quotes that pertained to the ACA between 2010 and 2015. This chapter provides more in-depth analysis to address my first and second research questions, "How have Oklahoma's state legislators (mis) represented the healthcare needs of their constituencies between 2010 and 2015?" and "In what ways have Oklahoma legislators represented the underinsured, Medicaid eligible, and Medicaid participating constituencies in government press releases?" Press releases reported legislators' direct quotes throughout the healthcare debate, shaping media portrayal of Oklahoma's legislative discussions. Whether these press releases were commissioned by specific offices or authored by Oklahoma legislators for personal interests remains unknown. However, several legislators contributed more quotes than others, lending greater name

recognition of particular government officials in the discussion of healthcare reform in Oklahoma between 2010-2015.

Thus, I included only legislators responsible for a minimum of ten substantive contributions to the healthcare debate between 2010-2015. Some contributors served only a portion of the 2010-2015 time frame. The legislators I analyzed included Governor Mary Fallin, R; Sen. Dan Newberry, R-Tulsa; Sen. Brian Bingman, R-Sapulpa; House Speaker Rep. Chris Benge, R-Tulsa; Rep. Mike Ritze, R-Broken Arrow; and Sen. Dan Newberry, R-Tulsa and are included in Table 2. Since a majority of Oklahoma legislators are conservative, a majority of the statements made by state legislators remain unsupportive of the ACA. In fact, all legislators analyzed in the following section withhold their support for ACA expansion in Oklahoma.

In the following sections, I provide a review of the categories and codes for this portion of the analysis. I then provide a brief biography of each legislator because, as both Fenno (1973) and Mayhew (1974) discuss, legislators' careers are comprised of a mutually constitutive relationship between personal positions, positions that promote their career, and positions that they maintain in the legislature. I then provide a detailed analysis of how each legislator uses particular information to inform their press release contributions. Here, I only use direct quotes from government press releases. I conclude with a discussion that details the implication of legislators' contributions. Accordingly, I outline how their positions influence the readership and thus, public opinion of ACA reform in Oklahoma.

Overview of Legislators Use of Codes by Category

Overall, legislators used codes that related to the categories of *place*, *divisive speech* and *Oklahomans* most prevalently throughout their contributions to government press releases. Although the overall make-up of their discourse is detailed in Figure 15, I explain how each legislator contributed to the total discourse in the following sections.

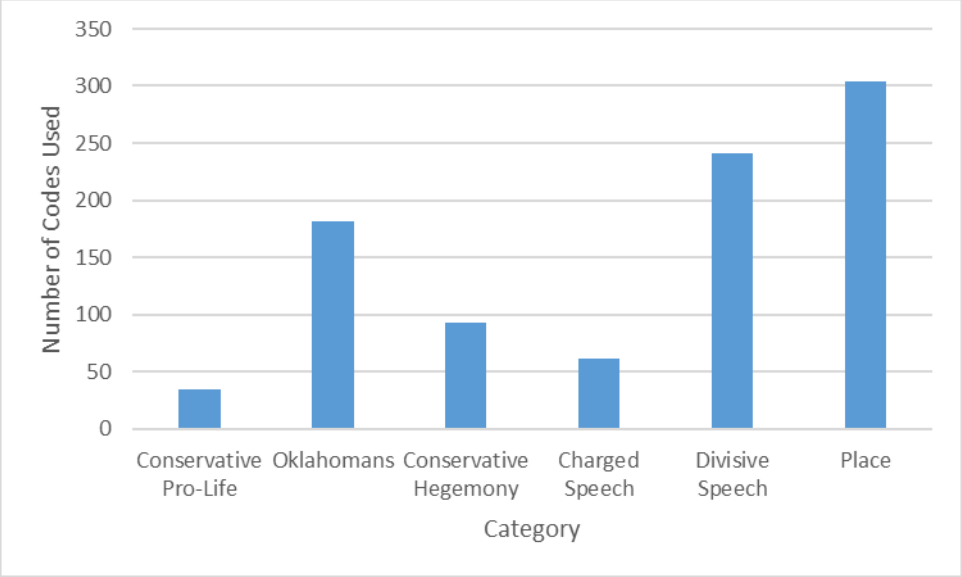

Figure 15: Summation of Legislator Code Use by Category

Figure 15 summarizes the legislators' code use by each of the categories. *place*, *divisive speech*, and *conservative pro-life* where used most often by the five legislators. The category for *conservative pro-life* was used the least, most likely due to less press releases solely focusing on birth control and abortion legislation. In contrast, the category *Oklahomans* was used in legislator quotes to refer to Oklahomans affected by healthcare reform. As a result, they had a relatively high count for this category. Likewise, relatively high numbers for the category *place* likely reflect legislators' preference for state-based alternatives to ACA expansion.

Codes found in both *place* and Oklahomans are often used in conjunction with *divisive speech*. For example,

> I along with many of my fellow legislators call on the people of Oklahoma to contact your State Representatives and ask them to fulfill their duty to protect the citizens of Oklahoma from this unconstitutional infringement on their unalienable rights. (Rep. Mike Ritze, R-Broken Arrow, House of Representatives 2013o).

In this example, "Oklahoma" is used to create a sense of unity among its citizenry as a front against the federal government. Accordingly, the terms "people" and "citizens" contribute to the category *Oklahomans*. Lastly, *divisive speech* is listed via the code "unconstitutional." This example also provides an excellent example of *conservative hegemony* in the use of the codes "duty to protect" and "unalienable rights." However, moderate counts for *conservative hegemony* and *charged speech* may be explained by less common use of these categories in direct quotes and greater use in press releases.

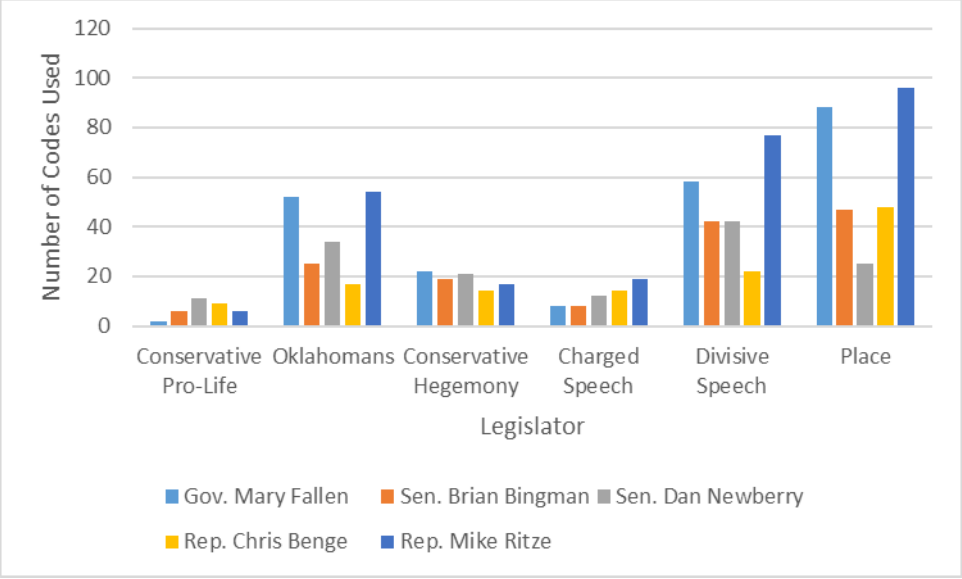

Figure 16: Comparison of Legislator Code Use by Category

As shown in Figure 16, legislators rely on different categories in their rhetoric. For instance, Gov. Mary Fallin and Rep. Mike Ritze are the greatest contributors to the categories *Oklahomans*, *divisive speech* and *place*. Sen. Dan Newberry is the greatest contributor to Conservative Pro Life. Lastly, all legislators contribute fairly equally to *conservative hegemony* and *charged speech* in their direct quotes. In the following sections, I provide a more detailed discussion of each legislators' category of use.

Governor Mary Fallin, R

Governor Mary Fallin has served in a variety of positions involving state and federal government. Prior to her second term as the first female governor of Oklahoma, she served two terms as a state representative for Oklahoma City, became the first woman lieutenant governor in 1995 serving three terms, and lastly, from 2007-2011 served as Oklahoma's 5th congressional district representative within the U.S. House of Representatives (ok.gov 2016). Her platform aligns with conservative ideology that includes reducing the size and involvement of the Federal Government by lowering taxes as a means to promote economic growth. Thus, she has a well-established career that has led her to become Oklahoma's head of state. Overall, Gov. Fallin's discourse contributions, shown in Figure 17, mirror that of the overall legislator analysis presented in Figure 15. Within her quotes in the press releases, Gov. Fallin uses fewer codes that pertain to the categories of *charged speech* and *conservative pro-life*. *conservative pro-life* speech may be reduced due to little coverage offered by the Oklahoma Governor's Office.

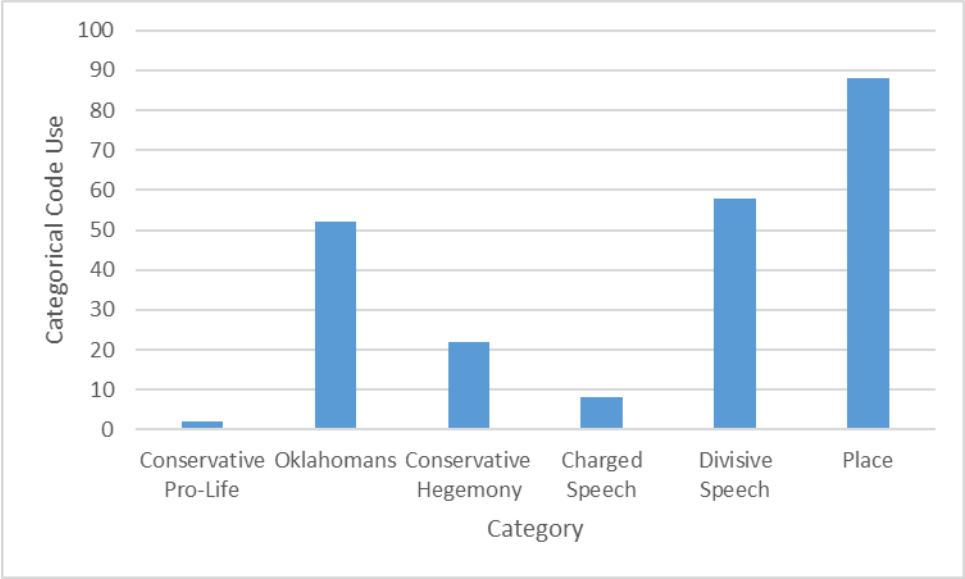

Figure 17: Governor Mary Fallin, R Code Use by Category

Gov. Fallin initially begins with a positive outlook towards federal healthcare reform via the $54 Early Innovator Grant Oklahoma received to establish a state-based market exchange (Oklahoma Governor's Office 2011). However, after the push from the House of Representatives later in 2011 to reject healthcare reform in favor of maintaining existing state-based programs, her tone changed to one that relies more heavily on conservative Oklahomans, *divisive speech*, and *place*. With these three categories combined, her discourse often encompasses the idea that a state-based program, such as Insure Oklahoma, would be the best option for creating a healthier Oklahoma, as opposed to a federally mandated system. For example:

Example 1:

> After thoroughly reviewing the 'early innovator' grant, I am happy to say that the federal assistance we are being offered is consistent with our mission to design and implement an Oklahoma-based health insurance exchange (Oklahoma Governor's Office 2011f).

Example 2:

> President Obama's health care law is unconstitutional and unaffordable. Not only will it limit choice and undermine the quality of American health care, it stands to cost the state of Oklahoma about half a billion dollars in the process (Oklahoma Governor's Office 2011b).

Example 3:

> Our second and equally important task will be to pursue state-based solutions that improve health outcomes and contain costs for Oklahoma families (Oklahoma Governor's Office 2012a).

She also uses the category for Oklahomans to discuss working families and the majority of Oklahomans, which in context of ACA healthcare reform refers to Oklahomans that already have insurance. Gov. Fallin pays little attention to Oklahomans who remain without access to affordable health insurance, referring to programs that expand coverage as entitlement programs. Reference to these types of government assistance programs as "entitlement programs" also falls under the code, *conservative hegemony*.

> Furthermore, the proposed Medicaid expansion offers no meaningful reform to a massive entitlement program already contributing to the out-of-control spending of the federal government (Gov. Mary Fallin, R, Oklahoma Governor's Office 2012a).

In total, Gov. Fallin's discourse mirrors that of the overall themes associated with the broader analysis of government press releases. This means that although she sometimes recognizes that healthcare needs to improve in Oklahoma, she provides little sustainable initiative dedicated towards enacting policies through the ACA to mitigate Oklahoma's healthcare issues.

Senator Brian Bingman, R-Sapulpa

Sen. Brian Bingman has served in several local and state government positions. Prior to serving in the State Senate, Bingman held private sector positions in the oil industry and served as the Mayor of Sapulpa. He also served as a member of the House from 2004 to

2006 and as a member of the Senate from 2006 to present where he also serves as the President Pro Tempore (oksenate.gov 2016). Overall, Sen. Bingman's discourse contributions, shown in Figure 18, mirror that of the overall legislator analysis presented in Figure 15.

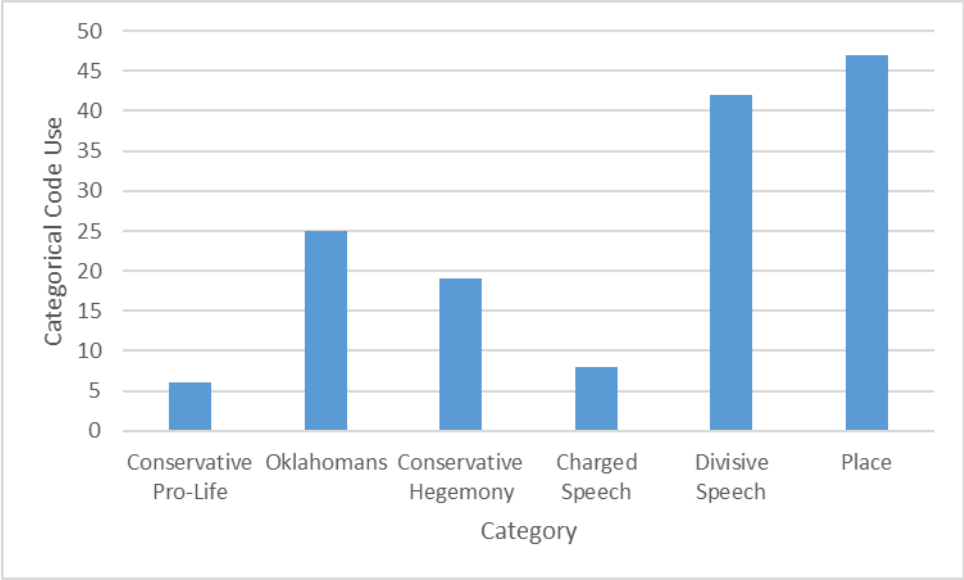

Figure 18: Senator Brian Bingman, R-Sapulpa Code Use by Category

Senator Brian Bingman, similar to Gov. Fallin, expressed initial support for ACA expansion via the acceptance of the $54 Early Innovator Grant (Oklahoma Governor's Office 2011). However, his attitude changed quickly, using *Divisive* and *charged speech* to refer to the ACA as a mechanism by which the federal government infringes upon state's rights. For instance, Sen. Bingman advocates that:

> ObamaCare represents a dangerous, unprecedented expansion of the federal government's reach into our everyday lives. Worse yet, it will kill jobs and crush small businesses under the weight of unsustainable cost increases. It is my hope that the Supreme Court will reject President Obama's unconstitutional healthcare law, just as we've done here in Oklahoma (Oklahoma Senate Office 2011f).

In this instance, Sen. Bingman relies on *charged speech* via the use of codes such as "dangerous," "kill," and "crush" followed by *divisive speech* using codes such as "President Obama's unconstitutional." This language in conjunction with *divisive speech* defines clearly the senators' sentiments for federal healthcare reform. Additional contributions mirror this combination of Charged and *divisive speech*, as seen in the following example:

> Republicans in the state Senate will do everything in our power to block ObamaCare in Oklahoma. When President Obama rammed through a trillion-dollar unconstitutional assault on the healthcare freedom of Oklahomans, he proved his values are fundamentally at odds with ours, said Senate President Pro Tempore Brian Bingman, R-Sapulpa. The fight to preserve healthcare freedom is far from over (Oklahoma Senate Office 2012n).

In his quotes, Sen. Bingman uses the terms "Oklahoma" and "Oklahomans" to create a sense of unity across the state. For example:

> Oklahomans know President Obama overreached when he forced his unconstitutional government healthcare takeover through Congress. That's why our state voted overwhelmingly to keep ObamaCare, and its individual mandate to buy government-sanctioned health insurance, from becoming law (Oklahoma Senate Office 2011f).

His overall discussions are heavily laden with *divisive speech*, *place*, and Oklahomans. Instead of addressing the underinsured population, he focuses on the business aspects surrounding the ACA such as federal overreach or the need to support businesses and their owners. Sen. Bingman rarely mentions specific groups of people such as women, veterans, or children. Instead, he refers to assistance programs as entitlement programs:

> We cannot support making Oklahoma more reliant on federal dollars, nor can we support growing our $16 trillion national debt to fund an unsustainable entitlement expansion (Oklahoma Senate Office 2012l).

Additionally, as mentioned in Chapter Four, Sen. Bingman contradicts his hegemonic values by supporting in-state pharmaceutical choices rather than utilizing free-market principles that would save state agencies $75 million per year:

Example 1:

> What Oklahomans want is conservative, common-sense healthcare reform to lower the cost of care using free-market principles (Oklahoma Senate Office 2012k).

Example 2:

> Friday's vote to adopt a new prescription drug plan for state employees was the result of thoughtful cooperation between the public and private sectors to ensure members will have the option of supporting home town pharmacies while enjoying significant savings (Oklahoma Senate Office 2011g).

Overall, Sen. Bingman fails to recognize Oklahoma's need for healthcare reforms in a manner that provides affordable access to preventative care for underinsured Oklahomans. His interests remain locked in efforts that maintain Oklahoma's current unhealthy landscape and short-sited business ventures that capitalize on fixed local markets. He fails to recognize that Oklahoma's opportunity for state-based healthcare reforms existed prior to ACA reforms and that the legislature took too little action to remedy the exclusive healthcare system.

Senator Dan Newberry, R-Tulsa

Prior to serving in the state senate, Sen. Dan Newberry received an education in Charismatic Ministry at Oral Roberts University. He currently serves in the senate as the Republican Chairman of the Business and Commerce Committee. Sen. Newberry also serves as a ranking member in the following committees: Appropriations, Appropriations Subcommittee on Select Agencies, Pensions, and Transportation and as the Senate Majority Whip. In the legislature and via interest groups, he is recognized for authoring the Oklahoma constitutional amendment against the ACA and for his pro-life position and subsequent legislation, of which he has received awards from Americans United for Life and

Oklahomans for Life—two pro-life interest groups active in Oklahoma(oksenate.gov). His discourse distribution, presented in Figure 19, does not mirror the overall distribution of discourses presented in Figure 15, with less contributions to place and relatively greater contributions to *conservative pro-life*, *conservative hegemony*, and *divisive speech*.

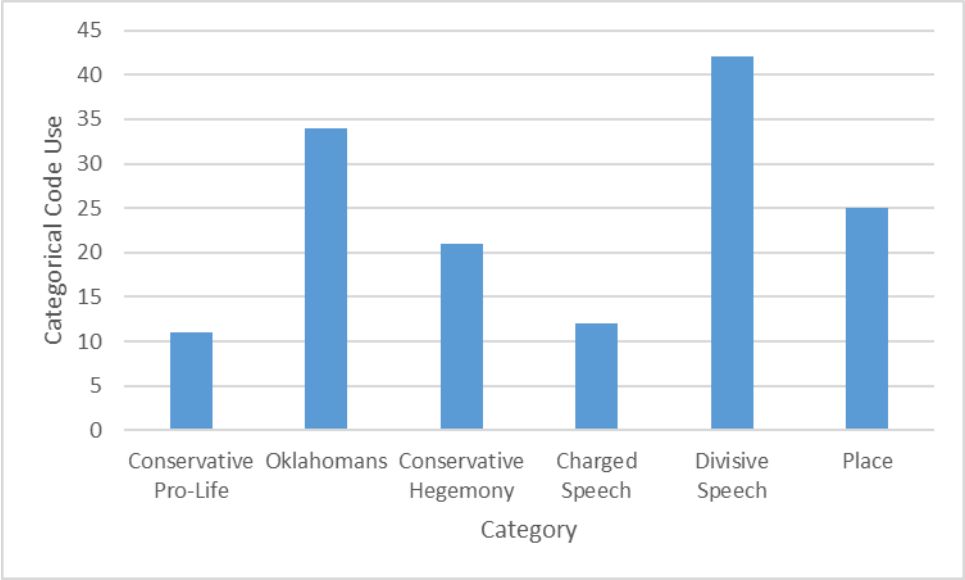

Figure 19: Senator Dan Newberry, R-Tulsa Code Use by Category

Sen. Newberry's contributions to *conservative pro-life* make sense considering his active involvement in developing pro-life legislation. He has made it known that he believes, "… every life has value and is sacred. It is my hope we can continue to make our state a safer place for the unborn" (Sen. Dan Newberry, R-Tulsa, Oklahoma Senate Office 2012f). Although his legislative statements espouse pro-life sentiments, they fail to encompass liberal interpretations of comprehensive pro-life legislation such as expanded health insurance access for thousands of Oklahomans, potentially offered through ACA expansion.

In fact, Sen. Newberry uses *divisive speech* and *Oklahomans* to create a sense of unity against federal healthcare reforms. He also references demographics that he views will be

harmed by ACA implementation, including Oklahoma families and seniors. In this way, he disregards the families that could be helped by ACA expansion and fails to detail how seniors, who already maintain access to Medicare, will be unnecessarily burdened by ACA expansion. For example:

> Bigger government and mandated healthcare will now put unnecessary burdens on Oklahoma families, small businesses and especially our senior citizens. Tax increases necessary to fund this so-called 'reform' will strap families across our state and nation, making economic and job growth more difficult. Billions of dollars will be cut from Medicare, raising premiums yet cutting benefits for seniors (Sen. Dan Newberry, R-Tulsa, Oklahoma Senate Office 2010j).

On that same note, he fails to recognize how insuring more Oklahomans may result in economic improvement in Oklahoma, of which, senior citizens may benefit. Sen. Newberry also refers to federal healthcare reform as socialized medicine. In additional reference to Oklahomans, Sen. Newberry fails to provide lacks a comprehensive discussion about the confines of SQ 756 which is similar to sentiments expressed in a majority of press releases. For example, he states:

> I'm proud that Oklahoma voters stood against this drastic turn toward a socialized medical system (Sen. Dan Newberry, R-Tulsa Oklahoma Senate Office 2010e).

In this instance, he over-emphasizes the scope of SQ756 to encompass a much broader interpretation of negativity against the ACA when in contrast, certain parts of the plan may be highly favorable among Oklahomans.

Sen. Newberry also maintains a relatively high code use for *conservative hegemony*, using codes such as "freedom of choice" and "encourage competition" to indicate preference for free-market business structures. For example:

> Now, more than ever, we need leaders who will step forward and repeal the law, replacing it with a healthcare solution that will protect the doctor-patient relationship, restore freedom of choice and encourage competition (Sen. Dan Newberry, R-Tulsa Oklahoma Senate Office 2012i).

In this instance, he states his preference for freedom of choice and competition between insurance companies, most likely in an effort to reduce prices. He fails, however, to recognize how the current healthcare system maintains exclusionary practices that inflate the healthcare to the point that thousands of Oklahomans cannot afford to purchase health insurance (Smith et al 2006; Mills 2016). Additionally, Newberry only values the economic contribution offered through increased competition between health insurance companies. He lacks the insight that by insuring Oklahomans, they have the potential to contribute more to Oklahoma's economy as healthy workers, which is echoed in research by Marathuppu et al. (2012), Oklahoma Governor's Office (2012d), and Leavitt Partners (2013).

Representative Chris Benge, R-Tulsa

Rep. Chris Benge served in Oklahoma's House of Representatives from 1998 to 2010. During his time, he served as chairman of the House Appropriations and Budget Committee and worked to promote transportation initiatives. After 2010, he served in Tulsa local government where he received several awards, such as the Defender of Free Enterprise Award in 2009, from the Oklahoma State Chamber. In 2013, Gov. Fallin appointed him to serve in his current position, Secretary of State. In this position, he also serves in the Governor's cabinet (Oklahoma Secretary of State 2016). Overall, Rep. Chris Benge's discourse contributions, shown in Figure 20, mirror that of the overall legislator analysis presented in Figure 15. However, he has a lesser contribution to *divisive speech* and *Oklahomans* than other legislators. Predominantly, his discussions deal with *place*.

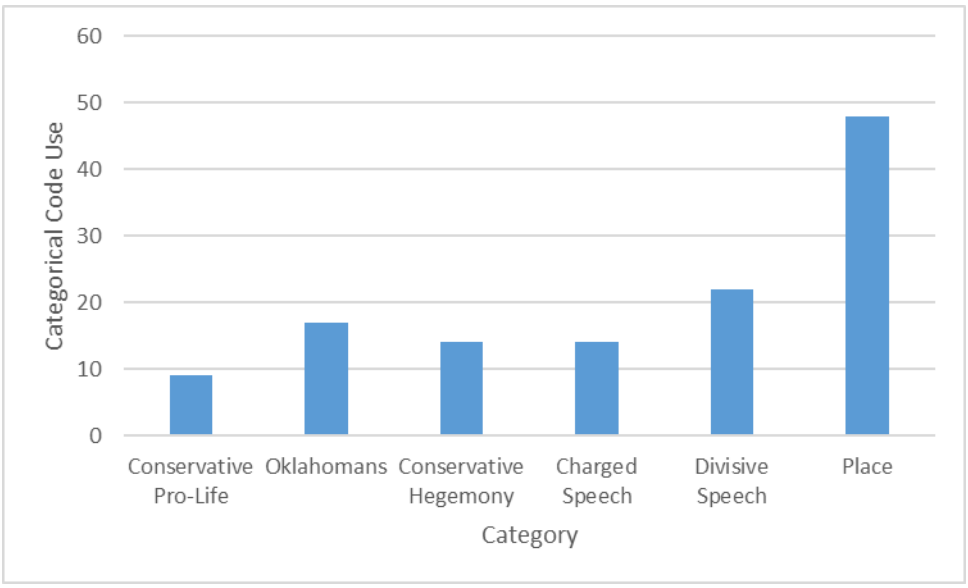

Figure 20: Representative Chris Benge, R-Tulsa Code Use by Category

Accordingly, his discourse pertains to economic interests of Oklahoma using a state-based approach to solve healthcare reform issues. For example,

> We should have the ability to expand on successful programs that are currently serving Oklahomans well, while encouraging creative ideas to expand access to affordable, quality healthcare in our state (Rep. Chris Benge, R-Tulsa, Oklahoma House of Representatives' Office 2010o).

This quote also shows Rep. Benge's preference for relying on state-based healthcare initiatives that depend on a volatile state budget as compared to a relatively slow-to-effect-change federal government budget. Additionally, Rep. Benge fails to recognize, like many of his fellow legislators, that Oklahoma legislators have had the opportunity to create legislation to expand healthcare services to the underinsured prior to ACA expansions. Instead of recognizing the potential for the ACA to bolster Oklahoma's economy by investing in Oklahoma's healthcare infrastructure via alleviating the cost-burden of healthcare, providing well-paying jobs, and supporting local businesses, he argues that, "If the measure becomes

law, it will wreck Oklahoma's already fragile state budget and place undue economic hardships on the people, especially our seniors, and businesses of our great state," (Oklahoma House of Representatives' Office 2010 f2).

However, even though Rep. Benge recognizes that Oklahoma's budget is fragile, he suggests using taxpayer funds to pay lawyers to challenge ACA implementation. This effectively directs funds away from investing in Oklahoma's healthcare system. He states:

> The cost of such a lawsuit is obviously a concern given our current budget situation, but what our state can definitely not afford to do is sit on the sidelines and let this bill become law. The high taxes, record debt and loss of personal choice within the healthcare system will irreparably change the landscape forever. We have to challenge this law, (Rep. Chris Benge, R-Tulsa, Oklahoma House of Representatives' Office 2010m).

In this way, not only does he fail to support improving healthcare for many of the underinsured, he effectively reduces the funding for those programs and dismisses the opportunity as Speaker of the House to garner legislative and community support to positively address longterm solutions for Oklahoma's healthcare issues. In these ways, Rep. Benge's discourse also corresponds with the overall analysis of government press releases in that he focuses on the Political and Economic implications of expansion with little attention to the Social implications beyond that of business owners and those with pre-existing insurance. He also fails to recognize the economic potential locked in the working class that remains with limited access to healthcare services (Maruthappu et al. 2012; Oklahoma Governor's Office 2012d; Leavitt Partners 2013).

Representative Mike Ritze, R-Broken Arrow

Prior to Rep. Ritze's tenure as a member of Oklahoma's House of Representatives, he served as a medical doctor and educator in the Tulsa area. His biography also notes

substantive involvement in Christian missionary programs where he served as a medical liaison. He is also known for his contributions as a co-author on HR 1054, the "Freedom of Healthcare Choice Act" in 2010. This bill worked to disable portions of the ACA being implemented in Oklahoma (House of Representatives 2016). Rep. Ritze's discourse, shown in Figure 21, mirrors that of the overall legislator discourse presented in Figure 15.

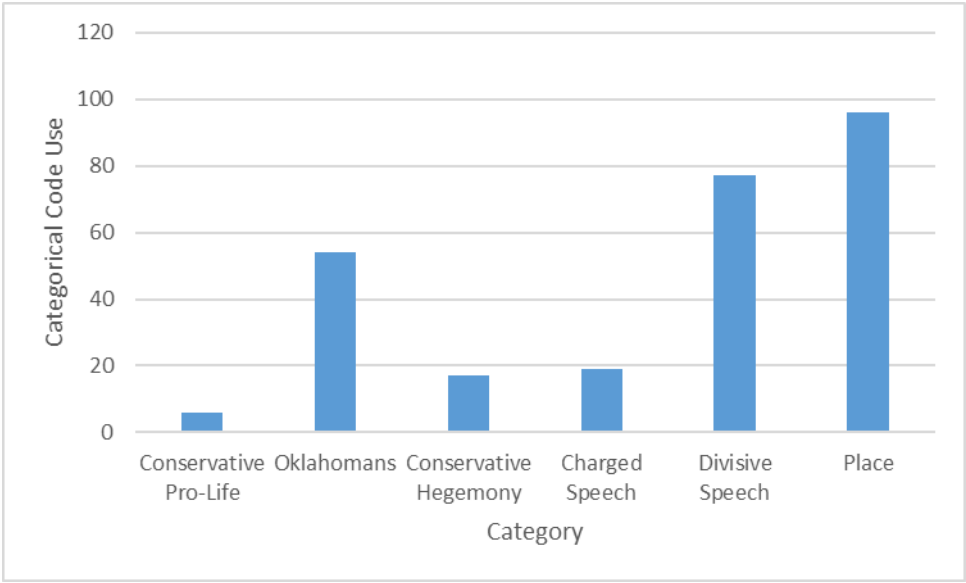

Figure 21: Representative Mike Ritze, R-Broken Arrow Code Use by Category

Representative Mike Ritze is the most prolific contributor to the discussion of ACA expansion between 2010 and 2015. In press releases that cover Rep. Ritze's sentiments, the author makes sure to include Rep. Ritze's credentials as a medical doctor when referring to healthcare legislation with modifiers such as, "Board Certified Family Practice Physician and Surgeon who has delivered over 2,000 babies" (Oklahoma House of Representatives' Office 2011q). This provides an authoritative voice to Rep. Ritze's arguments for or against healthcare reform.

Over time, Rep. Ritze's sentiments against the ACA include charged and divisive rhetoric that coincides with the general representation presented in the earlier press releases offered by government offices. However, as lawsuits were filed, Rep. Ritze's sentiments change from *charged speech* to *conservative hegemony* and *divisive speech* that is constitutionally-based, for example:

Example 1:

> The Patient Protection and Affordable Care Act, which is better known as ObamaCare, is unconstitutional we need to stand up for the rights of Oklahoma citizens (Oklahoma House of Representatives' Office 2011s)

Despite Ritze's shift in his discussions of ACA reform from charged to divisive, he still ranks as the highest user of categories such as Charged and *divisive speech* and *Oklahomans*. This is most likely because he contributes a majority of the discussion on the constitutionality of states' rights and the duty of Oklahomans to challenge the Federal Government.

For the category of *divisive speech*, he references Oklahoma's duty as a state to challenge the right of Congress to impose a tax on business and individuals who opt out of ACA-approved health insurance plans and the ability of Congress to provide subsidies. Rep. Ritze uses the category *Oklahomans* with code use that relates to the vote for SQ 756 such as "Oklahomans," "majority/most of Oklahomans," and "most voters." He states:

Example 1:

> When voters approve this amendment, the Oklahoma Constitution will tell the federal government that they would like to pursue their own course when it comes to health care (Oklahoma House of Representatives' Office 2010e2).

Example 2:

> The voters have told us not to accept ObamaCare in Oklahoma, and we should respect their wishes. (Oklahoma House of Representatives' Office 2011v)

By referring to Oklahomans as "voters" and "the majority," he shows a lack of understanding concerning the scope of SQ 756 and what Oklahoman's meant by that vote. He, like a majority of other legislators, over-emphasize the vote for SQ 756 to imply that Oklahoma voters do not want to participate in ACA expansions. This disregards the notion that SQ 756 pertained to only one facet of the comprehensive plan, other parts of which Oklahomans may support.

In additional reference to *Oklahomans* and in conjunction with categories *Divisive* and *charged speech*, Rep. Ritze offers criticism for federal assistance programs and references the need for a state-based solution. For example:

> Medicaid is a fiscal and humanitarian disaster, providing fragmented, lousy, and expensive care, Ritze said. It is a welfare system and enslaves participants in permanent poverty. Rather than expanding, it should be cut. The federal government should rescind all rules regarding Medicaid and return to the states their share of funds as block grants. States should be free to develop their own approaches to healthcare for the needy (Oklahoma House of Representatives' Office 2011w).

In this segment, Rep. Ritze uses *divisive speech*, referring to Medicaid and the federal government as failing entities. He combines this with *charged speech* with codes "disaster" and "lousy." Although he negatively portrays Medicaid and the federal government in preference of state-based initiatives, Rep. Ritze chooses not to discuss the concept that legislators, prior to the ACA, had the ability to develop healthcare policies to alleviate and provide care for Oklahoma's high underinsured populations. Additionally, Rep. Ritze uses politically incorrect references for users of Medicaid via the term "needy." This type of terminology use

subliminally disables the "needy" person from becoming a "contributor," adding to the systemic labeling of lower socioeconomic classes.

Rep. Ritze offers few direct quotes for *conservative pro-life*, although he maintains a pro-life, pro-woman position and supports legislation to allow individuals to deny providing services that conflict with their moral beliefs (Oklahoma House of Representatives' Office, 2011). Again as with all legislators represented in this portion of my analysis, pro-life stances halt at birth by failing to consider the life-long benefits associated with expanding healthcare benefits to thousands of Oklahoma.

Overall, Rep. Ritze's focuses on the divisive nature of state versus federal control of healthcare markets, mirroring some of the same tendencies outlined in the larger discourse analysis of government press releases. Accordingly, Rep. Ritze fails to realize the economic potential in low-income populations that remain with limited access to healthcare services (Marathuppu et al. 2012; Oklahoma Governor's Office 2012; Leavitt Partners 2013).

Summary of Legislators

In this analysis, legislators relied most heavily on Political and Economic discussions to guide coverage of ACA reforms. In this way, legislators used *divisive speech*, siting the powers outlined in the U.S. Constitution as the basis for the arguments against healthcare reform to foster support among all Oklahomans. In these arguments, they cite the responsibility of both the people and the states to encourage resistance against federal reforms. This in turn, explains a portion of the elevated counts for both Oklahomans and *place*.

Legislators provided some attention to *conservative hegemony* in that they support free-market principles, reflecting the Economic theme. However, this position is also associated

with *Oklahomans* and *place* in that legislators cite the effects of the ACA on business owners and the working class in addition to their support for state-based initiatives such as Insure Oklahoma. This again, explains a portion of the high counts for the latter categories.

In this summary, the theme Social was most selectively used by legislators. As this analysis only encompassed direct quotes from these specific legislators, less codes were available to analyze than presented in the overall press releases, available in Chapter Four. Similar to the overall analysis of press releases in Chapter Four, legislators rarely mention their constituencies beyond those in the working-class and business owners. Furthermore, by not engaging in discourse that encompass the theme Social, legislators miss the opportunity to engage in the broader spectrum of the political and economic implications associated with social progress for lower socioeconomic classes in Oklahoma. In this way, and consistently throughout the analysis, legislators fail to recognize the potential for positive change found in health policy reform for Oklahoma's lower-socioeconomic demographic. By not engaging in the potential locked in lower socioeconomic groups, Oklahoma limits its social, political and economic growth as a state.

Legislators represent constituencies and as many of these legislators hold positions as leaders of the majority party in the legislature, they are also responsible for leading the Republican party in Oklahoma. Additionally, in these elevated positions, they assume roles in which, as the party leader, they must consider, even more so, the *greater* constituency need across Oklahoma. The legislators that contributed most to ACA discussions were Republican, white, affluent males, from Tulsa (besides Gov. Fallin, a Republican, white, affluent woman from OKC). Accordingly, although large portions of Oklahoma's population live in Tulsa and Oklahoma, it could be that these legislators' priorities

disproportionately reflect the political orientations of urban areas rather than recognizing the need for healthcare expansion and reform in rural areas. In other words, this homogenized leadership may not adequately address the sentiments on healthcare across Oklahoma. Additionally, the discussion of ACA healthcare reform is represented primarily by white-affluent males which the Kaiser Family Foundation (2013) shows as the least at-risk population for reduced access to healthcare services. Accordingly, their limited view of the healthcare system may influence their perceptions of healthcare, thus influencing healthcare policy. It is possible that, based on legislative discussions, these legislators do not or cannot comprehend the hardships faced by thousands of Oklahomans seeking health insurance coverage, due to their positions, which insulate them from low-income demographics. Accordingly, these legislators have adopted positions and memberships that increase opportunities to insulate their privileged voting constituencies and bolster their careers by assuming positions in line with the national conservative party in place of their greater constituencies (Fenno 1973; Mayhew 1974; Mayhew 2106).

CHAPTER VI

CONCLUSIONS

This research was designed to reveal relationships between Oklahoma Legislators' discourse and healthcare reform. Accordingly, my research questions included:

1. How have government press releases framed legislative discussion of ACA healthcare reform in Oklahoma between 2010 and 2015?
2. How does the distribution of underinsured constituencies relate to the voting patterns and the positions of Oklahoma legislators surrounding healthcare reform?
3. In what ways have Oklahoma legislators (mis) represented the underinsured, Medicaid eligible, and Medicaid participating constituencies in government press releases?
4. How have Oklahoma's State Legislators (mis) represented the healthcare needs of their constituencies' between 2010 and 2015?

Media Framing of ACA Reform

Due to the reciprocal relationship between media outlets and their sources (Walters and Walters 1992; Shapiro and Block Elkron 2008), it is probable that government media offices worked in conjunction with legislators to shape the discussion of healthcare offered

by Oklahoma's government webpages. In this way, legislators contributed negative interpretations of the ACA that were then published and offered to the public for consumption. Due to the limited input espoused by government offices concerning the positive implications of the ACA, government press releases encouraged the proliferation of negative frames used to understand ACA reforms. This effectively dismisses research that shows the value of expanded healthcare access via mechanisms such as job creation, investment in healthcare infrastructure, and overall productivity of the individual (Oklahoma Governor's Office 2012; Maruthappu et al. 2012; Leavitt Partners 2013). The discourse presented disapproval of the ACA in a variety of ways. For instance, while some press releases focused on the expenditures associated with healthcare expansion, others focused on their negative impacts on quality of care, while others focused on the hindrance to state rights and support of federal assistance

Some criticisms used by legislators against healthcare reform include stating the programs inefficiency when compared with state-based solutions such as Insure Oklahoma. However, legislators chose to ignore that the inefficiencies of the ACA were created in part due to the resistance to the ACA led by conservative legislators. State compliance was one of the many parts needed to work in order to best implement the ACA (Beland et al 2014). Rather than concentrating state funds and legislative efforts on improving the healthcare system as prescribed by ACA requirements, the state legislature opted to encourage lawsuits against the Federal Government. Press releases also lack discourse that covers the repercussions of denying specific portions of the ACA such as Medicaid and price control legislation. For instance, legislators may criticize the ACA for lower-than-projected health outcomes or elevated prices but sidestep accepting mechanisms such as Medicaid expansion or price control efforts that might have mitigated those occurrences. In essence, legislators

in the State of Oklahoma did not provide the conditions under which the ACA could reach its healthcare reform potential and then criticized its effectiveness. In this way, the criticisms of health outcomes in Oklahoma should include focus more attention on the state legislatures inability to determine a workable measure to expand healthcare coverage rather than one-sided criticisms of federal options that were not allowed to come to fruition.

Relationships between Legislators, the Underinsured and SQ 756

Despite Oklahoma's high rates of underinsured constituencies, every county in Oklahoma voted for SQ 756, which shows little correlation between high rates of underinsured Oklahomans and votes for SQ756. However, the vote for SQ 756 represents only one facet of ACA expansion and fails to represent an overall understanding of constituencies' opinions on ACA expansions. Additionally, less than half of all registered voters turned out for SQ 756, illustrating legislators' generous interpretation of "the majority of voters" disapproval of ACA healthcare reforms. However, press releases and legislative coverage use the vote for SQ 756 as a proxy by which to base their positions against ACA expansion, thus contributing further to the negative perceptions of ACA healthcare reform. Exceptions to negative interpretations were confined to the members of the democratic caucus such as Sen. Connie Johnson, D-Oklahoma City and Sen. Jim Wilson, D-Tahlequah. To understand better the relationship between the underinsured and ACA healthcare reform in Oklahoma, more data could be gathered through surveys or interviews with constituencies, especially the underinsured. Additionally, an examination of prior votes on healthcare policy and the distribution of the underinsured might provide a more comprehensive understanding of the voting patterns of areas with higher rates of medically uninsured constituencies. Each of these suggestions would provide a better foundation from

which to answer the research question, "How does the distribution of underinsured constituencies correlate with the voting patterns and the positions of Oklahoma legislators surrounding healthcare reform?" and could be used to supplement legislators with better information about their underinsured constituencies.

Legislators' Representations of the Underinsured

Oklahoma legislators provided little recognition of those who would gain insurance coverage through ACA and Medicaid expansion. However, some legislators from the Democratic Caucus contributed several commentaries in support of ACA initiatives to extend coverage to the underinsured. Even more so, legislators effectively dismiss the concerns of the underinsured by refusing Medicaid expansion and simultaneously refusing to expand Insure Oklahoma. Legislators also referred to the underinsured populations as indigent, entitled, and needy (Oklahoma Governor's Office 2010; Oklahoma Senate Office 2012; Oklahoma House of Representatives' Office 2011). Furthermore, legislators refer to ACA and Medicaid expansion programs as entitlement programs. This is traditionally a conservative perception of assistance programs for low-income Americans. Additionally, minimal press release coverage was offered that addressed the opportunities for increased access granted through ACA expansion. Thus the underinsured remain underrepresented in the coverage and legislative positions offered by the Oklahoma legislature. To compound this problem, legislators in this research argue that allowing businesses to operate under free-market principles allows consumers more healthcare choice. Idealizing free-markets, however, displaces recognition of the pricing practices utilized by the healthcare industry, which shows that without price regulation, operating on free market principles in a fixed market results in elevated prices for the consumer (Smith et al. 2006, Mills 2016).

Legislators' Understanding of Healthcare Needs among Underinsured

Oklahoma's State Legislature failed to adequately represent the healthcare needs of their entire constituencies, recognizing, primarily the interests of Oklahomans with pre-existing health insurance and business owners. Although a majority of press releases and legislative discussion serviced the perceived political needs of their constituencies by following conservative platforms, legislators did not significantly improve the quality of healthcare for Oklahomans during this period. Specifically, press releases indicate that legislators preferred policies that maintained Oklahoma's healthcare system prior to the ACA. They also mentioned that Oklahomans would lose their insurance, disregarding the notion that these people would maintain health insurance coverage through alternative providers. Rather than complying with federal regulations concerning state-based programs such as Insure Oklahoma, legislators were unable to determine a solution that would sustain the public-private partnership. In this way, legislators' loyalty to party politics appears more prevalent than the pressure to address the healthcare needs of their constituencies.

Recommendations

This research shows that by limiting the information distributed by government media outlets, singular viewpoints are proliferated by that media. In this case, as Oklahoma's government media offices chose to present one-sided coverage of ACA reforms, their resulting media presented a narrow and negative outlook on ACA healthcare reforms. Ideally, I would encourage government media outlets to expose its viewership to conflicting viewpoints by contracting with or relying upon varied news sources. More tangibly, however, in order to encourage a broader scope of information incorporated in government press releases I suggest that legislators who maintain viewpoints contrary to the mainstream

position contact their media office regularly with prepared contributions. In the case of healthcare, this would mean greater involvement most likely from Democratic leaders in discussing the benefits of healthcare reform. I would also encourage groups seeking to challenge the majority opinion to adopt some similarities in the manner in which they address political issues. For instance, since conservative rhetoric encourages a focus on the economic implications of policy reforms even in healthcare reform, I would encourage Democratic (or other supports) to expound upon the economic shortcomings of the existing system while also exhibit perceived better economic opportunities offered through reform.

Additional Research Opportunities

Although this research worked to explain the relationship between Oklahoma legislators' discourse and healthcare reform, additional research is needed to better understand Oklahoma's healthcare landscape, specifically portions related to the ACA. Additional avenues for research include surveying Oklahoman's perceptions of the ACA and its implementation, interviews with underinsured demographics, business owners, and other Oklahomans as well as a comprehensive examination of health outcomes in the aftermath of ACA expansion.

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VITA

Elizabeth G. Armstrong

Candidate for the Degree of

Master of Science

Thesis: REPRESENTATIONS OF THE AFFORDABLE CARE ACT IN OKLAHOMA GOVERNMENT PRESS RELEASES 2010 TO 2015

Major Field: Geography

Biographical:

Education:

Completed the requirements for the Master of Science in Geography at Oklahoma State University, Stillwater, Oklahoma in December, 2016.

Completed the requirements for the Bachelor of Science in Recreation Management Summa Cum Laude at Oklahoma State University, Stillwater, Oklahoma in May, 2014.

Academic Memberships:
Gamma Theta Upsilon, Oklahoma State University, Secretary & Historian
Graduate & Professional Student Government Association, Representative
Oklahoma State University Triathlon Team

Experience:
Graduate Research Assistant, State Historical Preservation Office
Research Intern, Oklahoma Policy Institute
Recreation Management and Marketing Intern, Lake McMurtry Friends

Professional Memberships:
Association of American Geographers
Gamma Theta Upsilon