The Battle over Healthcare:
Discourse and Power in the New Jersey General Assembly

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Abstract

Progressive legislative healthcare reforms have, in the years after the passage of the Affordable Care Act, begun to seem more impractical than not in the United States. Drawing on ethnographic fieldwork in the New Jersey General Assembly, I focus in this thesis on the co-production of possibly-passable measures, and argue that the creation of a “legislatable” healthcare bill occurs as the result of agonistic encounters between legislative staff and others. Staffers evaluate the vast quantity of measures, which in many respects mirror neoliberal and biomedical influences, at a range of sites, including the district office. Through discourse analysis, I am able to reveal various discursive conditions of legislatability, as well as approach the specific tradeoffs surrounding understandings of accessibility, cost, and scale. This research builds on legal, medical, and political anthropologies, and contributes to a developing anthropological study of, as well as activist engagements to shape, health insurance policy in the United States.
Acknowledgements

This project would not have been possible without the hours of assistance of so many. First, thank you to JM, JH, and SB, who introduced me to “backstage” of the New Jersey General Assembly. I am incredibly appreciative of all of your support both during the research period and beyond in graciously offering to be interviewed and extending connections to other staffers and offices, as well as in showing me what it means to work in state government and at the service of a district. The thesis, as well as my future work after graduating from Swarthmore College, are all possible because of your help, for which I am deeply grateful.

Thank you to all of the staffers who volunteered to be interlocutors and speak to the legislative process in New Jersey. I appreciate all of your time in coordinating a meeting and answering my questions: our conversations both form the basis for this thesis and have introduced me to the complexities of legislative and constituent work.

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A Note on Terminology

There exists no clear consensus on the distinctions between “health care,” “healthcare,” and “health insurance.” Through conversations with my interlocutors and reviews of the existing literature, I have decided to use “healthcare” to represent the union of (1) agents (“providers”) which provide services (“health care”) to explicitly change one’s state of health, and (2) agents (“payers,” “insurers”) which request payments from the patient and related actors to “cover” the cost of health care services (“health insurance”).
1 // Introduction

*Health Insurance: Hegemony, Discourse, and Agonism*

"[Universal Health Coverage] is, by definition, a practical expression of the concern for health equity and the right to health. Moreover, access to services when needed and financial protection are valued for their own sake. People sleep well at night knowing that the health services they might need are available, of good quality, and affordable."


"Pure fantasy’ doesn’t begin to describe [a proposal for ‘Medicare-for-All’ by Senator Bernie Sanders].

“If he—or any leftist—were actually serious and honest, he’d say, ‘we’re going to need Denmark levels of taxation for this. So, everyone who’s already got coverage, you’re going to lose it, and your taxes are going to more than double, in return for which you will get… nothing.”

— Post on Facebook by New Jersey Assemblyman Michael Patrick Carroll (2018)

The second of the above quotations was sent to me by a New Jersey legislator’s chief of staff after an interview. This was not his position, he wrote (he and the assemblymember belonged to the Democratic Party), but a clear example of extreme and ardent opposition to healthcare reform. Assemblyman Carroll, who shared this response to an article discussing one of United States Senator Bernie Sanders’ “leftist” plans, caucuses with the Assembly Minority, or Republican Party.

Does that mean that the first quotation, taken from a World Health Organization publication, is the side of the Assembly Majority? Frankly, no. Although there do exist bills which seek to establish statewide Medicare programs, public options, and the like, “realistic” (or what I will label “legislatable”) challenges to the United States healthcare system from the majority party in both houses (as well as under a Democratic governor) seem to remain limited to only certain reforms which minimize state expenditures and sit squarely in the middle of the political spectrum. How is it that legislators’ opinions on the notion of “universal health coverage,” while drawing praise from the World Health Organization, seem to lie only at some
point between far-right vitriol and center-left uncertainty? How does reform become an impossibility, rather than possibility?

Through this thesis, I investigate the structures that ensure the movement of only some types of health insurance legislation, and therefore concentrate on the possibly, rather than on the impossibly, legislatable. The stagnancy and limits of reform invite applications of political theory, specifically that of hegemony. As I have shared my interest in the stagnancy of reform with others, I do not often have to wait long for the response, “But that’s just how it is, right?”

That there is stagnancy can serve as an indicator of some sort of hegemony in the U.S. governmental system. (I take this position, myself.) Superficially satisfied with this explanation, as a result, one might easily become complacent in the acceptance of that being so.

Contrasting with the sluggishness of insurance reforms are the everyday tragedies faced by those who find themselves caught between the number of actors in the “health insurance marketplace.” At a 2013 meeting of the New Jersey Senate Legislative Oversight Committee, a retired public-school teacher named Ms. Spector spoke on such difficulties in navigating the ever-changing marketplace. I quote a section of the transcript below, in which she interacts directly with the committee’s chair, Senator Robert M. Gordon:

MS. SPECTOR: ... Part of the problem that I was learning to deal with was recognizing networks, and support systems, and such. They were not— When you come from my kind of background, that’s a piece that isn’t readily a part of your thinking system. You don’t have that immediate support system, as many people do growing up in some way.... I also have this huge sense that it is my responsibility. And at that point, the shame factor was a piece of it. I didn’t want to go out and let all these other people outside of this therapy room know about these things. Now I’m certainly not ashamed of it. Now I can consider those things. But at the time—....

SENATOR GORDON: The thought just occurred to me, we have in the past created an ombudsman for the institutionalized, elderly, and similar positions across the State to assist populations that we feel need someone advocating for them. And the thought occurs to me that there might be some opportunity. I mean, it sounds like a big government kind of solution. But it seems to me that there may be an opportunity to create this kind of expertise and make it available to people who are out there who don’t
know how to deal with the claims process or what the latest rules are in a particular managed care company.

MS. SPECTOR: You learn fast.

SENATOR GORDON: I'm sure. (New Jersey Senate Legislative Oversight Committee 2013, 27-28)

In this brief excerpt of the hearing, several themes arise, including the neoliberalization of healthcare, the notion of personal responsibility, the idea of risk pools or populations, and the speed at which the system moves and at which the patient is required to adapt.

In this thesis, I intend to take an approach which builds on an understanding of the complexity and urgencies which emerge from the healthcare marketplace to critique the movements of legislative reforms. Though there very clearly exists some sort of hegemony in U.S. governmental structures which limits the scope of potential changes to health insurance law; less clear are the methods by which that hegemony is instituted, maintained, shaped, and challenged, and its implications for a state or country which at least outwardly espouses Democratic values. Concentrating specifically on a single session of the New Jersey General Assembly, this thesis will interrogate the legislative process of reforming the health insurance system through a framework combining understandings of hegemony, discourse, and agonism.

The first step in undertaking this journey is to understand the genesis of health insurance as a legislative and legislatable concept.

**Early Genealogy of United States Health Insurance Legislation**

To speak of a genealogy of health insurance in the United States invokes both concepts of “health insurance” (derived from early twentieth century British reforms) and “Krankenkassen”

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1 I use the metaphor of the genealogy here following Paul Starr’s (2011) *Remedy and Reaction*. With roots meaning “generation-study” or “race-study,” the term is fitting to describe this study of a specific type (that is, “health insurance”). I do not use “biography” so as to distinguish the specific form of writing’s vital implications from the study of health insurance *as it relates to* lives. The notion of a genealogy also carries a Foucauldian lineage: in this section, I “identify the accidents, the minute deviations... the errors, the false appraisals, and the faulty calculations that gave birth to those things [in this case, health insurance legislation] that continue to exist and have value for us” (Foucault 1977, 146).
The Battle over Healthcare

(“sickness funds,” derived from late nineteenth century German reforms). British health insurance was initially codified in 1911 through legislation which provided medical coverage for workers. Parliament later enacted a comprehensive social insurance system in 1946 which singularly covers every citizen’s health-related expenses through the oversight and payment of general practitioners and hospitals by ten regional health authorities. The latter set of sickness funds, implemented by Chancellor Otto von Bismarck in 1871 and extended to all workers by 1911, are best described as a set of not-for-profit entities organized based on industry and geographic region to which all participants and employers contribute payments and from which disbursals are made (Brasfield 2011, 204-210). Figure 1 provides a general summary of the two systems.

<table>
<thead>
<tr>
<th>British (“Beveridge”) Model</th>
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<tr>
<td>“Health Insurance”</td>
<td>“Sickness Funds”</td>
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<tr>
<td>Single-payer</td>
<td>Multi-payer</td>
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<tr>
<td>Financed through tax payments made to the government.</td>
<td>Financed through payments made by employers and employees to the government.</td>
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<tr>
<td>Many hospitals and clinics are operated by the government, though private doctors can also collect fees from the government.</td>
<td>Most hospitals and doctors are private but sickness funds cannot make a profit.</td>
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<td>The government has significant power to regulate costs.</td>
<td>The government has significant power to regulate costs.</td>
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*Figure 1: Summary of the British and German Health/Sickness Insurance Reform Models.*

Many histories of health insurance in the United States begin around 1912 (Brasfield 2011, Enos and Sultan 1977, Starr 2011), with former president and then-presidential candidate for the Bull Moose Party Theodore Roosevelt’s “Confession of Faith.” The speech, as reported by *The New York Times* (1912), is worth quoting at length:
It is abnormal for any industry to throw back upon the community the human wreckage due to its wear and tear, and the hazards of sickness, accident, invalidism, involuntary unemployment, and old age should be provided for through insurance. *This should be made a charge in whole or in part upon the industries, the employer, the employe [sic], and perhaps the people at large contributing severally in some degree.* Wherever such standards are not met by given establishments, by given industries, are unprovided for by a Legislature, or are backed by unenlightened courts, the workers are in jeopardy, the progressive employer is penalized, and the community pays a heavy cost in lessened efficiency and in misery. *What Germany has done in the way of old-age pensions or insurance should be studied by us, and the system adapted to our uses, with whatever modifications are rendered necessary by our different ways of life and habits of thought.*

Preserved here with abundant clarity is a call for *sickness* insurance (or Krankenkassen) based on the German social reforms, and *not* on the United Kingdom’s National Health Insurance Act.² Building on the work of Progressive Movement figures including John R. Commons, Louis D. Brandeis, and John B. Andrews, Roosevelt’s speech served only as a prelude to the American Association for Labor Legislation’s (AALL) efforts to pass a bill establishing compulsory health coverage.³

The AALL received little initial criticism for its model bill from the American Medical Association (AMA), with some state legislatures (including New Jersey’s) going so far as to introduce mirror versions. Congress even initiated hearings on a national health coverage plan in 1916 and passed the War Risk Insurance Act in 1917 to extend medical and hospital care to veterans. It later became clear, however, that a national bill would fail due to wavering support from medical practitioners and outright opposition from private insurance providers. Organized labor leaders, too, including the American Federation of Labor’s Samuel Gompers, objected to

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² The repercussions of industrialization are apparent in this quotation. There is a fascinating interplay here between “universal” social reforms and the populations which they seek to protect (in this case, industrial workers). I will return to this emergent theme at the end of this genealogy.

³ It is difficult, here, to avoid using the term “health insurance.” In my analysis, I treat the notion of “health insurance” as distinct from “sickness insurance,” even if the secondary authors which inform this distinction utilize both almost interchangeably. The subsequent section’s development will illustrate why such a cautious use of vocabulary may be necessary.
compulsory national health coverage for its effective elimination of a linchpin for labor organizing (Feldman 2000, 19-20).

**World War I and the Birth of United States Health Insurance**

The push for health coverage legislation drastically shifted in the wake of the First World War. This can be observed in 1918 remarks by Thomas W. Huntington, then president of the American Surgical Association:

> Among these [the legislative reforms being considered] are old age pensions, death benefits, pensions for widows and orphans, unemployment insurance and, finally, the most comprehensive and revolutionary of all, *health insurance*, whereby the medical care of the industrial worker and his dependents becomes a governmental function.... You are aware that social insurance in all its aspects bears the legend ‘made in Germany,’ for there it had its beginning.... With a clear understanding of German melting pot methods in moulding [sic] public sentiment, and with utter detestation of that sinister thing—*German Kultur*—we should hesitate long before subscribing to a dictum or a doctrine emanating from such a source. (114-116; emphasis in original).

Confronting these nativist threats to health coverage reform, supporters of such legislation began to more frequently employ the term “health insurance,” rather than “sickness insurance,” thereby implying that the idea’s origins lay with the British system and not the German model (Feldman 2000, 21).

Largely disappearing from the national discourse, health coverage legislation similarly vanished from the chambers of state legislatures. The New York Senate, driven by the lobbying of a coalition of labor and feminist organizations, passed a health insurance bill supported by the recently elected Democratic Governor Al Smith; however, Republican Speaker of the Assembly Thaddeus Sweet found success in prohibiting a likely consequential vote on the matter. The inability of Progressive campaigns to deseat Sweet in the subsequent elections, according to Paul Starr (2011), spelled the end for the Progressive mobilization of health insurance reform (34).
Delaying the Promise of the New Deal: 1932-1950

Health insurance reform once again rose to the national legislative debate with the release of a 1932 report of the Committee on the Costs of Medical Care (CCMC; Feldman 2000, 21). Among other findings, the CCMC determined that, in a collection of low-income groups, only about half of the population received some form of medical care; in stark contrast to this figure was the relatively insignificant average cost necessary to care for each citizen of the United States, reported to be anywhere from $20 to $40 per person per year (Gore 2013, 142). Of the numerous recommendations made by the CCMC, the third seems most prescient:

The Committee recommends that the costs of medical care be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods. This is not meant to preclude the continuation of medical service provided on an individual fee basis for those who prefer the present method. Cash benefits, i.e., compensation for wage-loss due to illness, if and when provided, should be separate and distinct from medical services. (Committee on the Costs of Medical Care 1932, 120)

Combining principles of both sickness and health insurance models, this recommendation is significant for two reasons. First, as alluded to above, it allows for the development of “sickness funds” contributed to by the payment of insurance and the development of a national health service funded by taxation. Second, it distinguishes forms of medical insurance from occupational insurances; that is, it makes the patient distinct from the worker. Given that these two characteristics continue to define the United States’ health system to the present day, there must have been a later point at which they were codified in policy.

Before this legislative work, however, came the report of the Committee on Economic Security (CES). Called to order by President Franklin D. Roosevelt in 1934, the CES included prominent members such as Emergency Relief Administration (ERA) Administrator Harry Hopkins, Secretary of Labor Frances Perkins, and Attorney General Homer Cummings. Despite pressure from Hopkins, the committee failed to put forward a compulsory health insurance bill
within its proposals for unemployment insurance and social security legislation, likely due to opposition by the AMA (Feldman 2000, 21-22). In the ensuing passage of the Social Security Act in 1935, the issue of high health care costs was addressed only cursorily, with employment and age-based reforms being slightly more favored. Roosevelt did continue to pursue legislation which would impact the health system, even calling for the right to “adequate medical care” in his 1944 “Economic Bill of Rights,” but Congress did not ultimately pass a bill along these lines, definitively excluding health insurance reform from the New Deal (Roosevelt 1950; Starr 2011, 38-9).

Taking office and later being re-elected after Roosevelt’s death, President Harry Truman seemed initially well-suited to bring health reform to bear with his Fair Deal. Though continuing his predecessor’s legislative negotiations, Truman met with little success in bills through Congress: in hindsight, this moment in history mirrors quite acutely the contemporary stagnations in United States legislative bodies’ ability (or willingness?) to move forward reforms to health insurance law. The midterm elections of 1950 witnessed an increase in campaigning by the AMA and allied private insurance corporations to remove proponents of such legislation (which was described as “socialized medicine;” Quadagno 2004), and the hope for comprehensive measures dwindled severely (Starr 2011; Feldman 2000).

**Strides toward a National Health Insurance: 1952-1965**

In the period after the election of President Dwight D. Eisenhower, wide-ranging reform remained unrealistic. However, the span from 1952 to 1965 brought several significant actions which could have served as the forerunners to a national health insurance system. Though the 1952 reports by the Social Security Administration and the President’s Commission on the Health Needs of the Nation, which advocated for expansions of insurance for social security beneficiaries, did not inspire legislative movement, Congress eventually enacted a coverage
program for the dependents of individuals who had served in the military as well as added
disability insurance for workers to existing policies in 1956. Conflict arose when Representative
Aime J. Forand introduced a bill to expand Social Security Act benefits to persons defined as
“permanently disabled” and over the age of fifty in 1957, which was debated in hearings during
June of the next year and again in 1959, and finally reintroduced and defeated in the House Ways
and Means Committee in 1960 (Feldman 2000, 26-27; Starr 2011, 44).

With elevating support for efforts to further nationalize health insurance, Representative
Wilbur Mills introduced an additional bill in 1960 to provide state-sponsored medical assistance
to the new “medically indigent elderly,” thereby expanding on earlier programs to provide
federal aid to states for welfare recipients’ care (Starr 2011, 44). Unusually supported by the
AMA, the “Kerr-Mills bill” passed both houses by the end of the year and became law as
President John F. Kennedy prepared to take office (Feldman 2000, 28).

Kennedy advocated both on his campaign and while in office for legislation that would
eventually form the basis of the Medicare program. Moved forward by President Lyndon B.
Johnson after Kennedy’s assassination, an initial and more limited version was passed in 1964 as
an addition to a Social Security bill. In 1965, however, Congress adopted a more comprehensive
“three-layered cake” combination of transpartisan legislative measures: (1) a Democrat-favored
compulsory hospital insurance program (to become Medicare Part A); (2) a Republican-favored
voluntary program to cover physicians’ bills (to become Medicare Part B); and (3) an AMA-
favored expansion of the Kerr-Mills program (to become Medicaid). This legislation

... institutionalized two tiers of public financing for health services. The benefits that the
elderly receive in the upper tier have been understood as an earned right, even though
seniors have never paid enough in payroll taxes to earn their insurance coverage (in fact,
the first wave of beneficiaries didn’t pay anything). That moral claim has nonetheless
given Medicare political security, making it unthinkable (at least until recently) to rescind
the program, cap it, or cut it in a recession. In contrast, the recipients of Medicaid, like
welfare, are not regarded as having earned any right, and that lack of a moral claim has made Medicaid politically insecure and more vulnerable to cutbacks. (Starr 2011, 47)

Further, regulation of Medicare and Medicaid positioned them to be distinctly managed by the federal government and state governments, respectively, thereby rendering the latter even more vulnerable to regressive cutbacks across the country.

The general division outlined by the 1965 legislation (national health insurance offered through Medicare, quasi-national health insurance offered through Medicaid, and sickness insurance offered through employers and private corporations) remains the standard today. Much of the remaining history between then and the present reflects the ideology of the three-layered cake, whereby access to a national health insurance system is limited to only a segment of the population. Throughout this entire genealogy, a single theme has continued: who has earned the right to insurance? This question is intimately tied to a neoliberal rationality in which the patient/citizen is not only a consumer of care but a possible worker. Embedded within the notion of healthcare reform, consequently, is a distinction built upon the basis of ability to work: those who can should find insurance through their employers, while those who cannot must either try to procure work or be provided for by either their family or (as a last resort) the government. This division is important, as it is specifically frames state-sponsored healthcare as a welfare measure, and not a universally-held right to be protected by governments, as the WHO statement cited at the beginning of this chapter suggests.

In the subsequent sections, I present anthropological perspectives on this stratified healthcare system, abstracting from analyses of the medical, legal, and political realities to approach a concept of legislatability which builds on theories of discourse and hegemony.
Toward an Anthropology of Health Insurance

I do not, in performing this analysis, purport to designate or imply that there does or could ever exist the anthropology of health insurance. Instead, numerous anthropological studies of health insurance have begun to take shape in the intersections of various subfields, including that of economic anthropology (see Fletcher [2016] for a political economic perspective on moral hazard and the Patient Protection and Affordable Care Act). Concentrating on health insurance as it emerged through a specific legislative process, I will outline how three subfields—medical, legal, and political anthropology—intersect to form a particular anthropology of health insurance which is most useful for this thesis. To simultaneously present a review of the literature and illustrate the subfields’ intersections and abstractions, I will employ the Patient Protection and Affordable Care Act (ACA) as a constant reference point.

Basic Security?

In a dissertation submitted in fulfillment of a doctoral program in anthropology at the University of Pennsylvania, Elizabeth Ann Hallowell (2015) wrote eloquently that “the Affordable Care Act and its regulatory enactment reconfigured a fault line in U.S. healthcare markets: that between the insurable and the uninsurable,” making the markets highly “contingent” for people attempting to navigate them (19). The notion of contingency, which builds upon the metaphor of the three-layered cake, has been explored in a range of contexts through different theoretical apparatuses which distinguish the narratives and experiences of the human being from the neoliberal Homo oeconomicus.

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4 In a later interlude, I will present the history of the ACA in greater depth, along with the periods which led to its passing.

5 See President Barack Obama’s remarks from March 23, 2010, before he signed the ACA: “And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care” (Obama 2010).
The need for a medical anthropology of health insurance and its reform was articulated most clearly in articles written by Rylko-Bauer and Farmer (2008) and later by Dao and Mulligan (2016), both of which reflected on the scope of previous works and various areas which remained unaddressed. Published during periods before and after the passage of the ACA, the papers highlight similar themes, those including (1) the commodification, privatization, and neoliberalization of health care; (2) modes of governance through insurance-based social welfare programs; (3) the persistence of inequalities in access to quality care driven by insurance policies and preexisting social inequalities; and (4) the (re-)definitions of everyday life by healthcare reform.

These four points are (unsurprisingly) entangled to an extent that to talk of one consistently requires mention of another; still, the isolation of each from the others allows for unique observations of their dimensions. Jessica Mulligan (2016) presents an intriguing framework that she terms the “financialization” of care in the United States, claiming that ...

... health care has been financialized in complex and still emerging ways that include: (1) expansion of markets through privatization, conversion of non-profit entities to for-profit corporations, and development of parallel private insurance markets that compete with public programs; (2) creation of novel financial instruments like health savings accounts to fund high deductible health plans that increase profitability and fan risk out to more participants; (3) widespread gaming of reimbursement systems to maximize revenues through manipulating electronic health records and risk-based premium payments; (4) managerial focus on shareholder value rather than health outcomes; and (5) speculative, risky expansions, mergers, and acquisitions aimed at profit maximization and consolidating market advantage. (39)

Further scholars have undertaken studies on the managerial narratives which accompany neoliberal policy shifts (Maskovsky 2010), changing meanings of consumer- and clinician-citizenships (Rivkin-Fish 2011), and the “everyday contexts in which market reforms [are] actually enacted” (Mulligan 2016, 5-6).

The “enactment” of insurance reform at the level of the everyday can be understood through the lens of governmentality. Drawing on the work of Michel Foucault, François Ewald
argues that “societies envisage themselves as a vast system of insurance, and by overtly adopting insurance’s forms they suppose that they are thus conforming to their own nature” (1991, 210). Ewald’s claims are mirrored and challenged in the anthropological literature, with authors arguing that changes in societal logics of health insurance work to govern practitioners’ understanding of habitus (Kirschner and Lachicotte 2001), accountability (Lamphere 2008), and ethicality (Kaufman and Fjord 2011), as well as are actively contested by providers (Uzwiak and Curran 2016).

Such modes of governance, operating within a neoliberal ideological framework, generate and exacerbate inequalities. A generally-shared association among anthropologists (see Ganti 2014), the inequities and inequalities generated within neoliberal systems have occupied central roles in the anthropological literature, including in the work of Rebecca Adkins Fletcher (2016), who explored disparities in access to health services, and James Ellison (2014), who identified “first-class wards” in Tanzania which were open to patients on the basis of wealth.

The final point is likely the most dramatic: health insurance systems can rework and redefine established forms of being. Through regulations and care models, studies have demonstrated how patients can receive “relative values” based on illness (Oldani 2010), how kinship is remade in the face of life insurance (Golomski 2015), and how moral valuations of life change before neoliberal ideologies (Abadia-Barrero and Ernesto 2016). These and other shifts were emphasized by Amy Dao and Mark Nichter (2016) in an article which highlighted the role of anthropology in analyzing the evolution of health insurance through nuanced approaches and theoretical apparatuses.

These four strains of discourse have taken shape both before and after the passage of the ACA, as reflected in the articles cited at the onset of this review and in a statement by critical
anthropologists published in 2014 (see Horton et al. 2014). The statement’s authors, many of whom were cited above, provided five strategies for critical medical anthropology to engage with the ACA: (1) empirical analysis “on the ground;” (2) empirical analysis through “studying up;” (3) challenges to the “cultural legitimacy” of market-based medicine; (4) historicization of the ACA within the “crisis in capitalism;” and (5) contextualization of the debate over the healthcare system (15-16). Drawing heavily on the calls to “study up” and contextualize, this thesis will interrogate the nature of health insurance reform as it emerges at the level of the legitimate state entity (in this case, the Legislature of the State of New Jersey).6

**Pub. L. 111-148**

The ACA is officially enacted by Public Law 111-148 (Pub. L. 111-148), passed as House of Representatives Resolution 3590 (H.R. 3590) during the second session of the 111th Congress on March 23, 2010. In order to contextualize this law and others like it, however, it is first necessary to understand what exactly a law is.

This question has haunted scholars for centuries. Charles-Louis Montesquieu argued in 1748 that laws are “appropriate to the people for whom they are made [such that] it is very unlikely that the laws of one nation can suit another” (Moore 2005, 13). Building on this idea, Clifford Geertz claimed that “legal facts are made not born, are socially constructed

... by everything from evidence rules, courtroom etiquette, and law reporting traditions, to advocacy techniques, the rhetoric of judges, and the scholasticisms of law school education. (Geertz 1989 [quoted in Moore 2005, 17])

Similarly, Karl Marx (1845-1846) took laws to form part of the superstructure: rather than being created by the state’s power, “they are... the power which creates it” (Moore 2005, 31). This

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6 It will be difficult to avoid the conflation of “state” (New Jersey) and “state” (governmental structures of the nation-state). While the literature abounds with uses of “State” to signify the philosophical construction of a governmental system, I avoid this convention for two reasons: (1) archetypes should not satisfy a critical anthropology; and (2) the “official” name for New Jersey used in governmental documents (such as bills) is the “State of New Jersey.” As such, this thesis requires some forgiveness and interpretation in order to distinguish state from state.
notion of law as its own form of power is contested by scholars including Emile Durkheim who, in 1933, put forth that “social life... tends inevitably to assume a definite form and to organize itself, and law is nothing else than this very organization in so far as it has greater stability and precision” (Moore 2005, 41). There exists no definite consensus, then, for what law is, only that it exists as or coexists with the notion of state power.

Bruno Latour echoes this complicated relationship in his Inquiry into Modes of Existence, which I will quote at length:

What makes law so hard to grasp is that as soon as it has been defined as a separate world, carefully delimited by its own tautologies, we notice how flexible it is, and with what confounding agility it absorbs all sorts of injunctions from other regions: politics, the economy, trends, fashions, prejudices, media. As a result, just when we think we have discovered it as a particular sphere, with its own regulatory modes, we notice that the legal institution is so porous that its decisions look like so many weathervanes, turning with every breeze.... In a matter of moments, we have passed from one extreme to the other: we were admiring the objectivity of law, its capacity to make all powers bow before it; now we are indignant that it is so supple, so obsequious, that it has the regrettable capacity to cloak the nakedness of power relations. (Latour 2013, 362; author’s emphasis)

How, then, can we possess the ability to interpret the law? Latour argues for an acknowledgement of law as a mode of existence which “depends on the passage of particular beings that have their own specifications, their own mode of visibility and invisibility, their own particular ontological tenor or tonality” (363-364). Under this framework, law exists at the intersection and mercy of a range of other forces including, as this section and the next will progressively indicate, the political.

Conceptualizing law in this way, three foci for further analysis arise: (1) the making of law; (2) the meaning of law; and (3) the implementation of law. The previous review of anthropological studies of health insurance systems illustrates the shape of the final stage in the current context; by incorporating a legally-attuned mindset, however, it would seem that further analysis is possible of the first two. Works such as that of Sally Engle Merry (1990) have
illustrated that the interpretations of law by various actors and its implementation in disparate contexts—two processes which she labels legal words and legal practices—import “powerful meanings not just to those trained in the law or to those who routinely use it… but to the ordinary person as well” (8-9), ultimately providing modes by which people can understand social relationships and by which the state can exercise force (10).

Anthropologists have also engaged with the processes through which laws are made. The first strain of these falls squarely in the terrain of legal anthropology (see, for example, Latour 2010). This focus identifies the interactions between “value objects,” to use Latour’s vocabulary, such as notions of authority, progress, organization, interest, weight (or importance), quality, hesitation (or delay), argumentation, coherence, and limitations (194-195). The second strain of these, rather than concentrating on the legal, emphasizes the development and enactment of the political.

**Obamacare**

Perhaps the most well-known politically-oriented ethnography of the legislative process is Jack Weatherford’s *Tribes on the Hill.* Originally published in 1981, the book was revised and reprinted in 1985 and summarized in a chapter in *Contemporary Cultural Anthropology* in 1986. Strongly resembling the antiquated accounts of “an anthropologist stumbling into the middle of a tribal village [where] the natives do bizarre things and speak in strange ways” (Weatherford 1985, 20), the ethnography serves an account of Weatherford’s experiences in the United States Congress, featuring chapters entitled “Coming of Age in Congress (or Fortunate

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7 Though not explained here, the header “Obamacare” reemphasizes and extends notions of a study of the political and politics. Originally conceived by opponents of the ACA, the term can be interpreted as a component of U.S. politics which refers to a structure which in some way enunciates groups (that structure being the ACA), as well as a political agent that enunciates its own outside (in this case being, potentially, *laissez-faire* and/or Republican approaches to regulating healthcare systems).

8 For another ethnographic (though non-anthropological) account of the United States Congress, see Eric Redman’s (2001) *Dance of Legislation.*
Discourse and Power in the New Jersey General Assembly

Senex!,” “Domesticating the Lobbies,” and “The Ritual of Legislation.” In the final chapter (“Clan, Culture, and Nation”), Weatherford briefly departs from his exoticization of the House of Representatives to conclude:

The people in Congress have thus far been reluctant to question their own _modus operandi_. They quickly point to external origins for the evils in American society. The finger of guilt jerks from the Soviet Union to the oil cartel, from Japanese imports to world terrorism. Even when looking inward at our own society, members of Congress only want to blame factors far from Washington. One politician blames big business, the next the immoral minority; one looks at pollution, the other at the loss of the work ethic among laborers. Only when on the campaign trail do they point the blame back at Washington. It is always easy to blame some group of people or some visible entity, but it is difficult to step back and examine one’s own social and cultural organization. But the Greeks knew (though they failed to act upon it) that the fate of human beings, their institutions, and even whole nations, often rests on small follies, little quirks in men’s _sic_ natures, which pull the world down around them. (269-270)

The potential and valid critiques of this passage and Weatherford’s project in general invoke an important question for the discipline: how can (or should) a political anthropology approach the United States and its institutions?

George Marcus (1999) prominently critiqued the notion of an anthropology of the United States performed by U.S. anthropologists, noting with derision the proposition that “the West is now only ready to receive equal and full treatment by anthropologists after they have tended to ‘the Rest’” (416-417, Marcus’ emphasis). Nicholas De Genova (2007) furthers and challenges this argument by questioning the existence of an ethnographic study _in_ and _of_ the United States which would not be conditioned and shaped by the centrality of racial oppression and imperialism. Drawing on feminist scholarship, Micaela di Leonardo’s (1998) _Exotics at Home_ offers a “middle way” between the purely relativizing approach (anthropology _in_) and purely essentializing approach (anthropology _of_) which takes up research subjects through theoretical analysis of experienced realities.
Legislatability: Discourse, Hegemony, and Agonism

Advancing this perspective of a political anthropology concerned with everyday realities in the United States, the lives of political institutions such as the Congress and entities such as laws and bills become valid subjects of analysis. One final interpretive step is necessary, however, before it is possible to truly approach them as such, and that is an honest evaluation of and distinction between politics and the political. I rely heavily on Chantal Mouffe’s (2013) work, which defines “the political” to denote relations of power, or the delineation of a constitutive outside, and which explains “politics” as the “ensemble of practices, discourses and institutions that seeks to establish a certain order and to organize human coexistence in conditions which are always potentially conflicting” (2-3). A political anthropology, then, can be understood as dealing with both the structures of power and the mechanisms through which that power is made manifest at the level of the everyday. I pursue this analysis further by approaching a theory of legislatability which sits at the intersections between hegemony, discourse, and agonism.

Hegemony, as a word in the English language, evolved from the Latin hegemonia, likely arising during the fifteenth or sixteenth century, and the ancient Greek ἡγεμονία (authority, or that which characteristic of a leader), according to the Oxford English Dictionary (2014). Antonio Gramsci wrote of hegemony (egemonia, in his native Italian) in his Prison Diaries, arguing that the concept of a “state does not mean only the apparatus of government but also the ‘private’ apparatus of hegemony or civil society” (Gramsci 2007, 108). From ἡγεμονία to egemonia, then, we can trace a clarification of what exactly it is that is characteristic of a ruler:

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9 For a related explanation of the political (circle), see again Latour (2013): “It is not absurd to consider composition via the political circle [POL] as one of the modes that will, on the occasion provided by objects—ordinary things, affairs, issues—give form and figure to other beings that are attached to them” (373). Similarly, Latour concentrates on the formation of groups, though Mouffe’s analysis places more weight on the statement of that which is “not like,” rather than that which is “shared.”
the latter specifies that the construction of a “civil society,” or the “non-state,” must be understood in addition to formal governmental structures.

Also important in Gramsci’s framing is the role of non-rulers in creating hegemony; this leads to a discussion on democracy (understood as a state of ruling in which a subordinate group has the capacity to enter the leading group):

In the hegemonic system, there is democracy between the leading group and the groups that are led to the extent that [the development of the economy and thus] the legislation [which is an expression of that development] favors the [molecular] transition from the groups that are led to the leading group. In the Roman Empire, an imperial-territorial democracy existed in the form of the granting of citizenship to conquered peoples, etc. In feudalism, democracy was impossible because of the establishment of exclusive groups, etc. (Gramsci 2007, 345)

Passages such as this one have led theorists to debate Gramsci’s intent and beliefs on the potential of democracy, with some theorists highlighting the precarity of struggle between competing hegemonies (“wars of position”) in a capitalist society with “exclusive groups” (Morera 1990).

Ernesto Laclau and Chantal Mouffe (2014) clarified this role of struggle in hegemonic fields, claiming that hegemony is most basically a “political type of relation, a form... of politics; but not a determinable location within a topography of the social” (125). These relations are (anti-)agonistic, and as such delineate the frontiers of objectivity in the social world (108); that is, the “wars of position” which constitute competing hegemonies are necessary and illustrate the fault lines between competing ideologies, perceptions, or worldviews. These relations and all of their objects are also constituted discursively (93). Invoking discourse as an integral component of hegemony, Laclau and Mouffe suggest the relevance of Foucault (2010), upon whom they expand. Some given discourse, “a [limited] group of statements [which] belong to the same discursive formation,” or which can be identified specifically and historically (117),
can only be understood within the particular context and through the particular modes in which it is formed.\(^{10}\)

Advancing from the theory of the statement, this thesis embraces a concept of legislatability in order to understand (1) which healthcare reforms are made to be possible in the New Jersey Assembly; and more importantly (2) how these reforms become possible, or legislatable. I will demonstrate that there does, in fact, exist a hegemonic discourse which defines what types of bills may be passed, but that the statements which compose this discourse are frequently contested. Agonistic struggles to determine the boundaries of legislatable reforms are not infrequent but are revealed generally only at the legislative “backstage,” away from media or other forms of “public” attention. This analysis, rather than framing more “ambitious” or left-wing reforms as impossible or unrealistic, emphasizes their contestation under the dominant hegemonic paradigm for determining legislatability. Functioning within a democratic system, the agonistic encounter which delineates such legislatabilities occurs between a range of actors and, if we are to believe Chantal Mouffe (2013), potentially considers all possible positions.

**Methods**

This thesis arises directly from ethnographic research in the New Jersey General Assembly, largely conducted between May and August of 2018, and supplemented by previous internships with state legislators stretching from high school to the present. Specifically, I engaged in participant-observation of several legislative functions as an intern, including a voting session, caucus meeting, and two committee hearings, in which I occasionally worked directly with legislators and legislative aides, and occasionally participated as a citizen and non-staff person by observing. Cognizant of the limited period during which to complete this

\(^{10}\) I use the term “statement” as the translation of Foucault’s “énoncé” throughout this paper.
fieldwork and the similarly limited frequency with which I (as an intern) would be able to participate in the daily operations of the State House, I enhanced my notes from these experiences with informal interviews of staff members at a range of positions, the analysis of most bills related to health insurance which moved through the Assembly during the first half of the 2018-2019 session, and the analysis of other health insurance-related discourses appearing in online media which I collected while completing daily press clips emails for my home district’s legislative offices.

This methodology changed significantly between May and August: initially, I had intended to interview residents of my own neighborhood on their experiences with health insurance, and pad any observations with notes from my work with the district’s legislators. These plans changed due to the confluence of two factors. First, I was unable to surmount difficulties in procuring interviews within my neighborhood. After one particularly hot Saturday of knocking on doors to no avail, I realized that my positionality as a college student conducting a research study during an election year on health insurance—a politically charged and often personal topic—perhaps overrode any connection which may have resulted from my belonging to the same neighborhood. This in and of itself leads to an important conclusion: the politicization of health insurance can be such that it ceases to be a medical theme under certain circumstances (such as when an apparent pollster calls or knocks on one’s door).

While it would have been possible to continue to pursue this project with several adaptations, a second factor arose: the topic of health insurance appeared very frequently during my work with legislative staff members (or staffers). I began to notice, just before I had my previous realization, a contradiction: while the Legislature and the Governor’s Office were both under the charge of the Democratic Party, “radically” progressive legislation on health insurance
The Battle over Healthcare

failed to advance past the level of the committee. Put differently, I started to see a clash between my ideas of progressivism and the realities in the Legislature; at the same time, I read no articles in preparing press clips and heard few conversations which I had not initiated that discussed this conflict. As the middle of the summer came, therefore, I reevaluated and reformed my project to this new area of interest.

This new focus placed me in a precarious ethical position. As stated above, I have worked in district offices (as well as on related campaigns) in New Jersey since high school, and had known many of the staffers with whom I was engaging currently as interlocutors but previously as acquaintances and mentors. My new role of researcher, then, was complicated in many circumstances by my standpoint as perceived by those with whom I was working and whom I was studying. Even further, I am faced in the writing of this thesis with two competing goals of representing the actions of the powerful honestly and practicing ethical integrity by honoring the ideals of privacy, anonymity, and confidentiality. I have consequently replaced all of the names of the staffers with whom I worked directly and/or interviewed with pseudonyms, but maintained the names of any committees or legislators which I observed or came across in discourse analysis. I have also taken efforts to disassociate the individual staffers with whom I worked from a specific legislator: this move ultimately sacrifices a possible analysis of power relations between staffers, but serves the primary goal of upholding ethical values.

Structure of the Thesis

In order to adequately present this argument, the thesis continues with an interlude describing the role of the staffer in contemporary New Jersey politics, and then a chapter detailing the state’s legislative process. These initial approaches offer an early perspective into
the discursive practices of the Legislature: even the depersonalized “process” of moving bills exists at its core as a set of agonistic encounters which regulate legislatability.

Transitioning away from this first part, I refocus my analysis on health insurance legislation with an interlude which describes the history of more recent national efforts to reform the healthcare system. The third chapter then features an analysis of several discursive conditions for legislatability, those being both formal and meaningful.

The fourth chapter extends beyond the narratives publicly disseminated to understand the specific “values” and “tradeoffs” considered in the decision of a measure’s legislatability. This chapter focuses on the poles of accessibility, cost, and scale, and ultimately transitions into a conclusion in which I postulate the potential for progressive reforms more generally.
Interlude

The Staffer

Figure 2: Photograph taken by the author during a voting session of the New Jersey General Assembly from the chamber floor.

Figure 3: Detail of Figure 2 emphasizing the row of staffers along the wall to the Speaker’s left.

Fieldnotes
During an Assembly voting session, as I stood with a mass of staffers around the perimeter of the floor of the chamber, as opposed to the balcony level accessible by the “public,” I was asked to “drop” bills in an office across the hallway. Previously, I had heard of bill dropping only in the past or future tense (e.g. “when I was dropping those bills...,” “I’ve got to drop some bills in Trenton...”). After an additional staffer signed their assemblymember’s name on the packet of papers, I carried the as-of-yet unintroduced bill off the floor and across a marble-paved hall filled with clusters of press representatives, staff members, guests, and others to an office where I reported the first prime sponsor (the assemblymember who would hold most control over the bill and whose name was also signed on the front). The packet received a sticker with a bill number and was filed.

Either on that day or soon after, the Office of Legislative Services would release the bill’s information through the Legislature’s publicly-accessible website (njleg.state.nj.us) and include it within an issue of the Legislative Digest under the heading “Bills Introduced.” Identifying the bill would be the assigned bill number, the name of the prime sponsors, a heavily-abbreviated synopsis, and the committee to which it was referred. The bill would then move between committees, houses, and floors. If passed, it could then be sent to the governor’s desk.

History

Susan Webb Hammond (2003) divides Congress into a formal and an informal structure: in the “front” are the representatives and senators, and in the “back” are shifting networks composed in some part by staff members (colloquially, staffers). Growing from 146 in 1891 to over 20,000 near the end of the twentieth century due to such factors as President Harry Truman’s signing of the 1946 Legislative Reorganization Act (79), the mass of staffers serves in various positions to facilitate the work of representatives and senators, of committees, and of
various administrative and other units within the branch of government. Popularized by shows including *The West Wing* and later *House of Cards* and *Veep*, staffers are hired, and not elected, to work for and occasionally in the place of governmental officials and agencies.

As of 2015, the New Jersey Legislature employed 757 staffers, making it the state with the fourteenth greatest number of total staff members in the United States ("Size of State Legislative Staff" 2016). These individuals are generally divided between district offices (located in each of the state’s forty districts) and the State House (located in the state’s capital, Trenton). Legislative assistants, outreach directors, and chiefs of staff typically circulate between a district office and Trenton to accompany and represent “their” respective legislator at meetings, voting sessions, and other events. Further, district office staff prepare and distribute mailings and official forms of recognition (e.g. citations, commendations), as well as provide various services, to engage and assist the district’s constituency. Legislative counsel, majority and minority office staff, and committee aides (among others), while largely remaining in Trenton, traverse different regions of the State House and the historic region of the city to communicate within and between governmental branches (e.g. Legislature, Governor’s Office).

New Jersey’s legislative staff remain for the most part out of the public’s gaze, similarly to the congressional staff observed by Webb Hammond (2003), though there are certainly some exceptions (see, for example, Marcus [2018] and NJTV News Online [2018]). This invisibility can serve to reinforce the democratic idea that, when elected, legislators will work specifically for the individual needs of their constituents. (It continues to surprise people, for example, that I have replied to emails as a legislator and even cast votes during a voting session.) Perhaps, also, this invisibility results from rapid turnover: a campaign manager for an incumbent legislator with
whom I worked in 2013 is now (only five years later) working in the Assembly Speaker’s office, and similar stories abound.

This rapid turnover prohibits any analysis of the Assembly as a constant “population” or “community.” Instead, as a locality, it becomes a (discursive and material) place in which staffs encounter bills, legislators, constituencies, and one another with the goals of advancing legislation, the careers of their assemblymembers, the needs of various publics, and their own future work. The Assembly might also be valuably interpreted as a workplace; unfortunately, there is little anthropological scholarship on staffs as workers, with perhaps the most applicable research being (1) statistical or economic in nature; and (2) more focused on the federal government than on individual states. One report from the Joint Center for Political and Economic Studies claims that senior staff in the United States Senate represent a stark lack of racial diversity: of the 336 staffs identified, only 24 were people of color (Jones 2015, 3). Similarly, an analysis completed by data-collection company LegiStorm identified a pay gap of $7,580 in the House of Representatives and $2,330 in the Senate between white and non-white chiefs of staff (Hetrick 2018).
2 // Legislative Process

Interaction and Conflict

“A bill is a proposed law. It is the vehicle for taking formal action such as establishing a new State program, making an appropriation, authorizing or prohibiting an activity, changing the language in an existing statute, or repealing a section of law.”

— New Jersey Legislator’s Handbook (Office of Legislative Services 2018d, 19)

“People get sick, they die. That’s the way it goes. I’m faced with decisions like this every single day…. The fact is that there are fifty million people in this country without medical insurance. If you’d like to change it, you should call your congressman.”

— Hospital Administrator Rebecca Payne in John Q (Cassavetes 2002)

Before approaching health insurance as it is articulated, I begin with a review of the legislative process in the New Jersey Legislature. Ethnographic accounts of legislative processes include Weatherford’s (1985) previously-cited classic Tribes on the Hill, which describes the “civic rituals” of the United States Congress through analogies provided by the broad anthropological scholarship from the years before the reflexive turn. In The Dance of Legislation, Redman (2001) refrains from such imagery and instead follows journalistically the movements of various bills.

This chapter reflects some synthesis between these two models. Redman’s style adeptly assigns human faces to the fetishized movements of bills, while leaving much of the analytical work to the reader. Weatherford’s intense reliance on theoretical framings benefits this section as well. Consequently, I aim in this chapter to present a thick description of the legislative process in New Jersey which both maintains a focus on the individual agents and the bills they interact with and incorporates anthropological theory to contextualize this process.

Drawing on Chantal Mouffe’s (2000, 2013) previously-cited theorizations on agonistic encounters, the legislative process may be analyzed as not a series of sites, but a series of encounters between agents in which bills’ legislatabilities are evaluated. These evaluations take
the form of “wars of position” in which the possibility of a piece of legislation moving forward is challenged agonistically by actors with varying interests (e.g. Democratic and Republican staffers, legislators, lobbyists). Following Laclau and Mouffe (2014), the legislatability of healthcare reforms is *overdetermined*, lacking both an absolute fixity (the political field changes constantly with elections and, unfortunately, tweets) and a constant non-fixity (legislation must obey certain structural requirements [see Chapter 3]). What is hegemonic about health insurance, then, are the “types of relations” which work to (over-)determine legislatability (125).

In this chapter, I present the stages of the legislative process and the various interactions between actors which constitute them.

**Drafting Bills**

Perhaps the most amorphous of the stages in the legislative process is that in which a bill is drafted. Beginning in district offices, the Senate, the Assembly, other states, and other localities, the process of preparing a bill for introduction involves additional legislators and state agencies. Not infrequently, bills are also filed to be introduced in future sessions.

So as to highlight this variability as a precursor to the bill’s future paths, I will refrain from presenting its technical components and content until the following chapter, which takes certain contents as its central theme. That leaves the sites through which the bill initially travels and the agents by which its movement is regulated. The places of origin for bills to be introduced by New Jersey assemblymembers are frequently the legislators’ district offices, where staff regularly interface with various constituents.\(^\text{11}\) From the district offices, bills will generally then travel digitally to and from the Office of Legislative Services (OLS), which physically operates within the State House, before they are ready to be introduced.

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\(^\text{11}\) There are exceptions to this general statement, such as when bills identical to ones already circulating in the Senate are drafted for the Assembly; however, it is frequently the district office’s staff who will request these copies.
District Offices: Constituents, Stakeholders, Staffers, Legislators

Each assemblymember (and senator, for that matter) receives financial allotments for district offices and legislative staff. Within these offices, staffers and legislators may legally conduct “legislative business” and are prohibited from campaigning or otherwise participating in “partisan political party activity” (Office of Legislative Services 2018d, 67-68). As an intern, I worked most days from these offices, interacting almost daily with the assemblymember, staffers, and constituents.

The term “constituent” is difficult to explicitly define, given that it means at a basic level “that which makes up,” or “constitutes.” Given the context, the hypothetical constituent may best be understood as either one of the whole body represented by the given legislator, or one of the whole body which elected the given legislator. The slight difference between these two meanings presents an important and classic conflict: is the duty of a legislator to a geographically-defined public, or to an electing public? In the present discussion, the issue becomes one over which parties should be defined as belonging in a given assemblymember’s constituency.

This constituency, under the framework implied by the staff position of “Constituent Services Director,” may then find assistance at the district office. My interlocutors explicitly divided this assistance in two categories: constituent services and policy work. Matthew, a staffer at the Assembly Majority Leader’s office, summarized this distinction clearly in the beginning of our interview:

I’m doing all things policy: monitoring bills for the Majority Leader that he’s sponsored and cosponsored, tracking them in the Assembly and the Senate, coming up with new ideas for legislation, working on existing pieces of legislation, just anything public policy related is my responsibility. I also do some constituent work. Obviously, we have two constituent services people, but sometimes I handle casework from constituents in our area that have issues, try to direct them to the correct government departments, contact our liaisons in these state departments. But mostly my position revolves around policy.
While this hard distinction presents several difficulties (in those cases to be discussed, for example, where constituents generate ideas for legislation), it allows us to distinguish further between constituents and stakeholders. Used occasionally by various interlocutors to describe entities which have some form of control over the legislative process, the group of stakeholders can be understood to include constituents as well as lobbyists, hospitals, businesses, and others. Following patterns suggested by those whom I interviewed, I therefore use “constituent” to refer to the mass of humans able to request “constituent services” (whether they voted for the assemblymember or not), and “stakeholder” to refer to those who are able to impact the movement of bills.

Within this class of stakeholders, I include the category of lobbyists. New Jersey has been identified with a strong, even if non-unified, insurance lobby: insurance agents have demonstrably affected both legislative and local levels of governance, with insurance agents using “their standing in the community to shape state health care reform” (Garnick, Swartz, and Skwara 1998, 142) and firms funding political campaigns (Hays 2005). In addition to insurance companies, a Hospital Association comprised of all hospitals in the state conducts research, releases reports, and manages lobbying efforts at the state and federal level (Morone and Dunham 1985).

Having clarified this vocabulary, I now turn to the question of idea generation: how do ideas for bills first arise? As suggested previously, the first class of relevant stakeholders is that of constituents who reach out to the office. Welcomed into the office through the constituent services “side,” individuals who reach out to the assemblymember for assistance with some government agency may generate an idea for legislation which would improve the delivery or
accessibility of the state’s services. Joseph, a staffer who works mainly on policy at a new assemblymember’s office, explained,

... what we try to do is at least be responsive to all of our constituents. And occasionally what arises from those conversations is some extremely positive things. You can have a constituent approach you like “I’m experiencing this, this, this, and this issue,” … but sometimes you’ll have a constituent say, “Hey, I’ve gone through every channel. What I think is missing from that equation is this.” What we can do with that is do the same thing that we could do with any private sector lobbying force. We can say, “Oh, hey, that is a great idea. Let’s get a draft of this. I’m going to get it back to you for your feedback; you let us know if you think this would address the problem.”

This narrative presents an interaction in which, after all possible paths fail, the staffer serves to translate a constituent’s need into legislation by initiating the drafting process and consequently transferring the case to the policy “side” of the office.

The office also receives ideas from in-house lobbyists (who work for and represent a single entity) and contracted lobbyists (who work for a firm and are hired to represent separate entities). Standing in for diverse organizations such as hospitals, labor unions, and political action committees (PACs), lobbyists enter the district office immediately through the policy side. Staffers receive these actors differently, with some such as Matthew claiming that “they’re really helpful in bringing to us ideas from all over the state,” and others such as Joseph more skeptically describing the “handing off” of legislation “straight from the private sector.”

Finally, district offices can draft bills using information gleaned from their own experiences and research. A number of resources, including the National Council of State Legislatures’ magazine State Legislatures, provide analysis of trends in legislative bodies across the United States, as well as research reports on contemporary issue areas. Staffers, additionally, frequently complete research projects: during the course of my fieldwork, I personally wrote and distributed memoranda on the use of social media accounts by elected officials, telecommunications, emergency response procedures, and civil rights, among other areas. In the
words of William, a chief of staff, “my job... essentially is making sure that the office is running smoothly as well as keeping our finger on the pulse of some of the policy issues that the assemblymember is following.”

**OLS and the District Office**

Once an initial draft of legislation has been prepared, using the ideas gained through the modes described above, at least one request is sent to the state’s Office of Legislative Services. This agency, among its other responsibilities, generates an abundance of documents for legislators and staffers, as described in the 2018-2019 *Legislator’s Handbook*:

The request will be recorded and assigned to the proper subject area section, where the section chief will assign it to a professional staff member. All assignments are performed on a confidential basis. The Central staff professional may contact the legislator by telephone or in writing to discuss the request and the appropriate form of the final product the legislator is seeking. Requests often take the form of research memoranda, bill drafts, letters to constituents, analysis of information obtained from an executive agency or interest group, analysis of executive regulations, legislative histories of bills or issues, or statistical reports. (Office of Legislative Services 2018d, 45)

The office, located within the State House, receives and generally responds to these requests through the Legislature’s email system and additional software installed on district office computers.

The OLS is essentially ubiquitous in the bill drafting stage, as demonstrated in this comment by Joseph:

So, the way it works is that myself or the chief of staff and the assemblywoman, we will sit down and come up with an idea of something that is just usually the framework: that we want to accomplish this, this, this, and this is what we have in mind. We’ll then take that to our Office of Legislative Services who will draft legislation and put it in the technical language. We will then review the draft, and if it’s approved, we will prepare introductory copies. If not, we will go back, work with the OLS aide who’s prepared it to refine any points that need to be, ad anything that needs to be added, take out anything that needs to be taken out.

After it has been completely prepared for introduction, a physical copy will be printed at the district office on legal-sized paper and brought to the State House.
Introduction and Sponsorship

Bills may be introduced either to the current legislative session or to the subsequent one through a process called “pre-filing.” This process begins when one assemblymember’s staffer acquires the signatures of other members on a cover to the printed bill (called a “fronter”); these signatures denote willingness to sponsor the bill.

Sponsorship is traditionally divided among prime sponsors and cosponsors. The first prime sponsor, who in many cases has directed the staff to initially draft the bill, colloquially and legally “has” the bill. This possession of a bill entails certain “rights,” such as the ability to select co-sponsors and to reintroduce the bill into the next legislative session. The sponsor (or, more realistically, the staff of the sponsor) must also manage the progress of the bill through the Assembly. One additional prime sponsor may sign on with the permission of the first prime who will also possess the bill; the level of ownership of additional prime sponsors, however, diminishes slightly, as the first prime’s rights prevail in the event of any disagreement. A bill may include an unlimited number of cosponsors from the same house, granted that the prime sponsors approve.

The subject of the sponsor is important within the Assembly, as future sections will illustrate. Besides being able to “re-pick [one’s bill] back up and introduce it again,” as Sarah, a staffer previously charged with constituent service management, explained, prime sponsors strongly identify with their “portfolio” of legislation. Joseph, in describing a potential interaction between a committee chair’s district office staff and himself, hinted that a claim that a

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12 This concept deserves additional explanation, given the relatively recent shift to a two-prime sponsor limit. The granting of “more prime” status to the first prime reflects previous traditions of allowing virtually unlimited prime sponsorship with the permission of existing prime sponsors. Though it is still possible to include more than two prime sponsors on a bill with the speaker’s permission, this practice has declined in popularity.
given bill is “really important” to an assemblymember’s portfolio may be a compelling reason to support it.

Once the bill has a prime sponsor, and frequently after additional members have agreed to sponsor or co-sponsor it, a packet containing three copies of the bill and the signed fronter is delivered to the Office of the Clerk of the General Assembly. Between November 15 and the first Tuesday in January before a new legislative session, bills must be pre-filed, meaning that they will not be considered formally introduced until the beginning of the session. Both pre-filed and regularly filed measures, however, will receive bill numbers and will be input into the Legislature’s database. During the current or next open session, the bill is formally introduced and receives its first reading when the Clerk announces the bill’s number, sponsor(s), and title.

Much of this process occurs away from the eyes of the district office staffer (or intern). It begins in an office across the hall from the Assembly Chambers with a numbered sticker being affixed to the bill packet and several notes being recorded in a log book. From there, it is only a matter of time until the most recent Legislative Digest includes the number, prime sponsors, synopsis, and committee reference under the heading “Bills Introduced.” The bill is also published on the Legislature’s public website.

Reference to Committee

Immediately after the bill is introduced, the Office of the Speaker of the Assembly refers it to one of the house’s committees.13 The vast majority of bills dealing with health insurance are referred to one of two committees, those being the Assembly Health and Senior Services Committee (AHE) and the Assembly Financial Institutions and Insurance Committee (AFI).

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13 The Speaker may also bypass the committees and move a bill directly to its second reading. This, however, is very rare.
How, though, is this decision made? One chief of staff, James, described it as a “black box."

It’s ultimately a decision that’s made by the majority office partisan staff. I always compare it a little bit to what happens in courtrooms with juries: it’s a little bit of a black box. So, it’s a decision made. Who makes the decision? From what I’m told, they try to do it as objectively and as professionally as possible. I don’t have a great grasp on what would make that division [between AHS and AFI]. If it were up to me, probably it would be that things more exclusively insurance-driven would go to AFI, and if it was things that touched on other aspects of health law, you’d send to Health.

Joseph described the decision as one which is ultimately political:

OLS… will reference a bill. They will reference the bill, say ‘Hey, I think this bill deals with health insurance, it goes to the Health Committee.’ Now, it is my understanding that the majority office then has the ability to say, ‘No, I think that it would be a little bit better suited for this committee chair,’ who could then move that, for example, into the Assembly Financial Institutions. And again, those are decisions that I think are largely influenced by the politics and what the specific legislation is, and how they think—at least the Speaker’s Office thinks—the one… chairperson is going to look at it versus another chairperson. And again, for better or for worse for outcomes.

So, while we do not ultimately learn the dynamics behind the committee reference process, it becomes apparent that one or two offices retain the ability to selectively assign bills to different committee chairs. In the 2018-2019 session, this could result in different receptions by committee chairs: the chairman of AHE, Assemblyman Herb Conaway, was a medical doctor before entering politics, and may by that fact alone, disregarding any ideological differences, respond to legislation differently than attorney and career politician Assemblyman John McKeon, who chairs AFI.

Following committee references, the committee chairs receive lists of relevant bills which they and their staff must evaluate. The following section describes the various processes through which that evaluation occurs and is driven.

**From the Committee to the Floor**

These lists are compiled by committee aides and other staff, including Miguel, a newer employee in the Assembly Majority Office. After showing me a printed spreadsheet which
covered multiple pages with columns describing bills, sponsors, and other information, he explained that one of his jobs is to offer the committee’s chair a “sense for the bill.” This “sense” combines the inputs of other assemblymembers, the movements of similar bills in the Senate, the opinions of lobbyists, and his own analyses.

From this characterization and the positionality of Miguel, we can read the presence of at least six parties involved in the movement of a bill from committee to the floor of the Assembly for its second reading: (1) the committee chair; (2) assemblymembers; (3) senators; (4) stakeholders; (5) party leadership; and (6) staffers. This chapter has so far treated to some degree each of these subjects; what remains unanalyzed, however, are the conflicts which arise between them. By dividing this stage of the legislative process into certain substages, I will present in greater detail how the discursive evaluation of bills coincides with—and is a direct result of—the interactions between different agents. The remainder of this section, consequently, will describe the following spaces for interaction: (1) the definition of an agenda; (2) the public hearing; and (3) the committee meeting and final vote.

Agenda

The development of a committee agenda, like the referencing of a bill to a committee, is a process generally opaque to the public. Simply lists of bills to be discussed and voted on during a particular meeting, agendas are developed by the committee chairs and their staff.

At this early stage of the committee process, the party leadership retains important influence: while unable to legally require or prohibit the inclusion of a certain bill on an agenda, as this right is reserved by the committee chair, the opinions of the Speaker or Majority Leader do effectively regulate which bills can be posted, or scheduled to be discussed and voted on by the committee. According to Matthew, discussing his work with the Assembly Majority Leader,
Definitely, as Majority Leader, we do have a lot of what we sometimes call political capital. That’s part of my job—learning, networking, meeting the other staff—so that when it does come time to post bills or vote on bills, I can—we can reach out to these offices and kind of see where they are on these bills. But it’s definitely the title. Definitely the title holds a lot of weight and the leadership role he has, but it’s also just his experience in the Assembly and the relationships he’s made.

This explanation, which oscillates frequently between identifications of the Majority Leader as an individual politician and as a collective office (e.g. use of “we”), illustrates how leadership can identify its power to impact the legislative process in circumstances ranging from the posting of an agenda to the final votes on a bill.

This “political capital,” as Matthew identified it, can be tapped into by other assemblymembers who wish to move their bills forward. Joseph described along the same lines the need for relationships with staffers from other offices, including that of the committee chair:

As a staffer, you want to establish relationships in the committee chair’s office so you can pick up the phone and say, “Hey, this bill is really important to the assemblymember’s portfolio. Would the chairperson be interested in sponsoring the bill?” Because typically, when someone’s name’s attached to something and they feel there’s something beneficial to it, I think it’s just a little bit natural to want to put a little bit more emphasis and push behind it. And once we have those existing relationships, it’s easier to get our priority bills up. And once we send it over to them, if this is someone that we work with pretty consistently, it ends up finding its way on an agenda, at least has been my experience.

As such, while individual assemblymembers may not occupy a position to post bills to agenda as easily as party leadership seems able to do, the improving of relationships between office staff may result in interactions which increase the bill’s potential for movement through the mode of sponsorship.

This line of reasoning applies as well to the roles of lobbyists at this stage. Joseph explained that, even while the priorities of legislators may be aligned, private sector stakeholders may exert enough pressure as to prevent a measure’s inclusion on a committee agenda:

People don’t have the same priorities. So a bill that could be extremely important to this office, the chair of that committee may... see that this bill needs a lot of work. Or, as we all know, lobbying and private sector influence are a part of government, for better or for worse. So perhaps a stakeholder sees that this is up for an agenda [on the Legislature’s
Lobbyists, then, can exercise an immense degree of pressure through networks similar to those in which staffers engage in between offices. This pressure may even be so great as to *force* chairs not to post bills, as suggested by the final conditional sentence. The movement of bills onto agendas, then, while relying on social networks between staff and legislators, may be regulated by diverse agents possessing varying degrees of control.

**Public Hearing**

Regardless of whether or not a bill is posted on an agenda, it may be discussed in a public hearing hosted by the committee. These hearings generally occur within the State House, though on occasion they are hosted around Trenton or in other symbolic localities (e.g. schools, community centers), and can feature two groups of speakers who will present testimony to the committee regarding an issue. The first witnesses, who may be pre-approved by the committee chair, are frequently government leaders or experts in the field of concern. (E.g. for a hearing on health insurance, physicians and representatives of state health departments will likely be invited to testify.) The second group is composed of members of “the public,” or more broadly, stakeholders.

Within this group of stakeholders, as before, both constituents and lobbyists may speak. Sarah describes the lobbyists as standing in the place of their clients,

> So... their role is to go with their clients, on behalf of their clients, to present testimony and answer legislators’ questions, meet with legislators, let them know “these are the pros and cons, this is what I think you should do.” They want their issues to be passed, so they have to go meet with legislators and go to the committee hearings and everything.

Surprisingly, the role of the lobbyist in this scenario does not differ too drastically from that of the constituent, according to Joseph, who suggested that individuals with strong opinions “go up and testify and get other people who have experienced similar things to go up there and testify to...
the importance of [some] legislation.” It would seem, then, that the public hearing offers a space where all stakeholders represented may possibly direct the future movement of a bill.

**Committee Meeting and Final Vote**

This leaves us with the committee meeting and final vote. Committee meetings are public, and may incorporate similar presentations by lobbyists and/or experts as described above. The final vote on whether a bill should proceed past the committee, either with or without amendments, does allow for each committee member to exercise some degree of control over the bill’s momentum. If it passes the committee’s vote, it will likely be referred back to the floor of the Assembly for its second reading, though it may be sent to another committee where it will repeat the process.

**Second Reading, Third Reading, Future Movements**

Once it returns to the Assembly floor, after moving between spreadsheets and agendas, the bills is again listed on the *Legislative Digest* as having been reported by a committee and on its second reading. It now reenters the control of the Speaker, who may decide when to offer its third reading. During the period between second and third reading, amendments ("floor amendments") may be proposed which will be voted on in addition to a vote on the bill itself.

Though there exist no prescribed elements which, when included, will result in a shorter gap between second and third reading, bill sponsorship and pleas to the Speaker may result in the bill moving more quickly, as Sarah described:

> If you can do bipartisan, that’s great. And you usually want it from the South, and Central, and North New Jersey, so that gives it a little bit more power. But you can always write a letter to the Speaker, if you’re in the Assembly, or the Senate President, if you’re in the Senate, to urge them to move this forward.

I encountered this response throughout the period of fieldwork at levels ranging from the district office to Assembly Majority Office. This indicates again the potential impact of a bill’s
sponsors, but ultimately identifies the Office of the Speaker as having the final decision over a measure’s ability to be voted on.

If the bill is posted for a third reading and vote, it may be debated in a session of the Assembly, and finally opened for a vote. Barring any debate, the third reading and voting period proceeds normally as some variation of the following:

**SPEAKER:** Resolution on the Clerk’s desk.

**CLERK:** [States bill number, sponsors, and synopsis.]

**SPEAKER:** [Calls on bill’s first prime sponsor.]

**SPONSOR:** Thank you, Mr. Speaker. I move the resolution.

**SPEAKER:** Assemblyman/Assemblywoman _________ moves the bill. Madam Clerk please open the machines for voting.

**CLERK:** [“Opens” vote-collecting machines, which list the bill’s number, status, and synopsis, a tally of votes in favor, votes against, and abstentions, and the votes of each assembly member.]

**ASSEMBLY:** [Members or their staff select one of four buttons on their desks to vote “yay,” vote “nay,” abstain, or not cast a ballot. In the Senate, legislators do not have the option to abstain.]

**SPEAKER:** Are all recorded who wish to be recorded properly recorded? Madam Clerk, please close the machine and take a tally.

**CLERK:** [“Closes” the machine and reads a tally of the vote.]

**SPEAKER:** [Announces whether or not the bill passes, and what its future movement will be.]

This entire process may take about one minute, and will repeat for as many bills as were scheduled to be voted on. Variations in this script do occur, as there may be a motion for debate where the sponsor moved the resolution; before the voting session, however, all members receive a script to follow should they be required to speak (e.g. to move a resolution).

In deciding how to vote on specific bills, legislators and their staff attempt to balance the views of various of the stakeholders introduced above. As Matthew described,
I think the hard part of our job and the legislators’ jobs is to try to find a balance. Right? It’s to try to not come out and say, “I support this side, and screw this side. They don’t matter.” All these people are constituents, all these people. Again, they’re our constituents: we’re trying to benefit all of them as much as possible. If you have a policy that helps the Medicaid recipient that hurts insurance companies, that might not be a great policy because health insurance companies employ so many people in our state. So, our job really is to navigate between opposition, to try to find compromises that have provisions that benefit everyone, so that when it actually comes time to vote, we can vote through this legislation with no problem.

Matthew’s example of legislation which aids the Medicaid recipient and harms the insurance company (employee) highlights again the importance of stakeholders in the legislative process. At times, the assemblymember may find himself/herself caught between the Democratic Party, corporate lobbyists, constituents, and personal judgments when deciding how to vote on a particular issue, as Sarah describes:

It’s definitely hard because you have to follow what the party says, but then you also have to listen to your constituency. ... But it comes to the point where—maybe it’s not even party lines—if you’re like, “This is going to be better for the people. I have to do it.” Like with the gun control issue. A lot of people were very upset about it, but the assemblymember recognized that “This is a really big issue that I feel passionate about, and I also think it’s going to be beneficial....” Which I think is hard for legislators to do.

We might imagine, following Sarah’s commentary, that the Democratic Party occupies an almost monolithic status in the legislative process, with assemblymembers strongly persuaded to “follow what the party says.” This characterization, however, does not stand up to further analysis. Despite New Jersey Democrats holding control of both the Senate and Assembly, in addition to the Governor’s Office after several years of a Republican governor, the two branches of state government still encounter conflicts in their negotiations. William explained this conflict as one which defies reasonable expectations, which is between sets of priorities, which extends more broadly into the realm of local party bosses:

When you look at the Democratic majority in both Houses, and you look at the fact that we have a Democratic governor in the front office, the environment is certainly set up for quite a number of things to go through efficiently, quickly get signed into law, etcetera, etcetera, whether that be the budget, or healthcare, or any other issue for that matter. But as you’ve noticed in the budget [negotiations, which featured a narrow escape from a state government shutdown] I’m sure, there were certain challenges. And so those
challenges are related to agreement and what the governor’s priorities might be, versus what the Legislature’s priorities might be. But even and above that, what do party bosses want? Right? Because party bosses are ultimately the ones who sort of pow-wow everybody at the local levels and decide on what the priorities might be for their particular regions.

Therefore, the process of reaching a vote and moving bills out of the legislative process to the governor’s desk implies some degree of intra-party dispute between legislators and actors both “from above,” such as the governor, and “from below,” such as partisan county chairs or bosses. Sarah, too, commented that conflicts between legislative leaders and the Governor’s Office may be causes for concern:

My only concern is what we saw with the budget: the games that were played, who’s going to make the better deal or be more stubborn. So I’m hoping with healthcare that doesn’t happen, because I think if the Democrats can come together and work together, then it’ll be beneficial. We can actually help people to get maybe a single-payer healthcare system, or just more affordable healthcare in general. Hopefully, we’ll see. We have, what, three more years to do that? And then see what happens in the next governor’s race.

Reflecting William’s concern over agreement, Sarah hopes that Democratic leaders’ willingness to cooperate, and not their stubbornness, will allow for the development and implementation of progressive policy.

Consequently, the process of posting, voting on, and advancing bills to the Senate and/or to the governor’s desk is one deeply steeped in a myth of party cohesion and profoundly impacted by intra-party conflicts. I extend the analysis of this myth and these conflicts as they relate to the theoretical framework outlined above and to the remaining chapters in the next and final section.

**Conclusion: Party Unity?**

In the first few pages of this thesis, I have demonstrated that there exists anything but consensus in the New Jersey Assembly; instead, numerous agents must agonistically interact in order to determine if a bill is legislatable. Yet, as I have also described, there seems to be a
desire to demonstrate some degree of common agreement within the Democratic Party: in describing the “sense” of a bill for committee chairs, as Miguel explained, the individual agonistic encounters between sponsors, chairpersons, lobbyists, constituents, leadership, and others become condensed into a sense of what conflict a bill could produce. Even at earlier stages, active steps are taken to ensure that the conflict arising from encounters does not define the assignment of capital to legislative measures, such as in the “black box” in which the Speaker’s Office and OLS determine the committees to which bills should be referenced. Drafting bills, too, involves the careful delineation between constituents, who enter through the “constituent services” side, and lobbyists, who enter through the “policy” side, within district offices.

Such efforts to hide conflict are not unique to the New Jersey Assembly. Mouffe (2000) describes the “sacralization of consensus” in European democracies, and its ultimate effect of cementing a “closed circle” of powerful elites (112-113). This legislative (and governmental) model works to move the radical left toward the center, while at the same time eliminating opportunities for groups who have traditionally been denied belonging in the state’s governmental procedures to act.

Revisiting the theory of overdetermination, we read in Laclau and Mouffe (2014) that “every historical bloc—or hegemonic formation—is constructed through regularity in dispersion, and this dispersion includes a proliferation of very diverse elements:

systems of differences which partially define relational identities; chains of equivalences which subvert the latter but which can be transformistically recovered insofar as the place of opposition itself becomes regular and, in that way, constitutes a new difference; forms of overdetermination which concentrate either power, or the different forms of resistance to it; and so forth. (128)

It is the uncertainty which accompanies the determination of legislatability, then, which defines the legislative process, and not allegiance to a party. Through the rest of this thesis, I take up
such a prioritization of contestation to understand the conditions under which healthcare legislation is evaluated.
Interlude

Recent Reforms: Toward National Health Insurance?

“Broadly defined and viewed in the context of the United States, national health insurance will be a program in which the federal government will finance and guarantee a broad range of medical services to all (or virtually all) of our citizens”


“... the emphasis on personal choice and less intrusive managed care may lead to somewhat higher health care costs, although there is reason to believe that the emphasis on preventive and primary care, as well as knowledge of the individual’s value system, could reduce costs. If health care costs continue to rise at levels substantially above the rate of inflation, the country may be forced to adopt a single-payer system....”


“The Affordable Care Act already represented a significant scaling back of liberal ambitions from Senator Kennedy’s proposals in the 1970s, of even what Clinton was calling for in the 1990s. In those debates, many Republicans had accepted the legitimacy of universal coverage as a national objective. That is no longer true; the earlier moral consensus has disappeared.”

- Paul Starr, *Remedy and Reaction* (2011, 281)

Fieldnotes

*In the middle of the summer during which I completed the bulk of this research, several family members and I received bills from Virtua Health Systems, in which our physicians work, for care administered years in the past. Certain that these services should be covered by insurance, I first called Virtua’s local office to confirm that the letters received in the mail were legitimate. Redirected to the two numbers listed on the letter, I left three messages with “Aaron” and the business office before finally getting in touch with “Sonya,” who offered to send an itemized bill.*

“Aaron” and “Sonya” worked for Apex Asset Management, LLC, a self-described “consistent, reliable leader in the collections industry” which had contracted with Virtua to handle their billing services (“Apex Asset Management | Debt Collection Agency”). Apex describes on their website a “suite of products and services designed to improve our clients’
revenue cycle, reduce administrative and labor costs, and minimize risk” (“Medical Collection”), with a hyperlink on the words “minimize risk” leading to a page on Apex’s compliance with federal policies (“Compliance”).

After calling Apex, I called Virtua back to request an itemized bill from my doctor, and was redirected to the Billing Department. Billing’s number forwarded the call automatically to Apex’s mailbox, at which point I hung up and made a final call to Virtua and reached my specific physician’s front desk. There, I left a message requesting an itemized bill for my 2016 well-visit.

History

One of the recurring themes in historical studies of United States health insurance is the notion of high costs. Large-scale federal efforts to deal with these costs came to a head in two pieces of legislation, one put forward during the Clinton administration in 1993, and the other during the Obama administration in 2010.

The first of these, officially coined the Health Security Plan, emerged in the form of legislation one year after President Bill Clinton was elected and, if we are to follow senior health care advisor to Clinton and sociologist Paul Starr’s recounting, after more than a decade of disorganized approaches to health insurance reform (2011, 79). Reportedly costing Americans $900 billion in 1993, healthcare had been recently dominated by forms of managed care such as health maintenance organizations (HMOs) which effectually limited, rather than expanded, patients’ ability to choose physicians or facilities (Starr 1994, 2). Rising out of these, among other, forces, Starr (1994) reports the cementing of a “negative consensus” which drove a dominant focus toward reform in the 1992 presidential election.
This same period, however, brought increasing *dissent* between Republicans and Democrats over the management of Medicare. With the projected depletion of Medicare Part A funds approaching, and the resurgence of a Republican majority in Congress in 1994, reform of Medicare, and the healthcare system by extension, became contentious and politically fraught (Brasfield 2011, 59).

In this atmosphere, then, President Clinton introduced a plan for national health insurance reform on September 23, 1993, to a joint session of Congress:

> Over the last eight months, [First Lady] Hillary and those working with her have talked to literally thousands of Americans to understand the strengths and the frailties of this systems of ours.... Millions of Americans are just a pink slip away from losing their health insurance, and one serious illness away from losing all their savings. Millions more are locked into the jobs they have now just because they or someone in their family had once been sick and they have what is called a pre-existing conditions. And on any given day, over 37 million Americans—most of them working people and their little children—have no health insurance at all. And in spite of all of this, our medical bills are growing at over twice the rate of inflation, and the United States spends over a third more of its income on health care than any other nation on earth. And the gap is growing, causing many of our companies in global competition severe disadvantage. (Clinton 1993)

Designed to embody six principles (security, simplicity, savings, choice, quality, responsibility), the legislation did not ultimately pass through Congress. Though the bill in its entirety did not pass; 1996 saw the passage of a Health Insurance Portability and Accountability Act which quietly incorporated several aspects of the Health Security Plan. Among these are its empowerment of the Secretary of Health and Human Services to conduct evaluations relating to health care delivery and payment and maintain an account for providing financial incentives to informants of health care fraud (Feldman 2000, 98).

The second major attempt to reform the health insurance system at a federal level is widely acknowledged to be the Patient Protection and Affordable Care Act, passed in 2010 under the administration of President Barack Obama. Through the establishment of insurance exchanges forced to operate under a set of rules, the ACA acts to regulate insurance markets with
the goal of increasing patients' ability to find quality insurance at lower costs (Starr 2011, 240). Among the regulations imposed are an individual mandate, a requirement that employers offer coverage, an expansion of Medicaid and the Children’s Health Insurance Program (CHIP), the provision of cost-sharing subsidies to eligible individuals and families, the provision of certain small business tax credits, and the expansion of coverage of dependents (“Summary of the Affordable Care Act” 2013).

What made this reform possible, as opposed to the earlier proposal? Starr (2011) cites Massachusetts’ bipartisan health insurance reform (led by Republican Governor and later presidential candidate Mitt Romney) as one case which demonstrated the possibility of “bipartisan” consensus on the need for legislative action (163). Bolstering this consensus-based interpretation, Brasfield (2011) argues that the participation and eventual support of the Pharmaceutical Research and Manufacturers of America (PhRMA), the American Medical Association (AMA), and the American Hospital Association (AHA) contributed to the bill’s momentum.

In the years since the ACA’s passage, Obama was reelected to serve a second term and ultimately succeeded by President Donald Trump in 2017. Having run on a platform which would repeal “Obamacare” and replace it with a plan providing “insurance for everybody” (Costa and Goldstein 2017), Trump has overseen several pieces of legislation and various regulations which limit the reach of the ACA.¹⁴ During his tenure so far, Congress has eliminated the individual mandate and Trump has put through an order allowing “association

¹⁴ Former United States Representative Tom MacArthur, representing New Jersey’s third congressional district, led much of the legislative work to accomplish Trump’s plans. He is relevant to this thesis in two additional ways. First, I worked on a campaign for an opposing candidate in 2014, when MacArthur was first elected; it was during this time that I met or sustained relationships with many of the staffers I would come into contact with during this research project. Second, MacArthur was not reelected in 2018 as the “blue wave” swept over the House of Representatives; there remains, consequently, uncertainty over the future of New Jersey politicians’ roles in the national health insurance reform debate.
health plans” to permit certain small businesses to associate together with a resultant higher purchasing power for the purpose of purchasing lower-priced health coverage options (“President Donald J. Trump is Addressing the Healthcare Issues Left by the Past Administration” 2018). In the days before I submitted this thesis, furthermore, he has even called for the complete dissolution of the ACA (Stanley-Becker 2019). These actions and accompanying discourses continue to threaten movements toward a nationalized healthcare system.
3 // Legislating Health Insurance

Conditions of Legislatability

"a. A taxpayer shall, for each month beginning after December 31, 2018, ensure that the taxpayer, if an applicable individual, and any dependent of the taxpayer who is an applicable individual, is covered under minimum essential coverage for that month.

"b. In the case of any taxpayer who fails to meet the requirements of subsection a. of this section, there shall be imposed a State shared responsibility tax equal to a taxpayer’s federal penalty that would apply for the taxable year under section 5000A of the Internal Revenue Code of 1986, as in effect on December 15, 2017 (26 U.S.C. s.5000A)."

- New Jersey Health Insurance Market Preservation Act, passed as P.L. 2018, c.31 (McKeon et al. 2018, C.54A:11-3)

"To preserve the freedom of the people of New Jersey to provide for their health care, no State or federal law or regulation shall compel, directly or indirectly, any person to obtain health care coverage, any employer to provide health care coverage to its employees, or any health care provider to participate in any health care coverage plan or program."

- ACR120 as introduced and referred to the Assembly Health and Senior Services Committee (DiMaio 2018, 1)

What makes health insurance bills legislatable? The previous chapter demonstrated that the movement of legislation is driven through interactions between a range of actors; in this chapter, I further the analysis to understand the basic conditions of legislatability at play. These conditions are both structural and meaningful, in that bills must both be presented in the correct manner to be even cursorily considered legislatable and reflect certain hegemonic discourses.

After presenting the basic structural features of legislation (a grammar, so to speak), I continue to the more complicated question of discourse by reviewing the stories of five “successful” (that is to say, passed) bills.

These pieces of legislation can be divided into two categories. The first of these situates the New Jersey as responsible for the health of its population, and thereby evokes Foucauldian analyses of the epidemiological state. The second focuses on “healthy firms” and ensures the profitability of health insurance corporations under a neoliberal framework which positions the state in such a way as to support (and not regulate) industry. These two conditions—at least one
of which it seems must be satisfied in order for a bill to be considered legislatable—conflict, beggining a deeper question: which weighs more heavily in the determination of legislatability, fiscal or biological health? I turn to this question in the conclusion.

The Structure of Bills

Very basically, bills in the New Jersey Legislature include six components: (1) an identification of the bill split between three sections; (2) the setting in which the bill was enunciated; (3) a history of the bill split between two sections; (4) the authors of the bill; (5) an enacting clause; and (6) a body of additional clauses.

The first subcomponent of these itself includes three subsections: the body in which the bill was introduced, the relevant category of bill, and the bill’s number. Bills can only emerge in one (“Assembly” or “A,” “Senate” or “S”) house of the Legislature, and not from non-legislative offices such as that of the governor, for example. The only legislature in question, additionally, is the New Jersey State Legislature: bodies “above” or “below” this level cannot introduce bills to, say, the state’s General Assembly, and vice versa. The house in which the bill was introduced is specified by the type of legislation it is; options include “Bill,” “Joint Resolution” or “JR,” “Concurrent Resolution” or “CR,” and “Resolution” or “R.” Each of these specifies a different relationship between the introducing house and (1) the non-introducing house; (2) the Governor’s Office; and (3) other legislative and non-legislative bodies. Finally, ascending lists of numbers accompany the eight potential combinations of house and type, making it possible to have a Senate Bill numbered “1” and an Assembly Joint Resolution numbered “1” at the same time.15 Therefore, the second bill cited at the beginning of this chapter, written ACR120, was

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15 For bills which become laws, the bill can be written as the combination of “Public Law” or “P.L.,” the year, “Chapter” or “c.,” and the chapter number. I will not focus on laws during the remainder of this section, but will instead concentrate on the text of bills regardless of their stage in the legislative process.
introduced in the Assembly, is a Concurrent Resolution, and is the 120th bill of that type to be introduced in the current session.

Synopses further identify bills. One sentence fragment (frequently lacking a subject, which is implied to be the bill itself) suffices as the bill’s synopsis, and describes generally what objects and actions the bill enumerates. ACR120, as an example, “proposes amendment to Constitution to prohibit State or federal law or regulation from compelling a person to obtain, provide, or participate in health care coverage.”

Finally, a description of the bill concludes its identification. Similarly a sentence fragment, the description begins with the bill’s type and concludes with a specific description of what the bill aims to do. From ACR120: “A Concurrent Resolution proposing to amend Article I of the Constitution of the State of New Jersey by adding a new paragraph 24” (emphasis in original).

With the bill identified, legislation must also address the bill’s setting. This is accomplished in two lines, the first of which will consistently say “STATE OF NEW JERSEY” and the second the ordinal number of the current legislative session (as in “218th LEGISLATURE”).

The bill’s history is presented in two sections. First, one line provides the date of introduction, regardless of the current status of the bill (for example, “INTRODUCED FEBRUARY 1, 2018”). A second section under the heading “CURRENT VERSION OF TEXT” indicates the stage of development at which the bill exists. For ACR120, as of the writing of this thesis, that version is still “As introduced.”

The bill must also announce its authors, or sponsors and co-sponsors. For ACR120, this section appears as follows:
Sponsored by:
Assemblyman JOHN DIMAIO
District 23 (Hunterdon, Somerset and Warren)

Co-Sponsored by:
Assemblymen Space, Harold J. Wirths, A.M. Bucco and Assemblywoman Handlin

Several aspects of this text block are noteworthy. First, despite the strict distinction between sponsors and co-sponsors, there is no separation of “first prime sponsors” and “prime sponsors.” Though only one sponsor has signed onto this bill, more could presumably agree to be included. Second, only the districts of the sponsors are included, indicating some greater importance of their roles, as opposed to those of the co-sponsors. This point is additionally supported by the capitalization of Assemblyman John DiMaio’s full name. Finally, the language of legislation very clearly identifies the genders of the authors, as opposed to the increased use of the title “assemblymember” in colloquial use.16

In the printed versions of bills appearing as electronic files accessible at njleg.state.nj.us, an effective clause follows the final identification of the bill described above. For ACR120, the clause reads, “Be It Resolved by the General Assembly of the State of New Jersey (the Senate concurring):” (emphasis in original). This general form, adapted based on the introducing house and bill type, “officially” initiates the active clauses in the bill, moving beyond the introductory identifications.

What follows is the bill’s body, which will vary depending on the legislation’s object and category. Having completed a description of the structure of bills in the Legislature, I continue to an analysis of “successful” healthcare-related bills to approach various conditions of legislatability.

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16 This gendered component is unique to the Assembly: Senators are addressed only as “Senator,” seen to be neutral in today’s lexicon (though etymologically referencing the male members of ancient Rome’s Senatus).
Successful Bills

By “success,” I mean the complete movement of legislation through the legislative process. Drawing on the previous chapter, this success entails the passage of a bill by each house of the Legislature, as well as its signing by the governor. Several bills regulating health insurance in the state have found such success, the stories of five of which are summarized below.

A3380: “New Jersey Health Insurance Market Preservation Act”

A3380, carrying six primary sponsors at the time of its final approval as P.L.2018, c.31, on May 30, 2018, was introduced in February of the same year. Referred to the Assembly Appropriations Committee, the bill mandated that each taxpayer in New Jersey “shall... ensure that the taxpayer, if an applicable individual, and any dependent of the taxpayer who is an applicable individual, is covered under minimum essential coverage,” or else pay a “shared responsibility tax” (McKeon et al. 2018). A3380 essentially mirrors the Patient Protection and Affordable Care Act’s (now-defunct) enforcement of an individual mandate through a monetary penalty at the state level.

In the Assembly Appropriations Committee’s report on the bill, the measure was officially determined to have an “indeterminate impact on State finances” (Assembly Appropriations Committee 2018), with possible new revenues being generated by the new tax. Approved by the committee with several amendments by a vote of 6-3-0 (six votes in the affirmative, three in the negative, zero abstentions), with the committee’s chair voting in favor of the bill, the measure received its second reading on April 5.\(^\text{17}\) It was passed by the Assembly on April 12 with a vote of 50-23-0 (generally following party lines), and immediately sent to and

\(^\text{17}\) Votes on bills are traditionally reported in this affirmative-negative-abstentions format. In the Senate, members are not able to abstain from voting; therefore, the reporting for any Senate votes (not including committee votes) will only appear as affirmative-negative.
passed by the Senate (22-13, again likely by party lines). Governor Murphy signed the bill just over one month later.

The bill itself supplements Title 54A of the state’s Statutes by inserting ten new sections (11-1 through 11-10). It took effect on January 1, 2019.

A4207

Introduced on June 18, 2018, A4207 was sponsored by the time of its approval on July 1, 2018, by Assembly Majority Leader Louis Greenwald and Senate Deputy Majority Leader Paul Sarlo. Now P.L.2018, c.51, the law exacts a reimbursement cap for hospitals on certain usages of emergency services by Medicaid patients:

A hospital… providing emergency services to patients enrolled in the State Medicaid fee-for-service program shall accept as final payment an emergency room triage reimbursement fee of $140.00 when the emergency services provided are for low acuity emergency room encounters. (Greenwald and Sarlo 2018)

Effectively, this bill incentivizes hospitals with emergency departments to (1) diminish their offerings of primary care services and (2) redirect (Medicaid) patients to non-emergency room settings. Besides achieving what may seem outwardly to be a public health habit-forming goal, the bill would decrease to some degree the expenditures of the state, as described by a fiscal analysis released by the Office of Legislative Services (2018a).

Passed out of the Assembly Budget Committee without amendments by a 9-4-0 vote on the same day it was received in the house, A4207 was approved by the Assembly on June 21 through a 45-28-0 vote (reflecting party lines, though at least two Democrats voted against it). Sent to the Senate, it passed by a 29-3 vote (reflecting party lines but also implying that some Republicans voted for it) and was signed by the governor less than a month later, on July 1.

The bill supplements Title 30 of the New Jersey Revised Statutes with two sections: 4D-7p and 4D-7q. It took effect on November 1, 2018.
A4228

A4228 was sponsored by Assemblymembers Carol Murphy, Herb Conaway, and Parker Space (the lone Republican sponsor), and Senator Troy Singleton. Introduced on June 18, 2018, and referred to the Assembly Budget Committee, the bill mandated that the State Health Benefits Commission (serving all public employees except for teachers and others in educational settings) and the School Employees’ Health Benefits Commission (serving educators and others at the state’s public schools) establish audits to identify enrollees and dependents eligible for coverage through Medicare. Those determined to be eligible for Medicare would then be legally obligated to enroll in the federal program as their primary provider, while able to retain secondary coverage through either the State Health Benefits Program (SHBP) or the School Employees’ Health Benefits Program (SEHBP; Murphy et al. 2018). According to the Office of Legislative Services (2018b), the implementation of this bill would both increase annual expenditures through the imposition of the new audits and potentially increase revenue gain in the recoveries resulting from transitions to Medicare as a primary coverage provider.

The bill was unanimously approved by the Assembly Budget Committee with amendments and given a second reading on the same day it was introduced. Three days later, it was unanimously passed by both the Assembly and the Senate. On August 10, Gov. Murphy signed it into law as P.L.2018, c.88. For sharing much of the same history as the previous bill (e.g. dates of introduction and passage, committee reference), and receiving unanimous support from both houses, this difference of over one month between signings is curious. Though I do not have any specific data that could explain this distinction, one could postulate that the context is important. On July 1, 2018, when A4207 was signed, both the legislative and executive branches had finally agreed upon a budget for the next fiscal year after an extended and unexpected dispute (see the previous interlude). A bill which would decrease expenditures, such
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as A4207, may have been a more reasonable measure to approve at the time than a bill which may increase revenue and/or decrease expenditures by some indeterminate amount.

Also contributing to the timeliness of the bills may be the dates at which they were slated to become effective. A4207 was scheduled to take effect “on the first day of the fourth month next following the date of enactment” (Greenwald and Sarlo 2018), whereas A4228 would take effect “immediately” (Murphy et al. 2018), thereby posing a more impending threat of fiscal uncertainty. Ultimately, however, the bill was signed by the governor, amending P.L.2008, c.89, and P.L.2007, c.103.

S105

S105’s history in the current session begins on January 9, 2018, with its referral to the Senate Health, Human Services, and Senior Citizens Committee. With seven primary sponsors and over three times as many co-sponsors (including the Speaker of the Assembly), the bill would expand coverage of family planning services under Medicaid to individuals who

(a) [have] an income that does not exceed the highest income eligibility level for pregnant women established under the State plan under Title XIX or Title XXI of the federal Social Security Act [currently 200 percent of the federal poverty level];
(b) [are] not pregnant; and
(c) [are] eligible to receive family planning services provided under the Medicaid program pursuant to subsection k. of section 6 of P.L.1968, c.413 (C.30:4D-6) and in accordance with 42 U.S.C. s.1396a(ii). (Weinberg et al. 2018)

The ability to legislate such a program at the state level was established by the ACA as amended by the Health Care and Education Reconciliation Act of 2010, and ensures that the federal government would pay ninety percent of the costs for such services, as clarified by a statement from the Assembly Budget Committee (2018). Given this federal matching rate and the narrow population targeted by the bill, the costs of such legislation to the State of New Jersey were estimated by the Office of Legislative Services to be minimal.
This bill was first introduced in 2013 as A4171/S2824, where it was passed by both the Assembly and the Senate but vetoed by the previous Governor Chris Christie (Wagner et al. 2013). It was reintroduced in 2014 and again passed both houses in 2015, but was ultimately vetoed again by Gov. Christie (Pintor Marin et al. 2015). The same story repeated in 2016 (Weinberg et al. 2016). Finally, in 2018, the bill was signed into law by the new and Democratic governor just six days after it passed both houses. After being reported out of the Senate Health, Human Services, and Senior Citizens Committee with a vote of 8-0-1 on January 22, the Senate approved the measure on February 1 by a margin of 35-5. In the Assembly, the Speaker assigned the bill to the Assembly Budget Committee, where it advanced to its second reading on February 12 with an 8-3-0 vote. The Assembly voted in favor of the bill generally along party lines (52-20-8) and sent S105 to the governor’s desk.

After it was signed, the bill took effect in June and amended P.L.1968, c.413.

S1878: “New Jersey Health Insurance Premium Security Act”

The “New Jersey Health Insurance Premium Security Act” was introduced in the Senate on February 15, 2018, and sponsored ultimately by Sens. Joseph Vitale and Troy Singleton, and Assemblyman John McKeon, Assembly Deputy Speaker Pamela Lampitt, and Assemblywoman Carol Murphy. Not universally present in legislation passed in New Jersey, this measure included in its final form a section describing its purpose:

> It is the intent of the Legislature to stabilize or reduce premiums in the individual health insurance market by providing reinsurance payments to health insurance carriers with respect to claims for eligible individuals. The Commissioner of Banking and Insurance, and the board of directors of the New Jersey Individual Health Coverage Program, are authorized to apply for, accept and receive federal funds to implement and sustain market stabilization programs. Preliminary planning, analysis, and implementation to effectuate the purposes of this act shall continue under the direction of the commissioner and the board. (Vitale et al. 2018).

To achieve the goal of lowering individual premiums, this legislation first directs the state’s Department of Banking and Insurance to apply to the United States Secretary of Health and
Human Services for a waiver of certain regulations imposed by the ACA designed to protect policyholders from inappropriate cost sharing mechanisms. If this waiver is granted, the Health Insurance Premium Security Fund created by the same bill will be charged with the task of distributing reinsurance plans to insurance companies to incentivize the lowering of premiums.\(^\text{18}\) This measure carries a one-time increase in administrative expenditures in the application for a waiver from the federal government and potential increases in costs and revenues with the program's operation (Office of Legislative Services 2018c).

The bill was first referred to the Senate Commerce Committee, where it was reported back to the Senate on the same day with amendments after a 3-2-0 vote. The Senate President then referred the measure to the Senate Budget and Appropriations Committee, which approved it with amendments through a 9-4-0 vote on March 5, 2018. After being recommitted to the Commerce Committee, reported back to the Senate after a 3-2-0 vote, referred again to the Budget and Appropriations Committee, and reported from the committee through an 8-4-0 vote, the bill was passed by the Senate on April 12 generally along party lines (24-13). On the same day, the bill was received in the Assembly and passed (46-22-0). On April 30, Gov. Murphy signed it into law as P.L. 2018, c.24.

The new law supplements P.L.1992, c.161, and draws on the federal statutes surrounding the ACA. Upon its signing, the act took immediate effect and the Department of Banking and Insurance was directed to apply for a “State Innovation Waiver.” The application was preliminarily approved on July 13, 2018, and ultimately approved on August 16 (Department of Health and Human Services (Pate 2018).

\(^{18}\) A reinsurance program safeguards insurance companies against financial fluctuations.
Two Conditions of Legislatability

Why were these diverse bills all able to be passed? In order to approach this question, I describe in greater detail two basic conditions of legislatability: (1) the bill must attempt to ensure the healthy state of the population; and (2) the bill must attempt to maximize the profit of insurance firms.

Healthy Population

Of the bills described above, A3380, A4207, and S105 sought to some degree to ensure the population’s health and/or access to healthcare. Many of the other bills under consideration similarly addressed this concern, with many of the proposed interventions aimed at patients with mental or behavioral conditions. Among these, some advocate for improved access to more general treatments such as telepsychiatry (Dancer 2018) and behavioral health services (Coughlin et al. 2018b), while the overwhelming majority mandate that insurance providers cover highly specific treatments for various conditions. In this latter category are several bills which respond to what has been called the “opioid crisis” (for example, see Conaway et al. [2018a]). Sonia Mendoza, Allyssa Stephanie Rivera, and Helena Bjerring Hansen’s recent article discusses the growing depiction of opiate addiction as, ironically to those aware of the government’s role in and the characterizations of the 1980s urban crack epidemic, a problem of “sympathetic… white 20-something suburban youth” (2018, 8); legislation expanding access to treatments for the “new” patients therefore advances this changing racialization of drug abuse to the policy stage.

Legislation also concentrates on the diagnoses of cancers and their treatments, as well as care for rare diseases, diseases of the immune system, diseases of the blood, metabolic diseases, infectious and parasitic diseases, diseases arising during pregnancy, and terminal diseases.
This effort to maintain the health of the population reflects Foucault’s (1978) interpretations of the eighteenth-century European state. Interpreting responses to a smallpox outbreak, Foucault demonstrates the replacement of individuals with a population-as-object described by a “normal” morbidity or mortality,” the health of which ultimately becomes the responsibility of the nation-state (90). Regulation of this public relies on a definition of risk that translates differences in a given population to “zones of higher risk and... zones of less or lower risk,” allowing the state to “identify what is dangerous” (89). Early epidemiological studies took up this notion of risk to identify the patterns by which biomedical diseases spread across populations, ultimately drawing conclusions on the frequently statistical correlations between individuals’ actions and a population’s (potential) state of health, disease, or danger.

One condition of legislatability, therefore, may be that the bill fulfills the goal of regulating the New Jersey population’s state of biomedical health. In order to achieve this goal, legislators have attempted to expand coverages and implement new programs.

Healthy Firms

A4228 and S1878 (described above) were also passed by the Legislature, but do not directly regulate the health of the population. Instead, they directly affect insurance firms by managing the costs of covering care. In the first, several of the state’s insurance programs would save money with the transition of eligible public employees to Medicare while, in the second, reinsurance plans are offered to private firms to encourage the lowering of premiums for consumers.

Premiums join other “cost sharing” mechanisms such as deductibles, copayments (“copays”), and coinsurances in their imposition on individuals, employers, or governments. The required cost sharing amounts to be paid by patients differ largely among plans, as do definitions of “networks” of health care providers. Providers are generally described as being located either
“inside” (in-network) or “outside” (out-of-network) of networks, while some networks (“tiered” networks) acquire a third dimension of quality. Depending on the plan, the range of services covered and costs levied inside, outside, and throughout the network differ. Legislation has engaged deeply with these issues, exploring the potentials for limiting out-of-network costs (Coughlin et al. 2018a; Schaer 2018) and expanding out-of-network service provision (Gove and Rumpf 2018), among other areas.

Through the sale of plans and collecting of cost sharing amounts, insurance companies seek to make a profit. Profitability for such firms describes the state when the price paid by the plan recipient is greater than the total compensation provided. To maximize this profit, insurance companies calculate risk, determining and applying to a population the individual probabilities of certain events occurring, and ultimately using these data to calculate a capital “against whose loss the insurer offers a guarantee” (Ewald 1991, 204). In the terrain of health insurance, the losses of certain states of health (judged to be differences from the population’s normal state) result in the insurer’s returning to the individual or family a financial compensation.

One other criterion for legislatability may then be whether or not the bill protects the profitability of insurance companies. What happens, however, when these two conditions conflict? I turn to this question next.

**Conclusion: Conditions and Conflict**

In this chapter, I have sought to understand the conditions of legislatability for healthcare bills in the New Jersey Legislature. There are both structural and meaningful conditions to consider: bills must align with hegemonic “grammars” and discourses in order to move through the legislative process and ultimately be passed. Two discursive conditions, in particular,
function to maximize the biological health of the population or the fiscal health of insurance firms.

What this analysis has not revealed, however, is the situation in which the satisfying of one of these conditions conflicts with that of the other. It would not be difficult to imagine a bill which seeks to provide coverage universally through a government system (e.g. "Medicare for All") and therefore to bolster the population's health, but which would also diminish the profitability of private firms. A2269 is such a bill, and was introduced for the first time in 2017 and again in the 2018-2019 session. In 2017, it was referred to the Assembly Health and Senior Services Committee, from which it did not advance; as of the submission of this thesis, it has sat in the same committee for over seventeen months in the current session without debate or movement. What would it take for it to advance? I turn to this question in the next chapter.
4 // Battles for Reform

Tradeoffs and Problem-Solutions

"I hope that justice prevails and the healthcare of Americans wins the day, but if overturned, we must fight back legislatively to ensure that healthcare and prescription drugs are affordable. This is a moral issue because healthcare is a right and should not be another sad example of income inequality in our country."

– Statement from Assemblywoman Carol Murphy (2018)

“So I guess that, in a sense, there’s two major battles going on, right? There’s one sort of messaging... and a personal battle between people that are affected on both sides — people who are uninsured and people who are insured — and people wanting health coverage and people wanting affordable health coverage. The other big battle going on is how to bring down the cost of healthcare more generally. So the people who are trying to deal with it from a policy perspective — even people who are progressive that are in the policy space — don’t think we can go to a single-payer system overnight. They think that what we really have to figure out is how to bring down the cost of healthcare. And that’s sort of what the whole thrust of the Affordable Care Act was to do, and other policy ideas along the way: how do we make healthcare less expensive in a way that doesn’t hurt any one particular aspect of the healthcare system?"

– James, Chief of Staff (2018 interview)

The previous chapters have illustrated how the legislative process is inherently interactional: through the encounters between agents, legislation is crafted, evaluated, and potentially advanced, as we can observe in the bills which have found success (see previous chapter for five examples). This progress implies the determination of certain bills as legislatable and ultimately functions to define how healthcare works in the State of New Jersey.

In this chapter, I extend the notion of legislatability to approach the conflicts which arise over what is possibly legislatable. This notion of possibility suggests a sort of mediation between ideas to stretch but ultimately satisfy the hegemonic constraints for what can constitute a healthcare bill. These constraints center on evaluations of accessibility, cost, and scale.

Theoretically, Thomas Kuhn’s (1962, 1974) analyses of scientific history are relevant: just as members of the scientific community practice and disseminate exemplary problem-solutions to establish relationships between experimental observations, concepts, and paradigms, so do
members of the Legislature (e.g. staffers, legislators) engage in the work of negotiating between hegemonic constraints. This comparison suggests that the spaces between paradigms/"values" would be the most contested; it is the efforts to satisfy both demands for increased accessibility and lower cost, for example, which function to test the limits of the current hegemony.

The application of Kuhnian theory also invites an analysis of the source(s) of challenges to the standing hegemony. After presenting the values and tradeoffs through which legislatability is negotiated (as well as demonstrating such an analysis through the case of universal healthcare), I continue to the constituent services “side” of legislative practice and interpret it as a potential site for introducing new problems which may not be able to be solved under the current “paradigm.”

**Negotiating Legislatability: Hegemonic Values and Conflicted Tradeoffs**

This section builds specifically on interviews with staffers working with the Assembly. The discourses revealed during the course of these conversations did not neatly reflect the unified vision of a party working together to pass legislation. Instead, discussions turned to various elements of health insurance legislation and then to the competing value judgments which arose. These values—accessibility, cost, and scale—recombine to limit one another, generating not a single “ideal” for healthcare bills but a complex set of discursive conditions through which staffers and legislators regulate the potential for change.

This line of argumentation stems from Arjun Appadurai’s (2013) analysis of the “spirit” of modern financial markets, building on the theorizations of Max Weber, Jacques Derrida, and Marcel Mauss. This spirit, following Appadurai, emerges from the frontiers of the financial market in the form of actors who “channel uncertainty so as to tame the machinery of risk” (249), or manipulate their chances in the market so as to maximize their profit on the verge of
losing it. We can imagine here the archetypical venture capitalist making high-risk investments in the hopes of seeing high returns. Appadurai uses this example to argue that realms of possibility may be understood as produced not by the majority aiming to “tame chance” but by “those who wish to use chance to animate the otherwise deterministic play of risk” (250). The comparison established here offers a basis for understanding how the possible reform can only become legislatable at the verge of its being impossible. That is, the spirit (or definition) of legislation emerges not only from single value judgments (accessibility, cost, and scale) but from the conflicts between them (e.g. how accessible can health care services be without posing too great a cost to the State of New Jersey?). In the analyses below, I begin by describing the three values previously mentioned and then tradeoffs between access and cost, and between cost and scale.

**Values: Accessibility, Low Costs, Appropriate Scale**

Though this thesis does not examine the issue of messaging in great depth, I begin this section on “values” with a brief analysis of the Public Leadership Institute’s (a progressive think tank) third edition of *Voicing Our Values: A Message Guide for Policymakers and Advocates* (Horn and Totten 2017). This guide, which appeared various times throughout my fieldwork, describes in its second section the narrative of the “radical right” in the wake of Donald Trump’s election to the presidency in 2016:

Social identity divides the world into us and them or the in-group and the out-group. The *us* can be something as unimportant as which football team a person supports. It can be about an individual’s social class or family, college or country…. But people also enhance their self-image by denigrating *them*…. Surely, Donald Trump seems to enjoy himself when he attacks his political opponents. And so do many of his supporters.

In a political debate, there are two possible groups to blame for the troubles of non-college educated Whites [sic]. The truthful and rational explanation is the rich have been and still are squeezing everyone else, making all of us relatively poorer. The phony emotional explanation is it’s the out-group, the non-Whites. Persuadable voters tend to hold both of these beliefs in their heads.
How can we direct them to the truth? (26; emphases in original)

On a section prescribing messaging guidelines on the ACA, the book proceeds as follows:

... persuadable voters do not want to lose their health insurance coverage or any guarantee of coverage, pay more in premiums or deductibles, or see a cut in government funding for their health care programs.

The key to persuasion is to focus on what they will or may lose....

You must personalize the debate. You are welcome to say that millions of Americans will lose health insurance, but don’t reference Medicaid. The fact is, few persuadable voters think their own insurance is actually at stake. But it is! Focus on the aspects of the GOP [Republican] bill that directly or indirectly affect families that get health insurance through an employer. Emphasize over and over that each and every one of their families will likely be harmed if this proposal is enacted....

As we emphasize throughout this book, persuadable voters want to know how the policy affects themselves, their families, and their friends. Tell them! ...

When the conversation turns to the uninsured, avoid language about poverty because it evokes negative ideas about welfare. Use the terms hard-working, families, children, and people with disabilities because these suggest the recipients need and deserve basic medical coverage. And as we have explained elsewhere, it’s more effective to say don’t deny them the security instead of give them the security. (57-58; emphases in original)

Through such guidelines, progressive organizations such as the Public Leadership Institute disseminate recommendations for progressive dialogue in the United States based on party unity and the subject of the “persuadable voter.”

Emerging from this guide is also a set of basic standards for progressivism in terms of healthcare reform: (1) reforms should not decrease or eliminate coverage; (2) reforms should not increase costs to be faced by the individual; and (3) reforms should protect all people, but not be specifically framed as welfare. Through these three points, we can observe the generation of three themes: (1) access to health care; (2) low costs; and (3) large-scale provision of care and insurance (for an analysis of the effort to avoid the idea of “welfare,” see Chapter 1’s genealogy).

The accessibility of health care relates to the regulation of both providers and recipients of care. Joseph, a legislative aide, offered an initial and comprehensive description of this value
as one of the main priorities of reform, answering one of my questions about what he values in health insurance legislation that what is important is

... the amount of people that we’re getting to have access to care. And I repeat that phrase a lot. I think that the most important in health insurance is access to care because you can tell me... “You have the ability to make decisions that work for you.” I certainly have the ability to go to the dealership and get a Lamborghini, but if I don’t have the money, and I don’t know how it works, I’m never going to utilize it.

He continued to describe this view of access as something which is both ensured for the health care recipient and cemented by the recipient’s ability to appropriately utilize services through the notion of literacy:

The other thing is that healthcare literacy, which is a term that I’ve recently become familiar with, is extremely important. And that goes in every level. It’s all the way down to the things I’m putting in my body—the nutritional value—all the way to ‘I’m going to the doctor: what does that mean? What is this doctor going to prescribe me? How do I then go to the pharmacy and get it? What if I can’t speak English? What if I can’t—what if I don’t have a ride to go get to the hospital?’ It’s the healthcare literacy component... and I think that that’s extremely important: for people not only to understand what kind of care they’re getting, but what the outcomes of that care will be, what the costs will be.

The role of healthcare legislation as enunciated by Joseph, therefore, is to support individuals as they navigate a complicated healthcare system, thereby ensuring its accessibility.

Gianna, another district office staffer, echoed Joseph’s claims early in our interview, but later transitioned to a view of access which leaned more toward the regulation of insurers.

Answering a question with William, a chief of staff at the same office, on healthcare as a “right,” she responded:

I think that it is a right personally. I mean, having access to health care should be something that all have. As for health insurance? As much as I’d like to say that I wish it was a right, I feel that it’s more that there’s really an issue with access, accessibility. That was kind of the point of the Affordable Care Act, was to try and give accessibility to all.... But besides that, absolutely, access to [healthcare] should be a right. I don’t necessarily know if I feel that it is treated that way. You know what I mean?

This uncertain contrast between health care and health insurance is telling: while, ultimately, Gianna claims that access to both treatments and insurance should be a right (and therefore
"inalienable," unable to be removed by the state), it is the latter which remains more distant from this objective. William answered similarly and provided the example of charity care support for hospitals, in which the state provides financial support for medical institutions to offer care for certain socioeconomic classes, as an instance of *health care* being treated as a right. As a result, even as the State of New Jersey does not fully support access to insurance—or the current mode of paying for medical care—as a right, it may acknowledge the care itself as a right, consequently mandating through legislation that providers offer it to patients.

Suggested in these quotations is also the second notion of cost. Costs, according to James, are inevitable in the healthcare system, and must be both divided and minimized:

JAMES: So there’s sort of two parts to that, right? One is the division of the cost, but then there’s the other issue of just overall cost. And I think what everyone’s in agreement is we have to find a way to bring down that overall cost as well. So if we find a way to make sure that there isn’t medical inflation going on and the prices of everything aren’t constantly going up, then it’s easier to cut up the pie. So it’s sort of like: first we’ve got to shrink—we usually talk about expanding pies, in this case, it’s how do we first shrink the pie, and then we can figure out how to cut it better.

JD: That makes sense.

JAMES: So I think that some of that policy wonk discussion is how do we bring down that cost of a procedure.... Even being someone who thinks themselves a center-left person, I have to accept the idea that there really is no such thing as a free lunch. So if something’s happening, somebody’s going to pay for it.

“Even” on the left, then, policy must consider its possible economic repercussions. The costs which might be impacted by legislation and are of concern are incurred for one of three subjects: the patients, the providers and insurers, and the state.

That individual patients can be charged for health care should come as no surprise, following the previous chapter’s analysis of neoliberal rationalities in New Jersey legislation. Perhaps also suggested by the messaging guide quoted above, the issue of premiums and other charges directly to the “consumer” occupies a central position in progressive discourses around health insurance. Matthew described his office’s legislative goal as making sure “that we have
lower premiums for our citizens, because that’s incredibly important for people that want to—for people that need to afford health insurance every year” (emphases added). Across our conversation, Matthew frequently reverted to the use of a “we”-subject, a practice repeated by several other interlocutors. This “we,” which also appeared in the second chapter, specifically locates the speaking subject within a sort of collective assemblymember-ship tasked with the obligation of maintaining lower costs for those whom it represents.

Joseph briefly departed from this collective and introduced hypothetical “I”-, “you”-, and “they”-subjects into a description of the need for transparency in prices (emphasized and divided here to illustrate the changes in subject):

I Say if I go to the hospital for a broken leg
THEY and they have to run blood work and all of these other things.
Oftentimes, the places that they send those other tests out to
I are not covered under my insurance plan. So I go in there under the impression, ‘Oh, my insurance is going to take care of all of this.’ When I’m leaving the hospital and my leg is fixed,
THEY they say,
I ‘Hey, Joseph, you owe $800. Would you like to pay that now, or would you like to have a payment plan?’
YOU And you’re like,
THEY ‘What are you talking about? What are all of these things?’
WE And to be honest, we found that insurance companies and the hospitals themselves were not all that clear in disclosing those [hidden costs].

The initial oscillation between the specific “I” and vague “they” transitions briefly to a more general “you” before the “we” introduced earlier presents a legislative solution. The blurred “I”/“you” distinction reflects a further difficulty in distinguishing between the “I” of the individual staffer and the “you” of the constituent, as indicated by the following comment from Sarah: “I don’t think health care should be something you need to pay so much for.”
While fascinating from a formalist perspective, why is this semantic uncertainty relevant to a discussion of costs? At a basic level which takes the "I"/"you" subject for granted, the collective assemblymember-ship signified by the "we" assumes an important role as supplying the legislative antidote to the conflict between "I"/"you" and "they" by ensuring that "I"/"you" is not the recipient of inappropriate or unexpected medical expenses. We can also interpret the "I"/"you"/"we" subject as it is juxtaposed against the "they" to indicate a perceived continuity between the staffer, the constituent, and the collective assemblymember-ship as united against those who impose inappropriate or unexpected costs. In either case, legislation becomes the appropriate mode for limiting the hospital bills of patients. 19

That collectivizing "we" must also maintain the financial stability of insurance companies and medical institutions by limiting their costs, even if this seems contradictory to the previous goal. William described the active "fight between providers and insurance companies [over] who pays the bill when care is administered" in New Jersey as a major force impacting the viability of legislative reforms. Following James, this "fight" is complicated by the sheer diversity of players with needs that are at times not totally unsympathetic:

Healthcare is incredibly complicated.... Perhaps with the exception of insurance companies that are often easier to vilify... most of those other players we don't think of as bad people. People like hospitals. If you lose a hospital, you never get it back. So you have to be uniquely concerned about hospitals. And people like doctors. These are people who went into a helping profession, took on enormous amounts of student loan debt, did incredibly stressful initial placements, worked their way up in the system—people think they deserve a fair living, and that's another piece of this. And obviously the same for nurses, or dentists, or any of these other employees.

Even insurance companies, however, must be supported in order to preserve the health care "marketplace," according to Joseph. After the passage of A3380, which extended the ACA's

19 This analysis owes much to the work of Rihan Yeh in Passing (2017).
individual mandate to New Jersey, it became necessary to pass S1878 to offer reinsurance programs to insurers so that they remain “whole” and able to provide competitive plans.

Legislation also must seek to diminish the potential costs to the state. These, as Miguel told me, are estimated by the Office of Legislative Services (OLS) and follow bills through the committee stage and through the remainder of the legislative process. These fiscal estimates become an important point of debate, described Matthew:

The thing about health insurance is a lot of times it does have fiscal implications. So not only are you debating about the legislation itself, but you’re debating about the fiscal implications of it and how it affects the budget.

Therefore, we can observe the importance of costs to the state, to the medical sector, and to patients in the framing and moving of bills to reform health insurance.

Finally, this section arrives to an analysis of scale, exemplified by an interaction between William and Gianna during our discussion, in which they expressed their fear of the potential repeal of the ACA:

GIANNA: There’s that ongoing fear with the possible repeal of the Affordable Care Act: what will happen to insurance plans then? I have that fear that people will be getting insurance plans that are accident only-type insurance plans and not realizing that preventative care—which is so important—isn’t included in that... If that does occur on a federal level, then we’ll have to try and focus our attentions on that and on the state level—to just try and protect the citizens of New Jersey as best we can....

WILLIAM: I think that the Affordable Care Act—when it was passed, the authors of it contemplated the idea of there being an entire nation of folks who would take it up, and therefore that the entire nation of folks would make it affordable enough so that enough people could get into it and benefit from it. I think because of political reasons we may never see the true potential of it, because it is under attack right now. But at the state level, I think it really does depend largely on what happens at the federal level in terms of how efficiently healthcare is administered as a right, so to speak, based on the size of the risk pool needed to really make it affordable.

GIANNA: I feel like some of our legislation sometimes that we introduce is a reaction to the action on the federal level, you know?

This question of scale or level, then, goes beyond the scope of the legal and into the relational: how should the passage of healthcare legislation within the state react to federal changes, and
how is it limited by this relationship? Further, how do (conservative) national-level reforms modify the duties of (progressive) New Jersey lawmakers to their constituencies? These discussions occupy a central position in the judgment of a given measure’s legislatability.

Having described considerations at three major value-laden poles (access, cost, and scale), I now turn to two conflicts which arise at the tradeoffs between them—that is, the conflicts which arise (1) when the goal of increasing accessibility conflicts with a desire to minimize costs; and (2) when the objective of minimizing costs must be considered in relation to the limits and responsibilities imposed by scalar differences.

Tradeoffs: Access/Cost, Cost/Scale

The previous descriptions of accessibility and costs readily suggest the first of these conflicts. Matthew described in our interview how “we’re working towards” a more comprehensive insurance system, one that acknowledges “that people should not be denied treatment because of their economic situations or their race, or any sort of discrimination.”

Even so, this vision remains a “work in progress

because I wouldn’t say that we have a current healthcare system that guarantees health care for everybody no matter what. And I think that’s kind of an impossible thing to achieve because, if you do that, imagine the costs to taxpayers.... As Democratic legislators that believe in the right to comprehensive health insurance, our goal is to make sure that we have as many in-network providers, as many people covered, as many things covered as possible. (emphases added to highlight repetition)

This repeated modification of goals with “as many” and the “as possible” at the conclusion of the statement illustrates that between access and cost there exists a limit to what feasible legislation can address. Matthew further described how certain patients-beneficiaries can also pose costs to the state and thus, presumably, the taxpayers. He explained A4207’s cap on emergency room reimbursements from Medicaid:

Our policies aim to reduce costs whenever we can.... We’re trying to incentivize primary care and at the same time you have someone that goes in for a low acuity cold or something. They go into an emergency room. They end up paying $600 because an
emergency room, they have to run all these tests on you. It’s very comprehensive because you’re in an emergency room. It’s not the kind of place you would go for something like a low acuity illness, like a cold or a fracture or something. Your costs end up skyrocketing, and for people on Medicaid, that ends up being costs to the state.... We try to incentivize primary care, things like that... we try to make health care and health insurance as comprehensive as possible while again at the same time not overburdening the state’s finances.

This explanation locates the Medicaid recipient as a potential cost to the state and prescribes policy which would minimize that cost, while at the same time working to increase the accessibility of “appropriate” health care services.

James offered a competing explanation of this juncture which did not identify the individual as generating costs, but rather as one whose incurred debts from out-of-network providers should be eased to increase the financial accessibility of medical services. At the same time, he described how the resulting unpaid bills must be redistributed:

In order to make sure that health care is accessible to everyone, we have to make sure that hospitals aren’t getting stuck with a bill they don’t deserve to be stuck with, that providers aren’t getting stuck with a bill, and insurance companies aren’t getting unfairly stuck with it. So there was an agreement that there should be some process there. Towards the end, and this is true of all legislation, the devil gets to be in the details. The biggest sticking point was what sort of arbitration model should we use.

This notion of an “unfair” cost distribution reflects Matthew’s concerns with the potential for programs to overburden the state, but also implies that some “fair” distribution exists in which each actor contributes what they ought to. Determining how to define fairness, then, becomes an important and conflict-ridden feature of the legislative process. At the boundaries between cost- and access-based values, therefore, a larger and context-specific debate over equitable distributions of costs which still improve (or at least not diminish) the healthcare system’s accessibility emerges.

Debts more than just represent challenges to accessibility, however: they may also be balanced against the scale of the intervention. This point of contact was raised in only one
conversation, in which James explained the use of state monies to support residents’ enrollment in the insurance exchanges established by the ACA:

... of course anything that can provide state dollars to make sure people know about the existence of the Affordable Care Act exchange is the big piece. And there’s some bills in there that do that. Because if people are able to find some form of insurance, that’s going to be helpful, because when more people are in the insurance market, the price of insurance stays down. And also to the individual, it’s less likely you’re going to get hit with major medical bills.

This brief quotation invokes a diversity of levels (from the individual to the national), actors (from the patient to the insurance company), costs (from insurance payments to program promotion), and possibilities (from low to high enrollment). To represent the potential realities suggested here would require a multi-dimensional analysis in which each variable is allowed to vary. What we can conclude, though, is that the costs to be incurred by the State of New Jersey from promoting enrollment in the ACA marketplaces may be justified by the possible relationships between actors at the national and individual level with costs: New Jersey patients would likely see their medical costs decrease, while non-New Jersey insurance companies and agencies would likely be faced with the costs of providing and regulating insurance.

Extrapolating from this specific instance, then, we might surmise that a further area of contestation in the legislative process is determining how costs will be allotted to or relieved from actors at different regulatory levels.

These two tradeoffs represent the potentially contested intersections between otherwise noncontroversial values. In the next section, I take up the issue of universal healthcare and analyze it under the above paradigm.

**Case Study: Universal Healthcare**

Discussions over initiatives which would establish a system of “Medicare for All,” a “single payer” system, or other variations of universal healthcare reflected the same values and
conflicts as those described above. This suggests that, at the level of the legislative backstage, there is in fact no significant difference between the interpretation of such bills and the interpretation of others relating to health insurance. I describe this case, as a result, to highlight the potential for contestation over a concept which may be seen as unrealistic.

Gianna described universal healthcare as a concept which could improve access to a higher “standard of care” for patients:

I have done some research on this... just comparing universal healthcare in Europe to healthcare here, and there’s always the argument that you don’t get the proper level of care, you’re not treating in a proper amount of time, or you’ll wait months for surgery on a broken leg, or something like that. From what I’ve learned through research, that’s not necessarily the case, but I feel that that is believed by a lot, by many people, that that would happen. I don’t necessarily feel that it would. But I also do feel that if we did do that, it would create a standard of care, and I think we need to establish that, you know?

James similarly reflected the potential impacts of legislation which would establish a universal healthcare system in our discussion, claiming that it could “allow employees more mobility” in choosing employers regardless of whether they offer comprehensive health benefits.

Following this claim, James argued that the passage of such a measure, while beneficial for constituents in the “long-term,” would generate immediate consequences:

All those things I’ve described would take probably ten or twenty years to flatten out, at best. And then one of the issues related to democracy generally—and Winston Churchill always said democracy’s the worst form of government except for all the others—is that people have to own the consequences of their votes. And they own them in the short-term. The issue is in the short-term that would feel like a large tax increase without any of the benefits really coming immediately. So perhaps the path forward, then, is finding ways to increase that pull gradually.

This comment strikes at the heart of a conflict between a will to increase accessibility and decrease costs. Beyond the perhaps more recognizable sentiment that universal healthcare reforms are “Bernie Sanders initiatives” which would never be pursued due to their costs, as Miguel explained to me, this statement implies that what remains a point of conflict is not just a potential for increasing costs to the state. Instead, there exists concern over a possible and
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temporary tradeoff between increased accessibility to employment and medical services and increased costs to constituents. What may be preventing such legislation from moving forward, reminiscent of the previous analysis, are the conflicts which arise in valuing both lower costs and greater access.

Conflicts also arise between the concepts of cost and scale. Joseph claimed that “at the state level, [a public option or other similar reform] is just entirely too cost-intensive.” Similarly, James offered a depiction of a state of having “over-spent ourselves” in New Jersey, implying that what might regulate the legislatability of these reforms is a discussion over what is economically feasible for a state to enact as opposed to that which is economically feasible for the federal government. Sarah reflected this conflict in arguing that it is Congress, and not the New Jersey Legislature, which must draft and pass legislation for a universal system.

Following this analysis I argue that it is not the case that a universal healthcare system is impossible or somehow distinct from other healthcare reforms in New Jersey, but is instead caught between the same tradeoffs. While many of the staffers interviewed were in favor of some form of universal provision of care, the possibility of such legislation being passed is presented as contingent on its ability to simultaneously appease values which easily come into conflict.

What this analysis has not incorporated so far are the specific methods through which those evaluations are made. Various interlocutors claimed to have completed “research” or encountered “studies,” and I, as an intern during the research period, was tasked with compiling briefs on a range of issues utilizing diverse academic, journalistic, and legal sources. These “internal” documents, however, represent only a fraction of the sources received and possibly considered. As presented in the second chapter, different stakeholders exercise varying forms of
control over the legislative process by lobbying legislators and their staff to draft, amend, support, or oppose bills. Beyond the notorious lobbyists and the reach of the party leadership, which maintain to varying degrees an aura of inaccessibility to the public, the constituent services “side” of the district office offers an underappreciated point of entry for residents to influence the development of policy. Before concluding this chapter, I hope to highlight the potential of this specific locality for shaping, specifically, healthcare policy.

**Constituent Services**

An allowance is provided to each legislator for the hiring of staff to operate a district office and assist the legislator in constituent and policy work. (Office of Legislative Services 2018d, 50)

I have argued so far from the “policy side” of the legislative process. Now, I will transition to the constituent services side in order to understand how, even at this theoretically greater remove from policymaking, there is still the possibility for stakeholders to influence the legislative process.

This final analysis does not reflect the explicit characterizations of my interlocutors, though would not likely invoke any opposition. As the quotation above indicates (as does my argument up to this point), there could be a tendency to view constituent services as distinct from “policy work.” Staffers’ titles support this hypothesis: it would be strange to see a “policy and constituent services director,” whereas the presence of both a “legislative aide” and a “constituent services director” in a single office or district would be reasonable. Throughout my fieldwork and interviews, this difference was reinforced; it was not until I had deeply analyzed my transcriptions, in fact, that I recognized my own unexamined assumptions about a policy/constituency divide and the consequent scarcity of mentions of movement between the two.
In a way, this should have been obvious, as it is not unheard of for all staffers in a smaller district office (with, for example, one legislator and three staff members) to interact with constituents and develop solutions to any problems which arise. Still, the discursive separation between the two proved strong and resulted in my perception of one (policy work) being somehow closer to the legislative process.

I came across one exchange, however, which defies this simplistic vision. I had asked William and Gianna to describe how they, from a constituent services perspective, engage different departments, agencies, and organizations, and received this response:

WILLIAM: Yeah, and so Gianna might have a couple of things to add to this, but I would say generally that oftentimes when we speak to some of the constituents out there, they’re not fully aware of what kind of services might be available to them and their children. And so I think that we do provide a great service in helping folks navigate, understand the different nuances in government, whether it be a department or an agency, a non-government organization that could possibly help out, a federally-qualified health center. There’s a lot out there, but I think that we are more than equipped to kind of help folks understand the way it works.

GIANNA: And I feel like we have definitely been introduced to many different organizations that I didn’t know before I was here that can help fill the gaps. And we also refer some of our constituents to those organizations. So those organizations might have a focus for seniors, for people with disabilities, or just in general any constituents. And where maybe insurance or Medicare or Medicaid may fall short, sometimes those nonprofits can kick in and help assist with the care for that constituent.

Through this example, we see the transformation of constituent services from an entity in which the staffer in situ of the legislator offers a service to the constituent to, ultimately, a place in which relationships with other organizations are wrangled to address “gaps” identified by constituents. Joseph described a similar process through our interview, with the commentary on gaps even extending so far as to inspire legislation.

Within the framework of constituent services, consequently, there exists a potential for constituents to impact the legislative process beyond the more traditional modes of writing letters or calling offices. This suggests that encounters even on this level, which seems outwardly
distant from policy work, can affect legislative maneuvering. I include this example to challenge the frequent division of district offices between the “political” and “apolitical” sides, as well as to indicate even further the mutability of healthcare reform. Put differently, it may be that interactions through constituent services have the ability to challenge hegemonic understandings of the limits of reform.

Conclusion: Agonism and Legislatability

What does this chapter suggest? In peril of favoring either a completely constructionist view which purports that healthcare reform is *completely* mutable by constituents or a completely structuralist perspective which defines the values of cost, access, and scale as *completely immutable* structures, I argue that change in New Jersey rests squarely in the domain of the possible. This argument positions healthcare legislation as something which is discursively co-created by a range of actors. These actors include legislators, as well as staffers and constituents. Through contestation—not unity—they define the limits of a field of possible reforms.

Through such an analysis of the loci of statement situated within the district office, I have demonstrated how a bill’s legislatability is determined in a mode similar to a Kuhnian problem-solution: what are the tradeoffs which must be made in order to adequately solve a given dilemma under the current paradigm? Contestations occur between shared paradigmatic values (increasing accessibility, lowering cost, recognizing scale). Universal healthcare, which may be represented as outside the realm of possibility in state and national contexts within the United States, is in actuality evaluated along these same values and may, in theory, advance either if it could offer a satisfactory solution to conflicts over its potential immediate, access-diminishing
costs and its relationship to understandings of state versus federal governance and cost bearing or if the constraints on legislatability change.
5 / Conclusion

Legislatable Healthcare: Discourse and Power

My discourse, “far from determining the locus in which it speaks, is avoiding the ground on which it could find support. It is a discourse about discourses: but it is not trying to find in them a hidden law, a concealed origin that it only remains to free; nor is it trying to establish by itself, taking itself as a starting-point, the general theory of which they would be the concrete models. It is trying to deploy a dispersion that is not related to absolute axes of reference; it is trying to operate a decentring [sic] that leaves no privilege to any centre... its task is to make differences: to constitute them as objects, to analyse them, and to define their concept.”

– Michel Foucault (2010, 205)

“It is only when the open, unsutured character of the social is fully accepted, when the essentialism of the totality and of the elements is rejected, that... ‘hegemony’ can come to constitute a fundamental tool for political analysis on the Left. These conditions arise originally in the field of what we have termed the ‘democratic revolution,’ but they are only maximized in all their deconstructive effects in the project for a radical democracy[, in the] affirmation of a ‘ground’ which lives only by negating its fundamental character; of an ‘order’ which exists only as a partial limiting of disorder; of a ‘meaning’ which is constructed only as excess and paradox in the face of meaninglessness—in other words, the field of the political as the space for a game which is never ‘zero-sum,’ because the rules and the players are never fully explicit. This game, which eludes the concept, does at least have a name: hegemony.”

– Ernesto Laclau and Chantal Mouffe (2014, 176-177)

Healthcare in the United States is notoriously complicated. Participants (or patients, or consumers) must embark on a quixotic journey not only in search of some frequently biomedical cure, but also in pursuit of financial assistance. This journey is highly individualized, with configurations of patient, plan, provider, and physician always potentially rearranging. Films such as John Q highlight such intersections as those between employment and coverage, leaving the viewer with a powerful and conflicting sense of the blasé in the unthinkable ironies generated between sickness and health, life and death. Our healthcare system, at the level of everyday experience, provokes fatal absurdities in which the reception of care is both regulated and haunted by the patient’s ability to pay.
In this thesis, I have focused primarily on health insurance as a legislative object in an attempt to approach a single question: how is it that some measures to reform such a complicated system move forward and others not? Through the frameworks of discourse, hegemony, and agonism, I sought to identify the generation of a concept of legislatability which sought to describe the ultimate potential for bills to become laws within the particular context of health insurance-related legislation introduced to the New Jersey General Assembly in its 2018-2019 session. Building on legal, medical, and political anthropologies, this framing permitted the unification of distinct focuses.

First, how does the legislative process work? The legislative process operates through encounters at its various stages (e.g. committee reference, second reading) to evaluate bills’ potential legislatabilities. Those which have been more favorably regarded by a range of governmental and non-governmental actors progress quickly through the process and are ultimately voted on. It is the figure of the staffer who ultimately drives forward this process, though the presence and impacts of other stakeholders in New Jersey (specifically health insurance corporations and their lobbyists) are powerful.

Second, what is legislatable? This question draws on a reading of bills passed by the Assembly. Through the presentation of five individual cases from the current session, I approach several basic conditions of enunciability which address the basic health of the state’s population and the maximization of insurance industry profit.

The third line of investigation interrogates the tradeoffs which occur in the discussions around legislatability. Within the place of the district office, in addition to other sites, the evaluations of discursive conditions generate contestations. Several conditions at play are accessibility, low costs, and appropriate scale, with conflicts tending to arise between access and
cost, and cost and scale. Beyond these legislative maneuverings, encounters through the constituent services “side” prove to be productive in advancing new understandings and forms of reform, and potentially even disrupting hegemonic constraints to what can be considered legislatable.

This leads us back to the issue of concluding. In one sense, the question at the heart of this thesis may be answered as follows: through encounters occurring between staffers and constituents, a diversity of legislative reforms to the healthcare system is produced, evaluated, and advanced in such a way as to balance competing values. What this conclusion avoids is a practical interpretation of the collected data. Can these observations be useful? How, and for whom? I turn to these final points now.

First, we must confront a question raised in Chapter 1 and throughout this thesis. How, from a rational perspective, could any government pass legislation which simultaneously protects structurally vulnerable constituencies, decreases costs for everyone, and supports the entire business sector, while also improving the quality of care? In the midst of such complexity, it seems impractical to expect any radical left-wing reform.

And yet, this impracticality is a new invention, as the interlude between Chapters 2 and 3 indicated. Forms of universal health insurance were considered possible, if not probable, in recent history, and could presumably be possible today. This leaves us with complexity, a theme anything but discounted. Even so, the penultimate chapter revealed that the opacity of negotiations over reform in essence can be framed as the conflicts between three values, meaning that complexity cannot be an adequate argument for prohibiting reform. The final and most basic point, that legislation will not satisfy every stakeholder, is almost too obvious to consider.
This argument, however, is more prevalent and insidious than is readily apparent. The notion of a diversity of stakeholders occupies every component of this thesis, from the movements of bills through the legislative process, to the entities subjected to the Legislature’s authority, to the companies whose additional costs must be minimized. What we are left with, then, is a deeper question of how much power different stakeholders have over regulating the legislatabilities of healthcare reforms. I propose that this repeated discursive situation of corporate and similar nonhuman stakeholders within the legislative process merits further analysis and engagement on academic, legal, and activist levels. My research was necessarily limited by its duration, my training, and my access to the field: future projects should build on the notion of legislatability to interrogate the specific manners through which such actors infiltrate and are secured within different sites at different governmental scales (e.g. local, state, national). Such investigations could fuel legislative and/or judicial, as well as more popular, calls to action.

That there exist such powerful and frankly terrifying stakeholders (think, corporate lobbyists), however, should not be taken to deny the active presence of human beings.

Constituents do influence the reform of the healthcare system, as indicated in the previous chapter, even if not always directly from the policy side. Further ethnographic research which dissects to a greater degree this relationship between constituents, staffers, and legislation is necessary to disrupt the traditional policy/service distinction.

At some level, then, the impossibility of reform suggests a malformed question: instead of bemoaning matters of “why not,” this thesis would suggest, there is greater potential in asking “how.” Still, though, it would be unethical for me to inflate this argument so much as to assume some universality: the “how” of legislating health insurance is certainly not constant across all
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contexts. From a particular standpoint, healthcare is legislated in a way which explicitly considers values, and not votes, even if concerns over the latter influence the definitions of the former. This perspective mandates a more plural accounting of healthcare that does not cynically limit the motivations of politicians to votes and not values, a version which ethnographies are particularly well-suited for providing.

Beyond being academically engaging, these questions of framing and plurality can carry incredible importance “on the ground.” It is, ultimately, the human being who will vote, require medical treatment, and find ways to pay (or not). Efforts to both understand these processes from diverse disciplinary positions and engage politically with these new understandings should not be neglected. Health insurance, to quote Amy Dao and Jessica Mulligan (2016), is a “contradictory social institution” which “accentuates but does not resolve tensions between granting universal access to care and rationing limited resources, between social solidarity and individual responsibility, and between private markets and public goods” (12-13). It is for this reason that it, in its multiplicity and its power over health and illness, must be deeply interrogated.

My thesis only just approaches these contradictions, offering a limited exploration of a segment of one context through which healthcare arises (the New Jersey General Assembly) and, in not being sufficiently deep or comparative, can on its merits stand only as a single and limited interpretation. Through its connections to and extensions of previous research, however, I hope that it can also stand as a suggestion for future recombinations of the legal, medical, and political worlds. Further investigations should seek to combine methods from various disciplines within and outside of anthropology (e.g. political science, law, history) in order to approach the overlaps between the legislative process and healthcare systems over a range of contexts. A comparative
approach taken to health insurance as it is experienced in legislative, (bio-)medical, and publicized places would also generate useful critiques and understandings.

Finally, in way of concluding, I would like to offer a hypothetical extension of these conclusions to a national perspective. It would be a welcome miracle if this thesis was disproved the day after its submission with the passage of “Medicare for All” in New Jersey or at a national level following intense debate between Democrats. Even as such conversations occur in Congress, however, I would suggest a heightened attention to instances of consensus and conflict: when do Democrats (or Republicans) universally agree, and when are factions formed? These points of agreement (perhaps around values of accessibility, low costs, and appropriate scale) may indicate a hegemonic condition to what reforms are possible, and not necessarily a universally accepted view of what reforms are best; that is, contestations may still be occurring over the paradigm’s problem-solutions, but away from the eye of a national public. Rather than solely lauding public consensus or dissent, then, it may be wise to look harder for non-publicized encounters, and even engage in them. It is there, and not necessarily in the publicized front, where legislative change can be made: even a Gramscian “[molecular] transition” of ideas may result eventually in a revolutionary disruption of the hegemonic “paradigm” for legislatability.
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